NHS Lothian Board

Wed 22 June 2022, 10:30 - 13:00

MS Teams

Agenda

10:30 - 10:35
5 min

1. Welcome

Verbal *John Connaghan*

10:35 - 10:37
2 min

2. Apologies for Absence

Verbal *John Connaghan*

10:37 - 10:40
3 min

3. Declaration of Interests

Verbal *John Connaghan*

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

10:40 - 10:45
5 min

4. Items proposed for Approval or Noting without further discussion

Decision *John Connaghan*

4.1. Minutes of Previous Board Meeting held on 06 April 2022

For Approval *John Connaghan*

06-04-22 Public Board Minutes (draft to meeting).pdf (18 pages)

4.2. Audit & Risk Committee Minutes - 21 February 2022

For Noting *Martin Connor*

ARC 21-02-2022 Minutes.pdf (8 pages)

4.3. Finance & Resources Committee Minutes - 17 January, 21 March and 20 April 2022

For Noting *Angus McCann*

F&R 17-01-22 Minutes.pdf (6 pages)
F&R 21-03-22 Minutes.pdf (3 pages)
F&R 20-04-22 Minutes.pdf (7 pages)

4.4. Healthcare Governance Committee Minutes - 22 March 2022

For Noting *Fiona Ireland*

HGC 22-03-22 Minutes.pdf (6 pages)

4.5. Staff Governance Committee Minutes - 02 March 2022

For Noting *Bill McQueen*

Staff Governance Committee Minutes - 02 March 2022.pdf (10 pages)

4.6. Edinburgh Integration Joint Board Minutes - 22 March 2022

For Noting *Angus McCann*

Edinburgh IJB Minute 22.03.22.pdf (3 pages)

4.7. West Lothian Integration Joint Board Minutes - 17 March 2022

For Noting *Bill McQueen*

IJB Minute 2022-03-17.pdf (7 pages)

4.8. Midlothian Integration Joint Board Minutes - 10 February and 17 March 2022

For Noting *Carolyn Hirst*

Midlothian IJB Minutes - 10 February 2022.pdf (11 pages)
Midlothian IJB Minutes - 17 March 2022.pdf (8 pages)

4.9. East Lothian Integration Joint Board Minutes - 24 March 2022

For Noting *Peter Murray*

East Lothian IJB Minutes - 24 March 2022.pdf (5 pages)

4.10. Appointment of Members to Committees & Integration Joint Boards

For Approval *John Connaghan*

22 June 2022 - Board appointments report (final 150622).pdf (3 pages)

Items for Discussion

10:45 - 10:50
5 min

5. Board Chair's Report - June 2022

Verbal *John Connaghan*

10:50 - 11:05
15 min

6. Board Executive Team Report - June 2022

Discussion *Calum Campbell*

BET Report 22 June 2022final_updated (2).pdf (19 pages)

11:05 - 11:10
5 min

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

Verbal *John Connaghan*

11:10 - 11:35
25 min

8. NHS Lothian Board Performance Paper

Discussion *Jim Crombie*

- Board Paper Performance June 2022 final2.pdf (4 pages)
- Board Paper Performance Appendix 1 June22 Final2.pdf (53 pages)

11:35 - 11:50
15 min

9. Scheduled Care Inpatient and Daycase Treatment Time Guarantee Options Appraisal

Discussion *Jacquie Campbell*

- Board Paper - Options Appraisal - Jun 22 - Final_Submitted.pdf (5 pages)

11:50 - 12:00
10 min

Break

12:00 - 12:10
10 min

10. Lothian Strategic Development Framework

Discussion *Colin Briggs*

The Full LSDF Engagement Report Appendices are available within the Admincontrol meeting folder.

- LSDF Board paper June 22 (1).pdf (4 pages)
- LSDF June Board paper appendix 1 Engagement Report June 2022.pdf (28 pages)
- LSDF Board June 22 appendix 2.pdf (1 pages)

12:10 - 12:20
10 min

11. IJB Schemes of Establishment

Discussion *Colin Briggs*

- 22 June 2022 NHSL Board - Review of the Integration Schemes.pdf (4 pages)
- Appendix 2 - EdinburghIntegScheme (Final draft).pdf (63 pages)
- Appendix 1 - East Lothian Revised IJB scheme - Final Draft post cons.pdf (68 pages)
- Appendix 3 - Midlothian IJB Integration Scheme FINAL DRAFT.pdf (67 pages)
- Appendix 4 - West Lothian Integration Scheme Revision 2022 - Final draft.pdf (44 pages)

12:20 - 12:30
10 min

12. Edinburgh Local Outcomes Improvement Plan Update

Discussion *Dona Milne*

- 2022 06 22 BOARD Paper - LOIP.pdf (32 pages)

12:30 - 12:40
10 min

13. 2021/2022 Financial Position

Discussion *Craig Marriott*

- NHS Lothian Finance Report 1-page cover Board 22 June 22.pdf (2 pages)
- NHS Lothian 2122 finance report - Board 22 June 2022 - M13 DRAFT.pdf (7 pages)

12:40 - 12:45
5 min

14. National Whistleblowing Standards - Annual Performance Report

Discussion *Janis Butler*

- National Whistleblowing Standards 1-page cover - June 2022.pdf (1 pages)
- 220622 NHSL Whistleblowing Performance Cover Report Final (002).pdf (2 pages)
- 21_22 Annual Whistleblowing Performance Report 060622.pdf (14 pages)

12:45 - 12:50
5 min

15. Corporate Risk Register

Discussion *Tracey Gillies*

- Board Corporate Risk Register Paper 22 June 2022 - Cover Page.pdf (1 pages)
- Board Corporate Risk Register Paper 22 June 2022 Final.pdf (27 pages)

12:50 - 12:55
5 min

16. Any Other Business

Verbal *John Connaghan*

12:55 - 12:58
3 min

17. Reflections on the Meeting

Verbal *John Connaghan*

12:58 - 12:59
1 min

18. Future Board Meeting Dates

For Noting *John Connaghan*

2022
03 August 2022
05 October 2022
07 December 2022

12:59 - 13:00
1 min

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

Decision *John Connaghan*

LOTHIAN NHS BOARD

Minutes of the meeting of Lothian NHS Board held at 9.30am on Wednesday 06 April 2022 using Microsoft Teams.

Present:

Non-Executive Board Members: Mr J. Connaghan (Chair); Mr P. Murray (Vice-Chair); Prof. S. Chandran; Mr M. Connor; Dr P. Donald; Mr J. Encombe; Cllr G. Gordon; Ms C. Hirst; Ms K. Kasper; Mr A. McCann; Cllr J. McGinty; Mr W. McQueen; Cllr D. Milligan; Ms T A Miller; Miss F. Ireland; Cllr S. Akhtar; Ms E. Gordon; Ms N. Akta; Mr P. Allenby and Mr P. Knight.

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

In Attendance: Mrs J. Butler (Director of HR & OD); Mrs J. Campbell (Chief Officer, Acute Services); Mr P. Lock (Director of Improvement); Dr J. Long (Director of Primary Care); Mrs J. Mackay (Director of Communications & Public Engagement); Ms T. McKigen (REAS Services Director); Mr C. Briggs (Director of Strategic Planning from 11am); Ms J. Ferguson (Foundation Director); Ms M. Campbell (Director of Estates and Facilities) Ms A. Macdonald (Chief Officer, East Lothian HSCP); Ms M. Barrow (Chief Officer, Midlothian HSCP); Ms A. White (Chief Officer, West Lothian HSCP); Ms W. Macmillan (Business Manager, Deputy Chief Executive Office) (Item 7); Ms J. Bennett (Associate Director for Quality Improvement & Safety)(Item 12); and Mr C. Graham (Secretariat Manager).

Apologies for absence: Dr R. Williams; Mr J. Crombie and Ms V. de Souza.

1. Declaration of Financial and Non-Financial Interest

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

2. Chair's Introductory Comments

2.1 The Chair welcomed Ms Gordon, Ms Akta, Mr Knight, Mr Allenby, and Ms de Souza to their first Board meeting as members having started on 1st April 2022. The Chair also reported that Mr Andrew Fleming had been appointed and would join the Board next week on 11th April.

2.2 The Chair highlighted that this may be the final Board meeting for Council Stakeholder Members ahead of the upcoming elections. The Board noted that Cllr Gordon would be standing down from City of Edinburgh Council but would re-join the Board as a Non-Executive Lay Member on 16th May.

2.3 The Chair also mentioned that this was Ms McAuley's first Board meeting as Interim Director of Nursing and that this would be Mr Lock's final Board meeting as he had now returned to his previous role with Deloitte's.

2.4 The Chair thanked Mr Lock for his role in helping NHS Lothian address the matters that the Board were on escalation for, being a key member of the Performance Oversight Board since its creation, his leadership role directly managing Dermatology and Oral Health Services performance and his work on ensuring effective oversight and management of the Board's vaccination programme.

2.5 Susan Goldsmith - valedictory comments

2.5.1 The Chair reported that this would be Mrs Goldsmith final Board meeting as she retires from NHS Lothian having worked in the NHS for the past 40 years.

2.5.2 Mrs Goldsmith started her journey in the NHS as a national financial trainee in England and subsequently worked in several healthcare systems across Scotland.

2.5.3 Mrs Goldsmith's relationship with NHS Lothian had spanned several reorganisations and structural changes, and she had performed the role of Director of Finance at the Sick Children's Hospital, Western General Hospital, St John's Hospital, Royal Infirmary Edinburgh and latterly as the Director of Finance of Lothian Health Board.

2.5.4 The Chair added that Mrs Goldsmith had a proud record of delivery against financial targets set against the backdrop of the fastest growing population in Scotland. Her focus throughout had stretched beyond the boundaries of finance and her knowledge and understanding of the service had been invaluable in redesigning services to meet the needs of the population of Lothian. Her leadership of the capital programme leaves a rich legacy of modernisation of the Primary Care estate and significant investment on the Royal Edinburgh Hospital site together with the world leading new build Royal Hospital for Children and Young People and DCN.

2.5.5 The Board Members passed on their thanks to Mrs Goldsmith for her support and direction and wished her all the best for her future in her retirement.

Items for Approval

3. 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 Board noted that no such requests had been made.

3.1 Minutes of Previous Board Meeting held on 09 February 2022 – Minutes were approved.

3.2 Healthcare Governance Committee Minutes – 25 January 2022 – Minutes were noted.

3.3 Audit and Risk Committee Minutes – 22 November 2021 – Minutes were noted.

3.4 Staff Governance Committee Minutes – 15 December 2021 – Minutes were noted.

3.5 West Lothian Integration Joint Board Minutes – 13 January 2022 – Minutes were noted.

3.6 Midlothian Integration Joint Board Minutes – 09 December 2021 – Minutes were noted.

3.7 Edinburgh Integration Joint Board Minutes – 07 December 2021 & 08 February 2022 – Minutes were noted.

3.8 East Lothian Integration Joint Board Minutes – 24 February 2022 – Minutes were noted.

3.9 Appointment of Members to Committees – The Board:

- Agreed that Mr. Peter Murray will stand down from the Audit & Risk Committee on 30 June 2022.
- Appointed Mr. Peter Murray to the Healthcare Governance Committee with effect from 1 July 2022.
- Re-nominated Mr. Peter Murray as a voting member of the City of Edinburgh IJB for the period from 27 June 2022 to 31 January 2024.
- Appointed Mr. Philip Allenby to the Finance & Resources Committee and the Audit & Risk Committee with effect from 6 April 2022.
- Nominated Ms. Val De Souza and Ms. Elizabeth Gordon as voting members of East Lothian IJB for the period from 1 August 2022 to 31 March 2025.
- Nominated Ms. Val De Souza as a voting member of Midlothian IJB for the period from 1 August 2022 to 31 March 2025, and as the lead NHS voting member from 1 September 2022.
- Appointed Mr. George Gordon to the Finance & Resources Committee with effect from 16 May 2022.
- Appointed Mr. George Gordon to the Pharmacy Practices Committee with effect from 16 May 2022.
- Nominated Mr. George Gordon as a voting member of West Lothian IJB for the period from 1 August 2022 to 15 May 2025.
- Appointed Mr. Peter Knight to the Healthcare Governance Committee with effect from 6 April 2022.
- Nominated Mr. Peter Knight as a voting member of City of Edinburgh IJB for the period from 1 May 2022 to 31 March 2025.
- Appointed Ms. Nadin Akta to the Staff Governance Committee with effect from 6 April 2022.
- Appointed Ms. Nadin Akta to the Remuneration Committee with effect from 6 April 2022.
- Nominated Ms. Nadin Akta as a voting member of Midlothian IJB for the

period from 1 September 2022 to 31 March 2025.

- Appointed Mr. Andrew Fleming to the Finance & Resources Committee and the Healthcare Governance Committee with effect from 11 April 2022.
- Appointed Ms. Elizabeth Gordon to the Pharmacy Practices Committee with effect from 6 April 2022.
- Nominated Ms. Elizabeth Gordon as a voting member of City of Edinburgh IJB for the period from 1 August 2022 to 31 March 2025.
- Nominated Mr. George Gordon as a voting member of City of Edinburgh IJB for the period from 1 June 2022 to 15 May 2025

3.10 National Whistleblowing Standards - Quarter 3 Performance Report – the report was noted.

Items for Discussion

4. Board Chair's Report – March 2022

4.1 The Chair reported on a recent Royal Infirmary of Edinburgh Accident and Emergency visit by the Mr JP Marks, Permanent Secretary to the Scottish Government and Ms Caroline Lamb, Chief Executive of NHS Scotland and Director-General Health and Social Care. The visit to this key operational unit had been to get an understanding of the pressures the system was facing, and efforts being made by staff. There had been a series of presentations from staff on respiratory medicine, workforce, and nursing.

5. Board Executive Team Report – March 2022

5.1 The Board noted the Board Executive Team report. The Chief Executive confirmed that Mr Craig Marriott had been appointed as Director of Finance to replace Mrs Goldsmith following her retiral and that Mr Alan Payne, Head of Corporate Governance had been seconded to the Scottish Government and that his post had now been recruited to with a new Board Secretary appointed.

5.2 There was discussion on the following topics:

5.2.1 **NHS Tayside – Oncology Workforce** - Miss Gillies reported that there had been a significant amount of work by tertiary boards across Scotland to consider how best to support NHS Tayside with oncology workforce challenges. It was acknowledged that helping NHS Tayside would impact on some of NHS Lothian's patient pathways and this was being worked through at a detailed level with Scottish Government colleagues to minimise detriment to other cancer service providing boards as well as NHS Tayside.

5.2.2 **National Treatment Centre** - Mr McQueen asked for an update on work to advance the development of the National Treatment Centre at St John's Hospital and the start and completion dates for the build. The Chief Executive explained that the timeline remained as previously reported however there is an emerging risk in that in the process of taking the Initial Agreement (IA) to the Scottish Government Capital Investment Group for the Cancer Centre we were planning that this would go in May 2022. However, NHS Assure had

now indicated that they require 3 months to review the IA. This delay was counter to the Scottish Government request to speed up the process. There had also been a request for the build to be net zero, whilst this was hugely important it would increase costs and would require refinement.

5.2.2.1 The Chief Executive had agreed the internal governance process with the Chair which would be through Finance and Resources Committee, Planning Performance and Development Committee (PPDC) and then to the Scottish Government Capital Investment Group for August/September 2022. There may be a requirement to hold an additional virtual PPDC session so as not to delay submission to the Capital Investment Group. The Board agreed to this internal governance process.

5.2.2.2 Ms Kasper asked about the workforce planning for the National Treatment Centre and timelines around capital investment and provision of new physical infrastructure. What conversations had been started with Scottish Government around provision of workforce to staff the new treatment centres as there would be a long lead time to train medical staff and bring physical facilities forward. Mrs Butler conformed that shared workforce, and 5-year recruitment plans were underway with Scottish Government as were discussions on the funding for the phased recruitment plan. It was hoped the outputs of these discussion would be known in the coming weeks and the recruitment plans for year 1 would commence. The Chair added that the plan was to recruit an additional 1500 staff of which Lothian would get its proportion. When funding arrives, it would partly answer the NRAC question. Finance and Resources Committee would investigate the future funding and charging mechanisms.

5.2.3 **Ukrainian Situation** – The Board noted that there were regular liaison meetings discussing impact on displaced people arriving and making sure there were proper connections to address issues. Mr Crombie was chairing the Board's Silver Tactical group that was dealing with any Ukrainian aspects and any urgent issues from there would be escalated to the Board's Gold Command group.

5.2.4. **Ockenden review of maternity services at Shrewsbury and Telford Hospital NHS Trust** - Miss Gillies confirmed that this was a deferred item at Healthcare Governance Committee. The Committee had received the first part of the report but was waiting on the final report. This would go back for discussion at Healthcare Governance Committee to decide if there was anything that needed to be escalated back for further Board discussion. There would be learning for the organisation from this report around maternity care and aspects of how adverse events are reported through. Prof. Chandran asked if there were any statistics showing the proportion of midwife led births versus others, mapping outcomes. These statistics would be helpful in the further discussion on the report. Miss Gillies would take this forward with Miss Ireland as chair of Healthcare Governance Committee.

5.2.5 **NRAC (National Resource Allocation Committee) Funding** - Cllr Milligan asked about negotiations with Scottish Government colleagues about the disproportionate allocation of resources and the Board's constant firefighting

and ability to meet targets with the current funding mechanism. The Chief Executive welcomed Cllr Milligan's comments. NRAC funding had been a long-standing issue. NHS Lothian had handled the pandemic well with some areas deteriorating slower than in other boards which showed the high level of work that been undertaken. However, having the headroom and ability for recovery was directly associated to NRAC funding. The issue of allocation of funding was being raised regularly with Scottish Government.

5.2.6 **SBRI Challenges & Long Covid App** - Mr Allenby asked for information on the SBRI challenges and long Covid App. Miss Gillies would provide further details and would also make the long Covid App demonstration recording from Healthcare Governance Committee available to Non-Executive Board Members.

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

6.1 No updates given.

7. NHS Lothian Board Performance Paper

7.1 Ms Macmillan introduced the report recommending that the Board discuss and review the current performance position of key metrics relevant to the Lothian Performance Recovery Programme and Remobilisation Plans.

7.2 Ms Macmillan summarised the current performance position as follows:

- Positive COVID-19 cases for Lothian residents had increased in January and February, with a marked increase in COVID positive inpatients. Staffing availability remained the key challenge across the Board, particularly evident in our nursing workforce and in social care settings due to a combination of COVID isolation, sickness absence, annual leave, and vacancies.
- In February, there was a further drop in performance in emergency department (ED) attendances across Lothian, however 4-hour attainment remained significantly below the standard which had been observed in various boards across Scotland. The significant issue for the Acute Sites is that the ability to admit patients from Emergency Departments has reduced, with hospital occupancy remaining high.
- The total number of delayed discharges has shown recent signs of variation and deterioration, with January 2022 delays across Lothian reaching the highest point in 2 years. The position in February and March is improving as the Board continues to focus on reducing and avoiding delays.
- The overall trend for outpatients was relatively stable, with a further reduction in those waiting over 12 weeks observed in February compared to previous months. This was a very different picture for inpatient and day case waiting lists, with patients waiting over 12 weeks and over 52 weeks further increasing due to the limited capacity available. Although most specialties were performing at or better than the Scottish average. For cancer services, staffing challenges continued to impact services and

referral numbers remained high into the final quarter of 2021/22 and notably above pre-COVID levels.

- In Mental Health Services there has been a deteriorating position in Psychological Therapies performance (% of patients seen within 18 weeks). In February CAMHS were ahead of their trajectory for reducing the number of patients waiting over 18 weeks. Members were already aware from previous briefings that meeting the trajectories agreed with Scottish Government in the recovery plans was reliant on recruiting additional staff to support this activity and this remained challenging.

7.3 The Chair asked about the system of review for patients with significant waiting times and whether regular assessment was part of the process. Mrs Campbell confirmed that several processes were in place for patients with long waits. This included regular contact with patients to check on for any change to clinical condition and the option to refer to consultant for clinical review.

7.4 It was acknowledged that the volume of patients waiting was significant and a process had been agreed with eHealth for more automation around Outpatients. Inpatients and Day Case continued with manual processes which had significant resource implications on top of the significant numbers waiting.

7.5 Mr McCann highlighted revisions and improvements to pathways and asked for further explanation on how pathways are structured and can be changed. A session for Board Members on this would be welcomed. The Chief Executive confirmed that an option appraisal would take place in 2 weeks' time, and it would be helpful if the Board Members could go through the outcome of this appraisal and improved pathways. The Chair and Chief Executive would discuss this further outside the meeting and look to arrange a session, perhaps sacrificing one of the Non-Executive informal sessions.

7.6 Mr Connor asked about increased Covid admissions and the intelligence breakdown as to whether patients were vaccinated, unvaccinated or if this was a mix. Also, what was the progress with use of treat at home antivirals to prevent admissions? Miss Gillies clarified that most patients being admitted to hospital were coming in with Covid rather than because of Covid and that all options around therapeutics were being offered on an outpatient basis. Antivirals were being delivered through pharmacies as independent prescribers with access support from specialist clinicians as patients did not receive hospital treatment when they were outpatients.

7.7 Mr McQueen asked about CAMHS and Psychological Therapies (PTs) performance, CAMHS reduced backlog and being ahead of trajectory and whether the need to appoint staff needed to be revisited. Ms Mckigen confirmed that there had been significant improvements in CAMHS, and the staffing model was constantly being reviewed. At the moment Helios remained in use and there remained work to do on the neurodevelopmental pathway so staff would be required to support that in future.

7.8 In relation to PTs there remained disruption caused by changes to the TRAK system which was impacting on access to the patient focused booking system. However there had been significant investment in staff. The changes to TRAK meant that staff were unable to outcome patients and there was due to be a cohort of patients coming off the system which would show in the next performance report with additional measures bringing performance back on track at the end of April 2022.

7.9 There was discussion on the challenges around recruitment and workforce. The Chief Executive commented that appropriate staffing levels had been a struggle across the organisation during the most recent Covid peak. It would take time to get workforce back to the right balance.

7.10 The Vice Chair asked about the ability to recruit to various roles that may be impeded by cohorting and distancing requirements. The Chief Executive referred to the example of the challenge at the RIE front door where the skill mix must be regularly reviewed due to staffing numbers and a current shortage of band 5 nurses. This situation was replicated across the whole system.

7.11 The Vice Chair asked for an update on the action in the Performance Report around Upper Gastrointestinal (UGI) Focus on UGI Multi-Disciplinary Team meetings (MDTs) to ensure Unscheduled Care prioritisation and target dates to be clearly shown on MDT (multidisciplinary team) lists. Mrs Campbell would provide the detail on that outside the meeting.

7.12 Ms Hirst asked about section 3.2.3 in the performance report which related to Flow. The Board noted that it had been reported to Healthcare Governance Committee and Planning Performance and Development Committee that overall attendances and numbers self-attending were reducing but performance figures were worsening, and this was the same picture throughout the UK not just in Lothian. Ms Hirst questioned whether the right model was being focused on or whether the model we have had to be revisited and whether this model was still fit for purpose. The Chair thanked Ms Hirst for this complex question and suggested that this would fit into the Non-Executive Board Members pathway session for further discussion.

7.13 Mr Knight commented on the charts within the performance report and inpatients waiting over 12 weeks. The Chair suggested that Mrs Campbell provide Mr Knight with further detail around the clinical prioritisation process and active management of clinical risk to give some assurance. The Chair also asked the Chief Executive to look at a briefing meeting for Non-Executive Board Members on options around recovery.

7.14 The Chief Executive clarified that in relation to inpatients waiting over 12 weeks the waiting times were significantly over 12 weeks with a significant number waiting in excess of 104 weeks. The whole system was recovering and the large number of delayed discharges in the system was a challenge for which whole system solutions to free up capacity were needed.

7.15 Ms Kasper asked about unscheduled care redesign progress. The Chief Executive confirmed that pathway development could be seen in the LSDF with reference to two evaluation reports from Derek Bell and Sir Lewis Ritchie.

7.16 The Board agreed the recommendations in the Performance paper:

- The Board acknowledges the supporting performance infrastructure in place which provides formal assurance on a wider set of metrics aligned to Board priorities through existing committees.
- The Board recognises the performance challenges detailed in this paper including exacerbated pre-existing performance issues and dips in performance following the impact of COVID-19 and current measures.
- To note the ongoing work seeking to refresh the Public Board paper, incorporating active governance principles which will further enhance coordinated and aligned performance reporting across the system.
- If deeper analysis regarding the mitigation plans or assurance provided for the corporate risks is required, these will be addressed via existing governance channels and designated board sub-committee.
- If further deeper dives are requested by the Board, these are addressed in separate reports to maintain the structure of the core performance report.

8. NHS Lothian Corporate Objectives 2022/23

8.1 The Chief Executive presented the 2022/23 Corporate Objectives to the Board for approval.

8.2 The Board noted the previous discussion on the Corporate Objectives at the March Planning Performance and Development Committee (PPDC). These were laid out in the same way as the Lothian Strategic Development Framework with a direct tie into the Strategic Performance Framework. The Corporate Objectives would be monitored quarterly by CMT and at mid and year end by the Board Members at PPDC.

8.3 The Chair picked up on the point around connectivity between the Corporate Objectives and LSDF. It was noted that the Corporate Objectives also picked up on points made as part of the NHS Lothian Annual Performance review by the Cabinet Secretary and Scottish Government colleagues. The Vice Chair suggested that it would also be helpful if a correlation could be drawn between the Corporate Objectives and Corporate Risk Register.

8.4 Dr Donald asked about workforce challenges and the move to an East Region Recruitment Service. Mrs Butler confirmed that this Service was part of a national commitment on shared corporate services and related to transactional delivery. This would not address workforce pipeline of supply issues which would be part of the national workforce plan.

8.5 The Board agreed to approve the 2022/23 Corporate Objectives with the regular review as outlined to assess progress. The Corporate Objectives would now be circulated across the organisation and publicly.

9. Lothian Strategic Development Framework Update

9.1 Mr Briggs introduced the report seeking Board approval to proceed to external engagement on the Lothian Strategic Development Framework (LSDF).

9.2 Mr Briggs outlined the engagement process and timescale for this. Mr Briggs would also have a session with new Non-Executive Board Members out with the meeting to bring them up to speed.

9.3 Mr Briggs explained the intention to build a relationship with Lothian citizens and third sector organisations and engage on needs and wants. This would be done as close to virtually as possible but some in person sessions would be needed to cover those who could not engage virtually.

9.4 The LSDF was now as user friendly as possible with the summary document to be translated into plan English and placed on both NHS Lothian's intranet and internet. The Board and the Planning Performance and Development Committee (PPDC) were being asked to approve the LSDF before proceeding to external engagement.

9.5 Since the last PPDC meeting the entire suite of documents had been formatted and a visual representation of the LSDF had been developed. Mr Briggs thanked Dr Donald for her assistance in proofreading the documents. Discussion at PPDC had identified areas to develop in relation to private sector interaction and tertiary education interaction (research and development). Mr Briggs had taken these areas forward with chambers of commerce and Prof. Chandran and Miss Gillies around research and development.

9.6 The Chair and Mr Briggs had also discussed the need for a clearer, punchier vision statement as part of the LSDF documents and at the centre of the visual representation. Mr Briggs would also consider how best to demonstrate links to the NHS Lothian values. The Chair acknowledged that whilst the NHS Lothian values could not be imposed onto other organisations, there was nothing wrong with the document highlighting the NHS Lothian values as a reference point.

9.7 Dr Donald welcomed the inclusiveness of the outlined engagement process and the establishment of the NHS Lothian Citizens Reference Group and congratulated Mr Briggs for bringing this mammoth piece of work to this stage. Ms Hirst added her congratulations and highlighted this would be a challenging and exciting time for health and social care systems. Ms Hirst asked about the Board's stewardship role with the LSDF engagement strategy. The Chair commented that Ms Hirst's remarks in relation to the Board's as stewards should be applicable to the entire system.

9.8 Mr Briggs confirmed that engagement was about having grown up conversations and that it was clear that NHS Lothian and its four partners had an equal say in this work. The Corporate Management Team as systems leadership, were focused on avoiding assuming things and taking on the role as stewards in a different way to previously.

9.9 Ms Mackay clarified that the establishment of an equalities reference group was work in progress with help from the Board's equalities lead. This would tap into the wider citizens reference group and EVOC expertise. Continues engagement has been used for some time now and this piece of work gives greater scope to reach out more widely. Cllr Gordon suggested that the Inclusion Scotland toolkit would also be worth looking at.

9.10 Mr Encombe highlighted the importance of quality methodology and strategy to support the LSDF and the need to translate vision, mission, and values to support leadership as part of change culture. Keeping things simple was important as well as clarity and drawing on expertise from others such as universities and business schools.

9.11 The Vice Chair pointed out that the Corporate Objectives contained references to Chief Officers bringing to life a clear drive towards system connectivity as described by Mr Briggs.

9.12 Mr Briggs welcomed the positive feedback received from the Board. In terms of timescale the intention would be to have everything on the NHS Lothian website by the end of the week and launched through social media for awareness. There would also be work on internal communications and a postcard programme over the next couple of weeks. It weas hoped to hold the first of the virtual sessions also in the next two weeks.

9.13 Mr Briggs explained that as most comments had now been captured in the LSDF and this document would now be frozen with a summary coming to the June Board meeting which would then lead to engagement and consultation. Mr Briggs emphasised this was the first phase of ongoing engagement throughout the adaptive life of the LSDF.

9.14 Ahead of bringing a paper back to the June Board Meeting, Mr Briggs would also circulate regular updates after the end of May once feedback had been gathered. There was discussion on the impact of ongoing engagement with the upcoming local elections in May. It was acknowledged that the Chair would be part of the spearheading of engagement with new leaders with the local authorities form their administrations. Cllr Gordon suggested that engagement should not wait for the formation of administrations in any of the areas, but it would be useful to submit a briefing paper to any appropriate groups. The Chair suggested that Mr Briggs continued to take advice of elected members.

9.15 The Board thanked Mr Briggs and his team for their work on the LSDF and the visual representation and agreed the recommendations in the paper, to:

- Approve the plan for external engagement, subject to minor changes to the visual representation (mission statement)
- Note timelines and arrangements for returning to the June 2022 Board with a final version of the LSDF

10. NHS Lothian Finance

10.1 February 2022 - YTD Financial Position - Mrs Goldsmith updated the Board on the financial position at Period 11 and NHS Lothian's year-end forecast position.

10.1.1 Mrs Goldsmith confirmed that as reported to Finance and Resources Committee in March there was now significant assurance of a breakeven position. The finance team were working on the year end accounts and a break-even position or even small underspend would be delivered.

10.1.2 In relation to Covid costs, Mrs Goldsmith confirmed the uncertainty made for a difficult year to manage to get to the breakeven position for 2021/22. The Chair, on behalf of the Board, thanked Mrs Goldsmith for her stewardship during the recent volatile period.

10.1.3 The Board agreed to accept the report as a source of significant assurance that NHS Lothian would achieve a breakeven outturn this financial year.

10.2 NHS Lothian 5 Year Financial Outlook and Outline Plan 22/23 - Mr Goldsmith updated the Board on the development of the NHS Lothian Financial Plan for 2022/23 for approval by the Board.

10.2.1 The Board noted that this was consistent with the Board's Standing Orders which states the requirement: "The Board shall approve its Financial Plan for the forthcoming financial year, and the opening revenue and capital budgets." Finance and Resources Committee, in its consideration of the Financial Plan for 22/23 and longer-term financial strategy had endorsed the plan, for initial budgets to be set.

10.2.2 The Board also had a requirement to set budgets for the delegated functions of the Integration Joint Boards (IJBs) for 2022/23. The outline plan presented would form the basis of a formal allocation of budgets to the IJBs.

10.2.3 Mrs Goldsmith highlighted the link between the plan, the Board's statutory duty to breakeven, the Corporate Objectives and Corporate Risk Register. There was also discussion around wholesale cost increases for electricity and gas and the impact for NHS Lothian despite forward purchasing. This had not been built into the plan and further conversations with Scottish Government around mitigations would be required.

10.2.4 In relation to Covid costs for 2022/23, Mrs Goldsmith confirmed that funding would be passed to IJBs and there would need to be dialogue as to how to manage the flow of funds back from IJBs. There was also work to do on funding of Covid costs for social care services.

10.2.5 Mrs Goldsmith also talked about NRAC funding which impacted the ability to plan for population growth. There was around a £100M cumulative deficit which meant lost opportunities to invest in services. The gap year on year was 1% (£12-14M). There was also a need for investment in physical capacity as part of the National Treatment Centre development.

10.2.6 The Chair commented that it was remarkable how much of the plan connected with the points made around links to strategy, performance, and workforce. It would be key to have clarity on the level of financial support for the new National Treatment Centres as soon as possible as the links to recruitment, workforce plans, and costs were important.

10.2.7 The Vice Chair and Ms Kasper asked about efficiency savings, the risks, assumptions, and organisational impacts around these. Mr McQueen added that any organisation with turnover of £2Bn should be able to achieve more efficiency savings with less input and that aspiring to 2 or 3% should be the limit of ambition.

10.2.8 Mrs Goldsmith confirmed that 2% was the uplift from Scottish Government and not NHS Lothian's assumption. The 2% only met the pay awards and remained a huge risk to us along with the energy costs. A spending review was being worked on to secure additional resource.

10.2.9 The Vice Chair commented that there was a need to invest in areas in the financial plan such as Home First and the Community structure. There remained a capacity issue with growing population, even if a zero delayed discharge position was to be reached to deal with population growth that would not deal with the front door challenge where people come for assessment.

10.2.10 Mr McCann as chair of the Finance and Resources Committee confirmed the Committee would continue to monitor the financial position, push on capital and revenue, and consider the risks around the care deficit.

10.2.11 The Board agreed to:

- Approve the Financial Plan as a basis for opening budgets only and submit to Scottish Government as required.
- Acknowledge that, based on the latest information available at this time, the F&R Committee accepted that the financial challenges around Covid next year means that we cannot offer assurance that NHS Lothian is able to deliver a balanced financial position for 2022/23 at this stage.
- Endorse the allocation of resources agreed by the Finance & Resources Committee for the purposes of budget setting.

11. Initial 2022-23 Forward Plan Covid and Flu Vaccination

11.1 Mr Lock highlighted a couple of issues see in the press recently. These administrative errors, now addressed, were encountered last week, and related to scheduling of patients and the inviting of a small number of 74-year-olds into the 75-year-olds booster programme and some children being wrongly sent the immunisation letter for children at clinical risk with a pre-existing condition. This error had been addressed by way of press release. For both errors there had been no health or adverse impact on patients.

11.2 Mr Lock outlined the report articulating current plans for the 2022-23 Covid and Flu vaccination programme. These plans had been developed based on planning assumptions provided thus far by the Scottish Government as well as local assumption about Winter 2022. The plan will be subject to revision pending further Joint Committee for Vaccination and Immunisation (JCVI) recommendations and national policy guidance associated with Covid vaccination.

11.3 The forward plan sets out steppingstone in terms of moving from the full mass vaccination emergency programme to a more sustainable long-term programme. This was being viewed as the transition year as JCVI guidance and numbers of people to be vaccinated was still being amended at short notice. The plan was based on several principles including maintaining local access for elderly and vulnerable people. Four of the large mass vaccination centres (MVCs) had now or would be closing as part of the move to a locally based model. There would also be a more sustainable workforce put in place to deliver the programme, with the Covid and Flu vaccination programme being aligned with other current vaccination programmes.

11.4 Mr Walls asked about glitches and the ongoing JCVI uncertainty and policy announcements and how the programme was positioned to react if changes did come out. Mr Lock emphasised that the team were working hard to rectify any glitches experienced and that additional quality assurance was being put in place as part of lessons learned. In terms of the programme being reactive, there was flexibility built into the plan, with an overall high level of capacity in the system to deliver vaccinations and this level was not currently being required. Take up rates were important as well. Planning the number of people depended on how many turn up. Current rates were 25% for the children's programme and 4th booster for over 75s was just under 50%.

11.5 Mr Lock added that the Scottish Government had requested surge plans on a contingency basis and how vaccination numbers delivered would be doubled over 2 weeks. At present there would be a challenge around locations and the maximising of capacity and staff. Delivery of surge plans would be clearer by the end of April 2022. Going forward the link between the immunisation delivery board and public health would be key. Mr Lock confirmed that Ms Milne would be bringing this update to future Board meetings.

11.6 Mr Allenby asked about digital consent, workforce, and flexibility of contracts. Mr Lock confirmed that there were people on staff bank that could be brought into the programme at short notice and that teams were looking at current workforce numbers and plans for future delivery. Mr Lock would provide further information on digital consent outside the meeting.

11.7 Ms Gordon asked about surge capacity staffing and potential impact on other services if staff were redeployed. Mr Lock clarified that there was current headroom for surge capacity but identifying sites to move to would be an issue. The hierarchy of staff for surge capacity had been looked at pre-Christmas due to the Omicron variant and at that time there was enough capacity within existing permanent workforce, additional hours, staff bank and

additional contractors with training for others. There would have to be consideration of the cost versus extra capacity balance.

11.8 Cllr Gordon welcomed the paper as the outgoing chair of the EICC MVC. Staff had worked extremely hard to deliver the vaccination programme but there was now a need to make sure appropriate communications are sent out about where the vaccinations would now take place. Current pharmacy capacity across Lothian seemed low and needed to be expanded for further cohorts during the year. Mr Lock explained that pharmacy capacity was important with one of the design principles being local access wherever possible. With Community Pharmacy there had to be a balance between delivery of the programme and delivery of core NHS services and in some areas, there was a shortage of pharmacist resource and well as the issue of how to schedule people into pharmacies for vaccination going forward.

11.9 Mr McQueen asked about permanent workforce. Mr Lock acknowledged there was further work to do around permanent workforce and in this transition year it was not yet clear what the sustainable settled programme would look like, at the moment it was difficult to be 100% clear what a permanent workforce should be. This work was being done by the Health and Social Care Partnerships and they were close to completing structures.

11.10 The Chair asked about clarity around funding of workforce. Mr Lock confirmed that Scottish Government had clarified there would be an NRAC share of £100M into NHS Lothian. It had been pointed out that NRAC was not the appropriate funding model for distributing vaccination expenditure. There was not yet funding clarity around estates and non-pay areas of the future programme and the risks were still being worked out. The Chair added that Finance and Resources Committee would continue to monitor the funding model and risks around this area.

11.11 The Board accepted the recommendations in the paper, to:

- note progress in the development of 2022-23 delivery plans.
- recognise progress associated with implementation of the Covid spring booster and universal vaccination of those aged 5 -11 years following publication of JCVI recommendations in February 2022.
- be aware of developments in HSCPs vaccination centre premises plans and recognise capital investment and leases would need to be met once these costs are finalised.
- note ongoing work to finalise workforce requirements, and to note that fixed term contracts for vaccination staff have been extended for three months (to 30th June 2022) to maintain required surge capacity associated with spring booster programme and allow further time to appoint staff to permanent posts.
- note programme works with the Immunisation Delivery Board to ensure there is coordinated oversight across all vaccinations.
- note that 2022-23 financial allocations have not been confirmed for non-pay elements of the programme and that work is ongoing to ensure costs fall within the current pay allocation provided.

11.12 The Chair thanked Mr Lock for all his work done with the Board and wished him all the best for the rest of his career.

12. NHS Lothian Quality Strategy Interim Review

12.1 Miss Gillies introduced the paper setting out the findings of an interim review of the Quality Strategy and the priorities for 2022/23.

12.2 Miss Gillies commented that the paper included a good level of detail and linked well with the Lothian Strategic Development Framework as previously discussed and looked to make the most of future opportunities. The new Non-Executive Board Members would be offered a briefing session with Ms Bennett out with the meeting.

12.3 Ms Bennett added that it had been important for all information to be included and that services see their words as part of improvement activities being described at Board level. The 2018 Quality Strategy had included several deliverables which the interim review had been set around. There were good examples of where quality management was being applied but it was fair to say that momentum had been lost during the pandemic. Leadership teams had signed up to practical engagement and it was a testament to frontline teams that planning, monitoring and improvement of services had continued throughout the pandemic.

12.4 The networks and care pathway work had matured but not at the rate, that would have been liked to see, however the six dimensions of quality remained woven through all work as could be seen in the paper.

12.5 Miss Gillies added that the interim review was a useful bedrock to help consideration of what to build into the Board's Corporate Objectives and what the next Quality Strategy may look like over the coming year.

12.6 The Chair welcomed this ethos and approach to delivering services and this runs through the organisation. The Chair noted that this answered and expanded on questions he had about the assurance system when he first joined the Board.

12.7 Mr Encombe asked about Integration Joint Boards (IJBs) Involvement Plans and if there was a 'Quality Light' version of the Strategy for areas unable to implement the full version. Miss Gillies commented that previously IJBs had been outside immediate purview, however initiatives such as the primary care network and patient safety work with Health and Social Care Partnerships now offered areas for local influence and allowed system leaders to work together on quality.

12.8 In relation to 'Quality Light', Ms Bennett stated that there was now increased access to training and a key strategy was for Quality Improvement coaching to be embedded into services, with coaches no further than two connections away from anyone. The Midlothian work around frailty and the use of GP practices to identify improvement opportunities was a good example of this.

12.9 Mr McQueen welcomed the offer of further briefing on the Quality Strategy and asked about how quality of care was consistently measured, it was not clear how progress on that was made in terms of quality-of-care outcomes. Miss Gillies stated that there were many things not routinely measured and that analytics support could be a constraint with this work. Thinking more strategically was a work in progress as was a shift to using quality planning and quality management in day-to-day work for every aspect of the organisation.

12.10 The Board agreed the recommendations in the paper to:

- accept the review findings against the Quality Strategy deliverables.
- approve the priorities for 2022/23 which seek to regain the momentum developed prior to the pandemic to implement the Quality Strategy, acknowledging the current service constraints.
- accept that, as we enter the final year of the Quality Strategy and conduct the final review, we will be laying the foundations for the next NHS Lothian Quality Strategy.

13. Corporate Risk Register

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

13.2 The Board noted the Corporate Management Team (CMT) recommendations following agreement at the February 2022 Board meeting to approve the description and grading of the Cyber Security risk and to remove the Care Home risk from the CRR and put it onto the Corporate Nursing Risk Register.

13.3 The Board further accepted the following CMT recommendations:

- The removal of the complaints risk based on comparative performance and risk grading and put it onto the Corporate Nursing risk register
- That the current Covid-19 risk is closed and a new risk accepted with a public health focus.
- Accept the new risk description related to timely discharge which has been re-framed to focus on hospital bed occupancy.
- A change in the description of the finance risk, following consideration at the January 22 meeting of the Finance and Resource Committee.

13.4 The Board noted that the Staff Governance committee had reduced its level of assurance for the violence and aggression risk from moderate to limited, based on internal audit findings.

13.5 The Board also noted that a paper setting out risks associated with performance was considered by the Planning, Performance and Development Committee at its March 2022 meeting, to inform a schedule of reporting. Healthcare Governance Committee continues to consider the impact of these risks to the delivery of person-centred, safe effective care as part of routine service reporting.

13.6 The updates provided by the executive leads on risk mitigation, set out in the Assurance Table at Appendix 1 of the paper were reviewed and noted.

14. Any Other Business

14.1 None.

15. Reflections on the Meeting

15.1 The Chair welcomed the improvements in the performance report and engagement with the Non-Executive Directors. There was also support for the way the Executive Directors were now updating the Board.

16. Next Board Meeting future dates

16.1 The next Board meeting would be held on Wednesday 22 June 2022 at 9.30am (Annual Accounts meeting).

Chair's Signature ……

Date ……

John Connaghan
Chair – Lothian NHS Board

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee meeting held at 9.30 am on Monday, 21 February 2022 via MS Teams.

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

In Attendance:
Ms J. Brown, Chief Internal Auditor; Ms J. Bennett, Associate Director for Quality Improvement & Safety; Mr C. Campbell, Chief Executive; Mr P. Clark, Grant Thornton; Ms S. Goldsmith, Director of Finance; Ms O. Notman, Head of Financial Services; Mr C. Marriott, Deputy Director of Finance; Mr W. MacMillan, Business Manager: Mr J. Old, Financial Controller; Mr A. Payne, Head of Corporate Governance; Mr D. Eardley, Azets; Mr P. Wynne, Interim Nurse Director; and Miss L. Baird, Committee Administrator.

Apologies: Mr J. Crombie, Deputy Chief Executive; Ms J. Campbell, Chief Officer Acute Services.

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

63. Minutes of the previous meeting held on 22nd November 2021

63.1 The minutes of the meeting held on 22nd November 2021 were accepted as an accurate record and approved.

64. Management of Violence & Aggression and Lone Worker Alarms

64.1 Mr Wynne presented the previously circulated paper.

64.2 Mr Wynne explained the report provided an implementation plan to address the recommendations identified by the internal audit into violence and aggression management and the wider work to mitigate risk 3455.

64.3 Mr Wynne confirmed that as part of the process of review the violence and aggression policy would be refreshed and controls set out to ensure that process in place were robust.

64.4 The Committee noted that the no recurring funding would address the immediate issues identified within the internal audit, and Mr Wynne would assess with colleagues from finance if additional funding if the need was identified during the plan.

64.5 Mr Wynne advised that that this was the first iteration of the implementation plan, and the Short Life Working Group would provide accurate timeline for the sequencing of actions and milestones within the plan as it progresses.

64.6 The Committee discussed concerns that the creation of the Violence and Aggression Team and the establishment of the Short-Life Working Group would

dilute the management focus and oversight of the recommendations. Mr Wynne would share the committee's concerns with the Short-Life Working Group and seek assurance around how the medium-term risk would transfer back to management and provide feedback to the Audit and Risk Committee. **PW**

64.7 The Committee noted the benefits of transferring to an electronic system, in that the system would become automated and data would be in real time information. Management will have sight of the position across the organisation.

64.8 The Committee approved the principle for the development and improvement work to determine a proportionate and risk-based approach, recognising the requirements of different departments, and ensuring that the controls and processes are commensurate with the level of risk identified through the key metrics.

64.9 The Committee approved the attached implementation plan.

65. Running Action Note

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

65.2 Mr Marriott advised that the Audit Scotland annual report on NHS Scotland would be released within the next two weeks. He advised that there will be a forthcoming development session.

66. Corporate Risk Register

66.1 Ms Bennett presented the previously circulated report. She noted that the paper was the standard paper that updates the Committee on progress made in the respect of the review of NHS Lothian's Corporate Risk Register.

66.2 The Committee discussed the route back into the governance structure for the Digital Oversight Board now that the Information Governance Committee was disbanded. Mr Marriott advised that the reporting line for the Digital Oversight Board was discussed at the Planning Performance and Development Committee and the decision taken to the Board to approve the reporting line.

66.3 The Committee noted that there was no update on the risk that patients are not being discharged in a timely manner, resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.

66.4 The Committee noted that at the December meeting of the Board had agreed the following CMT recommendations:

- A standard level of assurance for risk mitigation plans.
- A standardised committee paper to be used when submitting Board Committee papers related to specific risks on the Corporate Risk Register (CRR)
- Increase the grading of the Timely Discharge of Inpatients risk to Very High
- Remove the EU/Brexit risk which will be kept under review.

66.5 The Committee:

- Reviewed the updates provided by the executive leads on risk mitigation, set out in the Assurance table in Appendix 1.
- Noted that the February 22 Board approved the CMT description and grading of the Cyber Security risk following the agreement of the December 21 Board to include this risk onto the CRR. See para 3.5.2
- Noted that the February 22 Board agreed to remove the Care Home risk from the CRR and onto the Corporate Nursing Risk Register. See rationale below under para 3.5.3.
- Noted that management plans to mitigate risks associated with performance will be considered by the Planning, Performance and Development Committee (PPDC), with Healthcare Governance continuing to consider the impact of these risks to the delivery of person-centred, safe effective care.
- Noted that a paper is going to the March PPDC setting out the risk pertinent to the committee to inform an assurance reporting timetable
- Noted that the finance risk description was approved at the January 22 F&R Committee and the risk template is being updated to reflect discussion at this meeting.

67. Internal Audit

67.1 Internal Audit Progress Report – February 2022 – Mr Clark presented the previously circulated report.

67.1.1 Mr Clark advised the Committee that although the Complaints Handing audit report had been drafted. The Internal Audit Team had agreed that additional testing and a separate independent review of the complaints handling process would mean that the information within the report out be out of date before it was published. He explained that the internal audit team would assess Complaints Handling once the new processes were embedded.

67.1.2 It was noted that fieldwork for five audits was underway, and fieldwork completed for a further two, and one additional audit on waiting list initiative payments had been added to the plan.

67.1.3 The Committee accepted the report.

67.2 Internal Audit update paper – Responding to internal audit feedback and internal audit resourcing – Ms Brown presented the previously circulated report that set out a review of the feedback from the Audit and Risk Committee in respect of the internal audit on Violence and Aggression.

67.2.1 The Committee discussed the current co-sourced internal audit model, noting that at present there was only one NHS Lothian employee that made up the Intern Audit Team with Grant Thornton providing the rest of the resource that supported that completion of the Internal Audit Plan. Members recognised that the current model had become untenable, and the following action were agreed:

- That Grant Thornton would provide additional internal audit services to cover the delivery of the internal audit plan. It was hoped that this would ensure the delivery of the audit plan and increase the quality of the IA outputs.
- That NHS Lothian Internal Audit Team member would continue to support the delivery with Grant Thornton undertaking certain reviews relevant to their experience, through supervision and coaching by the Grant Thornton manager. This includes the routine follow up and Internal Audit administration tasks.
- That Grant Thornton would explore, with the NHS Lothian finance team, opportunities for school leavers and/or graduates, supported by a suitable qualification pathway. This would support longer term succession planning and build suitable Internal Audit skills within the NHS Lothian team. This would give NHS Lothian flexibility in future Internal Audit models alongside an ability to use these trainees more widely across NHS Lothian.

67.2.2 Ms Kasper thanked Ms Brown for her timely and comprehensive response to the concerns of the Committee.

67.2.3 Mr Marriott reassured the Committee that the cost implications associated with the additional resource from Grant Thornton was sustainable in the short term and he hoped that it would bring another more efficient and effective service with minimal wastage.

67.2.4 Mr Marriott reaffirmed the commitment to the co-sourced model but recognised that Ms Brown had struggled to appoint to the vacancies within the internal Audit team and they would have to re-consider the plan and whether the co-sourced model remained suitable for the organisation's needs.

67.2.5 The Committee accepted the report.

67.3 NHS Lothian Internal Audit Report – 2021/22 Payroll – Mr Clark presented the previously circulated paper.

67.3.1 The Committee noted that the paper had provided limited assurance and the three findings detailed therein:

- ePayroll not updated to reflect the changes to December 2021 pay dates (high).
- Finance dashboard audit reports are not scrutinised or monitored (medium).
- Payroll desktop instructions are not regularly reviewed and updated, nor is there evidence they have been read and understood by staff (low).

67.3.2 Mr Marriott acknowledged the significant concerns around the failure to pay December 2021 pay to staff in a timely manner and the impact this had on staff. He reported that management was investigating the matter to identify improvement required within NHS Lothian, and nationally, to avoid future errors, as well as ensure that there are robust payroll processes in place.

67.3.3 The Committee accepted the report, noting the action in place to mitigate concerns identified within the report.

67.4 Internal Audit Follow-up of Management Actions Report (February 2022) – Mr Clark presented the previously circulated report.

67.4.1 Mr Clark advised that twenty-four actions were being monitored, and of that twenty-four, two had been closed off, 10 were overdue and 12 were not due. He assured that the 10 actions that had passed their due date were either medium or low risk actions.

67.4.2 The Committee discussed outstanding management actions that were sitting with the Chief Officers of the Integration Joint Boards and progress that had been made against them. Mr Campbell took an action to raise the Committee's concerns around outstanding actions with the Chief Officers. **CC**

67.4.3 The Committee accepted the report.

68. Counter Fraud Activity

68.1 Mr Old presented the previously circulated report. He noted that since the November meeting nine referrals, and twelve operations were open.

68.2 Mr Old advised that the Counter Services Fraud Services Partnership Agreement was due to expire on 31at March 2022. He reported that an updated agreement had been disseminate for comment and review and most of the changes proposed were unmaterial in nature except for the inclusion of new Counter Fraud Standards. It was noted that there was no formal requirement for NHS Scotland to adopt these changes, but it was hoped that the final version would be issued by Scottish Government for Chief Executives to sign off by 1st April 2022.

68.3 It was noted that NSS were working with NHS Ayrshire and Arran to develop a service level agreement for Board to support the implementation of these changes. However, it was unlikely that all changes would be implemented and Board compliant with the standard by the deadline of 1st April 2022.

68.4 Mr Old assured the Committee that many of these processes were established within Lothian and the work proposed would only formalise current actions in place and provide consistency across the piece.

68.5 The Committee noted the requirement for Board to appoint an Officer accountable for Counter Fraud Services, a Counter Fraud Champion, and a Fraud Liaison Officer. Members recognised that it was up to individual Board who they appointed however, in Lothian the Director of Finance would lead on Counter Fraud Services with the support of their Fraud Liaison Officer.

68.6 The Committee accept this report as a briefing on the current status of counter fraud activity.

68.7 The Committee took a moderate level of assurance from the report, that all cases of suspected fraud were accounted for, and appropriate action was taken.

68.8 The Committee accepted the report.

69. NHS Lothian External Audit Plan 2021/22 – February 2022

69.1 Mr Eardley provided a detailed overview of the NHS Lothian External Audit Plan 2021/2022. He drew the Committee's attention to the key aspect of the report whilst noting that most of the fieldwork that would inform the report would be carried out remotely as in the previous year due to the current status of the pandemic.

69.2 Me Eardley report that the three key risks the Board was facing related to financial sustainability in terms of how the Board would respond to and recovery from the COVID 19 pandemic, financial and governance issue relating to further development of the Royal Hospital for Sick Children and Young People and the Department of Clinician Neurosciences, and how the Board ensures that they are maximising resources and ensure that they are able to deliver Best Value.

69.3 It was noted that there was no new standard or significant or fundamental changes to the detail of the NHS Lothian External Audit Plan 2021/2022 in comparison to the previous year.

69.4 Mr Eardley advised that the was confident that the NHS Lothian Annual Accounts were on target to be presented at the June Audit and Risk Committee, and then formally submitted to Audit Scotland by the deadline of 31 August 2022, as determined by Scottish Government.

69.5 It was noted that the focus on financial sustainability would consider the interplay between capital and revenue and how the Board interprets this risk whilst balancing its medium and long-term financial position.

69.6 Mr Eardley confirmed that the work of External Audit in completing their audit would not impact the ongoing public Inquiry work around the Royal hospital for Sick Children, or compromise the position of the Board in terms of the outcome of the public inquiry.

69.7 The Committee accepted the report.

70. Assurance, Quality and Business Case Framework

70.1 Ms Goldsmith presented the previously circulated report.

70.2 The Committee agreed to:

- Note the progress made in response to the internal audit report, July 2020 – Governance and Internal Controls: Royal Hospital for Children & Young People, and Department of Clinical Neurosciences Edinburgh
- Note that further work is required to develop implementation plans including wider awareness considerations across NHS Lothian
- Note that all the documents will be finalised for consideration by the Finance and Resources Committee in April 2022, given their oversight and assurance role on the property and asset strategy for the Board.

70.3 The Committee accepted the report.

71. Estates Internal Audit

71.1 Ms MacMillan gave a detailed overview of the previously circulated report.

71.2 Ms MacMillan drew the Committee's attention to the partial close of the action relating to the existing NHS Lothian policy in register of interests and sought to advice as to how proceed with the implementation of a single approach for the register of interests for the organisation.

71.3 Mr Campbell was keen to establish a single approach across the organisation for registering interests and the receipt of gifts. Hospitality etc, that did not allow of ambiguity on interpretation. Members recognised that in the absence of up-to-date national guidance that there needed to be a local policy in place in the interim. Mr Campbell took an action to clarify with Mr Payne what the requirement was and how this could be achieved and feedback to the Audit and Risk Committee. **AP/CC**

71.4 The Committee agreed to:

- To accept that all actions within the remit of Estates & Facilities directorate are now closed.
- To review appendix 1, which outlines a partial closure of an action due to existing NHS Lothian Policy (interests register).
- To accept the two remaining actions will be considered by the core Procurement function in NHS Lothian and updates will be provided directly under the Director of Finance portfolio.
- To acknowledge the Internal Audit team will now undertake further monitoring and follow-up audits of the implementation of these actions and the outcome of these will be provided at a future Audit & Risk Committee.

71.5 The Committee accepted the report

72. Any Other Competent Business

72.1 Mr Payne – The Chair noted that Mr Payne was leaving NHS Lothian for a new opportunity within Scottish Government. He thanks Mr Payne on behalf of the Committee for his value contribution and support over the years that he had worked on the Audit and Risk Committee

72.1.1 Members wished Mr Payne well in his new role.

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

73. Reflections on the meeting

73.1 The Chair noted that there was nothing to report to the Board at this time.

74. Date of Next Meeting

74.1. The next meeting of the Audit and Risk Committee will be held on Monday 11th April 2022 at 9.30 a.m. via Microsoft Teams.

75. Private Meeting with the External Auditor

75.1 The Chair agreed with Mr Eardley that the private session with the External Auditors would be deferred until the April 2022 Meeting.

Signed by the Chair
11-04-2022

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Monday 17 January 2022 by videoconference.

Present: Mr A. McCann, Non Executive Board Member (chair); Councillor S. Akhtar, Non Executive Board Member; Ms T. Gillies, Medical Director; Ms S. Goldsmith, Director of Finance; Mr B. McQueen, Non Executive Board Member; Mr P. Wynne, Interim Executive Nurse Director.

In Attendance: Mr C. Campbell, Chief Executive; Ms J. Campbell, Chief Officer, Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr H. Hamilton, Finance Manager, Acute Services; Dr J. Hopton, Programme Director; Mr C. Kerr, Senior Project Manager, Finance; Mr C. Marriott, Deputy Director of Finance; Ms T. McKigen, Services Director, Royal Edinburgh Hospital (item 49.2); Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes).

Apologies: Councillor G. Gordon, Non Executive Board Member; Mr I. Graham, Director of Capital Planning and Projects.

Chair's Welcome

The Chair welcomed members to the meeting.

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.

48. Committee Business

48.1 Minutes and Actions from Previous Meeting (17 November 2021)

48.1.1 Members accepted the minutes from the meeting held on 17 November 2021 as a correct record.

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

49. Capital

49.1 Property and Asset Management Investment Programme

49.1.1 Mr Kerr presented the previously circulated paper. Dr Hopton advised that discussions were ongoing with NHS Scotland Assure regarding the Western General Hospital energy infrastructure project. This has escalated by the Scottish Government due to the infrastructure risk and a formal response was expected by the end of January 2022. The assessment would be carried out for a full business case in March 2022 and this would come to the Committee. The Scottish Government Health Infrastructure Department ware aware of the timescales and were content.

49.1.2 All projects above NHS Lothian's delegated cost limit would now be processed by NHS Scotland Assure. It was noted that NHS Scotland Assure were currently working through their processes which would take time and may increase costs of projects due to delay.

49.1.3 Ms Goldsmith would ask a member of NHS Scotland Assure to give a presentation to the Committee about their process to increase Members' understanding but this would be in the future when processes were established.

49.1.4 There was discussion on the draft PAMIP tracker template. The tracker would be the responsibility of the Finance Director and the Director of Capital Planning on behalf of the Corporate Management Team and would aim to provide assurance to the Committee on the timeline and progress of the projects and whether the project manager was content that the building specifications were correct and that the specifications were being met.

49.1.5 It was suggested that the risks associated with any projects with limited assurance should be outlined in the 'risk' section of the PAMIP paper, and that start and end dates for each approval stage would be included in the tracker.

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

49.2 Royal Edinburgh and Associated Services Anti-ligature Door Replacement

49.2.1 The chair welcomed Ms McKigen to the meeting and she presented the previously circulated paper. It was noted that the door replacement was urgent due to the risk of patient suicide with the current doors. Members agreed to recommend that the service proceed directly to full business case rather than submitting an initial agreement to the Planning, Performance and Development Committee first. It was also noted that these works did not need to be discussed at PPDC in terms of overall strategy. The works themselves were expected to take a number of months.

49.2.2 Members accepted the recommendations laid out in the paper.

49.3 Scottish Hospitals Inquiry – update

49.3.1 Ms Goldsmith presented the previously circulated paper. Ms Goldsmith advised that the document management system purchased had been useful in finding the documents for the inquiry. Due to the wide questions posed by the Inquiry the number of review hours purchased had not been sufficient but the Inquiry had agreed to narrow the scope of the requests for more efficient responses. The project would be closed shortly with an additional resource going to the Corporate Governance Team and to Brian Currie and Iain Graham to continue this. The document management system would also be used for the anticipated Scottish and UK Covid public inquiries.

49.3.2 The cost of the Inquiry would increase in the next year. The Scottish Government had recognised this as a risk but had not agreed to fund this. This was likely to be resolved later in the year.

49.3.3 In response to a question about the risk of review hours purchased becoming unavailable through the vendor, Mr Marriot advised that this had been purchased through ATOS with engagement with National Procurement rather than directly from the vendor. The same vendor was being considered for the whole of Scotland for the Covid inquiry which would mitigate the risk of this becoming unavailable.

49.3.4 Members accepted the recommendations laid out in the paper and accepted significant assurance.

50. Revenue

50.1 Financial Position November 2021

50.1.1 Mr Marriott presented the previously circulated paper. He advised that drug spend had continued at a high rate over the past two years despite a decrease in activity during the covid restrictions. A 12% increase was forecast for drug spend compared with an overall funding uplift of 2-3%. The Scottish Government had agreed to set up a group to discuss a way forward on this. Ms Gillies advised that the increase in spend was driven by Scottish Government policy change on access to new medicines which was not funded; this had been previously raised to the Scottish Government by medical directors and board chief executives.

50.1.2 Ms Goldsmith advised that the medium term financial framework would make a distinction between funding associated with policy directives and funding associated with demand and capacity rather than focusing on breaking even.

50.1.3 It was suggested that a risk should be added to the risk register describing the risk of having an unfunded access to medicines policy which indirectly affected the ability to provide other services due to the need to find savings from their provision. **SG**

50.1.4 Mr Marriott advised that there were different funding streams from the Scottish Government for additional covid spend with different timescales, for example for test and protect, laboratory staffing, vaccination. The mixture of recurring and non recurring funding streams made financial management difficult.

50.1.5 Members accepted the recommendations laid out in the paper and accepted significant assurance for a breakeven position at the end of 2021/22.

50.2 NHS Lothian Financial Outlook and Outline Plan 2022/23

50.2.1 Mr Marriott presented the previously circulated paper. It was noted that there had historically been better cost and activity data in acute services than community services. A detailed study was done on primary care costs a few years ago but this was based on estimates. Due to the number of different types of services in primary care this could be approached in different ways – data would be available for community services provided by the Health and Social Care Partnerships and some data from contractors where cost is allocated according to activity. There was no activity monitoring in GP contractors since QOF reporting was stopped. Some work on trends in primary care spend could be done to get an indication of where the focus should be.

50.2.2 The uncertainty of the next financial year regarding covid related costs, flow of funds and level of risk was noted.

50.2.3 Mr Marriott advised that the Scottish Government would provide a one year settlement but would start work in May on the development of a three year settlement to provide more stability for planning in future years.

50.2.4 There had been a number of covid funding allocations that were based on need rather than NRAC which may signal a move away from NRAC parity as the only funding allocation method.

50.2.5 Plans for efficiency savings continued but were challenging due to service pressures, and savings were a mix of recurring and non recurring. One opportunity from the past two years was a change in risk tolerance which had allowed consideration of delivering services in different ways – plans for change could include efficiency savings. The medium term plan also set out how further efficiencies could be made in services not considering change. This would be supported by the sustainability and value team and by analytical services.

50.2.6 A significant amount of comparison with other Scottish health boards on efficiency savings had been done in the past and often due to the discrepancy on NRAC funding per head of population NHS Lothian had made good savings compared to other Boards. Comparison could be widened out to other health systems and organisations.

50.2.7 Members accepted the recommendations laid out in the paper.

50.3 Medium Term Financial Framework

50.3.1 Ms Goldsmith presented the previously circulated paper. It was suggested that the patient outcomes related to changes in services due to covid restrictions such as virtual consultations should be included as part of the framework. It was noted that both home services and hospital services were right for different patient groups and a clearer definition was needed as to where home services were appropriate and ensuring that patients were offered it at the right time.

50.3.2 It was noted that following the framework would result in more activity but that due to backlogs there would be no immediate savings made. Ms Goldsmith advised that the purpose was to ask the services to gather data about activity so that this could be used as a baseline for analysis of the impact of different models for change.

50.3.3 Comparisons with activity of other Boards were carried out as part of the mid year reviews and were shared with financial teams including comparison of health boards across the UK.

50.3.4 Members accepted the recommendations laid out in the paper and supported the direction of the work described.

50.4 Risk 3600 Finance – Mitigation Plan

50.4.1 Mr Marriott presented the previously circulated paper. A development session was planned to increase understanding on some of the issues involved.

50.4.2 Mr Marriott advised that the chief financial officers for the Health and Social Care Partnerships were part of the group overseeing this risk. The Integration Joint Boards had their own risk registers but these overlapped with NHS Lothian's.

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

50.5 Update on Royal Infirmary of Edinburgh Commercial Strategy

50.5 Ms Goldsmith presented the previously circulated paper. Members accepted the recommendations laid out.

51. Sustainability

51.1 Update on Sustainability

51.1.1 Dr Hopton presented the previously circulated paper. The response to the Scottish Government's draft strategy would be signed off through the Corporate Management Team and then sent to the Scottish Government.

51.1.2 Dr Hopton advised that there was a lot of interest from staff wanting to work on climate change sustainability in addition to their jobs and it would be useful to have someone to coordinate this and make sure sites were working together and sharing learning rather than duplicating processes.

51.1.3 Mr McCann advised that having discussed with Dr Hopton, he had agreed to take on the sustainability champion role among non executive directors, previously filled by Martin Hill.

51.1.4 It was noted that the sustainability targets from the Scottish Government were becoming more challenging, but Dr Hopton was confident that these could be achieved. One challenge was energy infrastructure for PFI buildings, particularly the Royal Infirmary of Edinburgh which was due to be handed back to NHS Lothian in 2027.

51.1.5 An update on eHealth involvement would be included in the next update. **JH**

51.1.6 Members accepted the recommendations laid out in the paper.

52. Committee Business

52.1 Reflection on the meeting

52.1.1 The chair agreed to highlight the following items to the Board at its next meeting: medium term financial framework; the suggestion that a risk be added to the risk register specifically on drug spend; and NHS Lothian's leading strategy for climate which was in line with the Scottish Government Strategy.

53. Date of Next Meeting

53.1 The next meeting of the Finance and Resources Committee would take place at **14.00** on **Monday 21 March 2022**.

54. Meeting Dates in 2022

54.1 Further meetings in 2022 would take place on the following dates:
- 20 April 2022, 9.30;
- 31 May 2022 (Tuesday), 14.00;
- 17 August 2022, 9.30;
- 19 October 2022, 9.30;
- 21 December 2022, 9.30.

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 2pm on Monday 21 March 2022 via MS Teams.

Present:
Mr A. McCann, Non Executive Board Member (Chair);
Mr B. McQueen, Non Executive Board Member;
Councillor S. Akhtar, Non Executive Board Member;
Councillor G. Gordon, Non Executive Board Member;
Ms S. Goldsmith, Director of Finance;
Ms T. Gillies, Medical Director;
Mr P. Wynne, Interim Executive Nurse Director.

In Attendance:
Mr C. Campbell, Chief Executive;
Mr J. Crombie, Deputy Chief Executive;
Ms J. Campbell, Chief Officer, Acute Services;
Mr C. Marriott, Deputy Director of Finance;
Mr I. Graham, Director of Capital Planning and Projects.
Ms T. McKigen, Services Director, Royal Edinburgh Hospital (item 49.2);
Mr A. Payne, Head of Corporate Governance;
Mr C. Graham, Secretariat Manager (minutes).

Apologies:

Chair's Welcome

The Chair welcomed members to the meeting.

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.

55. Committee Business

55.1 Scottish Hospitals Inquiry (SHI) - Ventilation Narratives

Mrs Goldsmith introduced the report outlining the five narratives prepared in relation to issues of ventilation which were, or in one case still, subject to dispute with IHSL. The Committee's commentary and agreement to issue to the SHI Team in due course is sought.

The Committee agreed to endorse and fully support the issuing of the five ventilation narratives to the SHI Team.

The Committee noted that the Theatre Corridor ventilation issue had not been resolved and is still in dispute with IHSL.

56. Revenue

56.1 2022/23 Financial Plan

Mrs Goldsmith provide the Committee with an assessment of the Financial Outlook for the next five years, and specifically the outline Financial Plan for 22/23.

This represented the third and final update on the 22/23 Outlook, with information having been previously shared with Committee at the November and January meetings.

The paper sets out the latest available financial position information based on the current forecast outturn, anticipated growth and assumptions around additional resources.

The paper also includes the financial information contained in the indicative budget allocation communicated to Lothian from the Scottish Government on the 9th of December and draws out a number of financial issues for next year relating to Covid-19.

The Committee agreed the recommendations in the paper, to:

- Consider the challenge to deliver financial balance across Core services with a £28m resource gap identified at this stage, and the associated risks inherent to current assumptions;
- Consider the assumed financial impact of Covid, whilst recognising those constraints impacting on our ability to commit financial resources;
- Endorse the Financial Outlook 2022/23 to be presented to the Board for approval and submission to the Scottish Government recognising that the risks around Covid funding mean that we are not able to provide assurance on delivering a balanced financial position next year.

56.2 Financial Update

Mrs Goldsmith update the Committee on the financial position at Period 10 for NHS Lothian.

The paper set out the financial impact from Covid-19 to January and provided an update on the main core pressures in year. It also set out the estimated outturn at year end based on current information and assumptions.

The Committee agreed the recommendations in the paper, to:

- Consider the financial position at January 2022 which reports a Core overspend of circa £1m year-to-date;
- Accept that, based on information available at this stage and assumptions around additional funding, NHS Lothian is able to provide significant assurance on its ability to deliver a breakeven position in 2021/22;
- Consider the financial impact of the Covid position at January 2022, and the potential for ongoing Covid related costs in the future; • Acknowledge the funding solutions to support the achievement of financial balance this year.

57. Date of Next Meeting

57.1 The next meeting of the Finance and Resources Committee would take place at **9.30am** on **Wednesday 20 April 2022**.

58. Meeting Dates in 2022

58.1 Further meetings in 2022 would take place on the following dates:
- 20 April 2022, 9.30;
- 31 May 2022 (Tuesday), 14.00;
- 17 August 2022, 9.30;
- 19 October 2022, 9.30;
- 21 December 2022, 9.30.

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 20 April 2022 by videoconference.

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

In attendance: Mr N. Bradbury, Capital Finance Manager; Mr C. Campbell, Chief Executive; Ms J. Campbell, Chief Officer, Acute Services; Ms M. Campbell, Director of Estates and Facilities; Ms M. Carr, Service Director Diagnostics, Anaesthetics, Theatres and Critical Care (item 2.3); Mr J. Crombie, Deputy Chief Executive; Mr I. Graham, Director of Capital Planning and Projects; Mr M. Gray, Laboratory Service Manager (item 2.3); Dr J. Hopton, Programme Director; Mr C. Marriott, Deputy Director of Finance; Ms G. McAuley, Interim Executive Nurse Director; Mr D. Mill, Senior Project Manager (item 2.5); Ms B. Pillath, Committee Administrator (minutes).

Apologies: Ms T. Gillies, Medical Director.

Chair's Welcome

The Chair welcomed members to the meeting and welcomed two new members, Andrew Fleming and Philip Allenby.

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

1. Committee Business

1.1 Minutes and Actions from Previous Meetings (17 January 2022 and 21 March 2022)

1.1.1 Members accepted the minutes from the meeting held on 17 January 2022 as a correct record subject to one minor correction, and accepted the minutes from the meeting held on 21 March 2022 as a correct record.

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

1.2 Committee Annual Report

1.2.1 Mr Marriott presented the previously circulated paper. Some comments were made regarding wording of the report which Mr Marriott agreed to incorporate into the final report before submitting to the Audit and Risk Committee.

1.2.2 It was noted that under item 7 the wording from the Committee Terms of Reference had been used to state that the Committee oversaw management of property and

estate in line with Scottish Government requirements. It was agreed that at the next review of the Terms of Reference the suggestion of adding to the remit of the Committee the responsibility to ensure that the estate was managed effectively, sustainably and efficiently would be considered. **CM**

1.2.3 Members accepted the recommendations laid out in the paper and approved submission of the report to the Audit and Risk Committee subject to the amendments agreed.

1.3 Committee Effectiveness Members Survey

1.3.1 Mr McCann presented the previously circulated paper. It was noted that the Planning Performance and Development Committee was expected to inform the Finance and Resources Committee of any relevant national policies and strategies. Mr Campbell advised that there were a large number of recommendations, guidance and requirements from the Scottish Government and that he and the executive team reviewed these and decided which key strategy announcements required to be considered at the Board.

1.3.2 Members accepted the recommendations laid out in the paper.

2. Capital

2.1 Property and Asset Management Investment Programme

2.1.1 Mr Graham presented the previously circulated paper. It was noted that that a breakeven position had been achieved, but more information was requested for the next update as to whether all planned works had been completed. **IG**

2.1.2 The programme boards and project managers were currently working on completing the key project dates on the tracker template.

2.1.3 Mr Graham advised that it had been estimated that the new NHS Scotland Assure governance assurance process had added approximately 15 weeks to the project time agreement. NHS Lothian's governance process also took 15 to 20 weeks but the two processes could not necessarily run simultaneously. The additional delay led to increased capital costs due to inflation of costs in the building industry. NHS Scotland Assure currently lacked full resource to carry out their work which may add to the time taken to complete the assurance process.

2.1.4 Mr Graham and Ms Campbell had met with Julie Crickmar, head of NHS Scotland Assure. NHS Scotland Assure were planning engagement with Boards and were sending out invitations to online briefing sessions, and the suggestion of a session at the Finance and Resources Committee in the future was also made. It was agreed that this would be taken forward in the future following the initial briefings. **IG**

2.1.5 Mr Graham advised that the Primary Care Programme Board would consider and agree a recommended prioritisation of projects considering different criteria. This would result in initial agreements being presented through the usual Board governance structure for decision.

2.1.6 Councillor Akhtar noted that health infrastructure resource would not automatically align with local authority house building projects and that the need for this would increase costs for NHS Lothian. Mr Graham advised that the capital planning team was engaged with the Scottish Government health and planning departments to consider how resources for health infrastructure could be allocated at the same time as new housing, and was also engaged with local authority planning teams in each area. It was noted that health infrastructure resource inclusion in new housing was not statutory.

2.1.7 Mr Graham agreed to consider how to incorporate updates on progress on primary care projects into the project tracker. **IG**

2.1.8 Members accepted the recommendations laid out in the paper and accepted significant assurance on the delivery of the programme. Members also accepted assurance that a breakeven position had been achieved and awaited formal report confirming this.

2.2 Assurance and Quality in Capital Planning

2.2.1 Mr Graham presented the previously circulated paper. Members noted the comprehensive and thorough assurance checklist. Mr Graham agreed to consider the suggestion of including a tracker that showed whether long running projects were on schedule, how to show running costs, and the addition of a glossary of acronyms.

2.2.2 It was noted that no information had been added on the workforce model in the tracker. Mr Graham advised that workforce assurance was included as part of the business case and agreed to ensure this part of the tracker was updated. Ms Goldsmith advised that any workforce risks related to projects would be considered at the Staff Governance Committee.

2.2.3 Members accepted the recommendations laid out in the paper.

2.3 Laboratory Information Management System – Full Business Case

2.3.1 The chair welcomed Mr Gray to the meeting and he presented the previously circulated paper. It was noted that the revenue costs for running the new system were based on the current resource for running the current system.

2.3.2 Giving assurance on the consideration of the challenges of implementation of a joint system with other health boards, Mr Gray advised that all the Boards involved were keen to have a standardised national system and had agreed to be involved in the implementation team and making key decisions on the standard process. Currently all boards were using different systems with different coding.

2.3.3 It had been agreed that each health board would implement their own instance of the new system, and each instance would be linked together. This reduced security and system failure risks but meant that a robust governance mechanism was needed at implementation stage for approval of changes to local systems and ensure that the systems would continue to be standardised as a whole.

2.3.4 It was noted that there was a risk of higher costs when including the contractor at the discussion stage. Mr Bradbury advised that the specifications at the time of tender were comprehensive and the contract reflected this, including key milestones with costs attached. The CLO had also had input into the contract and all the Boards had agreed on this. This gave some assurance that the agreed costs would not be increased.

2.3.5 Mr Gray advised that the current laboratory system interacted with hundreds of different information systems in use in the Board and that it was part of the contract that the new system must also link with these systems.

2.3.6 Members accepted the recommendations laid out in the paper and approved the business case, noting the potential for this project to make a substantial improvement to the efficiency of the laboratory system across Scotland.

2.4 Hospital Sterilisation and Decontamination Unit (HSDU) – Risk Update

2.4.1 Ms Campbell presented the previously circulated paper. Mr McCann noted that there had been concerns about the sustainability of the HSDU for some time and that this had been raised with the chair of the Healthcare Governance Committee in May 2019. The concern was now recorded on the risk register and work was progressing.

2.4.2 Members accepted the recommendations laid out in the paper. A further update would be brought to the Committee at the meeting in October 2022. **JCr**

2.5 Phase 2 Western General Hospital Energy Infrastructure – Full Business Case

2.5.1 Dr Hopton and Mr Mill presented the previously circulated paper. It was noted that there had been a 9 month delay in getting to this stage in the process for this project and that an increase in cost had been identified. Mr Mill advised that the increase in cost may be partly attributed to the delay with the NHS Scotland Assure process, but that market pressures had also led to an increase.

2.5.2 Mr Bradbury advised that as this project was funded by the Scottish Government, the risk associated with the increase in cost remained with them, and there was no direct impact on NHS Lothian's capital spending elsewhere.

2.5.3 Dr Hopton advised that NHS Scotland Assure was a new body and that there was a need to build a relationship with them and streamline processes. In the case of this project the requirement to engage with them came in late and it was the first time their process had been used which caused difficulties as their model did not align with NHS Lothian's model. In time these difficulties could be worked through.

2.5.4 Mr Crombie advised that the Scottish Government had initially not expected the NHS Scotland Assure process to add any cost to projects. If evidence was coming through nationally that costs had increased due to the process this would be subject to review at NHS Scotland's Capital Investment Group and an agreement would be made, for instance more resources for NHS Scotland Assure to streamline its processes, or additional money budgeted into capital investment projects. Expected timescales and therefore costs would become clearer in the next year.

2.5.5 It was agreed that it was important for NHS Scotland Assure to have a discussion with this Committee so that there was a common understanding on processes, and agreed to follow this up with them. **CM**

2.5.6 Mr Mill advised that the project was not specifically aimed at reducing carbon use but in ensuring the infrastructure was adequate for the opening of the new Cancer Centre, however the works would improve efficiency which would be a step towards becoming carbon neutral in the future. The new system would continue to be based on a gas heating system. Some revenue impacts of improved efficiency were expected, but this was difficult to quantify because of the complexity of the system and the limits of data collected.

2.5.7 Mr Graham noted that confirmation had been received from the Scottish Government on funding for the next phase of the project.

2.5.8 In response to a question on the likelihood of achievement of the target cost, Mr Graham advised that the target cost was based on a percentage of market testing and that there were options in the contract and a risk fund to cover any variations. The aim was to get the target cost as close to the final cost as possible and there was a robust process for this.

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

3. Revenue

3.1 <u>February 2021 YTD Financial Position</u>

3.1.1 Mr Marriott presented the previously circulated paper. He advised that work was ongoing with the Scottish Government on when and how to shut down covid services such as test and protect and the vaccination programme, and how to reallocate resources and the workforce engaged for these services was not recurring contracts. Guidance on when these services would be shut down was awaited.

3.1.2 Mr McQueen advised that a report was expected at the Staff Governance Committee on 21 June on the Scottish Government workforce plan and guidance on implementation of workforce policies, as well as an update on NHS Lothian's workforce plan.

3.1.3 Mr Marriott advised that the drugs overspend was due to increase in drugs costs and change in new drugs policies. The new drugs fund was the same each year and so did not cover increase in costs. There was engagement with the Scottish Government on this. It was possible that there had been some increase in costs due to increased waiting times for patients, but most of the high cost areas including cancer and palliative care had continued during the reduction of services due to covid and therefore were not experiencing the same level of backlog.

3.1.4 Members accepted the recommendations laid out in the paper and accepted significant assurance on the achievement of a breakeven position in 2021/22.

4. Scottish Hospitals Inquiry

4.1 Scottish Hospitals Inquiry Update

4.1.1 Ms Goldsmith presented the previously circulated paper. The next hearings would be held in May, and NHS Lothian employees would give witness statements. Witnesses were allowed to collaborate and there had been an informal meeting with the Inquiry team. The witness statements were currently being reviewed by the CLO and a summary would be available for circulation to the Committee before the hearings.

SG

4.1.2 All the witness statements would be made available before the hearings including those from the other witnesses – Scottish Government, Scottish Futures Trust and Mott Macdonald.

4.1.3 The Committee was committed to ensure that staff involved in the hearings would be supported. Ms Goldsmith advised that the CLO was providing support to witnesses and a workshop would take place prior to the hearing to help with preparation.

4.1.4 The cost to NHS Lothian of the Inquiry was significant and the amount of legal input required would be reviewed before the October 2022 hearings. There had not been agreement from the Scottish Government to fund the Inquiry for the previous year and there had been sufficient flexibility in the system to cover this. This would be revisited for future years.

4.1.5 There had been discussion at the Board regarding an independent arbiter to liaise between NHS Lothian's expert witnesses. Donald Inverarity, Infection Control Doctor, and Lindsay Guthrie, Head of Infection Control had been prepared for this but this would depend on whether they could be accommodated by the Inquiry.

5. Sustainability

5.1 Update on Sustainability

5.1.1 Dr Hopton presented the previously circulated paper. She advised that of the 12 new posts she had identified for the team, NHS Lothian had agreed funding for 3 to date. 2 of these were currently being advertised and the job description for the third was under discussion. The Scottish Government was considering asking Boards to put aside a certain amount of resources for the sustainability programme, and was also considering a national funding allocation for more support.

5.1.2 There was concern that significant work was required to comply with the Scottish Government's Climate Change Strategy but that sufficient resources were not being provided to carry this out. Dr Hopton advised that the funding provided to the team by NHS Lothian would help progress work but may not be enough to achieve the strategy and that she would like to see more funding allocation from the Scottish Government. Mr Marriott agreed to discuss the strategy resource discrepancy with Scottish Government colleagues.

5.1.3 It was noted that the active travel work was intended to cover sustainable travel options for both staff and patients. This included reducing patient travel by using Near Me consultations. Technology for analysing travel options was improving with the

potential to advise patients and staff of different travel options and inform clinic times and shift patterns. Members suggested that some metrics on active travel behavioural change would be useful for analysing impact.

5.1.4 Mr Mill advised that the most effective areas for investment in sustainability were likely to be theatres, including their use of anaesthetic gasses, single use products, energy use and waste produced. Pharmaceuticals was another area where there was likely to be a level of waste, but where there was not much data available at this stage.

5.1.5 Members accepted the recommendations laid out in the paper and commended the important work being carried out.

6. Reflections on the meeting

6.1 Mr McCann agreed to highlight at the next Board meeting the assurance received that NHS Lothian was well prepared for the Scottish Hospitals Inquiry hearings in May 2022, and the assurance received on mitigation of the HSDU risk.

6.2 This was the last meeting for Councillor Akhtar before the forthcoming council elections. Members thanked her for her contribution to the Committee.

6.3 This was the last meeting for Ms Goldsmith before her retirement; the chair thanked her on behalf of the Committee for her huge amount of work, commitment and expertise she had shown during her time as Finance Director. Ms Goldsmith thanked the Committee for being an effective and open forum for debate and support.

7. Date of Next Meeting

7.1 The next meeting of the Finance and Resources Committee would take place at **14.00** on **Tuesday 31 May 2022**.

8. Meeting Dates in 2022

8.1 Further meetings in 2022 would take place on the following dates:
- 31 May 2022 (Tuesday), 14.00;
- 17 August 2022, 9.30;
- 19 October 2022, 9.30;
- 21 December 2022, 9.30.

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 13.00 on Tuesday 22 March 2022 by video conference.

Present: Ms F. Ireland, Non Executive Board Member (chair); Ms C. Hirst, Non Executive Board Member; Mr B. McQueen, Non Executive Board Member; Ms T. Miller, Employee Director.

In attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Mr C. Campbell, Chief Executive; Ms J. Bladen, Talent Management Programme (observing); Ms J. Campbell, Chief Officer Acute Services; Mr J. Crombie, Deputy Chief Executive; Mr S. Garden, Director of Pharmacy; Ms T. Gillies, Medical Director; Ms J. Henderson; Talent Management Programme (observing); Ms P. Holland, Finance Manager (item 69.1); Ms J. Long, Director of Primary Care; Ms G. McAuley, Nurse Director Acute Services; Ms A. MacDonald, Chief Officer, East Lothian Health and Social Care Partnership; Ms T. McKigen, Services Director, Royal Edinburgh Hospital (item 70.1); Dr R. Millar, Consultant in Public Health (item 66.1); Dr D. Milne, Director of Public Health and Health Policy; Ms J. Morrison, Head of Patient Experience; Mr I. Orr, Talent Management Programme (observing); Ms I. Penman, Talent Management Programme (observing); Ms B. Pillath, Committee Administrator (minutes); Ms D. Robertson, Business Manager (observing); Mr C. Stenhouse, Talent Management Programme (observing); Ms F. Stratton, Chief Nurse Midlothian Health and Social Care Partnership; Mr C. Stirling, Site Director, Western General Hospital (item 66.1); Ms A. White, Chief Officer, West Lothian Health and Social Care Partnership; Dr C. Whitworth, Medical Director, Acute Services; Mr P. Wynne, Interim Executive Nurse Director.

Apologies: Dr P. Donald, Non Executive Board Member; Mr J. Encombe, Non Executive Board Member; Councillor G. Gordon, Non Executive Board Member; Ms L. Yule, Chief Nurse, West Lothian Health and Social Care Partnership.

Chair's Welcome and Introductions

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

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

65. Minutes from Previous Meeting (25 January 2022)

65.1 The minutes from the meeting held on 25 January 2022 were approved as a correct record.

65.2 The updated cumulative action note had been previously circulated.

66. Matters arising

66.1 Breast Screening Programme Adverse Event

66.1.1 The chair introduced Dr Millar and Mr Stirling to the meeting and they presented the previously circulated paper. It was noted that the service involved was not part of the national breast screening programme.

66.1.2 It was suggested that there should be a timescale for other Boards to report back that they had invited women overdue screening appointments who were now living outwith Lothian. This would be part of the action plan. The process for patients outside Lothian who may require recall was accepted as laid out in appendix 3b of the paper.

66.1.3 Members accepted the recommendations laid out in the paper and the processes detailed in the appendices. An update on progress with the action plan would be brought to the Committee at the meeting in September 2022. **DM**

66.2 Learning from Delayed Discharge Mortality Reviews

66.2.1 Ms Gillies presented the previously circulated paper. It was noted that 10% of patients surveyed had suffered adverse events which may have contributed to their death and members asked whether this was a similar percentage to patients in the same frailty category who did not have a delayed discharge but were in hospital due to their clinical needs.

66.2.2 Members also asked what actions were being taken to reduce the number of delayed discharges and to improve safety for these patients while they remained in hospital. Ms Gillies advised that it was recognised that even with a high level of clinical need, patients were safer at home than in hospital and that the adverse event rates were within the expected range.

66.2.3 Members were reassured that if a patient was on an end of life care pathway and wished to go home then they were identified at daily huddles and every effort was made to allow them to return home. It was suggested that these cases could be reviewed to see if any more could have been done to get them home sooner. It was noted that patients previously delayed but who then deteriorated before dying were not included in this review. Equally, the patients who successfully returned home for end of life were not included in the figures presented.

66.2.4 It was noted that some of the reviewers had not had access to charts or to records on the electronic prescribing system. Ms Gillies advised that this was not a concern – charts were completed on paper and then scanned in so the death review may have been completed before these became available on the electronic system. Not all reviewers had access to the electronic prescribing system as this was still being rolled out at the Royal Infirmary, but this would be complete by the end of the year.

66.2.5 Health and Social Care Partnership representatives at the meeting advised that the development of community services for palliative care and anticipatory care was something that was being worked on at the moment.

67. Committee Business

67.1 Workshop Feedback and Draft Committee Workplan

67.1.1 Ms Bennett presented the previously circulated paper. The draft workplan for 2022-23 had grouped items for discussion by theme, but it was noted that emerging issues would continue to be included at the next available meeting as required. Some items were also restricted in timing due national or regional data reporting schedules that were outwith NHS Lothian's control.

67.1.2 Members accepted the recommendations laid out in the paper and accepted the draft workplan in principle, with the understanding that small alterations could be made to accommodate reporting schedules.

67.2 Healthcare Governance Committee Annual Report and Assurance Framework

67.2.1 Ms Bennett presented the previously circulated paper. It was noted that the terms of reference stated that the Board should appoint a voting member of the Committee from each Integration Joint Board. It was agreed that this would be considered as part of a review of the terms of reference.

67.2.2 The non-executive members of the Committee had arranged to meet to discuss the Committee assurance statement further prior to the meeting in May where it would be considered by the whole Committee.

68.2.3 Members agreed to include all the areas listed at paragraph 3.2.1 in the assurance statement as having given only limited assurance in the past year. It was noted that the patient information single policy approach was a longer term piece of work so needed monitoring but not escalating at this stage. It was agreed that there was limited assurance on access to cancer services but that KPI compliance was not a problem. The Committee did not wish to add any further issues to this list.

68.2.4 Members accepted the recommendations laid out in the paper. The final annual report and assurance statement would be presented at the May meeting for approval before being submitted to the Audit and Risk Committee.

69. Person Centred Care

69.1 Urgent Care Access Redesign – Improving Patient Experience

69.1.1 Ms MacDonald presented the previously circulated paper with Ms Holland. The process of collecting data to measure the impact of the service redesign on patient experience was in the early stages and a small sample had initially been used. Data would be collected monthly starting from the end of April 2022.

69.1.2 Healthcare Improvement Scotland required ten in depth surveys per month to be carried out in each Board to measure the impact. It was agreed that this was a very small sample and also noted that the information requested in the survey was limited. Ms MacDonald agreed to discuss with the programme board the possibility of carrying out a local survey with additional questions in addition to the national programme.

69.1.3 More data was needed to understand why fewer people were now attending the Emergency Department as a percentage but that 4 hour performance had worsened and more data was needed to understand why some patients did not engage with the

NHS 24 route or decided to attend the Emergency Department after contacting NHS 24.

69.1.4 Ms MacDonald agreed to take these points back to the programme board and return to the Committee with an update on plans to take these areas forward. **AMacD**

70. Safe Care

70.1 Child and Adolescent Mental Health Service Medical Workforce

70.1.1 The chair welcomed Ms McKigen to the meeting and she presented the previously circulated paper. Members commended the amount of work done on using a multidisciplinary approach to ensure the service could be delivered safely in the face of a severe shortage of medical staff.

70.1.2 Ms McKigen advised that there were monthly meetings with the Scottish Government as part of the escalation of the service and that they had agreed to support a better regional approach to on call services which may make medical posts more attractive to applicants.

70.1.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance. Members also accepted the recommendation that moderate assurance be taken on the CAMHS service overall due to reduction in waiting times.

70.2 Healthcare Associated Infection Update

70.2.1 Ms Gillies presented the previously circulated paper. Members accepted the recommendations laid out and accepted moderate assurance.

71. Effective Care

71.1 Actions to address Did Not Attend (DNA) Rates

71.1.1 Ms Campbell presented the previously circulated paper. It was felt that more analysis was needed on the core issues of which patients were not attending appointments and why, and whether this was associated with inequalities of age, sex, ethnicity or socio-economic status. Ms Campbell advised this feedback was systematically requested from patients. A programme of work on inequalities was being carried out by Public Health and any did not attend work should align with this.

71.1.2 The majority of communication with patients about appointments continued to be by letter. The Outpatient Modernisation programme was currently working round all services which would allow the facility for text reminders and online appointments and there was support for this in the services. The role out was overseen by the Outpatient Modernisation Programme Board which reported to the Scheduled Care Board and the Planning, Performance and Development Committee.

71.1.3 The option for electronic communication using browser based software was currently available for patients but there was a very low take up so more work was needed on this. Some work had been done on the number of letters reported not to have arrived

with patients, but the problems occurred after they had been handed over to the postal service and it was not clear how to reduce this.

71.1.4 Members accepted the recommendations laid out in the paper and noted the work ongoing, and requested more information on the equalities element of the work with Public Health in the next update in six months' time. **JCa**

71.2 Scottish Intercollegiate Guidelines Network Annual Report

71.2.1 Ms Gillies presented the previously circulated paper. Ms Gillies agreed that the SIGN guidelines could be linked to the Policy guidelines on the website so that they were available for the public to access rather than staff only.

71.2.2 Ms Gillies advised clinicians' compliance with the guidelines had been reported on, but this had not been possible in this years' report. All these guidelines should be implemented and if it was not there should be a clear reason for this. If there were any concerns about guidelines not being implemented this would be escalated through the Quality Assurance Team to the Medical Director.

72. Exception Reporting Only

72.1 Controlled Drug Governance Team Annual Report

72.1.1 There was a question about staff absence and the inability to carry out important checks during the last year. Mr Garden noted that as patient care was a priority during that period and movement between buildings was limited, visits had not taken place but services had done self assessments and that this had been an appropriate approach. The vacancies had now been filled.

72.2 Members noted the following previously circulated paper:

72.2.1 Tissue Governance Annual Report;

73. Other Minutes: Exception Reporting Only

Members noted the following previously circulated minutes:

73.2 Clinical Management Group, 9 November 2021, 8 February 2022.

74. Corporate Risk Register

74.1 Ms Bennett presented the previously circulated paper. Members accepted the recommendations laid out.

75. Reflection on the Meeting

75.1 Members did not identify any items to be escalated to the Board or to another governance committee.

76. Date of Next Meeting

76.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 24 May 2022** by video conference.

77. Further Meeting Dates

77.1 Further meetings in 2022 would take place at 13:00 on the following dates:
- 19 July 2022;
- 27 September 2022;
- 29 November 2022.

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 2 March 2022 via Microsoft Teams.

Present:
Mr W. McQueen, Non-Executive Board Member (Chair);
Mrs J. Butler, Director of Human Resources and Organisational Development;
Miss T. Gillies, Medical Director
Mrs J. Campbell, Chief Officer, Acute Services
Ms C. Hirst, Non-Executive Board Member
Mr S. Chandran, Non-Executive Board Member
Ms K. Kasper, Non-Executive Board Member;
Ms J. Clark, Partnership Representative;
and Ms H. Fitzgerald, Partnership Representative.

In Attendance:
Mr C. Campbell, Chief Executive
Mr J. Crombie, Deputy Chief Executive
Ms R. Kelly, Deputy Director of Human Resources;
Ms A. Langsley, Associate Director of OD & Learning;
Dr S. Edgar, Director of Medical Education, NHS Lothian
Mr S Haddow, Head of Medical Workforce Planning, Human Resources (Item 5.3)
Ms J. McNulty, Associate Nurse Director, Theatres & Anaesthetics (Item 6.1)
Ms A. Langsley, Associate Director of OD & Learning, Training & Development (Item 2 & 6.4)
Ms J. Balkin, Regional Workforce Planning Manager, Human Resources (Item 7.2)
Mr N. McAlister, Head of Workforce Planning, Human Resources (Item 7.2)
Mr C. Bruce, Lead on Equalities and Human Rights, Public Health & Health Policy
Ms R. Suleiman, Equality and Diversity Adviser, Equality and Diversity Team
Ms M Campbell, Director of Facilities (Item 6.1.4)
and Mr G. Ormerod, Committee Administrator (minutes).

Apologies:
Ms Tracy McKingen, Pat Wynne and Tracy Anne Miller

Chair's Welcome and Introductions

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

41 Mr McQueen thanked Bryony Pillath and Chris Graham for their help and support with the Staff Governance Committee over the last year and welcomed Gary Ormerod to his role as Committee Administrator.

42 Presentation - Joy in Work

42.1 Mr Edgar and Ms Langsley provided the committee with an update on the approach taken to date, success and next steps in relation to Joy in Work. Mr Edgar highlighted

that Joy at work is focused on achieving success and fulfillment and employees want to be safe, supported and developed so that each day they feel fulfilled. Mr Edgar advised that there are proven methods for high quality care which bring about benefits for patients even in difficult times, but highlighted that stress and burnouts are on the rise.

42.2 Mrs Langley provided an overview of the physiological and safety needs and the steps health care teams can take and engage in to reduce burnout and stress. Learning networks have been set up at WGH over the last 18 months to gain an insight into employees 'what matters to them' issues.

42.3 Areas of improvement were noted within the presentation with clinical supervision at 43% and wellbeing was noted as very low. Mr Edgar confirmed they are looking to grow the network membership and focus on wellbeing, burnout and joy at work, with the 3rd National Joy at Work conference due to take place this year.

42.4 Mrs Butler advised that within the corporate objectives we are looking at staff feedback and a tool to engage with staff regularly as we currently lack a systemised way to do this in addition to iMatter. Mr McQueen thanked Mr Edgar and Ms Langlsey and asked for this work to be revisited in 6 months with the Committee. **AL & SE**

43 Minutes and Action Note of Previous Meeting held on 15 December 2021

43.1 The minutes from the meeting held on 15 December 2021 were approved as a correct record.

44 Matters Arising

44.1 Mr McQueen advised that work on the Healthcare Science Service – Accredited Registers paper (Item 35.5) is currently ongoing and is now expected in June. It was noted the Committee has picked up the reflections in respect to Violence and Aggression (V&A) and programme for wellbeing of staff and NHSL Board colleagues have been briefed with support from Mr Connor.

45 Staff Experience

45.1 Advancing Equalities Staff Network Action Plans – update

45.1.1 Mrs Kelly provided an update on the Advancing Equalities Action Plan and advised that we are coming to the end of the 2021/22 plan and most of the actions will be concluded by March but due to service pressures some of the actions will be carried forward into next year's plan. .

45.1.2 Mrs Kelly provided an overview of the ongoing actions and confirmed a Workforce Equality Project Support Manager has been appointed and was now helping to move forward some of the actions particularly the communications with staff networks. Over the next few months we will have a targeted approach to improving diversity and updating personal data on our HR System along with HR online improvements to further promote the Staff Networks. It was noted that the Transgender policy will not progress at an NHS Lothian level but will be suggested for a Once for Scotland approach, but guidance documents are available and staff in HR have experience in

this area.

45.1.3 Mr Bruce confirmed that work is going well with the corporate objective with CMT involved with the staff network member for coffee roulette and facilitated discussions and feedback on lessons learned. Mr Bruce advised that we continue to raise the profile of the network, but the impact of the pandemic and not being able to meet locally has slowed us down. Ms Sulieman advised that all networks are fully engaged and we hope the outcome and feedback will be as we planned and highlighted the opportunity as an organisation to celebrate our diversity and culture.

45.1.4 Mr McQueen noted the good progress and asked if managers could have a prompt as part of their staff appraisals to help with the improvement of personal data? Mrs Kelly acknowledged this and would take forward the suggestion..

45.2 Whistleblowing Report

45.2.1 Mrs Kelly presented the circulated paper and advised that since the last committee there has been one new stage 2 concern raised. Two separate concerns previously raised under stage 2 (276 and 277) have now been combined into a single concern due to being a similar case and a single investigation undertaken. Mrs Kelly highlighted that Appendix 3 details the draft Q3 Whistleblowing Performance Report (April 2021 – December 2021) that will go to the next board meeting.

45.2.2 Mrs Kelly advised that Ms Barclay, Whistleblowing Programme Manager had done some work on the format of the whistleblowing report following discussions with the SPSO and progressed this in preparation for Q4 and an annual report that will go to the board later in the year. Primary care contractors have been contacted for an update and the return will go into Q4.

45.2.3 Mrs Kelly highlighted that we are learning from whistleblowing concerns and are in the process of gathering information and sharing with a short life working group with an opportunity to gain insight from investigators who have commissioned the reports and through Ms Kasper meeting with whistleblowers if they wish once the process has concluded. Mrs Kelly advised that we are in the early stages of capturing data for stage 1 concerns and any feedback on how the process went. Mrs Kelly advised the Speak Up Q3 numbers are noted for information and referenced under appendix 4.

45.2.4 Mr McQueen commented that he was interested in the work to learn and to improve from feedback, if a complaint is upheld is this reported back to the whistleblower?
Mrs Butler advised the standards are provided to give feedback to the whistleblower including what findings and actions are being taken as part of the investigation to close to communication loop.

45.2.5 The committee noted and approved the recommendations.

45.3 iMatter - National Staff Survey Results

45.3.1 Mr Haddow advised that 2021 was the largest survey to date with 28,000 staff participating including all health and social care staff in East and West Lothian for the first time, with the data captured over the last 4 years available for comparison. The

response rate this year was over 50% with 83% of reports published. The threshold for receiving a report was reduced to 60% this year, which has been done in agreement with all other boards across Scotland.

45.3.2 Mr Haddow confirmed that the action plans response rate this year dropped to 15% but due to the pandemic pressures of work there was less of a priority put upon developing these action plans. The action plan period was also reduced from 12 to 8 weeks to allow teams to complete plans quicker for plans to be implemented.

45.3.3 Mr Haddow advised that for the coming year paper and email will still be used but we are also introducing SMS text and looking to move away from paper responses, which we hope will result in an increased response rate; as part of this we will target areas that currently use paper to encourage people to move away from this, but the paper option will always remain available.

45.3.4 A yearly component breakdown was shown with all 28 questions marked in respect of responses from highest to lowest; the 4 lowest scores were based around organisation level including visibility of senior management. The overall experience is scored at 6.8, which is similar to previous years.

45.3.5 Mr Haddow advised that the 2022 timeline has been shortened but over the same time period, teams have been split into 2 separate cohorts. All electronic responses and team reports will be available the day after the deadline to aid rapid improvement action to be prepared, with cohort 1 due to go out on 16th May and cohort 2 on 27th June. It was noted that iMatter are rolling out sub-level reporting for a further aggregated reporting that will allow teams to compare results.

45.3.6 Mr McQueen thanked Mr Haddow for his detailed presentation and the committee noted the work being undertaken.

45.4 Staff Engagement and Experience Progress Update

45.4.1 Ms Langlsey provided an update on staff engagement experience and sought a moderate level of assurance in relation to the corporate and local plans. Ms Langsley confirmed there are two core workstreams, corporate enablers and local SEE plans. Ms Langsley confirmed that corporately 21 business units have been identified, 12 plans received so far and following up with areas outstanding, plans received so far have been shared wider to provide inspiration for working across the system.

45.4.2 There has been progress with staff wellbeing and and non-reoccurring funding from Scottish Government and commitment to the wellbeing programme for the next 12 months that includes monthly book club, wellbeing books to support staff and hot food supplies for staff working out of hours.

45.4.3 Ms Langsley confirmed plans to deliver 4 annual leadership events and hopes to hold these face-to-face. A leadership talent management programme is also commencing on 9th March up to June with 12 General Managers.
The committee approved and noted the actions are on track.

46 Assurance and Scrutiny

46.1 Corporate Risk Register

46.1.1 3455 –Management of Violence and Aggression
Mrs McNulty confirmed that funding for 2 additional posts on a non reccurring basis had been approved to support the work on succession planning for the next 12 months. Mrs McNulty advised the action plans were transferred to a risk mitigation template and a short life working group has been set up and a project manager has been appointed.

46.1.2 Mrs McNulty advised that purple packs are going to MEG audit data system (MEG) to allow improved sign-off and work is ongoing for appointment of staff to help with training and purple packs.

46.1.3 Mrs Butler advised that it was agreed at the last committee that Ms Ireland would provide a written brief update to allow the committee to be updated on the significant actions and plans in place. Mr McQueen confirmed that an update would be helpful with allaying areas of concern identified in the internal audit review. Mrs McNulty confirmed that a written update would be provided outwith the meeting. .
JMcN

46.2.1 3828 – Nurse Workforce – Safe Staffing Levels
Mrs McNulty advised the key issues are the establishment gap, currently at 5.15% against the 5% target. The RIE and WGH have seen a shift in the establishment gap and SJH has seen a 0.5% increase despite recruitment. REAS dropped to 10.2% from 12.9% and pressure in all areas for Primary Care. Sickness rate at 6.8% is higher than last year and hours have been lost through staff sickness due to covid (Nov-Jan) and stress.

46.2.2 A Nursing and Midwifery Workforce Escalation Framework has been developed with the aim of setting a consistent approach and to mitigate staff pressures. Staffing levels are monitored routinely, and decisions taken at safety huddles on how to best deploy the staff across a site, partnership and on a pan-Lothian basis. Mrs McNulty highlighted some of the current risk mitigation plans (appendix 1) currently in place.

46.2.3 Mrs McNulty advised that further work is required to support staff health and wellbeing but an SBAR is progressing for a B4 role in Occupational Health to help with complex cases. A lot of focus on clinical ward and theatres areas with challenges but an improving picture overall.

46.2.4 Ms FitzGerald commented that the risk 3823 remains ‘High’ but this doesn’t detail the risk and highlighted that it would be useful to have this information so we know what we are supporting. Mr McQueen acknowledged this and asked for this to be included.
JMcN

46.2.5 The committee noted the recommendations and noted the work ongoing and that the risk remains very high.

46.3.1 5020 – Water Safety
Mrs Gillies reminded colleagues that this risk was added to the register for changing the use of properties and flush outlets due to the increased risk to Legionella plus routine use of properties across community areas.

46.3.2 Mrs Gillies advised that water safety groups have looked at and tested the water quality overall and not just for Legionnlla. Infection Prevention Control (IPCT) and estates and facilities are responsible for documenting and actioning and continue to test augmented care areas.

46.3.3 Mr McQueen advised the committee to continue to take limited assurances and to note the actions and work in progress.

46.4.1 3328 – Traffic Management
Ms M Campbell spoke to the traffic management update covering the 4 acute sites and the high volume of traffic and car parking across these sites. Staff behaviours and an increase in demand for parking alongside ongoing construction has impacted on traffic flow. The risk is currently 12 and there are a number of issues on each site that need to be addressed to review this score.

46.4.2 • REH – Manage the turning circle and concerns raised with parking and access to emergency vehicles.
• WGH - Major roadwork and restrictions to road and traffic access
• SJH – Work ongoing to replace barrier communication system
• ELCH – Additional car parking but not a red risk.
• RIE – Additional parking at Sherrifihall park and ride and a dedicated shuttle bus, but challenges with staff wanting to park on site and further access to permits.

46.4.3 Mr McQueen asked if we have a clearer idea for timescales for work commencing and finishing and was interested to hear any updates on number plate recognition and, if any, funding to lower the burden on car parking?

46.4.4 Mr Crombie advised that at WGH; Phase 2,3 and 4 will take place over the next 4-6 years and this will cause significant disruption to the campus but the risk is heightened because of the construction. Technology is an emerging issue but there is advice that new technology is available to maximise parking for greater flexibility for permits and non permit access and we are exploring this.

46.4.5 The committee recognised the current constraints and accepted the current risk and grading.

47 Health and Safety Assurance

47.1 Mrs Gillies advised that a Health and Safety review took place during December to ask members their views on the future direction and design of the Health and Safey committee. The Health and Safety team is valued and recognised as an advisory service to support management whilst competing pressures and demands for patients and the public in line with legislation against the risk.

47.2 It was noted that Health and Safety team and procurement met with the provider to discuss lone worker alarms. It was agreed that Facilities Directorate and
REAS and WLHSCP will receive the new devices from 1st April 2022 and learning is

being shared to help roll out for new areas.

47.3 Mrs Gillies advised that an HSE improvement notice was discussed at the Health and Safety meeting in February in relation to gaps in the management system and safety devices at Women's and Children's at SJH. It was noted that the safety notice has since been closed but work undertaken across the whole organisation for a greater oversight when non-safety specialised devices are being used.

47.4 Mrs Gillies advised the paper is not looking for assurance on this occasion due to the Health and Safety meeting being out of sync with this committee, and advised the most up- to date assurance and risks will come to the next meeting in June. Mr McQueen asked for a short written update to be provided on assurance and asked if the scheduling of meetings of the Health and Safety committee and this committee could be synchronised better, but acknowledged timing difficulties. **TG**

48. **Medical Appraisal**

48.1 Ms Gillies provided an update on medical appraisal and relicensing and advised the process was paused during 2020/21 due to Covid 19 to consider doctors working through the pandemic. There are a number of doctors who are still out of sequence and a subsequent paper will come back to this meeting later in the year with a further update.

48.2 The current progress with appraisals was detailed with appraisals reaching the 4-5 year cycle for revalidation. The process last took place in 2018/19 and all doctors are required to undertake appraisal and training review at NES. Ms Gillies advised the board recommendations are set out under 3.5.

48.3 Ms Gillies advised there is a general push from BMA around collecting evidence within appraisal and this is initiated from the employee. Ms Gillies advised that we have to be proportionate around this with a focus on doctors professional development and support through their PDP. She asked the committee to note the recommendation and to consider the impact of referrals and revalidation and changes made during the pandemic.

48.4 The committee acknowledged a number of conflicting pressures and accepted the task list that was ever changing

49. **Mandatory Training and Appraisal Compliances**

49.1 Ms Langsley provided an update on mandatory training and appraisal compliance and noted the moderate level of assurance and the service pressure and workforce challenges that have impacted on compliance and regular updates to CMT.

49.2 Ms Langsley advised that due to the pandemic this has had a negative impact on compliance levels for both mandatory training and appraisals. It was noted that regular updates have been made to the CMT meeting and an agreement for fire safety and healthcare-associated infections, with a standard of 80% compliance required to be met by 31st March 2022.

49.3 The committee noted the limited improvement over the last 6 months, with a small increase in Violence and Aggression compliance up by 5% and a 4% increase in

appraisal compliance to 35%; the current compliance levels were noted under Appendix 1.

49.4 Ms Langsley confirmed that a roboust process came into place in March 2020 with Tableau dashboards and data information transferred across to e-EES system to monitor performance. LearnPro was also set up in April 2021 to help managers take action and to provide managers with the ability to report information. The National work programme 'Once for Scotland' was paused but is expected to go live in the next few weeks.

49.5 Mrs Butler advised there has been a number of good conversations through CMT and the Lothian Partnership meeting this week and highlighted the importance of management action plans for improved data and reporting.

49.6 The committee noted the above points and took limited assurance that the 80% target would be met.

50. **Little France Car Parking**

50.1 Mr Crombie provided an update on the Little France car parking and confirmed there is a heightened risk on the campus due to significant congestion and a number of near misses and accidents and a need to introduce further controls. Mr Crombie reminded members that parking is an issue across all campuses but we are routinely looking to manage constraints across other sites.

50.2 Mr McQueen asked what is the frequency of the shuttle buses from the park and ride? Mr Crombie advised the first shuttle bus leaves at 5am; the shuttle bus is oversubscribed with double buses at peak times. We continue to monitor activity and can show utilisation of seats for each shuttle.

50.3 Mr Crombie confirmed that communication to staff is ongoing and working with the communications department for staff briefings, emails and FAQs. Weekly parking meetings have taken place at the RIE to capture ideas and feedback and this has worked well. Further improvements are being made to the site including a new cycle path, metal bike storage and hybrid electric charging points.

50.4 The committee noted the points raised and recommendations put forward.

51 **Sustainable Workforce**

51.1 Workforce Report

51.1.1 Mrs Kelly highlighted high sickness and Covid absences during November and December. The number of leavers and retirees was higher in comparison to previous years but highlighted, a lot of retirements have been paused due to the pandemic, the average retirement age across the year remains the same.

51.1.2 Mrs Kelly confirmed that Voluntary Retirement and Re-engagement Policy has been replaced with Retire and Return Guidance , this will allow staff to return into a substantive post or through the staff bank.

52 **Workforce Planning Update**

52.1 Mr McAlister gave an update on workforce planning for 2020–2023, with workforce plans required by April 2021, but delayed due to the pandemic. It was noted that guidance covering workforce plans has not been issued by the Scottish Government but is expected by the end of March for 2022-2025.

52.2 Mr McAlister provided an update on the key groups in scheduled care, mental health and children services for the 3 year development plan. It was confirmed the plan will be be underpinned by 12 months action plan and will go through Corporate Management Team (CMT), Lothian Partnership Forum (LPF) and Staff Governance.

53 **National Treatment Centre Workforce Model Recruitment Phasing**

53.1 Mrs Butler provided an update on the new National Treatment Centre and plans in place for recruitment when the centre is due to open by 2027. It was noted that by 2027 there will be 10 National Treatment centres equating to 1,500 WTE and this is the last centre to be up and running and the largest with 400 WTE staff.

53.2 Mrs Butler advised the programme board started in December 2021 and the workforce group commenced in January, there are significant risks and challenges raised, including demographics and these are highlighted within the work plan under appendix 1.

53.3 Mrs Butler highlighted that retirees and returns will be key for the consultant workforce due to the significant challenge for demographics in this area. International recruitment has already started with links to Yeovil NHS Trust and this will need to be scaled up to focus on theatre nursing. Training for PAs has also been highlighted as a challenge as training is only available in Birmingham, which NES have acknowledged, with 25 PAs currently in place.

53.4 Mrs Butler advised of significant risks and challenges around this work and a need to start this work early with recruitment of nurses in April 2022. We are also in discussion with the Scotish Government for early release of money and funding through capacity for the post of NTC manager.

53.5 Mr McQueen acknowledged that it was a very comprehensive paper. Ms Hirst also advised early conversations about why people aren't working at SJH and transport and accommodation may need to be considered. Mr McQueen confirmed he would raise with Chief Officers for IJB, West Lothian. **BMcQ**

53.6 The committee noted the progress but highlighted funding as a significant issue.

54 **For Information and Noting**

54.1 Staff Governance Work Plan 2021-22

54.1.1 Mrs Kelly advised that we are approaching the end of the year and working on the plan for next year.

54.2 Staff Governance Assurance Statement 2021-22

54.2.1 Mrs Kelly confirmed the staff governance assurance statement is ongoing and this would be ready for the next meeting on 1st June and this would bring assurance to a close for this year.

55 **Reflections on the Meeting**

55.1 Mr McQueen thanked everyone for attending today's meeting and for their contribution.

56 Date of Next Meeting

56.1 The next meeting of the Staff Governance Committee would take place at 9.30 on Wednesday 01 June 2022

Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 22 March 2022

Held remotely by video conference

Present:

Board Members:

Councillor Ricky Henderson (Chair), Angus McCann (Vice-Chair), Councillor Robert Aldridge, Bridie Ashrowan, Colin Beck, Carl Bickler, Heather Cameron, Siddharthan Chandran, Councillor Phil Doggart, Christine Farquhar, Councillor George Gordon, Ruth Hendery, Kirsten Hey, Jacqui Macrae, Councillor Melanie Main, Allister McKillop, Peter Murray, Moira Pringle, Judith Proctor and Richard Williams.

Officers: Matthew Brass, Jessica Brown, Tony Duncan, Rachel Gentleman, Jenny McCann, Mike Massaro-Mallinson, Kellie Smith, Jay Sturgeon

Apologies: Helen FitzGerald, Jackie Irvine, Ian Mackay and Grant Macrae.

1. Minutes

The minute of the Edinburgh Integration Joint Board of 8 February 2022 was submitted for approval as a correct record.

Decision

To approve the minute as a correct record subject to the amendment of Item 7, where Lay Members had expressed concerns on the Code of Conduct, and how they could participate in the consideration of reports when having declarable interests as a result of the nature of their role on the Board.

2. Rolling Actions Log

The Rolling Actions Log updated to March 2022 was presented.

Decision

To note the outstanding actions.

(Reference – Rolling Actions Log, submitted)

3. Savings and Recovery Programme 2022-2023

The proposed 2022-23 Savings and Recovery Programme was submitted to the Board for consideration in the approval of the subsequent Financial Plan for 2022/23.

Decision

1) To note the content of the 2022-23 Savings and Recovery Programme.
2) To note the approach to evolve the current transformation programme into a wider strategic programme that encompasses the principles of innovation and sustainability.
3) To agree the proposed plan to review and finalise IIAs for individual projects and the programme.
4) To review the budget setting and financial planning process prior to commencing next year.

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

4. 2022/23 Financial Plan

The draft 2022/23 Financial Plan for the Edinburgh Integration Joint Board was submitted for approval. The Plan included the delegated budgets from EIJB partners and compared these to the projected costs for the year, anticipated growth and assumptions around additional resources.

Decision

1) To note the 2022/23 budget offers from the City of Edinburgh Council and NHS Lothian and the resultant draft financial plan based on the revised delegated budgets, expenditure forecasts and proposed savings and recovery programme.

2) To agree that officers continue tripartite efforts with colleagues in the City of Edinburgh Council and NHS Lothian to bridge the remaining anticipated in year shortfall.

3) To agree to receive an update on progress on a regular and appropriate basis throughout the year, with updates including comparative data from the budget last year and the changes respective to that position of year.

4) To issue a direction to the City of Edinburgh Council for the uplifting of contracts in line with nationally agreed methodology.

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

5. Board Assurance Framework 2021/22 Cycle – Referral from the Audit and Assurance Committee

The Board Assurance Framework and associated annual assurance statement for the 2021/22 cycle had been referred from the Audit and Assurance Committee for approval.

Decision

To approve the revised Board Assurance Framework and associated committee annual assurance statement for the 2021/2022 assurance cycle.

(Reference – Audit and Assurance Committee, 18 February 2022 (item 10); Report by the Chief Finance Officer, Edinburgh Integration Joint Board, submitted)

6. Committee Updates

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

Decision

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

7. Valedictory Remarks

The Chair gave thanks to both Ian Mackay and Carl Bickler who were resigning from the Board and wished them well in the future.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within VIRTUAL MEETING ROOM, on 17 MARCH 2022.

Present

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

Non-Voting Members – Karen Adamson, Elaine Duncan, Steven Dunn, David Huddlestone, Jo MacPherson, Alan McCloskey, Ann Pike, Patrick Welsh, Alison White and Linda Yule

Apologies – Damian Doran-Timson, Jock Encombe and Lesley Cunningham

In attendance – Colin Briggs (Director of Strategic Planning, NHS Lothian), Susan Gordon (Community Planning Development Officer), Sharon Houston (Business Support Team Manager), Yvonne Lawton (Head of Strategic Planning and Performance), Karen Love (Group Manager), James Millar (Standards Officer), Rebecca Miller (Head of Strategy Development, NHS Lothian), Mike Reid (General Manager, NHS Lothian) and Fiona Wilson (Head of Health)

1 ORDER OF BUSINESS

Agenda item 15 (Prevention of Homelessness Duties Consultation) was considered before agenda item 14 (Members' Code of Conduct).

2 DECLARATIONS OF INTEREST

Agenda item 15 - *Prevention of Homelessness Duties Consultation*

Bill McQueen declared an interest in that his daughter worked in the rough sleepers quarters policy area of the Scottish Government. As his interest was remote, he would participate in the item of business.

3 MINUTES

The Board approved the minutes of its meeting held on 13 January 2022.

4 MINUTES FOR NOTING

a The Board noted the minutes of the Audit, Risk and Governance Committee held on 1 December 2021.

b The Board noted the minutes of the Health and Care Governance Group held on 17 February 2022.

5 MEMBERSHIP & MEETING CHANGES

- The Board confirmed the reappointment of Bill McQueen to the IJB as a voting member from 1 February 2022 to 31 January 2024.

- The Board confirmed the reappointment of Dom McGuire to the IJB as a voting member from 19 March 2022 to 4 May 2022.

- The Board agreed to extend Dave Huddlestone's appointment for a period of two years.

6 LOCAL OUTCOMES IMPROVEMENT PLAN REVIEW

The Board considered a report (copies of which had been circulated) and a presentation by the Community Planning Development Officer providing an update on the review process of the Local Outcomes Improvement Plan (LOIP).

It was recommended that the Board:

1. Note the update on progress with the review of the LOIP; and

2. Consider and discuss the focus areas of the LOIP and the links to the IJB Strategic Plan.

The Board agreed to delegate the matter to the Strategic Planning Group for monitoring and for providing updates to the IJB as and when required.

Decision

1. To note the terms of the report.

2. It was agreed that the matter would be further considered at the Strategic Planning Group and further updates would be provide to the IJB as needed.

7 LOTHIAN STRATEGIC DEVELOPMENT FRAMEWORK (LSDF)

The Board considered a report (copies of which had been circulated) by Colin Briggs and Rebecca Miller providing an update on progress in developing the Lothian Strategic Development Framework (LSDF), sharing the content of the LSDF summary document, appended to the report, and seeking support for the approach outlined. The report also sought support to progress to a period of public engagement.

It was recommended that the Board:

1. Consider the content of the attached LSDF summary;

2. Note that the approach outlined had been supported by the IJB Strategic Planning Group in February 2022; and

3. Support the LSDF to progress to a period of public engagement.

During discussion it was suggested that the importance of the role of carers and of young carers be included under the appropriate sections of the framework.

It was also noted that further updates might be presented to the IJB as needed.

Decision

To approve the terms of the report.

8 CHIEF OFFICER REPORT

The Board considered a report (copies of which had been circulated) by the Chief Officer providing a summary of key developments relating to West Lothian IJB and updating members on emerging issues including those related to Covid-19.

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

Decision

To note the terms of the report.

9 2021/22 FINANCE UPDATE AND QUARTER 3 FORECAST

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer providing an update on the 2021/22 budget forecast position for the IJB delegated health and social care functions based on the outcome of the Quarter 3 monitoring.

It was recommended that the Board:

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

2. Note the currently estimated financial implications of Covid-19 on the 2021/22 budget in terms of funding and expenditure; and

3. Note the current position in terms of the year end management and that significant assurance could be provided to the Board that an underspend position was deliverable for 2021/22.

Decision

To note the terms of the report.

10 WEST LOTHIAN IJB 2022/23 BUDGET

The Board considered a report (copies of which had been circulated) by the Chief Finance Officer setting out the outcome of the financial assurance process on the budget contributions West Lothian Council and NHS Lothian had identified to be delegated to the IJB for 2022/23, and seeking approval for the issue of Directions to partner bodies for delivery of 2022/23 delegated functions in advance of 1 April 2022. The report also provided an initial update on the financial outlook for the period 2023/24 to 2027/28.

It was recommended that the Board:

1. Note the financial assurance work undertaken to date on Partner budget contributions for 2022/23;

2. Agree that council and NHS Lothian core budget contributions be used to allocate funding to Partners to operationally deliver and financially manage IJB delegated functions from 1 April 2022;

3. Agrees that the Directions attached in Appendix 5 to this report are issued to West Lothian Council and NHS Lothian respectively

4. Note current assumptions around Covid-19 funding and expenditure for 2022/23;

5. Note the initial high level financial outlook for the period 2023/24 to 2027/28 based on current funding and expenditure assumptions;

6. Agree that in accordance with the CIPFA Financial Management Code and best practice, the IJB would prepare a medium term financial plan covering the next IJB Strategic Plan period of 2023/24 to 2027/28;

7. Note that the outcome of the National Care Service consultation would be kept under close review as it might have significant implications around current arrangements for the future delivery and funding of health and social care services and medium term financial planning assumptions; and

8. Agree the updated IJB Annual Financial Statement attached in Appendix 6 of the report.

During discussion, it was explained that that after the NHS Lothian budget was agreed, depending on its terms a further report might be brought back to the IJB advising of any changes and revising directions if required.

Decision

To approve the terms of the report.

11 STRATEGIC COMMISSIONING PLAN UPDATE

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

It was recommended that the Board:

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

2. Be assured by the progress being reported to date and the action being taken to address areas falling behind; and

3. Approve continuation of current strategic planning structures for the duration of the current strategic plan.

Decision

To approve the terms of the report.

12 WEST LOTHIAN PRIMARY CARE PERFORMANCE INDICATORS - SECOND DATA COLLECTION

The Board considered a report (copies of which had been circulated) by the Clinical Director of West Lothian Health and Social Care Partnership providing an update on the second data collection for the West Lothian Primary Care Performance Indicators.

It was recommended that the Board:

1. Note the contents of the report; and

2. Be reassured that performance across Primary Care in West Lothian was being maintained.

Decision

To note the terms of the report.

13 PREVENTION OF HOMELESSNESS DUTIES CONSULTATION

The Board considered a report (copies of which had been circulated) by the Head of Strategic Planning and Performance informing members of the joint Scottish Government and CoSLA consultation on prevention of homelessness duties and asking members to consider the draft response, which had been informed by the views of members of the Strategic Planning Group.

It was recommended that the Board:

1. Consider the draft response to the consultation; and

2. Approve the draft response and agree to its submission to the Scottish Government.

Comments from members highlighted the difficulty in defining areas covered in the consultation and noted that clarity was required on how those areas were linked. Current waiting lists and resulting costs were also discussed.

Decision

To approve the terms of the report.

14 MEMBERS' CODE OF CONDUCT

The Board considered a report (copies of which had been circulated) by the Standards Officer asking members to agree a draft Members' Code of Conduct to be submitted for ministerial approval.

It was recommended that the Board:

1. Agree the draft members' Code of Conduct in the appendix for submission to the Scottish Ministers for statutory approval; and

2. Note that any revised Code would become effective on the date specified by the Ministers.

Decision

To approve the terms of the report.

15 TIMETABLE OF MEETINGS 2022/23

A proposed timetable of meetings for 2022/23 session as well as a proposed timetable of meetings for the Strategic Planning Group had been circulated for approval.

Decision

1. To approve the IJB timetable of meetings for 2022/23.

2. To approve the Strategic Planning Group timetable of meetings for 2022/23.

16 WORKPLAN

A workplan had been circulated for information.

Decision

1. To note the workplan.

2. To include an update on elective surgery units at St John's hospital as part of the Chief Officer's report at the April meeting.

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 10 February 2022	2.00pm	Virtual Meeting held using Microsoft Teams.

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

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Jordan Miller (Staff side representative)
Fiona Stratton (Chief Nurse)	Miriam Leighton (Volunteer Midlothian)	Keith Chapman (User/Carer)
Hannah Cairns (Allied Health Professional)	James Hill (Staff side representative)	Wanda Fairgrieve (Staff side representative)

In attendance:		
Jill Stacey (Chief Internal Auditor)	Grace Cowan (Head of Primary Care and Older Peoples Services)	Nick Clater (Head of Adult & Social Care)
Gill Main (Integration Manager)	Elouise Johnstone (Programme Manager)	Jim Sherval (Public Health Practitioner)
Roxanne King (Business Manager)	Lois Marshall (Assistant Strategic Programme Manager)	Rebecca Hilton (NHS Lothian Representative)
Rebecca Miller (Strategic Planning)	Mike Broadway (Democratic Services Officer)	Andrew Henderson (Clerk)

Apologies:		
Joan Tranent(Chief Social Work Officer)	Johanne Simpson (Medical Practitioner)	Hamish Read (GP/Clinical Director)

Midlothian Integration Joint Board

Thursday 10 February 2022

1. Welcome and Introductions

The Chair, Carolyn Hirst, in welcoming everyone to this virtual Meeting of the Midlothian Integration Joint Board, extended a warm welcome on behalf of the Board to Gill Main. Carolyn expressed her gratitude and thanks to Mairi Simpson and Lesley Kelly for the work on the IJB and expressed gratitude to James Hill, who was attending his final meeting.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Minute of Previous Meetings

4.1 Minutes of the MIJB held on 9 Dec 2021

The Minutes of Meeting of the Midlothian Integration Joint Board held on 09 December 2021 were submitted and approved as a correct record.

4.2 Minutes of the Strategic Planning Group held on 17 November 2021

The Minutes of Meeting of the Strategic Planning Group held on 17 November 2021 were submitted and noted.

Midlothian Integration Joint Board

Thursday 10 February 2022

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Chair's Update Carolyn Hirst thanked members for attending the development session covering finance and flagged planning for 22/23 and encouraged members input at the next session. Carolyn Hirst also thanked Morag Barrow and her team for the monthly bulletins and indicated that feedback was welcome. In addition Carolyn Hirst highlighted her attendance at two Midlothian Community Planning Partnership Board meetings ensuring that a contingency plan was in place and to get an overview of the strategic plan for the following year. Carolyn Hirst flagged that Aprils board meeting would have a number statutory reports submitted.	To note the Chairs update	All to note	
5.2 Chief Officer Report – Morag Barrow, Chief Officer. Morag Barrow provided an overview of the Chief Officer Report outlining the key service pressures in addition to providing the board members with an update of the developments following the MIJB meeting of the 9th of December. Morag Barrow flagged a typo to the report on line page 4, point 3.2 paragraph 13, confirming that this should read 'preventing reoffending' and not 'promoting reoffending'. Morag Barrow outlined the report recommendations that the board prioritise policy	a) Carolyn Hirst to discuss Pharmacy refusal in Roswell with Councillor Milligan and escalate to NHS Lothian. b) Morag Barrow to submit paper covering strategic planning goals and submit to the next meeting of the MIJB. c) To otherwise note the contents of the report.	Carolyn Hirst Morag Barrow All to note	

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
objectives for the strategic planning group and outlined the recommended priorities: • Midlothian Hospital • Primary Care • Frailty • Learning disabilities • Workforce Following this a general discussion ensued with Morag Barrow, Grace Cowan and Hannah Cairns all responding to questions from members. In relation to public health and digital cross cutting, Morag Barrow acknowledged that Elouise Johnstone and Gill Main were currently working through the plan and this would be covered off. In answer to a question regarding NHS Lothian's Pharmacy Committee's refusal of a proposed pharmacy in Rosewell and what action the MIJB could take, Morag Barrow acknowledged that concerns are shared with regarding the pressure that pharmacies are under but the MIJB was limited with regard to what action it could take. Carolyn Hirst invited Councillor Milligan to discuss the matter further and following the agreement of all board members present agreed to raise the issue with NHS Lothian. Morag Barrow clarified that the 5 outlined priorities would touch and influence other areas and that they would be updated going forward. Morag Barrow then outlined the key points from the Audit Scotland			

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
report, acknowledging that the service had seen significant investment and acknowledged the workforce challenge and highlighted the work required in lead up to the National Care service. Following this the board agreed that Morag Barrow should continue with the work outlined in the report and that a paper should be submitted to the next meeting of the IJB. Grace Cowan clarified that regarding the hospital at home service planning would be undertaken over the next couple of months, noting the bringing forward of the opening of Liberton Day hospital and further ANP staff being factored in. An update was provided in relation to vaccinations, acknowledging that Midlothian was performing well although vaccine take up in 18-29 and 30-39 year olds was still lower in line with national trends but that that inclusivity groups and satellite clinics had been established in areas with lower take up. Grace Cowan confirmed the long term aim to ensure a sustainable winter with increased vaccinations and that the health and social care partnership would be taking on board Children's; Travel and shingles vaccinations and that a plan had been submitted to the vaccination board. Following this further discussion ensued. Nick Clater highlighted that Learning Disability services are open and broadly operating pre pandemic levels and that a report highlighting the current challenges was being written up. Hannah Cairns acknowledged a			

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
significant backlog with diabetes and weight loss waiting lists, outlining the steps being used to tackle this. Carolyn Hirst took the opportunity to thank Jill Stacey for her work with the IJB in the capacity of Chief Internal Auditor, in reference to comments in the report outlining Jill Stacey's intention to stand down and the process required to provide a replacement.			
5.3 Lothian Strategic Development Framework - Report by Rebecca Miller, Strategic Planning Rebecca Miller provided an overview of the Lothian Strategic Development Framework report highlighting the 5 pillars within the LSDF: • Children & Young People; • Mental Health, • Illness & Wellbeing; • Primary Care; • Scheduled Care & Unscheduled Care Rebecca Miller outlined that all sections had been developed in collaboration with the IJB and the H&SCP and that the LSDF should reflect the strategic plan with a view to finalise in June. The Midlothian IJB Strategic Planning Group meeting in January 2022 supported the submission of the summary document to the IJB. A discussion ensued amongst board members, Rebecca Miller clarified the difference between consultation and engagement and that the intention	a) To note progress to date in developing the LSDF. b) To note the content of the LSDF summary document appended to this report. c) To support the proposed approach the Lothian Health and Care System (LHCS) will take over the next five years to deliver improved outcomes, as set out in the summary document	All to note All to note Board members	

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
was for a long term public engagement that may involve specific consultations. In addition, regarding the use of robust self-care and self-management methods particularly for those with low health literacy, Rebecca Miller acknowledged that this would be a developing area. Following this all voting members present agreed to the recommendations outlined in the report.			
5.4 Reappointment of NHS Lothian Board Members to the Midlothian IJB Carolyn Hirst provided an overview of the report outlining the recommendation from the Lothian NHS board to reappoint herself and Tricia Donald to the Midlothian IJB. Following this, Councillor Milligan was appointed as chair of the meeting and all voting members present endorsed the proposals. Carolyn Hirst was then reappointed as chair. Morag Barrow acknowledged that Miriam Leighton had also joined the board and agreed to bring to the board for formality and governance.	a) To note and approve the reappointment of Carolyn Hirst and Patricia Donald as board members of the Midlothian IJB. b) Morag Barrow to submit report outlining the appointment of Miriam Leighton to the MIJB for formality and governance.	All to note Morag Barrow	
5.5 Financial Update - Out-turn 2021/22 and outline 22/23 financial position. - Report by David King, Interim Chief Finance Officer. David King provided an overview of the February finance paper highlighting that this was the second part of the three part approach to setting the budget and that it outlined and gave consideration to everything discussed at the IJB development	a) To note the projected out-turn position for 2021/22 b) To note the projected impact on the IJB's reserves	All to note All to note	

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
workshop held on the 13th January 2022 and set the date of the budget being set to the 17th of March. Following this a discussion ensued with David King and Morag Barrow responding to member's questions. Morag Barrow clarified that there was a requirement to follow partner's recruitment process and acknowledged regular contact with HR and further outlined methods used to improve recruitment. Morag Barrow highlighted challenges in recruiting for higher grade posts, who had longer notice periods among further operational challenges. David King clarified that additional funds would be included in the financial plans for 22/23 and that the ambition was to use the money to underpin services and to use for additional resources if possible. David King then discussed the additional funding that had been part of the Scottish Government's 22/23 budget amounting to £554 million nationally (the IJB's share being laid out in Appendix 1 of the report) and a further £22 million nationally for social care of which £335,000 would be allocated to Midlothian. Work was underway to lay out the proposed use of these funds in 22/23. David King also acknowledged a heavy reliance on COVID funding and encouraged members to consider its view on the matter going forward warning that at some point the future COVID funding would cease with service provision continuing.	c) To note the Scottish Government's 22/23 financial settlement d) To note the projected financial forecast for 2022/21	All to note All to note	

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.6 NHS Lothian Public Health - Partnership and Place - Presentation by Jim Sherval, Public Health Consultant Jim Sherval and Rebecca Hilton took members of the MIJB through the NHS Lothian Public Health Partnership and Place, outlining the intention to transform NHS Lothian into an even better employer, in addition to the 6 public health priorities and four spotlighted areas of focus. Jim Sherval provided examples of work conducted with planning and housing organisations, advising that work had been done in relation to the planning of physical activity and greenspace making reference to the City Region deal and cycle provision through Sherrifhall. Rebecca Hilton added the work around diabetes and that work had also been conducted around residents feeling safe in their local area to participate in physical activity. Following this, members took the opportunity to commend and endorse various aspects of the proposals outlined in the presentation. In response to comments regarding broader actions that could be taken Jim Sherval acknowledged that although the licencing act currently had public health provision, the civic government Scotland act didn't and that work was being done to fit this in going forward.	a) Presentation slides to be made available to members of the IJB. b) To note the contents of the presentation.	Jim Sherval All to note	

Midlothian Integration Joint Board

Thursday 10 February 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.7 Performance Overview Report – Report by Elouise Johnstone, Programme Manager, Performance Elouise Johnstone provided an overview of the Performance Overview Report and noted the purpose to update the IJB on the progress towards achieving its performance goals. Elouise Johnstone outlined that the IJB was currently meeting all of its performance targets and advised that the current targets had only been agreed until April 2022. In addition, Elouise Johnstone outlined a request to reallocate funds for a fixed-term Assistant Programme Manager (NHS Grade 6) and to recruit two WTE fixed-term Assistant Programme Managers (NHS Grade 6) for a period of two years. She advised that the March development session would be centred on performance reporting and that this would be fed into the new strategic plan. Elouise Johnstone also asked that Members to let her know if they were interested in joining a new Data Assurance & Governance Group which would meet for the first time in April. Members then considered the report and approved the recommendations.	a) Note the performance against the IJB performance goals. b) Further discussion at development session regarding IJB representation on Data Assurance and Governance Group c) Members approved reallocation of funding for recruitment of a fixed term NHS Grade 6 assistant program manager. d) Members approved the recruitment for two WTE fixed-term of 2 NHS Grade 6 term Assistant Programme Managers for a period of 2 years.	All to note Board Members Board members Board Members	
5.8 Clinical and Care Governance Report - Report by Fiona Stratton, Chief Nurse Fiona Stratton highlighted the purpose and contents of the Clinical Care and Governance Report highlighting ongoing work regarding complaints. Following this a discussion ensued amongst	To note and approve the content of this report	All to note	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
members during which progress on reducing the number of open adverse events was commended. Jock Encombe acknowledged previous work that had been completed in the area and suggested that the board could produce an update around QIT's.			

6. Any other business

No business other business was discussed.

7. Private Reports

No private reports were submitted for consideration.

8. Date of next meeting

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

- Thursday 17 March 2022 2.00pm Special MIJB Meeting and Development Workshop
- Thursday 14 April 2022 2.00pm Midlothian Integration Joint Board

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

The meeting terminated at 16:11

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Special Midlothian Integration Joint Board	Thursday 17 March 2022	2.00pm	Virtual Meeting held using Microsoft Teams.

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

Present (non-voting members):		
Morag Barrow (Chief Officer)	Hannah Cairns (Allied Health Professional)	Keith Chapman (User/Carer)
David King (Interim Chief Finance Officer)	Hamish Reid (GP/Clinical Director)	Johanne Simpson (Medical Practitioner)
Fiona Stratton (Chief Nurse)		

In attendance:		
Nick Clater (Head of Adult & Social Care)	Elouise Johnstone (Programme Manager)	Roxanne King (Business Manager)
Gill Main (Integration Manager)	Lois Marshall (Assistant Strategic Programme Manager)	Andrew Henderson (Democratic Services Officer)

Apologies:		
Tricia Donald	Wanda Fairgrieve (Staff side representative)	Joan Tranent (Chief Social Work Officer)

Midlothian Integration Joint Board

Thursday 17 March 2022

1. Welcome and Introductions

The Chair, Carolyn Hirst, in welcomed everyone to this virtual special meeting of the Midlothian Integration Joint Board. Apologies were noted on behalf of Tricia Donald, Wanda Fairgrieve and Joan Tranent.

2. Order of Business

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

3. Declarations of interest

No declarations of interest were received.

4. Minute of Previous Meetings

None submitted.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Chair's Update By way of a chairs update, Carolyn Hirst outlined that all Board Members will receive an email on Monday 21st March asking them to complete a self-evaluation survey aimed to evaluate the MIJB's 'fitness for purpose' and will help identify areas for improvement. It is based on the Integration Joint Board Checklist and consists of 20 statements to be rated in addition comments. Carolyn Hirst highlighted that members were being asked to complete this	a) To note the cancelling of the Development Workshop scheduled for 12 May 2022 and the rearranging of the Development Workshop to follow the Board meeting 16 June which will be extended to a three-hour meeting from 1 – 4pm. b) To otherwise note the Chairs update.	All to note All to note	

Midlothian Integration Joint Board

Thursday 17 March 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
now so that the experiences and reflections of new, outgoing and continuing members could be taken into account and it is hoped that this will be a starting point for the IJB's future development plan. Carolyn Hirst took the opportunity to urge all Board Members to complete the survey by the 31st March. In addition NHS Lothian and Midlothian Council are reviewing the Midlothian Integration Scheme and that public consultation will start this week with an end date of the 10th of April. The document will be made available on the Midlothian Council website and there will be consideration of the consultation feedback before the Council and NHS Lothian agree any changes to the scheme. It was acknowledged that Hamish Reid has submitted notice of his intention to leave the Midlothian HSCP as Clinical Director as of the 10th May and will also be standing down from the IJB Board. Carolyn Hirst acknowledged that Hamish's contribution would be recognised at the next Board meeting and advised the recruitment for a new Clinical Director post will be underway shortly. Carolyn Hirst highlighted that Councillors would cease to hold their position on the board on the 5th of May. The first Council meeting at which a new administration should be formed is scheduled to take place on the 24th of May, at this meeting agreement should reached on the four new Board appointees to the IJB and their substitutes. Referencing discussions with the Chief Officer and			

Midlothian Integration Joint Board

Thursday 17 March 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Vice Chair, Carolyn Hirst confirmed that the development workshop session on 12 May would be cancelled and that in its place the timing of Board meeting scheduled for 2 - 4pm on 16 June would be extended to a three-hour meeting from 1 – 4pm.			
5.2 Midlothian Integration Joint Board Strategic Plan 2022-2025 and Consultation Report – Paper Presented by Lois Marshall, Assistant Programme Manager. Lois Marshall provided an overview of the Consultation Report in reference to the Midlothian Integration Joint Board Strategic Plan 2022-2025, outlining that it was well supported by the community and social media and that the consultation report took into account feedback that had been received across the year. In relation to the MIJB Strategic Plan, Lois Marshall confirmed little change with the exception of some final updates, including an update relating to the consultation response about the importance of advocacy and some amendments to the layout with 'workforce' being brought to the front. Carolyn Hirst took the opportunity to thank Lois Marshall and colleagues for their work on the report. Carolyn Hirst additionally highlighted that the Consultation Report and the draft Strategic Plan had been considered at the Strategic Planning Group meeting on 16 March and that they had commended both documents to the Board. In response to comments as to whether the MIJB was agreeing to delegate approval for additional	a) The board agreed to the consultation report. b) The board agreed to approve in principle the strategic plan, noting future changes. c) To otherwise note the contents of the report.	Board Members Board Members All to note	

Midlothian Integration Joint Board

Thursday 17 March 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
updates or not, Lois Marshall clarified that consultations were taken throughout the year and that the equality summary had been pulled up in the integrated impact assessment. Lois Marshall highlighted that updates were also dependant on timescales and confirmed that further updates would be brought to April's MIJB meeting. From an operational standpoint, Lois Marshall highlighted that each service area would also be provided with their own action plan. Morag Barrow clarified that more detail would be added to the Workforce section over the next four weeks and advised that the action plans would sit in with the 5 pillars outlined in the Lothian Strategic Development Framework Report submitted to February's board meeting and that these would be brought to a future development session. Regarding unexpected feedback, Lois Marshall acknowledged that issues around communication, digital and finally staff and communities had been raised. A brief discussion ensued in relation to the digital delivery plan and Morag Barrow advised that she would like to be given sight of the plan in advance of it being submitted to SMT. Carolyn Hirst enquired as to whether the integrated impact assessment would be ready for April's board meeting. Responding to comments as to whether the action plan could be put on a development workshop agenda in the future. Carolyn Hirst confirmed that they were already looking at commissioning the planning documents and that they would need to			

Midlothian Integration Joint Board

Thursday 17 March 2022

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
liaise with partner organisations. Morag Barrow then took the opportunity to outline the next steps acknowledging the complete structural change over the previous 12 months, acknowledging difficulties collecting data and that work had been done to ensure transparency. Morag Barrow outlined the need for a robust infrastructure for reporting to the board over the next 12 months and referenced that the performance oversight board, which is scheduled to commence in April to provide more scrutiny. The board then agreed to approve the consultation report, and agreed to approve in principle the strategic plan, noting future changes.			
5.3 Midlothian IJB – 2022/23 Budget Setting – Report by David King, Interim Chief Finance Officer. The purpose of this report was to seek agreement to the 22/23 budget offers from the IJB's partners, to lay out the projected financial position for the IJB in 22/23 and to consider the projected increase in the IJB's reserves and the utilisation of these reserves. Finally the board was also asked to consider if the IJB could set a balanced budget for 22/23. The Board heard from Interim Chief Finance Officer, David King, who provided an overview of the budget setting process and outlined additional funding that been received from the Scottish Government throughout 21/22 in addition to funds that would be	a) Agreed that the budget offer from Midlothian Council meets the Scottish Government criteria. b) Agreed that the budget offer from NHS Lothian meets the Scottish Government criteria. c) Noted the projected movement in the IJB's Reserves.	Board Members Board Members All to note All to note	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
received in 22/23. David King then outlined that as section 95 officer for the MIJB he was satisfied that the budget was balanced albeit with non recurrent funding and outlined the next step as being work to ensure the budget translated into the directions. In response to comments regarding the letter submitted by Craig Marriot which makes reference to the delivery of efficient savings, David King clarified that the MIJB had minimal issues over 22/23 and that any additional benefits would flow through the system. There was then a brief discussion as to the requirements for the MIJB to set a balanced budget and it was noted that although the board may not be required to set a balanced budget, this would not stop members from agreeing to the recommendations outlined in the report. The Board, in considering the welcome support offered by its partners then agreed to set a balanced budget for 22/23.	d) Noted the projected financial position for 2022/23. e) Agreed that the 2022/23 budget proposal is, at this time, balanced and therefore agree to the IJB's outline 22/23 budget.	Board Members	

6. Any other business

No business other business was discussed.

7. Private Reports

No private reports were submitted for consideration.

8. Date of next meeting

Midlothian Integration Joint Board

Thursday 17 March 2022

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

- Thursday 14 April 2022 2.00pm Midlothian Integration Joint Board

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

The meeting terminated at 15:04

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 24 MARCH 2022
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Mr P Murray (Chair)
Councillor S Akhtar
Councillor N Gilbert
Ms F Ireland
Councillor S Kempson
Dr R Williams

Non-voting Members Present:

Ms M Allan	Mr D Binnie
Dr P Conaglen	Mr I Gorman
Mr D King	Ms A MacDonald
Dr C Mackintosh	Ms M McNeill

Officers Present from NHS Lothian/East Lothian Council:

Ms L Berry	Mr P Currie
Ms H Gray	Mr M Kennedy
Ms L Kerr	Ms R Miller

Clerk:
Ms F Currie

Apologies:
Dr P Donald
Councillor F O'Donnell
Ms L Cowan
Dr W Hale
Ms J Tait
Dr J Turvill

Declarations of Interest:
None

The IJB resolved to exclude the public from the discussion on Item 7.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN IJB ON 24 FEBRUARY 2022 (FOR APPROVAL)

The minutes of the meeting on 24th February 2022 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 24 FEBRUARY

The following matters were raised:

Item 2 – Councillor Shamin Akhtar requested an update on progress with the vaccination roll-out (particularly for ages 5 - 11 years) and also the situation at Edington Hospital.

Alison MacDonald reported that the staffing situation at the East Lothian Community Hospital remained challenging. The unprecedented levels of sickness absence continued to impact service delivery across the county, including at the Edington Hospital. A report would be presented to the next 'Gold' meeting at the end of the month, with a further update to members thereafter. On the vaccine roll out, she informed members that the new vaccination centre at the Corn Exchange in Haddington was performing well, as were other vaccine facilities across the county, and 5 – 11 year olds were now able to receive their jabs. However, an 'anti-vac' protest outside the Corn Exchange last weekend had caused some concern for staff and the police had been called to the facility twice. That incident aside, the uptake of vaccinations across the county was on a par with the national average.

3. CHAIR'S REPORT

The Chair and Laura Kerr updated members on recent progress with work to address health inequalities.

The Chair highlighted a report from the Common Wheel entitled 'Caring for All' which provided a perspective on the National Care Service (NCS). He said he would share a link to the report with members, for their information.

The Chair also updated members on the recent work of the IJB Chairs & Vice Chairs Group which would shortly be participating in a workshop on the NCS bill, community health & social care boards and collaborative commissioning. He said he would share further updates as this work progressed.

4. MEMBERSHIP OF EAST LOTHIAN IJB

The Chief Officer had submitted a report informing the IJB of the renewal of the term of office for Peter Murray and seeking agreement to the transitional arrangements for the approval of minutes.

The Clerk presented the report outlining the background and inviting members to agree the recommendations as set out in the report.

The members agreed to note recommendation i. The vote was taken by roll call on recommendation ii, and this was approved unanimously.

Decision

The IJB agreed:

i. To note the renewal of the term of office for Peter Murray as a voting member of the IJB appointed by NHS Lothian; and
ii. That the minutes of the most recent meetings, which could not be approved by the IJB or the Audit & Risk Committee before the change in voting membership, be submitted to the current Chairs for verification and signing.

5. 2022/23 BUDGET SETTING

The Interim Chief Finance Officer had submitted a report laying out the budget offers for 2022/23 from the IJB's partners (East Lothian Council and NHS Lothian) and considering if these met both the Scottish Government's and the IJB's own criteria for acceptance. Utilising the information provided from the partners, the report also considered the outline financial position for the IJB for 2022/23, and asked the IJB to agree to set its 2022/23 budget.

David King presented the report outlining the key points of the budget offers from the partners and the impact which their differing approaches to budget-setting had on the IJB's ability to agree its own budget for 2022-23. He also summarised details of additional funding for COVID costs and the impact that the current year underspend would have on the IJB's Reserves position. Mr King then considered both offers from the partners against the 3 tests: compliance with Scottish Government guidelines; fairness; and adequacy. He concluded that both offers met these tests and, based on the information provided by the partners, the IJB could set a balanced budget for 2022/23.

Mr King went on to highlight the next steps for the IJB which included considering how best to use the increased Reserves to push forward the IJB's Strategic Plan and manage ongoing pressures in the system; using the forecasts and confirmed budget details to create budgets for individual Directions; and financial planning for 2023/24. He also highlighted the question of non-recurring funding and its impact of future budgets and he encouraged the IJB to move forward on setting a multi-year financial plan.

The Chair thanked Mr King for providing a helpful picture of the current and future position. He acknowledged the potential impact of non-recurring funding but pointed to the development of the new strategic plan as an opportunity for the IJB to address some of these challenges.

Mr King responded to questions from Councillor Gilbert providing some background on the differing budget-setting processes adopted by the partners and confirming that the partners were required to honour their budget offers once made to the IJB. Although he added that it may be the case that the IJB was required to spend more than it had received during the year and, in such circumstances, further discussion would be required with the partners.

Richard Williams said he found the paper very clearly set out and the additional narrative helpful. However, he asked for further clarification on the reference to efficiency savings in the NHS forecast letter. Mr King and Ms MacDonald explained that this was a reminder that the IJB must consider how to do things differently and to

redistribute its budgets in a way that delivered more efficient services while also helping to reduce pressures elsewhere in the system.

Mr King also addressed questions from Councillor Akhtar about demographic growth within East Lothian and a strategy for dealing with pressures in 2023/24 in the absence of further COVID funding.

Ms MacDonald acknowledged that there had been a high COVID spend within budgets but that some of these larger outlays, such as staffing of the two additional wards at the Community Hospital, could be absorbed elsewhere in the system.

The members agreed to note recommendations iii and iv. The vote was taken by roll call on recommendations i, ii and v, and these were approved unanimously.

Decision

The IJB agreed:

i. That the budget offer from East Lothian Council met the Scottish Government criteria;
ii. That the budget offer from NHS Lothian met the Scottish Government criteria;
iii. To note the projected movement in the IJB's Reserves;
iv. To note the projected financial position for 2022/23; and
v. That the 2022/23 budget proposal was balanced and therefore agreed to set the IJB's indicative 2022/23 budget.

6. EAST LOTHIAN COMMUNITY HOSPITALS AND CARE HOMES PROVISION CHANGE BOARD

The Chief Officer had presented a SBAR updating the IJB on the progress of the East Lothian Community Hospitals and Care Homes Provision Change Board with a focus on the initial findings from the Capacity and Planning Working Group.

Iain Gorman presented the report updating members on recent progress from the 3 working groups: Communications and Engagement; Capacity and Planning; and Finance and Capital. He highlighted the findings of the Capacity and Planning working group around inpatient, care home and intermediate care capacity and wider property development considerations. He advised that this work was being done alongside consideration of the financial implications of re-provision which was the focus of the Finance and Capital working group. All proposals would be subject to consultation before any final decisions were taken and the main communication and engagement work would begin in May 2022.

The Chair said it was important for the IJB to get an update on the Change Board's progress and that the work currently being done by Laura Kerr would be critical to this and to the public consultation stage. He added that it would take some years for whole project to come to fruition.

Mr Gorman responded to questions from Councillor Akhtar on the options for intermediate care which would be presented as part of the engagement work and how dementia care housing would sit within the wider housing strategy.

The Chair concluded that the IJB must be focused on delivering services across the county and communities as a whole and that this focus must be clearly set out when consulting on any proposed changes.

Decision

The IJB agreed to:

i. Note the actions and work to date undertaken by the Change Board in relation to the 3 working groups; and
ii. Note the continuous and ongoing pressure on staff as a result of the impact of COVID-19 and service impacts of COVID-19 through high levels of sickness, high vacancies and staff self-isolating.

Valedictories

The Chair wished to place on record his thanks to David King for acting as Interim Chief Finance Officer over the past nine months. It had been a great pleasure to have him back in the role.

The Chair also thanked the four Councillors for their contributions during their varying tenures as voting members of the IJB. He offered his good wishes to Sue Kempson and Fiona O'Donnell who would be standing down from Council in May. He said it was impossible to understate the contribution Councillor O'Donnell had made to the IJB in her roles as Chair and Vice Chair during the past five years. He wished success to Neil Gilbert and Shamin Akhtar who were both standing for re-election; and he hoped to see them both return to the IJB in the future. He also thanked Shamin for her support and counsel as Vice Chair.

SUMMARY OF PROCEEDINGS – EXEMPT INFORMATION

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

Lothian Strategic Development Framework

The IJB considered a report updating them on progress in developing the Lothian Strategic Development Framework. The IJB agreed the recommendations contained within the report.

NHS LOTHIAN

Board
22 June 2022

Chair

APPOINTMENT OF MEMBERS TO COMMITTEES AND INTEGRATION JOINT BOARDS

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

2 Recommendations

2.1 The Board is recommended to:

- Appoint Cllr Derek Milligan to the Remuneration Committee with immediate effect.
- Appoint Cllr Shamin Akhtar to Finance and Resources Committee and Pharmacy Practices Committee with immediate effect.
- Appoint Cllr Stephen Jenkinson to Audit and Risk Committee with immediate effect.
- Appoint Cllr Harry Cartmill to Healthcare Governance Committee and Audit and Risk Committee with immediate effect.
- Re-Appoint the following people to the Pharmacy Practices Committee:
  - John Niven, Lay Member
  - Judie Gajree, Non-Contractor Pharmacist
  - Hazel Garven, Non-Contractor Pharmacist
  - Mike Embrey, Contractor Pharmacist
  - John Connolly, Contractor Pharmacist
  - Phil Galt, Contractor Pharmacist
  - Kaye Greig, Contractor Pharmacist
- To bring forward Ms. Elizabeth Gordon's appointment as voting member of East Lothian IJB to 25 June 2022, running until 31 March 2025. Dr Patricia Donald to step down from the IJB on 25 June 2022.

3. Discussion of Key Issues

3.1 Changes to the Board's membership

The appointments of the four local authority stakeholder non-executives' (Councillors Shamin Akhtar, Stephen Jenkinson, Harry Cartmill, and Derek Milligan) have now been confirmed by Scottish Government.

3.2 Audit & Risk Committee

Councillor John McGinty stood down from the Board on 30 April 2022 and Mr Peter Murray will stand down from Audit & Risk Committee on 30 June 2022. Two new Non-Executive Board Members are now being proposed to join the Committee.

It is recommended that the Board appoint Councillors Cartmill and Jenkinson to the Audit & Risk Committee with immediate effect.

3.3 Healthcare Governance Committee

Dr Patricia Donald will be stepping down from the Board on 31 July 2022 and Ms Carolyn Hirst on 31 August 2022. To provide cover for these changes and to allow a suitable induction period it is recommended that the Board appoint Councillor Cartmill to the Healthcare Governance Committee with immediate effect.

3.4 Remuneration Committee

With Councillor Milligan re-joining the Board, it is recommended that the Board appoint Councillor Milligan back on to the Remuneration Committee with immediate effect.

3.5 Pharmacy Practices Committee

There are regulations which prescribe the membership and operation of this committee. It has seven members, being one NHS Board member, three pharmacists, and three lay members. The NHS Board member convenes the committee. The regulations allow deputies to be used provided that the when the committee meets the prescribed membership categories are there. For practical reasons the NHS Board has appointed several individuals to fill the positions, as this facilitates convening the committee when a hearing is required and allows a fresh panel to consider any appeals.

Councillor Shamin Akhtar has agreed to re-join the Committee following stepping down for the recent local elections. The regulations state that the Board should appoint the convener, and that person cannot be an officer of the Board, nor a doctor, dentist, pharmacist, ophthalmic optician, or an employee of any of a person who is one of those.

The Lothian Area Pharmaceutical Committee has identified individuals to be reappointed to contractor and non-contractor pharmacist positions. It is recommended that the Board reappoint:

- John Niven, Lay Member
- Judie Gajree, Non-Contractor Pharmacist
- Hazel Garven, Non-Contractor Pharmacist
- Mike Embrey, Contractor Pharmacist
- John Connolly, Contractor Pharmacist
- Phil Galt, Contractor Pharmacist
- Kaye Greig, Contractor Pharmacist

3.6 East Lothian IJB

Request from Vice Chair to have Ms. Gordon's starting date with the IJB brought forward to 25 June 2022 to ensure the IJB Audit and Risk Committee on 29 June will be quorate. As NHS Lothian nominates 4 members for the IJB this would mean Dr Donald, who leaves the Board on 31 July, stepping down from the IJB on 25 June 2022. Dr Donald is unable to attend the IJB Audit and Risk Committee on 29 June.

4 Key Risks

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

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

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

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

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

8 Resource Implications

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

Chris Graham
Secretariat Manager
15 June 2022

LOTHIAN NHS BOARD

22 June 2022

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. The template for this report has been revised following feedback from Non-Executive Members, and 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

1.1 Alison MacDonald start date 20 June 2022 – Director of Nursing & AHP.

1.2 Fiona Wilson start date 27 June 2022 – East Lothian IJB.

1.3 Darren Thompson start date 4 July 2022 – Board Secretary.

1.4 NHS Pay Negotiations – further details to follow.

1.5 Service Pressure – COVID-19 numbers are down but significant unscheduled care pressure. The elective recovery will be challenging.

1.6 NRAC – Later in the agenda there is consideration on how we might improve our planned care programme but with delayed discharges being a significant challenge. This presents further pressure on unscheduled care.

1.7 NRAC (National Resource Allocation Committee) - For 21/22, NHS Lothian remains behind NRAC parity by 0.8%, equating to a value of circa £14m. Since 2015/16, Lothian has received over £80m less funding than NRAC parity would provide (cumulative). For 21/22, this cumulative shortfall increases to £100m. On the basis the SG maintains a 0.8% limit on parity funding as it has done in prior years, the NRAC funding stream we have received annually over a number of years will cease, at least temporarily for 22/23.

1.8 The additional NRAC funding received in recent years has been driven by a rising NRAC share in Lothian, rather than closing the parity gap. Stabilisation of Lothian's NRAC share at a 0.8% gap will result in no future additional NRAC funding for NHS Lothian. Based on the latest update to NRAC eight territorial boards (including Lothian) are behind NRAC parity with six Board's ahead.

1.9 With the number of Boards behind NRAC parity now in excess of those ahead, the challenge of returning all Boards to a parity position is more difficult. Getting boards that are currently behind their NRAC share to parity can only be delivered by returning those boards ahead of parity to equilibrium.

1.10 The impact of the shortfall in funding has resulted in a care deficit within Lothian and is evidenced by the challenge of delivering scheduled and unscheduled care targets that impacted even before COVID-19.

1.11 Recently the Scottish Government has allocated resources disproportionately to reflect need (Substance Misuse funding based on numbers of drug related deaths, COVID-19 funding based on costs incurred) and there remains an opportunity for the SG to redress the NRAC imbalance created by continuing to apply the principle of resource allocation based on need, particularly to Access resources where these are additionally available in 21/22.

1.12 Negotiations are continuing with SG colleagues to ensure that appropriate funding streams recognise the unique imbalance in funding impacting on NHS Lothian over a number of years. However, it is clear that our ability to recover from the impact of COVID-19 and the legacy of our NRAC driven care deficit will place a greater burden on our services to achieve national performance targets in the future.

2. Deputy Chief Executive

2.1 Reprovision of Eye Services - The Project Director and Senior Programme Manager (PM) are now in post and working with the newly appointed Lead Advisory team to deliver a clinical and technical briefing pack and exemplar design by September 2022. Clinical teams are being asked to re-validate previous specifications in association with developing requirements for the new site at Edinburgh Bioquarter. The intention is to re-engage the Principal Supply Chain Partner in October. Negotiations continue with Scottish Enterprise to secure the acquisition of the site and Heads of Terms are being finalised. The site is currently under exclusivity to the Board. Full Business Case submission is envisaged in late 2024 with operational status achieved in mid-2027. These dates are subject to detailed programming by the PSCP and have yet to be approved by Scottish Government. Clinical modelling is being undertaken to assess the viability of establishing a Protected Elective Orthopaedic Centre within the same build as the Eye Pavilion. Significant cost increases are anticipated in line with other National Treatment Centre projects.

2.2 National Treatment Centre (Lothian) - The Principal Supply Chain Partner has received the Board's revised technical and clinical brief, exemplar design and programmed activities to submit a Full Business Case by the autumn of 2024 have just commenced. Current forecast is an operational date of early 2027. A Project Director, Senior PM and a Lead Adviser have been appointed and are leading the clinical teams and all stakeholders through the business case and assurance process. Please note the dates referenced are subject to detailed programming by the PSCP and have yet to be approved by Scottish Government. A revised cost plan has been prepared indicating a significant increase to the case reported in July 2021 principally because of additional enabling works, additional area due to COVID-19 initiatives, ensuring a link to SJH and Net Zero Carbon initiatives as well as the well-rehearsed inflationary impact. A five-year phased workforce recruitment and investment plan has informed the Board's requests for Scottish Government funding and access to accelerated training. Discussions are well established to seek release of year 1 costs to enable the recruitment, training and development programmes to ensure we have skilled and experienced staff on day one opening of this important facility. Unfortunately, to date, we have been unable to have our investment proposals agreed with the SG NTC Team. Discussions continue.

2.3 Cancer Centre - The regional service model review has been and is providing detailed evidence to support our IA ambitions. This review included the ECC clinical management team, NHS Borders, NHS D&G, NHS Fife, and regional planning colleagues; all of whom have agreed the findings. The report has been shared with Scottish Government cancer policy colleagues who have supported this as the basis for an updated Initial Agreement. This will now proceed through NHS Lothian governance and our partner Boards- in June to August- and will be submitted to the Scottish Government following approval at both PPDC and F&RC. I would again reference the significant impact on costs linked to the pressures being seen across the UK and beyond capital programmes.

2.4 ECC Enabling Works - The Initial Agreement for the ECC Enabling (Demolitions and Decant of former DCN areas) was approved by LCIG in May 2022 and will now be presented to PPDC in August 2022. Subject to PPDC approval the IA will be submitted to CIG in September 2022 in conjunction with the main ECC IA. The ECC project team are currently progressing the decant plan with affected staff and liaising with NHS Assure and HFS about the future OBC submission**.**

3. Interim Executive Director of Nursing, Midwifery, & AHPs

3.1 Workforce - There has been a very positive response to our registered nursing adverts with a high number of students from our local universities and wider looking to work in NHS Lothian. There remain gaps in some specific areas and widening access to careers in healthcare continues to be a focus especially across the nursing job family. This includes routes into healthcare support work roles and opportunities to continue the career pathway to registration.
One example is within Mental Health where we have 20 places for healthcare support workers to study for a BSc (Hons) with Open University to become a registered Mental Health Nurse with REAS.

3.2 Care Assurance - Throughout the pandemic we have modified our approach to care assurance in line with national guidance, in June our Lothian Accreditation and Assurance System (LACAS) was remobilised for adult inpatients across Acute and Community Hospitals.

3.3 We launched the Children's Assurance - standards at RHCYP in April ensuring consistency across our system, with ongoing work to develop the scope of LACAS in other clinical settings. All outputs form the assurance reviews are taken through clinical and care governance groups to Healthcare Governance.

3.4 International Days of Celebration and Innovation - NMAHP teams took part in Dementia Awareness week in May, with dementia information café's, dementia simulation bus and awareness raising sessions providing staff, families and careers with support, education and reassurance.

During International What Matters to You day our focus this year was on gather patient WMTY stories, these were used to produce videos and materials shared across the system to highlight the importance of this question as way to set our

compass, change our minds and add value to the care, services, and leadership we provide.

3.5 RCN Scotland Awards - Linda Yule, Chief Nurse West Lothian Health and Social Care Partnership has been awarded the British Empire Medal for services during the pandemic.

Alison Williams, Research Nurse with the Emerge Team also has been awarded the British Empire Medal as founder of the rainbow boxes which were boxes with toiletries and items patients needed while in hospital as part of the response to the pandemic.

Frances Aitken has been shortlisted as a finalist for the national RCN Awards in the category of Nursing Older People for her significant work on stress and distress and improving outcomes for patients with Dementia across Lothian.

4. Medical Director

4.1 Work continues with the roll out of HEPMA into the Royal Infirmary of Edinburgh Pharmacy.

4.2 We are delighted that the support for patients with Long COVID-19 will be extended through the collaborative work with CHSS. Dr Heather Cameron, AHP Director will oversee this.

4.3 Several new medical leaders have started in the past two months, including Dr Jeremy Chowings as Deputy Medical Director for Primary Care and three new AMDs Professor Emma Reynish, Dr Corinne Love and Dr Dave Caesar.

4.4 Development of psychological safety and improvement of surgical technical and non-technical skills, was the subject of a research seminar I attended with University of Edinburgh and international colleagues, which will be a useful area for us to collaborate in.

5. Director of Finance

5.1 Andrew McCreadie has been appointed to the role of Deputy Director of Finance. Andrew has successfully fulfilled several roles in NHS Lothian over the past 20 years and his promotion is due recognition of the excellent support he has provided not only within Lothian but the wider finance community in Scotland. The next stage of the finance structural review is now in progress with the staff consultation phase having commenced. The focus of this exercise is to further enhance the finance team structure to adopt the key attributes of the business partner model.

5.2 The Resource Spending Review (RSR) was published on the 31st of May. The aim of the RSR is to set out spending plans for the remainder of the parliamentary term which support the Scottish Government's (SG) ambitions. The key messages are that there is a deteriorating economic environment, which will result in a worsening budgetary position. The response to the challenge is a renewed commitment to investment priorities and reform and an increased expectation of savings. There is also a commitment that public sector pay needs to be self-financing. This implies a

reduction in the headcount of the public sector with the aim to return the total size of the public sector workforce to pre-COVID-19 levels by 2026-27.

5.3 The Financial Plan for 22/23 was approved by the Board at its April meeting where a forecast deficit position of £28m was accepted. This was predicated on the basis that COVID-19 costs of c£80m would be fully funded. The latest allocation letter indicates that there will be a significant shortfall against COVID-19 actual costs. National work is underway to rebalance the available funding against forecast costs. Work also continues to improve the forecast outturn and the Quarter 1 review exercise will be pivotal in reassessing progress.

5.4 At the RIE, the life cycle proposals received previously are being refined in coordination with an updated Consort commissioned condition survey to develop a programme of works. This will assist in establishing the level of decant required to permit the works to proceed. The dispute raised by the Board with Consort on certain aspects of their performance continues to progress via the Dispute Resolution Procedure (DRP). There may be a hearing required in early June and a final decision should be available by the end of that month. While this has progressed, the Board has conducted meetings with the majority lender, the lenders technical adviser and one of the two investors to ensure that they are sighted on the DRP issues.

The Public-Private Partnership (PPP) Programme Director is finalising the contract management structure to support his role in overseeing all 10 PPP contracts and is liaising with Estates and Facilities given their expanded role going forward on the PPP sites.

5.5 The May hearing of the Scottish Hospitals Inquiry concluded in May and covered the theory and practice of ventilation and the background to RHCYP & DCN in early 2013. The timetable for the October hearing is still to be confirmed but it is expected to be for two weeks commencing 3rd October 2022. It is anticipated that the scope of the hearing will be split into 3 categories: design stage, procurement and financial close. Again, it is anticipated that NHS Lothian staff both current and retired will be called as witnesses.

6. Director of Human Resources and Organisational

6.1 3-Year Workforce Plan - The Staff Governance Committee (1 June 2022) received an update on the development of the 3-year Workforce Plan, which is aligned to the LSDF. The final version of the plan will be submitted to the Staff Governance Committee on 27th July before submission to the Scottish Government on 31st July. Scottish Government will review the Board plan during August and provide feedback by the end of August. Following any final adjustments to the plan, it will be published by October 2022. The plan will set out our workforce profile, risks and challenges plus actions being taken to mitigate these, workforce and recruitment plans for the opening of the NTC in 2027, COVID-19 workforce recovery, plans to introduce new roles/access different supply pipelines to reduce workforce gaps and the enabling support required from Scottish Government.

6.2 Workforce Advancing Equalities Action Plan 2022/23 - The Staff Governance Committee (1 June 2022) approved the Workforce Advancing Equalities Action Plan for this year. The plan was developed in partnership with our five staff networks (BME, Disabled Employees, LGBT+, Carers and Youth) and partnership colleagues. The plan has a range of actions including a commitment to develop strategic approaches to anti-discrimination, exploring a disabled employee's passport, understanding, and addressing the barriers to BME staff career progression and pastoral support for international recruits into our organisation.

6.3 Staff Wellbeing - As part of our staff wellbeing strategy – 'Work Well' we launched the Energise You programme on 25th May. Sally Gunnell, OBE, Olympic Medallist launched the programme. Sally shared what she has learnt about wellbeing, goal setting and building resilience during her time as a professional athlete and how she continues to draw on this in her everyday life and career. The Energise You programme runs through to March 2023 and involves sessions on nutrition, exercise, relationships, sleep and financial wellbeing. The sessions are being recorded so that staff unable to participate in the live stream can view at an alternative time. The initial session has been positively received by staff.

6.4 2022 Leadership Conference - This year's leadership conference is due to take place in-person on 26th October at O2 Academy Edinburgh. The theme of this year's conference is 'All teach, All Learn'.

7. Director of Public Health and Health Policy

7.1 COVID-19 Transition - The Omicron variant identified in November 2021 led to the highest rates of infection yet seen in Scotland, with significant pressures on the health and social care sector. As that peak subsided, although infection rates remained relatively high, protective measures were eased and the approach to mass testing and contact tracing was stood down in a phased approach. The Scottish Government adapted the strategic intent from a focus on suppressing cases to managing COVID-19, through reducing and mitigating harms.

In Lothian, community asymptomatic testing stopped on 18th April 2022 and the dual testing site in Musselburgh closed on 29th April 2022. A lessons learnt exercise was completed and report written to capture learning from the programme, such as the innovative approaches to increase access; pop-up LFD Collect, mobile testing capacity and dual testing facilities.

Contact tracing stopped on 30th April 2022. All staff from NHS Lothian Test and Protect team are now going through redeployment in line with the expectations of the National Test & Protect Workforce subgroup. A local workforce group comprising of colleagues from finance, ER and partnership as well as Test and Protect and HPT management has been providing oversight to the process.

There is currently a proposal under review by the Scottish Government for ongoing funding for a small, retained workforce to manage a future response to variants of concern (VAM) which is likely to be locally led. A decision on future funding and staffing model is anticipated soon and this may require amendment of future Test and Protect workforce plans.

In response to the change in national guidance, the Health Protection Team developed a COVID-19 transition plan to adapt our local approach in key settings, such as care homes and prisons. We will continue to prioritise support to our most vulnerable settings. Over the last month, we've seen an increase in non-COVID-19 disease, with our workload returning to a mix of different disease outbreaks and environmental situations. Our key priorities are to focus on being prepared for any new significant COVID-19 variants (VAM) or emerging disease, such as Monkeypox.

7.2 Immunisation - As of 1st May 2022, the Vaccination Transformation Programme is now complete and delivery of vaccinations in Lothian have been transferred from General Practice to our four Health and Social Care Partnerships in Edinburgh, East, West and Midlothian. There will be a programme of quality improvement work ongoing with the post-VTP process.

In response to this change in delivery mechanism, our local governance structures within NHS Lothian to oversee immunisation is also changing. An Immunisation Oversight Board (IOB) has been established to oversee Immunisation strategy and an Immunisation Delivery Board is being set up to steer activity and monitor uptake, inclusivity and safety, and will escalate to the IOB as necessary. A workshop engaging all stakeholders to discuss the shape of the new IDB structures, and any required subgroups, was held on 31st May.

In addition, the national governance landscape regarding vaccinations and immunisation is modernising. Scottish Government and Public Health Scotland are working in partnership to develop the Scottish Vaccination and Immunisations Programme (SVIP) with the intention of PHS taking over the lead role within 9 months' time.

8. Chief Officer Acute Services

8.1 Acute services remain under significant operational pressure from unscheduled care demand and staffing pressures, resulting in full hospital sites and very busy Emergency Departments. This continues to limit our ability to recover our elective programme and a risk-based option appraisal process has been completed to develop a framework to support recovery.

8.2 Within our laboratory service, work and run rates for combined laboratory COVID-19 testing at the Royal Infirmary Edinburgh (RIE), and Hub sites have decreased to around 1,500 tests per day as we continue to move out of the latest phase of the pandemic. Laboratory systems are continuing to process Flu or associated respiratory virus testing in combination with SARS-COV2 (COVID-19) testing. Work is reaching a steady state with consolidation Point of Care Testing (PoCT) at the 'front-end' of Acute sites, allowing quicker decisions to be made on patient flow, infection control and patient placement, using rapid Polymerase Chain Reaction (PCR) and Antigen technology - this testing accomplishes on average 1,500 POCT tests per week currently.

8.3 NHS Lothian continues to work with the Scottish Government and National Services Scotland to deliver the business-as-usual systems for pandemic testing and to explore the legacy effects of pandemic-related technologies, which will focus not only on securing screening capacity, but also on how to expand ability to detect variants

through ‘whole genome sequencing’. A process is underway to provide a contingency plan for the winter ahead and into 2023.

8.4 Laboratory blood sciences equipment for undertaking thousands of tests daily across Lothian went live with a new Supplier from November 2021 – Roche Diagnostics – and work is now in the final stages of implementation. Western General Hospital (WGH) and St John’s Hospital (SJH) are fully live, and the Royal Infirmary (RIE) site is in final stages of the robotic implementation, with final switch-on expected in June 2022. The Project is regional with NHS Fife and NHS Borders being on the same contract, with the same supplier. NHS Fife implementation will progress over the Summer of 2022 and NHS Borders will join the project in 2024. This has been a good example of East Region working with the three Laboratory teams working to provide upgraded and effective systems supplying the same tests across the region, to a population of about 1.4 million people.

8.5 SJH - A positive development that took place in May 2022 was the placement of a DaVinci robot at St John's Hospital. Urology and Theatre teams worked closely together to prepare for the introduction of this new patient pathway, learning from the experience at WGH, and the first Robotic Radical Prostatectomy at SJH was performed on 10th May.

8.6 WGH Personnel - Dr Colette Reid has been appointed as Associate Medical Director for Cancer Services at WGH, replacing Dr Larry Hayward who has stepped down from his role, though he continues as a Breast Oncologist within the Edinburgh Cancer Centre. Dr Moray Kyle has been appointed as Clinical Director for Oncology, replacing Dr Catriona Maclean who is retiring after a very successful career and recent stint as Clinical Director. Dr Jenni Crane has been appointed as Clinical Director for Acute Medicine at the WGH, replacing Dr Stuart Ritchie who has changed roles to become Clinical Director for Diabetes & Endocrinology in a pan-Lothian role.

8.7 Dementia Awareness Week 20th May – 5th June 2022, SJH - The theme for this year’s Dementia Awareness Week from Alzheimer’s Scotland is ‘Let’s Prevent, Care, Cure dementia together.’ We at SJH decided to make this about and for the public in West Lothian. We brought part of our Meaningful Activity Centre (MAC) to the front door and made an area for our ‘pop up’ Information centre.

8.8 We feel in SJH that the Distressed Care Team, along with all the ward teams, have made a huge difference in finding the ‘Unmet Need’ in patients with an Altered Reality. We wanted to let families and carers know how we do this – how we care for people that have an altered reality and how we improve their experience in hospital, and their journey forward. We gathered professionals from around West Lothian and devised a timetable of talks from them over two days, that would be available for the public to access. This covered topic including benefits advice, help that GPs could provide, advice on power of attorney and guardianship, social work, diagnosis and support, medications, assessment and advice for discharge, the reduction of distress within wards and support whilst in hospital. Information for Dementia Awareness week has been provided by Psychiatry. They also planned an excellent Information Day for 1st June, where members of the public could meet with Link workers to understand more about living with or alongside someone with a dementia diagnosis – a day filled with activity as well as vital information.

9. Director of Strategic Planning

9.1 The key focus for the Directorate since the last update has remained the LSDF. We have undertaken extensive internal and external engagement activity as detailed in the paper at this Board meeting.

9.2 Related, we have also begun the development of our Annual Delivery Plan submission, continued our input to the development of the case for the National Treatment Centre, submitted Initial Agreements for Phase 2 of the Royal Edinburgh Hospital redevelopment, progressed implementation plans for the scheduled care and unscheduled care programme boards, progressed work on the Regional Infectious Diseases Unit reprovision, re-started our work with the respiratory and diabetes MCNs, established the short-life working group for closed-loop insulin pumps, and continued our work across a range of other pieces.

9.3 We are pleased to note that Bhav Joshi, Hannah Fairburn, James Stevenson, and Eildih Markie are all moving on to promoted posts - Bhav in NHS Borders and other colleagues within the Lothian system. They have been fine members of the team and Eilidh in particular has played an unsung role in the development of both the South-East Major Trauma Network and the Royal Infirmary Major Trauma Centre.

9.4 We have also formally taken on the line management of the Unscheduled Care Programme and Jill Gillies therefore moves into the team.

9.5 All told we do remain below full-strength in the team, but we are actively recruiting and confident that we will attract yet more talent into the Directorate.

10. Director of Primary Care

10.1 The General Practice Out-of-Hours Service (LUCS) and Dental Out-of-Hours Service have successfully managed three public holiday weekends since the last Board report. This included a busy four-day Easter weekend, and key learning points from the Easter weekend were used to update the LUCS resilience plans and were tested over the May holiday and Queen's Jubilee public holiday weekend.

10.2 Progress continues in processing the expressions of interest to apply to the pharmaceutical list. The updated plan is here Current Position – Pharmacy Application Process (nhslothian.scot) and six public consultations are currently underway and can be found here Joint Consultations – Pharmacy Application Process (nhslothian.scot)

10.3 Contextual activity data for general practice has been provided to the Board for the first time and I am working with colleagues to develop further primary care indicators.

10.4 The final phase of transition of vaccination delivery from general practice to HSCPs was completed on 1 May 2022. This fulfils one of the key priority are

as of the GMS 2018 contract and represents a huge amount of work from HSCP and public health colleagues.

10.5 The Primary Care Joint Management Group has expanded its remit to also provide the Primary Care Programme Board function to ensure appropriate oversight and governance of the Lothian-wide primary care strategic plan in line with the Lothian Strategic Development Framework.

10.6 The Programme Board to produce the long-term strategic infrastructure plan for General Medical Services across NHS Lothian, with the development of a prioritised capital programme Initial Agreement, has been established and will report to the Lothian Capital Investment Group in the autumn.

11. Director of Communications, Engagement and Public Affairs

11.1 Planning - Director of Comms has been involved in discussions with colleagues nationally and with SG on developing a national comms strategy to support national strategic planning priorities. There is a need for public understanding via co-ordinated national messaging of what those priorities are, how services are evolving and how pandemic impacts are being managed.

Locally, plans are being implemented to support the Scheduling of Minors Injuries (launch June 27th) and ED Redirection. A strategy is also being developed to support Discharge Without Delay

11.2 Visiting - In response to staff concerns about pushback (sometime quite hostile) from members of the pubic on our requirement that they continue to practice basic Infection Prevention and Control measures guidance on our sites, we have raised awareness via media reporting, social media content and a poster campaign to stress the importance of doing so. We are also working on a campaign, #BeKind, to remind people that aggressive behaviour towards our staff is not acceptable.

11.3 MSPS/ MPs - The quarterly meeting was held on June 10th where there was a particular interest in waiting times, Unscheduled Care performance and access to Primary Care services

11.4 Engagement LSDF - We have been creating video content featuring example of service change and innovation, publicising virtual public meetings and organising a Lothian wide door drop to encourage people to share their views on the LSDF.

11.5 Commemorative Film - Several screenings took place of our hour-long film, Pandemic - NHS Lothian's Response to COVID-19, which reflected on the experience of staff during an extraordinary period. The film has bene warmly received by staff, public and patients and can be viewed online. It will be held in NHs Lothian's archive as a lasting record giving.

11.6 What Matters To You Day - There has been a team wide effort to speak to patients and staff across the organisation for What Matters To You Day. The resulting material played across the day and for several subsequent days and is being used to create

which can remind us of the importance of listening– even to the small things – throughout the year.

11.7 Connections magazine made its return after a near 2-year absence with a refreshed format and sharper focus**.**

12. Services Director – REAS

12.1 Inpatient services remain under pressure in acute adults, acute old age and acute young people with an expectation that this will continue due to the impact on people's MH of the COVID-19 pandemic. Occupancy remains near 100% in all areas. Delayed discharges in adult and old age Psychiatry continue to have an impact on flow. Discharge without delay self-assessment has been completed. Lothian is the first mental health area to use this and we are now waiting on the feedback report from Scottish Government to develop next steps. There are a number of work streams looking at smoothing the pathway across inpatient and community settings.

12.2 Nursing vacancies remain a pressure within REAS and other MH services. REAS have 63 newly qualified staff coming in September but this doesn't fill all vacant post. Work continues to develop alternative ways of working including the introduction of band 4 nursing roles, increase Art Therapy and Occupational therapy in the wards and increase Psychology provision.

We have also had permission from the Chief Nursing Officer for Scotland to expand our Open University (OU) provision for students. The OU has a well- established BSc in Adult, Mental Health Nursing and Learning Disability Nursing which has enabled HCSWs across NHS Lothian to undertake a degree whilst in paid employment.

There is an opportunity to pilot an alternative pathway which provides flexibility in how we recruit and deliver this course which would enable a widening access opportunity for individuals in REAS. The model will recruit candidates directly into a band 2 CSW post, with the expectation to undertake the K102 and K104 modules in the first 16 months of employment. This should enable entrance to 2nd year of OU BSc Mental Health Nursing. Upon successful completion of K102 and K104, employees will be appointed to Band 3 HCSW roles even if they chose not to progress further via the OU course.

Each student will remain an employee of NHS Lothian and work up to 26 hours per week. Clinical placements will take place within the organisation. Recruitment is underway with the first cohort starting in autumn

12.3 With the exception of CAMHs, Consultant Psychiatry input is better than some other areas in Scotland. An action plan is in place to support CAMHs including the introduction of Advanced Nurse Practitioners, expansion of administration services, introduction of an Unscheduled Care Service. This gave the clinical Governance Committee a level of assurance that the issues are understood and being addressed

12.4 CAMHs and Psychological Therapy performance remain on escalation and under close review by the Performance Oversight Board and Corporate Management Team. CAMHs are ahead of agree trajectory, Psychological Therapies are slightly behind mainly due to recruitment challenges but continue to improve.

Heather Cameron AHP Director has agreed to chair the group to review the Neurodevelopmental pathway which will require a multi-agency approach including education, Children's services and CAMHs

13. Director/Chief Officer, Edinburgh Integration Joint Board

13.1 System Pressures - As reported in previous reports, the Health and Social Care system remains under intensive pressure. The number of people delayed in hospital continues to fluctuate but has remained fairly stable overall during the past month.

We continue to see staffing shortages in providing community care at home and within care homes. This has been exacerbated more recently with the rise in cost of living and fuel prices, with reports of more carers leaving the care sector. We continue to work closely with our partner providers to mitigate any risks against this.

We continue to meet regularly with the Cabinet Secretary and Scottish Government officials to review performance. A Whole System Oversight Group has been established consisting of the NHS and Council Chief Executives and EHSCP Chief Officer to monitor progress against our trajectories and milestones relating to areas of pressure.

13.2 Bed Based Review - Following approval to progress with the phase 1 implementation from NHS Lothian's Corporate Management Team (CMT) and Capital Investment Group (LCIG) discussions have been ongoing with both partner organisations to agree the Heads of Terms for the transition of Drumbrae care home to NHS Lothian. Both organisations have agreed a market value lease for the property and the payment schedule is being negotiated. A paper outlining the agreed position will be presented to the CEC Finance and Resource committee on the 16th of June for consideration. There is a risk that committee are unable to agree the position which would impact on the implementation timescales, any delay to a decision could impact on the timescales to vacate the Liberton hospital site which is to be sold for redevelopment.

An implementation oversight group has been established and has met twice to oversee progress. The next meeting of the oversight group is planned for the 20th June. The group will continue to meet throughout the implementation process to ensure the project is progressing as planned.

Recruitment is underway to the nursing model in the newer 60 bed care homes. The model will be implemented iteratively one care home at a time. A targeted recruitment campaign is planned to generate interest in the roles through various employment websites in addition to the regular adverts via the NHS Job Train site

13.3 Matters of Interest - EIJB Membership - The EIJB has had a large turnover in regard to the membership in terms of representation from both NHS Non-Executive Directors and Elected members, ongoing work is taking place with the EHSCP Executive Management Team to induct the new members appropriately on EIJB matters.

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

14.1 Delayed Discharges - East Lothian Health and Social Care Partnership has experienced challenges in responding to delayed discharge pressures, with a resulting increase in hospital waits for clients, some the result of reduced capacity in Care Homes and Care at Home services. All teams, across the East Lothian Community Hospital, Home Care, Hospital to Home, Care Allocation and Rehabilitation services, continue to work together to tailor support for individual clients to meet their clinical and social care needs, to avoid admission and to facilitate early discharge.

14.2 Care Homes - All East Lothian care homes are open to admission, reflecting the ongoing reduction in COVID-19-positive cases, to low single figures. The increased flexibility of care home provision will assist in bringing down delayed discharges, however, staffing remains an ongoing challenge, which influences bed availability in some homes.

An unplanned Care Inspectorate inspection at the Abbey Care Home in North Berwick has highlighted concerns regarding cleanliness, catering and staffing. Action is underway to immediately address these aspects, while a full report is awaited.

14.3 Social Care Capacity - All providers are in a more settled position at the moment, with the HSCP providing support and guidance as required as the services continue to step up provision, to improve responsiveness and to recruit to vacant posts. Although the HSCP internal service continues to increase its input of care at home hours there remains a deficit in provision, meaning some client needs are unmet.

14.4 IJB Strategic Plan - Consultation and engagement is underway across East Lothian partners, geographical communities and communities of interest as part of development of the 2022-25 Strategic Plan. To improve reach and to reduce consultation fatigue, the Strategic Plan consultation was carried out alongside consultation on the East Lothian Local Housing Strategy 2023-28 and the East Lothian Local Development Plan 2025.

The Strategic Plan will set out the IJB's strategic priorities for the next 3 years, reflecting local East Lothian priorities as well as those arising at regional and national level.

The East Lothian Strategic Plan will align with the Lothian Strategic Development Framework (LSDF) as part of the co-ordinated remobilisation across the Lothian Health and Care System to improve service provision and to reduce waits.

14.5 IJB Annual Performance Report 2021-22 - Preparation of the report is underway and as with last year's report it will present performance against a range of nationally determined measures.

14.6 Scheme of Integration - Following revision by NHS Lothian and East Lothian Council, the Scheme was out for public consultation until 29th May 2022. A report on the consultation outcome is awaited.

15. Director/Chief Officer, Midlothian Integration Joint Board

15.1 Quality Management - Midlothian HSCP are in the process of reviewing and enhancing the four domains of the Midlothian HSCP Quality Management System (QMS) (Quality, Planning, Quality Control, Quality Assurance and Quality Improvement) to ensure that there is a robust platform from which to leverage the upcoming changes and developments as outlined in the new IJB Strategic Plan and subsequent Directions. It is anticipated that building on the current QMS system and filling the gaps will strengthen and align the strategic priorities with the operational delivery of services to support sustained change and foster deep connections between all aspects of the organisation**.**

15.2 Substance Use - To support local areas to implement Medication Assisted Treatment (MAT) Standards (initially 1-5 & 7), the Scottish Government has created a MAT Implementation Support Team (MIST). Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) has been successful in securing new annual investment for 4 years of £246,115. This has been augmented by £57,691 funding annually for the same period from MELDAP. This funding package (total £303,876) will assist with the implementation of the MAT Standards. Recruitment of HSCP/3rd Sector staff is underway. These staff will focus on supporting people into treatment, increase the level of support and improve retention in services. These being key areas for intervention and prevention in relation to near minimising drug related harm**.**

15.3 Mental Health and Resilience Service (MHARS) - One of the largest pieces of work that the HSCP continue to implement in a phased approach, and hope to fully deliver by the summer of 2022, was the redesign of the current Intensive Home Treatment Team (IHTT). The initial focus was to transform front door access for individuals who are experiencing an acute/relapse of their mental illness and/or crisis and distress with their mental wellbeing. Along with this new direction, Midlothian were also represented on the Pan Lothian Redesign of Urgent Care (RUC) with the Scottish Government, with the focus again being around an Individual having access to the right person at the right time. Additional funding was established, and the care model enhanced to support Midlothian continuing to be part of the ongoing RUC programme.

15.4 Adults with Exceptional and Complex Needs Service (ACENS) - The Adults with Exceptional and Complex Needs Service (previously known as Complex Care Service) is hosted for NHS Lothian by Midlothian HSCP. The service has seen a significant increase in demand over the past 2 years. A position paper was presented to NHS Lothian Chief Officers, to address the current financial gaps, with agreement to progress with a service model review, that will deliver a model of care fit for the future

15.5 Vaccination programme - The Spring booster programme ends on 30th June 2022. There has been an 89% uptake of vaccination for the over 75 population. The Evergreen programme of vaccinations will continue across the summer. A successful Housebound programme was completed ahead of schedule along with Care Home vaccination. Midlothian HSCP Inclusivity programme will continue to remain a focus across sites to support access.

The 5-11 years programme continues to run with a 69% DNA rate. This is an improvement from the start of the programme, likely due to children either being COVID-19 positive, or within the 12-week post infection period. 2nd doses are due to commence in June.

Following guidance from Scottish Government Chief Medical Officer relating to the Autumn/Winter flu/COVID-19 programme, planning is underway for all eligible cohorts, including children's flu, and staff vaccination.

The Midlothian Vaccination team have almost completed permanent workforce recruitment and will move out of Midlothian Community Hospital to 3 new bases across the county. These will provide additional access for residents, and will be supported with pop-up clinics, mobile units, and the continuation of the Housebound and care home delivery model.

The Midlothian Vaccination Transformation Programme (VTP) plan saw vaccinations transferring to the HSCP from GP Practice, under the new GMS contract. This was delayed by 6 months relating to the pandemic. However, all vaccinations have now been moved to the HSCP team, except for Shingles and Pneumococcal. Plans are in place for the transfer of these over the summer period.

15.6 System Flow - The introduction of the Scottish Government Discharge without Delay programme, coupled with additional system-wide demand, has resulted in a 42% increase demand, converting into patients who experience a delay in discharge. Significant additional investment to enhance the Home First approach has already been made, together with system transformation. Additional work is underway to consider lack of availability of Care Home beds in Midlothian, as well as additional Care capacity

15.7 Dynamic Scotland Digital COPD **-** The Dynamic Scotland programme commenced on the 1st of April 2022, to deliver digital elements of preventative care, within the current care model offered by Midlothian Community Respiratory Team. The programme aims to support people living within Midlothian who have Chronic Obstructive Pulmonary Disease to:

- improve the self-management of Chronic Obstructive Pulmonary Disease (COPD) in the community reduce Emergency Department attendances
- reduce admissions
- reduce Length of Stay

This is a 2-year funded programme, that will support improved management of COPD within the county.

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

16.1 Chief Nurse and British Empire Medal - The West Lothian Health and Social Care Partnership is proud to report that the Chief Nurse, Linda Yule, was awarded the British Empire Medal at a recent ceremony at Edinburgh City Council Chambers in recognition of services to health and social care during the COVID-19 19

pandemic. The British Empire Medal is granted in recognition of meritorious civil or military service worthy of recognition by the Crown.

16.2 Love Learning May - Following on from the successful 'Feel Good February', an initiative to promote staff health and wellbeing across the HSCP, 'Love Learning May' was launched to highlight the range of learning opportunities available across the partnership and to provide a focus on compliance with mandatory training. Love Learning May was launched by the Director through a video circulated to staff. Teams have developed individual initiatives to promote learning throughout the month and examples are being promoted via social media. The work supports the development of a learning culture across the partnership, a shared approach to learning, and development of the draft workforce plan which will be considered by the Integration Joint Board in June.

16.3 NHS Scotland Event - For the past year, the West Lothian HSCP has been working alongside colleagues from NHS National Services Scotland and North Lanarkshire HSCP to better understand the barriers and to consider how a more personalised approach to communication might increase the uptake of cervical screening in West Lothian. A range of stakeholders have participated in service design workshops to inform the development of the future approach. The work undertaken so far has been selected for inclusion as a presentation at the NHS Scotland Event in Aberdeen in June 2022. The event involves colleagues from Scotland and beyond coming together to consider challenges, to share best practice and the most innovative approaches to delivering the highest quality of care.

16.4 Lothian Employee Work Rehabilitation Service (EWRS) Launched - The EWRS is now available to NHS and council staff across the health and social care partnership and St John's Hospital. The service offers expert work rehabilitation support to staff so they can get back to work and manage their health in work. Staff work together with occupational therapy case managers to create a return-to-work plan that is tailored to individual needs. The service can provide expert advice, workplace interventions, and health condition management support to help people return to or stay in work. Managers are promoting the service within their teams, encouraging referrals and monitoring impact on sickness absence.

16.5 New IJB Strategic Plan - Work is underway to prepare for the new IJB strategic plan for the period 2023 to 2028. A strategic needs assessment is being completed to inform the priorities of the new plan. Workshops have also taken place with members of the IJB's strategic planning group and broader engagement, and consultation are planned.

16.6 Home First Transformation Programme - Work continues with the development of a whole system transformation programme which supports the principles of Home First. Workstreams spanning community and acute settings are progressing well. At the last meeting of the Community and Acute Planning and Commissioning Board in May 2022, a fourth workstream was added for the development of short- and long-term care at home improvements and oversight of a tender for care at home services. The aim of the refreshed approach is to ensure more robust and sustainable care at home provision which is clearly aligned to Home First and the partnership's proposed transformation outcomes.

17. The Board is asked to receive the report.

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

Approved by

Name	Designation
Calum Campbell	Chief Executive

Author(s)

Name	Designation	Name	Designation
Calum Campbell	Chief Executive	Dona Milne	Director of Public Health and Health Policy
Jim Crombie	Deputy Chief Executive	Jacquie Campbell	Chief Officer Acute Services
Gillian McAuley	Interim Executive Director of Nursing, Midwifery, & AHPs		
Tracey Gillies	Medical Director	Colin Briggs	Director of Strategic Planning
Craig Marriott	Director of Finance	Jenny Long	Director of Primary Care
Janis Butler	Director of Human Resources and Organisational Development.	Judith Mackay	Director of Communications, Engagement and Public Affairs.
Morag Barrow	Director/Chief Officer Midlothian IJB/HSCP	Judith Proctor	Director/Chief Officer Edinburgh IJB/HSCP

Alison Macdonald	Director/Chief Officer East Lothian IJB/HSCP	Alison White	Director/Chief Officer West Lothian IJB/HSCP
Tracey McKigen	Services Director - REAS		

Meeting Name: Board **Meeting date: 22 June 2022** **Agenda item:** *See Note 2*

Title: NHS LOTHIAN BOARD PERFORMANCE PAPER

Purpose of the Report:

DISCUSSION	**X**	DECISION		**AWARENESS**	**X**

The Board is being asked to consider the performance report so they are aware of the operational and strategic performance challenges which NHS Lothian are experiencing, reacting to and developing plans to mitigate against.

The risks during this remobilisation phase have largely remained the same and are detailed in this paper. There are several related corporate risks with corresponding action plans for the issues noted in this paper, with assurance and reporting structures in place for these across the Boards existing Sub-Committees.

If further deeper dives are requested by the Board, it is requested that these are addressed in separate reports to maintain the structure of the core performance report.

Recommendations:

This report is being provided to;

- facilitate Board Member oversight across agreed metrics, an executive summary has also been included.
- detail that the following KPIs **<u>are not meeting</u>** the standard or trajectory agreed at the latest reporting point:
  - Emergency Access (4hr) Standard
  - Delayed Discharges
  - 95 per cent of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment
  - Treatment Time Guarantee (100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (Treatment Time Guarantee)
  - Cancer 62 Day standard
  - Diagnostics radiology activity (MRI, Non-Obs Ultrasound, Barium Studies)
  - Diagnostics – GI Diagnostics incl. cystoscopy activity (Lower Endoscopy, Colonoscopy, Cystoscopy)
  - Psychological Therapies trajectories (total waiting list and those waiting over 18 weeks)
  - Average % bed Occupancy (Mental Health)
  - Staff Sickness Absence Rate %
  - Sustain and Embed Successful Smoking Quits at 12 Weeks Post Quit in 40% of SIMD Areas Most Deprived data zones within Lothian
  - Immunisation: MenB, PCV, MMR1, Hib/MenC, Rotavirus, MMR2, 4-in-1
  - Bowel Cancer Screening Uptake (2019)
  - Cervical Cancer Screening Uptake (2021)

Author: Wendy MacMillan **Date: 07/06/2022**	**Director: Jim Crombie** **Date: 10/06/2022**

NHS LOTHIAN

Board Meeting
22 June 2022

Deputy Chief Executive

NHS LOTHIAN BOARD PERFORMANCE PAPER

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board discuss and review the current performance position of key metrics relevant to the Lothian Performance Recovery Programme, National Standards and Remobilisation Plans.

1.2 The indicators included in this report are a high-level set of performance standards which are supported by a comprehensive framework of measures reviewed across existing committees. These are reported to and monitored by the relevant responsible officers and their clinical and senior professional staff. A key vehicle for monitoring the wider performance metrics in our health and care system will be managed through the Planning, Performance and Development Committee (PPDC) which will report into the NHS Lothian Board.

Any member wishing additional information should contact the Executive Lead responsible for the service area in advance of the meeting.

2 Recommendations

2.1 The Board members are asked to note the performance across NHS Lothian in relation to the metrics included in this paper.
2.2 Recognise that deeper analysis regarding the mitigation plans or assurance provided for the corporate risks will be addressed via existing governance channels and designated board sub-committee.
2.3 If further deeper dives are requested by the Board, these should be addressed in separate reports to maintain the structure of the core performance report.

3 Executive Summary: Key Messages

3.1 **Workforce:** Staffing availability remains a significant challenge across acute, community and social care settings due to a combination of COVID isolation, sickness, annual leave, and vacancies.

3.2 **Flow:** Due to pressures across the whole health and care system the ability to treat, discharge or admit patients from our Emergency Departments/ Front Doors continues to be compromised, linked significantly to high hospital occupancy remaining high. Although the number of patients delayed in their discharge remains lower than the January 2022 peak, the decrease achieved in Q4 has not been sustained and delayed discharge numbers continue to fluctuate in recent months. A significant portion of Mental Health Acute Beds, in particular Older Persons Services, continue to host patients delayed in their discharge. These difficulties remain due to a lack of appropriate placements and staffing availability in the community. Tackling delayed discharges continues to be a key priority for the Board. This continues to have a

detrimental impact on our performance against NHS Scotland's 4 Hour Emergency Access Standard.

3.3 **Scheduled Care:** The position remains largely unchanged from previous reports received by both the Public Board and PPDC. The number of people awaiting 'routine' treatment/operations, and the length of wait for treatment continues to increase in the absence of access to sustainable capacity to meet demand. The rise in the number of out-patient referrals has not been fully offset by an increase in activity and as a result the waiting list rose in March and April.

3.3.1 Urgent Suspicion of Cancer (USoC) and Urgent referrals rose from February to March and USoC referrals remained slightly higher in April than in February, though decreased against the March position.

3.3.2 TTG remains under significant pressure, due to a combination of staffing pressures, limited bed and theatre capacity. An increase in March p2 urgent demand is further compounding this pressure by using available capacity and thereby limiting capacity for non-urgent long wait patients.

3.3.3 NHS Lothian 62-day cancer performance remained below the trajectory of 82% in April 2022 and the 95% standard. Cancer 31-day performance has dipped below the 95% standard, however we continue to exceed the trajectory agreed. We are working to recover this position through the improvement actions and remobilisation plans detailed in this report. Diagnostic radiology services continue to access additional capacity, which continues to positively impact on all waiting times, with the exception of non-obstetric ultrasound where staffing pressures continue.

3.4 **Mental Health:**

3.4.1 For CAMHS (Child and Adolescent Mental Health Services), the Improvement Plan continues to be implemented, although the pace of improvement has been impacted by the challenges around recruitment and staff retention. Percentage of CYP (Children & Young People) starting treatment within 18 weeks was 70.5% (April 2022) compared to 62.4% (February 2022). The service is currently ahead of trajectory for reducing patients waiting over 18 weeks for treatment.

3.4.2 For Psychological Therapies, the service remains behind the anticipated trajectory. New patient appointment activity across Adult AMH was lower than planned due to staff sickness and annual leave/public holidays. The total waiting list size increased slightly, however, the over 18 week portion of the waiting list has decreased slightly. The Psychological Therapies Improvement Plan continues to be implemented, though the pace of improvement is impacted by the challenges around recruitment and staff retention as well as the TRAK changes which will provide long term benefits when fully implemented.

3.4.3 **Public Health:** Both bowel and cervical screening uptake did not meet the national standards, although it should be noted there is a lag in the data available. All vaccinations show the same broad pattern over the reporting period with some fluctuation over time. However, a number of these have not met the WHO uptake % recommendation.

4 Key Risks

4.1 Any relevant risks have been included within the narrative of the appendix.

5 Risk Register

5.1 NHS Lothian's Risk Register includes the risks associated with delivery of performance standards outlined in the Annual Operational Plan, Recovery Plans and Remobilisation Plans. The corporate risk register is subject to on-going review and update. Some of the key linked corporate risks to this paper have been included throughout appendix 1.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment associated with this grouping of performance metrics has not been undertaken. The directors for each service area are responsible for ensuring an integrated impact assessment is carried out where new services, redesign of services and new strategies/plans are referenced to allow NHS Lothian's Lead on Equalities and Humans Rights to follow up and review whether the necessary assessments have been completed as appropriate.

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

7.1 NHS Lothian Directors, IJB Chief Officers and their teams have supported the development of the Remobilisation Plan which NHS Lothian is currently working to enact. Any public engagement and consultation relating to the contents of the plan remains with this programme of work.

7.2 Patients are kept informed by their clinical care teams.

8 Resource Implications

8.1 Financial reporting will remain within the remit of the Director of Finance.

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07/06/2022
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List of Appendices

Appendix 1: Performance Metrics Summary

NHS LOTHIAN BOARD PERFORMANCE

JUNE 2022

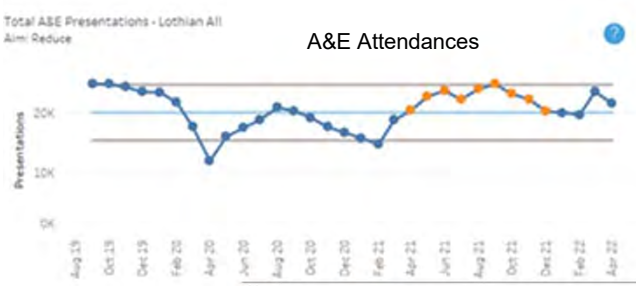
APPENDIX 1

UNSCHEDULED CARE & FLOW

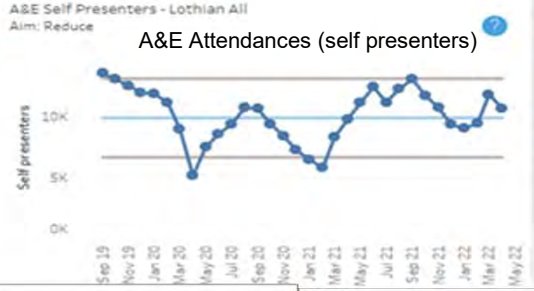
Reporting Month:	April 2022	**Oversight Mechanism:**	Unscheduled Care Programme Board, with additional reporting at Performance Oversight Board, Executive Leadership Team, Acute Senior Management Group (SMG) and GOLD.
Responsible Director(s):	Alison MacDonald – Chief Officer Jacquie Campbell – Chief of Acute Services	**Corporate Objective(s):**	Pillar 5 objective 30 – Redesign of Urgent Care – Phase 2 / Interface Care - On track 4 hour Emergency Access Target
Corporate Risk Grading:	5186- Very High (20) 3726- Very High (20)	**Corporate Risk(s):**	Risk 5186 – 4-Hours Emergency Access Target (via Healthcare Governance Committee) Risk 3726 – Hospital Bed Occupancy (via Planning Performance Development Committee)

Unscheduled Care & Flow - Environment & Context

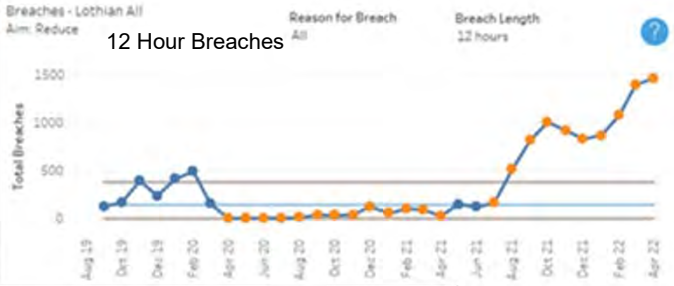
A&E Attendances

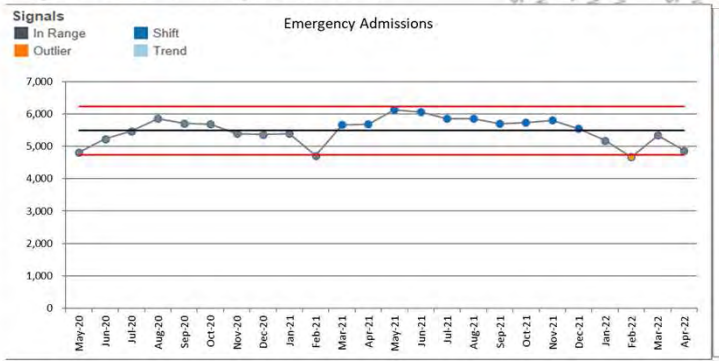


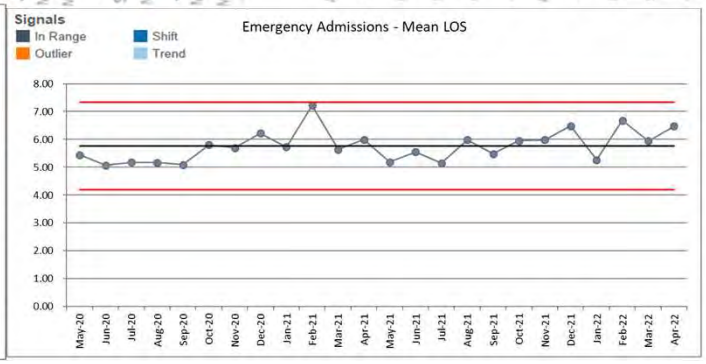
A&E Attendances (self presenters)



12 Hour Breaches

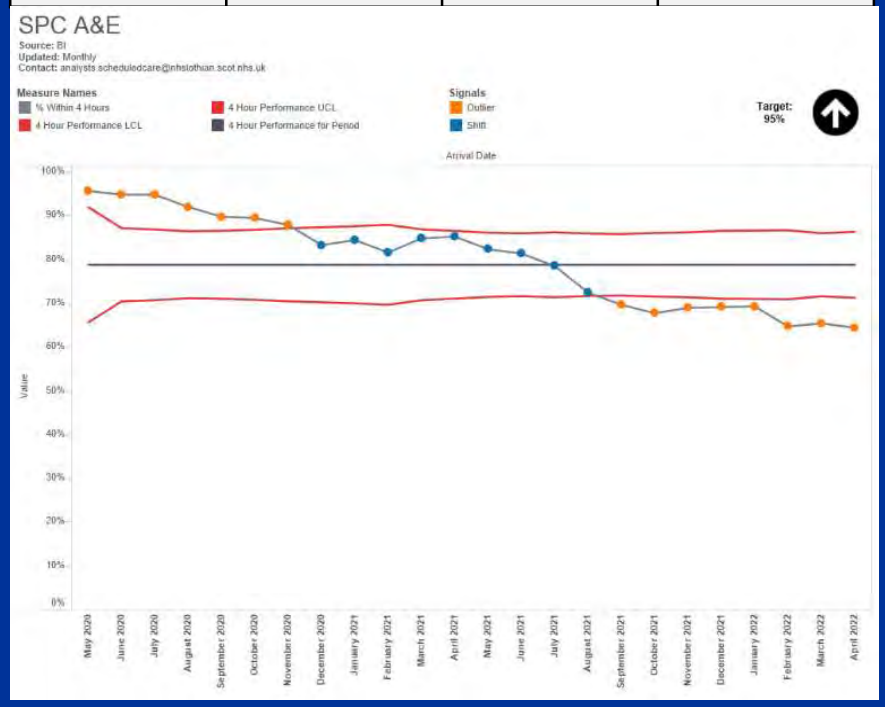






UNSCHEDULED CARE & FLOW – EMERGENCY ACCESS (4HR) STANDARD

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	95% Standard	64.4%	Management Information



Background, what the data is telling us, underlying issues and risks:

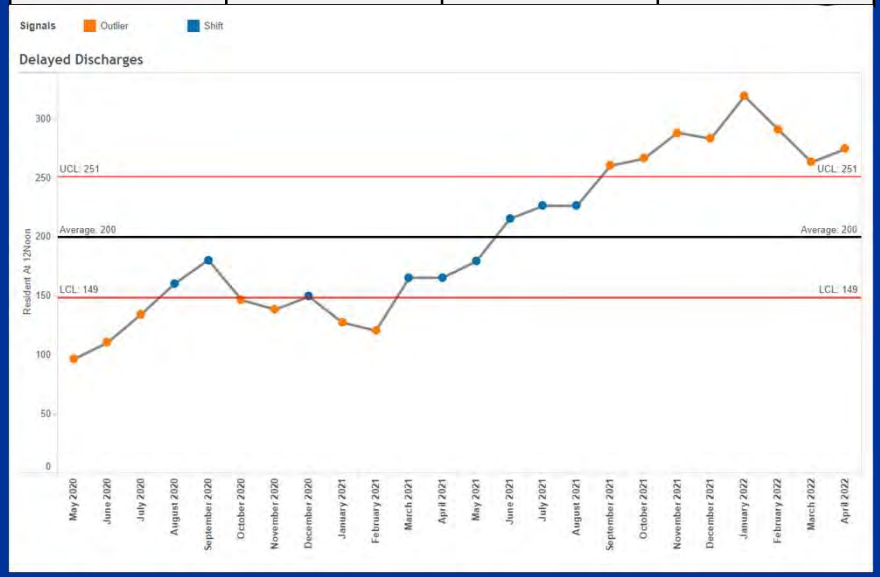
- Data is showing special cause variation.
- NHS Lothian's overall ED (Emergency Department) attendances had been gradually reducing since September 2021, however March 2022 has seen an overall rise in ED attendance levels at all four acute sites, this has reduced again slightly April.
- There continues to be significant challenges in delivering the 4-hour emergency access standard as shown in the graph, with performance remaining low at 64.4% in April 2022.
- Overall NHS Lothian has experienced a deterioration in the number of ED 4, 8, 12-hour breaches experienced in April 2022, compared with previous months.

Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Phase 1 Redesign of Urgent Care Pathway: - Maximise reduction and scheduling of self-presenter attendance	March 22	Patients receive timely access to the right care in the right place avoiding delays anywhere in the system.	Early implementation of Redesign of Urgent phase 1 continues to be closely monitored taking into consideration the impact of the pandemic and the way services are accessed pre and post COVID-1919	An evaluation is underway including a 50-patient pathway audit. The audit has been undertaken to identify pathways that are working well and those that require improvement. Findings from this this inform next steps.
Schedule all minor injury attendances Pan Lothian.	June 22			Implementation plan in place and progressing to schedule all adult minor injuries presentations with a go live date for end June 2022.
Continue robust local communication plans to optimise stakeholder understanding of urgent care.	Ongoing			Local communications and stakeholder engagement are continuing.
Embed signposting and re-direction.	Ongoing			Signposting policy has been approved and uploaded onto the NHS intranet page. Signposting/redirection is currently being embedded within SJH following their pilot and planning is progressing to implement and embed signposting/redirection within RIE ED.
Phase 2 Redesign of Urgent Care – Professional to Professional Urgent Care Referral Pathways and Interface Care -ensure clear referral pathways for GP's, SAS, AHP's to Interface Care Services i.e. hot clinics, MIA, SDEC	March 23	Patients receive timely access to the right care in the right place avoiding delays anywhere in the system.	Delivering high-quality care for defined groups of patients that safely provides an alternative to avoid hospital admission.	Referral pathways in place for GP, community pharmacy and SAS referrals to schedule minor injury appointments. GP and AP Scottish Ambulance referral pathways in place to Sae Day Emergency Care (WGH and SJH), surgical and medical hot clinics
Develop Pan Lothian Same Day Emergency (SDEC) Care model				SJH currently undertaking a pilot of a hybrid SDEC model, commenced Dec 21 to March 22. An evaluation of the current WGH model is in progress and once complete, the RIE and SJH will then undertake a scoping feasibility exercise for an SDEC model on each site. A SLWG is currently being established to assess the feasibility of a Pan Lothian SDEC across all three adult acute sites.
Optimising enabling services for Respiratory care and Outpatient Parenteral Antibiotic Therapy (OPAT) services.				Priority to enhance NHS Lothian OPAT and Respiratory enabling services to reduce attendances, admissions and overall length of stay. SLWG have been established, current service provision has being mapped with areas for enhancement identified and prioritised. A draft proposal is in development for approval.

UNSCHEDULED CARE & FLOW – DELAYED DISCHARGES

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	228 (RMP4)	282	Management Information



Background, what the data is telling us, underlying issues and risks:

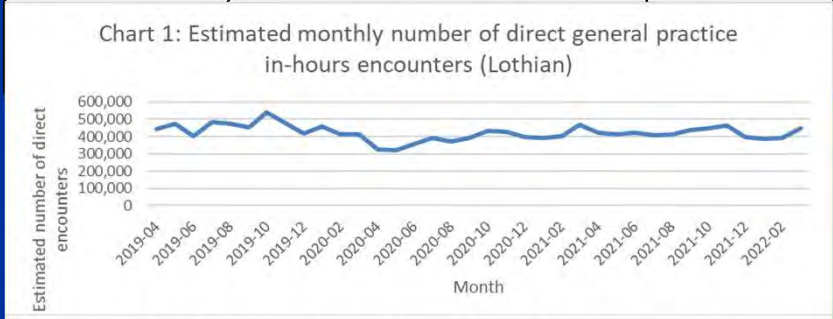
- Data is showing special cause variation.
- With the continued challenges in reducing delayed discharges, tackling this performance continues to be a key priority for the Board. It should be noted this remains a critical focus for the Board, with Executive Directors working with the HSCPs to deliver resilient improvement plans to relieve pressure both in the short, and longer term.
- HSCP delays have grown over the previous months attributed to Package of Care (POC) capacity. There also continues to be a challenge with attracting staff to advertised vacancies, due to the competitiveness of the local recruitment market within Health and Social Care.

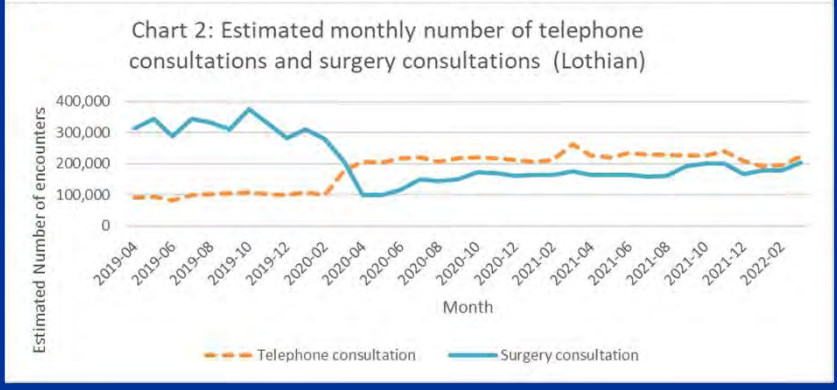
Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Implement a Discharge without Delay (DwD) approach from the Scottish Government Expert Guidance Paper on Optimising Flow Develop a Pan Lothian Discharge and Transfer Policy	Ongoing March 2022	The Discharge without Delay approach aims to reduce delay in every patient journey	To be realised	• Pan Lothian DwD Core Implementation Group meetings commenced in January 2022 and are being held monthly. • Self-assessment Tool completed jointly with acute sites and HSCP teams. • Acute sites and HSCP teams are developing their action plans following completion of the self-assessment. • Updated Discharge and Transfer Policy was approved by the Policy Approval Group in March.
HSCP led initiative(s) monitored and overseen by Corporate Management Team and GOLD (Including DCAQ project in Edinburgh)	December 2021 - ongoing	A variety of initiatives (funded on a non-recurring and recurring basis)	Reduced LoS Reduced/ avoided delayed discharges	• Ongoing • Regular updates at CMT and GOLD

PRIMARY CARE

Reporting month:	April 2022	**Responsible Director(s):** Jenny Long – Director of Primary Care
Oversight mechanism:	Primary Care Joint Management Group	
Primary Care (initial Measures for 22/23)	Estimated General Practice (in hours) activity	**Data Source:** Adastra





Background, what the data is telling us, underlying issues and risks:

- Charts 1 and 2 provide an indication of General Practice in-hours (8am-6pm, Monday-Friday) activity across Lothian based upon a sample of 9 practices where data reporting is robust. This data shows that activity has returned to pre-pandemic levels following a drop in activity between April and October 2020. In March 2022 there was an estimated 448,000 patient consultations across the 119 General Practices in Lothian, the equivalent of around 19,000 consultations a day.
- Chart 2 demonstrates the significant shift in the mode of consultation due to the pandemic, with more consultations taking place by telephone than face-to-face in surgery in order to minimise the risk of COVID-19 infection for patients and staff. Chart 2 shows that face-to-face have increased since the onset of the pandemic with now an almost 50:50 split. Practices are still working on the optimal balance of mode of consultation to provide safe and effective care, however the changes implemented due to the pandemic have resulted in more ways to access care more quickly through remote appointments or by consulting with more appropriate health services first, such as local pharmacies for minor illnesses.

Note: *Direct encounters are defined as a direct contact with a patient: face to face surgery consultation, telephone, video, clinic, home visit, e-consultation. These figures for Lothian have been estimated based on general practice activity from a sample of 9 GP practices. Please note this sample represents only approx. 7% of the Lothian GP practice registered patients and is not a random sample. Figures should be interpreted with caution and only used as a general indication of level of activity.*

PRIMARY CARE (2)

Chart 3: Weekly Number of Lothian General Practice Out-of-Hours service (LUCS) consultations and cases (number of patients)

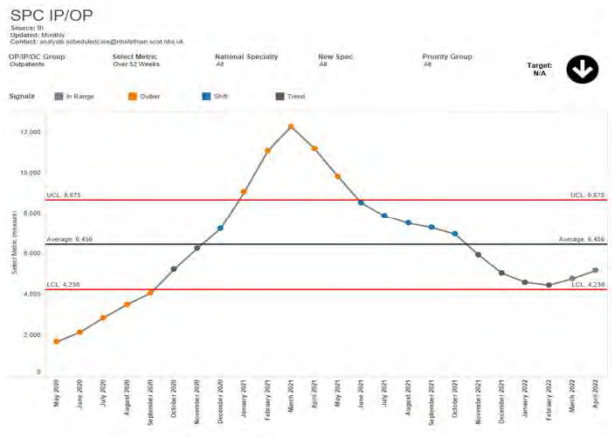
Background, what the data is telling us, underlying issues and risks:

- Chart 3 shows the Lothian General Practice Out-of-Hours service (LUCS) activity, which provides urgent general medical services when in-hours General Practices are closed. The peaks in activity in chart 3 correlate to public holidays as would be expected. LUCS experienced an initial dip in activity levels when COVID-19 restrictions were first put in place in March 2020, however, as the service supported the community COVID-19 pathway from the end of March 2020 overall activity has remained broadly similar but with more variation post-pandemic which likely reflects public behaviour relating to changes with COVID-19 restrictions. In March 2022 the average weekly activity was around 2,400 patient consultations.
- Like in-hours general practice, LUCS also made changes to their operating model at the onset of the pandemic with more patients receiving a telephone consultation than directly being appointed to one of the service's base locations. This has resulted in some patients receiving both an initial telephone consultation and then a subsequent face-to-face consultation, hence the difference between the number of consultations (grey line in chart 3) and number of cases (blue line in chart 3). The service is reviewing the best model to continue to deliver person-centred, safe and effective care.
- For the next update the charts will be converted to Statistical Process Charts (SPCs) for ease of interpretation.

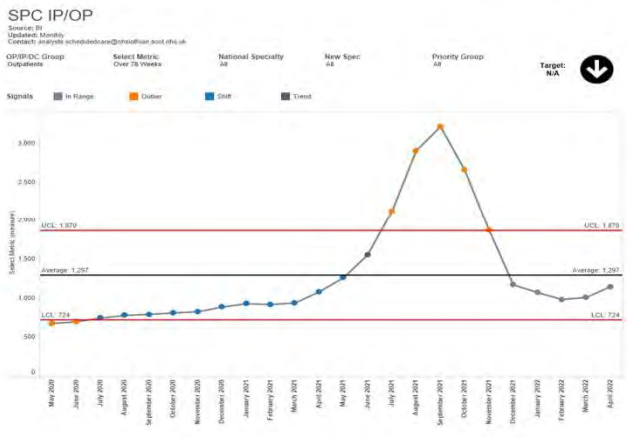
SCHEDULED CARE & DIAGNOSTICS

Reporting Month:	April 2022	**Oversight Mechanism:**	Outpatient Recovery Board, Inpatient/Day case Recovery Board, Scottish Cancer Recovery Board (SCRB) is the agreed organisational structure to monitor/performance manage recovery of Cancer Waiting Times and Cancer Recovery Board reports to that. Regular weekly/monthly/quarterly performance reporting is carried out through the Executive Team and Acute Senior Management Group.	
Responsible Director(s):	Chief Officer – Acute	**Corporate Objective(s):**	Diagnostics – Pillar 6 (no.42); Cancer Services – Pillar 6 (no.43) TTG – Pillar 6 (no. 40, 43); OP- Pillar 6 (no. 42, 43, 45)	On track
Corporate Risk(s):	• ID 3328 - Roadways/Traffic Management – High; • ID 3600 – Finance - Very High; • ID 3726 - Hospital Bed Occupancy – Very High; • ID 3828 - Nursing Workforce – Very High;		• ID 5185 - Access to Treatment- Very High; • ID 5186 - 4 Hours Emergency Access Target – Very High; • ID 5189 - RIE Facilities – High.	

Scheduled Care & Diagnostics – Outpatients Environment & Context



OP > 52 weeks

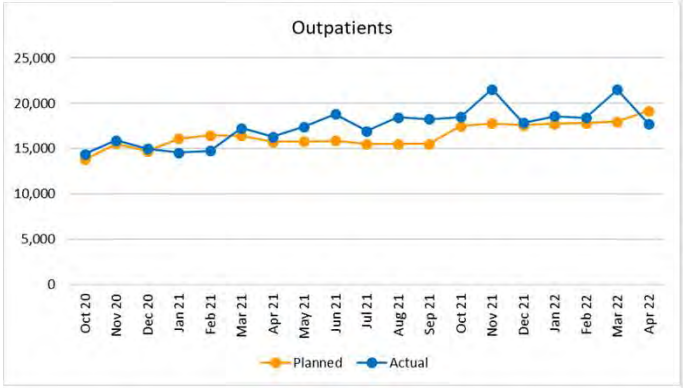


OP > 78 weeks

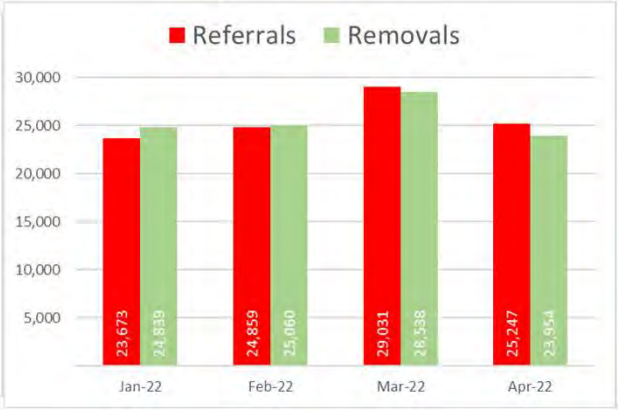
OP > 104 weeks

SCHEDULED CARE & DIAGNOSTICS

Scheduled Care & Diagnostics – Outpatients Environment & Context (cont'd)



OP Planned vs Actual Activity

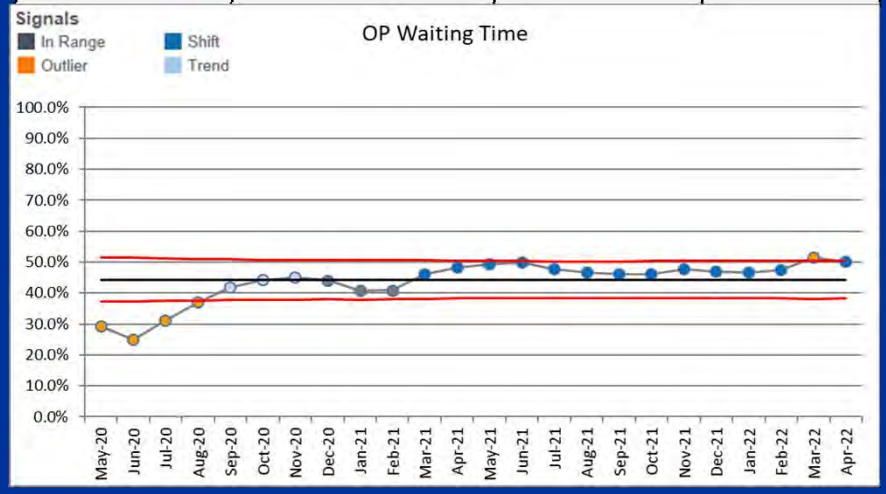


New Outpatient Referrals and Removals from the waiting list

USOC OP > 4 weeks

SCHEDULED CARE & DIAGNOSTICS – OUTPATIENT WAITING TIME (12 WEEKS)

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	95 per cent of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment	50.2%	Management Information



Background, what the data is telling us, underlying issues and risks:

- The trend of a reducing waiting list, and number of patients waiting over 12 weeks, has not continued into April.
- There has been an increase in referrals to the waiting list in recent months and though removals from the waiting list did increase during March (by an additional 3,500), it did not match the increased level of the referrals.
- Furthermore, April's removals were reduced as a result of the two public holidays.
- The increased March referrals and fewer removals in April impacted on performance in some specialties providing Urgent Suspicion of Cancer (USoC)/Urgent services; including Colorectal Surgery, Gastroenterology and Urology, which have seen a consequential dip in their waiting time performance.
- Most services continue to focus on reducing the backlog of long waits that accrued during the pandemic. However, over 85% of the total patients waiting over 104 weeks are within Dermatology (and the position is similar for over 52, and over 78 weeks), where the number is increasing while the service direct capacity at the demand from the most urgent patients.

Improvement actions planned, timescales and when improvements will be seen:

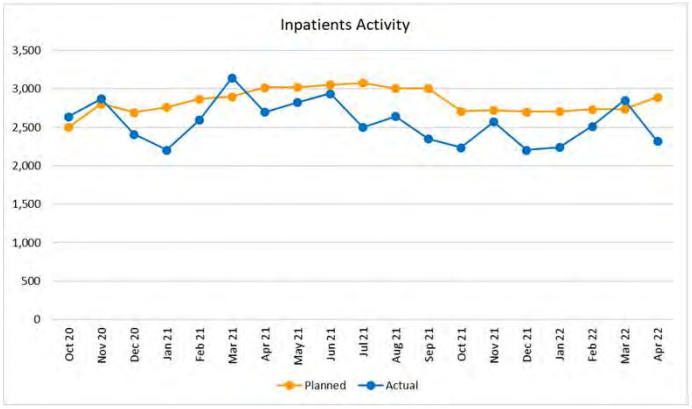
Action	Due By	Planned Benefit	Actual Benefit	Status
There is a Board-wide Outpatient (OP) Redesign Programme underway. All OP specialties will be engaged in the programme on a rolling basis, based on priority as agreed by the Outpatient Recovery Board and advised by Site Directorate Groups. We are collaborating with the National Centre for Sustainable Delivery (CfSD) to support our programmes of remobilisation, recovery, and redesign (RRR). This collaboration facilitates specialty networks to bring together colleagues from across Scotland to share best practice. We currently have a spread of services engaging in these programmes, including across Outpatients. These are led by each specialty or by the OP Redesign Programme. Gastroenterology and Urology are currently progressing through the Programme. Colorectal Surgery are amongst the services scheduled to engage with the programme, once the current tranche of services is complete.	Ongoing, and continuing throughout 2022/23.	Active Clinical Referral Triage streams patients to appropriate advice, virtual or face-to-face appointments. Patient Focused Booking (PFB) to support patient choice of a suitable appointment, whereby patients are sent an appointment letter. This can improve 'Did not attend' (DNA)/ cancellation rates. Patient Initiated Follow Up (PIFU) gives patients flexibility to arrange follow-up appointments when they need them and so reduce demand.	RefHelp GP referral guidelines reviewed/ updated, and training sessions. Impact survey - 82% respondents reported RefHelp has changed their practice. 17,200 patients contacted to book an appointment suitable for them since the programme's start in September 21; 7,600 returned to GP due to no response (44%). Of patients appropriate for PIFU, there has been a 6% reengagement rate since the project's start in April 21. 3,170 patients removed from the list; Return appointments no longer required.	12 specialties have completed through the programme; 27 are currently progressing through the redesign phase. Nine specialties implementing PFB. Rolling out to further services through OP Redesign. There are eight specialties using PIFU. Rolling out to further services through the OP Redesign programme.
Dermatology is engaging with the Performance Support Oversight Board, and developing an action plan for addressing the backlog of long waits	Ongoing, and continuing throughout 2022/23.	Job Plans updated to increased consultant and nurse activity. Focus External Provision activity at longest waits.	Job Plans signed off.	

Improvement actions planned, timescales and when improvements will be seen (cont'd):

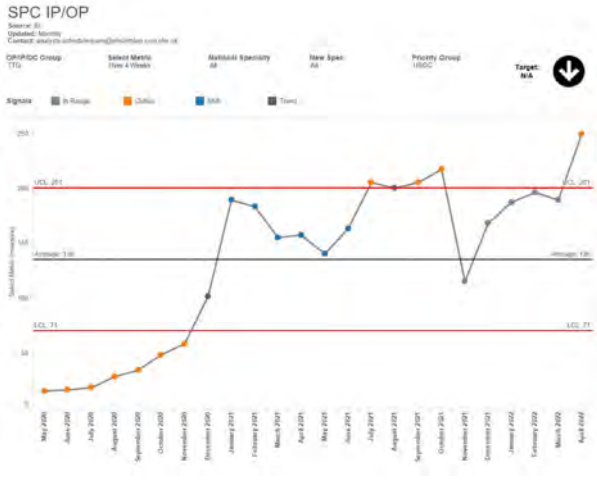
Action	Due By	Planned Benefit	Actual Benefit	Status
Procurement of External Provision.	Ongoing, and continuing throughout 2022/23.	Increase capacity to improve backlog.	Patient cohorts identified and streamed for booking.	2022/23 contracts agreed for Cataracts, Vascular, Dermatology and Ear, Nose & Throat.
Redesign of Qfit pathway in Colorectal for lower bowel symptoms.	Ongoing	Less invasive diagnostic test to stream patients to appropriate treatment plan.	New pathway now in place.	Went live 9th April 2022.

SCHEDULED CARE & DIAGNOSTICS

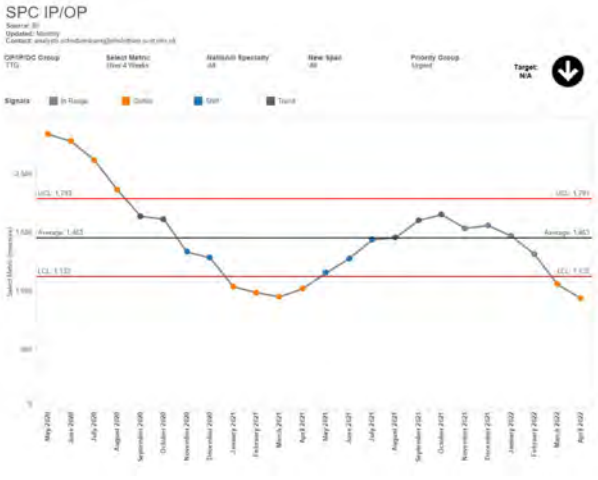
Scheduled Care & Diagnostics – Inpatients/ Daycases (TTG) Environment & Context



IP Planned vs Actual Activity (activity that is measured against the 12 Week Treatment Time Guarantee)



TTG USOC > 4 weeks

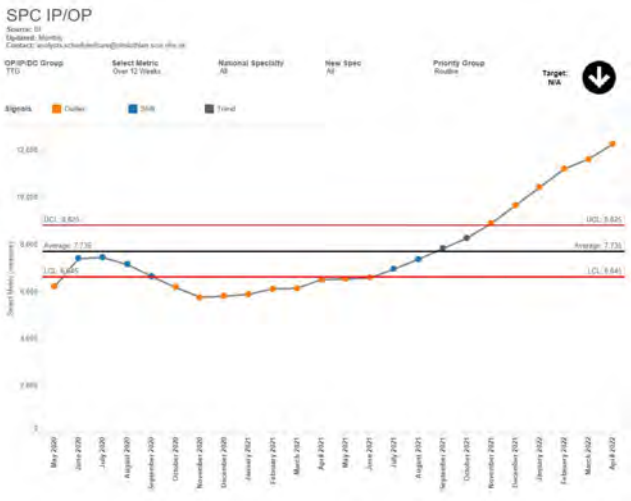


TTG Urgent > 4 weeks

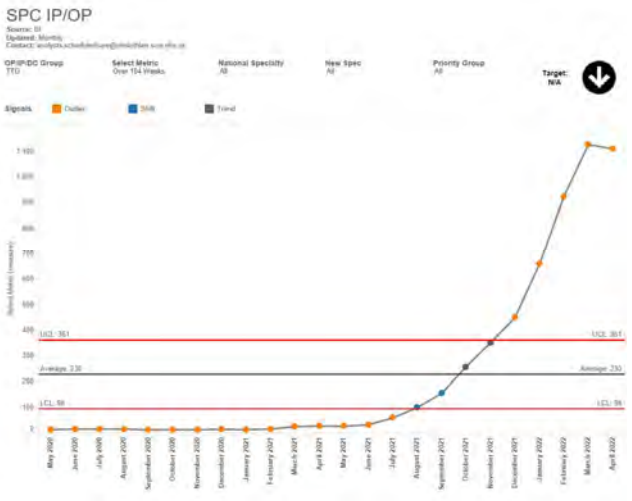
SCHEDULED CARE & DIAGNOSTICS

Scheduled Care & Diagnostics – Inpatients/ Daycases Environment & Context (cont'd)

TTG 'Soon' > 12 weeks



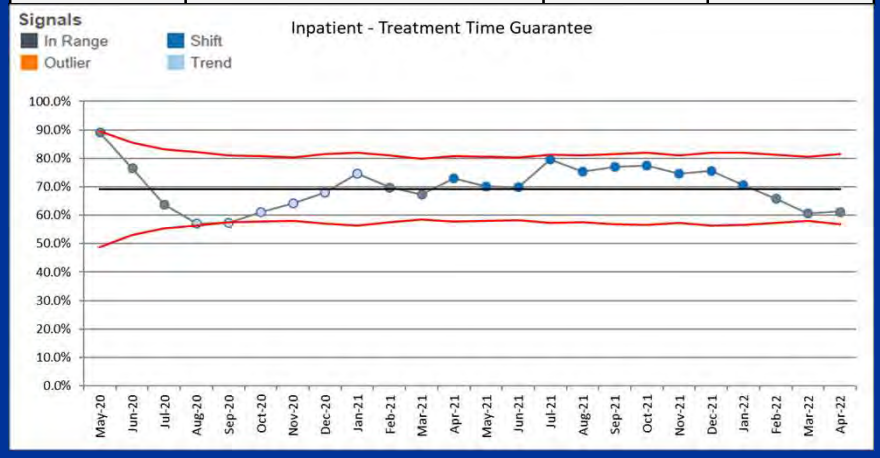
TTG 'Routine' > 12 weeks



TTG (all) > 104 weeks

SCHEDULED CARE & DIAGNOSTICS – INPATIENT TREATMENT TIME GUARANTEE

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	Treatment Time Guarantee (100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (Treatment Time Guarantee).	61.3%	Management Information



Background, what the data is telling us, underlying issues and risks:

- The recovery of Treatment Time Guarantee (TTG) is more challenging than for Outpatients, with our current activity remaining below pre-pandemic levels.
- TTG activity in April 2022 was 60% of the April 2019 level. The impact of limited theatre capacity for a sustained period throughout the pandemic is evident in the growing TTG waiting list, and the number of longer waiting non-urgent patients.
- There is a trend of increasing P2 demand, adding to the ongoing pressure of limited capacity available to meet the backlog of non-urgent patients.
- From our trajectories and activity forecasts it is anticipated we will continue to see a deterioration in TTG performance. Modelling has been carried out to project the growth in TTG patients waiting over 12 weeks. Three scenarios were modelled representing highest, high and lower levels of risk, in terms of the level of TTG activity:
  1. the current status quo of maintaining TTG activity levels at the 2021/22 average;
  2. increasing to 85% of pre-pandemic 2019/20 levels, and;
  3. further increasing to return to pre-pandemic 2019/20 levels.

- A more than three-fold increase in the current over-12 week backlog is suggested if TTG activity continues at 2021/22 levels. Increasing activity to 85% of pre-pandemic levels would also result in growth in the backlog, but to a lesser extent. Even a scenario of increasing activity to pre-pandemic levels suggests that a backlog would remain, though it would reduce.

- To provide a transparent, risk-based approach to TTG recovery an option appraisal was undertaken in April 2022. *Further details of the option appraisal are included in a separate paper presented to the Board.*

- Delivery options, and a high-level risk benefit analysis for them, were discussed. Our implementation plan would need to balance the risk of scheduled care recovery with impact on unscheduled care.

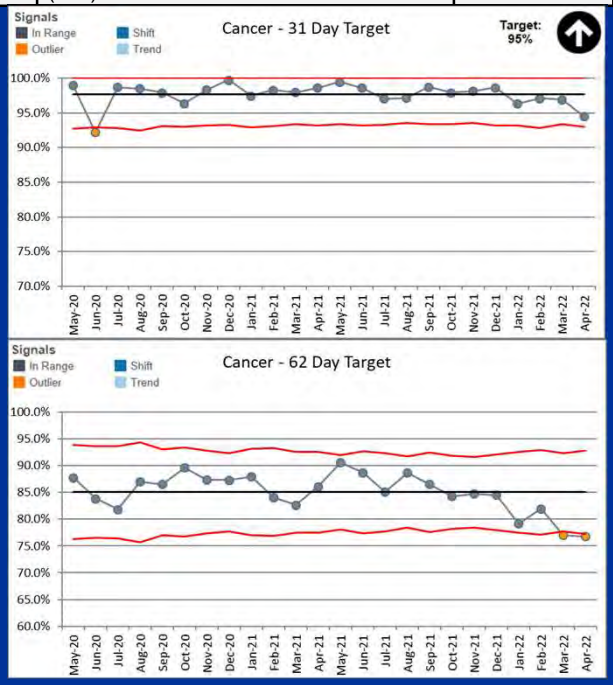
- Work is now being undertaken to scope activity yield, support requirements and constraints of feasible recovery options in more detail. The intention is to produce a phased implementation plan and begin increasing activity as soon as possible.

Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
TTG Scheduled Care Recovery option appraisal – initial assessment of implementation options.	June 2022	Develop plans to increase Day-case and Inpatient activity.		Site readiness groups established to assess implementation options' activity gains and impact.
Pre-operative assessment Demand, Capacity, Activity & Queue (DCAQ) and pathway efficiency.	August 2022	Patients prepared for surgery, so reduced cancellations. Face-to-face or telephone assessments provided appropriately.		Stakeholder group established.
Enhanced Recovery following surgery - General Surgery; Orthopaedics.	May 2022	Reduce Inpatient length of stay.	Agreed team roles required to support the programme.	Nurse recruitment complete.
Procurement of external provision.	Continuing throughout 2022/23	Increase capacity to improve backlog.	Patient cohorts identified and streamed for booking.	2022/23 contracts agreed for Orthopaedics foot/ankle & knee arthroscopy, Vascular.

SCHEDULED CARE & DIAGNOSTICS – CANCER 31 & 62 DAY STANDARD

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met (62d) Not Met Standard (31d) but met trajectory	95% Standard (agreed trajectory 82% (62d)) 95% Standard (agreed trajectory 87%) (31d)	76.8% 94.5%	Management Information



Background, what the data is telling us, underlying issues and risks:

- Data from the last reporting period (Q4 2021/22) was showing common cause variation which was below the Lower Control limit. The 5 most recent data points for 62 Days were below the mean, although this is not yet a signal of deterioration, the data has an Upper Control limit of 92.3%, therefore we recognise the current system has not been capable of meeting the 95% goal in the last two years. Through the improvement actions and remobilisation plans, we are working to recover this position.
- NHS Lothian 62-day cancer performance remained below the trajectory of 82% in April 22, with performance at 76.8%. Scotland's performance was 77.0%.
- 31-day cancer performance dipped just below the target of 95% but was above the trajectory of 87%; NHS Lothian's performance was 94.5% and for Scotland was 95.7%.
- Performance continues to be impacted across the board by:
    - sustained high referral numbers
    - ongoing staffing challenges
    - reduction in bed and theatre capacity
- As a result, wait times for outpatient appointments, endoscopy and radiology currently remains above 2 weeks.
- Guidance advised that from mid-March the pre-isolation period for surgical patients on a cancer pathway was no longer required. This means that an additional WTA (waiting times adjustment) will no longer be applicable for each patient in the lead up to surgery (previously 14 days isolation adjustment). Whilst this will impact on all tumour groups across 31- and 62-day pathways, the largest decline in performance will likely be seen in Urology, as the national change in status of Robot Prostatectomy from 'standard treatment' to 'non-standard treatment' has also recently started.

Improvement actions planned, timescales and when improvements will be seen:

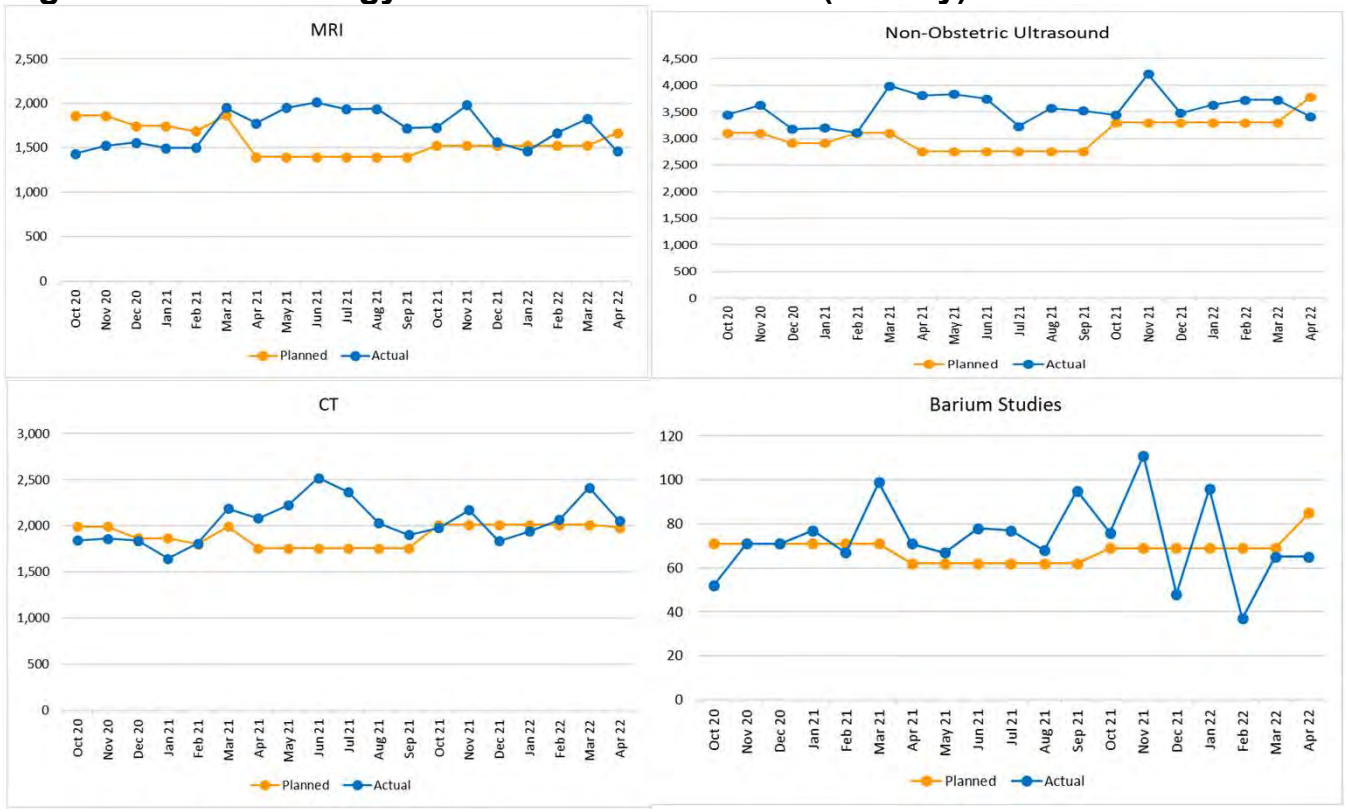
Action	Due By	Planned Benefit	Actual Benefit	Status
1. All tumour groups: Programme of work to review and update *all* tumour group timed cancer pathways	Various up to end Oct 2022	Up-to-date understanding of opportunities for improvement in the pathways, to support attainment of the National Cancer Standards		Head & Neck, Breast, Upper Gastrointestinal (UGI) and Gynaecology services are engaged. Draft Terms of Reference have been prepared to clarify expectations. Head and Neck presented at April Cancer Recovery Board (CRB), final amendments to be made before sign off.
2. Pathology and Radiology: Quality Improvement (QI) projects to aid appropriate prioritisation of Urgent Suspicion of Cancer (USoC) orders	End March 2022	Reduce average waiting time for USoC procedure/ sample reporting	Improved communication of priority following endoscopy.	Complete. Ongoing actions to be owned by services and overseen by the Diagnostics Recovery Board (DRB).
3. Urology Pathway improvement and development work	Various up to end June 2022 (excl. nephrectomy recovery plan)	Prioritise actions to reduce timings across various stages of the cancer pathway	Positive patient feedback on one-stop clinic. Additional flexible cystoscopies and surgical capacity.	One stop bladder clinic commenced in Dec 21. Demand, Capacity, Activity & Queue (DCAQ) improvement plan for Nephrectomy approved Dec 21. In house capacity for Robot Assisted Radical Prostatectomy (SJH) expected to commence May 2022. Flexible cystoscopy in non-theatre environment planned as regular activity in consultant job plan from Apr 22. Additional PSA clinics to help clear the backlog of patients has commenced (caused by increased referrals).

Improvement actions planned, timescales and when improvements will be seen (cont'd):

Action	Due By	Planned Benefit	Actual Benefit	Status
4. Endoscopy: Wait List Initiatives (WLIs) will be used for USoC patients in January.	End Jan 2022	Spread demand across bowel screening, colonoscopy, and flexi sigmoidoscopy to provide extra capacity for patients.	Providing extra capacity for patients and spread of demand across bowel screening, colonoscopy, and flexi sigmoidoscopy.	Complete – WLIs have continued
5. Dermatology: Trialing 'Hot Weeks', incl. for Melanoma patients, when only new USoC patients will be seen. Scottish Government Recovery & Redesign funding awarded for dermatoscopes – planning underway to roll out to GPs. Change Amber queue to urgent – bespoke letters being sent to GPs when patients are regraded from USoC to Urgent.	Various to end March 2022	Reduce waiting list for USoC OP appointments. Better quality referrals to support clinical triage and prioritisation based on clinical need.		Complete. Hot Week(s) commenced week beginning 24th Jan. First was a success with learning to be implemented for another one at the end of March. Aim to also increase biopsy capacity. Hot weeks will continue, on a 5-weekly basis throughout the rest of 2022, which treats only USoC and urgent patients. GPs are now asked to submit photos with referrals
6. Gynaecology: New consultant appointed and starting in May. Carry out DCAQ exercise once tracking resource has stabilized. Recruitment of Medical Secretaries	As soon as possible	Reduce backlog of patients due to additional resource, improving overall performance for service. To reduce delays in terms of write-up of reports.		Consultant due to start in May 2022. Repeated attempts to recruit, and ongoing.

SCHEDULED CARE & DIAGNOSTICS

Scheduled Care & Diagnostics – Radiology Environment & Context (activity)



SCHEDULED CARE & DIAGNOSTICS – RADIOLOGY ACTIVITY

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	Diagnostics: MRI Activity Variance (Planned Versus Actual)	-205	Management Information
Met	Diagnostics: CT Activity Variance (Planned Versus Actual)	71	
Not Met	Diagnostics: Non-Obstetric Ultrasound Activity Variance (Planned Versus Actual)	-362	
Not Met	Diagnostics: Barium Studies Activity Variance (Planned Versus Actual)	-20	

Background, what the data is telling us, underlying issues and risks:

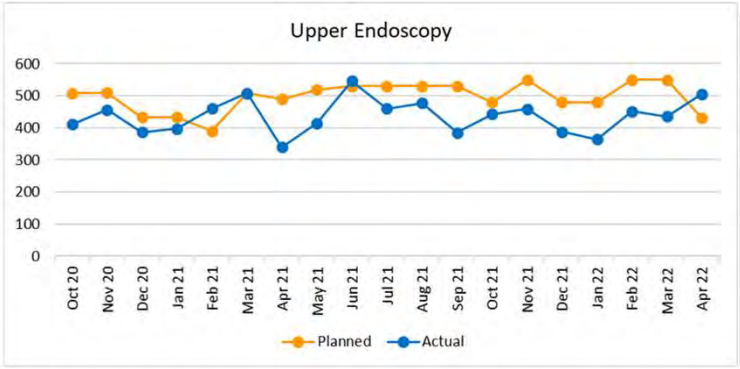
- Magnetic Resonance Imaging (MRI) – Activity has exceeded the plan consistently throughout the year due to availability of external capacity. Where activity matches, or is below the plan this is primarily due to reduced external capacity on public holidays.
- Computed Tomography (CT) - Similar to MRI where activity has exceeded plan this was primarily due to increased availability of external capacity. Where activity was below the plan this was due to reduced availability of external capacity e.g. in Dec 21/Jan 22 Spire hospital CT capacity was not available.
- Non-obstetric ultrasound - The Ultrasound service remains a particular cause for concern. Although activity levels have been maintained this has been supported by additional Radiologist scanning sessions through flexing job plans together with additional waiting list initiative (WLI) scanning sessions. The Ultrasound service is very reliant on Sonographer availability and this has been impacted by COVID-19 sickness, isolation, vacancies and maternity leave.
- Barium Studies - patient numbers are less than 5 in recent months.

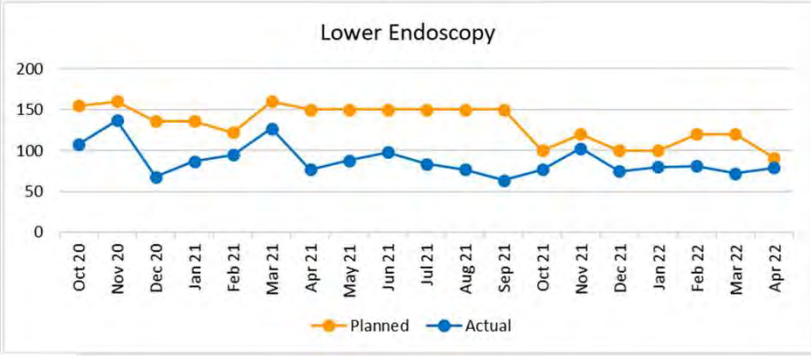
Improvement actions planned, timescales and when improvements will be seen:

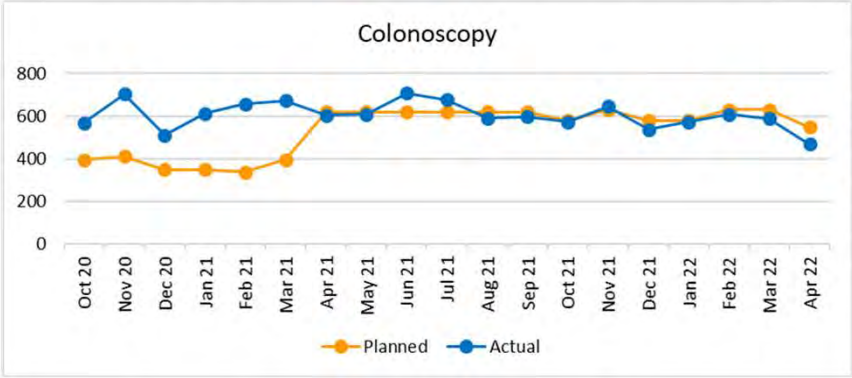
Action	Due By	Planned Benefit	Actual Benefit	Status
Increase mobile MRI capacity from 15 days per month to 18/ 19 days per month	Commencing in April 2022	Approximately 60 additional MRI appointments per month.	Dependent on scan type but will be monitored.	Commenced in April 22.
A mobile CT service, funded by Scottish Government Health Department (SGHD), based in NHS Forth Valley will provide capacity for NHS Lothian patients	June 2022	1,300-1,500 scans over a 13 week period.	To be monitored.	Commencing June 2022.
CT capacity to be provided by Golden Jubilee National Hospital (GJNH)	From April 2022	Capacity for 200 scans per year will be provided.		Commenced in April 2022.
Additional Radiographer and support staff to be recruited to increase internal MRI and CT capacity	Recruitment during January/ February 2022 Additional capacity from May 2022 once induction and training completed	Increased scanning capacity of in the region of 300-500 CT scans per month.	To be measured	In progress
Recruit lead sonographer for East-Sector	Interview Feb 2022	Improved service management and additional scanning capacity.	It is anticipated post-holder will provide around 6 scanning sessions per week once they have completed induction.	Candidate appointed with anticipated start date of end of May 2022.
Re-advertise to recruit to Sonographer vacancies	March 2022	Seek to recruit six Sonographers though will be particularly challenging due to National shortage of trained staff.	Recruitment process started.	Ongoing

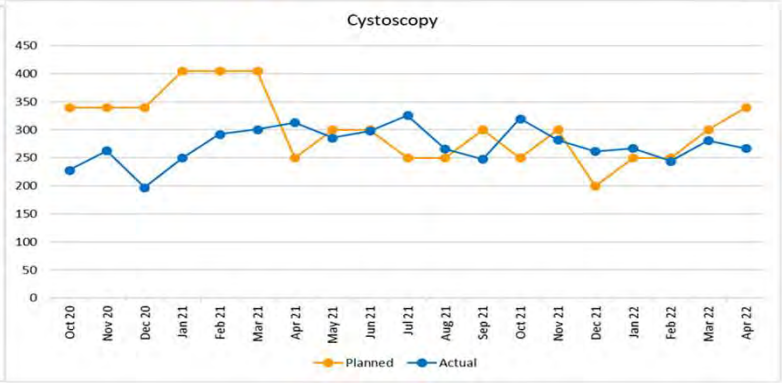
SCHEDULED CARE & DIAGNOSTICS

Scheduled Care & Diagnostics – GI Diagnostics incl. Cystoscopy Environment & Context (activity)









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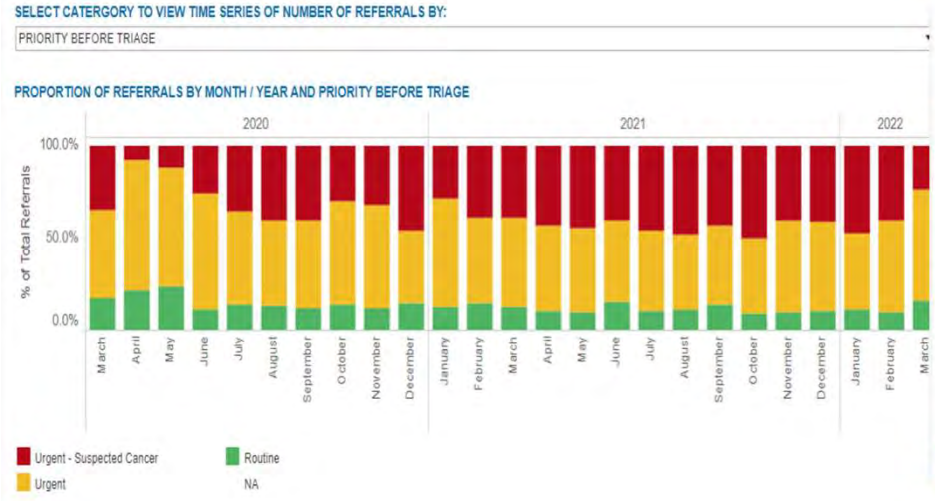
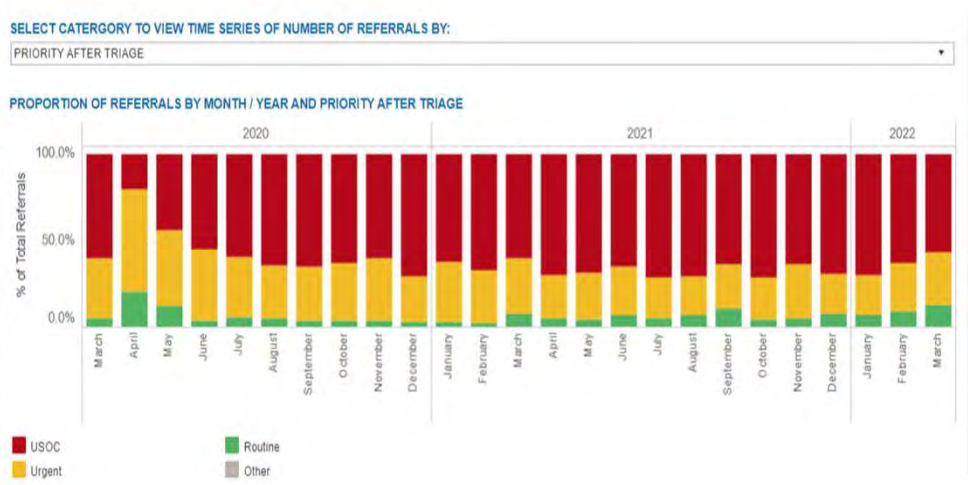
SCHEDULED CARE & DIAGNOSTICS

Scheduled Care & Diagnostics – GI Diagnostics incl. Cystoscopy Environment & Context (cont'd)





USoC Colon Referral Patterns Pre and Post-Triage (April Data not available on Tableau as of 27/5/22)

	2021									2022		
	April	May	June	July	August	Septemb..	October	November	December	January	February	March
Other											0.3%	
Routine	4.6%	4.3%	6.8%	4.8%	7.0%	10.1%	4.5%	4.6%	7.9%	6.9%	9.0%	12.6%
Urgent	25.2%	27.2%	28.3%	23.5%	22.2%	25.9%	24.0%	31.6%	22.4%	23.2%	27.7%	30.8%
USOC	70.2%	68.5%	64.9%	71.8%	70.8%	64.0%	71.5%	63.7%	69.7%	69.9%	63.0%	56.6%

SCHEDULED CARE & DIAGNOSTICS – GI DIAGNOSTICS INCL. CYSTOSCOPY ACTIVITY

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Met	Upper Endoscopy	75	Management Information
Not Met	Lower Endoscopy	-12	
Not Met	Colonoscopy	-79	
Not Met	Cystoscopy	-73	

Background, what the data is telling us, underlying issues and risks:

- The continued lower than planned level of 'new' lower endoscopy activity has been partly due to existing vacancies in endoscopy and those within nursing roles across NHS Lothian endoscopy locations. There has been an increase in upper endoscopy activity during the last month. Overall, new and repeat activity has increased since February 2022. This has been limited however due to increasing COVID-19-19 isolation by nursing staff and endoscopists, along with staff sickness, which have resulted in cancellation of lists when alternative operators could not be found. Workforce pressures continue to impact the activity we are able to deliver.
- Appointment slot prioritisation remains in place for Urgent Suspicion of Cancer (USoC), Bowel Screening and urgent high-risk surveillance patients, irrespective of diagnostic test. In order to ensure new, genetically high-risk patients are receiving their diagnostic investigations in a timely manner, ring-fencing of slots has been established. Currently high risk ulcer patients are being clinically revalidated by the clinical team.
- USoC demand remains higher than pre-pandemic levels, therefore 'new' upper and lower urgent and routine endoscopy waits remain extended. The demand for USoC colon pre- and post-triage has increased proportionately since 2020, as shown in the two charts on the previous page, with March 2022 showing a slight decrease in the percentage of USoC colonoscopy referrals post triage, compared with January and February. This is due to Qfit pathway implementation- a process that effectively identifies those USOC referrals that require an endoscopy reducing demand and freeing up capacity for other patients.
- Attendance at the regional Endoscopy Unit has increased by 15% since the need for COVID-19-19 PCR testing was discontinued at the end of January 2022. This is being monitored on a regular basis. On-going housekeeping of waiting lists is undertaken and local policies for patient cancellations and 'Did Not Attends' (DNAs) have been updated and are being implemented. Longest waiting patients are being reviewed and clinically validated to be booked or removed booked on a weekly basis.
- The utilisation of cytosponge for Barrett's surveillance patients has demonstrated a reduction in waiting times for these patients. Patients suitable for this procedure are triaged accordingly, which is now allowing patients suitable for this procedure to be booked within their target dates if they meet the clinical criteria. Capacity for patients who do not meet this criteria is ring-fenced on a weekly basis so that they are not further delayed.
- Delays in appointed clinical fellows taking up posts, requiring capacity to be moved from flexible cystoscopy to cover on-call rotas, continues to impact.

Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Recruitment to Nursing vacancies within endoscopy	Recurring advert for Band 5 nurses within endoscopy.	Improve nursing capacity within main sites.	Ability to utilise and improve capacity for endoscopy procedures, thereby reducing waiting times.	Ongoing – Western General Hospital (WGH) and Royal Infirmary Edinburgh (RIE) recruitment ongoing, posts advertised. Workforce paper and actions for Performance Oversight Board (PSOB). SBAR submitted to assist with recruitment issues.
Increase capacity at East Lothian Community Hospital (ELCH) to 20 sessions per week	Was due March 21 – have incrementally increased capacity but on-going nursing issues at ELCH - unable to confirm date nursing will be in place to facilitate capacity but likely Summer 22.	Increased endoscopy capacity by 10 sessions per week (approx. 48-50 patients, scope-type dependent).	Have now increased capacity to 15. Increased number of patients being scoped, thereby reducing waiting times.	Ongoing recruitment to open remaining sessions - 2 posts currently at advert. ELCH converting 2 x B5 nursing posts to B3 posts to assist with recruitment process and difficulties in recruiting B5 registered nursing. Meeting undertaken with ELCH service team highlighting need for nurse recruitment. To be followed up with staffing plan workforce paper for PSOB as above.
Utilisation of Room 4 WGH	Was due by Mid-2021	Increased capacity for endoscopy procedures (approx. 50-60 patients per week, scope-type dependent).	Will increase capacity, thereby reducing waiting times.	Room ready and posts being recruited to – see above for recruitment. Ongoing discussions re. ability to increase throughput of patients through WGH day bed area.
Recruit to current Nurse Endoscopist vacancies	Ongoing as previous adverts have not been successful	Increased ability to cover capacity - 6 scope lists per week (approx. 30-40 patients).	Reduction in waiting times as capacity will be increased.	Ongoing review of vulnerability of Nurse endoscopist workforce Advert currently out for trainee Nurse Endoscopist with academic component through NHS Education for Scotland (NES) established.
Reduction of 2m distancing within recovery areas	Ongoing – in line with latest Infection Prevention Control (IPCT) guidance.	Increase capacity.	Reduction in waiting times.	Charge nurses currently reviewing templates and timings to facilitate increase in capacity where able.
Long wait urgent Colon patient re-triage via telephone consultation and Qfit.	Commenced November 2021 – will continue until waiting list validated	Abnormal Qfit patients will be expedited and booked. Patients who no longer require it will be removed from the waiting list.	Only patients who require colonoscopy will be scoped. Decreases clinical risk and improves waiting times.	This is ongoing. A total of approximately 800 urgent colonoscopy patients being reviewed. Clear guidelines in place, patients are being expedited and booked if high Qfit or removed if they no longer meet criteria for colonoscopy.

Improvement actions planned, timescales and when improvements will be seen (cont'd):

Action	Due By	Planned Benefit	Actual Benefit	Status
Implementation of Qfit to determine need for colonoscopy	Now in place	Patients will only be triaged to colonoscopy if they have abnormal Qfit result.	Decreased referrals for colonoscopy. Improved waiting times.	Qfit pathway established in April 2022 and now colorectal team and Gastrointestinal (GI) clinical team implementing Qfit pathway and integrating into triaging practice, prior to decision being made to refer for scope. Standard Operating Procedure circulated to GI Clinicians.
Review of clinician templates	Commencing week beginning 24th January.	Maximising use of time, capacity and throughput. Potential to increase capacity. There are approximately 100 templates to be reviewed.	Increased capacity	Ongoing To date - RIE further session commencing 21st April 2022. ELCH AM sessions to increase - templates being built to accommodate this (increase from 8 patients on an upper endoscopy list to 10). SJH and WGH small increase in patient numbers where able to. Leith Community Treatment Centre (LCTC) templates being updated with increased slots thereby increasing capacity.
Roll out Cytosponge diagnostic procedure, an alternative to upper endoscopies - Cytosponge added to Triage	Now in place.	Cytosponge diagnostic procedure to reduce the number of upper endoscopies. Decrease number of referrals to Upper endoscopy for patients presenting with specific symptoms.	Decreased waiting time for Barrett's surveillance endoscopy. Decreased waiting times for Upper endoscopy for specific group patients triaged with Gastro-oesophageal reflux disease (GORD).	Ongoing – to date only small numbers of new patients are meeting the criteria for cytosponge with symptoms of GORD and are booked as soon as they are referred.
Review feasibility of insourcing external provider for weekend activity within main site	To commence as soon as possible.	Maximise use of endoscopy room availability and increase capacity. This would potentially increase capacity by 10 patients per day if one operator undertaking a full day list.	Increased capacity within NHS Lothian for endoscopy thereby reduce waiting times/ waiting list.	To commence feasibility and initiate discussions. Discussions commenced with ELCH for weekend working for this once staffing in place. Demand, Capacity, Activity & Queue (DCAQ) work to be undertaken following Performance Oversight Board request.
Recruitment to vacant Urology fellow posts and specialty doctor post, who will also provide Cystoscopy activity.	1st April 2022	Return to capacity levels quantified in trajectories	Awaited	Candidates awaiting final approvals incl. professional. To commence fully from July 2022.
Additional short term flexible cystoscopy capacity to manage long waiting patients	April – June 2022.	Additional 10 flexible cystoscopies per week.	Awaited	Implemented.

Improvement actions planned, timescales and when improvements will be seen (cont'd):

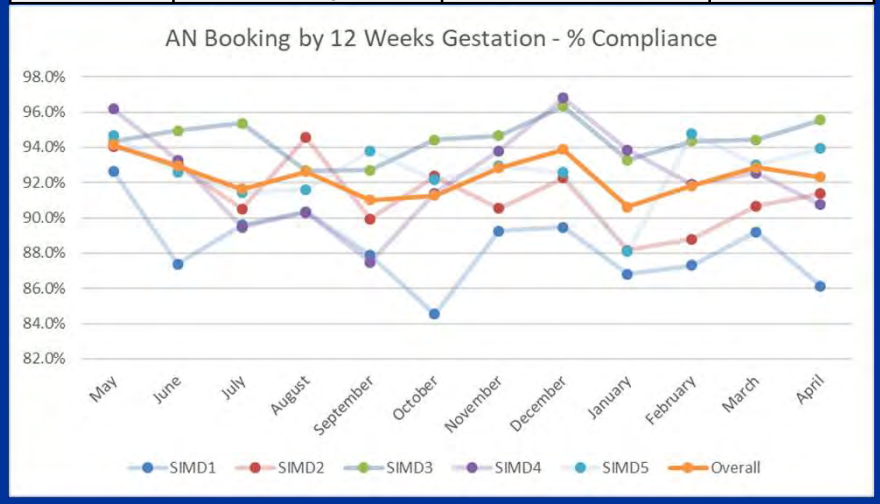
Action	Due By	Planned Benefit	Actual Benefit	Status
Additional capacity via weekend Waiting List Initiatives (WLIs)	Ongoing	Additional 20 flexible cystoscopies per week.	Additional activity	Ongoing.
Recruitment of nurse cystoscopist	Ongoing/ June 2022.	Additional flexible cystoscopy lists.	Additional flexible cystoscopy lists but no immediate impact as extensive training is likely to be required.	Ongoing – complex job evaluation process will delay delivery
One-stop visible haematuria clinic	Implemented	As right.	Improves patient pathway by reducing need for second patient attendance.	Implemented
Additional short term flexible cystoscopy capacity to manage long waiting patients	April – June 2022	Additional 10 flexible cystoscopies per week.	Awaited.	Implemented.

PREGNANCY SERVICES

Reporting Month:	April 2022	**Oversight Mechanism:**	Acute Senior Management Group (SMG)
Responsible Director(s):	Allister Short – Service Director Jacquie Campbell – Chief of Acute Services	**Corporate Objective(s):**	N/A
Corporate Risk Grading:	N/A	**Corporate Risk(s):**	N/A
National Standard:	LDP standard(s)		

PREGNANCY SERVICES – ANTENATAL CARE

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Met	At least 80% of pregnant women in each SIMD (Scottish Index of Multiple Deprivation) quintile will have booked for antenatal care by the 12th week of gestation.	SIMD 1 (most deprived): 86.14% SIMD 2: 91.37% SIMD 3: 95.54% SIMD 4: 90.76% SIMD 5: 95.10% Overall: 92.31%	Management Information

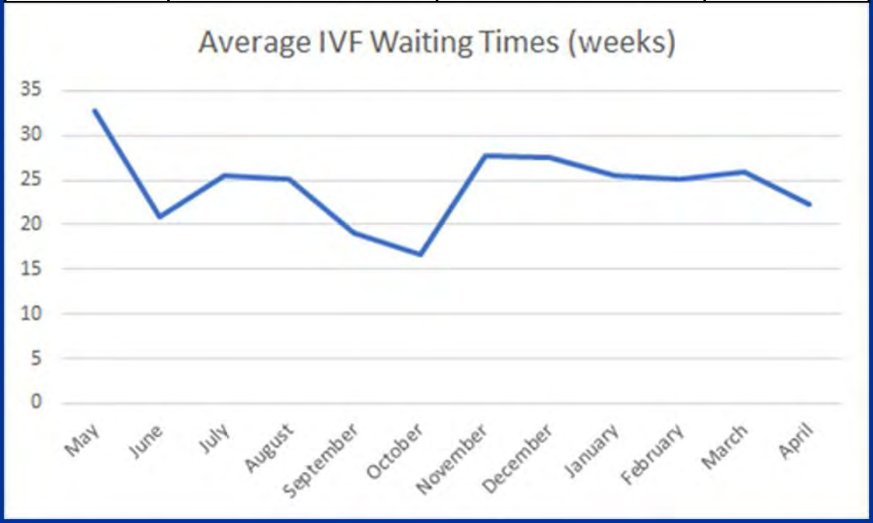


Background, what the data is telling us, underlying issues and risks:

- 80% standard achieved for all SIMD categories in each of the 12 months for the year to April 2022.
- Those in SIMD category 1 are less likely to book by 12 weeks gestation than other groups.
- Late booking may lead to issues with accessing early interventions and screening, such as smoking cessation, fetal alcohol syndrome, dietary advice, screening tests for congenital abnormalities and other public health interventions. In turn this may lead to poorer birth outcomes for mother and baby.

PREGNANCY SERVICES – IN-VITRO FERTILISATION (IVF) ACCESS

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Met	90% of eligible patients to commence IVF treatment within 12 months of referral.	100%	Management Information



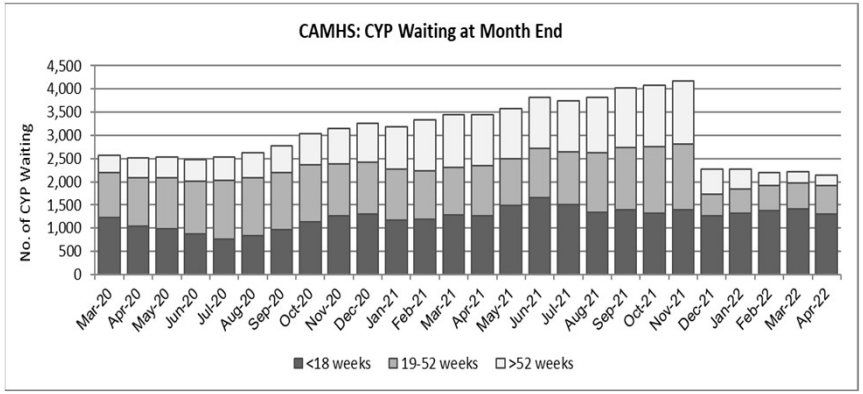
Background, what the data is telling us, underlying issues and risks:

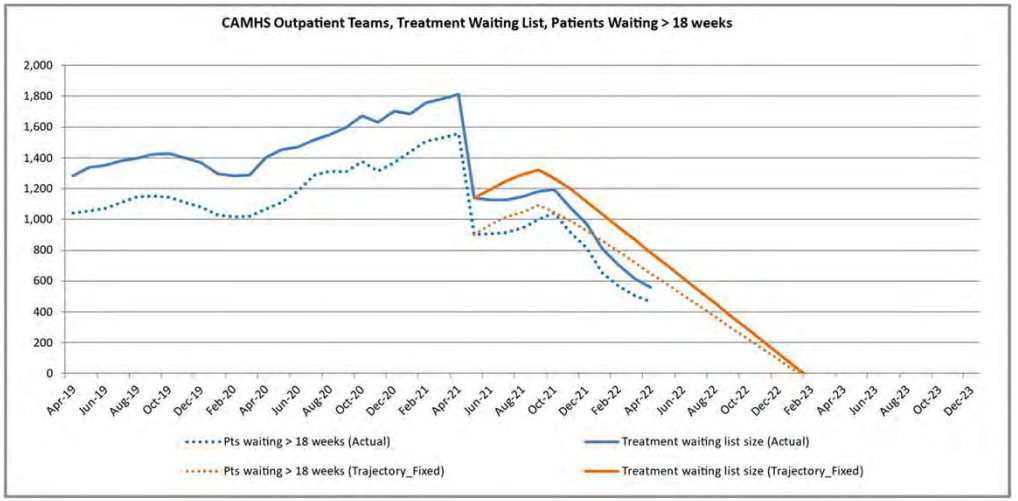
- The service currently meets the 52 week target for IVF treatment and has done so throughout the last 12 months.

MENTAL HEALTH SERVICES

Reporting Month:	April 2022	**Oversight Mechanism:**	Reported via CAMHS SMT, REAS Senior Management Team, CMT, Performance Support Oversight Board and PPDC, clinical and corporate risk(s) overseen by Healthcare Governance Committee.	
Responsible Director(s):	Tracey McKigen – Services Director	**Corporate Objective(s):**	LSDF Pillar Two – valuing our work with Children and Young People as the ultimate investment in prevention (objective no. 15)	On track
			LSDF Pillar Four – Continuing to develop the provision of services for Mental Health, Illness, and Wellbeing, with an emphasis on preventing ill-health (objective no. 24)	On track
Corporate Risk Grading:	5187 – Very High (20) 5188 – Very High (20)	**Corporate Risk(s):**	5187 – Access to Psychological Therapies Corporate Risk (via Healthcare Governance Committee) 5188 – Access to CAMHS Corporate Risk (via Healthcare Governance Committee)	

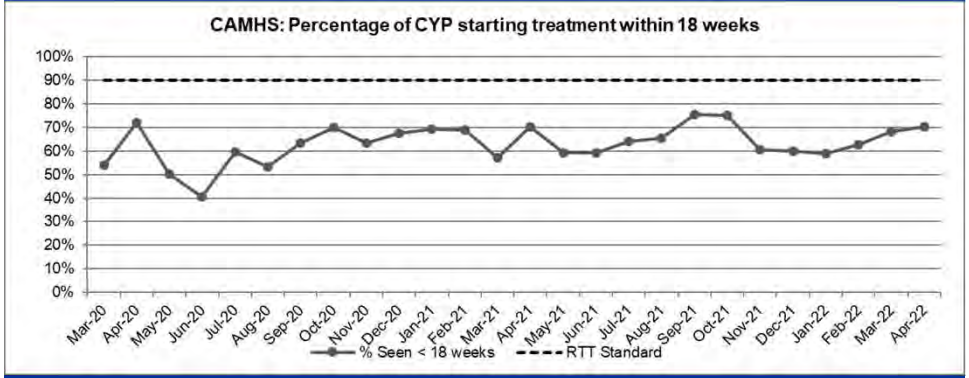
CAMHS - Environment & Context





MENTAL HEALTH SERVICES - 90% OF YOUNG PEOPLE ARE TO COMMENCE TREATMENT FOR SPECIALIST CAMHS WITHIN 18 WEEKS OF REFERRAL

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not met	90% Data is showing special cause variation but no recent signals of change. CAMHS are currently ahead of trajectory of reducing patients waiting >18 weeks for treatment by February 2023.	70.5%	Validated internal management information



Background, what the data is telling us, underlying issues and risks:

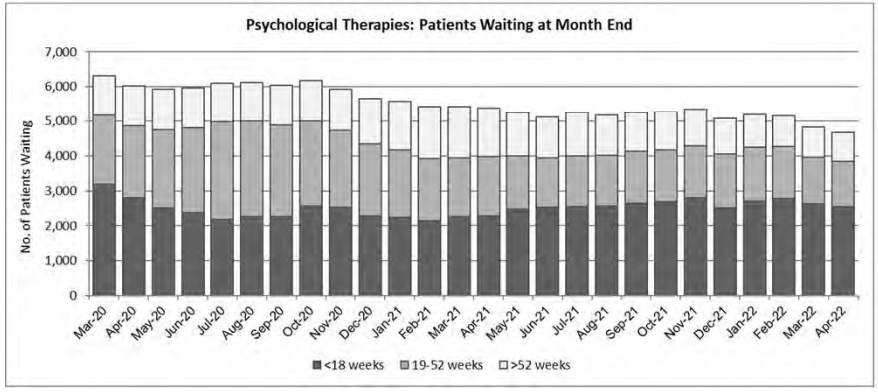
- Data is showing a slight upward trend in the percentage of CYP starting treatment within 18 weeks since January 2022. This has been a steady month-on-month increase from 58.9% to 70.5% in January 2022 to April 2022.
- The number of CYP waiting continues to decrease each month although there has been a slight increase in the >18 weeks waiting. However, of that number the number of >52 weeks continues to fall from 247 in March 2022 to 223 in April 2022.
- The CAMHS trajectory model indicated a treatment waiting list size of 785 and a trajectory of 649 patients waiting >18 weeks. However, we are ahead of trajectory on both these aspects with an actual waiting list of 560 and 465 patients waiting >18 weeks.
- The improvement in performance can be contributed to several factors. This includes the ability of the services to increase staffing establishment; a continued focus on CAPA implementation, in all Lothian Teams; and the utilisation of the HEALIOS team.
- The CAMHS Improvement Plan continues to be implemented, though the pace of improvement continues to be impacted by the challenges around recruitment and staff retention. Case holding staffing levels by October 2021 were expected to be 136.28 WTE. The case holding staffing count in April was 100.75 WTE and in March it was 93.87 WTE.

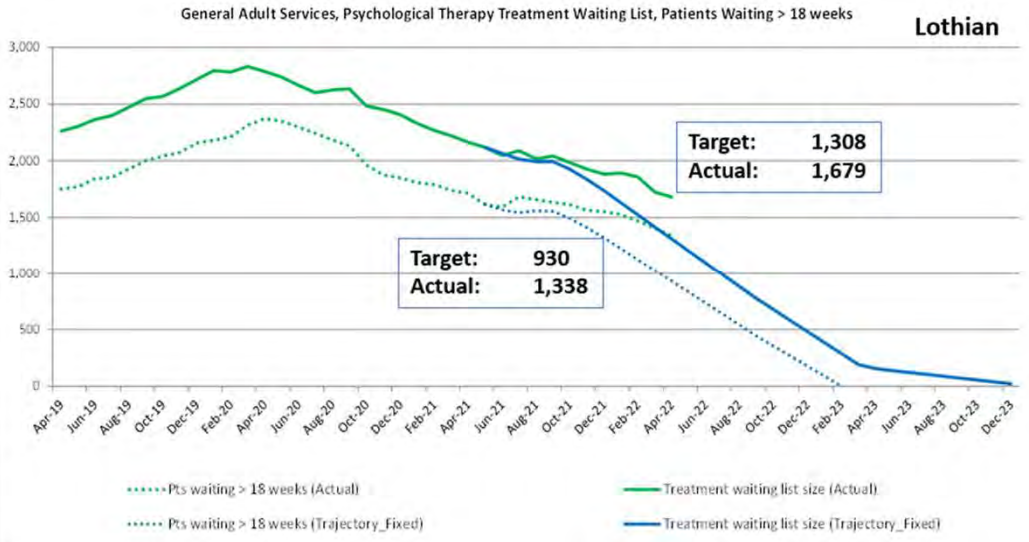
Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Current/Ongoing Actions				
Implementation of individual job plans and team capacity models on CAPA.	May 2022	Utilisation of current capacity to deliver service within all Lothian Outpatient Teams.	Reduction in the number of overall waits for treatment.	Completed in North and South Edinburgh localities and has resulted in further reduction in patients waiting >18weeks for treatment. CAPA capacity plans have now been completed for all Lothian teams for the April-June quarter. Teams are gathering data on the split between the ND allocation sessions within the job plans for new assessments and specific work. This will contribute to the mapping of the capacity for new patient assessment pick-ups across teams and in developing the ND trajectory.
Implementation of Healios to aid in the delivery of Neurodevelopmental Assessments.	Ongoing	Reduction in the number of patients waiting for assessment	Reduction in the number of overall waits for assessment	Work is ongoing to develop the Neurodevelopmental pathway within NHS Lothian. A large percentage of waits is contributed to ASD & ADHD assessments. Additional contract - Healios have been contracted to deliver up to 450 ASD & 100 ADHD assessments and further treatment appoints A new multi-agency pathway for young people who require support with ND is required
Additional support and recognising the challenges faced in North Edinburgh	June 2022	To provide enhanced locality support in North Edinburgh to provide valuable learning and inform the development of future operational management roles	Reduction in the number of overall waits for treatment and assessment within North Edinburgh Outpatient team.	North Edinburgh has seen significant improvement in CAMHS waiting times over the previous quarter as a result of clear operational management. There are currently plans to develop a more permanent leadership structure to ensure continual improvement within the outpatient team.

MENTAL HEALTH SERVICES - PSYCHOLOGICAL THERAPIES

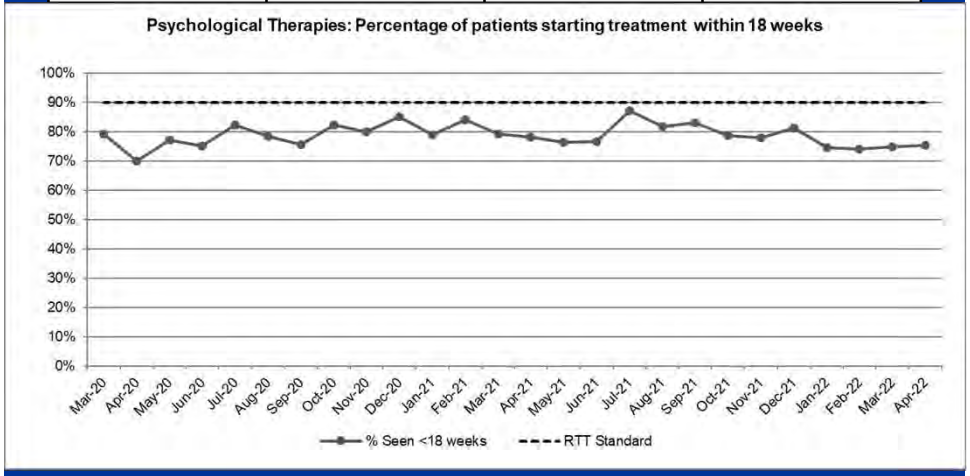
Psychological Therapies - Environment & Context





MENTAL HEALTH SERVICES - 90% OF PATIENTS WITH MENTAL HEALTH CONDITIONS THAT MEET THE SERVICE'S CLINICAL THRESHOLD SHOULD START TREATMENT WITHIN 18 WEEKS OF REFERRAL

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not met	Data is showing a decrease in the number of patients waiting >18 weeks, however this is slightly behind trajectory.	75.3%	Validated internal management information



Background, what the data is telling us, underlying issues and risks:

- The Percentage of patients starting treatment within 18 weeks has remained stable.
- The number of patient waiting >18 weeks has continued to decrease from 2208 in March 2022 to 2125 in April 2022.
- Total of new patient appointment offers made across Adult AMH teams in April was 270 which is less than the predicted 313 trajectory. This was due to staff annual leave/public holidays and further staff sickness issues.
- The trajectory had predicted that there would be a total of 1308 people waiting for psychological treatment in Adult Mental Health General Services, the actual number is 1679; this is higher than expected. In terms of those waiting > 18 weeks the trajectory predicted that there would be a total of 930, the actual number is 1338 as of the end of March 2022.
- This is due to the trajectory being set for sharp reduction in October, when we expected additional staff to take up post. These additional staff have been taking up post in December 2021 to March 2022, hence the lag. The trajectory submitted to the Scottish Government relied on AMH teams staffing of 76WTE; the current staffing across all teams is at 68WTE, the capacity is therefore less than expected. Staff are working to the job plans; the average new patient appointments offered per month over January-March was 300; the capacity expected was 301 per month.
- The recruitment of the more experienced and senior supervisory staff (3.1WTE) has not been completed due to national competitive recruitment context; this is particularly the case in Edinburgh which has the longest waiting times. The implementation of the proposed TRAK changes with PFB led to disruption of clinical service organisation from January to March 2022, as new staff did not have access to diaries for patient booking and out coming patients following the 1st treatment appointment to stop the clock. While treatment appointments can now have an outcome and be taken off the treatment waiting list, the system of Patient Focused Booking (PFB) is not yet operational, further testing is required.

MENTAL HEALTH SERVICES – PSYCHOLOGICAL THERAPIES

- There has been a reduction in the total number of patients waiting over 18 weeks for psychological treatment in all HSCP's, except for East Lothian, where there is an increase due to a significant and sustained increase in demand over the last 6 months. This is associated with a change in referral pathway in primary care in East Lothian, with a wider range of staff beyond GP's referring direct to psychological therapies. Although the additions to the treatment waiting list have not increased above the trajectory expectations, considerable additional time has been required with assessment and triage, There has been an ongoing reduction in the number of new patient appointments being offered in East Lothian, this is associated with staff vacancies and local management practise that is being addressed. Local discussions within East Lothian are taking place regarding the increase in the referral rate, alternative options are to be tried. There has been an increase in waiting times in Midlothian, although the proportion waiting over 18 weeks is less, this is being managed with a locally agreed action plan and new local leadership. Within Edinburgh, the patients with longest waits and high levels of complexity continue to be transferred from the PCMHT waiting list to the Psychology Therapy Waiting List; this is in addition to the demand from referrers. Edinburgh has introduced Thrive as the community MH programme; service development is ongoing regarding the scope and remit of the community provision alongside psychological therapy services.

- The Psychological Therapies Improvement Plan continues to be implemented, though the pace of improvement is impacted by the challenges around recruitment and staff retention as well as the TRAK changes in clinic organisation.

- The total number of days lost in adult Psychology, in March 2022, due to COVID-19 leave increased to 121; this is a substantial increase. Data for April COVID-19 leave is not yet available.

Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Completion of recruitment of additional staffing	March 2022	To reach the trajectory to eliminate >18 week waits by March 2023.	Meeting this trajectory is dependent on the success of recruitment to these posts	Recruitment to the supervisory positions remains the focus, as well as recruitment of vacancies at Band 8A, to replace experienced staff who are retiring or leaving the service.
Uplift in new patient appointments by 20% across all Adult Mental Health General Teams	Implemented and ongoing	To contribute to the reduction of patients waiting by accounting for an average 20% non-attendance rate	New patients pick up rates increased by 20% for each staff member, reflected in job plans	This has been implemented across all Adult Mental Health General Teams
Implementation of Digital Cognitive Behavioural Treatment packages for those with mild-moderate presentations as an alternative to psychological treatment.	Implemented and ongoing	Alternative evidence-based treatment offers following triage and assessment	Reduction in the number of additions to treatment waiting list	Approximately 700 referrals a month are made to these CBT packages mainly by GP's, this is managed and governed through psychology. Increased range of treatment offers available
Use of management reports across all services to show individual and team activity, in terms of new and return appointments, caseload size and average treatment duration. Personalised reports provided to all staff for monitoring.	Ongoing	To provide support to line managers with caseload management	To monitor performance levels commensurate with job plans. Increased transparency has contributed to reduction in the number of overall waits for treatment and assessment	Promoted transparency of individual targets and current performance. Line mangers are accountable for monthly case management to support job planned activity with each individual. Management reports for Edinburgh will be provided from April following the Trak changes.
Implementation of Patient Focused Booking for new treatment appointments and improved reporting	Ongoing	To generate consistency in new patient allocation according to the agreed job plans	To date, manualised version of PFB in place, automated version expected to lead to greater efficiency	Changes to Trak are being undertaken to support this. This was expected to be completed by February 2022. Implemented to date has been disrupted, such as with clinics being removed and out coming not being available. This has been further postponed due to ongoing operational difficulties. E-Health Teams have proposed a temporary fix, as is used in other services, but e-health recognise that more testing is required and there needs to be a solution with Interstate agreed.

MENTAL HEALTH SERVICES - THE AVERAGE % BED OCCUPANCY (INC. PASS) BASED ON WEEKLY DATA TIME POINTS

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not met	85-90%	75.3%	Validated internal management information

Background, what the data is telling us, underlying issues and risks:

- The percentage occupancy for REAS Adult Acute remains high. This was an increase from 99.4% in March 2022 to 102.4% in April 2022.
- The data does not include any admissions or REH patients residing in St John's Hospital.
- In summary – there are 80 funded Acute Adult Admission beds and 10 IPCU beds. Additional beds in use include
  - 6 beds opened / funded through COVID-19 in Braids ward
  - 9 Unfunded beds opened in Braids ward
  - Up to 5 contingency beds opened (1 in each of the 5 acute admission wards)
- There is higher acuity within the wards at the moment and additional beds have been opened within a ward area to accommodate the increasing demand. However, this is an unfunded establishment but reflects a lower occupancy level in the data. Additional beds are also being used at SJH and not reflective on this.

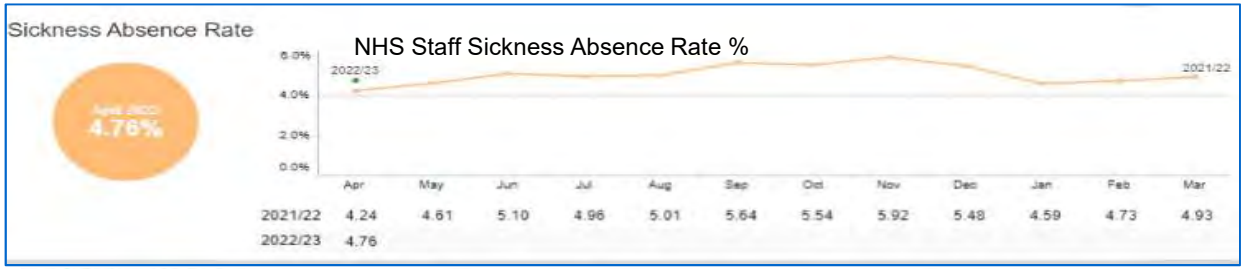
Improvement actions planned, timescales and when improvements will be seen:

Action	Due By	Planned Benefit	Actual Benefit	Status
Improvement group to discuss the reporting of Bed Occupancy figures to incorporate the difficulties of additional beds and funded bed establishment	Summer 2022	To understand the issues around the reporting of Bed Occupancy figures and how they can be better reflective of the pressures onsite	To understand the issues around the reporting of Bed Occupancy figures and how they can be better reflective of the pressures onsite	Occupancy remains very high. Consideration to be taken to display the number of patients who are occupying beds out with REH.
Programme of change and improvement has been established to improve patient flow	Ongoing (approx. 12 months)	To improve patient flow through Acute Mental Health and reduce delayed discharges	To improve patient flow through Acute Mental Health and reduce delayed discharges. This will be updated as the group progresses.	There are 3 workstreams that have been identified. Membership of the workstreams will span REAS, the HSCPs and patient/carer representation. This is currently being established. This group will report into, and be governed, by the Lothian Mental Health and LD Operational Group (chaired by Tracey McKigen).
Minimising the use of contingency beds	Ongoing	Safer patient care as staff will not be expected to look after more patients without additional resource.	Reduced staff stress and workload	4 contingency beds have been vacated, with work ongoing to not fill these beds. There will be close monitoring to ensure all other options are considered before a contingency bed is opened.

WORKFORCE

Reporting Month:	April 2022	**Oversight Mechanism:**	The 'Workforce Report' is received by the Staff Governance Committee, who consider the workforce position at the most recent reportable month, providing high level information with further details available through the Tableau Workforce Dashboards. The report shows the current position and highlights where there have been changes and progress from previous periods as well as actions that are being taken to address some of the areas of concern.
Responsible Director(s):	Janis Butler – Director of HR/OD	**Corporate Objective(s):**	PARAMETER ONE – OUR WORKFORCE (no. 49, 55) On track Corporate Activities- Improving Staff Experience (no. 108)
Corporate Risk Grading:	3828 – Very High (20)	**Corporate Risk(s):**	Risk 3828 – Nursing Workforce Corporate Risk (Staff Governance Committee)

Workforce - Environment & Context



	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22
WTE	22,307	22,363	22,417	22,516	22,530	22,660	22,749	22,775	22,768	22,845	22,892	22,945	22,801
FE	22,774	22,447	22,909	23,017	23,150	23,381	23,478	23,566	23,414	23,745	23,799	23,706	23,684
Establishment Gap %	2.05	0.38	2.15	2.17	2.68	3.09	3.10	3.36	2.76	3.79	3.81	3.21	3.73

WORKFORCE – STAFF SICKNESS ABSENCE RATE %

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (April 2022)	Data Source
Not Met	4%	4.76%	NHS Lothian Tableau Absence Dashboard

Background, what the data is telling us, underlying issues and risks:

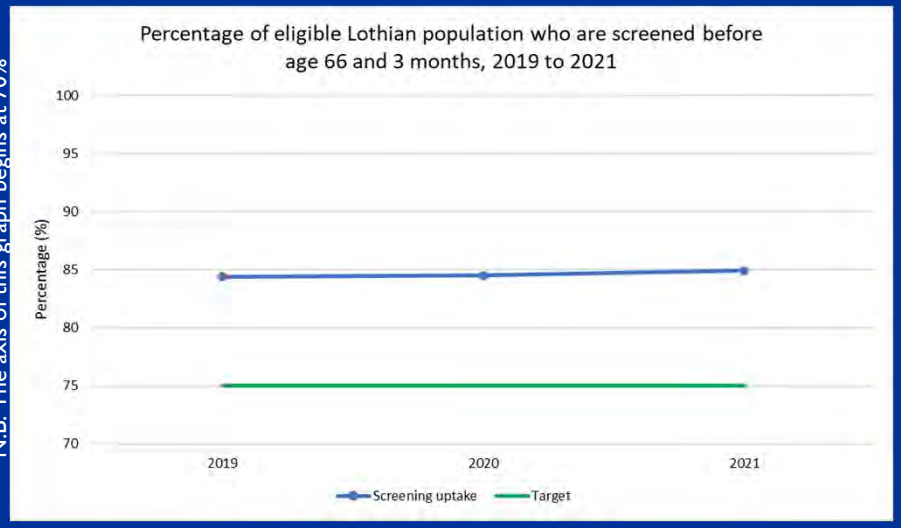
- Whilst the overall establishment gap % for April 2022 is relatively low at 3.21%, it is important to note that this overall figure can however be misleading as there will some areas associated with COVID-19 related posts that have not been fully incorporated into the recurring funded establishment. However, when looking at specific job families such as registered nursing there has been an increase in gap from 3.6% in April 2021 to 7.87% in April 2022. Key areas of pressure are St John's Site – 23.5%, East Lothian – 18.5%, Edinburgh HSCP - 17%, REAS - 16% and in all of these areas supplementary staffing covers less than 50% of the gap. Whilst efforts are on-going to recruit to gaps the underlying cause is that nationally there has been insufficient nurse training numbers. International recruitment is currently underway with the first batch due to begin starting in the next two months which will provide a new source of recruitment, however it is very unlikely to provide the scale of Additionality required to significantly reduce gaps. Services are also looking to develop and expand the band 4 workforce to support the registered workforce. The SG have increased intakes in the last few years, and it is anticipated that outputs will increase, however it is likely to take at least 2 to 3 years before there will be a significant increase.
- Sickness absence rates appear to be starting to reduce on levels recorded in the last quarter of the 2021/22 financial year. However, rates are likely to remain above pre-pandemic levels, reflecting the level of physical and mental burn out that staff have experienced through working through a protracted pandemic. In line with national reporting these rates exclude COVID-19 related absence.
- It is clear that anxiety/stress/depression/other psychiatric illness is by far the single largest volume of lost hours and the second largest in the terms of episodes. There remains a considerable focus on the health and wellbeing of our staff with a number of initiatives underway.
- We continue to implement our wellbeing strategy 'Work Well' which was launched in April 2021. Key actions from the strategy are the provision of a psychological support service (Here for You) for staff experiencing stress, anxiety and associated mental health issues. We have rolled put a system wide peer support service as part of the stepped care model of psychological support for staff. There are currently over 170 trained peer supporters in NHS Lothian, and we have commissioned training for a further 48 peer supporters during 2022/2023.
- On the 25 May we launched our wellbeing programme 'Energise You' with a keynote session by Sally Gunnell OBE. During 2022/2023 we will run 10 sessions on a variety of wellbeing subjects (i.e., sleep, nutrition, forming habits), this is supported by a Wellbeing Action plan Journal.

PUBLIC HEALTH

Reporting Month:	April 2022	**Oversight Mechanism:**	Public Health and Health Policy Core Senior Management Team	
Responsible Director(s):	Dona Milne, Director of Public Health and Health Policy	**Corporate Objective(s):**	LSDF Pillar One – Improving the Public's Health Corporate Activities – Reputation Management (Objectives 8, 9, 120)	On track/ delayed
Corporate Risk Grading:	N/A	**Corporate Risk(s):**	N/A	

PUBLIC HEALTH - ABDOMINAL AORTIC ANEURYSM (AAA) SCREENING

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (December 2021)	Data Source
Met	75%	84.9%	PHS



N.B. The axis of this graph begins at 70%

Background, what the data is telling us, underlying issues and risks:

The percentage of men who are undergo AAA screening remains high and above the national target of 75% between 2019 and 2021.

The uptake of screening for Abdominal Aortic Aneurysm (AAA) is based on the number of males who are offered screening and are tested before the age of 66 and three months

PUBLIC HEALTH - SUSTAIN AND EMBED SUCCESSFUL SMOKING QUITS AT 12 WEEKS POST QUIT IN 40% OF SIMD AREAS MOST DEPRIVED DATA ZONES WITHIN LOTHIAN

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (March 2022)	Data Source
Not Met	98 per month	31	PHS National Smoking Cessation Database

Background, what the data is telling us, underlying issues and risks:

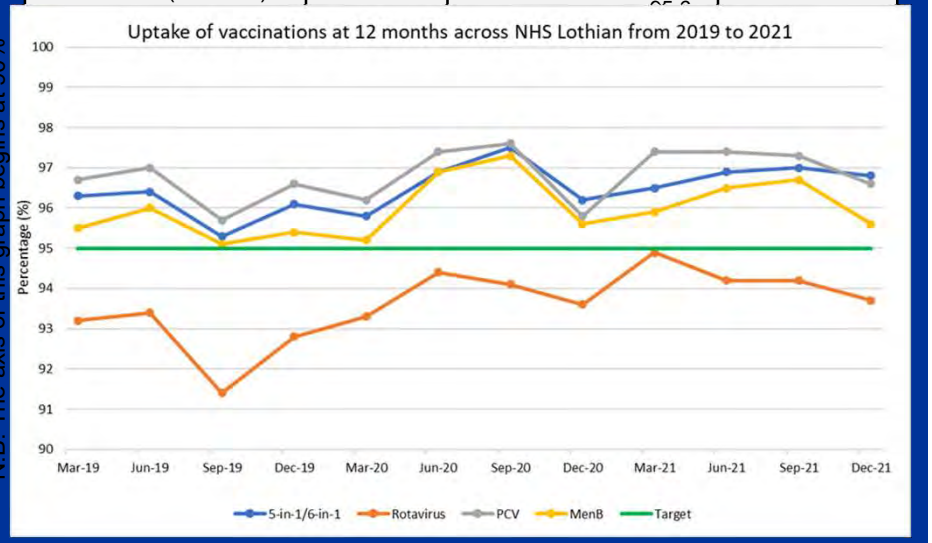
The Lothian target for sustained quits at 12 weeks in our 40% most deprived data zones is 98 people per month.

The monthly 12 week quits seen between April 2019 and March 2022 range from a high of 104 people in January 2020 to a low of 19 people in December 2021 with a downwards trend overall.

PUBLIC HEALTH – IMMUNISATION (1)

Performance Against Standard/ Trajectory		Standard/ Trajectory	Latest Performance (December 2021)	Data Source
5-in-1/6-in-1	Met	95%	5-in-1/6-in-1 96.8 %	PHS – updated quarterly
Rotavirus	Not Met		Rotavirus 93.7 %	
PCV	Met		PCV 96.6 %	
MenB	Met		MenB	

12m: Dep/Hep B/Hib/Polio/tetanus/pertussis,
12m: Rotavirus (2 doses),
12m: PCV,
12m: Men B (2 doses)



N.B. The axis of this graph begins at 90%

Background, what the data is telling us, underlying issues and risks:

The data above represent the percentage of the eligible population who have taken the offer of vaccination. Between 2013 and 2021 the 5-in-1 vaccine was replaced with the 6-in-1. The 6-in-1 covers Diphtheria, Hepatitis B, Haemophilus influenza B, Polio, Tetanus and Pertussis. PCV is the pneumococcal conjugate vaccine. MenB is the meningococcal B vaccine.

Uptake of the 5-in-1/6-in-1, PCV and Men B vaccines has been consistently above the WHO recommendation of 95% during the reporting period.

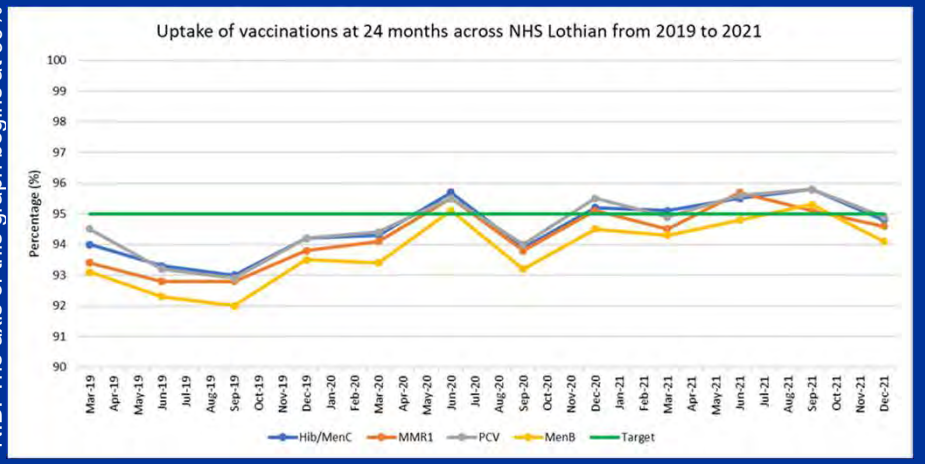
The Rotavirus vaccine programme began in 2014. The level of uptake has shown a broad upwards trend during the reporting period and presently sits at 93.7%, just below the WHO recommendation of 95%.

PUBLIC HEALTH – IMMUNISATION (2)

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (December 2021)	Data Source
Hib/MenC Not Met MMR1 Not Met PCV Not Met MenB Not Met	95%	Hib/MenC 94.8 % MMR1 94.6 % PCV 94.9 % MenB 94.1 %	PHS – updated quarterly

24m: Hib/MenC
24m: MMR1
24m: PCV (2 dose)
24m: Men B (3rd dose)

N.B. The axis of this graph begins at 90%



Background, what the data is telling us, underlying issues and risks:

The data above represent the percentage of the eligible population who have taken the offer of vaccination.

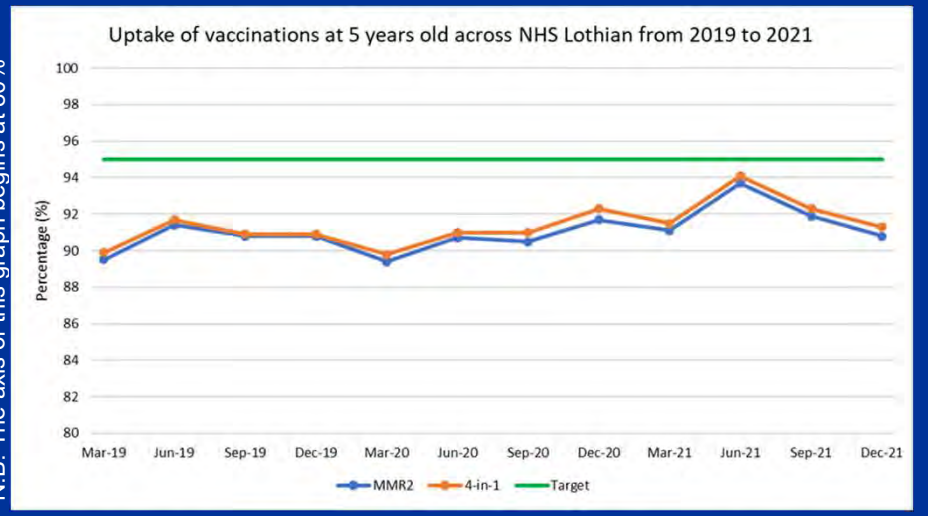
Hib/Men C is the Haemophilus influenza B/Meningococcal C vaccine. MMR is the measles, mumps and rubella vaccine. PCV is the pneumococcal conjugate vaccine. MenB is the meningococcal B vaccine.

All vaccinations show the same broad pattern over the reporting period with some fluctuation over time. The latest data points in December 2021 identify that uptake is between 0.1 and 0.9 percentage points below the WHO recommendation of 95%.

PUBLIC HEALTH – IMMUNISATION (3)

Performance Against Standard/ Trajectory		Standard/ Trajectory	Latest Performance (December 2021)		Data Source
MMR2	Not Met	95%	MMR2	90.8%	PHS – updated quarterly
4-in-1	Not Met		4-in-1	91.3%	

5 yrs: MMR2, 5 yrs: dip/tetanus/pertussis/polio



N.B. The axis of this graph begins at 80%

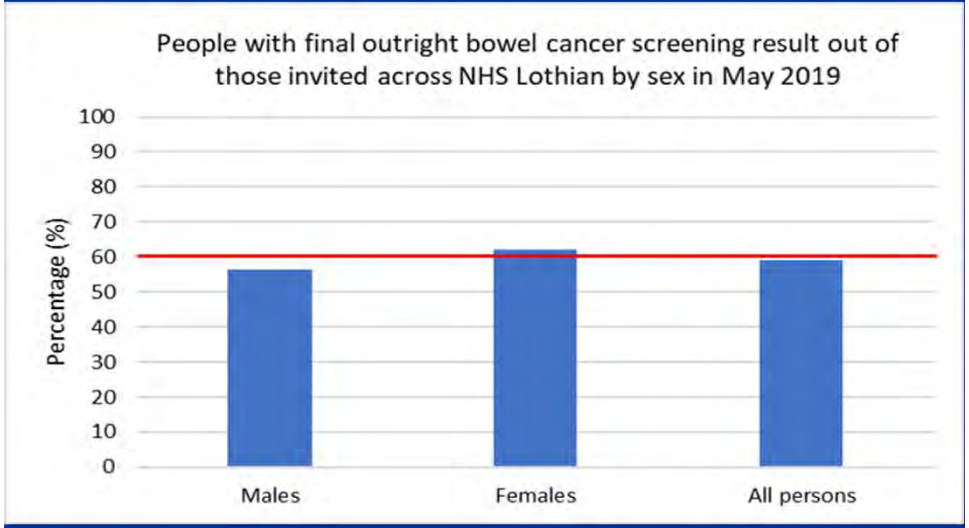
Background, what the data is telling us, underlying issues and risks:

The data above represent the percentage of the eligible population who have taken the offer of vaccination. MMR2 is the second dose of measles, mumps and rubella vaccine. 4-in-1 is the diphtheria, tetanus pertussis and polio vaccine.

The trend in both MMR2 and 4-in-1 is very closely aligned. Trend data are broadly stable during the reporting period with some fluctuation. Uptake rates for both MMR2 and the 4-in-1 remain below the WHO recommendation of 95% (MMR2 at 90.8% and 4-in-1 at 91.3%).

PUBLIC HEALTH – BOWEL CANCER SCREENING

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (May 2019)	Data Source
Not Met	60%	59.2%	PHS



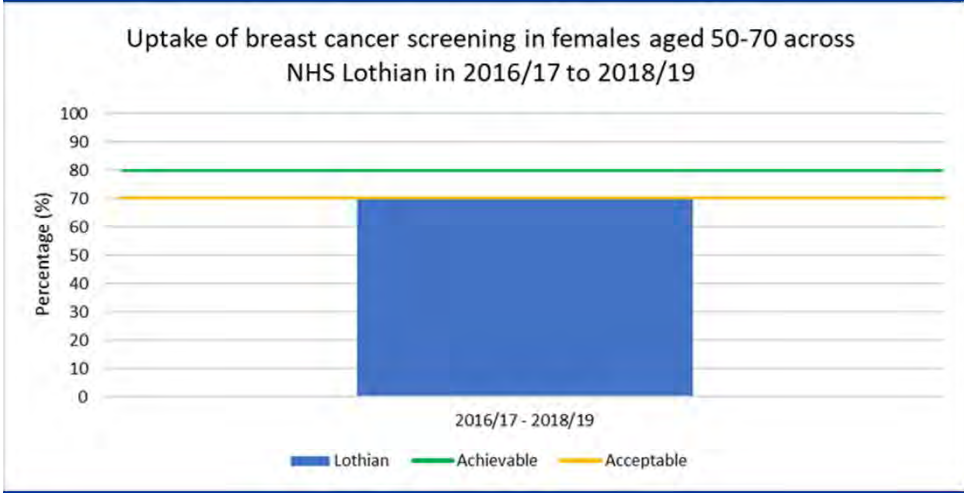
Background, what the data is telling us, underlying issues and risks:

These data represent the percentage of people who are invited to bowel screening who have a final outright screening test result available. These May 2019 data are the most recent available at present and represents people invited to be screened between 1st November 2016 and 30th October 2018.

The coverage of bowel screening in males in Lothian was 56.3%, with higher coverage in females at 62.1%. For the combined eligible population, coverage was 59.2%, 0.8 of a percentage point below the national target of 60%.

PUBLIC HEALTH – BREAST CANCER SCREENING

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (March 2019)	Data Source
Met	acceptable: ≥70% achievable: ≥80%	70.7%	PHS



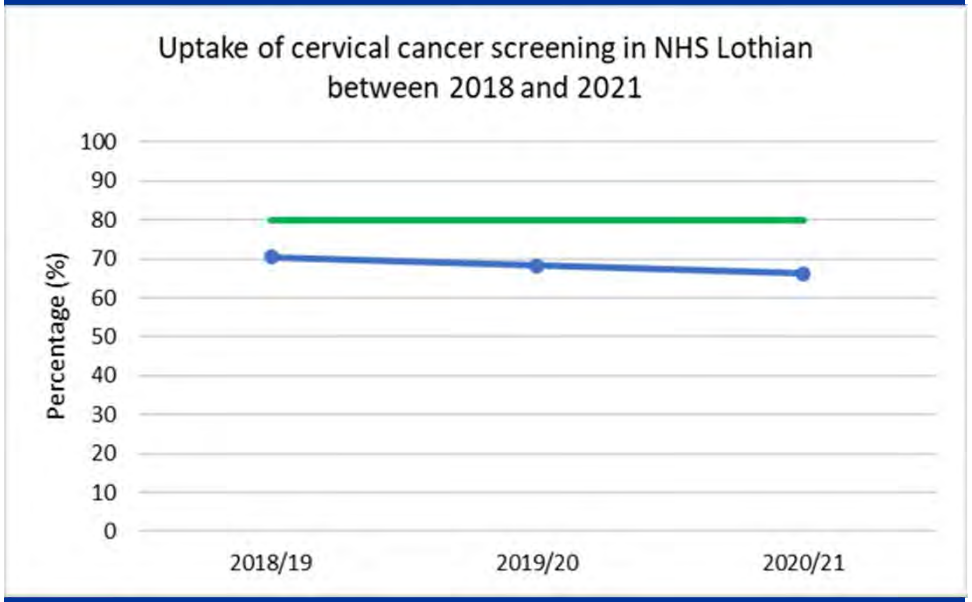
Background, what the data is telling us, underlying issues and risks:

This metric refers to the percentage of those invited to breast screening who attend. These data refer to females between the ages of 50 to 70 years old. The data is presented as three-year periods.

In the latest three year period of data presently available (2016/17-2018/19) the uptake was 70.7%, just above the acceptable threshold of 70%.

PUBLIC HEALTH – CERVICAL CANCER SCREENING

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (March 2021)	Data Source
Not Met	80%	66.2%	PHS



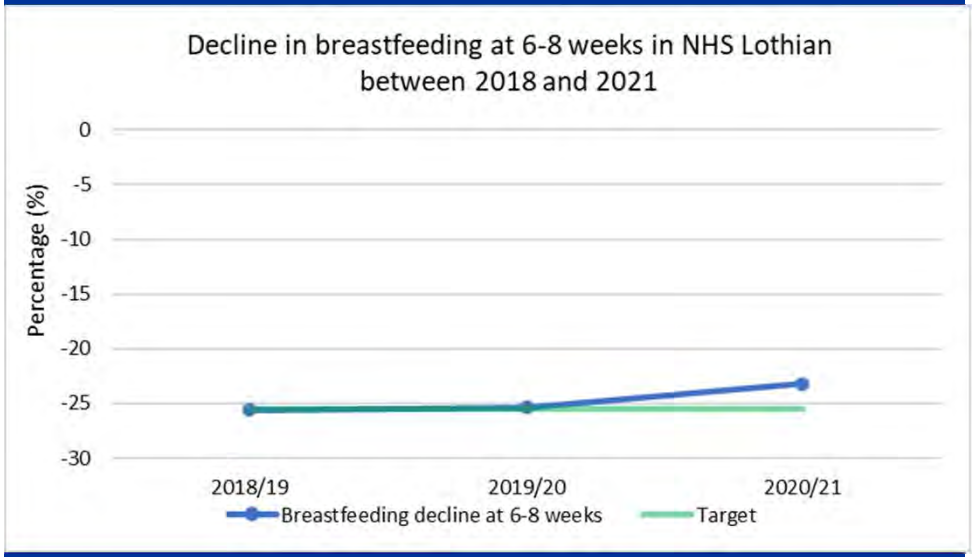
Background, what the data is telling us, underlying issues and risks:

These data refer to the percentage of women who participated in the cervical screening programme within the agreed time intervals out of the eligible population.

The percentage uptake of cervical screening in Lothian has shown a slight decline from 70.4% in 2018/19 to 66.2% in 2020/21. The national target of 80% has not been reached during this period.

PUBLIC HEALTH – MATERNAL & INFANT NUTRITION: DECLINE IN BREASTFEEDING AT 6-8 WEEKS

Performance Against Standard/ Trajectory	Standard/ Trajectory	Latest Performance (2020/ 2021)	Data Source
Met	Target -25.5% by 2024/25	- 23.2%	PHS – updated twice a year



N.B. this graph shows percentage reduction

Background, what the data is telling us, underlying issues and risks:

These data show the number of babies who were no longer being breastfed at 6-8 weeks, as a percentage of those babies who were ever breastfed.

There has been a small improvement in this measure, with a change of -25.6% in 2018/19 to a change of -23.2% in 2020/21. NHS Lothian is already achieving the national target set for 2024/25 of -25.5%.

NHS LOTHIAN

Board Meeting
22nd June 2022

Chief Officer, Acute Services

SCHEDULED CARE INPATIENT AND DAY-CASE TREATMENT TIME GUARANTEE (TTG) RECOVERY - OPTIONS APPRAISAL

1 Purpose of the Report

1.1 The purpose of this report is to provide detail of a risk based Options Appraisal completed in April 2022, to inform the strategic framework for Scheduled Care (TTG) recovery in NHS Lothian.

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

2 Recommendations

Board Members are asked to:-

2.1 **Note** the option appraisal process undertaken to define the strategic framework for Scheduled Care Inpatient/ Day-case Recovery.

2.2 **Acknowledge** that all options appraised retained capacity prioritisation for our most urgent patients.

2.3 **Approve** the preferred option: to increase Day-case and Inpatient activity, booked in date order by individual clinical priority. Accepting this may be amended to 'increase Day-case and Inpatient activity, booked in date order' if our proposal to Scottish Government (SG) to revert to the pre-Covid classification of urgent and routine is accepted.

2.4 **Recognise** the risks associated with recovering scheduled care services on unscheduled care, workforce and SG recovery performance targets.

2.5 **Approve** the principle of a phased implementation taking cognisance of workforce and capacity constraints.

2.6 **Accept** the intention for biannual review of our remobilisation plans to take account of seasonal pressures.

3 Discussion of Key Issues

3.1 NHS Lothian now has a significant backlog of patients awaiting planned treatment as a result of the Covid pandemic. A complex system of fully occupied sites due to unscheduled care demand and high volume delayed discharges, safe placement of patients in line with Infection Prevention & Control Team guidance and continued staffing pressures (for context there are currently 48 registered theatre practitioner vacancies and nursing vacancy gap across acute sites between 8.24% and 17.65%) has resulted in very limited capacity for scheduled care activity, with theatre activity at 60% of pre-Covid levels. A rising volume of very long waits for our most routine patients is a result of this limited capacity further compounded by a focus on utilising this limited capacity to manage our most urgent (P2) patients, in line with national clinical prioritisation guidance.

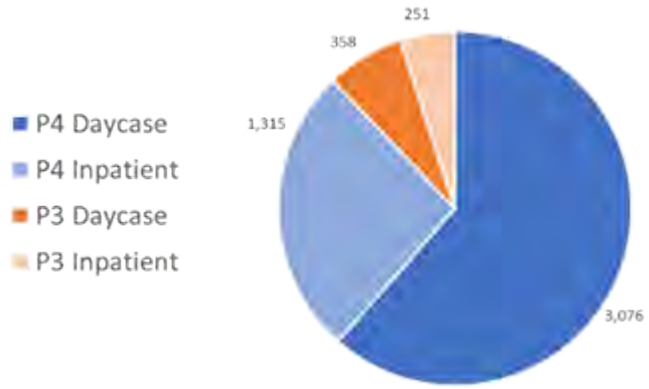
As at end of May 2022 more than 1,100 NHS Lothian Treatment Time Guarantee (TTG) patients (adult and paediatric) are waiting over 2 years for treatment, with 6,000 waiting in excess of 12 months. Whilst recognising the competing pressures around unscheduled care flow, highly occupied sites and workforce pressures, there is a need to remobilise scheduled care further to reduce the risks for patients due to extensive waiting times.

3.2 To provide a transparent, risk-based approach to stabilising and recovering scheduled care, an option appraisal process was undertaken by NHS Lothian on 14 April 2022. This process looked at TTG recovery and focussed on internal NHS capacity only. The process did not seek to address workforce, efficiency, productivity or financial implications, which have their own programmes in place.

3.3 The option appraisal was undertaken by 28 individuals including senior clinicians; the NHS Lothian executive leadership team; strategic planning; partnership and site and service directors, and was chaired by the Chief Officer, Acute services. The output from the option appraisal has informed the draft NHS Lothian scheduled care strategic recovery framework and implementation plan summarised here.

3.4 The context for the option appraisal was the NHS Lothian Inpatient and Day-case waiting list, broken down by clinical priority and specialty. This indicated the majority of long waits were Day-case patients:-

Chart: Proportion of TTG patients waiting over 52 weeks at end April 2022, not yet booked



3.5 To support the option appraisal five strategic criteria for recovery were ranked and weighted by the executive leadership team as follows:-

Strategic Criteria	Rank 1-5 (1 being the highest)	Weighting (total 100%)
Increase Inpatient/Day-case activity	1	30
Support individual Clinical Prioritisation	2	25
Systematically reduce long waits	3	20
Minimise adverse impact on USC flow	4	20
Improve 12-week TTG target performance	5	5

3.6 The following strategic options were then appraised using the ranked and weighted criteria above. Scoring was undertaken on an individual basis, using an electronic form collated during the session. Prior to scoring a detailed presentation was given on the benefits and risks associated with each option, with the main benefits being increased activity and supporting individual clinical prioritisation, and the main risk being impact on unscheduled care flow.

Short List Strategic Options	
Option 1	"Do Nothing". Maintain current capacity on P2 and use of surgical beds for USC demand

Option 2	Option 1 + Increase activity to meet all P2 demand
Option 3	Option 1 + Increase Day-case activity (up to 23 hrs – max of 1 night stay) a. booked in date order by priority – P3 then P4 b. booked by longest waits first
Option 4	Option 1 + Increase Inpatient activity a. booked in date order by priority – P3 then P4 b. booked by longest waits first
Option 5	Option 1 + Increase Day-case and Inpatient activity a. booked in date order by priority – P3 then P4 b. booked by longest waits first

3.7 Option 5a - to increase Day-case and Inpatient activity, booked in date order by priority – P3 then P4 – was confirmed as the preferred option.

3.8 Option 5b, 3a and 3b all scored highly and were very close in score to the preferred option.

3.9 Implementation of the preferred option 5a was discussed in detail with a series of specific solutions for each of the Adult Acute Sites (the Royal Infirmary of Edinburgh (RIE); St John's Hospital (SJH); Western General Hospital (WGH) and Princess Alexandra Eye Pavilion (PAEP)), being considered.

3.10 Initial assessment of the implementation options shows the **highest day-case activity gain** is by ring-fencing SJH Day Surgery Unit (and re-opening Theatres 11 and 12), and PAEP. These have the lowest impact on unscheduled care flow. This would address specialties with the high volume of long wait day-case P3 and P4 patients: General Surgery, Plastic Surgery (Hands), Urology, ENT and Orthopaedics.

3.11 Orthopaedics and Urology have the highest volume of long wait inpatients. The options to address the ***highest*** **volume** of inpatient long wait specialties are to:

- Ring-fence 10 orthopaedic beds at RIE. This would start to address high volume, very long Arthroplasty (hip and knee replacement surgery) waits;
- Ring-fence Urology beds at WGH and open five unfunded theatre sessions.

3.12 A phased implementation plan is required taking cognisance of workforce and unscheduled care pressures. This will be reviewed biannually, in October and March, to take into account seasonal unscheduled care demand.

3.13 Site-specific groups are now established on all acute sites and are currently working to assess the implementation options more fully. The outputs of these groups will define phasing, and include assessment of activity gains and service trajectory impact. Implementation plans need to be cognisant of extant developments such as the decant plan at RIE, critical care improvement works at SJH and WGH, and Hospital Sterilisation and Disinfection Unit (HSDU) upgrades.

3.14 It is accepted that ring-fencing day surgery and inpatient beds for scheduled care will have a direct impact on workforce, both in terms of current gaps and ability to utilise theatre staff to support other areas. It will also have an impact on unscheduled care flow. This could mean a higher number of patients in our Emergency Departments/ Front doors, with longer waits. Clear policies and procedures will need to be developed to support Site teams to maintain ring-fenced capacity.

3.15 It is important to note that in booking P3 patients before P4 there will be a delay in systematically reducing long waits. A proposal has been made to SG to revert back to pre-Covid waiting list classification of urgent and routine, this would maintain the principle of individual clinical prioritisation with most urgent patients having priority access to theatre sessions, whilst systematically booking the longest waiting routine patients in date order.

3.16 The scheduled care recovery plan will incorporate a communication and engagement process that includes all relevant stakeholders, including Health and Social Care Partnerships to ensure whole system awareness and support.

4 Key Risks

There are a number of risks associated with increasing scheduled care activity in current environment including:

4.1 Significant and on-going nurse staffing vacancies within theatres (48 registered theatre practitioner vacancies), critical care and ward areas (vacancies between 8.24% and 17.65% on acute sites). There are a number of mitigating actions underway including widening access routes to nursing, international recruitment and skill mix adjustment, however these will not address pressure in short term and will be a critical component in phasing increased activity.

4.2 All adult acute site are full with occupancy consistently above 90% and frequently at 100+%, meaning that dedicating beds for scheduled care recovery will have a direct impact on unscheduled care flow – potentially increasing patient volumes and length of wait at front door areas. (Optimal bed occupancy to support flow is 85%).

4.3 It is anticipated that the SG will set recovery milestones that systematically reduce long waits (First Milestone no patients over 104 weeks by March 2023). Our option appraisal process took account of continued clinical priority - booking P3 patients ahead of P4 will slow the systematic reduction of long waits and further limit our ability to meet SG milestones.

4.4 SG are currently reviewing the process and guidance on clinical prioritisation which may impact on our preferred option, as will our proposal to revert to pre-Covid classification of urgent and routine.

4.5 The growing impact on surgical trainees unable to undertake requisite number of procedures ahead of completion dates may adversely affect future consultant recruitment pipelines.

5 Risk Register

6 The following NHS Lothian Corporate Risks will be reviewed, updated and routinely monitored following Approval of this work:-

- ID 3600 - Finance;
- ID 3726 - Hospital Bed Occupancy;
- ID 3828 - Nursing Workforce;
- ID 5185 - Access to Treatment;
- ID 5186 - 4 Hours Emergency Access Target;
- ID 5189 - RIE Facilities.

7 Impact on Inequality, Including Health Inequalities

7.1 An impact assessment would not be required.

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

8.1 This paper does not propose strategy, policy or service change so evidence on how legal duties of involvement have been met and how the outputs from informing, engaging and consulting have been used is not required.

9 Resource Implications

9.1 The resource implications – capital and revenue - will be identified through development of the individual proposals within the proposed phased delivery plan, and approved through existing Governance routes.

Jacquie Campbell
Chief Officer
9th June 2022
Jacquie.Campbell@nhslothian.scot.nhs.uk

List of Appendices

None

NHS LOTHIAN

Board Meeting
22nd June 2022

Director of Strategic Planning

LOTHIAN STRATEGIC DEVELOPMENT FRAMEWORK

1 Purpose of the Report

The purpose of this report is to update the Board on progress with our engagement work to support the Lothian Strategic Development Framework (LSDF), and to seek Board agreement to adopt the LSDF as NHS Lothian "policy".

2 Recommendations

2.1 The Board is recommended to;

- **Note** the summary of engagement work and emergent themes;
- **Agree** changes to the LSDF proposed;
- **Agree** that NHS Lothian remains committed to continuous engagement;
- **Agree** that the LSDF now be considered NHS Lothian's strategic direction, and turn its attention to the implementation of the LSDF.

3 Discussion of Key Issues

Overview

3.1 As part of the Lothian Health and Care System (LHCS), NHS Lothian has been working to develop a strategic framework over the last eighteen months. The learning and implications of the pandemic have been key to this work.

3.2 Throughout this process the Board have been clear that;

- The final output is genuinely a flexible and adaptive framework bringing together the aspirations and plans of the five partners constituting the LHCS – East Lothian Integration Joint Board (IJB), Edinburgh IJB, Midlothian IJB, West Lothian IJB, and NHS Lothian;
- The LSDF guides the approach the system will take over the next five years;
- The LSDF has much that is sensitive to additional policy and directional asks over the coming years, and so will need to be able to respond to that. An example of this would be the National Care Service.

3.3 At the April Board meeting the Board agreed to;

- The draft version of the LSDF presented;
- That this draft version would be used for external engagement;
- The plan for engagement on the LSDF, and in particular that the period between Board meetings in April and June would be the initial external engagement period;
- This paper being brought back to this Board meeting to report on the initial engagement period and next steps.

3.4 The Strategic Planning and Communications, Engagement, and Public Affairs teams have executed the plan for the initial engagement period, including extensive use of

social media, externally-facilitated public meetings, and direct engagement with key stakeholders. A full report on the entirety of our engagement efforts supporting the LSDF process is attached at Appendix 1.

3.5 Of note, particularly, in respect of this initial engagement period, are;

- Social media updates through the NHSL website and Twitter, Facebook, and Instagram accounts;
- Direct conversations with the Edinburgh Voluntary Organisations Council (EVOC), the Scottish Council for Voluntary Organisations (SCVO) and a range of third-sector providers;
- Direct contact with partners from within the NHS (National Health Boards such as National Services Scotland, Public Health Scotland, the Scottish Ambulance Service, and neighbouring Health Boards such as NHS Fife, NHS Borders, NHS Forth Valley);
- Direct contact with other public sector bodies (local authorities, chambers of commerce, tertiary education);
- An Integrated Impact Assessment, involving citizens and representatives;
- Three public meetings facilitated by the RSA;
- A large number of comments submitted to us via the dedicated email address.

3.6 The scheduled “postcard drop” to every address in the Lothians is planned for late-June/early July.

3.6 The latter part of Appendix 1 outlines the key themes and the particular actions recommended for changes to the LSDF. Key for the Board to note and consider, however, are the following key themes.

Engagement

3.7 There was very strong support for the approach being adopted of honest, clear, and accessible presentation, and of working with citizens on how the system will respond.

3.8 There was very clear understanding, and concomitant strong support, that this was an initial period. Indeed, some participants requested that there be more reflection and engagement time beyond the initial period.

3.9 Informal discussions with Healthcare Improvement Scotland’s Community Engagement function have indicated that they welcome the approach we have taken.

3.10 Feedback during the initial period has been that the further engagement will need to make sure it can be at a more detailed level to ensure that the implementation of change will fully pick up worries and concerns citizens may have. It is noted that the LSDF does not necessarily explicitly say this and so a change will be made to that effect.

Content

3.11 There was strong support for the focus on prevention, anchor institutions, and investing in children’s services. There was a high-level understanding that the baseline for the system is unstable and that improvement may take some time. There was strong support for the aspiration outlined in the LSDF to work collaboratively across what we have previously described as “the public square”.

3.12 Multiple comments were made which highlighted that some parts of the LSDF do need further development – specifically, public health and primary care. This highlights the need to move on in these programme boards and bring that greater level of detail that further work will provide. This will be made explicit in a revision to the LSDF.

3.13 As would be expected, participants had very detailed points, often specific to their own experience of care and specific requests for increases in capacity in those areas. No specific actions are required in the context of the LSDF.

3.14 The explicit references to digital and scheduling were well-understood by participants. It would be too strong to describe this as universal positive support, but the discussion of these points was nuanced and accepted by participants, with a clear ask from those participants that there will need to be careful thought to tackle digital exclusion issues and ensure that use of digital is supportive and appropriate of achieving good clinical outcomes.

Omissions

3.15 Participants noted that there was a very broad range of services well-described in the LSDF. However, specific mention was made of greater explicitness on;

- Palliative care, and in particular on normalising and planning for the end of life;
- Supporting infrastructure such as transport;
- Issues such as cost of living pressures.

3.16 There were a large number of responses from citizens concerned about the future of the Astley Ainslie Hospital Campus (AAH) in South Edinburgh. In particular, these responses noted the importance to the local neighbourhood of the green space on the campus, and had a mixed response to the suggestion in the LSDF that LHCS would want to influence this site in future for affordable housing. Some participants suggested that NHSL should keep the site as a park and "healing green space".

3.17 On this last point, NHS Lothian's 2013-14 consultation on *Our Health, Our Care, Our Future* explicitly laid out that NHSL would be exiting the Royal Victoria, Liberton, and Astley Ainslie sites and would offer them for sale, in line with public sector guidance. NHSL has not identified a significant service delivery need to remain on the AAH site and this therefore remains the "settled will".

3.18 In line with the provisions of the Community Engagement Act of [xxxx], however,the disposal of the site will be subject to a specific engagement process with local community interests and interested parties. Appendix 2 lays out the work that NHSL is undertaking in this sphere and the work it will continue to do.

3.19 As was the case in internal engagement, there was some discussion about the best way to describe people who live in the Lothians, although no clear substitute for "citizens" was offered.

Comments from partner Health Boards

3.20 Written comments were received from National Services Scotland, Public Health Scotland, and the Scottish Ambulance Service. All were supportive. Of particular note, each offered suggestions for ongoing projects and pieces of work they wished to undertake to weave their own strategic approaches in. Public Health Scotland

commended the clarity of assessment and understanding of need in the LSDF, in particular.

Recommended changes

3.21 At this stage there is a need for some revised explicitness on the points above, where possible. However, the only major change is to make very clear within the document itself that the LHCS is that engagement will be continuous and ongoing in order to ensure that changes are designed and executed accurately and appropriately.

3.21 Discussion at the Planning, Performance, and Development Committee in May 2022 suggested that the NHS Board should be asked to adopt the LSDF as its strategic direction for the next five years, with an annual report outlining changes and progress published each year. This adoption is therefore the final recommendation of this paper. Clearly we will need to ensure that our partner IJBs recognise the outcomes of the engagement exercise and remain committed.

4 Key Risks

4.1 There is a risk that the LSDF cannot be implemented in its entirety. This is a risk associated with any and all strategy development. The adoption of an adaptive framework approach and constant updating provides some mitigation.

5 Risk Register

5.1 The LSDF is intended to help the system manage risks by outlining a diagnosis and policy to tackle our major issues in a coordinated and concerted way.

6 Impact on Inequality, Including Health Inequalities

6.1 The LSDF has reducing inequalities at its heart. It provides a platform for our own work but also our work as part of a much broader series of systems.

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

7.1 This paper and its appendices outline the initial engagement processes we have undertaken, both internal and external to the system. The Board has committed to continuous engaging on this work and its component parts.

8 Resource Implications

8.1 None at this stage.

Colin Briggs
Director of Strategic Planning
15th June 2022
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Appendices

1 – engagement work to date
2 – note in re AAH site

Lothian Strategic Development Framework

Engagement Outputs: October 2020 – June 2022

Introduction

Engaging with patients, carers and members of the public so that they can genuinely influence service improvement and development is a fundamental aim of the five organisations that together make up the Lothian Health and Care System.

As a health board, NHS Lothian has a legal responsibility *to engage meaningfully with the public over service changes and developments* under the NHS Reform (Scotland) Act 2004.

We are also mindful of the requirements of the Charter of Patients Rights and Responsibilities, and the guidance set out in the draft Quality Framework for Community Engagement and Participation:

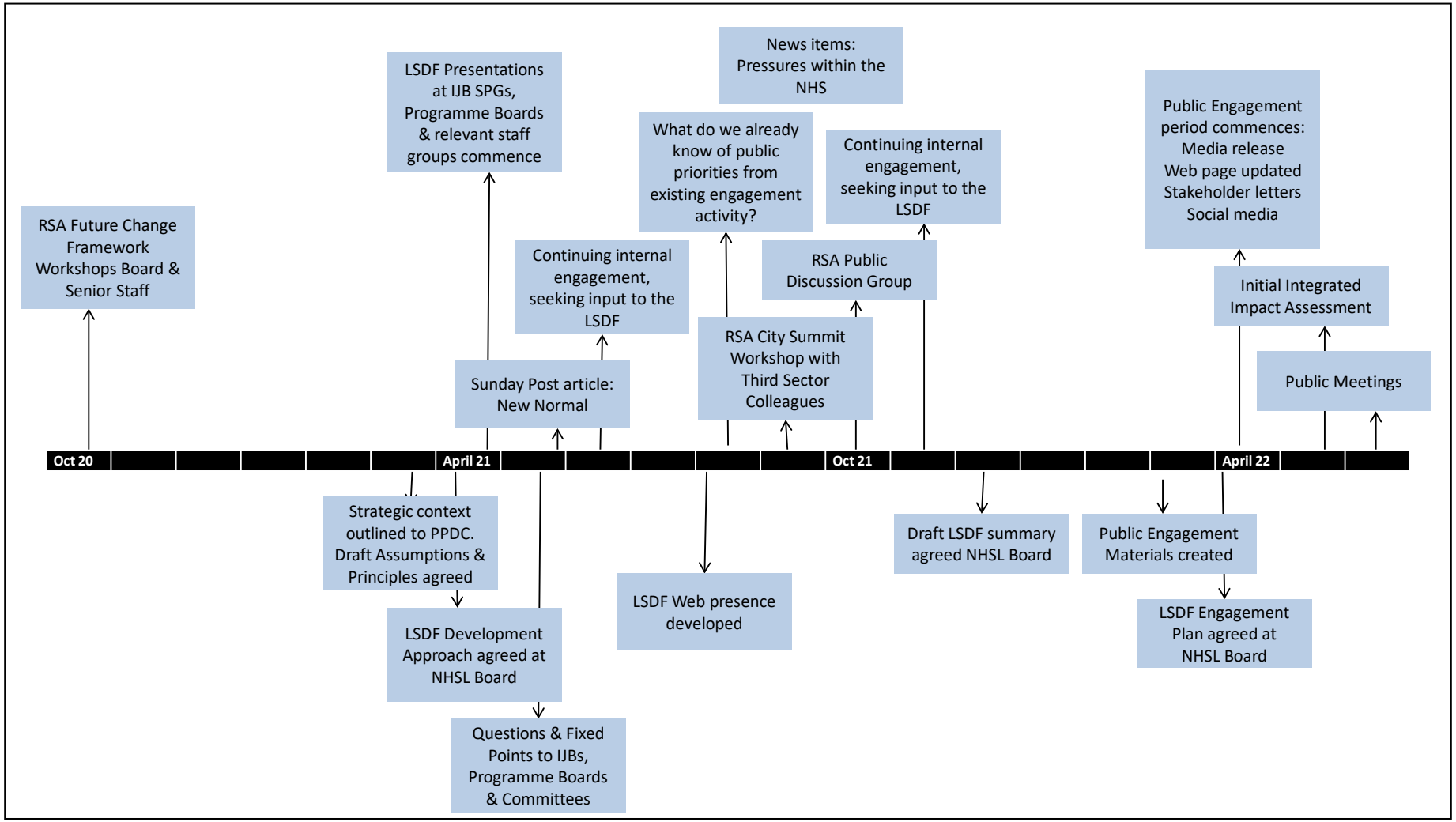
Charter of Patients Right & Responsibilities	***Quality Framework for Community Engagement & Participation***
Taking part in designing & providing local services *I have a right to be meaningfully involved in designing and developing health services in my area and in how they are delivered, and in decisions that significantly affect how services are run in the health board area I live in* *My local health board is responsible for assessing the local community's health needs and deciding how best to use their resources to meet those needs. They must provide opportunities for communities, the public, service users and NHS staff to influence decision making*	*Domain 2: Community Engagement in Service Planning and Design* *There is supported and effective involvement of people in service planning, strategy, design and improvement* *People representing communities are involved throughout the development, planning and decision-making process for service change and strategy development*

Engaging people allows us to consider more perspectives, and make more informed decisions, leading to better quality services and increased understanding and buy-in from those who use our services. Through better relationships, we can deliver positive change.

In developing the Lothian Strategic Development Framework, we have sought to engage with a wide range of stakeholders, including those who work for and with us, our partners across the public, private and third sectors and people who live in Lothian. We know that many stakeholders will fall into more than one of those groups.

A timeline of all engagement activities to date is shown in Figure 1 below:

Figure 1: LSDF Engagement Activities



This report outlines our engagement activity to date in several stages:

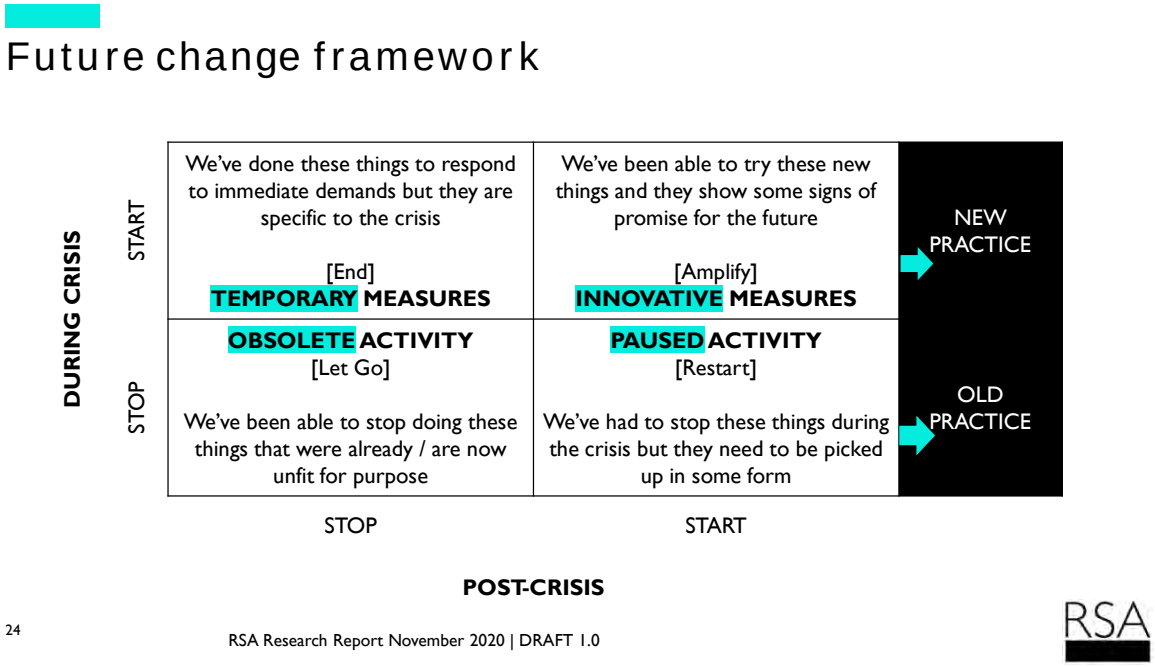
Autumn 2020	Initial engagement of staff and senior leaders across the Lothian Health and Care System, to learn from our experiences during the pandemic, and shape our future strategic direction. This activity informed the aims, objectives, principles and assumptions of the LSDF.
March – November 2021	Development of the LSDF draft, including high level plans under each of the "pillars", building on learning from staff engagement and existing public engagement activity
	Sharing our challenges with a wider cohort of officers and staff from across the Lothian Health & Care System
	Work with the RSA to gather intelligence via a "City Summit" with colleagues from the Third Sector, and via a Public Discussion Group
	Incorporating thinking from the above activities within the LSDF
November 2021- February 2022	Ongoing internal engagement with stakeholders across the Lothian Health & Care System, sharing the LSDF summary and individual Pillar sections for review, and incorporating comments and feedback
April – June 2022	Ongoing internal engagement with stakeholders across the Lothian Health & Care System (as above) Initial period of public engagement activity, sharing the LSDF with a wider audience and seeking comments and feedback. Initial Integrated Impact Assessment

A thematic summary of feedback received and proposed next steps concludes the report.

1. Initial Engagement of Staff and Senior Leaders

In 2020, NHS Lothian formed a strategic partnership with the RSA (Royal Society for Arts, Manufactures and Commerce) to work with senior leaders to apply the RSA Future Change Framework to our activities and shape our strategic direction going forward.

Figure 2: RSA Future Change Framework
Source: Pandemic Possibilities, RSA, November 2020



The RSA facilitated a series of strategy development workshops with over 100 senior leaders from across the organisation in October and November 2020 to explore what we know about crisis and change, learn from our pandemic experiences to date, identify where we need to develop new approaches, accelerate change or move on from approaches that are no longer fit for purpose, and clarify our aspirations and expected future challenges.

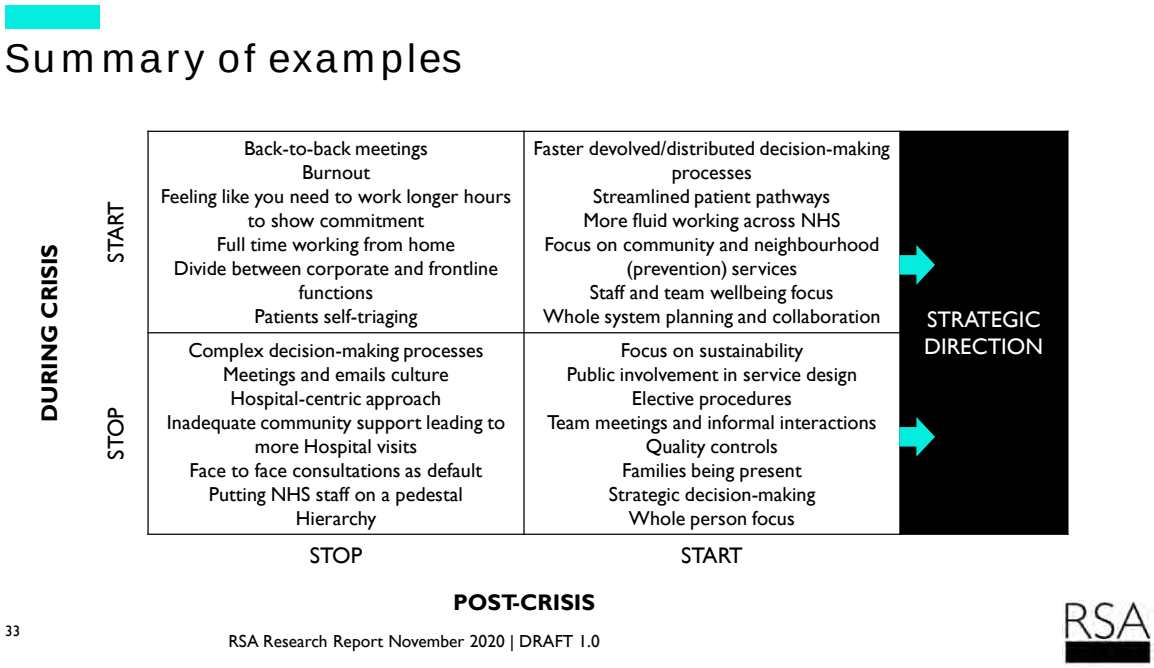
The active engagement of staff in these sessions was a testament to our workforce at a time when there were so many competing priorities, and there was a sense of genuine desire to seize and act on the opportunity for change. The tension between desire for change and the capacity for change was clear across all of the workshops, with 'the capacity of staff and teams to innovate and spread new practice compromised by fiscal, operational and time constraints and compounded by individual cognitive overload'[1]

> *I feel as though I am in a fast moving river - the current momentum is behind me but there are rocks in the way - hopefully the rocks will be pulled along in the current but if they mass together they provide a dam and we form a reservoir of inaction instead*

[1] Pandemic Possibilities: Applying the RSA Future Change Framework to support NHS Lothian's strategic review and improve population health outcomes. RSA. November 2020

The sessions rightly demonstrated pride in the efforts of staff in response to the pandemic, and our achievements in terms of teamwork and staff adaptability, resilience and rising to the challenge. Following the conclusion of the strategy development workshops, the Future Change Framework below provides a summary of suggestions from staff of things that we may wish to start, stop or continue as we move forward.

Figure 3: RSA Future Change Framework Output
Source: Pandemic Possibilities, RSA, November 2020



The output of the strategy development workshops informed the aims and objectives of the LSDF, and the Principles we have set out, with the Assumptions also influenced by an exploration of our parameters going forward.

For example:

- Our aim to improve population health is linked to the aspiration to focus on community and neighbourhood (prevention) services, and to focus on the whole person, as well as sustainability in its broadest sense.
- Our aim to improve the way in which we work with citizens and patients is linked to the aspirations for more streamlined patient pathways, to involve the public in service design, to ensure families are present and to focus on the whole person.
- Our aim to improve performance is linked to the aspiration to continue to improve quality and restart elective, or scheduled, procedures
- Through the Assumptions and Principles outlined within the LSDF, we aim to support consistent and effective strategic decision-making and whole system planning, and support efficient and effective decision-making.

A copy of the full *Pandemic Possibilities* report is attached at Appendix I

2. Development of the LSDF Draft

In March 2021, the concept for the Lothian Strategic Development Framework was shared with NHS Lothian's Planning, Performance and Development Committee. The discussion considered the current problems faced by the Lothian Health & Care System in terms of performance, finance, workforce and inequalities, and what we had learned from the strategy development workshops facilitated by the RSA.

It was proposed that the LSDF would include strategic headlines for key services and workstreams – presented within the LSDF as the six Pillars – taking into account parameters including digital opportunity, workforce & wellbeing and capital availability.

Subsequently, in April 2021, a paper was presented to the NHS Lothian Board to outline how the LSDF would be developed collaboratively by the five organisations that make up the Lothian Health & Care System where the workstreams cut across our organisational boundaries. Developing our plans through the existing Programme Board structure supported alignment with IJB Strategic Plans and Directions.

During the remainder of 2021, plans were developed under each of the Pillars, taking into account the output of pre-existing or ongoing engagement activity. For example:

Remote Outpatients (May 2020)

In May 2020, NHS Lothian undertook some initial engagement activity, to gather patient feedback on remote outpatient appointments. A copy of the feedback from this activity is available at Appendix II. Those who took part were reasonably confident about telephone and video appointments and the benefits of reduced ravel and increased safety during Covid were noted. Respondents acknowledged that some appointments may not be appropriate via video or telephone, including the delivery of sad news, or physical examinations and tests that would be best carried out in person. Respondents also noted that some people, living with sensory impairment, may find remote appointments less accessible. A significant proportion of respondents pointed to the potential for a "digital divide" and that some people may not have access to the required equipment or kit to attend appointments remotely.

These themes have been echoed in other work, including the Public Discussion Group convened by the RSA to inform the LSDF, the initial Integrated Impact Assessment that was carried out, and by the Alliance Report: *Health, Wellbeing and the Covid-19 Pandemic*[2], which noted the potential benefits of Digital but recommended that Digital access is not offered by default.

This suggests that, while there are significant benefits in seeking increase our digital offer going forward, we must ensure that the needs of different people and groups, including those with protected characteristics are considered in the design of digital services, and that we are able to

[2] Alliance: Health, Wellbeing & the Covid-19 Pandemic

offer a degree of choice of access for outpatient services, to ensure that no-one is disadvantaged unintentionally.

National Treatment centre (2019-2020)

Following approval of the Initial Agreement for the National Treatment Centre (NTC, formerly known as the Short Stay Elective Centre (SSEC)) at the end of 2018, the Project Team sought to involve people who live in Lothian in the development of the service model and design of the NTC facility. This was achieved through a series of engagement events and activities including a public survey, social media campaign, integrated impact assessment and the establishment of a collaborative working group with representatives from the 3rd sector, carers, community councillors, St John's Hospital stakeholders, lone parents, people with protected characteristic and people who had previously had elective surgery.

In terms of outputs:

- It was clear from the integrated impact assessment that transportation and parking was a concern, both in terms of accessing St John's Hospital on public transport early in the morning from rural areas of Lothian, and parking facilities on site.
- The collaborative working group worked with the then Short Stay Elective Centre Programme Board, in order to provide patient/public input on a range of issues and primarily transport and access. A series of three meetings were held prior to the Covid-19 pandemic, and feedback incorporated to developing plans
- The public survey generated 243 responses, which were incorporated into the developing design concept for the NTC. The survey focussed on the experience of receiving treatment at the NTC, seeking information on what would be important to patients prior to admission, during admission and on discharge from the NTC.

A refreshed NTC communications & engagement plan, reflecting changes since the pandemic and building on lesson learned to date has been commissioned by the NTC Programme Board. This work is ongoing.

Alliance: Health, Wellbeing & the Covid-19 Pandemic (February 2021)

In February 2021, Alliance published a report into the lived health and wellbeing experiences of people in Scotland during the pandemic, and their priorities for the future.

Amongst a wealth of other intelligence, Alliance captured respondents priorities for the future, to inform decision-making for remobilisation, recovery and renewal of health and care services:

1. Holistic person centred care as the foundation of healthcare services
2. People as empowered partners in decision making
3. Resourcing thriving, vibrant, asset based communities
4. Access to equitable and consistent care
5. Clear, inclusive communication
6. Digital, but not by default
7. Prioritising mental health

8. Investment in the NHS

These priorities served as a valuable guide as we developed the LSDF, and we believe they are reflected in our plans for the future. The full report can be accessed here:

https://www.alliance-scotland.org.uk/wp-content/uploads/2021/02/Health-Wellbeing-and-the-COVID-19-Pandemic-Final-Report.pdf

Healthcare Improvement Scotland: Seventh Citizen's Panel Report (March 2021)[3]

The Citizen's Panel for health and social care was established in 2016 to be nationally representative. In 2020, there were 1,163 panel members from across all 32 local authority areas in Scotland. The seventh panel survey, conducted in December 2020-January 2021, sought views on: health and social care experience since the start of the pandemic; the experience of virtual visiting; community support during the pandemic and priorities for health and social care in future.

Some of the relevant outputs from the survey, drawn from the report's Executive Summary, are included below. The full report can be accessed here:
https://www.hisengage.scot/informing-policy/citizens-panel/seventh-panel-report/

- Routine appointments opening back up (73%) was the top priority for respondents when asked about their priorities for support from health and social care organisations to improve their wellbeing over the next 6 months. This was followed by better access to GP services (65%) and shorter waiting times to access services (53%).
- One third of survey respondents (33%) had avoided accessing health and social care services and support during the pandemic when normally they would have accessed them. The most common reason for avoiding services was a reluctance to burden or put stress on the NHS (27%), followed by experiencing difficulties in getting an appointment (20%).
- Just under 7 in 10 respondents (69%) had contact with a health care professional and 8% with social care services since the pandemic was declared in March 2020. Respondents were most likely in both instances to have made contact via a telephone consultation.
- The majority of respondents would be willing to see a health or social care professional via online tools such as video consultations (64%) and via telephone consultations (58%) if it meant health services could resume. Over half of respondents (55%) said they would be willing to update information on their condition or wellbeing through an app, text or website if it meant health services could resume. Those in the 65+ age group were less likely to say they would use video or telephone consultations or an app, text or website.
- The survey included three open ended questions asking respondents to describe their priorities for their own health and wellbeing, for health services and for social care and

[3] Health Improvement Scotland: Seventh Citizen's Panel Report. March 2021

support services over the next 12 months. The responses were coded into common themes for analysis purposes. The key findings were:

- Priorities for individual health and wellbeing: Being healthy, safe and well was the top priority for respondents (30%). This was followed by access to health services or for services to resume (25%), a COVID-19 vaccine or other COVID-19 concerns (17%) and being able to see family and friends again (17%).
- Priorities for health services: Over half (52%) cited access to or availability of health services or for services to be reinstated. This was followed by getting back to normal (9%), getting the treatment or support required (8%), face to face appointments (8%) and timely access or better waiting times (7%).
- Priorities for social care and support services: The top response was access to these services if required (27%), followed by continuation of support or seeing services back up and running (8%) and care for the elderly/ vulnerable or those in care homes (6%).

Healthcare Improvement Scotland: The Redesign of Urgent Care: Gathering Views (September 2021)

The redesign of urgent care is a new Scotland-wide approach to support the public to access the right care in the right place.

Health Improvement Scotland (HIS) undertook a Gathering Views exercise in 2021, to support the development of the Redesign of Urgent Care across Scotland. In particular, HIS sought to hear from people who are more likely to experience barriers or disadvantage when accessing urgent care through 111. A number of themes arise from the responses to this exercise:

- Some people said they had difficulty understanding the automated 111 service
- Some people said they were not confident that their needs would be understood and accommodated when using the service, particularly those who did not speak English as their first language.
- Technology may be a barrier to access if no/limited access to services or limited knowledge and understanding around how to use devices.

The report makes a series of recommendations for NHS Boards, including a recommendation that we engage and involve people and communities in the design and delivery of redesigned urgent care services to ensure that they mitigate against creating further inequalities.

The full report is available here:

https://www.hisengage.scot/informing-policy/gathering-views/redesign-of-urgent-care/

In Lothian, the Unscheduled Care Programme team have engaged with the public to undertake an integrated impact assessment on the Redesign of Urgent Care, and have also obtained feedback

from patients who have used the new urgent care pathway. A mechanism to obtain feedback on a more regular basis is under consideration.

"The New Normal" (May – September 2021)

During this period, we began to share the challenges we were facing with the wider public, initially through an article that appeared in the Sunday Post in May 2021 as part of the "New Normal" series, exploring how health services might be delivered differently in future. The article can be accessed here: https://www.sundaypost.com/fp/new-normal-health-service/

In August 2021, we developed the Strategies section of the NHS Lothian website, to share our intent to refresh our strategy in light of the Covid-19 pandemic. The refreshed web page included:

- A copy of The Lothian Story (attached at Appendix III), which set out the questions we were trying to answer through the emerging LSDF, and what we thought would change in future.
- A set of presentation slides, containing more information on the challenges we were facing, and what we had learned so far during the pandemic

Continuing Internal Engagement (May – November 2021)

We continued to brief relevant internal groups on the emerging Strategic Development Framework, and to seek their views and input to the content, throughout 2021.

For example, in June 2021, members of the strategic planning team joined Daring to be Great, a development event for nursing and midwifery colleagues across the Lothian Health & Care system. A presentation on the emerging LSDF was shared, and four questions posed to delegates, seeking both their views as clinicians, and as a service user:

- In your clinical role as a service provider, what are the principles that matter most to you?
- As someone who uses NHS services, what are the principles that matter most to you?
- Following this presentation, what are the key messages that you would like the public to hear?
- What are you most worried about for the next five years?

An analysis of the feedback received informed the development of the "Improving the way we work with people" section of the LSDF.

A full list of all the internal staff groups the LSDF was shared with, and feedback sought, is available at Appendix III

Health & Social Justice in the Lothians (September 2021)

In September 2021, the RSA invited key organisations to an event hosted by the Lord Provost of Edinburgh. This event intended to explore how organisations in Lothian, together with the public, could better promote health and social justice as we transition from Covid-19 crisis.

Discussions at the event explored how organisations across Lothian had responded to the Covid-19 pandemic and noted:

- That we had seen community power in action early in the pandemic, as people stepped in to support one-another
- The agility and responsiveness of organisations, and particularly the third sector in supporting the move to Digital through delivery of essential tech and services
- The potential for "digital poverty" and exclusion, and the need to understand the limitations of online service delivery.
- The need to develop relationships between organisations to respond most effectively to the needs of our communities

Going forward, the group suggested that:

- We ensure that frontline staff are involved in helping to create the answers
- We recognise the need to introduce far better preventative measures, to address issues before they come to CAMHS or frontline services, and the critical role of the voluntary sector in that approach
- We note that value of youth work as an early intervention and prevention tool
- We look to invest differently, leaving behind pre-Covid success measures and looking to service users and young people to identify what success looks like
- We consider the potential to build on the Thrive Edinburgh model, which has been trying to bring together a cohesive approach across sectors in Edinburgh.

Many of these suggestions are reflected in the LSDF:

- The NHS Lothian Entrepreneur programme launched in September 2021, to explore big ideas for transformational change brought forward by frontline members of staff. At the time of writing, we are working to continue to progress those ideas, and develop our future thinking around public entrepreneurship
- Our Mental Health, Illness and Wellbeing plan sets out an intention to develop our Child and Adolescent Mental Health offering, to provide earlier support in the community with third sector colleagues
- Our plans for Children and Young People seek to build on the views and opinions of young people, and consider their wellbeing in a broad sense
- We recognise the strengths of the Thrive Edinburgh model, and we are seeking to take a similar approach across the Lothian Health & Care System.

Public Discussion Group (October 2021)

In 2021, NHS Lothian commissioned the RSA to run a series of public and stakeholder engagement sessions to inform the direction of NHS Lothian's Strategic Development Framework. These engagement sessions were intended to inform the policy and practice of NHS Lothian and wider stakeholders.

The NHS Lothian Discussion Group comprised of three public discussion sessions hosted in October 2021 with 19 residents from across Lothian. The overarching question for all three sessions was *"how can we make Lothian a healthier + happier place, now and in the future?"* To avoid unduly 1

steering the content of discussion, we chose a broad and open question that would allow participants to apply their own interpretation and understanding of the key concepts ('we', 'healthiness' and 'happiness') and to prioritise themes that fell within this expansive remit.

The group approached this question by first reflecting on the past, then casting their ideas towards the future, before considering what could be done in the present to move towards a healthier and happier future.

We also shared with the group some specific ideas that the Lothian Health and Care System might seek to develop further in future, including the way we access services including General practice, the redesign of Urgent Care and Hospital at Home.

Between the second and third workshops, the RSA sorted through all of the public input from the first two sessions and related homework activities, to identify all of the ideas for change and group them into themes. Figure 3 below provides a summary of the ten themes identified and the ideas that sat underneath each:

Figure 4: Themes and Ideas collated from NHS Lothian Discussion Group
Souce: *Citizens Views of Health and Wellbeing (Autumn 2021)*

Better coordination between different authorities working in Lothian • Improved coordination between authorities • Joint comms strategy • Smoother data sharing between organisations • Joined up care planning for individuals	**Staff training and workforce changes** • Staff training on diversity and inclusion topics. • Opening staff training up to community groups. • Training reception staff to level of auxiliary nursing. • Visible diversity in staff. • More generalist doctors.	**Using data in new ways** • Access to portal with health records/updates • Data from personal devices taken seriously • Smoother data sharing between organisations • GPs embedded in areas and aware of community assets.	**Incentivising healthy behaviour** • NHS working with advertisers. • NHS designing food packages/ eating plans. • Incentives to cycle/walk • Sports facilities free to those in greatest need. • More sports facilities.	**Diversity, inclusion and equal access** • Support system for patients with special access needs • Local tech support kiosks • Childcare services in GPs/schools • Staff/community training • Access to sexual health clinics and birth control
Comms, Education and Engagement • Healthy living curriculum in schools • Coaching/ classes in community and individuals • GP ombudsmen • More consistent engagement • Better signposting of different services • Cohesive local health information systems • More choice on NHS communication channels • NHS working with advertisers. • More holistic language • More transparency on spending	**Scheduling, signposting, referrals** • Local one stop hubs to signpost available services • Cohesive local health information systems • Community book with local health opportunities • Joined up care planning for individuals • Personalised 'portal' for booking and health data • Standardised booking system • All minor injury assessments scheduled • More self-referral opportunities • Data from personal devices taken seriously	**Supporting community resources** • Working with, supporting and investing in community groups and resources. • Health and social care organisations support Local Area Coordination. • Drop-in hubs (GPs of future?) for leisure and health • Deep understanding of local health needs/assets • Smoother data sharing with third sector • Developing health infrastructure through planning consent	**NHS in community and social prescribing** • Local nursing homes by large housing estates • Home visits and Hospital at Home • Dental check-ups at school • Access to care in leisure/sports facilities • GPs embedded in areas and aware of community assets. • More social prescribing • Prescribed holidays • Subsidised self-care • Cohesive local health information systems • Joined up care planning for individuals	**Different ways of accessing services** • Different consultation options: email, text, phone, video, in-person. • Local tech support kiosks • Tech/digital training • Home visits and Hospital at Home • Direct phone line for new parents • More walk-in centres • 24-hour crisis centres • Lothian buses coordinated with NHS Lothian • Open staff buses to public. • Free travel to onward referrals

From these ideas, the group prioritised seven particular actions that they would support:

1. ***Personalised NHS Portal*** *- All appointments can be booked on a personalised NHS portal which has some health data for yourself and dependents and shows past appointments and what appointments are available*

2. ***More joined up care plans for individuals*** *which span different services, clinics and third sector support – i.e. when a patient leaves hospital, care is filtered down to clinics and services in the community for aftercare. This stops being patient's responsibility*

3. ***Self-referral*** *– ability to self-refer and apply directly for physio and low-level mental health services without going through a GP*

4. ***Health infrastructure*** *- developers to take into consideration the inclusion of health provision in their planning with support from NHS to ensure provision of essential services and transport links*

5. ***Hospital at home scaled up*** *- to give people a comfortable and supported way to access healthcare from the comfort of their own home*

6. ***Increase Walk in Centres*** *- to provide triage system for access to further services, urgent care for minor issues and most importantly, a more human element at a point of stress and emergency*

7. ***Community hub support and signposting -*** *Creation of community hubs as one of a centralised system to discover the range of services available to you, support with social prescribing and facilitate better communication between services*

The majority of these ideas are reflected within the Lothian Strategic Development Framework and associated plans.

- Our Digital Directorate are exploring the potential for **a portal** through which appointments can be booked, and an online booking pilot is already underway.
- We have set out our intention to improve **communication across the Lothian Health and Care system**, to ensure care can be more effectively "joined up"
- We intend to **redesign the model of care within Primary Care services**, to support our citizens to access appropriate services directly
- We are currently working to consider how **hospital at home** services might be expanded, through our Unscheduled Care Prorgamme
- We have set out our plans to deliver services in future from **community hubs**, in which citizens can access a variety of services to support their health and wellbeing, and which may be provided by a range of public and third sector providers.

While it is not within the remit of the Lothian Health & Care System to ensure developers to take into consideration the inclusion of health provision in their planning, many of our Health & Social Care Partnership colleagues have been working with Local Authority planning departments to support this, and NHS Lothian recently provided a formal response to the Edinburgh City Plan 2030 to raise the profile of requirements for health provision. Going forward, we will seek to continue to influence planning decisions through our Partnerships and through our role as an Anchor Institution.

It is not currently our intention to increase the number of walk-in centres available across Lothian. This is largely because we do not believe we will have the staff available to provide this service consistently across the system. We hope our plans to develop both unscheduled care and primary

care services will deliver the intended benefits of these centres as listed above, and will continue to work with our communities to ensure this is the case.

A copy of the full report: Citizens Views of Health & Wellbeing, is available at Appendix V.

3. Internal Engagement (November 2021-February 2022)

Throughout the development of the LSDF, we have sought to engage with a variety of stakeholders within and outside the organisation to inform the developing content. Feedback and ideas generated between April 2021 and February 2022 were considered and, where appropriate, incorporated into the draft Framework. In February 2022, the content of the LSDF was frozen. All subsequent engagement work considered the Final Draft of the LSDF, as presented to the NHS Lothian Board in April 2022.

We have continued to share and present the LSDF at meetings with internal and external stakeholders, and to seek feedback on the content. As previously mentioned, a full list of all the meetings where the LSDF has been presented and discussed is available at Appendix IV. The input of our 28,000 staff, many of whom may also live within the Lothians, should not be underestimated.

At all meetings to date, the LSDF has been welcomed as a helpful signpost and guide to our direction of travel, and as a point of reference as site and service plans are developed.

As might be expected, the role of digital and technologies has been discussed frequently. It has been reported that evidence suggests participation in computerised interventions, for example, is not influenced by age or socio-economics, and noted that going forward both acceptance and effectiveness of digital tools should be measured. The potential risks associated with the use of technology and digital tools have also been discussed, with some stakeholders noting that "technology is great if it works". In a similar vein, some stakeholders have raised the need for investment in training to ensure that the workforce is confident and capable in using technologies and digital tools.

The experience of those who use our services has been a key topic, with discussion about how we might routinely engage our populations about how they feel when they access our services. It has been suggested that investment may be required to make sure we are able to link gathering information and using that information to inform, plan and deliver improvements. Further, it has been suggested that we consider giving greater focus to how we deliver care, rather than, for example the number of tests or procedures we deliver. Aligning tests and appointments to avoid multiple appointments and waits may be of greater value to our citizens.

Engagement has also arisen as a significant theme. There has been broad support for the concept of continuous engagement in the LSDF and its implementation, alongside a plea that we are respectful of the time of those volunteering to share their feedback, given that many community groups have recently been asked to share their views on multiple documents and ideas. The importance of engaging with our communities around what they can do to support good health and enhance capacity for self-management has been highlighted. Stakeholders were keen to see communities empowered to develop their own priorities and to collaborate on and co-design solutions, noting that investment in resource to support both outreach and the engagement of communities may be required.

In recent weeks, the rising cost of living has been highlighted, and a query raised about the potential impact of people choosing not to heat their homes, or not to eat. The Chief Executive of Energy Advice Scotland recently predicted that rising energy prices could lead to a catastrophic loss of life, as more people fall into fuel poverty.

The following specific additions to the text of the LSDF have been suggested:

1. **Pharmacy and Medicines**

Colleagues within Pharmacy and Medicines have suggested that it would be helpful to reference ***Achieving Excellence in Pharmaceutical Care: A strategy for*** **Scotland** within the LSDF, aligned to NHS Lothian developments. In particular it has been noted that the national strategy makes commitments relevant to Primary Care, specifically:

Commitment 1: To increase access to community pharmacy as the first port of call for managing self-limiting illness and support self-management of stable long term conditions, in-hours and out of hours.

Commitment 2: Integrating pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multidisciplinary team.

The role of Pharmacy and Medicines within the more detailed plans under each of the pillars could also be clarified, including the community pharmacy workstream within the Redesign of Urgent Care programme; the establishment of Advanced Therapeutic Medicinal Products infrastructure within Scheduled Care; the potential for enhanced contribution of Advanced Pharmacists with clinical, assessment skills in Scheduled Care areas to increase clinic capacity, reduce waiting times and ensure patients get the best from their medicines; Implementation of Hospital Electronic Prescribing and Medicines Administration (HEPMA) systems, and; the role of pharmacists and pharmacy technicians within the Mental Health, Illness and Wellbeing pillar.

It would also be helpful to reference the NHS Lothian Pharmacy and Medicines Service Strategic Plan 2021-26.

2. **Quality**

It has been suggested that we make explicit the role of Quality Management as we move forward with implementation of the LSDF, and reference the NHS Lothian Quality Strategy 2018-2023. Quality Management is a systematic approach to service planning and change focused on the patient/client and staff experience and outcome of care.

3. **The Person at the Centre and Patient Experience**

Concurrent to the development of the LSDF, NHS Lothian's Patient Outcomes Programme Board has been developing our "Person-Centred Statement". It is recommended that this Statement, once finalised, is incorporated into the LSDF

Alongside the statement, a Patient Experience strategy is in development, to support our commitment to improving the experience of our patients, families and carers so that it is the best it can be. Once complete, incorporating the strategy into the LSDF would be of value.

4. "Midway"

It has been suggested that we consider the potential to roll out the "Midway" model developed within Midlothian Health & Social Care Partnership across the Lothian Health & Care System. The aim of "Midway" is that, wherever someone makes contact with services, they will be welcomed by a 'what matters to you' response and an understanding of the social circumstances of someone's life. This supports self management through a shared agenda that mobilises a person's internal motivation to make change that can improve wellbeing.

The implementation of Midway within Midlothian H&SCP has had positive outcomes, and it is felt that there may be value to sharing this further. Building this approach would require an investment in time and training workshops to practice skills, build knowledge and confidence in the approach.

5. Other suggestions

As we seek to implement the LSDF, and further develop our plans, we have also been urged to consider:

- Including more detailed plans around Rehabilitation
- Seeking to increase the emphasis within the LSDF on children with life-limiting conditions
- Developing our plans around Primary Care to demonstrate the entirety of primary care services including, for example, community dietetics and phlebotomy
- The role of the unpaid carer

4. Initial period of Public Engagement, April-June 2022

Following the NHS Lothian Board meeting on April 6th 2022, we commenced an initial period of public engagement activity on the LSDF. The purpose of this activity was to:

- Explain the issues and challenges facing the Lothian Health & Care System
- Outline the work undertaken so far to engage stakeholders in developing our thinking
- Outline what we have heard from the public to date
- Explain our thinking, and the direction of travel that we think the Lothian Health & Care System should take
- Seek feedback from the public on our proposed direction, identify any potential problem areas, and seek to understand how these might be resolved
- Seek to build support for the proposed direction
- Establish a basis for ongoing and continuous engagement in the LSDF

It was our expectation that this period of engagement activity would:

- Build a shared understanding of the challenges that we face
- Support those who live and work in the Lothians to provide feedback on our proposed direction of travel, as set out in the LSDF
- Identify potential problem areas in our proposals, and seek to understand how those problems might be resolved

We anticipated that the outcomes of this initial period of engagement would be that:

- Lothian residents are able to influence the future strategic direction of the Lothian Health & Care System, informed by relevant data and information
- Lothian residents are supportive of the finalised direction of travel within the LSDF
- The Lothian Health & Care System has confidence that our future direction is cognisant of the priorities of our communities, and focussed on delivering the outcomes they value.
- A basis for ongoing and continuous engagement is established, to support the development of LSDF implementation plans.

To facilitate this initial period of engagement, we produced a suite of engagement materials:

- A finalised LSDF Summary
- LSDF Summary in Easy Read Format (Appendix VI)
- A full suite of LSDF documents, consistently presented
- An infographic, to summarise the content of the LSDF (Appendix VII)
- A standard slide deck, for use at Engagement events (Appendix VIII)
- A series of engagement prompts, to support stakeholders in their response

The LSDF page on the NHS Lothian website was updated at the beginning of April to include the materials above, including a narrated version of the slide deck. Banners were placed on both the front page of the NHS Lothian website, and on the staff intranet page to direct stakeholders to the LSDF.

Figure 5: Internet/Intranet Banner to direct stakeholders to LSDF webpage.

Articles promoting the LSDF and this period of engagement were placed in the Staff Weekly brief, along with a Director's Cut video from our Chairman.

A letter was drafted to external stakeholders including Local Authorities, partner NHS organisations and Chambers of Commerce, inviting them to comment on the LSDF (Appendix IX).

A media release and social media campaign alerted the public to the LSDF, alongside communication with Third Sector Interface groups and community planning colleagues across Lothian.

Comments were invited via our dedicated email address: loth.lsdf@nhslothian.scot.nhs.uk

Synthesis of emails received, and response

A total of 113 emails were received in response to the Lothian Strategic Development Framework. In addition to responses from members of the public, we also received responses from members of NHS Lothian staff, staff within stakeholder organisations and from partner organisations.

On the whole, respondents welcomed the opportunity to respond to the ideas and proposals outlined within the Lothian Strategic Development Framework, describing the framework as 'welcome and interesting', 'comprehensive', 'aspirational', 'far-reaching and impressive' with 'many good ideas and commitments', balancing ' current plans with the need for a wide re-think about how and where we deliver services'.

A number of respondents noted ideas that they felt were particularly positive within the framework, including the focus on environmental sustainability, increasing the use of technology and innovation, work to prevent ill health and support self management and plans to provide more support for people at home, including end of life care. One respondent commended 'the many references to digital first and the putting of the citizen at the centre'.

It was suggested that we make more reference to current and forthcoming digital developments across the system, including the development of a Paperlite solution for Mental Health services, as this will comprise 'a significant change to the way mental health services work and also provide the

baseline for more innovative developments' and to reflect the digital plans of Health & Social Care Partnerships and IJBs. More detail on how we will take forward "Digital First" across each pillar of the LSDF was also sought, with one respondent wondering whether: 'we might seek to consider how we can make work easier for our own staff who may be working between more than one system or desktop'.

While the benefits of digital tools to support remote appointments and interactions between citizens and clinicians were noted, there were also concerns that some people may find these digital tools difficult to use: 'many older people are less confident in the use of technology than younger people' and that promotion of alternatives to face-to-face contact might 'discourage certain patients from seeking an 'in-person' consultation when this would be important for them'. On the other hand, one respondent noted that digital tools could help to improve the accessibility of our services for those who are unable to communicate by telephone: If I message my bank on messenger for facebook they are able to send me a link to a secure chat window. There is no reason the NHS can't do the same. These challenges and opportunities were also noted by the citizen reference group and during the integrated impact assessment workshop undertaken regarding the LSDF.

The wider accessibility of physical services currently provided also emerged as a theme, with respondents noting that they are often sent appointments for an inconvenient time or at an inconvenient location. This might be due to work commitments, because the appointment is difficult to access via public transport or road: not directly accessible by public transport which means a car journey of over an hour along narrow country roads or personal circumstances: having to get out there is not only expensive (I need a taxi as there are bus changes and walking involved on public transport - neither of which I can do well) but wholly unacceptable. On a similar theme, one respondent expressed the view that the location of the proposed National Treatment Centre at the St John's Hospital site in Livingstone was: a relatively inaccessible site for the majority of Lothian residents and staff not served by such extensive bus services as the RIE and WGH and which will presumably result in increased car traffic impacting on the sustainability goals

One respondent noted a concern that moving to provide more care in the community for those with mental ill health may risk people with acute mental ill health being cared for in inappropriate settings: even now, there are pressures in achieving immediate appropriate care for those with acute serious mental health needs

Challenges in General Practice provision were also noted, including the risk of current challenges being exacerbated with the extensive volume of housebuilding in future years.

A number of respondents commented on the scale of the task in seeking to implement all of the ideas and proposals outlined within the LSDF, especially in light of the existing challenges described including financial challenges and those surrounding our workforce: I appreciate that the NHS is short of staff and all staff have been severely tested recently. Respondents suggested building a supportive culture within the Lothian Health and Care System, increasing the focus on prevention, and working to continue to innovate could help us to manage these challenges and to implement the LSDF. One respondent particularly sought a more central focus on innovation within the LSDF, and on bringing together: 'the various 'innovation' programs we have in Lothian...and co-locate them in some way'

Some respondents sought more detail about plans in specific areas, including our future plans for cancer services. Several respondents wondered whether we might consider an additional pillar for "Older People", reflecting the challenges of an ageing population and mirroring the pillar for Children & Young People. It was also suggested that our plans around maternity services should be developed, particularly in the context of several reports into safety in maternity services (most recently Ockenden).

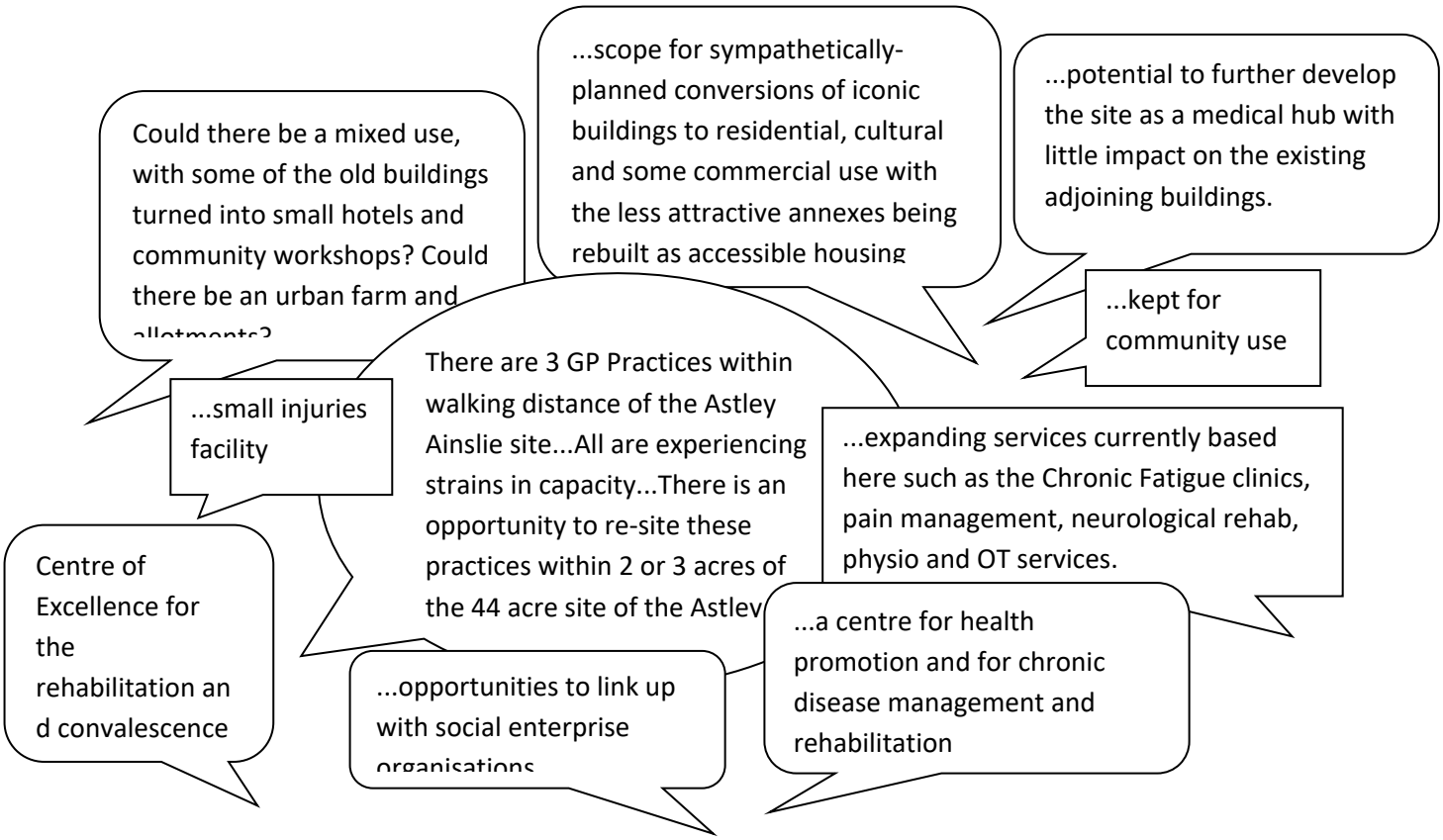
We have received a number of suggestions about how good health and wellbeing could be supported for the citizens of Lothian. Many of these suggestions pointed to 'the importance of green space for health and wellbeing' and some felt the LSDF should go further in acknowledging 'the value of open space for convalescence, public wellbeing, and the potential avoidance of certain healthcare and treatment costs'. Respondents pointed to ideas including green prescribing, 'small groups in nature for grief management' and 'more space for children with additional needs in nature'. These suggestions reflected the discussions of the Citizen Reference Group, where the value of open spaces and green spaces in supporting people's well being was strongly acknowledged. Another respondent suggested we seek to bring skills around nutrition and financial budgeting for children back into schools, to support development of a healthy and happy culture: during my school career, I had to create a monthly budget for a family of four. Nutritious, balanced meals with minimal waste had to be created on the funds left over after paying for the necessities - rent, power, travel etc... It taught us the value of money and how to live on a budget

One respondent suggested that the LSDF should include a greater focus on palliative and end of life care access and provision, noting that a huge proportion of the costs of healthcare are spent in the last year of someone's life. This reflected feedback from members of our own Palliative Care team.

Following our statement within the LSDF that we would seek to influence the ultimate use of the Astley Ainslie site, the significant affection that the local community feels for the site was clear from responses seeking more information on our plans for the site. Many were supportive of the suggestion that we might consider the need for affordable housing that many of our health ad care staff need access to, noting that this was 'a good idea' or 'a great idea' and that they were 'very sympathetic to the need for affordable housing for NHS workers' and 'would thoroughly endorse using part of the site for affordable housing, prioritising health and care staff'. Others queried whether the Astley Ainslie site should really be considered for this, commenting: 'I find it naive of you to suggest that health care staff would wish to live rather than work here' or wondering: 'Is there any point in zoning Astley Ainslie for affordable housing if health and care staff are not working "on site"?'

Respondents submitted a variety of ideas for how the site might be used or existing buildings adapted, as shown in figure 6, below:

Figure 6: Suggestions for the future of the Astley Ainslie site



Many respondents supported further engagement in the LSDF, requesting that the Lothian Health & Care System engage 'transparently and meaningfully with community groups, charities and local residents' as well as frontline staff, and seeking 'substantial opportunity for community partnership in the development of plans for the future'. Some suggested that we do more to increase awareness of the LSDF and the opportunity to comment.

Responses from statutory partner organisations indicated their view that the LSDF 'addresses local and national priorities', 'based on a clear assessment of the current demands and challenges within the system', and signalled their agreement with the direction of travel outlined within the framework. One respondent suggested that consideration be given as to whether the Lothian assumptions and principles...are consistent with those of Fife and Borders, and whether whether we could / should develop a similar set of assumptions from a more East Region perspective and what the implications of this might be

Public Health Scotland suggested that population health 'could be better positioned and integrated across the document' and to align the five year plans with the intent to improve population health 'by integrating clear actions linked to the service design/re-design elements of these focused on addressing or mitigating for inequalities of access and outcomes'. Public Health Scotland also suggested that: more could be said on the differing needs of communities and how these will inform the design, delivery and evaluation of services provided. This reflects the output of the initial integrated impact assessment of the Framework.

Public Health Scotland also made some specific suggestions to enhance the mental health aspects of the Framework.

A clear desire to work together and collaborate as we move forward was clear in responses from our statutory partners.

Public Meetings

NHS Lothian commissioned the RSA (Royal Society for the encouragement of the Arts, Manufactures and Commerce) to facilitate a series of online engagement events with a range of audiences as an "honest broker". Five online sessions were planned and delivered:

- One session was held with the pre-established Public Discussion Group (cross ref page xx), and focused on updating them on progress and the impact their input had made; and exploring next steps. A further session will be held with the group at a future date following the Board's consideration of the findings, to allow the group to reflect on the process/outcomes.
- Three sessions were held as open public sessions for Lothian residents, advertised through several NHS Lothian and local channels. These sessions consisted of outling the context, progress and ambitions of the LSDF; and then opening up the space for facilitated discussion and reflection. Participants came from across the Lothian region, and from backgrounds including community activism, advocacy, business and academia.
- One session was held with RSA Fellows, who participated from across Scotland. Although the majority of the participants were not resident in NHS Lothian's geographic catchment area, this session was intended to tap into the diversity of expertise and experience that the RSA Fellowship contains. Participants came from a variety of backgrounds and sectors, including heritage, civic society, health, consultancy and business.

In total 65 people registered to attend the events with 47 participating, with each session running for roughly 90 minutes. The feedback below is drawn directly from the synthesis provided by the RSA. A copy of the full feedback provided by the RSA is available at Appendix X.

Positive findings:

Participants were generally impressed with the structure and ambition of the LSDF.

The way that the LSDF was presented and written made it clear to participants that it was intended to be a top-level overview and vision – this did mean that there was a reflection that the "devil will be in the detail – how do we translate top level thinking into real action?", but the clarity meant that the LSDF was understood to not be trying to solve every problem or demonstrate every idea.

The layout of the report, particularly the graphic model demonstrating the overall approach, was praised as being a "great way of presenting very complex ideas".

Participants were pleased, and indicated trust, that the Lothian Health & Care System was actively and openly seeking input from the public and stakeholders, and that this was not just a tick box exercise.

The focus on, and commitment to, social justice and improving the lives of the residents of the Lothians was welcomed, with a recognition of the LSDF's ambition for NHS Lothian to truly utilise role and responsibility as an anchor institution.

Appreciation for the work which NHS staff have undertaken during the COVID-19 pandemic, and the significant strain they have been and continue to be under, was clear amongst participants. This helped shape awareness of the challenges that change will bring in an exhausted workforce, and positive feedback that the LSDF clearly articulates the role and importance of staff, and staff wellbeing. The clear identification by the LSDF of looming staffing challenges due to demographic/labour market changes was also highlighted as a strength of the document, helping to underpin the reasoning around why change is necessary: "We need to help educate the public to better understand how the system works and the pressure it is under – we need the public to help us create change"

Areas for clarification/inclusion:

Overall, the language/priorities of the LSDF were praised, however in some cases it became clear from participants that it would be beneficial to have further detail on certain areas. Examples included the consistent highlighting of mental health support, particularly for children and young people, throughout the sessions; and the reflection that certain voices/communities did not come across as strongly in the LSDF as they should (e.g., carers, the third sector).

As mentioned above, several participants commented on the success of the LSDF in making complex ideas accessible and avoiding jargon. One linguistic issue that was challenged by a few participants was around the use of the word 'citizen' in referring to the people the LSDF was seeking to serve. For some participants this raised a concern about potential exclusion, due to citizen carrying a different legal connotation than resident or person.

As explored above, participants were positive about NHS Lothian's approach to engagement, but there was a consistent plea for this to be an ongoing and evolving process. Moreover, several participants asked for the approach to be "co-creation rather than consultation", to truly allow participation and impact.

The challenges faced by NHS Lothian were noted as being rooted in both financial/infrastructure challenges but also systemic challenges. As noted above it was recognised by the participants that the LSDF is a top-level framework, rather than a step-by-step outline of actions; however, it was also requested that it contain clarity on how constraints and challenges around staff capacity and the difficulty of developing leadership/challenging existing culture can be addressed.

New digital technologies and approaches were broadly welcomed; however, concerns were raised across all five sessions about the challenges/dangers of excluding those without access to technology/confidence in using it. The risk of digital increasing rather than decreasing social and health inequity was highlighted as a very real one.

Generally, participants focused on pan-NHS Lothian ideas and responses, however some local issues around infrastructure and access were raised. Transport was highlighted as a consistent challenge, particularly for certain areas, and highlighted a theme where NHS Lothian is not in a position to solve the problem on its own.

The idea of the reduction of non-clinical space was highlighted as an ideal chance to encourage other organisations to provide help in a non-clinical setting, such as museums and galleries. This offers a space for creative thinking about new approaches and methods of utilising resources outside the NHS. In addition, the idea of better utilising existing NHS Lothian staff and infrastructure in new ways was highlighted by several participants.

The LSDF's commitment to a whole system approach, collaborating with the wider public, other sectors and stakeholders, and its own staff was very popular. However, some concerns were raised as to whether the use of terms such as 'Pillars' in the Framework could run the risk of creating new silos.

One participant raised a concern that human rights, particularly in terms of people with disabilities, was not prominent enough in the Framework.

Integrated Impact Assessment

As part of our engagement activity around the LSDF, an Integrated Impact Assessment workshop was held in May 2022, with participants drawn from NHS Lothian, the public and the third sector.

The challenges of undertaking impact assessment on a strategic document were noted, and a variety of potential positive and negative impacts were identified. A follow-up session was subsequently held to review the output of the initial workshop, and additional comments were noted. It was agreed that the IIA should be considered "interim" as many of the proposals wihin te LSDF will require further assessment.

While the final IIA report is not yet available for circulation, some draft recommendations have been discussed:

- Ensure relevant legislation is acknowledged as plans develop. In particular the group noted the proposed Disabled Children & Young People (Transitions to Adulthood) (Scotland) Bill

- Ensure broad, diverse user engagement as services and systems are designed and developed. In particular, ensure technologies are developed based on need and with service user experience in mind, considering the potential negative impacts identified in this IIA

- Work with partners to reduce lack of access to digital technologies, kit and broadband required to access digital services

- Ensure that, with the introduction of new technologies and access methods to services, that those who use our services continue to have a choice wherever possible

- Continue to undertake integrated impact assessment at relevant points as plans develop

Once complete, the IIA report will be appended at Appendix IX.

5. Summary of themes and proposed next steps

Throughout all of the engagement activity we have undertaken to date, the LSDF has been broadly welcomed as a useful guide and signpost, in outlining our plans for the future at a high level. We are delighted that respondents have received the LSDF positively, and **support our proposed direction** of travel.

We note the **potential for our plans for the future to be affected by changes** in the wider environment, including the outcome of the National Care Service consultation, the potential for new pandemics and variants and the availability of resources. Setting out our plans within a framework allows us to be flexible in response to future events, and update our plans.

We welcome the suggestions that we make the role of **Quality Management** explicit within the LSDF as we seek to implement our plans for the future; that we make reference to the national **pharmacy strategy: Achieving Excellence in Pharmaceutical Care**, and; that we update references to the refreshed national **Digital Health & Care strategy.** We will seek to make these amendments.

We recognise that the **Primary Care** pillar of the LSDF would benefit from further development, including more detail about our plans for Primary Care services beyond General Practice, and around Primary Care infrastructure. We will take this forward.

We note the suggestion that **Population Health** could be better positioned within the LSDF summary, and that each pillar should make clear their plans in relation to both population health, and digital opportunity. We will seek to develop this in the next iteration of the LSDF, as we develop our plans.

We note the view that **Palliative and End of Life Care** should have a greater presence within the LSDF. While we have touched on end of life care in Chapter 3 (Where We Want to Be) and Chapter 9 (Scheduled Care) of the LSDF, we recognise that the importance of both a good life and a good death could be highlighted in the LSDF summary, and that our plans in this area could be developed as we implement the LSDF.

A significant volume of responses sought more detail about our plans in specific areas, in particular around **Cancer**, **Older People**, **Maternity Services**, **Rehabilitation** and the **constraints and challenges** faced by the Lothian Health & Care System. We recognise that these areas do not fit neatly within any single pillar of the six that make up the LSDF. It is our intention to specifically develop our plans around Women's Health, Long Term Conditions, Ageing and Cancer over the coming year. More detailed information regarding our challenges in terms of workforce and finance is currently being developed, through workforce planning and the development of a Medium Term Financial Framework.

We have received a number of suggestions about pieces of work that should be mentioned explicitly within our plans including the **role of medicines and pharmacy** and the intention to implement **paperlite across mental health services**. We will seek to ensure that these suggestions are included as we develop and implement more detailed plans under each of the pillars.

We are aware of a number of concerns for the future that have been raised, including current **pressures on General Practice** services and the potential risk that our proposals to **shift the balance**

of care for mental health services might create pressures elsewhere. We will take these concerns into consideration as we develop our plans in these areas.

"Digital" has been one of the most prominent themes discussed throughout the development of the LSDF. In general, the opportunity to increase access and offer choice to citizens through digital developments has been welcomed across all groups. However, the potential for unintended negative impacts as a result of digital developments has been raised regularly, including the risk of **digital exclusion** for some citizens, and the risk of limiting access to services for people with sensory impairment or whose language is not English. It has been recommended that we seek to engage communities in developing and co-designing digital solutions, to ensure they are fit for purpose.

The need to measure both the acceptance of digital tools, and their effectiveness has been raised, alongside the potential to explore ways to improve our systems and knowledge and "make life easier for staff". A need to invest in workforce training has also been identified.

Continuing engagement as we implement the ideas outlined in the LSDF has been a key theme throughout LSDF discussions to date. There has been broad support for the concept of "continuous engagement" and a plea for **effective engagement at a variety of levels**, including working with communities around maintaining good health and to support self-management, and seeking to co-design solutions to issues with communities.

Given the concerns that engagement to date may have had limited reach, and that we should strive to reach all households across Lothian, we will continue with our plan to distribute a postcard to every household, inviting people to review and comment on the LSDF, and our dedicated email address will continue to operate.

To effectively achieve a continuing dialogue with our communities, and **support collaboration and co-design** as we seek to transform our services, we need to think carefully about our approach. There will be multiple strands and areas where we would benefit from seeking to work with our communities to understand the problems we need to solve in more depth and seek to co-design effective solutions. We have started conversations with a number of partners, who have expressed an interest in helping the Lothian Health & Care System to creatively reach and engage people across the Lothians, including those whose voices would benefit from amplification. This approach may require **investment in undertaking engagement, coordinating our efforts and recording and sharing the outputs** of our work.

The particular affection with which the **Astley Ainslie Hospital** site is regarded was clear in the responses of those who wrote to us specifically about the site. The decision that NHS Lothian would be exiting the site and would be offering it for sale in line with public sector guidance was made some time ago. We do not expect that the site will be required for service delivery in future, and so that decision remains. We would like to reassure respondents that, in line with the Community Empowerment Act, the disposal of the site will be subject to a specific engagement process with interested parties.

There were a number of areas in which respondents raised particular concerns, which are outside the remit of the Lothian Health & Care System. Many respondents mentioned the **value of green space** to support health and wellbeing, the role of **physical access and transportation** in reaching

health and care services and the value of education around **food and nutrition in schools**. We will continue to seek to work with our partners to support these issues.

Some respondents objected to the use of the term **"citizen"** within the LSDF as it was felt that it might exclude some people. We intend to continue to use the word citizen within the LSDF to mean any person who lives within Lothian.

One respondent was concerned that not specifically mentioning the **United Nations Convention of the Rights of Persons with Disabilities** might signal that the Lothian Health & Care System does not take seriously its responsibilities to disabled people. As we implement the LSDF we will work to ensure that the guiding principles of the convention are considered.

Understanding the experience of those who use our services, ensuring that the citizen **is at the centre** of our planning has also been a theme. The proposal to **expand the "Midway" model** builds on "patient experience" by focussing on what matters to the citizen in every interaction with public services.

As previously mentioned, NHS Lothian's Patient Outcomes Programme Board is currently seeking to develop a person-centred statement, and a Patient Experience strategy to describe how staff and care givers understand their responsibility in ensuring each patient not only receives excellent clinical care, but that it is delivered in a manner that treats them as an individual, recognises their needs and cares for them with empathy and compassion. Going forward the person-centred statement and Patient Experience strategy may influence the content of Chapter 3 of the Framework ("Where do we want to be").

As we seek to implement the LSDF, we will seek to consider the proposal to expand the "Midway" model across the System.

Appendices:

FULL APPENDICES AVAILABLE IN THE 'LSDF Full Engagement Paper Appendices (June 2022)' FOLDER WITHIN THE ADMINCONTROL MEETING FOLDER 22-06-2022

I	Pandemic Possibilities
II	Outpatients
III	The Lothian Story
IV	Internal engagement record
V	Citizens' Views of Health & Wellbeing
VI	LSDF Easy Read Summary
VII	Infographic
VIIII	Standard Slide Deck
IX	Stakeholder Letter
X	RSA Feedback on Public Meetings
XI	IIA Report – to follow

Appendix 2 – Astley Ainslie Hospital and disposal of the site

Astley Ainslie Hospital (AAH) currently remains an active healthcare facility with operational and clinical services on site, together with providing green space and accessibility valued by the local communities around the hospital grounds. In the 2013-14 financial year NHS Lothian consulted publicly and formally on its *Our Health, Our Care, Our Future* strategy and explicitly on disposing of the the AAH site.

At that time, and to this day, NHS Lothian recognises the opportunity to enhance the clinical facilities for patients and staff by moving services to the Royal Edinburgh Hospital site Hospital, with development phases to include for the services currently based at AAH.

As part of this work, and in recognition of the statutory duties laid on public bodies in the Community Empowerment (Scotland) Act of 2015, NHSL had undertaken engagement work on the future of the site.

NHS Lothian paused the ongoing engagement with planning authorities and community interest groups pending the completion of the Lothian Strategic Development Framework. During the LSDF process to date, the Lothian system has noted that the AAH site would potentially be a good one for affordable housing and community developments, but that the position with regards disposal of the site is otherwise unchanged.

It is intended to re-engage with known community groups and the wider community and town planning interests over the future opportunities of the site, in a transparent and positive way aligned with the mandatory guidance for Community Empowerment and Property Transactions for NHS Scotland bodies holding land in the name of Scottish Ministers.

Of note, the provisions of the Community Empowerment (Scotland) Act are clear that certain mechanisms are required to be in place when “Interested Parties” are identified. This limits the engagement possible.

Note: Scottish Government’s Property Transactions Handbook [https://www.pcpd.scot.nhs.uk/PropTrans/PTHome.htm] and The Community Empowerment (Scotland) Act 2015 [https://www.nhslothian.scot/YourRights/CommunityEmpowerment/Pages/assettransferrequest.aspx]

NHS LOTHIAN

Board
22 June 2022

Director of Strategic Planning

REVIEW OF THE INTEGRATION SCHEMES

1 Purpose of the Report

1.1 The NHS Board is a party to four integration schemes with the Local Authority for each area. Those schemes led to the establishment of the four Integration Joint Boards ('IJBs') in Lothian. The law requires the parties (the NHS Board and the Local Authority) to carry out a review of the integration scheme within five years from when the Scottish Ministers approved the scheme.

1.2 This report outlines work undertaken jointly across Lothian to ensure compliance with our duty to carry out a full review of the Integration Schemes. The report seeks NHS Board approval of the four draft revised Integration Schemes, subject to subsequent approval by Lothian Local Authorities where this is still outstanding. Formal approval from all parties will allow submission of the draft revised Integration Schemes to Scottish Ministers for their approval, as required by law.

1.3 Any member wishing additional information should contact the Director of Strategic Planning in advance of the meeting (colin.briggs@nhslothian.scot.nhs.uk).

2 Recommendations

The Board is recommended to:

2.1 Approve the four Lothian final draft revised Integration Schemes, subject to remaining approvals by Lothian Local Authorities.

2.2 Agree to the submission of the revised schemes to Scottish Ministers, once all final approvals from Lothian Council parties to the schemes have been obtained.

2.3 Note that the West Lothian Council Executive approved the West Lothian final draft revised Integration Scheme at their meeting of the 19th of April 2022, for submission to Scottish Ministers pending approval by NHS Lothian in June 2022.

2.4 Note that remaining Council approvals required are being requested at City of Edinburgh Council meeting on 30th June 2022, Midlothian Council on the 28th June 2022, and East Lothian Council on the 28th June 2022. It is anticipated that the final draft revised schemes will be approved by all remaining council parties on the dates outlined above.

3 Discussion of Key Issues

3.1 The Public Bodies (Joint Working) Scotland Act 2014, section 44, specifies a requirement to review Integration Schemes every five years from the initial formal approval of schemes granted by Scottish Ministers. The Act places a duty on Councils and Health Boards to do this (as the parties to the scheme). IJB's do not share that duty. The parties are required to identify whether any changes to the scheme are necessary or desirable, and if so, and with due public consultation, vary the scheme by jointly preparing a revised integration scheme.

3.2 For the Lothian schemes, the reviews should have been completed by late May 2020 (for East Lothian, Edinburgh, and Midlothian), and by mid June 2020 (for West Lothian). Plans initially considered in early 2020 to review the Integration Schemes Lothian wide were halted and made unfeasible at that stage by the coronavirus pandemic. Scottish Government accepted this delay (which had affected many Board and Council areas), however in mid 2021 Scottish Government requested that the statutory reviews were taken forward without further delay. NHS Lothian, in coordinating the current joint review of schemes pan-Lothian, has continued to liaise with the Scottish Government policy team to both involve them and to communicate ongoing progress.

3.3 Initial consideration of the Integration Schemes with colleagues in the Lothian Local Authorities and Health & Social Care Partnerships, taken forward before the pandemic, did not identify a fundamental problem with the existing integration schemes.

3.4 Building on this in 2021 an Oversight Group was convened with participation of nominated senior officers representing all of the parties to the Lothian schemes. This group provided strategic guidance on the scope and focus for the necessary review to be undertaken. The review was duly remitted to essentially 'Tidy Up' the existing schemes, rather than to consider anything more transformational with regard to delegated functions, scope and the operations of Lothian IJB's. This scope was set in recognition of the emerging national policy landscape in Health and Social Care particularly arising from the Independent Review of Adult Social Care, and the consideration of a new National Care Service. The Oversight Group also recognised that operational management arrangements for hosted services had changed significantly since the initial Integration Schemes had been written, and therefore requested that the operational detail be removed from the revised schemes (as such was out-of date and unnecessary). The group also requested that alongside the review of the Integration Schemes an up-to-date overview of the allocation of responsibility for hosted services should be developed. This work is being separately reported to the Corporate Management Team and sets out where responsibility currently lies for planning, commissioning, and delivery and makes recommendations for improvement to planning and performance monitoring.

3.5 The main areas reviewed in the 2021/22 review exercise are:

- A refresh of the Aims, Vision, Values, Outcomes of the IJB in line with current strategic plans

- A general refresh of all out of date text in the scheme - Operational Role of the IJB; Support for Strategic Planning; Professional Technical and Administrative support services; Performance Targets & Improvement Measures, Complaints processes, etc.

- The core Clinical and Care Governance element of schemes has largely been retained in the revised scheme in the existing form.

- An extensive update to the finance section of schemes has been completed collaboratively by finance leads across all of the parties, updating detail on Financial Governance; Payments to IJB; Financial Reporting; Process for Addressing Variance; Redetermination of Payments; Redetermination of Set-aside Amounts; Use of Capital Assets; Financial Statements; and External Audit etc.

- An extensive update to the Information Governance and Data Sharing section has been completed collaboratively across Information Governance leads, to better reflect the current protocols and arrangements in place across Lothian.

- As necessary subject expert input from council teams, Health and Social Care Partnership Teams, and from within NHS Lothian was gained to inform review work. / etc.

- Legal review of the revised schemes was led by the individual lead Local Authority solicitors, working with the coordinating manager for the review in NHS Lothian. The NHS Scotland Central Legal Office nominated solicitor has also reviewed and inputted to the revision.

3.6 Following approval by all parties in Lothian, the next step is to jointly submit the revised scheme to the Scottish Ministers for approval under section 7 of the Act. A revised integration scheme takes effect upon the date of approval by the Scottish Ministers. Lothian councils and NHS Lothian must then publish the new scheme.

4 Key Risks

4.1 The principle risk of failure to carry out a statutory section 44 review in the prescribed timescale, and therefore not complying with the law, has been managed via liaison with Scottish Government and completion of this review to revised timescales indicated in feedback to Scottish Government.

5 Risk Register

5.1 Submission of the revised schemes to Scottish Ministers completes our obligation for statutory review. Lothian IJBs are responsible for a range of ‘integration functions’ which relate to various risks on the Board’s corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This report does not relate to a specific proposal which has an impact on an identifiable group of people. However the NHS Board, Lothian Local Authorities, and Lothian IJBs have responsibilities to address inequality, which integration of Health and Social Care Services seeks to further support.

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

7.1 The statutory duty to review the Integration Scheme jointly also requires a period of public consultation to determine and inform any changes to the scheme. As the parties agreed that it was necessary or desirable to change the Integration Scheme, Section 46 of the Act was followed to vary the scheme. Section 46 includes a consultation requirement on the proposed changes, and parties to the scheme must take into account consultation views when finalising the scheme. Consultation to support revision of the scheme was therefore carried out jointly in each area and requested both general comments on any aspect of the scheme, and comments on specific proposed changes to the text of the scheme.

7.2 Consultation exercises ran in West Lothian in October 2021, and from 10/3/22 – 3/4/22; in Midlothian between 18/3/22 -10/4/22; in Edinburgh between 28/3/22 – 26/4/22, and in East Lothian between 2/5/22 – 29/5/22.

7.3 Consultation exercises in all four areas were hosted on council websites, with a link also placed on the NHS Lothian Consultation Zone webpage. Council and NHS Lothian Communication Teams and Health and Social Care Partnership managers supported the consultation exercises. Efforts were made to reach all statutory consultees through direct email, staff communications, community councils, public forums and networks, commissioned providers, partner organisations and stakeholder representatives including services users and carers. IJB members were also invited to contribute views. Information about the consultation was published on Health and Social Care Partnership (HSCP) websites and via social media.

7.4 All views expressed have been considered during the review process, and in finalising the revised schemes, as required by the Act.

8 Resource Implications

8.1 The process of review has been supported by management, legal, and staff time across all of the parties involved, in completing the review. There are no further new or ongoing resource implications following review completion.

Peter McLoughlin
Strategic Planning
25 May 2022
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Colin Briggs
Director of Strategic Planning
25 May 2022
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List of Appendices

Appendix 1: East Lothian Integration Scheme 2022 (For Approval)
Appendix 2: Revised Edinburgh Integration Scheme 2022 (For Approval)
Appendix 3: Midlothian Integration Scheme 2022 (For Approval)
Appendix 4: West Lothian Integration Scheme 2022 (For Approval)

Edinburgh Integration Joint Board

Revised Edinburgh Integration Scheme 2022
(Body Corporate)

Contents

Preamble – Aims and Outcomes

1.1 The work of the IJB (as hereinafter defined) will be guided by the integration planning principles as stated in the Public Bodies (Joint working) (Scotland) Act 2014 and will contribute to the achievement of nationally agreed health and wellbeing outcomes prescribed by the Scottish Ministers in terms of The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014, made under section 5(1) of the Act (as hereinafter defined). Namely:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.

2. People, including those with disabilities or long term conditions or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

5. Health and social care services contribute to reducing health inequalities.

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

7. People who use health and social care services are safe from harm.

8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

9. Resources are used effectively and efficiently in the provision of health and social care services.

To this end, the Parties are working towards:

- An affordable, sustainable and trusted health and social care system that is fair, proportionate and manages expectations;

- A people-centred, patient first and home first approach which offers informed choice;

- An integrated health and social care system which optimises partnership with the voluntary and independent sectors;

- A bed base optimised to provide the right care, at the right time, in the right place to support care pathways and informed choice;

- Care supported by innovation, data and the latest technology; and

- A motivated, skilled and representative workforce with a culture of continuous improvement.

The Parties (as hereinafter defined) will therefore:

- Embed improvements to prevention and early intervention;

- Work with partners to close the inequality gap;

- Positively transform the quality, experience and impact of our services;
- Partner to shift care from hospital to community settings; and
- Support our people and partners to use our collective resources effectively.

The provisions within this preamble do not and are not intended to create legally binding obligations on the Parties or either of them.

Integration Scheme

between

The City of Edinburgh Council, constituted under the Local Government etc (Scotland) Act 1994 and having its principal office at Waverley Court, 4 East Market Street, Edinburgh EH8 8BG ("**CEC**");

and

Lothian Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Lothian") and having its principal offices at Waverley Gate, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG ("**NHS Lothian**")

(together the "**Parties**", and each a "**Party**")

1. Background

A. The Parties are required to comply with either subsection (3) or (4) of section 2 of the Act (as hereinafter defined), and have elected to comply with subsection (3) such that the Parties must jointly prepare an integration scheme (as defined in section 1(3) of the Act) for the Edinburgh Area (as hereinafter defined).

B. In preparing this Scheme, the Parties: (a) have had regard to the integration planning principles set out in section 4(1) of the Act and the national health and wellbeing outcomes prescribed by the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014; (b) have complied with the provisions of section 6(2) of the Act; and (c) have followed the guidance issued by the Scottish Ministers regarding the governance arrangements that are considered by Scottish Ministers to provide the requisite degree of integration; and in finalising this Scheme, the Parties have taken account of any views expressed by virtue of the consultation processes undertaken under section 6(2) of the Act.

The Parties agree as follows:

2. Definitions and Interpretation

2.1 The following definitions shall apply throughout this integration scheme and the preamble, except where the context otherwise requires:

"Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"Chief Officer" means the individual appointed by the IJB pursuant to section 10 of the Act;

"Council Section 95 Officer" means the proper officer of CEC appointed to have responsibility for arrangements for the proper administration of the financial affairs of CEC in accordance with section 95 of the Local Government (Scotland) Act 1973;

"Edinburgh Area" means the local authority area served by CEC;

"EHSCP" means the Edinburgh Health and Social Care Partnership;

"IJB" means the Integration Joint Board for the Edinburgh Area, established by Order under section 9 of the Act;

"IJB Budget" means the total funding available to the IJB in the relevant financial year as a consequence of:

a) the payment for delegated functions from NHS Lothian under section 1(3) (e) of the Act;
b) the payment for delegated functions from CEC under section 1(3) (e) of the Act;
c) the amount "set aside" and made available by NHS Lothian under section 1(3)(d) of the Act for use by the IJB for functions carried out in a hospital in the area of NHS Lothian and provided for the areas of two or more local authorities; and
d) any use of EIJB reserves which the EIJB has approved in accordance with clause 10.4.6.

"Integration Joint Boards Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"Lothian IJBs" means the integration joint boards to which functions are delegated in pursuance of the integration schemes in respect of the local authority areas served by CEC, East Lothian Council, Midlothian Council and West Lothian Council respectively;

"Neighbouring IJBs" means the Lothian IJBs excluding the IJB;

"Operational Budget" means the amount of the payment made from the IJB to a Party in order to carry out delegated functions;

"Outcomes" means the health and wellbeing outcomes prescribed by the Scottish Ministers in The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014;

"Relevant Date" means 27 June 2015;

"Scheme" means this integration scheme;

"Standing Orders" means the standing orders for the regulation of the procedure and business of the IJB prepared in accordance with article 18 of the Integration Joint Boards Order; and

"Strategic Plan" means the plan which an integration joint board is required to prepare, in accordance with section 29 of the Act, in relation to the functions delegated to that integration joint board in pursuance of an integration scheme in respect of the relevant local authority area; and, except in its application to a strategic plan prepared or under preparation by one of the Neighbouring IJBs, means the strategic plan which the IJB is required to prepare in respect of the Edinburgh Area.

2.2 Words and expressions defined in the Act shall bear the same respective meanings in the Scheme, unless otherwise defined in the Scheme.

2.3 References to "Sections" are to the sections of this Scheme.

2.4 References to Annexes are to the annexes to this Scheme and references to Parts are to parts of the relevant Annex.

3. The Model

3.1 The integration model as set out in section 1(4)(a) of the Act applies in relation to the Edinburgh Area, namely the delegation of functions by each of the Parties to a body corporate (an "integration joint board") established under section 9 of the Act.

3.2 This Scheme came into effect on the Relevant Date.

4. Local Governance Arrangements

4.1 Membership

4.1.1 The IJB shall have the following voting members:

a. 5 councillors nominated by CEC

b. 5 members nominated by NHS Lothian in compliance with articles 3(4) and 3(5) of the Integration Joint Boards Order.

4.1.2 The Parties may determine their own respective processes for deciding who to nominate as voting members of the IJB.

4.1.3 Non-voting members of the IJB will be appointed in accordance with regulation 3 of the Integration Joint Boards Order.

4.1.4 The term of office of members shall be as prescribed by regulation 7 of the Integration Joint Boards Order.

4.2 Chairperson and vice chairperson

4.2.1 The IJB shall have a chairperson and a vice-chairperson who will both be voting members of the IJB.

4.2.2 The term of office for the chairperson and the vice-chairperson will be 24 months, but in the event of a local government election being scheduled, CEC may request that the NHS appoint a new chairperson three months in advance of that election (or the Parties shall agree an alternative arrangement).

4.2.3 The right to appoint the chairperson and vice-chairperson respectively shall alternate between each of the Parties, on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson.

4.2.4 The chairperson shall not have a casting vote.

4.2.5 Each Party may change its appointment as chairperson (or, as the case may be, vice chairperson) at any time; and it is entirely at the discretion of the Party which is making the appointment to decide who it shall appoint.

4.3 Disqualification, Resignation, Removal, Voting and other matters

The provisions of articles 8 to 19 (but excluding article 14) of the Integration Joint Boards Order shall apply in relation to the IJB.

5. Delegation of Functions

5.1 The functions that are delegated by NHS Lothian to the IJB (subject to the exceptions and restrictions specified or referred to in Parts 1A and 1B of Annex 1) are set out in Parts 1A and 1B of Annex 1. The services currently provided by NHS Lothian in carrying out these functions are described in Part 2 of Annex 1.

5.2 The functions that are delegated by CEC to the IJB (subject to the restrictions and limitations specified or referred to in Part 1 of Annex 2) are set out in Part 1 of Annex 2. For indicative purposes only, the services which are associated with these functions are described in Part 2 of Annex 2.

6. Local operational delivery arrangements

Directions

6.1.1 The IJB must direct the Parties to carry out each of the functions delegated to the IJB. A direction in relation to a given function may be given to one or other of the Parties, or to both Parties. The primary responsibility for delivering capacity (that is to say, activity and case mix) in respect of the services associated with the carrying out of a given function shall lie with the IJB and shall be reflected in the directions issued from time to time by the IJB. Subject to the provisions of the Act and the Scheme, the Parties are required to follow those directions.

6.1.2 Directions provide the mechanism for delivering the Strategic Plan, conveying the decisions of the IJB, clarifying responsibilities between the Parties and improving accountability. Directions should be well-articulated, achievable and measurable and should identify the financial resources allocated to them. They must contain sufficient information to enable the Parties to carry out their statutory functions.

` **Performance Management**

6.1.3 The IJB shall oversee delivery of the services associated with the functions delegated to it by the Parties. The IJB is the only forum where health and social care functions for the Edinburgh Area are governed by members of both NHS Lothian and CEC. Accordingly, NHS Lothian and CEC agree that the primary focus for performance management in respect of delivery of the delegated functions will be the IJB.

6.1.4 NHS Lothian and CEC will provide relevant and appropriate performance information so that the IJB can develop a comprehensive performance management system.

6.1.5 The IJB performance management reports will be available to both NHS Lothian and CEC for use in their respective performance management systems. However, it is expected that the voting members of the IJB will take responsibility for performance management at the IJB and will provide an account of highlights and/or exceptional matters to meetings of NHS Lothian and CEC.

6.1.6 In the interests of efficient governance, the relevant committees of NHS Lothian and CEC will continue to discharge their existing remits for assurance and scrutiny of the carrying out of NHS Lothian and CEC functions, regarding matters such as internal control, quality and professional standards, and compliance with the law. The IJB will not duplicate the role carried out by those committees other than in exceptional circumstances where the IJB considers that direct engagement by the IJB (or by a committee established by the IJB) is appropriate in order to secure the proper discharge by the IJB of its statutory responsibilities.

6.1.7 The Act does not change the current regulatory framework within which health and social care professionals practise, or the established professional accountabilities that are currently in place within the NHS and local government. Professional standards and compliance with the law remain the statutory duties of both NHS Lothian and CEC. The IJB has built on the existing professional and service governance arrangements already in place within NHS Lothian and CEC and, to further support efficient governance, the IJB will be the predominant body providing scrutiny and assurance for the operations, performance, and planning of the delegated functions. If the IJB does not provide the scrutiny and assurance in a particular area, then NHS Lothian and CEC will provide this through their own governance structures and inform the IJB of the outcome. An effective framework for clinical and care governance will be supported by linking both IJB scrutiny and assurance to the strategic oversight, assurance and scrutiny of the carrying out of NHS Lothian and CEC functions through the relevant governance committees of NHS Lothian and CEC.

6.1.8 Each of the Parties shall use reasonable endeavours to ensure that if one of its committees identifies an issue which is of direct and material relevance to the IJB, the Parties will inform the Chair and the Chief Officer.

6.1.9 The voting members of the IJB are councillors of CEC and non-executive directors (or other board members) of NHS Lothian. In their capacity as councillors and non-executive directors, they will be engaged in the governance of their respective constituent bodies, and it is likely that they will be members of one or more committees of those constituent bodies.

6.1.10 Given the overall vision as outlined in the preamble to the Scheme, it is the intention that the interests of NHS Lothian, CEC, and the IJB should be aligned. In all matters associated with the work of the IJB, the voting members of the IJB will be expected to play a crucial role in:

(a) communicating, and having due regard to, the interests of NHS Lothian or (as the case may be) CEC, but on the understanding that, in carrying out their role as a member of the IJB, their primary duties and responsibilities are those which attach to them in that capacity;

(b) communicating, and having due regard to, the interests of the IJB whilst discharging their role as a councillor or (as the case may be) as a non-executive director, but on the understanding that, in carrying out their role as a councillor or non-executive director, their primary duties and responsibilities are those which attach to them in that capacity.

6.1.11 Without prejudice to the role of the voting members of the IJB (as specified above) in relation to oversight of operational delivery of services in accordance with directions issued to either or both of the Parties by the IJB, the IJB will, through the Chief Officer, have an appropriate role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

6.1.12 In addition to the specific commitments set out above and the obligations regarding provision of information attaching to the Parties under the Act, each of the Parties will use reasonable endeavours to provide the IJB with any information which the IJB may reasonably require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability.

Support for Strategic Planning

6.1.13 The Parties will provide the IJB with all information that it may reasonably require to prepare its Strategic Plan, including information that is pertinent specifically to localities.

6.1.14 The Parties will advise the IJB of any intention to change service provision where that change would have a significant impact on the Strategic Plan.

6.1.15 The Parties will support the IJB in ensuring that the consultation process associated with the preparation of each Strategic Plan for the Edinburgh Area includes other integration authorities likely to be affected by the Strategic Plan. The integration authorities that are most likely to be affected by the Strategic Plan for the Edinburgh Area are the Neighbouring IJBs

6.1.16 NHS Lothian will procure that reciprocal provisions to those set out in Sections 6.1, 6.2 and to 6.3 are contained in the integration schemes of the Neighbouring IJBs.

6.1.17 The Parties will provide appropriate support (through the measures specified in Section 6.1.18) with a view to ensuring that the IJB can:

(a) effectively engage in all of the planning processes and support the Neighbouring IJBs in discharging their role, including contributing to the work of the Strategic Planning Groups for the Neighbouring IJBs as required;

(b) provide such information and analysis as Neighbouring IJBs reasonably require for the production of their Strategic Plans;

(c) inform Neighbouring IJBs as to how the services, facilities and resources associated with the functions delegated to the IJB by the Parties are being or are intended to be used with respect to carrying out of those functions in line with these planning processes;

(d) in a situation where Strategic Plans in one area are likely to have an impact on the plans in another area, ensure that these matters are raised with other relevant integration joint boards and resolved in an appropriate manner; and

(e) in a situation where Strategic Plans in another area are likely to have an impact on the Edinburgh Area, ensure that these matters are raised and any associated risks are mitigated for the benefit of service users.

6.1.18 The measures referred to in Section 6.1.15 are as follows:

(a) The chief officers for the Lothian IJBs sharing information and working collaboratively, taking reasonable steps to ensure that each of the Lothian IJBs is aware of emerging proposals intended to be described in any of the Strategic Plans which are under preparation by the Lothian IJBs;

(b) Regular meetings among the Chief Officers for the Lothian IJBs and relevant managers of NHS Lothian to provide those Chief Officers with an opportunity to communicate any proposed changes likely to be required by their integration joint boards which will impact on service provision for the population served by another integration joint board and to allow NHS Lothian managers to make the Chief Officers of the Lothian IJBs aware of any new developments which could have a bearing on Strategic Plans;

(c) Regular meetings between the Chief Officer of the IJB and relevant senior officers of CEC to provide the Chief Officer with an opportunity to communicate any proposed changes likely to be required by the IJB which may impact on service provision for other services delivered by CEC, and to allow CEC senior officers to make the Chief Officer aware of any developments which could have a bearing on the Strategic Plan.

6.2 Lothian Hospitals Strategic Plan and Lothian Strategic Development Framework

6.2.1 NHS Lothian have developed a plan (the 'Lothian Hospitals Strategic Plan') to support the IJBs to fulfil their duties. The Lothian Hospitals Strategic Plan does not and will not bind the IJB and the strategic plans of the Lothian IJBs have informed the Lothian Hospital Strategic Plan. The Lothian Hospitals Strategic Plan encompasses both functions delegated to the Lothian IJBs and functions that are not so delegated.

6.2.2 The Lothian Hospitals Strategic Plan was developed in partnership with the Lothian IJBs where integration functions are delivered by NHS Lothian in a hospital. It reflects the relevant provisions of the Strategic Plans prepared by the respective Lothian IJBs, as well as NHS Lothian plans for non-delegated functions.

6.2.3 The purpose of the Lothian Hospital Strategic Plan is to ensure that planning for hospital functions and use of hospital facilities are:

(a) responsive to and support each Strategic Plan prepared by the Lothian IJBs for delegated functions; and

(b) supports the requirement of NHS Lothian to deliver hospital services required by the IJB and other hospital services that are not the responsibility of the Lothian IJBs (e.g. tertiary, trauma, surgical, planned and children's services).

6.2.4 The Lothian Hospitals Strategic Plan will be a plan developed jointly by NHS Lothian and the Lothian IJBs. The elements of the Lothian Hospitals Strategic Plan addressing non delegated functions can only be agreed by the NHS Lothian Board after the four Lothian IJBs have been consulted and their views and requirements appropriately considered. Elements of the Lothian Hospitals Strategic Plan which cover functions delegated to the respective Lothian IJBs will be signed off by relevant Lothian IJBs in consultation with NHS Lothian and all Lothian IJBs.

6.2.5 NHS Lothian is continuing to work to refresh its strategy via development of the Lothian Strategic Development Framework. This work will be taken forward in collaboration with the Lothian IJB, in particular in those workstreams that cut across organisational boundaries and where there are clear benefits in working together to achieve the Parties' collective vision.

6.3 Professional, technical or administrative support services

6.3.1 Details of the full range of professional, technical and administrative support services provided to the IJB shall be recorded and updated on a regular basis to reflect any changes.

6.3.2 The support services log shall include (but not be limited to):

a. a description of the current support services provided by CEC and NHS;
b. identification of critical and high-risk support services including those required to ensure ongoing regulatory compliance and delivery of statutory obligations (for example, management of complaints and freedom of information requests);
c. details of how existing support services are organised and delivered (for example structure and location of teams and their roles and responsibilities) and details of lead officers responsible for delivery;
d. details of any established support service performance measures; and
e. details of the costs associated with support services provided to the IJB.

6.3.3 Regular reviews shall be performed to determine whether the range and quality of support services provided are sufficient to meet IJB current and future support requirements.

6.3.4 The IJB shall request and establish written engagement protocols among the IJB, CEC and NHSL, specifying how the support arrangements will be delivered and managed. The engagement protocols shall include (but not be limited to):

a. responsibilities and accountabilities of all parties including any specific requirements such as responsibility for complying with applicable statutory obligations;
b. regulatory requirements; and external scrutiny requirements and any service standards to be achieved;
c. details of relevant performance / service standards (where applicable);
d. ongoing monitoring, evaluation and review arrangements to ensure the level and quality of support is adequate for the IJB needs;
e. arrangements for considering, facilitating and agreeing requests for additional support from the IJB including any agreement on how these will be funded;
f. the requirement for the Parties to undertake a business impact assessment when future or planned developments/transformation programmes or organisational change impact on the services provided to the IJB;
g. issue escalation and dispute resolution arrangements including levels of authority, feedback mechanisms and details of external intervention (such as mediation) where required;
h. requirement for the engagement protocol (and any subsequent revisions) to be approved and signed by an appropriately authorised representative of the IJB, CEC and the NHS; and
i. inclusion, as an appendix, of the full schedule of services provided.

6.3.5 The Parties shall ensure that there are ongoing review and oversight arrangements to provide assurance that the level and quality of support services provided to the IJB remains adequate. These arrangements should include (but not be limited to):

a. an annual review of the quality of the full population of support services provided to the IJB aligned with the IJB budget setting process to confirm that the range; quality and cost of support services provided remains appropriate;
b. ongoing review of the quality of critical and high-risk support services at a frequency determined by the risk;
c. development of performance reporting to provide assurance on the operation of all critical or high-risk support functions;
d. determining the most appropriate senior management/governance forum for reviewing support services performance reports and approving any changes to established support arrangements; and

e. establishing an appropriate escalation process to ensure that the IJB Is advised of any significant regulatory or legislative breaches or concerns in relation to support services that could directly impact the IJB.

6.4 Performance targets, improvement measures and reporting arrangements

6.4.1 All national and local outcomes, improvement measures and performance targets which are connected exclusively with the functions delegated by the Parties to the IJB under the Scheme are the responsibility of the IJB to deliver; and the IJB is also responsible for providing all such information regarding integration functions which is required by either of the Parties to enable each of them to fulfil its obligations regarding reporting arrangements in respect of those functions.

6.4.2 Where particular national or local outcomes, measures or targets (and associated reporting arrangements) relate to services which are associated with both integration functions and functions which are not delegated by a Party to the IJB, the responsibility for the outcomes, measures or targets (and associated reporting arrangements) will be shared between the IJB and the Party or Parties which exercise those functions, and the IJB will be responsible for providing all such information regarding those integration functions as is required by the relevant Party to enable it to fulfil its obligations regarding reporting arrangements.

6.4.3 The performance framework will encompass a core set of indicators and measures identified by the Parties from publicly accountable and national indicators and targets which relate to services delivered in carrying out the functions of the IJB.

6.4.4 The Parties have obligations to meet targets for functions which are not delegated to the IJB, but which are affected by the performance and funding of integration functions. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details must be provided of any targets, measures and arrangements for the IJB to take into account when preparing the Strategic Plan. Where responsibility for performance measures and targets is shared, this will be set out clearly for agreement by the relevant Parties.

6.4.5 The continuous development of an effective performance framework for the IJB, taking account of relevant national guidance, will be supported by the parties and the IJB. The framework will be underpinned by the national health and wellbeing outcomes, and national integration indicators, and will be developed to drive change and improve effectiveness.

7. Clinical and Care Governance

7.1 Introduction

7.1.1 This Section of the Scheme sets out the arrangements that will be put in place to allow the IJB to fulfil its role with professional advice and with appropriate clinical and care governance in place. The Parties will expect the IJB to develop more integrated arrangements in the Edinburgh Area to complement the existing clinical and care governance arrangements and bring this together in an integrated and cohesive way with care governance.

7.1.2 The Parties have well established governance systems (including committees of NHS Lothian and Committees of CEC), to provide governance oversight in terms of clinical and care governance, as well as assurance for professional accountabilities. Those existing systems will continue following the establishment of the IJB and their scope will be extended so as to support the IJB in fulfilling its integrated clinical and care governance responsibilities.

7.1.3 This Section describes the relationship between the Parties' clinical and care governance systems and the IJB. Clinical and care governance is the process by which accountability for the quality of health and social care is monitored and assured. The relationship between these clinical and care governance systems and (a) the Strategic Planning Group and (b) the delivery of services within localities, will be via the Chair and Chief Officer of the IJB, and further supported by the non-voting professional members of the IJB. The IJB will be responsible for ensuring that the Strategic Planning Group has sufficient information regarding clinical and care governance to effectively fulfil its remit; and each of the Parties undertakes to provide all such information as the IJB may reasonably require from time to time to support the IJB in discharging that responsibility.

7.1.4 The Parties shall ensure that clinical and care governance shall have a high profile, in order to ensure that quality of care is given the highest priority at every level within integrated health and social care services. Effective clinical and care governance will be designed in order to provide assurance to patients, service users, clinical and care staff and managers that:

(a) Quality of care, effectiveness and efficiency drives decision-making about the planning, provision, organisation and management of health and social care services;

(b) The planning and delivery of services take full account of the perspective of patients and service users; and

(c) Unacceptable clinical and care practice will be detected and addressed.

7.1.5 Innovation, continuous learning and improvement and quality of service delivery (and its impact on outcomes) will be addressed through the development of the IJB's performance management framework pursuant to Section 6 of the Scheme.

7.1.6 The arrangements for local operational oversight by the IJB as specified in Section 5 will also apply to clinical and care governance.

7.1.7 Within its existing governance framework, NHS Lothian has:

(a) a healthcare governance committee, the remit of which is to provide assurance to the Board of NHS Lothian that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard and to provide assurance to the Board of NHS Lothian that NHS Lothian meets its responsibilities with respect to:-

i. NHS Lothian participation standards
ii. Volunteers/Carers
iii. Information governance
iv. Protection of vulnerable people including children, adults, offenders
v. Relevant statutory equalities duties;

and

(b) a staff governance committee, the remit of which is to support and maintain a culture within NHS Lothian where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The staff governance committee must ensure that robust arrangements to implement the (NHS Scotland) Staff Governance Standard are in place and monitored.

7.1.8 The staff governance committee has the primary role on staff governance matters but can and does refer matters of relevance to the healthcare governance committee.

7.1.9 The healthcare governance committee can request assurance from the staff governance committee on matters of direct relevance to its remit, e.g. quality of recruitment, learning and development, completion of mandatory training.

7.1.10 Within CEC, the Chief Social Work Officer has overall responsibility for the professional standards of CEC's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council (the "SSSC"), and all social work professional staff must by law be registered with the SSSC. This registration requirement will, in due course, extend to all social care staff employed by CEC and the voluntary and independent sectors.

7.1.11 Allied health professionals are required to register with their relevant professional body.

7.1.12 The Chief Social Work Officer reports annually to CEC on the operational performance and standards of the social work and social care service delivery areas, along with registration of this workforce and the external assessment of the Care Inspectorate on regulated care. The Chief Social Work Officer will provide a copy of this annual report to the IJB.

7.1.13 The Chief Social Work Officer also reports annually to CEC on standards achieved, governance arrangements and volume/quantity of statutory functions discharged. This report must comply with national guidance issued by the Scottish Government. The Chief Social Work officer will provide a copy of this annual report to the IJB.

7.1.14 For the avoidance of doubt, the rationale for using the relevant existing NHS Lothian and CEC committees (and associated arrangements) as a primary source of assurance for the IJB regarding clinical and care governance is that, following the establishment of the IJB, the Parties will have continuing governance responsibilities for both delegated and non-delegated functions and, against that background, the use of existing NHS Lothian and CEC committees avoids unnecessary bureaucracy. The IJB will be engaged through its membership of these committees and its relationship with the chairs of these committees. The IJB will be in a position to holistically consider the information and assurance received from the Parties in exercising its functions. If at any time the IJB is not satisfied with the information or assurance that it receives from the Parties, or with the effectiveness of the Parties' committees, it may address the issues of concern: (a) by requesting a Party to take appropriate steps to revise its clinical and care governance systems; or (b) by revising its own clinical and care governance systems.

7.2 Professional advice

There is a risk that a Strategic Plan and/or a direction issued by the IJB could have a negative impact on clinical and care governance and/or on professional accountabilities. This Section of the Scheme sets out the arrangements that will be put in place to avoid this.

7.2.1 NHS Lothian's Board has within its executive membership three clinical members (referred to below as **"Executive Clinical Directors"**): a Medical Director, a Nurse Director, and a Director of Public Health. Their roles include responsibility for the professional leadership and governance of the clinical workforce (medical, nursing, allied health professionals, healthcare scientists, psychology, pharmacy), as well as clinical governance within NHS Lothian generally. The creation of the IJB does not change their roles in respect of professional leadership, and they remain the lead and accountable professionals for their respective professions.

7.2.2 CEC has a Chief Social Work Officer who reports to the Chief Executive and councillors. The Chief Social Work Officer monitors service quality and professional standards in social care and social work, for staff employed in both adult and children's services, together with standards in relation to the protection of people at risk. The Chief Social Work Officer role also includes quality assurance of decision-making with regard to adult social care, mental health, criminal justice and children's services, in particular in relation to public protection and the deprivation of liberty.

7.2.3 The creation of an IJB does not change the Chief Social Work Officer's role in respect of professional leadership, and he or she will remain the lead and accountable professional for his or her profession.

7.2.4 The Chief Social Work Officer shall be a non-voting member of the IJB.

7.2.5 The IJB may elect to appoint one or both of the Medical Director and Nurse Director as additional non-voting members of the IJB.

7.2.6 The Integration Joint Boards Order requires NHS Lothian to fill the following non-voting membership positions on the IJB:

(a) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

(b) a registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and

(c) a registered medical practitioner employed by NHS Lothian and not providing primary medical services.

7.2.7 NHS Lothian will consider the advice of the Executive Clinical Directors, and of any other relevant officer it deems fit, before making appointments to fill the membership positions referred to in Section 7.2.6. The appointees will be professionally accountable to the relevant Executive Clinical Director.

7.2.8 NHS Lothian will develop a role description for the appointments referred to in Section 7.2.6, to ensure that their role on the IJB with regard to professional leadership and accountability is clearly defined and understood.

7.2.9 The three health professional representatives referred to in Section 7.2.6 will each also be:

(a) a member of an integrated professional group (should it be established), and/or

(b) a member of an NHS Lothian Board committee, and/or

(c) a member of a consultative committee established by NHS Lothian.

7.2.10 If a new 'integrated professional group' is established, then the Chief Social Work Officer must also be a member.

7.2.11 The three health professional representatives set out in Section 7.2.6 and the Chief Social Work Officer will be expected by the Parties to play a lead role in:

(a) communicating and having regard to their duties to NHS Lothian or CEC as the case may be whilst discharging their role as a member of the IJB;

(b) communicating and having regard to the interests of the IJB whilst discharging their duties as professionals employed by NHS Lothian or (as the case may be) CEC.

7.2.12 The members will be expected to communicate regularly with the Executive Clinical Directors, and CEC's Chief Executive as and when appropriate.

7.2.13 The presence of these four members will ensure that the decisions of the IJB are informed by professional advice from within the membership of the IJB.

7.2.14 The Chief Social Work Officer reports annually to CEC and this includes observations about the performance of the IJB, areas of strength and areas for improvement.

7.2.15 NHS Lothian includes a governance statement in its annual accounts, the content of which is informed by the annual reports of its governance committees (such as healthcare governance and staff governance) and certificates of assurance from its Executive Clinical Directors. The IJB may place reliance on these existing processes, and the Parties will provide any such reports from those processes as the IJB may require.

7.2.16 The Executive Clinical Directors shall be entitled to raise issues directly with the IJB in writing. The IJB shall be required to respond in writing when issues are raised in this way. The Chief Social Work Officer may also raise any issues directly at the IJB and in writing.

7.2.17 The engagement of professionals throughout the process to develop and consult on the Strategic Plan is intended to ensure that the IJB has all the required information to prepare a Strategic Plan which will not compromise professional standards.

7.2.18 In the unlikely event that the IJB issues a direction to NHS Lothian which is reasonably likely to compromise professional standards, then in the first instance the relevant Executive Clinical Director will write to the IJB.

7.2.19 If the issue is not resolved to his/her satisfaction, he/she must inform the Board of NHS Lothian before it takes action to implement the direction, and the following measures will apply:

(a) the relevant Executive Clinical Director must ensure that appropriate advice is tendered to the Board of NHS Lothian on all matters relating to professional standards;

(b) the relevant Executive Clinical Director must set out in writing to the Board of NHS Lothian any objections he/she may have on a proposal that may compromise compliance with professional standards;

(c) the Board of NHS Lothian will inform the IJB that it has received such objections, along with a statement of the views of the Board of NHS Lothian on those objections;

(d) if the Board of NHS Lothian decides to proceed with a proposal despite those objections, then the relevant Executive Clinical Director must obtain written authority from the Board of NHS Lothian to act on the proposal. The Board of NHS Lothian must inform the Scottish Government Health & Social Care Directorate if a request for such a written authority is made. A copy of that authority must be sent to the appropriate regulatory body, e.g. General Medical Council; and

(e) once the relevant Executive Clinical Director has received that written authority, then he/she must comply with it.

7.2.20 Regardless of whether written authority has been given, the Executive Clinical Directors, in their capacity as members of the Board of NHS Lothian, should always vote against a proposal that they cannot endorse as accountable officers. It is not competent to abstain from a decision.

7.2.21 The three professional clinical members on the IJB (two medical practitioners, one nurse) are non-voting members. They will be expected by the Executive Clinical Directors to raise any concerns in relation to matters which may compromise professional standards with the IJB.

7.2.22 If any of the three professional clinical members becomes aware of a matter arising from the conduct of IJB business which may compromise professional standards, he/she must immediately notify the Chief Officer of the IJB of his/her concerns, and if his/her concerns are not resolved by the Chief Officer to his/her satisfaction, must then raise the matter with the Chief Executive of NHS Lothian.

7.2.23 The Chief Social Work Officer will be a non-voting member of the IJB, and as such, will contribute to discussions and will provide relevant professional advice to influence service development.

7.2.24 In the event that the IJB issues an instruction to a Party which in the view of the Chief Social Work Officer compromises professional social work standards or the discharge of statutory functions, the Chief Social Work Officer must immediately notify the Chief Officer of the IJB of his/her concerns, and if his/her concerns are not resolved by the Chief Officer to his/her satisfaction, must then raise the matter with the Chief Executive of CEC.

7.3 Professionals Informing the IJB Strategic Plan

7.3.1 The IJB is required by the Act to formally consult both Parties on its Strategic Plan and take into account their views before it finalises the Strategic Plan. The Parties will ensure that the draft Strategic Plan is sent to the following senior professionals in order to secure their input and advice:

(a) NHS Lothian Medical Director

(b) NHS Lothian Nurse Director

(c) NHS Lothian Director of Public Health & Health Policy

(d) NHS Lothian Allied Health Professions Director

(e) Chief Social Work Officer

(f) Head of Place Development of CEC.

7.3.2 The engagement of CEC professionals will not be limited to social work staff, but will extend to related professionals, such as, but not exclusively, occupational therapists, home care, housing and social care staff.

7.3.3 The approach to locality planning and delivery including the arrangements for clinical and social care governance will be developed through the strategic planning process in a collaborative manner and determined by the IJB.

7.4 External scrutiny of clinical and care functions

7.4.1 NHS Lothian seeks assurance for internal control/quality through its Healthcare Governance Committee, which includes reports by external bodies such as Healthcare Improvement Scotland.

7.4.2 The Care Inspectorate (Social Care and Social Work Improvement Scotland) regulates, inspects and supports improvement of adult and children's social work and social care, and its reports feed into CEC's system of governance.

7.4.3 The IJB will consequently be informed of any relevant issues from external scrutiny, as a consequence of drawing from the systems already established by the Parties.

7.5 Service User and Carer Feedback

7.5.1 The Parties have a range of systems already in place to capture and respond to service users' experience, and these will continue to be used as the Parties implement the directions of the IJB.

7.5.2 As part of the wider strategic planning process (particularly the joint strategic needs assessment process) and the performance management framework, existing work streams on: (a) standards and quality improvement; and (b) service user feedback will be used to inform how the IJB can address the integration delivery principles and deliver on the Outcomes.

8. Chief Officer

8.1 In accordance with section 10 of the Act, the Chief Officer will be appointed by the IJB; he/she will be employed by one of the Parties and will be seconded to the IJB.

8.2 The Chief Officer will provide a strategic leadership role as principal advisor to and officer of the IJB and will be a member of the senior management teams of both Parties. The Chief Officer will lead the development and delivery of the Strategic Plan for the IJB and will be accountable to the IJB for the content of the directions issued to the Parties by the IJB and for monitoring compliance by the Parties with directions issued by the IJB. The Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved.

8.3 The Chief Officer will be jointly managed by both Parties in respect of operational delivery and will report directly to the Chief Executive of NHS Lothian and the Chief Executive of CEC. There will be a joint process for regular performance reviews, support and supervision with both Chief Executives.

8.4 Annual objectives for the Chief Officer will be agreed and the process will involve the chairperson of the IJB agreeing objectives with the Chief Officer relevant to his/her role with the IJB as well as the Chief Executives of CEC and NHS Lothian. The Chief Officer's performance against those annual objectives will be monitored through an agreed performance management framework established by the Party which is his/her employer.

8.5 If an interim replacement for the Chief Officer of the IJB is required (on the grounds that the Chief Officer is absent or otherwise unable to carry out his/her functions), the Chief Executives of CEC and NHS Lothian will initiate a joint selection process, identifying a list of potential

replacements; and selection of a suitable candidate will be undertaken against a set of agreed criteria. The interim replacement will be employed by one of the Parties and will be seconded to the IJB on an interim basis.

8.6 The Chief Officer will have operational responsibility for all of the functions delegated to the IJB, subject to the following exceptions:

8.6.1 services associated with delegated functions which are delivered at the Western General Hospital, the Royal Infirmary of Edinburgh, St John's Hospital and the Royal Edinburgh Hospital will (subject to the directions issued from time to time by the IJB) be operationally managed by NHS Lothian; and

8.6.2 each of the specific services associated with functions delegated by NHS Lothian which is proposed to be managed on a pan-Lothian basis as a 'hosted service' will be operationally managed by one of the chief officers of the Lothian IJBs, as proposed by NHS Lothian, in their role as a member of the NHS Lothian senior management team, subject to the directions issued from time to time by the IJB.

8.7 A group consisting of senior managers of NHS Lothian responsible for hospital functions delegated to the IJB and the chief officers of the four Lothian IJBs will be established, to ensure close working arrangements between:

8.7.1 chief officers of the four Lothian IJBs, and senior managers of NHS Lothian responsible for hospital services; and

8.7.2 the chief officer of a Lothian IJB responsible for the management of any hosted services on behalf of the other three Lothian IJBs, and the other Lothian IJB chief officers.

9. Workforce

9.1 A human resources and organisational development working group established by the Parties has prepared a work plan for integrating the health and social care workforce in Edinburgh. This group includes NHS Lothian partnership representatives and trade union representatives from CEC. The work plan guiding the work of the group includes a number of work streams, two of which focus on the implementation of an integrated senior management model and an organisational development plan respectively.

9.2 The organisational development plan, agreed between the Parties, is currently being implemented. This is a comprehensive plan which covers staff communication, staff engagement, staff and team development, leadership development and the training needs for

those staff members who will be responsible for managing integrated teams. In particular, it includes procurement of team and leadership development programmes.

9.3 Staff engaged in the delivery of delegated services shall remain employed by their existing organisation.

10. Finance

This section describes the arrangements in relation to financial management and monitoring of integrated resources. It sets out the method for determining the resources to be made available by CEC and NHS Lothian to the IJB. It also explains the financial governance and management arrangements, including budget variances, and the financial reporting arrangements among the IJB, CEC and NHS Lothian.

10.1 Finance Officer

10.1.1 In relation to the preparation of its accounts and their audit, the IJB is governed by the same legislation applying to local authorities and is required to make arrangements for the proper administration of its financial affairs through a Finance Officer with this responsibility.

10.1.2 The Finance Officer will be employed by CEC or NHS Lothian and seconded to the IJB. The holder of the post should be a member of a relevant professional accounting body, and the IJB should have regard to the current CIPFA Guidance on the role.

10.1.3 In the event that the Finance Officer position is vacant or the holder is unable to act, the Chief Officer shall secure, in consultation with the IJB Chair, and through agreement with both the CEC Section 95 Officer and the NHS Lothian Director of Finance, an appropriate interim dedicated resource to discharge the role.

10.2 Financial Management of the IJB

10.2.1 The IJB is responsible for determining its own internal financial governance arrangements and the Finance Officer will be responsive to the decisions of the IJB, and the principles of financial governance set out in this Scheme.

10.3 Principles of Financial Governance

10.3.1 The following principles of financial governance shall apply:

i. NHS Lothian and CEC will work together in a spirit of openness and transparency; and

ii. NHS Lothian and CEC will work in partnership with the IJB with the objective of agreeing sufficient funding of delegated functions in line with the financial elements of the Strategic Plan.

10.4 Financial Governance

10.4.1 The Parties will contribute to the establishment of an IJB budget. The Chief Officer will manage the IJB budget.

10.4.2 The Parties are required to implement the Directions of the IJB in carrying out the delegated functions in line with the Strategic Plan, provided that the IJB delegates the required level of resources to meet the anticipated cost of the delegated functions.

10.4.3 The Parties will apply their established systems of financial governance to the payments they receive from the IJB. The NHS Lothian Accountable Officer and the CEC Section 95 Officer have legally defined responsibilities and accountability for the financial governance of their respective bodies.

10.4.4 The Chief Officer in their operational role is responsible for the financial management of any operational budgets (as defined in Section 10 of this Scheme) that may be delegated to them by the Parties and is accountable for this to the NHS Lothian Chief Executive and CEC Section 95 Officer.

10.4.5 The IJB will develop and maintain its own financial regulations. The Finance Officer will periodically review these financial regulations and present any proposed changes to the IJB for its approval.

10.4.6 CEC will host the IJB Financial Accounts and will be responsible for recording the IJB's financial transactions through its existing financial systems. The IJB can hold reserves. It is a matter for the IJB to determine what its reserves strategy will be.

10.4.7 The IJB's Finance Officer is responsible for preparing the IJB's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

10.4.8 As part of the financial year end procedures and in order to develop the year-end financial statements, the Finance Officer will work together with NHS Lothian and CEC to coordinate an exercise agreeing the value of balances and transactions with CEC and NHS Finance teams. Each Party will provide information to this process on their recorded income, expenditure, receivable and payable balance with the IJB. The IJB's Finance Officer will lead on resolving any differences.

10.4.9 The Finance Officer will also be responsible for preparing a medium-term financial plan to be incorporated into the IJB's Strategic Plan. The Finance Officer will liaise closely with NHS Lothian and CEC to develop integrated medium-term financial planning and associated financial recovery plans taking account of assumptions around available funding and future service demands and service delivery models.

10.4.10 The Finance Officer will also be responsible for preparing the annual financial statement that the IJB must publish under section 39 of the Act, which sets out what the IJB intends to spend in implementation of its Strategic Plan.

10.4.11 The Finance Officer will be responsible for producing finance reports to the IJB, ensuring that those reports are appropriate for the needs of the IJB.

10.4.12 The Finance Officer will liaise closely with the CEC Section 95 Officer and the NHS Lothian Director of Finance and their teams in order to discharge all aspects of their role.

10.5 Resources Delegated to the IJB

10.5.1 The resources delegated to the IJB fall into two categories: (i) payments for the delegated functions; and (ii) resources used in large hospitals that are set aside by NHS Lothian and made available to the IJB for inclusion in its Strategic Plan.

10.5.2 Section 1(3)(e) of the Act requires that the Scheme must set out a method of determining payments that are to be made in respect of 10.5.1(i) above. Section 1(3)(d) of the Act requires the Scheme to set out a method of determining the amounts to be made available by NHS Lothian for use by the IJB under Section 10.5.1(ii) above.

10.5.3 It is expected that the net difference between payments into and out of the IJB will result in a balancing payment between CEC and NHS Lothian which reflects the effect of the directions of the IJB. The balancing payment will be reviewed throughout the year and depending on the expected value for the adjusting payment, it will be either made one-off prior to year-end or on a quarterly basis. Such payments will incorporate values previously treated as resource transfer.

10.6 Annual Budget Payments to the IJB

10.6.1 CEC and NHS Lothian will identify a core baseline operational budget for each function that is delegated to the IJB. This will be used as the basis to calculate their respective payments into the IJB's budget each year. The previously agreed "resource transfer" payments from NHS Lothian will be part of the annual budget payment to the IJB.

10.6.2 CEC and NHS Lothian have established financial planning processes which take into account the financial settlements they have received, and identified and assumed expenditure pressures, to arrive at opening annual budgets. These same processes will be applied to the core baseline operational budgets for the delegated functions in order to arrive at the annual payments to the IJB.

10.6.3 The CEC Section 95 Officer and the NHS Lothian Director of Finance are responsible for preparing the budget contributions from their respective party. The amounts to be paid will be the outcome of the above processes. They will consult with the Chief Officer and officers in both Parties as part of this process.

10.6.4 The CEC Section 95 Officer and the NHS Lothian Director of Finance will each prepare a schedule outlining the detail and total value of the proposed payment from each Party, and the underlying methodology and assumptions behind that payment. These draft schedules will identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. The schedules will also contain the detail and total value of set aside resources for hospital services, made under section 1(3) (d) of the Act.

10.6.5 The CEC Section 95 Officer and the NHS Lothian Director of Finance will refer the draft schedules to the Chief Officer so that they may have an opportunity to formally consider them.

10.6.6 The CEC Section 95 Officer and the NHS Lothian Director of Finance will thereafter present the final draft schedules to the Parties. The schedules must be agreed by the Director of Finance of NHS Lothian, the CEC Section 95 Officer and the Chief Officer.

10.6.7 CEC and NHS Lothian must approve their respective payments, in line with their governing policies.

10.6.8. The CEC Section 95 Officer and NHS Lothian Director of Finance will liaise closely with the IJB Chief Officer and Finance Officer on the assumptions to be used on annual budget contributions and will have due regard to the impact of any service re-design activities that have been a direct consequence of the IJB's Strategic Plan or Directions issued.

10.6.9 Both CEC and NHS Lothian will provide indicative three-year budget allocations to the IJB, subject to annual approval through their respective budget setting processes.

10.6.10 The Parties will ensure the Chief Officer and Finance Officer are actively engaged in their financial planning processes. The Chief Officer will be expected to feed into the planning processes with any intelligence that is relevant, e.g. the aims of the Strategic Plan, the effect of previous directions on activity and expenditure, projected demand-led changes in activity and

expenditure. The Director of Finance of NHS Lothian, the CEC Section 95 Officer and the IJB Finance Officer will ensure a consistency of approach and consistent application of processes in considering budget assumptions and proposals.

10.7 The set-aside of resources for use by the IJB

10.7.1 In addition to the payments to the IJB, NHS Lothian will identify a set aside budget for delegated functions in large hospitals. The set aside budget for delegated hospital services will be based on an apportionment of the relevant Lothian NHS Board budgets for the delegated hospital services (excluding overheads).

10.7.2 The core baseline budget for the set-aside functions in each council area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and the IJB.

10.8 Hosted Services

10.8.1 NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are currently provided as part of a single Lothian-wide service, commonly referred to as “hosted services”. The core baseline budget for the hosted services in each council area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and the IJB.

10.9 Due Diligence

10.9.1 Where it is proposed to transfer additional functions to the IJB, the Parties will share information on the financial performance over the previous two financial years of such functions. This will allow the Parties to undertake appropriate reviews to gain assurance as to whether the services are currently being delivered sustainably within approved resources, and that the anticipated payments will be sufficient for the IJB to carry out its integration functions.

10.9.2 If any such review indicates that the projected expenditure is likely to exceed the payments to the IJB, then the relevant Party will be notified. The relevant Party will be required to take action to ensure that services can be delivered within the available operational budget.

10.9.3 The Parties recognise that of the functions which are delegated to theIJB, there are some where there is greater potential for the actual expenditure to vary significantly from projections. The Parties will identify what those functions are and will ensure that information is provided to the IJB so that it is aware of the issues, and is able to focus on those functions within their systems for risk management and financial reporting. This process of due diligence will be informed by, amongst other things, the intelligence within the financial performance reports covering all integration functions that the IJB will routinely receive.

10.10 Process to agree payments from the IJB to the Parties

10.10.1 The IJB will determine and approve, in accordance with the Strategic Plan, the payments to the Parties which will accompany its directions to them for carrying out functions delegated to the IJB. The Parties are required to implement the directions of the IJB in carrying out a delegated function in line with the Strategic Plan, having agreed with the IJB the resources required to deliver the said directions.

10.10.2 The Finance Officer is responsible for providing the IJB with appropriate information and advice, so that it may determine what those payments should be.

10.10.3 Directions from the IJB to the Parties will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

a) the delegated function(s) that are to be carried out;
b) the outcomes to be delivered for those delegated functions; and
c) the amount of and / or method of determining the payment to be made, in respect of the carrying out of the delegated functions.

10.10.4 Once issued, directions can be amended by a subsequent direction by the IJB.

10.10.5 Where amounts paid to the IJB are subject to separate legislation or subject to restrictions stipulated by third party funders, the IJB must reflect these amounts in full, in determining the level of the payments to be made to the Parties in respect of the carrying out of the relevant function or functions. However, the IJB is not precluded from increasing the resource allocated to the relevant services.

10.11 Financial Reporting to the IJB

10.11.1 Budgetary control and monitoring reports will be provided to the IJB as and when it requires. The reports will set out the financial position and forecast against the payments by the IJB to the Parties in respect of the carrying out of integration functions and against the amount set aside by NHS Lothian for hospital services. These reports will present the actual and forecast positions of expenditure compared to budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.

10.11.2 NHS Lothian will provide information on the set-aside budgets which will be contained in financial reports to the IJB.

10.11.3 Both Parties will provide the required information on budgetary performance from their respective finance systems, and this will be co-ordinated and consolidated by the Finance Officer to provide reports to the IJB on all the IJB's delegated functions.

10.11.4 It is expected that as a minimum there will be quarterly financial reports to the Chief Officer and the IJB.

10.12 Process for addressing variance in the spending of the IJB

10.12.1 The IJB is required to deliver its financial out-turn within available resources.

10.12.2 The Parties will ensure that their respective budget monitoring and management systems will be applied to monitor and manage their expenditure in relation to delivery of integrated functions in accordance with directions issued to them by the IJB.

10.12.3 The manager leading this remedial action will be the Chief Officer in his or her operational capacity within the affected Party.

10.12.4 In the event that such remedial action will not prevent the overspend, then the Finance Officer will, together with the relevant Party, develop a proposed recovery plan to address the forecast overspend. The Finance Officer will then present that recovery plan to the IJB as soon as practically possible. The IJB has to be satisfied with the recovery plan, and the plan is subject to its approval.

10.13 Additional Payments by the Parties to the IJB

10.13.1 Where such a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end, and where there are insufficient available reserves held by the IJB to meet the overspend, then the Parties may make additional payments to the IJB.

10.13.2 The Finance Officer and the Parties shall engage in discussion and negotiation about the amounts to be paid by each Party.

10.13.3 The Parties recognise that the delivery of delegated functions in accordance with the Strategic Plan depends on their co-operation between each other and with the IJB and that all three parties must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. NHS Lothian and CEC will consider making interim funding available on a basis to be agreed between the Parties, with repayment in future years on the basis of the revised recovery plan by the IJB. If the revised plan cannot be agreed by NHS Lothian and CEC or is not approved by the IJB, the dispute resolution arrangements provided for in the Scheme will apply

10.13.4 Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the IJB, then the dispute resolution mechanism in this Scheme may require to be implemented.

10.14 Underspends

10.14.1 As part of their normal financial management systems, the Parties conduct in-year reviews of financial performance, and occasionally this may lead to a forecast of an underspend at the year-end on one or more budgets. In the event that this happens within the operational budgets then the following shall apply:

a) if the underspend is fortuitous and unrelated to any IJB direction then the underspend should be returned to the affected Party (through an adjustment to the payments to the IJB); and

b) the IJB will retain all other underspends.

10.15 Treatment of variations against the amounts set aside for use by the IJB

A process will be agreed between NHS Lothian and the IJB to manage any variations within the set-aside budget. This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the integrated payment as laid out above.

10.16 Redetermination of payments to the IJB

10.16.1 Redeterminations of payments made by the Parties for the carrying out of integration functions would apply under the following circumstances:

a. Additional one-off funding is provided to a Party or Parties by the Scottish Government, or some other body, for expenditure in respect of a function delegated to the IJB; or

b. The Parties, along with the IJB, agree that an adjustment to the payment is required to reflect changes in demand and/or activity levels

10.16.2 In all cases full justification for the proposed change would be required and both Parties and the IJB would be required to agree to the redetermination. The Parties would apply the process used to calculate the payment to the IJB (described earlier) to the affected functions and the Strategic Plan would be required to be amended as necessary.

10.17 Redetermination of set aside payments to the IJB

This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Operational Budgets as specified above.

10.18 Use of Capital Assets

10.18.1 The IJB, NHS Lothian and CEC will ensure there is awareness of all capital assets which will be used in the delivery of the Strategic Plan.

10.18.2 Changes in use of capital assets will flow from the Strategic Plan and the directions issued by the IJB to the Parties. The Strategic Plan process will outline any implications or requirements for capital assets.

10.18.3 The Parties will ensure that their capital asset planning arrangements take due cognisance of the above implications and requirements.

10.18.4 The Chief Officer of the IJB will consult with the Parties to identify the specific need for improvements/changes to assets owned by each which may be required in connection with the carrying out of integration functions. Where a capital investment need is identified, a business case will require to be developed. Any business case will set out how the investment will meet the strategic objectives set out in the Strategic Plan and identify the ongoing revenue costs/savings associated with implementation of the proposals.

10.18.5 The IJB, CEC and NHS Lothian will work together to ensure assets required in connection with the carrying out of integration functions are used as effectively as possible and in compliance with the relevant legislation relating to use of public assets.

10.19 Audit and Financial Statements

10.19.1 Section 13 of the Act requires that the IJB is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973. This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003, the Local Authority Accounts (Scotland) Regulations 2014 and other regulations under section 105 of the Local Government (Scotland) Act 1973)). These will be proportionate to the limited number of transactions of the IJB whilst complying with the requirement for transparency and true and fair reporting in the public sector.

10.19.2 The Parties will agree a clear timetable for the preparation of the IJB's annual accounts which will incorporate a process to agree any balances between the IJB and the Parties.

10.19.3 As part of the financial year-end procedures and in order to develop the year-end financial statements, the Finance Officer of the IJB will annually co-ordinate an exercise agreeing the value of balances and transactions with CEC and NHS Lothian finance teams. Each of the Parties will submit to the Chief Financial Officer their recorded income, expenditure, receivable and payable balance with the IJB. The Parties' respective finance representatives will then work to resolve any differences arising.

10.19.4 The IJB financial statements must be completed to meet the audit and publication timetable specified in the regulations (Regulations under section 105 of the Local Government (Scotland) Act 1973).

10.19.5 The Accounts Commission will appoint the external auditors to the IJB.

10.19.6 The financial statements will be signed in line with the governance arrangements for the IJB and as specified in the Local Authority Accounts (Scotland) Regulations 2014, made under section 105 of the Local Government (Scotland) Act 1973.

10.19.7 In all forms of audit, the Parties are expected to comply with related requests and to aid the audit process.

11. Information-Sharing and Data Handling

11.1 Arrangements for the sharing and joint processing of information among CEC, NHS Lothian, and the IJB are set out in a Memorandum of Understanding (the "MOU") which is designed to promote and support appropriate information governance for the integration of health and social care services. The MOU is subject to periodic review by information governance professionals from within each Party, and the wider Lothian IJBs.

11.2 The MOU sets out the framework through which each of the Lothian IJBs and the functions respectively delegated to them can share and process personal data. In particular, it details the more granular purposes, requirements, procedures and agreements which are required to ensure compliance with data protection law, including respective lines of responsibility.

11.3 The MOU is underpinned by an existing and long-standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian, CEC, East Lothian Council, Midlothian Council and West Lothian Council and the Chief Officers of the Lothian IJBs are all signatories. This Information Sharing Protocol sets out general principles around the sharing of personal information and is subject to periodic review by a sub-group of the Pan Lothian Data Sharing Partnership. Revisions or updates

will be recommended for signature by the Chief Executives of respective organisations on behalf of the Pan-Lothian Data Sharing Partnership.

11.4 Under these arrangements, CEC and NHS Lothian will continue to be Data Controller for their respective records (regardless of format) and will set out arrangements for the processing and management of information in accordance with the MOU. In respect of delegated functions delivered by the EHSCP, the MOU recognises the need for joint processing and sets out practical arrangements to achieve that through the EHSCP.

11.5 Processing and management arrangements will also reflect wider information governance considerations – for example, in relation to statutory and operational requirements around records management, information security and information compliance.

11.6 Arrangements for third party access to information will be managed in accordance with the MOU and the principles set out in the Pan-Lothian and Borders General Information Sharing Protocol.

11.7 Agreements and procedures will be reviewed annually by relevant Data Protection Officer (or their representatives), or more frequently if required.

12. Complaints

12.1 People who use services provided in pursuance of integration functions will continue to make complaints either to CEC or to NHS Lothian. Both Parties have in place well publicised, clearly explained and accessible complaints procedures that allow for timely recourse and signpost independent advocacy services, where relevant.

12.2 Complaints about the delivery of an integration function may be made to, and dealt with by, the Party which is required to deliver that function in pursuance of a direction issued by the IJB or (in a case where the direction is issued in respect of a given function to both constituent authorities jointly) to either of those constituent authorities.

12.3 When responding to complaints about a service which is delivered jointly, officers responsible for complaints handling within CEC and NHS Lothian will discuss the complaint, and identify which elements that are the subject of the complaint will be investigated by each Party, and agree which Party will prepare the written response at the end of the investigation. Failing agreement, the Chief Officer acting reasonably will decide which of the constituent authorities should prepare the written response and this will be signed by the Chief Officer.

12.4 On completion of the complaints procedure, complaints about specific social work functions may be referred the Scottish Public Services Ombudsman. At the end of the complaints process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman. Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate.

12.5 The Chief Officer will have an overview of complaints made about integration services and subsequent responses. Complaints about integration services will be recorded and reported to the Chief Officer on a regular and agreed basis. Regular trend analysis of complaints and complaint outcomes will also be carried out as part of a wider quality assurance framework.

12.6 Responsibility for responding to Scottish Public Services Ombudsman complaints enquiries will lie with the Party that dealt with the original complaint.

12.7 All independent contractors involved in the delivery of services associated with an integration function will be required to have a complaints procedure. Where complaints are received about the service provided by an independent contractor, the relevant Party will refer the complaint to the independent contractor in the first instance, either providing contact details or by passing the complaint on, depending on the preferred approach of the complainant. Complaints received about independent contractors will be recorded for contract monitoring purposes.

12.8 Complaints about the IJB should be made to the chairperson of the IJB. Staff within CEC and NHS Lothian will support the Chief Officer with the investigation and written response to the complainant, which will be signed by the Chief Officer.

12.9 The Parties will work together to align their complaints processes in as far as reasonably practicable to adopt an integrated approach to complaints handling, so that the process of making a complaint is as simple as possible for service users and complaints about services associated with integration functions are responded to clearly, thoroughly and timeously.

13. Claims Handling, Liability & Indemnity

13.1 The liability of either or both Parties and/or the IJB in respect of any claim that may be made by a third party in relation to any matter connected with the carrying out of integration functions shall be determined in accordance with principles of common law and/or any applicable legislation.

13.2 Where a claim by a third party is received by either of the Parties or the IJB in relation to any matter connected with the carrying out of integration functions (the body receiving such a claim

being referred to as the “Claim Recipient”), the Claim Recipient, shall, as soon as reasonably practicable, notify the other Party and the IJB (or, in the case of a claim received by the IJB, both Parties); and the Parties and the IJB (each being bound to act reasonably in this respect) shall then jointly assess:

13.2.1 which of them could be held to be liable (whether wholly or partly) in relation to the claim were it to be upheld by the court; and

13.2.2 (where two or more of them could potentially be liable) which of them is more likely to carry the primary liability.

13.3 For the avoidance of doubt, in the circumstances referred to in Section 13.2:

13.3.1 the Claim Recipient may acknowledge receipt of the claim, but shall avoid taking any step (without the prior written consent of the other Party and the IJB; or, in the case of a claim received by the IJB, the prior written consent of both Parties) which could prejudice the defence of the claim, pending completion of the assessment referred to in that Section; and

13.3.2 the Claim Recipient shall provide such information available to it as may be required to facilitate any formal intimation or other steps which either Party or the IJB may require to take under the terms of any relevant insurance policy or (as the case may be) the CNORIS scheme.

13.4 Where, on the basis of the assessment carried out in pursuance of Section 13.2, it is considered that only the Claim Recipient could be held to be liable in relation to the claim should it be upheld by the court, the Claim Recipient may conduct the defence of the claim and any associated negotiations as it sees fit, but shall continue to keep the others informed in that regard.

13.5 Where, on the basis of the assessment carried out in pursuance of Section 13.2, it is considered that the other Party and/or the IJB (or, in the case of a claim received by the IJB, both Parties) could be held to be liable in relation to the claim should it be upheld by the court, the Claim Recipient shall, following that assessment:

13.5.1 provide the other body or bodies which (on the basis of that assessment) could be liable in respect of the claim, with all such information in relation to the claim as is available to the Claim Recipient;

13.5.2 allow that other body or bodies (and/or its or their insurers or, as the case may be, the relevant officers acting under the CNORIS scheme) to conduct the defence of the claim

and any associated negotiations, subject to that other body or bodies indemnifying the Claim Recipient in relation to any loss or liability (including legal expenses on a solicitor-client basis, and any award of expenses) which the Claim Recipient might thereby incur; and

13.5.3 avoid taking any step which could prejudice the defence of the claim without the prior written consent of that other body or bodies.

13.6 Where, on the basis of the assessment carried out in pursuance of Section 13.2, it is considered that the Claim Recipient could be held to be liable along with another Party and/or the IJB (or, where the Claim Recipient is the IJB, along with either or both Parties) in relation to the relevant claim were it to be upheld by the court:

13.6.1 the Claim Recipient and the other body or bodies (and/or their respective insurers or, as the case may be, the relevant officers acting under the CNORIS scheme) shall conduct the defence of the claim and any associated negotiations; and

13.6.2 the costs of defending the claim (and any associated negotiations) shall be shared between the bodies (including the Claim Recipient) who (on the basis of the assessment carried out in pursuance of Section 13.2) could be held to be liable in respect of the claim, and the indemnity by the other body or bodies referred to in Section 13.5.2 shall be qualified accordingly.

13.7 Where two or more bodies are to conduct the defence of any claim (and any associated negotiations) under Section 13.5.2 or 13.6.1, the body which is considered (on the basis of the assessment carried out in pursuance of Section 13.2) to be more likely to carry the primary liability shall have overall control of the conduct of the defence (and any associated negotiations), subject to liaising closely with the other relevant body or bodies and taking due account of the requirements of its or their insurers (and/or, as the case may be, any requirements associated with the CNORIS scheme).

13.8 If both Parties, or if either or both Parties and the IJB, receive a claim relating to the same matter, the procedures set out in Sections 13.1 to 13.7 shall (subject to Section 13.9) apply, subject to such adjustments (as agreed among the relevant bodies) as may be appropriate to facilitate the efficient handling of the claims.

13.9 If both Parties, or if either or both Parties and the IJB, are parties to the same court proceedings arising out of a claim, each of them (and/or its or their insurers or, as the case may be, the relevant officers acting under the CNORIS scheme) may conduct its own defence of the claim against it (and any associated negotiations) in such manner as it may see fit and at its own expense; and the liability of each body in respect of the claim shall be as determined by the

court (or, if the claim is settled outwith the court proceedings) as agreed by each body in the context of the negotiations regarding settlement of the claim.

13.10 If a claim by a third party in relation to any matter connected with the carrying out of integration functions relates to services delivered in an area served by a Neighbouring IJB, or relates to services delivered within the Edinburgh Area under arrangements involving a Neighbouring IJB, each of the Parties, and the IJB, will liaise with each other and with the Neighbouring IJB in order to reach agreement as to how the claim is to be handled; the IJB and Neighbouring IJBs shall jointly develop and agree a protocol for the handling of claims of that nature.

13.11 The Parties and the IJB shall use all reasonable endeavours to operate the procedures set out in Sections 13.1 to 13.10 as rapidly as possible, and in a manner which complies with the requirements from time to time of relevant insurers and/or (as applicable) the CNORIS scheme; each of them undertakes to the others:

13.11.1 to provide all such information and render all such co-operation as may be reasonably required from time to time in connection with any such claim; and

13.11.2 if and to the extent that any matter which cannot be agreed between them requires to be dealt with under the dispute resolution procedure set out in Section 16, to operate the dispute resolution procedure as rapidly as possible so as to minimise any prejudice to (a) the efficient defence of the claim and/or (b) the ability of any body to access the benefit of any insurance policy or (as the case may be) the CNORIS scheme.

13.12 Where payment is made by either Party or by the IJB in settlement of a claim by a third party in relation to any matter connected with the carrying out of integration functions, the body which made payment (if that body is not wholly liable, on the basis of principles of common law and/or any applicable legislation, in respect of the matter which gave rise to the claim) shall be entitled to be indemnified by the other Party and/or the IJB (or, in a case where payment was made by the IJB, by either or both Parties) to the extent of its or their liability (as determined in accordance with principles of common law and/or any applicable legislation) in respect of the matter which gave rise to the claim; but due account shall be taken of any prejudice to the indemnifying body or bodies (including its/their ability to access the benefit of any insurance policy or, as the case may be, the CNORIS scheme) arising from any failure to comply with the other provisions of this Section 13.

13.13 For the avoidance of doubt, the principles set out in Section 13.12 shall also apply in respect of the expenses of defending any claim by a third party in relation to any matter connected with the carrying out of integration functions, and in respect of any award of expenses in connection with any such claim.

13.14 The arrangements set out in this Section 13 shall be subject to periodic review and adjustment, in order to reflect the requirements from time to time of insurers and the CNORIS scheme and to ensure efficiency in the handling of claims; any revised arrangements shall be recorded in a written agreement entered into by the Parties and the IJB.

14. Risk Management

14.1 Risk management processes will include risk monitoring, and a reporting process for the Parties and IJB via a Risk Register for the IJB. Risks will be continuously monitored and reported to the IJB.

14.2 The Parties will provide to the IJB sufficient support to enable it to fully discharge its duties in relation to risk management. This will be determined through the process describe in Section xx.

14.3 The IJB risk register will not duplicate the detail of risk registers within NHS Lothian and CEC. However, the IJB will update its risk register should there be any emerging themes/risks which have a bearing on its activities.

15. Dispute Resolution

15.1 In the event of any dispute between the Parties in relation to any matter provided for in this Scheme or any of the duties, obligations, rights or powers imposed or conferred upon them by the Act (a "**Dispute**"), the provisions of this section 14 will apply.

15.2 Either Party shall give to the other written notice of the Dispute, setting out its nature and full particulars (a "**Dispute Notice**"), together with relevant supporting documents. The Party giving the Dispute Notice will provide a copy to the Chair of the IJB. On service of the Dispute Notice, the Chief Executives of the Parties shall meet and attempt in good faith to resolve the Dispute.

15.3 Where the matter remains unresolved within 21 days of service of the Dispute Notice, the Parties shall inform the Chair of the IJB and may proceed to mediation with a view to resolving the issue. Any mediator will be external to the Parties and will be identified and appointed with the agreement of the Chair of NHS Lothian and the Chief Executive of CEC and failing agreement within 21 days shall be nominated by the Centre for Effective Dispute Resolution (CEDR) on the request of either Party.

15.4 The mediation will start not later than 21 days after the date of appointment of the mediator.

15.5 The Parties agree that the cost of the mediator will be met equally by NHS Lothian and CEC. The timeframe to resolve the issue will be agreed prior to the start of the mediation process by the Chair of NHS Lothian and the Leader of CEC and notified to the chairperson of the IJB.

15.6 The chairperson of the IJB will inform Scottish Ministers in writing of the Dispute and agreed timeframe to conclude the mediation process.

15.7 Where following mediation the issue remains unresolved, the chairperson of the IJB shall notify Scottish Ministers in writing. Scottish Ministers may then advise the Parties how to proceed.

15.8 The Parties shall cooperate with each other to mitigate any adverse effect on service delivery pending resolution of the Dispute.

15.9 Nothing in this Scheme shall prevent either of the Parties from seeking any legal remedy or from commencing or continuing court proceedings in relation to the Dispute.

Annex 1

Part 1A

Functions delegated by NHS Lothian to the IJB

Set out below is the list of functions that are delegated by NHS Lothian to the IJB, in compliance with the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014

Column A	*Column B*
The National Health Service (Scotland) Act 1978	

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	section 2(7) (Health Boards);
	section 2CB([1]) (Functions of Health Boards outside Scotland);
	section 9 (local consultative committees);
	section 17A (NHS Contracts);
	section 17C (personal medical or dental services);
	section 17I([2]) (use of accommodation);
	section 17J (Health Boards' power to enter into general medical services contracts);
	section 28A (remuneration for Part II services);
	section 38([3]) (care of mothers and young children) to the extent falling outwith the relevant services specified in Part 1B of Annex 1;
	section 38A([4]) (breastfeeding) to the extent falling outwith the relevant services specified in Part 1B of Annex 1;

([1]) Section 2CB was inserted by S.S.I. 2010/283, regulation 3(2).
([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.
([3]) The functions of the Secretary of State under section 38 are conferred on Health Boards by virtue of S.I. 1991/570.
([4]) Section 38A was inserted by the Breastfeeding etc (Scotland) Act 2005 (asp 1), section 4. The functions of the Scottish Ministers under section 38A are conferred on Health Boards by virtue of S.I. 1991/570 as amended by S.S.I. 2006/132.

section 39([5]) (medical and dental inspection, supervision and treatment of pupils and young persons) to the extent falling outwith the relevant services specified in Part 1B of Annex 1;

section 48 (provision of residential and practice accommodation);

section 55([6]) (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);

section 64 (permission for use of facilities in private practice);

section 75A([7]) (remission and repayment of charges and payment of travelling expenses);

section 75B([8])(reimbursement of the cost of services provided in another EEA state);

section 75BA ([9])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82([10]) use and administration of certain endowments and other property held by Health Boards);

section 83([11]) (power of Health Boards and local health councils to hold property on trust);

([5]) Section 39 was relevantly amended by the Self Governing Schools etc (Scotland) Act 1989 (c.39) Schedule 11; the Health and Medicines Act 1988 (c.49) section 10 and Schedule 3 and the Standards in Scotland's Schools Act 2000 (asp 6), schedule 3.

([6]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

([7]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([8]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([9]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([10]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([11]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

section 84A([12]) (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

section 98 ([13]) (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([14]);

NHS Lothians (Membership and Procedure) (Scotland) Regulations 2001/302;

The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;

The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;

The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;

The National Health Service (Discipline Committees) Regulations 2006/330;

The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;

The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;

([12]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

([13]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

([14]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

	The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([15]).
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 7 (Persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (Approved medical practitioners); section 34 (Inquiries under section 33: co-operation)([16]); section 38 (Duties on hospital managers: examination notification etc.)([17]); section 46 (Hospital managers' duties: notification)([18]); section 124 (Transfer to other hospital); section 228 (Request for assessment of needs: duty on local authorities and Health Boards); section 230 (Appointment of a patient's responsible medical officer);

([15]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.
([16]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([17]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([18]) Section 46 is amended by S.S.I. 2005/465.

	section 260 (Provision of information to patients); section 264 (Detention in conditions of excessive security: state hospitals); section 267 (Orders under sections 264 to 266: recall); section 281([19]) (Correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]); The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]); The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).
Education (Additional Support for Learning) (Scotland) Act 2004	
Section 23 (other agencies etc. to help in exercise of functions under this Act**)**	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(Public functions: duties to provide information on certain expenditure etc.); and section 32 (Public functions: duty to provide information on exercise of functions).

([19]) Section 281 is amended by S.S.I. 2011/211.
([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([25]).
Carers (Scotland) Act 2016([24]) Section 31 (duty to prepare local carer strategy)	

But in each case, subject to the restrictions set out in paragraph (a) of article 3(3) of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014, and only so far as (i) they are exercisable in relation to care or treatment provided by health professionals for the purpose of the health care services listed in paragraphs (a) to (f) of Part 2 of this Annex 1 or (ii) they are exerciseable in relation to the health care services listed in paragraphs (g) to (v) of Part 2 of this Annex 1.

([24]) Entry inserted by Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Amendment Regulations 2017/381 (Scottish SI) reg.2 (December 18,2017)

Annex 1

Part 1B

Additional functions delegated by NHS Lothian to the IJB

Set out below is the list of additional functions that are delegated by NHS Lothian to the IJB

(A) The functions listed in Part 1A of this Annex 1 insofar as they relate to the services listed below in relation to persons under the age of 18:

(a) Primary Medical Services and General Medical Services (including GP Pharmaceutical services)

(b) General Dental Services, Public Dental Services and the services provided by the Edinburgh Dental Institute

(c) General Ophthalmic Services

(d) General Pharmaceutical Services

(e) Out of Hours Primary Medical Services

(f) Services for people with Learning Disabilities.

Annex 1

Part 2

Services associated with the functions delegated by NHS Lothian to the IJB

Interpretation of this Part 2 of Annex 1

In this Part 2—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([26]); and

"the public dental service" means services provided by dentists and dental staff

employed by a health board under the public dental service contract.

a) Accident and Emergency services provided in a hospital.

b) Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;

(b) geriatric medicine;

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) psychiatry of learning disability.

c) Palliative care services provided in a hospital.

d) Inpatient hospital services provided by General Medical Practitioners.

([26]) S.S.I. 2004/115.

e) Services provided in a hospital in relation to an addiction or dependence on any substance.

f) Mental health services provided in a hospital, except secure forensic mental health services.

g) District nursing services.

h) Services provided outwith a hospital in relation to an addiction or dependence on any substance.

i) Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

j) The public dental service.

k) Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([27]).

l) General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([28]).

m) Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([29]).

n) Pharmaceutical services* and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([30]).

o) Services providing primary medical services to patients during the out-of-hours period.

p) Services provided outwith a hospital in relation to geriatric medicine.

q) Palliative care services provided outwith a hospital.

r) Community learning disability services.

s) Mental health services provided outwith a hospital.

([27]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.
([28]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.
([29]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.
([30]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

t) Continence services provided outwith a hospital.

u) Kidney dialysis services provided outwith a hospital.

v) Services provided by health professionals that aim to promote public health.

In each case, subject to the exceptions set out in Parts 1A and 1B of Annex 1 and to the restrictions set out in article 3(3) of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014.

NHS Lothian has also chosen to delegate the functions listed in Part 1 of Annex 1 in relation to the following services

(A) Provision for people under the age of 18 of:

i) Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
ii) General Dental Services, Public Dental Services and the Edinburgh Dental Institute
iii) General Ophthalmic Services
iv) General Pharmaceutical Services
v) Out of Hours Primary Medical Services
vi) Learning Disabilities

(B) The functions exercisable in relation to the prison health care service provided within HMP Edinburgh and HMP Addiewell.

Annex 2

Part 1

Functions delegated by CEC to the IJB

Set out below is the list of functions that are delegated by CEC to the IJB (being the functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014)

Column A	*Column B*
Enactment conferring function	*Limitation*
National Assistance Act 1948([31])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([32])	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968([33])	

([31]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([32]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

([33]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.

by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([34])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([35])	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.

([34]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.
([35]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([36])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions

([36]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Housing (Scotland) Act 2001([37])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([38])	
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([39])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	

([37]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([38]) 2002 asp 5.
([39]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Column A	*Column B*
Enactment conferring function	*Limitation*
Section 259	
(Advocacy.)	
The Housing (Scotland) Act 2006([40])	
Section 71(1)(b)	Only in so far as it relates to an aid or
(Assistance for housing purposes.)	adaptation.
The Adult Support and Protection (Scotland) Act 2007([41])	
Section 4	
(Council's duty to make inquiries.)	
Section 5	
(Co-operation.)	
Section 6	
(Duty to consider importance of providing	
advocacy and other.)	
Section 11	
(Assessment Orders.)	
Section 14	
(Removal orders.)	
Section 18	
(Protection of moved persons property.)	
Section 22	
(Right to apply for a banning order.)	
Section 40	
(Urgent cases.)	
Section 42	
(Adult Protection Committees.)	
Section 43	
(Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013([42])	

([40]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.
([41]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.
([42]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	
Carers (Scotland) Act 2016([43])	
Section 6([44]) (duty to prepare adult carer support plan)	
Section 21([45]) (duty to set local eligibility criteria)	
Section 24([46])	

([43]) Section 21 was inserted into the schedule of the Public Bodies (Joint Working) (Scotland) Act 2014 by paragraph 6 of the schedule of the Carers (Scotland) Act 2016 (asp 9).

([44]) Section 6 was inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg.3(2)(c) (December 13, 2017)

[45] Entry inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment Regulations 2017/190 (Scottish SI) reg.2(2) (June 16, 2017)

[46] Sections 24, 25, 31, 34 and 35 inserted by Public Bodies (Joint Working) (Prescribed Local Authority Functions etc.) (Scotland) Amendment (No. 2) Regulations 2017/449 (Scottish SI) reg.3(2)(c) (December 13, 2017)

Column A	*Column B*
Enactment conferring function	*Limitation*
(duty to provide support) Section 25 (provision of support to carers: breaks from caring) Section 31 (duty to prepare local carer strategy) Section 34 (information and advice service for carers) Section 35 (short breaks services statement)	

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A	*Column B*
Enactment conferring function	*Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([47]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([48])	

In each case, so far as the functions are exercisable in relation to persons of at least 18 years of age.

([47]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([48]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Annex 2

Annex 2 Part 2

Services currently associated with the functions delegated by CEC to the IJB

Set out below is an illustrative description of the services associated with the functions delegated by CEC to the IJB as specified in Part 1 of Annex 2.

Social work services for adults and older people
Services and support for adults with physical disabilities and learning disabilities
Mental health services
Drug and alcohol services
Adult protection and domestic abuse
Carers support services
Community care assessment teams
Support services
Care home services
Adult placement services
Health improvement services
Housing support/aids and adaptation in so far as they relate to adult with social care needs
Day services
Local area co-ordination
Respite provision
Occupational therapy services
Re-ablement services, equipment and telecare.

In each case, so far as the services are provided to persons of at least 18 years of age.

East Lothian Integration Joint Board

Revised Joint Integration Scheme
(Body Corporate)

East Lothian Integration Scheme 2022
(For Approval)

Contents

PREAMBLE

Health and Wellbeing Outcomes, and the Aims, Vision and Values of the Integration Joint Board (IJB)

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Revised Integration Scheme is intended to achieve the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act, namely:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

(and together the 9 Health and Wellbeing Outcomes, and the Aims, Vision and Values of the IJB specified in the preamble above shall be referred to in this document as ‘the Outcomes’)

Our vision and aims

The IJB's vision for the integration of health and social care in East Lothian is to support all people in East Lothian to live the lives they want as well as possible, achieving their potential to live independently and exercising choice over the services they use[1].

The IJB's strategic objectives are:

A. to make health and social care services more sustainable and proportionate to need and to develop our communities

B. to explore new models of community provision which involve local communities and encourage less reliance on health and social care services

C. to improve prevention and early intervention

D. to reduce unscheduled care and delayed discharges

E. to provide care closer to home

F. to deliver services within an integrated care model

G. to enable people to have more choice and control

H. to reduce health inequalities

I. to build and support partnership working

J. to support change and improvement across our services

The **values** that will underpin delivery of the Integration Joint Board's vision and outcomes are:

- to give people control over what happens to them is in itself promoting good health and wellbeing. The IJB will seek to maximise people's control over their lives as an integral part of the services we provide

- it is better to prevent health and social problems than to deal with them once they have occurred. The IJB will focus our attention and resources on prevention and early intervention

- that some people's social and economic circumstances lead to them having poorer health, wellbeing and life chances than others. IJB will work to tackle these inequalities by focusing our efforts on those at greatest risk

- it is right to offer people services as close to home as possible

- in working in partnership

[1] East Lothian IJB Strategic Plan 2019 - 2022, page 12

- in a single health and social care economy for East Lothian. We will invest the resources of the health and social care economy wherever it will have the greatest impact on meeting our shared objectives

- Recognise the interdependencies of services and will take a holistic approach to service provision, considering each individual in the context of their circumstances

- value the views of people who use our services

- value the diversity of East Lothian. We will work closely with our diverse communities to ensure they can contribute to the health and wellbeing of the population

Throughout all its work the Parties expect the IJB to be guided by the following ambitions:

- Provide the highest quality health and care services

- Always respect people's dignity and rights

- Support people to live independently at home

- Promote the principles of independent living and equality

- Do everything we can to reduce health inequalities

- Provide support and services so that people only have to go to hospital if they really have to

- Listen to people who use our services, and the people who care for them, working together to develop the services that are right for them

- Make sure that East Lothian people feel safe at home and in their communities

- Support people to take more responsibility for their own health and wellbeing

The provisions within this preamble are not part of the Revised Integration Scheme and are not intended to create legally binding obligations. They do however, give the context within which the Revised Integration Scheme should be read.

Integration Scheme

The Parties:

East Lothian Council, the local authority for the County of East Lothian constituted by the Local Government etc (Scotland) Act 1994 and having its principal offices at John Muir House, Brewery Park, Haddington, EH41 3HA ("the Council");

and

Lothian Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Lothian") and having its principal offices at Waverley Gate, 2-4 Waterloo Place, Edinburgh ("NHS Lothian")

(together referred to as "the Parties", and each being referred to as a "Party")

Background

A. The Parties are required to comply with either subsection (3) or (4) of section 2(2) of the Act (hereinafter defined), and elected to comply with subsection (3) such that the Parties jointly prepared a joint integration scheme (as defined in section 1(3) of the Act) for East Lothian Area.

B. The Parties entered into the East Lothian Joint Board Joint Integration Scheme in 2015.

C. In preparing the said East Lothian Joint Board Joint Integration Scheme, the Parties had regard to the integration planning principles set out in section 4(1) of the Act and the national health and wellbeing outcomes prescribed by the Public Bodies (Joint Working)(National Health and Wellbeing Outcomes)(Scotland) Regulations 2014, and have complied with the provisions of section 6(2) of the Act (consultation); and in finalising the said Joint Board Integration Scheme, the Parties took account of any views expressed by virtue of the consultation processes undertaken under section 6(2) of the Act.

D. Under s.45(3) of the Act, the Parties are obligated upon the instructions of the Scottish Ministers in the exercise of their power conferred by s.1(3)(f) of the Act, to jointly carry out a review of the said Joint Board Integration Scheme for the purpose of identifying and formalising any necessary or desirable changes required by the Scottish Ministers.

E. The Scottish Ministers instructed the Parties to revise the said Joint Board Integration Scheme to reflect changes necessitated by provisions contained in the Carers (Scotland) Act 2016, in so far as such requires a relevant local authority and health board to delegate some

of their duties in relation to adult carers to the IJB (hereinafter more specifically defined as "IJB"). The Parties therefore determined to delegate certain functions set out in the said Carers (Scotland) Act 2016 to the IJB and revised the said Joint Board Integration Scheme.

F. The Parties agreed to a new partially Revised Integration Scheme in accordance with the provisions set out in s.47 of the Act to reflect the instructions of the Scottish Ministers. This First Revised Integration Scheme was entered into in 2019.

G. Full review and subsequent revision of the Joint Board Integration Scheme as envisaged by s.44 of the Act has been carried out by the Parties in accordance with the provisions of s.44 (5) of the Act and it has been agreed that this agreement would constitute the new Revised Integration Scheme.

In implementation of their obligations under the Act, the Parties hereby agree as follows:

1 Definitions and Interpretation

1.1 In this Scheme the following expressions have the following meanings, unless the context otherwise requires:-

"Act" means the Public Bodies (Joint Working) (Scotland) Act 2014 (unless otherwise specified by reference to another Act);

"Chief Officer" means the officer described in Section 7 of this Scheme;

"Chief Finance Officer" means the finance officer appointed by the Board under the finance and audit requirements in section 13 of the 2014 Act and section 95 of the Local Government (Scotland) Act 1973, and described in section 9 of the Scheme;

"IJB Budget" means the total funding available to the IJB in the financial year as a consequence of:

a) The payment for delegated functions from NHS Lothian under Section 1(3) (e) of the Act;
b) The payment for delegated functions from the Council under Section 1(3) (e) of the Act; and
c) The amount "set aside" by NHS Lothian for use by the IJB for functions carried out in a hospital and provided for the areas of two or more local authorities under Section 1(3) (d) of the Act;

"IJB Strategic Plan" means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services in accordance with section 29 of the Act.

"Integration Dataset" means the collective Integration Indicators;

"Integration Indicators" means the indicators and metrics gathered by the IJB and required for monitoring and reporting purposes in compliance with the IJB's statutory and policy obligations;

"IJB" means the East Lothian Integration Joint Board established by Order under section 9 of the Act pursuant to this Revised Integration Scheme;

"Integration Joint Boards Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014;

"Integration Scheme or 'Scheme' or 'Revised Integration Scheme'" means this Revised Integration Scheme;

"Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"Lothian IJBs" means the IJBs to which functions are delegated in pursuance of the integration schemes in respect of the local authority areas served by, City of Edinburgh Council, East Lothian Council, Midlothian Council and West Lothian Council respectively;

"Neighbouring IJBs" means the Lothian IJBs excluding the East Lothian IJB;

"Operational Budget" means the amount of payment made from the IJB to a Party in order to carry out delegated functions;

"Outcomes" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;

"Performance Framework" means the IJB's agreed measurement and standard for managing, gathering and reporting the Integration Dataset and/or the Integration Indicators as the case may be;

1.2 Words and expressions defined in the Act shall bear the same respective meanings in the Revised Integration Scheme unless otherwise specified herein.

1.3 References to Sections are to the sections of this Revised Integration Scheme unless otherwise specified as being sections of an Act of Parliament, or has statutory meaning.

1.4 Reference to Annexes are to annexes to this Scheme and reference to Parts are the parts of the relevant Annex.

2 The Model to be implemented

2.1 The integration model set out in section 1(4)(a) of the Act applies in relation to the East Lothian Area, namely the delegation of functions by each of the Parties to a body corporate established by Order under section 9 of the Act.

2.2. The original scheme came into effect on the date the IJB Order to establish the IJB came into force.

2.3 This Scheme comes into effect on the date of approval by Scottish Minister's

3 Local Governance Arrangements

3.1 Membership

3.1.1 The IJB shall have the following voting members:

a) **4** councillors nominated by the Council; and
b) **4** non-executive directors nominated by NHS Lothian in compliance with articles 3(4) and 3(5) of the IJBs Order.

3.1.2 The Parties may determine their own respective processes for deciding who to nominate as voting members of the IJB.

3.1.3 Non-voting members of the IJB will be appointed in accordance with article 3 of the IJB's Order.

3.1.4 The term of office of members shall be prescribed by regulation 7 of the IJB's Order.

3.2 Appointment of chair and vice chair

3.2.1 The IJB shall have a chairperson and a vice-chairperson who will both be voting members of the IJB.

3.2.2 The term of office for the Chairperson and Vice Chairperson will be two years.

3.2.3 The Council and NHS Lothian may determine (out of those voting members nominated in terms of paragraph 3.1.2 of this Scheme) who they appoint as chairperson or vice-chairperson.

3.2.4 The Council appointed the first chairperson and NHS Lothian appointed the first vice-chairperson of the Integration Joint Board for the initial two year period from 1 April 2015.

3.2.5 The right to appoint the chairperson and vice chairperson respectively will continue to alternate between each of the Parties on a two-year cycle and on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson.

3.2.6 The chairperson shall not have a casting vote

3.2.7 Each Party may change its appointment as chairperson (or, as the case may be, vice-chairperson) at any time; and it is entirely at the discretion of the Party which is making the appointment to decide who it shall appoint.

4 Delegation of Functions

4.1 The functions that are to be delegated by NHS Lothian to the IJB (subject to the exceptions and restrictions specified or referred to in Part 1 of Annex 1) are set out in Part 1 of Annex 1. The services currently provided by NHS Lothian in carrying out these functions are described in Part 2 of Annex 1.

4.2 The functions that are to be delegated by the Council to the IJB (subject to the restrictions and limitations specified or referred to in Parts 1A and 1B of Annex 2) are set out in Parts 1A and 1B of Annex 2. For indicative purposes only, the services which are currently provided by the Council in carrying out these functions are described in Part 2 of Annex 2.

5 Local Operational Delivery Arrangements

5.1 Directions issued by the IJB via the Chief Officer

5.1.1 The IJB membership will be involved in the operational governance of integrated service delivery via two particular arrangements: (1) directions issued by the IJB via the Chief Officer of the IJB; and (2) oversight of performance management by the voting members of the IJB.

5.1.2 The IJB will issue directions to the Parties via its Chief Officer. The IJB must direct the Parties to carry out each of the functions delegated to the IJB. A direction in relation to a given function may be given to one or other of the Parties, or to both Parties. The primary responsibility for delivering capacity (that is to say, activity and case mix) in respect of the services associated with the carrying out of a given function shall lie with the IJB, and shall be reflected in the directions issued from time to time by the IJB. Subject to the provisions of the Act and this Revised Integration Scheme, the Parties are then required to follow those directions

5.2 Oversight of performance management by the voting members of the IJB

5.2.1 The IJB shall oversee delivery of the services associated with the functions delegated to it by the Parties. The IJB is the only forum where health and social care functions for the East Lothian Area are governed by members of both NHS Lothian and the Council. Accordingly the Parties agree that the primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB.

5.2.2 The Parties will provide performance information so that the IJB can develop a comprehensive performance management system.

5.2.3 The IJB performance management reports will be available to both Parties for their use in their respective performance management systems. However it is expected that the voting members of the IJB will take responsibility for performance management at the IJB, and will provide an account of highlights and/or exceptional matters to meetings of NHS Lothian and the Council.

5.2.4 In the interests of efficient governance, the relevant committees of NHS Lothian and the Council will continue to discharge their existing remits for assurance and scrutiny of the carrying out of NHS Lothian and the Council functions, regarding matters such as internal control, quality and professional standards, and compliance with the law. The IJB will not duplicate the internal operational oversight role carried out by the Parties' respective committees other than in exceptional circumstances where the IJB considers that direct engagement by the IJB (or by a committee established by the IJB) is appropriate and agreed by the Parties in order to secure the proper discharge by the IJB of its statutory responsibilities or duties under this Scheme.

5.2.5 Each of the Parties shall use reasonable endeavours to procure that in the event that one of its committees identifies an issue which is of direct and material relevance to the IJB, the chair of that committee will advise the Chair of the IJB and the Chief Officer of that matter and

will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

5.2.6 The Parties shall ensure that their respective standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, and its place as a common decision-making body within the framework for delivery of health and social care within the East Lothian Area.

5.2.7 The voting members of the IJB are councillors of the Council and non-executive board members of NHS Lothian. In their capacity as councillors and non-executive board members, they will be engaged in the governance of their respective constituent bodies, and it is likely that they will be members of one or more committees of those constituent bodies.

5.2.8 Given the overall vision as outlined in the preamble of this Revised Integration Scheme, it is the intention that the operational governance functions of both Parties and the IJB should be integrated. In all matters associated with the work of the IJB, the voting members of the IJB will be expected by the Parties to play a crucial role in:

a) communicating, and having due regard to, the interests of NHS Lothian or (as the case may be) the Council in overseeing the carrying out of the integrated functions, but on the understanding that, in carrying out their role as a member of the IJB, their primary duties and responsibilities are those which attach to them in that capacity; and

b) communicating, and having due regard to, the interests of the IJB in overseeing the carrying out of the integrated functions whilst discharging their role as a councillor or (as the case may be) as a non-executive board member of NHS Lothian, but on the understanding that, in carrying out their role as a councillor or non-executive board member, their primary duties and responsibilities are those which attach to them in that capacity.

5.2.9 This Scheme sets out detailed measures on the governance of integration functions throughout the text. Over and above these measures, the Parties will ensure that the IJB members are involved in overseeing the carrying out of integration functions through the following action:

a) The terms of reference, membership and reporting arrangements of the relevant committees of the Parties will be reviewed and the IJB will be consulted within this process (and all future reviews).

5.2.10 Without prejudice to the role of the voting members of the IJB (as specified above) in relation to oversight of operational delivery of services in accordance with directions issued to either

or both of the Parties by the IJB, the IJB will, through the Chief Officer, have an oversight role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.2.11 In addition to the specific commitments set out above and the obligations regarding provision of information attaching to the Parties under the Act, each of the Parties will provide the IJB with any information which the IJB may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability.

5.3 Support for Strategic Planning

5.3.1 The Parties will support the IJB in ensuring that the consultation process associated with the preparation of each Strategic Plan for the East Lothian Area includes other Integration Authorities likely to be affected by the Strategic Plan. The Integration Authorities that are most likely to be affected by the Strategic Plan for the East Lothian Area are:

(a) Midlothian Integration Joint Board
(b) Edinburgh Integration Joint Board
(c) West Lothian Integration Joint Board.

5.3.2 NHS Lothian will procure that reciprocal provisions to those set out in Sections 5.1, 5.2 and 5.3 are contained in the integration schemes of the Neighbouring IJBs in Lothian.

5.3.3 In addition the Scottish Borders Integration Joint Board shares a border with East Lothian Integration Joint Board and may be affected by the East Lothian Strategic Plan.

5.3.4 The Parties will to ensure that the IJB can:

(a) effectively engage in all of the planning process and support the Neighbouring IJBs in discharging their role including contributing to the work of the strategic planning groups for the Neighbouring IJBs as required;

(b) provide such information and analysis as Neighbouring IJBs reasonably require for the production of their Strategic Plans;

(c) inform Neighbouring IJBs as to how the services, facilities and resources associated with the functions delegated to the IJB by the Parties are being or are intended to be used with respect to carrying out of those functions in line with these planning processes;

(d) in a situation where Strategic Plans in one area are likely to have an impact on the plans in another area, ensure that these matters are raised with other relevant Integration Joint Boards and resolved in an appropriate manner;

(e) in a situation where Strategic Plans in another area are likely to have an impact on the East Lothian Area, ensure that these matters are raised and any associated risks are mitigated for the benefit of service users.

5.4 Lothian Hospitals Strategic Plan, and Lothian Strategic Development Framework

5.4.1 NHS Lothian developed a plan (the 'Lothian Hospitals Strategic Plan') to support the IJB initial Schemes to fulfil their duties. The Lothian Hospitals Strategic Plan does not and will not bind the IJB though the IJB Strategic Plans are intended to inform and support the Lothian Hospital Strategic Plan. The Lothian Hospitals Strategic Plan encompasses both functions delegated to the Lothian IJBs and functions that are not so delegated.

5.4.2 The Lothian Hospitals Strategic Plan (which is or shall be replaced either in whole or part by the Lothian Strategic Development Framework referred to in [5.4.4] herein) was initially developed in partnership with the Lothian IJBs where integration functions are delivered by NHS Lothian in a hospital. Such reflected the relevant provisions of the Strategic Plans prepared by the respective Lothian IJBs, as well as NHS Lothian plans for non-delegated functions and it is intended that the Lothian Strategic Development Framework shall reflect the same.

5.4.3 The purpose of the Lothian Hospital Strategic Plan (and the purpose of the forthcoming Lothian Strategic Development Framework) is to ensure that planning for hospital functions and use of hospital facilities are:

(a) responsive to and supports each Strategic Plan prepared by the Lothian IJBs for delegated functions; and

(b) supports the requirement of NHS Lothian to deliver hospital services required by the IJB and other hospital services that are not the responsibility of the Lothian IJBs (e.g. tertiary, trauma, surgical, planned and children's services).

5.4.4 The forthcoming Lothian Strategic Development Framework shall be developed jointly by NHS Lothian and the Lothian IJBs, until such time as such is completed the Lothian Hospitals Strategic Plan shall continue to subsist. The elements of the Lothian Strategic Development Framework addressing non-delegated functions shall only be agreed by the NHS Lothian Board after the four Lothian IJBs have been consulted and their views and requirements appropriately considered. Elements of the Lothian Strategic Development Framework which cover functions delegated to the respective Lothian IJBs will be signed off by relevant Lothian IJBs in consultation with NHS Lothian and all Lothian IJBs.

5.5 Professional, technical or administrative support services

5.5.1 The Parties agree to provide the IJB with the corporate support services that it requires to discharge fully its duties under the Act.

5.5.2 The Parties and the IJB will regularly undertake review of the support services put in place pursuant to the IJB Scheme to ensure that the IJB has available to it all necessary professional, technical or administrative services for the purpose of preparing its Strategic Plan and carrying out the integration functions. This process will from part of the annual budget setting process for the IJB.

5.6 Performance targets, improvement measures and reporting arrangements

5.6.1 All national and local Outcomes, improvement measures and performance targets (including the Annual Performance Report (as defined and required under the Act) which are connected exclusively with the functions delegated by the Parties to the IJB under this Revised Integration Scheme will become the responsibility of the IJB to deliver; and the IJB will also be responsible for providing all such information regarding integration functions which is required by either of the Parties to enable each of them to fulfil its obligations regarding reporting arrangements in respect of those functions.

5.6.2 Where particular national or local outcomes, measures or targets (and associated reporting arrangements) relate to services which are associated with both integration functions and functions which are not delegated by a Party to the IJB, the responsibility for the outcomes, measures or targets (and associated reporting arrangements) will be shared between the IJB and the Party or Parties which exercise those functions, and the IJB will be responsible for providing all such information regarding those integration functions as is required by the relevant Party to enable it to fulfil its obligations regarding reporting arrangements.

5.6.3 A set of shared principles will be developed and agreed between the Parties for targets and measurement based on existing best practice, and will be reviewed regularly as required.

5.6.4 A core group of senior managers and relevant support staff from each Party will continue to review and where necessary revise and further develop the Performance Framework, taking account of relevant national guidance. The Performance Framework will be underpinned by the Outcomes and will be further developed on an ongoing basis to drive change and improve effectiveness. The Performance Framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework will be intended to achieve.

5.6.5 A core set of Integration Indicators and measures will be identified by the Parties from publicly accountable and national indicators and targets which relate to services delivered in carrying out of the functions delegated to the IJB.

5.6.6 An Integration Dataset will be created for the IJB. The Integration Dataset shall include information on the data gathering, reporting requirements and accountability for each of these measures and targets and include, in relation to each target, the extent to which responsibility sits with or is to transfer to the IJB. Such shall be shared with and reviewed by the IJB and amended as appropriate following such review.

5.6.7 The Outcomes which apply to integrated health and social care, and the associated national indicators which underpin the nine health and wellbeing Outcomes will be used by the IJB to inform the development of the Performance Framework.

5.6.8 The IJB shall apply the Outcomes and Integration Indicators to inform and assist in setting local priorities and monitoring performance, and will be reported per national and local reporting arrangements.

5.6.9 The Integration Indicators will be aligned with the priority areas identified in the joint strategic needs assessment and the Strategic Plan and will be refined as these documents are reviewed and refreshed. The Integration Indicators shall be in line with IJB strategy and will demonstrably evidence the IJB's endeavours to achieve the Outcomes.

5.6.10 The Parties have obligations to meet targets for functions which are not delegated to the IJB, but which are affected by the performance and funding of integration functions. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details must be provided of any targets, measures and arrangements for the IJB to take into account when preparing the Strategic Plan**.** Where responsibility for performance measures and targets is shared, this will be set out clearly for agreement by the relevant Parties.

5.6.11 The Performance Framework may require information on functions which are not delegated to the Integration Board. Either one of the Parties, or the IJB, will be able to reasonably require information of that nature to be included within the Integration Dataset.

5.6.12 The continuous development of an effective Performance Framework, taking account of relevant national guidance, will be supported by the parties and the IJB. The framework will be underpinned by the Outcomes, and national integration indicators, and will used by the Parties and the IJB to drive change and improve effectiveness.

6 Clinical and Care Governance

6.1 Introduction

6.1.1 This Section of this Revised Integration Scheme sets out the arrangements that will be put in place to allow the IJB to fulfil its role with professional advice and with appropriate clinical and care governance in place. The Parties will expect the IJB to develop more integrated governance arrangements in East Lothian to complement the existing clinical and care governance arrangements.

6.1.2 The Parties have well established systems to provide clinical and care governance as well as assurance for professional accountabilities. Those systems will continue and the scope of these systems will extend to provide the IJB with the requirements to fulfil their clinical and care governance responsibility.

6.1.3 This Section describes the relationship between the Parties' clinical and care governance systems and the IJB. The relationship between these systems and the Strategic Planning Group and delivery of services within localities will be via the Chair and Chief Officer of the IJB. The IJB non-voting membership includes the Chief Social Work Officer and three health professionals who are determined by NHS Lothian. These members will provide a further link between the Parties clinical and care governance systems and the IJB as described in Section 6.2. It is for the IJB to ensure that the Strategic Planning Group has sufficient information to undertake its function and the Parties shall provide such information to the IJB as is necessary for it to do so. This is in line with the commitment in this scheme at 5.3.1 to provide the IJB with the corporate support services required to fully discharge its responsibilities under the Act, which includes support to the IJB, its Strategic Planning and localities.

6.1.4 Continuous improvement and the quality of service delivery (and its impact on outcomes) will be addressed through the development of the IJB's Performance Framework (pursuant to Section 5.6 of this Scheme).

6.1.5 The IJB will not duplicate the role carried out by the Parties existing governance arrangements other than in exceptional circumstances where the IJB considers that direct engagement by the IJB is appropriate in order to secure the proper discharge by the IJB of its statutory responsibilities.

6.1.6 The Parties agree that in the event that one of its committees within its governance arrangements identifies an issue which is of direct and material relevance to the IJB, the chair of that committee will advise the chairperson of the IJB and the Chief Officer of that matter and will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

6.1.7 The Parties shall ensure that its standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, the IJB's place as a common decision-making body within the framework for delivery of health and social care within the East Lothian Area and the Parties role in supporting the IJB to discharge its duties.

6.1.8 The voting members of the IJB are engaged in the governance of their respective Party, and it is likely that they will be members of one or more committees of the relevant Party.

6.1.9 The Parties will use reasonable endeavours to appoint voting members of the IJB (regardless of which party nominated the voting members) onto the NHS Lothian and Council governance arrangements with a remit relevant to the clinical and care governance of integration functions.

6.1.10 Within its existing governance framework, NHS Lothian has:

(a) A healthcare governance committee, the remit of which is to provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard and to provide assurance to the Board of NHS Lothian that the Lothian NHS Board meets its responsibilities with respect to:-

- NHS Lothian Participation Standards
- Volunteers/Carers
- Information Governance
- Protection of Vulnerable People including children, adults, offenders
- Relevant Statutory Equality Duties

and

(b) A staff governance committee, the remit of which is to support and maintain a culture within Lothian NHS Board where the delivery of the highest possible standard of staff

management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The Staff Governance Committee must ensure that robust arrangements to implement the (NHS Scotland) Staff Governance Standard are in place and monitored

6.1.11 The staff governance committee has the primary role on staff governance matters, but can and does refer matters of relevance to the healthcare governance committee.

6.1.12 The healthcare governance committee can request assurance from the staff governance committee on matters of direct relevance to its remit, e.g. quality of recruitment, learning and development, completion of mandatory training.

6.1.13 Within the Council, the Chief Social Work Officer has overall responsibility for the professional standards of the Council's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council (SSSC), and all professional staff must by law be registered with the SSSC. This registration requirement will, in due course, extend to all social care staff employed by the Council and the voluntary and independent sectors.

6.1.14 The Chief Social Work Officer reports annually to the Council on standards achieved, governance arrangements (including supervision and case file audits), volume/quantity of statutory functions discharged, the registration of the workforce and on training, including mandatory training and post-qualifying learning and development.

6.1.15 These reports must comply with national guidance issued by the Scottish Government. The Chief Social Work Officer will also provide a copy of these annual reports to the IJB.

6.1.16 The intention of using the existing NHS Lothian and Council internal governance as a primary source of assurance is to recognise that the Parties will have continuing governance responsibilities for both delegated and non-delegated functions, and that the Parties wish to minimise unnecessary bureaucracy. The IJB will be engaged through its voting membership being part of the Parties' internal governance arrangements. The IJB will be in a position to holistically consider the information/assurance received from the Parties and arrive at a determination for all of its functions. If the IJB is in any way dissatisfied with the information or assurance it receives from the Parties, or the effectiveness of the Parties internal governance arrangements, it may give a direction to the Parties to address the issue, or revise its own system of governance.

6.2 Clinical and Care Governance Risk

6.2.1 There is a risk that the plans and directions of the IJB could have a negative impact on clinical and care governance, and professional accountabilities. Section 6.3 of this Revised Integration Scheme sets out the arrangements that have been or will be put in place to avoid this risk.

6.3 Professional Advice

6.3.1 NHS Lothian has within its executive membership three clinical members (referred to below as '**Executive Clinical Directors'**); a Medical Director, a Nurse Director, and a Director of Public Health. Their roles include responsibility for the professional leadership and governance of the clinical workforce (medical, nursing, allied health professionals, healthcare scientists, psychology, pharmacy), as well as clinical governance within NHS Lothian generally. The creation of the IJB does not change their roles in respect of professional leadership, and they remain the lead and accountable professionals for their respective professions.

6.3.2 The Council has a Chief Social Work Officer who reports to the Chief Executive and councillors. The Chief Social Work Officer monitors service quality and professional standards in social care and social work, for staff employed in both adult and children's services, together with standards in relation to the protection of people at risk of harm. The Chief Social Work Officer role also includes quality assurance of decision-making with regard to adult social care, mental health criminal justice and children's services, in particular in relation to public protection and the deprivation of liberty.

6.3.3 The creation of an IJB does not change the Chief Social Work Officer's role in respect of professional leadership and he or she will remain the lead and accountable professional for his or her profession.

6.3.4 The IJB may elect to appoint one or both of the Medical Director and the Nurse Director as additional non-voting members of the IJB. The IJB's Order requires NHS Lothian to fill the following non-voting membership positions on the IJB:

(a) A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
(b) A registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and
(c) A registered medical practitioner employed by NHS Lothian and not providing primary medical services.

6.3.5 NHS Lothian will consider the advice of the Executive Clinical Directors, and any other relevant officer it deems fit before making appointments to fill the membership positions referred to in Section 6.3.4. The appointees will be professionally accountable to the relevant Executive Clinical Director. NHS Lothian will develop a role description for the appointments referred to in Section 6.3.4, to ensure that their role on the IJB with regard to professional leadership and accountability is clearly defined and understood.

6.3.6 The three health professional representatives referred to in Section 6.3.4 will each also be:

(a) A member of an integrated professional group (should it be established); and/or

(b) A member of a NHS Lothian committee; and/or

(c) A member of a consultative committee established by NHS Lothian.

6.3.7 If a new "integrated professional group" is established, the Chief Social Work Officer must also be a member.

6.3.8 The three health professional representative set out in Section 6.3.4 and the Chief Social Work Officer will be expected by the Parties to play a lead role in:

(a) Communicating and having regard to their duties to NHS Lothian or the Council as the case may be whilst discharging their role as a member of the IJB;

(b) Communicating and having regard to the interests of the IJB whilst discharging their duties as professionals employed by NHS Lothian or (as the case may be) the Council.

(c) The members will be expected to communicate regularly with the Executive Clinical Directors, and the Council's Chief Executive as and when appropriate.

6.3.9 The presence of these four members will ensure that the decisions of the IJB are informed by professional advice from within the membership of the IJB.

6.3.10 NHS Lothian includes a governance statement in its annual accounts, the content of which is informed by the annual reports of its governance committees (such as healthcare governance and staff governance) and certificates of assurance from its Executive Clinical Directors. The IJB may place reliance on these existing processes, and the Parties will provide any such reports from those processes as the IJB may require.

6.3.11 The Executive Clinical Directors shall be entitled to raise issues directly with the IJB in writing. The IJB shall be required to respond in writing when issues are raised in this way. The Chief Social Work Officer will be a non-voting member of the IJB, and can therefore raise any issues directly at the IJB.

6.3.12 The engagement of professionals throughout the process to develop and consult on the Strategic Plan is intended to ensure that the IJB has all the required information to prepare a Strategic Plan, which will not compromise professional standards.

6.3.13 In the unlikely event that the IJB issues a direction to NHS Lothian, which is reasonably likely to compromise professional standards, then in the first instance, the relevant Executive Clinical Director will write to the IJB.

6.3.14 If the issue is not resolved to his/her satisfaction, he/she must inform the board of NHS Lothian before it takes action to implement the direction, and the following measures will apply:

(a) The relevant Executive Clinical Director must ensure that appropriate advice is tendered to the board of NHS Lothian on all matters relating to professional standards;

(b) The relevant Executive Clinical Director must set out in writing to NHS Lothian any objections he/she may have on a proposal that may compromise compliance with professional standards;

(c) The board of NHS Lothian will inform the IJB that it has received such objections, along with a statement of the views of the board of NHS Lothian on those objections;

(d) If the board of NHS Lothian decides to proceed with a proposal despite those objections, the relevant executive clinical director will be provided with written authority from the board of NHS Lothian to act on the proposal. NHS Lothian must inform the Scottish Government Health and Social Care Directorate if a request for such a written authority is made. A copy of that authority must be sent to the appropriate regulatory body, e.g. General Medical Council;

(e) Once the relevant Executive Clinical Director has received that written authority, he/she must comply with it;

6.3.15 Regardless of whether a written authority has been given, the Executive Clinical Directors, in their capacity as NHS Lothian members, should always vote against a proposal that they cannot endorse as accountable officers. It is not sufficient to abstain from a decision.

6.3.16 The three professional clinical members on the IJB (two medical practitioners, one nurse) are non-voting members. They will be expected by the Executive Clinical Directors to raise any concerns in relation to matters which may compromise professional standards with the IJB.

6.3.17 If any of the three professional clinical members becomes aware of a matter arising from the conduct of IJB business, which may compromise professional standards, he/she must immediately notify the relevant Executive Clinical Director(s) of their concerns.

6.3.18 The Chief Social Work Officer must be a non-voting member of the Integration Joint Board, and as such, will contribute to decision-making, and will provide relevant professional advice to influence service development.

6.3.19 In the event that the Integration Joint Board issues an direction to the Council or NHS Lothian, which in the view of the Chief Social Work Officer compromises professional social work standards or the discharge of statutory functions, the Chief Social Work Officer must immediately notify the Chief Officer of his/her concerns and if his/her concerns are not resolved by the Chief Officer to his/her satisfaction they must then raise the matter with the Chief Executive of the Council.

6.4 Professionals Informing the IJB Strategic Plan

6.4.1 With regard to the development and approval of its Strategic Plan, the IJB is required to:

(a) establish a strategic planning group (which will review the draft Strategic Plan). This strategic planning group must include a nominee from both NHS Lothian and the Council in its membership, as well as representation from health professionals and social care professionals. NHS Lothian and the Council will make recommendations to the IJB with regard to the representation from health professionals and social care professionals;

(b) consult both NHS Lothian and the Council on its Strategic Plan, and take into account their views before it finalises the Strategic Plan.

6.4.2 There will be three opportunities within these arrangements for professional engagement in the planning process;

(a) at the IJB;
(b) in the context of the work of the strategic planning group; and
(c) as part of the consultation process with the Parties associated with the Strategic Plan.

6.4.3 The membership of the IJB will not be the only source of professional advice available to the IJB. In advance of the establishment of the IJB the Parties agreed that the chairs of all appropriate committees and groups will be informed that they are able to, and expected to, directly provide advice to the IJB. Those committees and groups may also advise an

integrated professional group that provides advice to the IJB. Those committees and groups include, but are not limited to:

(a) Local consultative committees that have been established under section 9 of the National Health Service (Scotland) Act 1978;
(b) Managed Clinical/ Care Networks;
(c) East and Mid Lothian Public Protection Committee (adult and child protection, drug and alcohol, violence against women, offender management etc). The IJB will consult this committee on any plans that may impact on the protection of children or vulnerable adults or people who are assessed as posing a risk;
(d) Any integrated professional group established.

6.4.4 NHS Lothian and the Council will ensure that the draft Strategic Plan is sent to the following senior professionals in order to secure their input and advice:

- NHS Lothian Executive Medical Director;
- NHS Lothian Executive Director of Nursing and Allied Health Professions
- NHS Lothian Director of Public Health & Health Policy;
- Chief Social Work Officer.

6.4.5 The engagement of the Council's professionals will not be limited to social work staff, but will extend to related professionals within social care, such as, but not exclusively, occupational therapists, home care and social care staff.

6.4.6 The approach to locality planning and delivery including the arrangements for clinical and social care governance will be developed through the strategic planning process in a collaborative manner for the IJB.

6.5 External scrutiny of clinical and care functions

6.5.1 NHS Lothian seeks assurance for internal control/quality through its Healthcare Governance Committee, which includes reports by external bodies such as Healthcare Improvement Scotland.

6.5.2 The Care Inspectorate (Social Care and Social Work Improvement Scotland) regulates, inspects and supports improvement of adult and children's social work and social care, and their reports feed into the Council's system of governance.

6.5.3 The IJB will consequently be informed of any relevant issues from external scrutiny, as a consequence of drawing from the systems already established by the Parties.

6.6 Service User and Carer Feedback

6.6.1 The Parties have a range of systems already in place to capture and respond to service users' experience, and these will continue to be used as the Parties implement the directions of the IJB.

7 Chief Officer

7.1 The Chief Officer will be appointed by the IJB; he/she will be employed by one of the Parties and will be seconded to the IJB.

7.2 The Chief Officer will provide a strategic leadership role as principal advisor to and officer of the IJB and will be a member of the senior management teams of the Parties. The Chief Officer will lead the development and delivery of the Strategic Plan for the IJB and will be accountable to the IJB for the content of the directions issued to the Parties by the IJB and for monitoring compliance by the Parties with directions issued by the IJB.

7.3 The Chief Officer will report directly to the Chief Executives of both Parties. There will be a joint process for the regular performance reviews, support and supervision with both Chief Executives. Annual objectives for the Chief Officer will be agreed and the process will involve the chairperson of the Integration Joint Board agreeing objectives with the Chief Officer relevant to his/her role with the Integration Joint Board as well as the Chief Executives of the Parties. The Chief Officer's performance against those annual objectives will be monitored through an agreed Performance Framework established by the Party which is his/her employer.

7.4 If an interim replacement for the Chief Officer of the IJB is required, in line with a request from the IJB to that effect (on the grounds that the Chief Officer is absent or otherwise unable to carry out his/her functions), the Chief Executives of the Parties will initiate a joint selection process, identifying a list of potential replacements; and selection of a suitable candidate will be undertaken against a set of agreed criteria. The interim replacement will be employed by one of the Parties and will be seconded to the IJB on an interim basis.

7.5 The Chief Officer will have operational responsibility for all of the functions delegated to the IJB with the following exceptions:

(a) The Chief Officer for NHS Lothian acute hospital services and directors responsible for the Western General Hospital, the Royal Infirmary of Edinburgh, St Johns Hospital and the Royal Edinburgh Hospital will provide delegated services on these hospital sites that will not be operationally managed by the Chief Officer.

Specific NHS Lothian functions that are managed on a pan-Lothian basis as a 'hosted service' which are solely the responsibility of NHS Lothian and not an IJB Delegated Function, which may be managed by one of the four chief officers in Lothian.

7.6 A group consisting of Directors responsible for hospital functions delegated to the IJB and the Chief Officers of the four IJBs in Lothian will be established to ensure close working arrangements between A) IJB Chief Officers, the Chief Officer of NHS Lothian acute hospital services and Hospital Site Directors and B) Chief Officers responsible for the management of a hosted service on behalf of the other three Lothian Chief Officers.

8 Workforce

8.1 The arrangements in relation to their respective workforces agreed by the Parties are:

(a) For staff managed by a line manager who is employed on different terms and conditions, the manager will observe the contract of employment and apply the employer's employment policies and procedures. Guidance will be available to assist the line manager. In addition the Parties will establish professional leadership lines of accountability to ensure clinical and professional standards are monitored and maintained;

(b) The Parties have agreed an Organisational Development Plan which is being implemented. There is a Human Resources and Organisational Group which includes Senior Managers and Trades Unions from both Parties.

8.2 The Parties have developed a Human Resources and Organisational Development plan which supports the workforce through the integration process. This is a comprehensive plan which covers staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams. This plan will be reviewed annually to ensure that it takes account of the Strategic Plan of the IJB and the development needs of staff within the IJB.

8.3 The Human Resources and Organisational Development plan will be monitored regularly and reviewed no less than once in any financial year.

8.4 The Parties will support the IJB to prepare a joint Workforce Development and Support Plan through the provision of professional, technical and support services described in Sections 5.4 and 6.1 of this Revised Scheme of Integration. The Workforce Development and Support Plan will sit alongside and be informed by the IJB's Strategic Plan.

9 Finance

9.1 This section describes the arrangements in relation to financial management and monitoring of integrated resources. It sets out the method for determining the resources to be made available by the council and the health board to the Board. It also explains the financial governance and management arrangements, including budget variances, and the financial reporting arrangements between the Board, the council and the health board

9.2 **Chief Finance Officer**

9.2.1 In relation to the preparation of its accounts and their audit, the Board is governed by the same legislation applying to local authorities and is required to make arrangements for the proper administration of its financial affairs; through the appointment of a proper officer for that purpose. The Board has appointed a Chief Finance Officer with this responsibility. The Chief Finance Officer will be employed by the council or the health board and seconded to the Board. The holder of the post should be a member of a relevant professional accounting body, and the Board should have regard to the current CIPFA Guidance on the role.

9.2.2 In the event that the Chief Finance Officer position is vacant or the holder is unable to act, the Chief Officer shall secure, in consultation with the Board Chair, and through agreement with both the council's Section 95 Officer and the health Board's Director of Finance, an appropriate interim dedicated resource to discharge the role.

9.3 **Financial Management of the Board**

9.3.1 The Board is responsible for determining its own internal financial governance arrangements; and the Chief Finance Officer will be responsive to the decisions of the Board, and the principles of financial governance set out in this Scheme.

9.4 **Principles of Financial Governance**

9.4.1 The following principles of financial governance shall apply:

- the health board and the council will work together in a spirit of openness and transparency
- the health board and the council will work in partnership with the Board with the objective of agreeing sufficient funding of delegated functions in line with the financial elements of the Strategic Plan

9.5 **Financial Governance**

9.5.1 The Parties will contribute to the establishment of a Board budget. The Chief Officer will manage the Board budget.

9.5.2 The Parties are required to implement the Directions of the Board in carrying out the delegated functions in line with the Strategic Plan. The Parties will apply their established systems of financial governance to the payments they receive from the Board. The health board's Accountable Officer and the council's Section 95 officer have legally defined responsibilities and accountability for the financial governance of their respective bodies.

9.5.3 The Chief Officer in their operational role within the health board and the council is responsible for the financial management of any operational budgets (as defined in section 9 of this Revised Scheme of Integration) that may be delegated to them by the Parties, and is accountable for this to the health board's Chief Executive and the council's Section 95 Officer.

9.5.4 The Board will develop and maintain its own financial regulations. The Chief Finance Officer will periodically review these financial regulations and present any proposed changes to the Board for its approval.

9.5.5 The council will host the Board's Financial Accounts and will be responsible for recording the Board's financial transactions through its existing financial systems. The Integration Joint Board can hold reserves. It is a matter for the Board to determine what its reserves strategy will be.

9.5.6 The Board's Chief Finance Officer is responsible for preparing the Board's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

9.5.7 As part of the financial year end procedures and in order to develop the year-end financial statements, the Chief Finance Officer will work together with the health board and the council to coordinate an exercise agreeing the value of balances and transactions with council and health board Finance teams. Each Party will provide information to this process on their recorded income, expenditure, receivable and payable balance with the Board. The Board's Chief Finance Officer will lead with the Parties on resolving any differences.

9.5.8 The Chief Finance Officer will also be responsible for preparing a medium-term financial plan to be incorporated into the Board's Strategic Plan. The Chief Finance Officer will liaise closely with the health board and the council to develop integrated medium term financial planning and associated financial recovery plans taking account of assumptions around available funding and future service demands and service delivery models.

9.5.9 The Chief Finance Officer will also be responsible for preparing the annual financial statement that the Board must publish under section 39 of the 2014 Act, which sets out what the Board intends to spend in implementation of its Strategic Plan.

9.5.10 The Chief Finance Officer will be responsible for producing finance reports to the Board, ensuring that those reports are appropriate for the needs of the Board.

9.5.11 The Chief Finance Officer will liaise closely with the council's Section 95 Officer and the health baord's Director of Finance and their teams in order to discharge all aspects of their role.

9.6 Resources Delegated to the Board

9.6.1 The resources delegated to the Board fall into two categories: (i) payments for the delegated functions; and (ii) resources used in large hospitals that are set aside by the health board and made available to the Board for inclusion in its Strategic Plan.

9.6.2 Section 1(3)(e) of the 2014 Act requires that the Scheme must set out a method of determining payments that are to be made in respect of (i) above. Section 1(3)(d) of the 2014 Act requires the Scheme to set out a method of determining the amounts to be made available by the health board for us by the Board under (ii) above.

9.6.3 It is expected that the net difference between payments into and out of the Board will result in a balancing payment between the council and the health board which reflects the effect of the Directions of the Board. The balancing payment will be reviewed throughout the year and depending on the expected value for the adjusting payment, it will be either made one-off prior to year-end or on a quarterly basis. Such payments would incorporate values previously treated as resource transfer.

9.7 Annual Budget Payments to the Board

9.7.1 The council and the health board identify a core baseline operational budget for each function that is delegated to the Board. This will be used as the basis to calculate their respective payments into the Board budget each year. The previously agreed "resource transfer" payments from the health board will be part of the annual budget payment to the Board.

9.7.2 The council and the health board have established financial planning processes which take into account the financial settlements they have received, and identified and assumed expenditure pressures, to arrive at opening annual budgets. These same processes will be applied to the core baseline operational budgets for the delegated functions in order to arrive at the annual payments to the Board.

9.7.3 The council's Section 95 Officer and the health board's Director of Finance are responsible for preparing the budget contributions from their respective Party. The amounts to be paid will be the outcome of the above processes. They will consult with the Chief Officer and officers in both Parties as part of this process.

- The council's Section 95 Officer and the health board's Director of Finance will each prepare a schedule outlining the detail and total value of the proposed payment from each party, and the underlying methodology and assumptions behind that payment. These draft schedules will identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. The schedules will also contain the detail and total value of set aside resources for hospital services, made under section 1(3) (d) of the 2014 Act.

- The council's Section 95 Officer and the health board's Director of Finance will refer the draft schedules to the Chief Officer so that they may have an opportunity to formally consider it.

- The council's Section 95 Officer and the health board's Director of Finance will thereafter present the final draft schedules to the Parties. This schedule must be agreed by the health board's Director of Finance, the council's Section 95 Officer and the Chief Officer.

- The council and the health board must approve their respective payments, in line with their governing policies

9.7.4 The council's Section 95 Officer and health board's Director of Finance will liaise closely with the Chief Officer and Chief Finance Officer on the assumptions to be used on annual budget contributions and will have due regard to the impact of any service re-design activities that have been a direct consequence of the Board's Strategic Plan or Directions issued. Both the council and the health board will provide indicative three year budget allocations to the Board, subject to annual approval through their respective budget setting processes.

9.7.5 The Parties will ensure the Chief Officer and Chief Finance Officer are actively engaged in their financial planning processes. The Chief Officer will be expected to feed into the planning processes with any intelligence that is relevant, e.g. the aims of the Strategic Plan, the effect of previous directions on activity and expenditure, projected demand led changes in activity and expenditure. The health board's Director of Finance, the council's Section 95 Officer and the Chief Finance Officer will ensure a consistency of approach and consistent application of processes in considering budget assumptions and proposals.

9.8 **The set-aside of resources for use by the Board under section 1(3) (d) of the 2014 Act**

9.8.1 In addition to the payments to the Board, the health board will identify a set aside budget for delegated functions in large hospitals. The set aside budget for delegated hospital services will be based on an apportionment of the relevant health board budgets for the delegated hospital services (excluding overheads).

9.8.2 The core baseline budget for the set-aside functions in each council area will be based on an appropriate methodology and agreed in partnership by the Health Board and Board.

9.9 **Hosted Services**

9.9.1 NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to the Lothian IJBs are currently provided as part of a single Lothian-wide service, commonly referred to as "hosted services".

9.9.2 The core baseline budget for the hosted services in each IJB area will be based on an appropriate methodology and agreed in partnership by the health board and Board.

9.10 **Due Diligence**

9.10.1 The Parties will share information on the financial performance over at least the previous two financial years of the functions and associated services delegated to the Board. This will allow the Parties to undertake appropriate reviews to gain assurance as to whether the services are currently being delivered sustainably within approved resources, and that the anticipated payments will be sufficient for the Board to carry out its integration functions.

9.10.2 If any such review indicates that the projected expenditure is likely to exceed the payments to the Board, then the relevant Party will be notified. The relevant Party will be required to take action to ensure that services can be delivered within the available operational budget

9.10.3 The Parties recognise that of the functions which are to be delegated to the Board, there are some where there is greater potential for the actual expenditure to vary significantly from projections. The Parties will identify what those functions are, and will ensure that information is provided to the Board so that it is aware of the issues, and is able to focus on those functions within their systems for risk management and financial reporting.

9.10.4 This process of due diligence will be informed by, amongst other things, the intelligence within the financial performance reports covering all integration functions that the Board will routinely receive.

9.11 **Process to agree payments from the Board to the Parties**

9.11.1 The Board will determine and approve, in accordance with the Strategic Plan, the payments to the Parties which will accompany its Directions to them for carrying out functions delegated to the Board. The Parties are required to implement the Directions of the Board in carrying out

a delegated function in line with the Strategic Plan, having agreed with the Board the resources required to deliver the said directions.

9.11.2 The Chief Finance Officer is responsible for providing the Board with appropriate information and advice, so that it may determine what those payments should be.

9.11.3 Directions from the Board to the Parties will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- the delegated function(s) that are to be carried out
- the outcomes to be delivered for those delegated functions
- the amount of and / or method of determining the payment to be made, in respect of the carrying out of the delegated functions.

9.11.4 Once issued, Directions can be amended or deleted or replaced by a subsequent Direction by the Board.

9.11.5 Where amounts paid to the Board are subject to separate legislation or subject to restrictions stipulated by third party funders, the Board must reflect these amounts in full, in determining the level of the payments to be made to the Parties in respect of the carrying out of the relevant function or functions. However, the Board is not precluded from increasing the resource allocated to the relevant services.

9.12 **Financial Reporting to the Board**

9.12.1 Budgetary control and monitoring reports will be provided to the Board as and when it requires. The reports will set out the financial position and forecast against the payments by the Board to the Parties in respect of the carrying out of integration functions and against the amount set aside by the health board for hospital services. These reports will present the actual and forecast positions of expenditure compared to budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.

9.12.2 The health board will provide information on the set-aside budgets which will be contained in financial reports to the Board.

9.12.3 Both Parties will provide the required information on budgetary performance from their respective finance systems, and this will be co-ordinated and consolidated by the Chief Finance Officer to provide reports to the Board on all the Board's delegated functions.

9.12.4 It is expected that as a minimum there will be quarterly financial reports to the Chief Officer and the Board.

9.13 **Process for addressing variance in the spending of the Board**

9.13.1 The Board is required to deliver its financial out-turn within available resources. Section 15 of this scheme sets out the arrangements for risk management, and financial risk (within the Board and both Parties) will be managed in line with those arrangements.

9.13.2 The Parties will ensure that their respective budget monitoring and management systems will be applied to monitor and manage their expenditure in relation to delivery of integrated functions in accordance with Directions issued to them by the Board.

9.13.3 The manager leading this remedial action could be the Chief Officer in his or her operational capacity within the affected party.

9.13.4 In the event that such remedial action will not prevent the overspend, then the Chief Finance Officer will, together with the relevant Party, develop a proposed recovery plan to address the forecast overspend. The Chief Finance Officer will then present that recovery plan to the Board as soon as practically possible. The Board has to be satisfied with the recovery plan, and the plan is subject to its approval.

9.14 **Additional Payments by the Parties to the Board**

9.14.1 Where such a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end, and where there are insufficient available reserves held by the Board to meet the overspend, then the Parties may make additional payments to the Board.

9.14.2 The Chief Finance Officer and the Parties shall engage in discussion and negotiation about the amounts to be paid by each Party.

9.14.3 The Parties recognise that the delivery of delegated functions in accordance with the Strategic Plan depends on their co-operation between each other and with the Board and that all three parties must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. In such discussions the Parties recognise and accept that an overspend is at the risk of the Party incurring the overspend and the residual amount of overspend after usage of reserves must, in the absence of any other agreement, be met by that Party.

9.14.4 Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the Board, then the dispute resolution mechanism in this Scheme may require to be implemented.

9.15 **Underspends**

9.15.1 As part of their normal financial management systems, the Parties conduct in-year reviews of financial performance, and occasionally this may lead to a forecast of an underspend at the year-end on one or more budgets. In the event that this happens within the operational budgets then the following shall apply:

- if the underspend is fortuitous and unrelated to any Board Direction then the underspend should be returned to the affected Party (through an adjustment to the payments to the Board)

- the Board will retain all other underspends.

9.15.2 The Board can hold reserves, as determined by its Reserves Policy.

9.16 **Treatment of variations against the amounts set aside for use by the Board**

9.16.1 A process will be agreed between the health board and the Board to manage any variations within the set-aside budget. This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Integrated payment as laid out above.

9.17 **Redetermination of payments (made under section 1(3) (e)) to the Board**

9.17.1 Redeterminations of payments made by the Parties for the carrying out of integration functions would apply under the following circumstances:

- Additional one off funding is provided to a Party or Parties by the Scottish Government, or some other body, for expenditure in respect of a function delegated to the Board

- The Parties, along with the Board, agree that an adjustment to the payment is required to reflect changes in demand and/or activity levels

9.17.2 In all cases full justification for the proposed change would be required and both Parties and the Board would be required to agree to the redetermination. The Parties would apply the process used to calculate the payment to the Board (described earlier) to the affected functions and the Strategic Plan would be required to be amended as necessary.

9.18 **Redetermination of set aside payments (made under section 1(3) (d)) to the Board**

9.18.1 This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Operational Budgets as specified above.

9.19 **Use of Capital Assets**

9.19.1 The Board, the health board and the council will ensure there is awareness of all capital assets which will be used in the delivery of the Strategic Plan.

9.19.2 Changes in use of capital assets will flow from the Strategic Plan and the Directions issued by the Board to the Parties. The Strategic Plan process will outline any implications or requirements for capital assets.

9.19.3 The Parties will ensure that their capital asset planning arrangements take due cognisance of the above implications and requirements.

9.19.4 The Chief Officer of the Board will consult with the Parties to identify the specific need for improvements/changes to assets owned by each which may be required in connection with the carrying out of integration functions. Where a capital investment need is identified, a business case will require to be developed. Any business case will set out how the investment will meet the strategic objectives set out in the Strategic Plan and identify the ongoing revenue costs/savings associated with implementation of the proposals.

9.19.5 The Board, the council and the health board will work together to ensure assets required in connection with the carrying out of integration functions are used as effectively as possible and in compliance with the relevant legislation relating to use of public assets.

9.20 **Audit and Financial Statements**

Financial Statements and External Audit

9.20.1 The 2014 Act requires that the Board is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973 (section 13). This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003, the Local Authority Accounts (Scotland) Regulations 2014 and other regulations under section 105 of the Local Government (Scotland) Act 1973). These will be proportionate to the limited

number of transactions of the Board whilst complying with the requirement for transparency and true and fair reporting in the public sector.

9.20.2 The Parties will agree a clear timetable for the preparation of the Board's annual accounts which will incorporate a process to agree any balances between the Board and the Parties. The reporting requirements for the annual accounts are as set out in legislation and regulations and are prepared following the CIPFA Local Authority Code of Practice.

9.20.3 As part of the financial year-end procedures and in order to develop the year-end financial statements, the Chief Finance Officer of the Board will annually co-ordinate an exercise agreeing the value of balances and transactions with the council and health board finance teams. Each of the Parties will submit to the Chief Finance Officer their recorded income, expenditure, receivable and payable balance with the Board. The Parties' respective finance representatives will then work to resolve any differences arising.

9.20.4 The Board financial statements must be completed to meet the audit and publication timetable specified in the regulations (Regulations under section 105 of the Local Government (Scotland) Act 1973).

9.20.5 The Accounts Commission will appoint the external auditors to the Board.

9.20.6 The financial statements will be signed in line with the governance arrangements for the Board and as specified in the Local Authority Accounts (Scotland) Regulations 2014, made under section 105 of the Local Government (Scotland) Act 1973.

9.20.7 In all forms of audit, the Parties are expected to comply with related requests and to aid the audit process.

10 Participation and Engagement

10.1 The Parties will support the Chief Officer, who will on behalf of the IJB, produce a strategy for engagement with, and participation by members of the public, representative groups or other organisations in relation to the decisions about the carrying out of integration functions as set out in this Section 10. The process to identify and provide support to the Chief Officer to develop the IJB's participation and engagement strategy is described in Section 5. As part of the process set out in Section 5 the Parties will:

(a) Make available to the IJB arrangements that are already established for consultation by one or both of the Parties. The IJB will consider a range of ways in which to connect with all stakeholders.

(b) Make available service/user participation and engagement teams to the IJB as this relates to function delegated within this Revised Integration Scheme.

(c) Make available communication support to allow the IJB to engage and participate.

10.2 The Parties expect that the IJB's participation and engagement strategy will be produced before the date the IJB approves the Strategic Plan for public consultation. When the IJB approves the Strategic Plan, Parties expect that IJB members must be satisfied that the Strategic Plan has had sufficient consultation and that the participation and engagement strategy has been followed.

10.3 The development of the participation and engagement strategy will be achieved using a collaborative response, involving the membership of the East Lothian Strategic Planning Group.

10.4 The Strategic Planning Group is expected to take both an advisory and active role in the undertaking of future participation and engagement around the implications of service development and re-design.

11 Consultation on this Revised Integration Scheme

11.1 A three stage approach was adopted to ensure sufficient involvement and consultation in the revision and further development of this This Revised Integration Scheme:

Stage 1: Informing and Engaging:
Initial review was undertaken and revisions made by officers of the Parties with the involvement of a range of professionals within both Parties. This draft was approved for consultation by the Parties

Stage 2: Consultation
A formal internal and external stakeholder consultation was held from 2/5/22 – 29/5/22.

Stage 3: Response to the consultation
This Revised Integration Scheme was further developed by officers, guided by the consultation, and submitted for approval by the Parties to submit to Scottish Government.

11.2 Further details of the people and groups involved in the informing, engagement and consultation on this Scheme are set out in Annex 4.

12 Information-Sharing and data handling

12.1 There is an existing and long standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian, City of Edinburgh Council, East Lothian Council, Midlothian Council, West Lothian Council and Scottish Borders Council are all signatories and has been subject to previous modifications to comply with the Integration Scheme Regulations. This Protocol is subject to periodic review by a sub group on behalf of the Pan-Lothian Data Sharing Partnership and any resultant updates will be agreed and form the Protocol to support this Revised Integration Scheme. Any updated Protocol, following consultation, will be recommended for signature by Chief Executives of respective organisations, and the Chief Officers of the Integration Joint Boards, once they have been appointed by the IJB, on behalf of the Pan-Lothian Data Sharing Partnership.

12.2 Procedures for sharing information between the Council, the other local authorities within NHS Lothian area, NHS Lothian, and, where applicable, the IJB will be drafted as Information Sharing Agreements and procedure documents. This will be undertaken by a sub group on behalf of the Pan-Lothian Data Sharing Partnership, who will detail the more granular purposes, requirements, procedures and agreements for each of the Lothian Integration Joint Boards and the functions respectively delegated to them. This will also form the process for amending the Pan-Lothian and Borders General Information Sharing Protocol.

12.3 The Council and NHS Lothian will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The IJB may require to be Data Controller for personal data if it is not held by either by the Council or NHS Lothian.

12.4 Arrangements for third party organisations access to records will be jointly agreed by all the Parties and the IJB prior to access.

12.5 Procedures will be based on a single point of governance model. This allows data and resources to be shared, with governance standards, and their implementation, being the separate responsibility of each organisation. Shared datasets governance will be agreed by all contributing partners prior to access.

12.6 Following consultation, Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of respective organisations, and the Chief Officers of the Lothian Integration Joint Boards.

12.7 The information sharing agreements and procedures have been established and shall be reviewed annually by the sub group of the Pan-Lothian Data Sharing Partnership, or more frequently if required. This will follow the process described in 12.2.

13 Complaints

The Parties agree the following arrangements in respect of complaints:

13.1 Any person will be able to make complaints either to the Council or to the NHS Lothian. The Parties have in place well publicised, clearly explained and accessible complaints procedures, which allow for timely recourse and signpost independent advocacy services, where appropriate. There is an agreed emphasis on resolving concerns locally and quickly; as close to the point of service delivery as possible.

Complaints can be made to:

- the Council by:
  - telephone: 0131 653 5290
  - email: feedback@eastlothian.gov.ukonline: www.eastlothian.gov.uk
  - in writing: Customer Feedback Team, East Lothian Council, John Muir House, Haddington, EH41 3HA (or Freepost Plus, RSTG-AGEL-RJYH, Customer Feedback Team, East Lothian Council, John Muir House, Haddington, EH41 3HA) ; or
  - in person by visiting any Council office where feedback forms are available.

- NHS Lothian by:
  - Telephone: 0131 536 3370
  - Email: feedback@nhslothian.scot.nhs.uk
  - In writing to NHS Lothian Patient Experience Team, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh, EH1 3EG.

13.2 There are currently different legislative requirements in place for dealing with complaints about health and social care. Complaints regarding the delivery of an integrated service will be made to, and dealt with by, the Party that delivers the integrated service, in line with their published complaints procedure, and consistent with any statutory complaints handling arrangements that apply. It is the responsibility of the Party initially receiving a complaint to make sure that it is routed to the appropriate organisation/individual, so that the person making the complaint only needs to submit a complaint once.

13.3 From 1 April 2017, the health and social work complaints handling procedures were aligned and therefore have the same stages and timescales, with the exception of timescale

extensions. Additionally, complaints about Social Work functions were merged into the Local Authority Model Complaint Handling Procedure in 2020 (now reflected in the updated East Lothian Council Complaints Handling Procedure). Joint working protocols have been adopted and will continue to be reviewed so that the process of making a complaint is as simple as possible and complaints about integrated services are responded to clearly, thoroughly and timeously. These joint working protocols will identify the lead organisation for each integrated service and will include the contact details of officers responsible for managing any complaints received

13.4 When a complaint covers both health and social care functions, responsible officers within the Council and NHS Lothian will, where necessary, work together to make sure all parts of the complaint are investigated and responded to within established time limits and the complainant is correctly signposted to the options open to them if they remain dissatisfied. Wherever possible, there will be a joint response from the identified Party rather than separate responses.

13.5 At the end of the process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman. Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate and information held by the Council may be shared with the Care Inspectorate.

13.6 Responsibility for responding to the Scottish Public Services Ombudsman lies with the Party who dealt with the original complaint. Where necessary, officers responsible for complaints handling within the Council and NHS Lothian will work together to provide a full response to any Scottish Public Services Ombudsman enquiry that covers both health and social care functions.

13.7 The Chief Officer will have an overview of complaints made about integrated services and subsequent responses. Complaints about integrated services will be recorded and reported to the Chief Officer on a regular and agreed basis. Regular trend analysis of complaints and outcomes will also be carried out as part of a wider quality assurance framework.

13.8 All independent contractors (General Practitioners, Community Pharmacists, Optometrists, opticians, General Dental Practitioners etc.) will be required to have a complaints procedure. Where complaints are received about the service provided by an independent contractor, the Party receiving the complaint will refer the complaint to the independent contractor in the first instance, either providing contact details or by passing the complaint on, depending on the preferred approach of the complainant. Complaints received about independent contractors will be recorded for contract monitoring purposes.

14 Claims Handling, Liability & Indemnity

14.1 The Parties and the IJB recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the IJB.

14.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

14.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

14.4 Each Party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

14.5 Each Party will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

14.6 Each Party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

14.7 In the event of any claim against the IJB or in respect of which it is not clear which Party should assume responsibility then the Chief Officer (or their representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which Party should assume responsibility for progressing the claim.

14.8 If a claim is settled by either Party, but it subsequently transpires that liability rested with the other Party, then that Party shall indemnify the Party which settled the claim.

14.9 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

14.10 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

14.11 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

14.12 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

15 Risk Management

15.1 Integration Joint Board

15.1.1 Risk management processes will include risk monitoring, and a reporting process for the Parties and IJB via a Risk Register for the IJB. Risks will be continuously monitored and reported to the IJB.

15.1.2 The Parties will provide to the IJB sufficient support to enable it to fully discharge its duties in relation to risk management. This will be determined through the process described in Section 5.4.

15.1.3 The Parties anticipate that the IJB will also develop and agree its own risk management procedure in relation to carrying out of integration functions including reports, which will cover all of its activities.

15.1.4 The risk management procedure will include:-

(a) A statement of the IJB's risk appetite and associated tolerance measures;

(b) A description of how the system of risk management will work in practice, including procedures for the identification, classification, recording and reporting of risk, and the respective roles of the IJB and its officers. This will explain how the output from the risk management systems within NHS Lothian and the Council will inform the IJB's system of risk management;

(c) A description of how the IJB system of risk management is informed by other related systems of NHS Lothian and the Council, such as complaints management, health & safety, adverse events management, emergency planning and business resilience;

(d) an agreement between NHS Lothian and the Council on the resources to be made available to support risk management;

15.1.5 The IJB risk register will not duplicate the detail of risk registers within NHS Lothian and the Council. However, the IJB will update its risk register should there be any emerging themes/risks which have a bearing on its activities.

15.2 **NHS Lothian and the Council**

15.2.1 Both Parties will continue to apply their existing policies and systems for risk management.

15.2.2 NHS Lothian covers four local authority areas, and there will be some 'hosted services' which one operational director manages on a Lothian-wide basis. The identification and management of risk for those hosted services will reflect the differing directions of the four IJBs.

16 Dispute resolution mechanism

16.1 The Parties will commit to working well together, listening to each other and will always work to resolve any issues before they require the Dispute Resolution process to be actioned.

16.2 Where either of the Parties fails to agree with the other on any issue related to this Revised Integration Scheme or any of the duties, obligations, rights or powers imposed or conferred upon them by the Act (a 'Dispute'), then they will follow the process described below:

(a) The Chief Executives of NHS Lothian and the Council, and the Chief Officer, will meet to resolve the Dispute within 21 calendar days of being notified of the issue;

(b) If unresolved, NHS Lothian, the Council, and the Chief Officer, will each prepare a written note of their position on the Dispute and exchange it with the others within 14 calendar days of the meeting in (a) above;

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions;

(d) In the event that the issue remains unresolved, representatives of NHS Lothian and the Council will proceed to mediation with a view to resolving the Dispute.

16.3 Scottish Government will be informed by the chairperson of the IJB of the Dispute, the mediation process being followed and the agreed timeframe to conclude the mediation process. A copy of this correspondence will be sent to the Chair of NHS Lothian and the Leader of the Council.

16.4 The mediator will be external to the Parties and will be identified and appointed with the agreement of the Chair of NHS Lothian and the Leader of the Council and failing agreement within 21 calendar days shall be nominated by the Centre of Effective Dispute Resolution (CEDR) on the request of either Party.

16.5 The mediation will start no later than 21 calendar days after the date of the appointment of the mediator.

16.6 The Parties agree that the cost of the mediator will be met equally by NHS Lothian and the Council.

16.7 The timeframe to resolve the issue will be agreed prior to the start of the mediation process by the Chair of NHS Lothian and the Leader of the Council.

16.8 Where following mediation, the Dispute remains unresolved the Parties agree that the chairperson of the IJB shall write to the Scottish Ministers to provide notification that agreement cannot be reached. Scottish Government may then instruct the Parties how to proceed.

16.9 The Parties shall cooperate with each other to mitigate any adverse effect on service delivery pending resolution of the Dispute.

16.10 Nothing in this Revised Integration Scheme shall prevent the Parties from seeking any legal remedy or from commencing or continuing court proceedings in relation to the Dispute.

ANNEX 1

PART 1

Functions delegated by the NHS Lothian to the IJB

Set out below is the list of functions that are to be delegated by NHS Lothian to the IJB in compliance with the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014

Column A	*Column B*
The National Health Service (Scotland) Act 1978	
All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of—
	section 2(7) (Health Boards);
	section 2CB([2]) (Functions of Health Boards outside Scotland);
	section 9 (local consultative committees);
	section 17A (NHS Contracts);
	section 17C (personal medical or dental services);
	section 17I([3]) (use of accommodation);
	section 17J (Health Boards' power to enter into general medical services contracts);
	section 28A (remuneration for Part II services);
	section 48 (provision of residential and practice accommodation);
	section 55([4]) (hospital accommodation on part payment);
	section 57 (accommodation and services for private patients);
	section 64 (permission for use of facilities in private practice);

([2]) Section 2CA was inserted by S.S.I. 2010/283, regulation 3(2) (as section 2CA) and re-numbered as section 2CB by S.S.I. 2013/292, regulation 8(2).

([3]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

([4]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

	section 75A([5]) (remission and repayment of charges and payment of travelling expenses);
	section 75B([6])(reimbursement of the cost of services provided in another EEA state);
	section 75BA ([7])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);
	section 79 (purchase of land and moveable property);
	section 82([8]) use and administration of certain endowments and other property held by Health Boards);
	section 83([9]) (power of Health Boards and local health councils to hold property on trust);
	section 84A([10]) (power to raise money, etc., by appeals, collections etc.);
	section 86 (accounts of Health Boards and the Agency);
	section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
	section 98 ([11]) (charges in respect of non-residents); and
	paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);
	and functions conferred by—

([5]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([6]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([7]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

([8]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([9]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

([10]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

([11]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

	The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([12]);
	The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;
	The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;
	The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;
	The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;
	The National Health Service (Discipline Committees) Regulations 2006/330;
	The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;
	The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;
	The National Health Service (General Dental Services) (Scotland) Regulations 2010/205;
	The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([13]);
Disabled Persons (Services, Consultation and Representation) Act 1986	
Section 7 (Persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002	
All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003	
All functions of Health Boards conferred by,	Except functions conferred by—

([12]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

([13]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	section 22 (Approved medical practitioners);
	section 34 (Inquiries under section 33: co-operation)([14]);
	section 38 (Duties on hospital managers: examination notification etc.)([15]);
	section 46 (Hospital managers' duties: notification)([16]);
	section 124 (Transfer to other hospital);
	section 228 (Request for assessment of needs: duty on local authorities and Health Boards);
	section 230 (Appointment of a patient's responsible medical officer);
	section 260 (Provision of information to patients);
	section 264 (Detention in conditions of excessive security: state hospitals);
	section 267 (Orders under sections 264 to 266: recall);
	section 281([17]) (Correspondence of certain persons detained in hospital);
	and functions conferred by—
	The Mental Health (Safety and Security) (Scotland) Regulations 2005([18]);
	The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([19]);

([14]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.
([15]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.
([16]) Section 46 is amended by S.S.I. 2005/465.
([17]) Section 281 is amended by S.S.I. 2011/211.
([18]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([19]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

	The Mental Health (Use of Telephones) (Scotland) Regulations 2005([20]); and
	The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([21]).
Education (Additional Support for Learning) (Scotland) Act 2004	
Section 23 (other agencies etc. to help in exercise of functions under this Act**)**	
Public Services Reform (Scotland) Act 2010	
All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by—
	section 31(Public functions: duties to provide information on certain expenditure etc.); and
	section 32 (Public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011	
All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011 **Carers (Scotland) Act 2016** s.12 (duty to prepare young Carer statement) s.31 (duty to prepare local Carer strategy) Carers (Scotland) Act 2016	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([22]).

But in each case, subject to the restrictions set out in article 3(3) of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014 so far as they extend to the services detailed in Part 2 of Annex 1 of this Revised Integration Scheme.

([20]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([21]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([22]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

PART 2

Services currently provided by NHS Lothian which are to be delegated

Interpretation of this Part 2 of Annex 1

In this part—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([23]); and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

The functions listed in Part 1 of Annex 1 are delegated to the extent that they are exercisable in the provision of the following services:

Part 2A

Provision for people over the age of 18

The functions listed in Part 1 of Annex 1 are delegated to the extent that:

a) the function is exercisable in relation to the persons of at least 18 years of age;

b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed at numbers 1 to 6 below; and

c) the function is exercisable in relation to the following health services:

1. Accident and Emergency services provided in a hospital.

2. Inpatient hospital services relating to the following branches of medicine—
   - general medicine;
   - geriatric medicine;
   - rehabilitation medicine;
   - respiratory medicine; and
   - psychiatry of learning disability.

([23]) S.S.I. 2004/115.

3. Palliative care services provided in a hospital.

4. Inpatient hospital services provided by General Medical Practitioners.

5. Services provided in a hospital in relation to an addiction or dependence on any substance.

6. Mental health services provided in a hospital, except secure forensic mental health services.

7. District nursing services.

8. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

9. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

10. The public dental service.

11. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([24]).

12. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([25]).

13. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([26]).

14. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([27]).

15. Services providing primary medical services to patients during the out-of-hours period.

16. Services provided outwith a hospital in relation to geriatric medicine.

17. Palliative care services provided outwith a hospital.

18. Community learning disability services.

19. Mental health services provided outwith a hospital.

20. Continence services provided outwith a hospital.

21. Kidney dialysis services provided outwith a hospital.

([24]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([25]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([26]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([27]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

22. Services provided by health professionals that aim to promote public health.

Part 2B

NHS Lothian has also chosen to delegate the functions listed in Part 1 of Annex 1 in relation to the following services:

Provision for people under the age of 18

The functions listed in Part 1 of Annex 1 are also delegated to the extent that:

a) the function is exercisable in relation to persons of less than 18 years of age; and
b) the function is exercisable in relation to the following health services:

1. Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
2. General Dental Services, Public Dental Services and the Edinburgh Dental Institute
3. General Ophthalmic Services
4. General Pharmaceutical Services
5. Out of Hours Primary Medical Services
6. Learning Disabilities
7. Health Visiting
8. School Nursing

ANNEX 2

PART 1A

Functions delegated by the Council to the IJB

Set out below is the list of functions that must be delegated by the Council to the IJB.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948([28])	
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958([29])	
Section 3 (Provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968([30])	

([28]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.

([29]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.

([30]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.
Section 12AA (Assessment of ability to provide care.)	
Section 12AB (Duty of local authority to provide information to carer.)	
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	

Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.
The Local Government and Planning (Scotland) Act 1982([31])	
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	
Disabled Persons (Services, Consultation and Representation) Act 1986([32])	
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.

([31]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

([32]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000([33])	
Section 10 (Functions of local authorities.)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions
The Housing (Scotland) Act 2001([34])	
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.
The Community Care and Health (Scotland) Act 2002([35])	

([33]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

([34]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.

([35]) 2002 asp 5.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	
The Mental Health (Care and Treatment) (Scotland) Act 2003([36])	
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	
The Housing (Scotland) Act 2006([37])	
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.

([36]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

([37]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.

Column A *Enactment conferring function*	*Column B* *Limitation*
The Adult Support and Protection (Scotland) Act 2007([38])	
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	
Social Care (Self-directed Support) (Scotland) Act 2013([39])	
Section 3 (Support for adult carers.)	Only in relation to assessments carried out under integration functions.
Section 5 (Choice of options: adults.)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	

([38]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

([39]) 2013 asp 1.

Column A *Enactment conferring function*	*Column B* *Limitation*
Section 9 (Provision of information about self-directed support.)	
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 .
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

Column A *Enactment conferring function*	*Column B* *Limitation*
The Community Care and Health (Scotland) Act 2002	
Section 4([40]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([41])	

In each case, so far as the functions are exercisable in relation to persons of at least 18 years of age.

Carers (Scotland) Act 2016

Section 6
(Duty to prepare adult carer support plan)

Section 21
(Duty to set eligibility criteria)

Section 24
(Duty to provide support)

Section 25
(Provision of support to carers: breaks from caring)

([40]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([41]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Section 31
(Duty to prepare local carer strategy)

Section 34
(Information and advice service for carers)

Section 35

(Short breaks services statements)

PART 1B

In addition to the functions that must be delegated, the Council has chosen to delegate the following functions to the IJB.

Column A *Enactment conferring function*	*Column B* *Limitation*
Criminal Procedure (Scotland) Act 1995	
Sections 51(1)(aa), 51(1)(b) and 51(5) (Remand and committal of children and young persons in to care of local authority).	
Section 203 (Local authority reports pre-sentencing.)	
Section 234B (Report and evidence from local authority officer regarding Drug Treatment and Testing Order.)	
Section 245A (Report by local authority officer regarding Restriction of Liberty Orders.)	
Management of Offenders etc. (Scotland) Act 2005	
Section 10 (Arrangements for assessing and managing risks posed by certain offenders.)	
Section 11 (Review of arrangements.)	
Social Work (Scotland) Act 1968	
Section 27 (Supervision and care of persons put on probation or released from prison.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence is deferred.)	

PART 2

Services currently associated with the functions delegated by the Council to the IJB

Set out below is an illustrative description of the services associated with the functions delegated by the Council to the IJB as specified in Part 1A and 1B of Annex 2.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare
- Criminal Justice Social Work services including youth justice

ANNEX 3

Proposed Management Arrangements for functions delegated to the IJB

The provisions within this annex are not intended to create legally binding obligations. They are intended to be illustrative of the proposed management arrangements for the functions delegated to the IJB.

The IJB will issue directions to the Parties via its Chief Officer. Those directions will in the main require that the Chief Officer take forward the development of the IJB's Strategic Plan, and lead on ensuring that the plan is delivered. As the Chief Officer will not be personally managing all of the integration functions, ensuring the Strategic Plan is being delivered will include getting assurance from other chief officers (for hosted services – see below) and other managers in NHS Lothian and the four local authorities in Lothian.

The Chief Officer will have direct management responsibility for the following services:

- All Council services described in Annex 2, Part 2.
- All NHS Lothian services described in Annex 1, Part 2 with the exception of the following:

a) Hosted Services

There are NHS Lothian services for which it would not be suitable for the Chief Officer to have operational management responsibility. The factors contributing to determining these services are the degree of medical specialism of the service and scale of the service required for it to be safe, efficient and effective.

NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are provided as part of a single Lothian-wide service. Where an IJB is nominated by NHS Lothian to 'host' such a service via one of the Chief Officers of the Lothian IJB's in their role as Joint Director of NHS Lothian, this is commonly referred to as a "hosted service".

b) Acute Hospitals

Services provided on the three acute hospitals in NHS Lothian (Western General Hospital, Edinburgh Royal Infirmary, St Johns Hospital) will be managed by the Chief Officer for NHS Lothian acute hospital services and the relevant hospital site Director.

ANNEX 4

Initial Integration Scheme Consultation

Further details of the people and groups involved in the engagement and consultation on the original East Lothian Integration Scheme are set out below:

Public and Staff consultation from December 17th 2014 to February 17th 2015 with responses received from:

- Members of the public
- Members of staff in East Lothian Council
- Clinical and non-clinical staff in NHS Lothian
- Third Sector Organisations and representative bodies

The members and organisations on the following groups and committees were consulted on the original Integration Scheme:

East Lothian Council Corporate Management Team
East Lothian Council
East Lothian Council's Audit and Governance Committee
East Lothian Health and Social Care Partnership Shadow Board
East Lothian Health and Social Care Partnership Shadow Strategic Planning Group
East Lothian Area Partnerships
NHS Lothian Corporate Management Team
NHS Lothian Board
NHS Lothian Strategic Planning Group
NHS Lothian Strategic Programme Managers
NHS Lothian Healthcare Governance committee
Lothian Area Clinical Forum
All staff of East Lothian CHP and East Lothian Council's Adult Wellbeing department
East Lothian Partnership forum
East Lothian joint planning groups
TSI (STRiVE) for all third sector members
East Lothian independent sector care at home and care home providers
Scottish Care
Carers of East Lothian
East Lothian Council Strategic Housing Department (including RSLs within East Lothian)
All General Practitioners in East Lothian
All Community Pharmacists in East Lothian
All Optometrists in East Lothian
All General Dental Practitioners in East Lothian
Press release and use of social media
Advert in East Lothian Courier Newspaper
Lothian Medical Committee
East Lothian Community Planning Partnership
MSPs (including all list MSPs)
Local MP
Midlothian, West Lothian, City of Edinburgh and Scottish Borders Councils
NHS Borders
Scottish Government Policy Department
Joint Improvement Team

Revised Joint Integration Scheme

Details of the people and groups involved in the engagement and consultation on the revised (2022) East Lothian Integration Scheme are set out below:

Public and Staff consultation from April 2/5/22 – 29/5/22.

The following organisations, groups and committees were consulted on the revised Integration Scheme:

East Lothian Council Corporate Management Team
East Lothian Council
East Lothian Council's Audit and Governance Committee
East Lothian Integration Joint Board
East Lothian HSCP Management Team
East Lothian Health and Social Care Partnership Strategic Planning Group
East Lothian Area Partnerships/Connected Communities
NHS Lothian Corporate Management Team
NHS Lothian Board
NHS Lothian Strategic Programme Managers
NHS Lothian Healthcare Governance Committee
Lothian Area Clinical Forum
All staff of East Lothian Health and Social Care Partnership
East Lothian Partnership Forum
East Lothian Joint Planning Groups
Third Sector Interface (TSI) (Volunteer Centre East Lothian) for all third sector members
East Lothian independent sector care at home and care home providers
Scottish Care
Carers of East Lothian
East Lothian Council Strategic Housing Department (including RSLs within East Lothian)
All General Practitioners in East Lothian
All Community Pharmacists in East Lothian
All Optometrists in East Lothian
All General Dental Practitioners in East Lothian
Press release and use of social media
Advert in East Lothian Courier Newspaper
Lothian Medical Committee
GP Sub-committee
East Lothian Partnership
MSPs (including all list MSPs)
Local MP
Midlothian, West Lothian, City of Edinburgh and Scottish Borders Councils
NHS Borders
NHS Borders Integration Joint Board
Scottish Government Policy Department(s)

Midlothian Integration Scheme

(Body Corporate)

Scheme Revision History:

June 21 2019

The Midlothian Integration Joint Board was established on 27 June 2015. The parties have reviewed and updated the integration scheme to incorporate new responsibilities arising from the Carers (Scotland) Act 2016 and associated regulations. Midlothian Council reviewed and approved this scheme for submission on 26 March 2019, and the NHS Board did so on 4 April 2019. The Scottish Government confirmed on 29 April 2019 that the Cabinet Secretary approved this revised scheme.

April 2022

The Public Bodies (Joint Working) Scotland Act 2014 requires the parties to the integration scheme (NHS Lothian and Midlothian Council) to carry out a review of the integration scheme within five years from when the Scottish Ministers approved the original scheme (June 2015). Formally undertaking review within this timeframe was delayed in the context of managing the COVID-19 pandemic. However, in line with the requirement from Scottish Government the parties have undertaken work to review and revise the scheme. Revision to the scheme was informed by consultation undertaken from the 18th of March to the 10th of April 2022. This revision is a general update to the scheme, and there are no changes to the delegation of legal functions or associated services to the IJB.

Contents

Preamble, Aims & Outcomes of the Integration Scheme

Health and Wellbeing **Outcomes, and the Aims, Vision and Values of the Integration Joint Board**

The work of the IJB will be guided by the integration planning principles as stated in the Act and will contribute to the achievement of nationally agreed health and wellbeing **outcomes** prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act. Namely:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

The IJB will also contribute to the achievement of the national criminal justice outcomes because the Parties have elected to delegate criminal justice social work.

Our Vision and Values
Everyone in Midlothian will have the right advice, care and support; in the right place; at the right time to lead long and healthy lives.

We will achieve this ambitious vision by changing the emphasis of our services, placing more importance and a greater proportion of our resources on our key values.

Prevention: You should be supported to take more responsibility for your health and wellbeing. We want to deal with the causes rather than the consequences of ill health wherever possible.

Independence, Choice & Control: You should be able to manage your condition + control your support. We will support you to live independently at home and promote the principles of independent living and equality.

Support the person not just the condition: Your support/treatment should consider key issues affecting your life as well as supporting you to manage your condition.

Recovery: You should be supported to recover good health and independence as far as possible.

Coordinated Care: Everyone who provides your care should be working together.

Throughout all its work the Parties expect the IJB to be guided by the following ambitions:

- Provide the highest quality health and care services
- Always respect the dignity and human rights of Midlothian citizens in the planning of health and social care.
- Support people to live independently at home.
- Promote the principles of independent living and equality.
- Do everything we can to reduce health inequalities.
- Provide support and services so that people only have to go to hospital if they really have to.
- Listen to people who use our services, and the people who care for them, working together to develop the services that are right for them.
- Make sure that Midlothian people feel safe at home and in their communities.
- Support people to take more responsibility for their own health and wellbeing.

The terms of this preamble are not part of the Integration Scheme and are not intended to create legally binding obligations. They do, however, give the context within which the Scheme should be read.

1. Integration Scheme

Parties and Definitions and Interpretations

The Parties:

- **Midlothian Council,** established under the Local Government etc (Scotland) Act 1994 and having its principal offices at 40-46 Buccleuch Street, Dalkeith, Midlothian, EH22 1DN ("the Council");
  and
- **Lothian Health Board**, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Lothian") and having its principal offices at Waverley Gate, 2-4 Waterloo Place, Edinburgh ("NHS Lothian")

(Together referred to as "the Parties", and each a "Party").

Background

The Parties are required to comply with either subsection (3) or (4) of section 2(2) of the Act, and have elected to comply with subsection (3) such that the Parties must jointly prepare an integration scheme (as defined in section 1(3) of the Act) for the Midlothian Area

In preparing this Integration Scheme, the Parties have had regard to the integration planning principles set out in section 4(1) of the Act and the national health and wellbeing outcomes prescribed by the Public Bodies (Joint Working)(National Health and Wellbeing Outcomes)(Scotland) Regulations 2014, and have complied with the provisions of section 6(2) of the Act (consultation); and in finalising this Integration Scheme, the Parties have taken account of any views expressed by virtue of the consultation processes undertaken under section 6(2) of the Act.

Under s.45(3) of the Act, the Parties are obligated upon the instructions of the Scottish Ministers in the exercise of their power conferred by s.1(3)(f) of the Act, to jointly carry out a review of the said Joint Board Integration Scheme for the purpose of identifying and formalising any necessary or desirable changes required by the Scottish Ministers.

The Scottish Ministers instructed the Parties to revise the said Joint Board Integration Scheme to reflect changes necessitated by provisions contained in the Carers (Scotland) Act 2016, in so far as such requires a relevant local authority and health board to delegate some of their duties in relation to adult carers to the IJB (hereinafter more specifically defined as "IJB"). The Parties therefore determined to delegate certain functions set out in the said Carers (Scotland) Act 2016 to the IJB and revised the said Joint Board Integration Scheme.

The Parties agreed to a new partially Revised Integration Scheme in accordance with the provisions set out in s.47 of the Act to reflect the instructions of the Scottish Ministers. This First Revised Integration Scheme was entered into in 2019.

Full review and subsequent revision of the Joint Board Integration Scheme as envisaged by s.44 of the Act has been carried out by the Parties in accordance with the provisions of s.44 (5) of the Act and it has been agreed that this agreement would constitute the new Revised

Integration Scheme. In implementation of their obligations under the Act, the Parties hereby agree as follows:

Definitions & Interpretation

1.1. In this Scheme the following expressions have these meanings, unless the context otherwise requires:-

"**Act**" means the Public Bodies (Joint Working) (Scotland) Act 2014;

"**Chief Officer**" means the officer described in Section 7 of this Scheme;

"**Chief Finance Officer**" means the finance officer described in Section 9.1 of this Scheme;

"**Council**" means Midlothian Council

"**IJB Budget**" means the total funding available to the IJB in the financial year as a consequence of:

- The payment for delegated functions from NHS Lothian under section 1(3)(e) of the Act;
- The payment for delegated functions from the Council under section 1(3)(e) of the Act; and
- The amount "set aside" by NHS Lothian for use by the IJB for functions carried out in a hospital and provided for the areas of two or more local authorities under section 1(3)(d) of the Act

"**Integration Joint Board**" or "**IJB**" means the Integration Joint Board to be established by Order under section 9 of the Act;

"**Integration Joint Boards Order**" means the Public Bodies (Joint Working (Integration Joint Boards) (Scotland) Order 2014;

"Integration Scheme" or "**Scheme"** or **"Revised Integration Scheme"** means this Revised Integration Scheme

"**Lothian IJBs**" means the integration joint boards to which functions are delegated in pursuance of the integration schemes in respect of the local authority areas served by, City of Edinburgh Council, Midlothian Council, East Lothian Council and West Lothian Council respectively.

"**Neighbouring IJBs**" means the Lothian IJBs excluding the IJB;

"**Operational Budget**" means the amount of payment made from the IJB to a Party in order to carry out delegated functions.

"**Outcomes**" means the Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act;

"**Parties**" means Midlothian Council and NHS Lothian

"**Regulations**" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014;

"**Strategic Plan**" means the plan which the IJB is required to prepare and implement in relation to the delegated provision of health and social care services in accordance with section 29 of the Act.

1.2. Words and expressions defined in the Act shall bear the same respective meanings in the Scheme unless otherwise defined in the Scheme.

1.3. References to Sections are to the sections of the Scheme.

1.4. Reference to annexes are to annexes to this Scheme and reference to Parts are the parts of the relevant Annex.

2. The Model to be implemented

2.1 The integration model set out in section 1(4)(a) of the Act will apply in relation to the Midlothian area. This is the IJB model, namely the delegation of functions by each of the Parties to a **body corporate** that is to be established by order under section 9 of the Act.

2.2 The original Scheme came into effect on the date on which the IJB is established by order under section 9 of the Act.

2.3 This Revised Scheme comes into effect on the date on which it is approved by the Scottish Ministers.

3. Local Governance Arrangements

3.1 Membership

3.1.1. The IJB shall have the following voting members:

a) **4** councillors nominated by the Council; and

b) **4** non-executive directors nominated by NHS Lothian, in compliance with articles 3(4) and 3(5) of the Integration Joint Boards Order.

3.1.2. The Parties may determine their own respective processes for deciding who to nominate as voting members of the IJB.

3.1.3. Non-voting members of the IJB will be appointed in accordance with article 3 of the Integration Joint Boards Order.

3.1.4. The term of office of members shall be as prescribed by regulation 7 of the Integration Joint Boards Order.

3.2 Chairperson and Vice Chairperson

3.2.1 The IJB shall have a chairperson and vice-chairperson who will both be voting members of the IJB.

3.2.2 The term of office of the chairperson will be two years, with the Council appointing the first chairperson for the period from the date on which the IJB is established until the second anniversary of that date, and NHS Lothian appointing the second chairperson for the period from the second anniversary of the date on which the IJB is established until the fourth anniversary of that date.

3.2.3 As from the fourth anniversary of the date on which the IJB is established, the power to appoint the chairperson will continue to alternate between each of the Parties on a two-year cycle.

3.2.4 The term of office of the vice chairperson will be two years, with NHS Lothian appointing the first vice chairperson for the period from the date on which the IJB is established until the second anniversary of that date. The provisions set out above under which the power of appointment of the chairperson will alternate between the Parties on a two-year cycle will apply in relation to the power to appoint the vice chairperson, and on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson.

3.2.5 The Parties may determine their own processes for deciding who to appoint as chairperson or vice-chairperson.

3.2.6 Each Party may change its appointment as chairperson (or, as the case may be, vice chairperson) at any time; and it is entirely at the discretion of the Party which is making the appointment to decide whom it shall appoint.

4. Delegation of Functions

4.1 The functions that are to be delegated by NHS Lothian to the IJB are set out in Part 1 Annex 1 (subject to the exceptions and restrictions also specified or referred to in Part 1 of Annex 1). The services currently provided by NHS Lothian in carrying out these functions are described in Part 2 of Annex 1.

4.2 The functions that are to be delegated by Midlothian Council to the IJB are set out in Parts 1a 1b of Annex 2 (subject to the exceptions and restrictions also specified or referred to in Parts 1a and 1b of Annex 2). For indicative purposes only, the services which are currently provided by the Council in carrying out these functions are described in Part 2 of Annex 2.

5. Local Operational Delivery Arrangements

The IJB membership will be involved in the operational governance of integrated service delivery via two particular arrangements: (1) directions issued by the IJB via the Chief Officer of the IJB; and (2) oversight of performance management by the voting members of the IJB.

5.1 Directions issued by the IJB via the Chief Officer

5.1.1 The IJB will issue directions to the Parties via its Chief Officer. The IJB must direct the Parties to carry out each of the functions delegated to the IJB. A direction in relation to a given function may be given to one or other of the Parties, or to both Parties. The primary responsibility for delivering capacity (that is to say, activity and case mix) in respect of the services associated with the carrying out of a given function shall lie with the IJB, and shall be reflected in the directions issued from time to time by the IJB. Subject to the provisions of the Act and the Scheme, the Parties are then required to follow those directions.

Oversight of performance management by the voting members of the IJB

5.1.2 The IJB shall oversee delivery of the services associated with the functions delegated to it by the Parties. The IJB is the only forum where health and social care functions for the Midlothian area are governed by members of both NHS Lothian and the Council. Accordingly the Parties agree that primary responsibility for performance management in respect of delivery of the delegated functions will rest with the IJB.

5.1.3 The Parties will provide performance information so that the IJB can develop a comprehensive performance management system

5.1.4 The IJB performance management reports will be available to both Parties for use in their respective performance management systems. However it is expected that the voting members of the IJB will take responsibility for performance management at the IJB, and will provide an account of highlights and/or exceptional matters to meetings of NHS Lothian and the Council.

5.1.5 In the interests of efficient governance, the relevant committees of NHS Lothian and the Council will continue to discharge their existing remits for assurance and scrutiny of the carrying out of the Parties' functions, regarding matters such as internal control, quality and professional standards, and compliance with the law. The IJB will not duplicate the internal operational oversight role carried out by the Parties other than in exceptional circumstances where the IJB considers that direct engagement by the IJB (or by a committee established by the IJB) is appropriate in order to secure the

proper discharge by the IJB of its statutory responsibilities or its duties under this Scheme.

5.1.6 Each of the Parties shall use reasonable endeavours to procure that in the event that one of its committees identifies an issue which is of direct and material relevance to the IJB, the chair of that committee will advise the Chair of the IJB and the Chief Officer of that matter and will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

5.1.7 The Parties shall ensure that their respective standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, and its place as a common decision-making body within the framework for delivery of health and social care within the Midlothian Area.

5.1.8 The voting members of the IJB are councillors of the Council and non-executive directors of NHS Lothian (or other board members). In their capacity as councillors and non-executive directors, they will be engaged in the governance of their respective constituent bodies, and it is likely that they will be members of one or more committees of those constituent bodies.

5.1.9 Given the overall vision as outlined in the preamble of the Scheme, it is the intention that the operational governance functions of both Parties and the IJB should be integrated. In all matters associated with the work of the IJB, the voting members of the IJB will be expected by the Parties to play a crucial role in:

a) communicating, and having due regard to, the interests of NHS Lothian or (as the case may be) the Council in overseeing the carrying out of the integrated functions, but on the understanding that, in carrying out their role as a member of the IJB, their primary duties and responsibilities are those which attach to them in that capacity;

b) communicating, and having due regard to, the interests of the IJB in overseeing the carrying out of the integrated functions whilst discharging their role as a councillor or (as the case may be) as a non-executive director of NHS Lothian, but on the understanding that, in carrying out their role as a councillor or non-executive director, their primary duties and responsibilities are those which attach to them in that capacity.

5.1.10 This Scheme sets out detailed measures on the governance of integration functions throughout the text. Over and above these measures, the Parties will ensure that the IJB members are involved in overseeing the carrying out of integration functions through the following action:

a) The terms of reference, membership and reporting arrangements of the relevant committees of the Parties will be reviewed and the IJB will be consulted within this process (and all future reviews).

5.1.11 Without prejudice to the role of the voting members of the IJB (as specified above) in relation to oversight of operational delivery of services in accordance with directions issued to either or both of the Parties by the IJB, the IJB will, through the Chief Officer, have an oversight role in the operational delivery of services by the Parties in the carrying out of integration functions. The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

(a) the responsibilities of each Party regarding compliance with directions issued by the IJB; or

(b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery.

5.1.12 In addition to the specific commitments set out above and the obligations regarding provision of information attaching to the Parties under the Act, the Parties will provide the IJB with any information which it may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability.

Support for Strategic Planning

5.1.13 The Parties will support the IJB in ensuring that the consultation process associated with the preparation of each Strategic Plan for the Midlothian Area includes other Integration Authorities likely to be affected by the Strategic Plan. The Integration Authorities that are most likely to be affected by the Strategic Plan for the Midlothian Area are:

a) East Lothian IJB

b) Edinburgh IJB

c) West Lothian IJB.

5.1.14 NHS Lothian will procure that reciprocal provisions to those set out in sections 5.1 and 5.2 are contained in the integration schemes of the Neighbouring IJBs in Lothian.

5.1.15 In addition the Borders Integration Authority shares a border with Midlothian IJB and may be affected by the Midlothian Strategic Plan.

5.1.16 The Parties will ensure the IJB can:

- effectively engage in all of the planning process including contributing to the work of the Strategic Planning Groups for the neighbouring IJBs as required;
- provide such information and analysis as neighbouring IJBs reasonably require for the production of their Strategic Plans;
- inform neighbouring IJBs as to how the services, facilities and resources associated with the functions delegated to the Midlothian IJB by the Parties are being or are intended to be used with respect to carrying out of those functions in line with these planning processes;
    a) in a situation where Strategic Plans in one area are likely to have an impact on the plans in another area, ensure that these matters are raised with other relevant IJBs and resolved in an appropriate manner;
    b) in a situation where Strategic Plans in another area are likely to have an impact on the Midlothian Area, ensure that these matters are raised and any associated risks are mitigated for the benefit of service users.

5.2 Lothian Hospitals Strategic Plan and Lothian Strategic Development Framework

5.2.1 NHS Lothian have developed a plan (the 'Lothian Hospitals Strategic Plan') to support the IJBs to fulfil their duties. The Lothian Hospitals Strategic Plan does not and will not bind the IJB and the strategic plans of the Lothian IJBs have informed the Lothian Hospital Strategic Plan. The Lothian Hospitals Strategic Plan encompasses both functions delegated to the Lothian IJBs and functions that are not so delegated.

5.2.2 The Lothian Hospitals Strategic Plan was developed in partnership with the Lothian IJBs where integration functions are delivered by NHS Lothian in a hospital. It reflects the relevant provisions of the Strategic Plans prepared by the respective Lothian IJBs, as well as NHS Lothian plans for non delegated functions.

5.2.3 The purpose of the Lothian Hospital Strategic Plan is to ensure that planning for hospital functions and use of hospital facilities are:
(a) responsive to and supports each Strategic Plan prepared by the Lothian IJBs for delegated functions; and
(b) supports the requirement of NHS Lothian to deliver hospital services required by the IJB and other hospital services that are not the responsibility of the Lothian IJBs (e.g. tertiary, trauma, surgical, planned and children's services).

5.2.4 The Lothian Hospitals Strategic Plan will be a plan developed jointly by NHS Lothian and the Lothian IJBs. The elements of the Lothian Hospitals Strategic Plan addressing non delegated functions can only be agreed by the NHS Lothian Board after the four Lothian IJBs have been consulted and their views and requirements appropriately considered. Elements of the Lothian Hospitals Strategic Plan which cover functions delegated to the respective Lothian IJBs will be signed off by relevant Lothian IJBs in consultation with NHS Lothian and all Lothian IJBs.

5.2.5 NHS Lothian is continuing to work to refresh its strategy via development of the Lothian Strategic Development Framework. This work is being taken forward in collaboration with the Lothian Integration Joint Boards, in particular in those workstreams that cut across our organisational boundaries and where there are clear benefits in working together to determine priorities to achieve our collective vision.

5.3 Professional, technical or administrative support services

5.3.1 The Parties agree to provide the IJB with the corporate support services that it requires to discharge fully its duties under the Act.

5.3.2 The Parties and the IJB will regularly undertake review of the support services put in place pursuant to the agreement to ensure that the IJB has available to it all necessary professional, technical or administrative services for the purpose of preparing its Strategic Plan and carrying out the integration functions. This process will from part of the annual budget setting process for the IJB which is described in Section 9.2.

5.4 Performance targets, improvement measures and reporting arrangements

5.4.1 All national and local Outcomes, improvement measures and performance targets (including the Annual Performance Report (as defined and required under the Act) which are connected exclusively with the functions delegated by the Parties to the IJB under this Revised Integration Scheme will become the responsibility of the IJB to deliver; and the IJB will also be responsible for providing all such information regarding integration functions which is required by either of the Parties to enable each of them to fulfil its obligations regarding reporting arrangements in respect of those functions.

5.4.2 Where particular national or local outcomes, measures or targets (and associated reporting arrangements) relate to services which are associated with both integration functions and functions which are not delegated by a Party to the IJB, the responsibility for the outcomes, measures or targets (and associated reporting arrangements) will be shared between the IJB and the Party or Parties which exercise those functions, and the IJB will be responsible for providing all such information regarding those integration functions as is required by the relevant Party to enable it to fulfil its obligations regarding reporting arrangements.

5.4.3 A set of shared principles will be developed and agreed between the Parties for targets and measurement based on existing best practice and will be reviewed regularly as required.

5.4.4 A core group of senior managers and relevant support staff from each Party will continue to review and where necessary revise and further develop the performance framework for the IJB, taking account of relevant national guidance. The framework

will be underpinned by the Outcomes and will be developed to drive change and improve effectiveness. The framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework will be intended to achieve.

5.4.5 A core set of indicators and measures will be identified by the Parties from publicly accountable and national indicators and targets which relate to services delivered in carrying out the functions delegated to the IJB.

5.4.6 The national health and wellbeing outcomes which apply to integrated health and social care, and the associated national indicators which underpin the nine health and wellbeing outcome measures will be used by the Integration Joint Board. These outcomes and indicators will be used to assist in setting local priorities and monitoring performance, and will be reported per national and local reporting arrangements.

5.4.7 The outcomes and integration indicators will provide information for the performance framework developed.

5.4.8 Indicators will be aligned with the priority areas identified in the joint strategic needs assessment and the Strategic Plan and will be refined as these documents are reviewed and refreshed. These priority areas will be linked to the Outcomes to demonstrate progress in delivering these.

5.4.9 The Parties have obligations to meet targets for functions which are not delegated to the IJB, but which are affected by the performance and funding of integration functions. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details must be provided of any targets, measures and arrangements for the IJB to take into account when preparing the Strategic Plan. Where responsibility for performance measures and targets is shared, this will be set out clearly for agreement by the relevant Parties.

5.4.10 The performance framework may require information on functions which are not delegated to the IJB. Either one of the Parties, or the IJB, will be able to reasonably require information of that nature to be included within the Integration Dataset.

The continuous development of an effective performance framework for the IJB, taking account of relevant national guidance, will be supported by the parties and the IJB. The framework will be underpinned by the national health and wellbeing outcomes, and national integration indicators, and will be developed to drive change and improve effectiveness.

6. Clinical & Care Governance

6.1 Introduction

6.1.1 This section of the Scheme sets out the arrangements that will be put in place to allow the IJB to fulfil its role with professional advice and with appropriate clinical and care governance in place. The Parties will expect the IJB to develop more integrated governance arrangements in Midlothian to complement the existing clinical and care governance arrangements.

6.1.2 The Parties have well established systems to provide clinical and care governance as well as assurance for professional accountabilities. Those systems will continue following the establishment of the IJB and the scope of these systems will extend to provide the IJB with the requirements to fulfil their clinical and care governance responsibility.

6.1.3 This section describes the relationship between the Parties' clinical and care governance systems and the IJB. The relationship between these systems and the Strategic Planning Group and delivery of services within localities will be via the Chair and Chief Officer of the IJB. The IJB non-voting membership includes the Chief Social Work Officer and three health professionals who are determined by NHS Lothian. These members will provide a further link between the Parties clinical and care governance systems and the IJB as described in section 6.2. It is for the IJB to ensure that the Strategic Planning Group has sufficient information to undertake its function and the Parties shall provide such information to the IJB as is necessary for it to do so. This is in line with the commitment in this scheme at 5.3.1 to provide the IJB with the corporate support services required to fully discharge its responsibilities under the Act, which includes support to the IJB, its Strategic Planning and localities.

6.1.4 Continuous improvement and the quality of service delivery (and its impact on outcomes) will be addressed through the development of the IJB's performance management framework (pursuant to Section 5.4 of this Scheme).

6.1.5 The Integration Joint Board will not duplicate the role carried out by the Parties existing governance arrangements other than in exceptional circumstances where the IJB considers that direct engagement by the IJB is appropriate in order to secure the proper discharge by the IJB of its statutory responsibilities.

6.1.6 The Parties agree that in the event that one of its committees within its governance arrangements identifies an issue which is of direct and material relevance to the Integration Joint Board, the chair of that committee will advise the chairperson of the Integration Joint Board and the Chief Officer of that matter and will co-operate with the IJB in supplying such further information and evidence in respect of that matter as the IJB may reasonably request.

6.1.7 The Parties shall ensure that its standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the IJB's powers and remit, the IJB's place as a common decision-making body within the framework for delivery of health and social care within the Midlothian Area and the Parties role in supporting the IJB to discharge its duties.

6.1.8 The voting members of the Integration Joint Board are engaged in the governance of their respective Party, and it is likely that they will be members of one or more committees of the relevant Party.

6.1.9 The Parties will use reasonable endeavours to appoint voting members of the Integration Joint Board (regardless of which party nominated the voting members) onto NHS Lothian and Council governance arrangements with a remit relevant to the clinical and care governance of integration functions.

6.1.10 Within its existing governance framework, NHS Lothian has :

a) A healthcare governance committee, the remit of which is to provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard and to provide assurance to the Board of NHS Lothian that NHS Lothian meets its responsibilities with respect to:-

- NHS Lothian Participation Standards
- Volunteers/Carers
- Information Governance
- Protection of Vulnerable People including children, adults, offenders
- Relevant Statutory Equality Duties

And

b) A staff governance committee, the remit of which is to support and maintain a culture within NHS Lothian where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The Staff Governance Committee must ensure that robust arrangements to implement the (NHS Scotland) Staff Governance Standard are in place and monitored

6.1.11 The staff governance committee has the primary role on staff governance matters, but can and does refer matters of relevance to the healthcare governance committee.

6.1.12 The healthcare governance committee can request assurance from the staff governance committee on matters of direct relevance to its remit, e.g. quality of recruitment, learning and development, completion of mandatory training.

6.1.13 Within the Council, the Chief Social Work Officer has overall responsibility for the professional standards of the Council's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council (SSSC), and all professional staff must by law be registered with the SSSC. This registration requirement will, in

due course, extend to all social care staff employed by the Council and the voluntary and independent sectors.

6.1.14 The Chief Social Work Officer reports annually to the Council on standards achieved, governance arrangements (including supervision and case file audits), volume/quantity of statutory functions discharged, the registration of the workforce and on training, including mandatory training and post-qualifying learning and development. These reports must comply with national guidance issued by the Scottish Government. The Chief Social Work Officer will also provide a copy of these annual reports to the integration joint board.

6.1.15 The intention of using the existing NHS Lothian and Council committees as a primary source of assurance is to recognise that the parties will have continuing governance responsibilities for both integration and non-delegated functions, and that the parties wish to minimise unnecessary bureaucracy. The integration joint board will be engaged through its membership being on these committees, and its relationship with the committee chairs. The integration joint board will be in a position to holistically consider the information/ assurance received from the parties, and arrive at a determination for all of its functions. If the integration joint board is in any way dissatisfied with the information or assurance it receives from the parties, or the effectiveness of the parties committees, it may give a direction to the parties to address the issue, or revise its own system of governance.

6.2 Clinical and Care Governance Risk

There is a risk that the plans and directions of the integration joint board could have a negative impact on clinical and care governance, and professional accountabilities. This section of the Scheme sets out the arrangements that will be put in place to avoid this risk.

Professional Advice

6.2.1 NHS Lothian has within its executive membership three clinical members (referred to below as '**Executive Clinical Directors'**); a Medical Director, a Nurse Director, and a Director of Public Health. Their roles include responsibility for the professional leadership and governance of the clinical workforce (medical, nursing, allied health professionals, healthcare scientists, psychology, pharmacy), as well as clinical governance within NHS Lothian generally. The creation of the IJB does not change their roles in respect of professional leadership, and they remain the lead and accountable professionals for their respective professions.

6.2.2 The Council has a Chief Social Work Officer who reports to the Chief Executive and councillors. The Chief Social Work Officer monitors service quality and professional standards in social care and social work, for staff employed in both adult and children's services, together with standards in relation to the protection of people at risk of harm. The Chief Social Work Officer role also includes quality assurance of decision-making with regard to adult social care, mental health criminal justice and

children's services, in particular in relation to public protection and the deprivation of liberty.

6.2.3 The creation of an IJB does not change the Chief Social Work Officer's role in respect of professional leadership and he or she will remain the lead and accountable professional for his or her profession.

6.2.4 The IJB may elect to appoint one or both of the Medical Director and the Nurse Director as additional non-voting members of the IJB. The Order requires NHS Lothian to fill the following non-voting membership positions on the IJB:

- A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under Section 17P of the National Health Service (Scotland) Act 1978;
- A registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and
- A registered medical practitioner employed by NHS Lothian and not providing primary medical services.

6.2.5 NHS Lothian will consider the advice of the Executive Clinical Directors, and any other relevant officer it deems fit before making appointments to fill the membership positions referred to in section 6.2.4. The appointees will be professionally accountable to the relevant executive clinical director. NHS Lothian will develop a role description for the appointments referred to in section 6.2.4, to ensure that their role on the IJB with regard to professional leadership and accountability is clearly defined and understood.

6.2.6 The three health professional representatives referred to in section 6.2.4 will each also be:

a) A member of an integrated professional group (should it be established); and/or
b) A member of a NHS Lothian committee; and/or
c) A member of a consultative committee established by NHS Lothian.

6.2.7 The three health professional representative set out in section 6.2.4 and the Chief Social Work Officer will be expected by the Parties to play a lead role in:

a) Communicating and having regard to their duties to NHS Lothian or the Council as the case may be whilst discharging their role as a member of the IJB;
b) Communicating and having regard to the interests of the IJB whilst discharging their duties as professionals employed by NHS Lothian or (as the case may be) the Council.
c) The members will be expected to communicate regularly with the Executive Clinical Directors, and the Council's Chief Executive as and when appropriate.

6.2.8 The presence of these four members will ensure that the decisions of the IJB are informed by professional advice from within the membership of the IJB.

6.2.9 NHS Lothian includes a governance statement in its annual accounts, the content of which is informed by the annual reports of its governance committees (such as healthcare governance and staff governance) and certificates of assurance from its Executive Clinical Directors. The IJB may place reliance on these existing processes, and the Parties will provide any such reports from those processes as the IJB may require.

6.2.10 The Executive Clinical Directors shall be entitled to raise issues directly with the IJB in writing. The IJB shall be required to respond in writing when issues are raised in this way. The Chief Social Work Officer will be a non-voting member of the IJB, and can therefore raise any issues directly at the IJB.

6.2.11 The engagement of professionals throughout the process to develop and consult on the Strategic Plan, is intended to ensure that the IJB has all the required information to prepare a Strategic Plan, which will not compromise professional standards.

6.2.12 In the unlikely event that the IJB issues a direction to NHS Lothian, which is reasonably likely to compromise professional standards, then in the first instance, the relevant Executive Clinical Director will write to the IJB.

6.2.13 If the issue is not resolved to his/her satisfaction, he/she must inform the board of NHS Lothian before it takes action to implement the direction, and the following measures will apply:

a) The relevant Executive Clinical Director must ensure that appropriate advice is tendered to the board of NHS Lothian on all matters relating to professional standards;
b) The relevant Executive Clinical Director must set out in writing to NHS Lothian any objections he/she may have on a proposal that may compromise compliance with professional standards;
c) The board of NHS Lothian will inform the IJB that it has received such objections, along with a statement of the views of the board of NHS Lothian on those objections;
d) If board of NHS Lothian decides to proceed with a proposal despite those objections, the relevant executive clinical director will be provided with written authority from the board of NHS Lothian to act on the proposal. NHS Lothian must inform the Scottish Government Health and Social Care Directorate if a request for such a written authority is made. A copy of that authority must be sent to the appropriate regulatory body, e.g. General Medical Council;
e) Once the relevant executive clinical director has received that written authority, he/she must comply with it;

6.2.14 Regardless of whether a written authority has been given, the executive clinical directors, in their capacity NHS Lothian members, should always vote against a

proposal that they cannot endorse as accountable officers. It is not sufficient to abstain from a decision.

6.2.15 The three professional clinical members on the IJB (two medical practitioners, one nurse) are non-voting members. They will be expected by the Executive Clinical Directors to raise any concerns in relation to matters which may compromise professional standards with the IJB.

6.2.16 If any of the three professional clinical members becomes aware of a matter arising from the conduct of IJB business, which may compromise professional standards, he/she must immediately notify the relevant executive clinical director(s) of their concerns.

6.2.17 The Chief Social Work Officer must be a non-voting member of the Integrated Joint Board, and as such, will contribute to decision-making, and will provide relevant professional advice to influence service development.

6.2.18 In the event that the Integrated Joint Board issues an direction to the Council or NHS Lothian, which in the view of the Chief Social Work Officer compromises professional social work standards or the discharge of statutory functions, the Chief Social Work Officer must immediately notify the Chief Officer of his/her concerns and if his/her concerns are nor resolved by the Chief Officer to his/her satisfaction. Must then raise the matter with the Chief Executive of the Council.

6.3 Professionals Informing the IJB Strategic Plan

6.3.1 With regard to the development and approval of its Strategic Plan, the IJB is required to:

a) Establish a strategic planning group (which will review the draft Strategic Plan). This strategic planning group must include a nominee from both NHS Lothian and the Council in its membership, as well as representation from health professionals and social care professionals. NHS Lothian and the Council will make recommendations to the IJB with regard to the representation from health professionals and social care professionals;
b) Consult both NHS Lothian and the Council on its Strategic Plan, and take into account their views before it finalises the Strategic Plan.

6.3.2 There will be three opportunities within these arrangements for professional engagement in the planning process;

a) At the IJB;
b) in the context of the work of the strategic planning group; and
c) as part of the consultation process with the Parties associated with the Strategic Plan.

6.3.3 The membership of the IJB will not be the only source of professional advice available to the IJB. In advance of the establishment of the IJB the Parties agree that the chairs of all appropriate committees and groups will be informed that they are able to, and expected to, directly provide advice to the IJB. Those committees and groups may also advise an integrated professional group that provides advice to the IJB. Those committees and groups include, but are not limited to:

a) Area Clinical Forum;
b) Local consultative committees that have been established under Section 9 of the National Health Service (Scotland) Act 1978;
c) Managed Clinical/ Care Networks;
d) East and Mid Lothian Public Protection Committee (adult and child protection, drug and alcohol, violence against women, offender management etc.). The IJB will consult this committee on any plans that may impact on the protection of children or vulnerable adults or people who are assessed as posing a risk;
e) Any integrated professional group established.

6.3.4 NHS Lothian and the Council will ensure that the draft Strategic Plan is sent to the following senior professionals in order to secure their input and advice:

a) NHS Lothian Executive Medical Director;
b) NHS Lothian Executive Director of Nursing and Allied Health Professions
c) NHS Lothian Director of Public Health & Health Policy;
d) Chief Social Work Officer.

6.3.5 The engagement of the Council's professionals will not be limited to social work staff, but will extend to related professionals within social care, such as, but not exclusively, occupational therapists, home care and social care staff.

6.3.6 The approach to locality planning and delivery including the arrangements for clinical and social care governance will be developed through the strategic planning process in a collaborative manner for the IJB.

6.4 External scrutiny of clinical and care functions

6.4.1 NHS Lothian seeks assurance for internal control/quality through its Healthcare Governance Committee, which includes reports by external bodies such as Healthcare Improvement Scotland.

6.4.2 The Care Inspectorate (Social Care and Social Work Improvement Scotland) regulates, inspects and supports improvement of adult and children's social work and social care, and their reports feed into the Council's system of governance.

6.4.3 The IJB will consequently be informed of any relevant issues from external scrutiny, as a consequence of drawing from the systems already established by the Parties.

6.5 Service User and Carer Feedback

6.5.1 The Parties have a range of systems already in place to capture and respond to service users' experience, and these will continue to be used as the Parties implement the directions of the IJB.

7. Chief Officer

7.1 The Chief Officer will be appointed by the IJB; he/she will be employed by one of the Parties and will be seconded to the IJB.

7.2 The Chief Officer will provide a strategic leadership role as principal advisor to and officer of the IJB and will be a member of the senior management team of one or both of the Parties. The Chief Officer will lead the development and delivery of the Strategic Plan for the IJB and will be accountable to the IJB for the content of the directions issued to the constituent authorities by the IJB and for monitoring compliance by the Parties with directions issued by the IJB.

7.3 The Chief Officer will report directly to the Chief Executives of both Parties. There will be a joint process for the regular performance, support and supervision with both Chief Executives.. Annual objectives for the Chief Officer will be agreed and the process will involve the Chair of the IJB agreeing objectives with the Chief Officer relevant to his/her role with the IJB as well as the Chief Executives of the Parties. The Chief Officer's performance against those annual objectives will be monitored through an agreed Performance Management Framework established by the Party which is his/her employer.

7.4 If an interim replacement for the Chief Officer of the IJB is required, in line with a request from the IJB to that effect (on the grounds that the Chief Officer is absent or otherwise unable to carry out his/her functions), the Chief Executives of the Parties will initiate a joint selection process, identifying a list of potential replacements; and selection of a suitable candidate will be undertaken against a set of agreed criteria. The interim replacement will be employed by one of the Parties and will be seconded to the Integration Joint Board on an interim basis.

7.5 The Chief Officer will have operational responsibility for all of the functions delegated to the IJB with the following exceptions:

- The Chief Officer for NHS Lothian acute hospital services and directors responsible for the Western General Hospital, the Royal Infirmary of Edinburgh, St John's Hospital and the Royal Edinburgh Hospital will provide delegated services on these hospital sites that will not be operationally managed by the Chief Officer.
- Specific NHS Lothian functions which will be managed on a pan-Lothian basis as a 'hosted service' by one of the four Chief Officers in Lothian.

7.6 A group consisting of Directors responsible for hospital functions delegated to the IJB and the Chief Officers of the four IJBs in Lothian will be established to ensure close working arrangements between a) IJB Chief Officers, the Chief Officer, for NHS Lothian acute hospital services and the Hospital Site Directors and b) Chief Officers responsible for the management of a hosted service on behalf of the other three Lothian Chief Officers.

8. Workforce

8.1 The arrangements in relation to their respective workforces agreed by the Parties are:

a) For staff managed by a line manager who is employed on different terms and conditions, the manager will observe the contract of employment and apply the employer's employment policies and procedures. Guidance will be available to assist the line manager. In addition the Parties will establish professional leadership lines of accountability to ensure clinical and professional standards are monitored and maintained.

b) The Parties have agreed an Organisational Development Plan which is being implemented. There is a Human Resources and Organisational Group which includes Senior Managers and Trades Unions from both organisations.

8.2 The Parties have developed a Human Resources and Organisational Development plan which supports the workforce through the integration process. This is a comprehensive plan which covers staff communication, staff engagement, staff and team development, leadership development and the training needs for staff that will be responsible for managing integrated teams. This plan will be reviewed and updated annually to ensure that it takes account of the strategic plan of the IJB and the development needs of staff within the IJB.

8.3 The Human Resources and Organisational Development plan will be reviewed annually in April each year. The Parties will also support the IJB to prepare a joint Workforce Development and Support Plan through the provision of professional, technical and support services described in Section 6.4 of this scheme. This Plan will sit alongside and be informed by the IJB's Strategic Plan. The Workforce Development and Support Plan will be developed within six months of the approval of the Strategic Plan by the IJB.

9. Finance

9.1 Financial Governance

This section describes the arrangements in relation to financial management and monitoring of integrated resources. It sets out the method for determining the resources to be made available by the Council and NHS Lothian to the IJB. It also explains the financial governance and management arrangements, including budget variances, and the financial reporting arrangements between the IJB, the Council and NHS Lothian.

9.2 Finance Officer

In relation to the preparation of its accounts and their audit, the IJB is governed by the same legislation applying to local authorities and is required to make arrangements for the proper administration of its financial affairs; through a Chief Finance Officer with this responsibility. The Chief Finance Officer will be employed by the Council or NHS Lothian and seconded to the IJB. The holder of the post should be a member of a relevant professional accounting body, and the IJB should have regard to the current CIPFA Guidance on the role.

In the event that the Chief Finance Officer position is vacant or the holder is unable to act, the Chief Officer shall secure, in consultation with the IJB Chair, and through agreement with both the Council section 95 officer and the NHS Lothian Director of Finance, an appropriate interim dedicated resource to discharge the role.

9.3 Financial Management of the IJB

The IJB is responsible for determining its own internal financial governance arrangements; and the Chief Finance Officer will be responsive to the decisions of the IJB, and the principles of financial governance set out in this Scheme.

9.4 Principles of Financial Governance

The following principles of financial governance shall apply:

- NHS Lothian and the Council will work together in a spirit of openness and transparency
- NHS Lothian and the Council will work in partnership with the IJB with the objective of agreeing sufficient funding of delegated functions in line with the financial elements of the Strategic Plan

9.4.1 **Financial Governance**

The Parties will contribute to the establishment of an IJB budget. The Chief Officer will manage the IJB budget.

The Parties are required to implement the Directions of the IJB in carrying out the delegated functions in line with the strategic plan, provided that the IJB delegates the required level of resources to meet the anticipated cost of the delegated functions.

The Parties will apply their established systems of financial governance to the payments they receive from the IJB. The NHS Lothian Accountable Officer and the Council Section 95 Officer have legally defined responsibilities and accountability for the financial governance of their respective bodies.

The Chief Officer in their operational role within NHS Lothian and the Council is responsible for the financial management of any operational budgets (as defined in section 10 of this Scheme) that may be delegated to them by the Parties, and is accountable for this to the NHS Lothian Chief Executive and Council Section 95 officer.

The IJB will develop and maintain its own financial regulations. The Chief Finance Officer will periodically review these financial regulations and present any proposed changes to the IJB for its approval.

The Council will host the IJB Financial Accounts and will be responsible for recording the IJB financial transactions through its existing financial systems. The Integration Joint Board can hold reserves. It is a matter for the IJB to determine what its reserves strategy will be.

The Board's Chief Finance Officer is responsible for preparing the IJB's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

As part of the financial year end procedures and in order to develop the year-end financial statements, the Chief Finance Officer will work together with NHS Lothian and the Council to coordinate an exercise agreeing the value of balances and transactions with Council and NHS Finance teams. Each Party will provide information to this process on their recorded income, expenditure, receivable and payable balance with the IJB. The Board's Chief Finance Officer will lead with the Parties on resolving any differences.

The Chief Finance Officer will also be responsible for preparing a medium-term financial plan to be incorporated into the IJB's Strategic Plan. The Chief Finance Officer will liaise closely with NHS Lothian and the Council to develop integrated medium term financial planning and associated financial recovery plans taking account of assumptions around available funding and future service demands and service delivery models.

The Chief Finance Officer will also be responsible for preparing the annual financial statement that the IJB must publish under section 39 of the Act, which sets out what the IJB intends to spend in implementation of its Strategic Plan.

The Chief Finance Officer will be responsible for producing finance reports to the IJB, ensuring that those reports are appropriate for the needs of the IJB.

The Chief Finance Officer will liaise closely with the Council Section 95 officer and the NHS Lothian Director of Finance and their teams in order to discharge all aspects of their role.

9.5 Resources Delegated to the IJB

The resources delegated to the IJB fall into two categories: (i) payments for the delegated functions; and (ii) resources used in large hospitals that are set aside by NHS Lothian and made available to the IJB for inclusion in its Strategic Plan.

Section 1(3)(e) of the Act requires that the Scheme must set out a method of determining payments that are to be made in respect of (i) above. Section 1(3)(d) of the Act requires the Scheme to set out a method of determining the amounts to be made available by the Health Board for use by the IJB under (ii) above.

It is expected that the net difference between payments into and out of the IJB will result in a balancing payment between the Council and NHS Lothian which reflects the effect of the directions of the IJB. The balancing payment will be reviewed throughout the year and depending on the expected value for the adjusting payment, it will be either made one-off prior to year-end or on a quarterly basis. Such payments would incorporate values previously treated as resource transfer.

9.6 Annual Budget Payments to the IJB

The Council and NHS Lothian identify a core baseline operational budget for each function that is delegated to the IJB. This will be used as the basis to calculate their respective payments into the IJB budget each year. The previously agreed “resource transfer” payments from NHS Lothian will be part of the annual budget payment to the IJB

The Council and NHS Lothian have established financial planning processes which take into account the financial settlements they have received, and identified and assumed expenditure pressures, to arrive at opening annual budgets. These same processes will be applied to the core baseline operational budgets for the delegated functions in order to arrive at the annual payments to the IJB.

The Council Section 95 officer and the NHS Lothian Director of Finance are responsible for preparing the budget contributions from their respective party. The amounts to be paid will be the outcome of the above processes. They will consult with the Chief Officer and officers in both Parties as part of this process.

- The Council Section 95 officer and the NHS Lothian Director of Finance will each prepare a schedule outlining the detail and total value of the proposed payment from each party, and the underlying methodology and assumptions behind that payment. These draft schedules will identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. The schedules will also contain the detail and total value of set aside resources for hospital services, made under section 1(3) (d) of the Act.

- The Council Section 95 officer and the NHS Lothian Director of Finance will refer the draft schedules to the Chief Officer so that they may have an opportunity to formally consider it.
- The Council Section 95 officer and the NHS Lothian Director of Finance will thereafter present the final draft schedules to the Parties. This schedule must be agreed by the Director of Finance of NHS Lothian, the Council Section 95 officer and the Chief Officer.
- The Council and NHS Lothian must approve their respective payments, in line with their governing policies

The Council Section 95 officer and NHS Lothian Director of Finance will liaise closely with the IJB Chief Officer and Chief Finance Officer on the assumptions to be used on annual budget contributions and will have due regard to the impact of any service re-design activities that have been a direct consequence of the IJB's Strategic Plan or Directions issued. Both the Council and NHS Lothian will provide indicative three year budget allocations to the IJB, subject to annual approval through their respective budget setting processes.

The Parties will ensure the Chief Officer and Chief Finance Officer are actively engaged in their financial planning processes. The Chief Officer will be expected to feed into the planning processes with any intelligence that is relevant, e.g. the aims of the Strategic Plan, the effect of previous directions on activity and expenditure, projected demand led changes in activity and expenditure. The Director of Finance of NHS Lothian, the Section 95 Officer of the Council and the IJB Chief Finance Officer will ensure a consistency of approach and consistent application of processes in considering budget assumptions and proposals.

9.6.1 **The set-aside of resources for use by the IJB under section 1(3) (d) of the Act**
In addition to the payments to the IJB, NHS Lothian will identify a set aside budget for delegated functions in large hospitals. The set aside budget for delegated hospital services will be based on an apportionment of the relevant Lothian NHS Board budgets for the delegated hospital services (excluding overheads).
The core baseline budget for the set-aside functions in each council area will be based on an appropriate methodology and agreed in partnership by the NHS Lothian and IJB.

9.6.2 **Hosted Services**
NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are currently provided as part of a single Lothian-wide service, commonly referred to as "hosted services".

The core baseline budget for the Hosted functions in each council area will be based on an appropriate methodology and agreed in partnership by the NHS Lothian and IJB.

9.7 Due Diligence

The Parties will share information on the financial performance over the previous two financial years of the functions and associated services delegated to the IJB. This will allow the Parties to undertake appropriate reviews to gain assurance as to whether the services are

currently being delivered sustainably within approved resources, and that the anticipated payments will be sufficient for the IJB to carry out its integration functions.

If any such review indicates that the projected expenditure is likely to exceed the payments to the IJB, then the relevant Party will be notified. The relevant Party will be required to take action to ensure that services can be delivered within the available operational budget

The Parties recognise that of the functions which are to be delegated to the IJB, there are some where there is greater potential for the actual expenditure to vary significantly from projections. The Parties will identify what those functions are, and will ensure that information is provided to the IJB so that it is aware of the issues, and is able to focus on those functions within their systems for risk management and financial reporting.

This process of due diligence will be informed by, amongst other things, the intelligence within the financial performance reports covering all integration functions that the IJB will routinely receive.

9.8 Process to agree payments from the IJB to the Parties

The IJB will determine and approve, in accordance with the Strategic Plan, the payments to the Parties which will accompany its directions to them for carrying out functions delegated to the IJB. The Parties are required to implement the directions of the IJB in carrying out a delegated function in line with the Strategic Plan, having agreed with the IJB the resources required to deliver the said directions.

The Chief Finance Officer is responsible for providing the IJB with appropriate information and advice, so that it may determine what those payments should be.

Directions from the IJB to the Parties will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- the delegated function(s) that are to be carried out
- the outcomes to be delivered for those delegated functions
- the amount of and / or method of determining the payment to be made, in respect of the carrying out of the delegated functions.

Once issued, directions can be amended by a subsequent direction by the IJB.
Where amounts paid to the IJB are subject to separate legislation or subject to restrictions stipulated by third party funders, the IJB must reflect these amounts in full, in determining the level of the payments to be made to the Parties in respect of the carrying out of the relevant function or functions. However, the IJB is not precluded from increasing the resource allocated to the relevant services.

9.9 Financial Reporting to the IJB

Budgetary control and monitoring reports will be provided to the IJB as and when it requires. The reports will set out the financial position and forecast against the payments by the IJB to

the Parties in respect of the carrying out of integration functions and against the amount set aside by NHS Lothian for hospital services. These reports will present the actual and forecast positions of expenditure compared to budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.

NHS Lothian will provide information on the set-aside budgets which will be contained in financial reports to the IJB.

Both Parties will provide the required information on budgetary performance from their respective finance systems, and this will be co-ordinated and consolidated by the Chief Finance Officer to provide reports to the IJB on all the Board's delegated functions.

It is expected that as a minimum there will be quarterly financial reports to the Chief Officer and the IJB.

9.9.1 **Process for addressing variance in the spending of the IJB**

The IJB is required to deliver its financial out-turn within available resources. Section 15 of this scheme sets out the arrangements for risk management, and financial risk (within the IJB and both Parties) will be managed in line with those arrangements.

The Parties will ensure that their respective budget monitoring and management systems will be applied to monitor and manage their expenditure in relation to delivery of integrated functions in accordance with directions issued to them by the IJB.

The manager leading this remedial action could be the Chief Officer in his or her operational capacity within the affected party.

In the event that such remedial action will not prevent the overspend, then Chief Finance Officer will, together with the relevant Party, develop a proposed recovery plan to address the forecast overspend. The Chief Finance Officer will then present that recovery plan to the IJB as soon as practically possible. The IJB has to be satisfied with the recovery plan, and the plan is subject to its approval.

9.9.2 **Additional Payments by the Parties to the IJB**

Where such a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end, and where there are insufficient available reserves held by the IJB to meet the overspend, then the Parties may make additional payments to the IJB.

The Chief Finance Officer and the Parties shall engage in discussion and negotiation about the amounts to be paid by each Party.

The Parties recognise that the delivery of delegated functions in accordance with the Strategic Plan depends on their co-operation between each other and with the IJB and that both Parties and the IJB must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. In such

discussions the Parties recognise and accept that an overspend is at the risk of the Party incurring the overspend and the residual amount of overspend after usage of reserves must, in the absence of any other agreement, be met by that Party.

Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the IJB, then the dispute resolution mechanism in this Scheme may require to be implemented.

9.9.3 **Underspends**

As part of their normal financial management systems, the Parties conduct in-year reviews of financial performance, and occasionally this may lead to a forecast of an underspend at the year-end on one or more budgets. In the event that this happens within the operational budgets then the following shall apply:

- if the underspend is fortuitous and unrelated to any IJB direction then the underspend should be returned to the affected Party (through an adjustment to the payments to the IJB)
- the IJB will retain all other underspends.
- The IJB can hold reserves, as determined by its Reserves Policy.

9.9.4 **Treatment of variations against the amounts set aside for use by the IJB**

A process will be agreed between NHS Lothian and the IJB to manage any variations within the set-aside budget. This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Integrated payment as laid out above.

9.9.5 **Redetermination of payments (made under section 1(3) (e)) to the IJB**

Redeterminations of payments made by the Parties for the carrying out of integration functions would apply under the following circumstances:

- Additional one off funding is provided to a Party or Parties by the Scottish Government, or some other body, for expenditure in respect of a function delegated to the IJB
- The Parties, along with the IJB, agree that an adjustment to the payment is required to reflect changes in demand and/or activity levels

In all cases full justification for the proposed change would be required and both Parties and the IJB would be required to agree to the redetermination. The Parties would apply the process used to calculate the payment to the IJB (described earlier) to the affected functions and the Strategic Plan would be required to be amended as necessary.

9.9.6 **Redetermination of set aside payments (made under section 1(3) (d)) to the IJB**

This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Operational Budgets as specified above.

9.10 Use of Capital Assets

The IJB, NHS Lothian and the Council will ensure there is awareness of all capital assets which will be used in the delivery of the Strategic Plan.

Changes in use of capital assets will flow from the Strategic Plan and the directions issued by the IJB to the Parties. The Strategic Plan process will outline any implications or requirements for capital assets.

The Parties will ensure that their capital asset planning arrangements take due cognisance of the above implications and requirements.

The Chief Officer of the IJB will consult with the Parties to identify the specific need for improvements/changes to assets owned by each which may be required in connection with the carrying out of integration functions. Where a capital investment need is identified, a business case will require to be developed. Any business case will set out how the investment will meet the strategic objectives set out in the Strategic Plan and identify the ongoing revenue costs/savings associated with implementation of the proposals.

The IJB, the Council and NHS Lothian will work together to ensure assets required in connection with the carrying out of integration functions are used as effectively as possible and in compliance with the relevant legislation relating to use of public assets.

9.11 Audit and Financial Statements

9.11.1 **Financial Statements and External Audit**

The legislation requires that the IJB is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973 (section 13). This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003, the Local Authority Accounts (Scotland) Regulations 2014 and other regulations under section 105 of the Local Government (Scotland) Act 1973). These will be proportionate to the limited number of transactions of the IJB whilst complying with the requirement for transparency and true and fair reporting in the public sector.

The Parties will agree a clear timetable for the preparation of the IJB's annual accounts which will incorporate a process to agree any balances between the IJB and the Parties.

As part of the financial year-end procedures and in order to develop the year-end financial statements, the Chief Finance Officer of the IJB will annually co-ordinate an exercise agreeing the value of balances and transactions with the Council and NHS Lothian finance teams. Each of the Parties will submit to the Chief Financial Officer their recorded income, expenditure, receivable and payable balance with the IJB. The

Parties' respective finance representatives will then work to resolve any differences arising.

The IJB financial statements must be completed to meet the audit and publication timetable specified in the regulations (Regulations under section 105 of the Local Government (Scotland) Act 1973). The Accounts Commission will appoint the external auditors to the IJB.

The financial statements will be signed in line with the governance arrangements for the IJB and as specified in the Local Authority Accounts (Scotland) Regulations 2014, made under section 105 of the Local Government (Scotland) Act 1973.

In all forms of audit the Parties are expected to comply with related requests and to aid the audit process.

10. Participation and Engagement

Participation and Engagement Strategy

10.1.1 The Parties will support the Chief Officer to produce a strategy for engagement with, and participation by members of the public, representative groups or other organisations in relation to the decisions about carrying out of integration functions as set out in section 4. The process to identify and provide support to the Chief Officer to develop the IJB's Participation and Engagement Strategy is described in section 5.3. As part of the process set out in section 5.3 the Parties will:

- Make available to the IJB arrangements that are already established for consultation by one or both of the Parties. The IB will consider a range of ways in which to connect with all stakeholders. The IJB will use existing consultation methods, for example (but not limited to), the Midlothian Citizens' Panel.
- Make available service/user participation and engagement teams to the IJB as this relates to function delegated within the Scheme.
- Make available communication support to allow the IJB to engage and participate.

10.1.2 The Parties expect that the IJB Participation and Engagement Strategy will be produced before the date the IJB approves the Strategic Plan. When the IJB approves the Strategic Plan the Parties expect that members must be satisfied that the Strategic Plan has had sufficient consultation and that the Participation and Engagement Strategy has been followed.

10.1.3 The development of the participation and engagement strategy will be achieved using a collaborative response, involving the membership of the Midlothian Strategic Planning Group.

10.1.4 The Strategic Planning Group is expected will take both an advisory and active role in the undertaking of future participation and engagement around the implications of service development and re-design.

Consultation on this Integration Scheme

10.1.5 A three stage approach was adopted to ensure sufficient involvement and consultation in the development of this Scheme:

- **Stage 1: Informing and Engaging:**
  Initial review was undertaken and revisions made by officers of the Parties with the involvement of a range of professionals within both Parties. This draft was approved for consultation by the Parties
- **Stage 2: Consultation**
  A formal internal and external stakeholder consultation was held from the 18th of March to the 10th of April 2022.

- **Stage 3: Response to the consultation**
  The revised integration scheme was further developed by officers, guided by the consultation, and submitted for approval by the Parties to submit to Scottish Government

Further details of the people and groups involved in the informing, engagement and consultation on the Midlothian Integration Scheme are set out in Annex 4.

11. Information Sharing & Data Handling

11.1 There is an existing and long standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian, City of Edinburgh Council, East Lothian Council, Midlothian Council, West Lothian Council, and Scottish Borders Council are all signatories, and had previous modifications to comply with the Integration Scheme Regulations. This Protocol will be subject to periodic review by a sub-group on behalf of the Pan Lothian Data Sharing Partnership, and any resulting update(s) agreed will form the Protocol in use to support this Scheme of Establishment. Any updated final Protocol, following consultation, will be recommended for signature by Chief Executives of respective organisations, and the Chief Officers of the Integrated Joint Boards, on behalf of the Pan-Lothian Data Sharing Partnership.

11.2 Procedures for sharing information between the Council, NHS Lothian, and the Integration Joint Board are available in Memorandum of Understanding document for the Sharing of information for the purposes of the integration of health and social care services. This Memorandum of Understanding will be subject to periodic review by a sub-group on behalf of the Pan Lothian Data Sharing Partnership to ensure that the detail, more granular purposes, requirements, procedures and agreements for each of the Lothian Integrated Joint Boards and the functions respectively delegated to them are kept up to date. This will also form the process for amending the Pan Lothian and Borders General Information Sharing Protocol.

11.3 The Council and NHS Lothian will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The Integration Joint Board may require to be Data Controller for personal data if it is not held by either by the Council or NHS Lothian.

11.4 Arrangements for Third party organisations access to records will be jointly agreed by both Parties and the IJB prior to access.

11.5 Procedures will be based on a single point of governance model. This allows data and resources to be shared, with governance standards, and their implementation, being the separate responsibility of each organisation. Shared datasets governance will be agreed by all contributing partners prior to access.

11.6 Following consultation, all periodically updated Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of respective organisations, and the Chief Officers of the Lothian Integrated Joint Boards.

11.7 Agreements and procedures will be reviewed annually by the sub group of the Pan-Lothian Data Sharing Partnership, or more frequently if required. This will follow the process described in 11.2.

12. Complaints

The Parties agree the following arrangements in respect of complaints:

12.1 Any person will be able to make complaints to either to the Council or to the NHS Board. The Parties have in place well publicised, clearly explained and accessible complaints procedures, which allow for timely recourse and signpost independent advocacy services, where appropriate. There is an agreed emphasis on resolving concerns locally and quickly; as close to the point of service delivery as possible.

Complaints can be made to:
The Midlothian Council by:
Telephone: 0131 561 5444
Email: feedback@midlothian.gov.uk
Online: www.midlothian.gov.uk/feedback
In writing to Midlothian Council feedback, Freepost SCO5613, Dalkeith, EH22 0BR

NHS Lothian by:
Telephone: 0131 536 3370
Email: feedback@nhslothian.scot.nhs.uk
In writing to NHS Lothian Patient Experience Team, Waverley Gate, 2 – 4 Waterloo Place, Edinburgh, EH1 3EG.

The IJB has also developed its own Complaints Handling Procedure which will be reviewed on a regular basis

12.2 There are currently different legislative requirements in place for dealing with complaints about health and social care. Complaints regarding the delivery of an integrated service will be made to, and dealt with by, the Party that delivers the integrated service, in line with their published complaints procedure, and consistent with any statutory complaints handling arrangements that apply. It is the responsibility of the Party initially receiving a complaint to make sure that it is routed to the appropriate organisation/individual, so that a service user only needs to submit a complaint once.

12.3 From 1 April 2017, the health and social work complaints handling procedures were aligned and therefore have the same stages and timescales, with the exception of timescale extensions. Additionally, complaints about Social Work functions were merged into the Local Authority Model Complaint Handling Procedure in 2020 (now reflected in the updated Midlothian Council Complaints Handling Procedure). Joint working protocols will be adopted so that the process of making a complaint is as simple as possible and complaints about integrated services are responded to clearly, thoroughly and timeously. These joint working protocols will identify the lead organisation for each integrated service and will include the contact details of officers responsible for managing any complaints received.

12.4 When a complaint covers both health and social care functions, responsible officers within the Council and NHS Lothian will, where necessary, work together to make sure all parts of the complaint are investigated and responded to within established time limits and the complainant is correctly signposted to the options open to them if they remain dissatisfied. Wherever possible, there will be a joint response from the identified Party rather than separate responses.

12.5 At the end of the process, complainants are entitled to take their complaint to the Scottish Public Services Ombudsman. Where appropriate, complainants will also be advised of their right to complain to the Care Inspectorate and information held by the Council may be shared with the Care Inspectorate.

12.6 Responsibility for responding to the Scottish Public Services Ombudsman lies with the Party who dealt with the original complaint. Where necessary, officers responsible for complaints handling within the Council and NHS Lothian will work together to provide a full response to any Scottish Public Services Ombudsman enquiry that covers both health and social care functions.

12.7 The Chief Officer will have an overview of complaints made about integrated services and subsequent responses. Complaints about integrated services will be recorded and reported to the Chief Officer on a regular and agreed basis. Regular trend analysis of complaints and outcomes will also be carried out as part of a wider quality assurance framework.

12.8 All independent contractors will be required to have a complaints procedure. Where complaints are received about the service provided by an independent contractor, the Party receiving the complaint will refer the complaint to the independent contractor in the first instance, either providing contact details or by passing the complaint on, depending on the preferred approach of the complainant. Complaints received about independent contractors will be recorded for contract monitoring purposes.

13. Claims Handling, Liability & Indemnity

13.1 The Parties and the Integration Joint Board recognise that they could receive a claim arising from or which relates to the work undertaken on behalf of the Integration Joint Board.

13.2 The Parties agree to ensure that any such claims are progressed quickly and in a manner which is equitable between them.

13.3 So far as reasonably practicable the normal common law and statutory rules relating to liability will apply.

13.4 Each Party will assume responsibility for progressing and determining any claim which relates to any act or omission on the part of one of their employees.

13.5 Each Party will assume responsibility for progressing and determining any claim which relates to any building which is owned or occupied by them.

13.6 Each Party will assume responsibility for progressing and determining any claim which relates to any heritable property which is owned by them. If there are any heritable properties owned jointly by the Parties, further arrangements for liability will be agreed upon in consultation with insurers.

13.7 In the event of any claim against the Integration Joint Board or in respect of which it is not clear which Party should assume responsibility then the Chief Officer (or their representative) will liaise with the Chief Executives of the Parties (or their representatives) and determine which Party should assume responsibility for progressing the claim.

13.8 If a claim is settled by either Party, but it subsequently transpires that liability rested with the other Party, then that Party shall indemnify the Party which settled the claim.

13.9 Claims regarding policy and/or strategic decisions made by the IJB shall be the responsibility of the IJB. The IJB may require to engage independent legal advice for such claims.

13.10 If a claim has a “cross boundary” element whereby it relates to another integration authority area, the Chief Officers of the integration authorities concerned shall liaise with each other until an agreement is reached as to how the claim should be progressed and determined.

13.11 The IJB will develop a procedure for claims relating to hosted services with the other relevant integration authorities. Such claims may follow a different procedure than as set out above.

13.12 Claims which pre-date the establishment of the IJB will be dealt with by the Parties through the procedures used by them prior to integration.

14. Risk Management

14.1.1 A shared risk management strategy which will include risk monitoring and a reporting process for the Parties and Integration Joint Board will be established in the first year of the Integration Joint Board. In developing this shared risk management strategy the Parties and the Integration Joint Board will review the shared risk management arrangements currently in operation. This in turn will provide a list of risks to be reported on.

14.1.2 The Parties will provide to the Integration Joint Board sufficient support to enable it to fully discharge its duties in relation to risk management. This will be determined through the process describe in section 5.3.

14.1.3 The Parties anticipate that the IJB will also develop and agree its own Risk Management Procedure in relation to carrying out of integration functions including reports which will cover all of its activities.

14.1.4 The Risk Management Procedure will include:-

a) A statement of the IJB's risk appetite and associated tolerance measures.
b) A description of how the system of risk management will work in practice, including procedures for the identification, classification, recording and reporting of risk, and the respective roles of the IJB and its officers. This will explain how the output from the risk management systems within NHS Lothian and the Council will inform the IJB's system of risk management.
c) A description of how the IJB system of risk management is informed by other related systems of NHS Lothian and the Council, such as complaints management, health & safety, adverse events management, emergency planning and business resilience.
d) An agreement between the Parties on the resources to be made available to support risk management.

14.1.5 The IJB risk register will not duplicate the detail of risk registers within NHS Lothian and the Council. However, the IJB will update its risk register should there by any emerging themes/risks which have a bearing on its activities.

14.2 NHS Lothian and the Council

14.2.1 Both organisations will continue to apply their existing policies and systems for risk management, and will implement any required restructuring of their risk registers to recognise the creation of the IJB.

14.2.2 NHS Lothian covers four local authority areas, and there will be some 'hosted services' which one operational director manages on a Lothian-wide basis. The identification and management of risk for those hosted services will reflect the differing directions of the four IJBs.

15. Dispute resolution mechanism

15.1 The Parties will commit to working well together, listening to each other and will always work to resolve any issues before they require the Dispute Resolution process to be actioned.

15.2 Where either of the Parties fails to agree with the other on any issue related to this Scheme of any of the duties, obligations, rights or powers imposed or conferred on them by the Act (A **"Dispute"**) then they will follow the process described below:

(a) The Chief Executives of NHS Lothian and the Council, and the Chief Officer, will meet to resolve the Dispute within 21 calendar days of being notified of the issue;

(b) If unresolved, NHS Lothian, the Council, and the Chief Officer, will each prepare a written note of their position on the Dispute and exchange it with the others within 14 calendar days of the meeting in (a) above;

(c) Within 14 calendar days of the exchange of written notes in (b) the Chief Executives and Chief Officer must meet to discuss the written positions;

(d) In the event that the issue remains unresolved, representatives of NHS Lothian and the Council will proceed to mediation with a view to resolving the Dispute.

15.3 Scottish Government will be informed by the chairperson of the IJB of the Dispute, the mediation process being followed and the agreed timeframe to conclude the mediation process. A copy of this correspondence will be sent to the Chair of NHS Lothian and the Leader of the Council.

15.4 The mediator will be external to the Parties and will be identified and appointed with the agreement of the Chair of NHS Lothian and the Leader of the Council and failing agreement within 21 days shall be nominated by the Centre of Effective Dispute Resolution (CEDR) on the request of either Party.

15.5 The mediation will start no later than 21 days after the date of the appointment of the mediator.

15.6 The Parties agree that the cost of the mediator will be met equally by NHS Lothian and the Council.

15.7 The timeframe to resolve the issue will be agreed prior to the start of the mediation process by the Chair of NHS Lothian and the Leader of the Council.

15.8 Where the Dispute remains unresolved after following the processes outlined in section 15.2 above, the Parties agree that the chairperson of the Integration Joint Board shall write to the Scottish Ministers to provide notification that agreement cannot be reached. Scottish Government will then instruct the Parties how to proceed.

15.9 The Parties shall cooperate with each other to mitigate any adverse affect on service delivery pending resolution of the Dispute.

15.10 Nothing in this Scheme shall prevent the Parties from seeking any legal remedy or from commencing or continuing court proceedings in relation to the Dispute.

Annex 1: Part 1 – Functions delegated by NHS Lothian to the IJB

Set out below is the list of functions that are to be delegated by NHS Lothian to the IJB in compliance with the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014.

The National Health Service (Scotland) Act 1978

All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978 except functions conferred by or by virtue of:

- section 2(7) (Health Boards);
- section 2CB([1]) (Functions of Health Boards outside Scotland);
- section 9 (local consultative committees);
- section 17A (NHS Contracts);
- section 17C (personal medical or dental services);
- section 17I([2]) (use of accommodation);
- section 17J (Health Boards' power to enter into general medical services contracts);
- section 28A (remuneration for Part II services);
- section 48 (provision of residential and practice accommodation);
- section 55([3]) (hospital accommodation on part payment);
- section 57 (accommodation and services for private patients);
- section 64 (permission for use of facilities in private practice);
- section 75A([4]) (remission and repayment of charges and payment of travelling expenses);
- section 75B([5])(reimbursement of the cost of services provided in another EEA state);
- section 75BA ([6])(reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);
- section 79 (purchase of land and moveable property);

([1]) Section 2CB was inserted by S.S.I. 2010/283, regulation 3(2)(as section 2CA) and re-numbered as section 2CB by S.S,I 2013/293, regulation 8(2).

([2]) Section 17I was inserted by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2 and amended by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 4. The functions of the Scottish Ministers under section 17I are conferred on Health Boards by virtue of S.I. 1991/570, as amended by S.S.I. 2006/132.

([3]) Section 55 was amended by the Health and Medicines Act 1988 (c.49), section 7(9) and Schedule 3 and the National Health Service and Community Care Act 1990 (c.19), Schedule 9. The functions of the Secretary of State under section 55 are conferred on Health Boards by virtue of S.I. 1991/570.

([4]) Section 75A was inserted by the Social Security Act 1988 (c.7), section 14, and relevantly amended by S.S.I. 2010/283. The functions of the Scottish Ministers in respect of the payment of expenses under section 75A are conferred on Health Boards by S.S.I. 1991/570.

([5]) Section 75B was inserted by S.S.I. 2010/283, regulation 3(3) and amended by S.S.I. 2013/177.

([6]) Section 75BA was inserted by S.S.I. 2013/292, regulation 8(4).

- section 82([7]) use and administration of certain endowments and other property held by Health Boards);
- section 83([8]) (power of Health Boards and local health councils to hold property on trust);
- section 84A([9]) (power to raise money, etc., by appeals, collections etc.);
- section 86 (accounts of Health Boards and the Agency);
- section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);
- section 98 ([10]) (charges in respect of non-residents); and
- paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);
- and functions conferred by—
- The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ([11]);
- NHS Lothians (Membership and Procedure) (Scotland) Regulations 2001/302;
- The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;
- The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;
- The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;
- The National Health Service (Discipline Committees) Regulations 2006/330;
- The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;
- The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;
- The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and
- The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55([12]).

([7]) Section 82 was amended by the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (asp 7) section 1(2) and the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 2.

([8]) There are amendments to section 83 not relevant to the exercise of a Health Board's functions under that section.

([9]) Section 84A was inserted by the Health Services Act 1980 (c.53), section 5(2). There are no amendments to section 84A which are relevant to the exercise of a Health Board's functions.

([10]) Section 98 was amended by the Health and Medicines Act 1988 (c.49), section 7. The functions of the Secretary of State under section 98 in respect of the making, recovering, determination and calculation of charges in accordance with regulations made under that section is conferred on Health Boards by virtue of S.S.I. 1991/570.

([11]) S.I. 1989/364, as amended by S.I. 1992/411; S.I. 1994/1770; S.S.I. 2004/369; S.S.I. 2005/455; S.S.I. 2005/572 S.S.I. 2006/141; S.S.I. 2008/290; S.S.I. 2011/25 and S.S.I. 2013/177.

([12]) S.S.I. 2011/55, to which there are amendments not relevant to the exercise of a Health Board's functions.

Disabled person's (Services, Consultation and Representation) Act 1986

Section 7 - (Persons discharged from hospital)

Community Care and Health (Scotland) Act 2002

All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.

Mental Health (Care and Treatment) (Scotland) Act 2003

All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003 except functions conferred by:

- section 22 (Approved medical practitioners);
- section 34 (Inquiries under section 33: co-operation)([13]);
- section 38 (Duties on hospital managers: examination notification etc.)([14]);
- section 46 (Hospital managers' duties: notification)([15]);
- section 124 (Transfer to other hospital);
- section 228 (Request for assessment of needs: duty on local authorities and Health Boards);
- section 230 (Appointment of a patient's responsible medical officer);
- The Mental Health (Safety and Security) (Scotland) Regulations 2005([16]);
- The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([17]);
- The Mental Health (Use of Telephones) (Scotland) Regulations 2005([18]); and
- The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([19]).
- The Mental Health (Safety and Security) (Scotland) Regulations 2005([20]);

([13]) There are amendments to section 34 not relevant to the exercise of a Health Board's functions under that section.

([14]) Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards under that Act.

([15]) Section 46 is amended by S.S.I. 2005/465.

([16]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([17]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([18]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([19]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

([20]) S.S.I. 2005/464, to which there are amendments not relevant to the exercise of the functions of a Health Board. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.

- The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005([21]);
- The Mental Health (Use of Telephones) (Scotland) Regulations 2005([22]); and
- The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008([23]).

Education (Additional Support for Learning) (Scotland) Act 2004

Section 23- (other agencies etc. to help in exercise of functions under this Act)

Public Services Reform (Scotland) Act 2010

All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010 except functions conferred by:

- Section 31 - (Public functions: duties to provide information on certain expenditure etc.);
- Section 32 - (Public functions: duty to provide information on exercise of functions).

Patient Rights (Scotland) Act 2011

All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011 except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36([24]).

Carers (Scotland) Act 2016

Section 12 - (duty to prepare young carer statement)
Section 31 - (duty to prepare local carer strategy)

But in each case, subject to the restrictions set out in article 3(3) of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations so far as they extend to the services detailed in Part 2 of Annex 1 of this Scheme.

([21]) S.S.I. 2005/467. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([22]) S.S.I. 2005/468. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([23]) S.S.I. 2008/356. Section 329(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 provides a definition of "managers" relevant to the functions of Health Boards.
([24]) S.S.I. 2012/36. Section 5(2) of the Patient Rights (Scotland) Act 2011 (asp 5) provides a definition of "relevant NHS body" relevant to the exercise of a Health Board's functions.

Annex 1: Part 2 – Services Currently Provided by NHS Lothian which are to be delegated.

Interpretation of this Part 2 of Annex 1

In this schedule—

"Allied Health Professional" means a person registered as an allied health professional with the 'Health and Care Professions Council';

"**General medical practitioner"** means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"**General medical services contract**" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"**Hospital**" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"**inpatient hospital services**" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"**out of hours period**" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004([25]); and

"**the public dental service**" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

The functions listed in Part 1 of Annex 1 are delegated to the extent that they are exercisable in the provision of the following services:

Part 2 A

Provision for people over the age of 18

The functions listed in Part 1 are delegated to the extent that:
a) the function is exercisable in relation to the persons of at least 18 years of age:
b) the function is exercisable in relation to care or treatment provided by health professionals for the purposes of the health care services listed at numbers 1-6 in the list below: and
c) the function is exercisable in relation to the health services listed in this part 2A

1. Accident and Emergency services provided in a hospital.

2. Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;

([25]) S.S.I. 2004/115.

(b) geriatric medicine;

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) Psychiatry of learning disability.

3. Palliative care services provided in a hospital.

4. Inpatient hospital services provided by General Medical Practitioners.

5. Services provided in a hospital in relation to an addiction or dependence on any substance.

6. Mental health services provided in a hospital, except secure forensic mental health services.

7. District nursing services.

8. Services provided outwith a hospital in relation to an addiction or dependence on any substance.

9. Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

10. The public dental service.

11. Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978([26]).

12. General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978([27]).

13. Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978([28]).

14. Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978([29]).

([26]) Section 2C was inserted by the Primary Medical Services (Scotland) Act 2004 (asp 1), section 1(2) and relevantly amended by the National Health Service Reform (Scotland) Act 2004 (asp 7), schedule 1, and the Tobacco and Primary Medical Services (Scotland) Act 2010 (asp 3), section 37.

([27]) Section 25 was relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 15.

([28]) Section 17AA was inserted by the National Health Service (Primary Care) Act 1997 (c.46), section 31(2) and relevantly amended by the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13), section 25. Section 26 was relevantly amended by the Health and Social Security Act 1984 (c.48), Schedule 1, and the Smoking, Health and Social Care (Scotland) Act 2005 (asp 13) section 13.

([29]) Section 27 was relevantly amended by the Health Services Act 1990 (c.53), section 20; the National Health Service and Community Care Act 1990 (c.19), Schedule 9; the Medicinal Products: Prescription by Nurses etc. Act 1992 (c.28), section 3; the National Health Service and Community Care Act 1997 (c.46), Schedule 2 and the Health and Social Care Act 2001 (c.15), section 44.

15. Services providing primary medical services to patients during the out-of-hours period.

16. Services provided outwith a hospital in relation to geriatric medicine.

17. Palliative care services provided outwith a hospital.

18. Community learning disability services.

19. Mental health services provided outwith a hospital.

20. Continence services provided outwith a hospital.

21. Kidney dialysis services provided outwith a hospital.

22. Services provided by health professionals that aim to promote public health.

Part 2B

NHS Lothian has also chosen to delegate the functions listed in Part 1 of Annex 1 in relation to the following services.

Provision for people under the age of 18

The functions listed in Part 1 are also delegated to the extent that:
a) The function is exercisable in relation to persons of less than 18 years of age; and
b) The function is exercisable in relation to the services listed in this part 2B

a) Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
b) General Dental Services, Public Dental Services and the Edinburgh Dental Institute
c) General Ophthalmic Services
d) General Pharmaceutical Services
e) Out of Hours Primary Medical Services
f) Learning Disabilities
g) Health Visiting
h) School Nursing

Annex 2: Part 1A – Functions delegated by the Council to the Integration Joint Board

Set out below is the list of functions that must be delegated by the Council to the Integration Joint Board.

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

National Assistance Act 1948([30])

Enactment conferring function	Limitation
Section 48 (Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	

The Disabled Persons (Employment) Act 1958([31])

Enactment conferring function	Limitation
Section 3 (Provision of sheltered employment by local authorities)	

The Social Work (Scotland) Act 1968([32])

([30]) 1948 c.29; section 48 was amended by the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 39, paragraph 31(4) and the Adult Support and Protection (Scotland) Act 2007 (asp 10) schedule 2 paragraph 1.
([31]) 1958 c.33; section 3 was amended by the Local Government Act 1972 (c.70), section 195(6); the Local Government (Scotland) Act 1973 (c.65), Schedule 27; the National Health Service (Scotland) Act 1978 (c.70), schedule 23; the Local Government Act 1985 (c.51), Schedule 17; the Local Government (Wales) Act 1994 (c.19), Schedules 10 and 18; the Local Government etc. (Scotland) Act 1994 (c.49), Schedule 13; and the National Health Service (Consequential Provisions) Act 2006 (c.43), Schedule 1.
([32]) 1968 c.49; section 1 was relevantly amended by the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Children Act 1989 (c.41), Schedule 15; the National Health Service and Community Care Act 1990

Enactment conferring function	Limitation
Section 1 (Local authorities for the administration of the Act.)	So far as it is exercisable in relation to another integration function.
Section 4 (Provisions relating to performance of functions by local authorities.)	So far as it is exercisable in relation to another integration function.
Section 8 (Research.)	So far as it is exercisable in relation to another integration function.
Section 10 (Financial and other assistance to voluntary organisations etc. for social work.)	So far as it is exercisable in relation to another integration function.
Section 12 (General social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (Duty of local authorities to assess needs.)	So far as it is exercisable in relation to another integration function.
Section 12AZA (Assessments under section 12A - assistance)	So far as it is exercisable in relation to another integration function.

(c.19) ("the 1990 Act"), schedule 10; S.S.I. 2005/486 and S.S.I. 2013/211. Section 4 was amended by the 1990 Act, Schedule 9, the Children (Scotland) Act 1995 (c.36) ("the 1995 Act"), schedule 4; the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13) ("the 2003 Act"), schedule 4; and S.S.I. 2013/211. Section 10 was relevantly amended by the Children Act 1975 (c.72), Schedule 2; the Local Government etc. (Scotland) Act 1994 (c.39), Schedule 13; the Regulation of Care (Scotland) Act 2001 (asp 8) ("the 2001 Act") schedule 3; S.S.I. 2010/21 and S.S.I. 2011/211. Section 12 was relevantly amended by the 1990 Act, section 66 and Schedule 9; the 1995 Act, Schedule 4; and the Immigration and Asylum Act 1999 (c.33), section 120(2). Section 12A was inserted by the 1990 Act, section 55, and amended by the Carers (Recognition and Services) Act 1995 (c.12), section 2(3) and the Community Care and Health (Scotland) Act 2002 (asp 5) ("the 2002 Act"), sections 8 and 9(1). Section 12AZA was inserted by the Social Care (Self Directed Support) (Scotland) Act 2013 (asp 1), section 17. Section 12AA and 12AB were inserted by the 2002 Act, section 9(2). Section 13 was amended by the Community Care (Direct Payments) Act 1996 (c.30), section 5. Section 13ZA was inserted by the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 64. Section 13A was inserted by the 1990 Act, section 56 and amended by the Immigration and Asylum Act 1999 (c.33), section 102(2); the 2001 Act, section 72 and schedule 3; the 2002 Act, schedule 2 and by S.S.I. 2011/211. Section 13B was inserted by the 1990 Act sections 56 and 67(2) and amended by the Immigration and Asylum Act 1999 (c.33), section 120(3). Section 14 was amended by the Health Services and Public Health Act 1968 (c.46), sections 13, 44 and 45; the National Health Service (Scotland) Act 1972 (c.58), schedule 7; the Guardianship Act 1973 (c.29), section 11(5); the Health and Social Service and Social Security Adjudications Act 1983 (c.41), schedule 10 and the 1990 Act, schedule 9. Section 28 was amended by the Social Security Act 1986 (c.50), Schedule 11 and the 1995 Act, schedule 4. Section 29 was amended by the 1995 Act, schedule 4. Section 59 was amended by the 1990 Act, schedule 9; the 2001 Act, section 72(c); the 2003 Act, section 25(4) and schedule 4 and by S.S.I. 2013/211.

Enactment conferring function	Limitation
Section 13 (Power of local authorities to assist persons in need in disposal of produce of their work.)	
Section 13ZA (Provision of services to incapable adults.)	So far as it is exercisable in relation to another integration function.
Section 13A (Residential accommodation with nursing.)	
Section 13B (Provision of care or aftercare.)	
Section 14 (Home help and laundry facilities.)	
Section 28 (Burial or cremation of the dead.)	So far as it is exercisable in relation to persons cared for or assisted under another integration function.
Section 29 (Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.)	
Section 59 (Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.)	So far as it is exercisable in relation to another integration function.

The Local Government and Planning (Scotland) Act 1982([33])

Enactment conferring function	Limitation
Section 24(1) (The provision of gardening assistance for the disabled and the elderly.)	

Disabled Persons (Services, Consultation and Representation) Act 1986([34])

Enactment conferring function	Limitation

([33]) 1982 c.43; section 24(1) was amended by the Local Government etc. (Scotland) Act 1994 (c.39), schedule 13.

([34]) 1986 c.33. There are amendments to sections 2 and 7 which are not relevant to the exercise of a local authority's functions under those sections.

Enactment conferring function	Limitation
Section 2 (Rights of authorised representatives of disabled persons.)	
Section 3 (Assessment by local authorities of needs of disabled persons.)	
Section 7 (Persons discharged from hospital.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated.
Section 8 (Duty of local authority to take into account abilities of carer.)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.

The Adults with Incapacity (Scotland) Act 2000([35])

Enactment conferring function	Limitation
Section 10 (Functions of local authorities)	
Section 12 (Investigations.)	
Section 37 (Residents whose affairs may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (Matters which may be managed.)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (Duties and functions of managers of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions

([35]) 2000 asp 4; section 12 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 5(1). Section 37 was amended by S.S.I. 2005/465. Section 39 was amended by the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and by S.S.I. 2013/137. Section 41 was amended by S.S.I. 2005/465; the Adult Support and Protection (Scotland) Act 2007 (asp 10), schedule 1 and S.S.I. 2013/137. Section 45 was amended by the Regulation of Care (Scotland) Act 2001 (asp 8), Schedule 3.

Enactment conferring function	Limitation
Section 42 (Authorisation of named manager to withdraw from resident's account.)	Only in relation to residents of establishments which are managed under integration functions
Section 43 (Statement of resident's affairs.)	Only in relation to residents of establishments which are managed under integration functions
Section 44 (Resident ceasing to be resident of authorised establishment.)	Only in relation to residents of establishments which are managed under integration functions
Section 45 (Appeal, revocation etc.)	Only in relation to residents of establishments which are managed under integration functions

The Housing (Scotland) Act 2001([36])

Enactment conferring function	Limitation
Section 92 (Assistance to a registered for housing purposes.)	Only in so far as it relates to an aid or adaptation.

The Community Care and Health (Scotland) Act 2002([37])

Enactment conferring function	Limitation
Section 5 (Local authority arrangements for of residential accommodation outwith Scotland.)	
Section 14 (Payments by local authorities towards expenditure by NHS bodies on prescribed functions.)	

The Mental Health (Care and Treatment) (Scotland) Act 2003([38])

([36]) 2001 asp 10; section 92 was amended by the Housing (Scotland) Act 2006 (asp 1), schedule 7.
([37]) 2002 asp 5.
([38]) 2003 asp 13; section 17 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), section 111(4), and schedules 14 and 17, and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 25 was amended by S.S.I. 2011/211. Section 34 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17.

Enactment conferring function	Limitation
Section 17 (Duties of Scottish Ministers, local authorities and others as respects Commission.)	
Section 25 (Care and support services etc.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 26 (Services designed to promote well-being and social development.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 27 (Assistance with travel.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 33 (Duty to inquire.)	
Section 34 (Inquiries under section 33: Co-operation.)	
Section 228 (Request for assessment of needs: duty on local authorities and Health Boards.)	
Section 259 (Advocacy.)	

The Housing (Scotland) Act 2006([39])

Enactment conferring function	Limitation
Section 71(1)(b) (Assistance for housing purposes.)	Only in so far as it relates to an aid or adaptation.

The Adult Support and Protection (Scotland) Act 2007([40])

Enactment conferring function	Limitation

([39]) 2006 asp 1; section 71 was amended by the Housing (Scotland) Act 2010 (asp 17) section 151.

([40]) 2007 asp 10; section 5 and section 42 were amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedules 14 and 17 and by the Police and Fire Reform (Scotland) Act 2012 (asp 8), schedule 7. Section 43 was amended by the Public Services Reform (Scotland) Act 2010 (asp 8), schedule 14.

Enactment conferring function	Limitation
Section 4 (Council's duty to make inquiries.)	
Section 5 (Co-operation.)	
Section 6 (Duty to consider importance of providing advocacy and other.)	
Section 11 (Assessment Orders.)	
Section 14 (Removal orders.)	
Section 18 (Protection of moved persons property.)	
Section 22 (Right to apply for a banning order.)	
Section 40 (Urgent cases.)	
Section 42 (Adult Protection Committees.)	
Section 43 (Membership.)	

Social Care (Self-directed Support) (Scotland) Act 2013([41])

Enactment conferring function	Limitation
Section 5 (Choice of options: adults)	
Section 6 (Choice of options under section 5: assistances.)	
Section 7 (Choice of options: adult carers.)	
Section 9 (Provision of information about self-directed support.)	

([41]) 2013 asp 1.

Enactment conferring function	Limitation
Section 11 (Local authority functions.)	
Section 12 (Eligibility for direct payment: review.)	
Section 13 (Further choice of options on material change of circumstances.)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 .
Section 16 (Misuse of direct payment: recovery.)	
Section 19 (Promotion of options for self-directed support.)	

Carers (Scotland) Act 2016

Enactment conferring function	Limitation
Section 6 (Duty to prepare adult carer support plan)	
Section 21 (Setting of local eligibility criteria.)	
Section 24 (Duty to provide support)	
Section 25 (Provision of support to carers: breaks from caring)	
Section 31 (Duty to prepare local carer strategy)	
Section 34 (Information and advice service for carers)	
Section 35 (Short breaks services statements)	

Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

The Community Care and Health (Scotland) Act 2002

Enactment conferring function	Limitation
Section 4([42]) The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002([43])	

([42]) Section 4 was amended by the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13), schedule 4 and the Adult Support and Protection (Scotland) Act 2007 (asp 10), section 62(3).
([43]) S.S.I. 2002/265, as amended by S.S.I. 2005/445.

Annex 2: Part 1B – Functions delegated from the Council to the Integrated Joint Board

In addition to the functions that must be delegated, the Council has chosen to delegate the following functions to the IJB.

Criminal Procedure (Scotland) Act 1995

Enactment conferring function	Limitation
Section 203 (Local authority reports pre-sentencing.)	
Section 234B (Report and evidence from local authority officer regarding Drug Treatment and Testing Order.)	
Section 245A (Report by local authority officer regarding Restriction of Liberty Orders.)	

Management of Offenders etc. (Scotland) Act 2005

Enactment conferring function	Limitation
Section 10 (Arrangements for assessing and managing risks posed by certain offenders.)	
Section 11 (Review of arrangements.)	

Social Work (Scotland) Act 1968

Enactment conferring function	Limitation
Section 27 (Supervision and care of persons put on probation or released from prison.)	
Section 27ZA (Advice, guidance and assistance to persons arrested or on whom sentence is deferred.)	

Annex 2: Part 2 – Services currently associated with the functions delegated by the Council to the IJB

Services currently associated with the functions delegated by the Council to the IJB
Set out below is an illustrative description of the services associated with the functions delegated by the Council to the Integration Joint Board as specified in Part 1A and 1B of Annex 2.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and Telecare
- Criminal Justice Social Work services

Annex 3: Operational Management arrangements

The provisions within this annex are not intended to create legally binding obligations. They are intended to be illustrative of the proposed management arrangements for the functions delegated to the IJB

The IJB will issue directions to the Parties via its Chief Officer. Those directions will in the main require that the Chief Officer take forward the development of the IJB's Strategic Plan, and lead on ensuring that the plan is delivered. As the Chief Officer will not be personally managing all of the integration functions, ensuring the Strategic Plan is being delivered will include getting assurance from other chief officers (for hospital acute services and hosted services – see below) and other managers in NHS Lothian and the Council.

The Chief Officer will have direct management responsibility for the following services:

- All Council services described in Annex 2, Part 2.
- All NHS Lothian services describe in Annex 1, Part 2 with the exception of the following:

Hosted Services

There are NHS Lothian services for which it would not be suitable for the Chief Officer to have operational management responsibility. The factors contributing to determining these services are the degree of medical specialism of the service and scale of the service required for it to be safe, efficient and effective.

NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are provided as part of a single Lothian-wide service. Where an IJB is nominated by NHS Lothian to 'host' such a service via one of the Chief Officers of the Lothian IJB's in their role as Joint Director of NHS Lothian, this is commonly referred to as a "hosted service".

Acute Hospitals

Services provided on the three acute hospitals in NHS Lothian (Western General Hospital, Edinburgh Royal Infirmary, St John's Hospital) will be managed by the Chief Officer for NHS Lothian acute hospital services and the relevant hospital site Director.

Annex 4: Integration Scheme Consultation

A three stage approach was adopted to ensure sufficient involvement and consultation in the development of this Scheme:

Stage 1: **Informing and Engaging:** A first draft was produced by officers of the Parties with the involvement of a range of professionals within both Parties

Stage 2: **Consultation**: A formal internal and external stakeholder consultation was held from December 17th 2014 to February 17th 2015.

Stage 3: **Response to the consultation:** A second draft guided by the consultation was produced by officers for approval by the Parties to submit to Scottish Government.

Further details of the people and groups involved in the engagement and consultation on the Midlothian Integration Scheme are set out below:

Public and Staff consultation from December 17th to February 17th with responses received from:

- Members of the public
- Members of staff in Midlothian Council
- Clinical and non-clinical staff in NHS Lothian
- Third Sector Organisations and representative bodies

The members and organisations on the following groups and committees were consulted on the Midlothian Integration Scheme.

- Midlothian Community Planning Partnership
- Midlothian Community Planning Working Groups
- NHS Lothian Board
- NHS Lothian Healthcare Governance committee
- NHS Lothian Corporate Management Team
- NHS Lothian Strategic Planning Group
- Midlothian Council
- Midlothian Audit Committee
- Midlothian Shadow Integration Joint Board
- Midlothian Older People's Management Group
- Midlothian Community Health Partnership
- Scottish Government
- Lothian Area Clinical Forum

Consultation for the amendment to the Integration Scheme in February 2019

The scheme has been updated to take account of the Carers (Scotland) Act 2016. There are no other substantive changes and in view of this there is considered no need to undertake a major consultation programme. However the document was published on the websites of both Midlothian Council and NHS Lothian for a four week period starting the week beginning the 11th February.

Consultation for the amendment to the Integration Scheme in April 2022

Again, a three stage approach was adopted to ensure sufficient involvement and consultation in the development of this Scheme:

Stage 1: Informing and Engaging:
Initial review was undertaken and revisions made by officers of the Parties with the involvement of a range of professionals within both Parties. This draft was approved for consultation by the Parties

Stage 2: Consultation
A formal internal and external stakeholder consultation was held from the 18th of March to the 10th of April 2022.

Stage 3: Response to the consultation
The revised integration scheme was further developed by officers, guided by the consultation, and submitted for approval by the Parties to submit to Scottish Government.

COMMUNICATING CLEARLY

We are happy to translate on request and provide information and publications in other formats, including Braille, tape or large print.

如有需要我們樂意提供翻譯本，和其他版本的資訊與刊物，包括盲人點字、錄音帶或大字體。

Zapewnimy tłumaczenie na żądanie oraz dostarczymy informacje i publikacje w innych formatach, w tym Braillem, na kasecie magnetofonowej lub dużym drukiem.

ਅਸੀਂ ਮੰਗ ਕਰਨ ਤੇ ਖੁਸ਼ੀ ਨਾਲ ਅਨੁਵਾਦ ਅਤੇ ਜਾਣਕਾਰੀ ਤੇ ਹੋਰ ਰੂਪਾ ਵਿੱਚ ਪ੍ਰਕਾਸ਼ਨ ਪ੍ਰਦਾਨ ਕਰਾਂਗੇ, ਜਿਨ੍ਹਾਂ ਵਿੱਚ ਬਰੇਲ, ਟੇਪ ਜਾਂ ਵੱਡੀ ਛਪਾਈ ਸ਼ਾਮਲ ਹਨ।

Körler icin kabartma yazilar, kaset ve büyük nüshalar da dahil olmak üzere, istenilen bilgileri saglamak ve tercüme etmekten memnuniyet duyariz.

اگر آپ چاہیں تو ہم خوشی سے آپ کو ترجمہ فراہم کر سکتے ہیں اور معلومات اور دستاویزات دیگر شکلوں میں مثلاً بریل (نابینا افراد کے لیے اُبھرے ہوئے حروف کی لکھائی) میں، ٹیپ پر یا بڑے حروف کی لکھائی میں فراہم کر سکتے ہیں۔

Contact 0131 270 7500 or email: enquiries@midlothian.gov.uk

INTEGRATION SCHEME

BETWEEN

WEST LOTHIAN COUNCIL

AND

NHS LOTHIAN

West Lothian Integration Scheme 2022
(Draft, for approval)

INTEGRATION SCHEME

1.0 The Parties

The Parties

a. The West Lothian Council, a local authority constituted under the local Government etc. (Scotland) Act 1994 and having its headquarters at West Lothian Civic Centre, Howden South Road, Livingston, West Lothian EH54 6FF ("the Council")

and

b. Lothian Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Lothian") and having its principal offices at Waverley Gate,2-4 Waterloo Place, Edinburgh ("NHS Lothian")

together referred to as "the Parties"

2.0 Definitions and Interpretation

"2014 Act" means the Public Bodies (Joint Working) (Scotland) Act 2014

"Board" means the West Lothian Integration Joint Board

"Chief Officer" means the member of staff of the IJB appointed under section 10 of the Act and described in Clause 8 of the Scheme

"Chief Finance Officer" means the finance officer appointed by the Board under the finance and audit requirements in section 13 of the 2014 Act and section 95 of the Local Government (Scotland) Act 1973, and described in Clause 10 of the Scheme

"Delegated functions" are the integration functions delegated by the Parties to the Integration Joint Board

"NHS Lothian" means Lothian Health Board

"Integration joint board" means a body corporate established by the Scottish Ministers under section 9(2) of the 2014 Act

"Integration functions" means the functions delegated by the Parties to the Board

"IJB Budget" and "Board budget" mean the total funding available to the Board in the financial year as a consequence of

The payment for delegated functions from NHS Lothian under section 1(3) (e) of the Act;

The payment for delegated functions from the Council under section 1(3) (e) of the Act; and

The amount “set aside” by NHS Lothian for use by the Board for functions carried out in a hospital and provided for the areas of two or more local authorities under section 1(3) (d) of the Act

“Operational Budget” means the amount of payment made from the Board to a Party in order to carry out the delegated functions

“Integration Indicators” means the indicators and metrics gathered by the IJB and required for monitoring and reporting purposes in compliance with the IJB’s statutory and policy obligations

“Integration Dataset” means the collective Integration Indicators

“Integration Joint Boards Order” means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014

“Integration Scheme Regulations” means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014

“Lothian IJBs” means the integration joint boards to which functions are delegated in pursuance of the integration schemes in respect of the local authority areas served by, City of Edinburgh Council, East LothianCouncil, Midlothian Council and West Lothian Council respectively

“Neighbouring IJBs” means the Lothian IJBs other than the Board

“Outcomes” means, as appropriate, the Health and Wellbeing Outcomes prescribed in Regulations under section 5(1) of the Act, local outcomes set by the Parties and the Integration Joint Board, or either or both of them

“Parties” means West Lothian Council and NHS Lothian

“Performance Framework” means the IJB’s agreed measurement and standard for managing, gathering and reporting the Integration Dataset and/or the Integration Indicators as the case may be

“Scheme” means this West Lothian Integration Scheme 2022

“Section 95 Officer” Section 95 Officer means the chief officer of the council, appointed under section 95 of the Local Government (Scotland) Act 1973 to be responsible for the council’s financial affairs

“Strategic Plan” means the plan which the IJB is required to prepare and implement in accordance with section 29 of the 2014 Act

“Strategic Planning group” means the group to be established by the Board under section 32 of the 2014 Act to secure the development of the Board’s Strategic Plan

3.0 Integration Model and Integration Functions

In accordance with section 2(3) of the 2014 Act, the Parties agreed the original integration scheme in May 2015. It was approved by the Scottish Ministers under section 7(4) of the 2014 Act on 16 June 2015. In pursuance of section 9(2) of the

2014 Act and the original integration scheme the West Lothian Integration Joint Board was established on 21 September 2015 by the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Scotland) Amendment (No. 2) Order 2015.

New integration functions were created by the Carers (Scotland) Act 2016. As a result the Parties followed a review process under sections 3, 6, 45 and 46 of the 2014 Act in 2019. They agreed a second integration scheme which was approved by the Scottish Ministers on 19 September 2019.

Section 44 of the 2014 Act requires a review to be carried out before the expiry of five years from the date of approval of an integration scheme. The Parties have carried out that review and have agreed a third integration scheme (West Lothian Integration Scheme 2022) for submission to the Scottish Ministers for approval. In preparing and finalising it, the Parties have had regard to the integration planning principles in section 4 of the 2014 Act. They have had regard to the national health and wellbeing outcomes in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014. They have complied with sections 3, 6, 44 and 46 of the 2014 Act on consultation and have taken account of views expressed through the consultation process.

This third integration scheme will have effect after approval by the Scottish Ministers and from the date ordered by them under section 9 of the 2014 Act.

4.0 Local Governance Arrangements

Membership

The Board has and shall have the following voting members:

a) **4** councillors nominated by the Council; and

b) **4** members nominated by NHS Lothian

The Parties may determine their own respective processes for deciding who to nominate as voting members of the Board.

Non-voting members of the Board will be appointed in accordance with article 3 of the Integration Joint Boards Order.

The term of office of members shall be the maximum of three years prescribed by regulation 7 of the Integration Joint Boards Order. Members can be reappointed after this period.

Chairperson and Vice Chairperson

The Board is required to have a chairperson and vice-chairperson who will both be voting members of the Board.

The Parties have decided that the position of Chair shall rotate between the Parties every two years, with the council holding the Chair for the first two years of the Board's existence, from 21 September 2015.

The term of office of the vice chairperson will mirror the arrangements for the Chair, with the holders of the posts alternating between the Parties accordingly. The provisions set out above under which the power of appointment of the chairperson will alternate between the Parties will apply in relation to the power to appoint the vice chairperson, and on the basis that during any period when the power to appoint the chairperson is vested in one Party, the other Party shall have power to appoint the vice-chairperson.

The Parties may determine their own processes for deciding who to appoint as chairperson or vice-chairperson.

Each Party may change its appointment as chairperson (or, as the case may be, vice chairperson) at any time; and it is entirely at the discretion of the Party which is making the appointment to decide who it shall appoint.

Support Services

The Parties agree to provide the Board with the corporate support services that it requires to discharge fully its duties under the 2014 Act.

The Parties and the Board will regularly undertake review of the support services put in place pursuant to the agreement to ensure that the Board has available to it all necessary professional, technical or administrative services for the purpose of preparing its Strategic Plan, carrying out the integration functions, and its administration, governance and statutory compliance requirements. This process will be carried out in consultation with the Board and will form part of the annual budget setting process for the Board. The outcome will be recorded and reported to the Board.

5.0 Delegation of Functions

The functions that are to be delegated by the health boards to the Board are set out in Part 1 of Annex 1. The services to which these functions relate, which are currently provided by NHS Lothian and which are to be delegated, are set out in Part 2 of Annex 1. The functions in Part 1 of Annex 1 are delegated only to the extent that they are exercised in the provision of services listed in Part 2 of Annex 1. Except where otherwise stated in the scheme those functions and services are delegated for persons aged 18 and over.

The functions that are to be delegated by the council to the Board are set out in Part 1 of Annex 2. The services to which these functions relate, which are currently provided by the council and which are to be delegated, are set out in Part 2 of Annex 2. These services are only delegated in relation to persons aged 18 and over.

In addition to the functions that must be delegated in accordance with the legislation, the Parties have chosen to delegate the following health functions to the Board in relation to the following Health services for people under the age of 18:

i. Primary Medical Services and General Medical Services (including GP Pharmaceutical services)
ii. General Dental Services, Public Dental Services and the Edinburgh Dental Institute
iii. General Ophthalmic Services
iv. General Pharmaceutical Services
v. Out of Hours Primary Medical Services
vi. Learning Disabilities.

These functions are generic services which are available to all within the population and therefore responsibility for these services as a whole is appropriate.

6.0 Local Operational Delivery Arrangements

Management Arrangements

The Chief Officer shall be employed by one of the Parties and shall be seconded to the Board as its Chief Officer and a member of its staff. The Chief Officer will nevertheless be responsible and accountable to the Parties for the management and delivery of the integration functions in accordance with the Directions issued by the Board to the Parties. They will be directed and managed by the Chief Executives of both Parties in that regard.

The Chief Officer is responsible to the Board for the delivery of the Strategic Plan.

The Parties and the Chief Officer shall secure the operational delivery of the integration functions in accordance with the Directions issued to the Parties by the Board.

They shall put in place a management structure, headed by the Chief Officer, to manage the delivery of and performance by them of the integration functions, and to manage the staff employed by the Parties in doing so. The integration services will be managed and delivered through close partnership working and protocols, and in conjunction with the health and social care and other functions of the Parties which are not integration functions.

The Parties shall provide the Board with information and performance management information required by it in terms of the powers conferred by the 2014 Act. The Parties recognise the importance of close co-operation and working in securing the delivery of the outcomes. The Board will therefore consult with and take account of the views of the Parties in decisions regarding the information to be provided and the dates and regularity to apply to its provision. The Chief Officer shall use that information to provide regular reports to the Board on at least a quarterly basis, and including sufficient information to ensure that the membership of the Board is able to adequately oversee the carrying out of the integration functions by the Parties. The Board shall have the ability to request and receive such additional information in relation to service performance and financial performance as is reasonably required by them to perform that duty.

In the interests of efficient governance, the relevant committees of NHS Lothian and the council will continue to discharge their existing remits for assurance and scrutiny of the carrying out of NHS Lothian and the Council functions, regarding matters such as internal control, quality and professional standards, and compliance with the law. The Board will not duplicate the role carried out by those committees other than in exceptional circumstances where the Board considers that direct engagement by the Board (or by a committee established by the Board) is appropriate in order to secure the proper discharge by the Board of its statutory responsibilities.

Each of the Parties shall use reasonable endeavours to procure that in the event that one of its committees identifies an issue which is of direct and material relevance to the Board, the Council will advise the Chair of the Board and the Chief Officer of that matter and will co-operate with the Board in supplying such further information and evidence in respect of that matter as the Board may reasonably request.

The Parties shall ensure that their respective standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the Board's powers and remit, and its place as a common decision-making body within the framework for delivery of health and social care within the West Lothian Area.

The Parties acknowledge that the Chief Officer's role in operational delivery will represent an important means by which closer integration of services, in accordance with the integration delivery principles specified in the 2014 Act, can be achieved. For the avoidance of doubt, the Chief Officer's role in operational delivery shall not displace:

a) the responsibilities of each Party regarding compliance with Directions issued by the Board; or

b) the principle that each Party's governance arrangements must allow that Party to manage risks relating to service delivery and legal compliance.

In addition to the specific commitments set out above and the obligations regarding provision of information attaching to the Parties under the 2014 Act, each of the Parties will use reasonable endeavours to provide the Board with any information which the Board may require from time to time to support its responsibilities regarding strategic planning, performance management, and public accountability.

Strategic Planning

The Board is required to establish a strategic planning group to develop a Strategic Plan in accordance with the legislation, describing the strategic vision and direction for the Board.

The Board is one of four integration joint boards in the area of NHS Lothian and the Parties and the Board require to work in co-operation amongst themselves and with those other local authorities and integration joint boards in preparing their Integration Schemes, in developing their respective Strategic Plans, in the delivery of the integration functions, and in the interaction with health and social care functions which are not integrated.

In developing and revising the Scheme the Parties have taken into account the other Schemes being developed and reviewed between NHS Lothian and other councils in its area, and the effects that all of those Schemes, and this one, may have on the others.

The Board also requires to have regard to the impact its Strategic Plan will have on services, facilities and resources to be used in relation to the Strategic Plans after their adoption or whilst they are being developed in those other areas. The Parties' will support the Board in putting in place a process and system to secure close collaboration, co-operation and the sharing of relevant information amongst the Chief Officers of the Lothian IJBs and amongst their Strategic Planning Groups. The Parties shall ensure through the line management arrangements for the Chief Officer set out in the Scheme, that the Chief Officer provides information to the neighbouring IJBs where the Board's Strategic Plan is likely to have a significant impact on their Strategic Plans, and makes representations on behalf of the Board to those other integration authorities where the interests and objectives of the Board and its Strategic Plan may be affected by the Strategic Plans elsewhere.

In particular, the Parties will provide the support the Board requires for the adoption of arrangements and processes which ensure that the strategic impacts on the neighbouring IJBs and their Strategic Plans are brought to the attention of the Board in its decision making, both in regard to integration functions and other functions and services which are not delegated.

Lothian Hospitals Strategic Plan, and the Lothian Strategic Development Framework

NHS Lothian has developed a plan (the 'Lothian Hospitals Strategic Plan') to support the Lothian IJBs to fulfil their duties. The Lothian Hospitals Strategic Plan does not and will not bind the Board and the strategic plans of the Lothian IJBs have informed the Lothian Hospital Strategic Plan. The Lothian Hospitals Strategic Plan encompasses both functions delegated to the Lothian IJBs and functions that are not so delegated.

The Lothian Hospitals Strategic Plan was developed in partnership with the Lothian IJBs where integration functions are delivered by the health baord in a hospital. It reflects the relevant provisions of the Strategic Plans prepared by the respective Lothian IJBs, as well as NHS Lothian's plans for non delegated functions.

The purpose of the Lothian Hospital Strategic Plan is to ensure that planning for hospital functions and use of hospital facilities are:

(a) responsive to and support each Strategic Plan prepared by the Lothian IJBs for delegated functions; and

(b) support the requirement of NHS Lothian to deliver hospital services required by the Board and other hospital services that are not the responsibility of the Lothian IJBs (e.g. tertiary, trauma, surgical, planned and children's services).

The Lothian Hospitals Strategic Plan will be a plan developed jointly by NHS Lothian and the Lothian IJBs. The elements of the Lothian Hospitals Strategic Plan addressing non delegated functions can only be agreed by NHS Lothian after the Lothian IJBs have been consulted and their views and requirements appropriately considered. Elements of the Lothian Hospitals Strategic Plan which cover functions delegated to the respective Lothian IJBs will be signed off by relevant Lothian IJBs in consultation with NHS Lothian and other Lothian IJBs.

NHS Lothian is continuing to work to refresh its strategy via development of the Lothian Strategic Development Framework. This work is being taken forward in collaboration with the Lothian IJBs, in particular in those workstreams that cut across our organisational boundaries and where there are clear benefits in working together to determine priorities to achieve a collective vision.

Performance targets, improvement measures and reporting arrangements

All national and local outcomes, improvement measures and performance targets which are connected exclusively with the functions delegated by the Parties to the Board under the Scheme will become the responsibility of the Board to deliver; and the Board will also be responsible for providing all such information regarding integration functions which is required by either of the Parties to enable each of them to fulfil its obligations regarding reporting arrangements in respect of those functions.

The continuous development of an effective performance framework for the Board, taking account of relevant national guidance, will be supported by the parties and the Board. The framework will be underpinned by the national health and wellbeing outcomes, and national integration indicators, and will be developed to drive change and improve effectiveness. The framework will be informed by an assessment of current performance arrangements and the development of a set of objectives which the framework will be intended to achieve.

The national health and wellbeing outcomes which apply to integrated health and social care, and the associated national indicators which underpin the nine health and wellbeing outcome measures will be used by the Board. These outcomes and indicators will be used to assist in setting local priorities and monitoring performance, and will be reported per national and local reporting arrangements.

Building on existing arrangements and practices and in consultation with the Board, a core set of indicators and measures will be identified by the Parties from publicly accountable and national indicators and targets which relate to services delivered in carrying out the functions delegated to the Board. Each Party will continue to review and where necessary revise and further develop the performance framework for the Board, taking account of relevant national guidance.

Indicators will be aligned with priority areas identified in the joint strategic needs assessment and the Strategic Plan and will be refined as these documents are reviewed and refreshed. These priority areas will be linked to outcomes to demonstrate progress in delivering these.

Where particular national or local outcomes, measures or targets (and associated reporting arrangements) relate to services which are associated with both integration functions and functions which are not delegated by a Party to the BOARD, the

responsibility for the outcomes, measures or targets (and associated reporting arrangements) will be shared between the Board and the Party or Parties which exercise those functions, and the Board will be responsible for providing all such information regarding those integration functions as is required by the relevant Party to enable it to fulfil its obligations regarding reporting arrangements.

The Parties have obligations to meet targets for functions which are not delegated to the Board, but which are affected by the performance and funding of integration functions. Therefore, when preparing performance management information, the Parties agree that the effect on both integration and non-integration functions must be considered and details must be provided of any targets, measures and arrangements for the Board to take into account when preparing the Strategic Plan. Where responsibility for performance measures and targets is shared, this will be set out clearly for agreement by the relevant Parties.

The performance framework may require information on functions which are not delegated to the Board to be included. Either one of the Parties, or the Board, will be able to reasonably require information of that nature to be included within the Integration Dataset where identified.

7.0 Clinical and Care Governance

Introduction

This section of the Scheme sets out the arrangements that will be put in place to allow the Board to fulfil its role with professional advice and with appropriate clinical and care governance in place.

The Parties and the Board have well established systems to provide clinical and care governance as well as assurance for professional accountabilities. Those systems continue and the scope of these systems will extend to support the Board with the requirements to fulfil their clinical and care governance responsibility.

Continuous improvement and the quality of service delivery (and its impact on outcomes) will be addressed through the development of the Board's performance management framework (pursuant to section 6 of this Scheme).

The Board has a Health Care and Governance Group which provides assurance that the quality of all aspects of health and social care within delegated functions is person centred, safe, effective, equitable and of the required standard. This group has also established a clinical and care governance framework in accordance with Public Bodies (Joint Working) (Scotland) Act 2104. This board also feeds into the respective governance work of both NHS Lothian and council.

The Board will not duplicate the role carried out by the Parties' existing governance arrangements other than in exceptional circumstances where the Board considers that direct engagement by the Board is appropriate in order to secure the proper discharge by the Board of its statutory responsibilities.

The Parties agree that in the event that one of its committees within its governance arrangements identifies an issue which is of direct and material relevance to the

Board, the committee will advise the chairperson of the Board and the Chief Officer of that matter and will co-operate with the Board in supplying such further information and evidence in respect of that matter as the Board may reasonably request.

The Parties shall ensure that their standing orders, schemes of delegation and other governance documents are amended (if required) to reflect the Board's powers and remit, the Board's place as a common decision-making body within the framework for delivery of health and social care within the West Lothian Area and the Parties' role in supporting the Board to discharge its duties.

The voting members of the Board are engaged in the governance of their respective Party, and it is likely that they will be members of one or more committees of the relevant Party.

The Parties will use reasonable endeavours to appoint voting members of the Board (regardless of which party nominated the voting members) onto NHS Lothian and council governance arrangements with a remit relevant to the clinical and care governance of integration functions.

Within its existing governance framework, NHS Lothian has:

- A healthcare governance committee, the remit of which is to provide assurance to the board of NHS Lothian that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard and to provide assurance to the Board of NHS Lothian that NHS Lothian meets its responsibilities with respect to:-

    - NHS Lothian Participation Standards
    - Volunteers/Carers
    - Information Governance
    - Protection of Vulnerable People including children, adults, offenders
    - Relevant Statutory Equality Duties

  And

- A staff governance committee, the remit of which is to support and maintain a culture within NHS Lothian where the delivery of the highest possible standard of staff management is understood to be the responsibility of everyone working within NHS Lothian and is built upon partnership and collaboration. The Staff Governance Committee must ensure that robust arrangements to implement the (NHS Scotland) Staff Governance Standard are in place and monitored

The staff governance committee has the primary role on staff governance matters, but can and does refer matters of relevance to the healthcare governance committee.

The healthcare governance committee can request assurance from the staff governance committee on matters of direct relevance to its remit, e.g. quality of recruitment, learning and development, completion of mandatory training.

Within the council, the Chief Social Work Officer has overall responsibility for the professional standards of the council's social work and social care staff. The workforce is also regulated by the Scottish Social Services Council (SSSC), and all professional staff must by law be registered with the SSSC. This registration requirement will, in due course, extend to all social care staff employed by the council and the voluntary and independent sectors.

The Chief Social Work Officer reports annually to the council on the registration of the workforce and on training, including mandatory training and post-qualifying learning and development. The Chief Social Work Officer will provide a copy of this annual report to the Board.

The Chief Social Work Officer also reports annually to the council on standards achieved, governance arrangements including supervision and case file audits and volume/quantity of statutory functions discharged. This report must comply with national guidance issued by the Scottish Government. The Chief Social Work Officer will also provide a copy of this annual report to the Board.

The intention of using the existing health board and council committees as a source of assurance is to recognise that the parties will have continuing governance responsibilities for both integration and non-delegated functions, and that the parties wish to minimise unnecessary bureaucracy. The Board will be engaged through its membership being on these committees, and its relationship with the committee chairs. The Board will be in a position to holistically consider the information/ assurance received from the Parties, and arrive at a determination for all of its functions. If the Board is in any way dissatisfied with the information or assurance it receives from the parties, or the effectiveness of the parties committees, it may give a Direction to the parties to address the issue, or revise its own system of governance.

Clinical and Care Governance Risk

There is a risk that the plans and Directions of the Board could have a negative impact on clinical and care governance, and professional accountabilities. This section of the Scheme sets out the arrangements that will be put in place to avoid this risk.

Professional Advice

NHS Lothian has within its executive membership three clinical members (referred to below as 'Executive Clinical Chief Officers'); a Medical Chief Officer, a Nurse Chief Officer, and a Chief Officer of Public Health. Their roles include responsibility for the professional leadership and governance of the clinical workforce (medical, nursing, allied health professionals, healthcare scientists, psychology, pharmacy), as well as clinical governance within NHS Lothian generally. The creation of the Board does not change their roles in respect of professional leadership, and they remain the lead and accountable professionals for their respective professions.

West Lothian Health and Social Care Partnership has appointed a Clinical Director, Chief Nurse and Chief AHP to ensure that there is strong local governance and accountability; linked closely to NHS Lothian clinical members.

The council has a Chief Social Work Officer who reports to the Chief Executive and councillors. The Chief Social Work Officer monitors service quality and professional standards in social care and social work, for staff employed in both adult and children's services, together with standards in relation to the protection of people at risk. The Chief Social Work Officer role also includes quality assurance of decision-making with regard to adult social care, mental health criminal justice and children's services, in particular in relation to public protection and the deprivation of liberty.

The creation of an Board does not change the Chief Social Work Officer's role in respect of professional leadership and he or she will remain the lead and accountable professional for his or her profession.

The Chief Social Work Officer must be a non-voting member of the Board. The Board may elect to appoint one or both of the Medical Chief Officer and the Nurse Chief Officer as additional non-voting members of the Board. The Order requires NHS Lothian to fill the following non-voting membership positions on the Board:

- A registered medical practitioner whose name is included in the list of primary medical services performers prepared by NHS Lothian in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;
- A registered nurse who is employed by NHS Lothian or by a person or body with which NHS Lothian has entered into a general medical services contract; and
- A registered medical practitioner employed by NHS Lothian and not providing primary medical services.

NHS Lothian will consider the advice of the Executive Clinical Chief Officers, and any other relevant officer it deems fit before making appointments to fill the membership positions referred to above. The appointees will be professionally accountable to the relevant executive clinical Chief Officer. NHS Lothian will develop a role description for the appointments referred to above, to ensure that their role on the Board with regard to professional leadership and accountability is clearly defined and understood.

The three health professional representatives referred to above will each also be:

- A member of an integrated professional group (should it be established); and/or
- A member of a health board committee; and/or
- A member of a consultative committee established by NHS Lothian.

If a new "integrated professional group" is established, the Chief Social Work Officer must also be a member.

The three health professional representative set out above and the Chief Social Work Officer will be expected by the Parties to play a lead role in:

- Communicating and having regard to their duties to NHS Lothian or the council as the case may be whilst discharging their role as a member of the Board;
- Communicating and having regard to the interests of the Board whilst discharging their duties as professionals employed by NHS Lothian or (as the case may be) the council.
- The members will be expected to communicate regularly with the Executive Clinical Chief Officers, and the council's Chief Executive as and when appropriate.

The presence of these four members will ensure that the decisions of the Board are informed by professional advice from within the membership of the Board.

The Chief Social Work Officer reports annually to the council on the registration of the workforce and on training, including mandatory training and post-qualifying learning and development.

NHS Lothian includes a governance statement in its annual accounts, the content of which is informed by the annual reports of its governance committees (such as healthcare governance and staff governance) and certificates of assurance from its Executive Clinical Chief Officers. The Board may place reliance on these existing processes, and the Parties will provide any such reports from those processes as the Board may require.

The Executive Clinical Chief Officers shall be entitled to raise issues directly with the Board in writing. The Board shall be required to respond in writing when issues are raised in this way. The Chief Social Work Officer will be a non-voting member of the Board, and can therefore raise any issues directly at the Board.

The engagement of professionals throughout the process to develop and consult on the Strategic Plan is intended to ensure that the Board has all the required information to prepare a Strategic Plan, which will not compromise professional standards.

In the unlikely event that the Board issues a Direction to NHS Lothian, which is reasonably likely to compromise professional standards, then in the first instance, the relevant Executive Clinical Chief Officer will write to the Board.

If the issue is not resolved to their satisfaction, they must inform the board of NHS Lothian before it takes action to implement the Direction, and the following measures will apply:

- The relevant Executive Clinical Chief Officer must ensure that appropriate advice is tendered to the board of NHS Lothian on all matters relating to professional standards;
- The relevant Executive Clinical Chief Officer must set out in writing to NHS Lothian any objections they may have on a proposal that may compromise compliance with professional standards;
- NHS Lothian will inform the Board that it has received such objections, along with a statement of the views of the board of NHS Lothian on those objections;

- If NHS Lothian decides to proceed with a proposal despite those objections, the relevant executive clinical Chief Officer will be provided with written authority from NHS Lothian to act on the proposal. NHS Lothian must inform the Scottish Government Health and Social Care Directorate if a request for such a written authority is made. A copy of that authority must be sent to the appropriate regulatory body, e.g. General Medical Council;
- Once the relevant executive clinical Chief Officer has received that written authority, they must comply with it.

The three professional clinical members on the Board (two medical practitioners, one nurse) are non-voting members. They will be expected by the Executive Clinical Chief Officers to raise any concerns in relation to matters which may compromise professional standards with the Board.

If any of the three professional clinical members becomes aware of a matter arising from the conduct of Board business, which may compromise professional standards, they must immediately notify the relevant executive clinical Chief Officer(s) of their concerns.

The Chief Social Work Officer will be a non-voting member of the Board, and as such, will contribute to decision making, and will provide relevant professional advice to influence service development.

In the event that the Board issues a Direction to the council or NHS Lothian, which in the view of the Chief Social Work Officer compromises professional social work standards or the discharge of statutory functions, the Chief Social Work Officer must immediately notify the Chief Officer of their concerns and if their concerns are nor resolved by the Chief Officer to their satisfaction must then raise the matter with the Chief Executive of the council.

Professionals Informing the Board's Strategic Plan

With regard to the development and approval of its Strategic Plan, the Board is required to:

- establish a strategic planning group (which will prepare and review the draft Strategic Plan). This strategic planning group must include a nominee from both NHS Lothian and the council in its membership, as well as representation from health professionals and social care professionals. NHS Lothian and the council will make recommendations to the Board with regard to the representation from health professionals and social care professionals;
- consult both NHS Lothian and the council on its Strategic Plan, and take into account their views before it finalises the Strategic Plan.

There will be three opportunities within these arrangements for professional engagement in the planning process;

  - at the Board;
  - in the context of the work of the strategic planning group; and
  - as part of the consultation process with the Parties associated with the Strategic Plan.

The membership of the Board will not be the only source of professional advice available to the Board. The chairs of all appropriate committees and groups will be informed that they are able to, and expected to, directly provide advice to the Board. Those committees and groups may also advise an integrated professional group that provides advice to the Board. Those committees and groups include, but are not limited to:

- Local consultative committees that have been established under section 9 of the National Health Service (Scotland) Act 1978;
- Managed Clinical/ Care Networks;
- West Lothian Public Protection Committee (adult and child protection, drug and alcohol, violence against women, offender management etc). The Board will consult this committee on any plans that may impact on the protection of children or vulnerable adults or people who are assessed as posing a risk;
- Any integrated professional group established.

NHS Lothian and the council will ensure that the draft Strategic Plan is sent to the following senior professionals in order to secure their input and advice:

- NHS Lothian Executive Medical Director;
- NHS Lothian Executive Director of Nursing and Allied Health Professions
- NHS Lothian Director of Public Health & Health Policy;
- Chief Social Work Officer.

The engagement of the council's professionals will not be limited to social work staff, but will extend to related professionals within social care, such as, but not exclusively, occupational therapists, home care and social care staff.

The approach to locality planning and delivery including the arrangements for clinical and social care governance will be developed through the strategic planning process in a collaborative manner by the Board.

External scrutiny of clinical and care functions

NHS Lothian seeks assurance for internal control/quality through its Healthcare Governance Committee, which includes reports by external bodies such as Healthcare Improvement Scotland.

The Care Inspectorate (Social Care and Social Work Improvement Scotland) regulates, inspects and supports improvement of adult and children's social work and social care, and their reports feed into the Council's system of governance.

The Board will consequently be informed of any relevant issues from external scrutiny, as a consequence of drawing from the systems already established by the Parties.

Service User and Carer Feedback

The Parties have a range of systems already in place to capture and respond to service users' experience, and these will continue to be used as the Parties implement the directions of the Board.

8.0 Chief Officer

Appointment

Whilst section 10 of the 2014 Act states that the Board shall appoint its Chief Officer, the Parties shall cooperate with and support the Board in the recruitment and appointment process. The Parties shall ensure the availability of appropriate technical, legal and human resources advice through the arrangements to be put in place for the provision of support services.

A job description, person specification, terms and conditions, salary, pension, responsibilities and powers shall be agreed after consultation with the Parties, to take into account the role of the Chief Officer in the Parties' organisations and their responsibilities for both integrated and non-integrated functions. To reflect the significance of the post to the Parties and the Chief Officer's duties and responsibilities, it is expected that the appointment shall be made after consultation by the Board with the Parties. The Parties shall work with the Board to establish a tripartite process for recruitment and selection, following the successful model used by the Board and the Parties in 2019 and in 2021.

Upon the appointment by the Board of the Chief Officer, the Parties shall at the same time confirm the appointment of the Chief Officer in relation to their own organisations and shall ensure that appropriate powers are delegated to them by the Parties to enable them to meet the requirements of the post.

If an interim replacement for the Chief Officer is required (on the grounds that the Chief Officer is absent or otherwise unable to carry out their functions, or that the post is vacant), the Chief Executives of the Parties will cooperate in putting suitable and effective interim arrangements in place to ensure that the duties of the Chief Officer in all three organisations are performed. Should those arrangements include the appointment of an interim Chief Officer then they will be employed by one of the Parties and will be seconded to the Board on an interim basis.

Operational Role

In terms of the 2014 Act the Chief Officer will report to and advise the Board in relation to its role and powers over the delegated functions, and they will also be accountable to the Chief Executives of the Parties in relation to operational and service delivery matters.

The Chief Officer will be a member of each of the council and health board senior management teams and together with the Chief Social Work Officer will have appropriate delegated powers to enable them to discharge their duties and to manage the two services and secure the operational delivery of the integration functions jointly and in an integrated manner.

Except for the services identified in Annex 3 the Chief Officer will be the senior manager in each of the Parties responsible for delivery of the delegated functions in accordance with Directions from the Board, and for the delivery of other health and social care functions which have not been delegated to the Board.

Chief Officers responsible for the Western General Hospital, the Edinburgh Royal Infirmary, St Johns Hospital and the Royal Edinburgh will provide delegated services on these hospital sites that will not be operationally managed by the Chief Officer.

Specific NHS Lothian functions will be managed on a pan Lothian basis as a 'hosted' service by one of the four Chief Officers in Lothian. The CO of a particular area will take responsibility for managing such services on a Lothian Wide basis where delegated services are delivered across the whole health and care system as a single service, subject to NHS Lothian requesting that the service be hosted pan Lothian by one IJB. A group consisting of Chief Officers responsible for hospital functions delegated to the Board and the Chief Officers of the Lothian IJBs will meet periodically to ensure close working arrangements amongst a) Chief Officers and Chief Officers responsible for hospital services and b) Chief Officers responsible for the management of a hosted service on behalf of the Chief Officers of the neighbouring IJBs.

9.0 Workforce

The Parties will provide for workforce planning and development in relation to the staff employed in the delivery of the integration functions and will develop an integrated Workforce Development Plan, in relation to teams delivering services.

The Parties will provide support to the Board in the development of workforce plans to meet the objectives of the Strategic Plan and to meet national requirements in relation to workforce planning for the health and social care workforce.

The Board will approve workforce plans and keep them under review.

10.0 Finance

This section describes the arrangements in relation to financial management and monitoring of integrated resources. It sets out the method for determining the resources to be made available by the council and NHS Lothian to the Board. It also explains the financial governance and management arrangements, including budget variances, and the financial reporting arrangements between the Board, the council and NHS Lothian.

Chief Finance Officer

In relation to the preparation of its accounts and their audit, the Board is governed by the same legislation applying to local authorities and is required to make arrangements for the proper administration of its financial affairs; through the appointment of a proper officer for that purpose. The Board has appointed a Chief Finance Officer with this responsibility. The Chief Finance Officer will be employed by the council or NHS Lothian and seconded to the Board. The holder of the post

should be a member of a relevant professional accounting body, and the Board should have regard to the current CIPFA Guidance on the role.

In the event that the Chief Finance Officer position is vacant or the holder is unable to act, the Chief Officer shall secure, in consultation with the Board Chair, and through agreement with both the council's Section 95 Officer and NHS Lothian's Director of Finance, an appropriate interim dedicated resource to discharge the role.

Financial Management of the Board

The Board is responsible for determining its own internal financial governance arrangements; and the Chief Finance Officer will be responsive to the decisions of the Board, and the principles of financial governance set out in this Scheme.

Principles of Financial Governance

The following principles of financial governance shall apply:

- NHS Lothian and the council will work together in a spirit of openness and transparency
- NHS Lothian and the council will work in partnership with the Board with the objective of agreeing sufficient funding of delegated functions in line with the financial elements of the Strategic Plan

Financial Governance

The Parties will contribute to the establishment of a Board budget. The Chief Officer will manage the Board budget.

The Parties are required to implement the Directions of the Board in carrying out the delegated functions in line with the Strategic Plan. The Parties will apply their established systems of financial governance to the payments they receive from the Board. NHS Lothian's Accountable Officer and the council's Section 95 officer have legally defined responsibilities and accountability for the financial governance of their respective bodies.

The Chief Officer in their operational role within NHS Lothian and the council is responsible for the financial management of any operational budgets (as defined in section 10 of this Scheme) that may be delegated to them by the Parties, and is accountable for this to NHS Lothian's Chief Executive and the council's Section 95 Officer.

The Board will develop and maintain its own financial regulations. The Chief Finance Officer will periodically review these financial regulations and present any proposed changes to the Board for its approval.

The council will host the Board's Financial Accounts and will be responsible for recording the Board's financial transactions through its existing financial systems. The Integration Joint Board can hold reserves. It is a matter for the Board to determine what its reserves strategy will be.

The Board's Chief Finance Officer is responsible for preparing the Board's accounts and ensuring compliance with statutory reporting requirements as a body under the relevant legislation.

As part of the financial year end procedures and in order to develop the year-end financial statements, the Chief Finance Officer will work together with NHS Lothian and the council to coordinate an exercise agreeing the value of balances and transactions with council and health board Finance teams. Each Party will provide information to this process on their recorded income, expenditure, receivable and payable balance with the Board. The Board's Chief Finance Officer will lead with the Parties on resolving any differences.

The Chief Finance Officer will also be responsible for preparing a medium-term financial plan to be incorporated into the Board's Strategic Plan. The Chief Finance Officer will liaise closely with NHS Lothian and the council to develop integrated medium term financial planning and associated financial recovery plans taking account of assumptions around available funding and future service demands and service delivery models.

The Chief Finance Officer will also be responsible for preparing the annual financial statement that the Board must publish under section 39 of the 2014 Act, which sets out what the Board intends to spend in implementation of its Strategic Plan.

The Chief Finance Officer will be responsible for producing finance reports to the Board, ensuring that those reports are appropriate for the needs of the Board.

The Chief Finance Officer will liaise closely with the council's Section 95 Officer and the health baord's Director of Finance and their teams in order to discharge all aspects of their role.

Resources Delegated to the Board

The resources delegated to the Board fall into two categories: (i) payments for the delegated functions; and (ii) resources used in large hospitals that are set aside by NHS Lothian and made available to the Board for inclusion in its Strategic Plan.

Section 1(3)(e) of the 2014 Act requires that the Scheme must set out a method of determining payments that are to be made in respect of (i) above. Section 1(3)(d) of the 2014 Act requires the Scheme to set out a method of determining the amounts to be made available by NHS Lothian for us by the Board under (ii) above.

It is expected that the net difference between payments into and out of the Board will result in a balancing payment between the council and NHS Lothian which reflects the effect of the Directions of the Board. The balancing payment will be reviewed throughout the year and depending on the expected value for the adjusting payment, it will be either made one-off prior to year-end or on a quarterly basis. Such payments would incorporate values previously treated as resource transfer.

Annual Budget Payments to the Board

The council and NHS Lothian identify a core baseline operational budget for each function that is delegated to the Board. This will be used as the basis to calculate their respective payments into the Board budget each year. The previously agreed

“resource transfer” payments from NHS Lothian will be part of the annual budget payment to the Board

The council and NHS Lothian have established financial planning processes which take into account the financial settlements they have received, and identified and assumed expenditure pressures, to arrive at opening annual budgets. These same processes will be applied to the core baseline operational budgets for the delegated functions in order to arrive at the annual payments to the Board.

The council’s Section 95 Officer and NHS Lothian’s Director of Finance are responsible for preparing the budget contributions from their respective Party. The amounts to be paid will be the outcome of the above processes. They will consult with the Chief Officer and officers in both Parties as part of this process.

- The council’s Section 95 Officer and NHS Lothian’s Director of Finance will each prepare a schedule outlining the detail and total value of the proposed payment from each party, and the underlying methodology and assumptions behind that payment. These draft schedules will identify any amounts included in the payments that are subject to separate legislation or subject to restrictions stipulated by third party funders. The schedules will also contain the detail and total value of set aside resources for hospital services, made under section 1(3)(d) of the 2014 Act.

- The council’s Section 95 Officer and NHS Lothian’s Director of Finance will refer the draft schedules to the Chief Officer so that they may have an opportunity to formally consider it.

- The council’s Chjef Finance Officer and NHS Lothian’s Director of Finance will thereafter present the final draft schedules to the Parties. This schedule must be agreed by NHS Lothian’s Director of Finance , the council’s Section 95 Officer and the Chief Officer.

- The council and NHS Lothian must approve their respective payments, in line with their governing policies

The council’s Section 95 Officer and health board’s Director of Finance will liaise closely with the Chief Officer and Chief Finance Officer on the assumptions to be used on annual budget contributions and will have due regard to the impact of any service re-design activities that have been a direct consequence of the Board’s Strategic Plan or Directions issued. Both the council and NHS Lothian will provide indicative three year budget allocations to the Board, subject to annual approval through their respective budget setting processes.

The Parties will ensure the Chief Officer and Chief Finance Officer are actively engaged in their financial planning processes. The Chief Officer will be expected to feed into the planning processes with any intelligence that is relevant, e.g. the aims of the Strategic Plan, the effect of previous directions on activity and expenditure, projected demand led changes in activity and expenditure. NHS Lothian’s Director of Finance, the council’s Section 95 Officer and the Chief Finance Officer will ensure a consistency of approach and consistent application of processes in considering budget assumptions and proposals.

The set-aside of resources for use by the Board under section 1(3) (d) of the 2014 Act

In addition to the payments to the Board, NHS Lothian will identify a set aside budget for delegated functions in large hospitals. The set aside budget for delegated hospital services will be based on an apportionment of the relevant health board budgets for the delegated hospital services (excluding overheads).

The core baseline budget for the set-aside functions in each council area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and Board.

Hosted Services

NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to the Lothian IJBs are currently provided as part of a single Lothian-wide service, commonly referred to as “hosted services”.

The core baseline budget for the hosted services in each IJB area will be based on an appropriate methodology and agreed in partnership by NHS Lothian and Board.

Due Diligence

The Parties will share information on the financial performance over at least the previous two financial years of the functions and associated services delegated to the Board. This will allow the Parties to undertake appropriate reviews to gain assurance as to whether the services are currently being delivered sustainably within approved resources, and that the anticipated payments will be sufficient for the Board to carry out its integration functions.

If any such review indicates that the projected expenditure is likely to exceed the payments to the Board, then the relevant Party will be notified. The relevant Party will be required to take action to ensure that services can be delivered within the available operational budget

The Parties recognise that of the functions which are to be delegated to the Board, there are some where there is greater potential for the actual expenditure to vary significantly from projections. The Parties will identify what those functions are, and will ensure that information is provided to the Board so that it is aware of the issues, and is able to focus on those functions within their systems for risk management and financial reporting.

This process of due diligence will be informed by, amongst other things, the intelligence within the financial performance reports covering all integration functions that the Board will routinely receive.

Process to agree payments from the Board to the Parties

The Board will determine and approve, in accordance with the Strategic Plan, the payments to the Parties which will accompany its Directions to them for carrying out functions delegated to the Board. The Parties are required to implement the Directions of the Board in carrying out a delegated function in line with the Strategic

Plan, having agreed with the Board the resources required to deliver the said directions.

The Chief Finance Officer is responsible for providing the Board with appropriate information and advice, so that it may determine what those payments should be.

Directions from the Board to the Parties will take the form of a letter from the Chief Officer referring to the arrangements for delivery set out in the Strategic Plan and will include information on:

- the delegated function(s) that are to be carried out
- the outcomes to be delivered for those delegated functions
- the amount of and / or method of determining the payment to be made, in respect of the carrying out of the delegated functions.

Once issued, Directions can be amended or deleted or replaced by a subsequent Direction by the Board.

Where amounts paid to the Board are subject to separate legislation or subject to restrictions stipulated by third party funders, the Board must reflect these amounts in full, in determining the level of the payments to be made to the Parties in respect of the carrying out of the relevant function or functions. However, the Board is not precluded from increasing the resource allocated to the relevant services.

Financial Reporting to the Board

Budgetary control and monitoring reports will be provided to the Board as and when it requires. The reports will set out the financial position and forecast against the payments by the Board to the Parties in respect of the carrying out of integration functions and against the amount set aside by NHS Lothian for hospital services. These reports will present the actual and forecast positions of expenditure compared to budgets for delegated functions and highlight any financial risks and areas where further action is required to manage budget pressures.

NHS Lothian will provide information on the set-aside budgets which will be contained in financial reports to the Board.

Both Parties will provide the required information on budgetary performance from their respective finance systems, and this will be co-ordinated and consolidated by the Chief Finance Officer to provide reports to the Board on all the Board's delegated functions.

It is expected that as a minimum there will be quarterly financial reports to the Chief Officer and the Board.

Process for addressing variance in the spending of the Board

The Board is required to deliver its financial out-turn within available resources.

Section 15 of this scheme sets out the arrangements for risk management, and financial risk (within the Board and both Parties) will be managed in line with those arrangements.

The Parties will ensure that their respective budget monitoring and management systems will be applied to monitor and manage their expenditure in relation to delivery of integrated functions in accordance with Directions issued to them by the Board.

The manager leading this remedial action could be the Chief Officer in his or her operational capacity within the affected party.

In the event that such remedial action will not prevent the overspend, then the Chief Finance Officer will, together with the relevant Party, develop a proposed recovery plan to address the forecast overspend. The Chief Finance Officer will then present that recovery plan to the Board as soon as practically possible. The Board has to be satisfied with the recovery plan, and the plan is subject to its approval.

Additional Payments by the Parties to the Board

Where such a recovery plan is projected to be unsuccessful and an overspend occurs at the financial year end, and where there are insufficient available reserves held by the Board to meet the overspend, then the Parties may make additional payments to the Board.

The Chief Finance Officer and the Parties shall engage in discussion and negotiation about the amounts to be paid by each Party.

The Parties recognise that the delivery of delegated functions in accordance with the Strategic Plan depends on their co-operation between each other and with the Board and that all three parties must approach such discussions in good faith, recognising the pressures and constraints on their respective budgets and services. In such discussions the Parties recognise and accept that an overspend is at the risk of the Party incurring the overspend and the residual amount of overspend after usage of reserves must, in the absence of any other agreement, be met by that Party.

Recurring overspends will be considered as part of the following year's budget process. If a solution to the overspend cannot be agreed by the Parties, or is not agreed by the Board, then the dispute resolution mechanism in this Scheme may require to be implemented.

Underspends

As part of their normal financial management systems, the Parties conduct in-year reviews of financial performance, and occasionally this may lead to a forecast of an underspend at the year-end on one or more budgets. In the event that this happens within the operational budgets then the following shall apply:

- if the underspend is fortuitous and unrelated to any Board Direction then the underspend should be returned to the affected Party (through an adjustment to the payments to the Board)
- the Board will retain all other underspends.

The Board can hold reserves, as determined by its Reserves Policy.

Treatment of variations against the amounts set aside for use by the Board

A process will be agreed between NHS Lothian and the Board to manage any variations within the set-aside budget. This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Integrated payment as laid out above.

Redetermination of payments (made under section 1(3) (e)) to the Board

Redeterminations of payments made by the Parties for the carrying out of integration functions would apply under the following circumstances:

- Additional one off funding is provided to a Party or Parties by the Scottish Government, or some other body, for expenditure in respect of a function delegated to the Board
- The Parties, along with the Board, agree that an adjustment to the payment is required to reflect changes in demand and/or activity levels

In all cases full justification for the proposed change would be required and both Parties and the Board would be required to agree to the redetermination. The Parties would apply the process used to calculate the payment to the Board (described earlier) to the affected functions and the Strategic Plan would be required to be amended as necessary.

Redetermination of set aside payments (made under section 1(3) (d)) to the Board

This process will reflect any variations in the activity that was used to establish the set-aside budget. Any cost variations will be managed in the same way as overspends and underspends within the Operational Budgets as specified above.

Use of Capital Assets

The Board, NHS Lothian and the council will ensure there is awareness of all capital assets which will be used in the delivery of the Strategic Plan.

Changes in use of capital assets will flow from the Strategic Plan and the Directions issued by the Board to the Parties. The Strategic Plan process will outline any implications or requirements for capital assets.

The Parties will ensure that their capital asset planning arrangements take due cognisance of the above implications and requirements.

The Chief Officer of the Board will consult with the Parties to identify the specific need for improvements/changes to assets owned by each which may be required in connection with the carrying out of integration functions. Where a capital investment need is identified, a business case will require to be developed. Any business case will set out how the investment will meet the strategic objectives set out in the Strategic Plan and identify the ongoing revenue costs/savings associated with implementation of the proposals.

The Board, the council and NHS Lothian will work together to ensure assets required in connection with the carrying out of integration functions are used as effectively as possible and in compliance with the relevant legislation relating to use of public assets.

Financial Statements and External Audit

The 2014 Act requires that the Board is subject to the audit and accounts provisions of a body under section 106 of the Local Government (Scotland) Act 1973 (section 13). This requires audited annual accounts to be prepared with the reporting requirements specified in the relevant legislation and regulations (section 12 of the Local Government in Scotland Act 2003, the Local Authority Accounts (Scotland) Regulations 2014 and other regulations under section 105 of the Local Government (Scotland) Act 1973). These will be proportionate to the limited number of transactions of the Board whilst complying with the requirement for transparency and true and fair reporting in the public sector.

The Parties will agree a clear timetable for the preparation of the Board's annual accounts which will incorporate a process to agree any balances between the Board and the Parties. The reporting requirements for the annual accounts are as set out in legislation and regulations and are prepared following the CIPFA Local Authority Code of Practice.

As part of the financial year-end procedures and in order to develop the year-end financial statements, the Chief Finance Officer of the Board will annually co-ordinate an exercise agreeing the value of balances and transactions with the council and health board finance teams. Each of the Parties will submit to the Chief Finance Officer their recorded income, expenditure, receivable and payable balance with the Board. The Parties' respective finance representatives will then work to resolve any differences arising.

The Board financial statements must be completed to meet the audit and publication timetable specified in the regulations (Regulations under section 105 of the Local Government (Scotland) Act 1973).

The Accounts Commission will appoint the external auditors to the Board.

The financial statements will be signed in line with the governance arrangements for the Board and as specified in the Local Authority Accounts (Scotland) Regulations 2014, made under section 105 of the Local Government (Scotland) Act 1973.

In all forms of audit, the Parties are expected to comply with related requests and to aid the audit process.

11.0 Participation and Engagement

Consultation on this Integration Scheme was undertaken in accordance with the requirements of the 2014 Act.

The stakeholders consulted in the development of this scheme were

- All prescribed consultees
- Staff of Parties.

As well as the stakeholders described above the draft scheme was posted on the West Lothian Health and Social Care Partnership website to allow wider exposure and comment from the general public.

Formal internal and external consultation was conducted between 15 January and 20 February 2015 for the initial scheme, and was conducted between 14th of March and 3rd of April 2022 for this revision of the scheme undertaken in 2021/22.

All responses received during the consultation were reviewed and taken into consideration in the production of the final version of this scheme.

A second draft was produced for approval by the Parties to submit to the Scottish Government.

The Parties will enable the Board to develop a Participation and Engagement Strategy by providing appropriate resources and support as part of the professional, technical and administrative support services to be provided by them and reviewed annually as part of the budget process. The Participation and Engagement Strategy shall ensure significant engagement with, and participation by, members of the public, representative groups and other organisations in relation to decisions about the carrying out of delegated functions. The Parties will encourage the Board to access existing forums that the Parties have established, such as West Lothian Citizens' Panel and other networks and stakeholder groups with an interest in health and social care. The strategy shall be developed alongside the Strategic Plan and will be presented for approval to the Board within one year of the establishment of the Board. The strategy will be subject to regular review by the Board.

12.0 Information Sharing and Confidentiality

There is an existing and long standing Pan-Lothian and Borders General Information Sharing Protocol, to which NHS Lothian and the Lothian councils are all signatories, and had previous modifications to comply with the Integration Scheme Regulations. This Protocol will be subject to periodic review by a sub-group on behalf of the Pan Lothian Data Sharing Partnership, and any resulting update(s) agreed will form the Protocol in use to support this Scheme of Establishment. Any updated final Protocol, following consultation, will be recommended for signature by Chief Executives of respective organisations, and the Chief Officers of the Lothian IJBs, on behalf of the Pan-Lothian Data Sharing Partnership.

Procedures for sharing information between the council, NHS Lothian, and the Board are available in Memorandum of Understanding document for the Sharing of information for the purposes of the integration of health and social care services. This Memorandum of Understanding will be subject to periodic review by a sub-group on behalf of the Pan Lothian Data Sharing Partnership to ensure that the detail, more granular purposes, requirements, procedures and agreements for each of the Lothian IJBs and the functions respectively delegated to them are kept up to

date. This will also form the process for amending the Pan Lothian and Borders General Information Sharing Protocol.

The council and NHS Lothian will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The Board may require to be Data Controller for personal data if it is not held by either by the council or NHS Lothian.

Arrangements for Third party organisations' access to records will be jointly agreed by all the Parties and the Board prior to access.

Procedures will be based on a single point of governance model. This allows data and resources to be shared, with governance standards, and their implementation, being the separate responsibility of each organisation. Shared datasets governance will be agreed by all contributing partners prior to access.

Following consultation, all periodically updated Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of respective organisations, and the Chief Officers of the Lothian IJBs.

Agreements and procedures will be reviewed annually by the sub group of the Pan-Lothian Data Sharing Partnership, or more frequently if required. This will follow the process described above.

13.0 Complaints

Any person will be able to make complaints either to the council or the health board. The Parties have in place well publicised, clearly explained and accessible complaints procedures which allow for timely recourse and signpost independent advocacy services where appropriate. There is an agreed emphasis on resolving concerns locally and quickly, as close to the point of service delivery as possible.

Complaints can be made to:

West Lothian Council by telephoning 01506 280000, emailing customer.service@westlothian.gov.uk, in writing to Customer Service Centre, West Lothian Civic Centre, Howden South Road, Livingston, West Lothian EH54 6FF, in person at any council office or by filling in the online complaints form.

NHS Lothian by telephoning 0131 536 3370, emailing feedback@nhslothian.scot.nhs.uk, in writing to NHS Lothian Patient Experience Team, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

There are separate complaints regimes and procedures which apply to councils and health boards, statutory and otherwise. The Parties are not able to dictate arrangements that the Board may wish to put in place in relation to the handling of complaints which may be directed at the Board, but the Parties shall ensure that a single gateway is provided for complaints to be made which relate to their performance of the delegated functions, to be managed by the Chief Officer as part of the management arrangements to be made by the Parties.

Complaints regarding the delivery of a delegated service will be made to, and dealt with by, the Party that delivers that service, in line with their published complaints procedure and consistent with any statutory complaints handling arrangements that apply. It is the responsibility of the Party receiving the complaint to make sure that it is routed to the appropriate organisation / individual so that a service user only needs to submit a complaint once.

Complaints made to the Board or to one or both of the Parties in relation to the delegated functions shall be allocated by the Chief Officer to one of the Parties to address, having regard in particular to the statutory social work services complaints procedure.

The Parties shall co-operate with each other and with the Board in the investigation and handling of complaints in relation to the delegated functions. When a complaint covers both health and social care functions, responsible officers within the Parties will, where necessary, work together to make sure all parts of the complaint are investigated and responded to within established time limits and the complainant is correctly signposted to the options open to them if they remain dissatisfied. Wherever possible there will be a joint response from the identified Party rather than separate responses.

14.0 Claims Handling, Liability & Indemnity

The Parties agree that the Parties will manage, defend and settle claims arising from the exercise of integration functions in accordance with common law and statute. The Parties shall be responsible for their own liability insurance and claims handing arrangements. The Parties will cooperate with each other and with the Board in the defence of any claims made in relation to the delegated functions.

15.0 Risk Management

The Parties shall maintain a risk management policy, strategy and risk register in relation to those functions for which they are operationally responsible under Directions issued by the Board to the Parties.

The Board shall maintain a risk management policy, strategy and risk register to ensure that risks to the Board's objectives are effectively identified, assessed and managed.

Those shall all build on the arrangements already in place prior to the review of the Scheme. Those arrangements shall be reviewed periodically by the Parties and the Board in accordance with their own internal governance arrangements.

The Parties shall provide the support and expertise of their own risk officers in developing and implementing the Board's risk management policy, strategy and risk register. Risk management resources within each partner body will continue to be available to support the Board in its management of risk.

The Parties shall make arrangements to ensure that the Board will receive regular reports on their management of risk,.and that their risk officers and committees dealing with risk cooperate with the Board as is required to identify and mitigate shared and common risks.

16.0 Dispute Resolution Mechanism

In the event of a failure by the Parties and the Board to reach agreement between or amongst themselves in relation to any aspect of the Scheme or the integration functions, the Chief Officer shall use their best endeavours to reach a resolution through discussion and negotiation with the Parties and the Board.

In the event that the matter remains unresolved, a meeting to seek a resolution shall take place amongst the Chief Executives of the Parties, the Chair of NHS Lothian, the Leader of the council, the Chief Officer and the Chair and Vice-Chair of the Board within 21 days.

In the event that the matter remains unresolved after this stage the Parties will proceed to mediation.

In the event that mediation is unsuccessful then the Parties will notify Scottish Ministers and seek a direction in accordance with s52 of the 2014 Act.

ANNEX 1

Part 1 Functions delegated by NHS Lothian to the Board

Functions prescribed for the purposes of sections 1(6) and 1(8) of the 2014 Act

Column A *Enactment conferring function*	*Column B* *Limitation*
The National Health Service (Scotland) Act 1978(a) All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978	Except functions conferred by or by virtue of – section 2(7) (Health Boards); section 2CB (functions of Health Boards outside Scotland); section 9 (local consultative committees); section 17A (NHS contracts); section 17C (personal medical or dental services); section 17I (use of accommodation); section 17J (Health Boards' power to enter into general medical services contracts); section 28A (remuneration for Part II services); section 38 (care of mothers and young children); section 38A (breastfeeding); section 39 (medical and dental inspection, supervision and treatment of pupils and young persons); section 48 (residential and practice accommodation);

	section 55 (hospital accommodation on part payment); section 57 (accommodation and services for private patients); section 64 (permission for use of facilities in private practice); section 75A (remission and repayment of charges and payment of travelling expenses); section 75B (reimbursement of the cost of services provided in another EEA state); section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25th October 2013); section 79 (purchase of land and moveable property); section 82use and administration of certain endowments and other property held by Health Boards); section 83(power of Health Boards and local health councils to hold property on trust); section 84A(power to raise money, etc., by appeals, collections etc.); section 86 (accounts of Health Boards and the Agency); section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services); section 98(charges in respect of non residents); and paragraphs 4, 5, 11A and 13 of Schedule

	1 to the Act (Health Boards); and functions conferred by— The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989; The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302; The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000; The National Health Service (Primary Medical Services Performers Lists) (Scotland) Regulations 2004; The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004; The National Health Service (Discipline Committees) (Scotland) Regulations 2006; The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006; The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009; The National Health Service (General Dental Services) (Scotland) Regulations 2010; and The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011.
Disabled Persons (Services, Consultation and Representation) Act 1986 Section 7	

(persons discharged from hospital)	
Community Care and Health (Scotland) Act 2002 All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002.	
Mental Health (Care and Treatment) (Scotland) Act 2003 All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003.	Except functions conferred by— section 22 (approved medical practitioners); section 34 (inquiries under section 33: cooperation; section 38 (duties on hospital managers: examination, notification etc.); section 46 (hospital managers' duties: notification); section 124 (transfer to other hospital); section 228 (request for assessment of needs: duty on local authorities and Health Boards); section 230 (appointment of patient's responsible medical officer); section 260 (provision of information to patient); section 264 (detention in conditions of excessive security: state hospitals); section 267 (orders under sections 264 to 266: recall); section 281 (correspondence of certain persons detained in hospital); and functions conferred by— The Mental Health (Safety and Security) (Scotland) Regulations 200);

	The Mental Health (Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005; The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and The Mental Health (England and Wales Crossborder transfer: patients subject to requirements other than detention) (Scotland) Regulations 2008.
Education (Additional Support for Learning) (Scotland) Act 2004 Section 23 (other agencies etc. to help in exercise of functions under this Act)	
Public Services Reform (Scotland) Act 2010 All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010	Except functions conferred by— section 31(public functions: duties to provide information on certain expenditure etc.); and section 32 (public functions: duty to provide information on exercise of functions).
Patient Rights (Scotland) Act 2011 All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011	Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36.
Carers (Scotland) Act 2016 Section 31 Duty to prepare local carer strategy (and associated responsibilities to publish and review)	

Part 2 Services currently provided by NHS Lothian which are to be delegated

- accident and emergency services provided in a hospital
- inpatient hospital services relating to the following branches of medicine—
  - general medicine
  - geriatric medicine
  - rehabilitation medicine
  - respiratory medicine
  - psychiatry of learning disability,
- palliative care services provided in a hospital
- inpatient hospital services provided by general medical practitioners
- services provided in a hospital in relation to an addiction or dependence on any substance
- mental health services provided in a hospital, except secure forensic mental health services
- district nursing services
- services provided outwith a hospital in relation to an addiction or dependence on any substance
- services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital
- the public dental service
- primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978
- general dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978
- ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978
- pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978
- services providing primary medical services to patients during the out-of-hours period
- services provided outwith a hospital in relation to geriatric medicine
- palliative care services provided outwith a hospital
- community learning disability services
- mental health services provided outwith a hospital
- continence services provided outwith a hospital
- kidney dialysis services provided outwith a hospital
- services provided by health professionals that aim to promote public health.

ANNEX 2

Part 1 Functions delegated by the council to the Board

Column A *Enactment conferring function*	*Column B* *Limitation*
National Assistance Act 1948 Section 48 (duty of councils to provide temporary protection for property of persons admitted to hospitals etc.)	
The Disabled Persons (Employment) Act 1958 Section 3 (provision of sheltered employment by local authorities)	
The Social Work (Scotland) Act 1968 Section 1 (local authorities for the administration of the Act)	So far as it is exercisable in relation to another integration function.
Section 4 (provisions relating to performance of functions by local authorities)	So far as it is exercisable in relation to another integration function.
Section 8 (research)	So far as it is exercisable in relation to another integration function.
Section 10 (financial or other assistance to voluntary organisations etc for social work)	So far as it is exercisable in relation to another delegated function.
Section 12 (general social welfare services of local authorities.)	Except in so far as it is exercisable in relation to the provision of housing support services.
Section 12A (duty of local authorities to assess needs)	So far as it is exercisable in relation to another delegated function.
Section 12AZA (assessments under section 12A - assistance)	So far as it is exercisable in relation to another delegated function.
Section 12AA (assessment of ability to provide care)	

Section 12AB (duty of local authority to provide information to carer.) Section 13 (power of local authorities to assist persons in need in disposal of produce of their work.) Section 13ZA (provision of services to incapable adults) Section 13A (residential accommodation with nursing) Section 13B (provision of care or aftercare.) Section 14 (home help and laundry facilities) Section 28 (The burial or cremation of the dead) Section 29 (power of local authority to defray expenses of parent, etc., visiting persons or attending funerals) Section 59 (provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision)	So far as it is exercisable in relation to another delegated function. So far as it is exercisable in relation to another delegated function. So far as it is exercisable in relation to another delegated function.
The Local Government and Planning (Scotland) Act 1982 Section 24(1) (The provision of gardening assistance for the disabled and the elderly)	
Disabled Persons (Services, Consultation and Representation) Act 1986(**b**) Section 2 (rights of authorised representatives of disabled persons)	

Section 3 (assessment by local authorities of needs of disabled persons)	
Section 7 (persons discharged from hospital)	In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which are integration functions.
Section 8 (duty of local authority to take into account abilities of carer)	In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions.
The Adults with Incapacity (Scotland) Act 2000(**c**)	
Section 10 (functions of local authorities)	
Section 12 (investigations)	
Section 37 (residents whose affairs may be managed)	Only in relation to residents of establishments which are managed under integration functions.
Section 39 (matters which may be managed)	Only in relation to residents of establishments which are managed under integration functions.
Section 41 (duties and functions of managers of authorised establishment)	Only in relation to residents of establishments which are managed under integration functions.
Section 42 (authorisation of named manager to withdraw from resident's account)	Only in relation to residents of establishments which are managed under integration functions.
Section 43 (statement of resident's affairs)	Only in relation to residents of establishments which are managed under integration functions.
Section 44 (resident ceasing to be resident of authorised establishment)	Only in relation to residents of establishments which are managed under integration functions.
Section 45	Only in relation to residents of

(appeal, revocation etc)	establishments which are managed under integration functions.
The Housing (Scotland) Act 2001 Section 92 (assistance to a registered for housing purposes)	 Only in so far as it relates to an aid or adaptation
The Community Care and Health (Scotland) Act 2002 Section 5 (local authority arrangements for residential accommodation outwith Scotland) Section 14 (payments by local authorities towards expenditure by NHS bodies on prescribed functions)	
The Mental Health (Care and Treatment) (Scotland) Act 2003 Section 17 (duties of Scottish Ministers, local authorities and others as respects Commission) Section 25 (care and support services etc) Section 26 (services designed to promote well-being and social development) Section 27 (assistance with travel) Section 33 (duty to inquire) Section 34 (inquiries under section 33: Co-operation) Section 228 (request for assessment of needs: duty	 Except in so far as it is exercisable in relation to the provision of housing support services. Except in so far as it is exercisable in relation to the provision of housing support services. Except in so far as it is exercisable in relation to the provision of housing support services.

on local authorities and Health Boards) Section 259 (advocacy)	
The Housing (Scotland) Act 2006 Section 71(1)(b) (assistance for housing purposes)	Only in so far as it relates to an aid or adaptation.
The Adult Support and Protection (Scotland) Act 2007 Section 4 (council's duty to make inquiries) Section 5 (co-operation) Section 6 (duty to consider importance of providing advocacy and other services) Section 11 (assessment Orders) Section 14 (removal orders) Section 18 (protection of moved persons property) Section 22 (right to apply for a banning order) Section 40 (urgent cases) Section 42 (adult Protection Committees) Section 43 (membership)	
Social Care (Self-directed Support) (Scotland) Act 2013 Section 3 (support for adult carers) Section 5	Only in relation to assessments carried out under integration functions.

(choice of options: adults) Section 6 (choice of options under section 5: assistances) Section 7 (choice of options: adult carers) Section 9 (provision of information about self-directed support) Section 11 (local authority functions) Section 12 (eligibility for direct payment: review) Section 13 (further choice of options on material change of circumstances) Section 16 (misuse of direct payment: recovery) Section 19 (promotion of options for self-directed support)	Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013.
Carers (Scotland) Act 2016 Section 6 Duty to prepare adult carer support plan (and associated responsibilities to review and provide information) Section 21 Duty to set local eligibility criteria (and associated responsibilities to publish and review) Section 24 Duty to provide support Section 25 Provision of support to carers: breaks from caring Section 31	

Duty to prepare local carer strategy (and associated responsibilities to publish and review) Section 34 Information and advice service for carers Section 35 Short breaks services statements	
PART 2 Functions, conferred by virtue of enactments, prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014	
The Community Care and Health (Scotland) Act 2002 Section 4 The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002	

Part 2 Services currently provided by the Local Authority which are to be delegated

- Social work services for adults and older people
- Services and support for adults with physical disabilities, learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Housing support services, aids and adaptations
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare.

ANNEX 3

The provisions within this annex are not intended to create legally binding obligations. They are intended to be illustrative of the proposed management arrangements for the functions delegated to the Board.

The Board will issue directions to the Parties via its Chief Officer. Those directions will in the main require that the Chief Officer take forward the development of the Board's Strategic Plan, and lead on ensuring that the plan is delivered. As the Chief Officer will not be personally managing all of the integration functions, ensuring the Strategic Plan is being delivered will include getting assurance from other Chief Officers (for hosted services – see below) and other managers in NHS Lothian and the Council.

The Chief Officer will have direct management responsibility for the following services:

- All Council services described in Annex 2, Part 2.
- All NHS Lothian services describe in Annex 1, Part 2 with the exception of the following:

Hosted Services

There are NHS Lothian services for which it would not be suitable for the Chief Officer to have operational management responsibility. The factors contributing to determining these services are the degree of medical specialism of the service and scale of the service required for it to be safe, efficient and effective.

NHS Lothian carries out functions across four local authority areas. Some of the functions delegated to all four IJBs in the NHS Lothian boundary are provided as part of a single Lothian-wide service. Where an IJB is nominated by NHS Lothian to 'host' such a service via one of the Chief Officers of the Lothian IJB's in their role as Joint Chief Officer of NHS Lothian, this is commonly referred to as a "hosted service".

Acute Hospitals

The three acute hospitals in NHS Lothian (Western General Hospital, Edinburgh Royal Infirmary, St Johns Hospital) will be managed by the relevant Site Chief Officer.

NHS LOTHIAN

Board Meeting
9th June 2022

Director of Public Health and Health Policy

EDINBURGH LOCAL OUTCOMES IMPROVEMENT PLAN UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to present the updated Edinburgh Partnership Local Outcomes Improvement Plan (LOIP), also known as the Community Plan, for 2022-2028 which focuses on reducing poverty and inequality in the city.

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

2 Recommendations

2.1 The Board are asked to note the content of the LOIP, which reiterates the previously agreed priority themes of a) enough money to live on; b) access to work, learning and training opportunities; and c) a good place to live. The Board are asked to take particular note of the areas of work outlined under each theme relating to the input from NHS Lothian.

2.2 The Board is asked to approve the 2022-2028 Edinburgh LOIP.

3 Discussion of Key Issues

3.1 NHS Lothian is a core community planning partner (as specified in the Community Empowerment (Scotland) Act 2015 along with Local Authorities, Police Scotland, the Scottish Fire and Rescue Service and Scottish Enterprise), and shares responsibility for producing a LOIP in all Lothian local authority areas.

3.2 The first version of the Edinburgh LOIP was approved in 2018. This update has been developed following a review and evaluation of the initial LOIP and takes into account the impact of the Covid-19 pandemic. The review of the LOIP noted good progress under actions related to Priority 1 and 2 and recommended re-focusing LOIP 3 to include greater emphasis on community empowerment and community wealth building. The updated LOIP also includes actions that are a direct response to the recommendations of the Edinburgh Poverty Commission.

3.3 The Edinburgh Public Health Partnership and Place team continues to lead on the delivery of the NHS Lothian elements of the plan, ensuring that the Board's responsibilities as a core community planning partner are being fulfilled. Staff from the public health team work alongside Health and Social Care Partnership strategic planning colleagues and public health practitioners to ensure a co-ordinated health service input to community planning activity.

3.4 NHS Lothian and Edinburgh HSCP staff lead work on two of the LOIP priority themes: LOIP 1 (enough money to live on) and LOIP 3 (a good place to live). Although not the lead, NHS Lothian are closely involved in the programme of work linked to LOIP 2. The Edinburgh Public Health Consultant (or their deputy) also co-chairs the LOIP Delivery Group which is the senior officer group responsible for co-ordinating LOIP activity.

3.5 Community empowerment and engagement has been central to the development of the updated LOIP. The initial plan was subject to extensive community engagement. The update has incorporated input from Edinburgh Voluntary Organisations' Council and the Edinburgh Association of Community Councils. The End Poverty Edinburgh group also has input to the work which has been incorporated into the updated LOIP.

3.6 Involvement in community planning is aligned with and complements the Lothian Strategic Development Framework, notably within the LOIP 3 work stream, which links with the Board's Anchor Institution work.

4 Key Risks

4.1 There are no specific risks related to the Board.
4.2 There are general risks if the Plan were to fail on the delivery of key outcomes relating to ending poverty and inequality in relation to the health and wellbeing of the citizens of Edinburgh, but these are risks shared by all partners involved in the LOIP.

5 Risk Register

5.1 None

6 Impact on Inequality, Including Health Inequalities

6.1 To date, no impact assessment has been carried out. This would be the responsibility of the LOIP Delivery Group to agree and lead on.

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

7.1 Not relevant to this paper as the Plan does not cover NHS Lothian services.

8 Resource Implications

8.1 Capacity and time from the Edinburgh Public Health Partnership and Place team as highlighted above.

Yvonne Kerr
Strategic Programme Manager
2nd June 2022
Yvonne.Kerr@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Edinburgh Local Outcomes Improvement Plan 2022-2028

THE EDINBURGH PARTNERSHIP

Edinburgh Partnership Community Plan 2022 - 2028

Contents

Foreword

Edinburgh is a successful and prosperous city for many, but many residents are still unable to access the opportunities that exist in our fantastic capital.

This Community Plan shows the commitment of the Edinburgh Partnership to work together to focus on reducing poverty and inequality within the city and improve the quality of life for all. The plan identifies those issues that require sustained joint working to make a difference.

Our plan for up to 2028 has been jointly developed by community planning partners. It is based on what our communities have said are the issues for them and their areas. It responds to the current challenges faced by the city, where the need for action to tackle poverty, climate change, economic recovery, and citizen wellbeing is greater than ever before.

Our plan is focused on tackling poverty and covers three central themes: enough money to live on, access to work, learning or training opportunities, and making sure people have a good place to live.

Community participation is at the heart of community planning. Edinburgh is made up of many communities and it is important to listen to what communities have articulated their needs and aspirations to be.

We will continue to measure, monitor, and develop the plan to reflect the changing needs of the communities as well as ensure that progress is being made towards the outcomes we have agreed.

It is up to all of us now to take on board these views and work together to deliver for our communities. This is the only way we will make a difference and ensure that Edinburgh has a positive, equitable, and inclusive future.

Cllr Adam McVey,

Chair, Edinburgh Partnership and Leader of The City of Edinburgh Council

Our vision and priorities

Purpose

The Edinburgh Partnership is the community planning partnership for Edinburgh. It is unique in the city for bringing together public agencies, the third sector, and the private sector with communities, for the single purpose of tackling poverty and inequality. Our vision focuses on improving the city, its services, and the lives of people who live and work here. Our vision focuses on prevention and early intervention, and through genuine partnership working, addressing the inequalities in our communities.

The Community Empowerment (Scotland) Act 2015 requires the Partnership to publish a Local Outcomes Improvement Plan (LOIP), or Community Plan. This document provides a framework and sets out our shared priorities for the city, and describes the areas where we, the Edinburgh Partnership, will work together to make improvements and meet these priorities to improve outcomes and reduce inequalities

This plan:

- sets the strategic direction for community planning in Edinburgh over ten years
- describes the shared priorities we are working to achieve
- describes what we are going to do to achieve those priorities
- describes how we are going to measure our progress on these priorities.

It aims to provide a framework within which every member of the Edinburgh Partnership (see **Appendix 1**) can make an active contribution to meeting our shared priorities to tackle poverty and inequality.

Partnership Vision

We have a clear vision to guide our work together:

Our vision is that Edinburgh is a thriving, connected, inspired, and fair city, where all forms of poverty and inequality are reduced.

This vision is more relevant today than ever before with the pandemic significantly impacting the city and the economic, physical, and social wellbeing of its citizens.

With this vision, we aim to set the direction needed for community planning partners in Edinburgh to begin to meet the long-term aspirations for the city set out by the Edinburgh 2050 City Vision and to support the local priorities set out in Locality Improvement Plans.

Community planning partners in the city already work together across many strategies, partnerships, and areas of policy, including the joint planning of services for:

- local communities, through Locality Improvement Plans established for each area of the city
- children and young people, through the Edinburgh Children's Services Plan
- health and wellbeing, through the Edinburgh Integration Joint Board, and the Edinburgh Health and Social Care Partnership Strategic Plan
- economic development through the Edinburgh Economy Strategy and the Edinburgh and South-East Scotland City Region Deal
- placemaking and sustainable communities, through the City Housing Strategy, City Mobility Plan, and City Plan 2030
- safer communities, through the Criminal Justice Outcome Improvement Plan, and

- environmental sustainability and climate change resilience, through the 2030 Climate Strategy.

Appendix 2 of this plan provides an overview of and links to the key partnership plans and strategies in place to guide this work, as well as the corporate plans of key partners such as Police Scotland.

This plan does not seek to replicate or capture the actions or outcomes included in each of these plans but instead seeks to articulate the additional actions needed, the additional leadership, integration, and collaborations required by the Edinburgh Partnership.

A focus on poverty and inequality

To focus our work, this community plan concentrates on a few key priorities where additional joint action is needed and has the greatest potential to address poverty and inequality in our city, recognising the adverse impacts of the pandemic and rise in the cost of living.

Edinburgh is recognised as an affluent and growing city but is also a city with wide levels of inequality and home to some of the most excluded communities in Scotland. Average incomes within the city are high, and employment rates have rarely been higher [1]. However, this masks that one in five of all children in Edinburgh grow up in poverty, that this ratio rises to one in four in some parts of the city[2] and that work alone is not necessarily enough to keep families out of poverty.

The evidence base is well established, and tackling poverty and inequality is the most important challenge jointly faced by all members of the Edinburgh Partnership. This challenge is critical to meeting priorities set out in strategic partnership and agency plans across the city. More than that, these are issues that cannot be addressed effectively by any one partner or partnership alone.

This focus on poverty and inequality is consistent with guidance provided through the Fairer Scotland Duty, and the requirement for public bodies to act to reduce inequalities of outcome caused by socio-economic disadvantage. It aligns with the direction provided by the new Public Health Priorities for Scotland, which encourages public services, third sector, community organisations, and others to work better together to address the drivers of inequalities in Scotland's health. In doing so, it encourages new preventative approaches to improving health and wellbeing.

Three priority workstreams

The drivers of, and solutions to, issues of poverty and inequality are entrenched and complex and require significant partnership effort and investment to resolve. Through consultation with partners and building on advice gathered from communities across the city, we have identified a series of areas where additional action and leadership (above and beyond the individual strategic plans and priorities of each Edinburgh Partnership member) is needed to prevent, mitigate, prevent undo the effects and causes of poverty and inequality. These actions build on guidance and advice published by agencies such as Health Scotland, the Joseph Rowntree Foundation, and the Christie Commission.

Throughout this plan, we will deliver actions to ensure that residents across all parts of Edinburgh have:

- **Enough money to live on:** Family income is often used as a key indicator

[1] NOMIS Annual Population survey Sept 2021

[2] End Child Poverty (ECP) coalition data 2020

of resources available and, by extension, of the ability to maintain an acceptable standard of living. Within this context, this workstream includes actions to maximise the income available to lower-income households and to ensure that residents have enough money to live on.

- **Access to work, learning, and training opportunities:** Worklessness remains the single most important predictor of poverty - 71% of households in which no adult is in work live on incomes below the poverty threshold. However, work alone is not necessarily enough to prevent poverty. This workstream aims to provide additional targeted services to help residents access the work, learning, and training opportunities they need to maintain a good quality of life.
- **A good place to live:** The places people live and work, the connections with others, and the extent to which they can influence the decisions that affect them, all have a significant impact on their quality of life and wellbeing. This workstream aims to articulate the additional actions we need to take to ensure residents can access an affordable, well-designed, safe, and inclusive place to live.

Across all three workstreams, the plan sets out our programme of work under each of these priorities. This programme is inclusive, and the actions will address the needs of all individuals experiencing poverty and exclusion, including those in areas generally considered to be more affluent.

This programme responds to the recommendations and actions proposed by the **Edinburgh Poverty Commission** during 2020 and will further develop over time, through ongoing dialogue with communities experiencing poverty and inequality.

To deliver these actions, we will:

- provide high profile leadership that ensures these priorities are embedded throughout the work of partners across the city
- create new opportunities for partner integration and collaboration to tackle these shared challenges
- build on work already in place across the partnership network to create new projects and partnership actions, and
- seek new ways to combine partnership assets to drive change and deliver improved outcomes.

The remainder of this document sets out the actions and activities we will lead on under each of these three workstreams. Each workstream sets out:

- **What we know** – evidence on the scale of the challenge and the opportunity to make improvements through partnership action.
- **What we do now** – current partnership activity already in place, and the additional activity needed to meet our vision.
- **The difference we will make** – the changes and actions that will be led by us through the implementation of this plan, and the outcomes those actions will deliver.
- **How we will know we have made a difference** – the performance indicators we will track throughout the life of this plan to provide insight into progress.

These indicators will form part of our performance framework which includes:

- Life experience stories: key to ensuring we are listening to individuals directly affected to inform future actions.
- Long term outcome indicators: key to monitoring the overarching challenges we aim to impact over the longer term.

- Medium term indicators: key to monitoring the impact of our joint actions taken forward under the priorities in this plan. These indicators may change as new areas for action are identified and implemented during the life of the plan.
- Progress on actions through output measures.

We have identified a suite of high-level outcome indicators which are shown under the three priorities and will be monitored throughout the life of the plan. These outcomes indicators are also summarised in **Appendix 3**.

The development of medium-term indicators and output measures focusing on the impact of the actions under the three priorities is underway. SMART target setting for the output measures will be part of the development and implementation of actions. Initial indicators, where agreed, are shown within the plan. However, these indicators need to reflect current actions being undertaken by the Partnership so will change during the life of the plan.

Priority 1: Enough money to live on

According to most standard definitions, a person is said to be in poverty when their resources fall below the level needed to meet their minimum needs. Family income is often used as a key indicator of resources available and, by extension, of the ability to maintain an acceptable standard of living and to take part in society. Within this context, a core element of most strategies to prevent, reduce, and mitigate poverty are actions to maximise the income available to lower-income households and to ensure that people, of all ages, have enough money to live on.

What do we know?

Evidence shows that poverty rates in Edinburgh are high. Action to improve incomes can have a significant impact on residents' lives.

- Latest data on poverty rates in Edinburgh shows no annual change. An estimated 78,900 people in Edinburgh were living in relative poverty after housing costs in the period to 2020, including 16,100 children.
- This data does not yet incorporate the full impacts of the COVID pandemic on poverty rates and levels. There is a view that poverty rates across the UK will rise driven in part by rising living costs including the cost of energy, planned benefits cuts, and slow earnings growth. The first official data covering the period affected by pandemic will be available in 2022.[3]
- Employment remains the best way to improve income but having a job does not always ensure that people have enough money to live on. 61% of people in poverty live in a household[4] where at least one adult is in work, with a trend of this increase in recent years[5]. Low pay and insufficient working hours are significant drivers of in-work poverty. Some 37,000 workers in Edinburgh earn less than the Real Living Wage of £9.50 per hour and 27% of Edinburgh workers are in jobs that do not provide 'satisfactory' pay, contracts, or hours[6]. Research highlights that harsh debt recovery practices, benefits delays, gaps or sanctions, health, and disability-related financial problems, and food, fuel, and housing costs are key drivers of financial insecurity[7].
- The 2019/20 Living Costs and Food Survey reported that lower-income households spend a higher percentage of their budget on food, housing, and energy.[8]

[3] End Poverty in Edinburgh – Annual Progress Report October 2020

[4] NOMIS definition: A household is a single person, or a group of people living at the same address who have the address as their only or main residence and either share one main meal a day or share living accommodation (or both). Households include at least one person aged 16-64.

[5] UK Poverty data, JRF (2019-20)

[6] Edinburgh Living Wage City – Action Plan (Oct 2021)

[7] Fitzpatrick S, Bramley G, Sosenko F, Blenkinsopp J, Wood J, Johnsen S, et al. Destitution in the UK 2018. York: Joseph Rowntree Foundation; 2018

[8] **UK Poverty Statistics - JRF**

- Additional actions, led by the public and third sector, can be effective in increasing the amount of money that residents have to live on. This can include support to maximise incomes, advice on benefits, advice on reducing costs, particularly energy costs, as well as direct measures to 'poverty proof' public services (such as reducing the cost of the school day).
- These actions can provide a significant impact for people, as well as delivering efficiencies for service providers:
    - a Social Return on Investment analysis[9] on services in Edinburgh and Dundee concluded that every £1 invested generated around £39 of health, social and economic benefits.
    - analysis has shown that for every £1 invested, around £15 of financial gain is generated from a mixture of increased income e.g. welfare benefits, income maximisation, rescheduled debts, one-off payments, or written-off debts.

What are we doing now?

Community planning partners provide a range of services to improve the financial position of low-income families. These include services provided by the City of Edinburgh Council, NHS Lothian, Edinburgh Health & Social Care Partnership, voluntary sector organisations, housing providers, and others. These services include welfare rights advice, income maximisation, debt advice emergency grant and loans, and housing advice and support services. Welfare rights and debt advice services are resourced in a variety of ways such as grants, tendered contracts, or direct from funders. Funding timescales often do not align which can reduce the ability of partners to plan properly and can result in the removal of services in different parts of the city or for different client groups. Accessibility and quality of services can vary so that people accessing services in different parts of the city may not be assured of the same level of service.

Across the system, there is, at present, no overview which allows for planning and coordination of services. As a result, it is difficult for partners to target services to those areas or groups where the need is highest, to ensure that maximum impact is being delivered for public investment, and to ensure that residents have a simple and accessible service in all parts of the city.

What difference will we make?

We will work together to deliver a more coordinated approach to planning income maximisation, support, and advice services. As a result, residents should have access to income maximisation support where and when they need it and receive the same high-quality support wherever they are in the city.

We will agree and implement a common Edinburgh approach to income maximisation to ensure that services are:

- more accessible to residents in need of support: services will be in communities with highest need in a range of locations such as community projects, health centres, and council locality offices

[9] Improvement Service: Analysis of Social Return on Investment of Co-locating Advice Workers

- targeted to those in greatest need, including specific groups (e.g. lone parents, low-income families, people with disabilities, people involved with the criminal justice system, people who are homeless, veterans, older people, and unpaid carers)
- more coordinated and avoid duplication; shared service standards will be established to ensure residents get the highest quality service wherever they access services and services will be available across the city. This will include improving links to other related services already targeting these groups.

In delivering these services and more active promotion of them, income maximisation is primarily viewed as a means to mitigate and reduce the effects of poverty and low income and to prevent crises brought on by debt and lack of affordable credit and financial management skills. We will also work to develop a prevention programme focusing on:

- Expanding on successful initiatives e.g. '1 in 5' programme in schools and supporting the requirement to 'poverty proof' all public services.
- Affordable credit.

To ensure that all stakeholders (i.e. wider than community planning partners e.g. Social Security Scotland, Department of Work & Pension, Home Energy Scotland) are involved and engaged, the governance for this work was reviewed and a sub-group of the LOIP Delivery Group formalised: The Income Maximisation & Poverty Group.

How will we know we have made a difference?

The following key measures will be used to track progress in the delivery of this workstream:

Outcome measures:

- Percentage of people living on incomes below the poverty threshold
- Percentage of children living in families on incomes below the poverty threshold
- Percentage of people living in destitution

Action specific measures:

Indicators focused on the actions are still to be defined as part of the service standards-setting work to be undertaken. These indicators will cover the following areas:

- Uptake of services
    - Number of people supported with welfare rights queries by the Advice Shop and other main providers in Edinburgh e.g. The Edinburgh Consortium funded by the EHSCP
    - Scottish Welfare Fund payments
    - Discretionary Housing payments

Outcomes for people supported

Priority 2: Access to work, learning, and training opportunities

Worklessness remains the single most important predictor of poverty. 74% of households in which no adult is in work live on incomes below the poverty threshold[10]. However, work alone is not necessarily enough to prevent poverty. We will provide additional targeted services to help residents access the work, learning, and training opportunities they need to maintain a good quality of life.

What do we know?

Unemployment in Edinburgh has increased since the pandemic and remains 54% higher than pre-pandemic levels. The pandemic has impacted some groups more, notably women, older and younger workers, and those from the BAME community. Our engagement with partners shows that additional action is needed to support residents with specific needs. We know that:

- 69% of young people with care experience secure a positive destination on leaving school, compared to a city average of 93%.
- Increasing educational attainment levels help improve outcomes in adulthood. In 2016-17, 86% of all school leavers left with at least one pass at National 5 or equivalent. By contrast, only 75% of leavers from the most deprived areas of Edinburgh (SIMD quintile 1) achieved this level of attainment. The figure for leavers with care experience was yet lower, at 46%.
- The 15–24 Learner Journey (published in May 2018)[11] found that some young people felt that the focus on attainment and qualifications within schools was not giving them the skills required to succeed in life, learning and work. As a result, some felt ill-prepared for life after school and this had a negative impact on their learner journeys. This was found to be particularly true of young people from socially disadvantaged backgrounds, who may have limited support to develop life skills at home.
- Work alone is not necessarily enough to prevent poverty, 61% of people in poverty in Edinburgh live in a family where at least one adult is in work. Work undertaken to map service provision related to employability, learning, training, and volunteering against client data[12], as well as discussions during the co-production of services with stakeholders, service providers, and service users has highlighted gaps in provision around three key areas.
  - People can find it difficult to get to the help they need quickly, with multiple agencies often working with members of the same family but not wholly joined up or connected. Systemic failure occurs when individuals and families are consistently losing out or not fully engaging.
  - Those in prison face challenges that require a clearer partnership approach to avoid homelessness, substance misuse, and reoffending. Support for

[10] NOMIS Annual Population survey March 2018

[11] Scottish Government publication May 18

[12] Data analysis undertaken by CPP covering data from around 20,000 clients in 2017/18

people with convictions needs to be coherent and holistic.

- Care experienced young people are less likely to engage fully and benefit from the current Edinburgh employability offer focused on young people.
- People from the BAME community are less likely to secure employment and even less likely to progress into higher-paid positions.

What are we doing now?

Edinburgh's employability offer is structured around an Employability Pipeline. Edinburgh's Job Strategy Group ensures this offer is a joined-up partnership approach, avoids duplication and identifies gaps and market failure, and offers solutions. As noted above, whilst this approach works for many, there are still some residents who face challenges and disadvantages that can only be tackled through partnership efforts.

We have good practice and learning already established. These include:

- a complex needs employability service with a focus on substance misuse, homelessness, and involvement with criminal justice services
- Statutory bodies, employability providers, and employers developing a cohesive strategy in supporting people with convictions in Edinburgh into work to reduce reoffending
- a learning evaluation from a four-year intensive family project with recommendations to tackle child poverty
- Extensive employability services for young people, including Developing Young Workforce and Edinburgh Guarantee, to create opportunities between schools, colleges, and employers and increase school engagement through to positive destinations
- Youth work supporting young people's achievements leading to increased educational attainment, employability, and health and wellbeing
- New change project led on and informed by those from the BAME community through a Citizen's Panel to tackle poverty and provide pathways to success being launched April 2022
- There is recognition that a supportive pathway, including volunteering, is critical for change and long-term success.

What difference will we make?

The practice identified above shows the potential of targeted partnership working to address gaps in service provision and support residents with complex needs. Through the delivery of this plan, we will work together to provide new targeted support to help residents whose needs are not met by other programmes into and through the Employability Pipeline. This will include delivery of additional support for:

- **Jobseekers and Job Changers:** we will extend the Edinburgh Guarantee offer to people of all ages to ensure everyone who needs a service gets access to one quickly, including job offers, training, and barrier removal support.

- **Excluded Families**: long-term integrated support for 60 identified families to help them into work. These families are not able to take up the existing employability offer as they have a high level of need compounded with often chaotic experiences. In some instances, there is a wider family network with little experience of regular work. We will provide long-term sustained pre-employability action to address this, ranging from young people

in school to adults who have never worked.

- **People on release from prison**: we will develop stronger links between community justice and employability services so we can offer a systematic, holistic, joined-up and long-term sustained partnership approach to working with people released from prison.
- **Young people with care experience**: we will recognise, promote and support wider achievement among young people with care experience by working together to:
  - improve engagement by broadening the range of quality educational experiences offered
  - ensure there are integrated and appropriate support services to enable them to achieve a sustainable positive destination.
- **BAME Citizens**: we will develop joined-up pathways for people from the BAME community to better access services, achieve improved outcomes, reduce household poverty, and have more input and agency over the services they need. We will also work with employers to improve recruitment from the BAME community.

How will we know we have made a difference?

The following key measures will be used to track progress in the delivery of this workstream:

Outcome measures:

- Number of households with no adult in employment
- Employment rates
- Number of young adults (16-19-year-olds) participating in education, training or employment

Action specific measures:

- Status tracking of 60 families over time
- Percentage of Edinburgh resident prison leavers with a positive (employment or training?) destination within six months of release
- Percentage of looked after young people who secure a positive destination on leaving school compared to a city average
- Percentage of school leavers living in most deprived areas gaining 1+ awards @ SCQF level
- Percentage of BAME community moving into employment and progressing into higher wage earnings

Priority 3: A good place to live

The places people live and work, the connections with others, and the extent to which they can influence the decisions that affect them, all have a significant impact on their quality of life and wellbeing. The physical environment, the social networks people belong to, the design of housing, accessibility to work, and the range of public services are key determinants of health and have a profound effect on the way people experience poverty and low income[13]. In particular, there is compelling evidence in Edinburgh that high housing costs trap people in poverty and reduce the opportunity to progress. Improving these determinants of health and wellbeing is fundamental to reducing inequality and poverty in the city.

The design of the environment in which people live provides opportunities to develop approaches to improving people's health and wellbeing that draw on all the assets and resources of a community, including how public services integrate and how communities build resilience. Our communities also need to prepare for and adapt to the challenges of climate change. The city's climate change strategy reiterates plans for Council-led housing developments within the 10-year sustainable housing investment plan to be net-zero. But all new housebuilding must be part of a coordinated approach to developing sustainable neighbourhoods across the city.

We aim to ensure residents can access an affordable, well-designed, safe, and inclusive place to live.

What do we know?

Evidence shows us that:

- The Edinburgh Poverty Commission stated that 'There is no pathway to ending poverty in Edinburgh without resolving the city's housing and homelessness crisis.' One in three Edinburgh households living in poverty are in this situation because of excessive housing costs.
- The average house price is six times the average gross annual earnings in the city, making Edinburgh the least affordable city in Scotland to buy a home[14].
- Housing costs in Edinburgh have continued to rise and the number of new homes being built is not meeting housing needs and demand, particularly for those on lower incomes. High housing costs pose a risk to the longer-term economic growth of the city and widen the inequality gap, particularly in key sectors such as health and social care.
- Those areas where poverty is highest also show lower than average satisfaction with their neighbourhood as a place to live, and lower than average perceptions of their neighbourhood as a safe place to be after dark[15].
- Communities expressed a shared desire for improving various services within

[13] Public Health Priorities for Scotland

[14] Affordable Cities review annual report

[15] The City of Edinburgh Council publication, Edinburgh People's Survey

their localities including more integrated transport systems and improved use of civic space. This helps to create a nurturing environment to facilitate the development of community projects and greater social value.

- The Poverty Commission report calls for more funding for affordable housing in the city and a focus on preventing homelessness. It also stresses the importance of the design principles behind 20-minute neighbourhoods to increase inclusion and connectedness[16].
- 20-minute neighbourhoods need to incorporate community wealth-building capacity. Local economic opportunities are essential for vibrant neighbourhoods and are a cornerstone for anti-poverty work. Community wealth building is a way in which the city's Anchor Institutions can align with community organisations to increase the value of public sector investment locally.

What are we doing now?

The Council and its registered social landlord (RSL) partners committed to delivering 20,000 new affordable and low-cost homes in Edinburgh by 2027. This included a commitment to support Edinburgh Health and Social Care Partnership's Strategic Plan priorities through investment to build around 4,500 affordable homes, integrated with health and social care services, to meet the needs of older people and people with complex physical and health needs.

The Place-Based Opportunities Board provides a forum for discussions about Edinburgh's public-sector estate and coordinates opportunities for accelerated investment through strategic partnership and review of public sector assets.

The City Plan 2030 updates housing targets to 36,911 new homes by 2032. It also proposes a 35% affordable housing target[17].

The Council has also created a team to coordinate activity across services to embed 20-minute neighbourhood approaches across all development activities.

The city climate change strategy also stresses 20-minute neighbourhoods as a key principle for the delivery of a just transition. The climate change priorities are all place-based approaches to delivering this change.

These are ambitious goals and show a commitment to encourage investment in new and existing housing, to drive place-led development, and bring about wider environmental, economic and social benefits.

However, additional support is required from the community planning partnership to deliver these commitments. In particular, work is needed to:

- deliver an approach to placemaking, which creates sustainable places based on 20-minute neighbourhood principles with well-located and co-located services shaped by the needs of local communities.

What difference will we make?

We will work together to:

- focus community planning partnership efforts in Wester Hailes and Liberton to deliver new development by the principles of 20-minute neighbourhoods.
- embed Community Planning Partnership community wealth building

[16] A Just Capital: Actions to End Poverty in Edinburgh

[17] City Plan 2030: Proposed Plan

work being led by EVOC across 20-minute neighbourhood work.

How will we know we have made a difference?

For this priority, a series of key aspirations have been identified:

A sense of belonging

- People's sense of wellbeing and belonging is increased

A sense of connection

- Social networks in local communities are strong
- Social connections and positive relationships are strengthened for groups in need

A sense of power and control

- Everyone feels they are an active part of their community
- People have opportunities to, learn, work, and volunteer

A sense of wellbeing

- Communities have access to quality natural environments
- Equitable access to local shops and services

A sense of security

- Everyone has access to safe and affordable places to live
- Levels of crime and anti-social behaviour are reduced

The following key measures will be used to track progress in the delivery of this workstream:

Outcome measures:

- Satisfaction with the neighbourhood as a place to live
- Neighbourhood is a place where people of different backgrounds get along
- Neighbourhood is a place where local people take action to help improve the neighbourhood
- Feeling of belonging in the immediate neighbourhood
- Walking distance to green space
- How safe people feel walking alone in their neighbourhood after dark
- Number of new affordable home approvals
- Number of new affordable home completions.
- Life expectancy (at birth)

Action focused measures:

- place-making - outcomes for communities.
- community wealth building e.g. uptake of community benefit portals such as **www.**ESESCommunities.org and **https://nhsnss.service-now.com/community_benefit /**.

Our approach

As a partnership, we are committed to transforming the way we work. We recognise the need to combine our resources, thinking beyond our organisational boundaries, to work more meaningfully with communities to deliver our shared ambitions for change.

Core to this success is the genuine engagement with residents and communities, recognising their knowledge and expertise and using this to influence, prioritise and shape all our activities.

We are committed to strengthening community influence and participation and creating opportunities for participation in different ways and at all levels, identifying and addressing the barriers to involvement. We will continue to use the National Standards for Community Engagement to inform our practice and improve the impact of this work evidencing the participation and views of our communities and how they have been considered. Additionally, our empowerment plan will augment and enhance work already done across the community and the voluntary sector in the city.

Our focus on 20-minute neighbourhoods and community wealth building means that community needs and benefits are directly incorporated into this work. But community empowerment is central to each LOIP priority: a co-ordinated income maximisation service can deliver better outcomes for Edinburgh citizens; the blend of universal and targeted employability services outlined in this LOIP is designed to meet the needs of as many of our citizens as possible; and healthy, affordable, sustainable places where people are safe and secure in their homes is a basic right.

We recognise for us to deliver we will need to strengthen and improve all aspects of the way we work, building and capitalising on our existing practice. Our new governance arrangements are designed to improve our decision-making and increase transparency and accountability.

Critical to achieving our priorities, is identifying, and committing the necessary joint resources. To do this we will:

- improve how we share information about residents, performance, and services
- use data and insight more effectively to drive change in the way we design, plan and deliver services
- work collaboratively to develop and support staff from all our organisations to work together, ensuring they have the appropriate skills and knowledge to deliver our ambitions and work effectively with communities
- take a practical approach to change, identifying, and maximising opportunities for rationalisation, collaborative working, and integrated service delivery
- develop a clear understanding of levels of expenditure on each priority, using this information to combine budgets to reshape services
- commit resources to support the administration and facilitation of community planning in the city

- support our accountability through a consistent approach to performance management and progress monitoring and reporting
- recognising that at times, legislative imperatives change priorities and impact on outcome development.

In delivering the plan we will collaborate with others to build and develop our understanding of the evidence, using this to influence investment decisions and to make the case for a change of policy and strategy at a national level.

Appendices

Appendix 1: Edinburgh Partnership Board

The City of Edinburgh Council

Edinburgh Affordable Housing Partnership

Edinburgh Association of Community Councils (EACC)

Edinburgh Chamber of Commerce

Edinburgh College

Edinburgh Garrison – Armed Forces

Edinburgh University

Edinburgh Voluntary Organisations' Council (EVOC)

Equality and Rights Network (EaRN)

Integrated Joint Board

NHS Lothian

Police Scotland

Scottish Enterprise

Scottish Fire and Rescue Service

Skills Development Scotland

Appendix 2: Key partnership strategies and plans (current at February 2022)

Only strategies and plans that have been finalised, as of February 2022, are shown in the list below.
Links to other key strategies currently in development will be added when finalised.

National Strategy/Plan	Link
Community Empowerment (Scotland) Act 2015	www.legislation.gov.uk/asp/2015/6 https://www.gov.scot/publications/community-empowerment-scotland-act-summary/
Fairer Scotland Duty –	www.gov.scot/FairerScotland https://www.gov.scot/publications/fairer-scotland-duty-guidance-public-bodies/
National Performance Framework	https://nationalperformance.gov.scot

National	
Strategy/Plan	**Link**
Public Health Priorities for Scotland	http://www.healthscotland.scot/our-organisation/our-context-public-health-in-scotland/public-health-reform
Social Enterprise strategy	https://www.gov.scot/publications/scotlands-social-enterprise-strategy-2016-2026/

Partnership	
Strategy/Plan	**Link**
Edinburgh 2050 City Vision	www.edinburgh2050.com/
Locality Improvement Plans	https://www.edinburghpartnership.scot/plans/locality-improvement-plans/1
Community Justice Outcome Improvement Plan	https://www.edinburghpartnership.scot/downloads/file/26/community-justice-outcomes-improvement-plan-2019-22

Partnership Strategy/Plan	Link
Edinburgh Children's Services Plan	https://www.edinburgh.gov.uk/edinburghchildrenpartnership
Edinburgh Compact Partnership Strategic Framework and Action Plan	https://www.edinburghcompact.org.uk/our-purposes/compact-strategy/
Edinburgh Economy Strategy	https://www.edinburgh.gov.uk/economicstrategy
Edinburgh Health and Social Care Partnership Strategic Plan	https://www.edinburghhsc.scot/whoweare/strategicvision/
Edinburgh and South-East Scotland City Region Deal	www.acceleratinggrowth.org.uk/
Edinburgh's Joint Community Safety Strategy 2020- 2023	https://www.edinburgh.gov.uk/downloads/file/28334/edinburgh-s-joint-community-safety-strategy-2020-to-2023
Climate 2030	https://www.edinburgh.gov.uk/2030-Climate-Strategy#:~:text=The%202030%20Climate%20Strategy%20sets,to%20live%20and%20work%20in.
Edinburgh Community Learning and Development Plan 2021-24	https://www.edinburghpartnership.scot/downloads/file/30/edinburgh-community-learning-and-development-plan
Edinburgh and South East Scotland Regional Prosperity Framework	https://esescityregiondeal.org.uk/regional-prosperity-framework

Partner (single agency) Strategy/Plan	Link
The City of Edinburgh Council - City Housing Strategy	https://www.edinburgh.gov.uk/council-planning-framework/housing-strategy/1
The City of Edinburgh Council - Local Development Plan - City Plan 203	https://www.edinburgh.gov.uk/cityplan2030
The City of Edinburgh Council - Strategic Housing Investment Plan	https://democracy.edinburgh.gov.uk/documents/s39972/7.5%20-%20Strategic%20Housing%20Investment%20Plan%20SHIP%202022-27.pdf
Edinburgh College – Strategic Plan	https://www.edinburghcollege.ac.uk/about-us/corporate-and-governance/strategy-and-policy
NHS – Out Health Our Care Our Future: NHS Lothian Strategic Plan 2014-2024	https://org.nhslothian.scot/OurHealthOurCareOurFuture/Pages/default.aspx
Police Scotland – Annual Police Plan	https://www.scotland.police.uk/spa-media/njykirkq/annual-police-plan-21-22.pdf
Police Scotland – Strategic plan	https://www.scotland.police.uk/about-us/how-we-do-it/strategic-planning/
Scottish Fire and Rescue Service – Strategic Plan 2019-22	https://www.firescotland.gov.uk/media/1143834/sfrs_strategic_plan_2019_22_v10.pdf

Partner (single agency) Strategy/Plan	Link
Scottish Fire and Rescue Service – Local plan	https://www.firescotland.gov.uk/media/1144207/localfrplanedinburgh2020.pdf
Strategy for our Veterans	https://www.gov.uk/government/publications/strategy-for-our-veterans
Inspiring Edinburgh's Volunteers Strategy	https://www.edinburghcompact.org.uk/what-we-do/volunteering-strategy/

Appendix 3: Table of outcome indicators

Enough money to live on							
Priority 1	**KPI**		**Earlier**		**Latest**	**Source**	**Comments**
	Percentage of people living on incomes below the poverty threshold	2019/202	15%	2019/2020	15%		The latest Poverty figures are for 2019/20 and remain static at 15% and do not show the full impact of Covid-19. Next data available Spring 2022
	Percentage of children living in families on incomes below the poverty threshold	2019/202	19%	2019/2020	19%		The latest Poverty figures are for 2019/20 and remain static at 19% and do not show the full impact of Covid-19. Next data available Spring 2022.
	Percentage of people living in destitution*		-		4%		Refreshed Poverty figures give a new baseline for people in destitution of 4.0. Next data available Spring 2022.

Access to work, learning and training opportunities							
Priority 2	KPI		Earlier		Latest	Source	Comments
	Number of households with no adult in employment*		12.4%	Jan-Dec 2020	16%	NOMIS	Latest figures from Jan-Dec 2020. Below Scottish average of 18.1%
	Employment rate*	Oct 19-Sep 20	76.7%	Oct 20-Sep 21	78.1%	NOMIS	The latest figures are from Oct 2020-Sep 2021. Unemployment 3.9%
	Percentage of young adults (16-19-year olds) participating in education, training or employment*	August 2020	92.4%	August 2021	92.5%	SDS	The latest figures are from August 2022. Consistent with the previous year and in line with the Scottish average.

A good place to live							
Priority 3	**KPI**		**Earlier**		**Latest**	**Source**	**Comments**
	Satisfaction of neighbourhood as a place to live by year*	2018	96%	2019	95%	SHS	Latest figures from the Scottish Household Survey. Consistent with Scottish average/trend.
	Percent who feel strongly that they belong in the immediate neighbourhood	2018	73%	2019	75%	SHS	
	Walking distance to green space *		Under 5 min 72%, 6-10 min 21%, 11 minute and more 7%	2019	Under 5 min 69%, 6-10 min 21%, 11 minute and more 9%	SHS	
	Percent who feel safe when walking alone in the local neighbourhood after dark*	2016-2018	82.1%	2018-2020	81.1%	SCJS	

A good place to live							
Priority 3	**KPI**		**Earlier**		**Latest**	**Source**	**Comments**
	Percent who agree that in their local neighbourhood people from different backgrounds get on well together*		71%	2019	69%	SHS	
	Percent who agree that their local neighbourhood is somewhere local people take action to help improve the area*		61%	2019	61%	SHS	
	Number of new affordable home completions	2018	966	2021	5790	ECC	Target to build 20,000 by 2027.
	Number of new affordable home approvals	2018	1475	2021	7500	ECC	

A good place to live							
Priority 3	**KPI**		**Earlier**		**Latest**	**Source**	**Comments**
	Life expectancy (at birth)*	2017-2019	Male - 78.38 Female – 82.5	2018-2020	Male - 78.4 Female – 82.5	ONS	The figures pre-date COVID19. Edinburgh remains above the Scottish average (76.9 Males, 81.06 Females). The Scottish average. In Edinburgh, life expectancy has increased since the 1980s but has stayed largely the same at around since 2010. In Edinburgh, a significant gap continues for those living in the most deprived areas compared to the least deprived areas. Those born in the least deprived areas are expected to live as much as 12 years longer than those in deprived areas.

*New Outcome indicator

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Meeting Name: Board **Meeting date: 22 June 2022**

Title: 2021/22 FINANCIAL POSITION

Purpose and Key Issues of the Report:
This paper provides an update to the Board on the financial outturn position in 2021/22 for NHS Lothian, including the cost of Covid.

DISCUSSION		DECISION		AWARENESS	X

This paper sets out the financial position for 2021/22. The paper details the following key points which have been considered by the Finance and Resources Committee:

- Lothian underspent by £1,422k in 21/22;
- Covid costs for 21/22 totalled £200m. The SG provided funding of £249m to add to £26m of Covid Reserves carried into 21/22 by IJBs;
- £75m of IJB Covid Reserves have been carried forward to 22/23;
- A significant challenge remains with the 22/23 Financial Plan gap at £107m, made up of a Core projected deficit of £28m and Covid costs of £79m.

Recommendations:

The Board is asked to accept that NHS Lothian has achieved its financial target of breakeven for the year 2021/22, subject to external audit review.

Author: Andrew McCreadie **Date:** 9 June 2022	**Director: Craig Marriott** **Date:** 9 June 2022

NHS LOTHIAN

Board Meeting
22nd June 2022

Director of Finance

2021/22 FINANCIAL POSITION

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position for 2021/22 for NHS Lothian, following consideration by the Finance and Resources (F&R) Committee.

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

2 Recommendations

2.1 The Board is asked to:

- **Accept** NHS Lothian has achieved its financial target of breakeven for the year 2021/22, subject to external audit review.

3 Discussion of Key Issues

Financial Position as at March 2022

3.1 NHS Lothian has operated within its Revenue Resource Limit for 2021/22, although this position remains subject to external audit. **An underspend of £1,422k is reported** for the year ending 31st March 2022.

3.2 In March NHS Lothian underspent by £1,359k, bringing the year end outturn position to £1,422k underspend against the Revenue Resource Limit. This position reflects a baseline operational overspend position of £6,003k offset by the net release of reserves flexibility of £7,425k. A summary of the year to date position is shown in Table 1 below with further detail by expenditure type attached in Appendix 1 and by Business Unit in Appendix 2.

Table 1: Financial Position to 31st March 2022

	YTD £'000
Pay	10,480
Non Pays	(28,000)
Income	11,517
Operational Position	**(6,003)**
Reserves / Flexibility	7,425
Core Variance	**1,422**

3.3 The Financial Plan presented to the Board in April 2021 showed a projected deficit for the year of £25m. In-year benefits from an improved operational position and other one-off items of flexibility have all contributed to achieving the final year-end underspend position.

Financial Impact of COVID-19 – 2021/22

3.4 COVID-19 has once again had a significant impact on NHS Lothian's finances during 2021/22. In total, £150m of additional costs/lost income has been incurred by NHS Lothian in relation to Covid. The quarter 3 SG Covid submission estimate was £128m, however additional Annual Leave provision and charges from NSS for Covid tests and PPE stock and equipment increased the overall cost to £150m overall.

3.5 Covid related allocations have been received from the Scottish Government during the year totalling £249m, adding to £26m of Covid resource carried into the year through IJB reserves. The total application of this is shown in table 2 below.

Table 2: Breakdown of Covid Funding and Costs

Covid 2021/22 Breakdown	**£m**
2021/22 SG Covid Allocations	£249
IJB 2020/21 c/f Earmarked Reserves	£26
Total Funding	**£275**
2021/22 Covid Costs	
Health Board Costs	£(133)
Partnership NHS Costs	£(17)
Total NHS Lothian Costs	**£(150)**
Partnership LA Covid Costs	£(50)
Total 2021/22 Covid Costs	**£(200)**
Balance - IJB Covid Earmarked Reserves c/f	£75

3.6 Table 3 shows the summary of the main categories of covid costs. The most significant element by far relating to the delivery of Covid Vaccinations across the Health Board area (£40m).

Table 3 – NHS Lothian 2021/22 Covid Costs Summary

NHS Lothian Covid Costs Summary 2021/22	**£m**
Covid Vaccination Costs	40
Acute Services - Additional Staffing Costs	13
Acute Supplies; Drugs & Loss of Income	13
TAP, Community Testing & Other Public Health Costs	12
NSS Charges for Testing Kits & PPE Stock & Equipment	10
Facilities Additional Costs & Loss of Income	9
Additional Annual Leave costs	9
Care Home; Home Care & Other Community Costs	8
Regional Lab; Sequencing & Other Lab Additional Costs	6
Additional Community Hospital Capacity	6
Primary Care /GP Costs	6
GP Prescribing	4
Unmet Savings	3
Mental Health Services & Buvidal Drug Costs	2
Other Covid Costs and Loss of Income	9
Total NHS Lothian Covid Costs	**150**

Efficiency & Productivity

3.7 Despite the impact of Covid, in total £25.3m of savings were delivered in the operational units, of which £6.4m was delivered on a non-recurrent basis. Table 4 shows the delivery of the savings by Business Unit.

Table 4: Efficiency Savings Achieved 2021/22

	Planned	Achieved			Shortfall
		Recurring	Non Recurring	Total	
	£k	£k	£k	£k	£k
Acute Services Division	13,659	12,579	430	13,009	(651)
Corporate Services	2,092		2,007	2,007	(85)
East Lothian Partnership	616	519	160	679	63
Edinburgh Partnership	4,232	2,456	313	2,769	(1,463)
Midlothian Partnership	564	469	55	525	(39)
West Lothian Hsc Partners	1,881	1,453	285	1,738	(142)
Facilities And Consort	3,020	1,150	1,883	3,033	13
Reas	1,000		1,264	1,264	264
Strategic Services	384			0	(384)
Service Improvement	292	292		292	0
Grand Total	**27,740**	**18,919**	**6,397**	**25,315**	**(2,425)**

Integration Joint Boards Year End Outturn

3.8 All four IJBs have reported an underspend on their NHS service elements, and this has resulted in general reserves being available to carry forward into 2022/23. In addition to this the IJBs have earmarked reserves also carried into 2022/23 for specific ongoing projects and initiatives including Covid services. Appendix 3 sets out the outturn position by IJB, showing the outturn before reserves and the value of the earmarked and general reserves being carried forward into the new financial year, including Covid funding noted above.

Financial Position into 2022/23

3.9 As reported to the Board in April, the overall gap for next year totals £107m and is split into two elements. There is a £28m gap relating to the Core financial position and a further £79m relating to projected NHS costs associated with Covid.

3.10 As we move into 2022/23 reporting there are further steps now required to refine the plan as information is made available and plans are updated. Final confirmation of uplift settlements and pay awards will be a key element of this.

3.11 Other key elements for review include:

- Ongoing dialogue with Integration Joint Boards;
- Assessment of the continued requirement for previously agreed investment.
- Recovery actions/efficiency schemes to be continually developed.
- Implementation plans produced to close the financial gap within Business Units.
- Review and assessment of the ongoing costs associated with Covid.
- A review of growth estimates.

3.12 Moving into the new year and with a Core Financial Plan gap of £28m, the potential volatility of Covid costs and uncertainty about funding, the challenge of recovery and remobilisation, and the reduced ability to provide focus to financial performance within services and our ability to deliver within financial constraints is all a concern and will require close management and control.

4 Risk Register

4.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

4.2 The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

5 Impact on Inequality, Including Health Inequalities

5.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

6.1 The implementation of the financial plan and the delivery of a breakeven outturn will require service changes. As this paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

7 Resource Implications

7.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Craig Marriott
Director of Finance
9th June 2022
Craig.Marriott@nhslothian.scot.nhs.uk

Appendix 1 - NHS Lothian Income & Expenditure Summary to 31st March 2022
Appendix 2 - NHS Lothian Summary by Operational Unit to 31 March 2022
Appendix 3 – NHS Lothian year-end outturn, by IJB

Appendix 1 - Lothian Income & Expenditure Summary to 31st March 2022

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)
Medical & Dental	324,818	324,818	332,009	(7,191)
Nursing	542,295	542,295	527,797	14,497
Administrative Services	151,237	151,237	149,937	1,300
Allied Health Professionals	92,430	92,430	89,907	2,523
Health Science Services	49,804	49,804	48,869	935
Management	9,481	9,481	7,943	1,537
Support Services	85,492	85,492	88,167	(2,674)
Medical & Dental Support	14,549	14,549	15,053	(504)
Other Therapeutic	48,974	48,974	48,031	942
Personal & Social Care	3,306	3,306	3,046	260
Other Pay	(5,401)	(5,401)	(4,516)	(885)
Emergency Services	5	5	26	(21)
Vacancy Factor	(239)	(239)	0	(239)
Pay	**1,316,750**	**1,316,750**	**1,306,270**	**10,480**
Drugs	139,213	139,213	150,098	(10,885)
Medical Supplies	117,042	117,042	120,067	(3,025)
Maintenance Costs	10,382	10,382	10,637	(255)
Property Costs	43,422	43,422	43,619	(197)
Equipment Costs	42,226	42,226	59,074	(16,848)
Transport Costs	11,388	11,388	10,713	676
Administration Costs	320,518	320,518	306,224	14,294
Ancillary Costs	18,035	18,035	18,909	(874)
Other	(27,010)	(27,010)	(28,008)	999
Service Agreement Patient Serv	46,574	46,574	49,256	(2,682)
Savings Target Non-pay	(819)	(819)	0	(819)
Resource Trf + L/a Payments	129,905	129,905	132,377	(2,472)
Non-pay	**850,877**	**850,877**	**872,966**	**(22,089)**
Premises	98	98	98	0
Gms2 Expenditure	154,629	154,629	155,436	(807)
Ncl Expenditure	888	888	806	81
Other Primary Care Expenditure	87	87	73	14
Pharmaceuticals	157,374	157,374	159,143	(1,769)
Primary Care	**313,076**	**313,076**	**315,557**	**(2,481)**
Other	**(1,589)**	**(1,589)**	**(1,261)**	**(328)**
Income	**(350,310)**	**(350,310)**	**(361,828)**	**11,517**
Extraordinary Items	**0**	**0**	**3,102**	**(3,102)**
CORE POSITION	**2,128,803**	**2,128,803**	**2,134,806**	**(6,003)**
Additional Reserves Flexibility	7,425	7,425	0	7,425
TOTAL	**2,136,228**	**2,136,228**	**2,134,806**	**1,422**

Appendix 2 - NHS Lothian Summary by Operational Unit to 31 March 2022

Description	Acute Services Division (£k)	Reas (£k)	Directorate Of Primary Care (£k)	East Lothian Partnership (£k)	Edinburgh Partnership (£k)	Midlothian Partnership (£k)	West Lothian Hsc Partnership (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Service Improvement (£k)	Research + Teaching (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Total (£k)
Annual Budget	**873,787**	**112,562**	**60,172**	**102,209**	**438,535**	**88,977**	**164,915**	**141,097**	**244,612**	**15,584**	**27,567**	**(9,431)**	**(143,426)**	**19,067**	**2,136,228**
Medical & Dental	(5,758)	(684)	(614)	(577)	(826)	(259)	(197)	0	(17)	1,578	182	(19)	0	0	**(7,191)**
Nursing	3,380	544	289	3,358	4,465	591	2,255	(33)	106	6	130	(594)	0	0	**14,497**
Administrative Services	1,347	9	(162)	(71)	319	(17)	71	(339)	2,766	(2,102)	(236)	(285)	(1)	0	**1,300**
Allied Health Professionals	(548)	310	(39)	116	1,585	236	756	(20)	134	(5)	(2)	0	0	0	**2,523**
Health Science Services	1,175	(1)	(15)	0	321	(4)	12	(10)	(643)	(2)	(5)	107	0	0	**935**
Management	(91)	9	121	5	528	15	24	(69)	812	226	8	(51)	0	0	**1,537**
Support Services	(26)	49	(289)	(25)	(60)	41	(2)	(2,183)	(203)	7	(23)	39	0	0	**(2,674)**
Medical & Dental Support	(902)	(1)	(0)	(125)	(10)	1	(1)	0	16	0	518	0	0	0	**(504)**
Other Therapeutic	(50)	908	(103)	(156)	(88)	137	66	0	268	(41)	(0)	1	0	0	**942**
Personal & Social Care	(27)	(25)	27	11	83	21	0	0	168	0	0	0	0	0	**260**
Other Pay	75	9	(187)	(7)	26	0	(0)	100	(901)	0	(1)	(0)	0	0	**(885)**
Emergency Services	0	0	0	0	0	0	0	(21)	0	0	0	0	0	0	**(21)**
Vacancy Factor	(166)	0	0	0	0	0	0	0	0	0	(73)	0	0	0	**(239)**
Savings Target Pay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Pay	**(1,589)**	**1,126**	**(972)**	**2,530**	**6,343**	**763**	**2,986**	**(2,575)**	**2,507**	**(333)**	**497**	**(802)**	**(1)**	**0**	**10,480**
Drugs	(10,007)	(14)	25	(101)	(329)	(93)	103	(2)	474	(635)	(306)	0	0	0	**(10,885)**
Medical Supplies	162	(106)	(13)	(207)	(1,250)	(30)	(54)	(1,163)	(45)	1	(320)	(0)	0	0	**(3,025)**
Maintenance Costs	(645)	(215)	7	(51)	(255)	(11)	(226)	(1,568)	(396)	3,144	(40)	0	0	0	**(255)**
Property Costs	(53)	(47)	(604)	(13)	(9)	102	(62)	796	(8)	(300)	1	0	0	0	**(197)**
Equipment Costs	(8,001)	(656)	76	(386)	(506)	(212)	(406)	(416)	(6,142)	(18)	(118)	(64)	1	0	**(16,848)**
Transport Costs	(303)	147	21	(39)	57	9	61	511	145	21	57	(0)	(11)	0	**676**
Administration Costs	(777)	(26)	2,047	(605)	1,858	(248)	(244)	2,052	1,210	(2,493)	51	(231)	58	11,642	**14,294**
Ancillary Costs	(302)	48	(148)	(24)	(13)	24	(21)	(87)	(347)	1	(5)	(0)	0	0	**(874)**
Other	41	4	19	0	23	0	36	172	703	0	0	0	0	0	**999**
Service Agreement Patient Serv	(693)	744	(0)	503	152	448	534	(77)	187	(4,985)	(38)	(2)	546	0	**(2,682)**
Savings Target Non-pay	(421)	0	0	0	(421)	8	0	0	16	(0)	(0)	0	0	0	**(819)**
Resource Trf + L/a Payments	(188)	(80)	(165)	81	(1,667)	(157)	48	(27)	(274)	(42)	0	0	0	0	**(2,472)**
Non-pay	**(21,186)**	**(201)**	**1,264**	**(844)**	**(2,360)**	**(161)**	**(230)**	**190**	**(4,477)**	**(5,306)**	**(717)**	**(298)**	**595**	**11,642**	**(22,089)**
Global Sum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other Payments/reimbursements	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gps Other Payments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gms2 Expenditure	(25)	(30)	(103)	(188)	(301)	(102)	53	(75)	(36)	0	(1)	0	0	0	**(807)**
Ncl Expenditure	0	0	81	0	0	0	0	0	0	0	0	0	0	0	**81**
Other Primary Care Expenditure	14	0	0	0	0	0	0	0	0	0	0	0	0	0	**14**
Pharmaceuticals	0	0	892	(460)	(659)	(228)	(614)	(0)	0	(699)	0	0	0	0	**(1,769)**
Primary Care	**(11)**	**(30)**	**869**	**(648)**	**(960)**	**(330)**	**(561)**	**(75)**	**(36)**	**(699)**	**(1)**	**0**	**0**	**0**	**(2,481)**
Fhs Non Discret Allocation	0	0	0	0	(19)	0	(55)	0	3	0	0	0	0	0	**(71)**
Bad Debts	(1)	(1)	0	(0)	(1)	0	0	(1)	(3)	0	(1)	0	(250)	0	**(258)**
Other	**(1)**	**(1)**	**0**	**(0)**	**(20)**	**0**	**(55)**	**(1)**	**1**	**0**	**(1)**	**0**	**(250)**	**0**	**(328)**
Income	2,816	29	47	1	(192)	(2)	(3)	1,202	471	70	(67)	341	6,805	0	**11,517**
Income	**2,816**	**29**	**47**	**1**	**(192)**	**(2)**	**(3)**	**1,202**	**471**	**70**	**(67)**	**341**	**6,805**	**0**	**11,517**
Capital Charges	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Profit/loss On Disposal	0	0	0	0	0	0	0	0	0	(3,102)	0	0	0	0	**(3,102)**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**(3,102)**	**0**	**0**	**0**	**0**	**(3,102)**
CORE POSITION	**(19,972)**	**924**	**1,208**	**1,039**	**2,811**	**270**	**2,137**	**(1,258)**	**(1,535)**	**(9,370)**	**(289)**	**(759)**	**7,148**	**11,642**	**(6,003)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	0	0	0	7,425	**7,425**
TOTAL	**(19,972)**	**924**	**1,208**	**1,039**	**2,811**	**270**	**2,137**	**(1,258)**	**(1,535)**	**(9,370)**	**(289)**	**(759)**	**7,148**	**19,067**	**1,422**

Appendix 3 – NHS Lothian Year-end Outturn, by IJB

		YTD Variance				
	YTD Variance £'000	East Lothian IJB £'000	Edinburgh IJB £'000	Midlothian IJB £'000	West Lothian IJB £'000	Non-Delegated £'000
Annual Budget	**2,136,228**	**142,488**	**612,223**	**116,431**	**224,137**	**1,040,949**
Delegated	**114,841**	16,433	71,799	9,466	17,117	26
Set Aside	**(1,596)**	(174)	(976)	(150)	(562)	266
Non Delegate	**1,130**	0	0	0	0	1,130
Total	**114,375**	**16,259**	**70,823**	**9,316**	**16,555**	**1,422**
IJB General Reserves	**(8,286)**	(1,697)	(3,151)	(753)	(2,685)	0
NHS Held Earmarked Reserves	**(104,667)**	(14,562)	(67,672)	(8,563)	(13,869)	0
Total	**1,422**	**(0)**	**0**	**(0)**	**0**	**1,422**

Meeting Name: Board **Meeting date: 22 June 2022**

Title: National Whistleblowing Standards – Annual Performance Report

Purpose and Key Issues of the Report:

DISCUSSION	X	DECISION		AWARENESS	

This is the first Annual Report presented to the Board as required by the National Whistleblowing Standards.

The report provides information to the Board on the progress with the implementation of the Standards.

The attached performance report covers the key performance metrics on which Boards are required to report to the Scottish Public Services Ombudsman

To note that since the implementation of the Standards (April 2021), 14 named concerns have been raised in compared with 4 named concerns prior to implementation (2020/21)

To note that on average Stage 2 concerns have taken 37 working days to respond to in full against the 20 working days target.

Recommendations:

Note:

The content of the Annual Report and the overall number of concerns raised under the standards (14). 3 under Stage 1 and 11 under Stage 2.

That the Annual Report contains data from Primary Care Contractors

That implementation of the Whistleblowing standards, links to the Corporate Objective – Improving Staff Experience (objective 10).

Author: Lynne Barclay **Date: 01/06/22**	**Director: Janis Buter** **Date: 01/06/22**

NHS LOTHIAN

Board
22 June 2022

Director of HR & OD

NATIONAL WHISTLEBLOWING STANDARDS – ANNUAL PERFORMANCE REPORT

1 Purpose of the Report

1.1 The purpose of this report is to present to the Board for discussion and noting the 1st Annual Whistleblowing Performance report covering the period 1 April 2021 to 31 March 2022.

2 Recommendations

The Board is invited to:

2.1 Note the content of the attached Annual Whistleblowing Performance report and note that during this year 2021/22, 14 named concerns have been raised under the Standards compared with 4 named concerns in the year prior to implementation (2020/21).

2.2 Note that as advised to the Board in April the Annual Whistleblowing Performance report contains data from our Primary Care Contractors.

2.3 Note that implementation of the Whistleblowing standards, links to the Corporate Objective – Improving Staff Experience (objective 10).

3 Discussion of Key Issues

3.1 As required by The National Whistleblowing Standards the Board are asked to note the content of the Annual Whistleblowing Performance report as attached at Appendix 1. Noting that the performance report has been discussed and noted by the Staff Governance Committee at its meeting on the 1 June 2022.

3.1 Since reporting to the Board in April performance figures from Primary Care Contractors have been received and included in the Annual Report, albeit they only cover concerns which were received during Quarter 4. Processes are now in place to gather figures on a quarterly basis, and these will be included in each quarterly report from Quarter 1 2022/23.

3.2 Overall, across the reporting year 2021/22 three Stage 1, eleven Stage 2 and three anonymous Whistleblowing concerns have been received. During Quarter 1 of 2022/23 a further two anonymous and one unnamed concern have been received. These three additional concerns are not reflected in the Annual Whistleblowing Performance report but will be reported in the 2022/23 Quarter 1 report presented to the Board in August.

3.3 On average Stage 2 concerns have taken 37 working days against the 20 working days timescales stipulated under the Standards, in which to be responded to in full. However, Stage 2 concerns vary in complexity, with the most complex of the concerns received taking 63 days to conclude. These figures have not changed since the report to the Board in April as no further Stage 2 concerns have been closed during Quarter 4. In line with the Standards the Whistleblower was advised of the revised timescales and kept up to date with the progress of the investigation.

3.4 Details of all the performance measures associated with the National Whistleblowing Standards are contained within the attached Annual Whistleblowing Performance report (Appendix 1).

3.5 Due to the low number of concerns received learning, changes or improvements to services are limited, and as there is a requirement in the Standards to maintain anonymity there is a real concern that those raising concerns may be identified.

However, learning from concerns is being recorded and shared with relevant management teams and service areas. In general, the concerns received to date have been complex, quite service specific and have been overlayed by cultural issues. A more systematic approach for capturing and sharing both system, process and cultural learning was put in place during Quarter 4. The output from this will be reflected in the 2022/23 Quarter 1 report.

3.6 As reported in April the Annual report now contains information relating to those cases referred into the formal Whistleblowing processes via our Speak Up Service.

4 Key Risks

4.1 In respect of the implementation of the standards, there is a risk that if the new standards are not widely promoted across the organisation, then staff will be unaware of how to raise a concern and consequently the organisation may lose the opportunity for improvement and learning. In order to mitigate this risk, there is ongoing communications and training.

5 Risk Register

5.1 There is no requirement for anything to be added to the Risk Register at this stage.

6 Impact on Inequality, Including Health Inequalities

6.1 At this stage there are no implications for health inequalities or general equality and diversity issues arising from this paper.

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

7.1 There is no requirement for engagement and consultation in relation to this paper.

8 Resource Implications

8.1 There are no specific resource implications associated with this paper.

Lynne Barclay
Whistleblowing Programme and Liaison Manager
1 June 2022
lynne.barclay@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Annual Whistleblowing Performance Report

Whistleblowing Annual Performance Report 2021/2022

Lynne Barclay
Whistleblowing Programme and Liaison Manager

Contents

Whistleblowing Concerns – 2021/2022

Context

The new role of Independent National Whistleblowing Officer (INWO), which is to be undertaken by the Scottish Public Services Ombudsman came into effect on the 1 April 2021. This provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing concern. On the same date the National Whistleblowing Standards were formally published, and the "Once for Scotland" Whistleblowing Policy went live.

The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in these services, whether they are directly employed by the NHS or a contracted organisation.

The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow. Health Boards have particularresponsibilities regarding the implementation of the Standards:

- ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

To comply with the whistleblowing principles for the NHS as defined by the Standards, an effective procedure for raising whistleblowing concerns needs to be:
'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'

A staged process has been developed by the INWO. There are two stages of the process which are for NHS Lothian to deliver, and the INWO can act as a final, independent review stage, if required.

- Stage 1: Early resolution – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
- Stage 2: Investigation – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
- The experience of all those involved in the whistleblowing procedure
- Staff perceptions, awareness, and training

Areas covered by the report

Since the go-live of the Standards in April 2021, processes have been put in place in NHS Lothian to gather whistleblowing information raised across all NHS services to which the Standards apply. Within NHS Lothian in all four Health and Social Care Partnerships (HSCPs) any concerns raised about the delivery of a health service by the HSCPs are reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Lothian. The Director for Primary Care has specific responsibilities for concerns raised within and about primary care service provision. Mechanisms are in place to gather information from our primary care contractors and those local contractors who are not part of wider National Procurement contracts managed by NHS National Services Scotland.

Implementation and Raising Awareness

- NHS Lothian began raising awareness of the Standards with staff from March 2021 via Weekly Brief, Leaders and Manager emails, and intranet banners.
- A series of 1 hour lunch and learn sessions took place throughout March 2021 via MS Teams. The sessions gave managers, supervisors, and team leaders the opportunity to understand what the introduction of the Standards meant for them and what their responsibilities are under the standard.
- Due to demand, further sessions have taken place and we will continue with two sessions per year, to allow staff to refresh their understanding, and to capture new managers within the organisation.
- Dedicated information sessions were also undertaken with our hard and soft facilities contractors, and we have process maps in place which outline how concerns should be raised within the organisation.
- The existing Whistleblowing intranet pages were updated to reflect the requirements of the new Standards, and include, manager and staff guides to raising concerns.
- Working with our student nursing and midwifery colleague information on raising concerns was added to their external student support pages. A similar resource is also available for our directly employed staff on an external webpage.
- We have also worked closely with our primary care colleagues, raising awareness through their Primary Care Joint Management Group. Processes are now in place with each primary care contractor group, and each has a dedicated NHS Lothian contact.
- We have produced flow charts across all areas, which outline both the processes for raising concerns from the Standards and how this translates and dovetails with local processes.

- In recognition of how a good conversation can make a difference in receiving and dealing with concerns we commissioned a Listening to Staff Concerns training programme which ran during September and November.
- In addition, we created posters and pocket-sized quick guides for staff, which provide information on the Standards and how to contact our Speak Up Advocates. Information is also included on accessing further information on both our internal and external website.

Our plans for 2022/2023

- We will continue to promote the Standards and how to raise concerns safely within the organisation and a systematised approach to sharing learning.
- We will train more managers in the skills to undertake a good investigation.
- Working with investigators and Executive Directors, we will review learning from the process and share as appropriate across the organisation.
- Working with our Speak Up Service, we will continue to gather information on barriers to raising concerns and look at way in which these can be addressed.
- We are currently working on a new induction programme, which contains a dedicated section on raising concerns and whistleblowing.
- Working with the Speak Up Ambassadors address any barriers identified by staff about raising concerns through the line management structure.

Performance Information April 2021 – March 2022

Under the terms of the Standards, the quarterly performance report must contain information on:

- Total number of concerns received
- Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed
- Concerns upheld, partially upheld and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage
- The average time in working days for a full response to concerns at each stage of the whistleblowing procedure
- The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days
- The number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1
- The number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2

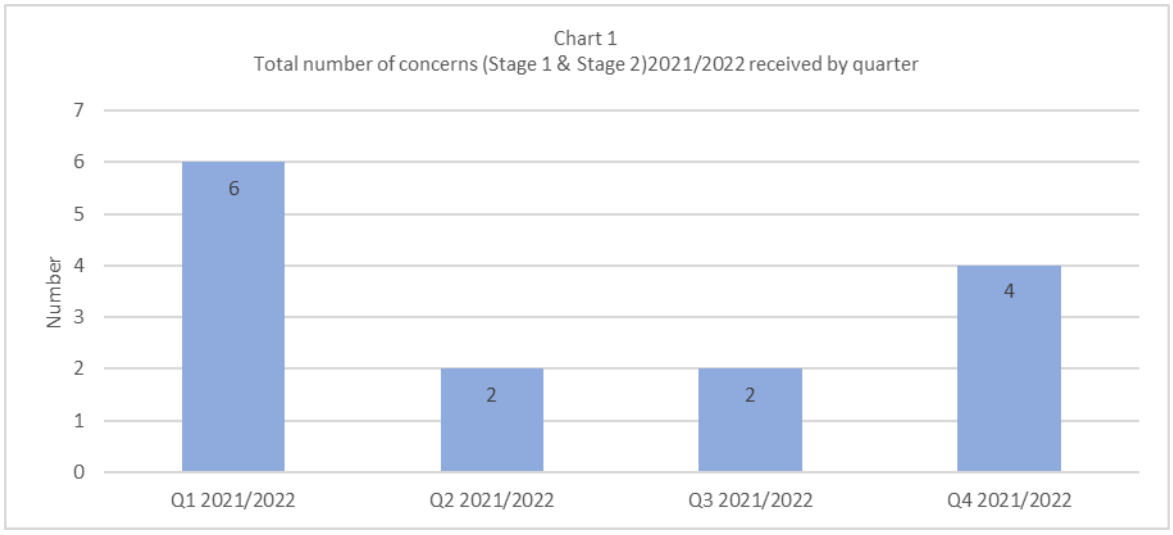
For reporting purposes, except for Charts 1 and 2, the figures and percentages are for the cumulative period (1 April 2021 to 31 March 2022).

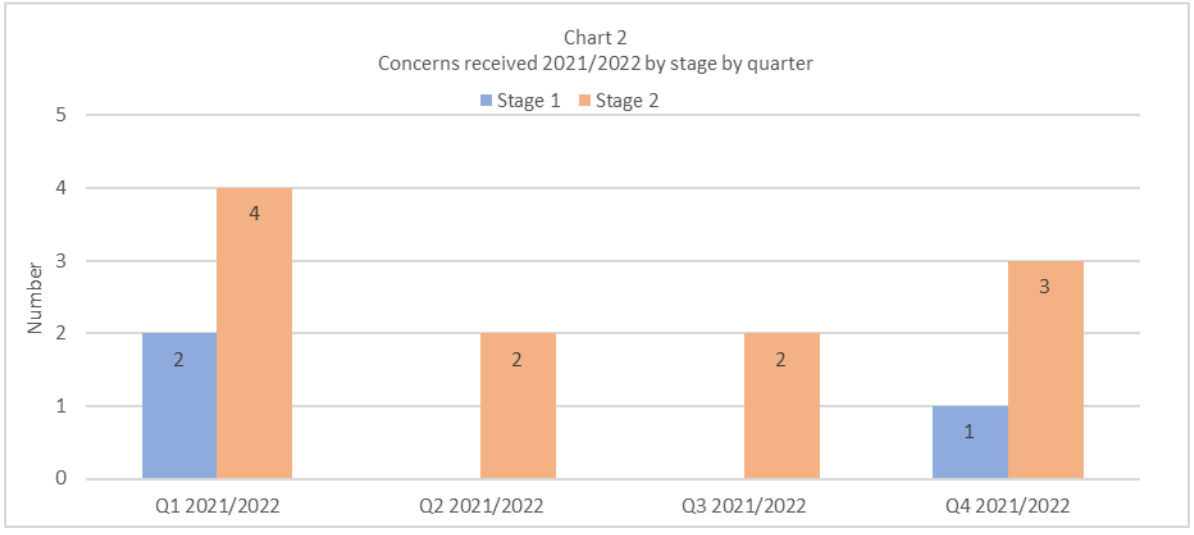
Total number of concerns, and concerns by Stage

Chart 1 details the overall number of concerns received each quarter since implementation in April 2021, with Chart 2 showing the breakdown between stage 1 and stage 2 concerns received over the same period.

To provide context around these figures, in the year prior to the implementation of the standards (April 2020 to March 2021) three anonymous and four named concerns were received. This compares to three anonymous and 14 named concerns in this first reporting year of the Standards. This may be reflective of the work which has been undertaken to promote the new Standards, the processes around recording and reporting beingmore robust and that staff may feel more confident in raising concerns knowing they have the protection afforded to them by the Standards and the INWO.

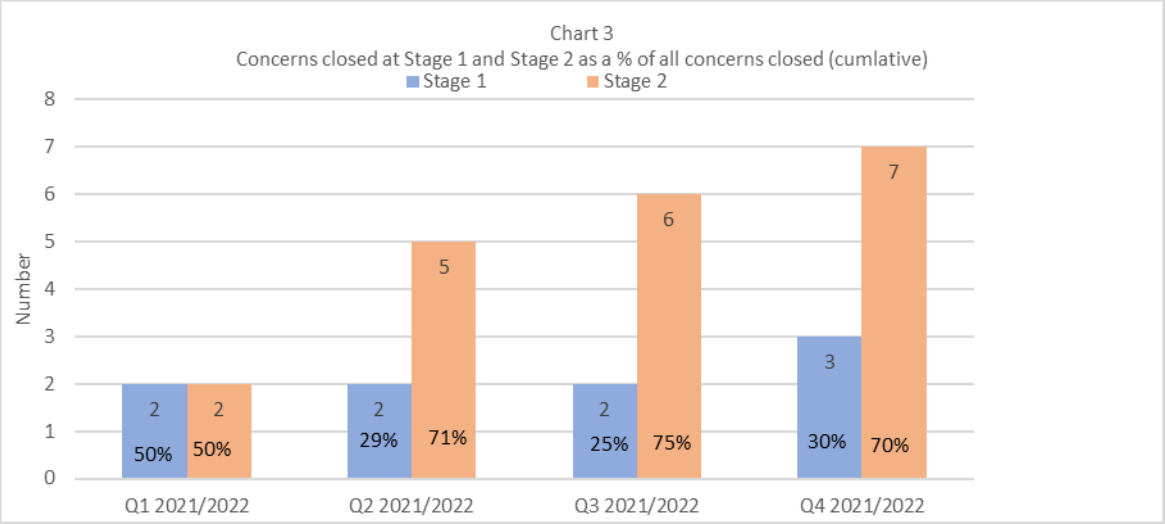
Of the eleven stage 2 concerns received and recorded under the Standards, two of the concerns were not appropriate for the whistleblowing process. Feedback was provided to those raising the concerns and they were directed to the most appropriate policy under which to pursue their concerns. These have been recorded in the Whistleblowing figures as not upheld in terms of the Standards.





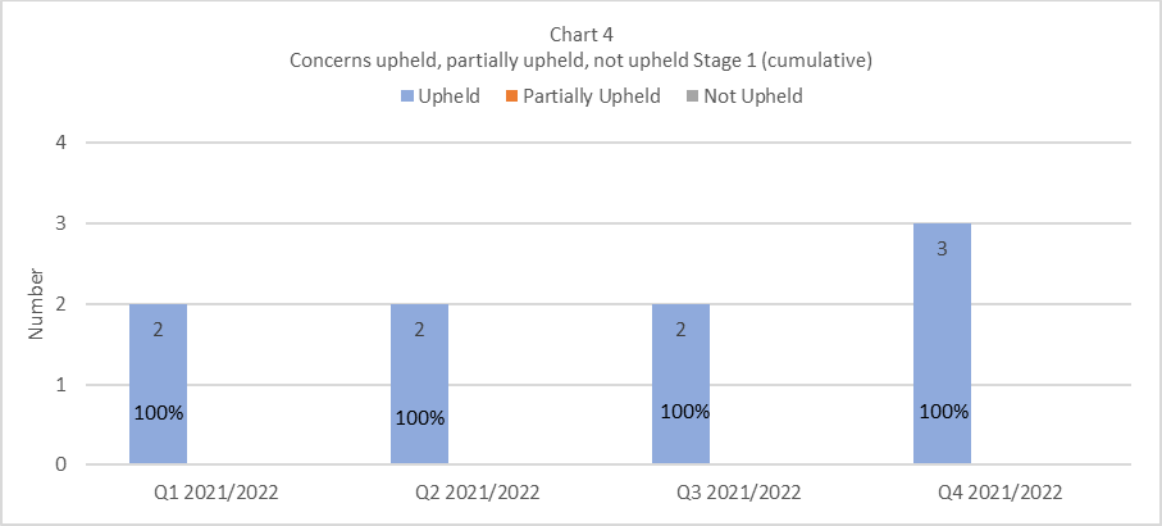
Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed

Chart 3 below, identifies the number of concerns closed at each stage as a percentage of all concerns closed, the data reflects the **cumulative** position as at quarter 4. There were no additional stage 1 concerns received in quarters 2 and 3, however a further stage 1 concern was received in quarter 4.

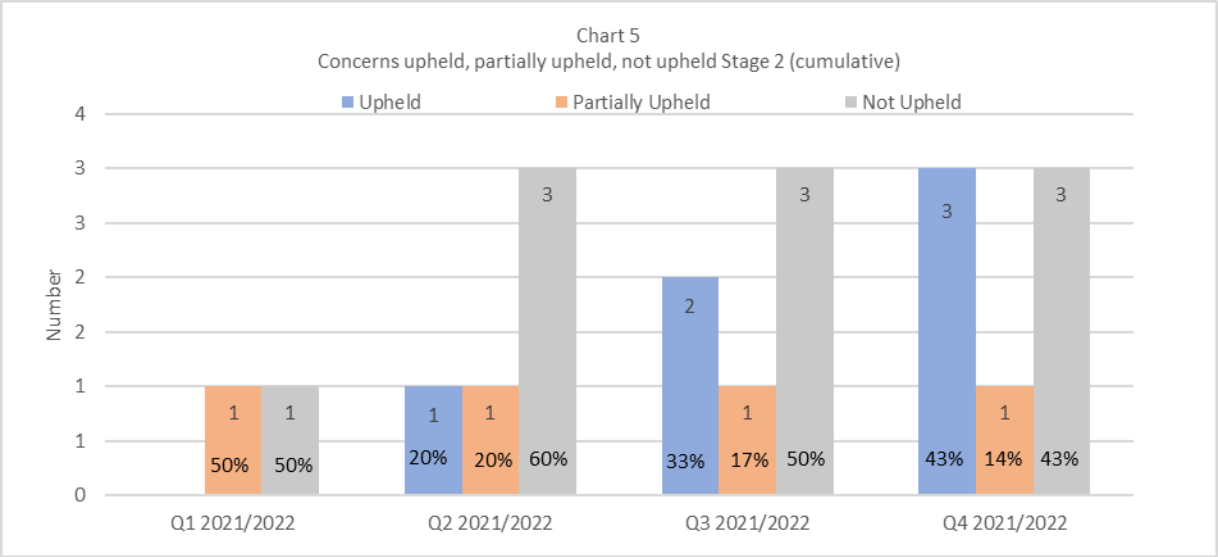


Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage

As previously referenced, the definition of a stage 1 concern - Early resolution is for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action, within 5 working days.
Chart 4 below details the outcome of the three stage 1 concerns which were received during the reporting year, the data is **cumulative**. During the reporting year none of the stage 1 concerns received have been escalated to stage 2.

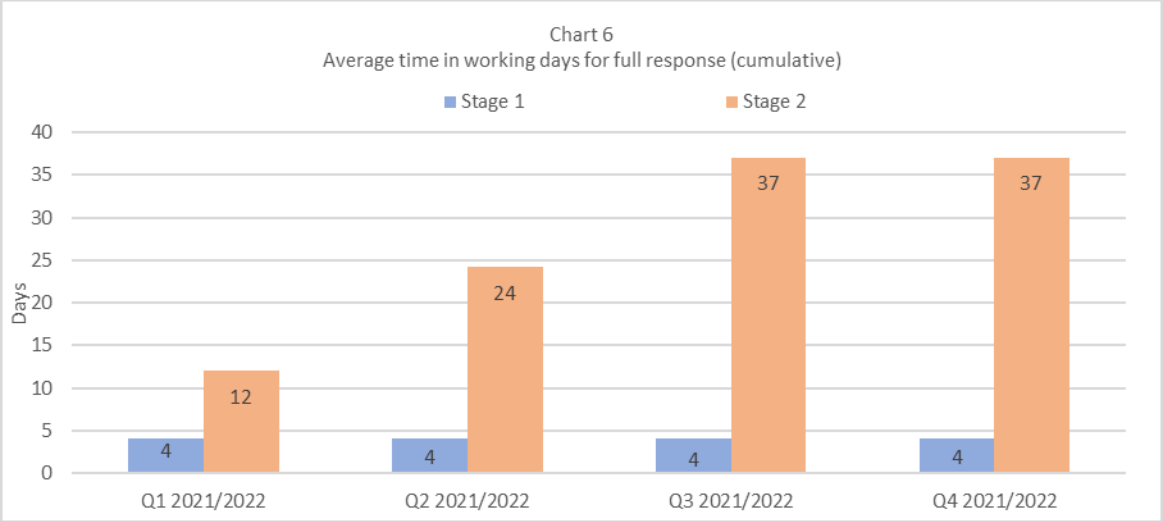


The definition of a stage 2 concern – are concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response within 20 working days. Chart 5 below details the outcome of the seven stage 2 concerns which have been closed at the end of quarter 4. Three further stage 2 concerns were received during quarter 4 these are still subject to ongoing investigations, as well as one stage 2 concern received in quarter 3.



The average time in working days for a full response

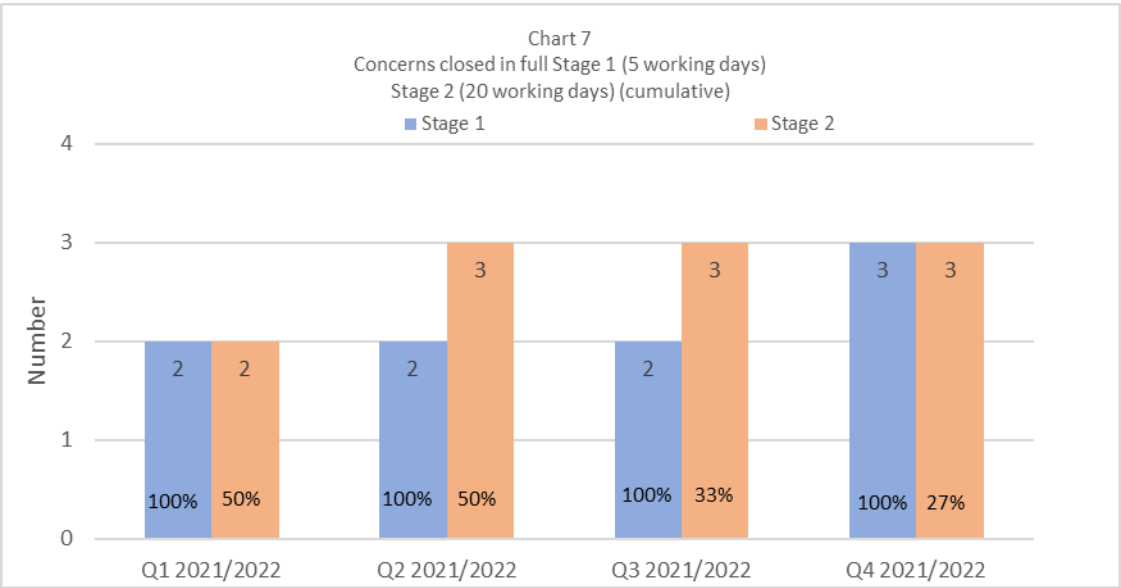
Chart 6 below details the average number of working days to respond to stage 1 and stage 2 concerns.



Due to the complexity of the stage 2 concerns received to date, it is taking on average 37 days to conclude investigations and for the outcome of the investigation to be communicated to the whistleblower.

Number and percentage of concerns closed in full within set timescales

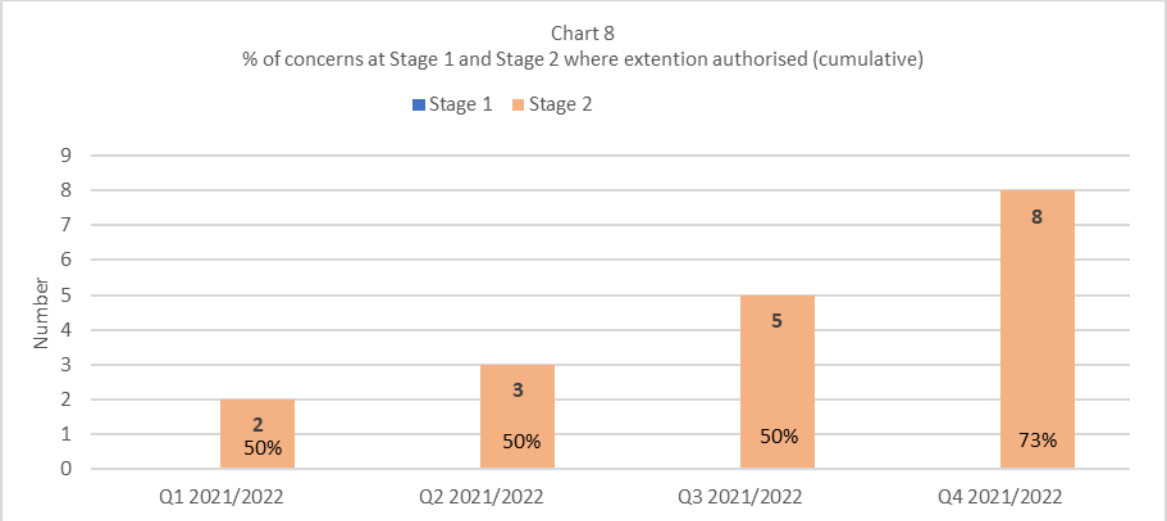
Chart 7 below details the number and percentage of concerns that have been closed in full for stage 1, and stage 2. As the number of stage 2 concerns increase the percentage of these being closed in full within 20 working days is reducing, this is attributable to the complexity of the cases currently being dealt with, and other factors out with the control of the investigators, for instance more people coming forward and wishing to speak to the investigators.



Concerns where an extension was authorised

Under the terms of the Standards, for both stage 1 and stage 2 concerns there is the ability, in some instances, for example staff absence, the number of witnesses involved or difficulty

in arranging meetings, to extend the timeframe in which a response is provided. The person raising the concern must be advised that additional time is required, when they can expect a response, and for stage 2 concerns an update on the progress must be provided every 20 days, details are shown in Chart 8 below. To date no stage 1 concerns have required an extension, however eight of the eleven stage 2 concerns received have had timescales extended. The whistleblowers are advised of the need to extend the timescales and are kept up to date with the progress of the investigation into their concerns throughout the process.



Primary Care Contractors

Primary care contractors (GP practices, dental practices, optometry practices and community pharmacies) are also covered by the Standards.

The Director of Primary Care wrote to all practices and community pharmacies in March 2021 advising that new National Whistleblowing Standards for the NHS in Scotland would come into force from 1 April 2021. In January 2022, a further letter was circulated providing an update on the requirements for local policies and information on the reporting process.

Primary care contractors were made aware of how to access NHS Lothian's Speak up Service for guidance through the process. Each contractor group were also supplied with a dedicated contact within NHS Lothian who would help with raising concerns.

Primary care contractors are required to report in line with the same key performance information as NHS i.e. quarterly reports on number of cases, cases closed etc. In instances where no concerns have been raised within either primary care or other contracted services there is no need to provide a quarterly return to the Board, but annual reports must still be submitted, setting out the concerns that have been raised over the year, or providing an explanation that there have been no concerns raised. As only one quarter's data has been requested in 2021/22, this annual reporting will be put in place from 2022/23.

Q4 returns have been received as outlined in the table below:

	No of Q4 Returns received	% Based on number of practices	No of Stage 1 concerns received	Time to respond	Outcome
GP Practices	79	66.39%	1	9 days	Partially upheld
Dental Practices	61	35.26%	0	n/a	n/a
Optometry Practices	15	12.30%	0	n/a	n/a
Community Pharmacies	21	11.54%	0	n/a	n/a

There were no stage 2 concerns recorded during Q4.

The figures above are based on the current primary care contractor cohort of:

- 119 GP practices including the challenging behaviour practice
- 173 general dental practices
- 122 optometry practices including domiciliary only and dispensing only
- 182 community pharmacies

Other Contracted Services – Not part of the wider National Procurement Framework

Our procurement team have contacted 36 local suppliers, who are not contracted through the National Procurement Framework, and put in place processes, which include templates for recording and reporting Whistleblowing concerns.

Returns are being requested quarterly, and suppliers are aware of the requirementto, on an annual basis, provide a nil return where no concerns have been raised during the reporting year.

For this reporting year, thirteen local suppliers have provided nil returns and four have shared with us their whistleblowing policies.

NHS National Services Scotland are responsible for putting processes in place for those contractors covered by the National Procurement Framework.

Anonymous Concerns

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However, good practice is to follow the whistleblowing principles and investigate the concern in line with the Standards, as far as practicable. NHS Lothian has decided that anonymous concerns should be recorded for management information purposes. The definition of an anonymous concern is 'a concern which has been shared with the organisation in such a way that nobody knows who provided the information'.

We have to date received three anonymous concerns, two in quarter 1 and one in quarter 2.

Where appropriate and applicable the outcomes from the investigations into anonymous concerns are shared with the service area. The number of anonymous concerns as a percentage of all concerns raised including those raised anonymously as at quarter 4 is 17%, compared to the 27% in quarter 2. This may indicate an increased trust in the process since its initial launch.

Learning, changes or improvements to services or procedures

System-wide learning, changes or improvements to services can be limited by the need to maintain confidentiality of individual whistleblowers. For each complaint that is upheld or partially upheld a documented action plan is put in place to address any shortcomings or apply the identified learning. The action plan is agreed and overseen by the Executive Director responsible for commissioning the investigation under the standards, this is principally the Executive Medical or Nurse Directors.

Of the eleven Stage 2 concerns recorded, four have actions plans in place and are currently transitioning from monitoring through the whistleblowing process to Business-as-Usual action/improvement plans and which will be monitored via the most appropriate committee/forum. A process is in place whereby the Executive Director commissioning the Whistleblowing investigation signs off on the actions from the whistleblowing action/improvement plan and ensures processes and reporting is in place to monitor implementation, either through a wider service improvement or action plan.

It was recognised that there was a need to capture both local and system-wide learning from investigations and processes have now been put in place to record this. From quarter 4 onwards, changes were made to the investigation report template to capture learning from an investigator's perspective. This includes any local or system wide learning identified during the investigation, and the Executive Director commissioning the investigation will also document any additional learning they have identified and agree/advise how best this will be shared and the appropriate forums for sharing.

In general, the concerns received to date have been complex and have been overlayed by cultural, relationship and communication issues. Improvement work is underway, for example it has been identified that the current once per year iMatter survey is not sufficient in itself to measure real time staff experience. It has been agreed as part of the Boards corporate priorities for 2022/23 we will explore the development of a tool/platform for capturing data on staff experience real time to augment the annual iMatter staff survey.

Experience of individuals raising concerns

All those who raise concerns are given the opportunity to feedback on their experience of using the Whistleblowing procedure in order that we can learn and make any improvements

in our processes as appropriate. For those raising concerns at stage 2 they are offered a follow up conversation with the Non-Executive Whistleblowing Champion, should they wish to discuss their experience of the process. To date four whistleblowers have taken up this offer to speak to the Non-Executive Whistleblowing Champion and their feedback to her has confirmed their experience has been positive in terms of how the investigation was undertaken, being kept up to date throughout the process and the way in which their anonymity was maintained throughout.

Level of staff perception, awareness and training

It is difficult to quantify staff perceptions, however prior to implementation of the standards, lunch and learn sessions were established and attendance at these was good. Managers and staff guides have been produced and have been widely publicised. Softer skills and investigation training for those who may be involved in taking or investigating whistleblowing concerns have been or are being set up. We will continue to monitor uptake, effectiveness and appropriateness of training and will review and refine as required. Communications continue to promote raising concerns in NHS Lothian and how this can be done. Lunch and Learn sessions will continue twice yearly on an ongoing basis, to allow new managers access to this training resource and for existing managers to refresh their learning. Through our communications on whistleblowing and how staff can raise concerns in general, we continue to promote the TURAS learning modules.

Whistleblowing and Speak Up

All stage 1 concerns which have been received during the reporting year, have been received by and handled directly by the service area. None have been escalated to stage 2 concerns.

Of the 11 stage 2 concerns which have been received during the reporting year, all have been through the Speak Up Service, the Board's identified confidential contacts.

The Board's Speak Up Service has been in operation for 3 years, and as part of the service they have explored reasons for users not raising concerns via business-as-usual routes, and the most common barrier is the perception is that "nothing will change". However, when raising concerns under the Standards, those accessing the Speak Up Service have reported that they are concerned they "may be seen as a troublemaker".

Some other examples of reported barriers to raising concerns under the Standards are:

- "I won't get promoted; I might not be supported if I speak up. Other have raised this and no one has done anything"
- "Raised via BAU but told it was not an issue by certain manager, not to questions their decision felt like detriment since raising, B&H culture"
- "Nothing will change/ My line manager says there is nothing they can do"

Further work will be undertaken in 2022/23 with the Speak Up Ambassadors to more fully understand how this perception may be changed and to look at ways to overcome these barriers when staff are raising concerns through the line management structure.
In relation to anonymous concerns, only 1 of the three anonymous concerns was raised via Speak Up, the other two were received directly or indirectly via the Director of HR & OD.

Whistleblowing Themes, Trends and Patterns

Analysis of the concerns raised by key themes is provided below. Where possible comparisons have been made against the Whistleblowing cases received pre-April 2021 with those raised post implementation.

Theme*[1]	Pre April 2021*[2]	Q1	Q2	Q3	Q4	Annual 2021/22
Patient Care/Patient Safety	10	2	3	3	4	12
Poor Practice	n/a	5	1	1	2	9
Unsafe working conditions	n/a	2	1	0	3	6
Fraud	5	0	0	0	0	0
Changing or falsifying information about performance	n/a	0	0	0	1	1
Breaking legal obligations	n/a	1	0	0	0	1
Abusing Authority	n/a	0	1	2	2	5
Management of a Service	11	n/a	n/a	n/a	n/a	n/a

*[1] more than one theme may be applicable to a single Whistleblowing concern
*[2] themes were broadened for reporting post April 2021

Concerns raised by Division

Division	Number
Edinburgh Health and Social Care Partnership	*
Acute Hospitals	7
Corporate Services	*
REAS	*

*to maintain anonymity where case numbers are lower than 5 actual case numbers have not been included.

Meeting Name: Board Meeting date: 22 June 2022

Title: NHS LOTHIAN CORPORATE RISK REGISTER

Purpose of the Report:

DISCUSSION		DECISION	✓	AWARENESS	

The report sets out recommendations with respect to specific risks and new risk processes that require decisions by the Board.

Recommendations:

1.1 Note the April 2022 Board accepted the following Corporate Management Team (CMT) recommendations:

- The removal of the complaints risk based on comparative performance, assurance level and risk grading and put it onto the Corporate Nursing risk register
- That the current Covid-19 risk is closed and a new risk accepted with a public health focus
- The new risk description related to timely discharge which has been re-framed to focus on hospital bed occupancy.
- The change in the description of the finance risk, following consideration at the January 22 meeting of the Finance and Resource Committee.

1.2 The CMT is recommending to the Board that Hospital Sterilisation Decontamination Unit (HSDU) Capacity is entered onto the CRR (rationale and description set out under section 3.2).

1.3 Review the updates provided by the executive leads concerning risk mitigation, set out in the Assurance Table in Appendix 1.

1.4 Note that a schedule of risk assurance reporting to the Planning, Performance and Development Committee is in development.

1.5 Note that the divisional high and very high risks will be considered in at the July 22 CMT as part of routine reporting.

Author: Jo Bennett Date: 06/06/22	Director: Tracey Gillies Date: 06/06/22

NHS LOTHIAN

Board
22 June 2022

Medical Director

CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to review NHS Lothian's Corporate Risk Register (CRR) and associated processes to ensure it remains fit for purpose.

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

2 Recommendations

The Board is recommended to:

2.1 Note the April 2022 Board accepted the following Corporate Management Team (CMT) recommendations:

- The removal of the complaints risk based on comparative performance, assurance level and risk grading and put it onto the Corporate Nursing risk register
- That the current Covid-19 risk is closed and a new risk accepted with a public health focus
- The new risk description related to timely discharge which has been re-framed to focus on hospital bed occupancy.
- The change in the description of the finance risk, following consideration at the January 22 meeting of the Finance and Resource Committee.

2.2 The CMT is recommending to the Board that Hospital Sterilisation Decontamination Unit (HSDU) Capacity is entered onto the CRR (rationale and description set out under section 3.2).

2.3 Review the updates provided by the executive leads concerning risk mitigation, set out in the Assurance Table in Appendix 1.

2.4 Note that a schedule of risk assurance reporting to the Planning, Performance and Development Committee is in development.

2.5 Note that the divisional high and very high risks will be considered in at the July 22 CMT as part of routine reporting.

3 Discussion of Key Issues

3.1 Role of the Corporate Management Team

3.1.1 It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading. A process has been established to meet executive leads prior to each CMT to inform the CMT risk paper.

3.1.2 The CMT then make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHSL risk management system including our assurance system.

3.1.3 Escalation of Risks

The CMT considered in October 2021, the Very High and High-Risk risks on the divisional risk registers, with an expectation that Directors will present to CMT their plans to mitigate these risks. Divisional risks that remain at a Very High and High level and that cannot be managed at a divisional level, will be considered for inclusion on the CRR. The July 22 CMT risk paper will consider these divisional risks as part of routine reporting.

3.2 Proposed Board Changes

HSDU Capacity

Description
There is a risk that HSDU is unable to meet current or future capacity demands for theatre equipment due to physical space limitations of the current department and lack of staff with appropriate competence to maintain and repair key equipment leading to closure of operating theatres and subsequent cancellation of patient operations impacting on quality of patient experience.

Governance
Finance and Resources Committee is the governance committee for assurance of this risk.

Management
The HSDU Oversight Programme Board, chaired by the Associate Director of Estates & Facilities, is the group with accountability for oversight and delivery of plans to mitigate this risk supported by:

- Estates & Facilities Senior Management Team
- Site Hospital Management Groups (DATCC)
- Corporate Management Team
- Surgical Device Programme Board
- Track & Traceability Programme Board
- NTC Programme Board
- National HSDU network

Grading

Very High (20)

4 Key Risks

4.1 The risk register process fails to identify, control, or escalate risks that could have a significant impact on NHS Lothian.

5 Risk Register

5.1 Will positively impact on the CRR and associated risk system

6 Impact on Inequality, Including Health Inequalities

6.1 Not applicable.

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

7.1 This paper does not consider developing, planning, designing services and/or policies and strategies.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Jo Bennett
Associate Director for Quality Improvement & Safety
06 June 2022
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: CRR Risks Assurance Table

Risk Assurance Table – All risks revised in June 2021 and approved at June 2021 Board

Datix ID	Risk Title & Description	Committee Assurance Review Date
5360	**Covid-19** There is an ongoing significant risk to the health of the population, particularly those who are clinically vulnerable, if we are unable to protect the population through vaccination and other public health control measures to break the chain of transmission or to respond to a new variant, leading to increased morbidity and mortality. New public health risk added April 2022. Executive Lead: Dona Milne	Healthcare Governance & Risk Committee (HCG) • May 2022 - Health Governance – accepted moderate assurance. **Outcome of Executive Lead Discussions** **February 2022 Update** • **Recommendation to Board via CMT to close original risk and accept a new risk with a public health focus risk linked to Board objective of health of the population** • **Rationale - that impacts of Covid on services are captured in other risks (nursing work force, access risks, hospital bed occupancy)** **April\May 2022 Update** • **April Board agreed to close previous risk and accept new risk with public health focus. See new risk description** • **The National IMT now meets fortnightly to review data and mitigations and this informs local and national actions** • **In Lothian, Gold has been paused as has the public health intelligence meeting The health protection team will continue to monitor data weekly with Public Health Scotland.** • **Management plans have changed significantly as a result of changes to government policy** • **Test and Protect has been stood down. Discussions are ongoing with Scottish Government about what each health board and PHS should retain for monitoring of future variants and responding to outbreaks. These plans should be agreed before the end of May.** • **Grading remaining high (15) Whilst we have achieved a high rate of covid vaccination in the population, other public health protective measures have been reduced considerably. We do not know if or more likely when a new Covid variant**

Datix ID	Risk Title & Description	Committee Assurance Review Date
		will arrive and if the vaccine will provide the same degree of protection against this new variant. • **Risk will be presented to HCG in May for assurance**
	Risk Grading:	**CMT/Board April 2022** High 15
3600	**Finance** There is a risk that the Board is unable to respond to the service requirements arising from the population growth in all age groups across NHS Lothian. This is because of a combination of the level of resource available both capital and revenue and uncertainty around future resource leading to inability to plan for, and deliver the additional capacity required. Executive Lead: Craig Marriot	<u>Finance & Resources Committee</u> • November 2020 – F&R continued to accept limited assurance on the management of this risk. • March 2021 – significant assurance accepted on the NHS Lothian ability to deliver a breakeven position in 2020/21 on the basis of the financial position as at 31 January 2021. Limited assurance on delivering a balanced financial position in 21/22 based on NHS Lothian 5-year Financial Outlook and Outline Plan 21/22. • January 2022 – F&R accepted limited assurance. **<u>Outcome of Executive Lead Discussions</u>** **<u>December 2021 Update</u>** • **The finance risk description was due to be discussed at the Nov F&R but due to a packed agenda was postponed to January 2022** • **Work continues to articulate the risk, concerning financial restraints/enablers related to service capacity and mitigate the current risk current and develop the longer-term financial plans.** **<u>February 2022 Update</u>** • **The refreshed finance risk description as set out in this assurance table was agreed at the January 2022 Finance and Resources Committee and remains very high.** • **The January Finance and Resources Committee accepted limited assurance with respect to risk mitigation plans in place and acknowledged that finance is also pertinent to a few other risks on the corporate risk register.** • **The Director of Finance has established and chairs a monthly meeting with finance oversight Board to monitor implementation of the plan** • **Short- and medium-term plans have been developed, however it is acknowledged that actions to improve operational capacity will require measurement of plans**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		across a number of the risks on the corporate risk register and are complex in nature. **<u>April\May 2022 Update</u>** • **Minor amendment to description to clarify capital and revenue resource based on non-executive feedback.** • **The Finance Oversight Board continues to meet and consider both strategic and operational financial issues and the impact on service provision. The magnitude of this risk has increased, due to SG COVID funding no longer being available at the level assumed, which was agreed by both parties. This could add to Lothians current deficit as outlined in the 22/23 financial plan. This is an issue for all Scottish Health Boards and is being discussed nationally. In response to the current situation Finance are developing with HR a COVID Exit Plan and establishing a Thematic Efficiency Programme.**	
	Risk Grading:	**Jan-Mar 2021** Very High 20	**CMT/Board June 2021** Very High 20
5186	**4 Hours Emergency Access Target** There is a risk that NHS Lothian will fail to deliver safe and timely unscheduled care to patients presenting to EDs due to the volume and complexity of patients, challenges in managing flow through the department, especially when maintaining red Covid streams, and availability of beds, leading to a delay in first assessment, diagnosis and subsequent treatment for patients and therefore increased likelihood of patient harm and poor experience of care. New risk created from previous risks 3203 & 4688. Approved by June 2021 Board.	<u>Healthcare Governance Committee –</u> person-centred, safe and effective care<u>.</u> • November 2020 - HCG accepted moderate assurance on the Winter plan which includes 4-hour performance in RIE ED. • Unscheduled Care Winter Plan, May 2021 HCG accepted Significant Assurance with respect to the 4-Hr Emergency Access Target to March 2021. • Scheduled for review as part of acute service report at November 2022 meeting. <u>Planning Performance & Development Committee</u> – Performance • June 2021 – Board agreed downgrade of risk from Very High to High. • Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed. • To be considered for assurance in September 2022.	

Datix ID	Risk Title & Description	Committee Assurance Review Date		
	Executive Lead: Jim Crombie	**Outcome of Executive Lead Discussions** **December 2021 Update** • **Continued review with no agreement on impactful plan as yet. Now agreed interim placement of patients in acute beds awaiting care at home packages** • **All patients in interim placements are tracked and subject to review at Gold command** • **Performance paper considered on 1 December by Board detailed 4 hr target and redesign of unscheduled care. No specific levels of assurance proposed or agreed** • **Board requested specific reference to workforce issues and linkage to nursing workforce risk on CRR – now noted in risk** • **Boar agreed to increase grading to very high (20) at December meeting.** **February 2022 Update** • **An annual implementation plan was presented to the USC Programme Board in December 2021. High level plan now agreed but detailed project plans, milestones, etc to be agreed and implemented.** • **Risk and plans in place to mitigate, to be presented to PPDC for assurance and agreement. Timing to be agreed.** • **The national redesign of urgent care programme went live in NHS Lothian on 1st December 2020. Since 31st January 2021, and the implementation of our 111 Flow navigation centre (FNC) pathway we have seen a steady increase in alternatives to attendance at our ED departments.** **April\May 2022 Update** • **Plans continue to be developed – due to go back to Performance oversight group (POG) in May\June.** • **Too early to evidence sustainable impact, however early data is encouraging. Following the launch of the first phase of the re-design of urgent care programme a total of 306, 624 Lothian residents have contacted NHS24 111 for an urgent care assessment. Of this number, 8% were direct to ED referrals and 9% to LFC for further triage.** • **PPCD agreed to have governance oversight of this risk in relation performance and to seek assurance from management on plans to mitigate. Mitigation plans to be presented to September meeting for assurance.** • **'Amber' pathway has been deleted from risk description as no longer relevant.**		
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**	**Board Dec 2021**

Datix ID	Risk Title & Description	Committee Assurance Review Date		
		Very High 20	High 16	Very High 20
3726	**Hospital Bed Occupancy** There is a risk that patients do not receive safe and effective care due to high level of bed occupancy, leading to increased risk of harm, poor patients and staff experience and impacting on flow resulting in crowding in front door areas and long waits for admission, cancellation of elective procedures and NHS Lothian's capacity to achieve national standards. Executive Lead: Jim Crombie	<u>Healthcare Governance Committee –</u> person-centred, safe and effective care<u>.</u> • September 2020 – delayed discharge was discussed as part of HSCP annual reports, with moderate assurance accepted. • November 2020 - HCG accepted moderate assurance on the Winter plan, which includes timely discharge. • Unscheduled Care Winter Plan, May 2021 HCG accepted Significant Assurance with respect to the Delayed Discharges to March 2021. • Scheduled for review as part of acute service report at November 2022 meeting. • HSCPs contribution to mitigation to be picked up as part of service report in September 2022. <u>Planning Performance & Development Committee</u> – Performance • June 2021 – Board agreed to downgrade risk from Very High to High.		
		<u>Outcome of Executive Lead Discussions</u> **<u>December Update</u>** • **Unscheduled care 1 year implementation plan due to go to Unscheduled care programme Board 14 Dec for discussion** • **An updated Discharge and Transfer Policy has been drafted and is out for consultation** • **Participation in SGs Discharge without Delay programme** • **HIS process mapping a ward in RIE** • **Internal Audit** • **Considered at each Board meeting as part of wider performance report. No specific levels of assurance proposed or agreed** • **Refreshed risk to go to Jan CMT to focus on bed occupancy in acute hospitals** **<u>February 2022 Update</u>** • **Re-framed risk and plan presented to CMT for agreement prior to PPDC for assurance and agreement** • **Minor modifications made at the request of CMT to be explicit on governance and to identify key timelines for actions in plans**		

Datix ID	Risk Title & Description	Committee Assurance Review Date		
		• An annual implementation plan was presented to the USC Programme Board in December 2021. • High level plan now agreed but detailed project plans, milestones, etc to be agreed and implemented. • Social care capacity in Edinburgh now escalated for enhanced monitoring by Performance oversight board and Gold command. Impact on flow through acute hospitals sustained. • Reduced attendance at ED will impact in time, though too early to quantify at this time • The national redesign of urgent care programme went live in NHS Lothian on 1st December 2020. Since 31st January 2021, and the implementation of our 111 FNC pathway we have seen a steady increase in alternatives to attendance at our ED departments **April\May 2022 Update** • The Board agreed a reframed risk description – hospital bed occupancy at its April meeting. • All subgroups in place and progressing implementation of plans • Milestones achieved: o Phase 1 went live on 1st December, currently being evaluated o Feasibility Assessment of phase 2 (improving professional to professional access to same day secondary and community care services) on target to complete April 2022 o An evaluation of the impact of the SDEC model within WGH is underway, the findings from this will be incorporated into the framework for delivery of an SDEC service in SJH and RIE. The evaluation will conclude in June 2022. o Updated Discharge and Transfer policy approved at March policy approval group. • Too early to evidence sustainable impact, however early data is encouraging. Following the launch of the first phase of the re-design of urgent care programme a total of 306,624 Lothian residents have contacted NHS24 111 for an urgent care assessment. Of this number, 8% were direct to ED referrals and 9% to LFC for further triage. • PPDC agreed the risk as the principal assurance committee at the March meeting. • Assurance paper will be presented to the September meeting.		
	Risk Grading:	**CMT/Board June 2021**	**Board Dec 2021**	**Board Apr 2022**
		High 15	Very High 20	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date
3829	**Sustainability of Model of General Practice** There is a risk that the Board will be unable to meets its duty to provide access to primary medical services in and out of hours for its population due to increasing population with multiple needs combined with difficulties in recruiting and retaining general practitioners, other staff and premises issues (e.g., leases or constraints on space), which will impact on patient care and experience and have a negative impact on other parts of the health and social care system. Executive Lead: Tracey Gillies	Healthcare Governance Committee • July 2020 – HCG continued to accept limited assurance. Acknowledged that risk needs to be re-evaluated. Deferred from January 2021 agenda. • Update paper went to HCG May 2021 - No assurance level of assurance proposed or agreed as paper setting out the current position. • May 2022 – HCG accepted moderate assurance. **Outcome of Executive Lead Discussions** **December 2021 Update** • **It is acknowledged that the strategic direction remains the same, through implementation of PCIPs as part of 2018 contract for general practice. Clarity is required regarding the role of the GP as expert medical generalist within a multi-disciplinary team which is to be nationally agreed. National and local work is ongoing to explore the 'right' model. Risk remains in relation to funding to fully implement, particularly in the context of population growth in Lothian** • **Although PCIPs are reported by each of the HSCPs as being 'on track', assurance cannot currently be given that PCIPs will deliver sustainable change to mitigate this risk.** • **A paper on role of Primary Care has been requested for the Planning, Performance and Development Committee in January 2022.** **February 2022 Update** • **It is acknowledged that there are specific aspects about the sustainability / model of general practice that need to be teased out. Although PCIPs are all on track and contribute to mitigation, further discussion is required to tease out some of the workforce and funding gaps.** • **Discussed at the Chief Officers meeting and a paper taken to CMT.** **April\May 2022 Update** • **Paper considered and accepted at CMT March 2022 following discussion with Chief officers. Key risk factors agreed as:** o **National workforce challenges across multiple professions contribute to recruitment and retention challenges in general practice and HSCPs** o **sufficient funding received by Scottish Government for the full ambition of the PCIPs**

Datix ID	Risk Title & Description	Committee Assurance Review Date		
		o **sufficient capital investment received by Scottish Government for general practice to ensure access for our growing population** • **Programme Board to be established to develop a Primary Care Programme Initial Agreement to address premises issues.** • **PCIP trackers continue to be 'on track'.** **Current general practice activity data shows return to pre-pandemic levels, although mode of consultation has shifted and will remain so. No practices have closed lists, although many are still operating 'restricted' lists** **One practice had handed back a contract in 21/22, which was successfully re-provided.** • **Based on this reviewed assessment of the risk, CMT agreed reduction in grading from very high (20) to 12 (High) (impact major, likelihood possible)** • **To be presented to HCG for assurance at meeting 24 May.**		
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**	**CMT March 2022**
		Very High 20	Very High 20	High 12
5185	**Access to Treatment** There is a significant risk that NHS Lothian will not achieve waiting time standards for 2021/22 and that waits further increase for inpatient, day case procedures, Out-patients, diagnostic and cancer patients which has been compounded by COVID 19 cancellations with demand exceeding capacity. This will lead to delay in diagnosis and potential progression of disease and hence poorer experience and outcomes for patients. New risk created from previous risks 3211 & 4191. Approved by June 2021 Board. Executive Lead: Jim Crombie	<u>Healthcare Governance Committee –</u> person-centred, safe and effective care<u>.</u> • November 2020 – HCG accepted moderate assurance on the Clinical prioritisation plan. • December 2020 – the Board accepted limited assurance that Remobilisation will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter. • January 2021 – HCG discussed recommendation of moderate assurance in relation to CAMHs, however deferred decision on assurance level with request to bring back further detail in 6 months. • March 2021 – HCG accepted moderate assurance that lung cancer patients are being managed appropriately, despite challenges of Covid-19. <u>Planning Performance & Development Committee</u> – Performance • October 2020 – Board accepted limited assurance that Remobilisation plans will mitigate growing volumes of long wait patients for scheduled care/ cancer services, against rising Covid infections & Winter. • September 2022 – paper is going to PPDC for assurance.		

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		Outcome of Executive Lead Discussions **December Update** • **Remobilisation 4 plans accepted by Scottish Government and approved by Board at December 21 meeting. No specific levels of assurance proposed or agreed** • **Plan in place, however, heavily compromised, and vulnerable** • **Gold command in place for continuous monitoring and action** • **Board requested specific reference to workforce issues and linkage to nursing workforce risk on CRR – now noted in risk.** **February 2022 Update** • **No further response from Scottish Government to remobilisation 4 plans - refresh due to be sent 18 Feb 2022** • **Risk and plans to mitigate to be presented to PPDC for assurance and agreement. Timing to be agreed** • **Plan in place, however, heavily compromised, and vulnerable. Gold command currently in place for continuous monitoring and action.** **April\May 2022 Update** • **A Scheduled Care Recovery Programme Options Appraisal was undertaken in April 2022 with Senior Management and Clinical colleagues. Once outcomes from the session are approved by the Scottish Government, Recovery Board remits will be reviewed and updated as required. Adoption of outcomes from the Options Appraisal may also require this risk to be updated, but impact cannot yet be stated or quantified.** • **Acute SMT monitors progress of plans routinely.** • **Acute services SMT have a robust process in place to review acute services high and very high risks which contribute to the mitigation of risks on the CRR.** • **PPDC agreed the risk as the principal assurance committee at the March meeting.** • **Assurance paper will be presented to the September meeting.**	
	Risk Grading:	**Jan-Mar 2021** Very High 20	**CMT/Board June 2021** Very High 20

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="2">5187</td><td rowspan="2">Access to Psychological Therapies

There is a risk that patients will wait longer than the national waiting times standards for Psychological Therapies which has been exacerbated by Covid 19 cancellations, impacting on patients/family experience and outcomes of care.

<u>New risk approved by June 2021 Board.</u>

Executive Lead: Calum Campbell</td><td colspan="2"><u>Healthcare Governance Committee –</u> person-centred, safe and effective care<u>.</u>

• New risk pertinent to HCG. Approved at June 2021 Board.
• Scheduled for review HCG in January 2023.

<u>Planning Performance & Development Committee</u> – Performance

• Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed.</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

<u>December 2021 Update</u>
• The current plans in place are impacting positively on performance and there is increased confidence that there will be further performance improvement as recruitment is being successful
• It is recommended to the CMT that we ask the Board to reduce the grading from very high to high based on improved performance and staffing.

<u>February 2022 Update</u>
• Currently not meeting planned trajectory due to delays in recruitment, the plan was based on staff being in post by October 2021, but recruitment took longer than expected and post holders started in December and January
• A proposal to SG for computerised CBT has been submitted and a response from the SG is expected by the end of February 2022.

<u>April\May 2022 Update</u>
• Signs of improvement and new processes are being embedded by current teams. Staffing however remains as challenge, due to an establishment gap and there are plans in place to reduce this gap.
• Referrals continued to be monitored with an increase in EL due to changes in the pathway, this is being reviewed.
• Computerised CBT proposal, discussed with SG and being considered for the next tranche of SG funding.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021
N/A</td><td>CMT/Board June 2021
Very High 20</td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date
5188	**Access to CAMHS** There is a risk that patients will wait longer than the national waiting times standards for CAMHS which has been exacerbated by Covid 19 cancellations, impacting on patients/family experience and outcomes of care. <u>New risk approved by June 2021 Board</u> Executive Lead: Calum Campbell	<u>Healthcare Governance Committee –</u> person-centred, safe and effective care<u>.</u> • CAMHS Medical Workforce paper went to March 22 HCG and moderate assurance accepted. Paper also planned to go to the Staff Governance committee. • New risk pertinent to HCG. Approved at June 2021 June. • July 2021 HCG accepted limited assurance with respect to plans in place to improve access, acknowledging significant work is taking place to rectify the current position. • An assurance paper was considered in February 2022 moderate assurance accepted with respect to clinical workforce plan and implementation as sustainable service provision. • Scheduled for review HCG in January 2023. <u>Planning Performance & Development Committee</u> – Performance • Considered at each Board through the Performance Report, no specific levels of assurance proposed or agreed.
		<u>Outcome of Executive Lead Discussions</u> **<u>December 2021 Update</u>** • **There are early signs of improvement, however the current plans to mitigate this risk are not fully implemented and successful recruitment is a rate limiter, as posts are going to advert but there are no applicants, which is a Scotland wide issue** • **The service is working with the Scottish Government to explore enhancing regional working to sustain regional services hosted by Lothian** • **Introduction and expansion of Helios is allowing us to mitigate some of the recruitment gaps.** **<u>February 2022 Update</u>** • **Current performance is ahead of trajectory; however, recruitment of specialist staff remains a risk, with contingency plans in place to manage this Scotland wide problem** • **The CAMHS LDP Standard Definitions and Scenarios document was updated in May 2019 to reinforce clarity for Boards on the scope of the standard. The standard applies where two conditions are met: (i) a child/young person has or is suspected to have a mental disorder or other condition that results in persistent**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		symptoms of psychological distress, and (ii) there is also the existence of at least either serious or persistent impairment to social functioning, or an associated risk that they child or young person may cause serious harm to self or others, or an associated significantly unfavourable social context • **From March 2022 Lothian will formally report the waits for those who meet the Scottish wide CAMHS specification which will bring us in line with other health Boards who have already made this change** • **Those who are currently waiting for neurodevelopmental assessment who do not otherwise meet the CAMHS specification will not be included in the figures from March 22 and will continue to be monitored locally.** **<u>April\May 2022 Update</u>** • **Performance continues to be ahead of trajectory. De-escalation discussed with SG, will be reviewed at the end of the summer and this will inform risk grading.** • **WTMS for the neurodevelopment pathway added to the key measures for this risk to demonstrate continued local monitoring.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		N/A	Very High 20
3828	**Nursing Workforce** There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and/or inability to recruit to specific posts. The subsequent high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience. Executive Lead: Nurse Director	<u>Staff Governance Committee</u> • July 2020 - Significant assurance that there is a robust mobilisation plan and mechanism to co-ordinate the responses across the nursing and midwifery workforce. Limited assurance that there is sufficient capacity in the event the pandemic requires that the Board delivers a full surge plan in acute and community, including supporting the NHS Louisa Jordan. • October 2020 – verbal update provided no new level of assurance agreed. • December 2020 – increase in grading to very high agreed. Significant assurances accepted that robust corporate oversight to co-ordinate and prioritise responses across workforce. Limited assurance regarding capacity to respond to increased demand due to Covid activity and increase in staff absence due to Covid isolation. • May 2021 – Staff Governance accepted grading reduced from Very High to High. • Paper went to Private Board August 2021 and agreed to increase grading from High to Very High. Follow up paper to go to September 2021 Board.	

Datix ID	Risk Title & Description	Committee Assurance Review Date		
		• December 2021 – Staff Governance accepted Moderate Assurance. • March 2022 – Staff Governance accepted Moderate Assurance.		
		<u>Outcome of Executive Lead Discussions</u> **<u>December 2021 Update</u>** • **Variation in vacancy gap continues across Health and Social care.** • **International Recruitment continues with staff in post by March 22** • **Recruiting to B2 and 3 in line with SG requirements are taking place and there has been a good response to adverts** • **Registered nurse shortages are a national issue and national discussions taking place** • **Paper to go to the next Staff Governance Committee in 2022** • **Continue to support the opening of beds at Liberton with support from Acute and the other HSCP.** **<u>February 2022 Update</u>** • **Moderate assurance accepted at the March Staff Governance Committee** • **Escalation framework in place and agreed responses** • **Agreement to systematically use across NHS Lothian the Safe Care Tool, to provide daily information on staffing, to inform planning and deployment of staff.** **<u>April\May 2022 Update</u>** • **There are plans to mitigate this risk and the March Staff Governance accepted moderate assurance with respect to these plans. There are a range of actions being progressed including:** ➢ **Development frameworks for non-registered members of staff who wish to progress into nursing roles, in partnership with educational institutions including Modern Apprentice Scheme** ➢ **Increasing the number of student nurses, and the proportion of those who convert to qualified posts in Lothian** ➢ **Proactive recruitment of posts particularly in high-risk areas and review of skill mix opportunities across a range of professions at a ward level.** • **Reliable mechanisms for monitoring and escalating staff issues across the system supported by clear communication plans are in place, however it is acknowledged that increasing trend in staff retiring is a key aspect of this risk.**		
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**	**CMT/Board Aug 2021**
		Very High 20	High 16	Very High 20

Datix ID	Risk Title & Description	Committee Assurance Review Date
5020	**Water Safety and Quality** There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety and provide assurance through documented evidence. This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water systems. New risk –approved by Board 12 August 2020. Executive Lead: Tracey Gillies	<u>Staff Governance Committee</u> • October 2020 – limited assurance accepted. • May 2021 - Limited assurance was agreed by the NHS Lothian H&S committee in. • March 2022 - Staff governance committee accepted limited assurance. **<u>Outcome of Executive Lead Discussions</u>** **<u>December 2021 Update</u>** • **Staff governance committee accepted Limited assurance on the control measures in place until an audit of documents can be undertaken** • **Moderate assurance accepted on the oversight mechanisms of the risk** • **Water safety plans are now complete for all NHS Lothian sites** • **Key areas of risk remain on sites operated by NHS Lothian's PFI partners and other 3rd Parties which include GP surgeries. The majority have not yet submitted Water Safety Plans to be reviewed by NHS Lothian Estates and the reporting system for exceptions, maintenance failures and abnormal water quality testing is not yet robust. At the current time, these are requested and reviewed on a quarterly basis.** • **In addition, there is a risk of failure to complete the estates and facilities aspects of PPM and monitoring in NHS Lothian owned buildings** • **NHS Lothian water safety group is writing to Chairs of Local Water Safety Groups and local Health and Safety Committees to request a quarterly report with pre-specified information which will include any exception reporting, monitoring or water sampling results which are outside of agreed parameters (e.g., temperature monitoring, water sampling results), results of AE audits, any planned remedial works, duty structures and changes in personnel with responsibility for water.** **<u>February 2022 Update</u>** • **Asset register for NHS Lothian owned properties is now complete and up to date** • **Full programme in place for statutory and mandatory PPM is in place with exception of WGH which will be complete by end Feb 2022** • **AE audits were completed Oct/Nov 2021and remedial actions are captured on a risk register, actioned locally prioritised by risk level** • **Water sampling regime is in place, agreed with infection control colleagues and exceeds legislative guidance**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **Water safety plan have not been received from all third parties as yet; a tracking system is in place to monitor receipt.** • **An IMT initially convened in July 2021 to explore an increased incidence of *Acinetobacter baumanii* infections in patients cared for in Intensive Care Unit at St John's hospital was recalled in November 2021** • **The IMT concluded it was plausible that exposure to water within either the Wallace Burns Unit or ITU was the source of some patient infections. All internal & external stakeholders including ARHAI, and Scottish Government were fully appraised of progress with this investigation via established reporting mechanisms** • **Staff Governance committee accepted limited assurance at March meeting.** **<u>April\May 2022 Update</u>** • **All buildings are back in use now.** • **All owned buildings have been audited and maintenance / compliance is being tracked on the CAFM (Agility) system. This will allow for greater levels of assurance that all completed when it should be.** • **Domestic staff are running water for a minimum of 2 mins as part of cleaning method statement so preventing any little used outlets.** • **Access denied issues are logged on the daily activity sheet which is signed off by the Nurse in Charge. Current review of SOP to capture actions if missed 3 consecutive days.** • **Still chasing water safety plans/risk assessments for 3rd party sites. Also 3rd party sites do not have clear processes in place to address any L+ results.** • **Staff Governance committee 2 March 2022 accepted limited assurance.** • **Director of Estates and Facilities agreed management actions to progress key measures.** • **Grading remains High (12) (Major impact/likelihood possible) Issues remain with 3rd party compliance records.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 12	High 12
3189	**Facilities Fit for Purpose** There is a risk that NHS Lothian is unable to deliver an efficient healthcare service because of unsuitable accommodation and clinical	<u>Finance & Resources Committee</u> • June 2020 - Moderate assurance agreed • January 2021 – moderate assurance accepted further review July 2021.	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	environments leading to potential delays in patient care and threatening patient and staff safety. Executive Lead: Jim Crombie	**<u>Outcome of Executive Lead Discussions</u>** **<u>December 2021 Update</u>** • **On track to complete plan for Jan 2022 – will be presented to Estates & Facilities SMT in the first instance** • **Moderate assurance accepted by F&R in November** • **Final plan and update on risk will now be presented at F&R in April 2022 when work to survey estate has been completed** • **Current plans monitored and prioritisation reviewed every 2 months by LSIG** **<u>February 2022 Update</u>** • **Updates to the plan and risk assessments have been completed and will be presented to Estates & Facilities SMT in the first instance** • **Risk to be presented to F & R April 2022 when work to survey estate has been completed and plan agreed by estates SMT** • **Asset surveys completed and uploaded to EAMs. Capital Investment Plan currently being created now to address any areas where we are either not compliant or where the asset is coming to the end of its life. This is not yet complete** • **Current plans monitored and prioritisation reviewed every 2 months by LSIG** **<u>April\May 2022 Update</u>** • **3-year backlog maintenance plan is going to Lothian Capital Investment Group (LCIG) in May for approval.** • **All assets are now logged on 'Agility' system, which enables PPM work to be scheduled and completion recorded.** • **Duty structure is up to date with Director of Estates & facilities as designated person. Reporting structure to Infection control and H&S committees to provide assurance is currently being enhanced.** • **Remains high (12), however currently recommending potential to reduce the grading on the basis of control measures now in place.** • **Risk is being presented to F&R for assurance in May.**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 12	High 12

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">5189</td><td rowspan="2">RIE Facilities

There is a risk that facilities in the RIE are not fit for purpose because of a failure to carry out required Life cycle Works and maintenance of the estate including:
• Infrastructure (lifts, electrical systems, heating, ventilation, water, medical gases)
• Water quality and management of water systems (flushing, temperature control, periodic testing)
• Window safety and maintenance
• Wire Safety

Leading to interruption to services, potential harm to patients and staff and significant remedial costs.

<u>New risk approved by June 2021 Board</u>

Executive Lead: Jim Crombie</td><td colspan="2"><u>Finance & Resources Committee</u>

• New risk approved by Board June 2021.</td></tr>
<tr><td colspan="2">Outcome of Executive Lead Discussions

<u>December 2021 Update</u>
• The executive oversight group was re-established on 1 December. Consort have submitted draft plan for discussion & review by NHS Lothian
• DRP 2 proceedings have now been approved
• Commercial Strategy for contract approved by November F&R & Board on 1 December
• Residual risk remains and appropriate assurance not yet in place. Will be considered at executive oversight group then to take to formal CMT

<u>February 2022 Update</u>
• Executive oversight group now divided into two alternate meetings with the same membership: one commercial and one operational
• Further work is required and DRP 2 proceedings are now expected to be finalised in February 2022
• Plan to present risk update to F&R in April
• Residual risk remains and appropriate assurance not yet in place.
• Given emerging discussions on lifecycle works and handover, the Executive oversight group is seeking advice on grading given ‘unknowns’ and uncertainty.
• Finance director has written to consort asking for much more detail and granularity on the current lifecycle offer and the Boards position has been reiterated.
• The hand back provisions and their definitions are being led by the new programme director for PPP and lawyers.

<u>April\May 2022 Update</u>
• DRP 2 has now commenced. Hearing on 8th June with statements now complete.
• Life Cycle plan proposals have been submitted by Consort; however this has not been accepted by NHS Lothian due to a lack of robust detail. Communication continues and formal feedback has been issued to Consort.
• Risk assurance paper will be submitted to F&R for meeting on 31st May 2022.
• Risks grading remains High (15) due to high-risk operational issues identified and ongoing issues surrounding life cycle works plan.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021</td><td>CMT/Board June 2021</td></tr>
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Datix ID	Risk Title & Description	Committee Assurance Review Date	
		N/A	High 15
3455	**Violence & Aggression** (Reported at H&S Committee) There is a risk of violent and/or aggressive behaviour of individuals, in mental health, learning disability services, and emergency departments; resulting in harm to person and poor patient and staff experience plus potential prosecution by HSE. Executive Lead: Nurse Director	Staff Governance Committee • October 2020 – moderate assurance accepted on processes in place, limited assurance on implementation of required actions. • December 2020 – moderate assurance accepted on processes in place, limited assurance on implementation of required actions, specifically on the use and provision of personal alarms. • May 2021 – Staff Governance accepted Limited Assurance re progress of actions to mitigate this risk and Moderate Assurance in terms of current staff safety. • December 2021 – Staff Governance Committee accepted reduction in the level of assurance to Limited assurance based on the internal audit findings. • March 2022 – verbal update provided to Staff Governance.	
		Outcome of Executive Lead Discussions **December 2021 Update** • **The November 2021 A&RC accepted limited assurance, with respect to internal audit findings and asked for plan to come back to the February 2022 meeting.** • **Staffing requirements related to the plan are being considered and will be discussed pending the diagnostic work, which will be the foundation for the plan.** • **To ensure continuity of service non- recurrent monies have been used for succession planning within the current V&A team, as there are a number of retirals and/or individuals leaving in 2022.** **February 2022 Update** • **At Dec 21 Staff Governance Committee accepted reduction in the level of assurance to Limited assurance based on the internal audit findings** • **Identicom contract for REAS and Facilities secured** • **Moving the purple pack onto and electronic system** • **SLWG has been established to progress actions from the Internal Audit Report and project manager recruited to co- ordinate this work.** **April\May 2022 Update** • **March Staff Governance Committee reduced level of assurance from moderate to limited, based on the internal audit findings.**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **The March 22 Staff Governance received a verbal update in March 22 on this risk. A SLWG has been established with a range of workstreams aligned to the Internal Audit recommendations. The group has prioritised action plan and the work is due to complete by August 22 to ensure sustainable solutions are in place**.	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 15	High 15
3328	**Roadways/Traffic Management** There is a risk that the road traffic infrastructure on the 4 acute sites (RIE, St John's, WGH, REH) is inadequate, due to the volume of traffic as a result of increased demand for parking plus construction projects causing interruption to traffic flow. This impacts on access to services, increasing levels of staff abuse and the potential physical harm to staff, patients, and the public. Executive Lead: Jim Crombie	Staff Governance Committee • October 2020 – limited assurance accepted regarding safe traffic management at the acute sites. • December 2020 – limited assurance accepted regarding safe traffic management at acute, East and Midlothian sites. Moderate assurance accepted for REH and community sites. • June 2021 Board – Governance and Management remain the same as does grading and adequacy of controls • March 2022 -accepted following levels of assurance accepted: ▪ Moderate – Astley Ainslie hospital, East and Midlothian premises ▪ Limited – Little France site, REH, WGH, St John's	
		Outcome of Executive Lead Discussions **December 2021 Update** • **Running action plan in place with oversight of local plans** • **Staff Governance accepted limited assurance** • **Additional actions by site noted in paper to Staff Governance committee and will be included in site plans from January 2022.** **February 2022 Update** • **Local plans updated, most notably re-introduction of parking permits to the Little France site and enhancement to transport to/from park and ride** • **Reputational risk noted due to significant media interest in changes at the Little France site** • **Ongoing minor changes in REH and St Johns** • **Plans are being implemented but too early to assess impact**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **Staff governance committee accepted following levels of assurance at March meeting:** ➢ **Moderate - Astley Ainslie hospital, East and Midlothian premises** ➢ **Limited – Little France site, REH, WGH, St John's** **<u>April\May 2022 Update</u>** • **Car sharing has now been deployed at RIE and transport from park & ride to RIE extended to 31 Oct.** • **Interim arrangements in place at REH due to ongoing issues with vehicles causing an obstruction - awaiting formal council consideration of Traffic restriction order (likely to take around 9 months).** • **WGH continues to be challenged by the levels of construction works and the impact that has caused to roadways, pedestrian access and parking.** • **Plans are being implemented but too early to measure impact. All TMGs have met more than once in the last quarter to review current levels of mitigation and any adverse events that have occurred.** • **Sites have notably (post Covid) become busier further increasing the challenge of managing car parking expectations** • **Staff governance committee accepted following levels of assurance at March meeting:** ➢ **Moderate - AAH, East and Midlothian** ➢ **Limited – Little France site, REH, WGH, SJH (which includes Whitburn Health Centre)** • **Committee agreed that where actions identified required resourcing, these were to be progressed**	
	Risk Grading:	**Jan-Mar 2021**	**CMT/Board June 2021**
		High 12	High 12
1076	**Healthcare Associated Infection** There is a risk of patients developing an infection as a consequence of receiving healthcare because of practice, equipment and environment where care is provided is inadequate or has inconsistent implementation and monitoring of HAI prevention	<u>Healthcare Governance Committee</u> • January 2021 - Moderate assurance accepted. Standing item on HCG agenda. • March 2021 – moderate assurance accepted overall, limited on ventilation systems in RIE theatres. • May 2021 – HCG accepted Moderate Assurance against plans in place to deliver the standards.	

Datix ID	Risk Title & Description	Committee Assurance Review Date
	and control measures and the threat of emerging and novel pathogens including Covid-19 leading to potential harm and poor experience for both staff and patients. Executive Lead: Tracey Gillies	• July 2021 and January 22 – HCG accepted Moderate Assurance against plans in place to deliver the standards. • August 2021 Board received the HAI annual report and metrics continued to be monitored through the Board performance report. • March 2022 – HCG accepted moderate assurance with respect to plans to mitigate this risk.
		<u>Outcome of Executive Lead Discussions</u> **<u>December 2021 Update</u>** • **IPCN staffing is a deteriorating position, as all the vacant posts were not filled, plus a number of existing staff are leaving to return to clinical duties, are retiring or on long term sick leave. The shortage of trained ICP nurses is a national issue and national conversations are taking place** • **Skill mix has been reviewed and the proposal for band 5 posts is being considered at Bronze Command** • **Unlikely we will meet the national HAI targets (March 22) but will be not far off, which is due to changes in remote prescribing and increase antibiotic use.** **<u>February 2022 Update</u>** • **ICPN capacity continues to be an issue, as not all vacant/new posts have been filled. Active recruitment continues with expectation that some, but not all posts will be filled** • **A new post, band 5 IPC Staff nurses has been created to try and address recruitment and is going to advert in February** • **Progress is being made in re-starting local self-assessment audits but remains dependent on reactive demand from incident management and COVID presentations** • **A work plan is being developed and aim to present at April PLICC** **<u>April\May 2022 Update</u>** • **Work plan remains under development – delayed due to ongoing COVID workload demand, incident management activity and staffing gaps. To be amended to reflect changes to loss of Care Home IPC remit and associated funding. Aim to agree workplan with the new Executive Nurse Director & HAI Executive lead once in post in June 2022.** • **IPC Audit remobilisation programme impacted by the same pressures noted above.**

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<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td></td><td></td><td colspan="2">Increased activity & input requested also now from IPCT in response to multiple capital planning projects (PAEP, RIDU, ECC, NTC) and Built Environment quality issues. Recruitment activity continues with varying success.
• Final end of year position to be confirmed (data validation) but LDP targets for CDI, SAB and ECB not met. Surgical site infection surveillance remains suspended by ARHAI.
• Assurance of moderate at accepted by HCG in March 2022. Annual Report will be submitted to July PLICC.
• Risk description and mitigation plan to be reviewed to ensure reflects residual risk
• Given current performance, grading remains the same – high (16).</td></tr>
<tr><td></td><td>Risk Grading:</td><td>Jan-Mar 2021
High 16</td><td>CMT/Board June 2021
High 16</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>5322</td><td>Cyber Security

<u>New risk approved by Board February 2022</u>

There is a risk of cyber-attacks on clinical and business critical systems within NHS Lothian and interdependent third-party digital systems because of an increase in new threats including malware and ransomware which bypass most traditional defence systems, resulting in critical systems being unavailable, causing significant disruption to patient care, privacy and wider services.

Executive Lead: Tracey Gillies</td><td colspan="2"><u>Finance and Performance Review Committee</u>

• Paper now planned to go to F&R May 2022 and a private Board May 2022.

<u>Outcome of Executive Lead Discussions</u>

<u>February 2022</u>
• The Board accepted the risk description at the meeting on 9 February 2022
• A paper offering assurance on the mitigation of the risk will be presented to F&R in April 2022
• The risk mitigation plan will also go to private Board once a year.

<u>April\May 2022</u>
• A number of systems and tools are in place which reduce the Cyber Attack risk at various levels across the organisation, as set out in the risk mitigation plan.
• A detailed Information Governance/IT security report is presented to every meeting of the Digital oversight board, which includes data on digital security metrics. This provides evidence that measures are performing as designed and are monitored on an ongoing basis.
• No change to grading - 12 (High)
• To be presented to F&R May meeting for assurance. Also, to be reported to private Board in May.</td></tr>
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Datix ID	Risk Title & Description	Committee Assurance Review Date
	Risk Grading:	**CMT/Board February 2022**
		High 12