BORDERS NHS BOARD: 30 JULY 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
1	Declarations of Interest Appendix-2020-85	-	
2	Minutes of Previous Meeting	-	
3	Matters Arising	-	
4	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** My overall impression is that the Remobilisation Plan is shaping up well and appears to have covered all that it should. Therefore the following comments/questions are more to do with detail than overall direction.	**June Smyth:** Noted thanks.
5	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **Cover Paper** P3. In the section on Equality and Diversity I note that a Health Inequality Impact Assessment was undertaken on the previous mobilisation Plans and that, quite properly, another will be completed for the Remob. Plan. It would be helpful if Board members could have sight of this when it has been done, not least because it seems to be generally understood that C19 has exacerbated some health inequalities, eg digital accessibility for disadvantaged people, and perhaps the very low uptake on Test & Protect may reflect a high proportion of disadvantaged people not coming forward with C19 symptoms for a variety of reasons.	**June Smyth:** Noted we will share HIIA on the remobilisation plan once it is completed.

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6	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **1. Intro** I appreciate we've had the opportunity to comment on this before but reading this again it strikes me that "Examples of the impact of remobilising services within a context of living with Covid-19 are outlined below…" may not be conclusive enough.'Examples' suggests that there are some other impacts which we've not mentioned and, if so, these will be ignored by SG. I realise it's difficult to capture everything but could we include everything we know about, or are there actually no more examples? Or is it the case that our monthly returns on C19 expenditure should cover the full breadth of expenditure and that this therefore just gives a flavour?	**June Smyth:** Noted. Paragraph has been edited to be more definitive.
7	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **3. Partnership** I think the references here to IJB should probably be to the H&SCP.	**June Smyth:** Updated to reflect comments.
8	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **4. High level planning** Winter Plan - perhaps not necessary to mention here, but I'd like to hear some firm commitment to have early and regular consultation with GP representatives since they highlighted a perceived lack of that in the formation of the last couple of winter plans.	**Gareth Clinkscale:** One of the GP sub members has been invited to join this year's Winter Board in additional to the Primary and Community Services Associate Medical Director. This will be a standing agenda on the new (Primary and Secondary Care) Interface Group which meets to consider cross-clinical-area operational and strategic issues.
9	COVID-19	**Malcolm Dickson:**	

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	Remobilisation Plan (Recovery) Update Appendix-2020-84	**5. Applying lessons learned to future C19 planning** P9, first bullet. Might it help to emphasise the variety/breadth of digital connectivity here to break it into three categories?, ie patient-practitioner one-to-one consultation; team and governance meetings; inpatient to family contact while visiting was not possible, via endowment funded devices loaned to inpatients. Also, should we include a bullet on “improved means of communicating with care home managers”? P11, last bullet ’Tracing’ - would establishing a mid to long term service be justifiable if C19 disappears within 18 mths? Could this be a dormant cohort of individual staff members, or is that is what is intended anyway? P14, I note that the NHSB C19 Ethical Advice and Support will provide an oversight of the Clinical Prioritisation process/framework, but shouldn’t there also be an ethics resource at the micro level so that clinicians can get timeous advice on arising dilemmas? Evidence from across Scotland is that Boards have all tackled the ethical element differently, but some provide this kind of operational support which seems to me to be worth attempting.	**June Smyth:** Updated to reflect the feedback. **June Smyth:** Added into the lessons learned section of the plan. **June Smyth:** At the moment we have been asked to plan that this need till continue for at least 12 months. Tracing team is being established to flex between Tracing and additional Health Protection support in recognition of the fluctuating nature of the demand. This will also help build a more resilient level of organisational expertise in this area longer-term **June Smyth:** The Ethical Advice and Support Group is built into the governance arrangements for both the oversight and micro (service)-level clinical prioritisation processes. The practical detail of how to access this needs to be finalised, but it is essential that this support is available and accessed where required.

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10	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **10 Acute** P19, elective surgery will only run at 50% of pre-C19 capacity. Couldn't a 24 hour, or at the very least a 16 hour, shift system allow us to increase that capacity while wrestling with the backlog? I appreciate that this would be disruptive to staff and would require additional pay, but I can't see the elective backlog ever being addressed if operating at 50% capacity. Similar arrangements might also benefit radiology and other diagnostics. P20, 1st para, "..routes of referrals from SAS into ambulatory care as well as other pathways…" - would this include MH & LD patients as suggested recently by SAS, thus relieving the ED of some pressure in that regard? Is this what is meant in the penultimate para on P25? P21 is largely a word for word repeat of P19, likewise P22 repeats the para at the top of P20.	**June Smyth:** The rate limiting factor in theatre capacity is staffing. Stage 1 of the Surgery Recovery plan aims to restart activity through the use of staff within current resources. Stage 2 and further expansion will require resources which will be weighed against other requests for additional resources across NHS Borders services. Recruitment will be required before a step increase can be delivered. Process work is underway which may deliver a gradual increase above the 50% starting level. This applies to Outpatient and Diagnostic workstreams. **June Smyth:** This will be reviewed as part of the "transforming urgent care" piece of work. **June Smyth:** Noted and plan updated.
11	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **12 MH & LD** Congratulations to this Service Area for the transformational use of Near Me - a great example to other services.	**June Smyth:** Thank you for the feedback this will be passed to the service

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12	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **14 Collaborative working** Theatre space at the Steeple not mentioned here. It may be that this private facility will not be able to spare space as they return to something like normality?	**June Smyth:** We are working closely with the Scottish Government team responsible for commissioning Spire capacity for NHS Boards. At present this is restricted to urgent work which we can accommodate locally. We have expressed interest in using this capacity if/when criteria changes.
13	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **14 Collaborative working** Theatre space at the Steeple not mentioned here. It may be that this private facility will not be able to spare space as they return to something like normality?	**June Smyth:** We have expressed an appetite to use external capacity to Scottish Government should this become available.
14	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Malcolm Dickson:** **16 Enablers/Interdependencies** With reference to patient transport, I repeat my earlier suggestion that Endowment Fund support should be sought for transport. It's a perfect example of non-core activity.	**June Smyth:** Noted and this will be considered.
15	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Fiona Sandford:** I agree with Malcolm that the plan is taking shape, however, I think it would be greatly improved by some rigorous proof-reading, always tricky with an evolving document with multiple authors.	**June Smyth:** Noted and proof reading will take place prior to submission

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		For example: elective surgery on p21 repeats what was stated on P 19. Malcolm also refers to other repetitions.	**June Smyth:** Again noted and plan has been updated.
16	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Fiona Sandford:** Like Malcolm, I'd like to know more re the 50% capacity for elective surgery- perhaps we can discuss that in the meeting.	**June Smyth:** See response to Q10 above.
17	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Fiona Sandford:** I look forward to hearing more about timelines- I'm sure these are being worked on.	**June Smyth:** Noted and will be shared in the presentation which will support the Board discussion on Thursday.
18	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Fiona Sandford:** I'd also like to know more about testing- final # p12-access to lighthouse testing capacity is being explored??	**June Smyth:** Narrative in plan extended to provide more detail re this.
19	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Fiona Sandford:** The chart on P24 showing the shift from F2F to other consultations is very enlightening- might other service areas be able to produce similar data?	**June Smyth:** Noted for next iteration of plan as more services develop this model and data becomes available and as a dashboard is developed.
20	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** I absolutely concur with Malcolm and Fiona's comments and would offer my own for Iris to consolidate in due course. Overall a huge amount of work to try and capture the most difficult of activities. Please see my comments below as constructive and an attempt to make this as easy a read as possible.	**June Smyth:** Noted thank you.
21	COVID-19	**Karen Hamilton:**	

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	Remobilisation Plan (Recovery) Update Appendix-2020-84	P3 would it be helpful to include the number of beds reduced as a consequence.	**June Smyth:** Plan updated to reflect this. There have been 29 beds lost due to moving to 4 patients per bay in DME, MAU and Surgery when compared to the pre-Covid bed footprint.
22	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P5 para 2, is this the same group referred to on P16 para 2?	**June Smyth:** Yes. Plan updated to make this clearer.
23	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P6 and 7 final bullet points on both pages - 'providing facilities' is this strictly the case?	**June Smyth:** Yes - this refers to Garden View and Waverley so is correct.
24	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P7 and 9 para 1 and 3rd Bullet point respectively mention reducing delayed discharge – aspirational or a reality??	**June Smyth:** The assumption is that we are still working collectively across the health and care system to reduce delayed discharges especially as we start to prepare to face winter pressures whilst still living with COVID-19.
25	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P12 final sentence spelling error, car(e) home testing	**June Smyth:** Noted and updated.
26	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P13/14 bullet pointed levels – are these in conflict with each other? Which level takes priority?	**June Smyth:** Noted and updated wording of bullet points
27	COVID-19	**Karen Hamilton:**	

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	Remobilisation Plan (Recovery) Update Appendix-2020-84	P14 para 1 under Primary and Community Services – is NHS Borders Recovery Board the same as Recovery Plan Group on P10? The document as a whole would benefit from a sense check to ensure terminology s consistent. In addition a glossary of explanations might help. The easier the document is to read the better? P14 should we mention conflicting demands on PACS premises space wise for clinics etc	**June Smyth:** Noted – yes same group plan has been updated to ensure consistency. A full glossary will be considered for the final iteration of our remobilisation plan. **June Smyth:** This is reflected in the introduction section of the plan where we give this as a specific example.
28	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P16 para 2 – see comment above P5 para 2? P16 final para under Social Care – Care Home and Care at Home Services – should we elaborate on the review process underway?	**June Smyth:** See response to Q22 above. **June Smyth:** paragraph edited to be clearer.
29	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P19 para 4 – sentence doesn't make sense to me?	**June Smyth:** Noted and plan edited.
30	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P21 repetitive from P19 as mentioned by Fiona P21 reduction in DD's as a consequence of increased OT's? Is it that simple?	**June Smyth:** Noted and plan updated. **June Smyth:** Sentence updated to read better, this is an action as part of reduction in DDs
31	COVID-19 Remobilisation Plan	**Karen Hamilton:**	**Cliff Sharp:** MH and LD services were historically combined until around 2003

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	(Recovery) Update Appendix-2020-84	P23 I know it fits our management structure but should we really put MH and LD together? Not sure if it does either patient group any favours.	when they were separated into two distinct Clinical Boards. In subsequent years the LD service felt that it was rarely discussed or highlighted within NHS structures and although it valued its distinct identity, it lost out in terms of NHS development, funding etc. Since both services are integrated and employ psychiatrists, psychologists, nursing staff, AHPs, social workers and support workers in integrated multidisciplinary teams, they have much in common. The opportunity was therefore taken to revisit managerial arrangements in 2012/13 when Simon Burt was appointed Joint General Manager of both MH and LD services, though each retains its own unique identity and character.
32	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Karen Hamilton:** P43 Content with the Finance section albeit relatively high level at this stage.	**June Smyth:** Noted.
33	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Stephen Mather:** I have no further questions	**June Smyth:** Noted.
34	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Bill Brackenridge:** A huge amount of work has gone into this and the plan, overall, seems very plausible - and has obviously taken into account the many challenging objectives set centrally. However, I think it would benefit from some clear forecast of the magnitude of the impact of the plan.	**June Smyth:** Noted thank you. **June Smyth:** We are currently finalising a separate submission to SG on activity levels

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			based on a number of assumptions relating to remobilisation. This will be touched on during the supporting presentation at the Board meeting. The impact on our space requirement to deliver services is still being considered as part of the detailed planning processes underway as we begin to remobilise our services and consider competing requests for space as well as additional resources. The financial impact of responding to COVID-19 and now remobilising our services is still being assessed.
35	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Bill Brackenridge:** It would be helpful to know, for acute services:- • The backlog by speciality - no doubt this would just have to be an estimate • What capacity will look like by speciality compared to pre-endemic capacity • Some estimate of how long each backlog will take to deal with - or, possibly more likely, how unmet demand is going to continue to increase.	 **June Smyth:** This is currently being worked on by the acute team and will be referenced to in the presentation
36	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Bill Brackenridge:** Likewise, for other sectors, it would be helpful to know the extent to which the plan will deal with previous levels of demand. If previous levels of demand cannot be accommodated, it would be good if we could spell out very clearly those services we will not be delivering.	 **June Smyth:** High level project plans have been produced, these are iterative and will be updated- more information to be given in the supporting presentation at the Board meeting.

37	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** The effort to develop these plans is acknowledged and appreciated, so thank you and I recognise that this is an evolving working document.	**June Smyth:** Noted thank you.
38	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** **Section 4: High level planning:** Under the heading of unmet demand. If the Recovery Plan is to be assessed against the areas specified, they have therefore, been identified as priorities but particularly for Long Term Conditions (LTC) such as stroke, COPD, MSK, cancer and heart disease, there is little narrative within the overall plan even for high level plans? Will this develop from an amalgam of service recovery plans?	**June Smyth:** We are currently working with clinicians, managers and planners to determine the likely impact of COVID-19 and lockdown on each of these areas and the necessary changes to service delivery that will be required to support them.
39	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** **Section 5: Applying lessons learnt:** From any of the positive changes, are there any data or measurements for change to support these improvements (recognising that staff capacity to capture data will have been challenging). Have there been any positive changes from a regional perspective?	**June Smyth:** We are in the process of developing local scorecards and await further guidance from SG on this.
40	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** **Section 10: Remobilising acute services:** Page 18, 2nd paragraph. If external funding is secured, how would this be used to increase capacity for elective and outpatients? Is capacity lower than pre-Covid levels because	**Gareth Clinkscale:** Additional funding would be used to increase staffing to increase capacity in both Outpatients and Theatres up until the point that the physical

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		the physical infrastructure limits returning to previous levels or is the capacity issue related to the back log of work or both? Would additional funding be used to fund different working patterns (e.g. evenings/weekends)?	infrastructure and ability to maintain adequate social distancing limits capacity; pre-COVID-19 levels cannot not be attained within the current hospital infrastructure. External provision would then be explored to increase activity beyond this level.
41	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** Page 21: If NHS Borders is unable to return to the pre COVID-19 bed base for unscheduled demand (due to social distancing requirements), there is presumably no option but to increase flow. There are several mentions of the positive impact on increasing inpatient occupational therapy and physiotherapy capacity on flow and discharge. With imminent winter planning, is there a case for proactive recruitment to increase flow?	**June Smyth:** The winter planning board is currently assessing options for addressing our winter pressures. Recommendations will come through our recovery planning process from mid-August relating to this.
42	COVID-19 Remobilisation Plan (Recovery) Update Appendix-2020-84	**Sonya Lam:** **Section 16: Enablers/Interdependencies** Page 39. The Medical education section is welcome. Any narrative on other trainees and students (e.g. Nursing, AHP) particularly with closure of temporary registers for students and the need for HEIs to progress students to complete their practice placements.	**June Smyth:** Thank you for your comments. We will look to updated this for the next iteration of our plan.

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Borders NHS Board Action Point Tracker

Meeting held on 3 October 2019

Agenda Item: Transformation Fund Update

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
13	13	The **BOARD** noted that business cases would be submitted in 2020 to enable long term decisions to be made.	**Rob McCulloch-Graham**	**In Progress:** Scheduled timeline for business cases to be agreed. **Update 05.03.2020:** Mr McCulloch-Graham advised that the intended timeline was for business cases to be submitted to the IJB in March and then where appropriate directions would be submitted to the Board for formal approval. **Update: 02.04.20:** Mr Rob McCulloch-Graham advised that the Integration Joint Board had received papers in regard to the Transformation Fund. The action on the action tracker related to future directions to be brought to the Borders NHS Board which would be in regard to a reduction in beds. Given the current COVID-19 pandemic he was unable to provide a timeline. **Update 07.05.20:** Mr Rob McCulloch-Graham confirmed that directions would not be issued until the autumn.

Meeting held on 2 July 2020

Agenda Item: Performance Briefing

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
15	11	The **BOARD** agreed that the Integration Joint Board would look into the position of delayed discharges across the system and present to the Health Board in due course.	**Rob McCulloch-Graham**	