

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 Robertson (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 IJBs 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.

Signed by the Chair on 24-06-20

Original in file