

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 10.15am on Wednesday, 24 June 2020 using Microsoft Teams.

Present:

Non-Executive Board Members: Mrs E 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; Dr R Williams and Professor M Whyte.

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

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

Declaration of Financial and Non-Financial Interest

- 27. The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.
- 27.1 Mr McCann declared an interest in respect of the Royal Hospital for Children and Young People commenting that the Public Enquiry terms of reference had been issued and that the enquiry would be chaired by Lord Brodie who was a neighbour.

28. Chair's Introductory Comments

- 28.1 The Chair welcomed Dr Heather Cameron advising that she was the new AHP Director and was shadowing Professor McMahon at this meeting. She advised that Mr D Small Director of Primary Care Transformation and Ms K Taylor, Communications Manager were also in attendance.
- 28.2 The Chair commented that it was important to acknowledge that this would be the last Board meeting for both Mr T Davison, Chief Executive and Mr A

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

- 28.3 The Chair invited Mr Crombie to make a few remarks in respect of Mr Joyce advising that she had been unaware that both Mr Crombie and Mr Joyce had started in the service together as Student Nurses.
- 28.4 Mr Crombie advised that Mr Joyce had started in the service as a Nursing Auxiliary in 1980 in Lanarkshire before coming across to NHS Lothian in 1981 to a learning disability facility called Gogarburn Hospital. It was there that he and Mr Crombie had met. Mr Crombie advised that since he had known Mr Joyce he had always been a lively character and had always been a Trade Unionist and a very clear advocate for employees and employee rights. Since these early days he had had a continued focus on striving to make sure that employees have a safe environment to work in and that they were able to advance and move their career forward. Mr Crombie advised that Mr Joyce had always had an intelligent logic to his arguments and this had fuelled many a debate.
- 28.5 Mr Crombie advised that Mr Joyce had continued to work in NHS Lothian since 1981 and had been a Shop Steward initially with COHSE a UK wide Union. In 1993 that union merged with NUPE and NALGO to create Unison the largest public sector union in the UK. Mr Joyce had been part of the team that orchestrated and supported the closure of Gogarburn Hospital and the transfer of its residents to more appropriate care and independent living which was very impressive.
- 28.6 Mr Crombie advised that as a union member Mr Joyce had been a long standing member of many national committees. He was appointed as Employee Director to in 2012. He had also been the Chair of the Joint Stewards Committee and the Chair of the NHS Lothian Partnership Forum. In addition since the inception of integration Joint Boards (IJBs) Mr Joyce had served on the East Lothian, Midlothian and West Lothian Boards.
- 28.7 Mr Crombie advised that Mr Joyce's retirement was well deserved and on behalf of NHS Lothian he wished him good luck and a long and happy retirement. These sentiments were echoed by the Board.

29. Items for Approval

- 29.1 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as the 'consent agenda'. The Chair reminded members that they had the opportunity to advise in advance if they wished matters to be moved out of this section.

- 29.2 Staff Governance Committee Minutes – 19 February 2020 - The Chair advised that Mr McCann wanted to comment on the Staff Governance Committee minutes of the meeting held on 19 February 2020. Mr McCann commented that the minute made reference to the fact that NHS Lothian had subsequently been notified that the Procurator Fiscal may pursue a prosecution against NHS Lothian following an adverse event in 2017. He commented that although the Board Committee was following through on this issue that he did not recall being aware of this and wondered how often prosecutions like this occurred and whether these should be notified to the Board.
- 29.3 Ms Gillies advised that the Healthcare Governance Committee received a twice yearly report on adverse events including advice on this type of statutory action which was extremely rare. She commented that it was important to point out that the issue referred to by Mr McCann was an intention and that it was not definite at this point that further action would be taken by the Procurator Fiscal. Ms Gillies commented from previous experience discussion on how to handle these cases would be held within the Executive Team followed by a discussion with the Chief Executive and the Chair about what would happen next. The Board were advised that legal advice had been obtained throughout the course of this case.
- 29.4 Mr McQueen commented that if the organisation was being charged he would have thought there would be a need for some engagement with at least the Chair of the Board. He advised as a Board Member he would like to understand what the proper process was. The Chair commented that if she was consulted in such a process that she would want the Board to be aware albeit it was a very rare occurrence. She suggested that a close eye should be kept on the case referred to and that this should be used as a test bed.
- 29.5 Mr Ash commented that there was now an opportunity for Committee Chairs to bring items to the attention of the Board. He felt that the current issue was one that he would expect the Executive Team to deal with although the Board should be made aware if a corporate decision was required. Professor Whyte concurred that this would be an appropriate way forward from a Healthcare Governance Committee perspective.
- 29.6 Cllr Gordon commented in respect of the Healthcare Governance Committee minute 58.1 that it should say on page 28 that it was 2019 and not 2020.
- 29.7 The Board approved items 2.1 - 2.7 on the agenda without further discussion.

Items for Discussion

- 30. Opportunities for Committee Chairs or IJB Leads to Highlight Material Items for Awareness**
- 30.1 The Vice-Chair advised that he wanted to raise matters that had come up at the Finance and Resources Committee on 17 June 2020. He advised that the

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

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

31. NHS Lothian Covid 19 Response

- 31.1 Professor McCallum commented that the number of case in Scotland continued to fall as did the rate of positive test results in care homes as one of the closed settings that was affected. The point was made that with the introduction of some easing of lockdown it was important that the system continued to monitor any change in the progress that had been made.
- 31.2 Professor McCallum advised that Covid had had a significant impact on the health and wellbeing of a large number of people. It would be important to ensure that not just elective services came back to address people who had treatment delayed but also rehabilitation services and ongoing support for mental health and wellbeing. The Board were advised of a wider piece of Scottish Government work looking at the health and wellbeing impacts as a result of shutting down the economy. She commented that if NHS Lothian as a large organisation was not playing in to this then it would be contributing to avoidable health detriment.
- 31.3 Mr Connor questioned whether there were any indications of why Midlothian was such an outlier. Professor McCallum advised that there was a more detailed piece of work ongoing to look at health and the community transmission in Midlothian. It was noticeable that other parts of the country with a similar socio economic makeup had faced similar patterns. In addition Midlothian had some large care homes that had been significantly affected at the beginning of the pandemic.

- 31.4 Ms Hirst commented in relation to recommendation 2.6 that there was a need to look at issues from whole system perspective. The Chair advised that to amplify this she had raised at the Board Chairs meeting the need to be clear what was meant by whole NHS system or whole Health and Social Care system.
- 31.5 Professor McCallum commented in terms of the level of resources in respect of care homes that the level of work being undertaken in these facilities most of which were private for profit organisations was at a level not seen for a good number of years and when systems were structured differently. She felt this was an issue that needed to be looked at as the virus was not going to go away. There would be a requirement to be swift in the management and prevention of outbreaks. There was also a need to embed the learning and support that was going into these facilities often at very intensive levels. It was noted that conversations around this were taking place nationally.
- 31.6 Professor McMahon commented there was work that needed to be done both from a corporate position and with the 4 Health and Social Care Partnerships (HSCPs) about what the infrastructure needed to be to address the ongoing demand around care homes. Professor McMahon felt that the work being undertaken through the Oversight Group was Lothian-wide.
- 31.7 Dr Williams commented that the response from Public Health and everyone had been phenomenal and it was important to have this appreciation noted. He advised that at this moment in time the system was well past the peak and it was not known whether there would be a second wave or not. At the moment the Covid numbers were extremely small with there being significant spare capacity in the system. He was concerned that there would be a tsunami of delayed discharges and there was a need to rapidly redesign services in order to get people in to the system and deal with the complications of people who had not been accessing health services. Dr Williams advised that he would like to see the system rapidly using the capacity created correctly. Cllr Gordon advised of discussions held at the Edinburgh IJB and sought advice on the cooperation level with private care homes as there had been a significant number that had declined the training opportunities and were only engaging around PPE and this was concerning. Professor McMahon advised this issue would be a report to be discussed later in the meeting.
- 31.8 The Chair echoed the points made by Dr Williams that the Board could have no sense of the scale of work that colleagues were having to do both in Lothian and across the country and asked for the Boards appreciation to be passed on to colleagues.
- 31.9 The Board agreed the recommendations contained in the circulated paper and welcomed the update report.

32. Test and Protect Programme

- 32.1 Mr Briggs reported that the index cases included residents of care home who had a positive test but would not have had any contacts. Nationally the number of contacts for index cases was very low. It was noted that all of the Older Peoples Care Homes were signed up to the social care portal and had ordered kits to be able to carry out testing for their staff. Mr Briggs referred to an announcement the previous day about the expansion of testing for staff which was targeted in services for older people, long stay mental health and for cancer services.
- 32.2 Mrs Mitchell commented in respect of testing capacity and intent to migrate to the national process when she read reports and the speed read there appeared to be a lot of cases waiting for testing and she sought assurance around the robustness and efficiency of the laboratory testing capability. She commented if the intention was to expand testing that it currently did not appear that issues were being turned around quickly enough with 100 people waiting for test results in the hospital.
- 32.3 Mr Briggs commented that the turnaround time within laboratories in NHS Lothian was somewhere between 4 and 24 hours depending on when the test reached the laboratory and this might impact on the 100 number. He advised that the 24 hour limit that was in place for NHS Lothian laboratories was being adhered to and was much closer to being between 4 and 6 hours. The turnaround time for lighthouse laboratories which include, self testing kits was longer than that although they had undertaken a lot of work to reduce the timelines. Mr Briggs commented there was also a possibility of a psychological barrier for some people about admitting to not having adhered to the spirit of the guidance. The tracing team were doing their best to reassure the public that they would not be in trouble and the approach was being undertaken from a public health perspective. Dr Donald clarified that her question related to case swabs and commented that everyone should have access to a test that had symptoms. Mr Briggs advised that home testing kits came with full instructions and there was no requirement that testing needed to be done by a nurse although the issue might be about receiving consent for someone who was suffering from cognitive decline. Professor McCallum advised that the community testing team and GPs would undertake this role.
- 32.4 The Vice-Chair commented that in the event of any spike or outbreak it would be important to get the results back quickly and this would mean the test being undertaken locally rather than through the UK sponsored laboratories. He questioned whether there was a confidence that there was sufficient local capacity for the quick turnaround in the event of a spike. The Board were advised that NHS Lothian was prudent in the way in which it was using its testing capacity. Mr Briggs commented in terms of its tracing capacity that NHS Lothian currently had 45 staff who had been reallocated from shielding categories who had been provided with training and equipment remotely to be able to support the service nationally.
- 32.5 Mr McCann commented that people might choose to decline an offer of a test for a variety of reasons or indeed the care home might decline on behalf of

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

- 32.6 Cllr O'Donnell commented given the announcement of the possible return of full-time education on 11 August she questioned what plans were in place and whether discussions had been held with local authorities in terms of how to respond to a position where somebody in a school environment tested positive. Mr Briggs commented that Edinburgh City Council had established a Public Health Advisory Group with NHS Lothian input and the previous day had began conversation not just about the outbreak response that would be led by the Public Health Team but about how to collectively work together to support a prevention suite of measures going forward. This would include a public health messaging system to the public and staff.
- 32.7 The Chair thanked colleagues for the work that had been undertaken and felt that if progress was maintained then the contact tracing system should be able to cope.
- 32.8 The Board agreed the recommendations contained in the circulated paper.

33. Enhanced Professional Oversight of Care Homes

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

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

- 33.2 Professor McMahon advised that a sub group had been established of the Oversight Group looking specifically at education and training. In response to a question about the position where a care home refused entry it was noted that to date no refusal had been experienced. If this were to occur this was where the unannounced inspections with the Care Inspectorate would play a significant role as this would require entry into the homes in order to observe any non compliance with infection prevention control and PPE use.
- 33.3 Dr Donald advised that she appreciated the collaborative partnership approach that was being taken. She questioned whether any extra resources or people were needed to support the process. Professor McMahon advised that a corporate support function had been established to support the Board around visits and education and training as well as the assurance process. He advised that within each of the four HSCPs area that the ask of Chief Officers and Chief Nurses was to review their current arrangements in terms of care home support teams and to ascertain if this was adequate.
- 33.4 Professor McMahon advised there was a process around the unannounced visits and these were not led by NHS Lothian but by the Care Inspectorate. At this point because of the Covid position the Care Inspectorate were required to ask the Director of Public Health if they could visit and inspect a care home. This request would be discussed between Professor McCallum and Professor McMahon to ensure that any such visit was appropriate given current circumstances in order not to add complications to a home that might already have Covid cases. The Board were advised that the Care Inspectorate had been asked to produce a fortnightly report to Parliament on the back of these inspections. The expectation was that 10 care homes would be visited each week across Scotland. It had been agreed locally that it would be helpful if one of the senior nurses could accompany the Care Inspectorate around one of those unannounced inspections in order to learn lessons as the Care Inspectorate would look at things in a slightly different way from NHS Lothian staff. The Board was advised that work was underway to choreograph the unannounced visits with the NHS Lothian planned visits that would be done in a supportive manner.
- 33.5 Dr Williams commented in respect of the shared governance between IJBs and NHS Lothian that one of the issues through the Covid work would relate to general work in particular in respect of staffing numbers and Covid safety and the general quality of care in care homes. It would be important to ensure that tensions around the governance requirements of IJBs and NHS Lothian were addressed. Professor McMahon commented that through the Strategic Oversight Group that all 4 Chief Officers and Chief Nurses were represented on the Group as was a representative of the Chief Social Worker as well as other people across the system. A key piece of work undertaken as a group

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

- 33.6 The Chair commented that Professor McMahon had provided her with assurance and comfort that this did not add to NHS Lothian's governance responsibilities and liabilities as a Board. She commented however that he had access to the usual escalation routes to the IJBs and the Care Inspectorate. There was a need to pick up the issue about the Healthcare Governance Committee responsibility under the new requirements.
- 33.7 Mrs Hirst felt that it was important that the wording in the paper provided clarity about roles and responsibilities. She advised that she had two different sets of responsibilities as a Board member and a member of an IJB and there was a need for clarity of roles and accountabilities particularly around Chief Officers. She felt that this understanding was beginning to be teased out with there being a better concept of accountabilities and responsibilities. Professor McMahon advised that the risk stratification work and the Corporate Risk Register entry would provide that clarity. In terms of the recommendations the Healthcare Governance Committee had been asked to take a lead in this area and the Audit & Risk Committee would have a role in respect of the Corporate Risk Register entry.
- 33.8 The Board agreed the recommendations contained in the circulated paper and in particular the delegation of this enhanced oversight process to the Healthcare Governance Committee. The Chair thanked Professor McMahon and his colleagues for developing this work to date.

34. Remobilisation Plan

- 34.1 Mr Crombie advised that the paper represented a composite remobilisation plan which he suggested would be the first of a series of such plans. He believed that this represented a whole system approach and that the elegance of the whole system interaction was not matured to its final point and subsequent papers would evidence a far greater degree of robust collaboration and engagement. Mr Crombie advised that the paper signalled that the system was not providing the whole suite of services that had previously been provided. Mr Crombie reported that the system would look to provide the best services for those in most need. The paper indicated that elements of routine elective provision had been postponed and it would be important not to underestimate the impact of this for a number of months or perhaps years.
- 34.2 Mr Crombie advised that the most recent management information had been released the previous day and reported 191,000 people would be waiting more than 12 weeks for an outpatients appointment with more than 71,000 across Scotland waiting for inpatient and day-case treatment. It was anticipated this might be a deteriorating position moving forward.

- 34.3 Mr Crombie advised that the clinical prioritisation process and attention to staff wellbeing had been key components of the process with work having been undertaken to address anxiety some of which were detailed in the paper. Mr Crombie felt that the paper heralded a transformation although there was a danger that if the service was not vigilant that service models would return to the old way of working and it would be important to ensure this did not happen. Mr Crombie felt that what was being experienced was also a seismic change for the population and patients and he was not clear that there had yet been effective engagement with them. He advised that a Remobilisation 2 plan would be requested and would take the system from September through to the end of March 2021 and would include winter planning and elements like the scheduling of unscheduled care activity.
- 34.4 Mr McCann commented that his question related to the urgency around dealing with the backlog in demand. He advised by way of context that at the end of the remobilisation plan there was a point about Nurse and Medical Directors needing to manage the expectations of Non Executive Directors and others around the impact of Covid on productivity and ways of working may be less well understood. He commented that he understood that flow would be much reduced due to the use of spacing and PPE etc but that there had been no reference around restarting face to face outpatients or elective care over the next 3 months. He advised that he was less clear about what was needed to get more services restarted and for example did consultants need to review large caseloads.
- 34.5 Mr Crombie advised that the elements of this were complex and probably best discussed in a workshop session where all of the issues could be gone into in a lot more detail. He commented however there was active and ongoing triage and that those who were waiting continued to be assessed and included a process of continuing to check with people to ensure that their conditions remained stable or was deteriorating or had indeed improved and would be ongoing. He commented that there was an issue that the system would see a decrease in capacity because of issues like PPE, social distancing etc. Ms Campbell advised that a process of active clinical triage of the waiting lists was being undertaken where patients could be clinically triaged for their level of urgency. The criteria had been agreed through the Clinical Prioritisation Group. It was pointed out for people that remained in the routine category they would also have active clinical triage.
- 34.6 Mrs Hirst commented on the reference in the paper to the likely requirement for extended plans and sought assurance about the involvement of IJBs in this as individual IJBs had been looking at their own recovery plans and that the Chief Officers had been engaged in producing mobilisation plans. She sought further information on the interaction between IJBs and NHS Lothian in producing the whole-system report that needed to go into the Government. Mrs Hirst felt that the quality and nature of the communication and the approach being taken including the ability for people to have a face to face conversation would be important and sought assurance about the plans that were in place to address these issues particularly with the public.

- 34.7 Mr Crombie assured the Board that in terms of remobilisation that weekly if not daily interactions were underway to discuss how better to engage. He advised that he had seen real evidence of collaboration between teams and Chief Officers and this was a seismic step forward in terms of the sharing of expertise and resource as well as challenges. The Board were reminded that previously a number of recovery forums had been established and all of these would be conduits for working up the process. Mr Crombie commented in terms of communication that he agreed with Mrs Hirst and there was already evidence that the public's patience was starting to wane and letters were now being received in terms of waiting times. He felt that the comprehensiveness of the messaging needed to start with a national focus in order that there was an explicitness of where the NHS was. Mr Crombie advised there was a danger that when people saw a relaxation of the lockdown requirements they would assume that the NHS was back to normal. There was a need to be explicit around clinical risk assessment and not to do harm to patients. The risk of clinical intervention needed to be balanced against the risk of Covid. The Board were advised that communications being sent to inpatients who needed to attend physically contained a significant focus on risk and what this meant for them as an individual. A similar communication was being produced for outpatients where hospital attendance was needed. There was also a need to communicate and educate people who did not meet the attendance criteria and explain to them the reasons for this and this would be an ongoing and significant piece of work. The Chair concurred with these views advising that she and colleagues were pressing for this message at national level as a matter of urgency.
- 34.8 Mr Murray commented that what was being discussed was the legacy of a recovery process that had been out of balance before the Covid experience. He did not think that it was fair that NHS Lothian should continue to wrestle with recovery whilst it was impossible to recover. He felt that the remobilisation plan was the only way forward and this was the process that needed to take precedence. He felt it would be important for this to be reflected to the Scottish Government in some form of communication. Mr Murray commented that the impact on the Risk Register needed to be captured. Mr Murray commented that if communications was to be a key issue it would be best to consider how to generally communicate across the country. The Chair commented that the Chairs Group had accepted the Cabinet Secretary's point around discussions in respect of scheduling unscheduled care and the importance of starting the early messaging around the scale of the challenge to the public.
- 34.9 Mr McQueen advised that within the papers there was a template looking at all available physical capacity in relation to the 2 metre social distancing. He questioned what the position would be if it was accepted that social distancing could happen at 1 metre whether this would have an impact on capacity and how quickly could the system readjust to that. He also sought an update on what was happening in respect of shielded NHS Lothian staff and whether there was capacity within the system to individually assess their workplaces to allow a return to work. Mr Crombie advised that a process of review had been started around social distancing. He advised that what had evolved from a

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

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

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

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

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

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

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

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

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

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

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

35. Scheduled and Unscheduled Care Performance

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

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

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

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

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

- 35.5 The Board were advised that for unscheduled care the system was still maintaining over 95% performance. Attendances had dropped significantly during the initial pre-Covid period although increasing attendances were now being seen particularly at the Royal Infirmary of Edinburgh. Mrs Campbell advised that the real focus was now on scheduling unscheduled care with a pilot in place in relation to minor injuries. It was noted that a 6 week pilot would start the following week at the Western General Hospital about scheduling GP scheduled referral the details of which were explained to the Board. It was hoped this would safely reduce the unscheduled care demand at the front door. The Board were advised that the winter plans were being pulled together and these were whole-system and would be risk assessed against the general principle about how to safely reduce demand and safely reduce length of stay for patients.
- 35.6 Mr McCann commented that he was interested in the concept of scheduling unscheduled care. He advised that NHS Lothian could offer alternative facilities but ultimately people may increasingly choose to attend ED. He questioned to what extent the system could move more rigorously to pre-screening for ED or whether this would benefit from a more national approach. Mr Campbell advised that the approach to scheduling for unscheduled care was absolutely a national one. There was also work underway to optimise the use of NHS 24 with it being noted that Call Mia was a national platform. It was noted that part of the work that the Scottish Government was undertaking around scheduling unscheduled care would be around communication and how to build on the learning from Covid. The Chair advised that NHS 24 were involved in this work on behalf of Chief Executives.
- 35.7 Mrs Campbell in response to a question from Mr McQueen advised that a specific Team which was clinically led looked at the triaging of patients to identify anybody who it was felt might have a detriment to their care. Ms Gillies advised there was a suggestion that the system was seeing a bit of stage drift with patients presenting at a later stage. This reinforced the need to maintain capacity to move urgent patients through the system as many of these patients would not be presenting through the normal GP referral route. This reinforced the decision to keep sufficient diagnostic capacity in the system in order to treat patients more effectively and move them to treatment swiftly. The Board were advised that the system would also see a number of patients who had been delayed coming through for treatment who might need reassessment particularly if it was cancer as their disease might have progressed. There would be a need to consider a risk benefit assessment discussion with those patients and this reinforced the need to reconsider every decision previously made.

- 35.8 Mr Murray questioned whether work was being undertaken with the trade unions in terms of resourcing the Louisa Jordan facility in Glasgow. Mr Campbell advised that she could not answer the position about trade unions specifically but her last discussion with the Scottish Government was that they were still looking at how best the Louisa Jordan facility could support Scotland in terms of recovery around elective care.
- 35.9 Mrs Butler advised in terms of trade union engagement that there had been general discussion but no recent direct engagement about staffing the Louisa Jordan facility. There had been a number of meetings planned which had been stepped down because of the need for the future model to be clarified.
- 35.10 Dr Williams advised that the Board had heard that the intention was for 50% face to face consultations in general practice. He advised that this position filled him with trepidation and anxiety and questioned where and when assurance would be provided that this was safe and appropriate. He commented that he felt if patients were not getting face to face consultations with their GP they would go to A&E. He felt it would be important therefore to evaluate the unintended consequences of that model. Mr Small advised that the 50% was not a blanket position and would depend on the individual practice and their use of technology. It was noted that there was also ways of ordering prescriptions on line that did not require a direct connection with the practice. He advised there were things that could be done which did not disadvantage anyone and made it easier for people to get access to primary care.
- 35.11 The Chair thanked colleagues for the useful discussion advising that this was an issue that would have to be revisited over time.
- 35.12 The Board agreed the recommendations contained in the circulated paper and welcomed the update report.
- 36. The Royal Hospital for Children and Young People, Department of Clinical Neurosciences and Children and Adult Mental Health Services Project Update**
- 36.1 Mrs Goldsmith referred to an email that she had issued the previous evening confirming that all of the documentation in relation to SA2 (Supplemental Agreement) had been received in an agreed format. The Lenders were in the process of doing their own due diligence. It was anticipated that this would be concluded by the following week. NHS Lothian's own due diligence report had been agreed by the Finance & Resources Committee where it had been agreed it would be shared with the Chair, Vice-Chair and the Chief Executive and Interim Chief Executive. This was also available for any other Board member who wished sight of it. The Board noted that this set out the context of why the system had entered into the structure of contracts that it had and the commercial terms associated with those. Issues around how to actually

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

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

37. Corporate Risk Register

- 37.1 Ms Gillies advised that the Board had discussed many aspects of the risks included in the Corporate risk register earlier in the meeting. The risks in respect of Covid were set out in the appendix with it being noted that it was very difficult to capture these on paper give the fluidity of the position. She felt however that it was important to set out the control measures in detail. She commented however that this made all of the other risks all out of date. Ms Gillies felt the time was now correct to ask the team that managed the risk register to engage with managers to update their risks. This would be undertaken over the next few months.
- 37.2 Mr Ash advised that the risk register was a regular item for discussion at the Audit & Risk Committee. He advised that one or two members of the Audit & Risk Committee would work with lead officers on this with a more detailed discussion being scheduled for the August Audit & Risk Committee meeting. After this point it was hoped to be able to come back to the Board having gone through the risk register in some detail. He advised that there was also a desire to look at some new processes that would link the assurance levels and mitigation action with the description of the risks.
- 37.3 The Board agreed the recommendations contained in the circulated paper.

38. Financial Update at April 2020

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

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

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

39. Future Board Meetings

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

40. Any Other Competent Business

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

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

- 40.2 The Vice-Chair advised that when he had retired from the NHS 2007 he retired from the position of Deputy Chief Executive of Lanarkshire and it was Tim that spoke at his retiral. The Vice-Chair advised that he had first met Tim in the early 1990s at the Management Centre at Stirling University as part of a development programme for Unit General Managers. Tim had been the Unit General Manager in the Glasgow Mental Health Unit with the Vice-Chair being the Unit General Manager in the R H in Paisley. The programme had been designed to establish and develop a cadre of leaders of whom Tim was a standout in the Vice-Chair's eyes as he was the only one to sport a bowtie and that became his USP. The Vice-Chair commented that he knew then that Tim had big ambitions. The Vice-Chair advised that Tim had had an outstanding and influential career in the Scottish NHS. He had transformed mental health services in Glasgow and developed a coherent strategy in Lanarkshire.
- 40.3 The Vice-Chair commented that Tim had led many national working groups and was instrumental in designing models of health and social care and integration as well as developing effective approaches to the rising demand for unscheduled care across Scotland. The Vice-Chair commented that Tim was a people person and commented that those people who had been here under the old regime when Tim first came to Lothian would recognise and be forever grateful that together with Brian Houston he achieved what all leaders said they would do but very few achieved. He had changed the corporate culture for the better and then the wider organisation to a more open, confident and engaging one which encouraged staff to a level of commitment and loyalty that fed through to better and higher quality for both staff and patients. The Vice-Chair commented that Tim was an inspirational leader and would be sorely missed not just by NHS Lothian but by the wider Scottish public sector. The Vice-Chair commented that Tim had much still to give and he was sure many opportunities would come his way. The Vice-Chair thanked Tim and wished him good luck in whatever he done next.
- 40.4 The Chair invited the Interim Chief Executive to say a few words of introduction to himself and also to give a message to Tim. The Interim Chief Executive introduced himself and advised that he would have an opportunity to meet with people over the coming weeks. He commented that he had had the pleasure since he came back to Scotland over the last 10 to 11 years of working with Tim in the Board Chief Executives Group. He advised that Tim was massively respected by all the Board Chief Executives. He advised that he was probably the best known Board Chief Executive in Scotland right across the service. The Interim Chief Executive commented the thing he would miss from Tim most was his ability to see both sides and communicate difficult messages especially sometimes to Scottish Government colleagues in a nice balanced manner.

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

41. Standing Order 5.23

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

Signed by the Chair 12-08-20
(Original on file)