NHS Lothian Board

24 June 2020, 10:15 to 12:30
MS TEAMS

Agenda

Declaration of Interests

1. Declaration of Interests — 5 minutes

Esther Roberton

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

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

Items for Approval or Noting

2. Items proposed for Approval or Noting without further discussion — 5 minutes

Decision

Esther Roberton

2.1. Minutes of Previous Board Meeting held on 13 May 2020

For Approval

Esther Roberton

13-05-20 Public Board Minutes.pdf (20 pages)

2.2. Finance & Resources Committee Minutes - 22 April 2020

For Approval

Martin Hill

FR 22-04-20 Signed Minutes.pdf (7 pages)

2.3. Healthcare Governance Committee Minutes - 14 January and 10 March 2020

For Approval

Moira Whyte

HGC 14-01-20 Signed Minutes.pdf (6 pages)

HGC 10-03-20 Minutes Signed.pdf (10 pages)

2.4. Staff Governance Committee Minutes - 19 February 2020

For Approval

Alison Mitchell

SGC 19-02-2020 Minutes Signed.pdf (10 pages)

2.5. **Audit and Risk Committee Minutes - 24 February 2020**

For Approval

Mike Ash

ARC 24-02-20 Signed minutes.pdf (9 pages)

2.6. **East Lothian Integration Joint Board Minutes - 26 March 2020**

For Noting

Fiona O'Donnell

EL IJB Minutes 26-03-20.pdf (6 pages)

2.7. **Edinburgh Integration Joint Board Minutes - 14 April 2020**

For Noting

Angus McCann

Edinburgh IJB Minutes 14-04-20.pdf (2 pages)

Items for Discussion

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

10 minutes
Esther Roberton

4. **NHS Lothian COVID19 Response**

40 minutes

4.1. **COVID-19 Public Heath Update**

Alison McCallum

COVID-19 PUBLIC HEALTH UPDATE.pdf (8 pages)

4.2. **Test and Protect Programme**

Colin Briggs

TaP June 2020.pdf (2 pages)

4.3. **Enhanced Professional Oversight of Care Homes**

Alex McMahon

2020 06 Board Care Homes Paper.pdf (14 pages)

5. **Remobilisation Plan**

15 minutes

Appendices available separately due to size – within the meeting documents folder on Admincontrol for Board Members and on the Board Papers webpage for members of the public

Jim Crombie

Public Board Paper_Remobilisation_June20_Final (003).pdf (3 pages)

6. **Scheduled and Unscheduled Care Performance**

10 minutes
Jacquie Campbell

Board Paper_Scheduled Unscheduled Care_Jun 2020_Final_Submitted.pdf (13 pages)

7. **RHCYP, DCN & CAMHS Project Update**

15 minutes
Verbal

Susan Goldsmith

8. **Corporate Risk Register**

10 minutes
Tracey Gillies

Board Corporate Risk Register Report 24 June 2020 - Final.pdf (48 pages)

9. **Financial Update at April 2020**

10 minutes
Susan Goldsmith

Board Meeting Finance Paper 24 June 2020 - (3 pages)

Final.pdf

10. Future Board Meetings

- 12 August 2020
- 02 September 2020
- 14 October 2020
- 04 November 2020
- 09 December 2020

11. Any Other Business

Verbal

Esther Roberton

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

Decision

Esther Roberton

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 13 May 2020 using Microsoft Teams.

Present:

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

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

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

Also Attending: Dr R Devine (Specialist Registrar in Public Health – shadowing Professor McCallum); Ms M Gray (NHS Lothian Project Manager, Edinburgh Health and Social Care Partnership – for item 3) and Ms W MacMillan (Business Manager, Executive Office)

An apology for absence was received from Professor M Whyte.

Declaration of Financial and Non-Financial Interest

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.

13. Chair's Introductory Comments

13.1 The Chair made the following introductory comments:

13.2 DCN Outpatient Appointments – The Chair advised that the first outpatient appointment at the new DCN facility would happen this morning. She put on record her thanks to all of the people that had made the move happen so smoothly. It was reported that there was a real enthusiasm amongst the staff who had made the initial move.

13.3 Malcolm Wright Retiral – The Chair reported that Mr. Wright had retired from his post as Director General and Chief Executive of the NHS in Scotland because of ill health. The Chair on behalf of the Board extended good wishes to Mr. Wright and commented that it was sad to see him depart under such circumstances. In the interim, Mr. John Connaghan had been appointed as Interim Chief Executive of the NHS in Scotland with Ms Elinor Mitchell having been appointed as the Interim Director General.

13.4 Ministerial Meetings - The Chair reported that a joint meeting had been held with colleagues from the West. The Minister for Public Health had on behalf of himself and others at the Scottish Government expressed thanks to NHS Lothian and other Boards for the way in which they had managed the current Covid-19 position.

13.5 Board Member Appointments/Extensions – The Board was advised that the paperwork for extensions and appointments of Board Members had been completed with feedback awaited from the Scottish Government. It was noted that Mr. Tom Waterson had been elected as the Employee Director designate and would take up appointment when Mr. Joyce retired later in the year. Mr Waterson would shadow Mr. Joyce at a future meeting.

13.6 Media Coverage – The Board noted the positive coverage of Lothian stories in both the BBC and STV the previous day. A link to these stories had been sent to Board Members and would be reissued.

13.7 Welcome and Introduction – The Chair welcomed Dr Devine and Ms Gray to the Meeting.

13.8 MS Teams Protocol – Board Members were reminded of the protocol to be used for MS Teams.

14. Items for Approval

14.1 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as the 'consent agenda'. The Chair reminded members they had had the opportunity to advise in advance if they wished matters to be moved out of this section. The Chair advised that Dr. Williams had requested that the item at 2.3 "Initial Agreement – South East Outer GP Provision" be subject to discussion. This was agreed and the following debate occurred:

14.2 Initial Agreement – South East Outer GP Provision - Dr. Williams advised that after having read the paper he wondered whether as issues progressed the Board should have a view on how the proposals fitted with its strategic aims in terms of providing care at home, nearer to home and in the community or whether this should be delegated to the partnership. The Chief Executive advised that this question went to the heart of the relationship with Integration Joint Boards (IJBs) in respect of their strategic planning and commissioning role and the Health Board. Technically, according to the legislation the IJBs set the strategic direction for the configuration and the delivery of Primary

Care and it was the Health Boards role to act in support in terms of the issues that it retained organisational responsibility for like IT and premises and contracts. A recent policy shift had passed responsibility for property to the NHS Board. The Chief Executive advised that when it was planned to deliver new facilities like those detailed in the paper and where the existing GPs owned often heavily mortgaged properties this represented a hurdle in moving into new facilities that might be more strategically located. The Chief Executive felt that this was an issue that between the Health Board and the IJBs needed to be sensibly managed. He felt that positive work was underway with the IJBs to bring life to their strategic objectives whilst being sensitive to the practical realities of owned premises that are no longer fit for purpose.

14.3 Dr. Williams commented that this was the position that he had assumed although it was not clear from the paper. He was unsure whether the Board were being asked to approve or note the paper. Dr. Williams advised he was content with the update provided.

14.4 The Chair commented that it was important to recognise that the Board needed to work closely with partners to manage the issue of fulfilling its strategic aims whilst recognising the challenges faced by independent contractors. Ms. Gray confirmed that she and her colleagues were working closely with NHS Lothian and Local Authority colleagues to deliver these aims on a collective basis.

14.5 Mr. Murray commented that there was a lack of public awareness of the points that had been raised particularly in terms of GPs being independent contractors and the role of IJBs. The Chair echoed these comments advising that there was a lack of knowledge in part that GP practices were independent contractors and could not be moved around by the Health Board as demand changed.

14.6 It was agreed that at all times the Health Board would work collaboratively with the IJBs to do the best to provide strategic primary care services whilst acknowledging the challenges that these practices often faced as contractors.

14.7 The remainder of the items for approval were approved as follows:

14.8 Minutes of the Previous Meeting held on 8 April 2020 – Approved.

14.9 Appointment of Members to Committees – The Board agreed to extend Mr Ash's appointment as a member of the Audit and Risk Committee to 31 August 2020 and to extend his appointment as the Chair to 31 July 2020 and defer Mr Connor's appointment as Chair to 1 August 2020. The Board also agreed to appoint Mr. McCann as the deputy for the Vice - Chair of Midlothian Integration Joint Board during its emergency recess period.

14.10 Initial Agreement – Re-Provision of the Hospital Sterilisation and Decontamination Unit – Approved.

14.11 Finance and Resources Committee Minutes – 25 March 2020 – Approved.

14.12 East Lothian IJB Minutes 27 February 2020 – Approved.

Items for Discussion

15. Opportunities for committee chairs or IJB leads to highlight material issues for awareness

15.1 Mr Ash advised that the Audit and Risk Committee had postponed consideration of the final audit report on the RHCYP/DCN project although he was confident that this could be discussed at the June meeting. He commented that the main reason for the delay was to provide external bodies with an opportunity to comment on the factual accuracy of the report. A verbal update would be provided to the June Board following the Audit and Risk Committee meeting on 22 June 2020. A substantive update would thereafter be provided to the August Board.

16. Public Health Briefing on Covid – 19

16.1 Professor McCallum advised that it gave her no pleasure to provide this report given the nature of the pandemic that had globally affected over 4 million people and resulted in 200,000 deaths. The report had drawn on national and local management data that although not the most sophisticated was felt to be transparent. The figures represented the position at a point in time and no disrespect was meant to those that had fallen ill or lost a loved one since the figures had been collated. There was a need to be transparent given comments about the scientific advice not being available in a timely fashion. The Board were advised that the Scottish data was based on data from Public Health Scotland and from National Records for Scotland.

16.2 The Board was advised that the paper painted a serious picture and that progress remained fragile. Professor McCallum advised that future papers would start to think about the impact of Covid-19 on the health of the population in more general terms and not just in terms of those who had contracted the disease.

16.3 Professor McCallum advised that information about hospital deaths was received quicker than for deaths in the community and there would therefore always be a lag in management data. Work was underway with Health and Social Care Partnerships and the Care Inspectorate to reduce the delay in the receipt of data.

16.4 Mr McCann raised a wider question in relation to testing and thinking ahead to the Test Trace Isolate Strategy (TTIS) He advised that the Chief Medical Officer (CMO) had reported that the tests being used in Scotland were 100% specific and 91% sensitive. There had also been intelligence that false negatives were running at around 30%. He sought advice on how accurate the testing was Professor McCallum advised there was a difference between the performance of the tests in the laboratory and at the point where a person

was approached for a test and the quality of the sample that went into the testing system. The issue about the 30% false negative rate increasingly related to human variation in the quality of the sample taken and variation in the human anatomy. Professor McCallum advised that although Covid-19 had caused havoc in the country it was still a low prevalence condition except in clusters. There was still caution about sensitivity and specificity.

16.5 Professor McCallum advised there was still a lot of tests undertaken under the auspices of the UK Government where positive results were not being reported back to Directors of Public Health in order to take Public Health action. It was noted that this related to the testing being done at the four Airport sites and this had been raised formally. Mr McCann questioned what proportion of the tests information was not being received back on and whether this was a minority. Professor McCallum advised this was a minority although the importance of key workers in other agencies to the spread of the infection in the community was one of the issues causing concern and local solutions would be developed through TTIS if National solutions were slow to come forward.

16.6 Mr McQueen commented on the dissemination rate and whether in the past few weeks testing more frequent testing in Care Homes had resulted in higher positive results relative to the general population. He questioned whether this skewed or distorted the measure of R data in section 6 of the report and whether a more precise number could be reported. Professor McCallum advised that more testing would provide a more complete picture of the estimated dissemination ratio although it could be argued that both Care Home residents and staff were being tested and that those staff existed and lived in the community and it was important to remember this. Professor McCallum advised that rather than causing distortion the approach provided a picture of particular parts of the community that would otherwise not be available.

16.7 Mr McQueen referred to the paper and the recommendation in respect of medical practitioners certifying death advising he was not clear what the Board was being asked to agree. Professor McCallum advised this was included in the paper as there was a Medical Death Review service in Scotland that had to work differently as part of its arrangements around Covid. The recommendation had been included to ensure that the Board was supporting the introduction of these new measures and was therefore a technical recommendation. The Chair commented it was not for the Board to approve as it was a nationally agreed position.

16.8 Miss Gillies advised that it was important to be aware that the cause of death certified by the doctor was to the best knowledge of the doctor and therefore did not reflect a forensic level of accuracy.

16.9 Ms Hirst advised she had contacted Professor McCallum about the incidence of infection and death rates across Lothian. She commented in respect of Care Homes and the lack of knowledge about prevailing medical conditions that this was a concern. She had raised at the Healthcare Governance

Committee the previous day the need for more clarity particularly in relation to Public Health about the responsibility of NHS Lothian Board Members and also for those sitting on IJBs in respect of the work of IJBs and HSCPs. The Chair advised this was an important point that would be picked up.

16.10 Professor McCallum and Miss Gillies responded to a point raised by Ms Kasper in terms of the time it took between a test being taken and results being received and the method of communicating this information back to patients. It was noted that the reporting routes were different for staff and patients and the differences were explained. The Chair advised there was also a difference in time in respect of national testing and those undertaken locally. Professor McCallum advised straightforward tests would come back quickly. However, because of timing issues some would take 48 – 72 hours. She was not aware of tests being undertaken locally taking 8 days for results to be reported with the norm being 48 hours unless they needed repeated.

16.11 The Chief Executive commented in respect of responsibility for Public Health that in terms of a national emergency there was a need to be pragmatic and be as clear as possible. The responsibility was principally for the Health Board and the operational delivery arm of the respective Local Authority. The Chair commented that Ms Hirst's point had been about Public Health more generally other than within the pandemic context and this could be the subject of a development session. The Chief Executive commented it was important to be clear that the Health Board was responsible for Public Health and Professor McCallum as Director of Public Health had a role in working closely with the Councils. The Chair stressed that the primary responsibility of the Board was for Public Health and the health of the population. The Board would return once the current crisis had passed to this issue.

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

17. Covid-19 – Operational Update

17.1 Mr Crombie advised that the paper followed the same format as the one presented to the April Board and built on that, and linked to the daily Speed Read and the Informal Non Executive Board Member briefings. He referenced the announcements made by the Prime Minister. He commented that NHS Scotland's position remained "Stay Home, Protect the NHS and Save Life's" and this was an important message. The Chair commented that it was helpful that the three devolved administrations were holding the same harder line.

17.2 Mr Crombie referred to the deferral of routine appointments for inpatients, day cases and in some cases diagnostic appointments. Technology was being used to offer some level of access although the impact and implications were significant. He reported that certain elements of the service had seen a plateauing of activity. Data from the previous day reported that there were 88 Covid patients in acute beds and 6 in critical care beds. The system had seen a recalibration starting to occur in the acute sector.

17.3 Mr Crombie highlighted the Care Home position that had been subject to much press coverage and discussion. There were now 55 Care Homes with around 272 deaths. He advised that previously there had been a significant drop in front door attendance with the position now having moved back to around 2/3 activity. The 4 Hour Emergency Access standard performance was noted at 95.4% compared to an April 2019 position of 87.3%. Mr Crombie commented on the clinical concerns that people were hesitating to access health care and the impact and implications of this was likely to be seen moving forward. In terms of A&E attendance and the age range of attendance it was reported at the Royal Infirmary of Edinburgh (RIE) in March 74% of those attending had been over 60. In April, 95% of those attending had been over 60 with this shift being seen in all of the adult sites.

17.4 The Board received an update on key actions. Mr Crombie updated on the significant success in recruitment in bringing additional staff into the system. He emphasised the focus on supporting staff through this difficult time. Moving forward Test Trace and Support would become central to the process with the phasing of this being described. Mr Crombie advised that shielding was an important part of Scotland's response to Covid. The number of people requiring shielding would continue for a period. A Shielding Clinical Advisory Function had been established with A&E colleagues and other clinicians being central to the process to support forward assistance to this group of patients.

17.5 Mr Crombie commented on the ongoing Public Health work and commented on the pre vaccine phase where the system would essentially start to reintroduce elements of scheduled care on a clinically prioritised basis. There would be a need to look at how to provide this level of service safely while the system continued to live with Covid in the hospital environment. Mr Crombie advised in respect of patients waiting more than 12 weeks when system recovery was being planned it would be important to recognise that what had effectively been the elective capacity would be significantly diminished because of the need to create red zones and Covid capacity. The new normal for Scheduled and Unscheduled Care would be significantly different.

17.6 Mr Crombie in response to a question from the Chair advised that rapid recruitment referred to clinical and facilities staff. The Chair commented that it was good to note that staff donations were being passed onto food banks and this demonstrated that even in these difficult times staff were thinking of others.

17.7 Mr Murray referred to the forthcoming recovery and renew paper in terms of the unprecedented change particularly in outpatients in respect of how patients would be managed. He questioned why the system was not increasing rapidly the number of outpatient appointments using new criteria and technology. He did not see any evidence that the system was giving the public confidence in respect of fears around issues like cancer diagnosis. Mr Murray advised he was worried that a way forward was not being articulated to the public. Mrs Campbell advised in relation to outpatients that there were a number of things happening in respect of alternatives already in place for outpatient consultations. She reported that between March and May the

system saw 4500 new outpatients by telephone consultation and just over 3100 return patients in the same way. “Near Me” was being deployed across the acute sector with this having risen from 250 “Near Me” consultations per week to a current position of more than 750. It was reported that many clinicians had found that telephone consultation worked as well or better as “Near Me” in some situations. Mrs Campbell and Miss Gillies advised of the differences between “Near Me“ and “Attend Anywhere”. Mr Murray commented that at the appropriate time this information should be communicated to the public. The Chair commented that there would be benefit in having a national approach to this, as it would sit well with the messages from Professor Leitch and others at the Scottish Government around the fact that the NHS was still open. Mrs Campbell advised an important part of the national message was that the NHS was still open but working differently. She reported that GP practices had been contacted and advised of the changes including the fact that referral might not result in a face-to-face consultation.

17.8 Mrs Mackay commented in terms of communications and the points raised by Mr Murray that the focus was now on what services are running and how services were opening up. There had not been any national guidance on this to date. Mrs Mackay would feed into her networks and suggest to Professor Leitch and colleagues that the approach discussed needed to be picked up in national messages.

17.9 The Vice Chair advised that he was struck by the statistics about the distortions in the impact on poorer communities and in socio-economic groupings. He commented he was not sure what actions were being taken to discriminate positively in ways that reflected the additional vulnerability of those in the poorer parts of the population and the black and ethnic minority populations. Mr Crombie advised that this was an important point and that part of the paper characterised some of the data that was being collected and analysed. Professor McCallum advised that locally the numbers were small with there being no obvious pattern about the impact of Covid across socio economic groups. A piece of work in terms of Integrated Impact Assessment was being undertaken both locally and nationally. Parallel work was being carried out with clinicians about an ethical decision making framework both locally and nationally. It was anticipated that the Clinical Advisory Group for Shielding would help to bring forward principles that could be applied to other vulnerable populations. The Vice Chair commented that there was an issue about ensuring that the national discussion and data gathering found its way into practical action on the ground in terms of populations. He was seeking assurance that the response that NHS Lothian genuinely reflected the additional needs of certain parts of the population including the availability of technology.

17.10 Mr McCann commented that the paper reported the success in recruiting and bringing on additional staff and he was interested how the system would deal with issues like their employment status and continuing education. He further questioned the position in respect of contact tracing and whether it was anticipated that this group of staff would come from an NHS background. The

Chair suggested that there were important issues in respect of recently recruited staff and this should be referred by Mr Crombie to the Staff Governance Committee for further consideration. Mr Crombie advised that this represented a strategic and operational policy in rapid deployment and the elegance around the process might not have been clear, as it should have been. Mrs Butler advised in terms of students there had been on-going communications with the higher education institutions. There was also clear national guidance setting out the employment arrangements. There was a number of staff who were returners to the service either through fixed term contracts or bank work.

17.11 Mr Crombie advised in terms of Test, Trace and Isolate capacity that this was now a significant focussed area of work with Mr Briggs having been central to this on a national basis. Mr Briggs advised that the position around TTIS was iterative. The Scottish Government had appointed a former Chief Executive to take oversight of the whole programme. The approach was to develop the national strategy first and this was now in place. It was reported that 1968 Contact Tracers were to be employed to work on a Call Centre basis. The national approach was to try to use staff that were shielded or who were otherwise not in their normal jobs. It was not clear when the nationally co-ordinated model would be up and running. Mr Briggs was Chairing a Group with the Directors of Public Health to get co-ordination across the whole service. It was anticipated that during July there would be a transition to a call centre with an App to provide additional support. Locally 150 people were being asked to contribute to the Contact Tracing process. The cost of the process was also being worked through.

17.12 The Chair advised that Mrs Mitchell had asked whether NHS Lothian had sufficient capacity to meet the target at the end of May. Mr Briggs advised that the approach was to be able to contact trace for closed settings and for staff by the end of May and this would represent a significant number of people. The Chair noted that this was a moving situation. Ms Hirst left the meeting.

17.13 Councillor O'Donnell commented in respect of tracing and tracking that Public Health Scotland were meeting with Councils in respect of redeploying staff into tracing roles. She felt it was important as staff moved back into their substantive roles that there should not be too much of an expectation on Councils. She referenced a Circular that had issued in respect of the redeployment of staff in community settings including Care Homes. She questioned what the plan was to deploy staff into these settings in order to keep people safe. Mr Crombie advised that there had been an interesting debate recently as the position in Nursing Homes had evolved. Staff testing meant there was potential for a significant number of staff to be taken out of the workforce. It was noted that Professor McMahon and others had been looking at this to create staffing to support this position.

17.14 Professor McMahon advised this picked up on the earlier point made by Ms Hirst in respect of NHS Lothian's responsibility in terms of Care Homes in particular given that they were almost entirely independent businesses. Teams had now been established in each HSCP to reach into Care Homes. A

pool of staff would be identified from the NHS Lothian staff bank who would be prepared to work in Care Homes or HBCCC settings to provide additionality. Initially the ask from Care Homes had been around infection and prevention control, training and advice and PPE. Staffing had now emerged as an issue in some but not all Care Homes. A workforce capable of being flexible enough to be deployed at short notice had been created. NHS Lothian was currently picking up the cost for that although moving forward there would be a need for some other arrangement to be put in place. It was noted that there was potentially a significant number of beds that would need to be supported in Nursing Homes, Care Homes and Residential Homes. Moving forward there was an intention for Student Nurses to have more Care Home experience as part of their three-year programme.

17.15 Councillor Gordon reported that he had been asked a number of questions about what was happening with Home Care Services where provision was provided by private providers and in house staff. He advised he was seeking information on issues like the levels of absence and whether Covid cases had been discovered by the service. Professor McMahon suggested this would be an issue that the 4 Chief Officers would need to pick up. He advised that no particular issues had been flagged at the twice-weekly meetings attended by the Chief Officers as part of the Gold Command process. Mr Crombie advised that the City of Edinburgh IJB had spoken positively about their capability and capacity to maintain and sustain Care Homes.

17.16 The Chair commented that she was pleased to see that the position had stabilised although it was important to recognise the system was still not out of the woods.

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

18. Scheduled and Unscheduled Care Performance

18.1 Mrs Campbell advised that the performance paper reflected the requirement to report to the Board on Treatment Time Guarantee (TTG) performance. The circulated paper provided the end of March 2020 position against last year's Annual Operating Plan (AOP). It was noted from an outpatient perspective NHS Lothian did not meet trajectory and had just over 20,800 patients waiting longer than 12 weeks for a new out-patient appointment against a trajectory of 18500. It was noted that prior to the high level of cancellations in the last two weeks of due to Covid-19 performance was on track to deliver the agreed trajectory. In terms of TTG 3,404 patients were waiting longer than 12 weeks for their treatment against a trajectory of 3100. The end of March trajectory was not met due to Covid-19 related cancellations in last two weeks of March. Mrs Campbell compared this performance with current position, advising that the number of new out patients waiting more than 12 weeks was 30,500, and 6,500 patients waiting more than 12 weeks for treatment (TTG) this position is directly related to the high volume of cancellations due to the Covid-19 pandemic.

18.2 The Board was advised that the focus of services had been on managing urgent suspicion of cancer and urgent patients. The end of March performance for 31 days was better than trajectory at 96.2%. The position in respect of 62 days although worse than trajectory had demonstrated an improving position at 83%.

18.3 The Board received an update on the actions being taken to mitigate the impact of Covid-19. There had been a focus on urgent suspicion of cancer and using technology when it was clinically appropriate to do so. The number of face-to-face attendances had been reduced and where necessary this was managed within the confines of social distancing. In terms of the high volume and long waits associated with outpatients, a process had been instigated where either an administrative or a senior clinical triage would be undertaken. This would allow patients to either be given advice only, be triaged to telephone, "Near Me" consultation or if need be upgraded to an urgent pathway. The process was about managing risk for high volume, high risk patients.

18.4 Mrs Campbell advised in terms of TTG that the focus continued to be around urgent patients and cancer patients. The implications of managing that volume of patients was closely linked to the Critical Care expansion plan and the staffing required to support Critical Care. The Board was advised that use had been made of the local independent sector for cancer work, colorectal, urology and breast patients. To date 60 such procedures had been carried out to help manage those high-risk patients.

18.5 The Board noted that another key area of focus was diagnostics that supported Unscheduled Care, Primary Care and Scheduled Care. A space stratification was being worked through to identify how many patients could attend in an hour and the implications of waiting space again with an absolute focus on urgent patients and urgent suspicion of cancer. Opportunities were also being taken to manage the infrastructure for diagnostics across a 7-day process and evenings to try to maximise the use of capacity.

18.6 Mr Murray questioned whether any opportunity has been taken to get a patient perspective on the new arrangements. He also commented on how the system could ever go back to the previous delayed discharge position when it had been possible to manage a positive change in the situation. In terms of Child and Adolescent Mental Health Services, he asked whether the system was employing the same level of technology-based opportunity. Mr Murray further questioned whether there was any indication that the Scottish Government would suspend TTG targets. The Chair advised that the suspension of targets would require a legislative change and any such change if progressed would take time. She commented however that attainment of the TTG would be an issue across the whole system and not just for NHS Lothian.

18.7 Mr McCann noted that attendance at ED was creeping up with the next paper suggesting that previously ED attendance had dropped by 50 -60 % and that

the reduction was mainly due to a reduction in minor injuries , sporting injuries as well as attendance by tourists. He questioned the reasons for the upturn in attendances.

18.8 Mrs Campbell advised in terms of patient feedback that this was not available now and given its importance, it would be developed through the Quality process. The “Near Me” national platform did collate patient feedback. She would ensure feedback was included as part of forward reporting.

18.9 In terms of delayed discharges a presentation had been given to the Corporate Management Team earlier in the week about building on and enhancing the “Home First” principles across all staff groups and the four partnerships. This would be a key area of culture change. One of the actions would be about purchasing additional capacity and this would need to be looked at moving forward. Mr Crombie advised that the ability of the system to reduce delayed discharges significantly contributed to the ability to manage Covid. It therefore had to be a key foundation action going forward. In terms of “Home First “ it was suggested by Mr Crombie that there was an opportunity for Non Executive Board Members who also sat on an IJB to ensure there was a focus of the systems on this issue. The Chair advised a key issue was the need to do the right thing for people who had been stuck in hospital.

18.10 Professor McMahon in respect of CAMHS and the use of technology reported that a lot of work had already been undertaken. CAHMS had led the way in Mental Health in the use of “Near Me”. On 14 April there had been 14 uptakes and on 9 May that had risen to 535 sessions. In the same period, the team had gone paper light. A digital Mental Health Strategy was also being developed. Professor McMahon advised he saw great opportunities with technology and computer based solutions not just in CAMHS but within the wider environment. The Chair advised through “Near Me” feedback there was some evidence that there were benefits to adopting this approach rather than a face to face consultation but for others it was the opposite and there was a need to be mindful of that. There was a need to ensure that patients had the necessary technology to take benefit of new ways of working.

18.11 Mrs Campbell advised in respect of the reduction in ED attendances and the reasons for subsequent increases in attendance that one of the significant reasons for the reduction had been around the Stay Home message and patients choice about not attending hospital. Activity had increased to about 2/3 of previous attendances with a differential being evident in the types of people presenting. At St John’s, the increase in attendances had been in the “minors” whereas at the RIE it was more in the “majors” category. The RIE were now back up to nearly normal admitting rates.

18.12 The Board was advised that a “Call MIA” platform was being used for minor injuries and was being well received and used. Early discussions were underway around minor ailments and in particular, with East Lothian where they were considering whether this could be managed locally rather than attending through the RIE. The Chair noted Ms Hirst had comments about

difficulties people had found in finding MIA on the website. There would be benefit in putting this on the front page of the website to make it easier to find.

18.13 Ms Kasper advised that her question related to increased referrals and additional outpatients as well as the reduction of referrals into the acute sector and the reasons for this stark reduction. Mrs Campbell felt that there were similarities with the "Stay Home "message and that patients were not attending their GPs in the previous volumes and this impacted on referrals. In terms of an outpatient routine perspective there had been an original misunderstanding where some GP practices had been holding onto their routine referrals and not sending them through. Miss Gillies advised that the system had not been in a stable position and it was therefore impossible to draw inferences from the numbers. The position was probably reflecting short-term changes in behaviour in line with the lock down guidance. Ms Kasper questioned whether the use of "Near Me" and telephone consultations were having an impact and whether that would be part of the lessons learned going forward. The Chair commented although it might be too early to tell that this would be an important issue moving forward.

18.14 Dr Donald noted that work was underway with GPs looking at new referral guidelines and a whole system approach. She sought further information on how new ways of working were being explored as this might influence the style of referrals and the type of information included as well as the information that patients were given for their future expectations. Mrs Campbell advised that there were GP RefHelp Advisors embedded in the service and this had been expanded just in advance of the Covid pandemic. There was an opportunity to look at the RefHelp guidance and update it to reflect current circumstances. The context of the referral into secondary care could also be looked at to reflect that the same number of patients would not be seen in future on a face to face basis. Miss Gillies advised that there would be a need to develop additional pathways for shielded patients so that they were not disadvantaged. The Chair commented that the increased profile for NHS 24 has generated a huge additional demand on the NHS Inform website with a lot of that being about self-help guides and redirection. If the opportunity presented to evaluate this, it would be interesting to see the impact and whether it would be sustained.

18.15 Mrs Mitchell questioned what evaluation structure was being put in place to test all of these new initiatives. She advised she wanted to understand how to get assurance that these new ways of working were not negatively impacting on patient outcomes. She commented on the need to understand the combined tools being used to get a holistic picture. The Chair commented this was important as the public might be happy to use these tools in the current situation and there was need to know whether that was something they would use in the longer term.

18.16 Miss Gillies advised there was a difference between the evaluation of experience that could be done in the shorter term and the evaluation of outcomes that would take a longer time. She commented she was keen to have an adequate Clinical Governance framework around this as there might

be some issues that were more difficult to pick up in a digital type consultation. There was a need to provide adequate alternatives and consider what kind of adverse events or complaints that might emerge. It was also important to keep an eye to the rest of the world where people for reasons of geography had been using technology for longer. This would be particularly important in respect of identifying when not to deploy this approach and the type of consultation it was not suitable for. There was risk of introducing non-intended anxiety signals into the system.

18.17 The Chair commented that there was expertise in house to do the evaluation framework but questioned whether there was the resource to do the actual evaluation. The possibility of engaging with Universities as well as identifying whether something was being commissioned nationally was discussed. Miss Gillies advised this would be an important issue to raise through the recovery and renewal process. There was an ability through the Data Loch and other sources to do work in house in respect of patients that had for instance been seen on multiple occasions.

18.18 The Chair commented that were some important messages to be taken forward. The Board welcomed the update report and agreed the recommendations in the circulated paper.

19. Post Covid - 19: Recovery, Renew and Tilt to Digital

19.1 The Chair advised that there was an invitation out for an informal Strategic Development Committee, which would pick up on conversations started the previous week. She commented that the Board needed to focus on the operational issues around the current position and on the recovery component which would cover the next 6-9 months The longer term renew might be a discussion that needed to be paused until the system got through the next challenging phase.

19.2 Mr Lock commented that the contents of the paper should be familiar to members because of the development sessions that had been held. The paper attempted to set out a framework around what was being done in response to Covid-19 and what was recovery and what was renew, as there had been many changes in terminology. He advised that remobilisation was within the recovery phase when elective activity and other services restarted. It was noted that all the aspects were interdependent. The paper set out a high-level work programme for delivery a lot of which was not significantly different from what had been proposed previously in the pre Covid-19 world although a lot of it would need to be revised to reflect learnings.

19.3 Mr Lock advised it was intended to take this work forward through the Strategic Planning Committee with timeframes reflected in the paper to cover the next 6 months and the run up to winter. There was a need to work collaboratively with partnerships with the CMT having discussed a system wide approach. Mr Lock commented that questions around the use of “Near Me”, evaluation, engagement and community capacity were important and needed to be addressed through a number of fora.

19.4 The Board noted from the paper the need to engage with patients and the public and this would be taken forward as a matter of priority over the next few weeks.

19.5 Mr Murray questioned whether the system was comfortable that duplication across other Health Boards could be avoided. He felt there would be interesting conversations in terms of engaging with IJB colleagues as both aspects needed to operate in consort. There was a need to avoid going too far without IJBs being aware of the potential benefits that would come out of this work. He advised that he would make the same comment about Public Health Scotland. Mr Murray commented that the paper talked about reporting up through the Strategic Planning Committee and questioned whether there was any benefit of reporting through the Healthcare Governance Committee given the complexity of the changes being proposed. Mr Lock advised that national alignment was important and discussions would be held later in the week to ensure alignment. He advised in terms of partnership he had set out issues that needed to be done by HSCPs with the question being how work was split and divided to allow joint working.

19.6 Miss Gillies advised in terms of the Healthcare Governance Committee point she felt this was something the Committee would want to stay sighted on but would need data to inform that conversation. There was an important point to tease out in respect of addressing two different issues that were progressing at different speeds and had a different destination. She felt there was a more immediate phase around how to meet clinically urgent requirements some of who were in the system now and whose treatment had been deferred. There were also those that had not yet come through as referrals from GPs due to reduced patient attendance. It was felt it could take many months to get on top of that position as there was significant volume of hidden work. This was also a longer-term piece of work in terms of embedding issues. Trying to do both issues at the same time was felt to be challenging for a system that was still not stable and back to steady state.

19.7 Professor McMahon felt that the Healthcare Governance Committee like other Committees would be part of the forward process as well as wider stakeholders like the IJBs and the public. This would link to the paper on delegation schemes that would be discussed later in the meeting. The Chair commented that work was already underway with Public Health Scotland. She advised that her sense was that NHS Lothian was working closely with the IJBs and they needed to be an integral part of the process including through the community planning process of which the system played a part.

19.8 Councillor O'Donnell questioned what the vehicles would be for ensuring that this meaningful engagement took place. She felt that the partners might be better placed to take forward some of the public engagement with the Citizen Panel approach being an effective way of getting engagement and feedback. The Chair commented from her experience that the issue was not about doing multiple engagement with the public on similar subjects by different agencies but about finding a strategic approach. Mr Lock advised that he and

colleagues would consider the best way to progress and this would include building on other engagement events.

19.9 The Vice Chair commented that public engagement would be critical particularly around feedback about how they felt services could be reshaped based on recent experiences. Each IJB had representatives of the community around the table and they should be specifically engaged as part of the forward work being developed by Mr Lock. It would be important that IJB s were driving the process as much as NHS Lothian was.

19.10 Mr Lock in response to a question from Mr McQueen advised that he was proposing a conceptual approach moving forward as Covid-19 was not going away and that a financial cost code would be established. Mr McQueen sought advice on the timescale for reporting to the Board and whether there was sufficient resource available given the analysis needed. Mr Lock advised that people had already been identified to work on recovery work and could be redirected with the work being chunked into tactical groups through targeted groups in order to get the correct people in place. At the CMT earlier in the week, it had been agreed to use existing Board Committees. In terms of resource, people were currently focussed on Covid and the issue was about the balance of staff time and management time into the other agendas moving forward.

19.11 The Chair advised that there were a number of non executive Board Members keen to get involved and the next informal Strategic Planning discussion should pick this up. She commented given resources and the demands on the team that currently remobilisation and recovery were the priority. The Chair commented that there was a need to consider the renew agenda fairly soon. She hoped that by August sufficient progress with RHCYP to allow us would have been made to allow a reduction in the frequency of Board Meetings and the reintroduction of Board Development sessions.

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

20. Healthcare Associated Infection (HAI) Update

20.1 Professor McMahon advised the Board that both the Staphylococcus aureus Bacteraemia (SAB) and Clostridioides Difficile infection (CDI)had been met. The Escherichia Coli Bacteraemia (ECD) standard for 2019 had been narrowly missed. The Board noted that for all three areas performance was within control limits and statistically was no different from other comparable Boards. This position had been reported to the Healthcare Governance Committee the previous day. The position in relation to SABs was an improving one with a key reason being around the work in respect of aseptic non-touch. The position and impact of the provision of tertiary services was also explained.

20.2 The Board noted that over the past few months a key issue for Infection Prevention Control had been around PPE which had been the biggest single

cause of anxiety for staff in health, social care and community settings. An iterative framework was in place and reflected changing guidance and issues around the national supply chain. In terms of DCN, close attention was being paid to Pseudomonas issues with good progress being made as staff move into the new facility. Professor McMahon advised there had been a number of incidents reported at the end of the previous year and these had all been reported as being closed off at the Healthcare Governance Committee.

20.3 The Board welcomed the update report and took moderate assurance as well as noting that a number of issues had been closed down.

21. Review of Integration Schemes

21.1 Professor McMahon advised that the work required around the legal requirement to review the schemes had legitimately been put on hold to address Covid. NHS Lothian was not unique in adopting this approach. There was a need to align the recovery and renewal work alongside the review of the schemes. Professor McMahon commented that it would be possible to use the infrastructure developed by IJBs to take forward community facing consultation and engagement.

21.2 The Chair advised that Mr Murray had questioned whether a derogation could be sought from the Scottish Government. It was noted that no letter of comfort had been received from the Scottish Government. Professor McMahon advised that across all of the local authority areas and with the NHS Lothian Chief Executive, there had been implicit agreement that all parties were content to proceed with the process set out in the paper as it was effectively for them to lead the review. Professor McMahon did not feel that there was a need for further delay around the process as this could link to the recovery work previously discussed. He felt this could be developed towards the end of the calendar year and that the magnitude of work suggested that a 6-month timeframe was not unreasonable. The integration schemes could be addressed at the front end of the process. The Chair commented that it would be important that any letter to the Scottish Government included an indicative timescale.

21.3 The Chief Executive commented that the timeline for the review would need to be agreed with the 4 Councils as they might have a different view. He advised that each of the Chief Officers, in their capacity of health & social care partnership directors, had an objective to support the Board and Councils in the review process. Through discussions with the Council Chief Executives, there had been no appetite to change the integration model (Integration Joint Boards) nor devolve children's services.

21.4 The Board agreed that the October meeting should be the backstop for the process to be developed with an update report being received at the Board meeting in August.

21.5 The Chair advised that the legal responsibilities around this issue lay with the Board Chief Executive and the Council Chief Executives. She commented

that the letter to the Scottish Government if possible should be a joint one with Council Chief Executives and should state that the Board had agreed the recommendations not to prioritise the review of schemes this side of the summer. An indicative timeline would be provided. Professor McMahon and the Chief Executive would progress.

22. Royal Hospital for Children and Young People (RHCYP), Department of Clinical Neurosciences (DCN), Children, and Adolescent Mental Health Services (CAMHS)

22.1 Mrs Goldsmith reported that this had been a very important week for the project with it being excellent to note that some staff had moved and patient appointments were being held. It was noted that all of the actions agreed as part of the NSS review with the exception of ventilation had been agreed and signed off by the Oversight Board. An update on other works was provided. The terms of the Supplemental Agreement (SA2) had not yet been finalised with the reasons for this being reported to the Board. Interim arrangements had been agreed for the operation of the contract in relation to Facilities Management until a steady state was reached. This approach had been agreed at the Executive Steering Team and the Oversight Board in order to prioritise services that needed to be put in place.

22.2 Mrs Goldsmith reported that until the Board received the SA2 the final programme of works would not be known. This was in the process of being tested in light of Covid-19. There was a commitment to moving this forward as quickly as possible.

22.3 Miss Gillies provided the Board with an update on discussions with clinicians in respect of the remainder of DCN. She advised that people were being encouraged to visit the new site to understand the benefits of bringing the second phase forward as quickly as possible. It was reported that surge capacity would be available if there was a spike in Covid activity. Miss Gillies in response to a question from the Chair advised that there would be opportunities to consider how to use the footprint at the Western General Hospital vacated by Critical Care. There had been no internal executive discussions around this at this point in time.

22.4 The Chair recorded thanks to all of those colleagues involved in getting to the current position.

23. Financial Report on Covid

23.1 Mrs Goldsmith reported that subject to an underspend of £619k for 2019/20 had been achieved. The annual accounts would be brought the Board on 24 June 2020 for sign-off. The finance team were keen to progress work for 2020/21 as this was complex in terms of what Covid and recovery would look like and what this meant for the financial framework. The key drivers around additional costs were described. Mrs Goldsmith advised until actual costs started to come through the ledger the overall picture would not be known.

The position in respect of anticipated allocations from the Scottish Government was discussed.

23.2 Mrs Goldsmith advised in respect of Appendix 1 that it had been agreed to take this to the Finance and Resources Committee in order to start reporting the actual position in respect of commitments in excess of £1m that needed to be submitted to the Scottish Government.

23.3 Mr Ash questioned whether it was anticipated that allocations would be provided on a pro rata basis or whether only a percentage of actual costs would be directly funded. He also questioned whether NHS Lothian's expenditure was in line with other Health Boards or higher given that Lothian was in a Capital City. Mrs Goldsmith commented that the first allocations had been made on an NRAC (National Resource Allocation Committee) basis. Mrs Goldsmith anticipated there would be a requirement to manage some of the spend within allocation.

23.4 Mr Ash commented that if the intention was to allocate based on NRAC then representation needed to be made through Chair and Chief Executive National Groups, as this was not reflective of the needs of a Capital City. The Chair commented that this was an important point and it was a credit to NHS Lothian that it had managed to balance its books.

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

24. Any Other Competent Business

24.1 DCN Move – The Chair advised that Professor McQueen and Mrs Morgan had asked for their congratulations and thanks to all the staff involved to be passed to the Board to reflect that the first patients were being treated in the new facility.

24.2 MP/MSP Meeting – The Chair reported that a productive and well-attended meeting had been held on 1 May 2020 with a follow up scheduled for 29 May 2020. The Speedread was being circulated on a daily basis to MP/MSP colleagues.

24.3 Future Board Meetings – The next Board Meeting on 24 June 2020 would be the Chief Executives last meeting. The Annual Accounts would be signed off at the meeting. Thereafter the next Board meeting would be on 12 August 2020. It was hoped that the September Meeting should be a Development session followed by an October Meeting and a November Development Session.

25. Standing Order 5.3

25.1 The Board agreed to invoke Standing Order 5.3 to allow a meeting of Lothian NHS Board to be held in Private. The reasons for this was based on the commercial and confidential nature of the business.

Chair's Signature ……

Date ……

Mrs Esther Roberton
Interim Chair – Lothian NHS Board

FINANCE AND RESOURCES COMMITTEE

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

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

In Attendance: Mr J. Crombie, Deputy Chief Executive; Mr I. Graham, Director of Capital Planning and Projects; Dr J. Hopton, Programme Director, Facilities (item 3.3); Mr A. McCreadie, Head of Management Accounts (item 4.1); Mr A. Payne, Head of Corporate Governance; Ms B. Pillath, Committee Administrator (minutes); Ms E. Roberton, Interim Board Chair; Mr D. White, Strategy, Planning and Quality Manager (item 3.5).

Apologies: Ms T. Gillies, Medical Director; Professor A. McMahon, Executive Nurse Director.

Chair's Welcome and Introductions

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

1. Declaration of Interests

1.1 The chair reminded members 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. The following declarations were made:

1.2 Mr McQueen declared a non financial interest in item 8 on the agenda regarding the initial agreement for reprovision of the HSDU, as vice chair of West Lothian Integration Joint Board, which had requested consideration of a site in West Lothian for provision of this service. Members agreed that as the interest was related to Mr McQueen's role as a Board member, he would not be required to leave the meeting for this item.

1.3 Professor Whyte declared a non financial interest in item 9 on the agenda regarding the Edinburgh Bioquarter joint venture, as an employee of the University of Edinburgh, which was one of the other partners in the venture, and due to her role in the project. Members agreed that as the viewpoint that Professor Whyte could provide would be a useful part of the discussion, she would not be required to leave the meeting for this item.

1.4 Mr McCann declared a non financial interest in item 10 on GP provision in South Edinburgh due to being a registered patient at a south Edinburgh GP practice. He decided not to leave the meeting for this item.

2. Committee Business

2.1 Minutes and Actions from Previous Meeting (25 March 2020)

2.1.1 The minutes from the meeting held on 25 March 2020 were approved as a correct record subject the correction of a typographical error.

2.1.2 The updated cumulative action note had been previously circulated.

2.2 Committee Members' Survey

2.2.1 A paper had been previously circulated. It was noted that although only four of ten Members responded to the survey the results received were mainly positive. The results from members' surveys of all Committees would be discussed and actioned by the Audit and Risk Committee.

2.2.2 It was noted that there was no specific expertise in the finance sector on the Board. This was being addressed as part of the criteria in the next round of Board member recruitment.

2.2.3 It was suggested that there should be more development opportunities for members of the Board. Mr Payne advised that NHS Education Scotland would soon release two modules for board members on audit and on finance. Ms Roberton suggested that this needed improvement nationally, especially for chairs of finance, staff governance and healthcare governance committees and that resources already available for other organisations could be considered for use as well as local work.

2.2.4 It was requested that for a future meeting Mr Payne report on what Scottish Government circulars and guidance the Committee should be receiving. A system was in place for distribution of circulars to relevant directors but there could be a more formal process through the governance route. **AP**

2.2.5 It was noted that there had previously been a committee chairs' meeting to ensure coordination between the Board committees but this was now a more general meeting for non executives. A way of ensuring collaboration between committees would be helpful.

2.2.6 Ms Roberton noted that the Finance and Resources Committee was not statutory and not all Boards had one. The Committee had the delegated power to make financial decisions at a high level. She would discuss this with Mr Payne at a future date.

2.3 Committee Annual Report 2019/20

2.3.1 Mr Payne introduced the previously circulated paper. It was noted that paragraphs 3.3. and 3.4 related linking spend to performance; this work was not ready in time for the report but the intention was to show the impact of spend on performance.

2.3.2 It was noted that the assurance need statement which formed the criteria against which the report was made had been developed several years ago and it was agreed that the review of the terms of reference of the committee this year would include review of the assurance need statement. **MH / AP**

2.3.3 Members approved the annual report with one correction agreed.

2.4 Draft Committee Workplan 2020/21

2.4.1 Mr Payne introduced the previously circulated workplan. This would be updated after each meeting and as required. It was noted that meetings were currently monthly to keep up to date with the RHCYP / DCN project but this may be reviewed once the project was complete.

2.4.2 It was suggested that the workplan did not reflect medium and long term strategy work, or work on best value and impact of spending on the service. It was agreed that the Committee did cover these areas and that the workplan should be developed to ensure a consistent approach.

2.4.3 Ms Goldsmith advised that actions on recovery from COVID-19 and associated spending would be brought to this Committee as ideas were developed.

2.4.4 Priorities in property and asset management were reviewed each year, but a review of overall development and longer term decisions was needed, for example on the quality of the estate and investment on digital working and how this would affect buildings.

2.4.5 It was noted that the financial context across all Health and Social Care partners was needed to ensure the most effective decisions were made.

2.4.6 Mr Hill asked that the oversight on the sustainability plan noted in the workplan be upgraded to reflect the Committees role in developing a strategic plan as designated Committee responsible for this area.

2.4.7 A developed version of the workplan for 2020/21 would be discussed at a future meeting. **AP**

3. Capital

3.1 Property and Asset Management Investment Programme

3.1.1 Mr Graham presented the previously circulated paper and noted that any revisions of long term plans due to the COVID-19 pandemic would be brought to future meetings.

3.1.2 Approval for funding had been received from the Scottish Government for the short stay elective centre at St John's Hospital, but the formal letter of approval had not yet been received. Mr Graham advised that this was being chased and was not holding up the works which were within delegated funding levels at this stage. No risk was anticipated.

3.1.3 Mr Graham advised that the programme was all expected to go ahead at this time but delays could be caused by the COVID-19 pandemic. There have been proactive moves to keep cash flow to contractors to reduce the risk of early warning notices when the COVID-19 restrictions were lifted. Long term changes to advice regarding social distancing may change requirements for the estate, for instance outpatient and office environments.

3.1.4 There was discussion about the accuracy of estimated costs for projects. Mr Graham advised that work was being done to improve this but that it was made difficult by volatile markets at this time. Ms Goldsmith advised that the estimate was partly aimed at giving a sense of the size of the project rather than giving a specific cost.

3.1.5 Members accepted the recommendations laid out in the paper, accepting significant assurance on the delivery of the programme for 2019/20, but limited assurance on delivery in future years.

3.2 Royal Hospital for Children and Young People, Department of Clinical Neurosciences, Child and Adolescent Mental Health Services

3.2.1 Ms Goldsmith presented the previously circulated paper. The supplemental agreement 2 had not yet been signed but negotiations continued with IHSL which continued to work on site. The air handling units needed to be ordered by Friday 24 April so as not to delay the programme and there had been agreement previously that these could be ordered before SA2 was signed with NHS Lothian making the order. However, IHSL had now asked for further discussion on this. The DCN moves to the new hospital were planned to commence the week beginning 11 May 2020. Fire enhancement works had been completed.

3.2.2 The legal advisors McRoberts were reviewing all correspondence and documentation and would report on risks and consistency with what the Board agreed to accept before SA2 will be signed. The expertise to do this is not available within NHS Lothian or the Central Legal Office. Mr Graham was leading on reviewing documents with McRoberts, supported by his team. NHS Lothian was ready to sign the agreement if the profile did not change.

3.2.3 The cabinet secretary was fully up to date with the plan for the DCN moves and was regularly briefed on progress and risks. It was noted that the risks associated with moving DCN while construction was ongoing in the building was with NHS Lothian as any problems would impact on the service. This risk can be mitigated to some extent by managing IHSL and Bouygues using contract management.

3.2.4 The programme dates for RHCYP moves were still provisionally 23 November 2020 but there was not full assurance on this as SA2 had not yet been signed and there was no assurance that the air handling units would be ordered before 24 April.

3.2.5 The risk noted at 4.3 in the paper about managing the site as operational and as a construction site would be owned jointly by the service and the project team and would relate to service management by Bouygues and IHSL. Clarification was needed on what the key tests for water safety and other areas would be and this was being checked. An update on operational financial management and NHS Lothian's agreement with IHSL and Bouygues would be brought to the Committee as this was deviating from the original contract. The arrangements had been worked through with Health Facilities Scotland. Any increases in operational costs due to the site being operational during construction would fall to NHS Lothian. **SG**

3.2.6 Ms Goldsmith advised that work was ongoing with Health Facilities Scotland on the complex management of the large number of PFI and PPP contracts now in place. A paper would be brought to the Committee on this. **SG**

3.2.7 Members accepted the recommendations laid out in the paper and noted the commercial position and progress made.

3.3 Initial Agreement for Reprovision and Development of the Hospital Sterilisation and Decontamination Unit

3.3.1 Mr Crombie and Ms Hopton presented the previously circulated paper which identified the options being considered for reprovision. It was noted that the risk resulting from loss of a HSDU was high, but that it was recorded as amber due to the contingencies in place for processing instruments.

3.3.2 It was noted that the advisory group at this stage did not include clinicians although clinicians were involved in different parts of the programme including design of the track and trace system. Mr Crombie noted good engagement with clinicians and agreed to include representatives on the oversight group.

3.3.3 Ms Hopton advised that there was no overall contingency plan in Scotland for the number or spacing of HSDU. Previously centralisation was considered to be the best option to reduce investment costs but in recent years the value of having more than one site for contingency was recognised especially now that private companies were not being used for resilience across Scotland. Regional collaboration was possible in the future for shared contingency in Scotland.

3.3.4 The development of the outline business case would include consideration of transport costs, land costs and proximity to the largest users as some of the factors. This would include consideration of a site in West Lothian.

3.3.5 Members accepted the recommendations in the paper and approved the initial agreement for submission to the Capital Investment Groups.

3.4 Edinburgh Bioquarter Joint Development Update

3.4.1 Ms Goldsmith presented the previously circulated paper. Members noted that NHS Lothian would benefit from being collaborators in this project and wanted to be involved.

3.4.2 The land and commercial aspect of the project was discussed. Ms Goldsmith advised that the aspiration for the project was life sciences research and start up businesses, but that for this to be accommodated land development of significant cost was required. This aligned well with the Council's local planning aims.

3.4.3 It was proposed in the paper that after becoming a strategic partner in the project rather than an investor NHS Lothian would continue to approach the Scottish Government for funding for the project as previously agreed, using the connection with the health department. The Scottish Government was already providing some support for the project through other means.

3.4.4 Professor Whyte explained that each of the four partners in the project had different ambitions: Scottish Enterprise aimed to recoup initial expenditure; City of Edinburgh Council was looking for investment in a deprived area of Edinburgh; University of

Edinburgh were looking to have a state of the art life sciences research centre; NHS Lothian were looking to be collaborators in research. Although the main aim of the project was not profit, Professor Whyte noted that none of the partners had the funding to build the facilities required and that commercial companies did not find building research centres profitable, so this work needed to include a package for development in order to progress.

3.4.5 Professor Whyte advised that the other project partners recognised the proposed model as a practical solution to allow NHS Lothian to be involved without the legal constraints of being a full partner.

3.4.6 Members accepted the recommendations laid out in the paper including to become a strategic partner in the joint venture rather than a full partner, and therefore cease further funding contributions.

3.5 South East Edinburgh GP Provision Initial Agreement

3.5.1 Mr White presented the previously circulated paper. He advised that the GP practices in the area had been involved with negotiations but that they had business concerns with the first option laid out in the initial agreement.

3.5.2 It was noted that there was a trend of GP practices preferring to work in buildings owned by the health board rather than individually. If the new practice proposed was built it would belong to NHS Lothian, whereas the two current practices in the area owned their buildings. In general more leases were being taken over by the Board.

3.5.3 Members noted that option 1 was the preferred solution with benefit for the local population and supported this for use in negotiation with the local GP practices. Option 2 was to build new premises on the edge of town which would move away from the current practices. It was noted that the Board's principal priority was to serve the needs of the population, recognising that GP practices often faced other business concerns.

3.5.4 Mr White confirmed that any newly built premises would include space for teaching. Professor Whyte noted that this could be a valuable area for teaching and agreed to liaise with Mr White on the development of the business case.

3.5.5 Members accepted the recommendations laid out in the paper with an amendment to recommend the initial agreement to the Board rather than to approve, given the likely capital value.

4. Revenue

4.1 2019/20 Financial Position

4.1.1 Mr McCreadie presented the previously circulated paper. The paper included any revisions due to COVID-19. Members accepted the recommendations laid out, accepting significant assurance that NHS Lothian would achieve financial breakeven for the year 2019/20. Members thanked all concerned for their work to achieve this satisfactory outturn.

5. Committee Business

5.1 Reflection on the Meeting

5.1.1 It was noted that an update on progress with the RHCYP / DCN project would be discussed at the Board.

5.1.2 It was agreed that the need for the Board to prioritise benefit to the local community while recognising that GP practices often had other business challenges making decisions about premises provision would be raised at the Board.

6. Date of Next Meeting

6.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 20 May 2020**.

7. Meeting Dates in 2020

31.1 Further meetings would take place on the following dates in 2020:
- 17 June 2020;
- 22 July 2020;
- 26 August 2020;
- 23 September 2020;
- 28 October 2020;
- 25 November 2020.

Signed by the Chair 25-05-20

Original kept in file

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 14 January 2020 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Professor M. Whyte, Non-Executive Board Member (chair); Ms J. Clark, Partnership Representative; Dr P. Donald, Non-Executive Board Member; Ms W. Fairgrieve, Partnership Representative; Ms C. Hirst, Non-Executive Board Member; Ms F. Ireland, Non-Executive Board Member; Mr A. Joyce, Employee Director, Non-Executive Board Member; Dr S. Mackie, Patient and Public Representative; Ms P. Whalley, Patient and Public Representative.

In Attendance: Ms L Cowan, Chief Nurse, East Lothian Health and Social Care Partnership; Ms J. Campbell, Chief Officer, Acute Services; Ms T. Gillies, Medical Director; Mr B. Houston, Chairman, NHS Lothian; Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahon, Executive Nurse Director; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator (minutes); Mr D. Small, Director of Primary Care Sustainability; Professor A. Timoney, Director of Pharmacy; Dr S. Watson, Chief Quality Officer.

Apologies: Ms J. Morrison, Head of Patient Experience.

Chair's Welcome and Introductions

The Chair welcomed members to the meeting and members introduced themselves. The Chair thanked the outgoing Chair, Professor Tracy Humphrey, for her contributions to the Committee.

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

58. Minutes from Previous Meeting (12 November 2019)

58.1 The minutes from the meeting held on 12 November 2020 were approved as a correct record subject to a minor addition at paragraph 49.8.

58.2 The updated cumulative action note had been previously circulated.

58. Patient story

58.1 The chair welcomed Dr Mackie and Ms Whalley from the patient representatives group to the meeting. Dr Mackie gave a summary of the patient representatives group's thoughts on enhancing the use of the patient story at the Healthcare Governance Committee, including ensuring lessons learned were discussed.

58.2 Dr Mackie then read out feedback from a 70 year old patient who had been admitted to the Emergency Department at St John's Hospital with dizziness, and went on to have radiology tests and a clinic appointment at the stroke unit before being discharged to the GP. The patient was impressed at the speed at which he was seen at the

Emergency Department and with the subsequent communication between different departments and flexibility in offering an appointment at the stroke unit in the Western General Hospital when there were none available at St John's Hospital. There was also good communication with the GP, although a problem getting a repeat prescription two months later showed a problem with communication between the GP practice and community pharmacist.

59. Mental Health Services Assurance

59.1 A paper had been previously circulated. The chair welcomed Ms McKigen to the meeting and she gave a presentation. The positive feedback from external reporting organisations was noted, including on the perinatal unit.

59.2 Professor McMahon gave a summary of the Board's position at Scottish Government escalation level 3 for mental health inpatient beds and CAHMS performance. A recovery plan had been developed and a project infrastructure set up to implement this, focusing on achieving 90% of waiting times within 18 weeks in adult inpatient mental health beds, Child and Adolescent Mental Health Service, and Psychological Therapies. This would be overseen by a programme board chaired by Judith Proctor. Currently CAMHS performance was 50%. It was emphasised that this related to only part of the large number of areas covered by Mental Health Services.

59.3 Ms Whalley summarised some patient feedback from advocacy work she had done in the wards at the Royal Edinburgh Hospital. Patients were happy with the new acute patient streamline which made them feel safer. They agreed with the reduction of rehabilitation beds and wanted time limit on rehabilitation and to know how long they would be there. Patients felt that some conditions such as learning disabilities should not be treated as inpatients and preferred the community model. There was a perception among patients that older people's mental health services were given less importance than adult mental health services. Professor McMahon noted that some of these points were covered in the Royal Edinburgh Hospital redevelopment plan, and that he would respond in more detail to the Patients' Council at the Royal Edinburgh Hospital.

59.4 The chair suggested that a further paper or papers should be submitted to future meetings focussing on improvement data on how goals were being met, and baseline data for measuring improvement, which would allow the Committee to take assurance. This should also reflect the major improvements made to quality of care particularly in the quality of care at the perinatal unit. **AMcM**

59.5 It was agreed that due to the large number of areas covered by Mental Health Services that any more specific areas with clinical governance concerns would be reported to this Committee separately. Professor McMahon would work on a matrix for presenting these areas. **AMcM**

59.6 Members noted the external assurance given in the presentation, including positive feedback from the Mental Welfare Commission and the Nursing and Midwifery Council. The presentation slides would be circulated to the group.

59.7 Members accepted limited assurance overall, pending the further report requested for the next meeting.

60. Safe Care

60.1 Winter Planning

60.1.1 Ms Campbell presented the previously circulated paper and explained the current patient flow pressures with the high number of patients attending the Emergency Departments. Although it was difficult to measure changing acuity of patients' conditions it was noted that a yearly increase in the number of elderly people in the local population meant that although the Emergency Department attendance rate per person may stay the same, there would be a higher number of total attendances, and the complexity of conditions was likely to be higher in patients with multi morbidities requiring a longer inpatient period.

60.1.2 A number of processes were in place to support staff during the busy period including senior management visibility, ensuring staff breaks are taken, listening to staff ideas for improvement, enhancing staffing levels where possible including different levels of staff; for instance clinical support workers to help with routine basic patient care.

60.1.3 It was difficult to measure quality of patient care during periods of high pressure, but monitoring of cardiac arrest rates and mortality rates could show whether intervention had happened at the right time. This would be part of the post winter evaluation. There would also be evaluation of eight hour and twelve hour waits at the front door.

60.1.4 Given the discussion, Ms Campbell amended the second recommendation in the paper and suggested that the Committee accept limited assurance on the ability to evaluate the impact of winter and the winter plan. Members accepted the recommendations laid out in the paper with this amendment.

60.2 Health and Safety Clinical Governance and Performance

60.2.1 Ms Gillies presented the previously circulated paper. The Health and Safety Team reported more generally to the Staff Governance Committee, but clinical governance areas of relevance to the Healthcare Governance Committee were brought here. Three of these areas were included in the paper, with the other three to be considered at the next Health and Safety Committee meeting in February 2020.

60.2.2 It was noted that REAS was the only service that had given limited assurance for all three risks. Ms Gillies explained that this was due to the complexity of the estate and the risks associated with the patient group, including patients out on pass. She noted that the local health and safety committee for REAS had a high level of engagement and high performance in managing these risks.

60.2.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance overall on the areas reported.

60.3 Healthcare Associated Infection Update

60.3.1 Professor McMahon presented the previously circulated paper. The HEAT target for *Clostridium difficile* Infections would not be met although there had been reductions. Broad spectrum antibiotic use in NHS Lothian was low compared to other Boards but

there was still more scope for reduction and continuous training work was needed to cover staff turnover. Approximately half of the CDI cases were related to antibiotics, the others could be attributed to community contacts and food hygiene.

60.3.2 The HEAT target for reduction of *Staphylococcus aureus* Bacteraemia and for *E. coli* infection was on track to be met. This was due to continuous work with doctors and nurses on using standard infection control precautions when interacting with patients, and learning from preventable cases.

60.3.3 Professor McMahon summarised the position of the four recent Incident Management Teams detailed in the paper. Members wanted to thank staff for the hard work across the service in investigating incidents and putting in place action plans. Even when the Scottish Government risk matrix scored 'green' there was a lot of work mitigating risks and learning from the incidents.

60.3.4 Members accepted the recommendations laid out in the paper and accepted moderate assurance on routine infection control processes with limited assurance in terms of incidents and managing public expectations and anxieties. There would be two reports on Healthcare Associated Infection direct to the Board this year, in recognition of the political focus and public anxieties.

60.4 Children and Young People Health and Wellbeing Programme Board Terms of Reference

60.4.1 This paper had been circulated under exception reporting but members agreed to move this to the discussion part of the agenda. At the previous meeting it had been agreed that the Programme Board would decide on the right chair for the group; they had now decided that the chair would be a non executive board member to ensure the right level of scrutiny. Professor McMahon would chair the board until a non executive member had been identified.

60.4.2 Members accepted the terms of reference.

61. Effective Care

61.1 Dental Services – quality of care data

61.1.1 Professor McCallum gave a verbal update. National indicators for community dental practice reporting were in development and were due to be finalised in February 2020 for reporting in dental practices to be implemented in April 2020. Work had been done on reporting on expected indicators which were likely to include measures on staff training and personal development and on adherence to standard infection control precautions. Once reporting had been established data would also be reported to the Healthcare Governance Committee.

61.1.2 Complaints reporting would not be included in the new indicators. Currently all dental complaints were made direct to the General Dental Council; they were looking for a local resolution alternative with oversight by the health board, similar to the arrangement for GP practices, but systems were not currently in place for this. It was noted that a number of dental complaints related to fees so guidance was awaited on how these types of complaints would be resolved.

61.2 GP and Primary Care Sustainability

61.2.1 Mr Small presented the previously circulated paper. Most of the Local Medical Committees had written to the Scottish Government raising concerns about the implementation of the GMS contract. There needed to be an understanding of what each health and social care partnership considered the risk to be and how to mitigate this.

61.2.2 There needed to be a definition of GP sustainability covering patient access, multidisciplinary workforce, and GP careers. Workforce pressures occurred where staff were recruited from one service to another. There needed to be overall strategic workforce planning for increasing training places and using resources where they were most needed.

61.2.3 It was noted that rising populations and new housing estates were creating pressures in all council areas, and all four health and social care partnerships made capital proposals for increasing primary care medical practice space. This was a problem all over Scotland but the pressures were greater in Lothian with the fastest growing population. Interest free loans were available from the Scottish Government for practice owners to expand practices to accommodate multi-disciplinary teams.

61.2.4 Members noted the improved situation on GP practices in financial difficulty and accepted the recommendations laid out in the paper, and accepted limited assurance. A further update would be submitted at the meeting in May 2020. **DS**

62. Exception Reporting Only

Members noted the following previously circulated papers for information:

62.1 Palliative Care Managed Clinical Network Annual Report;
62.2 MBRACE-UK Perinatal Deaths Annual Report;
62.3 Abdominal Aortic Aneurysm (AAA) Screening Annual Report;
62.4 Organ Donation Annual Report;
62.5 Resilience Annual Report.

63. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

63.1 Clinical Management Group, 10 September 2019, 8 October 2019;
63.2 Health and Safety Committee, 26 November 2019;
63.3 Area Drug and Therapeutics Committee, 6 December 2019;
63.4 Organ Donation Sub Group, 21 November 2019;
63.5 Public Protection Action Group, 18 December 2019;
63.6 Information Governance Sub Committee, 22 October 2019.

64. Corporate Risk Register

64.1 Ms Gillies presented the previously circulated paper. It was agreed that the two items related to the risk register that had been discussed at this meeting were at appropriate

levels of risk on the register: GP sustainability at 'very high' and Healthcare Associated Infection at 'medium'.

64.2 It was noted that complaints was still classed as 'very high' risk. Professor McMahon advised that work was in progress on the relationship between the feedback team and frontline staff in resolving complaints. Standardisation of process was required with more work on learning. Some work had been done but performance on 20 responses to complaints was still poor.

64.3 The risk for Brexit was classed as 'very high'. It was suggested that a reduction to this risk level could now be considered.

65. Date of Next Meeting

65.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 10 March 2020** in **Meeting Room 8**, Fifth Floor, Waverley Gate.

66. Further Meeting Dates

66.1 Further meetings would take place on the following dates in 2020:
- 12 May 2020;
- 14 July 2020;
- 8 September 2020;
- 10 November 2020.

Signed by the Chair

Date 31/03/2020

Original kept on file

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 10 March 2020 in Meeting Room 8, Waverley Gate, and 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present:
Professor M. Whyte, Non-Executive Board Member (chair);
Ms J. Clark, Partnership Representative;
Dr P. Donald, Non-Executive Board Member;
Ms C. Hirst, Non-Executive Board Member;
Mr D. Stewart, Patient and Public Representative;
Ms P. Collins, Patient and Public Representative.

In Attendance:
Ms J. Campbell, Chief Officer, Acute Services;
Ms T. Gillies, Medical Director; Mr B. Houston, Chairman, NHS Lothian;
Ms M. Hughes, Chief Nurse, West Lothian Health and Social Care Partnership;
Professor A. McMahon, Executive Nurse Director;
Professor A. Timoney, Director of Pharmacy;
Dr S. Watson, Chief Quality Officer;
Ms J. Morrison, Head of Patient Experience
Ms F Huffer , Deputising for Ms C. Myles, Midlothian Health and Social Care Partnership
Ms L Cowan, Chief Nurse, East Lothian Health and Social Care Partnership
Ms S. Gibbs, Quality & Safety Assurance Lead
Mr G. Curley, Director of Estates
Dr B. Hall, Scottish Clinical Research Fellow shadowing Tracey Gillies
Ms L. Baird, Corporate Governance Team (minutes).

Apologies:
Ms F. Ireland, Non-Executive Board Member;
Ms W. Fairgrieve, Partnership Representative;
Ms C. Myles, Chief Nurse, Midlothian 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.

67. Patient story

67.1 Ms Collins read out the patient feedback in respect of palliative care treatment received within the hospice, primary and secondary care settings. The family were very impressed with the ease of transition between the primary and secondary care settings. They noted that the quality of care received from the teams had been excellent. Key areas of improvement identified by the Public Representatives related

to ensuring that the ease of transition and timely interventions happened for every patient in Lothian not just in this instance.

67.2 The committee welcomed the positive feedback from the patient's family, recognising the need for timely interventions for every patient. The importance of monitoring long waits and how these are prioritised was noted. It was recognised that the patient experience team had worked closely with care opinion to gather feedback from staff and patients. Sharing experiences and responding to those concerns has risen, fand eeding back outcomes to patients and carers was a continuous process of improvement that remained ongoing.

68. Minutes from Previous Meeting (14 January 2020)

68.1 The minutes from the meeting held on 14 January 2020 were approved as a correct record subject to a minor correction to the attendees list.

68.2 The updated cumulative action note had been previously circulated.

68.3 The Chair noted that an update on the work of the Patient Outcomes Programme Board on dementia was presented at the February Meeting. It was recognised that the new measures would be picked up by the Health and Social Care Partnerships. Members agreed that no further update on dementia would come to Healthcare Governance; the action would be closed off.

68.4 It was noted that the subject of mental health was vast and thus challenging to present to the Committee. Further updates to the committee would be broken down into 3 areas. The first of the three reports would be brought to the May 2020 meeting. **AMcM**

69. Emerging Issues

69.1 Coronavirus Update – Ms Gillies took the committee through the report. She advised the committee that the pace surrounding coronavirus was fast moving and changed on a daily basis. NHS Lothian Executive Team remained committed to ensuring that staff had the most up to date guidance available. The importance of alignment with UK guidance to avoid confusion was recognised.

69.2 NHS Lothian remained in the containment phase. There was significant pressure on the Regional Infectious Diseases Unit (RIDU) and NHS 24, 111. Patients who were suspected to have contracted the virus were being directed to RIDU community based testing and the Western General Hospital (WGH) drive through service. In addition to the increased testing, RIDU had been fielding high volumes of calls from other specialities. The importance of preserving the human resource within the RIDU and critical care specialist services as NHS Lothian moves into the next phase were recognised.

69.3 NHS Lothian would continue to reinforce hand washing and hygiene messages and encourage staff to do the same. Hand washing and hygiene remained a key tool in infection control and the reduction of disease transmission. It was hoped that reinforcing key infection control practices such as hand washing and the utilisation of single use protective masks, aprons and gloves, would go a long way to relieve anxiety

of staff and the public. In addition to key messages there had been significant work to upscale the resource surrounding face fitting for masks. It was noted that upscaling had positive benefits in that more staff had been trained to fit masks but wastage had increased as a result. Challenges surrounding face fitting masks affected NHS Scotland as a whole and therefore would be considered at a national level going forward.

69.4 The committee discussed capacity required to support an outbreak in Lothian and how this would be achieved. Ms Gillies advised the committee of complex plans that would consider how to flex existing services and how capacity can be utilised to provide the space needed to deal with the potential outbreak in Lothian. Alternative methods in respect of how specialist advice can be provided through alternative routes, freeing up capacity with RIDU was being explored. Members noted that increasing capacity and physical space in an outbreak situation would also bring a need to increase staffing at a time where health workers would be most vulnerable to infection and the Board would be working with a reduced workforce.

69.5 The committee accepted the assurance from the report presented and the recommendations detailed therein.

70. Committee Effectiveness

70.1 Healthcare Governance Committee Annual Report and Assurance Need – The Chair spoke to the previously circulated annual report and assurance need report. Members reviewed each of the significant issues in turn. Members agreed that:

- The overarching statement should be amended to state the correct number of key areas of significant control weaknesses that they wished to be flagged.
- GP Sustainability – the wording in the report implied there were inadequate control measures in place; this was not an accurate reflection of the current position in Lothian. Members recognised both that the organisation was in a transitional stage and the need to pause to consider if the work to date was taking the organisation in the right direction. The risk to the organisation would remain but the level of assurance surrounding the action take to mitigate risk would increase. **There was agreement that the narrative surrounding GP sustainability would be updated to reflect good progress to date. The risk register would be updated to separate out risk relating to the implementation of the GMS contract and and greater risk related to the stability of out of hours provision. MW/SG**
- Delayed Discharges – the section should reference the additional risk relating to 'patient safety experience in front door areas'. Members recognised the challenges of occupancy on acute sites and how it impacts the front door. **There was agreement that the narrative would be updated to reference the additional risk relating to patient experience and clinical outcomes in front door areas. MW**
- Access to CAMHS – **the risk would remain in section 2 of the report.** The subject regularly featured at the Board and Healthcare Governance Committee. Mental health was a challenging area and work deliver services under a whole system approached was in progress.
- Children's Services – Members felt that there had been significant process made with Children's Services and the item should really be titled Governance of Cghildren's Services. Further assurance would be received in May 2020. **There**

was agreement that the narrative be updated to reflect significant progress to date and expected review in May. **MW**

- Dementia – would be removed from the list of key significant control weaknesses as in item 68.3 above.
- Dental Services – that were no concerns surrounding the provision of service. **The narrative would be change to reflect a concern surrounding monitoring of dental services, the service itself was adequate.** **MW**

70.2 The committee accepted the Healthcare Governance Committee Annual Report and Assurance Need subject to the revisions to section 2 of the report discussed.

71. Person Centred Culture

71.1 Patient Experience and Feedback – A paper had been previously circulated. Professor McMahon and Ms Morrison presented the paper to the committee, noting the key issues and successes within the service.

71.2 Members noted the most recent complaints performance against the 2 key targets (stage 1 – 5 days and stage 2 – 20 days). This includes the Scottish Public Services Ombudsman (SPSO) activity. Members were unable to take moderate assurance that the performance on complaints handling was moving towards a better and more sustainable position from the data provided within the form. Ms Morrison agreed to circulate additional data out with the meeting. A decision on the level of assurance would be taken following receipt of additional data. **JM/ ALL**

71.3 The committee welcomed the success of the business case. Work continues and the staff had been transitioned into the new structure. Recruitment of staff was almost complete and Ms Morrison anticipated that the majority of staff would be in post by April 2020. Members supported the next steps of the implementation of the business case.

71.4 The committee noted the range of work being done to support the patient experience agenda via Tell Us Ten Things (TTT), Care Opinion (CO). Patient Representatives were impressed with the work with Care Opinion; they noted that it was a positive channel of feedback for staff and patients. Professor McMahon took an action to extend the awareness of Care opinion within both acute and community settings. **AMcM**

72. Safe Care

72.1 Controlled Drug Team Annual Report

72.1.1 Ms Gillies spoke to the previously circulated report and explained that the report was designed to give insight into the governance systems around controlled drugs and demonstrate that controls were robust. In the absence of a covering paper Ms Gillies proposed the following recommendations:

- The committee supports the submission of the Controlled Drug Team Annual Report to Health Improvement Scotland (HIS), as the body that has oversight of external assurance.
- The committee accepts significant assurance that the governance controls surrounding controlled medicines are adequate and that there is a clear line of sight for those who have responsibility for the controlled drugs.

72.1.2 Professor Timoney explained that she was the responsible officer for the geographical area of Lothian. Her role covered all healthcare providers, institutions and pharmacies; she explained that her role extended beyond the NHS to ensure that there was oversight over the whole system ensuring that the system is not abused. Local networks of intelligence were also utilised to share key information in a formal way that showed the whole picture across Lothian. In addition, there was a programme of hospital support visits in Lothian that provided oversight of CD issues and offered the ability to take action when required; the programme was so successful in Lothian that it was being considered nationally.

72.1.3 The committee accepted significant assurance that governance control measures around controlled drugs in the Lothian region were robust. Members accepted the report and the proposed recommendations.

72.2 Public Protection Update

72.2.1 Professor McMahon spoke to the previously circulated report. He explained that the joint inspection in Midlothian was progressing well and outcomes of case files reviewed were positive to date. Access to Trak had expedited the case load in comparison to previous inspections. Next steps would focus on a series of focus groups and outcomes were awaited on the back of those meetings. In addition, there were some lessons that could be learnt around transitions of care from the Edinburgh inspection that would be shared with all partners.

72.2.2 The committee noted the report and continued progress to strengthen the public protection arrangements.

72.2.3 The committee accepted moderate assurance that robust systems and processes were in place for Public Protection.

72.3 Healthcare Associated Infection (HAI) Update

72.3.1 Professor McMahon spoke to the previously circulated report. He drew the committee's attention to the emerging threat from COVID 19 and the potential impact on the Infection control community given the lack of capacity within the specialty. In light of potential impact on performance from COVID 19, he proposed the committee may wish to reconsider the level of assurance proposed within the paper.

72.3.2 Members accepted the healthcare associated infection performance report for January 2020, noting good progress against the *Staphylococcus aureus bacteraemia* (SAB): interim target for 2019/20 and the *Clostridioides difficile* infection (CDI): interim target for 2019/2020. Work on the Gram-negative bacteraemia standard: interim target for 2019/2020 remained in progress.

72.3.3 The committee acknowledged the key performance indicator for Multi-Drug Resistant Organism Screening Programme clinical risk assessments for quarter 3 remains below optimal 90% compliance.

72.3.4 The committee noted the investigations and outcomes arising from a small number of possible infection incidents in the Department of Clinical Neurosciences, Western General Hospital, Ward 118 Critical Care, Royal Infirmary and Ward 2 Royal Hospital for Sick Children.

72.3.5 Professor McMahon took an action to establish links between to the Infection Control Services and Patient Representatives to support work with Duty to Inform, Engage and Consult People who use our Services **AMcM**

72.3.6 The committee took moderate assurance from the information in the report acknowledging that the risk associated with emerging threat to public health from a novel Coronavirus (COVID 19) was not quantifiable at this time. Members noted the potential impact of a lack of capacity in respect of speciality infection prevention control expertise on organisational key performance indicators and patient safety; recognising that proposals to recruit additional capacity into the specialty were underway.

72.4 Surgical Instrument Cycle Update

72.4.1 Mr Curley spoke to the previously circulated report. He explained that the programme of work has focused on reducing cancellations due to unavailable sterile equipment, Datix and customer complaints received, backlog trays and fast tracking. Overall performance had improved in all categories with the exception of specialist equipment, due to availability from suppliers and the rare nature of the work. It was anticipated that further improvement would be seen going forward.

72.4.2 The committee acknowledged the demonstrable progress against planned actions managed by the Surgical Instrumentation Cycle Programme Board. They noted:

- A reduction in the patient cancellation rate within theatres due to instrument issues linked to HSDU.
- A reduction in the number of Datix and CCF (Customer Complaint Forms) both showing a downward trend in 2019.
- A reduction of the number of backlog trays.
- A reduction in the number of fast track requests.

72.4.3 The committee acknowledged that in addition to the improvements, there had been supplementary benefits of:

- Theatre staff having more time available to focus on patient care.
- A reduction in the number of orthopaedic theatre lists requiring re-organisation to accommodate delayed instrument delivery, therefore less patients are fasted longer than necessary as patients receive their operations earlier in the day which causes less anxiety and a better patient experience.

72.4.4 The committee accepted the comprehensive report and agreed to move the reporting cycle to annual. Members recognised the hard work in the service, requesting the Mr Curley feedback their appreciation to staff members involved.

72.5 Brexit Risk

72.5.1 Mr Crombie presented the previously circulated report and explained that there was uncertainty throughout 2019 about whether Brexit would proceed and what form this would take. The UK exited the EU in January 2020. Trade deals were unlikely to be finalised in the near future. Mr Crombie proposed that the Brexit be put on hold as an agenda item until June or October 2020.

72.5.2 The committee agreed to support the removal of the Brexit risk from the Corporate Risk Register and a review, in June & October 2020, of any possible health service impacts arising from the UK/EU Trade Agreement negotiations and the evolving new relationship between UK and EU.

73. Effective Care

73.1 Framework for Primary Care Practitioners

73.1.1 Ms Gillies introduced the previously circulated report. She explained that the paper had been brought to Healthcare Governance to note ongoing work led by the four Health and Social Care Partnerships (HSCP) and NHS Lothian to ensure robust professional and governance frameworks were in place, ensuring the safety of both patients and staff working in Primary Care.

73.1.2 Mr Wynne summarised the key points within the report, noting the progress made to date. He recognised that the programme of work was very challenging, working over 4 localities each with individual directions and goals. It was proposed at this time there would be a pause to reflect on work to date and consider whether it was leading in the right direction.

73.1.3 Patient Representatives expressed concerns that organisational charts describing the core structure of the different HSCP organisations had not been available to NHS Lothian, noting that in their experience this often flagged underlying issues with structure in the organisation.

73.1.4 Ms Gillies explained the programme of work did not relate to General Dental Practitioners. She noted that the General Medical Services (GMS) Contract (2018) had created an opportunity for non-medical staff to work at an advanced level in order to support implementation of the contract, creating more capacity in general medical services with the aim of reducing workload for GPs and improving outcomes for patients.

73.1.5 The committee noted the structures in place and those under development to support governance and mitigate risk. It was recognised that this was an ongoing process. The committee accepted moderate assurance from the information within the report and the presentation made by Mr Wynne. A report would be brought back to the July meeting with the expectation that the Health and Social Care Partnerships provide robust organisational charts that clarify the issues raised within the report. **PW**

73.2 Reports on the practice of Ian Paterson

73.2.1 Ms Gillies spoke to the previously circulated report. She explained that the report was brought to Healthcare Governance to share lessons learnt from the investigation into the practices of Ian Paterson. There were risks to the organisation that an individual determined to evade the normal systems of governance will cause patient harm though poor clinical practice and poor behaviours. It was noted that such practices were more likely in smaller clinical specialties, where the measurement of the quality of care was less transparent and where work force pressures were more evident. It was hoped that by sharing lessons similar concerns can be picked up in NHS Lothian and mitigated.

73.2.2 Members questioned how NHS Lothian would be alerted to inappropriate behaviour that occurred out with NHS premises and practices. It was recognised that the professional bodies and NHS Lothian medical appraisal and revalidation processes rely on the practitioner being honest and raising any concerns at the time of appraisal. In addition to medical revalidation processes the External Providers Office would oversee governance practices and effective working of work commissioned within the private sector in Lothian. Ms Gillies took an action to flag when the Annual Report from the External Providers Office was due to be presented to the committee. **TG**

73.2.3 The committee took significant assurance that the surgical and oncological outcomes of breast cancer treatment were good and that the monitoring of surgical results and QPIs would highlight any areas of concern in the practice of any one individual.

73.2.4 The committee took moderate assurance that actions were in place to work effectively between the private sector and NHS both for patient care and communication about concerns and moderate assurance that concerns were raised, investigated and addressed in a fair, timely and appropriate way.

73.3 Medical Revalidation Annual Report

73.3.1 Ms Gillies presented the previously circulated report. She explained the report would inform both Staff Governance Committee and Health Care Governance Committee on outcomes of Q1 work om medical revalidation work overseen by NES.

73.3.2 The NES report had identified 3 recommendations:

- That the correct number of appraisals must take place every year subject to appropriate leave and absences.
- That staffs who are under short term employment with no training receive a regular appraisal.
- That all reviews are undertaken by trained appraisers.

73.3.3 The Healthcare Governance Committee agreed to:

- Note the outcome of the NES annual quality assurance survey on medical revalidation for NHS Lothian, St Columba's hospice, the Marie Curie hospice, and for Scotland.
- Note that NHS Lothian complies with the three recommendations in the report.

- Note the relationship between NHS Lothian and St Columba's and Marie Curie hospices for medical revalidation.
- Accept significant assurance that the medical appraisal and revalidation process was operating successfully in NHS Lothian, as recognised by this external review.

73.3.4 The Chair recognised that NHS Lothian's performance had been excellent. She commended Dr Doyle on the significant work on Medical revalidation.

74. Exception Reporting Only

Members noted the following previously circulated papers for information:

74.1 Breast Cancer Screening Annual Report;
74.2 Scottish Trauma Audit Group Annual Report;
74.3 Research and Development Annual Report;
74.4 Clinical Policy and Documentation Annual Report;
74.5 Tissue Governance Annual Report.
74.6 Diabetic Retinopathy Screening Annual Report
74.7 Maternity Services Liaison Committee Annual Report
74.8 Area Drug and Therapeutics Committee Updated Terms of Reference

74.9 The committee discussed uptake of breast screening in Lothian. It was recognised there are inequalities in the uptake of all screening programmes, this was not a matter that affected Breast screening only. Ms Gillies proposed that a report on uptake of all screening services in Lothian and the spread of equality in the uptake of services be brought to the Committee. The committee would request that Professor McCallum produce a report on screening for the May meeting. **MW/BP/AKM**

75. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

75.1 Health and Safety Committee, 18 February 2020
75.2 Area Drug and Therapeutics Committee, 7 February 2020
75.3 Public Protection Action Group, 18 December 2019;
75.4 Information Governance Sub Committee, 28 January 2020

76. Corporate Risk Register

76.1 The committee took stock of the risks considered over the term of the year and whether there were areas of risk that required to be explored further. It was noted that Coronavirus would be added to the Risk Register and Brexit would come off.

76.2 The Chair proposed that Members take some time to consider the risk register and feedback any risks they wish to explore to her directly. **MW/ALL**

76.3 Patient Representatives proposed that the significant control failures listed within section 2 feature on the Healthcare Governance Committee regularly. Members recognised that these issues were areas of concern to the committee and oversight though the agenda would be prudent.

76.4 Ms Gillies recognised the importance of looking at the whole system through a Healthcare Governance lens rather than focusing on the front door. It was recognised that many of the issues relating to overcrowding were exacerbated by hospital sites being fully occupied and flow of patients throughout services. Ms Gillies took an action to pull together a brief report on 'improving quality of care in over occupied hospitals' with Ms Campbell and Professor McMahon for the May meeting. The report would provide an overview of current measures both good and bad and the known risks. A second, more detailed report looking into specific areas of concerned identified in May would be brought to a future meeting. **TG/ AMcM/ JC**

77. Date of Next Meeting

77.1 The next meeting of the Healthcare Governance Committee would take place at **9.00am** on **Tuesday 12 May 2020** in **Meeting Room 8**, Fifth Floor, and Waverley Gate.

78. Further Meeting Dates

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

Signed by the Chair
Date 13-05-20

Original kept on file

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30 on Wednesday 19 February 2020 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms A. Mitchell, Non-Executive Board Member (chair); Ms C. Hirst, Non-Executive Board Member; Mr J. Crombie, Deputy Chief Executive; Mr A. Joyce, Non-Executive Board Member; Ms J. Butler, Director of Human Resources; Ms H. Fitzgerald, Partnership Representative; Miss T. Gillies, Medical Director (until 12.10pm); Professor A. McMahon, Executive Nurse Director and Ms J. Campbell, Chief Officer, Acute Services (until 12noon).

In Attendance: Mr Clint Waight, Radiopharmacy (Item 57); Ms R. Kelly, Deputy Director of Human Resources; Dr S. Edgar, Director of Medical Education (until 11am); Ms A. Langsley, Associate Director of Organisational Development and Learning; Mr I. Wilson, Head of Health and Safety (until 11am); Mr S Haddow, Head of Medical Workforce Planning and iMatter Operational Lead (Item 60.2) and Mr C Graham, Secretariat Manager.

Apologies: Councillor J. McGinty, Non-Executive Board Member and Mr S. McLauchlan, Partnership Representative.

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.

57. Our iMatter Story — Radiopharmacy

57.1 Mr Waight gave a presentation on the development of iMatter within Radiopharmacy. The presentation covered what is a Radiopharmacy; who are the Radiopharmacy team, their iMatter history and the difficulty with anonymity within small teams.

57.2 The presentation also looked at establishing a culture and values within the team that the team can own; living these values all the time and having a shared reputation; the impact on performance and absence rates after introducing own culture and values; how iMatter helped to shine a light on potential culture issues and provide a platform for discussions.

57.3 The Committee welcomed Mr Waight's presentation as it showed how iMatter had been used as part of an impressive approach to move the radiopharmacy department forward. This was a great leadership story demonstrating real leadership and opportunities for learning.

57.4 Mrs Butler stated that the presentation underlined the power of the story. The work within radiopharmacy was being capitalized on as part of the collection of powerful iMatter stories that can provide shared learning across the organization and show the real benefits of the iMatter process.

58. Minutes and Action Note of the Previous Meeting of the Staff Governance Committee held on 30 October 2019

58.1 The minutes from the meeting held on 30 October 2019 were approved as a correct record.

58.2 The Committee noted that the updated cumulative action note had been previously circulated and all actions were now complete or to be covered on the meeting agenda.

59. Assurance and Scrutiny

59.1 Corporate Risk Register

59.1.1 *3328 – Roadways/Traffic Management*

59.1.1.1 Mr Crombie reported that following on from the detailed position paper brought to the previous Staff Governance Committee meeting the issues reported in October remained. There had also been an update given to the NHS Lothian Health and Safety Committee the previous day.

59.1.1.2 The Committee noted that ongoing works at RIE, WGH and STJ had given focus to safety of the sites and in the last 6 months there had only been two roadways/traffic management incidents.

59.1.1.3 There was discussion on the consideration for applying for planning permission for additional parking and the substantial capital costs involved with such proposals. There was also consideration being given to other transport options such as the NHS Lothian park and ride facility for St Johns Hospital although uptake has been poor.

59.1.1.4 The overall corporate risk status remains and a paper would come back to the May meeting focussing on the campus' issues and giving an update on planning permission applications.

JC

59.1.1.5 The Committee agreed that this risk remained of great concern and that the profile for this risk should be raised. It was also agreed that these concerns should be escalated to the Board's attention given the increasing complexity involved.

AM/JC

59.1.2 *3455 – Management of Violence and Aggression (V&A)*

59.1.2.1 Professor McMahon presented the paper updating the Committee on work being undertaken to support and improve the current level of support to staff on Violence and Aggression management, given this remains a high risk on the corporate risk register.

59.1.2.2 The Committee noted that the V&A Team had been unable to develop as yet a communication strategy due to capacity issues and that there remained work to do. Purple Pack work and review continues to help shape and support service areas. The Committee asked that the Adverse Events chart be updated for the May meeting.

AMcM

59.1.2.3 Ms Hirst asked what the Purple Pack was. Mr Wilson explained that this was the Risk Management Tool created by the V&A Team which allows local managers to risk assess based on tasks which local teams undertake. This considers lone working and was a key part of local teams analysis of risks based on V&A incidents along with team members survey reports.

59.1.2.4 There was discussion on processes and procedures for managing unacceptable actions and how these are recorded. It was recognised that data around physical violence was probably more readily available than verbal abuse, which staff may not record.

59.1.2.5 The Committee agreed to the recommendations in the paper, namely:

- to note the steps being taken to review the organisations approach to the management of violence and aggression and strengthen organisational assurance.
- to note that the key areas where violence and aggression are highest i.e. within the Royal Edinburgh Hospital and Emergency Departments are well covered and there is good compliance with training
- to note that the violence & aggression management risk (3455) remains high.
- to take a moderate level of assurance regarding the implementation of the actions and to take a moderate level of assurance in relation to the process.

59.1.3 *Identicom Update Paper* - Mr Wilson updated the committee on recommendations and actions being implemented to improve the current level of support to staff and managers regarding the identification of "Category 1 Lone Workers" who require a Lone Worker Personal Alarm Device (Identicom).

59.1.3.1 There was discussion on the issue of non-activation; device procurement; external contractor delivery; development of an internet portal for device management; use of eLearning to demonstrate device competency and the online portal pilot with Edinburgh Health and Social Care Partnership.

59.1.3.2 It was noted that there still remained work to do around the management of the Identicom devices. Professor McMahon would undertake further actions out with the meeting and a further update would be brought back to the May 2020 Staff Governance Committee.

AMcM/JB

59.1.3.3 The Committee acknowledged the ongoing initiatives and support being provided by the H&S and MAT teams and agreed to take a <u>limited</u> level of assurance regarding the implementation of the actions taken to manage the provision and usage of Lone Worker personal alarms and a <u>moderate</u> level of assurance in relation to the process.

59.1.4 <u>3527 – Medical Workforce Sustainability</u> - Miss Gillies introduced the report providing the Committee with an update on the current level of risk in relation to medical workforce sustainability.

59.1.4.1 Miss Gillies highlighted that the report concentrated on the three aspects of support around medical workforce sustainability, namely areas of NHS Lothian influence, areas for NHS Scotland and areas out with this.

59.1.4.2 There was discussion on the performance of the NHS Scotland International Recruitment Unit and difficulties in bringing forward international candidates; actions undertaken in relation to changes within General Practice Specialty Training

recruitment numbers and the potentially significant impact of UK Pension tax regulation. It was noted that the impact of this regulation, although presented under medical workforce, would not be exclusively on medical workforce.

59.1.4.3 The Committee acknowledged feedback from the National International Recruitment Unit around the experience to date along with the excellent fill rates there had been to training programmes within the South East.

59.1.4.4 The actions that took place to alleviate the significant impact on services resulting from NES changing the mechanism of recruitment to 32 regional GP specialty training posts in the August 2019 recruitment cycle and measures that had been taken to support positive trainee experience were recognised.

59.1.4.5 The Committee appreciated the significant challenges to consultant workforce sustainability associated with changes in UK pension tax regulations and the substantial impact that they may have for individuals.

59.1.4.6 The Committee noted that the level of risk remains unchanged at high and that the impact of changes to pensions tax regulations if not resolved satisfactorily by the UK Treasury had the potential to further increase risk.

59.1.4.7 The Committee agreed to accept a moderate level of assurance that the controls in place mitigate any risks to immediate patient safety and quality of care related to this.

59.1.5 3828 – Nurse Workforce – Safe Staffing Levels - Professor McMahon outlined the report providing an update on the work in Lothian to address the Health and Care Staffing (Scotland) legislation (commonly referred to as the "safe staffing legislation") and to update on the risk around safe staffing levels risk (ID 3828) on the corporate risk register.

59.1.5.1 Professor McMahon explained that an NHS Lothian Programme Board had been established and the intention would be to have multidisciplinary representation on this group ahead of an expected partial implementation of the legislation in autumn 2020. Formal annual reporting was expected to begin 2022.

59.1.5.2 There were considerations to be made around the process of running workforce tools and decisions to be made in relation to additional posts. It was agreed that NHS Lothian Board assurance would need to be gained around processes and this should be formally reported to the April 2020 Board meeting. There was also discussion on nursing recruitment and retention policies and procedures; the new national integrated workforce plan and additional psychology training places.

59.1.5.3 The Committee agreed to retain the risk level as moderate and noted that the implementation programme for the Health and Care (Staffing) (Scotland) Act (2019) had not yet been announced by the Scottish Government, however it was considered likely to be enacted from Autumn 2020.

59.1.5.4 The Committee agreed to accept moderate assurance that the Board was well placed to address the requirements of the Health and Care Staffing (Scotland) legislation for the nursing and midwifery workforce and that the delegation of residual recruitment risks were being addressed through the operational business units.

59.1.5.5 The Committee took limited assurance that the Board was well placed to address the requirements of the Health and Care Staffing (Scotland) legislation for the wider clinical / professional workforce that are to be included in the legislation.

59.1.5.6 The Committee also agreed that due to the nature of this risk, this would be highlighted to the NHS Lothian Board.

AM/AMcM

59.1.6 Special Waste Management - Miss Gillies reminded Committee members that this risk had been created due to the company with the national contract for special waste entering administration. It was noted that new contracts were now coming into place through NHS National Services Scotland and running smoothly at operational level. It was noted that no concerns had been raised through the NHS Lothian Health and Safety Committee or local health and safety groups. Once the new national contract was finalised this risk could be regraded and may even be removed from the corporate risk register.

59.2 Health and Safety Assurance - Miss Gillies introduced the risk assurance levels for the quarter two Health and Safety prioritised risk topics. These covered Manual Handling, Windows and Balconies, Environmental Ligatures and Workplace Inspections. They were submitted to and discussed at the NHS Lothian Health and Safety Committee from all local area H&S Committees on 26th November 2019. The Committee also noted that the NHS Lothian Health and Safety Committee had met again the previous day (18/02/2020).

59.2.1 There was also discussion on local health and safety groups attendance at the NHS Lothian Health and Safety Committee. It was noted that currently attendance was good however, there was a concern around attendance from Midlothian HSCP. Miss Gillies would write to Midlothian HSCP to follow this up.

TG

59.2.2 The Committee received the Draft NHSL H&S Committee minutes for November 2019 and agreed to accept the proposed overall assurance levels for the four risk topics as follows - Moderate for Manual Handling, Moderate for Workplace Inspections, Moderate for Windows and Balconies and Moderate for Environmental Ligatures.

59.2.3 The Committee agreed to support the work of the Health & Safety team in providing support to all local H&S Committees to receive and collate suitable data to enable a realistic assessment of meaningful assurance levels. It was noted that the H&S team continue to develop and update their intranet pages to allow all staff access to all relevant guidance and lists of documentation required to enable the evaluation of data that is linked to assurance level evidence required.

59.2.4 The Committee accepted the moderate assurance within the quarterly returns from the Local H&S Committees to the main NHS Lothian H&S Committee meeting in November 2019 regarding the management of “Windows and Balconies” to restrict the opportunity of vulnerable patients exiting or falling from these facilities. However it was recognised that NHS Lothian had subsequently been notified that the Procurator Fiscal intends to pursue a prosecution against NHS Lothian following a fatal adverse event in November 2017.

59.2.5 The Committee acknowledged the work undertaken by Facilities management in conjunction with the Health & Safety Executive following this tragic event to ensure that all similar windows were rectified to ensure robust window restriction mechanisms are permanently in place to deter vulnerable patients from gaining the ability to defeat previous restriction hardware.

59.3 Staff Governance Workplan - Mrs Kelly introduced the report presenting the updated Staff Governance Workplan for 2019/20. It was noted that there had been confirmation from Scottish Government that Everyone Matters would continue for 2020 and this had been used as a basis for the workplan for 2020/21. The Committee agreed to approve the updated Staff Governance Workplan for 2019/20.

60. Healthy Organisational Culture

60.1 Whistleblowing Monitoring Report

Ms Hirst chaired the discussion for this item as Ms Mitchell was directly involved in this work as the current NHS Lothian Non-executive Whistleblowing Champion.

60.1.1 Mrs Kelly covered the monitoring data for the Whistleblowing and Speak Up cases that had been raised within NHS Lothian and updated the Committee on the new National Whistleblowing Standards and the potential impact of these standards on the current whistleblowing arrangements in NHS Lothian. The standards will be implemented on 27 July 2020.

60.1.2 Mrs Kelly reported that to date there had been 37 whistleblowing cases and that from October 2019 to now there had been 5 further new cases.

60.1.3 In terms of Speak Up contacts, for October to December 2019 there had been 8 contacts. It was noted that as agreed at the previous Staff Governance Committee the Speak Up Ambassadors would attend every second meeting of the Committee. It was also expected that there would be 6 or 7 new advocates in place over the coming weeks.

60.1.4 There was discussion around the new Whistleblowing Standards. The new standards cover any health organisation delivering a service so they were not just applicable to Health Boards.

60.1.5 The Committee noted that as part of Health Board's roles and responsibilities, the Cabinet Secretary for Health and Sport had appointed Non Executive Whistleblowing Champions to each Board and these people had taken up post from 01/02/2020. For Lothian this person was Katharina Kasper. Mrs Mitchell confirmed that she had already met with Katharina and that her understanding of the role and Katharina's understanding were aligned. Mrs Mitchell would continue to work with Katharina ahead of Mrs Mitchell leaving the Board in July 2020. It was noted that both Mrs Mitchell and Katharina would be notified of whistleblowing concerns raised moving forward as part of the handover process.

60.1.6 It was also noted that under the new standards there was an expectation for an Executive Director to lead the whistleblowing process. Mrs Butler stated that there had been discussion on this approach at the national HR Directors meeting and where the executive responsiblity should sit. Traditionally this had sat with HR Directors in Boards but it was not felt this was appropriate. For Lothian it had been agreed at the Executive Leadership Team that Mrs Butler would continue this role until Katharina Kasper had been in post longer with this arrangement to be reviewed before 27 July 2020 implementation date. Mrs Butler would continue with the short life working group and set up arrangements in the meantime.

60.1.7 There was discussion on the whistleblowing standards; culture change; embedding Speak Up as good practice and extending the Speak Up service into primary care and procurement arrangements for a Once for Scotland approach. It was noted that

currently there was no resource for the primary care workload or support for investigations.

60.1.8 Mrs Mitchell requested that an additional column be added to the report to incorporate trend information where cases may be borderline whistleblowing/grievance.

RK

60.1.9 The Committee noted the number and types of cases raised through the Speak Up Initiative from July to December 2019 and noted the update on the new National Whistleblowing Standards and the actions currently being taken to be ready to implement these in NHS Lothian at the appropriate time.

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

Mrs Mitchell thanked Ms Hirst and took back the Chair.

60.2 Health and Social Care Staff Experience Report - Mr Haddow presented the results from the 2019 staff experience report to the Committee. The presentation covered above average performance against most indicators, except action plan completion rates; KPI performance; response rates; EEI team scores; Staff Governance Standards Scores; CEO yearly components and a comparison between questions and actions to be taken to move forward in 2020, including:

- Maintaining and improving performance against 4 KPIs
- Improving action plan completion rates
- Developing and publicising local team stories via local and national iMatter website
- CMT / Directorate SMTs - developing narrative / action plans
- Reducing use of paper copies / moving to SMS text
- Continuing to deliver management training and developing the role of iMatter Faculty
- East Lothian H&SCP and West Lothian H&SCP extending iMatter to include all Social care staff in 2020

60.2.1 Mrs Butler made the point that there remained work to do with the IJB Chief Officers ahead of cohort 3, especially around conversion to action plan rates. It was noted that there had been a lot of great work around iMatter and it was hoped to host some sort of iMatter celebratory event in 2020. Mrs Butler asked members for any views around ways to improve conversion to action plan rates.

60.2.2 The Chair thanked Mr Haddow for the presentation and requested that the next report to the Committee cover trend analysis and highlight conversion rates.

61. Capable Workforce

61.1 2019 Director of Medical Education Report Update Paper – Dr Edgar introduced the report following up from the paper presented to the October 2019 Staff Governance Committee. The report included the requested worked example of data flow and quality activities linked to medical education and training in NHS Lothian, and an aligned question about celebrating success and sharing good practice.

61.1.1 There was discussion on shared quality control work; how data is turned into intelligence and moved forward to address quality issues; the development of actions plans for shared quality control work and the implementation of actions plans.

61.1.2 The Committee also discussed the Associate Director of Medical Education's role and responsibilities as part of the hospital management team.

61.1.3 The Committee noted the Medical Education Directorate governance structure graphic and worked example of educational quality control and appreciated how this activity was intended to function.

61.1.4 Members noted the flyer for the "Signpost to Success" medical undergraduate education celebration and sharing event on 13/05/2020 as an example of these on-going activities in NHS Lothian.

61.1.5 The Committee agreed to take moderate assurance from these examples that as a local education provider, NHS Lothian have processes in place to understand, support, develop and share intelligence linked to high quality medical education and training.

61.2 Medical Revalidation Annual Report - Miss Gillies introduced the report informing Committee members of the outcome of the review by NHS Education for Scotland (NES) of NHS Lothian's progress on medical revalidation in 2018-19.

61.2.1 The Committee noted that the NES review had made three recommendations for NHS Lothian and noted the Lothian position against each of these as contained within the paper.

61.2.2 There was discussion on the positive Lothian position within the report and it was noted that it was important that appraisal for doctors was not used as a performance tool.

61.2.3 The Chair stated that this was a good news story for Lothian and the Committee agreed to the recommendations in the paper.

61.2.4 The outcome of the NES annual quality assurance survey on medical revalidation for NHS Lothian, St Columba's hospice, the Marie Curie hospice, and for Scotland was noted.

61.2.5 Compliance with the three recommendations in the report and the relationship between NHS Lothian, St Columba's and Marie Curie hospices for medical revalidation was also noted.

61.2.6 The Committee agreed to accept significant assurance that the medical appraisal and revalidation process was operating successfully in NHS Lothian, as recognised by the external review.

61.3 Succession Planning for Leadership Roles - Ms Langsley updated the Committee on the current approach in NHS Lothian in relation to succession planning.

61.3.1 Ms Langsley reported that the paper had more detail on the approach to succession planning for leadership roles and was more focused on nurturing of talent pools. Other options and concepts to further strengthen succession planning included initiatives such as setting up of shadow boards to help people prepare for executive roles, gain experience and make the roles less intimidating. Work on these options would be progressed in the next year.

61.3.2 The Chair asked about timelines and outputs from this work. Mrs Butler stated that there were a range of other work programmes delivering at the moment and in the coming year there would be further development and risk assessment around succession planning this would include staff engagement and workforce planning.

61.3.3 There was discussion on quantifying of numbers within the senior management pools. Mrs Butler would look to put numbers from the leadership programmes raw data against talent pools. It would also be helpful to have high risk areas based against difficulty in recruiting identified.

JB

61.3.4 The Committee noted the current position in relation to succession planning and accepted a moderate level of assurance that succession planning was being addressed via the development of a range of talent pools.

62. Sustainable Workforce

62.1 Workforce Plan - Ms Butler introduced the report recommending that the Staff Governance Committee support the final draft of the NHS Lothian Workforce Plan 2020-23.

62.1.1 Ms Butler reported that the previous workforce plan had concluded in December 2019 and instead of waiting for the national integrated workforce plan and guidance to be published, NHS Lothian had decided to develop its own 2020-2023 plan. The national plan and guidance had subsequently been issued in December 2019 with advice that NHS Boards did not have to produce a 2020 plan. NHS Lothian decided to go ahead and publish its 2020 plan from 1 April 2020 given the work that had already been undertaken.

62.1.2 The Committee noted that the plan was in two parts – professional workstream leads and a piece around enabling works. It was planned to have annual action plans to support the high level workforce plan. 6 monthly progress reports would come back to the Staff Governance Committee.

62.1.3 The Committee agreed that this was a pragmatic and reasonable approach given the situation and accepted the recommendations in the paper, to:

- acknowledge that the plan had been developed with extensive involvement and contribution from members of the Workforce Planning and Development Programme Board in conjunction with Partnership colleagues.
- acknowledge that the Scottish Government National Health and Social Care Workforce Plan and updated Workforce Planning Guidance were only published on 19 December 2019.
- agree the 3 year plan and note that the plan will have a break point after 12 months to review and update given there are a number of key drivers such as the Health and Care Staffing Legislation the impact of which has yet to be fully worked through. This will also align to the revised timelines for publication of Board Workforce plans issued by the Scottish Government in December 2019.
- support 6 monthly progress reports to the Staff Government Committee to provide assurance on delivery

62.2 Workforce Report - The Committee noted the workforce report as at January 2020. It was also noted that there would be a full report on absence levels brought to the May meeting.

63. For Information and Noting

63.1 Members noted the following previously circulated items for information:

- Staff Governance Statement of Assurance Need
- Minutes of the Staff Engagement and Experience Programme Board held on 25 November 2019
- Minutes of the Workforce Development Programme Board held on 20 November 2019
- Minutes of the Lothian Partnership Forum held on 17 December 2019

64. Any Other Competent Business

64.1 There was no other business.

65. Date of Next Meeting

65.1 The next meeting of the Staff Governance Committee would take place at **9.30** on **Wednesday 27 May 2020** in **Meeting Room 8**, Fifth Floor, Waverley Gate.

66. Further Meeting Dates in 2020

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

Chair Signed 27/05/2020
Original held on file

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 9.00 am on Monday, 24 February 2020 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

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

In Attendance: Mr T Davison, Chief Executive (from 10am); Professor A McMahon, Executive Nurse Director; Ms J Brown, Chief Internal Auditor; Mr C Brown, Scott Moncrieff; Mr D Eardley, Scott Moncrieff; Mr C Marriott, Deputy Director of Finance; Mr J Old, Financial Controller (Item 61); Mr A Payne, Head of Corporate Governance; Mr M Hill, Non-Executive Board Member (Item 57); Ms S Gibbs, Quality & Safety Assurance Lead; Mr C Graham, Secretariat Manager (minutes) and Ms T Gray, PA to Head of Service – Infection Control (shadowing C Graham).

Apologies for absence: Dr R Williams, Non-Executive Board Member and 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.

50. Minutes of the previous meeting held on 13 January 2020

50.1 The minutes of the meeting held on 13 January 2020 were accepted as an accurate record.

51. Running Action Note

51.1 The committee accepted the running action note:

- Internal Audit Progress Report for Edinburgh IJB - update would come to the April 2020 meeting.

JB

- Audit Scotland: NHS in Scotland 2019 – This action would move over to the Interim Board Chair.

- Staff Lottery – Mr Marriott confirmed that the staff lottery had been wound up in December 2019, funds dispersed to staff and NHSL had self reported to the regulator with no actions coming back. It was accepted that the actions taken to mitigate risk had been appropriate and this action was now closed off.

- 4 hr emergency access standard – The Committee recognised that the context of this action had changed due to the recovery plan. The Committee agreed that an update on the escalation process would come to the April 2020 meeting.

JC

52. Results from Committee Members Survey

52.1 Mr Payne updated the Committee on the feedback from the recent member survey and encouraged members to consider what the next steps should be.

52.2 The Chair stated that arrangements were in place for the upcoming Board membership changes, which included his own term coming to an end. There are also plans in place for the appropriate handover of the Audit and Risk Committee Chair.

52.3 The current progress made by the Committee was good but there was always room for improvement - areas that could be further developed, and scrutiny of the assurances given.

52.4 There was discussion on the Corporate Risk Register work; priorities for investment and financial planning. The Chair stated that he intended to have either a face-to-face or electronic discussion with members following the April 2020 meeting, to consider areas for development.

52.5 The Committee also discussed succession planning; gender balance on the Committee; engagement with more learning and e-learning exercises; and how appropriate feedback from internal audit investigations are shared across the organisation to allow lessons learnt to be applied more widely.

53. NHS Lothian Corporate Risk Register

53.1 Ms Gibbs introduced the report setting out NHS Lothian's Corporate Risk Register for assurance.

53.2 The Chair made the point that the Risk Register currently comes to the Committee as well as the Board and the Healthcare Governance Committee. This is currently being reviewed to assess the value of this repetition.

53.3 Ms Gibbs stated that there was nothing significant to draw to the Committee's attention. It was noted that the Recovery Plan level 3 had been added with the Board having agreed to reduce the risk grading to 12. The Committee also noted that the HSCPs were continuing to work through the unscheduled care programme board, and appropriate controls were in place to discharge the risk.

53.4 Ms Gibbs also reported that there would be a BREXIT risk paper going to Healthcare Governance Committee shortly, however this risk had not changed much. The impact levels were not changing at this stage.

53.5 There was discussion on the role of the Audit & Risk Committee with regard to risk management, and how it should use the Corporate Risk Register report. The Committee highlighted that it would be helpful if the report clearly stated what the Committee was being asked to do. The Committee concluded it would be helpful to understand how other committees oversee risk management.

53.6 The Committee also discussed external factors that needed to be included within any narrative as part of achieving risk reduction. It was felt that better narrative would also help any potential new Committee members to understand the role of the Committee and the report.

53.7 Mr Payne highlighted that the Committee's role was to get assurance on the effectiveness of the risk management system. At the moment there is very little movement of the risk scores, despite the efforts that are being made to manage risk. Mr Brown added that the Committee's role was to oversee the risk management process, rather than carry out the detailed oversight of individual risks. Mr Payne explained that the revised format of the corporate risk register identified measures which should be used to monitor the impact of risk management activities.

53.8 The Committee recognised that as the format of the Risk Register had been updated, there was a need for either another Board workshop to go through the risks, or for the chairs of committees to clarify their role in risk management.

53.9 The Committee agreed that it would be appropriate to ask the governance committees how they oversee risk, and what mitigation and assurance had taken place. This issue should be covered in the committee annual reports, and Mr Payne agreed to issue a message to that effect.

AP

53.10 The Chair added that he would be writing to the new Interim Chair and would include a point on the risk management along with reflections on the item. There was also a need to discuss this directly with governance committee chairs.

53.11 The Committee agreed to accept the Corporate Risk Register which had been updated for Quarter 3 and noted the new format template now included for the new risk - The delivery of NHS Level 3 Recovery Plans.

54. Internal Audit Progress Report - February 2020

54.1 Ms Brown presented the paper providing a summary of internal audit activity since the November 2019 meeting and the ongoing progress in delivering the 2019/20 Internal Audit plan.

54.2 The Committee discussed progress in relation to internal audit work in the following areas:

- Edinburgh IJB – Directions Setting - report has been finalised alongside Financial Controls
- Three reports at draft report stage – Midlothian IJB Workforce planning arrangements; Consort parking arrangements and Acute Prescribing.
- Fieldwork ongoing in relation to the East Lothian IJB review, the Early Careers Framework and scoping and planning the remainder of the internal audit plan for this year.

54.3 The Committee highlighted that IJB directions are issued to the Board and the local authority, rather than to the HSCP. Ms Brown agreed to check that the language in the IJB directions report was appropriate. **JB**

54.4 The Committee also discussed the ambition of the Internal Audit plan for next year and asked if the size of the plan was realistic. Ms Brown stated that she was comfortable that there was an appropriate mix of audits with a balance between more strategic and operational areas.

54.5 The Committee noted the contents of this report.

55. Reports where all of the control objectives have significant assurance: Treasury Management

55.1 The Committee noted the report and passed on its thanks to the Treasury Management team.

56. NHS Lothian Internal Audit Review - Supporting Edinburgh Integration Joint Board - Directions Setting (December 2019)

56.1 Ms Brown outlined the finding of the internal audit review. The Committee noted that there were three areas of significant assurance, namely that:

- a policy is in place to define how Directions are set and what information should be included
- the policy ensures Directions will clearly align to the Strategic Plan and follow best practice
- a process is in place to ensure Directions are subsequently revised during the year in response to developments and there is a robust process in place to revoke/supersede previous versions

56.2 There was one area of moderate assurance:

- the policy ensures Directions set are achievable and are communicated with NHS Lothian and Edinburgh City Council, including setting expectations for their completion.

56.3 The Committee noted that the scope of the audit itself had been set by the Edinburgh IJB Chief Internal Auditor and that Ms Brown's team had delivered the scope as requested. Ms Brown explained that there had been a focus on design rather than operation and that the scope provided had been reported on.

56.4 There was discussion on the scopes for joint NHS/IJB audits; the commitment to work jointly with the IJBs; their plans and the synergy between Chief Internal Auditors.

56.5 There was also discussion on the timing of the report and whether it would have been useful for the IJB to consider the report first and to provide challenge.

56.6 Ms Brown made the point that given the number of debates taking place at a number of committees it may be helpful for the Chief Internal Auditors to consider all four IJBs plans for 20-21 and bring back an overall 2021 plan to the April or June Audit and Risk Committee.

JB

56.7 The Committee agreed that it was content with the report as it stood on the scope provided and the report was noted.

57. Private & Confidential: NHS Lothian Internal Audit - Investigation into RHCYP, DCN & CAMHS

57.1 Ms Brown introduced an update report on the progress and status of the internal audit report (phase 1) in respect of the RHCYP project. The paper gave an overview of the findings to date and the indicative timescales to conclude and issue the final report.

57.2 It was noted that the paper was being brought to the Committee to allow for any comments or suggestion that members would wish to pass on to the Board's Finance and Resources Committee. The Finance & Resources Committee will consider the same report on 26 February 2020. The Chief Internal Auditor intends to finalise the report by the end of March and present it to the Audit & Risk Committee on 27 April.

57.3 Ms Brown presented the update report which identified draft initial observations and recommendations to improve governance and internal control which NHS Lothian can take forward. She highlighted a number of issues which needed to be explored before the report is finalised, which may lead to the findings and recommendations being refined. The headings of the recommendations were:

- Strategic risk assessment
- Change control arrangements
- Working with Advisors
- The specific role and remit of the Finance and Resources Committee
- Project Governance
- Approvals - decision points and who was taking what decision when
- Clinical Engagement
- Procurement

57.4 The Audit & Risk Committee recognised that this was a helpful document. The Committee's discussion raised the following issues for the Finance & Resources Committee and the Chief Internal Auditor to consider:

- It would be helpful if the report clearly explains which individual or group has the authority to agree that the work has been completed to the required standard, before it can move on to the next stage.
- How do the above decision-makers get assurance from advisers and any gateway reviews before agreeing to move on to the next stage?
- What, if any, authority was given to advisers to act on behalf of the Board and its management? Did the authority to make a final decision always remain with an individual or group within NHS Lothian?
- What is the significance of the stage of 'financial close', and what does it practically mean in terms of obligations for the contractor? What should happen before the Board agrees to 'financial close'?
- There needs to a reflection on the role of a governance committee (such as the Finance & Resources Committee), and the level of detail it can reasonably be expected to consider. The answers to the above questions may highlight where within the project management system any detailed issues should be identified and addressed.
- To what extent was the project's established change control process consistently applied? Where the change control process was not applied, what were the reasons for this? What action can be taken to ensure that the change control processes always operate regardless of the circumstances?

- Who decided to issue the environmental matrix to the contractor?
- What were the reasons for issuing the environmental matrix?
- Where within the system of governance and control was there a check or checks which should have detected an error with the environmental matrix?
- What steps can we take to ensure that the process for the next formal change within this project takes into account the lessons learned from the findings to date?
- What practical steps can be taken to ensure that everyone who has a role in a capital project (such as clinicians) have the necessary knowledge, skills & experience to effectively discharge that role?
- As a general point, the management response needs to state what action is going to be taken to address all the issues which the final report may raise.

57.5 The Committee agreed that it would be appropriate for the Finance and Resources Committee to consider the update report and its recommendations, together with the observations from the Audit & Risk Committee, and then provide feedback to Ms Brown. As the audit is still a work in progress, the Committee also agreed that it would be appropriate for the Chair of the Finance & Resources Committee to provide an update to the Board when it is in private session.

57.6 The external auditors confirmed that they would liaise with Ms Brown, to inform their work and the follow-up to the Auditor General's Section 22 report.

57.7 The Committee noted that the timescale would likely be the end of March 2020 to allow enough time for completion of all fact checking. Parts of the report would be shared with individual parties for fact checking.

57.8 It was noted that an extra Audit and Risk Committee may be required at the end of March 2020 to allow a timeline for the final report to go to the 8 April 2020 Board meeting.

58. Draft 2020/2021 Internal Audit Plan

58.1 Ms Brown introduced the draft 2020/2021 Internal Audit Plan. It was noted that this was the initial first draft and the purpose of the update was to provide Committee members with an update on Internal Audit planning and the next steps to allow the plan to come to the 27 April 2020 Audit and Risk Committee meeting for fuller discussion and approval.

58.2 The initial draft plan was based on an update of the 3-year strategic internal audit plan, a consideration of previous internal audit review areas and areas which had been identified as higher risk, and a review against the latest strategic risk register.

58.3 The Committee discussed the initial first draft and whether there was any area of risk and/or themes they would like to be considered for the internal audit plan. It was noted that an updated plan would then go to the Corporate Management Team for review and consideration. Ms Brown pointed out that the Plan would also consider the balance of strategic vs operational focus, core assurance alongside any planned internal audit advisory work and the phasing of planned reviews alongside internal audit review sponsors.

58.4 The following points were noted:

- The Proposed Internal Audit Sponsor column should always show the Responsible Director's name.
- It was agreed to move the Governance (Assurance mapping and Blueprint for Corporate Governance) internal audit out of Quarter 1, given that the team concentrated on year-end processes at that time, and the audit was not time sensitive.
- Mr Payne highlighted that the Board had recently approved 'Our Priorities for Continuous Improvement'. Ms Brown agreed to consider this as part of the process of developing the internal audit plan.
- Mr Payne highlighted that the Internal Audit Charter needed to be reviewed, in light of the national work that he was currently undertaking to develop a model terms of reference for audit committees. He also highlighted that the revised Standing Orders for the Board reserves the appointment of the Chief Internal Auditor to the Board. Ms Brown agreed to work with him on that.

JB/AP

58.5 There was discussion on the review area of delayed discharges and working with council counterparts; financial sustainability; timing and scope around Recovery Plan work; Strategic higher areas of risk; how to avoid duplication of effort; the best use of the internal audit resource; environmental management and sustainability; pension tax implications for hospitals and general practice.

58.6 The Committee noted that the draft 2020/2021 Internal Audit Plan would go to the Corporate Management Team and the final Internal Audit Plan would come back to the 27 April 2020 Audit and Risk Committee.

JB

59. Follow-Up of Management Actions Report (February 2020)

59.1 Ms Brown introduced the summary of the progress made by management in closing agreed management actions arising from Internal Audit reports since the last meeting in November 2019. It was noted that there were no concerns around the implementation of management actions.

59.2 There was discussion around consultant job planning audit actions, relationship to TTG and performance outcomes. Ms Brown confirmed these areas would be picked up by Miss Tracey Gillies when the update paper on consultant job planning comes to the Committee.

JB/TG

59.3 The Committee also discussed the Patient Funds – Adults with Incapacity actions where no update had been provided. Ms Brown stated that there was an escalation process being followed to follow up on these actions. It was noted that outdated information available on the intranet had now been removed and the policy had been put under review.

59.4 The Committee noted the contents of the report.

60. External Audit Plan

60.1 Mr Brown and Mr Eardley introduced the document summarising the work plan for the 2019/20 Scott-Moncrieff external audit of NHS Lothian.

60.2 There was discussion on the work plan and areas such as executive remuneration, key audit risks, capital transactions, performance indicators, financial sustainability and targets, RHCYP/DCN/CAMHS audit risk and dual reporting arrangements with Audit Scotland.

60.3 There was further discussion on performance metrics and the context that these should be looked at against. For example, the agreed AOP with the Scottish Government which was based on resources available, level of financial resource in the system and the NHS Lothian NRAC position.

60.4 The Chair stated that this was a well set out, comprehensive and helpful report. However there was an element of implied conclusions and it would be up to the Committee and full board to lay out all relevant factors when the final report is received in June 2020.

60.5 The Committee accepted the plan as laid out and noted that the final Audit Report would come back to the June Audit and Risk Committee.

CB/DE

61. Counter Fraud Activity

61.1 Mr Old presented the report updating the Committee on counter fraud related activities since the Committee's last meeting, and providing assurance that all suspected frauds are accounted for and appropriate action is taken.

61.2 There was discussion around ongoing preventative work; internal controls; detection and cases that go to court. It was suggested that the Committee would find it helpful if a date that cases are referred to the Crown Office could be added to the Appendix 1 table, so that any pattern of delays could be picked up. Mr Old would take this forward.

JO

61.3 The Committee accepted this report as a briefing on the current status of counter fraud activity and agreed to take a significant level of assurance that all cases of suspected fraud are accounted for and appropriate action is taken.

62. Review of the NHS Lothian Standing Orders

62.1 Mr Payne introduced the report providing the Committee an opportunity to review the proposed revised Standing Orders.

62.2 The Committee reviewed the proposed revised Standing Orders for NHS Lothian, which fully adopt the text in the model Standing Orders. The Committee accepted significant assurance that the development of the model Standing Orders was a comprehensive exercise, and the model is up-to-date with legal and technical requirements. The Committee agreed to recommend the Standing Orders to the Board for approval.

AP

63. South East Payroll consortium business case

63.1 Mr Marriott informed the Committee that NHS Lothian had not been selected as the leadership board for the consortium. The Committee noted that this work would be led by NHS NSS.

64. Any Other Competent Business

64.1 There were no other items of competent business.

65. Date of Next Meeting

65.1 The next meeting of the Audit and Risk Committee will take place at **9.00** on **Monday 27 April 2020** in **Meeting Room 8&9, Fifth Floor, Waverley Gate**.

66. Future Meetings

22 June 2020
24 August 2020
23 November 2020

Chair Signed 22/05/2020.

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 26 MARCH 2020
VIA TELECONFERENCING

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

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

Officers Present from NHS Lothian/East Lothian Council:
Mr P Currie

Clerk:
Ms F Currie

Apologies:
None

Declarations of Interest:
Paul White declared an interest in relation to Item 4, in his role as an employee of ELCAP.

The Chair welcomed members to the meeting which was being conducted via teleconferencing. She also welcomed Marie Sharp of the East Lothian Courier who was present via telephone.

1. MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD OF 27 FEBRUARY 2020 (FOR APPROVAL)

The minutes of the East Lothian Integration Joint Board (IJB) meeting on 27 February 2020 were approved.

2. MATTERS ARISING FROM THE MINUTES OF 27 FEBRUARY

There were no matters arising.

3. COVID-19 EMERGENCY RECESS PROCEDURES

The Chief Officer had submitted a report putting in place procedures for a decision making process in the event that East Lothian Integration Joint Board and its associated committees were unable to be convened as a result of the current COVID-19 outbreak.

Paul Currie presented the report outlining the arrangements to be put in place for dealing with essential business over the coming weeks and informing members' that, once in emergency recess, all meetings of the IJB and its committees would be cancelled until further notice. He also highlighted the implications for the Integration Scheme review and the publication of the IJB's annual performance report.

The Chair referred to the section of the report relating to Engagement and the requirement for IJB meetings to take place in public. She said she was seeking advice from the Scottish Government on the issue of public meetings and, in the meantime, she reminded members that a representative from the East Lothian Courier was present at this meeting.

The Chair also confirmed that both she the Vice Chair had nominated Deputes in case of need. The Depute for the Chair would be Shamin Akhtar and the Depute for Peter Murray would be Fiona Ireland.

Mr Murray asked about the likelihood of additional funding to cover the cost of dealing with COVID-19 and if, in the meantime, all associated costs could be recorded to ensure that there is no detriment to the IJB.

Claire Flanagan said it was unclear at present if there would be additional funding for creating capacity in hospitals to deal with COVID-19. However, she was continuing to link with the partners and seek clarity from the Scottish Government. She agreed to update members when more information was available.

Alison MacDonald advised that a mobilisation plan had been drawn up and an application would be made to the Scottish Government for the funding needed to implement the plan. This was estimated to be £5m. She added that if the money was not provided then the work could not be done.

In reply to a question from the Chair, Ms MacDonald indicated that no additional staff training would be required as part of the mobilisation plan but training would be needed

to support the redeployment of staff to other duties. The costs had yet to be identified and the 4 Lothian IJBs were currently working on this.

Paul White asked about additional support for third sector organisations to help keep their staff safe, and help for third sector providers running Council-commissioned services who may have to cancel those services due to the impact of COVID-19.

Ms MacDonald advised that East Lothian Council had issued a letter to third sector providers confirming that they would not be disadvantaged by the impact of COVID-19. She also advised that a fund had been created, with money from the Scottish Government, to ensure third sector resilience and providers could apply directly for support. She confirmed that additional funding would be fast tracked to the areas that required support.

Ms Ireland referred to the recommendations contained in the report and the proposal that the emergency recess period last 'until further notice'. She suggested that it might be better to place a timescale on this, e.g. 3 months, at which point the measures could be reviewed.

She formally proposed that the following sentence be added to recommendation 2.2: "*These would be in place from 27th March 2020 for a period of up to 12 weeks, at which point the position would be reviewed*." This proposal was seconded by Mr Murray.

In reply to questions from the Chair and Councillor Akhtar, Ms MacDonald confirmed that a volunteer scheme had been set up, similar to that in England and Wales. To date, 2000 people had registered and the first 560 would receive their virtual induction on 30th March, with the remainder being filtered in over the coming weeks. These volunteers would undertake roles such as ward helpers or assisting in supporting vulnerable people in the community. However, they would not be working with patients with COVID-19.

Thomas Miller stated that a number of NHS Lothian administration staff were also willing to volunteer.

David Binnie asked if it was still the IJB's intention to issue a tender for services in June of this year. Ms MacDonald said that she was seeking advice and would update members once a decision had been taken.

Ms MacDonald responded to further questions from Mr Murray and Patricia Donald around the ongoing management of operational matters. She confirmed that all of the usual clinical and care governance reports would still be submitted and that the committee would hold virtual meetings to review issues. In addition, the DATIX system and other recording and reporting processes would remain in place and function as normal. She was also working closely with the other Lothian IJBs and the partners, and daily reporting on staffing issues was already taking place.

Ms MacDonald indicated that in relation to operational matters, such as staffing, her first point of contact would be NHS Lothian or East Lothian Council. However, she would report to the IJB if there was likely to be an impact on the delivery of the Strategic Plan.

Dr Donald felt that the situation was being managed very well and she reminded Ms MacDonald that the IJB members were also here to support her.

Ms MacDonald thanked Dr Donald. She then advised that, in addition to the measures already reported, a decision-making log for both health and social care would be maintained throughout the emergency recess period. This would record the decisions,

the reasons for decisions and how these accorded with national guidance. The relevant management teams would also be meeting daily. The IJB would be updated on a monthly basis, or more frequently if necessary, and this would include a staffing update. At the first full meeting of the IJB after the end of the recess period, a report would be presented listing the decisions taken at IJB level and those taken by the CO/CFO in consultation with the Chair and Depute Chair.

The Chair thanked Ms MacDonald and added that it would be useful to have a formal debrief at some point.

Councillor Neil Gilbert asked about current staffing levels in care homes and within the care at home sector. Ms MacDonald said she was in almost daily contact with independent care home providers and ELC care homes and no alerts had been received as yet. In relation to independent care providers at home, there had been a few issues but no major concerns regarding staffing. Overall, she said that services were managing at present but staffing could become a concern in the coming weeks. She added that the biggest issue was making sure that PPE was available for independent sector staff and she continued to liaise with providers and care homes on this matter.

Mr Currie then drew members' attention back to the report and to the implications for the Integration Scheme review and the publication of the IJB's annual performance report. He advised that the Scottish Government had confirmed that the review would not need to be as comprehensive as previously requested and NHS Lothian had appointed an officer to deal with the review of all four Lothian Integration Schemes. Regarding the annual performance report, this would still be due for publication by 31st July but it would not be as detailed as in previous years.

The voting members agreed unanimously to approve the recommendations as amended.

Decision

The IJB agreed to:

i. Approve the COVID-19 Emergency Recess Procedures as outlined in the report;

ii. Delegate to the IJB Chief Officer, in consultation with the IJB Chair and Vice Chair, the decision to invoke the COVID-19 Emergency Recess Procedures. These would be in place from 27th March 2020 for a period of up to 12 weeks, at which point the position would be reviewed;

iii. Delegate to the Chief Officer, in consultation with the IJB Chair and Vice Chair, provision for specific business, as set out in the report;

iv. Request that the Chair and Vice Chair each nominate a Depute for the purpose of approving business submitted during the Emergency Recess should they themselves be unavailable;

v. Note the acceptance of delay in completion of work to review the Integration Scheme and production of the IJB Annual Performance Report; and

vi. Approve the amended East Lothian Integration Joint Board Standing Orders reflecting the Emergency Recess provisions.

4. BUDGET 2020/21 UPDATE

The Chief Finance Officer had submitted a report presenting the IJB with an update on the assumptions and the principles in the budget offers from East Lothian Council and NHS Lothian for 2020/21. The report also provided an update on the ongoing challenges facing the IJB and the work to support delivery of savings in the coming financial year, 2020/21.

Ms Flanagan presented the report advising Members that, while at the time of writing no formal budget offers had been received, the offer from East Lothian Council had been issued earlier that afternoon and the offer from NHS Lothian was due in early April. She pointed out that the report had been written from a 'business as usual' perspective and did not include any additional funding required for the IJB's response to COVID-19. She summarised the key points of the indicative budget offers including the additional funding from the Scottish Government in relation to social care.

Ms Flanagan informed members that she considered both offers to be in line with the current financial climate and challenges, and that they were based on previous budget planning covering the next few financial years. She referred to the challenges predicted in 2020/21 and explained that as financial plans for the coming year had been refined these challenges had reduced and would continue to be addressed through ongoing mitigation measures. Further detail of these measures would be shared at future meetings of the IJB.

She also confirmed that she was currently in dialogue with the partners with a view to ensuring that the IJB retained its anticipated underspend from 2019/20 to further boost its reserves. She concluded by cautioning that the financial position could change rapidly and significantly but that any such change would be reported to members.

In response to a question from the Chair, Ms Flanagan advised that she was still in discussion with colleagues to provide clarity as to whether the sum of £1.801M of additional Scottish Government funding would be sufficient to cover the cost of the IJB's new obligations.

Mr Murray asked what was meant by the statement in paragraph 3.10 of the report: *"NHS Lothian are keen to understand how the IJB will support financial balance through the delivery of savings and efficiencies..."* Ms Flanagan explained that NHS Lothian's financial plans were not currently in balance and they would be asking the four Lothian IJBs to support them by delivering 3% savings. The East Lothian IJB had managed to do this over the past two financial years by achieving underspends in both years.

Mr Murray also commented that currently most Acute service provision was not directed by IJBs and if this were to change in the future IJBs would see more clearly where money was being spent. Ms Flanagan acknowledged this but added that IJBs were currently developing processes to better understand financial pressures across these services and to develop plans for dealing with these.

The Chair commented that this was another reason for maintaining regular dialogue with other IJBs.

The voting members agreed unanimously to approve the recommendations.

Decision

The IJB agreed to:

i. Consider the principles in the East Lothian Council budget offer for 2020/21;

ii. Consider the principles and the indicative budget offer from NHS Lothian;

iii. Note the challenges facing the IJB and the work to mitigate these and deliver savings;

iv. Note the wider risks and, in particular, the rapidly developing situation in response to the COVID-19 pandemic;

v. Note COVID-19 Emergency Recess Procedures and the corresponding delegated authority these bring; and

vi. Delegate to the Chief Officer, in consultation with the Chief Finance Officer, the IJB Chair and Vice Chair, the authority to agree budgets with Partners on behalf of the IJB.

Signed .....

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

Minute

Edinburgh Integration Joint Board

3.00pm, Tuesday 14 April 2020

Held remotely by video conference

Present:

Board Members:

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

Officers: Ann Duff, Rachel Gentleman, Lauren Howie, Gavin King and Angela Ritchie.

Apologies: Christine Farquhar and Ian McKay.

1. Delegated Powers - Covid-19

The Board considered a report in relation to the Covid-19 emergency which sought approval to suspend meetings and delegate authority to the Chief Officer to take all urgent decisions.

The report advised that due to the outbreak, subsequent government advice and restrictions put in place and pressures on staff resource, alternative arrangements were required to be made for this period.

Decision

1) To note that the Board meeting to consider the budget would take place on 28 April 2020.

2) To agree that all other Board and committee meetings should be suspended until 30 June 2020, with a Board meeting to be scheduled in July 2020 to review the arrangements.

3) To delegate authority to the Chief Officer to take any urgent decision on behalf of the Board, in consultation with the Chair and the Vice-Chair, until the arrangements were reviewed by the Board in July 2020.

4) To agree that monthly conference calls would be held to provide members with updates and information on actions taken which were relevant to the IJB.

5) To agree that decisions which were considered politically sensitive should be reported to the Board.

6) To note that any directions which were currently sensitive could be published at a later date, or a restricted version could be made publicly available.

7) To note that the Chair and Chief Officer had weekly meetings and that the Chair would send a summary of any relevant updates to Board members following these.

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

2. Covid-19 Response

The Board resolved that the report be made publicly available, with the exception of the appendices, and that the public be excluded from the meeting during consideration of the item of business on the grounds that it involved the disclosure of exempt information as defined under Standing Order 5.9.

The report provided information on the actions taken by the Edinburgh Health and Social Care Partnership in response to the ongoing Covid-19 crisis. A mobilisation plan had been prepared by NHS Lothian which set out actions to create capacity within hospitals and the community and manage with a predicted depletion in the workforce.

Decision

1) To homologate the agreement of the Chair and Vice-Chair to the IJB's element of the NHS Mobilisation Plan.

2) To issue the direction attached at appendix 1 to the report by the Chief Officer.

3) To note that the Chief Officer, in consultation with the Chair and Vice-Chair, would oversee the operational implementation of the plan in line with authorities delegated through the NHS Lothian and Council arrangements.

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

Declarations of interest

Ella Simpson declared a non-financial interest in relation to the above item as EVOC was a potential recipient of funds for the third sector.

NHS LOTHIAN

Board Meeting
June 24, 2020

Director of Public Health and Health Policy

COVID-19 PUBLIC HEALTH UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board receive this update on COVID-19 which provides an update on the impact of the pandemic in Lothian.

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

2 Recommendations

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

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

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

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

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

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

3 Discussion of Key Issues

Background

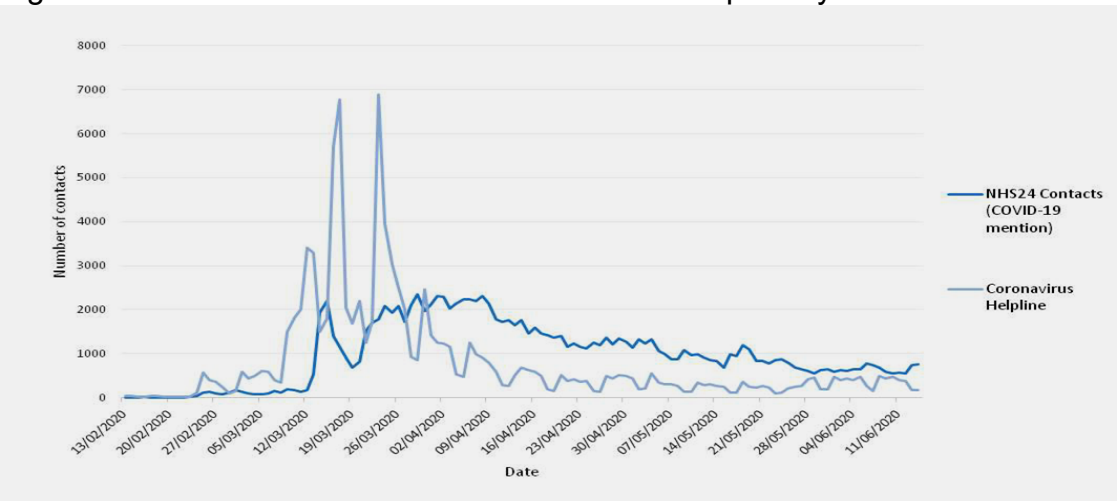
The pandemic continues to affect individuals and communities across the world. As of June 16, there have been 7,976085 cases (3,951,031 last month) and 436,430 deaths (277,098 last month) associated with COVID-19 reported globally since 31st December 2019. Since last month's report, an additional 78,953 people have tested positive in the UK (this said to include all UK sources), taking the total to 298,136.

4 The pandemic in Scotland

4.1 In Scotland 18066 patients have tested positive. The proportion of positive tests has fallen from approximately 19% to 8.6%. The number of deaths registered in Scotland that mention COVID-19 on the death certificate has continued to fall each week; 70 deaths were registered between June 8-14.

4.2 Public Health Scotland data indicate that, across Scotland as a whole, 331.5 people per 100,000 population have tested positive for COVID-19. The Lothian rate is just above the all-Scotland incidence. This remains an underestimate as people were not tested routinely during the period of widespread community transmission in March and into April when the focus was on self-isolation and lockdown as the public health measures necessary to reduce transmission. While there has been a significant decline from the peak of 7000 calls per day, the NHS24 COVID-19 advice helpline is still receiving 357 calls per day. In Lothian, the number of calls is continuing to fall with a 7 day rolling average of 100 calls per day with 72 community hub calls.

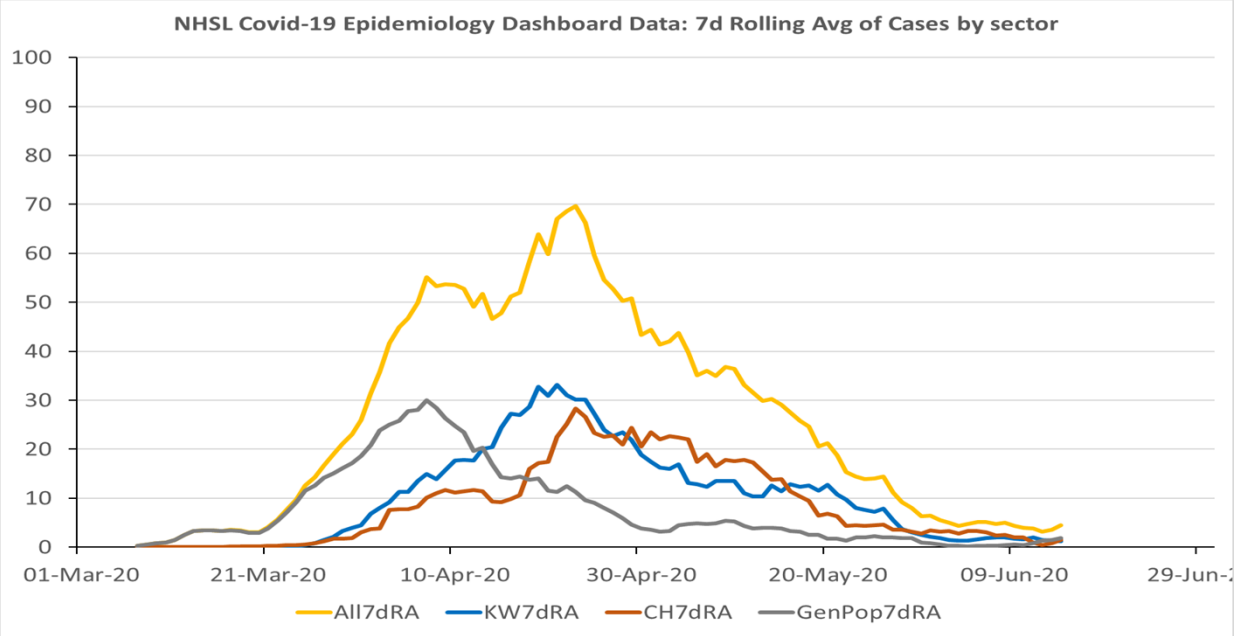
Figure 1: Number of NHS24 and NHS111 contacts per day



4.3 Number of confirmed cases over time

The daily number of confirmed cases illustrates the course of the outbreak to date (the epidemic curve). It also identifies the number of cases per day that require follow up, tracing of contacts, advice and support to self-isolate, including formal restriction under the Public Health Act (Scotland) 2008 where this is required. Confirmed cases of COVID-19 in NHS Lothian are now down to single figures a day. In the seven days to 13-Jun-20, 13 (42%) of 31 detected cases have been in the general population, 10 (32%) in care home residents and 8 (26%) in key workers and their families.

Figure 2: NHS Lothian Seven day rolling average of cases by sector



4.4. **Variation by Local Authority**

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

Table 1: Variation in confirmed cases by local authority (local data from week commencing June 14, 2020)

Local Authority	Number of confirmed cases	Rate per 1000
East Lothian	240	2.3
Edinburgh	1564	3.0
Midlothian	482	5.3
West Lothian	382	2.1
NHS Lothian	2669	3.0

4.5 **Age and sex distribution of positive cases**
The incidence of confirmed cases remains highest in people aged over 85 years and, at is higher among women. The incidence has declined in all age groups since the beginning of April 2020.

4.6 **Deaths by gender, occupation and socio-economic group**
While incidence is higher among women, death rates are higher among men. At national and international level, the risk of COVID-19 and COVID-related death varies by socio-economic group. As with incidence rates, while absolute numbers are small,

premature death rates are higher in those who were employed in key worker roles.

Figure 3 COVID-19 death rate by SIMD quintile, March to May 2020
Comparison between all-cause and COVID-related death rates

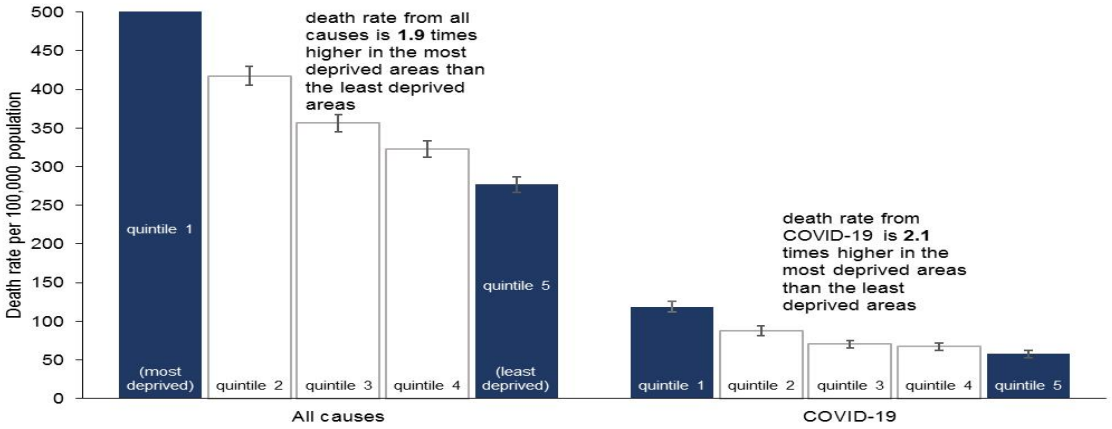
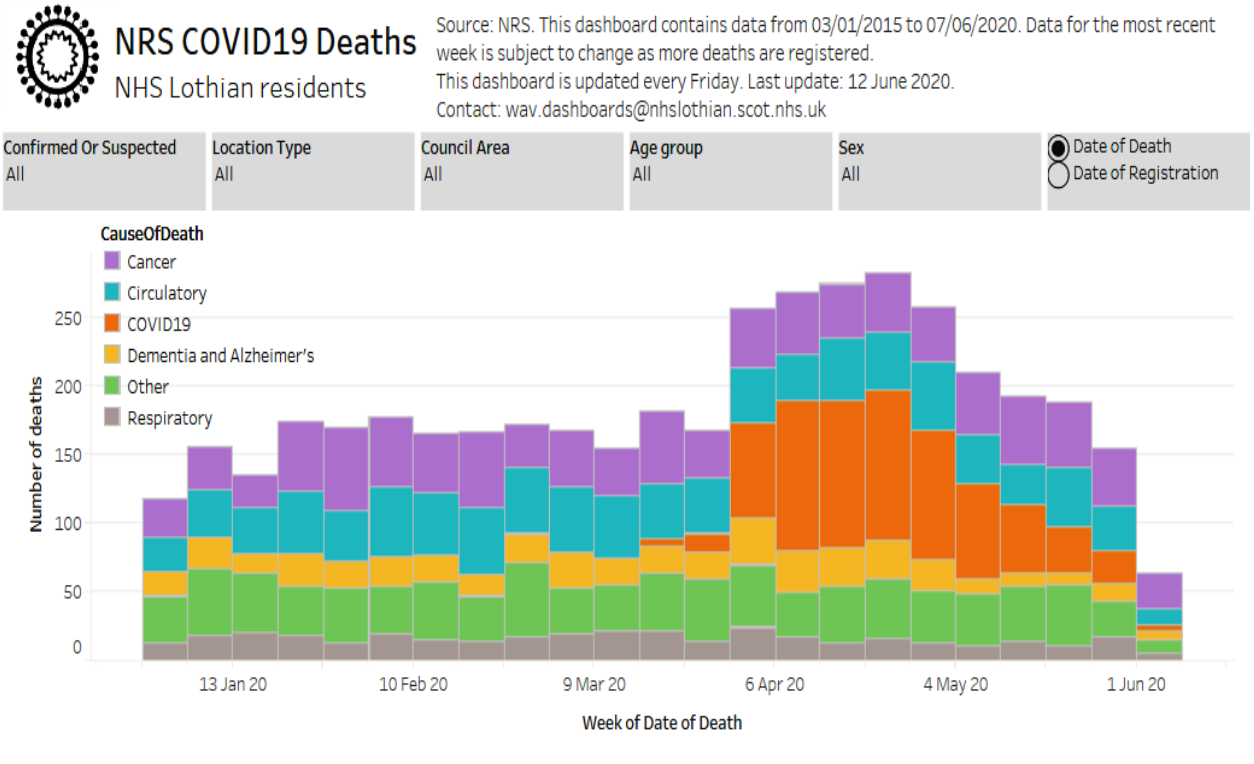


Figure S4: COVID-19 death rate by SIMD quintile, March to May 2020
https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/weekly-and-monthly-data-on-births-and-deaths/deaths-involving-coronavirus-

4.7 Deaths by main cause January to June 2020

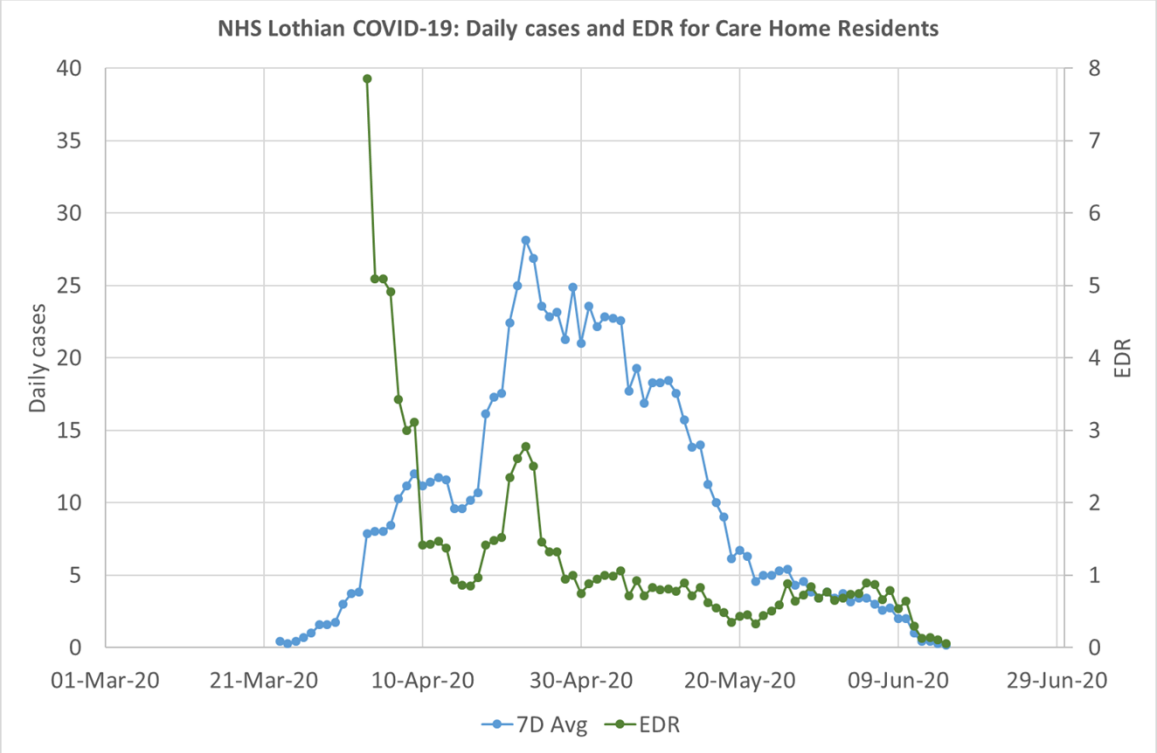
Figure 4 shows death by main cause by date of death. COVID-19 deaths shown include confirmed and suspected deaths. The data illustrate the excess deaths from COVID-19 occurring from mid-March, peaking in April and declining throughout May.



5 Care Homes and Closed Settings

5.1 At the peak of community transmission, and before lockdown, people in closed settings were exposed and as has occurred globally, outbreaks in care homes and closed settings have occurred. Since the report in May, the number of cases and the estimated dissemination ratio have reduced significantly as shown in Figure 5.

Figure 5: Seven day average number of new confirmed cases and Estimated Dissemination Ratio



5.2 While the Director of Public Health has an overall assurance role, the main focus of the public health team is outbreak prevention, management and control. Although the peak in new infections and deaths seen in April and early May 2020 is now over, the Health Protection Team continues to support 18 care homes and nine care homes have had new cases within the last 14 days. Since a new case in a care home (either first case, or first case following a 14 day gap) offers the greatest opportunity for prevention, Health Protection organises multiagency incident management teams for these homes including Health and Social Care Partnerships, care homes manager, care inspectorate and outbreak response and testing team. The resultant control measures usually include visits by HSCP care home support team, and testing of all consenting residents (where clinically appropriate to do so) and consenting staff who have not previously tested positive.

5.3 Testing in the context of an outbreak of COVID-19 is undertaken as part of an enhanced outbreak response. While some staff who test positive are completely asymptomatic, around 70% of staff who test positive as part of mass testing have symptoms that are consistent with COVID-19 on detailed review. These may be mild or atypical and not recognised as COVID-related. Household self-isolation has also been challenging as, where there are household contacts, they are also often care or key workers. As noted previously, to enable low paid care staff to self-isolate and avoid falling into poverty, they would require the practical and financial support that is usually

available to those excluded from work or otherwise restricted under the Public Health (Scotland) Act 2008.

6 Minimising the risk of significant community transmission as restrictions are lifted

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

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

7 Mitigating the wider impact of COVID-19 related disease

7.1 The additional risk of developing COVID-19 is compounded by the differential impact of measures designed to address the pandemic. These also have adverse effects on health and health inequalities and are felt most keenly by children and young people, people on low incomes, with poorer health and those groups that are often stigmatised or excluded.

7.2 Mitigation plans are being developed to provide ongoing practical, social, educational, employment and financial support for those individuals and communities that continue to face difficulties as a consequence of the impact of COVID.

To complement these measures, and to protect population health, it will be important to ensure that the policies implemented contribute to the development of a more inclusive and sustainable society and economic response to the challenges ahead.

8 Key Risks

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

9 Risk Register

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

10 Impact on Inequality, Including Health Inequalities

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

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

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

12 Resource Implications

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

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June 18, 2020
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This paper draws on the work of Dr Naomi Honhold, Dr Philip Conaglen, Dr Frederike Garbe Dr Janet Stevenson, Dr Lorna Willocks, Chris Bruce, Lothian Analytical Services, the wider public health and health policy directorate and colleagues in Public Health Scotland.

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Appendix 1: Measuring the transmissibility of disease using the Estimated Dissemination Ratio versus R

The Estimated Dissemination Ratio (EDR) is a direct and assumption free measure of how the dynamic of the epidemic is changing and is probably a more useful measure at local level than R. R, the reproduction rate, is a measure of the average number of secondary infections that occurs following the introduction of an infected person into a susceptible population. R is a precise measure of rate of spread but difficult to estimate for a new condition with asymptomatic and presymptomatic spread, unknown levels of susceptibility in the community and limited information about social contact as its estimation requires large populations, several data sources and significant assumptions to be made to do so in most situations. Similarly to R, an EDR of 1 indicates that 1 infected person infects one other person on average.

Appendix 2: Data Sources

- The most recent, detailed Scottish data cover the period up to June17 for epidemiology and activity and this report draws heavily on the Public Health Scotland COVID-19 reports [https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/covid-19-statistical-report/; https://beta.isdscotland.org/media/4756/2020-06-17-covid19-publication-report.pdf].
- The most recent data on deaths is June 17th **[**https://www.nrscotland.gov.uk/files//statistics/covid19/covid-deaths-report-week-24.pdf**].**
- Douglas M, Katikireddi SV, Taulbut M, McKee M, McCartney G. Mitigating the wider health effects of covid-19 pandemic response. BMJ 2020;369:m1557

NHS LOTHIAN

Board Meeting
24th June 2020

Director of Strategic Planning

TEST AND PROTECT PROGRAMME

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board **note** progress with the development of the Lothian Test and Protect (TaP) Programme.

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

2 Recommendations

2.1 The Board is recommended to note progress with TaP.

3 Discussion of Key Issues

3.1 Board members are aware of the elements of TaP on a national level;

- Increasing testing capacity;
- Building a tracing system to trace contacts and break the chains of transmission;
- Isolating individuals with positive results, and;
- Supporting those individuals as necessary.

3.2 This has also most recently incorporated the Cabinet Secretary commitment to offer workers in Care Homes who are asymptomatic a test on a weekly basis.

3.3 The lead for TaP is the Director of Strategic Planning, and a twice-weekly tactical group incorporating representation from public health, occupational health, laboratories, health and social care partnerships, and staff-side, has been established.

3.4 Testing capacity within NHS Lothian laboratories is currently at approximately 1200 tests per day, with plans in hand to expand this to 1500 tests per day in the next month. Nationally, the intention is to move to approximately 15,000 as a staging post, with the ability to flex up to 50,000 tests per day across Scotland if required. This non-NHS capacity is provided by the UK Government and is known as “Lighthouse” capacity.

3.5 NHSL labs are currently using an average of approximately 900 of these tests per day, focussing on symptomatic cases where these are new cases, are cases being treated for COVID-19, are new presentations at the community COVID-19 hub, for key health and care staff, or where clinical management or placement is dependent on a quick turnaround in labs. This capacity is also used to support outbreak management within care homes.

3.6 Testing capacity for other potential cases, including self-referred cases, and asymptomatic care home workers, is streamed towards the UK “Lighthouse” capacity. During the week of 15th June, additional capacity has been provided in the form of the “social care portal”, which is providing in the region of 9500 tests per week for care home workers.

3.7 NHS Boards are now required to have in place plans to offer tests to all care home workers, and the estimate is that there are approximately 12,000 workers in 188 establishments across the 4 local authority areas. These are not employees of NHS Lothian and indeed the proportion who are employees of local authority partners is a minority. Nonetheless, HSCPs have worked with these establishments and the current plan is that between 8th June and 22nd June 93% of all workers across the Lothians will have been offered a test. There are still definitional issues to be worked through as to how "all care home workers" will be measured, to take into account annual leave, sick leave, that some homes will have outbreaks under active management, etc.

3.8 NHSL has commenced its contact tracing service. As at 16th June, 216 index (first positive) cases had been contact traced, with less than 1 contact per index case. Plans are being developed to move to a national call centre model from mid-July, whereby complex tracing (key worker, care home worker, NHS staff, prisoner, etc) will be traced by NHS Boards and simple cases from the call centre. NHSL has identified more than 100 staff from shielded categories to support this service in the interim.

3.9 Isolation and support work is led by local authorities and indications are that this is working well to date. This incorporates food supplies, mental health support, and support for income and employment issues as required.

4 Key Risks

4.1 The key risks associated with this work are that without an effective Test and Protect programme Scotland will not be able to release lockdown arrangements.

5 Risk Register

5.1 This is covered on the corporate risk register as part of the COVID-19 risk analysis.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out as this is national policy targeted at the COVID-19 pandemic.

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

7.1 The Scottish Government is running a national communication campaign on TaP.

8 Resource Implications

8.1 The resource implications are currently over 100 staff members with associated salaries and infrastructure. The funding of these posts is being worked through nationally.

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List of Appendices

(none)

NHS LOTHIAN

Board Meeting
24 June 2020

Executive Director Nursing, Midwifery & Allied Healthcare Professionals

ENHANCED PROFESSIONAL OVERSIGHT OF CARE HOMES

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board accept this paper as the first in what will be regular updates to the Board in regards to the particular aspects of care homes that the Executive Nurse Director has been asked to take accountability for as detailed at paragraph 2.1. This paper does not address testing, outbreak management and ongoing surveillance which sits with the Director of Public Health (DPH).

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

2 Recommendations

2.1 To acknowledge the additional responsibilities on the Board, through the accountability bestowed upon the Executive Nurse Director, in relation to the 4 areas of Covid care in care homes for older people.

- Workforce requirements and supply of mutual aid
- Infection prevention and control, including PPE and cleaning requirements
- Education and training
- Supportive Review / Visits

and the requirement to provide professional advice to all other care home / residential facilities and care at home services operating within the Board area.

2.2 To note this work is closely aligned to a further Board responsibility for testing, outbreak management and ongoing surveillance which sits with the Director of Public Health (DPH).

2.3 To approve the delegation of the Board assurance on enhanced professional oversight of Care Homes to NHS Lothian Healthcare Governance Committee.

2.4 To support the risks arising from this additional responsibility and accountability for Care Homes for the Board to be included in the corporate risk register, and to delegate the approval of the terms of this to the Audit and Risk Committee.

3 Discussion of Key Issues

3.1 The Scottish Government issued a series of guidance and Cabinet Secretary Letters between 15th and 20th May 2020 establishing arrangements for an enhanced professional oversight of care homes (appendix 1 summarises the chronology).

3.2 These arrangements place a new and additional responsibility on Local Authorities and Health Boards, through the relevant clinical and professional leads, to provide daily support and oversight of the care provided in care homes within the Local Authority / Board areas as a consequence of the Covid pandemic.

3.3 The Cabinet Secretary has issued a Variation Order on the role of the Executive Nurse Director to be accountable for nursing leadership, support and guidance to care homes specifically in relation to Covid workforce requirements (including the provision of mutual aid from NHS resources), infection prevention and control including Personal Protective Equipment (PPE) and cleaning requirements, provision of education and training and supportive reviews or visits of all care homes and care at home.

3.4 The Chief Nursing Officer has provided clarity around the extent of the Executive Nurse Director's accountability. The Cabinet Secretary letter of 18th May states accountability for care homes and care at home services, it has been clarified that in respect of care at home services the Executive Nurse Director would have a professional advisory role only and matters relating only to social care are a matter for the Chief Social Work Officer within the Councils and the Chief Officers of the IJB.

3.5 Medical Directors and Directors of Public Health also have responsibility within the revised arrangements. Medical Directors are required to support provision of specialist medical and pharmacy input to care homes and the Director of Public Health is responsible for testing (of staff and patients), outbreak management and ongoing surveillance.

3.6 A governance framework has been established for the leadership, care and support elements of the new responsibilities (appendix 2) and proposes that the Board oversight is via the Healthcare Governance Committee.

3.7 It has been agreed with the H&SCP Joint Directors that the framework established for care homes for older people will be used to support this requirement for enhanced professional oversight across all residential care facilities within the respective Local Authority boundaries, which is a total of 188 establishments. It should be noted however that this framework does not extend to the care home staff and patient testing, outbreak management and ongoing surveillance which will be subject to a separate sub structure feeding into the NHS Lothian Strategic Oversight Group. This will be detailed in a separate Board paper being brought by the Director of Public Health.

3.8 The normal regulatory arrangements for care homes are via the Care Inspectorate (CI). These remain and under the Coronavirus Bill the Care Inspectorate are required to report fortnightly to the Scottish Parliament on all inspections carried out. Under the current arrangements for the Covid 19 outbreak the Director of Public Health has to approve all Care Inspectorate visits to care homes. Under the revised enhanced professional oversight arrangements a senior Nurse from NHS Lothian is now participating in all unannounced Care Inspectorate visits taking place, together with Healthcare Improvement Scotland (HIS). The NHS and HIS representatives are particularly focussing on infection prevention and control measures in the care homes, including the provision and use of Personal Protective Equipment (PPE) and the cleaning requirements to manage Covid within the care home. To date 6 unannounced inspections have been carried out in Lothian under this joint visiting arrangement with one further inspection planned.

3.9 The parallel requirements of the Care Inspectorate and the Health aspects of assurance has led to improved sharing of intelligence between organisations and participation of CI in all levels of the NHS Lothian governance structure.

3.10 Whilst the Board has an escalation via the Chief Nursing Officer / Director General of NHS in Scotland and ultimately to the Cabinet Secretary the Care Inspectorate as the regulator has statutory powers and can take a facility through the legal process to revoke

the registration. The CI also has a statutory power of entry to care homes to ensure people are safe and well. This underlines the importance of the various bodies working extremely closely to deliver the respective responsibilities and accountabilities, regulation, inspection and support.

3.11 There are longstanding locally supportive infrastructures via the Community Nursing teams and / or Care Home Support Teams as well as the Locally Enhanced Service agreements with GP practices. Under the enhanced arrangements for professional oversight these arrangements will be further enabled to provide additional support to Care Homes as necessary.

3.12 Each H&SCP has been allocated an identified Consultant in medicine of the elderly to provide any specialist support that is necessary, over and above the GP Locally Enhanced Service arrangements. A liaison Pharmacist has also been identified to provide care home support around medicines and prescribing as required and each partnership has a Clinical Education practitioner to provide access to education that is more clinically focussed, enhancing the existing provision.

3.13 Given the impact of Covid 19 has been largely on care homes for older people the work within the Board and H&SCPs has been focussed on this group of facilities. This approach was confirmed in the CNO letter of 15th June 2020, but does recognise that should clinical input, advice and support be required by other residential care settings within the Board area there is an expectation that the Executive Nurse Director will provide professional advice. Table 1 summarises the distribution of Care Homes for Older People by sector, together with bed numbers and staff numbers. The detail by H&SCP is included at appendix 3.

Table 1 Care Homes for Older People

Number of	**Care Homes**	**Beds**	**Staff**
Local Authority	19	758	795
Voluntary	16	596	504
Private	74	3903	3595
TOTAL	**109**	**5257**	**4894**

3.14 It is Scottish Government policy currently to require patients being discharged from hospital to care home facilities to have two negative Covid tests prior to discharge.

3.15 The current Public Health requirement is for care homes to close to admissions for 14 days after the last notified infection. The number of care homes closed to admissions as a consequence of outbreaks varies but as of 16th June 2020 13 care homes (out of 109) are closed.

3.16 Additionally care home providers can opt not to take new residents according to their business model / organisational policy. This is not an aspect of the care home service that the Board can control; it is out with the extent of the accountabilities delegated to the Executive Nurse Director on behalf of the Board.

3.17 Through the daily huddles and weekly oversight group the extent and range of visits and support to care homes will be choreographed to ensure that the visits do not overlap or overwhelm the care home.

3.18 NHS Lothian has developed a structured approach to the care home review / visits to be carried out by H&SCP colleagues. This has been tested in each of the partnerships and schedules for conducting the reviews / visits have been developed and deployed within each H&SCP.

3.19 It is recognised that there may be areas of concern that require escalation. Each stakeholder will have a prescribed escalation route. The importance of these escalations running in parallel and balance is critical to the credibility of the processes being put in place. There is work underway with the Care Inspectorate to ensure appropriate and proportionate escalations take place.

3.20 Each of the H&SCP have a Care Home Support Team, although these are at different levels of maturity across the Board. These teams are key to both supporting the visits and reviews of care homes and either directly providing, or facilitating the teams that will provide, wrap around input to address any concerns identified.

3.21 The Board's accountability is very specifically focussed, through the Executive Nurse Director and the Director of Public Health, to 5 aspects of care provision. These are

- Testing, outbreak management and ongoing surveillance - responsibility of the Director of Public Health and subject of a separate Board paper.
- Workforce requirements and supply of mutual aid
- Infection prevention and control, including PPE and cleaning requirements
- Education and training
- Supportive Review / Visits

3.22 Workforce requirements and supply of mutual aid
A standardised approach to the delivery of mutual aid has been developed, this is illustrated at appendix 4. The workforce mutual aid process is a position of last resort for the care homes. The local normal escalation / contingency arrangements should be exercised before instigating the mutual aid arrangements. The NHS Lothian Staff Bank is providing supply against a planned level of demand, dictated by the H&SCP. This is closely monitored at the pan Lothian daily huddles and takes account of the staff testing schedules and the identified areas of concern arising from local reporting and supportive visiting. Additional ad hoc supply could be made available if the need arose.

3.23 Infection Prevention and Control (including PPE and cleaning requirements)
The extant arrangement for provision of Infection Prevention and Control (IPC) to care homes is through a dedicated post in the Health Protection team, currently part of the Public Health resource.

Funding has been agreed, through the Corporate Management Team, to enhance the team providing the Infection Prevention Control support to community services and care homes. This will establish a more robust team embedded in the H&SCP, with appropriate supervisory and specialist support.

NHS Lothian has a well-established process in place for the management of PPE. The Executive Nurse Director chairs meetings three times a week which has oversight of the use and supply of PPE across all areas and offers an opportunity to highlight any concerns around the supply to care homes. .

The current process for all care homes is to seek PPE through their business as usual routes and this is supplemented by the HSCP Hubs through supply from NSS. This system is working well and there is a Memorandum of Understanding in place between

Scottish Government, National Services Scotland, H&SCPs, Scottish Care and the Coalition of Care & Support Providers to ensure the adequate provision of PPE

3.24 Education and Training

Care homes will have access to a range of training and education through existing models, either via the local authority, private training groups or the care home provider.

The Clinical Education department have identified a link person for each H&SCP. A prioritised suite of training activity is being offered on demand to care homes, delivered as bite sized sessions of 30 minutes to enable participation during the working duty. The topics being offered are pertinent to improving the care delivered to patients with Covid 19:-

- Infection Prevention & Control and Safe Use of PPE
- Food, Fluid & Nutrition
- Management of Dementia & Delirium
- End of Life Care

It is acknowledged that the requirement for training may not be satisfied by the provision of a single training session. In addition to this "formal" training input all opportunities to promote learning and good practice are being taken by those visiting care homes, either to deliver care (e.g. the district nursing teams), to provide support and decision making (e.g. the care home support team, GPs, specialist nurses) or those undertaking support visits as part of the Board's wrap around input to care homes.

It is acknowledged that the number of attendances at training is not the most useful measure of success in this regard, rather the outcomes being observed during supportive visits will demonstrate the effectiveness of the training and ongoing reiteration of messaging.

3.25 Supportive Review / Visits

The review of care homes is a daily activity, and a dataset developed by the Scottish Government is being expanded to provide a more comprehensive picture of care home activity and outcomes. This will focus efforts around supportive visits, staffing and education where most required.

The purpose of the supportive visits is to provide a line of sight for the Executive Nurse Director, independent of other regulatory visits (described above in paragraph 3.7). Together with key metrics the outcomes of these visits will provide the assurance to the Executive Nurse Director and subsequently the basis of the reporting to the Board. It is proposed to report regularly via the NHS Lothian Healthcare Governance Committee.

Each H&SCP is determining a local schedule of visits, based on the priority care homes and the resource intensity to deliver this. An electronic tool to capture key observations has been developed to optimise the clinicians time in carrying out these visits and the subsequent write ups. It is recognised that few visits will be a one off; the majority of care homes will require some form of supportive follow up and the H&SCP / Board need to have adequate resources to deliver the support identified. The enhancement of Care Home Support Teams and Community and Care Home IPC is therefore essential to assuring the standards of care relating to Covid 19 being delivered in care homes.

4 Key Risks

4.1 NHS Lothian has acquired accountability for the standards of care delivered by commercial companies in a range of facilities over which it has no direct jurisdiction. All efforts to deliver on this accountability are founded in the ability of staff to work co-operatively and supportively with these care homes and the extent of the receptiveness of the care homes to that support. The risk that sub optimal care is provided is being mitigated through a co-operative and supportive approach to the accountabilities, working closely with the Care Inspectorate, the IJB's / H&SCP and the representative body for many care homes – Scottish Care.

4.2 The Coronavirus Bill includes the provision for the Scottish Ministers and / or public bodies to intervene in the event a care home provider was unable to continue to deliver care. This responsibility to take over and run a facility in such an event may be delegated to the NHS Board. This is a position of last resort and every effort to mitigate reaching this outcome would be put in place by a series of interventions by both the Health partners and the Care Inspectorate.

4.3 The risks around the capacity to deliver testing as per Scottish Government policy are addressed in a separate paper on the testing arrangements there is however a risk to the continued delivery of care if a significant number of care home staff are isolated as a consequence of being close contacts of positive staff cases. This risk is being mitigated through provision of and training in the use of PPE, and the use of Staff Bank to meet demand for staffing against known testing schedules.

4.4 Financial costs have already been incurred i.e. circa £400,000 in relation to enhancing the Community and Care Home Infection, Protection and Control and to support to the Executive Nurse Director take forward the work that is now required. In addition, there will be further costs of staff time undertaking visits and education and training.

5 Risk Register

5.1 The change in responsibility and accountability of key officers within the Board in relation to the standards of care (specific to Covid 19) places a significant risk upon the Board for services that are not within the Board's direct control.

5.2 There is a complexity in the landscape in which this risk sits, as there are other stakeholders and the regulator who have responsibilities and accountabilities also.

5.3 A project risk register has been initiated and a risk strategy has been considered by the NHS Lothian Care Home Oversight Group. This group will review the risks around all aspects of the delegated accountability on a weekly basis in the first instance. The extent of the risks described above is beyond the control of the project team and any one H&CSP therefore it is proposed to take define the corporate risk for approval on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 This paper describes the response to a policy directive from the Scottish Government. An impact assessment has not been carried out.

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

7.1 This paper describes the response to a policy directive from the Scottish Government.

8 Resource Implications

8.1 As described in paragraph 3.22 c£400k has been agreed on a recurring basis to enhance the Community and Care Home IPC.

8.2 A non recurring expenditure of c£15k has been agreed to provide hardware and electronic solutions to data capture and reporting of visits to care homes.

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Appendix 1: Chronology
Appendix 2 : Care Home Governance Framework
Appendix 3: Care Homes for Older People
Appendix 4: Care Home Workforce Mutual Aid

Appendix 1 Chronology

15th May 2020

Scottish Government issued an update to the **National Clinical and Practice Guidance for Adult Care Homes** in Scotland during the COVID-19 Pandemic.

17th May 2020

Cabinet Secretary Letter setting out new and additional responsibilities for **multi professional oversight of care homes from local authorities and Health Boards**.

18th May 2020

The role and responsibility the Health Board Executive Nurse Director is subject to a Cabinet Secretary Variation Order, effective from the 18th May to the 30th November 2020 with the **Exec Nurse Director having accountability for the provision of nursing leadership, support and guidance within the care home and the care at home sector**.

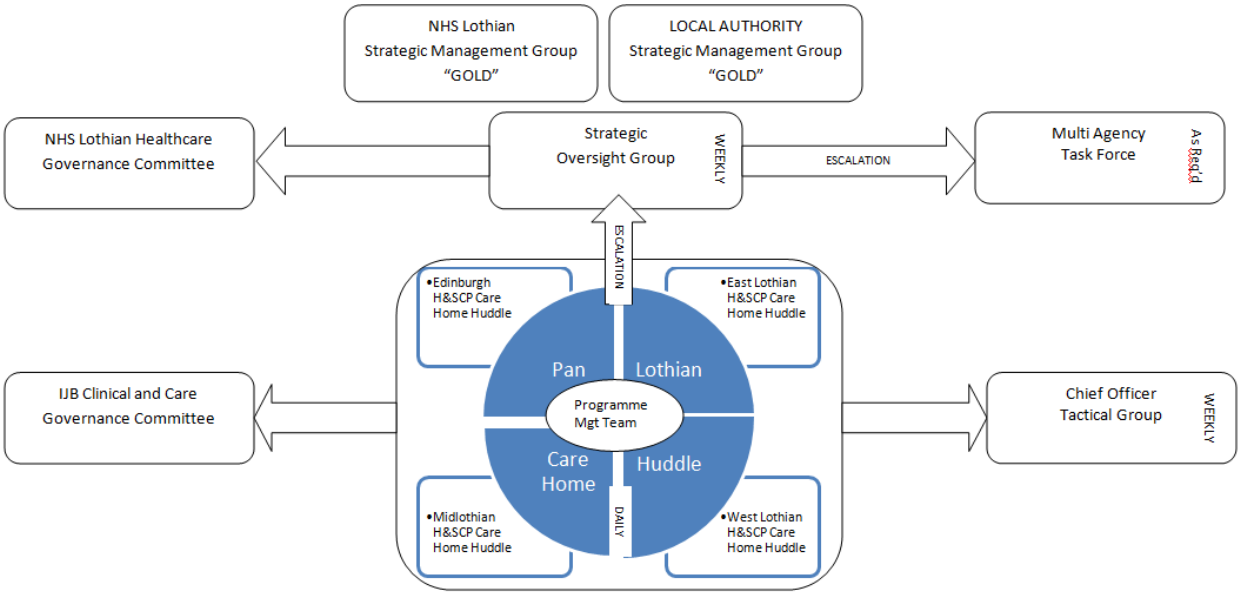
20th May 2020

The Interim Chief Medical Officer has instructed Health Boards to encourage the **involvement of geriatricians in supporting older people in care homes**.

15th June 2020

The Chief Nursing Officer has provided **clarification around the accountabilities** for Executive Nurse Directors.

Appendix 2 Governance Structure



Appendix 3 Care Homes for Older People

Care Homes - Edinburgh	ServiceProvider	Registered_Places	ServiceType
Braid Hills Nursing Centre	BUPA Care Homes (ANS) Limited	119	Private
Abercorn Nursing Home	Abercorn Care Ltd	18	Private
Ashley Court Care Home	Randolph Hill Nursing Homes (Scotland) Ltd	57	Private
Belgrave Lodge Nursing Home	Dixon Sangster Partnership	33	Private
Braeside House	Royal Blind Asylum and School	70	Voluntary or Not for Profit
Cameron Park Nursing Home	Sheila and Campbell Normand, a partnership trading as Cameron Park Nursing Home	24	Private
Chamberlain Road Nursing Home	Elder Homes Limited	29	Private
Claremont Park Nursing Home	Claremont Park Limited	34	Private
Cluny Lodge Nursing Home	Elder Homes Limited	72	Private
Erskine Edinburgh Home	Erskine Hospital	72	Voluntary or Not for Profit
Gilmerton	Four Seasons Health Care (Scotland) Limited, a member of the Four Seasons Health Care Group	60	Private
Lennox House	Viewpoint Housing Association Ltd	35	Voluntary or Not for Profit
St. Raphael's Care Home	Viewpoint Housing Association Ltd	63	Voluntary or Not for Profit
Struan Lodge Nursing Home	Struan Lodge Ltd	30	Private
Eagle Lodge	Salvation Army	35	Voluntary or Not for Profit
Davidson House	Salvation Army	40	Voluntary or Not for Profit
Queens Bay Lodge	Church of Scotland Trading as Crossreach	28	Voluntary or Not for Profit
The Elms	Church of Scotland Trading as Crossreach	40	Voluntary or Not for Profit
Morlich House	Church of Scotland Trading as Crossreach	23	Voluntary or Not for Profit
Fords Road Home for Older People	City of Edinburgh Council	36	Local Authority
Clovenstone House	City of Edinburgh Council	35	Local Authority
Ferrylee	City of Edinburgh Council	43	Local Authority
Jewel House	City of Edinburgh Council	32	Local Authority
Cherry Oak Care Home	City of Edinburgh Council	19	Local Authority
Southpark	Southpark	32	Voluntary or Not for Profit
Guthrie House	Guthrie Court Limited, a member of the Four Seasons Healthcare Group	88	Private
Camilla House	Sanctuary Care (Kler) Limited	39	Private
Marian House	Viewpoint Housing Association Ltd	35	Voluntary or Not for Profit

Blenham House Care Home	Randolph Hill Nursing Homes (Scotland) Ltd	60	Private
Strachan House Care Home	Barchester Healthcare Ltd	83	Private
Marionville Court	City of Edinburgh Council	60	Local Authority
Castlegreen	Tamaris (Scotland) Limited, a Member of the Four Seasons Health Care Group	60	Private
Viewpark	Abercorn Care Ltd	21	Private
Spring Gardens	Abercorn Care Ltd	21	Private
Belleville Lodge Nursing Home	Mansfield Care Limited	29	Private
Braeburn Home	Braeburn Home	18	Voluntary or Not for Profit
North Merchiston	Tamaris (Scotland) Limited, a Member of the Four Seasons Health Care Group	60	Private
Inch View	City of Edinburgh Council	60	Local Authority
Forthland Lodge Care Home	Antonine Care Limited	47	Private
Lorimer House Nursing Home	Lorimer House Ltd	37	Private
Murrayfield House Nursing Home	HC-One Limited	100	Private
Letham Park Care Home	Renaissance Care (No1) Limited	70	Private
Sir James McKay House	Scottish Masonic Homes Limited	20	Voluntary or Not for Profit
Thorburn Manor Nursing Home	Thorburn Manor Limited	34	Private
Drumbrae Care Home	City of Edinburgh Council	60	Local Authority
Cairdean House	Care UK Limited	90	Private
Eildon House	Eildon Care Limited	24	Private
Canal View Care	Canal View Care Limited	20	Private
Royston Court	City of Edinburgh Council	60	Local Authority
Colinton Care Home	Whitefield Nursing Home Limited	53	Private
St. Margaret's Care Home	Whitefield Nursing Home Limited	60	Private
Manor Grange Care Home	Manor Grange Care Home LLP	83	Private
Victoria Manor Nursing Home	HC - One Oval Limited	118	Private
Lauder Lodge	Care UK Community Partnerships Ltd	60	Private
Morningside Manor Care Home	Morningside Manor Limited	42	Private
Cramond Residence	Cramond Residence Limited	74	Private
Northcare Manor	Northcare (Scotland) Ltd	74	Private
Haugh House	Mansfield Care Limited	10	Private
Craighall House	Mansfield Care Limited	12	Private
Murrayside	Care UK Community Partnerships Ltd	63	Private
Glencairn	Renaissance Care (No 6) Limited	26	Private
Milford House Care Home	Renaissance Care (No 5) Limited	28	Private
Trinity House Care Home	Trinity Craighall LLP	55	Private
Queens Manor Care Home	Barchester Healthcare Homes Limited	60	Private
Northcare Suites	Northcare (Scotland) Ltd	76	Private

Edinburgh Subtotal	**3169**

Care Homes - East Lothian	ServiceProvider	Registered_Places	ServiceType
Lammermuir House	Tamaris Healthcare (England) Limited, a member of the Four Seasons Health Care Group	48	Private
Belhaven Nursing Home	East Lothian Council	11	Local Authority
Muirfield Nursing Home	Randolph Hill Nursing Homes (Scotland) Ltd	60	Private
Hilton Lodge Nursing Home	The Stewart Partnership, Trading as Hilton Lodge Private Nursing Home	20	Private
Florabank	Florabank Home Limited	22	Private
Haddington Care Home	Haddington Care Ltd	68	Private
Adamwood Nursing Home	Rollandene Ltd	13	Private
Eskgreen	East Lothian Council	30	Local Authority
Carberry House Care Home	Carberry House Care Home, a partnership	27	Private
St. Anne's Care Home	Sisters Of Charity Of St Paul The Apostle	37	Voluntary or Not for Profit
Drummohr Nursing Home	HC-One Limited	60	Private
The Abbey	East Lothian Council	30	Local Authority
Fidra House	Randolph Hill Nursing Homes (Scotland) Ltd	60	Private
Astley House	Astley House Nursing Home Limited	40	Private
Tyneholm Stables	Sanctuary Care (Kler) Limited	45	Private
Tranent Care Home	HC-One Limited	60	Private
Crookston Care Home	East Lothian Council	40	Local Authority

East Lothian Subtotal	671

Care Home Midlothian	ServiceProvider	Registered_Places	ServiceType
Springfield Bank Nursing Home	HC-One Limited	70	Private
Nazareth House	Nazareth Care Charitable Trust	37	Voluntary or Not for Profit
Rosehill	Society Of The Sacred Heart	11	Voluntary or Not for Profit
Highbank	Midlothian Council	40	Local Authority
Archview Lodge Care Home	Barchester Healthcare Ltd	78	Private
Newbyres Village	Midlothian Council	61	Local Authority
Drummond Grange Nursing Home	Barchester Healthcare Ltd	114	Private
Pittendreich Care Home	St Philips Care Limited	27	Private
Thornlea Nursing Home	Thornlea Nursing Homes Ltd	33	Private
Pine Villa Nursing Home	Mansfield Care Limited	19	Private
Aaron House Care Home	Aaron House Limited	66	Private

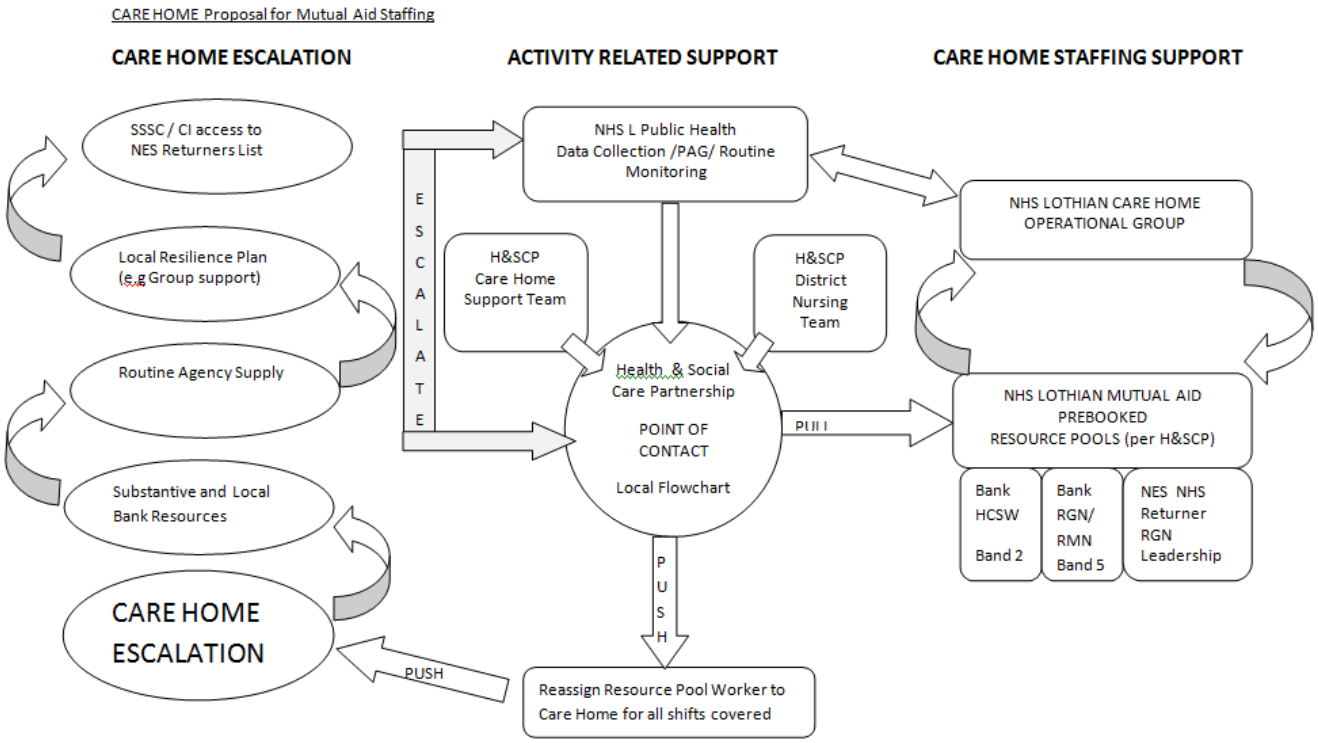
Midlothian Subtotal	556

Care Home West Lothian	ServiceProvider	Registered_Places	ServiceType
Heatherfield Nursing Home	Heatherfield Community Care Ltd	60	Private
Meadowvale	Meadowvale Care Limited, a member of the Tamaris Group	52	Private
Whitdale House	West Lothian Council	32	Local Authority
Redmill Nursing Home	HC-One Limited	68	Private
Crofthead House Nursing Home	Croftwise Care Ltd	57	Private
Broxburn Nursing Home	Broxburn Nursing Home Ltd	43	Private
Holmesview	Randolph Hill Nursing Homes (Scotland) Ltd	60	Private
Middleton Hall Care Home	Four Seasons (TRONAS) Limited	56	Private
Blackfaulds House Nursing Home Ltd	Blackfaulds House Nursing Home Ltd	25	Private
Linlithgow Care Home	HC-One Limited	80	Private
Livingston Nursing Home	Tamaris (Scotland) Limited, a Member of the Four Seasons Health Care Group	58	Private
Peacock Nursing Home	Peacock Medicare Ltd.	80	Private
Woodlands Nursing Home	Peacock Medicare Ltd.	81	Private
Limecroft	West Lothian Council	39	Local Authority
Craigmair Interim Care Home	West Lothian Council	30	Local Authority
Burngrange Care Home	West Lothian Council	40	Local Authority

West Lothian Subtotal	**861**

NHS LOTHIAN TOTAL	**5257**

Appendix 4 Care Home Workforce Mutual Aid



NHS LOTHIAN

Board Meeting
24/06/2020

Deputy Chief Executive

NHS LOTHIAN COVID-19 REMOBILISATION PLAN

1 Purpose of the Report

1.1 The purpose of this report is to provide assurance to the Board that the process of Remobilisation has begun in line with the Scottish Governments next phase of the NHS response to COVID-19.

1.2 On the 25th May 2020, the first iteration of NHS Lothian's COVID-19 Remobilisation Plan was submitted to the Scottish Government. A second and final version was submitted on 10th June; this covered our initial priorities focused on the period to the end of July 2020. Members should note that we will be asked for extended plans in the next month which would cover the period running to March 2021 including details of our Winter Plan.

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

2 Recommendations

2.1 It is recommended that the Board accept a moderate level of assurance.

2.2 This is felt to be an appropriate level of assurance given:

- There remain some areas where further action is required;
- This Remobilisation Plan has been approved by Scottish Government;
- The plan development is part of an iterative process given the dynamic nature of the national and local response to COVID-19;
- The service plans detailed herein are derived from a process of clinical prioritisation to ensure we manage the risks associated with delayed treatment.

3 Discussion of Key Issues

3.1 The initial priorities set out in the Remobilisation Plans are whole system in nature & include:

- Diagnostics and treatment for cancer;
- Urgent treatment for cardiac disease, transplants, renal failure;
- Mental health
- Routine treatments where additional delays caused by the pandemic may have made the clinical picture an urgent one;
- Services for children, where the impact on a child's development could be disproportionate;
- Dental and ophthalmic services where significant underlying disease may have built up;
- General Medical Practice capacity to see patients with non-urgent but significant health problems that will worsen over time.

3.2 The above list is in addition to services which were sustained through the first wave of COVID-19 including support for pregnancy and unscheduled care services.

3.3 Active clinical triage and clinical judgement will be continually utilised as before, to ensure we manage the risks associated with delayed treatment.

3.4 There is no intention to re-start routine face-to-face outpatients or elective care during this three-month period, however, clinically-led assessments will evaluate risk on an individual patient basis.

3.5 Primary care (general practices and community pharmacies) have and will remain open. In addition, the community COVID-19 Pathway Hubs and assessment centres will be maintained to provide support to GP practices in managing COVID-19 activity appropriately.

3.6 Within the activity template submitted, it should be noted the elective elements of the template had been complete, based on the pattern of activity over the previous 8 weeks to predict figures moving forward. Members should note the levels of activity detailed will not impact on the growth of routine waiting patients.

4 Key Risks

4.1 Effective risk management is the foundation of our planning for remobilisation. From a clinical risk management perspective, our approach is principally based on active clinical triage. A number of system wide risks are captured in our management system risk registers.

4.2 The key risk to our remobilisation plans relate to the system capacity needed to deliver increased activity, and their likelihood increases as activity increases, thus affected a higher risk rating.

4.3 The key risks to delivery of this remobilisation plan at a whole system level are:

- Risk of COVID-19 demand exceeding COVID-19 capacity
- Risk of continued build-up of ‘backlog’
- Risk of reduction in productivity
- Risk of adequate and appropriate PPE
- Risk of staff availability
- Risk of inadequate eHealth hardware and infrastructure

4.4 Both sector and service specific risks are outlined within the relevant sections in the remobilisation plan.

5 Risk Register

5.1 There are no new risks raised which are not currently recorded in our management system risk registers.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment has not been carried out. The Remobilisation Plan summarises a collection of initiatives that will require their own impact assessments to be carried out this key component of effective planning will be evident through the ongoing stages of remobilisation.

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

7.1 Ongoing and future work, both in the remobilisation and renewal agendas, will have a view on informing, engaging and consulting with those who use our services.

8 Resource Implications

8.1 The resource implications as of May 2020, were forecast to include additional costs of £149.8m associated with the COVID-19 response across the Board and four Health and Social Care Partnerships (HSCPs). Of this, £71m is anticipated in the four months to the end of July.

8.2 Physical distancing, hygiene and PPE measures will impact the facilities available and normal (pre-COVID19) working practices of staff.

Wendy MacMillan
Business Manager (Executive Office)
11/06/2020

List of Appendices
(Available separately due to size – through Admincontrol for Board Members and on the Board Papers webpage for members of the public)

Appendix 1: Draft Remobilisation Plan 25th May 2020
Appendix 2: Draft Remobilisation Plan Appendix 3 (25th May 2020)
Appendix 3: Draft Remobilisation Plan Addendum 9th June 2020
Appendix 4: Draft Addendum Appendix 1 (9th June 2020)
Appendix 5: Draft Addendum Appendix 2 (9th June 2020)
Appendix 6: Draft Addendum Appendix 3 (9th June 2020)
Appendix 7: Draft Addendum Appendix 4 (9th June 2020)
Appendix 8: Draft Addendum Appendix 5 (9th June 2020)
Appendix 9: Draft Addendum Appendix 6 (9th June 2020)
Appendix 10: Draft Addendum Appendix 7 (9th June 2020)

NHS LOTHIAN

Board Meeting
24th June 2020

Chief Officer, Acute Services

SCHEDULED & UNSCHEDULED CARE PERFORMANCE

1 Purpose of the Report

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

1.2 Any member wishing additional information should contact the Executive Lead.

2 Recommendations

Board Members are recommended to:

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

2.2 **Acknowledge** that management information indicates that 95.2% of patients seen were seen within the TTG in April 20 – however this high percentage arises from unusually few patients having being seen within the month. There were **5,750** patients waiting longer than 12 weeks.

2.3 **Acknowledge** that current remobilisation plans are focussed on safely and incrementally resuming services based on clinical prioritisation, with focus on Urgent Suspicion of Cancer and urgent activity, whilst maintaining Covid and non-Covid pathways. That plans align to the Scottish Government's Re-mobilise, Recover and Re-design framework.

2.4 **Take limited assurance** that current remobilisation plans will reduce high volumes of long waiting patients in line with waiting time targets for scheduled care and cancer services;

2.5 **Acknowledge** that NHS Lothian unscheduled care performance of 95.5% for May 2020 exceeds target, and that although front door demand is increasing it remains lower than in the pre-Covid period. Please see Appendix 6;

2.6 **Recognise** that the pandemic response from Health and Social Care Partnerships has been to increase community capacity along with a focus on Home First, resulting in a significant reduction in the number of delayed discharges;

2.7 **Note** that Scottish Government have advised that next phase of remobilisation plans will be to end March 2021, which will encompass the winter plan.

3 Discussion of Key Issues

3.1 In the light of Covid-19, NHS Lothian is implementing new ways of working, for example optimising virtual care including telephone and video consultations, as well as 'Call MIA' for minor injuries. In addition the system is looking at ways to schedule unscheduled care where clinically appropriate, as well as other demand management initiatives through the use of active clinical referral triage, patient initiated follow up and Ref-Help guidance.

3.2 Surgical and diagnostics capacity is currently focussed on Cancer and priority 2 patients i.e. those requiring surgery within 4 weeks. A high proportion require access to critical care beds so activity is being balanced with demand for critical care Covid beds and theatre capacity. Additional capacity is secured with SPiRE for colorectal, urology, and breast, and recently commenced for neurosurgery. Balancing risk for some cancer patients has seen an increase in non-surgical pathways including hormone therapy and watchful wait monitoring.

3.3 Unscheduled care Covid mitigations have focussed on establishing and monitoring of robust red (Covid) and green (non-Covid) pathways to safely cohort patients as part of mobilisation plans, and on safely reducing demand, for example through 'Call MIA'. The unscheduled care programme is also focused on winter interventions to support system flow, while progressing key work streams concerned with developing urgent care pathways - scheduling unscheduled demand.

4 Key Risks

4.1 Risks to performance include on-going requirement to have designated Covid and non-Covid pathways. Physical distancing measures have impacted on capacity, which combined with requirements for changing PPE between procedures and cleaning regimens, are impacting on productivity.

4.2 There is an unknown risk in terms of patient outcomes due to increasing waiting times, reduced referral rates, delayed diagnosis or treatment and patient choice in not attending for their planned appointment/ treatment.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

6.1 Capacity restrictions and waiting list delays may impact differentially on patient groups. Further work looking at the health impact of Covid for patients will be taken forward as part of the future public health work programme. New ways of working could result in the growth of the 'digital care divide' as the move to virtual healthcare may impact vulnerable groups with limited access to technology. An equality impact assessment is currently being undertaken to look at these issues.

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

7.1 A public communication and engagement exercise is being planned as part of the Board's re-mobilisation, recovery and re-design work programme.

8 Resource Implications

8.1 Significant resource implications are associated with Covid recovery, and these are being fully collated via the Finance Team.

Jacquie Campbell
Chief Officer, Acute Services
11th June 2020

Appendix 1 – Covid Impact on Performance

In line with Scottish Government requirements NHS Lothian ceased all non-urgent elective activity from 16th March. Over 70,000 outpatient appointments and 3,000 inpatient & day case procedures have since been cancelled, resulting provisionally in 36,321 outpatients waiting longer than 12 weeks in May 20. This is a 74% increase on figures for March 20, when Covid began. Provisionally 8,405 inpatients were also waiting longer than 12 weeks as a result of Covid - an increase of 147% on March 20 performance when pandemic cancellations began - please see Appendices 2 & 3.

Cancellations have also resulted in significant increases in waits for key diagnostic tests including Endoscopy, the largest portion of Gastroenterology Diagnostics; for Urology Diagnostics (Cystoscopy); and for Radiology. Cancer activity continues to be a priority for NHS Lothian, balancing risks of efficacy and vulnerability. Please see Appendices 4 & 5.

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

The table below illustrates current performance relative to April 2019. Data for May 2020 is not yet available for some of these metrics:-

Metric		May 2020	Apr 2020	Apr 2019	Annual Change (most recent month available vs Apr 19)*	Target
Delayed Discharges	Standard	81	63	217	-62.7%	200
	Standard & Complex	89	74	246	-63.8%	-
4 Hour ED Waiting Time		95.5%	95.4%	87.4%	9.3%	95%
Outpatient >12 week waiting time p		36,321	28,163	24,755	47%	19,390
Treatment Time Guarantee p		8,405	5,750	2,597	224%	3,028
Cancer Waiting Times (31 day target) p		N/A	95.0%	91.1%	4.3%	95%
Cancer Waiting Times (62 day target) p		N/A	82.2%	74.3%	10.7%	87%

p Some provisional management information
* Green denotes an improvement >=5%, red, deterioration >=5%, and amber no change >=5% since Apr 2019.
N/A = validated data not yet available

Appendix 2 - Impact of Covid on Outpatients

Outpatient performance is detailed below in terms of patients waiting over 12 weeks for a new outpatient appointment:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20 - provisional
NHSL OP >12 Wk Performance	**24,307**	**25,529**	**23,274**	**20,855**	**28,163**	**36,321**
OP Trajectory	26,269	25,051	20,393	18,100	19,139	19,390
Difference	-1,962	478	2,881	2,755	9,024	16,931

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

All Outpatient Covid Cancellations as at 28/5/20, using Covid-19 Cancellation Code:-

		Mar – Jul 20
All Priorities i.e. Routine, Urgent & USoC	New	19,655
	Return	46,118
	Radiology	4,358
	Unknown	82
	Total Cancellations	**70,213**

Impact of Covid on Outpatient Waits:-

	Pre-Covid – Early March 20	**May 20**	**% Change**
Waiting List Size – Urgent & Urgent Suspicion of Cancer	7,618	5,829	-23.5%
Waiting List Size – Routine	52,051	47,782	-8.2%
Referrals	6,303	4,874	-22.7%
>12 Week Breaches	21,817	36,321	+66.5%
>26 Week Breaches	6,886	12,202	+77.2%
>52 Week Breaches	334	803	+140.4%

Appendix 3 – Impact of Covid on Inpatients

IPDC performance is detailed below, in terms of patients waiting over 12 weeks for an Inpatient or Day case procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20 - provisional
NHSL TTG (IPDC) >12 Wk Performance	**2,622**	**2,788**	**2,753**	**3,404**	**5,750**	**8,405**
TTG (IPDC) Trajectory	2,839	3,190	2,922	3,100	3,141	3,028
Difference	-217	-402	-169	304	2,609	5,377
% of all patients seen, seen within the Treatment Time Guarantee	74.7%	74.2%	77.3%	80.2%	95.2%	-

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

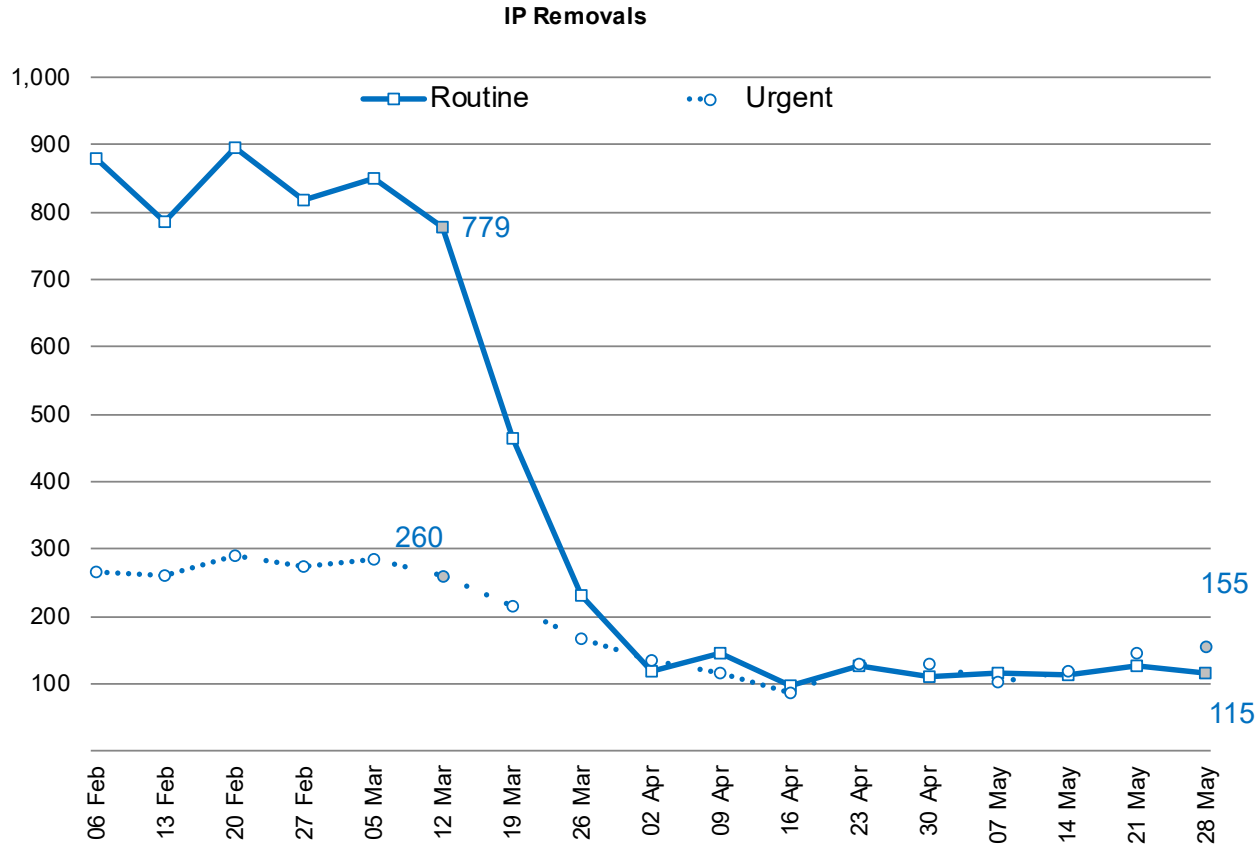
All Inpatient Covid Cancellations as at 28/5/20, using Covid-19 Cancellation Code:-

	Mar – Jul 20
Routine	2,279
Urgent	426
Total IP Cancellations	**2,705**

Covid Impact on Inpatient Waits:-

	Pre-Covid – Early March 20	**May 20**	**% Change**
Waiting List Size – Urgent & Urgent Suspicion of Cancer	1,677	2,056	+22.6%
Waiting List Size – Routine	9,699	10,492	+8.2%
>12 Week Breaches	3,033	8,405	+177.1%
>26 Week Breaches	810	2,151	+166.6%
>52 Week Breaches	61	146	+139.3%

Inpatient Removals (Activity) by Priority:-



Appendix 4 - Covid Impact on Diagnostics

Gastroenterology diagnostic performance is detailed below, in terms of patients waiting over 6 weeks for a diagnostic procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20
Upper Endoscopy	625	374	792	1,276	1,823	1,909
Colonoscopy patients waiting over 6 wks	933	521	879	884	1,406	1,517
Flexible Sigmoidoscopy (Lower Endoscopy) patients waiting over 6 wks	340	297	332	331	464	502
Gastroenterology Diagnostic Performance	1,898	1,192	2,003	2,491	3,693	3,928
Gastroenterology Diagnostic >6 Week Trajectory	2,034	1,794	1,269	744	-	-
Difference	-136	-602	734	1,747	-	-

Urology diagnostic performance is detailed below, in terms of patients waiting over 6 weeks for a diagnostic procedure:-

	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20	May 20
Flexible Cystoscopy (Urology Diagnostic) Performance	323	340	362	599	765	792
Urology Diagnostic >6 Week Trajectory	385	395	245	95	-	-
Difference	-62	-55	117	504	-	-

Radiology diagnostic performance is detailed below, in terms of number of patients waiting over 6 weeks for a radiology scan:-

Specialty Radiology - CT Lothian	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20
CT Performance	101	112	97	203	1,049
Trajectory >6 weeks	100	40	0	0	200
Difference	1	72	97	203	849

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

Specialty Radiology - General Ultrasound (not Vasc)	Jun 19	Sep 19	Dec 19	Mar 20	Apr 20
General Ultrasound Performance	3	2	6	9	2,565
Trajectory >6 weeks	10	0	0	0	0
Difference	-7	2	6	9	2,565

There were 43 breaches for Barium Studies in April 20, compared to 5 breaches in total across 2019/20.

Appendix 5 - Covid Impact on Cancer Performance

The following tables detail 31 and 62 day cancer performance against trajectory using management information:-

31 Day performance	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Urological	86.4%	92.9%	91.2%	81.7%	86.4%	92.2%	89.4%	85.9%	90.3%	97.1%	98.5%	92.2%	89.4%
Colorectal (screened excluded)	82.9%	76.7%	78.3%	73.3%	78.1%	88.6%	90.3%	83.3%	96.3%	77.4%	81.5%	87.1%	93.8%
Colorectal (screened only)	100.0%	55.6%	100.0%	87.5%	20.0%	83.3%	72.2%	77.8%	55.6%	55.6%	80.0%	100.0%	60.0%
Melanoma	100.0%	100.0%	95.7%	100.0%	88.9%	100.0%	93.8%	97.9%	100.0%	100.0%	100.0%	85.7%	83.3%
Breast (screened excluded)	97.1%	97.5%	97.5%	100.0%	100.0%	100.0%	100.0%	98.1%	97.5%	97.0%	97.1%	98.0%	100.0%
Breast (screened only)	78.1%	91.1%	95.1%	97.1%	100.0%	100.0%	96.6%	97.7%	96.9%	71.1%	100.0%	97.7%	100.0%
Cervical (screened excluded)	75.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	100.0%	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a
Head & Neck	100.0%	100.0%	100.0%	93.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.2%	100.0%	100.0%
Lung	95.2%	100.0%	93.9%	98.6%	94.9%	94.9%	98.5%	100.0%	100.0%	96.3%	100.0%	100.0%	98.4%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ovarian	66.7%	100.0%	100.0%	85.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	100.0%
Upper Gastro-Intestinal (GI)	96.4%	95.1%	100.0%	100.0%	97.3%	100.0%	100.0%	100.0%	100.0%	95.7%	100.0%	100.0%	100.0%
All Cancer Types	91.1%	93.9%	94.5%	92.2%	92.2%	96.2%	94.3%	95.2%	96.1%	90.7%	96.2%	96.2%	95.0%
All Cancer Types Trajectory	92.6%	92.8%	92.5%	94.7%	94.4%	93.7%	94.7%	94.8%	94.8%	94.6%	95.1%	94.9%	95%
Difference	-1.5%	1.1%	2.0%	-2.5%	-2.2%	2.5%	-0.4%	0.4%	1.3%	-3.9%	1.1%	1.3%	0.0%

62 Day performance	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20
Urological	51.4%	45.2%	51.7%	61.3%	48.8%	47.8%	77.1%	50.0%	67.7%	70.6%	71.4%	58.1%	57.8%
Colorectal (screened excluded)	37.5%	61.9%	41.7%	55.0%	54.5%	38.1%	61.1%	60.0%	68.8%	64.0%	44.4%	75.0%	82.6%
Colorectal (screened only)	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	5.9%	22.2%	11.1%	55.6%	35.7%	50.0%	50.0%
Melanoma	75.0%	72.2%	82.4%	90.9%	66.7%	94.8%	89.7%	93.6%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened excluded)	95.7%	73.9%	84.0%	75.9%	95.8%	92.9%	95.7%	85.3%	100.0%	87.0%	80.0%	90.9%	89.5%
Breast (screened only)	97.1%	95.7%	97.7%	90.2%	100.0%	97.2%	97.0%	95.8%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	0.0%	100.0%	100.0%	75.0%	100.0%	100.0%	25.0%	0.0%	n/a	100.0%	33.2%	50.0%	50.0%
Cervical (screened only)	0.0%	n/a	0.0%	n/a	0.0%	n/a	0.0%	n/a	0.0%	n/a	n/a	n/a	n/a
Head & Neck	100.0%	88.9%	100.0%	73.3%	88.9%	100.0%	91.7%	100.0%	100.0%	88.9%	100.0%	85.7%	100.0%
Lung	90.5%	76.2%	93.3%	90.5%	82.1%	83.3%	82.4%	87.5%	84.0%	100.0%	100.0%	82.8%	83.3%
Lymphoma	66.7%	100.0%	75.0%	50.0%	100.0%	83.3%	100.0%	66.7%	33.3%	100.0%	33.3%	100.0%	100.0%
Ovarian	0.0%	40.0%	75.0%	100.0%	100.0%	33.3%	100.0%	100.0%	n/a	n/a	100.0%	50.0%	66.7%
Upper Gastro-Intestinal (GI)	100.0%	90.9%	100.0%	92.3%	94.7%	94.7%	92.9%	93.1%	94.4%	96.2%	95.5%	100.0%	100.0%
All Cancer Types	74.3%	70.6%	78.0%	75.4%	75.8%	78.5%	78.9%	80.8%	83.8%	85.2%	78.2%	83.0%	82.2%
All Cancer Types Trajectory	78.0%	81.8%	81.5%	82.8%	84.2%	81.2%	82.1%	84.0%	84.1%	84.1%	88.1%	88.3%	87%
Difference	-3.7%	-11.2%	-3.5%	-7.4%	-8.4%	-2.7%	-3.2%	-3.2%	-0.3%	1.1%	-9.9%	-5.3%	-4.4%

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

NHS Lothian reported compliance to the 4EAS standard of 95.5% for the month of May 2020. Chart 1 below shows 4EAS performance for NHS Lothian and Table 1 beneath shows the month to date figures for 4EAS by Site as at 1 June 2020.

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

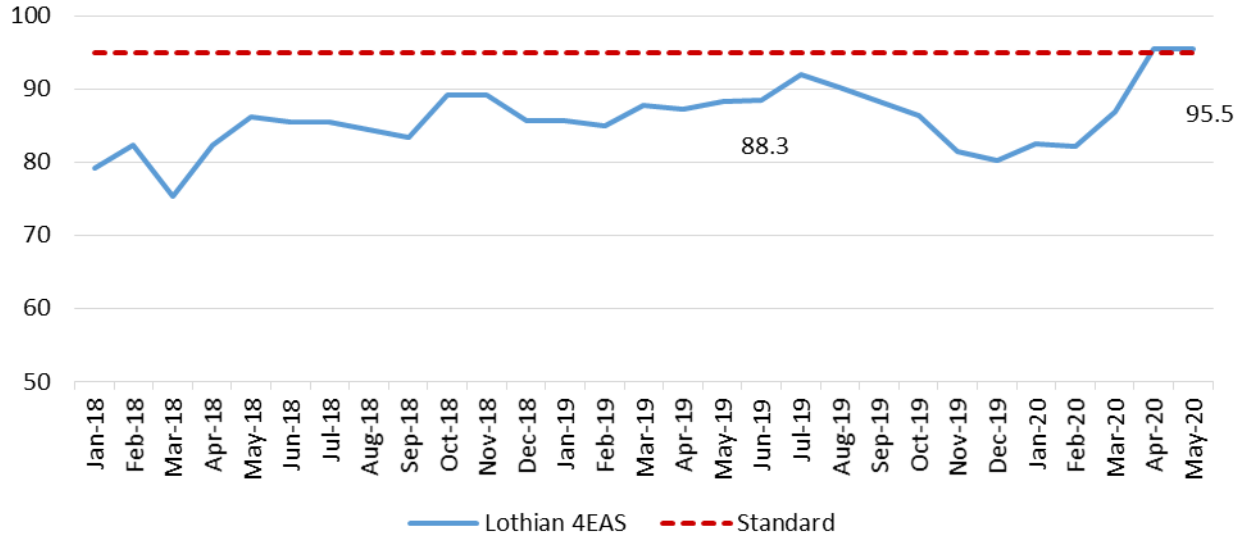


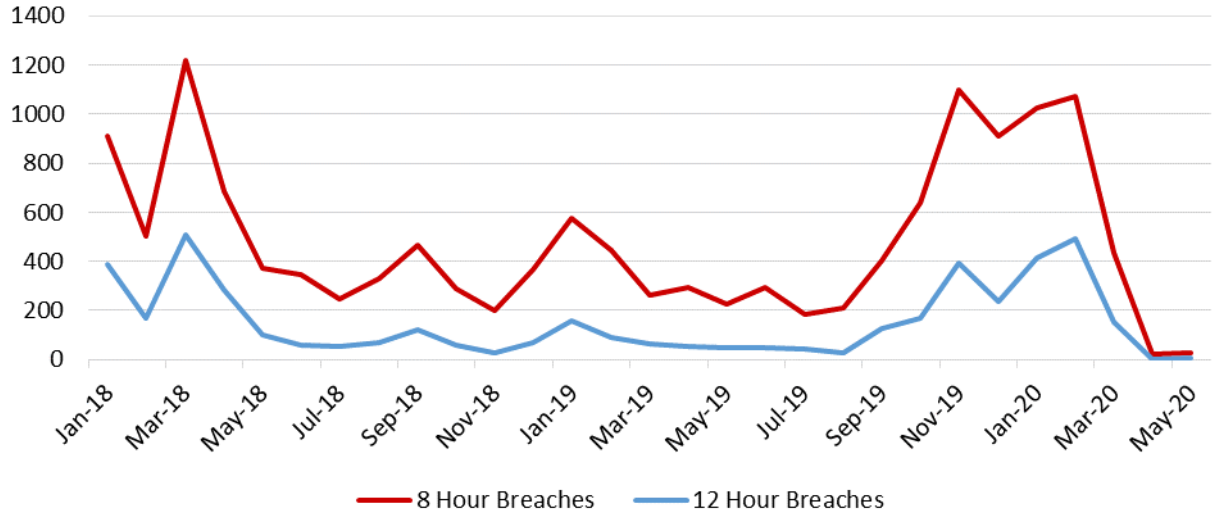
Table 1: 4 hour Emergency Access Standard May 2019 vs May 2020

	May 19	May MTD	Difference
Royal Infirmary of Edinburgh	81.8%	95.8%	+14.0%
Western General Hospital	90.6%	91.6%	+1.0%
St John's Hospital	94.8%	95.9%	+1.1%
Royal Hospital for Sick Children	94.9%	98.1%	+3.2%
NHS Lothian	88.3%	95.5%	+7.2%

To date activity at each of the Acute sites has dropped considerably primarily due to the Covid-19 pandemic. This is largely due to the public messaging around staying at home. As a result each of the Acute Sites has designated Red (Covid-19) and Green (non-Covid-19) wards and pathways established to safely cohort patients as part of mobilisation plans.

March 20 attendances were down to 6,600 for NHS Lothian which is 27.3% of those recorded for March 2019. April 20 attendances were down even further at over 11,700, which is 50% of those recorded in April 19, and May 20 attendances down to over 8,000, 35% of those recorded in May 19.

Chart 2: Total NHS Lothian Breaches Jan 18 – May 20



Site Details:-

Following a 46% reduction in ED activity (for all triage categories except 7 & 9) across March/April the RIE has seen a steady increase in attendances throughout May. The average number of presentations per day was 231 compared to 150-160 in March and April. In April Minor Injuries saw on average 31 patients per day, however, this also increased steadily throughout May, with an average of 54 per day across the month. The last week of May saw a further increase with average of 68 MIU patients seen per day that week and 78/79 on the last Saturday/Sunday of the month, which was the typical number of MIU attendance figures pre-Covid.

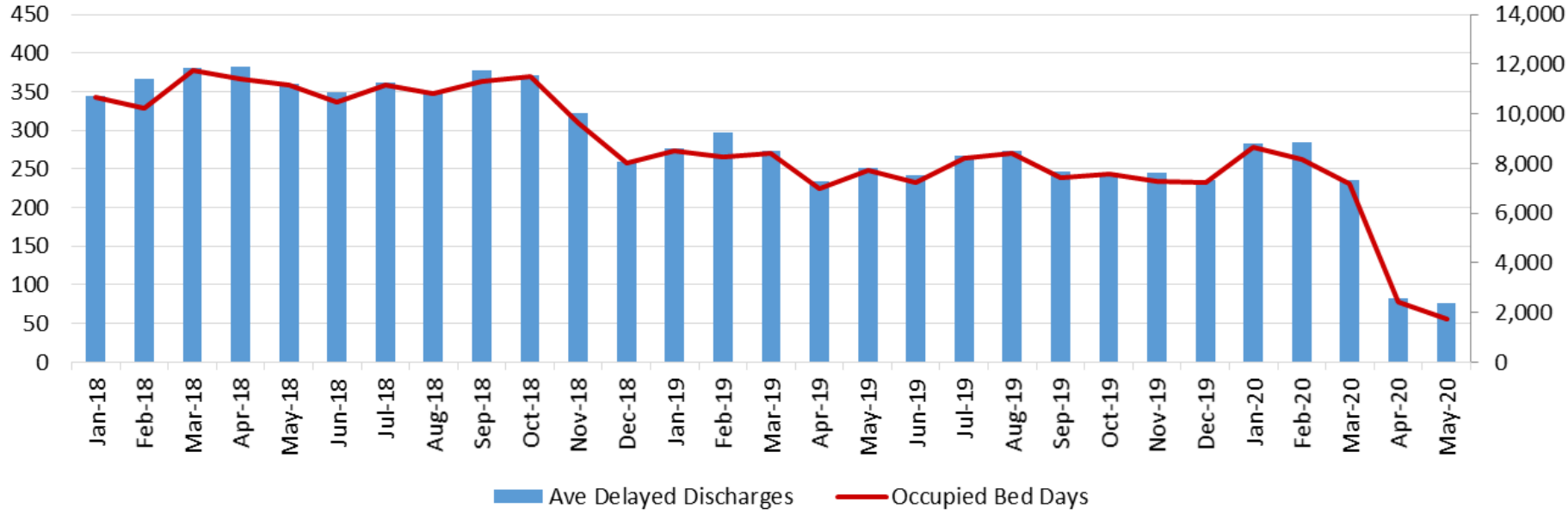
The WGH in May has seen a steady increase in attendances across medical and surgical pathways with daily averages increasing from an average of 41 per day in April to 57 per day in May. The WGH minor's **unscheduled** flow has also increased in May by 49% against April with activity for the month of May averaging 27 per day, which is approximately still a 49% decrease against Jan/Feb pre-Covid activity. However since the commencement of the new Minor Injuries 'Call MIA' service the unit has also seen 268 new patients as part of the conversion to scheduled care. These 268 patients received a video consultation assessment (average 4 per day) and of the 268 patients assessed, 78 required a scheduled follow-up appointment. The remaining 190 patients did not require to attend the hospital

(approximately 3 per day). The activity through this service has increased steadily; the last week in May saw an average of 12 patient per day being assessed with 8 patients not requiring hospital attendance.

Attendances to St John's ED have increased from a daily average of 84 in April to 111 in May, compared to 164 in January and February. In May, majors made up 59% of attendances and minors 41%, compared to 62% and 38% in April. Admissions to hospital increased in May to a daily average of 45 patients, from 30 in April. 'Call MIA' for minor injury scheduled face to face appointments at St John's was launched on the 1st of June.

Chart 3 illustrates the significant reduction in delayed discharge numbers in April and May:-

Chart 3: NHS Lothian Average Delayed Discharges and Occupied Bed Days [1] Jan 18 – May 20 (MTD to 22 May)



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

NHS LOTHIAN

Board
24 June 2020

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

The Board is recommended to:

2.1 Note the addition of a new risk associated with Covid-19 and removal of the Brexit risk, as agreed by the Board in April.
2.2 Accept the corporate risk register, as set out in Appendix 1.

3 Discussion of Key Issues

3.1 Covid-19

3.1.1 The Board is fully sighted on the risk associated with Covid-19 and is considering detailed papers on the NHS Lothian response and the remobilisation plan in items four and five of the agenda. Healthcare Governance Committee considered the risk at its May meeting and accepted limited assurance on the management of the risk overall.

3.2 Risk Register Update

3.2.1 As a result of pressure on the system due to Covid-19, quarter four updates have not been provided for all corporate risks. A piece of work will be undertaken over the coming months to fully consider the effect of Covid-19 on all relevant risks.

3.2.2 Updates have been provided for some risks, which are narrative in nature and describe the impact of the current Covid-19 situation, set out in appendix 1.

3.2.3 The risk level for HAI (1076) has increased from medium (9) to high (16) as a result of Covid-19.

3.2.4 Risks have now been aligned with the Board`s four priorities for continuous improvement, rather than previous objectives.

3.2.5 There are 19 risks in total on the corporate risk register. The 9 risks at Very High (20) are set out below.

1. The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge
2. Patient Safety in Royal Infirmary of Edinburgh Accident & Emergency Department
3. Achieving the 4-Hour Emergency Care standard
4. Timely Discharge of Inpatients
5. General Practice Sustainability
6. Access to Treatment (organisational risk)
7. Access to Treatment (patient risk)
8. Delay in providing clinical care for RHCYP and DCN patients in new facility (new risk)
9. Health of the population and impact on NHS Lothian services from Covid-19

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian.

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

6.1 Not applicable.

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

7.1 This paper does not consider developing, planning and/or designing services, policies and strategies.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

Sue Gibbs
Quality & Safety Assurance Lead
4 June 2020
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List of Appendices

Appendix 1: Corporate Risk Register

Appendix 1

Corporate Risk Register

Risk 4984 – Covid-19

Corporate Objective	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
Protect and improve the health of our population	There is a significant risk to the health of the population from the current Covid-19 outbreak and that NHS Lothian will not have sufficient capacity to respond because of the number of people requiring care, including critical care, reduced numbers of staff available to deliver care due to illness or isolation, timely availability of supplies leading to reduced quality and safety of patient care as well as physical and psychological pressure on staff. There will also be a significant impact on routine activity including waiting lists as resources are	• 1076 – HAI • 3191 - Access to treatment (patient) • 3211 – Access to treatment (organisational) • 3726 - Timely discharge • 3829 – General practice sustainability **Associated Plans** • Covid-19 mobilisation plan • HSCP mobilisation plans (x4) **Assurance Committees** • Healthcare Governance	**Governance and management** Healthcare governance committee and Board will receive timely updates. **Strategic management group `Gold` meets weekly, COVID-19 Executive Huddle twice a week; both chaired by chief executive. Supported by eight `Silver` topic specific tactical groups, chaired by relevant directors:** • **Test, trace, isolate, support** • **PPE** • **Care homes** • **Physical distancing** • **Primary Care** • **HSCPs** • **Public Health** • **Acute services** Huddles in place at all hospital sites throughout day to monitor and respond to capacity and staffing deployment. Command centres in place in each HSCP. Daily cascade of information to operational management.	Covid-19 dashboard • Summary of confirmed cases, probable cases, possible cases and exposure • Covid-19 positive hospital movements • Current positive cases by ward • Delayed discharge patient list by responsible authority • Capacity and staff availability	**HCG accepted limited assurance at May meeting on this risk overall.** **Situation changing rapidly and detailed update papers are provided to the Board and HCG committee.** **Key developments highlighted below:** **Recognising the specific risk to the residents and staff in care homes, support is being provided through training, additional workforce and the Health protection team is leading on testing, contact tracing and management of outbreaks.** **Test trace isolate and**

Corporate Objective	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
	diverted to managing the impact of Covid-19.	**Grading** • Very high (20)	Daily communications update to all staff, including promotion of up-to-date Government advice (Health Protection Scotland (HPS) and NHS inform) to public around access to health service and public health measures including self and family isolation. **Plans** Covid-19 mobilisation plan in place. HSCP mobilisation plans (x4) Pandemic plan in place for each hospital site based on NHS Lothian Pandemic strategy, which includes: • Arrangements for command, control and communication • Clinical responses • Capacity, staffing and impact on normal business • Business resilience supply chain and service interdependencies Development and Implementation of Covid-19 Community pathway model (Primary care) including Covid assessment centres at RVB, WGH, East, Mid and West Lothian Development of self-management support guides and helpline **Workforce** Workforce plan in place to increase capacity and deployment of workforce through a number of measures including: • Recruitment of additional staff • Deployment of staff with clinical skills currently working in other roles • Updating of clinical skills		**support processes established.** **Remobilisation plan developed, with specific risks and mitigatation identified within plan.**

Corporate Objective	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
			• Training to include Supply and guidance on use of PPE • Co-ordination of community nursing staff availability and pressures via staff bank: • Supplementary staffing – Covid-19 supplementary staffing action plan All with due recognition of advice contained in the Covid-19 workforce guidance. Introduction of testing for some staff to limit unnecessary isolation periods. Enabling staff to work from home where possible to preserve capacity to support front line and essential functions Advice line for Health and social care staff and volunteers: • general enquiries and sign posting to support • HR enquiries • Helpline for staff **Services** Cancellation of all non-urgent elective surgery - discussion with GJH and independent sector for urgent cases. Cancellation of face to face outpatient activity, following detailed clinical risk assessment. Where possible, adopting different mode of delivery e.g. telephone or video consultations. Deployment of `Near me` technology in all GP practices to support video consultations. Stopping all non-essential activity and development work to enable resource to be		

Corporate Objective	Risk Description	Linked Risks	Controls	Key Measures	Updates/actions
			used to support front line service delivery including Primary Care. **Adequacy of Controls** Inadequate; control is not designed to manage the risk and further controls and measures required to manage the risk.		

Risk 4813 – Royal Hospital for Children & Young People/Dept of Clinical Neurosciences

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
Achieving value and sustainability	There is a risk to patient safety, experience and outcome of care plus financial impact, due to the delay in providing clinical care for RHCYP and DCN patients on the Royal Infirmary of Edinburgh campus.	• (3600) Finance • (4191) Access to Treatment (Patient) • (3189) Facilities Fit for Purpose • (1076) HAI **Associated Plans** • **Assurance Committees** • Healthcare Governance • Finance & Resources **Grading** • Very high (20)	**Governance and management arrangements** An Oversight Board, chaired by the CNO on behalf of the Scottish Government meets weekly and reviews progress. Within NHS Lothian, an executive steering group also meets weekly to review progress against plans and associated measures. This group is chaired by the Director of Nursing; membership includes Chief Executive, Finance, Medical, HR and Employee Directors, Chief Operating Officer. **Plans and processes** There are 6 technical work streams as listed below, each with an action plan • Ventilation • Water quality • Drainage • Fire safety • Electrical • Medical gases Prioritised programme of works to be agreed with contractor. In addition, a service continuity plan is in place for current RHSC and DCN, led by the acute services COO and reported to the Executive steering group, weekly and to the SG oversight group as required. This includes, for example: • Winter planning • Additional staffing and transport for double-running pharmacy and lab services	• Number of complaints • Number of helpline enquiries from the public • Number of adverse events • HAI data and inspections Each technical workstream has **a** dashboard of measures against adherence to programme dates. (once agreed with contractor). Service continuity action plan progress against programme is reported fortnightly.	**April 2020 Update** **Last reported to F&RC on 22 /04/20, who noted the update and requested a paper go to the May 2020 Board.** Executive Steering Group is meeting weekly and Oversight Board continues to meet fortnightly. Handover of DCN facilities, except cleaning, completed in w/c 20/04/20, enabling Board to plan DCN migration to start 11th May. Inpatient moves and theatres will transfer when Covid 19 impact allows. Four technical work streams have been closed with all issues resolved for: - Water quality - Drainage - Fire safety

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
			• Ongoing maintenance via estates and facilities • Sustaining facilities e.g. restaurant on existing sites Regular Health & Safety walkrounds take place on both RHSC and DCN existing sites. Ongoing HAI inspections including monthly walk rounds by Infection control colleagues Elective admissions to DCN limited and DCN wards not used for boarding. Communications being managed proactively with regular briefing for staff via email and intranet. Helpline in place for patients and families. Response to press enquiries provided as required. Additional costs agreed with Scottish Government to manage the financial impact, as well as ongoing commercial discussions with contractor. **Adequacy of Controls** Satisfactory: commercial arrangements and work streams process in place to progress with the contractor. The control is adequately designed to manage the risk but dependant on contractor response.		- Medical gases Outstanding ventilation and electrical safety actions on programme to be closed by end April. Commercial agreement for remedial ventilation works in critical care and haematology-oncology nearing sign-off with contractor. Programme, including impact of Covid 19 on construction working, to be confirmed. All recommendations and requirements from the HAI inspection reports for existing DCN and RHSC have been closed. Adequacy of controls remains satisfactory.

Risk 3600 – Finance

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Achieving Value and Sustainability	There is a risk that the Board is unable to respond to the service requirements arising from the population growth in all age groups across NHS Lothian. This is as a result of a combination of the level of resource available and uncertainty around future resource leading to inability to plan for, and deliver the additional capacity required.	• (3211 & 4191) Organisational/ patient access to treatment risks **Associated Plans** • Board strategic plan • IJB strategic plans • Annual operational plans **Assurance Committees** • Finance and resource committee • Audit and risk committee **Grading** • Very high (20)	**Governance and management** Robust governance is in place through a comprehensive reporting framework to Finance and Resource Committee, which in turn, provides assurance to the Board. This incorporates reporting on: • delivery of the strategic financial plan • Financial performance Quarterly review meetings take place where acute services COO, site/service directors in acute and REAS, and joint directors in Primary Care are required to update the Director of Finance on their current financial position including achieving delivery of efficiency schemes. **Policies, procedures and plans** • There is a financial plan in place which maximises the use of non-recurring resource to support service delivery • There is a plan in place to further develop financial strategy by developing a financial framework for key service areas listed below, which is being tested during 2019/20. Associated measurement plans are being developed as an integral part of this work so that there is a baseline for each service, to test future investment proposals against. ➢ Scheduled care ➢ Unscheduled care ➢ Cancer services ➢ Women`s and children`s services ➢ Primary Care ➢ Mental health	In-year financial performance Delivery against Scottish Government financial targets: • Capital • Revenue • Cash • In-year care deficit Measurement plan being developed alongside the service-based financial framework.	**January 2020 Update** **Risk Grade/Rating remains Very High 20.** **The Draft minute of the 27 November 2019 Finance & Resources Committee states:** **21.1 Financial Position.** **21.1.1 It was noted that although a balanced budget may be achieved, there was still a care deficit and that it should be recognised that current funding arrangements were not sufficient meet this. This had been previously raised with the Scottish Government.** **21.1.2 Members accepted the recommendations laid out in the paper and accepted moderate assurance.** **NHS Lothian continues to plan to break-even at end 2019/20 and the**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
			• The sustainability and value agenda has associated measures to demonstrate that resources are used as efficiently and effectively as possible. • This supports investment in quality and innovation which delivers both improved resource utilisation and enables transformation of the future delivery of health and social care. **Adequacy of controls** Inadequate control due to a combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs requiring significant service redesign response. The extent of this is not yet known, nor tested.		**risk to achieve break-even remains Very High.** **The Assurance for risk has changed to Moderate from Limited.**

Risk 3203 – 4 hour Emergency Access Standard (organisational)

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk that NHS Lothian will fail to meet the 4 hour performance target for unscheduled care which could mean that patients fail to receive appropriate care, due to volume and complexity of patients, staffing, lack and availability of beds, lack of flow leading to a delay to first assessment, a delay in diagnosis and therefore in treatment for patients and a reputational risk for the organisation.	• 3726 – Timely discharge of inpatients • 3211 & 4191 – Access to Treatment (when there are peaks of activity which lead to the cancellation of scheduled activity). **Associated Plans** • NHS Lothian Annual Operational Plan • Lothian Hospitals Plan • IJB Strategic Plans and directions • **Covid-19 Mobilisation Plan** **Assurance Committees** • Healthcare Governance • In addition keep reporting to NHS Board	• **A System Transformation Plan (STP) has been developed with first draft submitted to SG which details all unscheduled care improvement activity across the next 1,3 and 5 years to which the unscheduled care programme board/committee will be responsible for delivery.** • **The Unscheduled Care Committee is in place to develop a robust Winter plan through whole system engagement – this is covered in the STP also.** • The Unscheduled Care Committee is a whole system committee, chaired by a Chief Officer from the IJB to develop and share current ways of working from across the Acute and Community system. • An Unscheduled Care Programme Board has been established to manage short, mid and long term unscheduled care improvement. A programme board focussed on the redesign of the RIE front door is in place. • Emergency Access Quality and Performance group review implementation of the Lothian improvement Plan. • Routine review and planning of Front door demand and capacity based on real-time data. • There are a number of programme boards /groups in place to manage demand from Health and Social Care which includes Front Door Redesign	• Levels of crowding in the emergency departments. • The number of 8 hour and 12 hour breaches. • Time to first assessment (standard is 15 minutes) • Time to triage • Wait for a bed • Level of boarding (should be zero). • Length of stay. • Number of cancelled elective procedures. • Performance against emergency access standard and trajectory. • Delayed Discharges	**April 2020 Update** • **The Current Covid-19 outbreak has resulted in a number of actions to ensure risks associated with 3202 are minimised including but not limited to:** ○ **Development of a Mobilisation Plan to detail response across Acute/Primary/Social Care in response to COVID-19.** ○ **Establishment of a community pathway model to provide local dedicated and consistent medical advice, triage and treatment for people with symptomatic covid-19 symptoms** ○ **Implementation of Near Me/Attend Anywhere to allow video consultations with patients from the acute sites and reduce flow and unscheduled care presentations.** ○ **Call MIA service launched on 1st April enhancing current Minor Injuries Service offering remote assessment by ANP.** ○ **The messaging around isolation measures (and cancelling of some outpatient services) have resulted in a significant**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
		Grading • Very high 20	at RIE & SJH. • **Establishment of twice daily Executive Briefing Huddles to manage current covid-19 issues and action planning.** • **Establishment of twice weekly SMT meetings to manage response and provide strategic leadership in system response to covid-19 outbreak** **Adequacy of Controls** Adequate but partially effective		**reduction in attendances at all Acute sites which in turn has resulted in improved performance however there is concern that vulnerable groups may be waiting longer before seeking medical advice due to covid-19 outbreak which may result in inflated demand post covid-19.** ○ **Front Door Areas have been split into Red and Green zones for BAU patients and Covid-19 patients to ease flow concerns and separate high risk covid patients from non infected patients.**

Risk 4688 - 4 Hour Emergency Access Standard (Patient)

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk to patient safety and outcome of care in RIE ED due to unreliable timely triage, assessment, treatment and discharge due to overcrowding leading to increased likelihood of patient harm and poor experience of care. **Following the COVID-19 outbreak, general activity has reduced to the department with overall performance improved as captured in the April update.**	• (3600) Finance • (3454)Complaint management • (3189) Facilities fit for purpose **Associated Plans** • NHS Lothian annual operational plan • Lothian hospitals plan • IJB Strategic plans and directions **Assurance Committees** • Healthcare governance • Additional reporting to NHS Lothian Board **Grading** • Very high 20	**Governance and management** • Robust governance process in place through routine reporting to HCG committee • Routine review at RIE site management group who monitor demand and capacity and its impact on patient safety, escalating issues to the Acute Services senior management team where required. • Improvement Plan in place to achieve reliability and delivery of the 6 essential actions monitored by the NHS Lothian Emergency Access Quality Performance Group, (EAQP). • 2 x hourly safety pause in place which is increased to hourly during periods of extremis, informed by real-time data. • Escalation process in place to senior leadership and 'whole system' to identify appropriate response where required informed by real-time data. • Safety debriefs are held following any incidents and SAEs are subject to review and learning shared and improvement plan put in place and monitored by management team. • **Daily site strategic COVID meetings to ensure safe and effective patient flow and patient placement** **Adequacy of Controls** Not noted on current risk	• Levels of overcrowding in ED • Time to Triage/first assessment • Wait for a bed • Time to triage • Major/Minors – compliance with 4 hour target • Complaints • Adverse Events & Harm • Staff Experience (iMatter)	**April 2020 Update** **As a result of the current COVID-19 situation, the department has been impacted in the following ways;** - **Overall activity into the department has halved.** - **Performance has improved with Mar-20 recording a four hour compliance of 87% and every day after 13th March delivering 90% plus.** - **As of 10th April, performance is 95%.** **The department has also been split into red and green zones with the green zone receiving non-COVID patients and the red zone treating COVID patients.**

Risk 3726 – Timely Discharge of Inpatients

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	• 3203 – 4 hour Emergency Access Standard (organisational) • 3211 & 4191 – Access to Treatment (when there are peaks of activity which lead to the cancellation of scheduled activity). **Associated Plans** • NHS Lothian Annual Operational Plan • Lothian Hospitals Plan • IJB Strategic Plans and directions • **Covid-19 Mobilisation Plan** **Assurance Committees** • Healthcare Governance • In addition keep reporting to NHS Board	• NHS Lothian Board (bi-monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. • Each Partnership manages delayed discharges through a range of for a such as Delayed Discharges oversights groups • The Unscheduled Care Committee reports against Delayed Discharge Performance and mitigations monthly • A new Unscheduled Care Programme Board is to be established into which delayed discharges will also report • **A System Transformation Plan (STP) has been developed with first draft submitted to SG which details all unscheduled care improvement activity across the next 1,3 and 5 years to which the unscheduled care programme board/committee will be responsible for delivery.** • The Unscheduled Care Committee is in place to develop a robust winter plan through whole system engagement – this is covered in the STP also. • **Establishment of twice weekly SMT meetings to manage response and provide strategic leadership in system response to covid-19 outbreak**	• Delayed Discharges • Length of stay. • Number of cancelled elective procedures.	**April 2020 Update** **The Current Covid-19 outbreak has resulted in a number of actions to ensure risks associated with 3726 are minimised:** **East Lothian** • **Beds to open in ELCH at the request of NHS Lothian to maximise the Lothian wide bed base.** • **Leuchie House - 12 additional community bed spaces in EL which are available to other partnerships** • **Haddington Care home has agreed to the block purchase of 10 places to maximise flexibility for admissions** **Edinburgh** • **Additional Bed Capacity has been created at Liberton and Drumbrae aswell as at Care Home Capacity across city.** **Midlothian** • **New 20 beds in MCH for palliative covid patients** • **Increase capacity of Hospital at**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
		Grading • Very high 20	Adequacy of Controls Adequate but partially effective		**Home with focus on respiratory illness** **West Lothian** • **Increase community hospital bed capacity to support transfers from acute** • **Establish capacity to support provision of intermediate care in a care home or at home with a short term supported living package - 20 beds to be commissioned from private sector to support delivery** • **Increase available capacity of Care Homes to facilitate hospital discharges through block purchase of 10 beds and release of 6 beds through postponement of respite care** **Prior to the outbreak of Covid-19 there was agreement through the unscheduled care programme board that a collaborative approach would be taken across the whole health and social care system to deliver the Lothian Home First approach. Standard principles have been drafted and agreed by all the IJB Chief Officers and will be overseen by an infrastructure of delivery and oversight groups. Home First teams are also being established within each HSCP to improve capacity to deliver principles.**

Risk 3829 – GP Sustainability

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Update/Actions
Improving staff experience	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.	• Facilities Fit for Purpose (3189) • Nursing Workforce (3828) • Medical workforce (3527) • Finance (3600) (risk of running 2c practices and premises issues) **Associated Plans** • National Premises Plan • NHS Lothian/HSCP premises plans • IJB strategic plans • Primary care improvement plans • GMS contract implementation • Out of Hours action plan • Ehealth priorities **Assurance Committees** • Healthcare Governance **Grading** • Very high 20	**Governance and management** • Robust assurance mechanisms are in place to monitor delivery of plans through regular reporting to Healthcare Governance Committee and also to the Board and Strategic Planning Committee when required. • Development of Primary Care vision with links to HSCPs, Primary care improvement plans and IJB strategic plans. • Tripartite arrangements are in place with responsibilities for Board, GP-Sub-Committee and HSCPs clearly set out. **Policies, procedures and plans** • Implementation structure for the new GMS contract is in place through GMS Oversight Group which oversees implementation of local plans and measures associated improvement across NHS Lothian. • The Primary Care Joint Management Group review the position monthly with practices experiencing most difficulties to ensure a consistent approach across the HSCPs and advise on contractual implications. This includes review of a list of restrictions **on** access maintained by the PCCO to identify potential and actual pressures on the system which is also shared with HSCPs. • Practitioner Services Division (PSD) has the ability to assign patients to alternative practices. • "Buddy practices" through business continuity arrangements can assist with cover for short-term difficulties. • Recruitment and retention – tracking and training programmes to support	• Number of practices with restricted list • Patient assignments to practices • Number of, and length of time as 2C practices • Number of contracts handed back to health board • Number of Out of Hours bases closures • Achievement of Out of Hours outcomes • National evaluation of GMS contract; local measures being developed • Funding available to support implementation of plans • HSCP PCIP trackers	**January 2020 Update** **Risk Register for GMS Contract implementation has been developed and agreed. Overall risk rating is "high". Contract implementation is only one part of the issues relating to primary care sustainability.** **HSCPs will review their risk ratings on GP sustainability between January and March 2020. This will inform the corporate risk level. At present Edinburgh and Midlothian are "very high" and East and West Lothian are "high".** **Out of Hours sustainability plan was agreed by HSCPs for 2019/20. Further long term plan to be presented in April 2020.** **The HGC agreed in**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Update/Actions
			Adequacy of Controls Remains inadequate as Primary Care Improvement Plans are at midpoint of implementation programme and GP retention and recruitment is a national issue. Risk grading therefore remains very high/20.		**January 2020 to receive a further update in May 2020.**

Risk 3211 – Access to Treatment (Organisational Risk)

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk that NHS Lothian will fail to achieve waiting times targets for inpatient / day case and outpatient appointments, including the overall Referral To Treatment target, due to **significant numbers of cancellations made suddenly as a result of Covid-19. Referral rates have also dropped significantly as a result of the pandemic which could alleviate impact in the short term, but risk lies in longer term recovery of services. Prior to Covid-19,**	• 3726 – Timely discharge of inpatients • 3203 - Unscheduled Care 4 Hour Performance **Associated Plans** • National Waiting Times Improvement Plan • Scheduled Care Recovery Plan • NHS Lothian Annual Operational (Strategic) Plan • Lothian Hospitals Plan • IJB Strategic Plans and directions • **Modernising out-patients, Theatre Improvement Plan, Cancer SOP.**	**Governance and management** • NHS Lothian Board Performance Reporting • **Establishment of twice daily Executive Briefing Huddles to manage current Covid-19 issues and action planning.** • **Establishment of twice weekly Secondary Care meetings to manage response and provide strategic leadership in system response to Covid-19 outbreak** • Performance reporting at Executive Leadership Team (ELT) and Scheduled Care Recovery Board – **n.b. these have been replaced by other mechanisms for scrutiny and recording of decisions during March/April 2020, as above.** • Monthly Acute Service Senior management Team (SMT) meeting – monthly outturn and forecast position • Controls and actions for this risk are also reviewed quarterly at Acute SMT to ensure any areas of concern are highlighted and action agreed • Weekly Acute Services Senior management Group (SMG) meeting • Monthly Access and Governance Committee to ensure compliance with Board SOPs relating to waiting times – **n.b. this has been cancelled for March/April but a twice-weekly virtual meeting**	Number of people for whom we are breaching the Government's access standards: • Access to treatment for cancer services (31 days, 62 days). • The Treatment Time Guarantee for relevant inpatient and day case treatment. • 90% of planned/elective patients to be treated within 18 weeks of referral • 8 Key Diagnostic Tests – the Board must ensure that the verified report of the test or investigation is received by or made available to the requester within 6 weeks of receiving the request • 95% of patients to be seen within 12 week access to a first outpatient appointment Also: % of non-recurring funding (to improve access performance) which is spent.	**April 2020 Update** **No specific updates at March 2020 Healthcare Governance meeting (HGC), though it was noted within the Corporate Risk Register Paper at the meeting that an update had been made on the Risk at the January 2020 meeting. The detail of this is not included within the March 2020 HGC minutes.** Moderate assurance was accepted around healthcare governance arrangements across NHS Lothian's Acute Services; in terms of performance trends across various measures to Sept 2019; and proposed new arrangements to strengthen ward to board arrangements **at**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
	demand had significantly exceeded capacity for specific specialties. All of these risks could lead to potential reputational damage.	**Assurance Committees** • Healthcare Governance **Grading** • Very high 20	**between the Head of Access and Service Managers has been established for discussion of issues.** • Modernising Outpatients Programme Board which considers demand management, clinic optimisation and modernisation **but which was cancelled in March due to Covid-19.** • **Prioritisation of urgent and emergency elective work** • **Introduction of new ways of working including near me and telephone consultations.** • **Access to Independent sector capacity to manage clinically triaged cancer in-patient/day case plans** • **Utilisation of GJNH to support cardiac/ thoracic urgent activity.** • **A revised communications strategy has been established to ensure that both patients and referrers are appropriately informed of the length of waits. This may need to be reviewed in light of increased long waits, caused to patients who have had procedures cancelled as a result of Covid-19.** **Policies, procedures and plans** • **Expedited adoption of pre-planned efficiencies e.g. NearMe/Attend Anywhere/Call MIA and tele-support, community based initiatives, streamlined triaging and reduced referral rates, all within governance frameworks but also in parallel to development of a New OP Model, which should evaluate, embed and sustain these new improvements as far as**	Operational efficiency measures, such as: - Did Not Attend rate - Rate of theatre utilisation - Rate of theatre cancellations Proportion of consultant time directly attributed to clinic or theatre. - Use of virtual technologies going forwards	**the January 2020 HGC meeting** (within the Acute Assurance paper).

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
			possible. (Cancer and TTG also to be considered within the model.) • **Management had previously developed service-based sustainability plans, aligned to national themes, to manage existing backlog and recurring gap between demand and capacity. Impacts of Covid-19 are yet to be understood, including in terms of timeframe, but work is already underway to plan and implement post-Covid Recovery, including adoption of expedited best practice approaches.** • **Resources had pre-Covid been prioritised according to the clinical risk matrix. This has been temporarily superseded by clinical judgments balancing patient vulnerabilities in terms of Covid, but it is anticipated that the matrix would be returned to, once Covid activity ceases or becomes part of core HB function.** • **Lothian Waiting Times Improvement Programme Board became the Scheduled Care Recovery Board in late 2019, and plans to review sustainability plans at sub-specialty level for high risk areas, post-pandemic. The Board is focused on designing the service for the future and its programme structure is aligned to the national framework.** • **Service trajectories were developed for 2020/21 but these will need to updated in light of the impact of Covid-related cancellations - also capacity available following the crisis period, including in terms of external provision/ scope for waiting list initiatives etc.** • £21.5m of non-recurring financial support		

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
			to increase capacity. • £18.5m of non-recurring financial support. • **Previously scope for improvement had been identified with recommendations made to** specialities e.g. target of 10% DNA rate, theatre session usage targets, consultants - 10 PAs recommendation of 6 directly attributed to clinic or theatre. • Also - increase in staffing in Bowel screening to carry out pre-assessment. Increased number of bowel screening sessions to meet increased demand and reduce length of wait effective from 1 June 2019. • National elective care centres in place to increase capacity **Adequacy of controls** **Some controls are in place and additional controls were being designed and as such, overall control was inadequate. Risk remained high while demand continues to exceed available capacity – this will need to be reviewed again once the post-Covid landscape is better understood.**		

Risk 4191 – Access to Treatment (Patient Risk)

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
Improving the quality of healthcare	**As a result of Covid-19 there is a significant risk that patients will wait longer than described in the relevant national standard due to high numbers of cancellations being made suddenly. Prioritisation of USOC/urgent and emergency workload during Covid impacting on routine patient waiting times. Shielding and isolation requirements impacting on patients ability to attend for consultation/ treatment National Screening programmes cancelled.** **Referral rates have also**	• 3726 – Timely discharge of inpatients • 3203 – Unscheduled Care 4 Hour Performance • 3211 – Access to Treatment (Organisation Risk) **Associated Plans** • NHS Lothian Quality Strategy • NHS Lothian Annual Operational Plan. • IJB Strategic Plans and directions – with regard to demand management, and GP referrals • **New OP Model (to also consider Cancer and TTG) & NearMe/Attend Anywhere** • **Site mobilisation plans**	**Governance and management** • **Establishment of twice daily Executive Briefing Huddles to manage current Covid-19 issues and action planning.** • **Establishment of twice weekly Secondary Care meetings to manage response and provide strategic leadership in system response to Covid-19 outbreak.** • There are Acute Performance reviews led by the Chief Officer for specialties on the clinical risk matrix. These are supported with more regular meetings for example led by the Head of Access with service management and clinicians to develop and implement ideas for improvement, and to facilitate links with the outpatients and theatres programmes. • **The Scheduled Care Recovery Board (formerly the Lothian Waiting Times Improvement Board), was developing sustainability plans at sub-specialty level for high risk areas, and will resume this post-Covid. The Board is focused on designing the service for the future and will do so in terms of Covid impacts. Its programme structure is aligned to the national framework.** • The Modernising Outpatients Programme Board is managing the change in delivery of 64,000 appointments to March 2020. This was calculated as 15.9% of the national target of 400,000 as outlined in the Modernising Outpatients Report (2017). This involves potential change in referral processes, demand management, clinic optimisation and role modernisation. **A final position against the 64,000 target was**	• **Cancelled or delayed access to treatment due to COVID** • **Outcome measures** • Waiting times, including those for surveillance patients • Adverse events linked to waits • Number of complaints linked to waits • **Patient experience feedback**	**April 2020 Update** **No specific updates at March 2020 Healthcare Governance meeting (HGC), though it was noted within the Corporate Risk Register Paper at the meeting that an update had been made on the Risk at the January 2020 meeting. The detail of this is not included within the March 2020 HGC minutes.**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
	dropped significantly as a result of the pandemic. Longer term the impact of both of these on service quality and patient safety and experience will need to be understood and addressed as soon as possible. This will also need to be addressed against a background of demand exceeding capacity for in-patient / day case, outpatient services, 31 and 62 day cancer standards and diagnostic procedures within specific specialities.	**Assurance Committees** • Healthcare governance **Grading** • Very high 20	**expected by late June 2020, but due to Covid-19 may now be later.** • Service developed trajectories are used to monitor performance, early indications of pressures, and opportunities to improve efficiencies/productivity. **These will need to be re-set for 2020/21 in light of impacts of Covid.** **Policies, procedures and practices** • **Prioritisation of USOC/ urgent and emergencies during Covid period** • **Access to GJNH for urgent cardiac and thoracic procedures** • **Access to independent sector for clinically triaged cancer procedures** • A clinical risk matrix is regularly updated to inform how we prioritise resources; • Cancer performance improvement plans focus on Urology, Colorectal, Melanoma and Lung 62 day performance, and are regularly reviewed at meetings**, including by the Chief Officer, although current dates have had to be postponed until post the Covid-crisis. Breast Cancer will also be reviewed as part of the next set of meetings.** • **Mitigation through expedited consolidated adoption of planned technologies such as NearMe/ Attend Anywhere/ Call MIA and other tele-support, community based initiatives, streamlined triaging and streamlined referrals.** • Enhanced cancer monitoring and escalation, **where appropriate is continuing during Covid, albeit against a landscape of cancellations and altered practices.** • **Not all patients who have been deferred need to engage with their GP to have the**		

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
			priority of their endoscopy upgraded/ booking expedited - GPs are under significant pressure and as a result it is not essential for the patient to be re-referred however some patients do chose to make contact with their GP. If a patient's condition changes, they can contact the service to report the change in symptoms which will result in a discussion between the service management team and a consultant who will be able to upgrade and expedite the booking of the patient's endoscopy. • Specific controls are in place for patients referred with a suspicion of cancer. Trackers are employed to follow patients through their cancer pathways. **Cancer tracking will provide a valuable mechanism to ensure no cancer patient exits the system unintentionally while appointments are cancelled/deferred. Trackers undergo ongoing training and will adhere to national guidance on how to record cancer waits during the Covid pandemic.** **Adequacy of controls** Some controls are in place and additional controls were being designed and as such, overall control was inadequate. Controls and actions are now being reviewed quarterly at Acute CMG to ensure any areas of concern, **including impacts of Covid-19,** will be highlighted and actioned. **Risk remained high while demand continues to exceed available capacity, and this could be exacerbated by Covid cancellations and options available for post-Covid Recovery.**		

Risk 4820 - Delivery of level 3 recovery plans

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
Improving the quality of healthcare	There is a risk that the Board does not deliver NHS Lothian's Level 3 Recovery Plans to agreed timescale impacting on patient experience and outcome of care.	• (3203) 4-hour target (organisational) • (4688) Patient safety - RIE ED • (3211) – Access to treatment (organisational) • (4191) – Access to treatment (patient) • (4921) REB inpatient beds • (4813) RHCYP and DCN • (3726) – Timely discharge **Associated Plans** • Recovery plan • Financial plans • Underpinning plans for all associated linked key risks **Assurance Committees** • Assurance of this risk is reserved to the Board	**Governance and management** Routine reporting to every Board meeting. Assurance levels provided by relevant committees for linked risks are also provided to the Board through reporting of the corporate risk register to every Board meeting. Fortnightly reporting to Scot Gov oversight group. These arrangements are underpinned by robust reporting for each of the 6 challenging service area work streams: • Scheduled care & cancer programme delivery Board (chair: acute services Chief Operating Officer) • Unscheduled care & delayed discharge programme Board (Chair: IJB Chief Officer) Supported by unscheduled care committee • Mental Health & learning disabilities Programme Board (Chair: IJB Chief Officer) - weekly operational meeting • Paediatric programme Board (chair: Board non-exec director); RHCYP/DCN oversight Board The Strategic planning committee and Finance and Resources committee also receive and respond to regular reports. In addition, the sub-committees of the Board receive reports on the relevant individual linked key risks and provide	Core recovery plan metrics are in place and monitored by the Board: • Delayed discharges • 4 hour ED waiting time • Outpatient >12 week waiting time • Treatment time guarantee • Cancer waiting times (62 day target) • Mental health and learning disability bed occupancy • CAMHS>18 week target • Psychological therapies > 18 week target • Paediatrics and St Johns	**<u>January 2020 Update</u>** • Moderate assurance agreed by the Board and risk grading change to high (12) at Jan 2020 Board meeting

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
		Grading • High 12	appropriate assurance levels. **Plans** A Director of Improvement has been appointed and a formal recovery plan has been developed and submitted to Scot Gov early December – currently awaiting sign-off. The Integrated care forum (4 IJBs, 4 councils and NHS Lothian) provides a forum to ensure a whole system approach and collaborative working. **Scheduled care/Cancer waiting times** A Programme Director and infrastructure to support delivery is in place. Projects in place include: • Additional, non-recurring investment for outpatients and TTG • Plans for elective centre at St Johns **Unscheduled care/delayed discharge** Programme Director in place with internal and external improvement support in place. Key work includes: • additional investment to address 4EAS • Resign of services at front door RIE • New models of care such as Hospital at home • Range of work within HSCPs to increase community capacity **Mental Health** Number of short term actions in place including 13 additional beds in REH and completion of anti-ligature works at St John's.		

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
			Longer term plans in place for improvement including: • adult mental health pathway • development of Home First approach • access to CAMHs and psychological therapies **Policies** National policies and targets provide a framework for improvements in delivery of these services. **Adequacy of Controls** An adequate framework of controls and governance arrangements is in place and operating as intended. Hence, the adequacy of controls is satisfactory.		

Risk 4921 – Bed Capacity in Acute Mental Health

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
Improving the quality of healthcare	There is a risk that acute admissions exceeds the inpatient bed capacity due to increasing demand, beds being reduced in the move to The Royal Edinburgh Building, and barriers to patient flow through the adult mental pathway leading to patients having to be boarded overnight in other specialities, being placed out of area or sleeping in areas within wards not designed for this purpose.	• Finance (3600) **Associated Plans** • Capital Plans **Assurance Committees** • Healthcare Governance **Grading** • High 15	**Governance and management** A scheduled annual report on governance and quality arrangements is presented to Healthcare Governance committee with additional reporting on specific issues as required. As part of level 3 escalation, a weekly report is submitted to Scottish Government via the Director of improvement. A local operational group is in place with membership from REAS and the HSCPs. Performance an plans are reviewed every 2 weeks at REAS SMT. Multi-agency action plan in place for adult acute mental health. A range of information is collated to measure effectiveness of plans and to inform actions. • Formal recording of patients with delayed discharge for acute and rehab services • Daily and Weekly monitoring and review of admission and discharge criteria and LoS **Plans** Adult acute mental health capacity action plan is in place. Various QI work streams are in place to improve patient pathway and interface between locality and hospital based services o Adult Acute Capacity Action Plan o REAS and IJBs working collaboratively to improve patient pathway Additional capacity made available and future requirements in the planning stage.	• Length of Stay • Bed Occupancy • Number boarded and out of area patients, within REAS and out with • Adverse Events • Complaints	**<u>April 2020 Update</u>** **<u>No change since last reviewed in January 2020.</u>** HCG committee accepted moderate assurance at the meeting on 12 Jan 2020

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
			Policies and procedures A variety of measures are in place to plan/ monitor bed state in real time and maximise flow including: • Daily huddles of acute ward SCNs and CNM • Weekly Patient Flow meeting • Weekend meeting of Drs on call, CCN, IHTT & MHAS • Daily rapid run down meetings on acute wards for regular review and decision making • 10am bed state information emailed to range of clinicians & managers across REAS and Edinburgh localities • Escalation of cases where barriers to discharge have been identified (e.g. delays in deep clean, funding for goods / furniture) that are considered relatively easy to resolve via daily MATT (Multi Agency Team Touchdown) • Identification of patients considered clinically suitable to 'board' overnight in other areas e.g. Harlaw, Eden and Ritson to create capacity for admissions. Clinical notes are taken with patient and verbal handover provided at time patient accompanied to the 'boarding' ward. • Development of key worker system within acute wards to promote better continuity and co-ordination of care, in turn helping to ensure discharge happens at right time • Key Worker SOP drafted and awaiting sign off via Acute Exec SMT. Canned text for Key Worker one to ones available • Review of patients returning from pass to consider appropriateness of extending these to create some capacity for admissions • Accessing available beds including St John's Hospital and out of area where necessary • Sofa bed procured and SOP required due to environmental ligature concerns • Datix – adverse event reporting and review		

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
			• Quarterly reporting process and compliance with H&S policies ensuring H&S policies are complied with and risk assessments are undertaken to identify local risks and implement management controls **Policies** A range of policies are in place to support these arrangements: • Pass plans • Boarding • Delayed discharge • Health and Safety policies **Adequacy of Controls** Adequate but partially effective – plans in place for a more robust mechanism supported by data, but not yet fully implemented.		

Risk 4694 – Waste Management

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
Achieving value and sustainability	There is a risk that NHS Lothian will not be compliant with statutory Health and Safety and environmental regulations for disposal of special waste because of the abrupt ending of the national contract leading to potential harm to people and the environment and financial penalties.	• (3600) Finance **Associated Plans** **Assurance Committees** • Staff governance via Health and Safety Committee **Grading** • High (15)	**Governance and management** • Health &Safety committee, who report to Staff Governance Committee, provide oversight and receive regular reports on performance of the agreed contingency arrangements • Lothian Infection Control Advisory Committee (LiCAC) provides professional advice and receives a quarterly report • Sustainable Development Management Group (SDMG) also receives a quarterly report • A waste management committee structure is in place to oversee waste management on a national and regional basis. This membership of the group incorporates national experts • The national and regional groups meet quarterly. Regional consortia chairs report operational issues and risks and national solutions or contingencies sought, where appropriate • Currently a weekly teleconference is also held to report impact of issues arising during contingency and to seek speedy resolution • Facilities Adverse Event Review Group review all significant adverse events reported on DATIX **Policies, procedures and plans** • Statutory environmental regulations in place for disposal of special waste • NHSL Waste Management Policy • SHTN3 Waste Management Procedures for NHS Scotland • Procedure for waste disposal from infectious diseases of high consequence	Non-compliances with waste management disposal procedures including: • Waste correctly stored and segregated at ward and department level • Colour coding used correctly • Waste packages identifiable • Staff communication processes in place • Waste disposal guidance available • Waste consignment notes available • Vehicle compliance with ADR Reported incidents on service impact via Datix.	**January 2020 Update** **The contingency arrangements for the management of healthcare waste remain in place and no adverse impact on patient care has been reported. The new contractor, Tradebe, is preparing to implement the new contract and the date for this for NHS Lothian is Feb/March 2020. Fortnightly teleconferences to ensure effective communications remain in place both locally and nationally. Concern has been expressed nationally about the new requirement for all boards to undertake pre-acceptance audits on all clinical waste producing areas including all community practices (>500). Although NHSS is engaged with SEPA to agree a mutually acceptable approach to this new standard for Scotland it is likely that we will need to invest in additional resources to achieve this on a recurring basis.** **As a consequence of medicinal waste being observed in the infectious/sharps waste stream, it is also being proposed that** all Boards **replace orange lidded sharps boxes (disinfection treatment) with blue**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates
			• A new national contractor has been appointed with service anticipated as commencing between November 2019 and February 2020 • Current contingency arrangements are in place with 3 contractors for collection of waste and these are operating effectively • Revised local contingency operating and monitoring procedures are in place • Staff training in place including LearnPro module for all staff involved in the handling of clinical waste • Additional waste management capacity has been put in place via an application for a Waste Management Licence at Midlothian Community Hospital ensuring effective and efficient removal of waste from RHSC and community areas. • Regular audits of waste management/disposal are carried out by the Waste Management Officer. Exceptions are reported quarterly to LICAC, Facilities Heads of Services meeting and SDMG • External audit is also carried out through SEPA inspections and follow up reports as well as regular DGSA audits and reports **Adequacy of controls** Adequate but partially effective as contingency arrangements still operating.		**(incineration). This will require a complete change in clinical practice in this regard ad bring additional disposal costs of approximately £300/tonne. No decision has yet been taken on this issue.** **Options to develop a comprehensive and detailed training programme for the presentation and disposal of clinical waste are being developed. Initial arrangements are being taken forward to provide this for Facilities waste handling/management staff however given the above it is recommended that nursing staff are engaged with this.** **The actions and control measures which are being implemented still represent moderate assurance to the Staff Governance Committee.** Staff Governance Committee accepted moderate assurance in July 2019.

Risk 3454 – Learning from Complaints

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk that learning from complaints and feedback is not effective due to the lack of reliable implementation of complaints and feedback processes leading to the quality of patient experience being compromised and adverse effect on public confidence and expectation of our services.	• (4688) 4 hour access- patient • (4191) Access to treatment – patient • (3328) Traffic management • (3829) GP sustainability • **(4984) COVID-19** **Associated Plans** **Assurance Committees** • Healthcare Governance **Grading** • High 16	**Governance and management** Robust governance and management processes are in place with regular reporting to Healthcare governance committee. Periodic reporting directly to the Board, as required. Corporate Management Team and Executive Nurse Director's group review and respond to weekly and monthly reports. These are underpinned following additional controls: • At a service level, senior management teams routinely review and respond to complaints and patient experience. This is also part of monthly quality and performance management arrangements • Similar arrangements are mirrored throughout Operational management structures • Clinical Management groups and equivalent groups in HSCPs consider complaints and learning as standing agenda items • Periodic internal audits **COVID-19 update** • **Directed members of the team to support a staff advice line** • **Had to accommodate a number of staff self isolating and shielding** • **We have advised the SPSO that we will not meet 20 day standard but will prioritise SPSO cases** • **Continue to chase cases over 75 days in order to reduce this backlog** **Policies, procedures and plans** Policy & procedure for management of feedback and complaints is in place with associated toolkit	• Compliance with measures set out in the complaint procedure including: • Monthly reporting of response times – 5/20 days • 9 national KPIs - that form the basis of the annual report. • SPSO decisions • Compliance with Internal Audits	**April 2020 Update** **Further update on complaints data being given to HCG to support moderate assurance. Improved performance with 20-days** The data/intelligence will be presented to the pertinent governance committee when providing assurance on management of the risk. November 2019 – Moderate assurance accepted.

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
			to support implementation. Patient Experience Team have QA process in place whereby all complaints closed which are graded as major or extreme are reviewed and feedback shared with service for learning. Parliamentary SPSO Reports from other Boards and all Decision Reports are circulated and reviewed for learning. Through monthly nurse directors meetings, twice yearly meetings of senior nurses across Lothian, clinical change forums workshops on complaints handling as well as through patient stories at Healthcare Governance committee we attempt to evidence learning from complaints. Plans are in place to implement new structure for the Patient Experience Team to support the complaints handling procedure. **Adequacy of controls** Inadequate – governance processes and improvement plans are in place, but yet to be fully implemented.		

Risk 3527 – Medical Workforce

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
Improving staff experience	There is a risk that the availability of medical staffing will not be adequate to provide a safe and sustainable service to all patients, because of the inability to recruit and retain doctors. Specific issues include availability of doctors through specialty training schemes and retention of capacity in service through senior medical staff due to changes in pension tax rules. This affects the ability to provide a safe and sustainable service and to meet government commitments.	• (3211 & 4191) Access to treatment - organisational and patient. • (3829) GP sustainability • (3828) Nursing workforce • (3203 & 4688) 4 hour target (organisational and patient) **Associated Plans** **Assurance Committees** • Staff governance **Grading** • 16 – currently considering recommendation to increase to 20 (Impact 5, likelihood 4)	National work force planning group in place. Board Medical directors feed in requirements through the regional workforce group. NHS Lothian Workforce planning and development Board in place to co-ordinate work force planning for all professional groups. This is underpinned by: • NES national recruitment plans in place for training schemes to match identified work force requirements. • Programme for clinical fellow recruitment in place (numbers risen from 6 to 70 since beginning of programme) • Policy/framework in place for use of locum/agency staff managed through NHS Lothian staff bank. • New service developments are required to have a workforce assessment as part of approval process. • Medical education directorate have systems and processes in place to support and ensure the well-being of trainees. • Use of alternative workforce to fill gaps (Advanced nurse practitioners, physicians associates) • Maintaining high 'fill rates' for training programmes through retaining positive inspection reports (Royal colleges, GMC) and monitoring improvement when action is requested. Regular reporting to Staff Governance Committee which includes update on recruitment and highlights significant risks. Reported to Board as part of update on all workforce issues.	• Sickness and Absence Rates • Recruitment – number of applicants, numbers recruited • Establishment gaps • Bank & agency usage • Number of unfilled shifts • Number of consultants >=10 pas • Number of doctors working< full time • Vacancy Rates	**<u>January 2020 Update</u>** **<u>An updated paper will be produced for the February Staff Governance Committee.</u>**

Priority for Continuous Improvement	Risk Description	Linked Key Risks	Controls	Key Measures	Updates/Actions
			Adequacy of controls Adequate but partially effective.		

Risk 3189 – Facilities Fit for Purpose

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
Improving the quality of healthcare	There is a risk that NHS Lothian is unable to deliver an efficient healthcare service because of unsuitable accommodation and clinical environments leading to potential delays in patient care and threatening patient and staff safety.	• (1076) Healthcare Associated Infection • (3454) Management of Complaints & Feedback • (4191) Access to Treatment – Patient • (3455) Violence & Aggression **Associated plans** • Organisation Financial Plan • Capital Investment Plan **Assurance Committees** • Finance & Resources Committee **Grading** Current: High 16	**Governance and Management** A Management Process and structure for reporting of Backlog Maintenance (BLM) has been implemented to inform risk management plans and review are through the following groups follows: • Property & Asset Management Strategy (PAMS) Group • Capital Steering Group • Lothian Capital Investment Group (LCIG) • Scottish Government through the annual Property & Asset Management Strategy Controls considered by these groups, who monitor and respond to this risk are as follows: • The results of the sample of Board estate surveyed annually • Ensure that 20% of the Board's estate is surveyed annually for physical condition and statutory compliance by the surveyors appointed by Scottish Government • Review the outcome of surveys with the Operational Hard FM Managers and review and assess risks in accordance with the operational use of the properties to ensure priorities are addressed **Policies, procedures and plans** • Capital Investment Plan which addresses refurbishment and re-provision of premises, linked to the Estate Rationalisation Programme includes the termination of leases and disposal of properties no longer fit for purpose. • Recurring capital funding approved of £2.5m to undertake priority works (high and significant areas)	• Performance Dashboard In-house • PFI premises • Datix adverse events related to built environment • RIDDORS events • Scart tool compliance • Complaints and HSE involvement, formal and informal • Audit water quality systems • Ventilation systems audit. • Audit sample inspection of our estate 20% annum • Results of sample inspection of estate (20% per annum)	**April 2020 Update** **PAMS and backlog maintenance implemented and operational.** **2020 plan in delivery and under the governance of LCIG – Lothian Capital Investment Group.** **Implementation plans for 2020 shall be impacted by Covid 19 restrictions and the risk to delivery shall be evaluated over the next few weeks once Covid reduces.** **Closure of sites remain on track although the impact to Covid has had an impact of delivery timescales but significant impact.** **Opportunity exists within the planned asset capital planning, where the hard service teams are replacing CAFM to Agility, this**

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
			• The Procurement Framework has been implemented that allows issues identified to be rectified without the need for lengthy tendering exercises • Quarterly infection control meeting • Water quality group **Adequacy of Controls** Adequate but partially effective.		**presents an opportunity to identify assets / condition and implement a criticality review. This is a long term project but a significant opportunity to ensure the right assets are invested and control to ensure the facilities remain fit for purpose.**

Risk 3455 – Violence & Aggression

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
Improving staff experience	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.	• (3189) Facilities fit for purpose **Associated Plans** **Assurance Committees** • Staff Governance via Health & Safety Committee **Grading** • High 15	Robust management in place through operational management structures. Staff Governance Committee has oversight, receiving and responding to reports from the NHS Lothian Health and Safety Committee at every meeting. Clear operational management structures and processes to monitor effectiveness of plans to address identified risk at service level and escalate specific risks where required are in place through Local Health and Safety Committees, who report to the NHS Lothian H&S Committee. The local group monitor assessment and improvement plans. (Purple Packs). Range of data regularly reviewed at local level, Range, local Audits. These management structures are underpinned by the following: • Management of violence and aggression policy in place. Range of supporting policies; Lone working, Restraint – consideration and alternatives, Alarm response policy. • Policies and procedures on patient assessment and care planning to minimise risk of V&A behaviours also relevant. • Comprehensive training programme for management of V & A, tailored to specific service needs. This includes training in preventative measures (safe wards / activities / stress & distress). • Expert team available to provide advice and assistance to services. • Process in place to assess and allocate a range of safety alarms at operational level. With requirement for services to have local procedures in place for use of and response, including regular testing. • Consideration of the built environment in all new builds/opportunities for re-design/re-	• Number of V&A adverse events and those with harm • Number staff trained • Staff Experience • Number assigned alarm/walkie-talkies/ and those in active use • Range of local audit data to evidence compliance with local procedures. • Number of appropriate services with plan in place, (purple pack), updated at least annually following completion of risk assessment. • HSE Notices and/or prosecutions.	**January 2020 Update** **The next Staff Governance Committee will be held on 19th February 2020.** **The October 2019 Staff Governance Committee accepted Moderate Assurance**.

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
			configuration in existing buildings. • All adverse events reviewed as appropriate to level of harm, themes identified and appropriate improvement plans developed and implemented. **Adequacy of Controls** Adequate but partially effective; control is properly designed but not being implemented properly.		

Risk 3328 – Roadways/Traffic Management

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
Improving the quality of healthcare	There is a risk of injury to staff, patients and the public from ineffective traffic management as a result of inappropriate segregation across NHS Lothian sites leading to loss of life or significant injury	• (3455) Violence & Aggression • (4191) Access to Treatment • (3454) Complaints & Feedback • (3189) Facilities Fit for Purpose **Associated Plans** • Capital Investment • Property Asset Management Strategy • Financial Plan **Assurance Committees** • Staff Governance Committee through Health & Safety **Grading** High 12	**Governance and management** • A clear management Process and structure which monitors and reviews the controls set out for reporting has been implemented as follows: • Site specific Traffic Management Groups • Reported in Facilities H&S quarterly reports • Reported to Health & Safety Corporate group via Facilities Health & Safety Group • Escalation process in place through the management governance process should congestion become an issue on any site. Governance process is - Local Traffic Management Groups to Facilities Quarterly Reports, Facilities Health & Safety Group (also reported to Facilities Heads of Service) Overarching Health & safety Group/ **Policies, procedures and plans** • The commission of Independent expert reviews of road infrastructures on high traffic high inpatient sites to inform risk/ • Action plans have been developed across all sites by the Local Site Traffic Management Groups and high risk items approved subject to funding. • Traffic surveys have been conducted across all hospital sites, and action plans have been prepared and subject to regular review. • Operational Team to direct and control vehicular movements, within risk areas. • Additional dedicated car park personnel in high volume traffic sites has been implemented • A policy for reversing has been implemented across all sites, which includes – all NHS L vehicles have been fitted with reversing cameras and audible alarms, no reversing unless with the	• Datix adverse events related to traffic accidents • RIDDORS adverse events related to traffic accidents • Litigation • HSE involvement formal and informal • Police involvement relating to accidents • Compliance to legislation • Audit of road and pathway networks	**<u>April 2020 update:</u>** **<u>No change to the previous update although the COVID-19 response is having an impact on the site infrastructure due to the temporary restrictions on public visiting, construction projects etc.</u>** Commencing the process to identify a training provider to update relevant staff competency during 2020/21. Construction projects on WGH causing a likely increase in the level of risk – currently being reviewed. Due for consideration by Staff Governance Committee February 2020 – recommended levels of assurance will be moderate overall; but limited assurance for WGH, RIE & SJH sites due to construction work

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates
			assistance of Banksman. • Risk assessments and procedures are developed and regularly reviewed where risks have been identified, and a more task specific process has been developed. • Work Place Transport Policy available and reviewed within agreed timescales. **Adequacy of Controls** Inadequate; control is not designed to manage the risk and further controls and measures required to manage the risk.		The data/intelligence will be presented to the pertinent governance committee when providing assurance on the management of this risk.

Risk 1076 – Healthcare Associated Infection (HAI)

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
Improving the health of the population	There is a risk of patients developing an infection as a consequence of healthcare interventions because of inadequate implementation and monitoring of HAI prevention and control measures. HAI potentially increases morbidity and mortality and results in further treatment requirements, including potential extended stay in hospital. There is also a risk of patients developing an infection linked to the built environment. This includes organisms associated with water such as *Pseudomonas aeruginosa* and	(3189) Facilities fit for purpose (3828) Nursing workforce **Associated Plans** • Capital Plans **Assurance Committees** • Healthcare Governance **Grading** • **High 16**	**Governance and Management** Robust management processes are in place through The Pan Lothian Infection Control Committee (PLICC), the Health & Social Care Partnerships, Royal Edinburgh and Associated Services Infection Control Committee (HSCP & REAS ICC) and Lothian Infection Control Advisory Committee (LICAC). • LICAC includes consideration of public health and environmental health risks. Comprehensive data is considered at every meeting, and action directed. This includes nationally reported measures through the mandatory surveillance programmes. • PLICC provides assurance to Healthcare Governance Committee. PLICC receives reports from the local infection control committees which are in place for all acute hospital sites. The HSCP & REAS ICC receive reports for community hospitals. Mandatory key performance data is also considered at a wide variety of operational management groups who will direct local action. • Lothian Infection Control advisory committee (LICAC) receives reports and minutes from PLICC and provides professional advice to the Healthcare Governance Committee on all infection control issues. • The Decontamination Programme Board, chaired by the Director of Public Health, provides strategic direction and oversight on this subject and provides expert advice to PLICC and LICAC. • HAI Level 2 Quality indicator data is available on Discovery (level 1) dashboard providing	• SAB Rate • CDI rate • ECB Rate • MDRO screening compliance • HPS Surveillance Reports (benchmark with other Boards) • Compliance with mandatory HAI training • Audit compliance data and associated action plans • 100% compliance with HAI SCRIBE • Number of IMT/PAG with confirmed transmission or acquisition/harm • Facilities Monitoring Scores • Antibiotic prescribing rates for high risk antibiotics	**April 2020 update** **COVID 19** **All IPCT activities are focused on supporting the organisation to maintain a safe working environment for staff and patients during COVID 19 outbreak.** **The risk grading has been adjusted to high as the ongoing impact is likely to increase depending on when impacts of national community controls impact on transmission. The impact is Major but at present manageable with diversion of resources.** **Mandatory surveillance Programmes have been suspended due to pandemic. CNO Letter 25.3.20**

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
	other commonly occurring environmental organisms. There is also a risk to patients from failure to decontaminate reusable invasive and semi invasive medical equipment effectively. **April 2020 COVID 19 Pandemic NHS Scotland is in pandemic emergency status. for COVID19 outbreak. There is an increased pressure impacting on all NHS Lothian services and facilities.** **There is changing guidance as the situation develops and this is taking significant resource allocation.**		access and oversight to clinical and senior management teams of NHS Lothian performance against other Boards and NHS Scotland performance. • To support Local Delivery Plan Standards all Clostridioides (formerly Clostridium) difficile infections, Staphylococcus aureus bacteraemia (SAB) and E coli Bacteraemia (ECB) are reviewed monthly to identify themes and key areas for improvement. The outcomes of this are shared in monthly reports to the Acute Clinical Management Group and other local governance or improvement meetings. **Policies and procedures** The above management arrangements are underpinned by the following mandatory policies and procedures: • The national infection control manual provides comprehensive, evidence based guidance and is supported by a range of specific policies, guidance and procedures to assist implementation of Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs). • A comprehensive range of policies, guidelines and procedures and patient information leaflets are available via NHS Lothian intranet to supplement national policy and guidance. Quick reference guides are provided. • HAI SCRIBE (System (for) Controlling Risk In the Built Environment) provides a framework to implement national standards and guidance into new builds, refurbishment and maintenance programmes. • National HAI Standards outline roles and responsibilities from Board to Ward. • Cleaning matrix in place to direct appropriate		20200425 CNO Letter to Boards rega **Some surveillance activities has been retained** **Mortality SAE reviews have been suspended due to pressures on clinical staff** **The LDP statistics for 1.4.19-31.3.20 will be completed and submitted to HCG in May 2020** **Compliance with HAI SCRIBE. This has remained inconsistent. There is reduced capacity within IPCT to support as resources are diverted to support COVID 19 pressures.** **Advice from the Scottish Government that hospital construction sites are essential, Risk assessments are to be prepared by construction companies in order to**

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
	There is the potential for staff to become overwhelmed or to become ill during the pandemic impacting on their health and well being		cleaning of environment and equipment. • Antimicrobial guidelines are in place to promote prudent prescribing to reduce the risk of antimicrobial associated CDI and contribute to reduction in antimicrobial resistance. • HAI Education strategy is in place which includes mandatory training and a planned programme of education and training for all staff. **Practice and audit:** • A team of specialist IPC practitioners are available to provide advice and assistance to NHS Lothian. This includes provision of a duty infection control nurse 7days per week 0830-1600. Urgent clinical advice on infection management is available via the on call microbiologist/virologist out of hours. • Clinical teams undertake local SICPs audits to provide assurance of compliance and identity areas for further improvement through local action plans. These data are collected and available in QIDS. • The IPCT undertake a planned risk based programme of audit. Outcomes are shared with the local clinical teams, site management team and other key stakeholders including facilities teams to inform remedial action and improvement work through their local action plans. • Active surveillance programme for alert organisms is maintained in line with mandatory requirements. • All outbreaks, incidents and data exceedance are investigated by the IPCT Where needed, a problem Assessment Group (PAG) or Incident Management Team (IMT) is convened to further investigate and manage any significant		**establish a safe systems of work allowing them to re-start work on sites.** **HAI Scribe Lead Advisor will where possible continue to provide urgent advice and attend teleconference meetings subject to clinical activity** **Audit Routine/snapshot audits have been suspended and will only be undertaken as required for PAG and IMTs.** **Development and the move of HAI audits to QIDS has been paused** **All non-essential Quality Improvement Work in NHS Lothian has ceased for the forseeable future anticipated until at least until the end of August 2020** **Summary of IPC activities impacted**

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
			event or outbreak. • Formal debrief meetings are undertaken following IMT to identify wider system needs and share learning. These outcomes are reported to the Local ICC, PLICC and LICAC. • The infection service undertake multi-disciplinary ward rounds to review complex patients with transmissible infections twice weekly on RIE, WGH and SJH sites. RHSC has a weekly ITU ward round. Significant adverse event review (SAE) are requested in response to all CDI and SAB deaths where this is recorded on part 1 or part 2 of the death certificate (a cause/contributory factor). **Adequacy of controls** Adequate but partially effective; control is properly designed but not being implemented properly. **COVID 19** **A number of groups have been set up in the organisation to coordinate activities and develop and translate national guidance for operational use as the situation develops guidance for guidance as the situation. IPC are providing support and input to these groups as required. Team members duties have been adjusted to support the pandemic management** **The organisation provides a daily speed read which guides staff to current or changing information. There is also support for staff health and well being.**		 20200407 Temporary changes t

Risk 3828 – Nursing Workforce

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
Improving staff experience	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.	(3829) GP sustainability **Associated Plans** **Assurance Committee(s)** Staff governance **Grading** • **Medium 6**	**Governance and management** • Safe staffing group provides oversight of delivery of plans for meeting staffing requirements and reports to Staff Governance Committee • Professional governance issues relating to staffing levels reviewed at the Board Nurse Directors group • Workforce governance meetings led by the ND **(Acute / Primary Care)** / Chief Nurse **(REAS)** to review data and amend practice locally will report to Safe Staffing. • A robust escalation process is in place through huddles to senior nursing management to resolve concerns over real time concerns about staffing levels. Weekly reports on staffing issues/shortages produced from DATIX and reviewed at corporate level and through operational management groups • E-rostering and SafeCare live tools deployed to inform local decision making around deployment of available resource • Prospective roster review enables action to identify and resolve potential staffing issues • Recruitment group develops and monitors effectiveness of the recruitment plan/ **Policies, procedures and plans** • Health & Care Staffing (Scotland) (commonly referred to as "safe staffing" legislation) will provide a series of requirements of the Board to ensure that there is appropriate staffing • **Professional long term** planning of staffing requirements is undertaken through the two Nursing and Midwifery workforce planning groups (one for Acute inpatient, one for community) and a REAS workforce group	Establishment gap target: 5% Agency Expenditure target 30% ↓ Sickness target to reduce by 0.5% per year for 3 years from 2019/20 PAA target 21.5% E-rostering KPIs Safe Care compliance gaps NMWWP Tools signoff (annual)	**January 2020 Update** **Management Actions** **Multi disciplinary discussions as legislation affects all clinical staff groups.** **Scottish Government briefing delivered to Board members.**

Priority for Continuous Improvement	Risk Description	Linked Key Risk	Controls	Key Measures	Updates/Actions
			A range of routine data is collated and reviewed to inform and plan staffing requirements: ➢ Nursing and Midwifery Workload and Workforce Tools Output ➢ Compliance with E-rostering rules / eR KPIs ➢ Dashboards/Tableau™ ➢ Staff bank / agency utilisation ➢ Operational risks reported to Work force planning groups ➢ Clinical Quality Indicators / CAIR dashboard A recruitment plan is in place, including a generic recruitment process in place to maximise opportunity to fill posts. • Widened access to nursing roles and development opportunities including modern apprenticeships, return to practice and annexe 21 DN training • Programme in place to timetable annual use of nationally accredited Nursing and Midwifery workload and Workforce Planning tools, including a risk assessment and prioritisation matrix to determine required establishment levels • Significant adverse events where staffing issues are a factor are reported and reviewed for learning and improvement. **Adequacy of controls** Satisfactory		

NHS LOTHIAN

Board Meeting
24th June 2020

Director of Finance

FINANCIAL UPDATE AT APRIL 2020

1 Purpose of the Report

1.1 This paper provides an update to the Board on the financial position after 1 month of 2020/21.

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

2 Recommendations

2.1 The Board is recommended to:

- **Accept** this as a source of **significant assurance** that the Finance & Resources Committee (F&R) has considered the first report on the 2020/21 financial position and has asked for further information before agreeing its level of assurance on achieving a breakeven position in 2020/21. The Committee has also agreed that it has significant assurance that work is being progressed to develop an updated financial forecast against which to monitor financial performance, and to contrast against the previously agreed Financial Plan;

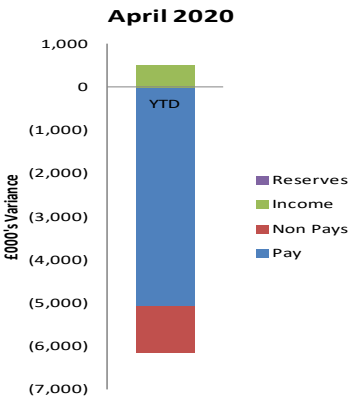
3 Discussion of Key Issues

3.1 At its meeting on the 17th of June, the F&R Committee received a paper on the Period 1 financial position, and an update on the progress being made around updating the financial plan for Covid-19 in this financial year. The F&R paper highlighted a month 1 overspend of £5.6m, of which an estimated £5m related to additional unfunded expenditure relating to Covid.

3.2 A summary of the Month 1 position is shown in Table 1 below.

Table 1: Financial Position to 30th April 2020

Variance	Mth 1 £000's
Pay	(5,079)
Non Pays	(1,079)
Income	513
Reserves	0
Total	**(5,645)**



3.3 The most significant impact on the financial position for April 2020 is the costs incurred in supporting the services to deal with Covid-19. There is no additional funding assumed from the Scottish Government at this point for 2020/21 and there are costs committed within the detailed Board Local Mobilisation Plans (LMPs) that have not yet been incurred within the

financial position, including additional capacity commissioned by IJBs. Table 2 highlights key areas of spend.

Table 2: Summary Breakdown of Covid-19 Additional Costs Incurred

	£000's
Nursing	£2,495
Medical & Dental	£749
Support Services	£295
Other Pay Costs	£307
Total Pay Costs	£3,845
Non Pay Costs & Loss of Income	£1,247
Net Total Covid-19 costs	**£5,092**

Breakdown of COVID Costs	£000's
Supplementay Staffing - COVID area or to cover staff	£1,582
Costs charged directly to COVID specific Cost Centres	£2,654
Overtime / Excess PT hours Costs	£1,280
COVID General Ward Costs	£3,347
Critical Care COVID Wards Costs	£1,660
E-health Equipment for departments	£307
Other COVID Costs/ Loss of Income / Higher costs incurred	£1,252
Total COVID Costs	**£12,082**
Ward Budgets Available	£(5,089)
Reported Underspend Medical Supplies	£(1,901)
Total Net COVID Costs	**£5,092**

3.4 Given the level of complexity and turbulence caused by Covid on financial performance, the Committee agreed that it was too early to reach its conclusion on the level of assurance that the Board will deliver a breakeven position in 2020/21, and further information is required. The Director of Finance assured the Committee that, if not for Covid, the health board would be in a strong position to deliver breakeven following a successful year end in 19/20.

3.5 The F+R committee was informed that the process has begun to replace the estimated costs within the LMPs with actual costs. They were also updated on the impact of Covid on current financial plan assumptions, including those resources initially set aside for specific cost pressures which may no longer be required.

3.6 Lothian Finance personnel are working with other health boards as part of a Peer Review programme to ensure costs are consistently identified. The programme aims to capture inputs into the LMPs consistently, and sets out other metrics for measuring outputs. This will form the basis of revised financial forecasts for this year. This will be incorporated into a Quarter 1 Review.

3.7 As well as overlaying the immediate mobilisation plans onto the extant financial plan to produce an updated forecast, the F+R committee received an update on the requirement for the health board to consider the information contained within emerging Re-mobilisation plans which will set out how each health board re-sets its healthcare provision for the future, incorporating Covid. This work is at a very early stage, but detailed work will continue and will be included as part of the Q1 Review. The Committee accepted significant assurance on this work identifying a robust updated forecast.

4 Key Risks

4.1 The F+R committee was updated on the financial risks relating to Covid and the completion of Local Mobilisation Plans (LMPs) to ensure an accurate capturing of costs, including the following issues:

- At this stage all Boards remain unclear as to whether there will be sufficient additional resources available to support the costs of Covid across all health boards;
- When preparing LMPs, all Boards are required to ensure that all offsetting benefits are captured in the estimates. This includes resources such as ward budgets where these areas have been re-designated as Covid wards, flexibility identified from the reduction in activity elsewhere (eg Theatres) and additional

flexibility emerging across other areas as developmental plans which attract incremental funding are paused;

- Any planned expenditure in excess of £1m (the threshold for larger Boards including Lothian) will be required to seek approval from the SG to commit this spend. In total Lothian has circa £9m of requests sitting with the SG which now require a retrospective approval. While this remains outstanding a degree of financial risk remains with this Board.

5 Risk Register

5.1 The corporate risk register includes the following risk:

Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. ***(Finance & Resources Committee)***

5.2 The Finance & Resource Committee meeting on 17 June included discussion of risk management, the impact of financial uncertainty and a loss of funding on the six dimensions of the quality of care, and the need to actively consider the six dimensions as part of normal committee business.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no new implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

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

7.1 The implementation of the financial plan and the delivery of a breakeven outturn will require service changes. As this particular paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

Susan Goldsmith
Director of Finance
17th June 2020
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