Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 7 May 2020 at 9.00am in the Lecture Theatre, Borders General Hospital via Microsoft Teams.

Present:
Mrs K Hamilton, Chair
Dr S Mather, Vice Chair
Mrs F Sandford, Non Executive
Mr M Dickson, Non Executive
Ms S Lam, Non Executive
Mr J McLaren, Non Executive
Mrs A Wilson, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs N Berry, Director of Nursing, Midwifery & Acute Services
Dr C Sharp, Medical Director
Dr T Patterson, Joint Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Strategic Change & Performance
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Mr A Carter, Director of Workforce
Dr J Bennison, Associate Medical Director
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Deputy Hospital Manager
Mr G Clinkscale, Hospital Manager
Ms S Laurie, Communications Officer

1. Apologies and Announcements

Apologies had been received from Dr Amanda Cotton, Associate Medical Director.

The Chair confirmed the meeting was quorate.

The Chair recorded the thanks of the Board to all of the staff across NHS Borders for the additional and different work they were undertaking during the current pandemic.

The Chair on behalf of the Board acknowledged the sad passing of Angie Cunningham, a member of the nursing staff and offered the condolences of the Board to her family and work colleagues.

The Chair announced that although Dr Stephen Mather had been due to conclude his non executive appointment in May, he had agreed to stay on for the time being until he could proceed with the sale of his property after lockdown. She further advised that interviews for a replacement non executive were currently on hold due to the pandemic, but would be progressed as soon as the Public Appointments Unit were granted permission to proceed.

2. Declarations of Interest

The Chair sought any verbal declarations of interest pertaining to items on the agenda.

Mr Malcolm Dickson declared that his sister in law worked for the Northumbria Foundation Trust.

The **BOARD** noted the verbal declaration and the inclusion of the Declarations of Interest for Mr A Bone and Mr A Carter on to the Register of Interests.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Borders NHS Board held on 2 April 2020 were approved.

4. Matters Arising

4.1 **Action 13:** Mr Rob McCulloch-Graham confirmed that directions would not be issued until the autumn**.**

4.2 **Action 14:** Mrs June Smyth advised that the matter had been built into the recovery planning timeline and she would engage with the Board further in due course.

The **BOARD** noted the action tracker.

5. COVID-19 Local Mobilisation Plans

Mrs June Smyth provided an overview of the process undertaken in regard to the formulation of the Local Mobilisation Plan. The plan was not currently in the public domain due to the constant evolution of the content. The current plan was iteration 4 which had also mapped across reference to the Health & Social Care Partnership plan.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

Dr Stephen Mather enquired about the modification of local equipment given the delay in receipt of ventilators. Dr Cliff Sharp confirmed that a number of anaesthetics machines had been identified for modification locally if required.

Mrs Fiona Sandford welcomed the answer to her question in regard to oxygen and enquired about monitoring oxygen requirements. Mrs Nicky Berry assured the Board that Dr Jonathan Aldridge and his colleagues had a process in place to monitor oxygen requirements on a daily basis with contingency arrangements in place to increase supply when necessary.

Mrs Alison Wilson assured the Board that there was a process in place in regard to the supply of oxygen cylinders and should usage escalate, deliveries to NHS Borders would be increased to 3 times per week.

Mrs Berry commented that Dr Aldridge had been keen to record his thanks to the Board for their support and interest in the provision of critical care at NHS Borders. A patient had been able to leave the ITU at NHS Borders after 40 days of care and another was due to leave later that day.

Mrs Sandford suggested the wording on page 5 in regard to "catastrophic" might be changed to something less alarming given the progress that had been made.

Mrs Wilson acknowledged the amount of work and change that Dr Aldridge and his team had undertaken in addressing the pandemic.

Mrs Smyth advised that feedback had been sought from the military liaison colleagues in terms of overall planning for the pandemic. The feedback received had been that Dr Aldridge and his team had been ahead of other boards in their thinking and actions, which had allowed the organisation to be in such a good position now.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted and supported the process being followed to finalise the plans to mobilise and respond to the COVID-19 influenza pandemic.

6. COVID-19 Local Mobilisation Plan Costs/Financial Governance

Mr Andrew Bone provided an overview of the content of the paper and highlighted the scope and process for identifying costs regarding the pandemic. He further spoke of the impact on reporting, planning and governance. He further clarified that the risk described was in relation to the financial matter to be addressed by the Scottish Government and UK Treasury. A single plan of financial templates would be submitted to Scottish Government for both NHS Borders and the Health & Social Care Partnership in regard to the delegated functions. In terms of a process for assurance in regard to the IJB elements, the Scottish Government were now describing the process to be implemented.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

Dr Stephen Mather enquired if all PPE for NHS Borders was nationally procured and if Scottish Government expenditure for it would appear on NHS Borders financial balance sheet? Mr Bone commented that the majority of NHS Borders PPE was sourced nationally and funded at a national level and would not appear in NHS Borders financial reporting. Where the organisation had experienced some supply issues, it had procured at a local level and sourced additional supplies as well as being in receipt of some donations of equipment and this would be recorded against our budgets.

Dr Mather enquired if the total cost of the pandemic for NHS Borders would be removed from the financial balance sheet, leaving NHS Borders in the same financial situation as it was in before the pandemic. Mr Bone confirmed that a Scottish Government mechanism had been put in place whereby they would cover the financial cost of the pandemic on NHS Borders for the 3-4 week period in March. Provisional figures had been agreed and actual costs would be confirmed through the final year end position. Mr Bone advised that the organisation was still expected to deliver the forecast outturn as advised to the Board prior to the pandemic.

Dr Mather enquired about bridging the financial gap should Scottish Government and Westminster be unable to agree a financial allocation. Mr Bone commented that it was unlikely that the Scottish Government had an identified resource for the pandemic for the next 12 month period and there was no certainty in terms of forecasting. Should NHS Borders finances be inadequate to plan for the

impact of the pandemic over the next 12 months, then the current financial plan would require further revision to ensure resources were allocated to the areas of highest priority, as well as revisiting the Annual Operational Plan to ensure it remained valid for the future. This would be discussed in detail with the Scottish Government as required.

Dr Mather sought assurance that payments to creditors were made within normal timescales. Mr Bone provided assurance that the current credit payment system remained operating and there had been no slippage to the timeline as a result of the pandemic.

Cllr David Parker commented that he understood from COSLA colleagues that the Scottish Government were looking for more money to allocate to the NHS.

Further discussion focused on: the national budget; Scottish Government funding allocations to the NHS; expectations on carry forward positions into 2020/21; and potential to benchmark the cost range of acute beds and ITU beds against other health boards in Scotland and the wider UK.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted the contents of the report.

The **BOARD** acknowledged the impact on reporting timescales, including Annual Accounts.

The **BOARD** took limited assurance that actions were in place to mitigate the risks identified in the paper.

7. Clinical Governance Update

Dr Cliff Sharp introduced the update by commenting that it had been some 6 weeks since the organisation had moved to an emergency status with an entire focus on preparations for the COVID-19 pandemic. Many staff had been redeployed from their current jobs into other roles and departments to assist with the pandemic and he wished to recognise the flexibility of staff during that mobilisation.

He reminded the Board that during the pandemic swift action had been taken in various areas including the commissioning of new beds in care homes and step down facilities and lowering the thresholds for the movement of patients to enable transfers to take place. A review would be undertaken to look at all of the various elements of patient care that had taken place to ensure the organisation continued to uphold the highest standards of quality whilst also ensuring patients were in the appropriate setting for their requirements.

Mrs Laura Jones commented that an Ethics Advice and Support Group had been formed as an advisory group to assist in planning for the worst case scenario, should there be a lack of national guidance, an exhaustion of resources, etc. Various contentious subjects had been discussed at the group to formulate protocols and processes should they be required.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

Dr Stephen Mather noted that the graph on page 4 highlighted that 7 patients had tested as negative but had presumed COVID-19 recorded on their death certificate. He enquired if there had been a change in recording from the Lord Advocate given it was a legal document and required to be as

accurate as possible. Dr Sharp commented that guidance had now been received on recording COVID-19 on the death certificate where it was the primary or contributing factor to the demise of the patient.

Mr Malcolm Dickson enquired about using volunteers for the Track and Trace initiative. Mrs Jones commented that the first aspiration was to use existing staff to meet all the needs required and then should there be a need for additional support the intention was to explore the use of volunteers. She emphasised that there were a high number of volunteers who were in the over 70s age bracket and work would need to be taken forward to look at their safety in the hospital setting, should they wish to continue to volunteer.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted the report.

8. Healthcare Associated Infection Prevention and Control Report

Mr Sam Whiting provided an overview of the content of the paper and drew the attention of the Board to the additional infection control support that NHS Borders had received from NHS Lothian.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes), however some remained unanswered and were addressed at the meeting.

Question 25: Mr Whiting confirmed that a range of spot checks had been carried out in the Borders General Hospital and had observed very good hand hygiene practice. There was also a provision of wipes for surfaces and the efficacy of the wipes had been checked in regard to COVID-19.

Question 26: Dr Tim Patterson advised that he had appointed an ex Consultant in Public Health, Dr Alan Mordue to lead on the staff clusters study work which was to identify all staff clusters, enumerate them and identify any hotspots or areas of difficulty to maintain social distancing. The clusters study work would feed into the preparations for the next wave of transmission should it occur.

Mr John McLaren enquired if the study would pick up the environment for corporate services where hand washing facilities were not present and social distancing could be a challenge given office space. Dr Patterson commented that he would welcome partnership involvement in the study.

Mr Whiting commented that in regard to hand hygiene in non clinical areas, there was limited resource available and the focus had to be on the highest risk areas. The hand hygiene observations focused on the world health organisation's 5 moments of hand hygiene and to replicate those in non clinical environments would not be relevant. He suggested public health messages on hand hygiene and cleanliness could be put into non clinical areas.

Ms Sonya Lam thanked Mr Whiting for his explanation to her question (24) and asked a follow up question about the false negative range. Mr Whiting commented that there was variation and his sensitivity level of 90% was based on representation by a Virologist in charge of NHS Lothian, who had analysed a range of different organisations testing kits in order to quantify the sensitivity and specificity. He further commented that there were many factors involved including how the test was taken, how swabs were taken, at what point in the infection the swab was taken, etc.

Questions 27 and 28: Mr Whiting assured the Board that the quality of the majority of the PPE being used by NHS Borders was in line with the CE quality mark and had been supplied through national procurement. There were some smaller quantities of PPE that had been sourced outwith the national supply route due to increased demand and a process agreed by the COVID-19 Pandemic Committee had been put in place to ensure such items were fit for purpose.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted the report.

9. COVID-19 Care Homes

Dr Tim Patterson provided the Board with an overview of the content of the paper and highlighted that: arrangements had been put in place in regard to the provision of a community infection control team for both the community and care homes; there had been development of policies and capture of knowledge of the pandemic; and lots of joint activity undertaken across both NHS Borders and Scottish Borders Council from the start of the pandemic.

Mr John McLaren highlighted that guidance had been issued from Scottish Government on how NHS staff were to be managed to support the local authority staffing of care homes.

Mr Malcolm Dickson enquired about compiling testing statistics for care homes. Dr Patterson advised that an exercise had been undertaken whereby all staff in a single care home had been tested and all had received negative results and those results were recorded.

Mr Dickson enquired about primary and community services. Dr Patterson confirmed that any primary and community services staff who were working in a care home would be included in the care home testing regime.

Mr Dickson was keen to establish the extent of infection outwith care homes and hospitals if possible. Dr Patterson advised that work had been carried out in that regard and it was clear that locally the rate of transmission was lower than the national data suggested, however as lockdown would ease he anticipated there could be a second wave of infection.

Cllr David Parker welcomed the positive joint working that had taken place between NHS Borders and Scottish Borders Council to support Saltgreens Care Home.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted the report.

10. COVID-19 Risk Register

Mrs Carol Gillie commented that in addition to the organisations' strategic risk register a new COVID risk register had been established. Ms Lettie Pringle as Risk Manager had formulated the register in conjunction with colleagues and would keep it under review. She further advised that the PPE risk had been mitigated from a very high risk rating to a high risk rating and suggested the register provided a good snapshot of concerns in preparation for further waves of infection.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** approved the strategic risk linked to COVID 19

The **BOARD** noted the risks associated with COVID 19.

11. COVID-19 Recovery Plan

Mrs Carol Gillie gave a presentation to the Board on the proposed recovery plan whilst continuing to deal with the pandemic and provide health services for the population of the Borders.

During discussion several points were raised including: Golden Jubilee were not offering routine elective capacity at the present time; testing provision; provision of Louisa Jordan as a COVID-19 hospital to provide additional capacity to Boards for low level patient care; longer term predictions; anticipated increase in hospital activity over the next 5-6 weeks; lower length of stay was consistent with patients being keen to return home; remobilisation of services was underway with early priorities for cancer cases; framework for services for social distancing, building compliance and risk assessments; Spire commissioned by Scottish Government for 3 months from April with Boards responsible for paying for variable costs of staffing and consumables; and modelling work for COVID-19 and non COVID-19 activity moving forward.

Mr Ralph Roberts commented that Health Boards were expecting to be asked for their Remobilisation Plans for the next 3 month period. He was keen that NHS Borders remobilisation plan was built from the bottom up and there was an understandable desire of many services to return to normal business as quickly as practical.

The **BOARD** noted the presentation.

12. COVID-19 Test, Trace, Isolate

Dr Tim Patterson provided an update on the Test, Trace, Isolate initiative. He advised that all Boards were expected to be ready to go live on 25 May. For NHS Borders the first phase of the initiative would involve up to 16 staff, scaling up after 4 weeks to around 40 staff, which was in anticipation of an increase in the circulation the virus. He commented that it was a very resource intensive process.

Cllr David Parker enquired if there was a breakdown of COVID-19 cases by postcode in Scottish Borders. Mrs June Smyth advised that for those admitted to hospital that data would be available.

Mrs Fiona Sandford enquired if the digital app being tested on the Isle of Wight would be used in Scotland. Dr Patterson advised that there was a national steering group looking at apps, as Glasgow had also developed an app. Mrs Sandford suggested any app or digital tool used should be a UK wide system.

Mrs Alison Wilson welcomed the Once for Scotland approach to Test, Trace, Isolate (TTI). Dr Patterson commented that there had to be a national solution to cope with any increase in infection once lockdown restrictions were eased.

Mr Ralph Roberts commented on the resources associated with the initiative and the likely cost implications for health boards. He suggested the Board would need to understand the impact on the services it would be able to provide if it had 40 staff employed on TTI for up to 2 years as well as how that would impact on the recovery plan.

The **BOARD** noted the update.

13. Finance Report for the 11 month period to 29 February 2020

Mr Andrew Bone reminded the Board that they had received a verbal update on the 29 February 2020 financial position at the last meeting, however he had been keen to highlight that he believed the outturn position remained on track not withstanding COVID-19 costs. In regard to the capital position there was slippage in the capital plan of about £500k mainly due to the impact of COVID-19 on contractors who were unable to come on site. He had agreed with Scottish Government that funding would be deferred in the intervening period. The present assumption was that funding would be reinstated however that had yet to be clarified.

Mr Bone also advised the Board that the internal audit contract with Grant Thornton Auditors, had been extended for a 6 month period. There were 2 outstanding audits regarding Turnaround and Delayed Discharges which were both deferred.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** noted the Financial performance at end February 2020 (as previously reported).

The **BOARD** noted the impact of COVID-19-19 on the expected outturn position for revenue and capital expenditure and the management thereof.

The **BOARD** noted the anticipated delay to the reporting of the March 2020 outturn performance and preparation of the board's Annual Report.

The **BOARD** noted the extension of existing contractual arrangements for Internal Audit provision.

14. Performance Briefing February / March 2020 – During COVID-19-19 Pandemic Outbreak

Mrs June Smyth provided an overview of the content of the report and highlighted performance against the delayed discharge trajectory and the significant reduction in community delayed discharges as of the previous day.

The Chair commented that the Board had already recorded a series of questions and answers on the paper (attached to these minutes) and she invited further questions.

Dr Stephen Mather enquired about potential risk averse behaviour. Dr Cliff Sharp commented that over the previous 6 weeks, due to the need to move things quickly, there had been progress with moving away from being overly risk averse, and he provided the example of Attend Anywhere being used as a key tool which had previously been slow to implement.

Mrs Nicky Berry commented that in regard to the delayed discharges situation, an integrated huddle had been formed in the Borders General Hospital to review patients for discharge. The integrated huddle had been in place for 3-4 months and had made good progress. She advised that there was a degree of risk appetite involved and a need to ensure there were proper robust processes in place to support discharges across the whole system.

Ms Sonya Lam enquired about delayed discharges readmission rates. Mr Gareth Clinkscale commented that there had been a reduction in readmissions. Mr Rob McCulloch-Graham further commented that readmissions continued to be measured and integrated huddles had been formed and were running in Community Hospitals. He commented that there had been an increase in the level of nursing home capacity available through the opening of 14 beds in Upper Deanfield. He agreed that there needed to be a continued focus on appropriate decision making to ensure patients were not kept in Community Hospitals when they did not need to be, due to available capacity being perceived in some of those locations.

Mr John McLaren enquired about sickness absence figures for staff over the perceived beginning of the COVID-19 period in January and February 2020. Mr Andy Carter advised that the sickness absence figures for January were 3.6% and for February 4.6%.

Mr McLaren further commented that as the organisation had moved into the COVID-19 planning stage it had at that time had an expectation of sickness absence of up to 20%. Mr Carter confirmed that the assumption of a 20% sickness rate had been based on a worst case scenario exercise undertaken by NHS Lothian on behalf of the East Region. He advised that he would forward a summary of sickness absence rates to the Board.

Mr Ralph Roberts drew the attention of the Board to page 4 of the report which showed the March position, which was broadly in line with expectations. He further advised that sickness absence levels for all clinical boards were reported to the COVID-19 Pandemic Committee and that Mr Carter would be running a sickness absence data report the following week for the previous month. He suggested the Board may wish to view that report which would detail the actual COVID-19 and non COVID-19 absence levels.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** agreed to receive a copy of the sickness absence report detailing COVID-19 and non COVID-19 absences.

The **BOARD** noted the Performance Briefing for February and March 2020.

15. Board Business April-July 2020

Miss Iris Bishop provided an overview of the content of the paper and highlighted the expectation that Governance Committee agendas would be focused on COVID-19 related matters.

The **BOARD** was content with the questions and answers provided ahead of the meeting (as attached to the minutes).

The **BOARD** accepted the revised business plan for 2020 as a consequence of COVID-19.

The **BOARD** considered and approved re-establishing the Board Sub Committees with effect from 1 June. All meetings would be held either by Microsoft Office Teams or Telephone Conference calls in order to enable social distancing.

The **BOARD** considered reinstating its substantive corporate governance arrangements from 1 August 2020. All meetings would be held either by Microsoft Office Teams or Telephone Conference calls in order to enable social distancing. This will remain subject to review depending on the impact of COVID-19 on the organisation.

16. NHS Board Performance Escalation Framework

The **BOARD** noted the report and that NHS Borders remained at Level 4 of the NHS Board Performance Escalation Framework.

17. Any Other Business

The Chair commented that she was pleased to see the approvals pathway section on each Board paper had been fully completed.

18. Date and Time of next meeting

The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday 4 June 2020 at 9.00am via Microsoft Teams.

The meeting concluded at 11.40am.

Signature: ……..
Chair

BORDERS NHS BOARD: 7 MAY 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
1	Register of Interests Appendix-2020-51		
2	Minutes of Previous Meeting	**Sonya Lam:** Correction to title from Mrs to Ms Lam. I was absent for most of the meeting and joined in the discussions on the Local Mobilisation Plan, so not sure whether I was really there for the actual meeting.	**Iris Bishop:** The minutes have been amended.
3	Matters Arising Action Tracker		
4	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Stephen Mather:** What are the updated changes for iteration 4 of this document and, can we have sight of the submitted document?	**June Smyth:** LMP4 (circulated separately) is our 'last' local mobilisation plan now that we move onto recovery. We are using the LMPs as a record of the journey we've been on as we moved to respond to COVID-19. All of the sections that were in the last plan (LMP3 dated 15th April) which was circulated through Chief Execs office have been updated to reflect the position as at end of April, plus we added in the following sections: New Sections: • Shielding of Most Vulnerable Patients • Clinical Governance • Ethical Framework • COVID-19 Testing • Workforce Challenges • Risk Management

			• Recovery Plan Boards are not yet putting their mobilisation plans into the public domain – but we have circulated it separately to Board members so we can discuss the plan at the meeting on Thursday as required.
5	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P4 The promised ventilators from stock allocated to Scotland - are they no longer promised?	**June Smyth:** The last we heard from Health Facilities Scotland they were held up in customs. We are awaiting a further update.
6	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P5 Catastrophic failure of oxygen - is the only proposed solution shipping patients needing ventilation to Edinburgh?	**June Smyth:** In that instance we would look to invoke mutual aid initially with Boards in the East Region (Lothian and Fife) and if they had similar capacity challenges then we would look across NHS Scotland. Our local modelling shows that for this current period this is unlikely. National modelling and assumptions to date only take us to the end of June. We continue to adapt and update our local modelling with actual data and link in with other modelling teams across NHS Scotland (and wider as appropriate).
7	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P7 IFF the peak was 8th April and then we had 36 inpatient beds and 7 ITU, AND if we are modelling on patient admissions, then why are we planning for between 89 upscaling if necessary to 156 inpatient Covid beds? I know we want to build in resilience (perhaps much more so than in the past, but I'm not clear why we are proposing 2.5*)	**June Smyth:** See information at end of this paper (too large to insert in the table)
8	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P13 Thank goodness for our in-house laundry P16 # beginning 'A draft Addtional....'. I really can't fathom the meaning of this #!	**June Smyth:** Primary care have clarified (see below) – I think this was an editing error (when converting bullet points into narrative):

			We looked at how we could bring GPs in at weekends and OOH to support high numbers of potential COVID patients who could not be looked after in hospital – no longer deemed necessary and additional funding going to individual practices. We clarified the on going status of the pneumococcal vaccine during COVID and confirmed that GPs would not start prescribing domiciliary Oxygen. We have offered driver support to take prescriptions from dispensing practices out to individual shielding or house bound patients.
9	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P25 Ethical Framework. Can you indicate how often this had to be invoked during this period? Finally - where are we on upscaling test and trace?	**June Smyth:** An update on the ethical framework has been included in the Board Clinical Governance and Quality paper. The group has worked on the basis of reviewing plans from clinical teams for the worst case demand projections and the impact this would have on the prioritisation of resources. The group has reviewed the organisations plans for 6 areas to date detailed in the CGQ paper. In terms of contract tracing, Public Health have produced an indicative service plan for contract tracing. Boards have been asked by Public Health Scotland (PHS) to: 1. Immediately implement contact tracing from 25th May for at least 3 months 2. Consider plans for potentially up to 2 years or when a vaccine is available. The service plan is based on planning assumptions provided by PHS and describes estimated resource requirements in the short term and indicative forecast costs to the organisation per year if this service plan was implemented in the longer term in the Scottish

			Borders. The ongoing Service Plan beyond 4 weeks will be dependent on ongoing discussions with PHS around their proposed national model and forecast volumes of contact tracing calls required to be conducted at Board level. We are currently assessing space requirements relating to the needs of this team.
10	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Sonya Lam:** Noted and thank you for such a comprehensive report. Cover Paper: With regard to Equality, Diversity and Inclusion, understandably this wasn't completed because of the urgent need to respond to C-19 as a priority, but will have been considered in terms of the impact on older people and BAME as service users and staff.	**June Smyth:** In terms of BAME: • NHS Borders is working diligently to supply appropriate PPE and train staff in use thereof. • If concerned, employees should to engage their line managers • A risk assessment can be undertaken to consider level of PPE adopted and/or prospects, viability of redeployment or home-working • National HR Directors are seeking Once For Scotland guidance, as matter of some urgency • Led by Public Health England, research continues to look into the relative high level of incidence of health & social care workers from BAME backgrounds dying from CV-19
11	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Sonya Lam:** Page 27: Staff Well Being: Knowing that MSK (Musculoskeletal) injuries are usually a frequent reason for staff sickness, has there been access to staff physiotherapy services (digitally enabled)?	**June Smyth:** Yes, the OHS physiotherapist continues to offer a service but no face to face appointments (use of telephone and Near Me consultations). Staff can self refer online as per the normal process.
12	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Sonya Lam:** Page 25: Staff Governance: In terms of Whistleblowing, the Scottish Government has delayed the introduction of the National Whistleblowing Officer role and the Whistleblowing	**June Smyth:** We have a well established process and policy linked to Whistleblowing. It has been something that has been reported at each Staff Governance Committee and whilst the Committee has been stood down we

		Standards. Are we assured that staff are able to speak up about patient or staff safety at an early stage? Has there been a change in the number of whistleblowing concerns?	have continued to be conscious of the need to monitor this. Work on Staff Wellbeing and the returning HR functions to normal will capture any issues which have affected staff adversely. This will be dealt with in a supportive way in line with our policy. In the event of workers having a degree of reluctance to raise issues, trade union and professional organisation representatives play a vital role in channelling employee concerns to appropriate managers for consideration and if necessary, action. The Employee Director continues to be vocal in expressing any employee concerns.
13	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Sonya Lam:** Page 29: I welcome capturing the experience and learning and actioning into the recovery phase. Will this approach be useful for when services resume to the new normal and what changes may have a positive impact on service delivery and performance e.g. changes in the way services have been provided using digital solutions.	**June Smyth:** Yes we are building this into our plans around recovery and have some proposals being developed re how to specifically capture frontline staff experiences and stories to help inform our plans.
14	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Karen Hamilton:** LMP Document itself p11 last para, 'trajectory to reduce delayed discharge not met'. Also mentioned in 7.1 Performance Briefing P2. How far off are we? Will increased testing requirements delay this further?	**Rob McCulloch-Graham:** Our target trajectory would mean that we should be at zero now; our delays currently stand at 20. We are continuing to bring this number down to single figures and then onto zero; this remains our aim. The additional testing regime has a potential to add 1 or 2 days onto the length of stay for any patient to be discharged. The majority of our delays now are people awaiting care home placements, so as part of the mobilisation we have invested in a new facility in Upper Deanfield Care Home and have therefore opened 14 additional nursing care beds. This facility

			took its first additional on 5 May 2020 and is expected to have a significant impact on our delays further.
15	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Karen Hamilton:** Final paragraph - Noted this is a snapshot of current position, any update? How to keep the Board informed and assured of progress on Recovery?	**Carol Gillie:** We will pick this up in the presentation but would anticipate this being a regular item on the Board agendas.
16	COBID-19 Local Mobilisation Plan Costs/Financial Governance Appendix-2020-53	**Fiona Sandford:** p10: If we are benchmarked with an expected cost range for acute beds, below for ITU and on the median for H&SC, then why, (further down the page) do we assess the risk as high that the available funds will be insufficient? (is it because of the point on P6 above, and if so should we not be benchmarking with RUK?	**Andrew Bone:** There are two main drivers for the overall risk assessment in relation to Covid. Firstly, the lack of certainty around what the longer term response will look like means that forecasting to March 2021 is based on limited data and is essentially an extrapolation of short term response. This means we do not presently have cost certainty. Secondly, this position is reflected across the wider UK health sector. UK Treasury is understandably seeking a level of control over the total costs and there remains an ongoing negotiation around the level of funding and to what extent health systems will be expected to offset costs through reprioritisation of existing plans. The overall risk rating reflects the fact that there is further work required to establish mitigating actions – predominantly, this will be through refined modelling and national assurance mechanisms to ensure that funding is aligned to actual costs. I would anticipate that we can bring this risk down in the timelines of the next board meeting.
17	COBID-19 Local Mobilisation Plan	**Sonya Lam:** Paper noted. I acknowledge the impact on reporting	**Andrew Bone:** A revised schedule is being finalised in agreement

	Costs/Financial Governance Appendix-2020-53	times and take limited assurance that actions are in place to mitigate the risks identified in the paper. Point 6.5.6: Regarding the revised external auditors programme, what are the likely changes to the programme?	with our external auditors and should be available shortly. The audit was scheduled to begin early May and is now provisionally agreed to commence in early August, subject to Audit Scotland completing revisions to their overall workplan. At present we expect that the final completion of audit will be within the agreed three month extension.
18	COBID-19 Local Mobilisation Plan Costs/Financial Governance Appendix-2020-53	**Sonya Lam:** Point 6.8.4: If Scottish Government has indicated that allocations will only be made following validation of costs and national benchmarking of board plans for hospital beds, are there variations across the NHS Boards that might provide an increased financial risk to NHS Borders?	**Andrew Bone:** At this stage we are expecting allocations to be matched to costs incurred and this should provide mitigation against any risk to funding arising from variation between HBs. There is expected to be some variation in costs between boards, for example where individual regions have been impacted disproportionately in relation to actual infection rate. The process described (benchmarking and peer review, together with specific SG process on H&SC costs) is intended to ensure that there is a level of consistency in service models.
19	COBID-19 Local Mobilisation Plan Costs/Financial Governance Appendix-2020-53	**Sonya Lam:** Page 12: Regarding delayed discharge reduction. I welcome the introduction of community pulmonary rehabilitation support. Is this an introduction to this service (i.e. new) or is it an embedded evidence based intervention for this client group that is being further developed/extended?	**Rob McCulloch-Graham:** This is a relatively new service which we are confident will address the Covid19 challenges by preventing admissions and keeping people out of hospital and supported in the community. There have been pilots undertaken in other boards and we will monitor and collect impact evidence form this service to inform any future expansion or continuation of this work.
20	Clinical Governance Update Appendix-2020-54	**Sonya Lam:** Noted. Page 7. What are the aims of the internal research project and local perspective?	**Laura Jones:** The local study will look at all patients who presented with symptoms of COVID19, requiring admission to the BGH and who swab tested positive for COVID19. Patient presenting between the 13th March 2020 to the 30th April 2020 will be reviewed, approximately 90

			patients. The team will look at the demographics of all of these patients (age on admission, gender, ethnicity, town of residence), pre-existing health conditions (obesity/heart/lung disease, hypertension, stroke, cancer, on immunosuppressive treatments), symptoms on presentation, findings on investigations and what treatments were used (oxygen, fluids, antibiotics). The team will then go on to look at the outcomes of these patients i.e. how many were discharged home, how many died, how many required admission to ITU and how many were readmitted. They will then apply some statistics to see if there was any association between the patient's demographics/pre-existing health conditions/clinical presentation/results of investigation with each of the above 4 outcomes. This will highlight if there was any factors (e.g. obesity, age etc) which led to a poorer outcome (either death/admission to ITU) and if there was anything significant which made it more likely that a patient would recover and be able to go home. Any learning from this would be used to inform NHS Borders response to COVID moving forward.
21	Clinical Governance Update Appendix-2020-54	**Karen Hamilton:** Volunteering - Can the 'unused' volunteers be of any use in the Testing scenario?	**Laura Jones:** We haven't explored this yet but happy to scope this out with team leading this. Would need to consider principle of safeguarding our volunteers.
22	Clinical Governance Update Appendix-2020-54	**Karen Hamilton:** Formal Complaints - Interesting to note significant reduction in complaints over Pandemic.	**Laura Jones:** This has been very low compared to the norm. Eights complaints have been received in March, 9 in April and 3 in May to date. In addition, a number of informal concerns have been managed by the team member who has remained in place.
23	Healthcare Associated	**Stephen Mather:** I understand the reasoning behind suspending	**Sam Whiting:** No. As we are not doing any surveillance for surgical

	Infection Appendix-2020-55	surveillance of surgical site infections. Are the incidences of SSI going to be logged as adverse events for the foreseeable future?	site infections we are not aware of any cases. However, the Infection Prevention and Control Team are looking at recovery – particularly surveillance activity in the context of the wider plans to resume elective activity at some point. The expectation is that we will have capacity to resume this activity in June on the basis of both existing COVID-19 data reporting and existing additional admin support remaining unchanged.
24	Healthcare Associated Infection Appendix-2020-55	**Sonya Lam:** Noted. Page 8, Fig 6: Is the figure of 1 in 5 staff testing positive, possibly higher if there is a significant false negative rate. Are other Boards experiencing the same test results? Is there detail about areas/staff groups where positive tests are more prevalent?	**Sam Whiting:** Recent validation of lab tests conducted by NHS Lothian confirmed a sensitivity level of 90%. On that basis, it would be reasonable to expect a higher infection rate than formally reported. NHS Lothian found similar sensitivity and specificity levels across a wide range of different laboratory testing platforms in use. We do not have comparative data on staff infection rates by Health Board. Public Health are leading a review staff clusters to inform interventions to reduce the risk of staff-to-staff transmission.
25	Healthcare Associated Infection Appendix-2020-55	**Karen Hamilton:** Hand Hygiene - One would anticipate 100% and good to see additional Gel dispensers. Are we providing surface wipes (for desks/laptops etc) as well?	**Sam Whiting:**
26	Healthcare Associated Infection Appendix-2020-55	**Karen Hamilton:** Outbreaks - Clusters of staff – where are they and are we looking into deep dive as to reasons?	**Sam Whiting:**
27	Healthcare	**Karen Hamilton:**	**Sam Whiting:**

	Associated Infection Appendix-2020-55	PPE - What proportion of donated items have we needed/used. Who for? What and Where from?	
28	Healthcare Associated Infection Appendix-2020-55	**Karen Hamilton:** PPE - Noted as Issue for disposable fluid resistant gowns as at 27/04/20 could be a significant problem in next 5-10 days – Resolved?	**Sam Whiting:**
29	COVID-19 Care Homes Appendix-2020-56	**Malcolm Dickson:** I am impressed by the extent of monitoring underway and support which has been offered to Care Homes in the Borders already. However, in John Connaghan's 'one size fits all' letter, the second requirement was that all territorial Boards should have created a prioritised schedule of visits to all care homes in their areas by 24.4, followed by weekly updates, and we don't appear to have responded to that element of his letter.	**Tim Patterson:** Malcolm guidance now changed to read Physical visits: it is recognised that undertaking physical visits by individuals or small assessment teams, that are not immediately necessary or could be done over the phone, could exacerbate the risk of introducing COVID-19 into a previously unaffected care home. In view of this it has been agreed that in developing a programme of visits to each local care home on a risk prioritised basis you should factor in this risk into your assessment process. This risk involves the delicate balance of providing adequate assurance that all measures necessary are being followed whilst not increasing the risk of introduction. Where a visit to an individual care home may potentially be of benefit, consideration should initially be given to use of a virtual visit (FaceTime, etc.) either as a precursor to, or instead of, a physical visit. New clinical guidance: New clinical guidance for care homes has been published on the HPS website. This covers in particular updated advice on testing and admissions. You can access it here: https://www.hps.scot.nhs.uk/web-resources-container/information-and-guidance-for-social-or-community-care-and-residential-settings/
30	COVID-19 Care Homes Appendix-2020-56	**Sonya Lam:** Noted.	
31	COVID-19 Care	**Karen Hamilton:**	**Rob McCulloch-Graham:**

	Homes Appendix-2020-56	Are we assured that all Care Homes have robust HAI processes to contain and manage Covid+ residents?	All care homes within the Borders have procedures in place to minimise ongoing infection. They are in close consort with NHS Borders Infection Control services and are monitored via the Care Inspectorate to ensure compliance. The council has daily input from external care providers, which is shared with colleagues to ensure sufficient support and advice is available.
32	COVID-19 Risk Register Appendix-2020-57	**Stephen Mather:** Appendix 3 - Is PPE being used in accordance with national guidelines?	**Lettie Pringle/Sam Whiting/Nicky Berry:** In regards to single use PPE we are following UK government guidance https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe NHS Borders has accepted non-standard eye protection in the past but because national supplies have improved NHS Borders is no longer accepting these items.
33	COVID-19 Risk Register Appendix-2020-57	**Stephen Mather:** Appendix 3 - Is there any shortage of PPE equipment in the most hazardous locations eg ICU, A&E?	**Lettie Pringle/Sam Whiting/Nicky Berry:** At each meeting of the PPE Group, which meets 3 times per week, the representative from each Clinical Board is asked the following questions and to date all have confirmed that there has not been an instance where this has been an issue:- • Since the last call are you aware of any member of NHS Borders staff being denied access to appropriate PPE? • Are you are aware of any member of NHS Borders staff not knowing where or how to access appropriate PPE?

			This is supported by a PPE dashboard to monitor the levels of PPE available across NHS Borders.
34	COVID-19 Risk Register Appendix-2020-57	**Stephen Mather:** Appendix 3 - Are we looking to use reusable kit where appropriate and, are we able to source such equipment?	**Lettie Pringle/Sam Whiting/Nicky Berry:** There are supply issues around reusable PPE but NHS Borders are using this where we can.
35	COVID-19 Risk Register Appendix-2020-57	**Stephen Mather:** Appendix 4 - The impact and consequences listed seem to be somewhat unlikely (eg patient being injured or killed when under the bed whilst it is being operated). Are we looking for problems which don't really exist? Nonetheless, the overall risk is serious so, should we be using these beds at all given that the current BGH bed occupancy is less than expected and planned for?	**Lettie Pringle/Sam Whiting/Nicky Berry:** The risk associated with electronic profiling beds is well established in healthcare; the Health & Safety Executive has published numerous guidances on this subject (example attached). There have been safety action notices issued from Health Facilities Scotland on electric profiling beds connected to instances of serious injuries and death. Please see link to patient death in NHS Lothian. http://news.bbc.co.uk/1/hi/scotland/3281259.stm  epb-health-care.pdf NHS Borders has purchased these beds in response to initial COVID-19 predicted figures. In regards to removing beds from use, there is an action to be undertaken to move these beds in to off-site storage to minimise the usage and there are ongoing discussions with the bed supplier to partly address this risk. This does not completely mitigate the risk as these beds could be used in an emergency situation should this type of situation arise in the future.
36	COVID-19 Risk Register Appendix-2020-57	**Malcolm Dickson:** This appears pretty comprehensive but I noticed that there was no mention of (1) the risk of further delays to elective/scheduled healthcare once this can be resumed, simply because of the increasing	**Gareth Clinkscale:** Risk is being updated to reflect impact of further backlog on waiting times. **Lettie Pringle/Sam Whiting/Nicky Berry:**

		size of the backlog, and (2) the risk of NHS services in the Borders, including Primary and Community Services being overwhelmed by patient elected postponement of presentation/access until after emergency measures are relaxed. Shouldn't we be trying to get a handle on this by asking Primary and Community Care what their rate of daily presentation/access has been since restrictions were introduced?	This will form part of the recovery process in identifying longer term risks which will be entered onto the COVID-19 risk register. Work is currently ongoing with clinical boards to ensure these areas of risks are identified and recorded on the COVID-19 risk register.
37	COVID-19 Risk Register Appendix-2020-57	**Fiona Sandford:** Finally from me, on the COVID Risk Register 2020-57 why is oxygen supply just medium risk - 'catastrophic failure' is used in the LMP	**Lettie Pringle:** The medium risk reflects the current risk faced by the organisation in regards to oxygen supply. This risk may fluctuate depending on certain factors that may increase/ decrease the risk.
38	COVID-19 Risk Register Appendix-2020-57	**Sonya Lam:** Approve the strategic risk for Covid-19 and note associated risks. Where did the HillRom and Medstrom 5000 come from? Did we purchase them or are they old stock?	**Lettie Pringle:** HillRom beds are currently being leased to NHS Borders. Medstrom beds have been purchased by NHS Scotland.
39	COVID-19 Risk Register Appendix-2020-57	**Karen Hamilton:** P3 – second bullet point at top - Noted training input – good, will this include understanding on what is a Covid Risk or 'normal' risk? Track record of entering risk has not been great and we need to make sure it is here.	**Lettie Pringle:** It is highlighted through training that the risks to be entered onto the COVID19 risk register are directly relating to COVID-19 response. Continual support is offered to risk owners who are unsure which risk register to report a risk on to. Advice can be sought through the risk team or the safety advisor (if this relates to a health and safety risk) and this is highlighted within the COVID-19 risk register intranet page and guidance.
40	COVID-19 Recovery Plan Presentation		
41	Finance Report for the 11 month	**Malcolm Dickson:** This is very informative despite the inevitable	**Andrew Bone:** There is a single submission which is compiled by

	period to 29 February 2020 Appendix-2020-58	number of known unknowns. The appendix on Covid costs, at para 3.4, states "NHS Boards are required to submit a weekly financial return…. In relation to Covid-19" and that this will be in the form of a single submission covering both Health and Social Care for their region. I presume that, in our case, this will be compiled by NHS Borders using its own information plus data from SBC, but that the Scottish Government cannot expect the NHS to be accountable for SBC data?	NHS Borders finance team with input from the IJB Chief Finance Officer, using information provided by the SBC finance team in relation to the Social Care element. The submission has been separated into two sections – covering non delegated NHS board responsibilities and delegated IJB functions. Board DoFs have advised Scottish Govt. that it is not appropriate for them to undertake scrutiny of council expenditure reported within the IJB delegated functions. The assurance and monitoring process established by David Williams, Director of Delivery for H&SC at Scottish Government, will be the vehicle for testing both health and social care expenditure within delegated IJB functions under the combined submission.
42	Finance Report for the 11 month period to 29 February 2020 Appendix-2020-58	**Malcolm Dickson:** Table 1 in the same appendix shows a higher forecast spend in Q4 of 20/21 than each of Q2 and Q3. Is there a particular pandemic related logic behind this or is it a reflection of seasonal pressures? Para 6.5.4 refers to an allowed delay of up to 3 months for publication of our annual accounts. Have we opened discussion on this with our external auditors (Audit Scotland)?	**Andrew Bone:** Phasing of Covid Costs: The phasing of costs into Q4 is an artefact of the modelling – the main component of this figure is the cost of deferred annual leave for NHS employees. This figure (c.£1.4m) has not been phased in the plan and is reported against March 2021 at present. Audit –(see also q.16): a revised timescale for audit has been provisionally agreed with Audit Scotland, with the Audit expected to begin early August (previously scheduled for early May). Audit Scotland have advised that there may be some further disruption to the schedule once they have evaluated the wider impact on their programme, including local authority and IJB accounts. Both NHS Borders

			finance and Audit Scotland are in regular contact on ongoing basis. At present there is not expected to be any further delay (beyond the estimated 3 months).
43	Finance Report for the 11 month period to 29 February 2020 Appendix-2020-58	**Malcolm Dickson:** I was assured by the benchmarking reported at 6.85 showing that our costings are not out of alignment with the average for other Boards.	**Andrew Bone:** To note: Further benchmarking work is to be undertaken and updates will be shared as they become available. Figures presented to DoFs remain embargoed while quality assurance is undertaken.
44	Finance Report for the 11 month period to 29 February 2020 Appendix-2020-58	**Sonya Lam:** Noted	
45	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Stephen Mather:** Delayed discharges have halved since covid-19. What has happened to achieve this and, can it be maintained when normal service is resumed?	**Rob McCulloch-Graham:** There are a number of factors involved in the discharge of patients from hospital. As the board is aware, the partnership has put in a number of resources and additional capacity to support discharge over the last 2 years; we have also improved our processes for discharge. Although we have no empirical evidence, it is a commonly held view amongst all professions involved in discharge that Covid19 has reduced any risk averse behaviours / decision making and given a substantial impetus to drive these processes to access increased capacity more effectively. We had began to see a greater degree of success in reducing delayed discharge within the BGH prior to Covid19. We introduced the same methodology on a daily basis across all community hospitals. This, linked with the pressures and motivation outlined above, has resulted in a significant improvement in reducing

			delays. We are however still above our intended trajectory and are maintaining our efforts and have successes in further increasing our nursing home capacity by opening a further 14 nursing care beds within a new facility in Upper Deanfield.
46	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Stephen Mather:** As at 13th April, there is a cumulative lost outpatient activity of 8855. What plans are being developed to make inroads into this total and, when will it be predicted that this total will be eliminated?	**June Smyth:** As part of the overall Board Recovery Planning work, the Acute team has established an Acute Recovery Programme to lead recovery efforts. The outpatient recovery workstream is doing a number of things to plan for lost activity including: • identifying which patients need seen first out of the significant routine backlog to ensure clinical priority • testing social distancing measures in outpatient departments • rolling out Near Me (formerly Attend Anywhere) where appropriate • planning for the re-establishment of routine activity Guidance has been requested from Scottish Government on when routine activity can restart. The number of lost outpatient appointments will continue to climb until this guidance is provided and we can restart routine appointments.
47	Performance Briefing February/March 2020 During COVID-19	**Stephen Mather:** There is a cumulative lost inpatient activity of 414. How much of this is day-case activity and, what is the plan to make inroads into this total?	**June Smyth:** Approximately 78% lost inpatient activity is Day Case. As part of the Acute Recovery Programme there is an ITU/HDU/Surgery Recovery workstream which is doing a number of things to enable the return of

	Pandemic Outbreak Appendix-2020-59		routine inpatient capacity including: • identifying which patients need seen first out of the significant routine backlog to ensure clinical priority • seeking to create a combined HDU to release the Day Procedure Unit (our current COVID-19 HDU) back to Day Case surgery • agreeing a non-COVID-19/COVID-19 ITU model to release Theatres back to Theatres • assessing what PPE means for Theatres capacity as this will undoubtedly slow throughput Guidance has been requested from Scottish Government on when routine activity can restart. The number of lost inpatient appointments will continue to climb until this guidance is provided and we can restart routine operating.
48	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Malcolm Dickson:** This is an understandably abbreviated report, but nevertheless useful. Can someone tell me what 'vertical booking' means in relation to theatre lists?	**June Smyth:** Vertical booking means lists are not booked specialty - specific but booked to mix specialties to ensure maximum activity in a minimal theatre footprint. Pre-Covid a specialty would have had a list to itself for a morning or full day. Part of our COVID-19 response means we will have multiple specialties (and therefore surgeons) operating in one theatre in any one theatre session.
49	Performance Briefing February/March 2020 During COVID-19 Pandemic	**Malcolm Dickson:** Procurement of some capacity in the Spire in Corstorphine for cancer surgery, using our own surgeons, seems like a good solution for urgent cases. I guess there will be additional Covid-19 costs arising, including travel/accommodation for	**June Smyth:** Yes that is correct we will need to capture and include these costs in any forecasts. **Andrew Bone:** We do anticipate additional costs, including invoicing

	Outbreak Appendix-2020-59	our staff which we will need to capture and include in forecasts?	for marginal costs (supplies, etc.) incurred by Spire Healthcare. This continues to be subject to regular update in the weekly mobilisation plan financial forecast as figures are clarified.
50	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Malcolm Dickson:** On page 4, reference is made to staff sickness absence. I was surprised at the low level of non-Covid related sickness absence. This is surely yet more evidence of the very positive commitment during this emergency across all staff groups.	**Andy Carter:** The March 2020 sickness absence level (Non-Covid) was 4.77% of available hours. The equivalent sickness absence level one year ago (March 2019), before the pandemic outbreak, was 4.73%. The workforce has been very committed and diligent in responding to Covid-19 pressures. **June Smyth:** These are the sickness absence figures that were recorded in March. April figures will be calculated next week once SSTS closes on 8th May. Through the Pandemic Committee structures we are monitoring COVID-19 and non COVID-19 related sickness absence in each of the business units and overall.
51	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Sonya Lam:** Noted Page 2: What are the barriers to the remaining delayed discharges?	**Rob McCulloch-Graham:** There are currently 20 delayed discharges on NHS Borders sites; 15 people in community hospitals and 5 people in mental health wards. We are continuing our work to bring this number down to single figures and then onto zero; this remains our aim. The majority of our delays now are people awaiting care home placements, so as part of the mobilisation we have invested in a new facility in Upper Deanfield Care Home and have therefore opened 14 additional nursing care beds. This facility took its first additional on 5 May 2020 and is expected to have a significant

			impact on our delays further. The other main source of delay are patients in the Guardianship / Adult with Incapacity process; these are being followed up effectively by our mental health colleagues but within the legal constraints.
52	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Sonya Lam:** Page 4: There seems quite an increase between the C-19 sickness absence for LD and the non C-19 sickness absence?	**June Smyth:** The LD service usually has a low sickness absence rate, however with a headcount of only 22 when one person goes off the figure becomes disproportionally high. The sickness absence stat presented relates to 1 employee who was off for 30 hours. The COVID-19 stats covers 5 employees – 4 who were self isolating as they had symptoms themselves and 1 who was self isolating due to a household member with symptoms.
53	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Sonya Lam:** Page 4: Refer to Page 20 of the LMP. What are the plans for introducing Near Me for priority areas defined by Scottish Government? What are the priority areas?	**June Smyth:** See detailed update later in the paper
54	Board Business April-July 2020 Appendix-2020-60	**Malcolm Dickson:** All measures described seem eminently sensible. I may not have interpreted the Audit Committee proposed business correctly, but is the end result no Audit Committee between March and October this year? I understand that the reporting delays will make an October meeting the important one, but has Internal Audit activity completed ceased for the time being, or is there some work that might be done as desktop research with online discussion	**Iris Bishop:** My apologies for not being clearer. You will recall we stood down all of the Board Governance Committees in order to ensure Directors were not overburdened with tasks during the period April to August. The intention of this paper was to assure the Board that there was no specific business that it needed to transact on behalf of the Board Governance Committees during April to August.

		provided that does not impinge on our Covid efforts?	The proposal now is to bring all of the Board Governance Committees back on line from June (May for the Clinical Governance Committee), with agendas focused on COVID-19 in the first instance, and then any other normal business that they felt they could manage at that meeting. So we are proposing the Audit Committee will meet in June. In regard to internal audit activity, as you know it was approved by the virtual Audit Committee meeting at the end of March that a joint market test with NHS Lothian would be undertaken to enter into a four year contract for our Internal Audit service, however given the COVID 19 situation that process was deferred for 6 months and an extension of the audit contract for 6 months was agreed with our current internal auditors, Grant Thornton. The 2020/21 Internal Audit Plan was pushed back to July given the COVID 19 situation.
55	Board Business April-July 2020 Appendix-2020-60	**Sonya Lam:** Accept revised business cycle and re-establishing board sub-committees Page 2: Could the board have earlier site of the Winter Period Evaluation (via email) before the October meeting?	**Iris Bishop:** We should be able to accommodate this request.
56	Board Business April-July 2020 Appendix-2020-60	**Sonya Lam:** Staff Governance Committee didn't meet in March, so if doesn't meet in June, there is a long period between the last meeting and October.	**Iris Bishop:** The proposal now is to bring all of the Board Governance Committees back on line from June (May for the Clinical Governance Committee), with agendas focused on COVID-19 in the first instance, and then any other normal business that they felt they could manage at that meeting. So we are proposing the Staff Governance Committee will meet in June.

57	NHS Board Performance Escalation Framework Appendix-2020-61	**Sonya Lam:** Noted	

With reference to the earlier question from Fiona:

7	COVID-19 Local Mobilisation Plans Appendix-2020-52	**Fiona Sandford:** P7 IFF the peak was 8th April and then we had 36 inpatient beds and 7 ITU, AND if we are modelling on patient admissions, then why are we planning for between 89 upscaling if necessary to 156 inpatient Covid beds? I know we want to build in resilience (perhaps much more so than in the past, but I'm not clear why we are proposing 2.5*)	See below

- Covid spread increases at an exponential rate. This results in very rapid increases in demand
-

  Covid inpatient capacity was modelled based on a number of assumed rates of increase. We modelled these at
  - 6% daily increase – this was the overall increase we experienced up to peak demand
  - 15% daily increase – this was the increase in cases in Scotland during the first two weeks of the pandemic
  - 23% daily increase – this was the increase we experienced in the Borders in the first 10 days of the pandemic

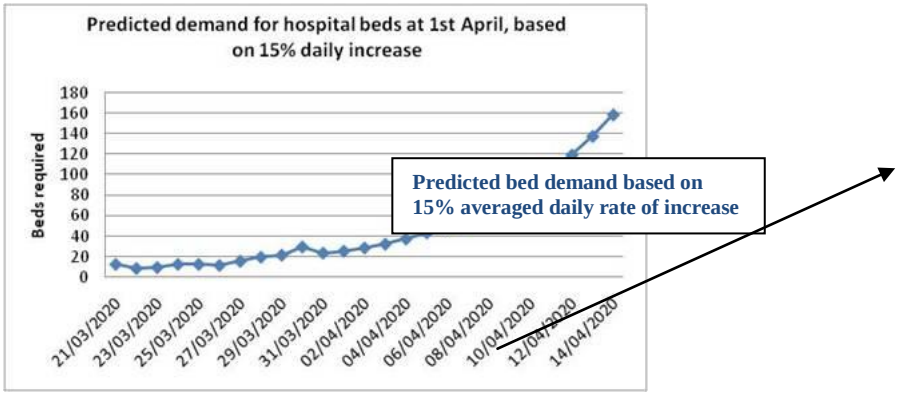
- We are now clear that the first wave of Covid infection has peaked. In the event, we did not require the capacity that we had initially planned for

- However our estimates are that at the end of this wave, we can expect no more than 10% of the susceptible Borders population to have had Covid and therefore have (assumed) immunity – i.e., 90% of the population will not be immune

- Most predictors suggest that we are likely to have at least one or two more waves of Covid infection. The extent of this will be decided by how we lift lockdown measures. Some people think the future waves will be higher than this first wave.

- We have to be able to rapidly scale up our Covid capacity to deal with this.

- To illustrate the effect of an exponential rise in Covid, based on the actual number of cases at 31st March, if we had seen a 15% daily increase (middle modelling estimate), we would have exceeded our planned capacity within 2 weeks:



With reference to the earlier question from Sonya:

53	Performance Briefing February/March 2020 During COVID-19 Pandemic Outbreak Appendix-2020-59	**Sonya Lam:** Page 4: Refer to Page 20 of the LMP. What are the plans for introducing Near Me for priority areas defined by Scottish Government? What are the priority areas?	See below

Near Me Update April 2020

All Boards have been tasked with accelerating use of Near Me as part of the response to Covid-19. This was initially in General Practice and then within high priority specialties in secondary care.

A national Programme has recently been mobilised to provide support and share learning. This is made up of enlisting staff from other areas like HIS and access collaborative.

Locally we have a team of 6 staff working at least part and full time on configuring services and users as well as supporting uptake. We have also assigned a Programme lead. The local team undertakes the initial engagement with services and gets the technology in place and appropriately configured to get services started. There is national support available to develop pathways and documentation with services. This has had mixed success so far and local teams have doen a lot of this work with services. The relationship between national and local teams needs refined to be effective. It is still bedding in especially as many of these are people who have not worked with Near me or these services before.

We have broadened out the Programme to factor in any service that expresses an interest and can see benefits for their patient cohort.

We have grouped the work into the following broad service areas / workstreams:

- General Practice
- Mental Health
- Community teams
- Acute specialties
- Social work reach in to NHS patients

We are now starting to see the number of consultation increase daily as staff find ways to incorporate Near me into current ways of working. There are still many staff and services that have been set up but are not yet using the tool. We will follow up with those as part of the Programme and where useful enlist the national team to support them in developing pathways and documentation.

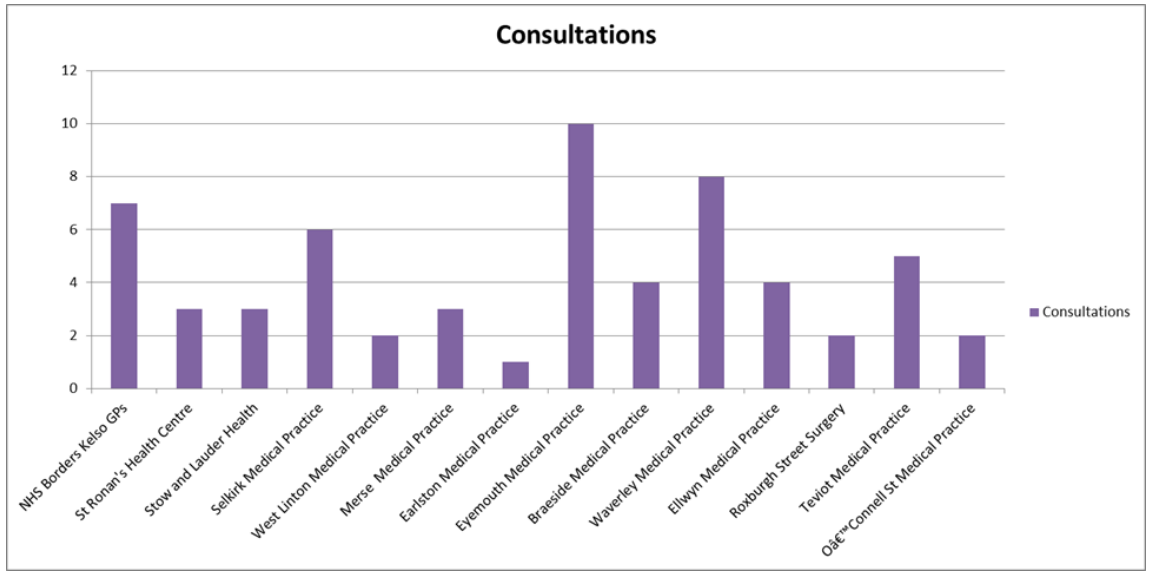
Everyone has access to and is using the national resources available to learn for other boards and services which has proved very helpful.

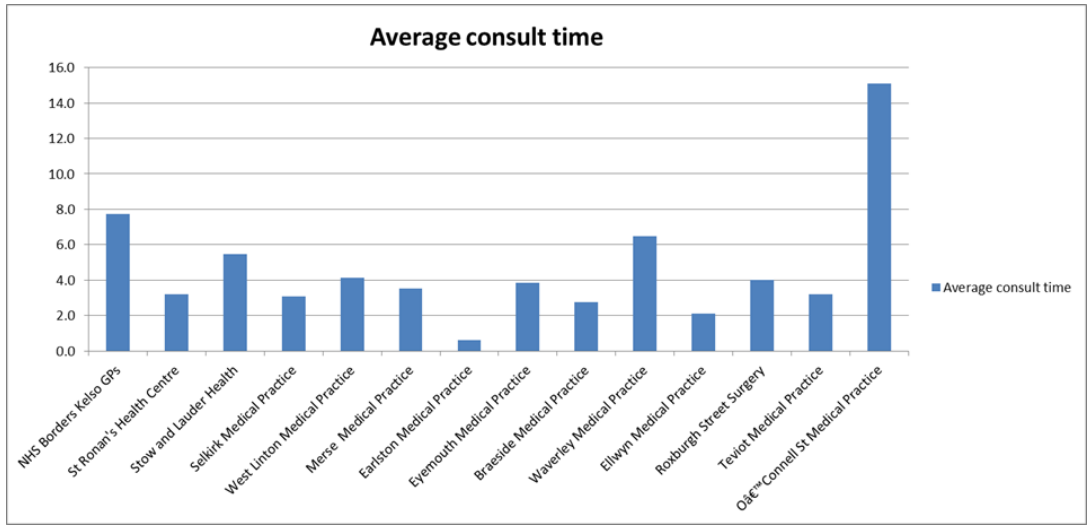
We are also linking in with SBC and Clare Richards will assist Social Work teams if they want to use Near me for their client groups where there is no NHS involvement.

All consultation are logged on the national infrastructure which allows us to start reporting non uptake and duration of consultations.
The table below shows the increase in consultations since we started on 16th March.

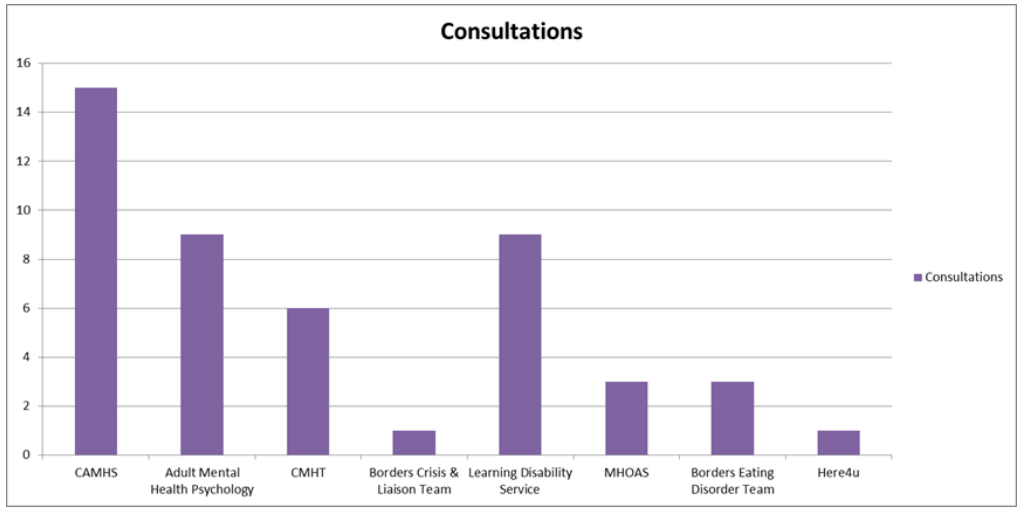
Near Me / Attend Anywhere - From 16/03/20	26-Mar	03-Apr	10-Apr	17-Apr	24-Apr
AHPs (SLT)					20
BECS / HUB	16	27	28	36	43
Chronic Pain					3
Community Nurses (Bladder, Bowel & Pelvic Floor,FNP)				8	19
Dental (Hawick & Oral Surgery)			1	1	7
Dermatology					3
Dietetics (Weight Management Team)					2
General Practices	32	111	152	208	251
GI	2	2	2	3	3
Haematology					
LDS (includes LDS AHP's)		1	3	4	11
Mental Health – Services (includes MH AHPs)	14	54	73	127	159
Neurology				2	2
Obstetrics					3
Occupational Health/Work & Wellbeing				1	2
Oncology				6	8
Paediatrics (including AHPs)	20	57	82	107	127
Palliative care Community Nurses					0
Respiratory				7	11
School Nurses				6	7
Sexual Health					4
Others	1	14	23		
AHPs				21	
Total	**85**	**266**	**363**	**537**	**685**

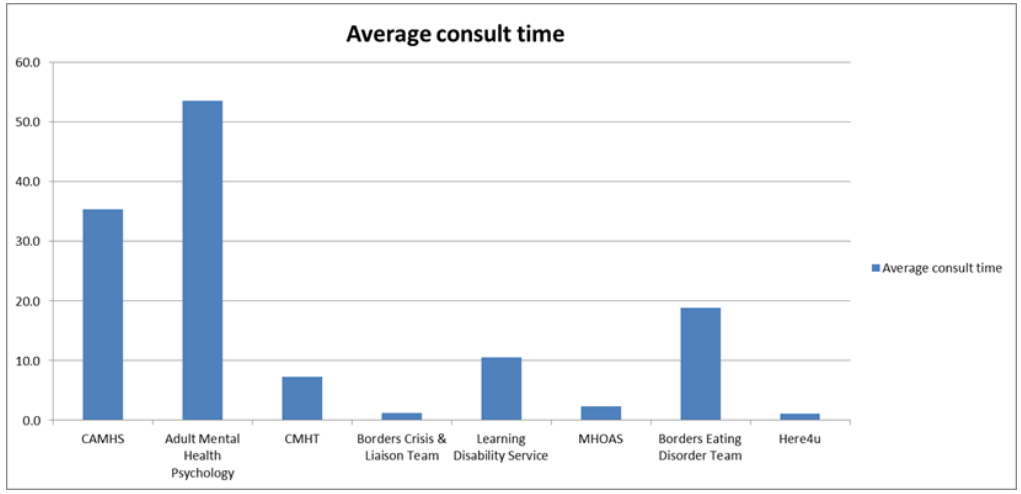
We can also break this down to service areas and star to look at the duration of each consultation.
In terms of General Practice we now have 14 of 23 practices actively using Near Me at 24th April.





Mental Health has made good use of Near me across a number of teams and have more planned. They are being very proactive in using the technology for their patient cohort.


Consultations
16
14
12
10
8
6
4
2
0
CAMHS
Adult Mental Health Psychology
CMHT
Borders Crisis & Liaison Team
Learning Disability Service
MHOAS
Borders Eating Disorder Team
Here4u
Consultations


Average consult time
60.0
50.0
40.0
30.0
20.0
10.0
0.0
CAMHS
Adult Mental Health Psychology
CMHT
Borders Crisis & Liaison Team
Learning Disability Service
MHOAS
Borders Eating Disorder Team
Here4u
Average consult time