Borders NHS Board

NHS Borders

Minutes of a meeting of the **Borders NHS Board** held on Thursday 4 June 2020 via MS 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 A Cotton, Associate Medical Director
Dr J Bennison, Associate Medical Director
Dr A Howell, Associate Medical Director
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Deputy Hospital Manager
Mrs C Oliver, Communications Manager
Dr K Allan, Associate Director of Public Health
Ms L Pringle, Risk Manager
Mr G Clinkscale, Interim Associate Director of Acute Services

1. Apologies and Announcements

Apologies had been received from Mrs Carol Gillie, Interim Director of Estates & Facilities.

The Chair confirmed the meeting was quorate.

The Chair welcomed a range of attendees to the meeting including, Mrs Laura Jones, Head of Clinical Governance & Quality, Mr Sam Whiting, Infection Control Manager, Ms Lettie Pringle, Risk Manager, Mr Keith Allan, Associate Director of Public Health and Mr Gareth Clinkscale, Associate Director of Acute Services

The Chair formally recorded the thanks for the Board to Mrs Carol Gillie as Interim Director of Estates & Facilities who was retiring from NHS Borders at the end of June.

The Chair reminded the Board that a series of questions and answers on the Board papers had been provided and their acceptance would be sought at each item along with any further questions.

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.

3. Minutes of Previous Meeting

The minutes of the previous meeting of the Borders NHS Board held on Thursday 7 May 2020 were approved.

4. Matters Arising

4.1 **Action 15:** Mrs Fiona Sandford thanked Mr Andy Carter for the paper on "Absence During the COVID-19 Pandemic". She enquired why the number of people identified with underlying health conditions and for shielding had increased in April when they should have been known about in March. Mr Carter explained that the timing for the increase in numbers was in line with the national and local GP letters released. Mrs Nicky Berry commented that the shielding criteria had widened to include other conditions and remained on-going.

Mrs Sandford commented that it was important the Board did not lose sight of sickness absence, especially given the potential for stress and exhaustion in staff to be realised after the initial peak in the pandemic. She requested the Board be kept updated. It was noted that both the Finance and Performance reports captured sickness absence figures and detail. Mr Ralph Roberts reminded the Board that the Staff Governance Committee as part of its remit would receive, review and scrutinise sickness absence information and data for the organisation.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the Action Tracker

5. COVID 19 Re-Mobilisation Plan

Mrs June Smyth provided an overview of the content of the paper. She commented that a short development session would be held on the Re-mobilisation plan at the conclusion of the Board meeting.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the process in developing the first iteration of NHS Borders COVID-19 Recovery Plan in response to the pandemic, which was submitted to the Scottish Government on 25th May 2020.

6. Quality & Clinical Governance Report

Mrs Laura Jones provided an overview of the content of the report and highlighted 2 specific points being: the section on resuscitation during COVID-19 and care homes. Mrs Jones commented that the Clinical Governance Committee had looked at resuscitation against a background of conflicting national guidance and risks to patients and staff. There had been 4 key pathways identified and she provided assurance to the Board that the risk assessment remained under constant review to ensure the balance was correct and review was made as further revised guidance was released.

She further advised in regard to Resuscitation pathway 4 about the application of resuscitation in the general community setting and advised that current local advice that all health care settings should apply full PPE prior to chest compressions was now being reviewed in line with recent advice from the Resuscitation Council UK (RCUK) for the general community. RCUK now advises that standard PPE can be worn with a covering over the patient's mouth and nose during chest compressions in a resuscitation attempt. This reflects the evolving risk profile in the general community. Local guidance for pathways 1-3 will remain unchanged until the level of risk presented by coronavirus lessens but will remain under constant review.

Mrs Jones further provided assurance to the Board in regard to the activity around care homes and the new guidance received from the Cabinet Secretary providing a new responsibility for Directors of Nursing in regard to care homes. Sadly as of the previous day 8 care home deaths had been recorded due to COVID-19 in Scottish Borders.

Dr Stephen Mather commented that the Clinical Governance Committee had discussed as length the matter of resuscitation and had covered all issues. The Committee had been assured that what had been proposed was correct and appropriate.

The Chair enquired about the potential reinstatement of a Director of Acute Services role. Mr Ralph Roberts explained that in recognition of the extended workload on the Director of Nursing in regard to Care Homes and the wider links to community services, he had wished to provide Mrs Berry with additional support for the Acute Services element of her role. He had therefore formulated an Interim Associate Director of Acute Services role, which Mr Gareth Clinkscale had taken up and allowed Mrs Berry capacity to focus on care homes issues.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the report.

7. Healthcare Associated Infection Prevention & Control Report

Mr Sam Whiting provided assurance to the Board in regard to the provision of supplies of PPE, commenting that there were regular deliveries being received. He further commented that staff were no longer required to decontaminate single use eye protection.

The Chair commented that a staff share had been issued in regard to the use of PPE and she enquired if that had been planned or if there had been an issue raised which had lead to the staff share. Mr Whiting commented that spot checks were undertaken on the use of PPE and it had been noted that in some areas there had been a misunderstanding of sessional use of PPE and single use of PPE. As poor practice had been observed it had been important to provide assurance to staff on the correct donning and doffing procedures for single use PPE and sessional use PPE.

Dr Cliff Sharp commented that in respect of PPE in connection with the Black, Asian and Minority Ethnic (BAME) population the organisation was keen to take particular account of individuals needs for PPE. Managers were undertaking risk assessments with their BAME staff to ensure they had the correct level of PPE for their role, especially given the national information that BAME people were a COVID-19 higher risk category.

Dr Sharp further commented that infection control colleagues had also been available to support care homes with their PPE training and infection control advice given the constantly changing situation for care homes.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the report.

8. COVID-19 Test and Protect

Dr Keith Allan provided a presentation on Test and Protect.

Dr Amanda Cotton sought clarification that if staff were contact traced, asymptomatic and asked to isolate for 14 days, evidence contesting their asymptomatic status did not allow them to return to work earlier. Dr Allan confirmed that the guidance at present was that if you were contact traced from a confirmed case then you had to isolate for 14 days. He reminded the Board that there were staff testing policies in place however, if a household member was confirmed positive, then anyone contact traced was asked to isolate for 14 days. National guidance also confirmed that those contact traced with a negative test outcome were still required to isolate for a period of 14 days.

Mr Andy Carter commented that if a member of staff was asymptomatic and required to isolate for 14 days they may be able during that period to work from home depending on their role.

Dr Allan clarified that when someone was contact traced they were asked to self isolate for 14 days. If they had a positive test result, their contacts would then be traced. If they had a negative test result they would be asked to self isolate for 7 days and no further contact tracing would be undertaken. Risk mitigations were put in place at each stage of the process.

Dr Stephen Mather suggested the success of tracing or testing was predicated on capacity to trace and the consent of those being tested. He sought assurance on the capacity to test, capacity to trace and what authority the organisation had if a contact refused to self isolate.

Dr Allan commented that testing capacity at a national level was undertaken through national laboratories. There had been a delay in receiving results into the local system from the national Lighthouse laboratory and those results were being made available on the ECOSS national system. Locally there was capacity to test, each test was by consent and therefore if someone did not consent to a test they were not compelled to take the test and public health advice would be based on symptoms and exposure to contacts. There were pieces of legislation under the COVID-19 regulations and Public Health Scotland Act that could be utilised should an individual be deemed as a very high risk.

Dr Tim Patterson commented that the majority of people would voluntarily comply with the regulations. He reminded the Board that contact tracing should be seen as part of a wider package of measures including social distancing, hand washing, sneezing protocols, etc.

Mrs Alison Wilson enquired about arrangements for independent contractors such as community pharmacists and optometrists. Dr Allan advised that risk assessments would be required to be done for the different levels of exposure.

Ms Sonya Lam enquired how contact trace callers would be able to verify they were genuine. Dr Allan commented that it was an important point and a telephone line service number had been set up so that anyone wishing to verify the call made to them could call the Borders General Hospital (BGH) and they would be put through to the contact tracers number.

Mrs Fiona Sandford enquired how easy it was for a member of the public to get a test locally or by post. Dr Allan advised that there was capacity locally for testing. Individuals could book a test on line and drive to the testing centre or have a test posted to them. There was evidence of self-testing being acceptable and should people be unable to access booking a test on line a telephone number was also available to call to book a test. The mobile testing unit was based in Galashiels on a rotational basis with other areas.

Mrs Fiona Sandford enquired about the national app availability and antibody testing. Dr Allan advised that Health Protection Scotland were looking at the position regarding a national antibody test and the national app would be whatever the UK government decided.

The **BOARD** noted the questions within the circulated Board Q&A had been answered during the presentation.

The **BOARD** noted the presentation.

9. Finance Report

Mr Andrew Bone reminded the Board of the discussion at the previous meeting in regard to disruption to reporting cycles and he hoped to be back to normal reporting cycles by the end of June. Mr Bone commented that the report was a high level interim report and in terms of the 2019/20 year end position he asked the Board to be assured that all of the financial targets for the year end 2019/20 would be met. He advised that the final allocation adjustment for 2019/20 was still awaited however he was confident that it would be as close to the position as described in the report.

In terms of moving into 2020/21 the report provided a limited level of information. Work was on-going to identify and clarify the detailed level of impact of COVID-19 costs.

Mr Bone advised that the Scottish Government summer budget had been published verbally the previous week and he would provide Board members with a short briefing on the content via email.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the report and the continued work to finalise the 2019/20 Year end outturn position.

The **BOARD** took significant assurance that the Board had met its financial performance targets for 2019/20, subject to confirmation of final allocation adjustments as outlined in the report.

The **BOARD** noted that normal financial reporting remained suspended for 2020/21 Month 1 (April) as a result of disruption following Covid-19 emergency measures.

The **BOARD** noted the information provided in relation to 2020/21 Month 1 pay expenditure including the financial planning impact of the Board's COVID19 response to end April 2020.

10. Performance Briefing

Mrs June Smyth presented the shorter abridged report and highlighted that Delayed Discharges were beginning to increase and as of that morning there were 30 delayed discharges with 25 in Community Hospitals, 2 in Mental Health and 3 in the Borders General Hospital. In regard to waiting times she confirmed that cancer cases had continued to be addressed throughout the COVID-19 period and waiting times were a key focus of recovery planning. As discussed earlier in the meeting the detailed breakdown of sickness absence could be included in the performance report. There were a range of standards not being reported on and as part of the recovery planning those standards would gradually be brought back into position and reported on as data became available.

The Chair commented that it was frustrating that the delayed discharges figures had increased given the progress that had been made in addressing them during the pandemic. She was keen to see strategies and processes to return to a zero position.

Mr Rob McCulloch-Graham agreed that it was frustrating that delayed discharges had again increased given all of the processes remained in place. He assured the Board that all of the leads on the integration huddle were reviewing each individual delayed discharge to identify where the blockages were. He reminded the Board that Upper Deanfield had been opened to provide additional nursing care however a number of delayed discharges had not been appropriate for that facility. He advised that he was looking to commission further Queens House beds if possible.

Mrs Smyth advised that there were daily updates from the integrated huddle and it was currently planning for the 3 delayed discharges in the Borders General Hospital to be placed in nursing care home placements by the end of the following week.

Mrs Nicky Berry spoke of the success of the integrated huddle and advised that the new General Manager, and Associate Director of Nursing, for Primary and Community Health Services would be part of the single integrated huddle in future. The Chair welcomed the formation of a single integrated huddle to address delayed discharges and suggested the work needed to be focused upstream to stop patients becoming delayed discharges.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the Performance Briefing for April 2020.

11. Strategic Risk Register

Dr Tim Patterson provided an overview of the content of the report and spoke of the new way of summarising strategic risks. He hoped the report was clear in showing what was new and what updates had been made from the previous risk levels.

Mr Malcolm Dickson welcomed the diagram as a useful summary.

The Chair commented that it was a difficult document to work through and therefore the summary provided by Ms Lettie Pringle was very helpful. She suggested the layout in terms of the next report might capture the RAG status on one page.

The **BOARD** noted the questions and answers provided.

The **BOARD** noted the report

12. Endowment Fund Board of Trustees Minutes: 20.01.20

The **BOARD** noted the minutes.

13. Board Committee Memberships

The Chair introduced the report and provided a brief overview of the content.

The Chair advised that she and Miss Iris Bishop were currently working with the national Boards to identify a non executive to join NHS Borders as an interim measure.

The **BOARD** approved the membership and attendance of Non Executive members on its Board and other Committees as recommended by the Chair to take effect from 1 July 2020.

14. Any Other Business

14.1 The Chair commented that it was Mrs June Smyth's birthday and the Board recorded their best wishes to June.

14.2 Mrs June Smyth advised the Board that a new camera set up would be in place for the next meeting which should enable a clearer sound and picture quality.

The **BOARD** noted the updates.

15. Date and Time of next meeting

The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday 2 July 2020 at 9.00am via Microsoft Teams

The meeting concluded at 10.29am.

Signature: …………………………………..
Chair

BORDERS NHS BOARD: 4 JUNE 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
1	Minutes of Previous Meeting	-	-
2	Matters Arising from the Minutes	**Malcolm Dickson:** Item 6 on Covid-19 costs. 4th para. Andrew may well be covering this in his Finance Report later on in the agenda so, if he is, we can ignore this question. He reported that SG would cover costs for the 3-4 week period in March. Has there been further commitment from SG for continuing costs? And is there any risk that 'Covid consequential' costs in non-Covid services during recovery might not be covered, eg extra staff costs to run two MRI scanners to catch up with backlog?	**Andrew Bone:** SG have confirmed agreement in principle to the Local Mobilisation Plan submission. Funding will not however be released on the basis of the plan; the process laid out by SG colleagues is that funding for Covid-19 related activities is to be on a reimbursement of actual costs basis following validation of costs through national/regional review process outlined in last month's paper. SG have advised that they expect NHS Boards to receive an allocation for costs incurred to date in July based on a submission of actual reported costs to date, to be submitted in late June. Thereafter it is likely (but not confirmed) that allocations will be made on a similar basis, monthly in arrears. There is a significant risk that costs of delivering recovery will not be supported by additional allocations. The national Re-mobilise, Recover, Re-design framework document published on 31st May emphasises the need to "... ensure resources are allocated where they are most needed to ensure the whole system operates effectively and efficiently". There is no indication that there will be additional investment beyond the immediate requirements of the Covid19 emergency response.

3	Action Tracker	**Karen Hamilton:** Thanks for update – has been concern that absences might increase as we come out of Crisis – burn out/emotional release etc – any early sign of this?	**Andy Carter:** Always a possibility but Occupational Health report no increase in number of Self- or Management Referrals to their service, at present. Hear4U counselling service has seen modest uptake. Staff reminded to use annual leave. HR picking up some sense of staff keen to return to their substantive roles/pre-Covid19 bases. Consideration of reinstating workplace coaching facility for staff.
4	Action Tracker	**Sonya Lam:** Page 1. What is the impact of delaying the directions until the autumn? Are there any risks? Are there any directions that should be considered earlier into the recovery planning?	**Rob McCulloch-Graham:** The development session of the IJB in conjunction with NHSB and SBC recovery plans will feed into the future directions issued. The landscape has changed because of c19 and it is essential we take this into account to inform future directions to be issued by the IJB.
5	COVID-19 Re-Mobilisation Plan Appendix-2020-62	**Malcolm Dickson:** Any consultation with H&SCP? I note mention of membership of the RPG from Adult Social Care, and Primary and Community Services, but nothing relating to the H&SCP.	**BET:** In establishing the Recovery group (RPG) it was agreed by BET to do this in a bottom up way. This therefore included members from each of the Business units as well as Social care. This therefore includes representatives from all of the H&SCP (as an operational delivery arm). The sign off of the final version of the first draft iteration of the RMP was done quickly because of the required timescales but included the opportunity for all members of BET, including the IJB CO to provide final comments / input. The Re-Mobilisation plan has also been shared with members of the council's Corporate management team. The members of the H&SCP leadership team have

			also been involved in discussions on the impact of the Pandemic on the IJB's Strategic Implementation Plan and this will be explored further at the IJB development session on the 24th of this month.
6	COVID-19 Re-Mobilisation Plan Appendix-2020-62	**Stephen Mather:** We will not return to the previous normal and the new normal will need to fully embrace technology changes/advances *eg* teleworking, remote consultations. Scottish Government must give a firm street in establishing priorities for NHS Scotland. NHS Borders must manage public expectations and not allow pressure groups and charities with their own specific agendas to dominate the recovery plan.	**BET:** Agree; Our re-mobilisation plan and all discussions with services continues to emphasise that our services will need to fully embrace technology and new ways of working in the future. The SG Framework for re-mobillising health services, published on 31st May provides some clarity on expectations, against which we will be able to assess / develop our plan.
7	COVID-19 Re-Mobilisation Plan Appendix-2020-62	**Karen Hamilton:** Public and wider staff group will be interested to see progress towards the 'new normal' they have been promised. Any indication of when this plan will be in the public domain? Will we be engaging with our Public Members for example?	**June Smyth:** The supporting comms and engagement plan will evolve as mobilisation progresses and services are re-established. Communication with staff is already underway and this will be extended out more widely to external stakeholder groups in line with service developments and overarching messaging from NHSScotland. Public Members will be sent a copy of the draft remobilisation plan after the board meeting on Thursday.
8	COVID-19 Re-Mobilisation Plan Appendix-2020-62	**Sonya Lam:** Can we predict when we will return to normal unscheduled non C-19 activity?	**Gareth Clinkscale:** We are already seeing an increase in non-Covid unscheduled activity although not yet back to pre-Covid levels. We have modelled on a 7% increase in attendances week on week until returning to full demand week beginning 21st June.

9	COVID-19 Re-Mobilisation Plan Appendix-2020-62	**Sonya Lam:** If delayed discharges are on an upward trajectory, what needs to happen to address this? Would the Day of Care survey provide any insights?	**Rob McCulloch-Graham:** We are hovering around the 20 mark with a proportion of this group relating to individuals with substantial needs, for which we don't have capacity currently. We need to develop this facility / services. Upper Deanfield was an initial attempt to do this in the context of the COVID emergency response. This need remains and we need to take a more determined effort to commission this within our provision.
10	Quality & Clinical Governance Report Appendix-2020-63	**Karen Hamilton:** All data is heading in the right direction which is encouraging. Para 1 Page 6 re donning PPE before CPR presumably this applies to First Responders? Do they have PPE? What is SAS view on this – do we know?	**Laura Jones:** Yes this does apply to first responders where PPE is accessible. The Scottish Ambulance Service is asking all staff to wear full level 3 PPE in their response to an arrest. Only where full PPE is not available should they wear standard PPE and should carry out chest compressions only.
11	Quality & Clinical Governance Report Appendix-2020-63	**Karen Hamilton:** Penultimate para page 6 – should we note the back up for Nurse Director to manage additional duties – (interim Associate Director of Acute Services?)	**Laura Jones:** Post of Associate Director of Acute Services reinstated to ensure appropriate support for Director of Nursing, Midwifery and Acute Services at this time of increased workload for COVID response, recovery and mutuality arrangements.
12	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Page 4: Is the review of C-19 related deaths for BGH and Community Hospitals? Are Care Home deaths reviewed in a different way?	**Laura Jones:** All COVID 19 deaths in a NHS Borders hospital setting are being reviewed under the mortality review process. The current NHS Borders mortality review process has not extended to care home residents where their death occurs in the care home, where they are admitted to hospital prior to death the patient would be captured under the NHS Borders mortality review process. Scottish Borders Council (SBC) run care homes or

			private care homes may have their own process for review of deaths but unable to advise on this.
13	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Page 5/6: Are there any adjustments for CPR in non-C-19 environments in the knowledge that some may be asymptomatic?	**Laura Jones:** The guidance applies to treating any patient at this time given that we remain in sustained transmission healthcare workers are asked to treat all patients as suspected COVID until we are advised otherwise. The NHS Borders risk assessment has been split into 4 pathways acute hospitals, non acute hospitals/inpatient areas, GP practices/community outpatient clinics, general community. Following the Resuscitation Council UK guidance and based on current level of risk in each setting staff are required to Don full PPE for pathways 1-3 before commencing CPR. In pathway 4, for the general community, staff are asked to cover the patients mouth and nose, and wear a minimum of standard PPE before commencing chest compression only CPR following Resuscitation Council UK current guidance and based on current risk in the community.
14	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Care Home Clinical Governance. o What are the connections with Care Home Clinical Governance and the role of the Care Inspectorate and the Scottish Social Services Council (in their regulation of care workers in care homes or residential care).	**Rob McCulloch-Graham:** Professional governance for care is through the chief social work officer and Care Inspectorate . We have received a shift in national policy to ensure NHS boards provide support and scrutiny of clinical processes within care. This is especially so across infection control. **Laura Jones:** The IJB as commissioners of care home services would be responsible for ensuring an appropriate standard of care is delivered. There should be

			appropriate internal processes in place to seek assurance from care home providers against agreed Key Performance and Quality Indicators during regular review sessions. Assurance and exception reporting against these indicators should be provided to Scottish Borders Council by responsible officers and subsequently back to the IJB as commissioners of care home services. The Chief Social Work Officer would retain professional responsibility for care workers in SBC run care homes and would liaise with the Scottish Social Services Council where professional issues arise which require referral. The care inspectorate has an additional external scrutiny role to ensure standards of care are delivered for the public.
15	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Care Home Clinical Governance. o Have or will the supportive visits included the Care Home Education Facilitators (CHEFs) as a source of information albeit on quality learning environments?	**Laura Jones:** Yes, the CHEFs will be drawn on as a source of information about care homes and will form an ongoing part of the support system for care homes.
16	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Care Home Clinical Governance. o What are the workload implications for NHS Borders undertaking these supportive visits?	**Rob McCulloch-Graham:** We have strengthened our care home review team and linked them with our district nursing teams. **Laura Jones**: There are 23 care homes in the Scottish Borders all having an initial visit, thereafter work is underway to scope out the ongoing improvement support needed and how to maintain regular contact with care homes to deliver this support.

			NHS Borders have deployed a member of staff to support this initially and will draw in others as support needs are identified. This support is in addition to the time being dedicated already by those members of the daily care home strategic oversight group and operational group.
17	Quality & Clinical Governance Report Appendix-2020-63	**Sonya Lam:** Care Home Clinical Governance. • In terms of the new Nurse Director roles, if the Nurse Directors are now to be accountable for nursing leadership, support and guidance, where did this accountability sit before? Who is accountable for other groups of staff, support staff, care assistants? Where does this new accountability sit within the governance framework for care homes and care at home?	**Laura Jones/Nicky Berry:** The Chief Officer for Health and Social Care Services Integrated Services is responsible for the operational delivery and assurance of services/care which is commissioned through the Integrated Joint Board (IJB) against service standards. This would include care homes as a delegated service from Scottish Borders Council (SBC) to the IJB. NHS Borders and SBC retain responsibility for any staff they employ who may work in a care home setting and in that respect are accountable for professional leadership, support and guidance to their staff in addition to professional governance. Responsible professional officers for NHS Borders (Medical Director, Director of Nursing, Midwifery and Acute Services, Joint Director of Public Health) or SBC (Chief Social Work Officer, Joint Director of Public Health) services provide assurance reports to the NHS Borders Board Clinical Governance Committee for Health Services or Scottish Borders Council for Social Care Services; and then back to the IJB on behalf of the employing organisation and in support of the Chief Officer for Health and Social Care Services (as members of the IJB).

			The Chief Officer for Integrated Services would be responsible through operational delivery responsibilities and monitoring of service levels/quality for escalation of any clinical or care governance concerns for professional advice and support. This is detailed in the scheme of integration and NHS Borders Code or Corporate Governance; and papers including a Clinical and Care Governance Assurance Framework considered and agreed by the IJB in 2016.
18	Healthcare Associated Infection Appendix-2020-64	**Malcolm Dickson:** Fig.5 on test results per day since 9 Feb: 1. Do these stats only cover BGH testing unit and, if so, shouldn't we be trying to collate numbers from community testing also in order to have a fuller understanding of the all-Borders picture? 2. The most recent results show four consecutive days with no positive results. Has this continued at or near zero?	**Sam Whiting:** The data in this graph covers all tests undertaken across Borders – not just BGH. The graph goes up to the 22nd May. Since then we had 1 new positive case on 24th May and 2 new cases on 27th May.
19	Healthcare Associated Infection Appendix-2020-64	**Malcolm Dickson:** Fig.6 on staff and household contacts tested. Latest figures show a possibly significant increase in positives to 10%, but the timeline ends on 12 May - any idea whether there has been any change upwards or downwards since then?	**Sam Whiting:** This looks like natural variation - the results for the subsequent weeks are:- 13/05/20 – 19/05/20 = 6.9% 20/05/20 – 26/05/20 = 0%
20	Healthcare Associated Infection Appendix-2020-64	**Karen Hamilton:** Final Para Page 5 – volume of requests high necessitating additional support from NHS Lothian? Why? And can we capture them to provide info to others?	**Sam Whiting:** The volume of queries has reflected the constantly changing national guidance, changes in consumables being supplied such as PPE and hand gel, complexity of patient placement including prioritisation of single rooms, discharge planning for suspected, confirmed and shielding patients and also

		(Iris)Final page – the link to SNO letter doesn't seem to work? I have a copy but just in case others have problems?	when discharging to shielding relatives, staff and patient testing, ventilation, cleaning, social distancing. More recent queries relate to service recovery and to reduce workload, we have developed generic advice for application across multiple service areas.
21	Healthcare Associated Infection Appendix-2020-64	**Karen Hamilton:** Final page – the link to CNO letter doesn't seem to work?	**Iris Bishop:** There was a fault with the embedded attachment on the paper received. This has been rectified and the document has been saved as an additional attachment to the paper to ensure it is visible to all.
22	COVID-19 Test & Protect Presentation	**Stephen Mather:** Testing of patients, staff and public is laudable in the pursuit of information. How is this information going to be used in tracing contacts and what measures can be taken to compel people to isolate if found to be a trace contact? Are there sufficient tracers to implement trace and track?	**Tim Patterson:** ***Will be picked up as part of Test & Protect presentation***
23	COVID-19 Test & Protect Presentation	**Alison Wilson:** What will be the process for the Independent Contractors, particularly community pharmacy, who have remained open throughout the last few months. What will a positive test mean for them as it's very difficult for the staff to socially distance? There seems to be conflicting advice – some Boards saying tracking stops at the premises door, others that if staff follow the PPE guidance then unlikely they will be asked to self-isolate.	**Tim Patterson:** ***Can be picked up as part of Test & Protect presentation***

24	Finance Report Appendix-2020-66	**Karen Hamilton:** Recommendations – we are asked to '**Take** Significant Assurance' – a new one on me – presumably not the same as Noting?	**Andrew Bone:** Apologies if this was unclear. I intended to indicate to Board members that – although there are still a small number of adjustments to be finalised – we now have a high degree of confidence that the year-end position for 2019/20 has been delivered. This is consistent with the suggested approach to assurance suggested through the Clinical Governance Committee to specify the "level of "assurance" given
25	Finance Report Appendix-2020-66	**Karen Hamilton:** Page 2 2nd Bullet – how sure are we that this will happen??	**Andrew Bone:** Agreement has been reached subject to confirmation of final costs identifiable against Covid19 – the delay has only been in relation to the broader disruption to normal reporting processes which has meant that costs are only now being finalised. I have discussed this personally with Scottish Government finance colleagues and I do not foresee any issue over this allocation.
26	Finance Report Appendix-2020-66	**Karen Hamilton:** Page 7 – reduction in OATS activity over winter – do we know why? Base budget carried over and relatively mild winter 19/20 equals less spend? Also Brain freeze!!! - Family Health Services?? Page 9 – final Para – please elaborate!	**Andrew Bone:** Income received from patients visiting Borders and being hospitalised/receiving treatment. This is volatile to seasonal trends in general. The OATS activity is relatively small and unpredictable in nature, so we would expect a moderate level of variance from plan in any given year. FHS Income - this is the income received from patients as contributions to their care by Independent Contractors i.e. Dental & Ophthalmic.

27	Finance Report Appendix-2020-66	**Karen Hamilton:** Page 9 – final Para – please elaborate!	**Andrew Bone:** Pay expenditure is slightly overspent before we match against Covid costs. Once we consider where we would expect to receive funding for Covid this results in a broadly breakeven position on pays. The concern raised in the final paragraph is intended to provide a note of caution about taking too much assurance from this position. This isn't a full April report and we won't have a true position until end of June (reporting on 2 months to end May). There are two issues flagged in this paragraph: Firstly, there remains a possibility that the pay expenditure position shown within the report will be adjusted retrospectively in future periods should we identify any savings delivery that has not been highlighted at this stage as a result of the suspension of normal business in relation to Turnaround programme. Secondly, costs are broadly breakeven despite activity being substantially reduced. A wide range of clinical services have been operating on a reduced programme as a result of Covid19 considerations. This includes routine outpatient clinics and non-urgent planned surgery. Despite this, our overall pay costs are in line with budget. There is a concern therefore that when we remobilise services as part of the recovery plans, there will be additional staffing requirements to deliver within the "new normal" operating conditions.

28	Finance Report Appendix-2020-66	**Malcolm Dickson:** On page 8 the table includes a line for 'Board Non-recurring Efficiency Targets' - I'm a bit confused by the entries for this in the Outturn Actual and Outturn Variance columns, should the figure not appear in the outturn actual column with the outturn variance entry blank?	**Andrew Bone:** The transactions underpinning this variance are entirely budgetary in nature. No actual costs/income are reported against this line. The variance represents the difference between the budget and the zero expenditure reported. The "negative" budget figure is set to represent the required level of non-recurrent savings – the reduction from £8.66m (plan) to £5.73m (revised budget) is after adjustment to service budgets to mandated savings schemes, allowing **the residual balance to be reduced.** Although not matched against the target, there is an offset that supports delivery of this figure in year and therefore underpins the board's overall financial balance in 2019/20. The offset occurs predominantly in two lines within the table: firstly, external healthcare providers – where it is noted that expected savings were exceeded in year – and secondly within the "Unallocated funds" line (i.e. board reserves).
29	Performance Briefing Appendix-2020-67	**Malcolm Dickson:** It must be really frustrating for all of those who have put considerable effort into reducing delayed discharges that, following an admirable and steady decline, DDs have resolutely refused to go below 15-20. Of course we would have been delighted with these figures B.C. (Before Covid) but, as our Chair has previously commented, it would be really good to maintain a low level A.C (After Corvid). Is there any speculation as to why we can't reach target zero, or was that just too ambitious a target?	**Rob McCulloch-Graham:** With regards to Delayed Discharges, we almost got to single figures at one stage, but they have stubbornly remained around the 20 mark. A significant proportion of these are awaiting Nursing Care Residential of which we have very few in the Borders. Queens House is our main destination. We progressed a plan to re-open the closed section of Deanfield Care Home with a mixed staff group of carers and nurses from our hospitals and mental health teams. We developed a capacity for 14, but only managed 5 admissions. The model we created

			was still not suitable to fully match the needs of the cohort it was targeting. The work was done at pace, in the context of the CV emergency and will need to be re-visited in light of the ongoing position. We have now closed this facility, however we intend to use the learning and to work closely with Queens House to create the capacity, and provision model required. So I remain optimistic we will get Delayed Discharges down to single figures.
30	Performance Briefing Appendix-2020-67	**Stephen Mather:** As we cautiously move into remobilisation, how are we going to step up surgical procedures to reduce the backlog? Is it time to consider extending the theatre working day to three sessions?	**Gareth Clinkscale:** A Surgery Recovery Group has been established which is being led by our Clinical Director for Anaesthetics. This group is currently planning those changes that need to be made to restart routine activity; can we develop a 'green' protected elective ward, how do we segregate theatre, screening for routine patients, isolation guidance for routine patients and what the service model/workforce model needs to look like to achieve all of this. Changes to the number of sessions is being considered however plans are currently restricted to within the Board's financial envelope hence our capacity for further out of hours working will be limited.
31	Performance Briefing Appendix-2020-67	**Karen Hamilton:** Page 2 Delayed Discharges – disappointing that we cannot meet trajectory – of necessity this must be a joint approach between all parties – patients/families/ NHSB/SBC? Care Homes etc etc – has pandemic given us any pointers/learning on how to improve this?	**Rob McCulloch-Graham/Nicky Berry:** Already answered in previous replies.

32	Performance Briefing Appendix-2020-67	**Karen Hamilton:** Page 3 Waiting times/electives – a reminder from Chairs meeting with Ministers and east Chairs that Golden Jubilee are very keen to undertake work on our behalf.	**Gareth Clinkscale:** Our position remains that Golden Jubilee are looking for Surgeons to travel to provide this urgent activity. We can accommodate this local urgent activity in the BGH at present and so no benefit in sending away. If/when routine capacity is offered then depending on which specialties, we would be keen to explore further. **Cliff Sharp:** Acknowledged; the latest SG Framework for the Recovery of Cancer Surgery makes it clear that use of GJNH is open to Boards if local capacity to deliver urgent cancer surgery in their own "Green Site" or "Amber Zone" is exceeded, alongside private facilities where necessary.
33	Strategic Risk Register Appendix-2020-68	**Stephen Mather:** Each risk has an Executive as responsible lead but, there are clinical risks which cut across the responsibilities of Executives. Would it not be appropriate to share the responsibility of those risks? *Eg* risk 1588 which could be both DoN and MD responsibility and risk 1593 which should have clinical responsibility as well.	**Tim Patterson/Lettie Pringle:** The Lead Executive has a joint responsibility with the risk owner to ensure the risks are appropriately managed. The examples given have lead executives and risk owners that cover these responsibilities e.g. 1588 – lead executive is MD and risk owner is DoN 1593 – lead executive is MD giving the clinical responsibility element to this risk. In addition to this, the Board Executive Team can access all strategic risks held within the risk register.
34	Strategic Risk Register Appendix-2020-68	**Karen Hamilton:** General Comment - Given the structure now in place for Governance Committees to own relevant risks should we be concerned that these Committees have been stood down over Covid and only just coming back into operation.	**Tim Patterson/Lettie Pringle:** Whilst these committees have been postponed due to COVID response, the risks are still being managed by the lead executive and risk owners. The governance committees' role was to be assured that strategic risks are being managed effectively. During the time the governance committees have been stood down, and to ensure resilience, the Board

			Executive Team has been monitoring all strategic risks on a six monthly basis.
35	Endowment Minutes Appendix-2020-69	-	-
36	Board Committee Memberships Appendix-2020-70	**Malcolm Dickson:** I'm happy to agree with the suggestions relating to me. **Sonya Lam:** Approved.	-