Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 3 December 2020 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr M Dickson, Non Executive
Mr T Taylor, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Mr B Brackenridge, 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 & Operations
Dr T Patterson, Joint Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & 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
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Infection Control Manager & Laboratory Service Manager
Mrs C Oliver, Communications Manager
Mrs S Horan, Deputy Director of Nursing
Mrs J Stephen, Head of IM&T
Ms S Pratt, Strategic Lead PCIP
Dr K Buchan GP, GP Executive

1. Apologies and Announcements

Apologies had been received from Dr Lynn McCallum, Medical Director.

The Chair formally welcomed Ms Lucy O'Leary, Non Executive member, to her first meeting of the Board.

The Chair welcomed a range of attendees to the meeting including, Ms Jackie Stephen, Head of IM&T, Ms Sandra Pratt, Strategic Lead PCIP, Dr Kevin Buchan GP, Mrs Laura Jones, Head of Clinical Governance & Quality, Mr Sam Whiting, Infection Control Manager and Ms Rachel Pulman, Nurse Consultant Public Protection.

The Chair confirmed the meeting was quorate.

The Chair welcomed members of the public to the meeting.

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. The Q&A would not be revisited during the discussion.

The Chair then announced that a short private meeting would be held at the conclusion of the public meeting to consider a matter classed as "person identifiable".

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 was an executive member of the Board of Northumberland Health Trust.

Ms Sonya Lam declared that her partner was appointed a temporary specialist adviser to the Scottish Government.

The **BOARD** noted the declarations by Mr Malcolm Dickson and Ms Sonya Lam as per the Board Q&A document.

The **BOARD** approved the inclusion of the declaration of interests for Mrs Lucy O'Leary in the Register of Interests.

3. Minutes of Previous Meeting

The minutes of the previous meeting of Borders NHS Board held on 24 September 2020 were approved.

The minutes of the Extra Ordinary meeting of Borders NHS Board held on 22 October 2020 were approved.

4. Matters Arising

4.1 **Action 13:** Mr Rob McCulloch-Graham confirmed that given the continuing pandemic a target date of April 2021 was likely.

4.2 **Action 15:** The Chair confirmed for clarity that it had been agreed outwith the meeting that the Board would look for a further report at this meeting on delayed discharges. However, she had agreed with the Non Executive members that it would be too soon to get a full and accurate comprehensive report (including the analysis of the Grant Thornton Audit report) so the matter had been remitted back to the next Resources & Performance Committee meeting. Therefore the action would be closed on the action tracker for the Board.

The **BOARD** noted the Q&A.

The **BOARD** noted the action tracker.

5. Laboratory Information Management System (LIMS)

The **BOARD** ratified the recommendation from the Resources and Performance Committee to approve NHS Borders continued participation and commitment to the national Outline Business Case for a LIMS as a committed partner in the procurement and development of the Final Business case.

6. Name Change for Melburn Ward

The **BOARD** ratified the decision of the Board Executive Team to approve the name change of Melburn Ward to Borders Specialist Dementia Unit.

Mr Tris Taylor commented that as a general observation it might be helpful for people if there was a general principle about descriptive names for locations to enable people to navigate successfully through complex sites.

7. Road to Digital 2020/21 Update

Mrs Jackie Stephen provided an overview of the content of the paper and commented that due to the impact of the Pandemic, IM&T had redirected their services to support the organisation to respond to the Pandemic through rolling out MS Teams, Office 365, Near Me and building and providing equipment to enable staff to work from home. That redirection had impacted on IM&Ts ability to take forward its planned programme of work. She advised that there were challenges with network performance and GP wifi, however the main issue of skills and capacity remained. Contract resource had been brought in to take forward as much work as possible in the last 4 months of the financial year. In looking forward and planning for the next 3 years, she advised that a new Digital Strategy would be commissioned and a detailed work plan for the next 12 months was being finalised.

The Chair enquired about the 100 waiting requests. Mrs Stephen commented that time was a factor and for some programmes, such as Diabetes Testing on Wards, the equipment was starting to fail. She advised that the IT Team spent much time on updating and patching old systems as they posed a potential risk, instead of being able to progress with the transformational IT programme of work.

Mr Tris Taylor enquired if the purpose of the report was to update on the delay with the baseline Road to Digital programme of work or to update on the specific work delivered as a consequence of the Pandemic. Mrs Stephen commented that the report provided an explanation as to why the Road to Digital baseline programme of work had been delayed, and the amount of work undertaken in its stead due to the Pandemic. She further advised that a number of schemes had been closed and there were 3 high risk areas left to resolve.

Mrs Alison Wilson thanked Mrs Stephen and the IM&T Team for all the work they had achieved over the past 9-10 months. She enquired how much investment in digital systems or IT staff would be required to take the organisation forward in the next 2-3 years. Mrs Stephen commented that the programme of work for the next 3 years would need to be analysed to understand the net costs of systems and hardware as well as staff skills and resource. She reminded the Board that the programme for the previous 2 years had cost around £1m in capital and over £1m in staff, resources and services, which had been mainly funded through non recurrent funding sources. She commented that the Director of Finance had agreed to work with her to formulate a solid financial plan going forward.

Mrs Wilson enquired if the current staffing model could be capitalised upon in terms of skill mix. Mrs Stephen advised that the current staffing model was being reviewed in terms of skill mix to ensure the service was not single person dependent.

Mr Bill Brackenridge echoed Mrs Wilson's comments on the fantastic work that IT had achieved over the past few months. He noted that investment in IT over the past few years had been lacking and suggested a step back to look at what IT support would be required in the future, given the move to multiple electronic systems, in order to ensure it would cope in a time of even bigger demand.

Mrs June Smyth commented that it was good to hear the positive messages from the Board for Jackie and her Team. She drew the attention of the Board to the logistics of the work that the IT Team had undertaken and emphasised the complexities involved, especially with ward changes, staff working from home, supporting new technologies and procuring and building equipment.

Ms Sonya Lam commented that she was encouraged by the fact that there was a digital strategy in place and reflected that the Pandemic had shown that it was an enabler for change. It was often difficult to try and transform services through a normal business as usual approach and she suggested in terms of the workforce, as people were able to work from home it might broaden the talent pool available to the organisation.

Mr Ralph Roberts also thanked Mrs Stephen and her team for their work during the pandemic and referred to the conversation regarding investment. He reminded the Board that the level of capital investment available to the NHS across Scotland for the next 5 years was significantly over committed. He recognised that there would be a need to reprioritise schemes locally which would have an impact on all aspects of the capital programme.

Cllr David Parker commented that Scottish Borders Council (SBC) had made progress with IT through out-sourcing to CGI and he suggested in light of SBC's investment in CGI, both organisations could think about how to maximise any joint working opportunity, as well as understanding what a strategic partnership might look like. He recognised that respective governance and national NHS funding processes were different, but commented that they should not stop the ability of making systems work for the partnership. Mrs Smyth referred to the joint strategy for health and social care as outlined by Mrs Stephen and said that it would be revisited.

Mr Taylor enquired if IT was sufficiently recognised in cross functional transformation plans, given it was one of the key levers to deliver the transformation of services and efficiencies. The Chair commented that IT was linked into looking to the future.

Mr Andrew Bone commented that the Chief Financial Officer of Scottish Borders Council had been in contact with him in regard to CGI and he would discuss further with Mrs Stephen outwith the meeting.

Mrs Stephen thanked the Board for their support of the IT staff and for the interesting discussion. In regard to joint working she advised that she would be exploring that further along with the NHSS national products as well as the new Health and Social Care digital strategy.

The **BOARD** noted the Q&A.

The **BOARD** noted the progress against the plan and improving position in relation to infrastructure risk.

8. COVID-19 – Remobilisation Resurgence

Mrs June Smyth provided an overview of the content of the paper and highlighted: the 2 outstanding actions from the remobilisation plan; an update on resurgence plans; the winter checklist; vaccination programme; and the advice received from the Scottish Government in regard to there not being an annual operational plan for 2021 given the expected continuation of the pandemic. Mrs Smyth further commented that whilst remobilisation planning had been challenging, resurgence planning was more complex especially given the logistics of vaccination requirements.

Further discussion focused on: recognising and planning for the challenges ahead; openness and clarity of communications issued; commencing the vaccination programme and the associated logistics for transporting and the timeline for receiving further supplies; 45364 people vaccinated with the flu vaccination; and the expectation to extend testing arrangements for patients coming into hospital, hospital staff and care staff, until the pandemic has abated.

The **BOARD** noted the Q&A.

The **BOARD** noted the update on the COVID-19 Remobilisation (Recovery)/ Resurgence Plans.

9. Primary Care Improvement Plan (PCIP) Update

Ms Sandra Pratt and Dr Kevin Buchan provided an overview of the content of the update and highlighted: that the PCIP Executive Committee had continued to work throughout the COVID-19 pandemic; recruitment that had been challenging had improved over the previous 2 months for first contact physiotherapist and Associate Nurse Practitioner (ANP) posts; an ANP mentorship programme had been put in place for trainee ANPs; and a new primary care mental health service had been developed through utilising Action 15 funding and there would be on-going monitoring and oversight of the service.

Dr Buchan emphasised that the commitment to the PCIP had been significant throughout the pandemic and had elevated the Scottish Borders up the league table compared to other Board areas. He was awaiting a new national document which was expected to announce a slippage of the contract over a period of 12-18 months as well as some additional funding, given the impact of the pandemic. The slippage would enable further services to be developed and the contract to then be fully completed. He highlighted that the original contract end date of 31.03.2021 had always been ambitious.

Mr Tris Taylor enquired how GPs felt in terms of whether they were being released to focus on their role and any feedback from other primary care staff on the new ways of working that would be initiated through the contract. Dr Buchan commented that the contract was looking for GPs to develop into medical expert generalists and the current conditions were conducive to that ideology. He advised that there were other services that operated from GP Practices and the essence of the contract was the right thing for GP services in the future to be part of multi-disciplinary teams within Practices.

Ms Pratt commented that it had been a challenge to enable services to see how big a change and opportunity it was for their professions. Much work had gone into developing different career structures and developing the community model. The ethos was about delivering services to people in the community through linked up primary care services instead of via a central clinic and acute services. She advised that all posts were permanent and funded at 52 week cover.

Mrs Alison Wilson welcomed the paper and suggested it could be more positive in its narrative. She enquired about the funding figure of £1.9m and £400k shortfall and also there were benefits to the GPs in going forward and if so how they would be quantified.

Dr Buchan advised that the figure of £1.9m was an educated guesstimate of the further additional resources that would be required to fully implement the first phase of the contract. This had been done like all other Boards to set out the extra money required and the quantum had come back in line with our NRAC share. While the figures were not perfect they were a good starting point. In terms of quantifying measures, there were no explicit measures stated in the contract however, he suggested GP behaviours, recruitment and retention, less early retirements, and less burnout would be reasonable assessments of the success of the contract. He suggested measures would be put in place in terms of staff performance and impact on patient wellbeing in the first instance.

Mr Rob McCulloch-Graham congratulated Dr Buchan and his GP colleagues who were involved in the PCIP. He advised that partnership working with GPs had been assisted through the formation of the GP Executive which had both GPs and Executives involved and had brought a pragmatic leadership to the table. In terms of scale he commented that it was a £3.2m investment with 70 new staff appointed in the heart of communities.

Ms Sonya Lam enquired how much drive there was from Scottish Government in regard to AHPs or pharmacy support in terms of advancing professional practice. Ms Pratt commented that there was nothing explicit from the Scottish Government and support was contained within the contact document and Memorandum of Understanding around the PCIP. There was nothing direct to the professions. Dr Buchan suggested Mrs Nicky Berry might follow up that point outwith the meeting and let him know if there was anything further available.

The **BOARD** noted the Q&A.

The **BOARD** noted the progress of PCIP to date and support the proposal to establish ongoing governance once services are mainstreamed.

10. Finance Report for the period to the end of October 2020

Mr Andrew Bone provided an overview of the content of the report. He highlighted that c.£11m of funding in relation to COVID-19 had been received from the Scottish Government of which £5.6m had been utilised to date in relation to NHS costs: there was an expectation that further funding would follow; the delivery of savings was in line with the forecast identified at Quarter One; and core operational performance had improved as services were no longer running at the level they were pre COVID-19.

The **BOARD** noted the Q&A.

The **BOARD** noted that the board is reporting a £4.73m deficit for the seven months to 31st October 2020.

The **BOARD** noted that the position includes release of £5.59m in relation to confirmed Covid-19 allocation and that this funding is matched to spend incurred to date.

The **BOARD** noted that the performance against core operational budgets continues to demonstrate improvement against forecast at Quarter One review and that the impact of this improvement on the year end outturn position will be considered at Mid Year review.

The **BOARD** noted the position reported in respect of non-delivery of savings (£4.68m) remains in line with the expected position as identified at Quarter One Review.

The **BOARD** noted the adjustments made to Month 7 report to align the year to date financial performance report with assumptions made at Quarter One Review.

11. Quality & Clinical Governance Report

Mrs Laura Jones highlighted a range of quality measures as well as the HSMR and crude mortality rates. She assured the Board that within the context of COVID-19 there remained close monitoring systems in place.

The Chair enquired if any communications had been released to let the public know how to access the revised urgent care arrangements? Mrs Clare Oliver advised that Health Boards had been asked to delay the release of local communications in that regard until after the Scottish Government announcement by the Cabinet Secretary which was due later that afternoon.

The **BOARD** noted the Q&A.

The **BOARD** noted the report.

12. Healthcare Associated Infection Prevention & Control Report

Mr Sam Whiting drew the attention of the Board to page 8 and the reference to infection control spot checks. He spoke of the prioritisation of those spot checks since the paper had been written and assured the Board that full standard infection control precautions audits were being prioritised as they provided a higher level of detail and greater assurance in terms of standards being achieved. He then referred to page 10 and the COVID-19 activity where the last data point on the graph referred to 50 cases. There was a time lag in the data and the confirmed actual figure for that week was 60 cases. Mr Whiting also drew the attention of the Board to infection control team capacity on page 12 and advised that appointment to the vacant infection control nurse posts had been unsuccessful and recruitment to those posts would be re-commissioned. In the meantime short term support to the team would be identified and the qualifications for the posts were being benchmarked and revised in line with the approach in other Health Boards.

The **BOARD** noted the Q&A.

The **BOARD** noted the report.

13. NHS Borders Performance Report

Mrs June Smyth provided an overview of the content of the report.

Mr Tris Taylor recognised that the Resources and Performance Committee (R&PC) would be receiving the full delayed discharges information that had been previously requested, however he wished to clarify that there seemed to be some confusion about his request given he was directed towards previous evaluations which were not a performance matrix. His request had been about the controls on the over-all programme in relation to delayed discharges, which was likely to be more management information and business analysis than an evaluation. He commented that it did not feel like the assurance information that had been previously provided gave an adequate correlation against forward trajectories. He suggested sharing his previous email with Mr Rob McCulloch-

Graham in regard to his detailed delayed discharges queries, to enable granularity to be given to the report to be submitted to the next R&PC meeting.

The Chair commented that it would be helpful for Non Executives to articulate any specific areas of concern they had in regard to delayed discharges directly to her and Mr McCulloch-Graham to enable discussion at the forthcoming R&PC.

The **BOARD** noted the Q&A.

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

14. Child Protection Update

Ms Rachel Pulman provided an overview of the content of the report. She advised that the main priority for child protection in times of COVID-19 was to make sure staff were keeping child protection in mind, recognising the challenges that it posed for children and families to access the service and for staff to see children. She commented that when schools were reopened it had been a great support for children and there had been an increase in referrals for children both due to schools and the national campaign, compared to a significant reduction in referrals at the start of COVID-19.

Mr Tris Taylor enquired about the potential impact on looked after children. Ms Pulman commented that the impact potentially would be a delay in having some of their health needs met in terms of their mental health. Delays to assessments would be the biggest issue, however the majority of children were in foster or guardianship care which ensured their immediate health needs were met.

Further discussion focused on: recognising that the Board received the Annual Reports from the Children Protection Committee and the Adult Protection Committee; and that Ms Pulman was the nurse consultant for public protection and the organisation had adopted the public protection model used by other Health and Social Care Partnerships.

The **BOARD** noted the Q&A.

The **BOARD** noted the update.

15. Area Clinical Forum Update

Mrs Alison Wilson provided a verbal update to the meeting as the ACF had met earlier that week. She commented that the ACF had: been concerned that PMAV training had been suspended; noted that Mental Health Teams had designed new techniques for safe restraint during COVID-19; noted an increase in GP complaints; noted concerns from the Area Ophthalmic Committee that some patients had been advised to return to their Opticians in order to speed up their referrals; noted concerns about the resilience of staff, especially those on the front line, given the winter period and its usual pressures would be further compounded by COVID-19.

Mr John McLaren enquired how the Board had sight of GP complaints. Mrs Wilson commented that quarterly reports were received and Primary and Community Services received an Annual Report. It was also noted that once a year the Clinical Governance report contained an annual report on GP complaints.

The **BOARD** noted the update.

16. Public Governance Committee Update

Mr Tris Taylor commented that there was an opportunity for the Board to consider how to create conditions to support public governance progress, through supporting the introduction of adequate assurance information systems, data literacy and cultural quantification. He would be speaking with officers in regard to ideas to take forward the development of an organisational approach to engagement.

The **BOARD** noted the Q&A.

The **BOARD** noted the update.

17. Clinical Governance Committee Update

The **BOARD** noted the update.

18. Staff Governance Committee Update

The **BOARD** noted the update.

19. Resources & Performance Committee Update

The **BOARD** noted the update.

20. Consultant Appointments

The **BOARD** noted the new consultant appointment.

21. Endowment Fund Board of Trustees minutes: 10.09.2020

The **BOARD** noted the minutes.

22. Resources & Performance Committee minutes 03.09.2020

The **BOARD** noted the minutes.

23. Clinical Governance Committee minutes 29.07.2020

The **BOARD** noted the minutes.

24. Staff Governance Committee Minutes 18.08.2020

The **BOARD** noted the minutes.

25. Public Governance Committee Minutes 04.02.2020

The **BOARD** noted the minutes.

26. Area Clinical Forum Minutes 23.06.2020

The **BOARD** noted the minutes.

27. Scottish Borders Health & Social Care Integration Joint Board minutes 19.08.2020, 23.09.2020

The **BOARD** noted the minutes.

28. Any Other Business

There was none.

29. Date and Time of next meeting

The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday 4 February 2021 at 9.00am via MS Teams

The meeting concluded at 10.55am.

Signature: ……..
Chair

BORDERS NHS BOARD: 3 DECEMBER 2020

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Appendix-2020-108 Declarations of Interest	**Malcolm Dickson:** Because external healthcare providers and purchasers are mentioned in the Finance Report I declare that my sister-in-law is an Executive member of Northumberland Health Trust Board.	**Iris Bishop:** Thank you Malcolm I will note in the minutes.
2	Appendix-2020-108 Declarations of Interest	**Sonya Lam:** I declare my partner is a temporary specialist advisor for the Scottish Government	**Iris Bishop:** Thank you Sonya I will note in the minutes.
3	Minutes of Previous Meetings 24.09.2020	**Karen Hamilton:** item 13 - Penultimate para, did the meeting of palliative care models with Dr McCallum take place? Item 14 – second para – were the two IC posts filled? Item 15 – final para – let's not lose the idea of links between IJB and Public Governance	**Ralph Roberts:** see update from FS below **Sam Whiting:** If the IC posts referred to are the Infection Control posts then, 'no' - these posts remain vacant and are being re-advertised after the shortlisted candidates withdrew prior to interview.
4	Minutes of Previous Meetings	**Fiona Sandford:** Fine NB Lynn and I chatted over teams on Palliative Care models	**Ralph Roberts:** Agreed
5	Minutes of Previous Meetings	**Sonya Lam:** 4.1 Minute 5: COVID-19 Re-Mobilisation Plan (Recovery). I note there is nothing on the risk register for unmet demand and that risk had not been quantified. Should this be captured in one of the existing strategic risks (1588?) that the Clinical Governance Committee oversees in relation to patients and clinical activities?	**Ralph Roberts:** As June Smyth has been on Annual Leave I would be happy to take the suggestion on board.
6	Matters Arising	**Karen Hamilton:**	**Rob McCulloch-Graham:** Action 13.

		Action 13 – can we identify a date yet when this will be actioned? Either way can we record this please. Action 15 – update required see Action 9 below Action 9 – R & P action included here for completeness. I would like some suggestion and agreement as to how we should action track this matter going forward as it is getting confusing!	This action originated before the Pandemic, and was related to agreements made by the IJB in February and March of this year, for the investment of Transformation Funding. There was an expectation that these investments would lead to further "Directions" from the IJB relating to the future number of hospital beds, care beds and home care. Changes required in both health and social care due to Covid 19 and the National Review of Social Care due to report in January we expect major changes to be required for future provision. We do not therefore expect the IJB to be in a position to determine its future commissioning plans, until further modelling and planning around both hospital care and social care are complete. This will not be achieved before April of 2021. **Rob McCulloch-Graham:** Action 9. The letter I received as IJB CO, from the Chair and CEO sought to clarifying the request as to what this report should provide; 1. a clear Action plan, an updated trajectory for improvement 2. whether further action is required in relation to the availability of resources to support improvement

			3. any further directions that the IJB may want to make 4. report on the reasons behind individual delays and the impact this is having on the time patients wait to be discharged. Point 2 is being addressed by the IJB on December 16th. Point 3, has already been addressed in the decisions of the March IJB and in the reply to action 13. There are no further "directions" required for the Delayed Discharge programme. NHSB Audit Committee on the 14th December will receive a report from their Internal Auditors, Grant Thornton examining why the good performance at the beginning of the pandemic has deteriorated. This report and the appended action plan addresses the remaining. I would suggest that this report and the outcome of the NHSB Audit Committee be reported to the next R&P committee. Recognising that Delayed Discharge is an accountability, shared across NHSB, SBC and the IJB, I would suggest this report is a shared report. **Ralph Roberts:** Suggest we note that R&P Committee has asked for update and Board agree this is appropriate and R&P committee

			will escalate to Board if required. Also to note that Audit committee will receive the audit report and can escalate of not assured that action plan is in place and R&P Committee update is not adequate. The Board will see progress with outcome in future performance reports. On that basis would suggest this action can be closed.
7	Matters Arising/ Action Tracker	**Fiona Sandford:** Action 13 – would be good to see a definite time line	**Rob McCulloch-Graham:** See reply above in 6
8	Appendix-2020-109 Laboratory Information Management System	**Karen Hamilton:** Noted. **Malcolm Dickson:** Content to agree **Fiona Sandford:** Noted	**-**
9	Appendix-2020-109 Laboratory Information Management System	**Sonya Lam:** Happy to approve	**-**
10	Appendix-2020-110 Name Change for Melburn Ward	**Karen Hamilton:** Exec summary , bullet point 6 – surprising statement but it does underline the issue – we should always challenge assumptions! Do we know how this ward came to be called Melburn? General comment – the Exec Summary should be a brief précis of the paper – in this case the narrative is simply a repletion of the Exec Summary.	**Nicky Berry:** We do not know how this ward came to be called Melburn. Enquiries are ongoing **Nicky Berry:** noted
11	Appendix-2020-110 Name Change for Melburn Ward	**Malcolm Dickson:** Content to agree. Abbreviation should be BSDU rather than BDSU.	**Nicky Berry:** agree BSDU (Borders Specialist care Dementia Unit)
12	Appendix-2020-110	**Fiona Sandford:** Fine	**-**

	Name Change for Melburn Ward		
13	Appendix-2020-110 Name Change for Melburn Ward	**Sonya Lam:** Happy to ratify the change of name. Will there be associated communications/media awareness raising?	**Nicky Berry:** yes – team have been asked to contact Comms to take forward once agreed.
14	Appendix-2020-110 Name Change for Melburn Ward	**Tris Taylor:** In favour of the clarity provided by a descriptive name.	**-**
15	Appendix-2020-111 Road to Digital 2020/21 Update	**Karen Hamilton:** Exec Summary – second para – I don't understand the concept of 'resound', what does this mean? Covid response section – the volume column is not hepful unless we have some base line dat – eg 'rolled out to 3644 users' out of how many? Current programme status section – para 3 – these timescale sa re very short – are they achievable? Para 7 – risks associate with not taing forward these aspects of the programme?	**Jackie Stephen:** Sorry should read 'respond' That is 100% of all users who have a windows account for MS Teams There isn't really a baseline for the other aspects as no target. Highly unlikely we will meet end January for W10 replacement though we will explore if possible – it will mean paying for the additional extended support mentioned. I am flagging the problem and what we might be able to do so there is some awareness and no complete surprises. Relates to 1. GP Order Comms – risk is that new CTAC centres will operate less efficiently – continue with risks associated with order & results reconciliation in GP Practices. 2. ECasenotes – continue to rely on paper and high costs associated with that. No savings opportunities to reduce staffing

			and increase in storage & retrieval costs.
		Mitigation section – first sentence doesn't make sense?	Yes – sorry too much haste – we will prioritise high risk items and mange across the plan as best we can – where we can't we will flag to the Bard and ensure on risk register.
		General comment – this paper (and others) would have benefitted from numbered section to make commenting easier and despite these points made IM&T staff should be commended on the work they have completed over this difficult time.	Accept that and apologies for poor quality of this paper. Thank you
16	Appendix-2020-111 Road to Digital 2020/21 Update	**Malcolm Dickson:** Again very happy to acknowledge flexibility and commitment of IMT management and staff in responding to C19. Also pleased to see "the team are working on a refreshed plan for the next three years, clinical and organisation prioritisation of the schemes and a review of scope and governance. Once this is complete a new plan and proposal will be brought to the Board early in 2021." Not sure what this means: "There is a key dependency on a second resilient facility location being identified to mitigate the single data centre but interim mitigation allows the programme to continue". I thought we had just created a second resilient facility location? Or was that for existing systems only and we need something else for RTD products?	**Jackie Stephen:** Thank you This is my error in editing an older paper – that sentence on resilient facility shouldn't be part of this paper – the facility is now live with the final bits of work for connectivity planned. I'm really annoyed at myself for not reviewing well enough – sorry --- Jackie
17	Appendix-2020-111 Road to Digital 2020/21 Update	**Fiona Sandford:** As the Flu Vacs are listed as an in-flight project, what about IM&T's role in preparing for Covid vacs? Concerning to note that support for current Windows	**Jackie Stephen:** The team built clinics in EMIS web and provided support with design of the solution to fit the business process, facilitation and training for staff. Also supply of

		version runs out in January – would be good to know more about how we mitigate this risk, and associated costs	devices where needed. Mitigation will most likely be to purchase additional extended support for security patching. Costs are being finalised, but best guess currently £40,000
18	Appendix-2020-111 Road to Digital 2020/21 Update	**Sonya Lam:** Well done to the team for the progress made in these challenging circumstances. I welcome the work on a refreshed plan for the next three years and understand the need to prioritise schemes but wonder what our vision is for digital and whether we need a digital strategy to guide how our future plans meet our aspirations.	**Jackie Stephen:** Thank you The Road to Digital Programme Board is reforming and has recognised the need to for a Digital Strategy – we are preparing a proposal to seek consultancy to support us with that work over the next few months.
19	Appendix-2020-111 Road to Digital 2020/21 Update	**Tris Taylor:** P4 'Mitigation' first sentence seems incomplete. The paper is descriptive and mostly qualitative, please could we see clearer quantitative information/visualisations of actual v baseline/baselines?	**Jackie Stephen:** Sorry Tris, see my answer above regarding my shoddy editing. See my answer above re baseline for MS teams – there were no real targets for the Covid work just getting it out to those who identified a need – very much working through as it evolved. – There were no installations of Teams prior to Covid work and a very small number of services on Near me – I can get that for you before the Board.
20	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Karen Hamilton:** **Exec Summary, Up date on Remob Issues**, CPAP – in summary is it correct to assume the issue is with people/staff rather than equipment? Noted it is raised with SG and later in papers, do we have a solution?	**June Smyth:** Yes the issues are around the staffing levels and training needed to be able to carry out this procedure outwith ICU and also the physical restraints of the BGH footprint; we currently have 10 available CPAP machines however the acute team do not anticipate the need for capacity above and beyond 6 patients.

		Preparing for winter section – Appendix 1 is the wrong attachment.	Apologies the correct document is embedded now. Winter Planning Programme 2020-21 -
		Appendix 3 Self Assessment –good to see a preponderance of Green/Amber items generally – well done.	Noted thank you
		Section 5, item 4 – do we have a comms plan as suggested for changes to delivery plan and can you elaborate on the phrase ' Work ongoing for COVID-19 workforce model	Flu Comms Plan in place
		Section 5 Item 8 – comment that there be the usual robust festive weekend plan – should this be enhanced and lesson applied from last year?	Noted regarding lessons learned and we can confirm we do have an enhanced plan this year for the festive weekend.
		Section 5 Item 11 para 3 of response– progress on recruitment to increase capacity in certain locations	We have recruited 8 out of an approved 20 HCSWs so far, they arrive in the clinical areas Monday 7th December. These individual were recruited from people who either supported us with the initial COVID response so were ready to start after some additional training and orientation to clinical areas. We will be appointing the remainder of these posts from interviews that happened week of 23rd November and this week. A risk to this is the delays in PVG clearance at present.

			Recruitment of registered nurses is challenging with no applicants to a previous advert, skill mixing across clinical areas is being addressed to support safe levels of staffing. Noted thank you
		Section 5 Item 11 para 5 of response – accepted. Section 5 Item 14 any issues with the transition?	Work with NHS Lothian and the Regional lab is progressing with the Regional Hub anticipated to be operational by mid January 21. If there is for any unexpected reason a delay then there is the option for the samples to be coordinated by NHS Borders Testing Team however this would require significant additional resource, the IT system described below should avoid the need for this though. National colleagues are making good progress with an IT portal that allows care home managers and staff to book tests. If this is operational before the hub samples will be processed at Partner Labs.
		Section 6 1.2 – when might this be in place?	This piece of work will likely be reviewed following the winter period; this will include scoping of a seven day service. No timescales identified as of yet.
21	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Malcolm Dickson:** Any update on SG response to our CPAP limitations?	**June Smyth:** To date no response received from SG, a further submission to John Connaghan is due 02/12/20 regarding winter preparedness from Jan-Mar 21 this again is asking for us to confirm CPAP capacity which we are

			confirming is 6 (see explanation in Item 13)
		NHS Borders has received a waiting times allocation which is £1m less than was outlined as required in the AOP? Has the impact of this, as detailed in this report, been communicated to SG? If so, was there any response? 6999 outpatients over 12 weeks and 1561 inpatient and day cases over 12 weeks seems to indicate the risk of harm to a significant proportion of both sets of patients, and that's without any future slight increase in C19 patients in BGH which would add further impact to scheduled care. I'm sure I've asked this question before, but will ask it again because the answer is not clear in the report - does the Integrated Winter Planning Board contain sufficient representation from GPs, who are crucial to success? And how do we know we have their buy-in?	NHS Borders along with other boards submitted our breach projections in October 20, we also submit planned v actual activity to SG on a monthly basis, and the acute team continue to clinically prioritise patients. No feedback has been received to date. Kevin Buchan, Chair of GP subcommittee is a member of the Integrated Winter Planning Board. In addition, a winter bid for Near Patient Testing was approved by the Board and is in the process of being rolled out across 10 of the 23 GP practices - due to funding constraints we were not able to role this out to all 23.
22	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Lucy O'Leary:** Winter preparedness self-assessment part 6 (Respiratory Pathway): Is planning for respiratory service being influenced by prospective demand from "long Covid" patients? (Recognise that this is early days so unlikely to have detailed demand modelling for this – but are the links in place to gather and use intelligence as it emerges?)	**June Smyth:** Long Covid' and the sequelae of Covid affect people in multiple different ways and across a range of clinical specialties. To help the Board develop the most effective services to support ongoing care for people following Covid, we are establishing a Covid clinical network. This will be led by a Covid Clinical Lead who will be an existing clinician with an interest in Covid with dedicated time to bring together all relevant clinical teams, develop protocols and advise the Board on the most appropriate ways of supporting patients. The post is currently

			being recruited and we would hope to establish the network in January. Covid Clinical Network and Clinical
23	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Fiona Sandford:** Assume that CPAP issue is of staff expertise? I don't think we have the correct appendices – we seem to have 2 copies of our response and not the letter from JC. Difficult to get to grips fully with the costing shortfall without sight of both letters. I find the plans for the Covid vaccine roll out a little thin – I know there are a lot of unknowns and I hope more detailed plans exist? I find the code names for the vaccines a little odd – I realise there may be a whiff of commercial sensitivity but the media are all over which vaccine is which… Would be good to know a little more about 'lessons learned' from the flu vaccine and what will change Good to see a good number of green RAGs and no red!	**June Smyth:** Please see response in Question 13 Apologies correct document is now embedded in Question 13 Overall our flu campaign this year has been very successful with over 45,000 people vaccinated to date. Our DN teams have managed a significant caseload and our community clinics were well run and managed. There were a number of small changes made to community clinics throughout phase one and those changes will continue to be applied for future flu phases and the covid vaccination roll out. With regards to the planning for the covid vaccination roll out there will be a small number of community clinics in wave 1, however the majority of people in wave 1 will be seen through OH settings and at their place of residence. Key learnings that have been taken from

			phase one of flu were that the distribution of letters needs to be managed differently and that we had under estimated the capacity needed in our booking hub. We have now increased capacity in our booking hub and are in the process of implementing a phone solution to help manage demand. Letters will also be issued differently moving forward with us having local control over how many letters are released and when they are released. As the Covid vaccine is a new vaccine that requires specific handling there are a number of additional precautions that need to be taken and requirements that need to be met. While lessons learned from the flu programme are important these requirements are a determining factor in our planning for the roll out of the vaccine.
24	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Sonya Lam:** Page 49: CPAP and associated workforce capacity. If patient outcomes are effective when proactively managed with CPAP, can there be greater workforce flexibility between CPAP in ITU and CPAP out of ITU, as there may be patients who require CPAP for a short period where their acuity doesn't warrant the full support of ITU. Have respiratory physiotherapists been included as part of the workforce capacity? Waiting times: I realise the risk of harm cannot be quantified for 6999 outpatients over 12 weeks and 1561 inpatient and day cases over 12 weeks but is there a breakdown of these numbers in terms of priority groupings. What are our mitigating actions?	**June Smyth: CPAP Narrative Provided by Consultant Anaesthetist**- CPAP is a relatively niche therapy for COVID and falls into two groups. The first group is those who are too frail to benefit from invasive ventilation on ITU, in which case CPAP is the ceiling of treatment and this can therefore be provided on ward 5 once the COVID pods are installed. The second group is a small cohort of younger fitter patients who aren't unwell enough to require invasive ventilation but not quite managing without some form of respiratory support. These patients have the potential to deteriorate very quickly are therefore tend to be managed on the ITU. Neither group can be

		What are the key findings of the strategic assessment has been undertaken aimed at identifying our readiness for any resurgence.	predicted to be on CPAP for a short period and we would expect therapy to continue for several days once commenced. We don't anticipate the number of patients requiring CPAP to be large. Ward 5 has always provided CPAP therapy prior to COVID I would only expect to be providing CPAP in large numbers if we had a third COVID wave at least the magnitude of the first wave in April, in which case ITU is likely to be at- or over-capacity and providing ITU staff to help on ward 5 will be difficult. Instead it would be appropriate to assess each patient and place them in the most appropriate unit (ward 5 or ITU). Lacking staffed beds on ward 5 may mean we take the patient to ITU rather than move staff to ward 5, or vice versa. Respiratory Physiotherapy is provided on all BGH inpatient wards as required. Physiotherapy workforce takes a whole-system approach providing specialist input on a clinically prioritised basis. Discussions between the Associate Director of AHPs and the Acute Services Quadrumvirate are ongoing to ensure appropriate levels of physiotherapy staffing are present in critical care and downstream wards in line with Physiotherapy escalation plans and triggers. The waiting times are broken down into P2 (within 1 month), P3 (within 3 months) and P4 (longer than 3 months). P1 Patients being

			emergency not electives. We have taken the view that we need to primarily design the elective surgical service to perform surgery on P2 patients within the appropriate time frame, and we need to have objective tools to move patients between prioritisation groups should their condition change so that if routine patients become more urgent then they can be escalated and get surgery within the appropriate time frame. This is overseen by a prioritisation group comprised of senior clinicians and service managers who monitor waiting times and waiting list size, and can reallocated theatre sessions to allow urgent cases to be completed when required. There is an acknowledgement that the waiting time for P4 patients will be long. Communication has been sent to patients and we are looking at alternative solutions to try to address this We have now concluded the strategic assessment and are in the process of transferring the risks identified to the strategic risk register and developing lessons learned report.
25	Appendix-2020-112 COVID-19 Remobilisation Resurgence	**Tris Taylor:** Appendices: Letter to John Connaghan: is undated. - Section 'Funding': can we see a summary of options for cost containment?	**June Smyth:** Noted thank you **Andrew Bone:** At this stage we are not anticipating that there will be a requirement to introduce actions to reduce the overall cost of

			the plan. As described in the paper, the confirmed resources of £0.9m leave us with a gap of £0.56m against the plan. Following confirmation of SG allocations for Covid we have reviewed the overall resource plans against our Q1 review forecast and we anticipate that we will be able to manage the shortfall through release of additional non-recurrent flexibility in year. This is achieved through a combination of IJB reserves (carry forward of balances not spent in relation to 18/19 winter plan) and offset against core service under spends.
		- Letter section 'Summary of Winter Plan': as far as I remember, the IJB Discharge to Assess direction was made in 2017 in advance of winter 2017/18; on the face of it it would seem if NHSB is only now introducing a related policy that its implementation has taken a long time. Would be grateful to understand more about this.	**Rob McCulloch-Graham**
		Out Of Hours RAG table section 9 has a typo.	Noted thank you
26	Appendix-2020-113 PCIP – TO FOLLOW	**Sonya Lam:** Page 18/19. With the challenge around premises and sufficient accommodation, has or will digital technology been an enabler with remote consultations? Will the new model around 111 introduced this week have an impact? Page 54. I welcome the Health Inequalities Impact Assessment. In the section on 'How will the programme impact on the causes of health	**Ralph Roberts:** Yes, in the right clinical circumstances; Impact of change in Digital use will be factored into planned review of Primary care premises that is just commencing using external support. Impact on PC will need to be monitored and assessed as new model is embedded;

		inequalities, why is this section N/A? I would have thought there would be an impact on access to services	
27	Appendix-2020-114 Finance Report	**Karen Hamilton:** Noted. **Malcolm Dickson:** Noted. **Fiona Sandford:** Noted.	-
28	Appendix-2020-114 Finance Report	**Sonya Lam:** I understand that the underspend in core operational performance (£3.85m in M7) would be reflected in an improvement to the year-end forecast but can we prioritise this financial improvement against, for example addressing our challenges with waiting times. I realise this may be a simplistic view and know that there are other factors impacting on our ability to address our performance such as vacancy levels or C-19 restrictions but are there plans in place to use funding in part to mitigate our clinical risk? What is causing the emerging levels of staff vacancy?	**Andrew Bone:** Unfortunately the resource constraints in delivering improvement are largely in relation to physical infrastructure and workforce – finance is not currently the rate-limiting factor. We do however continue to seek options to mitigate deterioration in access performance and to support clinical remobilisation and risk management. To the extent that this is achievable, financial resources are being prioritised to this objective in year. It is likely however that the impact of winter on Acute capacity will mean that options for delivering improvement in the current financial year are limited. The increase in staff vacancies is to some extent an artefact of the increase in workforce demand – i.e. we are not seeing a reduction in staffing, rather it is an increase in the number of posts we wish to fill. The core vacancies are – for the most part – arising because staff are being deployed to high priority services introduced as part of the Covid19 plan.
29	Appendix-2020-114 Finance Report	**Tris Taylor:** Could you point me toward documentation on the reserves? I am likely to have missed things while on leave. Thank you. If it's just a terminology change from 'contingency' I understand.	**Andrew Bone:** Yes, apologies – this is the case. The only 'general' reserves are the board contingency, of which £1m has now been released recurrently against planned savings delivery in line with the financial plan.

30	Appendix-2020-115 Quality & Clinical Governance Report	**Karen Hamilton:** **Clinical Effectiveness - Reshaping Urgent Care** – plans noted but can we be assured that we have robust baseline data to evaluate improvement as well as patient feedback . In relation to public feedback I am curious to know how well this has been publicised to the public and what impact this might have on them? **Person Centred Care – Complaints** – it is good to see the Flu Vaccination issue highlighted and lessons learned as we move in to the much more complex COVID-19 vaccination programme. **Volunteering –**no thank you event this year bit we have a Christmas Card designed by a child who was a patient in Ward 15.	**Diane Keddie:** We have existing data sets and as we take forward this rapid change, locally datasets are being tested and the national dataset is to be finalised. It is anticipated this will be out to boards in the next week and this will change as the national project develops. The national communication will be launched mid January 2021, locally lead Diane Keddie will be working with the communications team to work through the toolkit. Staff communications have been put out and public communications are in progress. The patient /public feedback process is part of the test of change and is being developed. Self presenters to emergency department given verbal education on the changes to urgent care. National leaflets not available yet but we are reviewing the local information as part of the change.
31	Appendix-2020-115 Quality & Clinical Governance Report	**Malcolm Dickson:** Graph 2 seems to tell us that the death rate for Covid-19 during this second wave is not as high, yet, as during the peak of the first wave. Would the rate of deaths per Covid patient tell us whether hospital care has improved, possibly due to experience and learning, or are there too many other factors which are different this time round (eg increased testing)? Page 4 & 5/ 106 & 7. Very pleased to see progress on BUCC. Early days yet but am anticipating that this will lead a sea change in urgent care flow, and the downstream effects.	**Laura Jones:** It may be too early to say and there are multiple factors to consider in this type of analysis but we will monitor this and bring back any findings we have. The Voluntary Services Manager links closely with Volunteer Centre Borders in delivering our local volunteering programme, they in turn have strong links across the community based voluntary services.

		Page 9/121 Volunteering: does our volunteer service communicate regularly with community-based local voluntary services to promote a joined-up, mutually supportive relationship to the benefit of patients?	
32	Appendix-2020-115 Quality & Clinical Governance Report	**Lucy O'Leary:** Page 8 of the report is missing I think	**Iris Bishop:** We discussed and the full report was made available.
33	Appendix-2020-115 Quality & Clinical Governance Report	**Fiona Sandford:** HSMR – while we know that the main reason for our higher mortality rates is our on-site palliative care unit, it's important that we don't put our higher HSMR rate down to just one factor	**Laura Jones:** Absolutely agree we should not be complacent and we should be rigorous in our approach to the review of deaths. This was considered at Board Clinical Governance Committee who were assured by process underway to review cases of COVID and non-COVID deaths. This will continue under our continual programme of mortality reviews.
34	Appendix-2020-115 Quality & Clinical Governance Report	**Sonya Lam:** I welcome the establishment of the BUCC. COVID Assessment Centre, Borders Emergency Care Service and Ambulatory Care: are all these services being provided as they currently exist with their own staff but from one location or are there moves to look at the totality of what patients and the public require and redesign accordingly? What trajectory would we expect to see in terms of improvement of our performance indicators over what timescale?	**Diane Keddie:** Additional staffing has been recruited to the BUCC including a SCN for a interim period to assist in developing the service. As we learn about the needs and activity this will inform the next steps. The aim is to reduce the self presenter to the Emergency Department (ED) through education of the public and to provide scheduled appointments as well as the increased use of technology when required. The trajectory is difficult to predict as we are into the busiest time of year however I hope we will see a significant reduction in self presenters to ED over the next 3 months. We are monitoring this as part of the change and

			development.
35	Appendix-2020-115 Quality & Clinical Governance Report	**Tris Taylor:** Section 'Person Centred Care' - please could you supply a list of the metrics used to monitor performance in this area.	**Laura Jones:** There are a range of measures relating to: 1. Care opinion stories and criticality levels 2. Feedback obtained from the patient feedback volunteers against the 3 key questions (% patients/carers/family members that felt satisfied with the care and treatment provided, % of patients/carers/family members tha thought staff providing care understood what matters to the patient, % patients/carers/family members that felt they had the information and support needed to help make decisions about their care and treatment 3. Patient experience measures of responsiveness to patient feedback under national complaints measures (can provide full set of national measures as required) 4. Under the Excellence in Care programme new measures are currently being scoped and tested around compliance with 'What Matters to Me' and person centred care planning in adult acute and community inpatient areas
36	Appendix-2020-116 HAI Report	**Karen Hamilton:** **Hand Hygiene** - good to see the escalation process in place – can you elaborate please.	**Sam Whiting:** The revised process is that in week 3 of each month, any area that has not submitted an audit are escalated to the relevant, management quadumvirate to give a window of opportunity to escalate and address

			before the end of the month. This new process commenced in November and there is an early indication of improvement but this will continue to be closely monitored.
37	Appendix-2020-116 HAI Report	**Malcolm Dickson:** Noted. **Fiona Sandford:** Noted. **Sonya Lam:** Noted	-
38	Appendix-2020-116 HAI Report	**Tris Taylor:** In the section on c diff, there's a note saying the baseline year makes it an especially difficult target - interested to understand whether any other categories have especially difficult, or especially easy, targets as a result of outlying baseline years. Hand hygiene - what information do we have, if any, on reported reasons for lower compliance?	**Sam Whiting:** For *E.coli* bacteraemia NHS Borders baseline was a rate of 33.7 compared with a Scottish rate of 38.4. For *S.aureus* bacteraemia NHS Borders baseline was a rate of 17.6 compared with a Scottish rate of 16.8. We do not have data on this.
39	Appendix-2020-117 Performance Report	**Karen Hamilton:** **Delayed Discharges –** note the volatility of the numbers pre and post Covid. Helpful info here which I will refrain from commenting on until we receive the full report on this issue at the next R&P Committee. **Waiting times –** figures are alarming to say the least and I anticipate we may be challenged on these when we report to the Health And Sport Committee at SG on 15th December. Can you assure me that SG are regularly updated with our position (which in truth will be reflected across Scotland). Also how are we preparing our patients and public with this news.	**June Smyth:** Noted thank you NHS Borders along with other boards submitted our breach projections in October 20, we also submit planned v actual activity to SG on a monthly basis, the acute team continue to clinically prioritise patients. No feedback has been received to date. The communication team review the national data releases in respect of waiting time figures and work with the relevant clinical and management colleagues to prepare briefings to

			issue as required; which can include information to staff, media (public) and elected members / MPs / MSPs.
		Acute Programme – could we have comparative date to support the statement 'not to previous levels seen prior to COVID-19' Noted the **final statement** that it has been agreed to stand down Mid Year Report this year – do we have an audit trail for this?	Noted- P&P are meeting with the BI Team this month to review how performance is reported going forward. This was agreed through board agenda setting in November.
40	Appendix-2020-117 Performance Report	**Malcolm Dickson:** Page 3/142 Diagnostics under pressure, affecting urgent cases. I recall that, when we ordered a new MRI scanner, some thought was given to running two scanners simultaneously for a while although this never materialised. Is the new MRI scanner in place and operating? I appreciate that C19 restrictions mean that longer times are required between and possibly during screening, so would it be sensible to reconsider simultaneous screenings with slightly less staffing for each screening?	**June Smyth:** We are securing a mobile scanner to be run as a second scanner to support waiting list backlog and provide additional capacity as to a time when this is not needed.
41	Appendix-2020-117 Performance Report	**Fiona Sandford:** Look forward to a clearer view on DD once we get the full report to R&P I look forward to a discussion on how we manage waiting times given our funding shortfall	**June Smyth:** Noted for both thank you
42	Appendix-2020-117 Performance Report	**Sonya Lam:** Noted	-
43	Appendix-2020-117 Performance Report	**Tris Taylor:** Delayed discharges: firstly, please could you point me to reports mapping delayed discharges against admissions?	**Rob McCulloch-Graham:** Replies to actions 13 and 9 above relate to some of these requests. I will ask that reports are provided to reply to

		Secondly, the supplied information appears (to me, a lay person) to show no sustained correlation between forecast and actual performance. The persistent high variance from forecast suggests planning assumptions and/or performance need to be adjusted. Without detailed qualitative information on forecast and actual costs, benefits and timescales of associated business-as-usual and change programme activity, broken down by workstream and aggregated for the full picture, it is not possible to ascertain whether the Board has adequate controls in place, nor therefore is it possible to make an accurate determination of the level of associated risk. Open actions on the Board and Resources & Performance Committee Action Trackers indicate that there is a demand for this lack of information to be rectified and an expectation that this demand would be met today, but there is not a paper on the agenda. It is important we understand specifically why progress is not being made on providing the requested data; any constraints on its production need to be visible otherwise it is not possible to determine to what extent the deferral of the requested report is warranted.	the first request. There are many factors at play in relation to the causes of delayed discharge, a simple "cause and effect" evaluation would not provide the required insight. The IJB received extensive evaluation reports on the investment decisions on the Discharge Programme in February of this year. A further agenda item is set for the next IJB on the 16th of December which will outline the future proposed evaluation. The discharge programme records a significant amount of information on patient flow and the reasons for delays. Managerial oversight of these outcomes has lead to many iterative changes to the programme. A revised action plan has been agreed across NHSB, SBC and IJB management and is now in place. This will be reported to the forth coming Audit Committees of the NHSB and IJB. These have been operational changes,decided by managers, the overarching strategies agreed by the IJB remain as agreed. With regards to a request for data, greater specificity of that request would help teams focus their reply.
44	Appendix-2020-118 Child Protection Update	**Karen Hamilton:** Penultimate para Training – has there been a decline in accessing training over COVID and if so should we	**Nicky Berry:** Face to Face Multi-agency child protection training has been suspended during Covid. There has been a lot of work

		take action given the concerns raised around stresses within families over lockdown?	progressed by the training and development team to transfer the training onto a web based platform which was delivered to the first cohort in November 2020. There is also an e-learning Public Protection Module (adult/child) that is mandatory for all NHS staff. There has been communication via staff share asking NHS staff to be alert to child protection concerns and how to report them and this message will be continued to be shared. NHS Borders staff can access child protection consultation for the child protection team in respect to individual cases.
45	Appendix-2020-118 Child Protection Update	**Malcolm Dickson:** This is a good update and probably ought to lead to a similar type of report to the Board annually (although without the repeated text next time!). Does the Community Planning Partnership get combined reports on Child Protection? What is missing from this report is data on Health Board referrals (broken down in to those referrals emanating from ED, GPs, CAMHS etc) and the trend in these over several years. Otherwise we don't know if the actions taken have been effective. We all know that information sharing is critical, so it is important for the Health Board to seek assurance that all health professional are applying information-sharing standards and practices consistently. On the same theme, what level of training do ED professionals, CAMHS staff, GPs etc receive on child protection information-sharing, and is this refreshed? Is Child Protection specifically mentioned in the PCIP?	**Nicky Berry:** We would need to clarify in respect to what reports the Community Planning Partnership receive re child protection, we have not been asked to submit a report specifically from health. However there is an annual Public Protection Report that is completed by the chair of the Public Protection Committee which I would expect should be shared with the partnership. We do have data in respect to the source of child protection referrals and subsequent actions, to date this has not been collated into a formal report, but is something that can be reported on moving forward. All NHS staff and GPs can access the Multi-agency child protection training that is delivered on behalf of the Public Protection Committee. NHS child protection team also deliver child protection up-dates across NHS

			Borders. Information sharing responsibilities is included in all training delivered. Conversations have taken place with clinical governance re how NHS Borders ensures that Public Protection is considered a priority across all services and is incorporated into service improvements plans.
46	Appendix-2020-118 Child Protection Update	**Fiona Sandford:** Noted. **Sonya Lam:** Noted	-
47	Appendix-2020-118 Child Protection Update	**Tris Taylor:** P4, first bullet under 'Sufficient prioritisation', final sentence appears to be a note for resolution prior to paper publication. P5, 'A quality assurance framework', first bullet, 4th sub-bullet - 'Neglect and the use of the Neglect' seems like a typo P7, 'Services are in place', second bullet, can the impact of the challenges be quantified please, including any increase/decrease in risk borne by children and/or staff.	**Rachel Pulman:** This was used as a heading to focus what areas NHS Boards have a responsibility for. The information below was to highlight what is in place in Borders to meet this recommendation. Yes, there is missing text, should say Neglect tool kit. The challenges in meeting the recommended 4 week timeframe have been in relation; - staff availability to complete health assessments due to absence and redeployment of staff to support Covid response. - Availability of clinic space and reduced ability to home visit - Families self isolating - Delayed parental consent The 4 week assessment is a holistic health assessment of wider health needs and any immediate health needs would be addressed

			via GP services. 'Near Me' is being used to support the completion of health assessments were appropriate. The Child Protection/LAC Nurses have overview of the children who are LAC and we are able to identify when children have had/not had health assessments and request follow up. There are regular multi agency reviews in relation to LAC and health is a key component of this, and provides an opportunity to ensure that health needs are being met.
48	Appendix-2020-119 PGC Update	**Malcolm Dickson:** Noted. It would be helpful if June Smyth and Rob M-G could perhaps virtually meet with Chair of Public Governance and Chair of IJB's Strategic Planning Group to see if synergies might be created by overlapping models of public engagement.	**June Smyth/Rob McCulloch-Graham:** Agreed
49	Appendix-2020-119 PGC Update	**Karen Hamilton:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
50	Appendix-2020-120 CGC Update	**Fiona Sandford:** A very good summary of our meeting prepared by Laura – Note that a significant number of items also appear in 2020-115 above – perhaps we should work to ensure the Board don't get duplicate information?	**Iris Bishop:** Thank you for your feedback.
51	Appendix-2020-120 CGC Update	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
52	Appendix-2020-120	**Tris Taylor:**	**-**

	CGC Update	Taking an assurance position is a welcome approach.	
53	Appendix-2020-121 SGC Update	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
54	Appendix-2020-122 R&PC Update	**Karen Hamilton:** Noted **Malcolm Dickson**: Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
55	Appendix-2020-122 R&PC Update	**Tris Taylor:** Typo 'complaint' for 'compliant' on Equality & Diversity cell in table	**Iris Bishop:** Thanks I will amend.
56	Appendix-2020-123 Consultant Appointments	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
57	Appendix-2020-124 Endowment Fund minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
58	Appendix-2020-125 R&PC minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
59	Appendix-2020-125 R&PC minutes	**Tris Taylor:** Please could the ToR for the Third Sector Interface Group be circulated as I have not received them (could be an email issue)	**Iris Bishop:** I will chase this up for you.
60	Appendix-2020-126 CGC minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	**-**
61	Appendix-2020-127 SGC minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted	**-**

		Fiona Sandford: Noted. **Sonya Lam:** Noted	
62	Appendix-2020-128 PGC minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	-
63	Appendix-2020-129 ACF minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	-
64	Appendix-2020-130 IJB minutes	**Karen Hamilton:** Noted **Malcolm Dickson:** Noted **Fiona Sandford:** Noted. **Sonya Lam:** Noted	-