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IB(M) 20/05
Minutes: 55 - 68

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
Interim Board
held via Microsoft Teams
on Tuesday 2nd June 2020

PRESENT

Prof J Brown CBE (in the Chair)

Dr Jennifer Armstrong	Ms Susan Brimelow OBE
Cllr Jim Clocherty	Prof Linda de Caestecker
Ms Jane Grant	Mr Allan MacLeod
Mr John Matthews OBE	Ms Dorothy McErlean
Dr Margaret McGuire	Mr Ian Ritchie
Mrs Audrey Thompson	Mr Mark White

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Mr John Donnelly	..	Senior General Manager, Capital Planning (For Item 65)
Mr William Edwards	..	Director of eHealth
Mr Graeme Forrester	..	Deputy Head of Corporate Governance and Administration
Mrs Susan Manion	..	Interim Director of GP Out of Hours Service (For Item 62)
Mrs Geraldine Mathew	..	Secretariat Manager (Minutes)
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Dr Kerri Neylon	..	Clinical Director, GP Out of Hours Service (For Item 62)
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Prof Angela Wallace	..	Interim Executive Lead Infection Prevention and Control (For Item 59)
Ms Sharon Wearing	..	Chief Officer Finance and Resources, Glasgow City HSCP (For Item 65)

			ACTION BY
55.	**WELCOME AND APOLOGIES**		
	Prof Brown opened the meeting and welcomed all members present. He welcomed Mr Ian Ritchie and Mr John Matthews OBE, to their first Interim Board meeting as Vice Chairs of NHSGGC. There were no apologies noted. **NOTED**		

56.	DECLARATIONS OF INTEREST		
	Prof Brown invited those present to declare any interests in the topics being discussed. Prof Brown declared an interest in respect of Item 65 – Glasgow North East Health and Care Centre Outline Business Case, given his role as an Independent Director of Glasgow Life, specifically, that Glasgow Life held responsibility for the provision of Library Services in Glasgow. The Interim Board did not consider this a significant conflict of interest and as such, were content to note this. **NOTED**		
57.	**MINUTES OF THE MEETING HELD THURSDAY 19th MAY 2020**		
	On the motion of Mr John Matthews, seconded by Mr Allan MacLeod, the minute of the Interim Board Meeting of Tuesday 19th May 2020 [Paper No. IB(M)20/05], was approved and accepted as an accurate record. **APPROVED**		
58.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Interim Board reviewed the Rolling Action List [Paper No. 20/23]. Members agreed with the recommendation to close 7 actions from the Rolling Action List. In addition, Prof Brown confirmed that information had been circulated in respect of Langlands Unit and the governance approach to the suspension of the Standing Committees' work plans. **APPROVED**		
59.	**COVID-19 UPDATE**		
	The Interim Board considered the paper 'Response to COVID-19 – Interim Board Summary' [Paper No. 20/24] presented by the Chief Executive, Ms Jane Grant. The paper provided an update on the overall position in respect of the NHSGGC response to manage COVID-19 to provide assurance to members. Ms Grant highlighted that the position within the Acute Division was beginning to stabilise. She noted that the bed base for ITU had returned to the normal capacity. However, there remained a significant number of inpatients, although this position was reducing slowly. The key areas of focus continued to be support to care homes, testing of staff, the 'Test and Protect' initiative, and the Mobilisation Plan. The first draft of the Mobilisation Plan was submitted to Scottish Government and initial feedback received was positive. Prof Brown thanked Ms Grant for the update and invited comments and questions from members.		

In response to a question raised regarding the number of staff shielding and the capacity within Occupational Health to support this cohort of staff, Prof de Caestecker, Director of Public Health, advised that there was sufficient resource within the Occupational Health Department to support these staff members, and staff continued to be kept informed with regular 'keeping in touch' contact.

In respect of resources to support the work with care home and contact tracing work, a significant number of staff from other areas of the organisation had been mobilised to support these crucial areas of work. This included a number of health improvement staff, public health staff, and other staff carrying out non-essential roles. Contact was made with a number of staff currently shielding, to organise training and equipment for these staff to support the contact tracing programme. Consideration was being given to requirements in the next six months. Routine contact tracing would move to a national centre, with a team retained locally to respond to complex cases.

In response to a question raised about the timescale for this to become fully operational, Prof de Caestecker highlighted that the programme was fully operational, with all positive cases being contact traced. As restrictions on movement and social distancing were relaxed, consideration would need to be given to the impact of this on the transmission rate of the virus, which would influence arrangements required moving forward.

A question was raised regarding antibody testing for staff. Prof de Caestecker advised that there were still scientific uncertainties about the relationship between the presence of antibiotics in a sample and immunity. Whilst there was no clear indication of the likely requirements, she assured members that plans were being considered in preparation for this.

In response to a question regarding the current position of the planned Major Trauma development at the Queen Elizabeth University Hospital (QEUH), Dr Armstrong, advised this continued to be progressed, with recruitment of staff underway to ensure that the necessary resource was available. Work also continued to take forward capital planning work in respect of the development of the Centre for Excellence for Scheduled Care at Inverclyde Royal Hospital (IRH) and Royal Alexandra Hospital (RAH), and plans to review space requirements for major trauma at the QEUH were being progressed.

A question was raised regarding the significant charge given to NHSGGC to provide support to care homes and the care at home sector, responsibility for implementation of care solutions and development of new ways of delivering health care. Ms Grant advised that many colleagues including the Director of Public Health and the Nurse Director, continued to work closely with Health and Social Care Partnerships (HSCPs) and Local Authorities, to develop a systematic approach to a range of issues including testing and visiting. In addition, Ms Grant attended a weekly meeting with Chief Executives of Local Authorities to discuss the issues. The initial issues in respect of Personal Protective Equipment (PPE) had been addressed swiftly. Ms Grant commended all colleagues who had undertaken these additional and challenging responsibilities. She assured members that NHSGGC continued to follow Scottish Government guidance on testing in care homes and would align with the national position recently announced by the Cabinet Secretary.

Further detail was requested in respect of the number of cases of patients at GGH who acquired COVID-19 while there, the number of deaths, the causal factors for these patients contracting COVID-19, had transmission of the virus reduced, and how many new COVID-19 infected cases were there at GGH in the month of May. Prof Angela Wallace, Interim Executive Lead for Infection Control, provided additional information, and was pleased to report that cases of COVID-19 at GGH in April 2020, had significantly reduced in May 2020, with a total of 4 cases confirmed in the month, the last case of which was detected on 7th May.

Furthermore, she commended staff for their ongoing efforts to ensure standard infection control procedures, and noted that dedicated senior Infection Control nurses were based at each site, including GGH, to ensure oversight, provide support to the patient pathway and to provide support to staff.

In respect of the causal factors, Prof Wallace assured members that an Infection Control Doctor was reviewing all of the cases of patients within that cohort and there was emerging evidence that over a third of the patients within that cohort would not have met the current symptoms indicators of COVID-19. The case definition and symptoms were being updated as we learn more about the virus but presentation in the elderly was still being debated and case definitions have to be updated to reflect this growing body of evidence. In addition, there was growing evidence in relation to the number of asymptomatic individuals who continue to test positive for COVID-19. If we were unable to determine who among staff and patients were positive, then delay in implementing control measures was inevitable. In addition, if exposures occur, then they would all be deemed as hospital onset.

Prof Wallace assured members that National Guidance was followed at all times and that NHSGGC were one of the first NHS Boards to implement enhanced PPE on 3rd April 2020, more than two weeks before it was reported nationally that NHSGGC was in a period of sustained transmission. Prof Wallace highlighted that implementing infection control guidance in the cognitively impaired frail elderly population was a significant challenge but staff were committed to supporting all patients including the frail and elderly. She highlighted that additional measures had been adopted across NHSGGC, including at GGH. For example, screening of all patients in the ward regardless of symptoms had been introduced by the Infection Control Doctor. This was before universal screening of the over 70s was introduced. She also implemented the cessation of movement within contact cohorts. Both of these measures were in addition to recommendations from National Guidance. Detailed work was ongoing to obtain data, and Prof Wallace assured members that this would be presented via the Clinical Governance arrangements in due course.

Dr Armstrong noted that it was understood that many of the patients were transferred from QEUH to GGH as part of a previously agreed clinical pathway which had been in place prior to the COVID-19 pandemic. The South sector Team were in the process of reviewing the clinical cases to review the clinical pathway. Furthermore, Dr Armstrong confirmed that reporting of all Significant Clinical Incidents (SCIs) had continued via the Strategic Executive Group (SEG). In addition, Dr Armstrong indicated that she had requested that the Acute Infection Control Committee and the Board Infection Control Committees consider the information being reviewed.

In response to a question raised regarding the significant drop in numbers of patients in ICU and the physiology/pathology of the virus in respect of the emerging view that ventilation of patients may not always be beneficial and the emerging

	clinical view that haematological therapy may be beneficial, Dr Armstrong noted that a significant amount of work was undertaken to ensure that ventilation was available to every patient that required it. She acknowledged that clinically not all patients would benefit from ventilation. However, all patients were assessed on a case by case basis, and, all those who may require ventilation were able to receive this care, as the capacity was able to meet the requirements. Additionally, it had emerged that the effects of COVID-19 infection, could affect patient's haematology and increase the risk of blood clotting. As such, treatment with the use of increased doses of blood thinning agents had been used effectively. The Thrombosis Committee has reviewed the drug doses to help this issue as this clinical complication was recognised early. Dr Armstrong noted that a paper detailing this was presented to the SEG, and subsequently circulated to West of Scotland Boards for information, as part of the Medical Director's twice weekly catch up. There was a question raised regarding the reduction in attendance to Emergency Departments (ED) and what consideration had been given to prevent a significant rise in inappropriate attendances post-COVID-19. Ms Grant advised that a considerable amount of work had been undertaken in respect of this. Mr Best added that as COVID-19 emerged, there was a marked change in attendances to ED. Work was underway to ensure that, as restrictions were relaxed, patients continued using the most appropriate care setting. As such, signposting at EDs had commenced, and ongoing work with HSCPs continued in relation to hubs and mental health triage processes. Dr Armstrong described work underway with NHS24 colleagues in relation to learning what worked well in recent months. There was clear evidence that early intervention and discussion with a senior clinician was extremely beneficial for patients, to ensure that those patients who require rapid access receive this quickly or directed to self-care. It was critical that the changes implemented were fully supported, to ensure that patients continued to receive the right care, in the right place, at the right time, to avoid unnecessary presentations to ED, thus increasing the risk of transmission of COVID-19. In response to a question raised regarding the increasing evidence that patients recovering from COVID-19 require rehabilitation over a prolonged period of time and what plans were being made to address this, Dr Armstrong noted that there was an Allied Health Professional (AHP) representative member of the Recovery Tactical Group. She noted that AHP services have continued to provide urgent and emergency care throughout this time. The teams have been asked to consider new ways of working and digital solutions as part of recovery planning. The success of the Mental Health Assessment Units was acknowledged and a question was raised regarding the plans in place for reducing the number of Mental Health Assessment Units, whilst capitalising on their successes. Ms Millar reported that plans were in place to continue operating the Units over the next three months. This would allow an evaluation of the Units, whilst ensuring that patients continued to be treated. Ms Millar acknowledged the longer term role of the Units in relation to unscheduled care, and this would be considered moving forward. A question was raised in relation to the significant improvements made in delayed discharge performance, during COVID-19, and why performance appeared to be deteriorating. Ms Millar reported that there were a range of issues in relation to confidence in care homes and resources levels of homecare services. A number of actions were being taken to address this, including close working with patients and their families, collaborative working with Acute Division colleagues, joint working with care home colleagues, and daily review of performance. Stabilisation of the homecare workforce remained an important element of recovery, and it was		

acknowledged that this was a national issue. Ms Millar assured members that HSCPs continued to monitor the position closely and undertake key actions to address this.

Prof Brown thanked Ms Grant and colleagues for the update. The Interim Board were content to note the report and were assured by the information provided.

NOTED

60. PERFORMANCE UPDATE

The Interim Board considered the paper 'Interim Performance Update' [Paper No. 20/25] presented by the Director of Finance, Mr Mark White. The paper provided an overview of the current performance position across NHSGGC in relation to a number of high level key performance indicators.

Prof Brown invited comments and questions from members.

In response to questions from members in respect of the significant variations in day to day activity of Attend Anywhere, Mr Best reported that Attend Anywhere was in the process of being rolled out to all areas throughout primary and secondary care, therefore the variations reflected the continued roll out period. In addition, many GP Practices were also utilising telephone consultations. Mr Best clarified that the type of clinic taking place would also be a determinant of the use of Attend Anywhere, and various ways of conducting these were being explored. Mr Best commended the work of colleagues within the eHealth Department who had worked tirelessly to implement the use of digital solutions.

A question was raised in relation to the number of patients waiting >6 weeks for a key diagnostic test and if there were plans in place to ascertain the clinical urgency of routine referrals that had been made. Mr Best confirmed that urgent referrals and suspicion of cancer referrals had continued to be treated, as category 1 priority. He noted that consideration was now being given to category 2 and 3 non-urgent referrals, with close working with primary care colleagues to establish priority of clinical need.

Prof Brown thanked Mr White and Mr Best for the update. He commended the Executive Team for their efforts to maintain the performance position. The Interim Board were content to note the report and were assured by the information provided.

NOTED

61. FEEDBACK FROM AREA PARTNERSHIP FORUM

Ms McErlean, Chair of the Area Partnership Forum, noted that the Area Partnership Forum continued to meet on a weekly basis, and Ms McErlean also met with the full time officers on a two weekly basis. She noted the key areas of discussion, including engagement with Recovery Planning. In addition, care homes had been included as a standing item on the agenda. A meeting with the Chairs of the HSCP Staff Partnership Forums had also been arranged to discuss recovery planning.

Prof Brown thanked Ms McErlean for the update and wished to express his thanks on behalf of the Interim Board to the members of the Area Partnership Forum for

	their ongoing commitment to supporting the NHS GGC efforts to respond to the pandemic. **NOTED**		
62.	**GP OUT OF HOURS UPDATE**		
	The Interim Board considered the paper 'NHSGGC GP Out of Hours Service Resilience and Redesign' [Paper No. 20/26] presented by Ms Susan Manion, Interim Director of GP Out of Hours Service, and Dr Kerri Neylon, Clinical Director, GP Out of Hours Service. The paper provided an update on progress of the delivery of a sustainable service for GP Out of Hours. Prof Brown invited comments and questions from members. A question was raised in respect of the staffing capacity within NHS24 to manage calls and the flexibility to increase this when required. Ms Manion reported that extensive analysis had been completed, prior to COVID-19, which considered demand fluctuations across a wide range of periods, for example, seasonal and public holidays. Furthermore, an Escalation Plan was in place, and this included a number of alert systems and additional administrative staff should there be increases in demand. In addition, Dr Neylon reported on the range of work being done in partnership with GP colleagues to ensure that telephone consultations were a key part of the patient pathway and implementation of Attend Anywhere would be embedded to allow GPs to work remotely. In response to a question raised about access to GP and Acute patient records, Dr Neylon confirmed that this had been addressed and GPs working within the GP Out of Hours Service had access to the clinical portal. Work was being progressed to ensure that this was accessible to house visiting GPs also. There was a question raised about the physical locations for the services planned for Inverclyde and Vale of Leven. Ms Manion advised that, prior to COVID-19 and the enactment of the Business Continuity Plans, work was undertaken to ensure that the location of the service in Inverclyde was clarified going forward and that efforts continued to ensure services in both Inverclyde and the Vale of Leven were resumed as quickly as possible. Dr Neylon confirmed that the GP Out of Hours Service remained actively engaged with Inverclyde HSCP colleagues and the Integrated Lead GP at the Vale of Leven to ensure that this was expedited. In response to a question regarding feedback received from GP colleagues, Dr Neylon reported that a number of issues that GP colleagues had reported had been addressed, such as the implementation of an appointments system to manage workload and prevent walk-in attendances, and reconfiguration of the working environment to make this more comfortable for patients and GPs. Initial feedback received had been positive, with ongoing engagement with both the Local Medical Committee and the General Medical Council. Additionally, there had been more GP interest in the salaried contracts and alternative working arrangements offered. There was a question raised about reporting of progress to the Scottish Government. Ms Grant clarified that this was being managed as a package, along with the other areas of escalation, including unscheduled care and elective performance. The GP Out of Hours paper had been shared with the relevant Scottish Government colleagues.		

	A question was raised regarding media campaigns for the GP Out of Hours Service changes. Ms Bustillo, Director of Communications and Engagement, reported that the communications approach being taken would include the implementation of Attend Anywhere. The Communications Team continued to work closely with Ms Manion and Dr Neylon to develop communications plans. Prof Brown thanked Ms Manion and Dr Neylon. The Interim Board were content to note the report and were assured by the information provided that positive progress continued. **NOTED**		
63.	**CLINICAL AND CARE GOVERNANCE UPDATE**		
	The Interim Board considered the paper 'Clinical and Care Governance Update' [Paper No. 20/27] presented by the Medical Director, Dr Jennifer Armstrong. The paper provided an overview of the ongoing monitoring of clinical and care governance during the COVID-19 pandemic. Prof Brown invited comments and questions from members. In response to questions raised regarding two outstanding issues which had arisen from the Clinical and Care Governance Committee, those being, prison healthcare and enhanced monitoring of medical education at Royal Alexandra Hospital (RAH), Ms Grant agreed to provide an update to Interim Board members on these issues by email, with a comprehensive report presented to the full Board meeting scheduled on 30th June. Members were content with this approach. An update on the Ethical Advice and Support Group was requested, and Mr Ritchie confirmed that both he and Mr Matthews were members of this group. He advised that the group last met on Thursday 28th May, and considered a consent form in relation to COVID-19. There was positive discussion about the consent form and suggestions to enhance this were made. Mr Ritchie noted that there had not been any significant ethical issues presented to the group for consideration to date. Questions were raised regarding the temporary suspension of the Acute Clinical Governance Committee and the Board Clinical Governance Forum and the governance process by which clinical and care governance matters were being managed. Ms Grant clarified that the Strategic Executive Group (SEG) had been established to manage critical business matters, including clinical and care governance. There had been a paper outlining the emergency COVID-19 arrangements for governance which had been presented to the SEG and had been approved. This was to ensure that clinical staff and senior managers could focus on the response to COVID-19. Ms Grant assured members that clinical and care governance continued to be delivered across NHSGGC and mechanisms were in place to address any issues via the SEG. A copy of the SEG paper would be circulated to Interim Board Members. Dr Armstrong added that consideration was being given to the resumption of the Board Clinical Governance Forum, however this would be dependent on the position in respect of COVID-19. In response to questions regarding the governance of Adult Support and Protection and Child Protection matters, Ms Millar assured members that multi-disciplinary reviews continued to take place, with key issues highlighted and managed		**Dr Armstrong** **Ms Vanhegan**

	immediately. The Chief Officers Group continued to review emerging issues and concerns, with weekly reporting to Scottish Government thereafter. Prof Brown thanked Dr Armstrong, Ms Grant and Ms Millar, for the update. The Interim Board welcomed the report and were assured of the information provided that clinical and care governance matters continued to be addressed. **NOTED**		
64.	**FINANCE UPDATE – 2019/20 MONTH 12 FINANCE REPORT**		
	The Interim Board considered the paper 'NHSGGC – 2019/20 Out-turn Report' [Paper No. 20/28] presented by the Director of Finance, Mr Mark White. The paper provided an update of the year-end out-turn position. Prof Brown invited comments and questions from members. In response to a question regarding the increasing budget challenge for 2020/21, the underlying deficit, the increasing challenge of the Financial Improvement Programme, and what the implications were for the 2020/21 budget strategy, Mr White clarified that there were no changes planned in respect of the budget strategy. The current financial position remained positive and work continued to analyse the month 2 position and the areas of underspend. Furthermore, consideration was being given to the impact of resumption of elective activity and how the financial position could be maintained moving forward. Due to time constraints, the Chair proposed that further questions on the Finance Report be responded to by Mr White via email. These included: 1. Further information on how a break-even position was achieved within East Dunbartonshire HSCP and the source of the additional contribution. 2. The impact of the underspend within the health element of the East Dunbartonshire HSCP budget being used to contribute partially to the overspend within the social care element of the budget. 3. IJB Reserves – further information was requested in respect of the level of funding set aside as earmarked reserves and what level of funding was set aside as general reserves. Mr White agreed to respond to the above questions via email. Prof Brown thanked Mr White for the report. The Interim Board would anticipate further information in respect of the points raised, via email. **NOTED**		**Mr White**
65.	**GLASGOW NORTH EAST HEALTH AND CARE CENTRE OUTLINE BUSINES CASE**		
	The Interim Board considered the paper 'Glasgow North East Health and Care Centre Outline Business Case' [Paper No. 20/29] presented by Ms Susanne Millar, Chief Officer, Glasgow City HSCP, and Mr William Edwards, Director of eHealth. Prof Brown welcomed Mr John Donnelly, Senior General Manager, Capital Planning, and Ms Sharon Wearing, Chief Officer Finance and Resources, Glasgow City HSCP, to the meeting.		

	Prof Brown invited comments and questions from members. In response to a question regarding the approval of the project in relation to the assessment of the future of Lightburn Hospital, Ms Grant reported that this continued to be an ongoing element of the discussion in relation to this project. Furthermore, as part of COVID-19 recovery, a review of the whole of NHSGGC estate was required. There were questions raised regarding the adaptability of the plans to the changed environment following the pandemic and if the plans remained fit for purpose. Mr Edwards confirmed that the Business Case aligned with the Digital Strategy, which included maximisation of Attend Anywhere across community sites and Acute sites. He assured members that the plans for the facility had been designed to be as flexible as possible. Ms Wearing added that a significant amount of bookable space had been designed to allow use by different types of services. She highlighted that there remained some services which could not be provided digitally, for example, accommodating visits with parents and relatives of looked after children, and the design of the facility had ensured full agility in this respect. In response to a question regarding the flexibility of the facility to accommodate community activities, and the hours that the building would operate, Ms Wearing advised that many of the services operate between 8am and 10pm. In addition, the activities of the Library and of the Health Improvement Teams, may also require evening and weekend opening. She assured members that consideration had been given to these important matters and that the needs of the community had very much been taken into account throughout the design of the facility. Prof Brown thanked Ms Millar, Mr Edwards, Mr Donnelly, and Ms Wearing for the report. The Interim Board were assured by the information provided and were content to approve the Glasgow North East Health and Care Centre Outline Business Case, for onward submission to the Scottish Government Capital Investment Group. **APPROVED**		
66.	**FEEDBACK FROM AREA CLINICAL FORUM**		
	Mrs Thompson, Chair of the Area Clinical Forum, noted that the last meeting of the Area Clinical Forum had taken place on Friday 28th May. The Forum received a detailed update on care homes, implementation of the Test and Protect Programme, the current COVID-19 position, an update from HSCPs, Recovery Planning, Personal Protective Equipment (PPE), and eHealth access. Discussion took place about the resumption of community optometry services and the implications of COVID-19, social distancing and new ways of working. There was also discussion about the resumption of dental services, specifically in relation to paediatric dental procedures which required general anaesthetic, the flow of patients through clinics and the impact on waiting times. Prof Brown thanked Mrs Thompson for the update, and wished to note thanks to all Area Clinical Forum members for their continued support and contributions. **NOTED**		

67.	**AOCB**		
	There was no other business noted.		
68.	**DATE OF NEXT MEETING**		
	Tuesday 16th June 2020, 09:30am Full Board Meeting – Tuesday 30th June 2020, 09:30am		
	The meeting concluded at 11:45am		