LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 4 December 2019 in the Carrington Suite, Scottish Health Service Centre, Crewe Road South, Edinburgh, EH4 2LF.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mr M Ash; Mr M Connor; Dr P Donald; Cllr G Gordon; Ms C Hirst; Professor T Humphrey; Mr A McCann; 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) and Professor A McMahon (Executive Director, Nursing, Midwifery & AHPS – Executive Lead REAS & Prison Healthcare).

In Attendance: Dr E Bream (Consultant in Public Health and Quality Directorates Lead for Emergency Departments, Primary Care and Mental Health for Item 52); Mrs J Butler (Director of HR & OD); Ms J Campbell (Chief Officer, Acute Services); Ms E Johnstone (Quality and Safety Information Manager – Primary Care for Item 52); Mr P Lock (Director of Improvement); Dr N Maran (Consultant Anaesthetist and Associate Medical Director, Quality Improvement for Item 52); Dr R McGregor (Shadowing Ms T Gillies); Mr C Stirling (Site Director, Western General Hospital for Item 52); Dr S Watson (Chief Quality Officer) and Mr D Weir (Business Manager, Chairman, Chief Executive and Deputy Chief Executive's Office).

Apologies for absence were received from Mr J Crombie, Mr M Hill, Ms F Ireland, Mr A Joyce, Councillor J McGinty, Mrs J Mackay, Councillor D Milligan and Professor M Whyte.

Declaration of Financial and Non-Financial Interest

The Chairman 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.

Chairman's Welcome and Introduction

The Chairman welcomed members of the public and press to the Board meeting. In addition he welcomed Dr Richard McGregor advising that he would be shadowing Ms Gillies. He also welcomed Dr Elizabeth Bream, Dr Nikki Maran, Mr C Stirling and Ms E Johnstone to the meeting advising that they were in attendance to participate on the discussion around the NHS Lothian Quality Strategy: Annual Update Report 2018-2019.

50. Items for Approval

50.1 The Chairman sought and received the agreement of the Board to agree items 2.1 – 2.9. The following were approved.

50.2 Minutes of previous Board meeting held on 2 October 2019 – Approved.

50.3 Appointment of Members to Committees – The Board agreed to appoint Stanley Howard and Brian McGregor to the Pharmacy Practices Committee as lay members for the period 4 December 2019 to 3 December 2022. It was also agreed to reappoint Michael Ash as a voting member of Edinburgh Integration Joint Board for the period from 1 February to 31 July 2020. Finally it was agreed to appoint Professor Moira Whyte as a member of the Healthcare Governance Committee with immediate effect and as Chair of the Healthcare Governance Committee with effect from 1 February 2020.

50.4 Change to the Schedule of Board Meetings – the amended schedule of Board meetings was approved.

50.5 Review of Scheme of Delegation – the Board approved the Scheme of Delegation.

50.6 Audit & Risk Committee Minutes 17 June 2019 and 26 August 2019 – Noted.

50.7 Staff Governance Committee Minutes 31 July 2019 – Noted.

50.8 Finance & Resources Committee Minutes 25 September 2019 – Noted.

50.9 Midlothian Integration Joint Board Minutes 22 August 2019 and 12 September 2019 – Noted.

50.10 East Lothian Integration Joint Board Minutes 20 August 2019 and 11 September 2019 – Noted.

Items for Discussion

51. Opportunity for Committee Chairs or Integrated Joint Board (IJB) Leads to Highlight Material Issues for Awareness

51.1 Mr Ash commented that although the Minutes of the most recent meeting of the Audit & Risk Committee were not before the Board he felt it was important to advise of discussion around the internal audit report on the Quality directorate which had been circulated to the Board as part of the debate at the current meeting. He also advised of discussion around the need for internal audit reports once published and posted on the website to be transmitted to the relevant Board Governance Committee for awareness. He advised that these actions would be followed up.

52. NHS Lothian Quality Strategy: Annual Update Report 2018-2019

52.1 The Chairman welcomed and introduced Dr Watson and his colleagues advising that they would provide an update on the progress, current position and future intentions around the NHS Lothian Quality Strategy. The Board received a short video presentation consisting of enthusiastic participants in the Quality Programme.

52.2 The Board were reminded that in 2016 it had approved a prototyping programme about how to put quality and care at the heart of the organisation. It was noted that this had been progressed through networks involving a significant number of people and pathways aligning to areas of operational concern. The process had been progressed with a focus on normal business and making real change at ground level. Progress had been delivered through a core team of improvement advisers and a senior team to support local development, embedding quality into routine business and to coach people. The Board were advised that since the inception of the Quality Strategy that the landscape had changed and Lothian was now seen as a place to undertake the prototyping of national accreditation programmes. Dr Watson advised that all Executive Directors had actively played key roles in the development and introduction of the Quality Strategy and provided details of these to the Board.

52.3 The Board were advised that a key issue moving forward was how to resource the Quality Programme given that it did not have national funding. Dr Watson advised that the Director of Finance and her team had been helpful in resourcing the process with the input of the Sustainability and Values Group being welcomed. In order to develop the process the Executive Team had utilised a process of agile meetings to progress issues without the need for significant amounts of paper. Dr Watson commented that there was a need for this agility now to become balanced with a requirement to report progress to the Board and its sub-committees and secondary to the wider NHS Lothian organisation in order to share and celebrate achievements. The key work programmes were explained and categorised against the issues set out in the Quality Strategy. The Board noted that other organisations had been inspired by the Lothian approach.

52.4 Dr Watson advised that the pull on central resources was becoming an issue and that there was also a squeeze in the middle of the department which the Executive Team were aware of. He commented that it had been helpful that non-recurrent funding had been made recurrent and this provided security to the Directorate and its staff. The Board noted that work for the following year had been planned and aligned to the recovery actions particularly in respect of high volume clinical pathways where access was an issue i.e. orthopaedics, dermatology and child and adolescent mental health services (CAMHs). This work would be taken forward in conjunction with Health Improvement Scotland (HIS) as part of an accelerator programme with a view to spreading it to other Health Boards.

52.5 The Chairman echoed the points made by Dr Watson advising that at a previous NHS Board Chairs Group the virtues of the Lothian approach had been extolled in the presence of the Cabinet Secretary where it had been reported that NHS Lothian was a vanguard Board with details of the detailed progress having been reported.

52.6 The Board received a short video presentation covering activity at the Blackford Ward, Astley Ainslie Hospital, mental health project in respect of patient care and safety, CAMHs psychology as part of a HIS accelerator programme in respect of queuing methodology to reduce waiting times, orthopaedics around hip fracture care which had resulted in a reduced length of stay and the identification of "golden patients", primary care and the benefits of sign-posting patients to appropriate services, frailty with a view to giving patients realistic care and reducing prescribing and inappropriate admissions, urology where QI had been used to improve waiting

times with a particular focus around flexible cystoscopy resulting in better access for patients. Finally an update was provided on the Western General Hospital where a site based approach had been adopted with a view to marrying the culture of the site to Quality Improvement. The approach had demonstrated a reduction in cardiac arrest rates as well as an increase in financial efficiency and productivity in a number of areas. It was noted that in infectious diseases work was underway to look at the rate of penicillin usage and the need to use the most cost effective drugs.

52.7 Dr Watson advised that the Quality Improvement Programme had strong links into the work being undertaken by the Director of Human Resources and Organisational Development around leadership.

52.8 The Chairman welcomed the comprehensive update and invited Board members to participate in a question and answer session.

52.9 Mr Murray advised that he had found the report and presentation to be interesting and helpful and commented that he recognised the value of continuous improvement. He commented however as a Board member that he would welcome a triangulation around how to attend to risks through the organisation in respect of clinical care and finance. He felt that the general improvement work needed to be referenced with a focus around issues like the treatment time guarantee report and issues around the 62 day wait for cancer. He commented that he had not seen these issues reflected and questioned whether this was a focus of attention in respect of the Quality Improvement work. He also felt that representation of the Board was an aspect that was missing from a strategic perspective.

52.10 Dr Watson commented in respect of clinical care aspects that all of the work had been commissioned through the Executive Team with a focus on areas of significant organisational challenge and provided examples of work undertaken in primary care and mental health. He advised in respect of how to join up the bright spots of work that this was a significant challenge that would be addressed and that NHS Lothian would be one of the first organisations to join up small dots into a wider perspective although there was currently no template on the shelf for undertaking this work. In terms of cancer the point was made that a number of people had been through the training programme although it was recognised that it was difficult to get people fully engaged when they were dealing with other infrastructure issues and this had been drawn to the attention of management and leadership. Dr Watson commented that work with colleagues in cancer would continue.

52.11 The Chief Executive commented in respect of 62 day cancer performance that the diagnostic pathway and in particular around endoscopy was a significant challenge and that progress was being made. He advised that the system was constantly striving through opportunities in innovation and research and development etc to focus on organisational challenges a lot of which was down to looking at capacity in the first instance. He commented that a twin track approach was needed as quality in itself would not fix the challenges facing the organisation and there would be a need to invest in capacity. Ms Campbell provided the Board with an update on work around urology and flexible cystoscopy advising that this linked to 62 day pathways and the waiting time. She commented that the focus of available capacity was used to treat urgent patients in the queue. An update was also provided on QI work in dermatology and HIS access collaboratives.

52.12 Mrs Hirst commented that the report was useful although she had a concern that it concentrated on a measurable matrix and that as a Board member she was interested in qualitative measures and the impact on patients particularly from a pre and post QI perspective. The point was made that the video presentation had touched on the benefits of the process for patients within the Blackford Pavilion at the Astley Ainslie Hospital and other areas. Professor McMahon commented that as part of the QI work undertaken to date there had been a focus on a patient experience questionnaire where positive outcomes and experiences had been reported. Mrs Hirst commented however that this type of information was not coming through in the narrative in the Board paper. Dr Maran acknowledged this point but assured the Board that all programmes as part of the planning phases included a focus on encouraging users to give their views about the service they received. She commented that all improvement work was focussed on the impact on patients and users. The Board were advised that the Programme Board in the acute sector was absolutely focussed on patient experience as part of the monitoring process which included receiving patient stories which were rich in detail. It was agreed that the issues raised by Mrs Hirst would be captured in future reports to the Board with it being noted that there was a need to also share this type of information in other public facing arenas.

52.13 Dr Watson in response to a question about how the Quality Programme dovetailed into the Sustainability and Values Group and whether a big project approach was adopted advised that the Project office approach worked well. He commented that the Quality agenda was a significant part of the Sustainability and Values Group and he felt that the support and challenge from the Group was positive. Dr Watson advised that discussions had been held about what project management needed to look like and the different skill sets required to support the process. He commented that in the early stages of the QI Programme that a different skill set from that adopted in project management was needed to deliver the programme. He commented now that QI had been embedded and that a programme of work had been developed there was now a need to adopt a more gateway type of approach and that he felt that processes were now becoming more aligned. Mr Connor advised that the issue was about making sure that projects were monitored and he felt that the utilisation of a Project office helped to weld together a more systematic approach. Mrs Goldsmith commented that she and colleagues recognised the input of QI into sustainability particularly in respect of increased efficiency and productivity. Prescribing was mooted as an example of joint work with it being noted that the Sustainability and Values process had supported this by providing a project manager who was part of the Academy as well as coaching people and developing networks. Dr Watson advised that now that Quality Improvement was becoming more embedded into business as usual that the previous agile approach now needed to be more formalised in terms of infrastructure.

52.14 Dr Donald questioned the position in respect of the use of measurement and impact tools around patient responses. Dr Watson advised that this was an area of constant challenge and that considerable work was undertaken to measure these types of issues although he was conscious there was a danger that the process could end up doing nothing but measuring. He advised that there was a lot of engagement with staff and that the impact of the QI process in terms of staff and patients was being measured. Dr Bream advised that she was looking at toolkits in

order to maximise the measurement benefit and that these were in the process of being developed. Dr Watson commented that he felt there was sometimes too much focus on measurement and that in some instances this could be challenging and off putting to participants. He commented however that measurement tools were in place for all of the 6 dimensions of quality and described the maturation approach that was being adopted. Dr Watson advised that there were a lot of matrixes in play although he was keen to ensure that outcomes were only measured once. Dr Maran advised that the acute quality programme had established outcome measures to track big issues in the programme and advised that every piece of improvement work was registered and followed a project template with clear aims and measures. Dr Watson commented that in Appendix 2 of the report that detail was provided around the impressive work undertaken around patient falls at the Western General Hospital.

52.15 Mr Stirling commented from his perspective the main challenge had been that initially there had been a broad base of enthusiastic people and that the key issue was to align this to the bigger picture. His focus had been on moving from enthusiastic amateur status to a more professional approach and that tools were married together for all significant projects with it being stressed that sometimes there was a need to disinvest from areas that were not adding value. He commented that new measurements were being developed and highlighted the "attend anywhere" initiative which resulted in significant reductions in patient miles and carbon footprint. Mr Stirling commented in respect of maturation spread for the Western General Hospital that the focus was on delivering outcomes and financial returns.

52.16 Dr Williams advised that he had welcomed the positive and reassuring presentation which was not often seen by Board members and this linked back to earlier debate around the Audit and Risk Committee observations. He suggested that there would be benefit in including a standard section in all Board and Board committee papers referencing quality work.

52.17 Professor Humphrey advised that she would also like to echo the positive comments made about the presentation and the progress of the Programme. She suggested that a key issue was about how to scale up the project to make it systemic in the organisation. She commented from her perspective as the Chair of the Healthcare Governance Committee that she did see evidence of the benefits of the Quality Improvement Programme albeit it was not specifically labelled as such. She suggested that there was a need to focus discussion at the Committee to highlight the important work that was being done in this area. Dr Watson advised that as work became more embedded in the fabric of the organisation then the quality logo would probably become less visible. He advised that he was conflicted about the use of branding as there was a possibility that this might disengage some people from the process. He commented however that he was determined to make the quality experience real at the front line and the band width to support this would be an issue. He commented that the internal audit work had been helpful and updated on plans to hold a Quality conference in 2020 to which each Board member would be invited to attend. He advised that he also intended to bring more regular monitoring papers to the Board and that he would welcome the input of Board members in developing the process moving forward.

52.18 Mrs Mitchell echoed the previous comments about the quality of the work and the outputs. She commented however that she was concerned about what was being done with the outputs and the need to train people in the methodology. She questioned where the outputs from the process were being shared. Dr Watson concurred that outputs were not being shared widely enough at the moment albeit good experiences were being publicised through clinical change forums on a local basis. In respect of training he commented that he felt that people had 100 seconds in each hour to participate in quality work it would be important to develop an efficient way of utilising this time with training needing to be relevant and proportionate. He advised that whole day training events were now being held and that this was an efficient way of engaging with people although it was important to recognise that people did not need to have "the badge" to be able to participate in quality improvement work. He advised in terms of scalability that 80% of GP practices in Lothian were actively engaged in the Quality Improvement Programme and were doing outstanding work. Ms Johnstone provided the Board with details of the sharing mechanisms undertaken through the primary care programme including the development of a network web page and the work with the clinical team to write up a clinical support document. Bowel screening was put forward as a good example of where a positive toolkit had been developed. Posters developed for conference events were made available on a virtual basis in order to demonstrate benefits and progress. Ms Johnstone advised that there was a strong focus on the virtual sharing of experiences and information. The Chairman advised that he had been unaware but pleasantly surprised to learn about the spread of the programme within primary care.

52.19 Councillor O'Donnell with respect to the GMS contract questioned how information was shared and the links with IJBs. She asked how quality was defined and how it was measured as well as how the patient experience sat within this. Dr Watson commented that in 2001 the Institute of Medicine had published a paper defining quality of health as being safe, timely, efficient, effective, equitable and patient centred. He advised that in NHS Lothian a further criteria had been added in respect of sustainability in relation to the environment. He commented that the primary care QI programme had been successful because of the good networking arrangements that had been put in place. Ms Gillies commented that the GMS Oversight Group which included IJB members was another way of ensuring that people were sighted on what was happening on the ground.

52.20 The Chief Executive commented that when the Quality Improvement initiative had first been established that the first phase had been to generate interest with the second phase being about sustaining and growing the process with the next steps of the forward programme needing to be considered as the third phase. He felt that the system should congratulate itself and feel good about what had been done to date commenting that in Lothian work was more complex and substantial than other Health Boards. He recognised however that this work was being taken forward using a small infrastructure and was dependent upon a small core of staff. He advised that as part of the previous external support team process lead by Sir Jim Mackay that he had been hugely impressed and congratulatory about the Lothian QI work in the Emergency Department and had intended to implement a similar approach within his own Trust. The Chief Executive commented that despite a lot of hard work there had been an increase of 6% in attendances at the Emergency Department. He advised that the challenge moving forward was to make Quality

part of the heart of the organisation and he felt that this was the fundamental challenge that needed to be addressed. He commented that only a small amount of money was being invested in innovation and robotics and that the future third phase of the QI Programme would require targeted investment in the infrastructure in order to support further progression and to ensure that the Programme did not go backwards as currently it was not possible to scale the process as quickly as he would have liked.

52.21 The Chairman thanked the Quality Team for the excellent update advising that he felt that the Board had received assurance around prioritisation, evaluation and measurement and the need to consider focussing moving forward on the patient outcome and experience. In terms of the points made about visibility and general awareness of reporting the need to spread awareness at Board level and wider into the organisation was recognised. The Chairman advised that he recognised the conflict between making the process more visible and embedding this in business as usual with the debate at the meeting reflecting where the organisation was on this journey.

52.22 The Chairman commented that it would be important to reflect on the proposal that quality should feature as a standard section on Board and Board Committee papers. He felt there was a need to move away from a silo approach and think about how aspects needed to link together.

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

53. NHS Lothian Recovery Plan Update

53.1 The Chairman commented that it was important to remind the Board that whilst addressing the recovery plan that the circulated paper subsumed issues around waiting times and the winter plan.

53.2 Mr Lock advised that the paper was intended as an update and would touch on the process and current position as well as how to progress other performance aspects. He advised that comments had been received from the Scottish Government on the reported plan. He advised the Board there was a factual inaccuracy in the paper in that the recovery plan had been submitted to the Scottish Government the previous Friday and that positive comments had been received on it. Mr Lock advised that he was keen for the project plan to go to the Scottish Government Oversight Board who would then decide where NHS Lothian sat in terms of the escalation framework with there being a possibility that this position would be reviewed downwards.

53.3 The Chief Executive advised that he and colleagues were in active dialogue about how to get into the de-escalation process and he felt that NHS Lothian was now in a more positive position in terms of meeting the criteria for this to happen. He commented however that unscheduled care continued to be a vulnerability albeit that dialog with the Scottish Government was now more positive.

53.4 Mr Lock advised that he felt that good progress was being made although there remained as reported by the Chief Executive significant risks around areas like unscheduled care. He provided a brief overview of progress being made. The

Board were advised in terms of outpatients and treatment time guarantees (TTG) that since September the numbers have reduced in line with trajectory. The Board were advised that a challenging plan for reduction in the second part of the year was in place and that good work was also underway in respect of 62 day cancer care waiting times with the October data providing confidence of sustained improvement.

53.5 Mrs Campbell advised that the circulated paper in respect of scheduled care had demonstrated that the outpatient position was showing signs of improvement and although the position was still above trajectory there was confidence around the actions deployed. In terms of the risk to delivery in December the focus was on exploring capacity at East Lothian in the new hospital. She advised that TTG continued to perform better than trajectory with there having been a positive reduction between September and October in terms of the number of patients waiting more than 12 weeks. The Board were advised that one of the recovery actions had been around the utilisation of 2 theatres at Forth Valley with it being advised that at this point in time the second theatre had not come on stream causing a risk to 550 cases with work being undertaken to consider how to mitigate this position. Mrs Campbell advised that another area of risk in respect of TTG was in respect of unscheduled care performance and as result of pressures a number of patients had been postponed specifically in orthopaedics at the Royal Infirmary of Edinburgh.

53.6 Mrs Campbell advised that the diagnostic and endoscopy position had improved and that there would be no patients waiting more than 12 weeks at the end of March 2020. She also updated the Board on the previously referenced flexible cystoscopy improvements. The Board were advised that a CT and MRI recovery action was in place involving a change in protocols and pathways particularly in respect of head injury and cardiology. The Board were advised in terms of the 62 day cancer target that there had been a 3.5% improvement between July and October 2019. A weekly monitoring group had been convened and had proved to be beneficial with this approach being expanded to cover lung cancer.

53.7 Mr McQueen questioned what impact the pension and taxation issues were having on the ability to run waiting list sessions given the dependency on these. Mrs Campbell advised that this was variable across services although it was clear that there had been a reduction in the number of consultants willing to undertake waiting list initiatives and this was a concern given it was an embedded part of the sustainability process. She commented in terms of job plan sessions that there was a need to quantify the position and that in contracts there was always a focus on out of hour services. Ms Gillies advised that as job plans developed the detail of issues like this would be brought back to the Board.

53.8 Mr Murray questioned the risk to patients of NHS Lothian not meeting the TTG guidance. It was pointed out that this depended on the specialty and was the reason why a clinical risk matrix had been deployed for use in areas of limited resource in order to ensure that the most needy patients were prioritised. The Board were reminded of the 'keeping in touch' approach and if during contact with patients their health status had changed then their position on the waiting list would be reassessed. It was noted that currently there were no outcome measures to demonstrate the effectiveness of this approach. Ms Gillies reassured the Board that the system would look at any known negative impacts and instigate an appropriate

investigation although she agreed that social personal and economic impacts were not captured. The Chief Executive commented that data was kept in respect of 'keeping in touch' contacts. It was agreed that the consequence of call back of patients needed escalated and that there was a need to record what had happened to those patients. Mr Murray commented that if NHS Lothian was held to account as a consequence of NRAC detriment then the impact of this needed to be evidenced. The Chief Executive commented that there was a recognition that resourcing needed to be addressed.

53.9 Dr Williams advised in respect of paragraph 3.6 in the paper in relation to CAMHS and psychological therapies that reference was made to the fact that once the backlog had been tackled that performance should return to target. He commented that a simple hyperlink to the paper to add in narrative around processes and outcome would be helpful as supporting information. Professor McMahon commented that it was intended to focus on CAMHS and psychological therapies at the January 2020 Board meeting and that this would demonstrate the improvements that had been made. Dr Watson commented that in 2020 as part of the active QI process that consideration would be given to looking at referral pathways and how to manage these.

53.10 Cllr O'Donnell sought an update on the role of the private sector and work in respect of quality improvement on patient journeys. She referred to the need to cancel orthopaedic appointments and questioned how the quality of external service providers would be monitored. The Board were advised that the external provider office had created a clinical and service specification which was utilised before engaging with either in service providers or external providers and that this included issues around the management of adverse events. Cllr O'Donnell questioned what processes were in place in terms of comments made about not being able to get patients home as quickly as would be desired. Mrs Campbell advised that the expectation would be that the same number of patients would be treated with consideration being given to the issues that were causing the delays with it being noted that the external provider office were very experienced in this area.

53.11 Mr Lock reiterated that unscheduled care remained the biggest point of risk and that there was a need to recognise the position at the Royal Infirmary of Edinburgh and the Western General Hospital with active consideration being given to reducing length of stay and how to get patients out of the hospital more quickly. He advised that a number of actions had been set out to address this position and that this was being taken forward as a priority on management time and attention. Mr Lock commented that it was important to mention that the delayed discharge position had slightly deteriorated in October although it was too early to tell whether this was a trend and there would be a need to see progress in this area. He advised that the key issue was how to improve throughput in the acute sector and that a number of system wide approaches were being considered. In particular a Royal Infirmary of Edinburgh Recovery Meeting had been established with Partnership engagement and in terms of capacity short term actions were being considered. The Board were advised that although the Royal Infirmary of Edinburgh was the largest site that all acute adult sites were full and therefore mutual aid was less available and was impacting on the number of patients waiting at the front door. The Board noted that the circulated paper detailed actions in place for patients fit for discharge and the processes to move them out of a hospital bed in order to be looked after more

appropriately. The focus was on getting patients discharged earlier in the day with a whole system approach with Partnership colleagues being adopted in respect of how to reduce the length of stay. Reference was made to the West Lothian Hospital at Home Team whose focus was on preventing patients presenting at the front door and also reaching in and pulling out patients to get discharged earlier. It was noted that the City of Edinburgh were also looking at exploring the Hospital at Home model to bridge gaps in packages of care using the Red Cross and investing in additional social work. The Board were advised that additional beds were being opened in East Lothian to provide step-down facilities in order to bring people out of the acute hospitals in order to maintain flow in the system.

53.12 The Chief Executive commented that currently there was a worrying tension at management level around the acute and Health & Social Care Partnerships particularly around the front door in respect of concerns around overcrowding. He commented that it was important that the Board recognised that when staff were working under significant pressure that there was a danger that behaviours could become compromised. He felt that there was a need to continue working with Edinburgh in respect of delayed discharge reductions as the current position equated to two wards at the Royal Infirmary of Edinburgh. The Chief Executive commented that the benefit of Mr Lock's engagement was his ability to look at the position on a whole system basis without having an operational management responsibility. He reiterated the earlier point that the earlier discharge of patients would make a significant difference to the current pressures being experienced in the acute sector. He felt that delayed discharges was the systems main achillies heel and needed to be addressed. He commented that NHS Lothian was not unique in this position as this was a central belt phenomenon although other Health Boards have lower rates of attendance. He advised that NHS Lothian was also an outlier in respect of 4 hour waits largely as a consequence of hospitals being full to capacity. The Chief Executive commented that he would like to pay tribute to the management staff at the Royal Infirmary of Edinburgh who were going beyond the call of duty and working stretched hours which was not a sustainable position moving forward. He commented however that an improving position had been evidenced over the previous few weeks.

53.13 Mr McCann advised that he was aware of the problems described and that the IJB had also discussed similar concerns. He questioned what should be done differently in respect of engagement between the Health Board, Council and IJB in terms of coming together more than was currently the case. The Chief Executive commented that the only way out of the current position was to improve performance and until that happened tensions would remain within the system with it being important to stress that overcrowding was a significant safety issue. He advised that there was a need for the City of Edinburgh to improve their delayed discharge position thereby allowing 50 beds to be freed up providing additional headroom within the acute sector. The approach adopted at the Royal Edinburgh Hospital was referenced with it being noted that this had made an improvement in bed occupancy from 105% down to 90% and had therefore reduced the temperature in the organisation. Mrs Goldsmith commented that she did not think that currently there was a consensus about the type of capacity and quantum needed to make a difference and that there was currently not a proper plan in place to get the system into a balance position. Mr Lock advised that this was part of his remit and that he intended to create integrated team working with a lot of the issues being about understanding current

restrictions on what people felt they were able to do. He advised that there were a number of good plans in existence within the City of Edinburgh.

53.14 Professor Humphrey commented that she also felt that unscheduled care was a priority and sought advice on how Board members could be assured that this was also a priority for the Health and Social Care Partnerships. She questioned whether comprehensive plans were in place to address what was a complex issue. She also questioned what evidence was available about actions that would make a difference and were worth scaling up and what steps were taken to step down workstreams that were not working. Ms Campbell advised that she and colleague were looking at multiple actions and considering how best to measure these as the system should not be cancelling elective programmes of work. She assured the Board that consideration was being given to how best to measure outcomes and what could be scaled up and also stopped.

53.15 Cllr Gordon commented that during these debates there was always reference made to issues around Edinburgh in respect of capacity and resource. He felt that there was a need to consider how to get the two organisations to work better together to address capacity issues and agree what plan of action could be put in place as it was important to recognise that Edinburgh did not have the resource available to open up facilities like satellite units. He felt that moving forward there was a need to be clear about the plan. The Chief Executive commented that the main challenge for colleagues in the council was that they needed to make choices about their priorities with it being noted that the City of Edinburgh was a significant outlier in delayed discharges and that in his view there was therefore a requirement for prioritisation around adult social care.

53.16 Mr Murray commented in respect of interactions with the IJBs that the best way to achieve this would be through the Strategic Planning process and interfaces with the Annual Operational Process (AOP) in terms of obtaining clarity about how interaction could be undertaken to deliver results. He felt that there was a need for IJB directions to align to collaboration work and that there was a need for interaction across the two systems. Professor McMahon commented that he felt that a key issue was about all parties using the same narrative at the same time and that there was a need to reflect on that. He advised that he felt that the creation of the Integrated Care Forum (ICF) provided an appropriate vehicle to get relevant people around the table albeit there was a need for more regular engagement. Mrs Goldsmith advised that one of the key reasons why the financial position was only reporting moderate assurance was because of the issues discussed with there being a need to provide resource to get additional capacity.

53.17 The Chairman commented that it was important to recognise the critical situation that the system was in. The Chief Executive advised that the system was in the middle of the budget setting process and it was unlikely that details of the health budget would be available before February 2020 although there was speculation in the system suggesting that there would be a reduction in Health and Social Care resource. He advised that when discussing these issues with Scottish Government colleagues that he was encouraging the adoption of a holistic Health and Social Care budget to counter the perception that health budgets were protected. Board members were advised that part of this process would be to encourage ring-fencing in order to give priority to adult social care budgets. Mrs Goldsmith advised that

section 95 finance officers had agreed to meet to discuss the financial position and the range of options.

53.18 The Chief Executive commented that the risk for the NHS Board in respect of the extant tensions was that it was the Health Board that got escalated in terms of the performance and not Councils and that the delayed discharge was a compromising factor in escalation. The Chairman commented that even if the NHS system had not been escalated in the performance framework that the issues would still be on the table to be addressed.

53.19 Cllr O'Donnell commented that the Chief Executives concerns were real and that she felt there was a need for political engagement over and above the current officer to officer approach.

53.20 The Chairman welcomed the useful discussion and commented that this only reinforced the decision to keep closer order regarding engagement around these issues through the move to monthly Board meetings.

53.21 The Board agreed the recommendations considered in the circulated paper.

54. RHCYP, DCN and CAMHS Update

54.1 The Chairman commented that for reasons of commercial and contractual issues there would be a further discussion on this item in the private session of the Board to be held immediately following the Public Board meeting.

54.2 Mrs Goldsmith advised that there had been considerable work undertaken over the previous few months with support from Ms Morgan the Senior Programme Director appointed by the Scottish Government and others in order to produce a clear programme of work and the delivery timescale to ensure that the new hospital could open safely. It was noted that the main issue of rectification remained around critical care ventilation and that the Board was also taking the opportunity to enhance ventilation in haematology / oncology and elements of fire safety. The other key outstanding issue was the design of the replacement air handling unit.

54.3 Mrs Goldsmith advised that the contractual mechanism for delivering these outstanding works was through the change process set out in a project agreement with IHSL. However the scale and nature of the works and the timescale to which they must be delivered meant that the normal change process would need to be adapted to allow progress to be made. The Board had entered into commercial discussions with IHSL which were in the process of being concluded. The principles of the approach had been agreed by the Oversight Board which had established a Commercial Sub-Group. The Finance and Resources Committee had also endorsed the approach being taken.

54.4 Mrs Goldsmith commented that at this stage the initial programme received from IHSL remained deliverable within the timelines announced by the Cabinet Secretary to move DCN in spring 2020 and RHSC in the autumn. The Board noted that considerable progress had already been made to address actions to support the existing Sciennes site and DCN at the Western General Hospital through the winter

period and beyond and these were detailed in the circulated paper. The Board were also advised of unannounced HEI inspection visits had taken place in October in both the Royal Hospital for Sick Children and DCN. Verbal feedback had been positive and the draft report was due on 4 December 2019 to be reviewed and signed off by NHS Lothian by 18 December 2019.

54.5 The Board noted that an Executive Steering Group currently continued to meet on a weekly basis with the Oversight Board now having moved to a 2 weekly frequency. There was therefore significant engagement in the process.

54.6 The Board noted that the Auditor General and the Board's External Auditor were preparing a section 22 report due for publication on the 18 December 2019. The Board had had an opportunity to review the draft for factual accuracy. The Auditor General would brief the Scottish Parliament's Public Audit and Post Legislative Scrutiny Committee on the section 22 report and the committee might decide to take evidence from the Board's Accountable Officer (Chief Executive). The date for this had yet to be agreed.

54.7 The Board noted that the Cabinet Secretary had confirmed the appointment of the Right Honourable Lord Brodie QC PC as Chair of the Public Enquiry into the matters of concern that had arisen at the Queen Elizabeth University Hospital campus - Glasgow and the Royal Hospital for Children and Young People – Edinburgh. The Cabinet Secretary would provide an update on the terms of reference and timescales of the enquiry in the New Year. Mrs Goldsmith advised that the Central Legal Office had appointed two solicitors to support this work and that senior and junior counsel would be appointed once the remit of Lord Brodie's work was finalised. In the meantime work was underway in order to concatenate relevant files and ensure these were fit for purpose for use by the enquiry.

54.8 The Director of Finance in response to a question from Mr McQueen in respect of the Auditor General section 22 report advised that she and the Chief Executive had had an opportunity to reflect on the report which they had felt was fair and balanced with some issues around nuances having been fed back. It was noted that the section 22 report raised issues for other parts of the NHS system other than just NHS Lothian.

54.9 Mrs Goldsmith commented in respect of a budget for the ongoing legal process that she was unclear about this at the moment and had discussed a joint approach with Glasgow. She advised that at the appropriate time she would bring forward an assessment of the financial quantum to both the Board and Finance and Resources Committee.

54.10 Mrs Mitchell questioned the risk profile around recruitment and the viability of recruitment to posts. Mrs Campbell advised that recruitment was challenging and was currently under review with efforts being made to make this as flexible as possible. Ms Gillies commented there were specific issues around maintaining the existing site particularly in respect of the parallel running of pharmacy services. An update on nursing recruitment was provided by Professor McMahon advising that different routes were being considered including the utilisation of modern apprenticeships.

54.11 At the suggestion of Mr Murray it was agreed that Mrs Goldsmith would pull together key themes discussed at previous meetings of the Scottish Parliament's Public Audit and Post legislative Scrutiny Committee and in the first instance refer this back to the Finance and Resources Committee.

54.12 Dr Williams commented on the key risks and noted that NHS Lothian had an action plan and that the Scottish Government Oversight Board was receiving regular progress reports from the Senior Programme Director. He questioned whether there was a parallel process for Board Committees to obtain the same advice. In terms of the public enquiry he advised that he had welcomed the fact that the Cabinet Secretary had said that she would seek patients comments in the development of the terms of reference although he felt that it was important that the Board would also be able to comment. Mrs Goldsmith advised that at this point she did not know whether the NHS Boards input would be sought. She advised that the Senior Project Director provided reports to the Executive Steering Group which to date had not yet reported through the NHS Boards Governance Committee's albeit the Finance and Resources Committee were updated on the commercial position. Dr Williams felt this was a slight disconnect. Mrs Goldsmith advised that she would include such information in future updates to the Finance and Resources Committee.

54.13 Mr Connor questioned in terms of the contractual position whether NHS Lothian would sign the contract and whether the Scottish Government were content with the contractual position that was being adopted. Mrs Goldsmith advised that issues were more explicit this time and that the paper to be discussed in the private session would also be submitted to the Oversight Board the following day and had been generated by work undertaken by the Commercial Sub-group which included representatives from the Scottish Government. It was noted that the Oversight Board also included representatives from the Scottish Government. It was noted that the Oversight Board would be asked to sign-off the private Board paper at their meeting the following day.

54.14 The Board considered and discussed the issues raised in the circulated report.

55. 2019/20 Financial Position and 2020/21 Financial Outlook

55.1 The Board accepted the circulated report as a source of significant assurance that the Finance and Resources Committee had considered the year to date and year end forecast position of NHS Lothian and the required actions to support breakeven and had accepted the moderte assurance currently provided on the achievement of breakeven by the yearend. Mrs Goldsmith advised that as previously reported that the uncertainly around performance and capacity issues meant that only moderate assurance could be taken at this stage.

55.2 The Board were advised that for the following financial year that finance colleagues were modelling a 3% pay uplift and that 2020/21 would be a more difficult financial year. The assessment for 2020/21 was that NHS Lothian would see a start position similar to that in previous years once recovery plans were in place. It was noted that if the financial uplift to NHS Lothian reduced to 2% then this would result in an additional gap of £15m. Discussion was also held about some of the consequentials

arising from the General Election. The Board noted the list of financial risks contained in the circulated paper.

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

56. Corporate Risk Register

56.1 Ms Gillies advised that the Corporate Risk Register which had been updated for quarter 2 included templates in the new format for the new risks; The Royal Hospital for Children and Young People and Department for Neurosciences and the lack of bed availability at the Royal Edinburgh Building. It was noted that the template for the new risk; the delivery of NHS level 3 recovery plans was currently being finalised.

56.2 The Board also noted that all of the actions required from the Internal Audit of Risk Management in February 2019 had been completed and agreed as closed. This had been evidenced through the process of developing the corporate risk register in the new format. The point was made in terms of unscheduled care that the report reflected that despite using all of the strategies to mitigate risk that these had had minimal impact.

56.3 Mr Murray applauded the revised report and asked if it would be possible for narrative in future iterations to separate out finance and care elements and provide examples of how care issues were being attended to. Ms Gillies commented in respect of specific issues around the Royal Hospital for Sick Children that the Executive Steering Group had put a lot of extra focus into improving facilities for staff and that this had also been considered by the Oversight Board. It was felt that the risk to the care of patients would be low. She pointed out however that infection risks could not regarded as negligible in the current environment and that work was under way to make the environment as safe as possible.

56.4 The Board agreed the recommendations contained in the circulated report.

57. Future Board Meetings

57.1 The dates of future Board meetings were agreed.

58. Invoking of Standard Order 4.8 – Resolution to Take Items In Closed Session

59.1 The Chairman sought permission to invoke Standing Order 4.8 to allow a meeting of Lothian NHS Board to be held in Private. The Board agreed to invoke Standing Order 4.8.

60. Date and Time of Next Meeting

60.1 The next meeting of Lothian NHS Board would be held at 9:30am on Wednesday 8 January 2020 at the Scottish Health Services Centre, Crewe Road, Edinburgh.

Chair's Signature.....

Date.....

Mr Brian Houston
Chair – Lothian NHS Board