Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 7 October 2021** at 9.00am **via MS Teams**.

AGENDA

Time	No		Lead	Paper
9.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	Verbal
9.01	**2**	**DECLARATION OF INTERESTS**	Chair	Verbal
9.02	**3**	**MINUTES OF PREVIOUS MEETING** 02.09.21 Extra Ordinary Meeting	Chair	Attached
9.05	**4**	**MATTERS ARISING** Action Tracker	Chair	Attached
9.06	**5**	**STRATEGY**		
	5.1	Strategic Risk Register Report	Director of Public Health	Appendix-2021-68
	5.2	Regional Health Protection Service	Director of Public Health	Appendix-2021-69
9.30	**6**	**FINANCE AND RISK ASSURANCE**		
	6.1	Resources & Performance Committee Minutes: 06.05.21	Board Secretary	Appendix-2021-70
	6.2	Audit Committee Minutes: 15.06.21, 20.07.21	Board Secretary	Appendix-2021-71
	6.3	Endowment Committee Minutes: 07.06.21	Board Secretary	Appendix-2021-72
	6.4	Financial Performance - August 2021	Director of Finance	Appendix-2021-73
9.50	**7**	**QUALITY AND SAFETY ASSURANCE**		
	7.1	Clinical Governance Committee Minutes: 19.05.21, 21.07.21	Board Secretary	Appendix-2021-74
	7.2	Quality & Clinical Governance Report	Medical Director	Appendix-2021-75
	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2021-76
	7.4	Care of Older People in Hospitals: Update on Falls	Director of Nursing, Midwifery & AHPs	Appendix-2021-77

10.30	**8**	**ENGAGEMENT**		
	8.1	Public Governance Committee Minutes: 23.02.21, 05.05.21	Board Secretary	Appendix-2021-78
	8.2	Area Clinical Forum Minutes: 23.03.21	Board Secretary	Appendix-2021-79
10.35	**9**	**PERFORMANCE ASSURANCE**		
	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2021-80
10.50	**10**	**GOVERNANCE**		
	10.1	Borders NHS Board – Business Cycle 2022	Board Secretary	Appendix-2021-81
	10.2	Consultant Appointments	Director of Workforce	Appendix-2021-82
	10.3	Scottish Borders Health & Social Care Integration Joint Board minutes: 26.05.21, 28.07.21	Board Secretary	Appendix-2021-83
10.59	**11**	**ANY OTHER BUSINESS**		
11.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 2 December 2021 at 9.00am via MS Teams	Chair	*Verbal*

AT THE CONCLUSION OF THE PUBLIC MEETING THE BOARD WILL RECONVENE FOR ANY MATTERS OF RESERVED BUSINESS

Borders NHS Board

Minutes of an Extra Ordinary meeting of the **Borders NHS Board** held on Thursday 2 September 2021 at 11.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Ms S Lam, Non Executive
Ms H Campbell, Non Executive
Cllr D Parker, Non Executive
Mr J Ayling, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr T Patterson, Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mrs N Berry, Director of Operations
Mr A Carter, Director of Workforce
Mrs C Oliver, Communications Manager
Mr C Myers, General Manager P&CS

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Lucy O'Leary, Non Executive, Mr Tris Taylor, Non Executive, Mrs Alison Wilson, Non Executive, Mr Andrew Bone, Director of Finance, Mr Rob McCulloch-Graham, Chief Officer, Health & Social Care and Mr Gareth Clinkscale, Director of Acute Services

1.2 The Chair to welcomed Mr Chris Myers, General Manager, Primary & Community Services to the meeting who would be speaking to the item on Coldingham Branch Surgery.

1.3 The Chair welcomed members of the public to the meeting (Mr C Easton, Mr D Thomson, Ms P Bells, Ms F Clift, Ms E Johnstone, Mr D Jones, Mrs R Hamilton MSP, Ms J Sutton, Ms M Fenty, Mr A McGilvray, Mr N Wray, Ms E Johnstone, Dr K Robinson GP).

1.4 The Chair to confirmed the meeting was quorate.

1.5 The Chair reminded the Board that a series of questions and answers on the papers had been provided and their acceptance would be sought at each item on the agenda along with any further questions. The Q&A would not be revisited during the discussion.

2. Register of Interests

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

The **BOARD** noted there were none.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Borders NHS Board held on 24 June 2021 were approved.

4. Matters Arising

The **BOARD** noted the action tracker.

5. Coldingham Branch Surgery

5.1 Mr Chris Myers provided an overview of the content of the paper. He highlighted: the background to the matter; the public engagement process that had been undertaken; the concerns of the Medical Practice in being unable to sustain dispensing services from the Coldingham Branch Surgery; the site visit undertaken; the correspondence with the practice patients; discussions with Coldingham Community leaders; the review of GP and pharmaceutical service provisions in the area and their potential lose; the recruitment campaigns undertaken to fill staffing vacancies; and the correspondence received from the Medical Practice.

5.2 Mr Myers advised that the GP Sub Committee had noted the Eyemouth Medical Practice situation in terms of sustainability of services in a rural location with recruitment challenges. The Area Pharmaceutical Committee had also considered the provision of services in the context of the Pharmaceutical Care Services Plan and had noted the nearest Community Pharmacy was located in Eyemouth some 3.5 miles from Coldingham.

5.3 Mrs Clare Oliver drew the attention of the Board to section 3.3 of the paper and confirmed that ownership of the building was outwith the scope of the Board as the buildings were privately owned by the Medical Practice.

5.4 Mrs Oliver recorded her thanks to the local community for their contributions to the engagement process. She advised that the scope of the engagement had been based on the Eyemouth Medical Practice sustainability issues and detailed the process undertaken. There had been a consultation period of 6 weeks and scrutiny and advice had been provided by Healthcare Improvement Scotland Community Engagement colleagues.

5.5 The Chair summarised the conversation and gave recognition to: the impact on the local community service users of closing the Coldingham Branch Surgery; the significant impact on the provision of primary medical services to the patient population of 6,500 provided by the small Eyemouth Medical Practice team if the closure did not go ahead; and the potential impact on other Practices if patients had to register with another Practice in Duns, Greenlaw and Berwick. She reminded the Board that the short life working group had reviewed the situation, the evidence and

the consultation outcomes and recommended that the Board support the withdrawal of the dispensing contract and closure of the branch surgery.

5.6 Mrs Sonya Lam commented that she recognised that it was not an easy decision to make in terms of centralising services to Eyemouth and a balance was needed in terms of what was viable. She enquired about any added value in centralising services. Mr Myers commented that the closure would allow the practice to reduce the risk to the practice and the partnership itself and would create more clinical time in the existing workforce to provide direct clinical care to patients. He advised that the Practice had been part of the process and they were looking at a number of mitigating measures for their patients to ensure they would continue to have access to the practice, such as flexibility of appointments for those travelling to the practice on public transport and reviewing the repeat prescriptions process. He emphasised that the Practice were very sympathetic to the situation and were keen to support their patients as best they could.

5.7 Mrs Harriet Campbell commented that there appeared to be a significant number of prescriptions, in the region of 3000 for around 800 patients, and she enquired if some of those patients were suffering from health inequalities and what engagement had taken place with those patients who would be impacted the most by the closure of the branch surgery. She further enquired about what would happen if the Board did not withdraw the dispensing contract and the practice advised that it could not fulfil the contract requirements.

5.8 Mrs Oliver commented that the engagement team were not privy to specific patient detail due to confidential requirements. She assured the Board that the entire practice population has been consulted and access to prescriptions and pharmacy dispensing had been the main theme of the consultation feedback. Mrs Campbell enquired if work had been undertaken on health inequalities and Mrs Oliver commented that a freestanding piece of work on health inequalities was being taken forward.

5.9 In terms of the dispensing contract, Mr Myers commented that the contract could not be surrendered by the Practice, the Board would have to withdraw the contract. If the contract was not withdrawn then the Eyemouth Medical Practice would remain in the current situation with an inability to recruit to a dispensing post and therefore putting the rest of the partnership under pressure leading to a further fragility of primary medical services for the population of the Eyemouth Medical Practice.

5.10 Mr Ralph Roberts suggested that both decisions needed to be separated, one decision was in regard to the dispensing contract and the other was in regard to the closure of the branch surgery. He commented that the dispensing decision was linked to the availability of pharmaceutical services and the branch surgery was a parallel issue. He advised the Board to keep both decisions separate even though they were interlinked.

5.11 Mr Roberts recognised that it was a difficult decision for the Board and there would undoubtedly be an impact from whatever decision was made. There had to be a good balance of risk on the judgement made and when a further discussion with politicians and stakeholders had taken place earlier in the week, views and concerns had been clearly expressed and acknowledged. He further commented that as a Board it had to make difficult decisions and look at matters in the wider

context of the provision of primary medical services and he recommended with a heavy heart that the proposals be supported.

5.12 Mr Roberts emphasised to the Board that it was important to continue to work with the Eyemouth Practice and local communities to identify ways to mitigate any health inequalities impacts as much as possible wherever possible.

5.13 Mr Roberts advised that Mr Tris Taylor had asked that if the Board were supportive of the recommendations, that the Board agree to support work to be taken forward in co-production with the local community and the Eyemouth Medical Practice to assist the patients most impacted by the decision.

5.14 Dr Lynn McCallum reflected the clinicians voice in the matter and advised that she had spent an afternoon with the Eyemouth Medical Practice and it had been evident to her that there had been lots of brainstorming and soul searching by the partners with a desire to deliver the highest and safest clinical care possible to the practice population. The partners had not been able to identify a way to do that safely and effectively. She commented that the partners were deeply unhappy that they were in the position of seeking the dispensing service contract be removed and the branch surgery be closed.

5.15 Mr John McLaren enquired about any provision of pharmacy home delivery services in the area and if the public transport bus timetables could be influenced to assist patients. Mr Myers commented that there was one pharmacy home delivery service in place that was not an NHS service and patients might incur a charge for the service. He commented that the provision of any pharmacy home delivery service would be a business decision for community pharmacies. In terms of public transport, discussions would be taken forward with Border buses to help mitigate impacts on patients where possible.

5.16 Mr James Ayling commented that he agreed with the recommendation to close the branch surgery premises and supported the view on co-production as relayed by Mr Roberts on behalf of Mr Taylor.

The **BOARD** noted the current situation relating to the sustainability concerns of the Coldingham Branch Surgery.

The **BOARD** noted that a Short Life Working Group was established to undertake a review, with the aim of ensuring the safe and sustainable delivery of medical and pharmaceutical services to meet the needs of the Scottish Borders Population in the area.

The **BOARD** noted that following the conclusions of the review, the paper made recommendations on the future provision of services in Coldingham Branch Surgery. The **BOARD** considered and accept those recommendations.

In the context of a lack of appropriate mitigating measures, and due to the potential impacts of sustaining the Coldingham branch surgery and dispensing service on the overall sustainability of the whole of Eyemouth Medical Practice putting at risk the provision of General Medical Services for a much wider population, the **BOARD** supported the recommendations of the Short Life Working Group that:

a) NHS Borders withdraw the dispensing service contract, and;

b) NHS Borders endorse the closure of the Coldingham Branch Surgery.

The **BOARD** agreed that work would be taken forward in co-production with local communities, other stakeholders and sectors to explore ways for the Eyemouth Medical Practice to manage their appointment service to link to those patients who required public transport and for the provision of potential home delivery pharmacy services.

The **BOARD** would monitor progress through it's Action Tracker.

6. Any Other Business

There was none.

7. Date and Time of next meeting

7.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 7 October 2021 at 9.00am via MS Teams.

7.2 The Chair advised that an Extra Ordinary Board meeting would be held on Wednesday 29 September 2021 at 4pm to agree the Annual Report and Accounts.

The meeting concluded at 11.46am.

Signature: ……..

EXTRA ORDINARY BORDERS NHS BOARD: 2 SEPTEMBER 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Declarations of Interest		
2	Minutes of Previous Meetings	**Karen Hamilton:** Noted	-
3	Matters Arising	**Karen Hamilton:** None	-
4	Appendix-2021-63 Coldingham Branch Surgery	**Karen Hamilton:** No further questions.	-
5	Appendix-2021-63 Coldingham Branch Surgery	**Lucy O'Leary:** I am happy to support the recommendation made by the Short Life Working Group as set out in the paper	-

Borders NHS Board Action Point Tracker

Meeting held on 4 February 2021

Agenda Item: Care Of Older People In Hospitals Update

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2	13	The **BOARD** sought a 6 monthly update on Falls.	**Sarah Horan**	**Complete:** Scheduled for the 7 October Board meeting.

Meeting held on 2 September 2021 (Extra Ordinary)

Agenda Item: Coldingham Branch Surgery

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
3	5	The **BOARD** agreed that work would be taken forward in co-production with local communities, other stakeholders and sectors to explore ways for the Eyemouth Medical Practice to manage their appointment service to link to those patients who required public transport and for the provision of potential home delivery pharmacy services. The **BOARD** would monitor progress through it's Action Tracker.	**Chris Myers / Clare Oliver**	

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Keith Allan, Associate Director for Public Health
Author:	Lettie Pringle, Risk Manager

STRATEGIC RISK REGISTER REPORT

Purpose of Report:

The purpose of this report is to update the Health Board of the risks within the strategic risk register

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This report has been approved by Board Executive Team.

Executive Summary:

The Health Board is responsible for ensuring that there is a clear and appropriate management structure for ensuring that NHS Borders has effective systems which enable risk to be identified and decisions to be taken at an appropriate level.

As part of the Board's risk management arrangement, the Strategic Risk Register has been reviewed and updated. Discussions have taken place with each risk owner to identify the current level of risk, current control measures and action which will be taken to reduce/mitigate these risks.

To support the Board in discharging its responsibilities, it has delegated aspects of risk governance to the Governance Committees. Each committee has a responsibility for providing assurance to the Board in respect of the risks that fall within its specific remit. This requires each Governance Committee to use the Strategic Risk Register to consider risks that may require further scrutiny (for example, risks evaluated as very high) and seek assurance from individual risk owners regarding the management of these risks, including the adequacy of existing control measures and progress against any actions required for improvement. This responsibility has sat with Governance Committees since April 2020.

It is anticipated within the coming months for there to be an additional strategic risk documented relating to the outcome of the National Care Service consultation which will identify the potential impact on the future of NHS Borders and the provision of a unified health service, as well as any impact on partnership working. The process of completing NHS Borders response to the consultation will inform the development of the risk assessment.

Impact of item/issues on:	
Strategic Context	To ensure the Board has sight of the risks identified as having an impact on the strategic direction of the Health Board.
Patient Safety/Clinical Impact	Strategic risks that will affect us achieve our corporate objectives such as safe patient care
Staffing/Workforce	Risk management is included in existing managerial duties.
Finance/Resources	By identifying strategic risks to the organisation minimisation of impacts can be implemented
Risk Implications	Strategic risks may exist that have not been identified.
Equality and Diversity	In compliance with equality and diversity
Consultation	Process inclusive of senior risk owners through Board Executive Team

Glossary

Consequence	The outcome of an event being loss, injury, ill health, disadvantage or gain.
Hazard	A source of potential harm or a situation with a potential to cause loss.
Likelihood	Used as a qualitative description of probability or frequency.
Residual Risk	The remaining level of risk after the risk has been managed/ treated.
Risk	The chance of something happening (an opportunity or hazard) that will have an impact (good or bad) upon objectives. Risk is measured in terms of its consequences and likelihood.
Risk Appetite	Risk appetite is a term used to explain what amount and type of risk the organisation is willing to accept or tolerate.
Risk Assessment	A systematic process of evaluating the potential risks that may involve a project activity or undertaking.
Risk Control	That part of risk management, which involves the implementation of policies, standards, procedures and physical changes to minimise adverse risk.
Risk Level	The level of risk calculated as a function of likelihood and consequence.
Risk Management	A systematic approach to the management of risk, staff and patient/client/user safety, to reducing loss of life, financial loss, loss of staff availability, loss of availability of buildings or equipment, or loss of reputation. Risk management involves identifying, assessing, controlling, monitoring, reviewing and auditing risk.
Risk Management Process	The systematic application of management policies, procedures and practices to the tasks of establishing the context, identifying, analysing, evaluating, treating, monitoring and communicating risk.
Risk Matrix	A tool used to calculate the level of risk based on likelihood and consequences
Strategic risk	Risks associated with the strategic direction of an organisation. Strategic risks are often a function of uncertainties that may be driven by government policy, standards, competition, court decisions or a change in stakeholder requirements

Strategic Risk Register Update – September 2021

Understanding strategic risk forms a component part of ensuring that corporate values and objectives are attained.

Strategic risk is defined as: **"*risk concerned with where the organisation wants to go, how it plans to get there, and how it can ensure survival*"**

(British Standards Institute Risk Management BS 31100:2011).

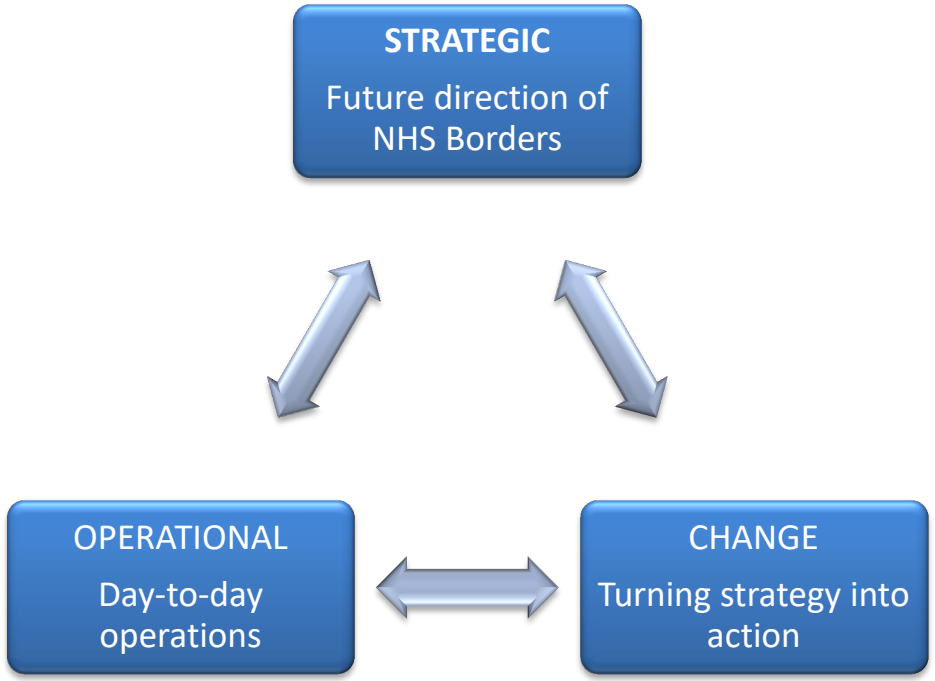


Chart 1: Strategic and operational risk framework

The strategic risk identification closely reflects the corporate direction of the organisation through implementing Board strategies and risks to attaining the Corporate Objectives. BET have a watching brief to identify further risks as strategic issues arise.

The strategic risk register is now held within the electronic risk management system. This allows the risk owners to update risks in real time.

A gap analysis exercise has been carried out on the strategic risk register following internal audit recommendations. This identified a number of new strategic risks, including the eight new risks that are included within this report.

As part of the governance structure for strategic risks, particular risks are fed into each governance committee, as identified by each risk owner:

Audit Committee	Full strategic risk register/ risk management process
Clinical Governance Committee	Risks associated with patients/ clinical activity/ clinical aspects
Public Governance Committee	Risks associated with communication/ engagement
Resource and Performance Committee	Risks associated with finance/ organisational performance
Staff Governance Committee	Risks associated with workforce
Board Executive Team	Risks that require gold command assurance/ crisis risks

Three risks have been removed from the system as part of the gap analysis exercise, two of which have been included as part of wider risk assessments and another which has been removed as it was identified as a historical risk and no longer relevant.

Ref	Lead Exec	Risk	Previous Risk Level	Current Risk Level	Lead Governance Group	Comments
14	Tim Patterson	Coronavirus and COVID19. (ID1682)	Very High	Very High	Board Executive Team	Risk reviewed regularly, current controls maintained
23 NEW	John McLaren	Staff Wellbeing during and post COVID-19 pandemic (ID3915)	Medium	Very High	Staff Governance Committee	Risk transferred from COVID crisis risk register and escalated to very high following escalating risks in staff wellbeing across the health board
18 NEW	Tim Patterson	Reducing the harm from inequalities (ID3129)		Very High	Public Governance Committee	New risk, risk reviewed to incorporate employment inequalities as well as health inequalities
5	Tim Patterson	Failure of Resilience. (ID1592)	High	Very High	Performance and Resource Committee	It is expected the likelihood of this risk will fluctuate, reflecting current operational risks arising relating to day-to-day activities
1	Andrew Bone	Non-achievement of financial targets (RRL and CRL), (ID1589)	Very High	Very High	Performance and Resource Committee	Risk controls maintained
17 NEW	Andrew Bone	Potential to comply with infection control standards and precautions relating to fabric and layout of buildings (ID583)		Very High	Clinical Governance Committee	This risk was previously recorded as a high risk within the operational risk register and was escalated to a very high strategic risk in light of COVID-19
16 NEW	Ralph Roberts	Number of people whose discharge from Hospital is delayed impacting on clinical outcomes (ID398)		Very High	Clinical Governance Committee	Issue remains on going as a consequence of whole system delays in the system and overall service pressures; both NHS Borders and SBC working together to resolve delayed discharges and patient flow; significantly impacted by COVID activity and subsequent service pressures
19 NEW	Ralph Roberts	Risk to COVID-19 vaccination programme delivery (ID3127)		High	Performance and Resource Committee	
2	Lynn McCallum	Destabilisation of clinical services due to ability to recruit and retain medical workforce (ID1591)	High	High	Clinical Governance Committee	A more robust action plan is in place to reduce this risk level. As actions are introduced and become successful controls, there is an expectation this will reduce the risk level.

9 **UPDATED**	Tim Patterson	Failure to plan effectively for a significant outbreak for communicable disease e.g. epidemic, pandemic (ID1596)	High	High	Clinical Governance Committee	This risk replaces the previous strategic risk for pandemic influenza which has been expanded to cover all epidemics/pandemics
4	Ralph Roberts	Sustainability of organisational leadership. (ID1597)	High	High	Staff Governance Committee	Risk controls maintained
6	Andrew Carter	National and regional agenda for training delivery not fully implemented. (ID 1594)	High	High	Staff Governance Committee	Risk controls maintained
3	Ralph Roberts	Effectiveness of partnership working. (ID1585)	High	High	Board Executive Team	Risk controls maintained
20 **NEW**	Andrew Carter	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up (ID3766)		Medium	Staff Governance Committee	
21 **NEW**	June Smyth	Failure to implement remobilisation successfully (ID2958)		Medium	Board Executive Team	
8	Lynn McCallum	Failure to meaningfully implement clinical strategy. (ID1593)	High	Medium	Performance and Resource Committee	Through successful implementation of actions and reviewing the consequences in line with the risk matrix this risk has been reduced
10	Andrew Bone	Financial decision-making in partner organisations' budgets impacts on NHS Borders. (ID1586)	Medium	Medium	Performance and Resource Committee	Risk controls maintained
22 **NEW**	Andrew Bone	Board breaches of Code of Corporate Governance (ID2686)		Medium	Performance and Resource Committee	
7	Andrew Carter	Impact of Brexit on Health Board. (ID 1595)	High	Medium	Performance and Resource Committee	It is expected this risk may fluctuate as risks outwith our control impact on the supply chain. Continual contingency planning is undertaken to ensure NHSB is prepared for these eventualities reducing the likelihood of occurrence
12	Lynn McCallum	Unacceptable Clinical Performance. (ID1588)	High	Medium	Clinical Governance Committee	Further risk controls indentified to reduce the risk level

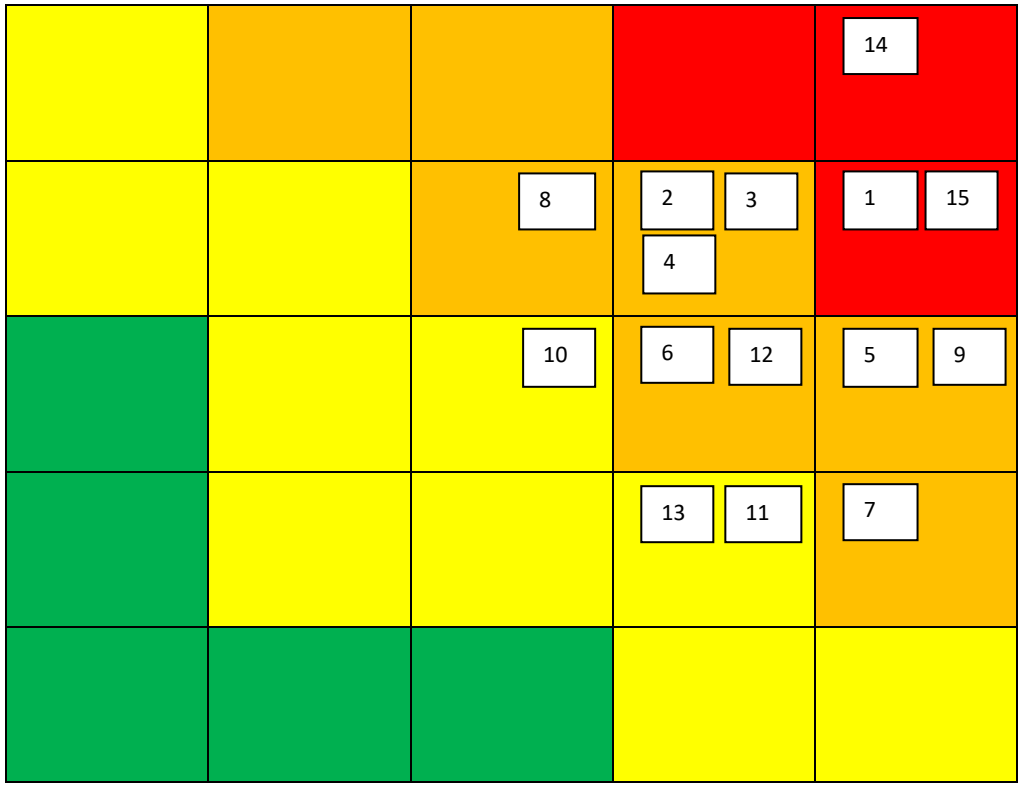
Risks Removed from Strategic Risk Register

Ref	Risk	Risk Level Achieved	Reason for Removal
15	Non-achievement of financial targets during COVID-19 pandemic (ID1767)	Very High	Merged with Risk 1
11	Industrial Action (ID1587)	Medium	Historic risk, no longer relevant
13	Cultural Change (ID1655)	Medium	Merged with Risk 21

Risk Movement

Following a gap analysis undertaken in 2020, benchmarking against a small NHS Health Board and a larger Health Board, a number of strategic risks were identified, risk assessed and added to the strategic risk register. The below charts highlight the increase in risks. 65% of strategic risks are graded as very high or high risks to NHS Borders.

As at June 2020



As at September 2021

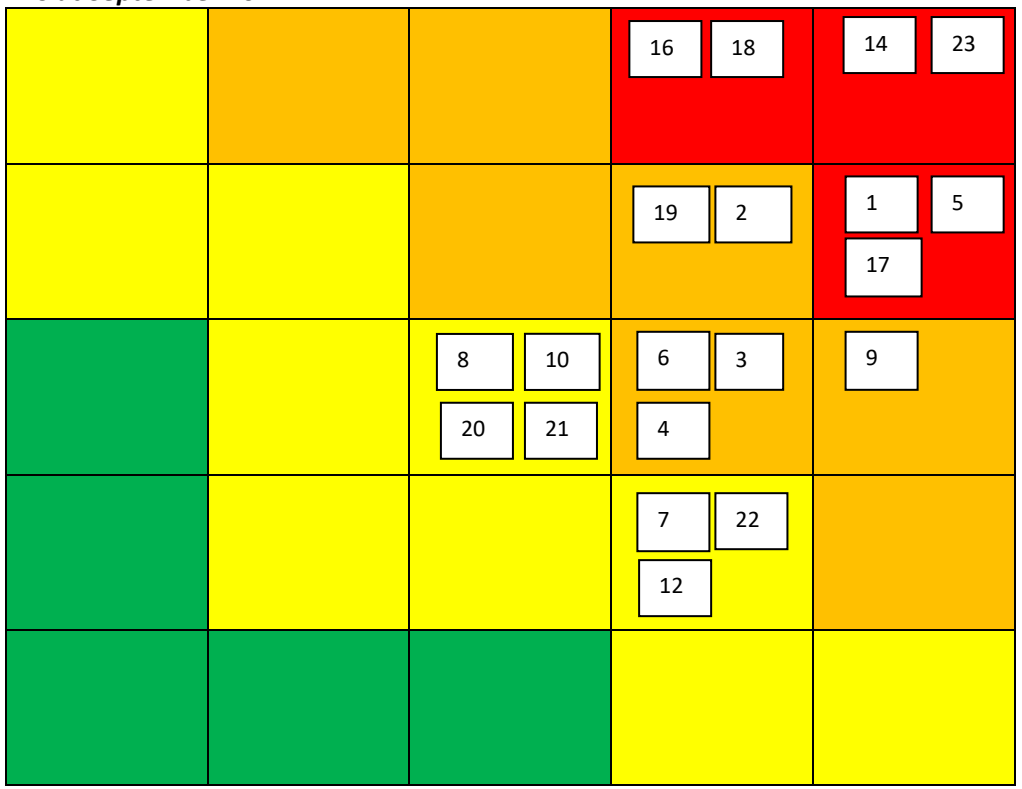


Chart 2: Strategic risk movement

Scrutiny and Assurance

For each strategic risk a governance group is identified by the risk owner as the group to provide scrutiny and assurance.

Between April 2021 and August 2021, risks were presented to the Clinical Governance Committee, Performance and Resource Committee, Public Governance Committee and Board Executive Team. Further reports are due to be presented at the Staff Governance Committee in October and the Audit Committee in December.

	Risks managed appropriately and proportionately		Systems are in place to record these risks		
	Assurance Given	Assurance Not Given	Assurance Given	Assurance Not Given	Comments
Audit Committee					Report Due December 2021
Clinical Governance Committee					Committee not assured that some risks were being managed appropriately and proportionately. A small number of risks appeared not to be managed in a timely manner. Insufficient information available to be assured that risks in development are being managed in a timely manner.
Public Governance Committee					Committee not assured that some risks were being managed appropriately and proportionately. It was noted that the Committee is assured work in ongoing to rectify the concerns raised.
Performance and Resource Committee					
Staff Governance Committee					Report due in October 2021.
Board Executive Team					

Chart 3: Scrutiny and assurance

Recommendation

The Health Board is asked to note the strategic risk report update.

Appendix 1 – NHS Borders Strategic Risk Register

Ref	ID	Risk Owner	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Expected date of target level achieved or closed	Risk Action Plan
14	1682	Patterson, Tim	Coronavirus and COVID-19	On 31 December 2019, World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan, Hubei Province, China. A novel Coronavirus (SARS coronavirus-2 (SARS-CoV-2)) was subsequently identified from patient samples.In early January 2020, the cause of the outbreak was identified as a new Coronavirus. While early cases were likely infected by an animal source in a 'wet market' in	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	17/03/2020	V High (25)	High (15)	Managed (Treat)	Operational plans in place Regular update to the Health board Governance structures in place e.g. COVID-19 Pandemic Committee Joint working with SBC BGH Coronavirus hub – weekly meetings and updates, surge resources where needed, work streams redirected where appropriate, emergency planning roles, supply chain monitoring, long term resiliency, focus on output and discipline and does not tolerate meetings that achieve neither PPE coordination group Workforce protection – PPE, escalation criteria in place, multichannel communications,	No	Virus mutations occur Government initiatives impact on outcome No local community studies to give true figure of public infectedUncertainty over national modeling and future direction of community infection Uncertainty over virus characteristics e.g. asymptomatic, pre-symptomatic spread; atypical presentation; extent of population infection and subsequently immunity Inappropriate PPE used/no PPE used Patients moved within hospital wards increasing likelihood of infection Vaccination not mandatory	31/01/2022	31/03/2022	Re-Mobilisation plan for NHS Borders created Monitor government financial packages being put in place to assist in COVID-19 pandemic Pandemic planning updated to reflect most up to date information from the government Monitor national effort in producing medical equipment Communications to all staff regarding alternative roles that can be undertaken to assist in demand on NHS Borders during pandemic Workforce planning being developed in line with national planning Digital transformation involved in resilience planning for pandemic situation Horizon scanning/ forecasting to be undertaken for short, medium and long term planning Lessons learnt to be monitored continually to ensure learning from all scenarios Continued cross collaboration with partners e.g. SBC, NHS Scotland, Scottish Government Ensure access to most up to date information on the progress of the virus communicated to staff Forecast local potential absenteeism to gain insight on virus being transmitted to staff; tolerance of risk versus health of workers Operational risks being developed in relation to infection control/PPE

				Wuhan, ongoing human-to-human transmission is now occurring.There are a number of coronaviruses that are transmitted from human-to-human which are not of public health concern. However COVID-19 can cause respiratory illness of varying severity. Currently, there is no vaccine and no specific treatment for infection with the virus. On the 30 January 2020 the World Health Organization declared that the outbreak constitutes a Public Health Emergency of International Concern.11 March 2020 WHO declared COVID-19 a pandemic. WHO risk assessment 17					staggered work times, health checks for front line staff, home working where available, Public health official engagement both nationally and locally, OH support for staff members Supply chain stabilisation – order management, critical equipment identification, local optimisation, sourcing plans, resilience planning, Scottish government supportPublic/ Patient engagement – communications to the public through national and local means, scenario based risk communications, training, fact based reports on issues, situation communications Financial – Relevant scenarios based on latest epidemiological and economic outlooks, working capital requirements, government support Day-to-day				

				March 2020 is very high. Since early March the UK (including the Borders) has experienced a large outbreak of Covid-19 disease resulting in large number of cases, deaths and pressure on UK health systems.					working reprioritised to ensure coverage for pandemic situation Business continuity plans in place Emergency planning undertaken Social distancing to be adhered to Health and well support to staff Support to care homes for public health and infection control advice Local vaccination programmes align with national programme					

23	3915	McLaren, John	Staff Wellbeing during and post COVID-19 pandemic	COVID-19 threatens all operations as a result of its potential impact on duty of care and staff wellbeing.	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable.	10/05/2021	V High (25)	Medium (9)	Managed (Treat)	NHS Borders policies and procedures NHS Borders training Occupational Health support to all staff Ensure daily situational updates sent to all staff via COVID19 update Creation of wobble rooms, enabling staff to find some quiet time during their working day Free access to Wellbeing Apps Covid microsite and FAQs regularly updated Training for staff being deployed from other areas Refreshment trolleys located throughout organisation Practical advice available on microsite including information around childcare, accommodation, financial, transport etc COVID-19 risk assessments and controls in place COVID-19 age calculator to access vulnerability and supporting individual risk	No	Significant concerns from staff and management regarding patient flow Reduced capacity within inpatient units impacting on staff wellbeing Reduced staffing	30/11/2021	31/12/2021	Ongoing development of initiatives through the staff wellbeing group Communication and posters to be issued informing staff of all support available

										assessments Permitted by Scottish Government to recruit final year nursing students as HCSWs on 15 hour contracts (6 x 15 hour contracts WFH risk assessment tool and supporting guidance documentation Funding through Charities together to support staff wellbeing initiatives Staff Wellbeing Group established Direct engagement between organisation and trade unions Open discussions around risks Occupational Health & Safety Forum Local Partnership Forums HSE Readiness SLWG Risk Management Board WFH SLWG Joint working with SBC to improve delayed discharges					

18	3129	Patterson, Tim	Reducing the harm from inequalities	Risk related to failure to address inequalities resulting in poorer health outcomes for certain groups or parts of the population, including health and social care workers.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Promote excellence in organisational behaviour and always act with pride, humility and kindness.	02/12/2020	V High (20)	High (12)	Managed (Treat)	Whilst this is a societal issue, the health board can put in actions to mitigate. NHS Borders agreed a health in all policies approach Joint Health Improvement Team delivers on national/local priorities and offers training to understand their role in reducing inequalities Screening programme Effective partnership with different sectors to help reduce health inequalities Advocating to reduce health inequalities Equality and Diversity in Employment Group, overseeing implementation of equalities act Best practice (PIN) Policy framework in recruitment, pay terms and conditions and employment Equalities mainstreaming report Monitoring of workforce statistics iMatter staff experience tool	No	Quality services with allocation of resources proportionate to needMitigation of inequalities through employment and procurement processesInequalities within society is outwith NHS Borders full controlPay imbalance centered around genderWorkforce reporting Evidence of impact of policy framework	01/04/2022	31/03/2022	Whole system approach involving NHS looking at service provision, training and service allocationNHS Borders working towards Living Wage employer statusChild Poverty action plansMoney worries app developed through Healthy Living NetworkWorking with children and young people leadership groupWorking with SBC to support health impact assessment for Fairer Scotland Duties Act (2018)ADP – Drug related death action planImplement and embed Anti Poverty StrategyDevelopment and implementation of workforce strategy, integrated workforce plan and equalities mainstreaming report

									Partnership and employee relations and access to support (contact officers and occupational health)					
16	398	Roberts, Ralph	Number of people whose discharge from Hospital is delayed impacting on clinical outcomes	Patients receiving care in inappropriate settings because of extended hospital stays and delays in discharge, resulting in lower quality of care and poorer outcomes.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	15/09/2021	V High (20)	Medium (9)	Managed (Treat)	Admission and discharge processes agreed DD target in place; DD monitoring / reportingDD Audit taken place with relevant action plan Daily discussion on whole system planning through Integrated Huddle Integrated service planning through Strategic leadership team and Winter planning board;	No	Information evidences continued levels of DD, particularly in Community Hospitals, Complex MH patients and less frequently in the BGH	30/11/2021	31/03/2022	Increase short term capacity for Care Home beds and POC Develop plans for long term Care Home capacity and Commissioning strategy Progress DD Action plan (following DD Audit) Progress SIP and ensure implementation provides clear plan to address DD on an ongoing basisEnsure IJB 21/22 Budget supports reduction of DD Embed effective implementation of agreed Discharge processes with delegated servicesembed agreed DD processes effectively within Acute services
17	583	Bone, Andrew	Potential to comply with infection control standards and precautions relating to fabric and layout of buildings.	Risk to NHS Borders of patients catching a healthcare associated infection associated with limited single room provision and specification of multi-bedded bays.Current fabric/specification of inpatient buildings does not provide the	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	05/10/2020	V High (20)	Medium (5)	Managed (Treat)	-Infection Control policies (including isolation guidance)-Infection control training for staff-Robust infection surveillance to identify possible increased infection incidence i.e. clusters and outbreaks including sophisticated IPC software systems to enhance reporting including contact tracing.	No	Borders General Hospital has wards with 6-bedded bays which are very cramped with inadequate storage for equipment. To provide a context - we put 6 patients into an area 56m2. compared with the current national standard of 64m2 for 4 beds. Certain pathogens such as Norovirus are so transmissible - especially in the context of gastrointestinal symptoms and 6 patients sharing 1 toilet that when one patient succumbs, it is normal for other patients to be	30/09/2021	30/09/2030	Confirm future role and purpose of Ward 5 to inform refurbishment requirementsDevelop plan for re-developing/new build BGH in accordance with Clinical Strategy "The Borders General Hospital will be a modern fit for purpose facility which will be the key to NHS Borders delivering 21st Century health and social care".

				appropriate standard for preventing HAI.Constraints and limitations of inpatient facilities do not enable patients to maintain 2 metres social distancing from each other (detailed in attached SBAR). This increases risk of cross transmission of pathogens requiring droplet or airborne precautions.						Identification of cross transmission would lead to outbreak response to control and reduce risk of further spread.-SGHD requirement to increase single rooms when undertaking major refurbishment-Liaison between bed management team and infection control team-Pre-admission MRSA screening-HAI admission screening/assessment and transfer documentation-PPE (to protect staff, visitors and patients)-Whenever a broken sink is replaced or an area subject to significant refurbishment, hand wash basins are replaced with models that comply with current national guidance.-24/7 access to IPC advice including dynamic situational risk assessment.-Robust communication systems both		affected. An episode of projectile vomiting can travel great distances (>3 m forward spread and 2.6 m lateral spread).(J Infect Prev. 2014 Sep; 15(5): 176–180.)Current guidance relating to the COVID-19 pandemic highlights the importance of physical distancing which cannot be achieved in our current multi-bedded bays.Ultimately, the only way to mitigate this risk is to increase spacing between patients either by reducing the number of patients in multi-bedded rooms or re-provision of inpatient services in more spacious accommodation.Consideration has been given to introducing screens between beds but this would introduce greater risks. (reduced airflow, increased temperature, moving and handling risks, access to patient, observation of patients, increased cleaning requirements)			

									within and across the wider organisation i.e. IPCT daily safety brief, hospital safety brief and daily outbreak meetings when needed. -Co-location of IPCT and laboratories facilitates 'real-time' reporting of laboratory results.-Regular IPC spot-check and audit activity of clinical areas to check on staff practice and cleanliness.-High visibility of IPC team members in clinical areas.-Highly accessible supply of personal alcohol-based hand rub.-Routine and terminal clean protocols-Staff wear face masks while working in clinical areas-Patients supported and encouraged to wear masks in multi-bedded bays when not in bed or on their chair.-All inpatients are screened for COVID-19 to support clinical decision making on appropriate patient placement. This					

									reduces the risk of patients with COVID-19 being placed in multi-bedded bays with patients who have a negative screen result.-Confirmed COVID-19 patients are either isolated in single rooms or cohorted with other confirmed positive patients.-Inpatients in multi-bedded bays are asked to wear a mask if they can tolerate it when they are not in their bed or on their chair.-Increased cleaning frequency in patient areas.-Repeat patient screening for COVID-19 as determined by SGHD.-Staff wear PPE with many having received recent training on safe donning and doffing of PPE. Staff have ongoing access to this training.-Staff supported and encouraged to undertake regular LFD testing.-Tristel Fuse cleaning agent is being used for the high risk patient pathway.-Where possible					

										encourage natural ventilation of areas by opening windows/doors (windows restricted to <100mm)- Engineering control measures, mechanical ventilation – operating times extended.PPM schedules in place.-Ventilation rates – programme in place to measure air changes/hour by a contractor.- At times where there is excess inpatient capacity and there are empty beds in multi-bedded bays, prioritisation should be to place patients in the four corners of the room first and fill the middle two beds last.- Check on compliance with admission and repeat COVID-19 screening.- Agreement for criteria to reduce number of patients in multi bedded bay				

1	1589	Bone, Andrew	Non-achievement of financial targets (RRL and CRL)	Non-achievement of financial targets (RRL and CRL) andNon achievement of financial targets (RRL and CRL) during Covid19 pandemic	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	21/10/2019	V High (20)	High (10)	Managed (Treat)	Additional support and expertise in financial turnaround Improved communication and staff engagement to agree how financial sustainability is achieved Put in place a structure to deliver financial turnaround including work streams with executive leaderships and accountability supported by a well resourced PMO Put in place processes and decision making which is clear and supports financial turnaround Annual Operational Plan Ongoing review and update of the financial plan. Maintain strong links with SG – quarterly meetings Seek support similar to the boards in special measures Medium and longer term planning Horizon scanning and networking.	No	Update. As at Q1 review 2021/22 the board is projecting a financial deficit of £8.49m. This position assumes additional resources will be provided to fully fund ongoing costs of COVID 19 response. The financial gap of £8.49m is £2.09m increase on gap described in the board's financial plan for 2021/22 (£6.4m). This position has been shared with Scottish Government and it is expected that there will be further dialogue around additional support required to manage the position in 2021/22. As at 12/08/21 no date is confirmed for these discussions.	31/08/2021	31/03/2023	Finance benchmarking with peer HBs through national/regional networks to ensure Local Mobilisation Costs are robustly assessed (ongoing from May20)Review of Capital planning assumptions with SG colleagues via National Infrastructure Board (NHSB/NIB meeting mid-July20).Review of Financial Plan at Q1 Review (July20) to include specific focus on both Covid-19 and "recovery/renew" workstream.Interim financial governance arrangements implemented to ensure grip & control in relation to Covid-19 related expenditure.Regular reporting of spend against Covid-19 Local Mobilisation Plan (LMP) to Scottish Government colleagues in agreed template.Covid-19 specific financial reporting to BET and NHSB Board as part of routine finance reports (monthly).Increased frequency of national finance networks to ensure consistency in approach with peer systems, including weekly Corporate Finance Networks and Director of Finance meetings chaired by Scottish Government Health Department Interim Finance Lead.Directors of Finance/Strategic Change review of Turnaround Programme to assess impact of delays in current programme and opportunities for reprioritisation of future plans arising from LMP/renew workstreams.Direct dialogue with SG finance colleagues to ensure that financial planning assumptions are in line with those made nationally.Regular (monthly) update to financial forecasts for Covid related expenditure.Phased reintroduction of Grip & Control actions from May20 including: Vacancy Management process; Grip & Control workstream.Production and implementation of a financial recovery plan for the next 3 financial years which returns the organisation to financial sustainability Creation of a NHS Borders financial strategy which details the road

										Organisational and public awareness of the financial environment and challenge. Ensuring we have financial grip and control. Ensure management information and reporting is timely, accurate, understood and acted upon. Monitoring of financial position and delivery of efficiency. Robust project management. Focus on quality Senior Clinical input into decision making Work closely with East Region Review/ benchmark of all services (Discovery) and identify variation Develop Integrated working with health and social care partners facilitated through the Executive Management Team (SBC and NHS) Increase Focus of the organisation/ board onto the financial agenda Creation of a new					map on how this will be delivered Increase dialogue with the public and communities to address the financial challengeEnsure clinicians are at the centre of financial turnaroundDevelop an integrated financial plan across IJB, SBC and NHSEnsure financial accountability is accepted at every level of the organisation Organisational engagement which delivers change releasing cash at paceWider clinical input to develop and implement plans and strategiesTransformational changes to all services requiredReview demand, protocols and thresholdsRealising realistic medicineIncreased focus on quality and clinical variationLink with national and regional efficiency work streams and shared services programme

									Board Sub Committee – The Finance & Resources Committee Increase in the resources to support the financial agenda – set up of a Project Management Office Improve financial awareness in the organisation					
5	1592	Patterson, Tim	Failure of Resilience	Failure to have adequate and tested resilience in place for NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	V High (20)	Medium (5)	Managed (Treat)	Training and exercising business continuity plans overseen by Resilience Committee Monitoring that adequate plans exist & are relevant]Continue to implement actions coming out of internal audit, including exercise plan, e-learning for selected groups, and awareness raising Process for updating resilience plans agreed IT implemented new technology stack including improved recovery and restore solutions to minimise impact and	No	Internal audit on business continuity highlighted a number of gaps including keeping business continuity plans up to date. The implementation of the business continuity electronic system should assist in addressing this issue. Related to this is the release of staff to complete the business continuity plans.Whilst an agreed location for a second resilient facility is underway, this still remains a risk to the organisation until the project is completed	30/10/2022	30/10/2022	Transfer secondary equipment to the resilient facility when availableAction plan in progress following internal audit recommendationsDraft Resilience Policy

									likelihood of failure. Agreed location for a second resilient facility and procurement underway to build Electronic business continuity system implemented to increase and support joint working between departments to highlight key dependencies					
2	1591	McCallum, Lynn	Destabilisation of clinical services within NHS Borders	NHS Borders destabilisation due to ability to recruit and retain medical workforce	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	High (16)	High (12)	Managed (Treat)	Developing non medical models including advanced practice roles in other professional groups including physician associates Expansions of clinical development fellow model to specialities outwith medicine Establishing a CESR programme to support junior doctors through a non-training route to consultant level posts Work across East Region Programme Board to look at consultant & trainee gaps and regionalised models of service delivery for smaller	No	No overall medical workforce plan. Agreed approach to demand and capacity planning on an annual cycle. Better control of Out-of-Area referrals would stabilise local capacity provision and workforce. Establish practice resilience model in organisation	31/03/2022	31/03/2022	Ongoing action to review and manage demandWorkforce plan to address increasing complexities and volumes of patients being treated Financial plans which returns NHS Borders to financial stabilityImprove medical job planning Development of the future of BGH business case Resilience and sustainability plan for general practicePhysicians assistants to be recruited to aid medical staffing

									specialities Medical education action plan to maintain a high quality of placements and training experience Job planning model being rolled out to have consistent information on capacity Whole system overview of consultant vacancies being taken by Medical Director Practice resilience models currently being reviewed to identify at an early stage practice destabilisation					
19	3127	Roberts, Ralph	Risk to Covid-19 Vaccination programme delivery	There is a risk that the Covid-19 Vaccination Programmes is not delivered to fully satisfy national requirements	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of	02/12/2020	High (16)	High (16)	Managed (Treat)	NES putting together training pack waiting for green book chapter. Local training pack developed to highlight local processes and procedures for staff and public Use experienced vaccinators for the first wave as vaccine is drawn down Operational group in place to monitor risks that arise Strategic oversight by Gold	No	Business continuity plan requires developmentNo processes in place should allergic reaction occur in rural locationGPs to be approved as vaccinators for programmeSecurity risk assessment required for Covid vaccinationSingle freezer to store vaccinations, no replacement available on site, minimal resilience in placeNo confirmed budget	06/01/2022	31/12/2020	Create Business Continuity PlanDevelop processes for rural areas if allergic reaction occursMonitor budget for COVID-19 vaccination programmeContinuity in place for freezer in case of break downConfirmation and approval of vaccinators

					our local population					Command Pharmacy processes in place to ensure labeling correct Adverse Event recording system in place to record events specifically relating to COVID19 vaccination programme Clinical Prioritisation Working with HR to manage any staffing issues that arise Winter Planning underway to reduce risks relating to winter period that may impact on delivery of this programme Secure storage identified Public and staff information leaflet Staff support available to all staff (Work and Wellbeing team etc) Security policy in place Backup generators in place					

9	1596	Patterson, Tim	Failure to plan effectively for a significant outbreak for commuicable disease e.g. epidemic, pandemic	Commuicable disease planning not prioritised due to operational priorities and other strategic priorities.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	22/10/2019	High (15)	Medium (5)	Tolerate	Operational plans Business continuity plans for health services Vaccination program for staff and vulnerable patient groups, where a vaccine is availableResponse arrangements will be based on strengthening and supplementing normal delivery mechanisms as far as is practicablePlans on an integrated multi-agency basis with risk sharing and cross-cover between all organisationsWork across the organisation seeking to mobilise the capacity and skills of all healthcare staff (including students and those who are retired), contractors and volunteersTreatment and admission criteria should remain clinically based and hospital admission criteria should be applied in a transparent, consistent and equitable way that utilises the capacity available for the seriously ill	No	Lack of staffing and estate to implement plans	31/01/2022	31/01/2021	Ensure plans are up-to-date Exercise plans to ensure they are effective

									and most likely to benefit					
3	1585	Roberts, Ralph	Effectiveness of partnership working	Less effective service delivery as a result of ineffective partnership working with key organisational partners	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	High (12)	Medium (6)	Managed (Treat)	Established IJBJoint Chief Officer accountable to NHS Borders Chief Exec and Scottish Borders Council Chief Exec.Joint team meetings at an operational levelThe creation of the joint Executive Management TeamSharing of information facilitated through the IJB e.g. audit committeeEstablished Community Planning PartnershipUse of the Social Care Fund and Transformation Fund to pump prime projects that will deliver integrated working Governance arrangements in placeIJB governance in place, Executive Management Team between NHSB, SBC and the IJB. Strategic plan agreed	No	Whilst controls have been put in place to reduce this risk to an acceptable level, they will take time to be fully effectiveNeeds greater joint working between NHSB and SBC supported through IJB.The IJB requires further resource to support more communication amongst staff teams and across the population.Joint financial planning has started however requires time to bed in.Joint performance reporting in place to report to IJB, this should also report to NHSB Board and Council.	10/12/2021	31/03/2022	Further communications across staff and population, newsletter, locality working groups, road shows, IJB governance and joint working arrangements agreed.Review Operational leadership arrangements for HSCP in light of DNAHP post change and IRASC Progress action plan from integration self assessmentReview effectiveness of Partnership working in light of COVID response and develop opportunities to further improve, building on COVID successReview effectiveness of Partnership working and develop longer term opportunities for further improvementAgreement of strategic implementation plan, governance and capacityDevelopment of locality plansDevelop locality management model and integrate locality teamsCreate joint financial framework

									regular meetings with staff groups and members of the public through locality working groups. Chief Officer attends the Staff joint Forum.Newsletters published.							

6	1594	Carter, Andy	National and regional agenda for training delivery not fully implemented	Incomplete delivery of statutory/ mandatory and professional skills training	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	22/10/2019	High (12)	Medium (8)	Managed (Treat)	NHS Borders Statutory and Mandatory training policyIdentification of Executive Directors as Statutory/Mandatory Risk owners and Project Manager Implementation of the Central Booking system to ensure dynamic and robust monitoring and reporting of Statutory and mandatory training compliance Managers and Employees consulted about Statutory and Mandatory training issues through SMWG, APF and reports to NHS Borders Audit Committee, Clinical Executive Operational Group and Staff Governance Committee.Cycle of reporting to HEI's and NES.Internal audit action planEmployers Liability Insurance.Topic specialists keep up to date with current risks and good practice control	Yes		01/08/2022	01/11/2020	Inclusion in dashboard report to staff governance committeeAnnual review of Statutory and Mandatory training policy.Accurate identification of statutory and mandatory training requirementsSenior managers to ensure staff are released for Statutory and Mandatory training as identifiedRegular review of SLA's with third partiesEnsure annual compliance position is reported to the governance committeesSupport to managers to ensure implementation of effective PDPs

									measures.Quarterly performance reviewsLearnPro tools in place to monitor complianceLearnPro process for manager accountability						

4	1597	Roberts, Ralph	Sustainability of organisational leadership	Disruption to organisational leadership arising from the required changes to the leadership team as a result of future succession planning	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	22/10/2019	High (12)	Medium (8)	Managed (Treat)	Project Rise for the development of senior managers' leadership skills had been in place; Strategic Implementation plan PMO-processes giving structure to decision making. Vacancy management system.Limited training programme available for management skills/decision making.Appraisal/ PDP undertaken-objective setting.National /Organisational strategies available.Workforce Planning for NHS Borders and Health & Social Care PartnershipOngoing succession plan for Executive Team: new DoF, DoW, MD, DN & DAS now in post; CO recruitment underway and interviews set for end Sept 2021BET team development programme in place Induction programme for new Directors in place Plans for long term	No	Staff training and support given to managersWhilst controls have been put in place to reduce this risk to an acceptable level, they will take time to be fully effectivePotential gap in Operational leadership - plans being developed; some risk associated with Recruitment	30/11/2021	30/11/2021	Complete appointment of new MDComplete Induction for new Executive Colleagues Recruitment for gaps in BET to progress as quickly as practicalWork with new Director of Workforce to develop ongoing training plansReview Operational leadership arrangements for HSCP in light of DNAHP post change and IRASC

									recruitment to future DN&M completed and new post holder in place from 1st June 21; New DAS in place Borders Quality approach now developing alongside new Decision making arrangements						

21	2958	Smyth, June	Failure to implement remobilisation successfully	COVID-19 remobilisation plans were put in place in May 2020 to support NHS Borders in moving from reduced services to a business as usual approach, allowing for contingencies to be put in place as the virus fluctuates and to reduce the pressure on the board using a whole system approach. Failure to implement this successfully will have ramifications throughout NHS Borders.	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	15/07/2021	Medium (9)	Medium (6)	Managed (Treat)	Pandemic Committee/Gold Command established Plans for escalation of COVID-19 response in event of a second wave of the pandemic include step down of elective remobilisation plans in order to release bed capacityPlans for escalation of COVID-19 response in event of a third wave of the pandemic including bed escalation plan and potential step down of elective activity to release staff/bed capacityPlanning for winter may require remobilisation plans to be amended depending on the availability of resources such as staffing e.g. reduction of elective activityDiscussions with Lothian to revisit our Service Level Agreement levels may lead to other changes in activity levelsall patients considered urgent continued to be treated, including	Yes		30/09/2021	30/03/2022	Review remit of Recovery GroupMonitor controls in place to ensure risk level is not escalatingAssess appropriateness of clinical services over timeA health promoting health service is a national initiative whose concept is that 'every healthcare contact is a health improvement opportunity'. All staff promotes this message.

										those with urgent cancer referrals / diagnosesBusines s cases have been developed for each of the mandatory services (required by Scottish Government) which have been robustly scrutinised in order to determine the levels of staffing required for these to continue to operate over an anticipated 12 months. The assumption has been made that all deployed staff will continue to be available to these services until at least the end of March 2021, to enable external staff to be recruitedThe flexibility to scale up and scale down services is important and we are maintaining a dynamic equilibrium between staffing-up new services (such as the new functions established / required in response to COVID-19)and the need to either bringing					

										established services back on-stream or increasing the levels of services offeredThe internal remobilisation working group considers all resource requests brought forward by services assessed as critical in order for them to either continue to operate as a COVID-19 response function, remobilise services to a greater level than which they are currently operating, respond to winter pressures or to deliver the extended 'flu vaccine programme for 2020The Clinical Oversight group continue to advise on clinical prioritisation of the remobilisation plan at an organisational level, including the allocation of resources and timing and order of recommencement of services. Clinical					

										prioritisation of individual patients continues to take place at service level – based on royal college or other internal guidelines - supported by local Clinical Prioritisation Groups to review the allocation of resources on an individual patient-specific basis. A group has been established to assess patients for surgical procedures using the Scottish Government Guidelines for Prioritisation of Cancer SurgeryEscalation triggers provide an early warning of the potential need to implement additional capacity or other measures and a weekly update is shared with Gold CommandPredictive modeling is in place to plan for a potential further peak (or peaks) of COVID-19 demand. This work is informed by national guidance and early warning from Public					

										Health Scotland and UK-wide information, but is also advised and guided by local intelligence and knowledge, particularly from our local Public Health teams, testing and tracing services and the local authority. Robust plans continue to exist to rapidly increase inpatient capacity should COVID-19 activity increase to a level that impacts on NHS Borders healthcare servicesExternal recruitment exercisesUse of temporary isolation structures in ITU/ critical careStaff wellbeing support; psychological support for staff members, collecting your voices, staff risk assessments, supporting working from homeThe local remobilisation group is ensuring health inequalities impact assessments are being undertaken and an equalities					

										focus will continue to be important in ensuring equityNational and local updated policies and guidanceFinancial plans in placeQuarterly financial forecasts submitted to Scottish GovernmentBusiness continuity plans in place and accessible electronicallyStructures in place for Clinical Boards to escalate issuesOperational Planning Group now in place, replacing Recovery Planning Group but continues to oversee COVID-19 related issues and proposals, making recommendations to BET/Gold Command.New SG assurance template in place which will assist in the assessment of service capacity and situation (yellow/amber/red/black)- to be reviewed alongside modeling reports to provide update on actual position and modeled future					

									positionPlans being developed should the Board be required to respond to increased RVIs in paediatrics						

8	1593	Smyth, June	Failure to meaningfully implement clinical strategy to meet the needs of the population	Ensure the Clinical Strategy is implemented successfully across NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	Medium (9)	Medium (6)	Managed (Treat)	Fiscal Financial controlPublic engagement process.Public Health strategy and monitoring of population healthStaff engagement processes underpinned by principles of partnership working.Scheme of Integration, strategic plan, and commissioning implementation plan.Proactive contact with political and media stakeholders.Board Executives & Non Executives to attend the SBC area forum network.Regular engagement with staff around key strategic issues.The establishment of NHS Borders Financial Turnaround Programme has resulted in a number of programmes of work being established across all business units. Each area of work has been cross referenced with the key principles of the clinical strategy to ensure	Yes		30/09/2021	30/03/2022	Developed robust community services to support people in their own homesService reviewsExplore future DGH modelProactively engage with SEAT Acute Services programmeProactive partner in Borders CPPDevelopment of Public Involvement StrategyExplore impact and opportunity of Community Empowerment ActComplete Road to Digital including network refresh, VDI, Trak and applications upgradeCreate Target Operating Model to fit the new technologies. Ensure staff have adequate training in new technologies.As part of TOM develop service delivery model and workforce planUtilise national e-Health networks to gain synergies and improvements locally

									their alignment and to ensure that any changes are consistent with the direction of travel of the organisation.							

10	1586	Bone, Andrew	Financial decision-making in partner organisations' budgets impacts on NHS Borders	Financial decision-making in partner organisations' budgets impacts on NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	Medium (9)	Medium (6)	Tolerate	1.Work as part of the NHS Scotland Corporate Finance Network to jointly highlight the impact of the reduction2.Scheme of integration agreed and actioned 3.Issue of directions 4.Integrated working with Chief Officer and Chief Finance Officer5.Regular meetings between CFO and NHS DoF/members of NHS Finance team provided an opportunity to share information. 6. The development of health and social care integration & integrated budget. Development sessions for board members 7.Operational integrated working 8.Service redesign opportunities9.Integrated Reporting 10.Regular meetings between NHS Borders and SBC Finance departments 11.Share information on financial outlook	Yes		31/12/2021	31/12/2021	Improved understanding of their budgets and sources of funding which impact on their services - financial awareness work streamIntegrated working/ servicesService redesignClarity on how the increased funding to the IJB is supporting service redesign and reducing pressure in the NHSConfirm resources for Integrated management structures and ensure this is reflected in financial governance arrangements.IJB financial plan which underpins the IJB strategic planReview of set aside budgets in line with the letter from NHS Scotland DoFJoint financial planning (SBC,NHSB, IJB)

									and financial plan to promote better understanding of financial challenges and impact of decisions12.Agreement of information sharing protocol 13.Alignment of budget timetables14.Alignment of financial planning15.Coordination of internal audit plans16.Quarterly meetings with SG finance 17.Longer term financial planning18.Clarity of system and process19.Use of the transformation budget and social care fund20.Set up of the Executive Management Teams which meets regularly, develop understanding, communication and relationships and focus on key issues					

20	3766	Carter, Andy	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns and ideas for improvement	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	14/04/2021	Medium (9)	Medium (6)	Managed (Treat)	Hard copy posters displayed throughout NHS Borders at acute, community, MH and LD sites.Working Group supporting the implementation of whistleblowing legislation, policy and processes which will develop into the oversight groupOnce for Scotland policy supported by local guidance and processesWhistleblowing legislationWhistleblowing intranet pagesOH support offered to whistleblowersStrong links with CG&Q/Risk colleagues to capture potential whistleblowing incidents recorded in adverse eventsUpdated Decision making framework developed and to be implementedBorders Quality Approach devised and Implementation plan being developed (long term approach);	Yes		01/04/2022	01/04/2022	Infrastructure planning to be undertakenWhistleblowing development session with the health boardPromote whistleblowing legislation, policy and processes to support understanding and thus support the attainment of an open and transparent cultureQuarterly report to Staff Governance CommitteeAnnual whistleblowing report to health boardDevelopment of whistleblowing confidential contacts networkDevelopment of process in linking data of adverse events with the local whistleblowing processesDevelopment of process to measure the culture around whistleblowingDelivery of awareness sessions throughout NHS BordersImplement updated Decision making framework (as part of Borders Quality approach) Develop Implementation plan for Borders Quality approach

12	1588	McCallum, Lynn	Unacceptable Clinical Performance	Unacceptable performance by:-Doctors and dentists, pharmacy-Nursing, midwifery and AHPs-Independent contractors	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	21/10/2019	Medium (8)	Medium (8)	Tolerate	1. Training & Induction2.Policy for introduction of new procedures and treatments (ADTC, Clinical Gov Committee), GMC/NMC professional standards and so on.3. HCPC - health and care professionals' council. 4. Strong focus on local SPSP and strict adherence to procedures enforced.5. HSMR and other clinical outcomes measures are monitored closely e.g. quality dashboards, weekly safety dashboard, mortality reviews, mortality and morbidity review, quality, safety and HAI core audits, patient feedback, clinical audits6.Appraisal & revalidation for all Doctors, Registered Nurses and Midwives7.Clinical Governance framework8.Healthcare governance systems9.Significant Adverse Event Review process with Adverse Event	Yes		30/06/2022	03/12/2019	Investigations process to be developed for claimsLearning from complaints/adverse eventsDeveloping clinical leadership to support good practiceFostering and supporting flexible medical recruitment Introduction of revised Nursing revalidation processDevelop systems that provide assurance about the quality of care deliveredImplement leadership programmes: SCN programme with NES/QMU, Programme for Person Centered Care with QMU, Back to BasicsMonitor controls to ensure they are still effective and risk is not escalating

									Management Policy. Duty of candour process. 10. Value Based Recruitment standard recruitment process for all staff across NHS Borders.11. Patient feedback investigations and SPSO case review.12. Yearly group supervision in midwifery. 13. Annual Fitness to Practice process for GPhC. 14.GPhC community pharmacy inspection process.					

7	1595	Carter, Andy	Impact of Brexit on Health Board	Overall Brexit uncertainties and outcomes	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	22/10/2019	Medium (8)	Medium (4)	Managed (Treat)	Current medical staffing, NHS B not overly reliant on EU nationals. 5% as at Sept 2018. GMC reviewing cross EU qualification mechanisms. GMC/NMC following the Mutual Recognition of Professional Qualifications (MRPQ) DirectiveLocal Workforce Plans in place which capture the implications of Brexit.Recruitment and retention strategy aimed initially at consultant medical staff and registered nursesUK government systems to support EU nationals remaining in UKGov funding remains constant currently with UK contingency planning being undertaken.National procurement dept is identifying the at risk supply chains to/from EU countries and increasing stock holding. East of Scotland Health Boards have	No	Late direction from the Government on Brexit deal implications stifles contingency planning.Delay in guidance being issued due to COVID-19 pandemic.Longer term plans not yet established such as improving resilience of medicine supply chain and minimising future shortages of medicines.Increasing domestic manufacturing in UK.Redesigning the Emergency Medicines Buffer Scheme.Adding to the pandemic influenza preparedness stock.	31/03/2022	01/04/2021	Brexit group to review risk level in light of readiness returnMonitoring and seeking to influence through appropriate channels Scottish and UK GovernmentsOngoing contingency planningIncorporating variables into workforce and business planningCommunications to staff to be issued

										added to procurement risk profile as more information becomes availableLocal procurement staff instigate an escalation process if any supplier raises Brexit as a reason for disruption,UK contingency planning for medicines/medical supplies, alternative supply routes identified for medicines. Once for Scotland response. Six week medicine stocks held on UK soil by pharmaceutical companiesNSS leading on purchasing core stock of primary and secondary care COVID-29 critical and supportive care medicines via established NHS Scotland procurement frameworks where possible and additional stock is being sourced to meet NHS Scotland's requirement via UK led sourcing work streams.Information sharing about					

										continuity of medicines supply across NHS Scotland.Build up of stocks in the National Procurement Distribution Centre (NDC)Analysis of all UK suppliers preparednessFreight capacity secured for category 1 goods; including human medicines, biological materials such as blood and organs, medical devices and clinical consumables, and PPE supplies. Express freight service for small quantities of urgent and critical supplies for a period of 6 months from 31 December 2020Triage system set up by National Procurement dept for medicine/ medical supplies.Public Health UK is presenting proposals to UK government. Involvement of World Health Organisation.Food price increase to be viewed as a cost pressure and					

									highlighted to the Finance Team. Continued monitoring.No plans to hold additional stock or stockpile food supplies. Ensure major event produce is fully stocked. Menus adjusted if required.Implementation of business continuity plans/ short term contingencies.Contingency plans on essential fuel users, business continuity plan for staff transport would apply.Government Direction issued November 2020 (attached in documents section)					

22	2686	Bone, Andrew	Board breaches of Code of Corporate Governance	The risk that NHS Borders does not comply with the code of corporate governance	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	29/10/2020	Medium (8)	Medium (8)	Tolerate	Code of corporate governanceGovernance committeesInternal Audit on governanceRegular checks of declarations of interestRegular checks on gifts and hospitality2 yearly counter fraud awareness session with BoardAppointed counter fraud championAnnual governance statement	Yes		29/10/2021	29/10/2020	Road shows - code of corporate governanceMonitor controls in place to ensure risk is not escalating

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Dr Tim Patterson, Director of Public Health
Author:	Jan McClean, Director of Regional Planning Prof Peter Donnelly, Professor of Public Health, St Andrews University

REGIONAL HEALTH PROTECTION SERVICE

Purpose of Report:

The purpose of this report is to brief the Board on work to progress the implementation of a regional model for Health Protection services across NHS Borders, Fife, Forth Valley and Lothian.

Recommendations:

The Board is asked to **endorse** the approach to the implementation of a regional model for Health Protection services.

Approval Pathways:

This report has been developed informed by discussion with

- Regional Health Protection Oversight Board
- Directors of Public Health - NHS Borders, Fife, Forth Valley and Lothian

Executive Summary:

1. In late 2020, Chief Executives and Directors of Public Health from NHS Borders, Fife, Forth Valley and Lothian agreed to explore regional collaboration opportunities in Health Protection services
2. The main drivers are the impact of the pandemic and emerging workforce issues in some Boards
3. A formal Options Appraisal process was undertaken in March 2021 involving Consultant and Nursing representation from each of the 4 Boards along with Partnership representation, confirming support for a regional model which retained some local elements of service delivery
4. The regional model will focus on largely nurse-led Board teams providing routine Health Protection services, with regional resources identified and deployed for strategic work, specialty areas and mutual aid/surge capacity.
5. A formal project structure is in place to support implementation and governance requirements at a regional level
6. Key issues being worked through include: intraoperability between Boards; HR issues including differences in roles and grades; out of hours arrangements
7. It is intended to have enhanced regional working by December 2020 with a regional model in place by spring 2022.

Impact of item/issues on:	
Strategic Context	This project aligns with the ambition to ensure a sustainable, resilient and efficient Health Protection service across the East Region.
Patient Safety/Clinical Impact	A sustainable and resilient model of service delivery will support a timely and appropriate Health Protection response that prevents and reduces harm to the population from communicable diseases and environmental hazards.
Staffing/Workforce	A regional model will provide greater workforce resilience with opportunities to develop a more nurse-led approach across the Region, a model which NHS Borders has already adopted. There are existing workforce challenges in the Health Protection service in NHS Borders, which is part of the wider Public Health function, with reliance on a small number of individuals.
Finance/Resources	It is anticipated that the regional model will be delivered within the current financial envelope. The opportunities to release clinical time will be maximised through avoiding/reducing duplication across 4 Boards.
Risk Implications	A project risk register is maintained. Key risks include: • Ability to implement a regional model within current operating context • Securing IT intraoperability between Boards • Securing an agreed model for out of hours work
Equality and Diversity	Not currently undertaken
Consultation	Partnership representation was secured at an early stage of the project, with ongoing involvement.
Glossary	

Regional Health Protection Service

1. Purpose of the Paper

The purpose of this paper is to provide Borders NHS Board with an update on work to progress the implementation of a regional model for Health Protection services across NHS Borders, Fife, Forth Valley and Lothian.

2. Background

In December 2020, the Chief Executives and Directors of Public Health from NHS Borders, Fife, Forth Valley and Lothian agreed to explore the potential opportunities afforded through regional collaboration in Health Protection services with the aim of delivering improved service resilience, sustainability, minimise duplication and ensure a service fit for the future. This decision was influenced by the inevitable impact of the Covid 19 Pandemic on Health Protection services but also separately occurring workforce challenges within some of the Boards.

Led by Professor Peter Donnelly, Professor of Public Health Medicine, University of St Andrews and Jan McClean, Director of Regional Planning, a formal project and associated governance arrangements were put in place in January 2021 to explore options for regional working with the benefit of Partnership involvement at every stage.

An Oversight Board was established to provide senior level governance for the project with representation from Chief Executives and Directors of Public Health from the 4 participating Boards together with Partnership representation. A Clinical Reference Group was established with representation from both Nursing and Consultant teams in each Board and Partnership representation. The Clinical Reference Group provided essential specialist Health Protection knowledge and clinical engagement necessary to consider and develop potential options for regional collaboration, with a recognised formal Options Appraisal process adopted. Engagement with clinical teams from across the 4 Boards was enthusiastic and constructive throughout the process despite the challenging pandemic operating context. Issues raised by the Health Protection teams as particular challenges included:

- On-call rotas
- Staff retention
- Training and education of Health Protection Nurses
- Role development for nurses
- Service resilience and workforce planning

Health Protection Teams recognised and supported the need for change and the opportunities presented through the Project.

The preferred option describes a model where small local, largely nurse led Board teams provide routine Health Protection services, with regional resources identified and deployed for strategic work, specialty areas and mutual aid/surge capacity.

A series of meetings with individual Board Executive Teams took place over the early summer, with all confirming support to move to implementation of a regional model. An additional request was made to bring forward proposals on options for out of hours work, an area where there are challenges with resilience and sustainability.

3. Current Service Arrangements

Health Protection is currently provided in each Board as part of the wider Public Health function. While there are differences between the 4 Boards in relation to the scope, scale and delivery models, there are many aspects which are the same or similar e.g development and use of Standard Operating Procedures; strategic plans; specialist work on specific diseases.

All Boards have a mixed workforce with Specialist Nurses, Consultant grades and in some Boards, Nurse Consultants, with some variation in the deployment and roles and responsibilities of staff. The Covid 19 pandemic has seen Health Protection teams augmented with additional staff at various grades to support the significant increase in workload. All Boards currently operate an out of hours on-call rota, an aspect of the service which has been identified as fragile and challenging to operate.

4. The Vision for Future Service

The vision for Health Protection services in the East Region is a resilient, sustainable function which is fit for the 21st Century and maximises the skills of the workforce.

The regional working arrangements will:

- focus on specialist areas of work e.g. Tuberculosis, which can be shared across 4 Boards supporting development of specialist interest and expertise and avoid duplication of effort
- coordinate plans for responses in specialist areas such as ports, airports, nuclear related issues
- agree and maintain regional Standard Operating Procedures ensuring consistency of approach and reducing unnecessary duplication thereby freeing up time for other activities
- offer immediate mutual aid or surge capacity to be directed to areas of need when required, providing service and workforce resilience
- provide opportunities for shared training and education across the Region, offering wider opportunities and economies of scale and making the East Region an attractive service to work/remain
- provide opportunities for Specialist Nurses and Nurse Consultants to lead on aspects of regional work, maximising their skills and knowledge and providing an opportunity for career progression

- support the sharing of good practice and collaborative working, providing opportunities for organisational development and shared values.

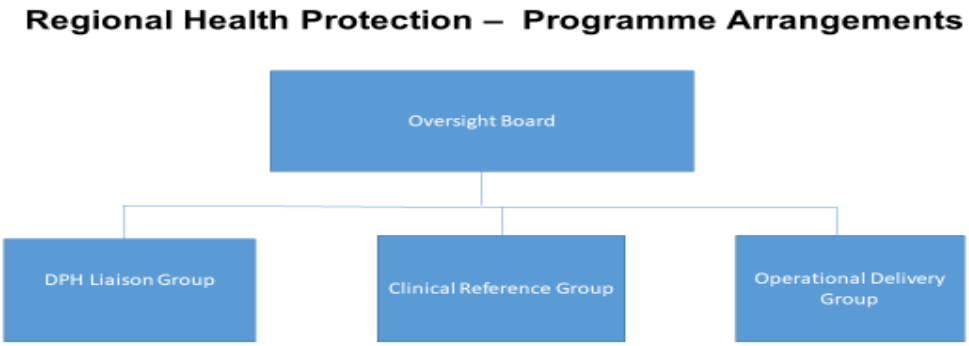
The local elements will:

- provide routine Health Protection services such as nurse led day to day handling of routine issues using agreed Standing Operating Procedures
- maintain important local knowledge and interface with key stakeholders e.g. Environmental Health

Out of hours arrangements have been identified as a particular challenge for all Boards and further work will focus on assessing potential solutions which will be brought forward for consideration by the end of 2021.

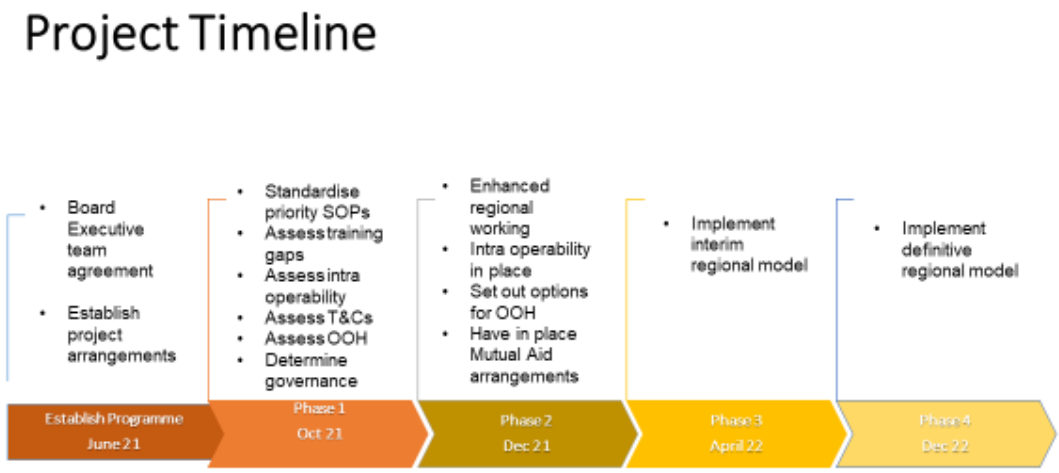
5. Project arrangements and Timescales

The Project structure has now been revised to take account of project implementation with the establishment of key groups to support delivery.



The Oversight Board includes representation from Board Chief Executives, Directors of Public Health, HRD Lead for the project, Partnership representation and the Project Team. Directors of Finance and eHealth and others will be invited to attend as required.

The following timeline has been agreed with the Oversight Board:



6. Progress to Date

The following progress has been made:

- Health Protection systems have been mapped with more detailed assessment of intraoperability planned with eHealth support
- Financial baseline information has been collated with Directors of Finance preparing financial principles to support the project
- Regional Standard Operating Procedures (SOPS) are being developed where no national SOPS are available
- Nurse grades and roles are being profiled to identify and understand variation
- An audit of out of hours activity will support understanding of the scale and nature of out of hours work

Stakeholder engagement is ongoing with interested groups such as Public Health Scotland, Scottish Public Health Network and Scottish Directors of Public Health Group.

7. Resource Implications

It is assumed that the regional model will operate within the existing financial envelope confirmed across the 4 Boards. It is noted however that there may be a requirement to support IT solutions to establish intraoperability between Boards.

8. Recommendations

Borders NHS Board is asked to :

- Note the above update

- Confirm support for the Vision for Health Protection Services in the Region and the timescales for defining and implementing the new model of service
- Continue to support progress with implementation

Jan McClean
Director of Regional Planning

Prof Peter Donnelly
Project Advisor

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

RESOURCES & PERFORMANCE COMMITTEE MINUTES 06.05.2021

Purpose of Report:

The purpose of this report is to share the approved minutes of the Resources & Performance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Resources & Performance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Resources and Performance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	R&PC – Resources & Performance Committee

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 6 May 2021 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr M Dickson, Non Executive
Ms S Lam, Non Executive
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Mr J McLaren, Non Executive
Cllr D Parker, Non Executive
Mrs A Wilson, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mrs J Smyth, Director of Strategic Change & Performance
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Mrs N Berry, Director of Nursing, Midwifery & Operations
Dr T Patterson, Director of Public Health
Mr A Carter, Director of Workforce

In Attendance:
Miss I Bishop, Board Secretary
Mrs S Horan, Deputy Director of Nursing, Midwifery & AHPs
Dr A Cotton, Associate Medical Director
Mrs C Oliver, Head of Communications
Mrs S Paterson, Deputy Director of Finance
Mr G Clinkscale, Associate Director of Acute Services

1. Apologies and Announcements

1.1 Apologies had been received from Dr Janet Bennison, Associate Medical Director Borders General Hospital and Dr Nicola Lowdon, Associate Medical Director Primary & Community Services.

1.2 The Chair confirmed the meeting was quorate.

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

2. Declarations of Interest

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

2.2 Ms Sonya Lam declared that her partner was a specialist advisor for the Scottish Government.

2.3 Mr Malcolm Dickson declared that as the Finance Report mentioned external healthcare purchasers and providers, his sister-in-law was an Executive Director on the Board of Northumberland Health Trust.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declarations made by Ms Sonya Lam and Mr Malcolm Dickson.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 4 March 2021 were approved.

4. Matters Arising

4.1 **Action 7:** Mr Andrew Bone advised that it was likely to be June before a final schedule of dates would be available. Mr Ralph Roberts reminded the Committee that the project would be tracked through the Capital Investment Group (CIG). The Chair enquired if the Committee were content to mark the action as closed on the Action Tracker given it would be tracked through the CIG and any slippage would be advised to the Committee through the normal Capital update mechanism. Mr Malcolm Dickson advised that he would be content provided the Police, Fire & Rescue & Safer Communities Board was kept up to date via James Ayling, once he demitted office.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 7 on the action tracker.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the action tracker.

5. COVID-19 Remobilisation Plan 2021/22

5.1 Mrs June Smyth advised that the Remobilisation Plan was not yet in the public domain and had therefore been delegated by the Board to the Resources & Performance Committee. She provided an overview of the content and advised that an underpinning action plan was being developed. In regard to waiting times she advised that the usual submission of templates for waiting times was not required this year, however work had been completed on those locally. The remobilisation plan also outlined the capacity that had been remobilised whilst still dealing with the pandemic and that would be revisited. The acute team had also revisited the pathways in place for theatres and intensive care in order to increase overall capacity and those pathways had been fully risk assessed and would be scrutinised by the Pandemic Committee.

5.2 Mr Tris Taylor pointed out some minor formatting issues. Mr Taylor then enquired about the clinical prioritisation framework and if service users were involved in the process and if they should be in the future. Mr Taylor also enquired about the status of the screening programmes.

5.3 Mrs Smyth commented that in regard to the clinical prioritisation process it was the clinical voice and advice that was required in regard to decision making as the pandemic was progressing.

5.4 Dr Lynn McCallum commented that as a clinician on the front line during the early stages of the pandemic there were a range of difficulties to be overcome in terms of resources, oxygen flow, staffing and other matters. Due to clinicians being given the time to look for solutions and work with other colleagues a range of innovative changes were progressed. Where there had been struggles previously to engage clinicians in financial turnaround the pandemic had created an urgency for change across the system, which the whole system had embraced.

5.5 In relation to public engagement and stakeholder engagement at the time of the start of the pandemic clinicians had been desperate to work out how to manage the expected deluge of cases and fast spread of the pandemic, as currently being seen in India. As the country went into lockdown the focus of clinicians remained on the health care provision and the public were not in a position to engage at that time. In terms of the future it would be preferred to engage and collaborate with the public however at that time it was not possible.

5.6 Mr Ralph Roberts commented that at the start of the pandemic the Health Board had been operating under emergency powers and was required to make decisions quickly. At that time it would have been impractical to engage with the public in the timescales required, however, as patient and public involvement and engagement had been further developed over the past year the organisation would be in a better position to take that forward in the future. It was also noted in the meeting chat that an Ethics group involving lay members had been in place to review any difficult prioritisation issues.

5.7 Dr Tim Patterson commented that in regard to the screening programmes they had all been paused at the start of the pandemic. Since October 2020 screening programmes had been remobilised and their status had been shared with the Clinical Governance Committee. He advised that the remobilisation of screening programmes had been challenging in terms of public perceptions and confidence in attending for screenings as well as dealing with increased waiting times for appointments. Some additional capacity had been sourced to address the backlog of appointments and some public communications would also be progressed.

5.8 Mrs Smyth advised that in terms of assurance in regard to public involvement and engagement a lot of communications during the pandemic period had been shared with the organisations recognised public members.

5.9 Mrs Fiona Sandford commented that the remobilisation plan was a major shift in how services would be delivered and noted that public engagement and good communications were an essential part of the success of remobilisation. She commented that she would like to hear more about the communications and engagement programme potentially at a future Non Executives session. The Chair agreed to make it a feature of a future session.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** formally approved RMP3 for 2021/22, on behalf of NHS Borders Board.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the feedback received and our replies, and noted the underpinning action plan that has been developed based on the commitments outlined in RMP3.

6. Finance Performance March 2021

6.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: the forecast to achieve breakeven; work on the annual accounts; reporting of a small in year underspend; specific expenditure on COVID-19; the impact of COVID-19 on savings

targets; and the draw down of funding from the Scottish Government to support this position.

6.2 Ms Sonya Lam enquired what the medium term meant for the review of the decrease in prescriptions. Mr Bone advised that it recognised emerging information as there was normally a time lag on information flows. The information available was based on actual payments made up to the end of January 2021 and then indicative volumes for February and March. He commented that there had been a drop in terms of volumes for the last quarter.

6.3 Mrs Alison Wilson commented that it was a 3 month time lag period for information flows which meant the final year end figures would not be available until the end of June. She had received feedback from GP colleagues and Community Pharmacies that they expected volumes to increase from April.

6.4 Dr Lynn McCallum commented that prescriptions in the next financial year were likely to rise especially in regard to chronic disease management as that had been impacted by COVID-19. Mr Bone assured the Committee that a level of growth in prescribing levels consistent with the level of growth pre COVID-19 had been built into the financial plan for next year and would be monitored through the normal quarterly review process.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** took significant assurance that the Board would achieve its financial target (i.e. breakeven) at March 2021.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the Board was reporting a small under spend for the twelve months to 31st March 2021.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the position remained draft pending final audit of the Board's Annual Accounts.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in relation to COVID-19 expenditure and how that expenditure had been financed.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in respect of savings delivered in year and the additional support provided by the Scottish Government to offset further non-delivery of savings during 2020/21.

7. Draft Capital Plan 2021/22

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: an update in terms of the individual projects; the pharmacy service dispensing robot funding; and total carry forward.

7.2 The Chair enquired about capacity to carry out capital projects approved through charitable funds given that had been an issue in the past. Mr Bone commented that a discussion had taken place with the Trustees in regard to both NHS and non NHS projects and how they would be resourced. He suggested he bring back an overarching report of all the projects managed through the programme of work including both NHS and non NHS funded. The Chair welcomed the suggestion of an overarching report to show the full extent of projects.

7.3 Mrs Alison Wilson enquired when confirmation from the Scottish Government would be received in regard to the capital allocation for NHS Borders and also if there was any risk in terms of funding for the Road to Digital programme. Mr Bone advised that the capital allocation confirmation was likely to be received in June and he confirmed that the Road to

Digital funding was in relation to revenue and not capital. He further commented that the Road to Digital programme had been mentioned as a new revenue risk in the financial plan as the £1m level of resources were significant. The funding stream of "non cash delegated" had now been removed by the UK Government and did not exist in the Scottish Government or NHS Scotland. Mr Bone suggested a solution had been achieved for 2021/22 and further work would need to be developed and taken forward to find a solution for the long term funding of the digital plan for the future.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update provided on the 2021/22 capital plan

Mr Tris Taylor left the meeting.

8. Financial Turnaround Programme

8.1 Mrs June Smyth commented that the Financial Turnaround programme timeline was being revisited with the intention of bringing the programme back on stream. In terms of clinical engagement the learning from the pandemic would be valuable in engaging with the clinical community and supporting leadership on corporate issues.

8.2 The Chair enquired if the programme would be rebranded. Mrs Smyth confirmed that the intention was to rebrand as the conversation moving forward would be focused on financial sustainability as opposed to financial turnaround.

8.3 Mr Bone commented that he expected the Scottish Government to issue a letter to invite the Board to discuss the financial plan and the savings plan in the context of the deficit in the plan.

8.4 Ms Sonya Lam noted the intended relaunch of the programme in June and enquired at what point the Board would see the programme. Mrs Smyth commented that the programme would continue to report to the Board via the Resources & Performance Committee, however the intended June relaunch may be delayed in order to pick up the financial position and impact of continuing COVID-19 mitigations.

8.5 Mr James Ayling referred to the assumptions section of the report which suggested schemes that required capital monies might not be delivered, as capital monies were diverted to COVID-19 response schemes and he enquired if they were income or revenue based. Mr Bone commented that the assumption reflected the need for capital resources to be reprioritised in response to risks identified in early phase of COVID-19 but remained a risk at this stage. Capital financing for saving schemes is in relation to enabling activities to support service change and release of revenue savings. The caveat in relation to COVID-19 had been a standing assumption throughout the pandemic.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the report.

9. Performance Briefing

9.1 Mrs June Smyth provided an overview of the content of the report and highlighted the error in the table at item 1.7, and that the business intelligence team were still running the delayed discharges data.

The Chair enquired if there was sufficient focus on the assessment of individuals for care at home solutions. Mrs Nicky Berry commented that both she and Jen Holland were working on a phased approach and had noted a higher demand for packages of care and the need to flex up to meet demand. It was unclear if the demand was related to geographical issues and the intention was to merge Home First and SBCares to enable a larger pool of resource to be available. Phase 1 of the programme of work included: a weekly delayed discharge meeting to ensure systems and processes were followed; ensuring the Moving On policy was being followed; prevention of admissions; criteria and assessment of discharge to assess to take place at home and not in the hospital; and education across social care and nursing. Phase 2 would be the availability of flexible resources and the longer term would be to review the number of care homes and residential homes required.

9.2 Mrs Lucy O'Leary enquired how the conversation with care home providers would be taken forward. Mr Rob McCulloch-Graham commented that relationships with the independent sector were more positive than they had been pre COVID-19. Conversations had already commenced and a revised commissioning strategy would be taken forward with input from the independent sector, to look at care provision and the potential of a Care Village.

9.3 Dr Lynn McCallum suggested input from the Consultant Geriatricians should be a key influence in the revised commissioning strategy.

9.4 Mr McCulloch-Graham commented that given the impact of the pandemic and the uncertainty as to whether the recommendations from the Derek Feeley report might be agreed and the wish to revise the commissioning strategy in co-production with the independent sector the intention was to produce a final strategy by April 2022.

9.5 Ms Sonya Lam enquired when the Committee would receive the fuller performance report for performance measures across the whole organisation. Mrs Smyth commented that normally the format of the performance report would be agreed at the start of each financial year and it was slightly delayed this year. Over the past year whilst the Committee had received abridged reports, data collection had remained in place in regard to the HEAT Standards and discussions would take place with the Scottish Government in regard to their expectations of data collection around the Remobilisation Plan. There would also be conversations with the Non Executives outwith the meeting on the kind of performance data that they would wish included in a performance report.

9.6 Mr Ralph Roberts commented that the NHS Scotland Board Chief Executives were currently in conversation with the Scottish Government in regard to influencing what any incoming government might require in terms of a suite of performance reporting. It had been suggested the focus might be rebalanced from healthcare delivery and move towards population health and addressing inequalities and health outcomes.

9.7 Ms Lam commented that as a Committee it needed to be assured on organisational performance and given the abridged reports she was unable to confirm she was fully assured. Mrs Berry commented that she was not sure that any Health Board across the country would be able to provide its' Board with assurance given the current on-going pandemic. However, she wished to advise the Committee that the HEAT target standards and other important performance areas such as delayed discharges, were being regularly monitored with improvement plans being instigated where required.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Performance Briefing for March 2021.

10. Complex Care Unit – Learning Disabilities

10.1 Mrs June Smyth advised the Committee that the paper provided an update on the status of the discussions in regard to the provision of a new unit. The key issue on the provision of a new unit had been the potential use of NHS land and the complexities involved in that. Land had now been identified by Scottish Borders Council (SBC) and it was suggested that the NHS land issue be closed and the project be taken forward by SBC with the intention of the Learning Disability service providing a full case to the Integration Joint Board for agreement.

10.2 The Chair sought assurance that any new build would provide the required capacity for the future. Mr Rob McCulloch-Graham clarified that a potential supplier had been identified for 8 places and the current usage was 12 places, so further negotiation and modelling would take place to ensure any unit was future proofed in terms of capacity. He advised the suggested site would be in the central Borders areas and having a facility in the region would lead to savings.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update on the work to develop a local Learning Disabilities Complex Care Unit.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that in light of new options for the location of the unit having been recently identified, consideration of using NHS land will be paused.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the Chief Officer for Health & Social Care will be taking a paper regarding this development to a future meeting of the Integrated Joint Board (IJB) regarding the commissioning of such a unit.

11. Any Other Business

11.1 The Chair commented that she was in conversation with the Chief Executive and Board Secretary in regard to the formation of the Board papers packs and the addition of hyperlinks from the agenda to the papers was being progressed.

11.2 The Chair commented that she would circulate her master list of acronyms to Non Executive colleagues for their information.

12. Date and Time of Next Meeting

12.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 2 September 2021 at 9.00am via MS Teams

The meeting concluded at 10.49am.

Signature: ……
Chair

RESOURCES & PERFORMANCE COMMITTEE: THURSDAY 6 MAY 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Malcolm Dickson:** As external purchasers and external providers 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 formally note in the minute of the meeting.
2	Declarations of Interest	**Sonya Lam:** I declare that my partner is a specialist advisor for the Scottish Government.	**Iris Bishop:** Thank you Sonya I will formally note in the minute of the meeting.
		MINUTES OF PREVIOUS MEETINGS	
3	Minutes of Previous Meetings	**Harriet Campbell:** Sorry, expect lots of stupid questions from me over the next wee while: Point 4: Forensic Medical Examination Suite. What is this for and what would it do? I am imagining all sorts of Silent Witness type work but I bet that's wrong.	**Lynn McCallum:** No question is a stupid question! The FME suite is essentially a specific area within the hospital that is designed to support an examination following a rape or sexual assault. These areas are being developed to support more survivors of these experiences to come forward and should be a stark difference to police stations or Emergency Departments. As well as an examination area, they should have comfortable seated areas to allow appropriate support to the survivor. The examination is undertaken by a specially trained doctor or nurse.
4	Minutes of Previous Meetings	**Harriet Campbell:** On the Q&A (point 9) what is NRAC? And what is the significance of NRAC parity?	**Andrew Bone:** The majority of NHS funding is set based on a historic formula and is fixed as 'baseline'. This means that each year NHS Borders receives approximately 80% of its funding at the same level as previous years.

			NRAC (National Resource Allocation Formula) is a weighted population formula that is used to distribute additional funding to NHS regions (with some exceptions). It makes adjustment for demographic and health factors affecting the population. Because these factors continue to shift along with the overall size of the population, each Health Board's overall share of the available resources can shift away from their formula share over time. Scottish Government have made a commitment that no health board will be more than 0.8% from parity. A correction factor is applied annually to NHS budgets which distributes additional resources to those HBs whose share is below 'parity'. NHS Borders is currently within NRAC parity and has been for a number of years. Our share is c.2.1% of overall population. It is projected that the board will increase its share over the next 5 years due to size and age of population.
5	Minutes of Previous Meetings	**Malcolm Dickson:** Noted	-
6	Minutes of Previous Meetings	**Karen Hamilton:** Item 5 para 2 Messaging to staff on Financial savings? Any strategies agreed as to how this will be achieved?	**Andrew Bone:** We have not yet agreed a communications plan for how we will engage with staff on financial savings during the next 12 months. Work continues on development of our approach to savings for 2020/21 – we can provide a verbal update to the meeting if that is helpful?

		MATTERS ARISING	
7	Matters Arising	**Malcolm Dickson:** The action tracker includes: "Complex Care Unit – Learning Disabilities The RESOURCES AND PERFORMANCE COMMITTEE requested an update on the project early in 2021, along with an answer to the query raised by Mr Dickson." There is certainly an update provided to the 6 May R&PC but no answer to my question which was something like - We seem to currently have 12 patients located in units outside the Scottish Borders and yet the proposal is only to build an 8 bed unit. Why don't we seek at least 12 and allow the operators to accommodate patients from outside the Borders if our numbers fall below 12?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
8	Matters Arising	**Karen Hamilton:** Action No 7 FME suite – do we have any update?	**Lynn McCallum:** We are awaiting an update from the design team but they are meeting next week and we are hopeful to have timescales from then. Currently aiming for this to be completed by the end of the year.
		COVID-19 REMOBILISATION PLAN 2021/22	
9	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** Appendix A – really silly point but would it be possible to have the glossary in alphabetical order in any future similar report?	**June Smyth:** Noted thank you- the teams have worked on the basis of order of appearance but happy to take the feedback on board
10	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** Another stupid question, sorry. I am a little confused as to why the draft plan submitted in February remains the plan to be approved. I see that there were no substantive changes but there were queries which have been responded to. Why is it not necessary to include these	**June Smyth:** In usual years, our Annual Operational Plan (which RMP3 replaces this year) would be updated/amended following feedback from Scottish Government (SG) and any comments received from local stakeholders on the submitted plan. This year, as a result of

		answers in the plan to be approved?	the pandemic and the ongoing pressures relating to this, SG advised of a lighter touch, whereby Board's would not be required to update their plans and re-submit them, and were happy to have confirmation that any feedback would be taken on board as plans were being implemented. We have therefore attached in the appendices the letter we received following our review meeting with SG representatives, and our responses for completeness rather than an amended plan. We didn't receive any substantive feedback / comments from local stakeholders, with no amendments requested.
11	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Harriet Campbell:** And one substantive query: 11.12.2 says that 'patients should not be expedited solely because of time waited for surgery', but does there not come a time for some patients when this should be a relevant factor in person-centred care? If not do some P3/4 patients simply end up constantly pushed further down the list and effectively never treated?	**June Smyth:** Our first priority is clinically urgent patients. The risk of harm to these patients as a consequence of delay is high. Residual capacity is used for patients on routine waiting lists, and for this group we treat in strict date order. We aim to utilise all available capacity, which will on occasion mean booking out of turn where the alternative is capacity wasted. There is no doubt that high volume surgical services that undertake what are usually considered "routine operations" have been disproportionately affected over the last 15 months**.** Our response to meeting this challenge is aimed at improving productivity, and accessing additional capacity where possible. This is something the acute Quadrumvirate and relevant Clinical Directors are actively working

			on.
12	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Malcolm Dickson**: Noted. Well done to all concerned. Happy to approve RMP3 formally.	-
13	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Karen Hamilton:** Approval Pathways – correct to assume that this remains the same as the Draft already submitted? 1.4 Exec summary. Any bullet pointed activities that may present significant challenges – essentially are they all 'do-able'?	**June Smyth:** Yes the draft remains as submitted to Scottish Government (see also Q10 above). With regards to the bullet points, as things stand at this point in time there are no significant risks relating to these, although with regards to the last bullet point (expand the role of primary/community based care, embedding a whole system approach to Mental Health & Wellbeing) we are still awaiting further information from SG on what this will entail.
14	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**James Ayling:** Really useful document for me as a new member of the Board.	-
15	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Fiona Sandford:** Happy to approve. At some point, it would be good to hear about how we plan to communicate to the general public the planned changes in service delivery. (expectation management)	**June Smyth:** Scottish Government has asked boards not to publish their plans at this point given the election on 6 May. The Communications & Engagement team are, however, in discussions with services around how best to communicate with the public and other stakeholders in the interim around specific issues (such as waiting times and backlog, access to primary care etc). Once we receive confirmation from SG that we are able to publish RMP3 (and when) we will finalise a communications plan.
16	COVID-19	**Sonya Lam:**	**June Smyth:** The high level action plan

	Remobilisation Plan 2021/22 Appendix-2021-10	I acknowledge the considerable effort that has gone into RMP3. I recognise that RMP3 remains as per the draft which was submitted to Scottish Government in February. The Covid-19 and remobilisation has changed considerably since February, which makes the translation of RMP3 into a working action plan important for the Committee to be assured of delivery. The action plan for 2021/22 for noting is very high level with a focus around delivery in business units. To be assured the Committee needs sight of greater detail of outcomes of these plans and how these outcomes span across business units. A measurement framework including trajectories is required, so we can be assured of delivery. What are the timescales for the Committee to see the performance framework, the risk assessment and the health inequalities assessment?	attached to RMP3 is a first cut on an underpinning action plan, outlining the commitments that were contained within the 'story' outlined in RMP3. The business units are now working on developing a more robust plan which would include timescales etc.. Delivery against the plans will be monitored through quarterly performance reviews which we will bring back on stream during 2021/22 (having been stood down in 2019/20 due to the financial turnaround programme to free up capacity). An update on progress against the plans will also be included in the twice yearly *Managing our Performance* report. The Access Board will monitor performance against RMP3 waiting times trajectories, and report by exception through the performance reviews and performance reports to the Board / Resources & Performance Committee. The process to develop the more detailed action plans will include engagement with the necessary teams to ensure a risk assessment is conducted and the risk register is reflective of this and that also a HIIA is carried out. We are aiming for this work to be complete by end of June 2021.
17	COVID-19 Remobilisation Plan 2021/22 Appendix-2021-10	**Sonya Lam:** There are elements in RMP3 not visible in the high level action plan such as:- • Page 6 of RMP 3 (1.9). 'It is therefore essential that time for staff decompression is built into our	**June Smyth:** Thank you Sonya, we'll take this on board as we develop the more detailed action plans and ensure these omissions are included within the corporate/support service section. Staff decompression is a very real

		• remobilisation plan and any expectation and targets for this set by Scottish Government. What is our understanding of staff decompression? What do we think SG will set for a target. • Pg 8 of RMP3 (1st para) 'Aim to work collaboratively with staff and service users; to be more agile and devolve decision-making and ensure greater shared accountability'. How will we action and measure this?	issue for the Health Board and its workforce. We are not yet entirely clear how SG will allow for this. The experience of the last 15 months has been sustained pressure for many. Restrictions formerly placed on taking annual leave have been lifted over the last 6 weeks and staff are now enjoying substantial blocks of time off. The Staff Wellbeing Group and Occupational Health & Safety Forum are evaluating the impact of the wellbeing offerings to staff e.g. Here 4 U, and planning support services for 'living with covid' in our communities. In terms of any targets relating to RMP3, we are waiting to hear from Scottish Government (SG) as to plans to monitor RMP3, and whether Board's will continue to be required to report on the previous HEAT standards. SG Operational Planning reps are currently having conversations around what proportionate monitoring should include and how this will be coordinated. With regards to our commitment relating to devolved decision making and accountability, we have internally been working on this over the last quarter of 2020/21. We are introducing a more streamlined approach to operational decision making from the end of May, which has been designed in conjunction with members of the Remobilisation Planning Group, supported by a commitment to embed a quality management system approach across the organisation. We are using an improvement

			approach to all of this, bringing the new ways of working into effect and refining as we go. The quality system discussions are at an early stage, and evaluation will be built in as the work moves forward.
		FINANCE PERFORMANCE MARCH 2021	
18	Finance Update Appendix-2021-11	**Malcolm Dickson:** I take significant assurance that the Board will achieve its financial target of break-even at March 2021. I note all the positions summarised at Section 2.	-
19	Finance Update Appendix-2021-11	**Karen Hamilton:** Very clear and readable report – Noted.	-
20	Finance Update Appendix-2021-11	**James Ayling:** Para 5.7 refers to recurring release (£1m) of the Board's contingency reserve for 2020/21. The RMP (18.7.1) refers to a further possible release of contingent reserves. How much is left of the reserves and is the recurrent depletion of the contingency fund viewed as a risk with consideration being given as to how to augment in time? Again a really useful paper for a new member.	**Andrew Bone:** Prior to 2020/21 the board held a £2m contingency reserve which was used to manage pressures emerging in year. The financial plan for 2020/21 released £1m of this recurrently against our financial deficit, leaving £1m held in reserve. Other reserves held by the board are related to specific investment programmes where costs in year are anticipated to be below the final projected cost. We review our financial plan and the risks within on a quarterly basis, with consideration of any adjustments to plan required as a result of emerging issues in year. Given the relative scale of our underlying deficit we have directed much of our 'flexibility' towards management of this position which diminishes our ability to mitigate new/emerging risks as they arise. We do however work closely with SG colleagues to consider how this position can be managed in year and to agree the conditions for any additional support required.

			Moving forward I would seek to agree a revised strategy for management of financial risk as part of our three year financial planning which will be undertaken during the course of 2021/22.
21	Finance Update Appendix-2021-11	**Fiona Sandford:** Clear report, thank you	-
		DRAFT CAPITAL PLAN 2021/22	
22	Draft Capital Plan 2021/22Appendix-2021-12	**Harriet Campbell:** Again, it's silly but it would be helpful if the glossary were in alphabetical order (less of an issue here as not many acronyms but all the same). Why is patient flow a capital commitment? I would have expected it to be a revenue one. Or doesn't the split work like that here? (sorry, probably another silly question). The same question applies to Estates maintenance.	**Andrew Bone:** Noted. I'll make sure we review this for future reports. Apologies – this heading is slightly misleading. This refers to the redesign of the emergency department and other areas of the Borders general hospital to improve the patient flow through the building. The maintenance costs are in relation to life cycle works to maintain the fabric of the building. This can include replacement of plant & machinery, as well as refurbishment of clinical areas (e.g. wards). Note - NHS capital expenditure has a slightly modified definition relative to private sector. I can provide further briefing on this if it would be helpful.
23	Draft Capital Plan 2021/22Appendix-2021-12	**Malcolm Dickson:** Page 4.- Innovation Fund, Q2 activity: "Assessment criteria to be introduced for project requests against this fund". I suggest that BCIG would be the best vehicle to agree draft criteria and that these then be considered for approval by R&PC since NEDs may wish to influence the nature of prioritisation. For instance, I've previously	**Andrew Bone:** I will pick this up with colleagues and we will ensure that the proposed approach is presented to future meeting of RPC.

		suggested that criteria should include improving patient experience, safety and outcomes, as well as seeking efficiency savings. In the latter case, it may be that a percentage of the savings accrued should be retained by the Business Unit concerned, with the remainder being retained centrally in the Capital budget.	
24	Draft Capital Plan 2021/22Appendix-2021-12	**Karen Hamilton:** I have to ask – where does the Adult Changing Facility sit here? I thought it was in the Capital Plan but perhaps I am mistaken? Were we not considering a standalone facility?	**Andrew Bone:** This report only describes the NHS funded capital schemes. Although we are using BCIG as the vehicle for coordinating the overall resource requirements to deliver capital projects the Adult Changing Facility is charitable funded and has been excluded from this report. If helpful we can consider whether there should be recognition of other capital works within this report moving forward.
25	Draft Capital Plan 2021/22Appendix-2021-12	**Fiona Sandford:** Echoing Karen – Adult changing facility?	**Andrew Bone:** As per above.
		FINANCIAL TURNAROUND PROGRAMME	
26	Financial Turnaround Programme Appendix-2021-3	**Harriet Campbell:** Alphabetical order again please? I'm only saying this three times as I have no idea if everyone sees all of my questions or if only the relevant bits go to each person. 3.2 Schemes totalling £1.3M FYE should be possible for 2021/22, however progressing of these will be subject to service capacity becoming available. Is it likely/realistic that this capacity will become available? Presumably that's what the validation process was assessing and can we have an update please? There is a reference in Appendix 1 to income generating	**June Smyth:** Noted thanks. The current estimate is based on the desktop exercise. The validation process will confirm if this is possible and realistic. The validation process is currently underway and we will provide an update to the committee in September. Income generating activities are those such as

		services. What are these (sorry, another newbie question I know).	our external facing laundry services and canteen.
27	Financial Turnaround Programme Appendix-2021-3	**Malcolm Dickson:** Noted.	-
28	Financial Turnaround Programme Appendix-2021-3	**Lucy O'Leary:** 3.2 – schemes possible for 2021/22 are "subject to service capacity becoming available" What kind of capacity is meant here? Operational staffing? Project management resource? Something else? A couple of examples would help, please	**June Smyth:** Through the PMO we have Project Management capacity available. Each service will need to confirm they have the clinical and management support needed to progress these schemes. Examples are a review of the medical secretary structure, review of admin in MH, and changes to the way polypharmacy is delivered.
29	Financial Turnaround Programme Appendix-2021-3	**Karen Hamilton:** Accepting of the challenge that will limit progress here however a continued focus on presenting a full savings plan for 22/23 will be achievable?	**June Smyth:** We are commencing discussions across all services regarding future savings, The paper and timeline we will present to the committee in September will clarify how we will be developing a full plan for 2022/23.
30	Financial Turnaround Programme Appendix-2021-3	**Fiona Sandford:** My points echo Karen's and Malcolm's	-
		PERFORMANCE BRIEFING	
31	Performance Briefing Appendix-2021-14	**Harriet Campbell:** What does "delayed discharges over 72 hours '3 days includes delays over 2 weeks mean'?" Am confused – surely 3 days is 3 days and 2 weeks is rather more than that? Does it mean that the numbers in the red boxes are cumulative (ie in March 21 there were a <u>total</u> of 27 DDs of which 18 were over two weeks? Sorry, just not clear (to me	**Rob McCulloch-Graham:** Delayed Discharges are reported at two key points which match national targets, past and present. The original target for Delayed Discharges was for patients to be discharged within 2 weeks of being clinically fit and optimally functioning, which is why we continue to report this. The updated

		anyway). Looking at the breakdown of reasons, are these 'normal' proportions? Ie is the main difficulty often waiting for a residential home, or is this particularly high at the moment and if so do we know why?	target was for patients to be discharged within 72 hours (3 days) of being declared clinically fit and optimally functioning. To make the reporting of both numbers clear we report both figures separately, so the number over 3 days is the total of the number over 3 days, and the number over 2 weeks is that figure. So to clarify the number reported over 3 days **includes** the number over 2 weeks delayed, so Harriet is right there were a total of 27 DDs over 3 days, 18 of which were over 2 weeks delayed. The descriptor for the line would read better as follows: **Standard** / **Dec-20** / **Jan-21** / **Feb-21** / **Mar-21** DDs over 2 weeks: 8 / 3 / 8 / 18 DDs over 72 hours (3 days) - includes delays over 2 weeks: 15 / 7 / 11 / 27 Occupied Bed Days (standard delays): 688 / 478 / 528 / 903 Regarding the delayed discharge reasons - these have been assessed for the position as at 25th March 2021. A misapportionment has been made to one category of figures meaning that the waits for residential homes appeared higher than they should be. the table should read as embedded:

			Corrected Delayed Discharge Reason Ch Quality assurance processes will be reaffirmed to make sure this does not reoccur.
32	Performance Briefing Appendix-2021-14	**Harriet Campbell:** It might be helpful to see absences as numbers as well as percentages? I suspect that some of the larger percentages actually equate to not that many people. Is that right?	**Andy Carter:** Yes, formula is (Hours lost to sickness absence) divided by (Total available hours in that area) x 100, so 1 full-time person off sick in a team of 10 full-timers = 10% sickness absence. 78 employees were absent (unavailable for 1 work episode or more) for reasons associated with Covid-19, during March 2021. 435 employees were absent (unavailable for 1 work episode or more) for reasons **other than** Covid-19, during March 2021. Will revise dataset for next meeting.
33	Performance Briefing Appendix-2021-14	**Malcolm Dickson:** Disappointing to see both DDs and consequential OBDs both now increasing, despite the active efforts being made. Will we only ever see sustained improvement if available places in Nursing and Residential Homes increase significantly plus a substantial increase in the proportion of those elderly people needing high levels of care being cared for at home?	**Rob McCulloch-Graham:** It will be a combination of factors. Having the correct Policy, Strategy and Process to reduce delays, compliance with those and the capacity of reablement/intermediate care, home care and residential care. All of these factors impact on patient flow into, through and out of hospital.
34	Performance Briefing Appendix-2021-14	**Lucy O'Leary:** 7.1 Not sure I understand these figures. Imbalance between admissions and discharges at month end implies a rise in occupied beds. Cumulatively over 4 months there	**June Smyth:** This question has been passed to the Business Intelligence Team, who provide the data, to investigate and respond, the response will be circulated separately and as soon as it

		are 271 net extra beds filled. That can't be right (only a 1.6% rise in occupancy and we don't have 17,000 beds!). So what's not being counted here – what accounts for the other "missing" exits from BGH beds?	becomes available.
35	Performance Briefing Appendix-2021-14	**Karen Hamilton:** Exec summary 1.1 Delayed discharges I note Malcolm's comments and wonder if this is the only solution. Comparators' to other Boards of similar size and resources? The problem being as I am sure we are all aware that this performance adversely affects so many other targets and is not good for patients! 1.7 do we have a firm assessment base for the difference between '**residential** care' (not nursing) and care at home given this is the largest group waiting?	**Rob McCulloch-Graham:** 1.1 see reply to Malcolm above. 1.7 This is the question we are grappling with currently. The steering group has challenged a number of discharge demands for nursing care which have in the end should have been for normal residential care. Training and oversight has been improved and will need to be maintained as staffing cohorts change.
36	Performance Briefing Appendix-2021-14	**Karen Hamilton:** 3. Waiting times – how are we getting this message to the public that waits are and may get longer?	**Nicky Berry:** We have recently updated the 'added to waiting list' letter that is sent to all patients who are added to a waiting list for Surgery. This letter now includes a link to website that shares information on how long patients who have been operated on have waited. The website also includes a link to the national clinical prioritisation guidance. We are now looking at a similar letter for patients added to the Outpatient waiting list. A key opportunity for managing patient expectation is when they agree to a referral with their GP. As such, GPs have all been provided with access to the website with waiting times to encourage a conversation about likely waiting times.

			The waiting times team are also considering how we communicate further with patients when they have reached 26 weeks. The Head of Communications is working with the Chief Executive and Quadumvirates (via the RPG) to inform a regular dialogue with the public about the progress of remobilisation.
37	Performance Briefing Appendix-2021-14	**Karen Hamilton:** 9 Performance Standards going forward. Explanation of review referred to please?	**June Smyth:** On the onset of COVID-19 we reduced the number of standards/targets we reported upon to the Board to free up business intelligence (BI) team capacity to focus on the pandemic. The Planning & Performance team are in discussions with the BI team to assess if data is available for the wider suite of targets/standards that we previously reported on, and if the BI team have capacity to support this. We are also waiting to hear from Scottish Government regarding any reporting / monitoring arrangements for Boards on RMP3, which would be incorporated into the performance report to the Board.
38	Performance Briefing Appendix-2021-14	**James Ayling:** Delayed discharges obviously remain a real problem for us and for those patients for whom the delay does not result in a better long term outcome for them....I assume there may be some. I suspect it is very difficult to categorise any better outcome patients as a sub section of the overall delayed discharge figures. Do we ever speak to patients/their families post discharge and ask them about their discharge experience and where he/she felt it may have got bogged down by say duplication of work, communication issues etc and ascertain if there	**Nicky Berry:** We don't seek feedback at present and I'm happy to look at this it's a good point. I've asked patient experience if we've had any feedback through the complaints process.

		are any trends emerging?	
39	Performance Briefing Appendix-2021-14	**Fiona Sandford:** Echo Malcolm's question	**Rob McCulloch-Graham:** It will be a combination of factors. Having the correct Policy, Strategy and Process to reduce delays, compliance with those and the capacity of reablement/intermediate care, home care and residential care. All of these factors impact on patient flow into, through and out of hospital.
		COMPLEX CARE UNIT – LEARNING DISABILITIES	
40	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Harriet Campbell:** I'm sure this has been previously discussed (another newbie question, sorry) but if there are currently 12 Scottish Borderers currently placed outwith the Borders and 2/3 new placements required each year, why is the proposal for an 8 bed unit?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
41	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Malcolm Dickson:** See my comment under Matters Arising.	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh

			up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
42	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Lucy O'Leary:** 12 out of area placements currently 2-3 new placements required pa Implies a 4-6 year average stay in a placement. Is this correct? (It sounded a bit low to me given the lifelong nature of the needs and the level of challenge). And is there any "churn" in individual placements, ie does the 2-3 pa include people moving between different out of area placements? if the person was placed in a stable environment closer to home, would we expect length of stay to rise, requiring more places to meet current levels of demand?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a "void agreement" within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
43	Complex Care Unit – Learning Disabilities	**Karen Hamilton:** Are we still confident that the size and capacity is sufficient and future proof and will revised plans impact on this?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has

	Appendix-2021-15		been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a “void agreement” within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.
44	Complex Care Unit – Learning Disabilities Appendix-2021-15	**Fiona Sandford:** Agree with Karen and Malcolm – have we got the capacity right?	**Rob McCulloch-Graham:** Negotiations have still to take place with the provider, what has been provided before has been an example. We may well agree to block purchase more beds, but would have to weigh up the need to pay for any vacancies that we might not be able to fill in the future. Another option is that the IJB and SBC have the first option on any available beds, in this way we could match our demand without having a “void agreement” within the lease/contract. The risk in this arrangement is that we expect the residents will hold long term leases and require these places for a significant period. We will need to determine the best option through considering our future demand profile as Malcolm suggests and select the best option and quantum on places.

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

AUDIT COMMITTEE MINUTES 15.06.21, 20.07.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Audit Committee.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Audit Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Audit Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

Minutes of a Meeting of **Borders NHS Board Audit Committee** held on Tuesday, 15th June 2021 @ 2 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director
Mr M Dickson, Non Executive Director (Chair)
Ms S Lam, Non Executive Director
Mrs F Sandford, Non Executive Director
Mr T Taylor, Non Executive Director

In Attendance: Mr A Bone, Director of Finance
Mrs J Brown, Director, Audit, Grant Thornton
Mr G Clinkscale, Associate Director of Acute Services
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs L Farrell, Audit Manager, Grant Thornton
Mr A Haseeb, Senior Audit Manager, Audit Scotland
Mrs L Jones, Head of Quality & Clinical Governance (Item 4)
Mr K Lakie, Deputy Hospital Manager (Planned Care) (Item 6.2)
Mr R McCulloch-Graham, Chief Officer (Item 6.3)
Mrs S Paterson, Deputy Director of Finance, Head of Finance
Dr T Patterson, Director of Public Health
Mrs L Pringle, Risk Manager (Item 4)
Ms M Richardson, IIA Trainee, Grant Thornton
Mr R Roberts, Chief Executive
Mr G Samson, Audit Senior, Audit Scotland

1. **Introduction, Apologies and Welcome**

Malcolm Dickson welcomed those present to the meeting.

Apologies had been received from Mrs G Woolman, Director, Audit Scotland.

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meetings: 22nd March 2021**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
Andrew Bone highlighted that the revised timescale for implementing the findings within the Pharmacy Controls Internal Audit report were noted on the action tracker as 31st May 2021, however this had subsequently slipped to 31st July 2021 and would be picked up through the follow up process.

The Committee noted the action tracker.

Strategic Risk Register – Update on Internal Audit Recommendations
Malcolm Dickson provided background for the benefit of the new Committee members noting it had been highlighted to the Audit Committee that there may be too much focus on support services functions within the Strategic Risk Register so Internal Audit had been asked to look at subject matters on risk registers in other Health Boards to allow Borders to use as a benchmark and highlight areas which could be looked at in the future. Laura Jones advised that she and Lettie Pringle had worked with each Director to review their portfolio in terms of strategic responsibilities and mapping out the risks presented at an organisational level. Laura highlighted that the context has changed significantly due to the response to the Covid19 pandemic and subsequent remobilisation. It was noted that there were 28 risks on the strategic risk register which is greater than what was expected at the start of the exercise and reflects the additional risks now presented across Boards due to the pandemic. The report presented today was to give the Committee assurance that this piece of work had been undertaken and they would now be looking at how these risks will align with the other Governance Committees in terms of ongoing scrutiny and assurance. Sonya Lam welcomed the work to align the risks with the relevant Governance Committees and enquired how these strategic risks align with NHS Borders' organisational objectives. Laura confirmed that due to the way the risks are logged within the register it would provide the ability to ensure alignment with the corporate objectives and she would ensure that this is included as part of the work. Tris Taylor referred to the adequacy of controls column which had a "no" against a number of items and enquired if this meant that there were not adequate controls in place but had been approved as content with this. Lettie Pringle explained that this meant that the initial risk assessment had highlighted a gap against the target level which required additional mitigation; the action plans attached to each risk are developed in response to this gap assessment. Tris also enquired if there were any risks arising from failure to discharge our duties as an employer to provide equitable access of employment to people who have protected characteristics. Laura confirmed that there was a broad overarching risk around inequalities which relates to staff, patients and the public. Laura agreed to look at the detail and to provide additional content to ensure it covered the point being made as well as looking at who the supporting Director should be and advise if any changes are required.

The Committee noted the update.

5. **<u>Governance & Assurance</u>**

5.1 *Audit Follow Up Report*
Laura Farrell spoke to this item. Laura highlighted appendix 1 and in particular the revised timescale of 31st July 2021 for implementing the recommendations within the Pharmacy Controls report and advised that Internal Audit would continue to monitor through the follow up report if the Committee were content with this revised timescale. Sonya Lam referred to the first action relating to drugs trolleys being kept locked when not in use and the Emergency Department reinstating its controlled drugs cabinets to ensure secure storage of medication brought in by patients. Sonya enquired about the further delay and what is stopping this from being resolved. Andrew Bone explained that the outstanding action relates to the reinstatement of random spot checks for patients using the lockable cabinets when bringing medication into hospital. Gareth Clinkscale confirmed that reminders have been issued to all areas reminding staff to lock drugs in the correct cabinet. Andrew agreed to ask the Director of Pharmacy for a progress update but did not envisage the timescale being brought forward owing to it currently being mid June. Both Sonya Lam and James Ayling noted their concern in regard to the patient safety element and felt this should be implemented as a matter of urgency and were not content to ratify the revised timescale of 31st July 2021. Ralph Roberts assured that there was a

procedure in place and that the issue related to the spots checks being undertaken robustly enough to give adequate assurance. Andrew suggested that once an update on actions had been sought from the Director of Pharmacy this then be discussed by the Board Executive Team who will ascertain if additional mitigations are required to be put in place to bring forward the timescale. An update would be provided to the Committee in due course. Following discussion it was agreed to ratify the revised timeline subject to the update received from the Director of Pharmacy. Tris enquired if the target dates for follow up of audit reports were unrealistic. Malcolm Dickson explained that deadlines have had had to be flexible and have been put back due to the pandemic, however noted that it was not normal practice to have so many outstanding actions within the follow up report.

Laura also referred to the Public Engagement and Involvement recommendations and advised that no update on progress had been received. Tris Taylor confirmed that the deferral has gone through the Public Governance Committee and they were content with this. It was noted that this was due to be discussed at a meeting in the near future.

The Committee noted the report.

6. **Internal Audit**

6.1 *Internal Audit Report – Covid19 Financial Controls*

Laura Farrell spoke to this item which noted that the audit had concluded that there was partial assurance with improvement required and one medium and two low risk findings. Laura advised that the medium risk finding related to the application of the Covid19 Scheme of Delegation and for the sample test undertaken on Covid spend it had been found that 22 out of the 25 selected had not been approved in line with the Covid19 Scheme of Delegation. It was also noted that the Covid19 delegated authorities were not reflected in PECOS ensuring that spend across the Covid19 cost centres is authorised accordingly. Laura advised that additional testing had been undertaken to verify this against the original NHS Borders Scheme of Delegation and this identified two exceptions where items of expenditure had been approved by individuals without delegated authority. In regard to the two low risk findings it was noted that there was no formal process and procedure documentation relating to Covid19 expenditure for reporting to Scottish Government (SG) and there were inconsistences found in the LMP submission including Covid19 expenditure not approved in line with SG limits. Laura confirmed that feedback from management has been received with remedial action against all these points. Andrew Bone gave assurance that this is being taken very seriously and actions are being progressed timeously to ensure there are no weaknesses within the controls for financial transactions. In terms of the medium rated finding it was noted that a review will be undertaken by the end of June and processes will be aligned and training undertaken by the end of September.

The Committee noted the update report.

6.2 *Internal Audit Report – Waiting Times*

Laura Farrell spoke to this item which noted that the audit had concluded that there was no assurance and two high risk findings had been reported. Laura referred to the first finding, namely that monthly sampling and checking of patient waiting times is not operating in line with NHS Scotland guidance. It was noted that sampling of patient records has not taken place since October 2019 and management had been unaware of this. For the second finding it was noted that governance arrangements have not been operating consistently resulting in a lack of scrutiny. It was noted that

the Access Board had not met between March 2020 and January 2021 due to the pandemic and had only been meeting intermittently prior to that time resulting in an absence of governance oversight during this period. It was noted that appropriate assurances had been received against both recommendations with a detailed action plan being put in place to recommence the monthly audits and the Access Board having started to meet on a more regular basis. Gareth Clinkscale confirmed that the sampling of patient records had stopped in October 2019 and this had not been picked up, primarily due to the Access Board being stood down for a number of months due to the pandemic. Gareth advised that this group is now meeting on a regular basis and the Terms of Reference is currently being refreshed and there will be more of a focus around assurance in terms of national guidelines in relation to all access standards. It was noted that there is a functionality on Trak which will allow an electronic audit to be undertaken which will reduce the manpower associated with this task. Until this is in place the manual audit sampling would take place. Kirk Lakie advised that the issue around the use of unavailability and retrospective adjustments picked up in 2012/13 within another Board meant all Boards had been audited independently with Borders getting a clean bill of health at that point. It was noted that Borders' use of unavailability is generally very low and Kirk was keen to establish a dashboard to provide baseline information on the use of unavailability and retrospective adjustments month on month to allow assurance to be taken if numbers remain low. Sonya Lam enquired where the Access Board reports to within the organisation. Ralph Roberts advised that this reported to the Clinical Executive Operational Group prior to the pandemic. It was noted that an exercise is currently underway to map out where groups will report in future and it was anticipated that this would report to the Operational Planning Group going forward but yet to be confirmed. Fiona Sandford asked for an explanation of unavailability codes. Kirk explained that there is guidance around the recording of patient waiting times which includes definition of patient-initiated unavailability, a category which suspends recording of the length of wait (i.e. 'stops the clock'). Patients can initiate this situation when they choose to request another date for treatment due to holidays etc. During this period the patient is not actively waiting. Kirk offered to provide the Committee with a summary of unavailability codes and where these should be applied if that would be helpful. This was agreed. Ralph Roberts added that once someone is identified as unavailable the time for which they are unavailable does not apply to their waiting time measurement hence the importance of this being done in an appropriate way otherwise it could be seen as a way of changing the Board's performance against waiting times targets.

The Committee noted the report.

6.3 *Internal Audit Report – Primary Care Improvement Plan (PCIP)*
Laura Farrell spoke to this item which noted that the audit had concluded that there was partial assurance with improvement required and two medium and two low risk findings had been reported. For the first medium finding it was noted that there was a lack of detailed action plans at the workstream level with no clear action plan to meet the objectives of the PCIP. For the second medium finding it was noted that there was inconsistencies in the progress reports from each of the workstreams to the PCIP Exec Team. It was also noted that the IJB did not receive a regular update in relation to the PCIP with this appearing to be on an ad hoc basis rather than a standing item on the agenda. For the low risk findings Laura advised there was a lack of KPIs to measure achievement of PCIP priorities for all the worksteams and owing to two key members of staff retiring there was a loss of knowledge and continuity. Laura noted that from discussion with management there was an opportunity of embedding these roles within Primary Care going forward. Rob McCulloch-Graham accepted the report in full and highlighted the management responses which provided

detail on how the areas identified would be improved. Rob went on to provide some background where it was noted that the Primary Care Exec Team had been formed a number of years ago to drive through the six workstreams included within PCIP and the group is made up of officers within NHS Borders, four GP's and himself representing the IJB. Rob accepted that there is no significant evidence of KPIs and advised that management will work with the workstreams to develop these. Rob explained that the IJB had received two full updates to date, with the expectation of them receiving three during the course of the year. Rob assured that if any decisions are required to be made these would be taken as appropriate to the IJB. In regard to staffing Rob confirmed that a thorough handover is being undertaken with those staff leaving post and advised that there has been agreement to appoint further project management staff to drive through the overall plan. It was noted that as this is a mainstream piece of work resources have been allocated within the Primary and Community Services team. As a final point Rob advised that the Primary Care Exec Team had been put in place to implement PCIP in line with the Government's Memorandum of Understanding (MoU) and the GMS Contract and this has worked so well that it will be retained within Borders as it will be instrumental in taking forward the Primary Care Strategy. Malcolm Dickson referred to the finding relating to reporting to the IJB suggesting this be a standing item on the agenda and appreciated that the IJB had received updates, albeit not as regular as felt would be adequate, but felt it was for the IJB to decide how often it received an update report. Ralph Roberts assumed that the report would be issued to the IJB Audit Committee for them to reflect on this finding. Jo Brown confirmed that she was content for the report to be shared with the IJB Audit Committee. Rob agreed to ensure that that they are provided with a copy of the report to take this forward. Sonya Lam referred to the MoU and asked if this was likely to change and if this was the case would the six workstreams still progress. Rob did not expect the MoU to change the six priority areas, any changes would be more in relation to the GP contract and he did not envisage a major impact. Ralph Roberts added that three workstreams will be progressed over the year but over time all six will require to be delivered. Malcolm Dickson noted that although there were shortcomings identified within the report, it had to be acknowledged the remarkably rapid progress made with PCIP over the past few months and this had not been hampered by the pressures of the pandemic to quite the same extent as other areas of the organisation had been.

The Committee noted the report.

6.4 *Internal Audit Annual Report 2020/21*

Jo Brown spoke to this item. Jo explained that the annual report ties up all of Internal Audit's work undertaken during 2020/21 and provides the audit opinion as required by the Public Sector Internal Auditing Standards. This is also used to inform management's consideration around the governance statement which links to the Annual Report and Accounts. Jo drew the Committee's attention to page 11 which provided details of Internal Audit's overall opinion for 2020/21 which was noted as partial assurance with improvement required. In particular the patient sampling of waiting times data which gave no assurance was listed, as well as the ongoing work NHS Borders are taking forward with risk management, as areas which management may wish to include within the Governance Statement. Malcolm Dickson asked for clarification around the assurance framework as it stated this was reviewed on at least a quarterly basis by the Board as he did not feel that this was the case. Jo clarified that by assurance framework they meant the broad framework around risk management and the consideration of strategic risks which would impact on the Board's objectives. Jo agreed to amend this paragraph to provide clarity.

Andrew Bone reminded of the session held with Non Executive Directors on the draft annual accounts in May and that during that session there were some comments around the relevance of disclosures etc. Andrew explained that one of the routes for making disclosures within the annual accounts is through issues raised within Internal Audit's Annual Report and wished to clarify that from the Annual Report presented today elements had been picked up which will become disclosures within the final accounts. An example of this would be the no assurance around the waiting times audit as this is deemed as high risk.

The Committee noted the report.

6.5 *Draft 3 Year Internal Audit Plan 2021/22 – 2022/23 & Annual Plan for 2021/22*
Jo Brown spoke to this item and explained that the report presented was the draft three year Internal Audit strategy for discussion today. Jo explained that in drafting the plan the strategic risks facing the organisation are taken into consideration. It was noted the plan is devised taking into account the Public Sector Internal Audit Standards and the audit universe. It was further noted that the plan is also drafted whilst taking into account NHS Borders' Internal Audit budget.

Jo advised that the plan had been discussed with individual Directors as well as the Board Executive Team. It was noted that the plan sets out 102 Internal Audit days which is comparable to prior years and is across six reviews and the follow up process. James Ayling appreciated there was a budget set for Internal Audit but asked if this had been reviewed to ensure that it was still adequate for what was required to be looked or if the scope is determined by the extent of the risk or by the size of the budget we currently have. Andrew advised that when the tender was undertaken the budget was not reviewed to see if what we were spending was adequate for the level of risk we had, however no issues had been raised over the last year. Jo added that the work undertaken within the current budget was sufficient to allow them to provide an opinion for the Governance Statement and if it was felt at any point that the budget was not going to allow them to do this it would be raised with the Director of Finance. Jo assured that they work with management around emerging risks and do consider flexing the plan or building in additional works if required. Sonya Lam referred to the sickness absence audit as she felt that the remit for this audit should be much broader as there appeared to be a larger risk around the recruitment and retention of staff. Jo advised that this had also arisen when the Board Executive Team had considered the plan and confirmed that she would be happy to reconsider the scope and broaden it for that particular audit if required. This was agreed.

Malcolm Dickson went on to raise some questions on behalf of Tris Taylor and following discussion it was agreed that it would be more appropriate to pick these up outwith the meeting. Jo offered to run a session on Internal Audit to provide an overview of the function of Internal Audit and how it operates within NHS Borders, if that would be helpful, particularly for the new members. Andrew noted that a similar offer had been put forward from External Audit.

The Committee discussed the draft 3 year Internal Audit Plan 2021/22 – 2022/23 and approved the Annual Audit Plan for 2021/22 with the proviso that the scope for the sickness absence audit is broadened to include recruitment and retention.

7. **External Audit**

7.1 *Audit Scotland Report – Tracking the Implications of Covid19 on Scotland Public Finances*
Andrew Bone spoke to this item which was an update to an earlier report from Audit Scotland which drew out the areas of focus for future audit arising from the pandemic.

The Committee noted the report.

8. **Fraud & Payment Verification**

8.1 *NFI Update*
Susan Paterson spoke to this item and advised that she had included the full report presented at the previous meeting for the benefit of the new members. Susan highlighted that out of 1,113 matches a total of 1,018 have been investigated, with the remainder being followed up. Susan highlighted the "Payroll to Amberhill" match and advised that further discussion with Counter Fraud Services was required. It was noted that a further three matches have been received since the report was issued which would be included within the report to the September meeting.

The Committee noted the update.

9. **Integration Joint Board**

The Committee noted the link to the IJB Audit Committee agenda and minutes.

10. **Items for Noting**

10.1 *Information Governance Committee Minutes: 23rd March 2021 (Draft)*

The Committee noted the draft minutes of the Information Governance Committee on 23rd March 2021.

10.2 *Audit Committee Self-Assessment Checklist*
Andrew Bone spoke to this item. Andrew reminded the Committee that a self-assessment is completed on an annual basis, however due to the new members and a new Chair in July it had been agreed to undertake this exercise again within approximately six months. Andrew confirmed that the recommendations within the report had been taken forward by the Audit Committee Chair with the Board Chair.

The Committee noted the consolidated self-assessment and the agreed actions which had been progressed.

13. **Any Other Competent Business**

None.

14. **Date of Next Meeting**

Extraordinary meeting arranged for Tuesday, 20thJuly 2021 @ 2.30 p.m.

Monday, 13th September 2021 @ 2 p.m., MS Teams.

Minutes of a Meeting of **Borders NHS Board Audit Committee** held on Tuesday, 20th July 2021 @ 2.30p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director
Mr M Dickson, Non Executive Director (Chair)
Ms S Lam, Non Executive Director
Mrs F Sandford, Non Executive Director
Mr T Taylor, Non Executive Director (Left meeting at 2.45 p.m.)

In Attendance: Mr A Bone, Director of Finance
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs K Hamilton, Chair
Mrs S Harkness, Senior Finance Manager
Mr A Haseeb, Senior Audit Manager, Audit Scotland
Mrs S Paterson, Deputy Director of Finance, Head of Finance
Dr T Patterson, Director of Public Health
Mr G Samson, Audit Senior, Audit Scotland
Mrs G Woolman, Director, Audit Scotland

1. **Introduction, Apologies and Welcome**

Apologies were received from Mr R Roberts, Chief Executive and Mrs Joanne Brown, Director, Audit, Grant Thornton.

Malcolm Dickson advised that, following discussion with the Director of Finance, the agenda would be re-ordered with item 3, 4 and 5 to be considered in the revised order of 5, 4 and 3. This was in order to highlight to Committee members the changes to the Board accounts prior to consideration of the Auditor's report, and to make members aware of the implications of an issue related to the Endowment accounts.

2. **Declaration of Interest**

Malcolm Dickson declared that his sister in law is an Executive Director at Northumbria Healthcare Trust.

3. **2020/21 Annual Audit Report (including ISA 260 requirement)**

Gillian Woolman presented this item. Gillian referred to the covering letter and advised that subject to receipt of a revised set of annual report and accounts for final review, it was anticipated that an unqualified audit opinion would be issued. Gillian confirmed that the audit had been undertaken using the Audit Scotland Code of Audit Practice and a final version of the annual audit report would be issued once the annual report and accounts have been certified. Gillian went on to take the Committee through the covering letter highlighting key areas. Gillian referred to appendix B, namely the proposed wording for the letter of representation, and confirmed that this would be reviewed again in light of the issue with the Endowment Fund accounts. Gillian proceeded to take the Committee through the draft annual audit report for 2020/21 and

highlighted the key messages and any other areas of interest to members. Although there would be late changes to the Board accounts, as reported by Susan Paterson, Gillian felt that the report gave assurance to Committee members on the annual accounts for 2020/21.

Malcolm Dickson referred to paragraph 15 noting the much improved working papers and felt Finance officers deserved to take the credit for this and noted his appreciation. Malcolm also referred to item 8 of the action plan, namely required ICT improvements and in particular prioritising disaster recovery testing, as he felt that assurance was required that this would be followed up. Andrew Bone confirmed that he would ensure that the Committee has sight of progress made against these going forward.

The Committee noted the 2020/21 annual audit report from External Audit.

4. **Corporate Governance Framework**

4.1 *Review of Corporate Governance Framework 2020/21*
Susan Paterson spoke to this item. Susan explained that the aim of the document was to provide evidence on the level of scrutiny undertaken to allow the Chair of the Audit Committee to sign a Statement of Assurance and ultimately allow the Chief Executive to sign the Board's Governance Statement. Susan referred to appendix 4, namely the letter from the Chair of the Audit Committee to the Director of Health Finance, Corporate Governance and Value in regard to any significant issues which required to be raised. Susan confirmed that there were no significant issues which required disclosure to the Scottish Government Audit and Risk Committee. Andrew Bone added that he had advised the Director of Health Finance, Corporate Governance and Value at Scottish Government of the endowment issue and he was fully aware of the situation. James Ayling referred to page 16 as there appeared to be narrative missing at paragraph 17. Susan agreed to add in the missing text.

The Committee reviewed and commented on the Corporate Governance Framework for 2020/21.

5. **Annual Accounts 2020/21**

Andrew Bone referred to the issue in regard to the management of investment income gains and losses and advised that the Board of Trustees have commissioned independent legal advice. As the outcome of this was still awaited it was not yet known whether or not any adjustments would be required to the accounts, therefore the Committee would be unable to recommend to the Board approval of the annual accounts as the Endowment Fund accounts formed part of the consolidated Board accounts. Andrew felt that it was very likely that an adjustment would be required to the Endowment Fund accounts and if material enough they may require to be brought back to the Audit Committee. It was noted that there may also be an impact on the extraordinary Board meeting on the 28th July 2021 to approve the annual accounts with this potentially having to be re-scheduled.

Gillian Woolman confirmed that Audit Scotland would link with Geoghegans, the External Auditor for the Endowment Fund but stressed that whilst the value of the funds would be material in relation to the group accounts, the nature of the adjustment may

not be regarded as significant. This would be clarified by follow up and Audit Scotland would amend their final report if necessary to provide commentary on this issue.

5.1 *Final Annual Report and Accounts 2020/21*
Susan Paterson spoke to this item. Susan referred to the covering report which listed the amendments made to the version seen at the session for Non Executive and Executive Directors on 2nd June 2021. Susan highlighted that there had been two substantive changes made, namely inclusion of figures for the IJB outturn and reserves and charges for PPE and Covid testing kits. It was also noted that correction was required within the presentation of the IJB position within the Board's accounts, a net surplus having been incorrectly presented as a net deficit. This would be amended within the final version as well as the relevant Notes affected by this. Asif Haseeb asked for clarification in regard to the IJB accounts that changes would also be made to the prior year. Susan confirmed that they would be and a comparator over the two years would also be provided within the final version.

The Committee noted the final Annual Report and Accounts for 2020/21 and the most recent adjustments made to these.

5.2 *Final Endowment Fund Annual Report and Accounts 2020/21*
Susan Paterson spoke to this item and advised that the accounts had been audited by Geoghegans, the External Auditor for the Endowment Fund. Susan confirmed that there had been no substantive changes from the last pack seen, with only two minor amendments which she highlighted. It was further noted that the issue in relation to the treatment of investment income gains and losses would be addressed prior to presentation of final Endowment accounts. Andrew Bone referred back to the earlier discussion (Item 5) and the expectation that the changes to Endowment fund accounts will be determined through consideration of independent legal advice commissioned by Trustees. Andrew advised that these changes would be subject to further audit and that the actions to address this issue will be shared with Audit Scotland with regard to their audit of the consolidated Board accounts.

The Committee noted the final Endowment Fund Annual Report and Accounts for 2020/21 as presented, and that these remain draft pending conclusion of the issues highlighted.

5.3 *Final Patient's Private Funds Annual Accounts 2020/21*
Susan Swan spoke to this item and advised that these accounts had been audited by Geoghegans. Susan explained that these funds are typically held on behalf of patients in long stay beds and formed part of the consolidated Board accounts. It was noted that an unqualified opinion had been received.

The Committee noted the final Patient's Private Funds Annual Accounts for 2020/21.

6. **<u>Any Other Competent Business</u>**

Malcolm Dickson thanked all Committee members, both past and present, for their support as he stepped down as Chair and to the Internal and External Auditors for all their help and assistance throughout his chairmanship.

Karen Hamilton, on behalf of the Committee, thanked Malcolm for his integrity and diligence as Chair of the Audit Committee over the past 3 years.

It was noted that a further meeting of the Audit Committee may be required to review final accounts following resolution of the outstanding issues discussed.

7. **Date of Next Meeting**

Monday, 13th September 2021 @ 2 p.m., Microsoft Teams

BE
06.08.21

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

ENDOWMENT FUND BOARD OF TRUSTEES MINUTES 07.06.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Endowment Fund Board of Trustees with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board for mutual awareness.

Impact of item/issues on:

Strategic Context	As per the Endowment Fund Board of Trustees Terms of Reference, the Board of Trustees report to OSCR and ensure that there is mutual awareness with Borders NHS Board.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 7th June 2021 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Mrs N Berry, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee
Mr M Dickson, Trustee (Chair)
Dr L McCallum, Trustee
Mrs L O'Leary, Trustee
Cllr David Parker, Trustee
Dr T Patterson, Trustee
Mr R Roberts, Trustee
Mrs F Sandford, Trustee

In Attendance:
Ms C Barlow, Fundraising Manager
Mrs B Everitt, PA to Director of Finance (Minutes)

1. **Introduction, Apologies and Welcome**

Malcolm Dickson welcomed those present to the meeting. Apologies had been received from Mrs K Hamilton, Trustee, Ms Sonya Lam, Trustee, Mrs A Wilson, Trustee, Mr J McLaren, Trustee, Mr T Taylor, Trustee, Mrs J Smyth, Director of Strategic Change & Performance and Mrs S Paterson, Deputy Director of Finance.

2. **Declaration of Interests**

There were no declarations of interest.

3. **Minutes of Previous Meeting – 17th May 2021**

The minutes were approved as an accurate record

4. **Matters Arising**

Action Tracker

The action tracker was noted.

5. **Endowment Fund Annual Accounts 2020/21**

5.1 *Final 2020/21 Report from Trustees and Annual Accounts*
Andrew Bone referred to the email circulated earlier in the day which recommended deferring approval of the Endowment Fund Annual Accounts at today's meeting. Andrew explained that this was due to issues raised, both at the Endowment Strategy workshop and on receipt of the draft Annual Accounts, around the appropriateness of treatment of investment income and how this is applied within the accounts. Andrew felt that there was sufficient concern around the way in which this income is treated to warrant deferral of approval to the accounts pending further investigation. Andrew advised that legal advice would require to be sought to ascertain whether or not the treatment of this income was permissible both in accounting terms and charity

law. It was noted that the Scottish Government has extended the deadline for approval of NHS Board consolidated accounts to 30th September 2021 and that there is therefore flexibility to extend approval of the Endowment Fund annual accounts within this overall timescale. Andrew provided Trustees with an update on the issues that had been raised around the treatment of this income noting that the current treatment appears to have been in place for a number of years but that there is no written policy which describes this approach. Andrew outlined the issues raised as follows:

> Income generated on investments and the gain or losses on the investment portfolio are currently recognised through unrestricted funds. Andrew noted that the question raised by new Trustees was whether this approach was compliant with current charity law and whether this income should in fact be attributed to restricted or unrestricted funds in proportion to the investment within the overall portfolio. Lucy O'Leary referred to the large number of restricted funds and asked if there was a sense of the length of time that funds may potentially not have been receiving income due to them. Andrew was unable to confirm at this time but recognised that this is likely to be a matter for further investigation and that any proposed resolution would be developed with regard for legal advice once received.

Andrew went on to provide Trustees with a list of actions which would require to be considered in relation to this, namely:

- Defer approval of accounts until legal advice is sought. This was agreed.
- Key individuals scope out exactly what advice is being sought. Agreed that the Director of Finance, James Ayling and Harriet Campbell meet to discuss this within the next two weeks.
- Procurement of legal advice and what steps to be taken. Andrew asked for a view on whether advice should be sought from the CLO or from an independent organisation. Andrew proposed waiving the usual tendering process due to the tight timescales should independent advice be the preference. James Ayling suggested asking the CLO in the first instance on the appropriateness of asking them for advice on this topic. This was agreed.
- Andrew proposed suspending any further commitment against unrestricted funds, including the General Fund, until this matter is resolved. Ralph Roberts asked if there were any current commitments which would require to be paused or would the intention be to only put a hold on any expenditure from this point. Colleen Barlow advised that she was aware of one request in the last six weeks and would need to check that this had been fully spent. Colleen agreed to check the status of this and other bids over the last 12 months. Harriet Campbell highlighted that some projects will be using underlying capital funding and felt that these should be able to progress rather than being put on pause.
- There was a risk that income may require to be redistributed and Andrew suggested that the General Fund be held as a provision for this. It was felt that by suspending any further spend on the General Fund this action would suffice rather than creation of a specific provision. Andrew acknowledged that in effect this would provide the same mitigation of any financial risk. It was agreed that Andrew would work

with Colleen to provide Trustees with an update on any existing plans against which there may be a requirement to suspend expenditure.

- James Ayling proposed that Internal Audit, using contingency days within the annual audit plan, be requested to undertake an audit if it was felt this is required once legal advice has been sought. Agreed that this should be discussed further at the meeting between the Director of Finance, James Ayling and Harriet Campbell to determine if this is required.
- Director of Finance to discuss with Geoghegans, External Auditor for the Endowment Fund and Audit Scotland, the Board's External Auditor.
- A governance review to be undertaken of all the relevant paperwork and processes as previously agreed. This was confirmed.
- As per discussion at the last meeting the Director of Finance will be writing out to Trustees within the next two weeks outlining proposals for setting up an Endowment Governance Working Group.

Malcolm Dickson appreciated that Trustees may still wish to comment, or seek clarification, on other areas within the accounts and suggested that these be forwarded to Susan Paterson within the next two weeks.

The Board of Trustees noted the update on the final 2020/21 Report from Trustees and Annual Accounts.

5.2 *External Audit Memorandum*

Andrew Bone proposed that this item be deferred until final approval of the accounts. This was agreed.

6. Governance Framework

6.1 *Endowment Governance Working Group – Draft Workplan*

Andrew Bone provided a verbal update where it was noted that all the governance documentation, routinely reviewed as part of the workplan in January, will be in scope as part of the governance review to be undertaken and will include any other issues raised over the last 12 months. The working group would include a small number of Trustees but Andrew assured that all Trustees would have the opportunity to comment on the final pack. It was noted that there may be potential for discussion with the Scottish Charity Regulator (OSCR) should any policies require to be amended on the back of the findings.

The Board of Trustees noted the update.

7. Any Other Business

Grant Application to NHS Charities Together

Colleen Barlow advised Trustees that the Staff Wellbeing Group were working up a further grant application to NHS Charities Together to secure £77k for staff mental health and resilience coming out of the pandemic. An update paper would be provided to the September Board of Trustees meeting.

The Board of Trustees noted the update.

8. **Date and Time of Next Meeting**

Monday, 27th September 2021 @ 2 p.m. via MS Teams.

An extraordinary meeting to be arranged to approve the Endowment Fund Annual Accounts when timings are known.

BE
09.06.21

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Andrew Bone, Director of Finance
Author:	Samantha Harkness, Senior Finance Manager

FINANCIAL PERFORMANCE - AUGUST 2021

Purpose of Report:

The purpose of this report is to provide board members with an update in respect of the board's financial performance (revenue) for the period to end of August 2021.

Recommendations:

The Board is asked to:

- **Note** that the board is reporting a £3.70m deficit for five months to end of August 2021.
- **Note** the position reported in relation to Covid-19 expenditure and assumptions around funding in relation to same.

Approval Pathways:

Financial monitoring reports are issued to budget holders during the third week of each month. The reports for the period to end August were issued during the week ending 24th September.

This report was presented to BET on Tuesday 5th October 2021.

Executive Summary:

SECTION 3 provides an overview of the board's financial performance for the five months to end August 2021.
Table 1 – summarises income & expenditure for the year to date (£3.70m deficit)

Section 3.5 – describes changes impacting on the reported position arising from implementation of budget changes in line with Quarter One review. The impact of these changes is described in Table 2.

Memorandum: At month 4 the reported position was £4.55m deficit. On a 'like for like' basis the reported position at Month 5 would be £5.82m deficit. Following Q1 review the year to date position has been amended by £2.12m, recognising availability of resources to offset financial performance. This results in a restated position at Month 5 of £3.70m. The corresponding position at Month 4 would have been £2.86m. This adjustment is in line with the practice introduced in 2020/21 by the Director of Finance to align financial reporting with quarterly forecasts in order to reduce the scale and impact of late changes to financial reporting during the final quarter of the financial year.

Section 3.6 provides further commentary on the year to date performance, including key

drivers for variance against plan (budget) within business units.

SECTION 4 summarises the impact of COVID pandemic on the reported performance during the period.

SECTION 5 notes the key risks arising from the report. Financial sustainability is recorded on the board's strategic risk register and remains as 'high risk'. Management of the projected in year deficit remains subject to further discussion with Scottish government in relation to availability of additional support to non-delivery of savings.

Impact of item/issues on:	
Strategic Context	Impact on statutory financial targets.
Patient Safety/Clinical Impact	This report is for monitoring purposes and does not include any recommendations impacting on these dimensions.
Staffing/Workforce	
Finance/Resources	
Risk Implications	Risks are covered in the report.
Equality and Diversity	Compliant with Board policy requirements.
Consultation	Regular monitoring of financial performance is a requirement of the board's code of corporate governance and is not subject to consultation.
Glossary	• Acute Services includes General Surgery, Orthopaedics, Theatres And Critical Care, Obstetrics and Gynaecology, Paediatrics, Outpatients, Cancer Services, Diagnostics, BGH Pharmacy, Community Nursing, Planned Care • Set Aside includes General Medicine, Medicine for the Elderly, Accident and Emergency • IJB Directed Services includes Mental Health, Learning Disability, Allied Health Professionals, Family Health Services, External Providers, Social Care Fund, Integrated Care Fund • Corporate Directorates includes Executive Directorates, Estates and Facilities • External Healthcare providers includes Other NHS Scottish Boards, OATS, Private ECRs & Grants SGHSCD - Scottish Government Health and Social Care Department IJB - Integration Joint Board RRL - Revenue Resource Limit CRL - Capital Resource Limit AOP - Annual Operational Plan UNPACS - Unplanned Activity SLA - Service Level Agreement ECR - Extra Contractual Referrals OATS - Out of Area Treatments DME - Department of Medicine for the Elderly ASDU - Area Sterilisation and Disinfection Unit PCIP - Primary Care Improvement Plan LMP - Local Mobilisation Plan RMP - Remobilisation Plan RRL - Revenue Resource Limit

FINANCE REPORT FOR THE PERIOD TO THE END OF AUGUST 2021

1 Purpose of Report

1.1 The purpose of the report is to provide board members with an update in respect of the board's financial performance (revenue) for the period to end of August 2021.

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** that the board is reporting a £3.70m deficit for five months to end of August 2021.

2.1.2 **Note** the position reported in relation to Covid-19 expenditure and assumptions around funding in relation to same.

3 Summary Financial Performance

3.1 The board's financial performance as at 31st August 2021 is a cumulative deficit of £3.70m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for five months to end August 2021

	Opening Annual Budget[1]	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m
Revenue Income	246.40	292.97	99.78	99.59	(0.19)
Revenue Expenditure	246.40	292.97	107.24	110.75	(3.51)
Surplus/(Deficit)	**0.00**	**0.00**	**7.46**[2]	**11.16**	**(3.70)**

3.2 Following the Quarter One Review, the Boards projected outturn deficit rose from £6.4m as previously reported within the 2021/22 Financial Plan to the current position expected outturn of £8.49m.

3.3 For the period to the end of August, funding of Covid-19 expenditure has been assumed and allocated to match reported spend within business units. This approach is consistent with the presentation of the board's financial plan. It is expected that actual funding will continue to be released on a retrospective basis (as in 2020/21) following submission of quarterly Local Mobilisation Plan (LMP) tracker as part of the board's financial performance monitoring report to Scottish Government.

[1] Opening budget reflects the board's recurring budget as at 1st April and excludes ring-fenced allocations received in relation to Scottish Government portfolio budgets (non-recurring).
[2] Imbalance in year to date budget reflects phasing profile of planned income & expenditure.

3.4 In line with the financial plan and revised Quarter One Review, no efficiency savings have been reported against Business Units within the year to date position. The financial plan assumes that delivery of savings will be phased in the second half of the year following remobilisation of services. This assumption will be reviewed at end of month 6 (September) in preparation of the board's updated (mid year) forecast.

3.5 **Impact of Month 5 Adjustments on financial performance trends**

3.5.1 In order to align reporting to the assumptions outlined in the Quarter One review and to ensure consistency with the Scottish Government reporting templates a number of adjustments have been made to the financial performance report as at month 5. These adjustments also take into account the amended year end forecast of £8.49m over spend as indicated in the quarter 1 review.

3.5.2 Prior to month 5 the year to date performance has excluded a number of elements included within the forecast and financial plan which are expected to be managed corporately through the release of reserves and Scottish Government brokerage.

3.5.3 Table 2, below, shows the impact of these adjustments on financial performance trends.

Table 2 – Impact of Month 5 adjustments on financial reporting, Apr-Aug 2021

	Month 1 £m	Month 2 £m	Month 3 £m	Month 4 £m	Month 5 £m
*Unadjusted Position**	(1.13)	(2.66)	(3.35)	(4.55)	(5.82)
Adjustments at Month 5					
Board savings	0.17	0.34	0.51	0.68	0.85
New Pressures	(0.19)	(0.38)	(0.57)	(0.76)	(0.95)
Release contingency to Savings	0.11	0.21	0.32	0.43	0.53
Board Reserves - additional flexibility	0.34	0.67	1.01	1.35	1.69
Trend (adjusted)	(0.71)	(1.81)	(2.08)	(2.86)	(3.70)

**As reported Months 1-4*

3.5.4 The board savings are realised from schemes undertaken corporately (i.e. out with business units) and are matched against the element of the board's recurring deficit which was excluded from business unit savings targets within the financial plan.

3.6 **Financial Performance –Budget Heading Analysis**

3.6.1 **Income**

3.6.2 Table 3, below, presents analysis of the board's income position at end August 2021.

Table 3 – Income by Category, year to date August 2021/2022

	Opening Annual Budget £m	**Revised Annual Budget £m**	**YTD Budget £m**	**YTD Actual £m**	**YTD Variance £m**
SGHSCD Allocation	226.65	240.14	91.40	91.40	-
SGHSCD Anticipated Allocations	-	31.99	(0.44)	(0.44)	-
Family Health Services	10.24	10.99	5.02	5.02	-
External Healthcare Purchasers	4.24	4.39	1.88	1.71	(0.17)
Other Income	5.27	5.46	1.92	1.90	(0.02)
Total Income	**246.40**	**292.97**	**99.78**	**99.59**	**(0.19)**

3.6.3 The shortfall in income recoveries from external healthcare purchasers reflects the decrease to elective activity patient flows between health boards during the course of 2020/21, which continues into 2021/22.

3.6.4 Operational performance by business unit

3.6.5 The financial plan is predicated on a projected expenditure trend associated with the remobilisation of services on a phased basis to September 2021. This assumes that core operational budgets would report an under spend of £3m over the first six months of 2021/22, in line with final quarter performance in 2020/21.

3.6.6 Actual performance during the first five months of 2021/22 has been out of line with financial plan due to continuing pressures on staff and services across NHS Borders arising from the current operating environment, and an increase in Covid-19 positive patients across the NHS Borders Hospital sites. The financial plan assumptions were revisited at Q1 review in light of revised trends and continue to be reviewed in preparation of the mid year forecast.

3.6.7 Table 4 describes the financial performance by business unit at August 2021.

Table 4 – Operational performance by business unit, August2021

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	61.03	69.34	29.22	27.97	1.25
Acute Services - Savings Target	(2.13)	(2.12)	(0.88)	-	(0.88)
TOTAL Acute Services	**58.90**	**67.22**	**28.34**	**27.97**	**0.37**
Set Aside Budgets	25.30	27.24	11.38	11.77	(0.39)
Set Aside Savings	(1.09)	(1.09)	(0.45)	-	(0.45)
TOTAL Set Aside budgets	**24.21**	**26.15**	**10.93**	**11.77**	**(0.84)**
IJB Delegated Functions	105.76	132.55	52.48	52.09	0.39
IJB – Savings	(4.74)	(4.74)	(1.98)	-	(1.98)
TOTAL IJB Delegated	**101.02**	**127.81**	**50.50**	**52.09**	**(1.59)**
Corporate Directorates	32.81	24.93	4.04	4.02	0.01
Corporate Directorates Savings	(0.34)	(0.28)	(0.12)	-	(0.12)
TOTAL Corporate Services	**32.47**	**24.65**	**3.91**	**4.02**	**(0.11)**
External Healthcare Providers	28.55	30.69	12.94	12.96	(0.02)
External Healthcare Savings	(0.51)	(0.51)	(0.21)	-	(0.21)
TOTAL External Healthcare	**28.04**	**30.18**	**12.73**	**12.96**	**(0.23)**
Board Wide					
Depreciation	4.67	4.67	1.94	1.94	-
Planned expenditure yet to be allocated	(2.91)	16.39	-	-	-
Financial Recurring Deficit (Balance)	-	(11.23)	(4.68)	-	(4.68)
Financial Non-Recurring Deficit(Balance)	-	1.32	0.55	-	0.55
Board Flexibility	-	7.00	3.02	-	3.02
Total Expenditure	**246.40**	**292.97**	**107.24**	**110.75**	**(3.51)**

3.6.8 **Acute services** (non-delegated functions) are reporting a net under spend of £0.37m after non-delivery of savings. This includes a £1.25m under spend on core operational budgets. This reflects ongoing significant slippage on clinical supplies due to reduced levels of elective activity, as well as on-going vacancies against clinical workforce; vacancies are offset in part by on-going use of supplementary staffing, including agency, for both medical and registered nurse workforce.

3.6.9 **Set Aside.** Acute functions delegated to the IJB are reporting £0.84m overspend, of which £0.45m relates to non-delivery of savings. The balance is in relation to core service with increased expenditure on clinical workforce, including use of medical agency and additional nursing support to the Emergency department. Expenditure is above forecast trajectory due to continued pressure on unscheduled care flows and inpatient beds.

3.6.10 **IJB Delegated.** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an under spend on core budgets of £0.39m. A reduction in primary care services expenditure within public dental services is the main driver for the under spend reported in August. This reflects the reduction in throughput in dental services as a result of pandemic infection control measures.

3.6.11 **Corporate Directorates** are reporting a small under spend excluding savings. There are pressures within Estates linked to an increase in costs of clinical Waste, as well as cost pressures in respect of thestaff residencies, these are offset by underspends linked to vacancies and skill mix specifically across Director of Nursing and Infection Control as well as an increase in income from external customers within Laundry.

3.6.12 **External Healthcare Providers.** There is a small overspend being reported in this area linked to the unmet savings target which is mostly offset by small underspends within the core budget.

4 Covid-19 Expenditure

4.1 Reported within the Core operational budgets as detailed in table 3 is Covid-19 expenditure and anticipated funding. Table 5 summarises this within each business unit.

Table 5 – summary Covid-19 expenditure for five months to end August 2021

	Revised Annual Budget[3] £m	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Covid-19 Expenditure				
Acute Services	0.37	0.31	0.32	(0.01)
Set Aside	0.09	0.07	0.10	(0.03)
IJB Directed Services	1.66	1.61	1.64	(0.03)
Corporate Directorates	4.15	1.60	1.59	0.01
Total Covid-19 Expenditure	**6.27**	**3.59**	**3.65**	**(0.06)**

[3] The revised annual budget for COVID represents funding currently assumed within service budgets and is will continue to be amended monthly in reflection of the resource commitments identified within LMP reports.

4.2 During the last five months funding has been allocated into operational budgets in line with plans which have been approved through RPG/OPG Gold command, ensuring that expenditure linked to Covid-19 is in line with the expected Local Mobilisation plans.

4.3 The approach taken to reporting of spend is in line with SG requirements and recognises that some elements of expenditure will be financed by the board, where existing resources have been redeployed to meet Covid-19 requirements. As anticipated within the board's plan this 'direct offset' is unlikely to be material given the expected remobilisation of services over the first six months of 2021/22.

5 Key Risks

5.1 There are no new risks reported within the risk register as a result of the issues described in this report. The board continues to recognise a 'very high' risk in relation to its long term financial sustainability and this is described in greater detail within the financial plan and on the board's strategic risk register. This risk will continue to be reviewed through the board's quarterly financial forecasts.

5.2 The director of finance continues to discuss resources available to the board to support delivery of a breakeven performance. Scottish Government have confirmed that support for non-delivery of savings remains under consideration on an NHS Scotland basis.

Author(s)

Samantha Harkness Senior Finance Manager Sam.harkness@borders.scot.nhs.uk	Andrew Bone Director of Finance andrew.bone@borders.scot.nhs.uk

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

CLINICAL GOVERNANCE COMMITTEE MINUTES 19.05.21, 21.07.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Clinical Governance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Clinical Governance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

Borders NHS Board
Clinical Governance Committee
APPROVED

Minute of meeting of the **Clinical Governance Committee** held on Wednesday 19 May 2021 at 10am via Teams

Present

Mrs F Sandford, Non Executive Director (Chair)
Mrs A Wilson, Non Executive Director
Ms S Lam, Non Executive Director
Mrs H Campbell, Non Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Head of Clinical Governance & Quality
Dr L McCallum, Medical Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr J Bennison, Associate Medical Director, Acute Services
Mrs N Berry, Director of Nursing Midwifery & Acute Services
Mrs S Horan, Associate Director of Nursing/Head of Midwifery
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager
Mr K Alan, Associate Director of Public Health
Mrs E Sykes, Infection Control Nurse

1. Announcements & Apologies

The Chair noted that apologies had been received from:

Mr R Roberts, Chief Executive

The Chair welcomed:

Mrs H Campbell, incumbent non executive director member to the Committee and noted thanks to Mr J McLaren, outgoing non exec member for his contributions to clinical governance in his time as Member of Committee.

Mrs K Hamilton, Chair NHS Borders Board
Mr K Lakie, Deputy Hospital Manager item 5.5
Mr G Clinkscale, Hospital Manager item 5.6

The meeting was confirmed as quorate.

The Chair announced the Annual Improvement plan tabled at the end of the meeting is intended to be a live document and invited attendees to consider how the meeting went and feedback any comments at the end of the meeting so plan can be updated accordingly.

2. Declarations of Interest

Ms Lam declared that her Partner is Specialist Advisor with the Scottish Government. There were no other declarations of interest noted.

3. Minute of the Previous Meeting

Adjustments were made to Medical Education item paragraph four, page nine. No further amendments were made and the Minute of previous meeting held on the 17 March 2021 was approved.

4. Matters Arising/Action Tracker

Action tracker was updated accordingly.

The **CLINICAL GOVERNANCE COMMITTEE** noted the Action Tracker.

5. Patient Safety

5.1 Infection Control Update

Mr Whiting reports that the Infection Control workplan has been approved by Infection Control Committee, with the expectation further actions will be added throughout the year in line with improvement and learning activity. Mr Whiting acknowledges the plan is ambitions given the team still face challenges, in particular with capacity issues, but this is allowing the team to create opportunity to work differently. Discussion has taken place with senior leads on how the Infection Control Team can support Clinical Nurse Managers to pick up the spot check activity.

Mr Whiting gave background on how hospital cleanliness data is obtained. He noted concerns are scores are not consistent with what is happening in the wards. Audits are undertaken by domestic supervisors in their own areas and consistently being reported as compliant but the reports don't appear to be taking into account the fabric of the buildings. Mr Whiting will follow up with Supervisors to get a better understanding of their process and offer appropriate support with audits.

Mr Whiting gave update on the team capacity and how critical it is to improve the capacity of the team. Vacant post has been advertised and applications received.

Discussion took place regarding the criteria for an Infection Control Nurse and what can be further considered in terms of skill mix should they not be successful on appointing following interviews.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that processes are in place to address identified issues.

5.2 Care Home Clinical Care & Governance

Mrs Flower reports that all 26 repeat assurance visits were completed by the end of March. RAG scoring system is in place to highlight when return visits are required. A mapping exercise took place to look at roles and how these can be combined to ensure all care homes are equally covered.

Two further senior posts in care homes and two for practice educators have been advertised. It is hoped that this increase in workforce will facilitate addressing actions from gap analysis currently being undertaken.

Infection Control assurance visits continue and there is better joint working with Community Nursing, GPs and Social Care.

Discussion took place how variation in anticipatory care pathways is being addressed, the committee agreed that standardisation is challenging due to the varying systems used by the different agencies.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the ongoing work and systems in place to address any identified issues.

5.3 Quarterly Hospital Standardised Mortality Report

Mrs Jones commented that there was nothing in the report which required escalation. Mortality reviews on all COVID and 20% of non COVID deaths have been completed and report will be brought back to the Committee before presenting to the Public Board. Any learning from these reviews will be shared with the organisation.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by its content.

5.4 Strategic Clinical Risk

Mrs Pringle gave the Committee and update on the gap analysis done since previous report and the new risks with a clinical element identified. There are four clinical strategic risks in development which are not yet on the report. These will be included on the next scheduled report along with risk level.

Discussion took place regarding the meaning of unacceptable clinical performance element of the report and the need to add this risk in line with other boards. The Committee felt the title was misleading and Mrs Jones agreed to adjust it.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that systems are in place but await additional risks to be agreed before being fully assured by the content.

5.5 Elective Access

Mr Lakie attended to give Committee and overview of the rising waiting times and clinical risks this poses the organisation. The paper covers what NHS Borders have been doing to mitigate and manage these risks. Available capacity has been used to address patients in high risk groups, but this has knock on effect on routine referrals where patients face a disproportionate wait. Mr Lakie reports that the Scottish Government have introduced a clinical prioritisation framework to aid in a consistent approach to identification of patients and their clinical priority; this has been implemented and is reviewed regularly.

Good progress has been made on stabilising the system including reviewing some of the innovations introduced during the pandemic. Focus in now on putting in place infrastructure and policy to ensure conversations are taking place with patients who are now facing much longer waits. Mr Lakie explained the process the Organisation went through to adapt the framework within NHS Borders to apply it consistently.

Dr McCallum asked that the Committee note how challenging and complex this approach is from a whole system point of view. There has been no direction from the Scottish Government as yet in relation to milestones. This information will be presented at a future meeting once this information is available.

Ms Lam asked if there has been an equality & Diversity assessment of the process. Mr Lakie commented that the focus has been on clinical prioritisation framework and the complexity alluded to adding another level of complexity will be challenging. The Committee agreed that getting it right from a clinical perspective is important initially but would like to see some focus from an Equality & Diversity point.

Further discussion took place about risk issues relating to the process and Mrs Berry and Mr Clinkscale commented that this has been a very complex piece of work and the process; trajectories and milestones will be refined moving forward with support from the Scottish Government.

Ms Lam drew attention to those patients who may find it difficult to convey changes in their condition as the framework at present relies on patient self direction. Mr Lakie informed the Committee that NHS Borders are aware that this cohort will need different support and this issue is being addressed. Mr Lerpiniere referenced maintaining an oversight of patients' mental health.

Discussion took place regarding assurances to the Committee in particular with a view to progress towards milestones and conveying changes in waiting times framework and processes to the general public, in particular with a view to adherence to Duty of Candour commitment.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and asks that this item be kept on agenda in order that the Committee is fully assured of progress towards milestones.

5.6 Emergency Access Standard

Mr Clinkscale attended with presentation on Emergency Access Standard. Following the presentation there was discussion on the ongoing work to improve performance against the Emergency Access standards and the challenges and impact of sustained poor performance, particularly since the start of the pandemic.

Mrs Hamilton enquired about cost savings, Mr Clinkscale intimated that as this programme is nationally driven the focus was on improving performance and making services safer for patients. Where monies have been invested programmes are fully evaluated which includes looking at delivering efficiencies.

Mrs Wilson commented that she was concerned about capacity to deliver the amount of work required; the Committee agreed that this was a huge commitment; Mr Clinkscale commented that they were working with Clinical Governance colleagues on acquiring some Quality Improvement support.

Ms Lam asked about the trajectories for improvement and what those key indicators would like in order for the Committee to be assured that there was progress towards the plan. She also asked if they were looking at bed occupancy and re-admission rates along with the four hour target.

Mr Clinkscale agreed that there are other areas to work on but did explain that the re-admissions rate in particular was not something that was giving too much concern. Other areas for concern and the progress towards them are already reported in the divisional reports.

Dr McCallum commented that she would be interested in seeing the length of stay data and how this has been affected by de-conditioning of patients during the pandemic which may have led to longer stays or increased number of incidence of falls & pressure damage. The data will be available following DOCA+ audit which will be taking place in June.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and are assured that processes are in place but need further information on trajectories are required to be fully assured.

6. Person Centred

6.1 Patient Experience Report including Scottish Public Service Ombudsman (SPSO) position

Mrs Jones invited questions on the report.

Dr McCallum highlighted that despite all the disruption over the last 14 months we are still receiving positive responses on how well we are performing and in particular how we have coped during this past year which is testament to our staff.

Ms Lam enquired if there were any areas that the Committee needed to be mindful of or if there was correlation with other reports in terms of data. Mrs Jones commented that we are fortunate that we can keep an eye on identified ‘hot spots’ due to the structure of Clinical Governance & Quality Team so any commonalities are pickled up and addressed.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and are assured by its content

7. Effectiveness

7.1 Clinical Board Update (Acute Services)

Mr Clinkscale talked to acute services report. He commented that the Margaret Kerr reopened last month which is vital for palliative care patients.

Staff vacancy rates have increased and plans are in place to address this risk. This is being seen nationally and is a challenge. Models of care delivery will look different during recovery.

Falls remain a concern, additional bed sensors have been purchased and staff reminded on good falls management practice.

Mrs Jones has reached out to healthcare Improvement Scotland (HIS) regarding increase in falls which is being seen in all boards in Scotland. This may be linked to complications of our elderly demographic having been virtually housebound this last year being one issue. The Committee agreed that it is important to keep sight of this and continue to highlight in divisional reporting to the Committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and cannot be fully assured without further information on the issues reported.

7.2 Clinical Board update (Primary & Community Services)

Mrs Flower stated that of the eleven actions noted following Healthcare Improvement Scotland Inspection of Community Hospital eight have been closed. Education on Person Centred Care planning is underway and they are working alongside colleagues in Mental Health and Acute Services to progress this. Work is also underway on the Moving on Policy and how this will be managed across the organisation.

Mrs Wilson asked for further analysis on dental waiting times, this will be added to the next report to the Committee. Discussion followed regarding NHS dental access as this is largely being driven by the Scottish Government.

Progress on the eleven SAEs has been made and there are now only two open.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured with process in place but would like further information to be fully assured on highlighted issues.

7.3 & 7.4 Clinical Board Updates (Mental Health & Learning Disabilities Services)

Mr Lerpiniere reported that SAER activity continued to be addressed and progress had been made.

ED Crisis team have been under significant pressure in particular following changes in how referrals are coming in to the system. Staff have moved on to other areas so staffing in Crisis Team is particularly thin. Different skill mixes have been explored and staffing issues are being addressed.

Safeguarding process for out of area placement has been stepped up and visits continue when possible. The service is now assured with the care being provided whilst an alternative placement is found.

Mrs Jones acknowledged the hard work Mr Lerpiniere and the team have done in progressing SAER position forward. Mental Health Services have continued a sustained reduction in falls rate and Clinical Governance are looking at ways to capture this and share success.

Mr Lerpiniere commented that the adverse events have been looked at collectively and action plan formulated.

The CLINICAL GOVERNANCE COMMITTEE noted the above reports and is assured processes are in place to address any issues.

8. Assurance

8.1 Clinical Governance Committee Annual Improvement Plan

There was no time to discuss this item. Chair asked that the Committee keep an eye on the plan and share any views with Mrs Jones and Mrs Sandford. The plan will be updated regularly and shared with the Committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the Improvement Plan.

9 Items for Noting

There were no items presented for noting

10 Any other Business

How did we do?

- Ms Lam would like colleagues to clarify meaning of compliance and applicability in relation to Quality & Diversity in their papers.
- Dr McCallum commented that she likes this Committee and its whole system approach
- Mrs Pringle asked if there could be better clarity on assurance definitions
- Ms Campbell asked for a narrative with presentations in future
- Mr Lerpiniere asked that we rotate the Clinical Board reports on the agenda to ensure equal scrutiny.
- Mrs Hamilton thanked the Committee for welcoming her to the meeting. She asked for more clarity on the assured principles.

11. Date and Time of next Meeting

The Chair confirmed that the next meeting of the Clinical Governance Committee is on **Wednesday 21 July at 10am via Teams Call**

The meeting concluded at 12:15

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 21 July 2021** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non Executive Director (Chair)
Mrs A Wilson, Non Executive Director
Ms S Lam, Non Executive Director
Mrs H Campbell, Non Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Head of Clinical Governance & Quality
Dr L McCallum, Medical Director
Mrs N Berry, Director of Nursing Midwifery & Acute Services
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager
Mrs E Dickson, Clinical Nurse Manager Acute Services
Dr T Patterson, Joint Director of Public Health

1 Apologies and Announcements

The Chair noted apologies received from:

Mr R Roberts, Chief Executive
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr J Bennison, Associate Medical Director, Acute Services
Mrs S Horan, Associate Director of Nursing/Head of Midwifery

The Chair welcomed:

Mrs M McQuade, Clinical Director Public Dental Services	(item 7.3.3)
Mrs V Hubner, Head of Work & Wellbeing	(item 8.1)
Dr K Kiln, Public Health Registrar &	
Mrs J Brennan, Board Screening Coordinator	(item 8.2)

The meeting was confirmed as quorate.

The Chair apologised for the later arrival of Realistic Medicine Action Plan. This has been marked for noting with a more in depth discussion to come to a future meeting.

2 Declarations of Interest

Ms Lam declared that her Partner is Specialist Advisor with the Scottish Government. Mrs Campbell noted that she was dealing with estate of person who committed suicide.

There were no other declarations of interest noted.

3 Minute of Previous Meeting

Ms Lam was wrongly recorded as Mrs, updated in minute to Ms as requested. There were no further changes and minute of 19 May 2021 was approved.

4 Matters Arising/Action Tracker

Ms Lam commented on the consistency of papers. Discussion took place regarding the consistency. Mr Lerpiniere commented that the reporting parameters need to be in line with each relevant board. This will be discussed out with the meeting.

ACTION: Mrs Jones will organise meeting with Mrs Berry to discuss content of each board report and share with the Non-Executive Committee Members in order to have a more consistent approach. Nov 2021-09-08

Mrs Campbell asked where the follow up of the not assured or partially assured items are recorded.

ACTION: Mrs Campbell to contact Mrs Jones or Ms Laing with items missing from Action Tracker.

5 Patient Safety – items taken out of sequence

5.2 Care Home Clinical & Care Governance

Mrs Flower gave update on care home visits which was not fully included in paper. She reported that these visits have now been completed and a gap analysis has been initiated. This will look at areas for improvement in each of the care homes and what is required. A reference group to develop integrated healthcare framework has been set up. The Lead nurse attended the inaugural meeting and was reassured by the discussions which took place around gap analysis.

Mrs Berry commented that they have successfully recruited and appointed two Senior Nurses and two Practice Educators for Care Homes. It is anticipated that these posts will commence in August.

Discussion took place on the Care Home report and if it would sit better within the Primary and Community Services Report. The Committee agreed going forward that updates on Care Home Clinical Governance would be addressed in the Primary Care Divisional report as appropriate.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by its content and direction of travel with care homes.

5.1 Infection Control Report

Mr Whiting noted that the annual report had been written and will be presented at the Committee meeting following next Infection Control Committee.

Mr Whiting brought attention to an error on page 8 of the update; hand hygiene compliance for AHPs was 97.8% and not 84%, bringing total to 98.2%.

Laboratory has instigated a new process in response to an issue in Ward 7 regarding a delay in positive Covid results being accessed.

Training in new process for monitoring compliance is progressing but has been slow mainly due to capacity issues and staffing on wards. On a positive note Mr Whiting reported that they have been successful in recruiting a trainee infection control nurse.

Mrs Campbell enquired about Ecoli and c.diff targets and what the consequence of not reaching them. Sam explained the background and structure behind both targets and the risks and consequences. He also gave an update on the CAUTI group the change of Chair for this group and the ongoing work to address any Ecoli issues.

Further discussion took place on the Government's overview and monitoring of the targets and when they would follow up if we were consistently not meeting targets. Mrs Berry reiterated how important it was for NHS Borders to get behind the CAUTI group which will help in establishing structures to ensure the Ecoli targets are met as there is not such a robust structure as there is for c.diff reporting.

Mrs Campbell asked about the discrepancies between external monitoring and self monitoring of cleanliness. Mr Whiting explained a bit of the background into the reasons for self monitoring and acknowledged that these issues were being addressed the inconsistencies in the figures from both self and external monitoring. He explained that it was worth noting that the issues with cleanliness of the fabric of the buildings were something that was being seen Nationally.

Discussion took places about the systems and processes following a question from Mrs Lam about non adherence or badly functioning processes and systems. Estates are looking at different systems to assist in making reporting much more user friendly and streamlined. Mr Whiting agreed to bring an update on this issue within a future report to the committee.

Mrs Berry does note that there is a process within NHS Borders to report issues to Estates.

ACTION: Mr Whiting will expand the section on Ecoli and c.diff reporting to include more information.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents

5.3 Adverse Event Overview

Mrs Jones reported that the level of adverse events and learning from these remain at a stable level. And learning from adverse events has been implemented.

Mrs Jones drew attention to Duty of Candour and how it applies in Covid 19 situations. NHS Borders has sought advice advice on how this applies in a couple of different scenarios. One is in the event of Covid 19 outbreaks in a Hospital setting and the other is how it will apply when there are delays in diagnosis and treatment logged through Datix system for reporting adverse events. Mrs Jones is not aware of any events logged for delays in treatment but NHS Borders have had outbreaks during both waves one and two which were escalated through the Medical Directors and guidance was sought from Central Legal Office. This has started a National Debate on how Duty of Candour is applied. There will be a deeper dive into Duty of Candour and the annual report will be brought to Committee in September.

Ms Lam enquired about what happens with the negligible and minor events and if there was any deeper analysis into what these are and how they are addressed. Mrs Jones commented that the themes and trends are report to the appropriate groups or committees and escalated as appropriate. These are also reported thematically to the falls group for action in order not to miss any trends.

Mr Lerpiniere asked if the question about Duty of Candour extend to Covid 19 deaths in care homes now that NHS Borders have oversight of care homes. Mrs Jones confirms that this does extend to Care Homes and information is shared with Mr S Easingwood, Chief Social Work Officer.

Mrs Campbell asked that the report contain more detail on the follow up when duty of candour is triggered to give a more general assurance on a regular basis between annual reports.

Discussion followed regarding the complexities of Duty of Candour in particular in the care homes.

ACTION: Mrs Jones will discuss inclusion of instances of Duty of Candour in divisional reports.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the content but would like more regular updates.

6 Person Centred

6.1 Claims Update

Mrs Jones commented that NHS Borders are in general aware of 50% of claims as they have been through our Significant Adverse Event and Complaints processes. There are no particular themes, trends or cluster of events.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the content

7 Effectiveness

7.1 Clinical Board update (Mental Health Services)

Mr Lerpiniere presented the report he has completed a thematic review of most significant adverse events in mental health, these tend to be related to death by suicide. The review is presented to Medical Managers and Mental Health Education Group to identify common themes and how these can be addressed. The commonalities identified had been mainly around paperwork and consistency of

reporting at MDTs and care plans. There are plans to develop a death by suicide review group in line with National action plan.

CAMHS have seen an increase in young people with eating disorders placing additional demand on service. This is not unusual to the Borders as this increase has been seen Nationally. CAMHS continues to be a concern in particular the ability to meet 18 weeks treatment time guarantee which has resulted in young people being admitted to Huntlyburn which is not appropriate. Inability to admit to young persons unit in Tayside had a knock on effect on services in Borders which in turn had knock on effect on adult mental health services.

The 18 weeks target in other parts of service has also been difficult to reach with capacity and financial constraints being cited.

Mr Lerpiniere commented that figures from RENEW the new primary care mental health service had now been included in the graphs. He continued to give some background into the inevitable issues which had been highlighted as with every new service and stated that these were being addressed.

Concerns were also noted regarding the difficulties with securing bank staff which appear to have been heightened following centralising bank administration and more fixed term staff being deployed.

Discussion too place regarding the issues with CAHMS and bank staff issues. Mrs Berry gave an update on the development of dashboard which will help identify where beds are available for young people with mental health issues. She also updated the Committee on the reports produced by Lothian regarding Bank Staff centralisation and where staff are being deployed and the reports have indicated that so far this does not appear to have an adverse effect on availability of staff in the Borders.

Dr McCallum reported that she is involved with Eating Disorders Group for South East Scotland; she gave the Committee some insight into the group and their remit.

Ms Lam asked how optimistic Mental Health Service is in recruiting psychologists. Discussion followed regarding the challenges in recruiting the right calibre of staff particularly to CAHMS.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents

7.3.3 Dental Care Services update

Mrs McQuade gave an update on Dental Services and their challenges whilst working in line with guidelines. There was no available data as yet but this will be reported at a future date. Anecdotally however it appears that NHS Borders are recovering well and very much in line with National Recovery plan. They are experiencing difficulties with unscheduled care of unregistered patients which is having an effect on recovery in some practices. Recruiting to fixed term contracts to address unscheduled care would go some way to addressing this but obtaining staff is an issue with outflow into the job market.

Mrs McQuade gave an update on impact of use of PPE in aerosol generated procedures and commented that team wellbeing is extremely important and the service is doing their utmost to support them.

There is also concern around oral health inequalities is also a concern, oral health improvement programmes are now back up and running but staffing remains an issue with staff being redeployed elsewhere.

Discussion followed regarding the report and increase in private dentistry having a detrimental effect on NHS Dental Treatments and the importance of maintaining equitable access to dental health as this can have an effect on other health issues.

Mrs Sandford drew attention to the issues in compliance with ventilation recommendations to ensure that this issue is on the risk register and the Committee can be assured that this is being followed up. It is noted that Estates are supporting the repair and upgrading of ventilation.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

7.2 Clinical Board update (Learning Disabilities Services)

Out of area placements continue to be an issue all patients are reviewed appropriately. Demand and capacity modelling is underway and will be included in future paper.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents

7.3.1 Clinical Board update (Primary & Community Services)

Mr Williams commented that they are more than happy to review content of reporting and will be guided by the Committee.

The areas of concern in the report were highlighted, these being incident reporting with falls being the main issue and in particular the Knoll Hospital. This however is related to a couple of specific patients along with increased incidence of violence and aggression which has skewed the figures slightly. Incidence of pressure damage are also under review.

Staff isolating and sickness absence in community nursing has been a concern along with staff being redeployed to the acute service to address shortfalls in staffing there. Community huddled has been initiated to address staffing and bed gaps in the community.

Supporting a whole system approach there is a bid to utilise community treatment room care to help alleviate pressures on hospital emergency care.

Mrs Sandford enquired about the families not getting home support. Mr Williams noted that this is predominantly a staffing issue. The model is being reviewed and adjusted to ensure correct governance is in place. Ms Lam also commented on the care at home first service issues in particular the palliative care pathways. Again Mr Williams commented that Mrs Flower has been looking at the pathways for the management of patients in this cohort.

ACTION – Mrs Flower to bring update on palliative care pathways in the community at a future meeting.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents. Updates are required on delayed discharges, palliative care and staffing to be fully assured.

7.3.2 Primary & Community Services Falls update

The Committee agreed that this update regarding falls was covered in the Primary & Community update.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents

7.4 Clinical Board update (Acute Services)

Mrs Dickson drew attention to falls being a significant issue. Unsure why this is but they are working closely with the falls group to address this. Vacancies are continuing to cause an issue with utilisation of surge beds having a knock on effect on the ability to staff hospital appropriately.

Mrs Sandford asked if there is a plan in place to address the insufficient consultant quota. Dr McCallum gave an update on this position and the impact of test and protect tracing and staff isolation. Vacancies are not being filled but solutions are being sought across Scotland.

Mrs Pringle noted that the staffing challenges are on the operational risk register as a high risk.

Ms Lam enquired if there was data available on de-conditioned patients

Mrs Dickson is not aware of figures, discussion followed regarding National initiatives in place to address the difficulties with de-conditioned patients and how they can be supported both in the community and acute services. Mr Williams commented that linking services will help but acknowledges that this is challenging when staffing and resources are low.

Mrs Jones commented that the staffing pressures and level of strain is far greater than during initial waves of pandemic and it is important that we reflect this in the next reports to Board. Mrs Sandford also commented that it is important the Board is aware of staff resilience and how exhausted staff are now feeling.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is aware of the issues and the work on going and is not assured by the content.

8 Assurance

8.1 Work & Wellbeing Annual Report 20/21

Mrs Hubner noted that as activity is very different she is unable to compare to last years progress. Recommendations remain similar to last few years and the service acknowledges the staffing challenges. Training for senior leaders has been ongoing and they are hoping to see improvement in the next year.

Mrs Campbell noted that she is uncomfortable that counselling figures are not on the increase given discussion about staff being under immense pressure. Mrs Hubner did

note that services were suspended at the beginning of the pandemic. She did note that staff uptake of counselling has seen an increase since the report was written. Due to increase on demands on services bank staff are being utilised. Vacancy in staffing has been advertised.

Following comments from both Mrs Campbell and Ms Lam the Committee noted the importance of NHS Borders not meeting statutory and legal requirements of meeting patient staff and safety being on the risk register so the issue can be addressed.

The Committee would like to see a brief update on progress of activity at future meeting.

ACTION: update on status of activity at November's meeting.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is aware of the issues, in particular addressing legal requirements and is partially assured by the content.

8.2 Screening Services update

Dr Patterson gave a brief update on background of services since start of the pandemic and the difficulties they have faced.

Dr Kiln talked to the paper given reassurance that the service performs above the National average. Equity of access is addressed and monitored. Comparison data for this year has been looked at to ensure bowel screening waiting times which appeared to had increased in the last reporting period; she noted that the comparison data had indicated that this has not continued into this year. Dr Kiln gave an overview of maternity screening following introduction of BadgerNet system, data however is incomplete. Short Life Working Group is to be convened to address the data discrepancies.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the content.

9 Items for Noting

Realistic Medicine Action Plan has been sent to Scottish Government detailed report to come to future meeting.

Public Health Governance Group Minutes & Tracker March 2021 (a)

Acute Services Clinical Governance Board Notes May 2021 (b)

10 Any Other Business

There were no further items of competent business to record.

11 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on Wednesday 8 September at 10am via Teams Call.

The meeting concluded at 12:35

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Lynn McCallum, Medical Director
Author:	Laura Jones, Head of Clinical Governance and Quality

QUALITY & CLINICAL GOVERNANCE REPORT OCTOBER 2021

Purpose of Report:

The purpose of this report is to provide the NHS Borders Board with an exception report on activities and progress across areas of patient safety, clinical effectiveness and person centred care.

Recommendations:

The Board is asked to **note** this report.

Approval Pathways:

This report has been reviewed by the Board Executive Team.

Executive Summary:

This exception report covers keys aspects of patient safety, clinical effectiveness and person centred care in the context of the current pandemic response to COVID 19 within NHS Borders, including:

- Clinical prioritisation preparations against COVID 19 projections
- HSMR and COVID 19 deaths
- Adverse events and patient safety priorities
- Patient experience

The Board is asked to note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee.

Impact of item/issues on:

Strategic Context	The 2020 Vision for Healthcare in Scotland and NHS Borders Corporate Objectives guide this report.
Patient Safety/Clinical Impact	Clinical prioritisation is underway to manage the NHS Borders response to the demands of the COVID 19 pandemic. This has required adjustment to core services and routine care.
Staffing/Workforce	Service and activities are being provided within agreed resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response.
Finance/Resources	Service and activities are being provided within agreed resources and staffing parameters with additional

	COVID 19 resources being deployed to support the pandemic response.
Risk Implications	Each clinical board is monitoring clinical risk associated with the need to adjust services as part of the heightened pandemic response.
Equality and Diversity	Compliant.
Consultation	The content of this paper is reported to Clinical Board Clinical Governance Groups, the Pandemic Committee and Board Clinical Governance Committee.
Glossary	BGH– Borders General Hospital RSV – Respiratory Syncytial Virus CGC – Clinical Governance Committee HSMR – Hospital Standardised Mortality Rate SAERs – Significant Adverse Event Reviews SAEs – Significant Adverse Events SPSP – Scottish Patient Safety Programme ERG – Expert Reference Groups SPSO – Scottish Public Services Ombudsman

1 CLINICAL EFFECTIVENESS

1.1 Clinical Prioritisation

1.1.1 NHS Borders, along with other Boards in Scotland, are currently facing more extreme pressures on services than have been experienced in most people's working careers. Demand for services is intense and is exacerbated by significant staff challenges, due to absence and vacancies, and by the third wave increase in COVID 19 demand.

1.1.2 To deal with existing demand, it has already been necessary to reduce certain services, including elective operating and some mental health services, and to operate at staffing levels that are sub-optimal. In order to address the additional challenge of an increasing third wave of COVID 19 demand, especially hospitalisations for COVID, it may be necessary to identify and deploy staff from other areas to support the immediate pressure within the Borders General Hospital (BGH).

1.1.3 The clinical prioritisation process has been reinitiated in order to do this. This has involved:

1. All services reviewing current staffing levels, risk status and potential impact of deployment of staff away from the service at 10%, 25% and 50% of establishment
2. The Clinical Prioritisation Group has reviewed the individual service submissions and agreed which services are able to support potential release of staff and the impact of this. Services are divided into three groups
    a. Services that are fully able to release staff at 10% of establishment
    b. Services that may be able to release staff with impact on services
    c. Services that are unable to release staff

1.1.4 A risk assessment matrix has been shared to provide some objectivity to discussions Following this process, a range of services have been identified with potential to release staff. Over the last two weeks:

- detailed operational plans for deployment of staff have been developed
- fair and robust processes for deployment of staff have been confirmed

- detailed risk assessment of services following staff deployment are being undertaken
- a third Clinical Prioritisation meeting has been held to confirm these decisions

1.1.5 It should be noted that this process would be likely to move a number of services from amber status into red status, and all services would be operating at reduced capacity and with recognised risk to patient care. The Clinical Prioritisation process aims to ensure the most robust balancing of risks across services and that the process is clinically-led across all clinical boards.

1.1.6 It should be further noted that planning has to take account of a range of modelled scenarios rather than a clear prediction of demand. This unpredictability is likely to be further exacerbated by other variables as we approach winter, including levels of flu, norovirus and Respiratory Syncytial Virus (RSV) infections and the impact of unmet need during the pandemic on services. To most effectively manage this, NHS Borders will:

- Develop modelling scenarios at different levels of risk for all aspects of winter pressures
- Maintain and further develop the Clinical Prioritisation process to ensure difficult decisions around staff allocation and level of service provision are determined through a robust and considered methodology

1.1.7 The detail of this process was reported to the Board Clinical Governance Committee (CGC) in September 2021 with note that NHS Borders will need to be aware that service provision will continue to be sub-optimal due to these combinations of pressures and further more difficult clinical decisions may need to be made around continuation of services.

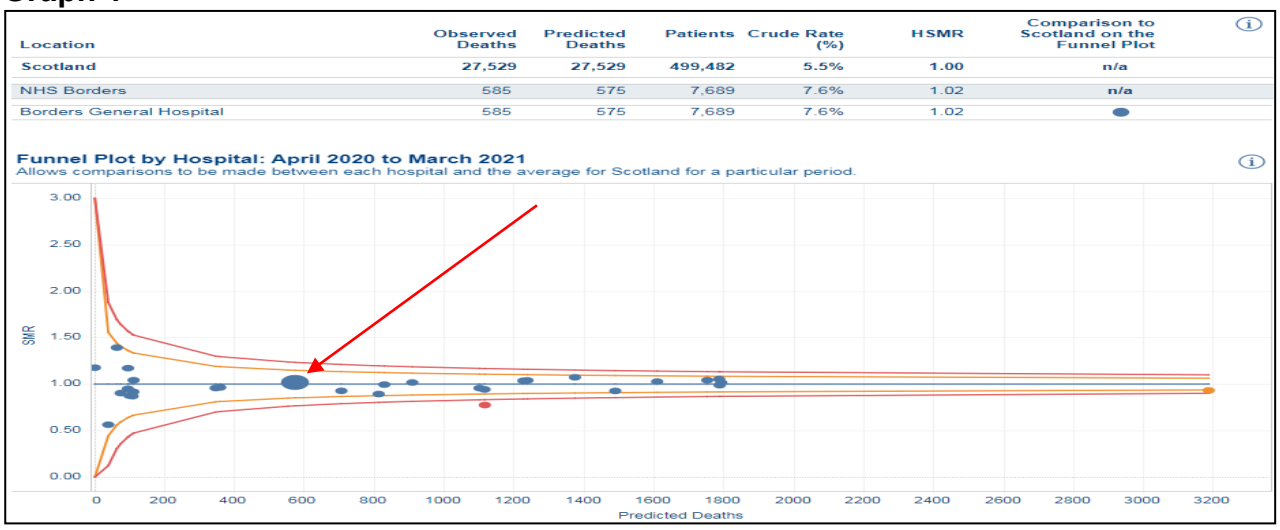
2 PATIENT SAFETY

2.1 Hospital Standardised Mortality Rate (HSMR)

2.1.1 The NHS Borders HSMR for the ninth data release under the new methodology is **1.02.** This figure covers the period **April 2020 to March 2021** and is based on 585 observed deaths divided by 575 predicteddeaths. The funnel plot below shows **NHS Borders HSMR remains within normal limits** based on the single HSMR figure for this period:

Graph 1

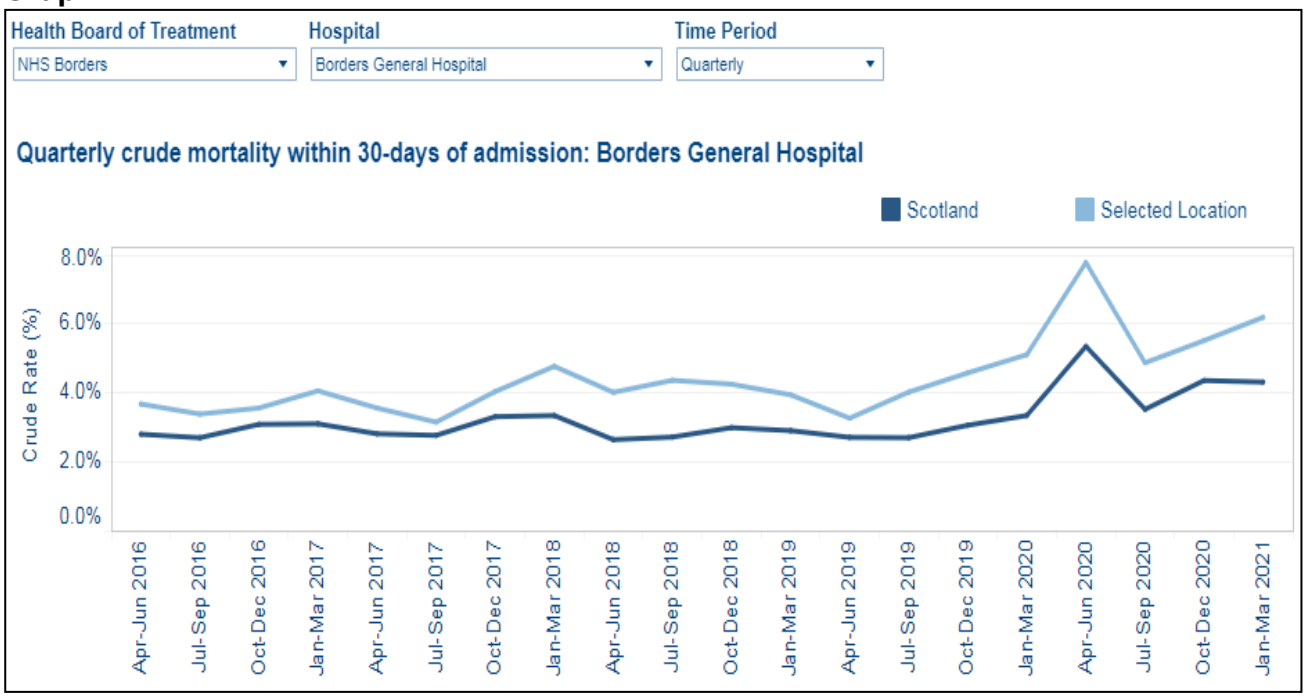
Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	27,529	27,529	499,482	5.5%	1.00	n/a
NHS Borders	585	575	7,689	7.6%	1.02	n/a
Borders General Hospital	585	575	7,689	7.6%	1.02	



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.1.2 NHS Borders crude mortality rate is presented in Graph 2 below:

Graph 2



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.1.3 NHS Borders crude mortality rate for quarter January 2021 to March 2021 was **6.2%.** No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the BGH by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.1.4 COVID deaths have contributed to an elevated crude mortality rate for the last quarter of 2019/20 and first quarter of 2020/21. During the period January to June 2020 there were additional deaths relating to COVID 19, at the same time there was a significant reduction in admissions to the BGH. As a result the crude mortality rate for this quarter is elevated.

2.1.5 During the second Wave of COVID 19 NHS Borders have experienced increased deaths from COVID 19 mirrored by an elevated crude mortality rate for the last two quarters of 2020/21.

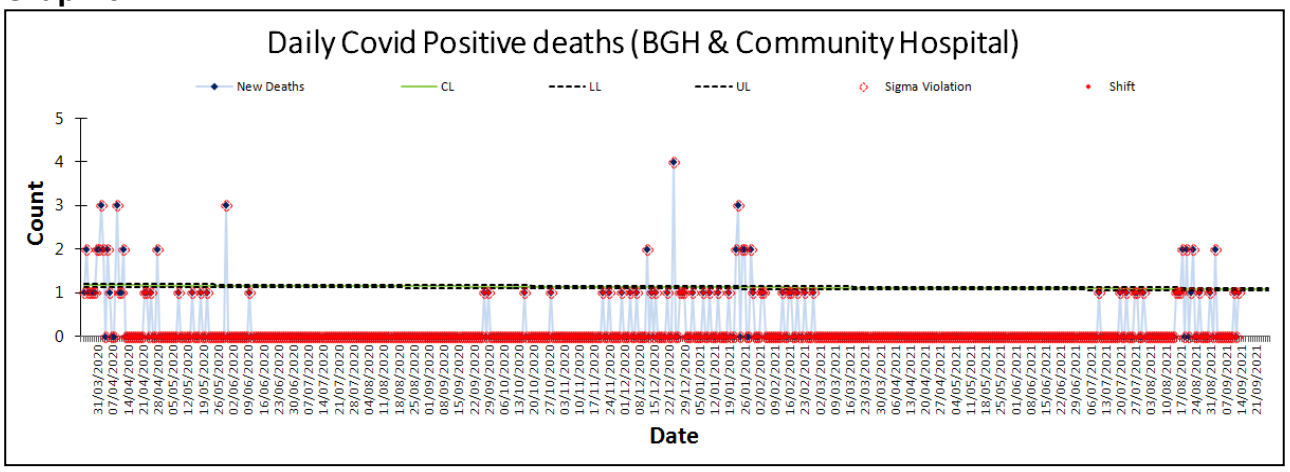
2.1.6 COVID 19 deaths between March 2020 and February 2021 occurring in a hospital within 30 days of admission have been reviewed for learning to inform the local delivery of care. Deaths from COVID 19 occurring in Wave 3 are currently being reviewed for learning to influence the organisations on-going response to the pandemic. In addition, twenty percent of non-COVID 19 deaths are reviewed as part of the continual mortality review system.

2.1.7 Advice has been sought through NHS Scotland Medical Directors and directly from the Scottish Government Chief Executiveas to how the Duty of Candour should be applied in the context of COVID 19 nosocomial spread within inpatients. Guidance is awaited to inform local actions.

2.2 COVID 19 Deaths

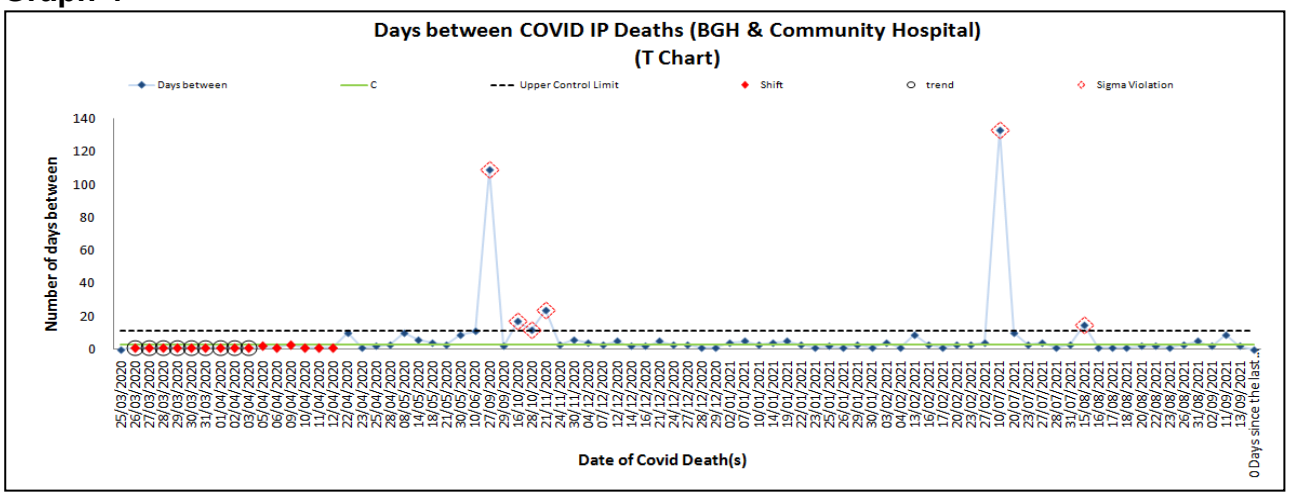
2.2.1 There have been a total of 107 COVID 19 positive deaths in the BGH or NHS Borders Community Hospitals up to the 13 September 2021. Graph 3 shows the COVID positive deaths by day:

Graph 3



2.2.2 Graph 4 shows the days between COVID 19 deaths. As at the 13 September 2021 it has been 0 days since the last COVID 19 death in the BGH or NHS Borders community hospitals:

Graph 4



2.3 Adverse Events

2.3.1 Adverse events are reported and managed through the electronic adverse recording system (Datix) system across NHS Borders.

2.3.2 Within the national framework the adverse outcome grading for all reported adverse events has been broken down into three categories:

Category 1 – Major or extreme adverse outcomes
Category 2 – Minor or moderate adverse outcomes
Category 3 – Negligible adverse outcomes

2.3.3 All adverse events are subject to a review. The level of review is determined by the extent of any harm caused to a person (the grading of the event) and decisions made by the Commissioning Manager and a triumvirate of senior managers within the organisation.

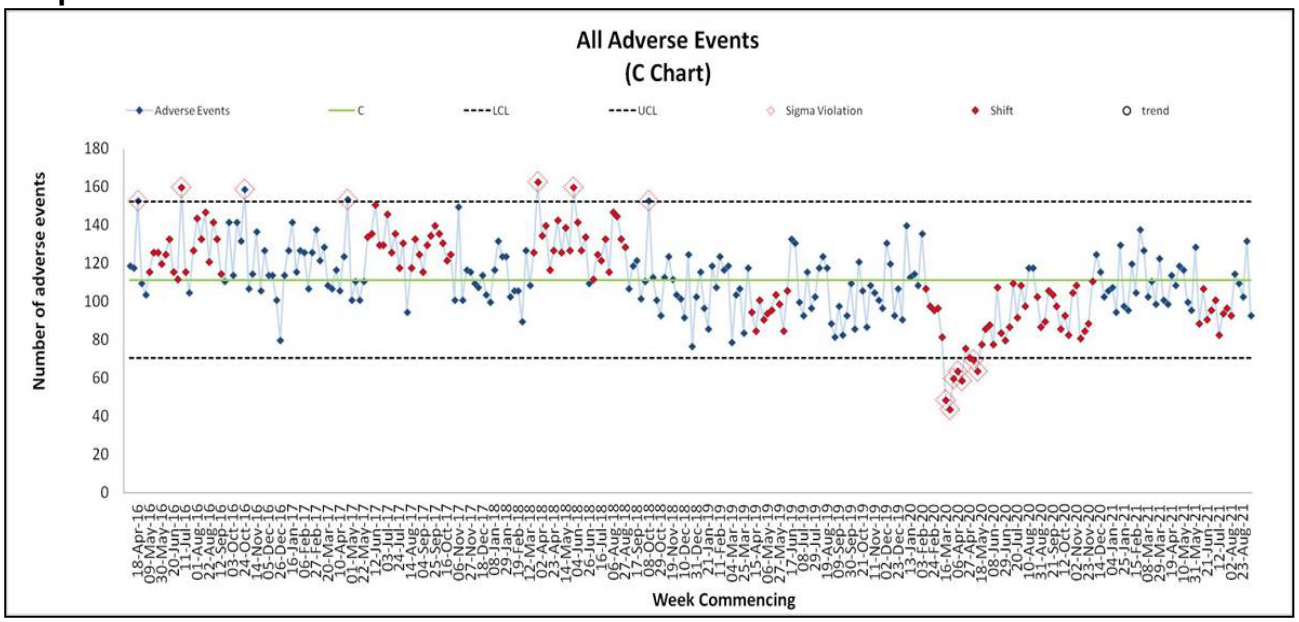
2.3.4 The review will be either a:

Level 1: Significant Adverse Event Review (SAER)
Level 2: Management Review
Level 2: Fall Review
Level 2: Pressure Ulcer Review
Level 3: Initial Review

2.3.5 This process is guided by the Adverse Event Management Policy which has been reviewed and updated to reflect the Duty of Candour requirements.

2.3.6 Graph 5 shows all reported adverse events for the whole of NHS Borders:

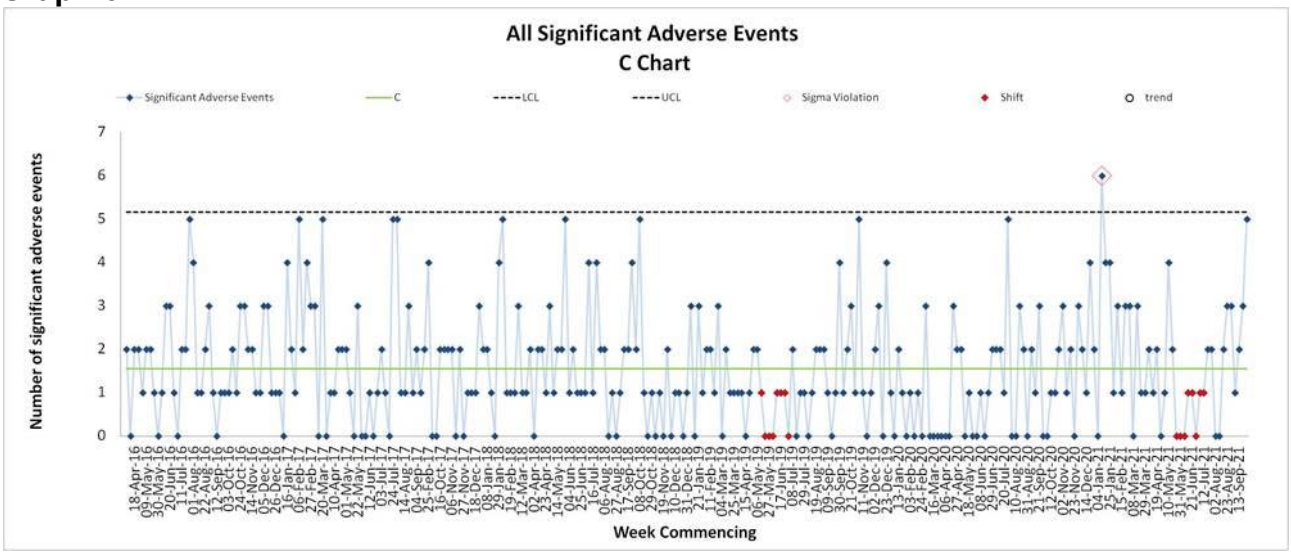
Graph 5



2.3.7 There was a period of 9 weeks between May and July 2021 where the number of adverse events had decreased, evidenced by the shift below the current average. The last 5 weeks has shown a return to normal variation.

2.3.8 Graph 6 shows all Significant Adverse Events (SAEs - Major and Extreme):

Graph 6



2.3.9 The number of serious adverse events remains within normal limits following a shift below the mean between May and June 2021.

2.3.10 Table 1 details the SAE's where a review is in progress and the type of review which is underway:

Table 1

Type of Review	Number of Reviews Underway
Level 1 Significant Adverse Event Review	15
Level 2 Management Review	4
Level 2 Fall Review	0
Level 2 Pressure Ulcer Review	4
Level 2 Drug Death Review	2
Level 2 Safety Management Review	1
Child Death Review	3
Awaiting Review Decision by Quadumvariate	2
Total	**30**

2.3.11 The patient safety team are currently supporting acute teams to complete reviews within the national timeframe and provide feedback to services. Five out of the 15 Significant Adverse Event Reviews are in the final stages of draft. SAERs have also been impacted by the current pandemic response and ongoing service pressure given the reliance on clinical and managerial colleagues to act as lead reviewers. The patient safety team continues to prioritise workload to provide as much additional support as it possible at this time ensuring SAERs continue to be progressed and that patients and families are informed of progress.

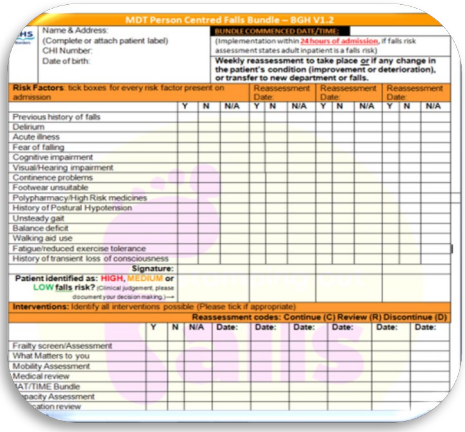
2.4 Scottish Patient Safety Programme (SPSP) Priorities

2.4.1 To remobilise the SPSP Acute Adult work streams two Expert Reference Groups (ERG) have been working nationally to identify improvement priorities. These were identified as deteriorating patient and falls prevention.

2.4.2 Testing has been carried out within four Health Boards including NHS Borders for falls, over the last few months with plans to launch the collaborative in September 2021.

2.4.3 ***Deteriorating Patient -*** Within NHS Borders we continue to see good compliance with completion of NEWS2 observations and appropriate escalation if indicated. Critical care outreach do not report any increase in workload over the changes to NEWS2 and the cardiac arrest data reflects normal variation within the BGH.

2.4.4 Development and testing is currently underway within the Community Hospitals to adapt the NEWS2 chart for the Community Hospital settings together with the trial of a Treatment Escalation Plan for use throughout the organisation which will include patient / family input as well as documentation of appropriate realistic expectations of care for each individual patient.


MDT Person Centred Falls Bundle – BGH V1.2

Name & Address: (Complete or attach patient label)
CHI Number:
Date of birth:

BUNDLE COMMENCED DATE/TIME: (Implementation within 24 hours of admission, if falls risk assessment states adult inpatient is a falls risk)

Weekly reassessment to take place or if any change in the patient's condition (improvement or deterioration), or transfer to new department or falls.

Risk Factors: tick boxes for every risk factor present on admission	Y	N	N/A	Reassessment Date	Y	N	N/A	Reassessment Date	Y	N	N/A	Reassessment Date	Y	N	N/A
Previous history of falls															
Delirium															
Acute illness															
Fear of falling															
Cognitive impairment															
Visual/Hearing impairment															
Continence problems															
Footwear unsuitable															
Polypharmacy/High Risk medicines															
History of Postural Hypotension															
Unsteady gait															
Balance deficit															
Walking aid use															
Fatigue/reduced exercise tolerance															
History of transient loss of consciousness															
Signature:															
Patient identified as: HIGH, MEDIUM or LOW falls risk? (clinical judgement, please document your decision making.)→															

Interventions: Identify all interventions possible (Please tick if appropriate)

Reassessment codes: Continue (C) Review (R) Discontinue (D)

	Y	N	N/A	Date:	Date:	Date:	Date:	Date:	Date:
Frailty screen/Assessment									
What Matters to you									
Mobility Assessment									
Medical review									
MAT/TIME Bundle									
Capacity Assessment									
Education review									

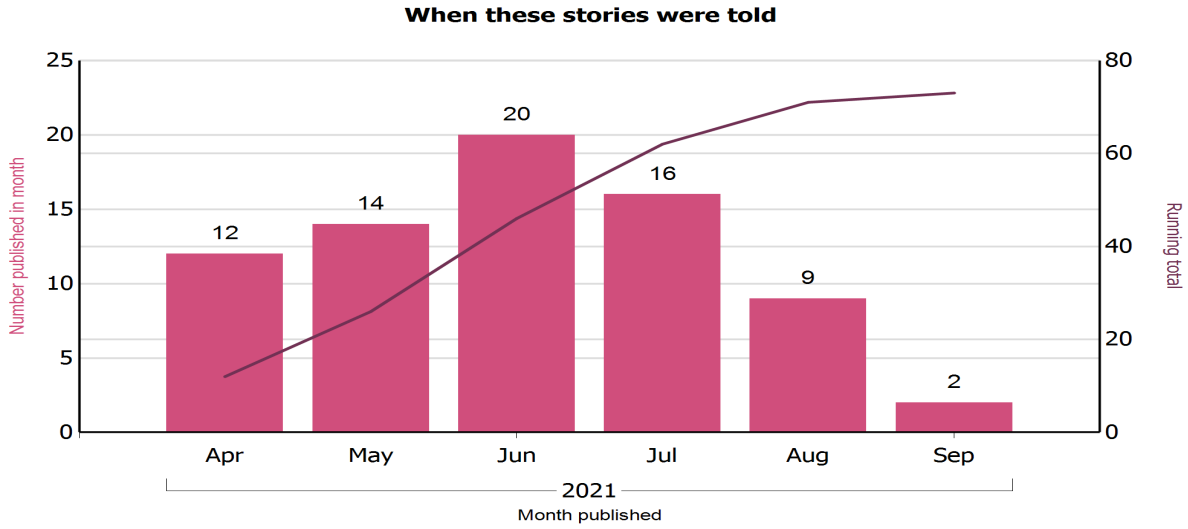
2.4.5 ***Falls/Slips and Trips -*** Falls continues to be a key priority area for NHS Borders and quality improvement work has remobilised in this area. Testing is underway of the new Multidisciplinary Team Person Centred Falls Bundle within the Medical Assessment Unit and Haylodge.

3. PERSON-CENTRED HEALTH AND CARE

3.1 Patient Experience - Care Opinion

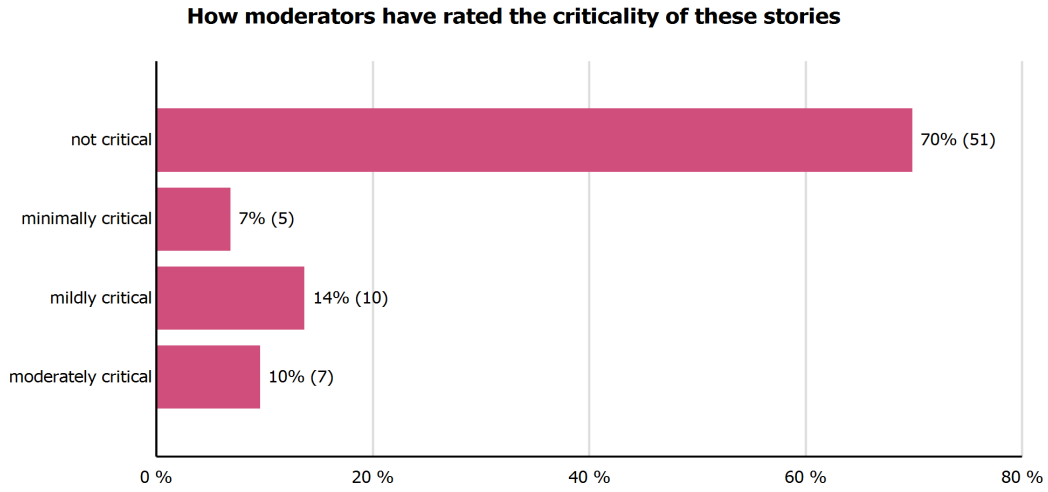
3.1.1 For the period 1 April 2021 to 31August 202173 new stories were posted about NHS Borders on Care Opinion. Graph 1 below shows the number of stories told in that period, as at 14 September 2021 these 73 stories had been viewed 10,176 times.

Graph 7



3.1.2 Graph 8 provides a description of the criticality of the 73 stories:

Graph 8

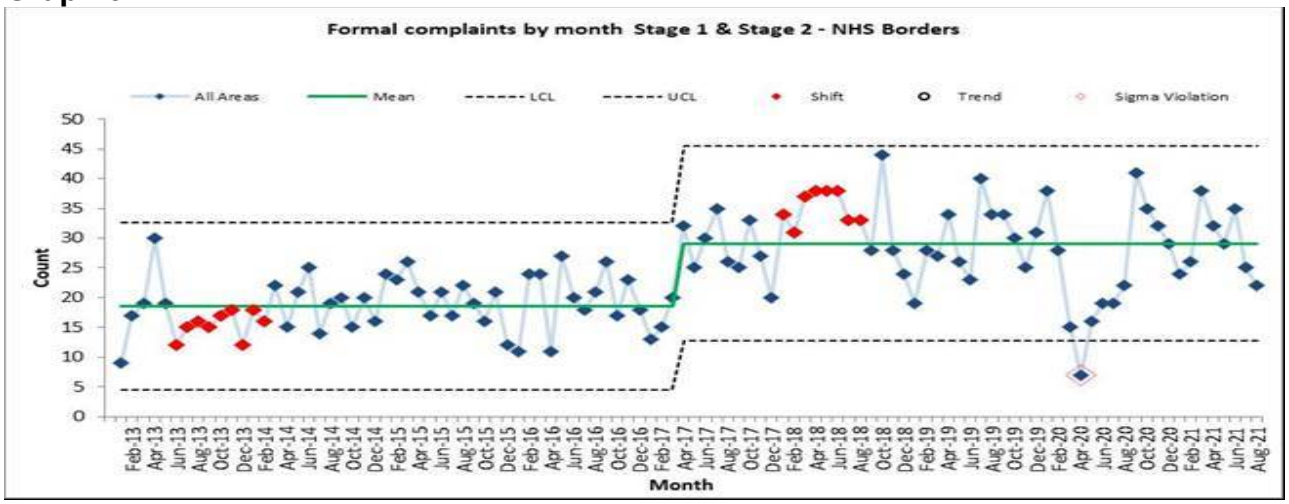


3.1.3 The word clouds below summarise what people feltwas good and what could be improved in their posts about NHS Borders for this period:

3.2 Patient Experience - Complaints

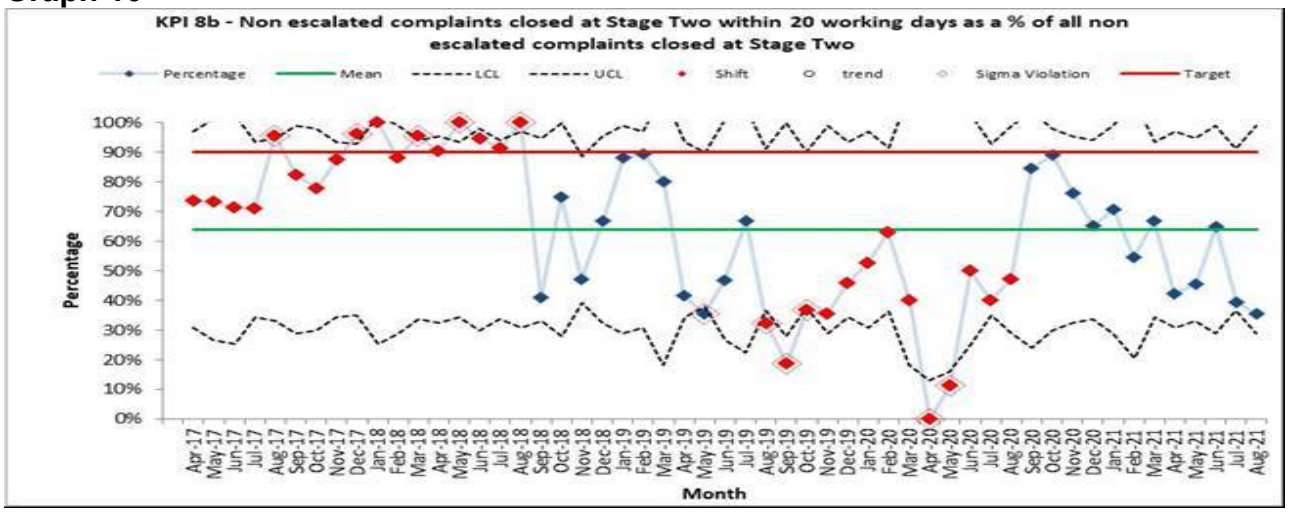
3.2.1 Graph 9 below gives the number of formal complaints received by month. The numbers of complaints being received are within normal limits following a reduction between March and August 2020 in the early months of the COVID 19 pandemic:

Graph 9



3.2.2 Graph 10 below shows the percentage of complaints responded to within 20working days. As front line services continue to prioritise the remobilisation of services and on-going response to the COVID 19 pandemic clinical pressures have impacted on the ability of frontline clinical staff to respond to complaints investigations within normal timescales. This has impacted on the ability to consistently deliver responses within the 20 working day target. This is likely to continue over the autumn and winter period with the projected service demand profile:

Graph 10

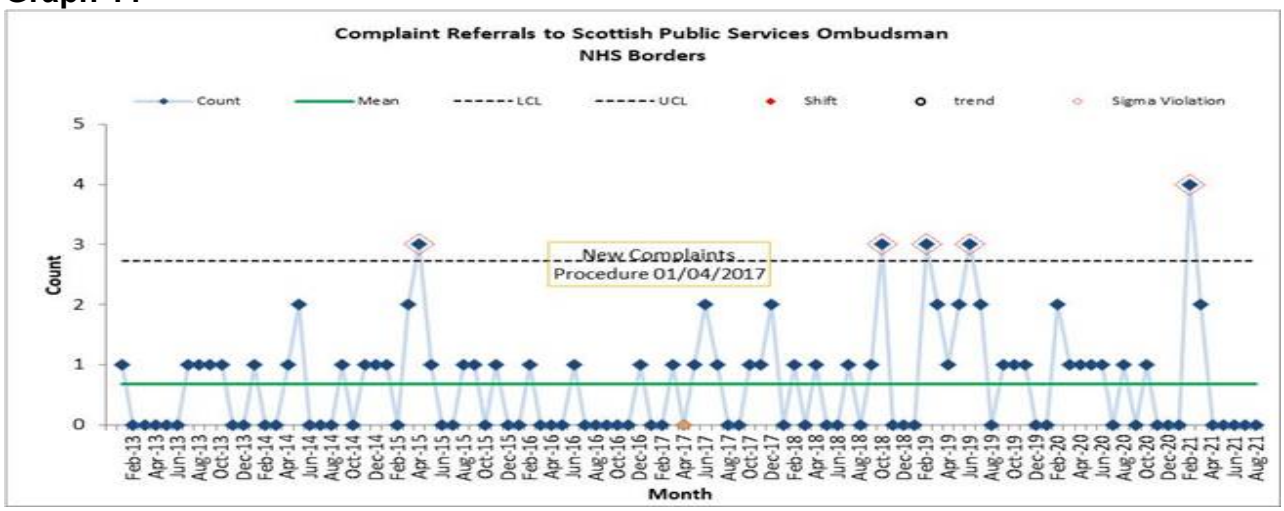


3.3 Scottish Public services Ombudsman (SPSO)

3.3.1 The SPSO are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the involvement of the SPSO is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling.

3.3.2 Graph 11 below shows complaint referrals to the SPSO to 31 August 2021. The graph shows a breach of the upper control limit in February 2021. Whilst the SPSO have not confirmed that they are investigating any new cases since March 2021, there have been two enquiries from the SPSO and a decision is awaited on whether these will be investigated:

Graph 11



Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Sarah Horan, Director of Nursing, Midwifery and AHPs
Author(s):	Natalie Mallin, HAI Surveillance Lead Sam Whiting, Infection Control Manager

HEALTHCARE ASSOCIATED INFECTION PREVENTION AND CONTROL REPORT September 2021

Purpose of Report:

The purpose of this paper is to update Board members on the current status of Healthcare Associated Infections (HAI) and infection control measures in NHS Borders.

Recommendations:

The Board is asked to **note** this report.

Approval Pathways:

The format of this report is in accordance with Scottish Government requirements for reporting HAI to NHS Boards. This report has not been submitted to any prior groups or committees but much of the content will be presented to the Clinical Governance Committee.

Executive Summary:

This report provides an overview for Borders NHS Board of infection prevention and control with particular reference to the incidence of Healthcare Associated Infections (HAI) against Scottish Government targets for infection control.

The report provides updates on:-

- NHS Borders infection surveillance against Scottish Government targets including *S.aureus* bacteraemia, *C.difficile* infections and *E.coli* bacteraemia
- Cleanliness monitoring, hand hygiene and the Infection Control compliance monitoring programme
- Infection Control work plan
- Incidents and outbreaks

Impact of item/issues on:

Strategic Context	This report is in line with the NHS Scotland HAI Action Plan.
Patient Safety/Clinical Impact	Infection prevention and control is central to patient safety
Staffing/Workforce	Infection Control staffing issues are detailed in this report.

Finance/Resources	This assessment has not identified any resource implications.
Risk Implications	All risks are highlighted within the paper.
Equality and Diversity	This is an update paper so a full impact assessment is not required.
Consultation	This is a regular bi-monthly update as required by SGHD. As with all Board papers, this update will be shared with the Area Clinical Forum for information.
Glossary	See Appendix A.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

1.1 There has been an increase in incidents related to COVID-19 across NHS Borders with evidence of nosocomial transmission. This coincides with an increase in community prevalence of COVID-19.

1.2 NHS Borders had a total of 14 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2021 and July 2021, 9 of which were healthcare associated infections.

1.2a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated SAB rate per 100,000 total occupied bed days (TOBDs) by the end of 2021/22 (using 2018/19 as the baseline).

1.2b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 16 healthcare associated SAB cases per financial year. We are not currently on target to achieve this.

1.3 NHS Borders had a total of 3 *C.difficile* Infection (CDI) cases between April and July 2021, 2 of which were healthcare associated infections.

1.3a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 total occupied bed days (TOBDs) by 2021/22 (using 2018/19 as the baseline).

1.3b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 9 healthcare associated CDI cases per financial year. We are currently on target to achieve this.

1.4 NHS Borders had a total of 40 *E. coli* Bacteraemia (ECB) cases between April and July 2021, 27 of which were healthcare associated.

1.4a The Scottish Government has set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2021/22 (using 2018/19 as the baseline) and with a total reduction of 50% by the end of 2023/24.

1.4b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 25 healthcare associated ECB cases by 2021/22. We have not met this target. NHS Borders is not currently a statistical outlier from the rest of Scotland.

2.0 *Staphylococcus aureus* Bacteraemia (SAB)

See Appendix A for definition.

2.1 Between April and July 2021, there have been 13 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 1 case of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 1 shows a Statistical Process Control (SPC) chart showing the number of days between each SAB case. The reason for displaying the data in this type of chart is due to SAB cases being rare events with low numbers each month.

2.3 Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system.

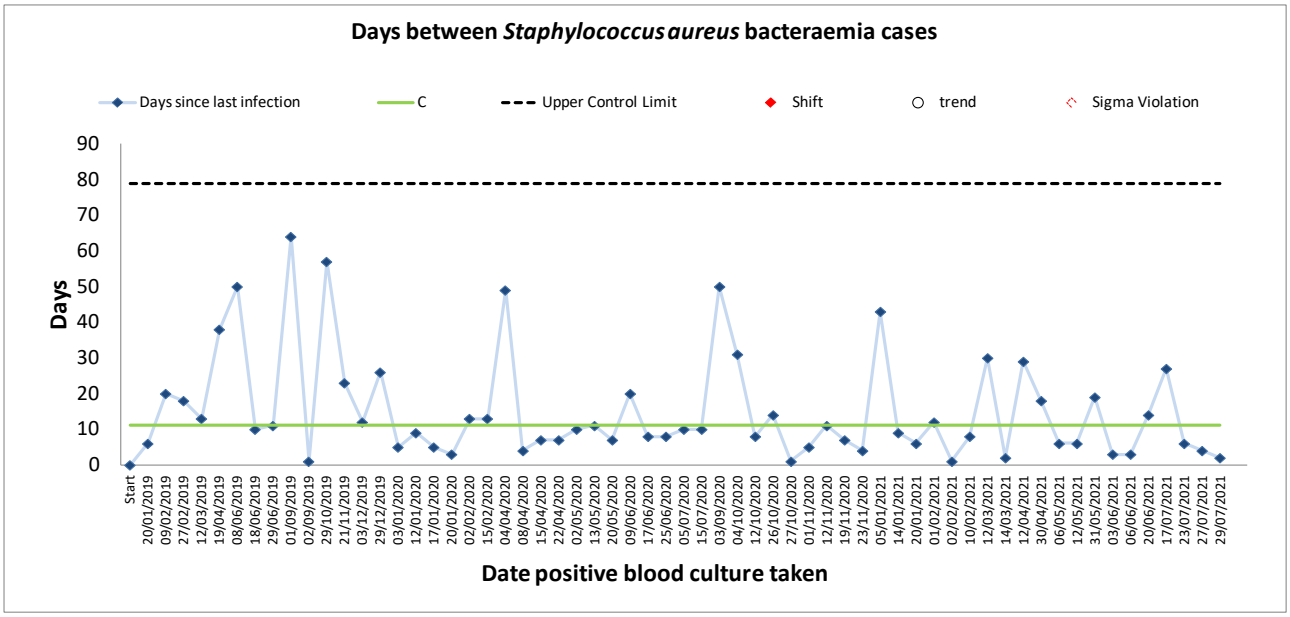


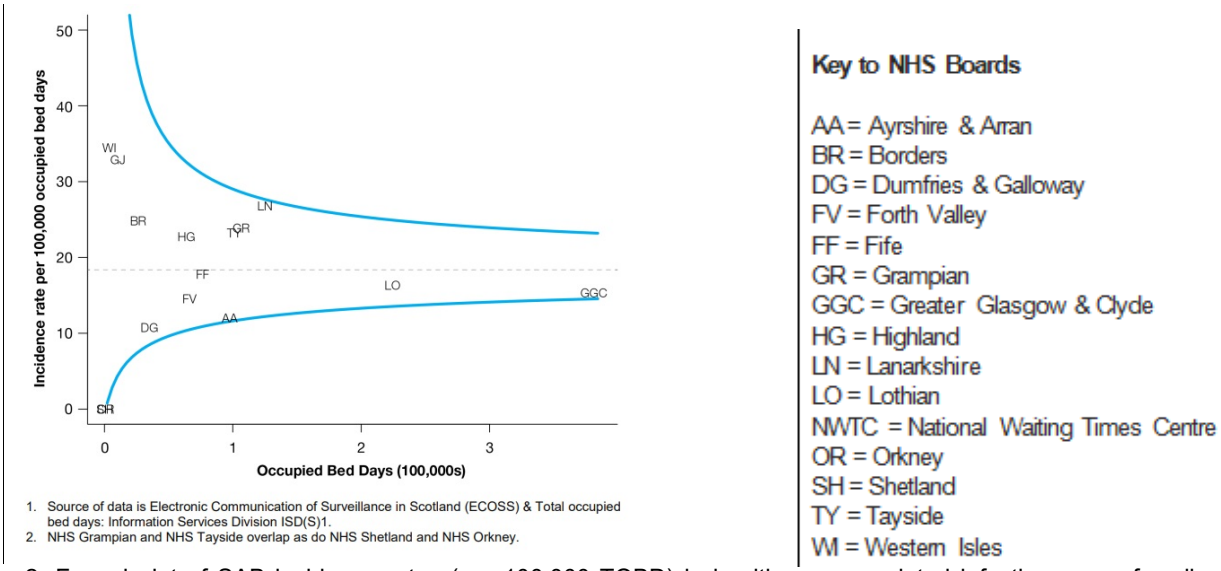
Figure 1: NHS Borders days between SAB cases (January 2019 – July 2021)

2.4 In interpreting Figure 1, it is important to remember that as this graph plots the number of days between infections, we are trying to achieve performance above the green average line.

2.5 The graph shows that there have been no statistically significant events since the last Board update.

2.6 Health Protection Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 2 below shows the most recently published data as a funnel plot of healthcare associated SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 1 2021 (Jan 2021 – Mar 2021).

2.7 During this period, NHS Borders (BR) had a rate of 24.9. The Scottish average rate was 18.4.

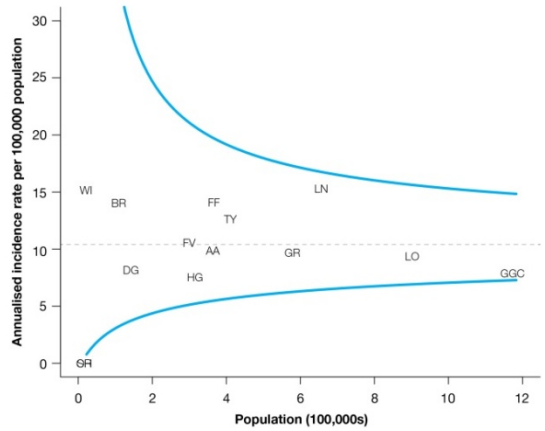


1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Grampian and NHS Tayside overlap as do NHS Shetland and NHS Orkney.

Figure 2: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q1 2021

2.8 A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger Health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days. Figure 2 shows that NHS Borders was above the Scottish average rate but within the blue funnel which means that we are not a statistical outlier.

2.9 Figure 3 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q1 2021. During this period NHS Borders (BR) had a rate of 14.0 which was above the Scottish average rate of 10.4; however, we are not a statistical outlier from the rest of Scotland. Community acquired SAB cases had no healthcare intervention prior to the positive blood culture being taken.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Shetland and NHS Orkney overlap.

Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q1 2021

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 4 below shows a Statistical Process Control (SPC) chart showing the number of days between each CDI case. As with SAB cases, the reason for displaying the data in this type of chart is due to CDI cases being rare events with low numbers each month. The graph shows that there have been no statistically significant events since the last Board update.

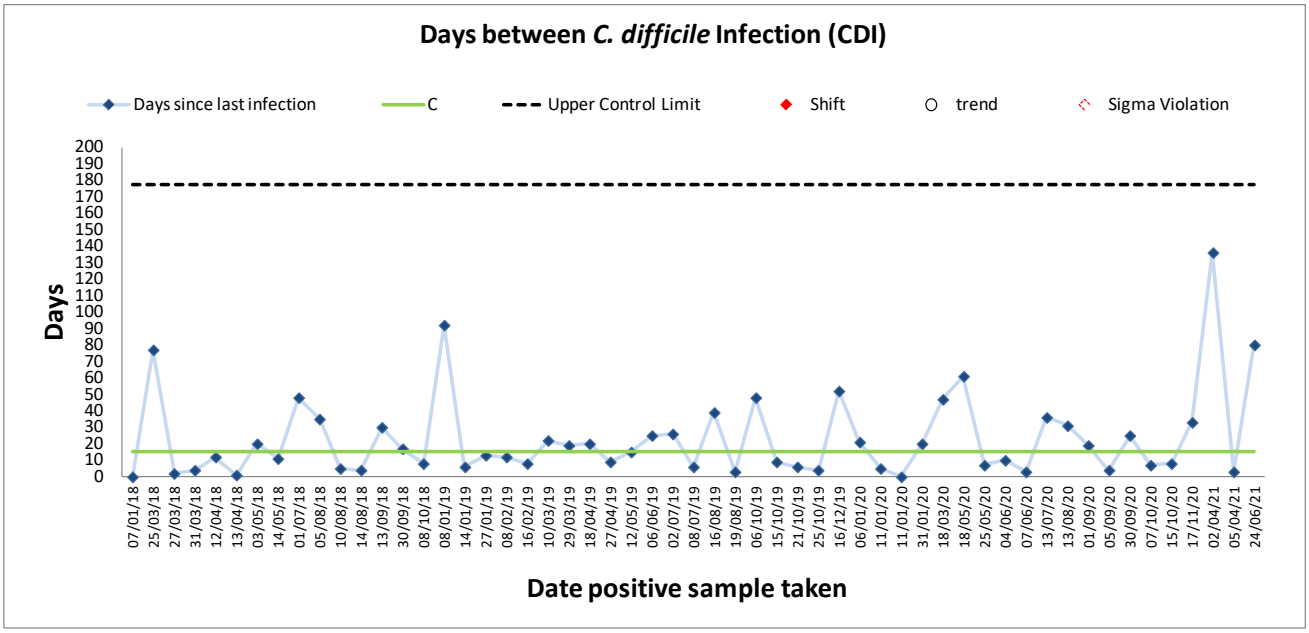
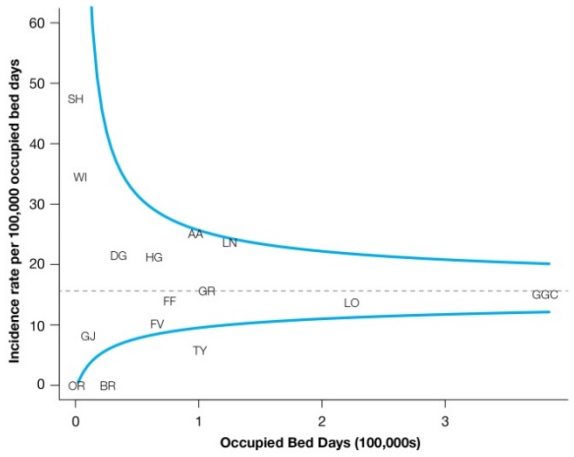


Figure 4: NHS Borders days between CDI cases (Jan 2018 – July 2021)

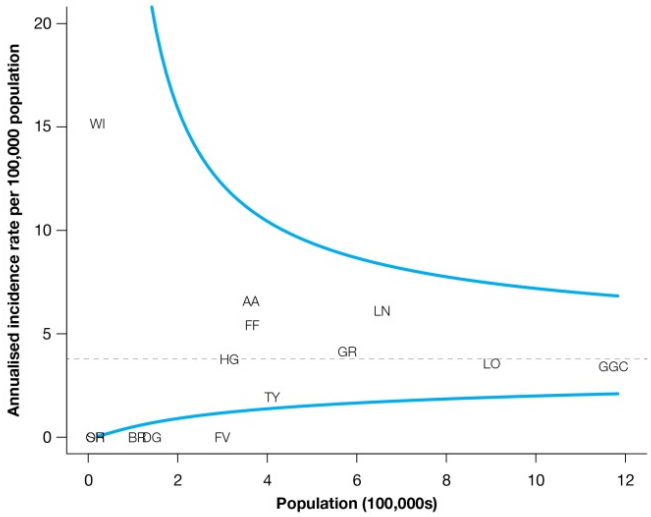
3.2 Health Protection Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q1 2021. The graph shows that NHS Borders (BR) had a rate of 0 which is below the Scottish average rate of 15.6.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q1 2021

3.3 Figure 6 below shows a funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q1 2021. The graph shows that NHS Borders (BR) had a rate of 0.0 which is below the Scottish average rate of 3.8.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Borders and NHS Dumfries & Galloway overlap as do NHS Orkney and NHS Shetland.

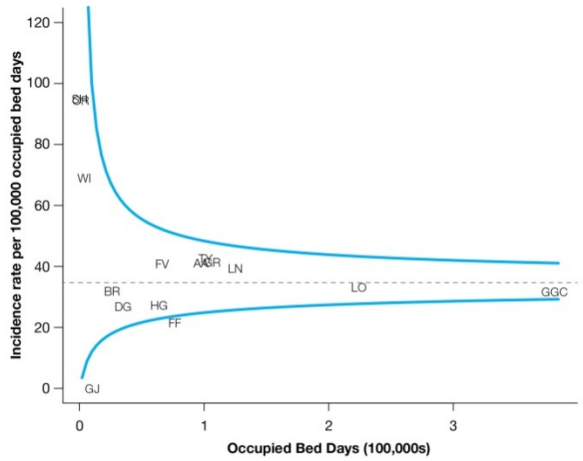
Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q1 2021

4.0 *Escherichia coli (E. coli)* Bacteraemia (ECB)

4.1 The biggest risk factor for patients in relation to *E. coli* Bacteraemia is Catheter Associated Urinary Tract Infection (CAUTI). COVID activity has been prioritised by the Infection Prevention and Control Team over the last year and this has impacted on capacity for improvement activity associated with CAUTI. The Prevention of CAUTI group has now been re-established and the group meets bi-monthly to identify and implement improvement activity.

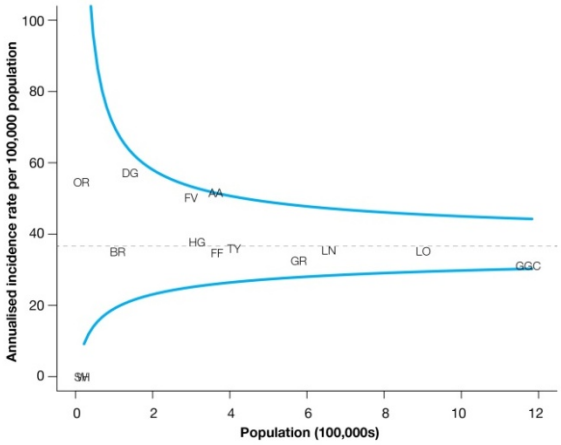
4.2 Health Protection Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 7 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q1 2021. NHS Borders (BR) had a rate of 32.0 for healthcare associated infection cases which is below the Scottish average rate of 34.7.

4.3 Figure 8 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q1 2021. NHS Borders (BR) had a rate of 35.1 for community associated infection cases which is below the Scottish average rate of 36.6. Community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Orkney and NHS Shetland overlap as do NHS Ayrshire & Arran, NHS Grampian and NHS Tayside.

Figure 7: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q1 2021



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Shetland and NHS Western Isles overlap.

Figure 8: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q1 2021

5.0 NHS Borders Surgical Site Infection (SSI) Surveillance

5.1 The Scottish Government updated the requirements for HAI surveillance on the 25th of March 2020. In light of the prioritisation of COVID-19 surveillance, all mandatory and voluntary surgical site infection surveillance has been paused from this date. Mandatory surveillance of *E.coli* bacteraemia, *Staphylococcus aureus* bacteraemia and *C. difficile* Infections has continued but as light surveillance only.

6.0 Hand Hygiene

For supplementary information see Appendix A

6.1 The hand hygiene data tables contained within the NHS Borders Report Card (section 2, p.12) are generated from wards conducting self-audits.

6.2 NHS Borders' hand gel supplier (GoJo) periodically undertook hand hygiene audits and delivered ward-based training prior to the COVID-19 pandemic. A new nurse has recently been employed by the company and visited NHS Borders on the 31st August to undertake independent hand hygiene audits across 4 areas initially. Overall compliance across these areas was 72%, however; we are awaiting a further breakdown and analysis of this data in order to inform improvement activity.

6.3 The importance of strict hand hygiene continues to be promoted as part of the COVID-19 precautions aimed at patients, staff and members of the public.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 The process of training Clinical Nurse Managers (CNMs) to complete spot checks out with their own area is ongoing. Uptake and training has been limited due to Infection Control Nurse capacity combined with staffing pressures across the acute site preventing the release of CNMs. To date, three CNMs have been trained and dates agreed for training a further two CNMs.

7.2 The IPCT will retain management and oversight of the spot checking process including collation, and reporting to governance groups of spot check outcomes.

7.3 Full detailed Standard Infection Prevention and Control Precautions (SICPs) audits continue to be completed on a risk assessed basis by the Infection Prevention and Control Nurses.

8.0 Cleaning and the Healthcare Environment

For supplementary information see Appendix A.

8.1 The data presented within the NHS Borders Report Card (Section 2 p.12) is an average figure across the sites using the national cleaning and estates monitoring tool that was implemented in April 2012.

9.0 2021/22 Infection Control Workplan

9.1 The 2021/22 Infection Control Work Plan is an ambitious work plan given the ongoing management to the COVID-19 pandemic. As at 23/08/2021 68% of actions due for completion have been completed with 7 actions outstanding.

9.2 The Infection Prevention & Control Team report to each Infection Control Committee on progress against the 2021/22 work plan highlighting potential risks associated with any delay in implementation. The Infection Prevention and Control Team prioritise activity associated with the highest risks such as outbreak management.

10.0 Outbreaks/ Incidents

COVID-19

10.1 Since the last Board update up until 31st August 2021, there have been twelve COVID-19 related incidents for which a Problem Assessment Group and/or Incident Management Team was convened. This is a significant increase in comparison to the last Board update when we reported no COVID-19 related incidents. Two of these incidents occurred in July but were single cases only and ten incidents occurred in August. This increase coincides with the rise in community COVID-19 prevalence.

10.2 Throughout the month of August, there were COVID-19 clusters in the following areas: X= Redacted data

Ward affected	Total positive patients	Total positive staff	Total deaths
Medical Assessment Unit (MAU)	8	X	X
Ward 4	X	X	X
DME 14	X	X	X
Ward 7	11	X	X

10.3 There is evidence of introductions of COVID-19 into the hospital from new admissions which reflects the wider increase in community prevalence. Whilst patients are screened for COVID-19 on admission, there are insufficient single rooms to accommodate all admissions for five days (average incubation period for COVID-19). This has resulted in a number of instances where patients in multi-bedded bays with a negative COVID-19 test on admission subsequently developed symptoms and tested positive prior to their day 5 inpatient screen, or were asymptomatic and tested positive on their day 5 screen. In these instances, each positive case resulted in multiple contacts, some of which subsequently became COVID-19 positive.

10.4 ARHAI Scotland produces data on COVID-19 cases by hospital onset status using national definitions (Appendix B). NHS Borders data for week ending July 4th 2021 to week ending 29th August is displayed in Figure 9 below.

Cumulative COVID-19 Cases by Hospital Onset Status
Summary

For NHS Borders, the total number of COVID-19 cases reported to National ARHAI Scotland, with specimen dates from week-ending 4 Jul 2021 to week-ending 29 Aug 2021, when including the community onset infections, was 2,366.

	% of total	n =
Community onset	98.6%	2,332
Non-Hospital onset	0.7%	17
Indeterminate Hospital onset	0.2%	4
Probable Hospital onset	0.2%	4
Definite Hospital onset	0.4%	9
Grand Total	100.0%	2,366

Figure 9: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

10.5 NHS Borders is working with ARHAI Scotland to undertake further analysis of the recent COVID-19 clusters and single case incidents. This analysis includes Whole Genome Sequencing (WGS) of COVID-19 positive cases from August 2021 to identify potential epidemiological links and routes of transmission of COVID-19 within the healthcare environment. The review is ongoing but initial feedback has confirmed nosocomial transmission and links between some of the clusters.

10.6 Learning from each incident is captured and acted upon in real time where appropriate. A full learning review of all incidents and outbreaks has not yet been completed due to the prioritisation of COVID-19 management.

11.0 Infection Prevention and Control Team Capacity

11.1 Following successful interviews, a new trainee infection control nurse commenced post on the 10th of August. One further infection control nurse post has been advertised and candidates shortlisted.

11.2 The Infection Prevention and Control Team are currently undertaking a service review with the potential for future skill mix alterations.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections *(*also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as hand hygiene and cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections *(CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA). More information on these organisms can be found on the NHS24 website:

Clostridioides difficile :**http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1**

Staphylococcus aureus :http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA:http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets
There are national targets associated with reductions in *C.diff* and SABs. More information on these can be found on the Scotland Performs website:

http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Understanding the Report Cards – Hand Hygiene Compliance
Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – *'Out of Hospital Infections'*
Clostridium difficile infectionsand *Staphylococcus aureus (*including MRSA*)* bacteraemiacases are associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
MRSA	0	0	0	0	0	0	0	0	0	1	0
MSSA	1	4	4	0	4	3	2	2	3	3	5
Total SABS	1	4	4	0	4	3	2	2	3	4	5

Clostridioides difficile infection monthly case numbers

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Ages 15-64	1	0	0	0	0	0	0	0	0	1	0
Ages 65 plus	2	2	1	0	0	0	0	2	0	0	0
Ages 15 plus	3	2	1	0	0	0	0	2	0	1	0

Hand Hygiene Monitoring Compliance (%)

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
AHP	100	100	100	98.1	100.0	98.0	98.8	98.8	97.8	96.4	97.8
Ancillary	96	100	100	91.9	94.9	96.7	99.3	92.6	100	98.8	95.2
Medical	100	100	100.0	100.0	92.3	95.0	97.0	92.4	96.3	96.2	94.3
Nurse	99.5	100	98.7	99.6	99.6	98.5	97.7	99.3	98.8	97.3	97.6
Board Total	**98.8**	**100.0**	**99.7**	**97.4**	**96.7**	**97.1**	**98.2**	**95.8**	**98.2**	**97.2**	**96.2**

*Self audit hygiene data reporting paused due to prioritisation of COVID-19 related work

Cleaning Compliance (%)

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Board Total	93.3	96.3	96.3	96.2	97.4	95.3	95.4	95.1	95.3	95.5	96.0

Estates Monitoring Compliance (%)

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Board Total	98.8	98.1	98.2	98.0	98.2	99.6	98.1	98.7	97.1	97.6	97.2

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	2	2	0	2	2	2	1	0	1	2
Total SABS	0	2	2	0	2	2	2	1	0	1	2

Clostridioides difficile infection monthly case numbers

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Ages 15-64	1	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	1	1	0	0	0	0	2	0	0	0
Ages 15 plus	1	1	1	0	0	0	0	2	0	0	0

Cleaning Compliance (%)

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Board Total	96.1	95.5	96.3	95.4	96.5	96.0	96.7	97.3	93.6	95.3	96.1

Estates Monitoring Compliance (%)

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Board Total	99.4	99.0	99.1	98.1	99.1	98.8	99.1	98.5	93.1	95.5	95.0

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Haylodge Community Hospital**
- **Hawick Community Hospital**
- **Kelso Community Hospital**
- **Knoll Community Hospital**

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	1	0	0	0	0	0	0	0	0
Total SABS	0	0	1	0	0	0	0	0	0	0	0

***Clostridioides difficile* infection monthly case numbers**

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

***Staphylococcus aureus* bacteraemia monthly case numbers**

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
MRSA	0	0	0	0	0	0	0	0	0	1	0
MSSA	1	2	1	0	2	1	0	1	3	2	3
Total SABS	1	2	1	0	2	1	0	1	3	3	3

***Clostridioides difficile* infection monthly case numbers**

	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021
Ages 15-64	0	0	0	0	0	0	0	0	0	1	0
Ages 65 plus	2	1	0	0	0	0	0	0	0	0	0
Ages 15 plus	2	1	0	0	0	0	0	0	0	1	0

Appendix A

Definitions and Supplementary Information

Staphylococcus aureus Bacteraemia (SAB)

Staphylococcus aureus is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *Staphylococcus Aureus* (MSSA), but the more well known is MRSA (Meticillin Resistant *Staphylococcus Aureus*), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be found at:

Staphylococcus aureus : http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA:http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemia. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemia for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemia can be found at:

http://www.hps.scot.nhs.uk/haiic/sshaip/publicationsdetail.aspx?id=30248

Clostridioides difficile infection (CDI)

Clostridioides difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridioides difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridioides difficile* infections can be found at:

http://www.hps.scot.nhs.uk/haiic/sshaip/ssdetail.aspx?id=277

Escherichia coli bacteraemia (ECB)

Escherichia coli (*E. coli*) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell.
When it gets into your blood stream, *E. coli* can cause a bacteraemia. Further information is available here:

https://www.gov.uk/government/collections/escherichia-coli-e-coli-guidance-data-and-analysis

NHS Borders participate in the HPS mandatory surveillance programme for ECB.This surveillance supports local and national improvement strategies to reduce these infections and improve the outcomes for those affected. Further information on the surveillance programme can be found here: https://www.hps.scot.nhs.uk/a-to-z-of-topics/escherichia-coli-bacteraemia-surveillance/

Hand Hygiene

Information on national hand hygiene monitoring can be found at:

http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at:

http://www.washyourhandsofthem.com/

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%.The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by the Healthcare Environment Inspectorate. More details can be found at:

http://www.nhshealthquality.org/nhsqis/6710.140.1366.html

APPENDIX B

ARHAI Scotland COVID-19 Hospital Onset Definitions

Day of sampling post admission	Nosocomial categorisation
Before admission	Community onset COVID-19
Day 1 of admission/on **admission to NHS board**	Non-hospital onset COVID-19
Day 2 of admission	Non-hospital onset COVID-19
Day 3 of admission	Indeterminate hospital onset COVID-19
Day 4 of admission	Indeterminate hospital onset COVID-19
Day 5 of admission	Indeterminate hospital onset COVID-19
Day 6 of admission	Indeterminate hospital onset COVID-19
Day 7 of admission	Indeterminate hospital onset COVID-19
Day 8 of admission	Probable hospital onset COVID-19
Day 9 of admission	Probable hospital onset COVID-19
Day 10 of admission	Probable hospital onset COVID-19
Day 11 of admission	Probable hospital onset COVID-19
Day 12 of admission	Probable hospital onset COVID-19
Day 13 of admission	Probable hospital onset COVID-19
Day 14 of admission	Probable hospital onset COVID-19
Day 15 of admission and onwards to discharge	Definite hospital onset COVID-19
Post discharge	Community onset COVID-19

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Sarah Horan, Director of Nursing, Midwifery & AHPs
Author:	Paul Williams, Associate Director AHPs and NHS Borders Falls Lead

CARE OF OLDER PEOPLE IN HOSPITALS: UPDATE ON FALLS

Purpose of Report:

As requested by Borders NHS Board this paper provides an update on NHS Borders' current position in relation to the prevention and management of Falls and the future strategic approach across the Health and Social Care Partnership.

Recommendations:

Borders NHS Board is asked to **note** the current situation and strategic approach being taken by NHS Borders in relation to falls prevention and management. It is asked to **note** the ongoing challenges facing clinical teams, clinical governance improvement facilitator capacity and staff capacity to engage in strategic and quality improvement work.

Approval Pathways:

This report has been approved by Sarah Horan, Executive NMAHP Director and has been reviewed by the 'Back to Basics' clinical governance group.

Executive Summary:

- The incidence of both falls and falls with harm within NHS Borders has increased over the last 12 months.
- The clinical governance team continues to provide significant support to clinical areas regarding ongoing falls management and prevention in an inpatient setting
- NHS Borders Falls Strategic Group has reconvened and is delivering on 3 workstreams:
    - Inpatient falls management
    - Community prevention and pathways
    - NHS Borders Falls prevention strategy
- The impact of the Covid-19 pandemic has contributed to an increase in inpatient falls, and a disruption to falls prevention pathways and services.
- In order to deliver on the 3 workstreams identified, opportunities for internal and external support are being explored.

Impact of item/issues on:

Strategic Context	Falls prevention and falls management continue to be a significant driver both locally and nationally and the impact of community falls have a direct impact on NHS services and system pressures.

	This works aligns to the Older People's Pathway which is a current priority across the HSCP.
Patient Safety/Clinical Impact	Falls remain one of NHS Borders' largest reportable incidents on Datix and Falls with harm remain an ongoing risk.
Staffing/Workforce	Current workforce pressures have the potential to impact staff compliance with falls documentation and clinical decision making. Staffing pressures may also impact staff engagement with strategic work and additional capacity is needed to develop community pathways and Board strategy document.
Finance/Resources	Request for external funding through the Healthcare Improvement fund was sought but unsuccessful. Other avenues of external funding are currently being explored.
Risk Implications	Falls and falls with harm remain a risk within many clinical areas. The organisational risk to not addressing community falls prevention should not be ignored.
Equality and Diversity	Nil applicable
Consultation	Nil at present
Glossary	AHP – Allied Health Professions NMAHP – Nursing, Midwifery, Allied Health Professions SAS – Scottish Ambulance Service CGC – Clinical Governance Committee MAU – Medical Assessment Unit SBC – Scottish Borders Council QI – Quality Improvement

1. Aim

1.1 The aim of this report is to provide an update to Borders NHS Board on the work that is underway across NHS Borders in relation to falls prevention and management. It is hoped that this report will provide assurance that NHS Borders is taking the correct approach to falls prevention strategically and that appropriate processes and systems are in place for the ongoing clinical governance work around falls management.

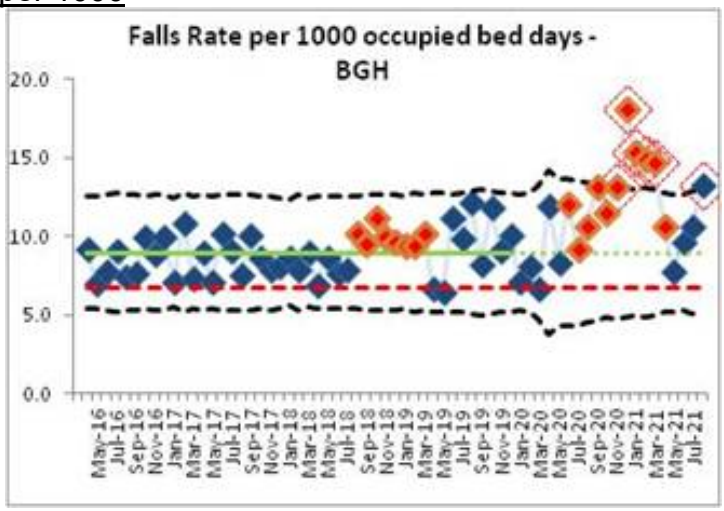
2. Context

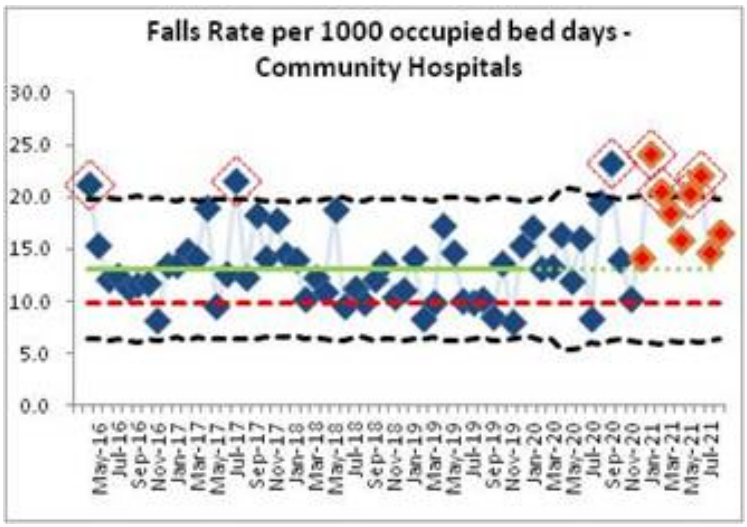
2.1 As will have been noted from the Board Clinical Governance Report and from the minutes of the Board CGC, the numbers of inpatient falls has increased over the last 12 months as can be seen below in figure A. This has been a nationally recognised trend and whilst there is no singular reason it seems likely that a combination of increased frailty and complexity within the community due to periods of lockdown, combined with unprecedented workforce challenges within inpatient areas has contributed to this significant trend. NHS Borders' 'Back to Basics' group in conjunction with the clinical governance team have been reviewing our local processes to ensure that staff are as equipped and informed as possible in order to prevent unnecessary falls within our inpatient settings. Ongoing data analysis helps support this clinical governance work to identify particular areas of concern.

2.2 This increase in inpatient falls incidence may also correlate to the demobilisation of some preventative and early intervention community services and pathways during the pandemic period. Day hospital services, face to face consultations, falls prevention classes, Live Borders classes, SAS falls pathway referral process, SBC community Occupational Therapy access, and Home First capacity have all been impacted during 2020/2021 and some of these services are yet to remobilise fully.
This context has reinforced the need for a strategic approach to falls prevention across the HSCP.

3. Inpatient Falls Data

3.1 The below data demonstrates the current fall rates and falls with harm.
Figure A: Falls rate per 1000





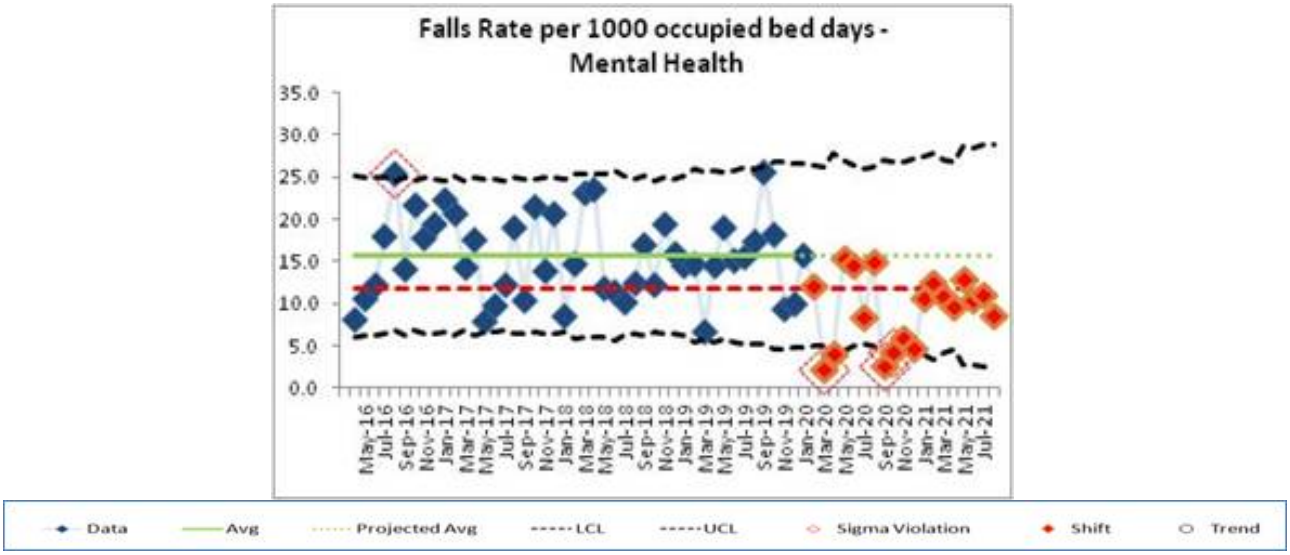
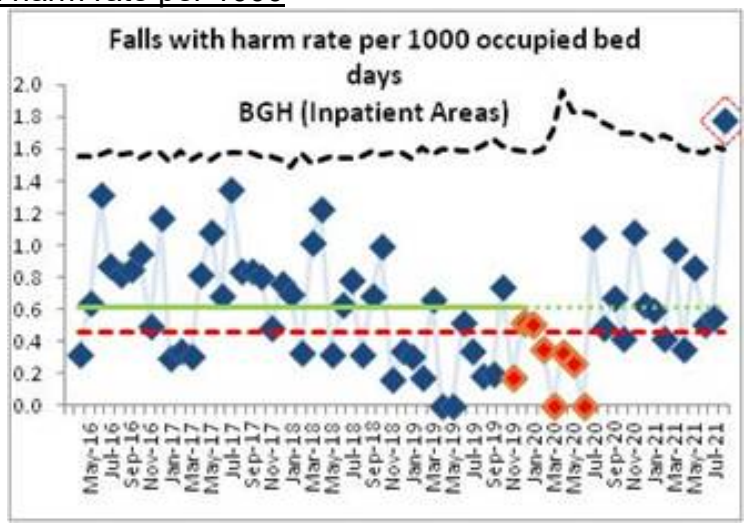
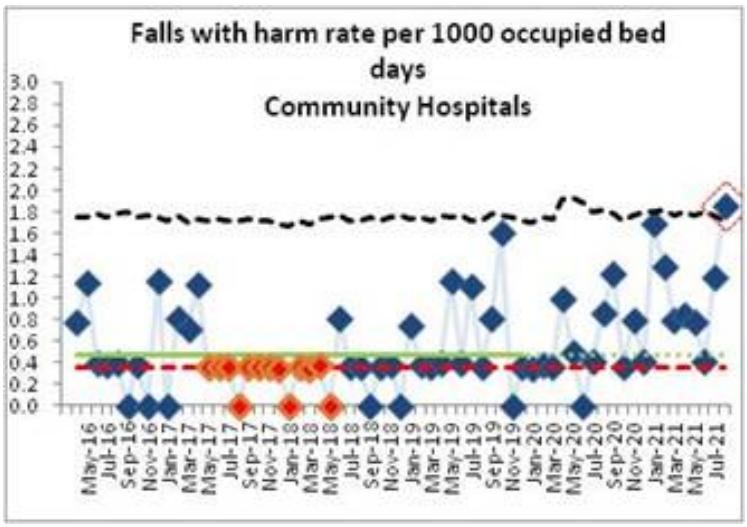


Figure B: Falls with harm rate per 1000





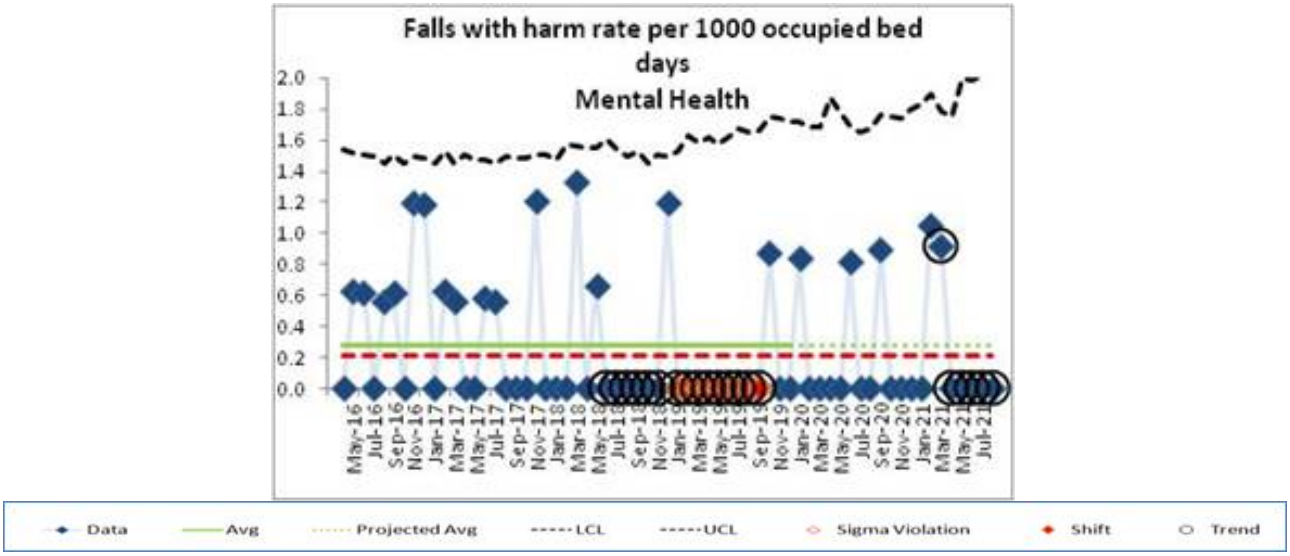


Figure C: Ward Audit data Aug 2021

FALLS DOCUMENTATION	BGH	Community Hospitals
Actual returns as a percentage of expected returns (20 per month per inpatient area)	49.44%	100.00%
Has a falls safety assessment been completed within 24 hours of admission	98.73%	97.65%
Assessment of risk completed (Section 1)	34.09%	85.90%
Safety Concerns completed (Section 2)	50.00%	94.87%
Actions documented (Section 2)	50.00%	91.03%
If the patient has fallen has a post fall record been completed	45.45%	85.71%
Bed Rail Risk Assessment completed	58.82%	93.44%

3.2 Figures A and B show a concerning rise in both the number of falls and falls with harm across the BGH and Community Hospitals. A deep dive into this data has shown several individual patients accounting for a large number of falls, however this does not mitigate the significant upward trend.

3.3 Figure C shows recent audit data from August 2021 outlining compliance with falls documentation. The correlation between compliance and falls within the BGH is likely to be relevant with the unprecedented and continuing workforce pressures within the BGH a significant factor relating to this poor compliance. This highlights significant scope for improvement and is being addressed by the Inpatient Falls group.

4. Inpatient Falls Management

4.1 Significant work continues from the Clinical Governance team to support clinical areas regarding inpatient falls management. It should be noted that the Quality improvement facilitator allocated to Falls Prevention and Management has had to be redeployed into patient-facing ward roles on two occasions during the pandemic due to workforce pressures therefore reducing the visibility and impact of this important improvement facilitator role.

4.2 A Board-wide Inpatient Falls Management group has been established as a workstream of the Falls Strategic Group in order to focus to current increase in falls both within the BGH and community hospitals. This group has representation from all 3 clinical boards and numerous professional groups. The group have reviewed the current

processes, paperwork, high risk areas and previous QI projects to help direct their work. This work is being led by Zoe Spence (Improvement facilitator), and supported by Christine Proudfoot, Dementia Nurse Consultant.

Current work includes:

- Redevelopment of falls bundle for inpatient use to simplify the process of risk assessment and mitigating actions to put in place.
  This new bundle is currently being piloted in MAU, BGH and Haylodge community Hospital
- Development of falls microsite for staff information
- Reviewing Falls learnpro modules
- Reviewing NHS Borders documents/ policies relating to falls
  now completed with the exception of Board-wide strategy document.
- New improved bed and chair sensors based on the patients BMI and more visual safety clues such as coloured falls risk blankets
- Reviewing relevant Datix trends and data with weekly reporting
- Supporting staffing training and awareness by taking training to clinical areas
- Supporting Falls awareness week in Sept 2021

This work is ongoing and is supported by the wider Clinical Governance Team, under Laura Jones.

5. Falls Strategic Group

5.1 NHS Borders reconvened the Falls Strategic Group in 2021 after a 12 month hiatus. Paul Williams (Associate Director AHPs) has taken on the role of Falls Lead for NHS Borders and chairs this group. Membership of the group includes clinical representatives from across the 3 clinical boards and numerous staff groups. The group also includes representatives from Scottish Borders Council, Scottish Ambulance Service, Scottish Fire and Rescue, and potential third sector involvement which is being identified.

5.2 The purpose of the group (as taken from the terms of reference) is as follows:

> *"This multi agency group has been established as a strategy group for the prevention and management of falls for individuals over the age of 65 years, across the Scottish Borders. The group is accountable via the regular governance arrangements within all the partner organisations and oversight provided by the Integrated Joint Board (IJB). The group recognises that the risk of falling is not exclusive to those individuals aged over 65 years. However it has been agreed that the remit of this group will initially focus on this section of the community.*
>
> - *To support a more consistent multi agency approach to falls prevention and management and in doing so, improve experiences and outcomes for older people, their families and carers.*
> - *To ensure efficient, effective and sustained improvement in the risk assessment and management of falls through the implementation of the National Falls Prevention and Management Framework.*
> - *To support multi-agency collaboration and co-ordination across health and social care by sharing learning to inform all improvement."*

5.3 The group has agreed on 3 workstreams to achieve this purpose:

- Inpatient Falls Management
- Community Falls Prevention and Pathways

- Development of an NHS Borders Falls strategy

6. Community Falls Prevention and Pathways

6.1 The community prevention and pathways group has brought together a wide range of professionals and organisations to review current pathways and referral routes for those at risk of falling, or for those that have suffered a fall.

6.2 Work to date has included:

- Initiation of mapping of current services/ organisations providing falls prevention input. This can include low level health improvement advice to specialist input.
- Initiation of mapping of current referral process and locality gaps
- Discussion regarding use of locality hubs to identify high risk members of the community that may benefit from early intervention/ preventative input

6.3 Future work to include:

- Development of resources/ information for all staff to be able to provide universal advice and education regarding physical activity, balance, nutrition to aid falls prevention
- To link to the Older People's Pathway work to ensure that all services/ referrals are being delivered with the correct pathway
- To further develop falls prevention services in line with restructuring of AHP community services

7. Falls strategy

7.1 In order to achieve the above and to ensure the appropriate governance and accountability is in place, and to ensure that the organisation continues to prioritise the area of falls prevention, it is the intention of the Falls Strategic Group to assist in the development of an NHS Borders Falls strategy. This Falls strategy will align to the strategic aims of the IJB and the Board's clinical strategy. It is hoped to develop an action focussed strategy that supports staff and managers to focus on prevention and early intervention regarding falls prevention and to provide appropriate information on the safe management of falls.

7.2 In order to deliver this piece of work and to support the community falls prevention and pathways work it has been acknowledged that a lack of capacity may be a significant limiting factor. A bid to the National Value Improvement Fund to provide leadership and strategic capacity to carry out this work was unfortunately unsuccessful and whilst other external funding sources are being explored, an approach to deliver this internally this strategy document by March 2022 has been agreed.

8. Recommendation

8.1 Borders NHS Board are asked to note the ongoing work of the Falls Strategic Group and the ongoing work of the Clinical Governance team in regards to falls prevention and falls management. The Board are asked to support the development of an NHS Borders Falls strategy. The committee are asked to note the current challenges regarding capacity to deliver this work and the plans in place to address this.

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

PUBLIC GOVERNANCE COMMITTEE MINUTES 23.02.21, 05.05.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Public Governance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Public Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Public Governance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Compliant.
Consultation	Not Applicable.
Glossary	-

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Tuesday, 23 February 2021
2.00 – 4.00 p.m. via MS Teams

Present:

Tris Taylor, Chair and Non Executive Member
June Smyth, Director of Strategic Change & Performance
Clare Oliver, Head of Communications & Engagement
Margaret Simpson, Public Member
Lynn Gallacher, Borders Carers Centre
Fiona McQueen, Chair Public Partnership Forum
Michael Scouler, Chaplain
Carol Graham, Public Involvement Officer

In Attendance:

Chris Myers, General Manager, Primary & Community Services
Derek Blues, Improvement Scotland Community Engagement
Phillip Lunts, Strategic Planning Lead
Fiona Doig, Head of Health Improvement/Strategic Lead – Alcohol & Drugs Partnership
Marion Phillips (Committee Administrator)

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting.

2. Apologies & Announcements

Apologies had been received from: Lynn McCallum (Medical Director), Laura Jones (Head of Quality & Clinical Governance), David Parker (Non Executive Member), John McLaren (Employee Director), Iris Bishop (Board Secretary).

This meeting was not quorate but the Chair agreed that the meeting should continue as there were no items for formal approval.

Margaret Simpson was having network issues and left the meeting and Clare Oliver offered to call her after the meeting to update.

3. Minutes of Previous Meeting:

The minutes of the meeting held on 17 November 2020 were noted as an accurate record and will be formally approved at the next meeting.

4. Matters Arising

4.1 Action No 41:. **TT to write to SG Committee.**

Action No 42: **TT to look at previous reports for feedback prior to next annual report.**

Action No 43: **JS to send out most recent report**

Action No 45: **Update at meeting in May**

Action No 46: **To be closed**

Action No 47: **To be closed**

Action No 48: **To be closed**

The Committee noted the action tracker

5. Business Agenda Items:

5.1 Chairs Update

Tris Taylor shared with the committee the letter to Karen Hamilton, Chair of NHSB and the response received from Ralph Roberts, Chief Executive, regarding the needs of unpaid carers as discussed at the previous meeting. June Smyth commented that following the report given to the Board that she had an action to arrange for a discussion with the Chair of this committee and the Chair of the Strategic Planning Group that sits under the IJB to discuss opportunities for consistent approaches to public involvement and engagement activities. A meeting had been arranged in March to work on a plan about how to improve some of our public involvement activities and formulate better going forward and would report back to the next meeting.

Lynn Gallacher stated that she was slightly disappointed with the response and the impression that what we are doing is good enough when it was not really. There was reference to the Carers Voice but it is actually Borders Voluntary Care Voice which is different. Lynn added that there was a difference between meaningful engagement and tokenistic engagement which makes no difference to the carers who still do not feel listened to.

Tris Taylor commented that he did have sympathy with Lynn's response and said that he perhaps had phrased his letter wrongly but ultimately it was the welfare of unpaid careers that was concerning. Lynn Gallacher commented that before decisions are made within NHS Borders carers should be consulted and involved. A previous example was when all the NHS support dementia day services were closed without consultation. This happened at the same time as SBC closed day centres and this impacted on a lot of carers. The voluntary organisations had to pick up the fallout from this. There was a need to make sure that carers are involved in the decision making process. A lot of decisions are made which can have a ripple effect and the carers are aware that savings and efficiencies need to be made but if they and service users are not included in the decision making it can actually end up wasting money. This needs to sit with managers who have the strategic direction but this does not always translate into actions and it's the actions that carers need to be part of. If we can work together then we help make savings and cost efficiencies in a way that will have a positive impact on people's lives.

Clare Oliver added that she would set up a meeting with Lynn Gallacher to allow dialogue to begin and share thoughts together. Tris Taylor responded that from a NHS perspective we need to look at the governance and what processes are in place.

June Smyth added that she would like to look further into the dementia day service changes to understand what happened and what, if any, involvement and engagement activities took place and would provide an update at the next meeting. She confirmed this was the type of service change that stakeholders including unpaid carers should expect to be involved and engaged

with. Looking forward, by incorporating public involvement into the communications team we would be able to draw on their resources and their previous work with stakeholders. By May onwards we would have named representatives from the 3 clinical boards to this committee who will provide updates around involvement and engagement activities that have taken place and also forward planning on them. The planning team within NHSB had restructured and now has planning business partners who work alongside the clinical boards and provide support to leads to ensure that any service changes include appropriate engagement with stakeholders before any decisions are made. Lynn Gallacher thanked June and added that this sounded really positive and the right way to go forward and would be happy to provide the platforms for access to carers to help aid this.

Clare Oliver added that going forward she would like to be able to build this process upwards and look at barriers etc to make sure that this is a process that works for everybody.

The Committee noted the letter and the response

Action – June to update at next meeting
Action – Clare Oliver to set up meeting with Lynn Gallacher

The Workplan was taken off the agenda to be reviewed and will come back to the next meeting

5.2 Public Involvement & Engagement Update

Clare Oliver presented this quarterly activity update to the Committee. While the situation around COVID restrictions was having an impact it was a good opportunity to reassess the situation and look at improving working relationships, scoping out what needs improving and how we can help. We are looking at the gaps within our engagement network and Carol Graham is working on this and by using virtual meetings we are able to speak to more voluntary groups. We are looking to build on our Public Partnership Forums and have had good engaging meetings, we are able to get our management to come along and talk and dealing with issues that the groups want to discuss.

Looking at the audit committee findings, we are asking for a pause in the timescales to allow us to look at what it is we are doing. As a reminder the three findings of the audit were to update the involvement and community engagement strategy, update the process of engagement and lastly looking at resources and supporting carers. The timescales have slipped and although some services have been impacted we have had to look at other services and how we access them. There is a feeling that this is a good time to expand our engagement networks and reach out and how they can help us to develop our services going forward. We are proposing that we reach out through partnerships and communities and ask if anyone would consider getting involved and expressing their views to come forward and contact us. We would like to build up a reference group up to 200 people to allow us to have a full and fair representation from the public and partners in voluntary sector. We have meetings arranged shortly with our partners and across SBC to start building engagement from the ground up with a co-produced model.
There is work going on around inequalities, which will be expanded further by Phillip Lunts, and the Older Persons Pathway. Work on the pathway commenced pre-Covid and we are ready to pick this up again. Clare concluded that although a strategy is not finalised we are working in the background to ensure our strategy and engagement is fulfilled across the Borders.

Tris Taylor commented that 200 people would be great representation and would allow people to ignore those things in which they are not interested and participate more fully in cases in which they are. Tris expressed concern about the work that has been deferred during the pandemic and asked whether the committee members were content that we had enough oversight of the activity to provide assurance that the public is being considered and elements of the population are not being left behind. He did acknowledge that does cross over the Clinical Governance Health and Equalities and Public Involvement agenda around the way services are changing.

The committee noted the update

Michael Scouler left the meeting

6.1 Health Inequalities Programme Post Covid – Phillip Lunts & Fiona Doig

Phillip Lunts shared a presentation with the group about the Health Inequalities and Public Governance and learning from the lessons of Covid. There was an action plan prepared in readiness and challenges for winter following the first spike from Covid, and included was how to address the vulnerabilities of particular groups around Covid. We then entered the second phase of Covid knowing that certain groups would be adversely affected more than others. We then looked at identifying these groups. Certain groups are disproportionately affected by Covid and these include older people over 75, health care workers and social care workers, people living in high areas of deprivation, people with co-morbidities and the BAME group. Phillip then went on to look at a modeling exercise which looked at comparing the impact of Covid against inequalities. The stark reality from this highlighted that within two years and four months more people will die from unavoidable causes e.g. suicide, drugs, inequalities, than would die from an unmitigated Covid pandemic. Or another way of looking at that is that you will see four times as many deaths in ten years as you would see from one unmitigated Covid pandemic. Thinking about how much effort and resource has gone into dealing with the Covid pandemic and in reality we are seeing this number of deaths every 4 years due to inequalities.

We need to look at resolving this and ensuring that the people who suffer most from these health inequalities get the support they need. This is an issue that underpins our services and can affect everyone who has a health inequality and we all need to be aware of it. From a recent report there are 5 principles that include: allocating resources to the services beneficial to the needs; training the workforce to understand their role in reducing inequalities; working in partnership in other sectors; improving employment and procurement processes; and finally advocating to staff the need to reduce health inequalities and how they can help. We have sufficient data within the Borders to allow us to pinpoint exactly where there are levels of deprivation and we can identify where older people are most at risk.

The Health Board has committed to addressing health inequalities as an organisational priority, there is more senior leadership involved in the steering group from across the organisation. While we are developing plans the next step is to speak to the disadvantaged groups to find out what we can do to make a difference. We will look at services that potentially disadvantage people perhaps not allowing them to gain access for a variety of reasons. We would like to take a 'ward to board' approach, from the wards upwards and which also includes all communities too. Previously we took the patient safety programme and embedded this into our principles and would suggest that the same is done with health inequalities making it robust. The final stage would be monitoring and evaluation the effectiveness of the programme.

The actions required are, we need to review and develop core data. Establish co-production approach to encourage skills and resources. Select four clinical areas that we can deep dive and look at services being used and how accessible they are and then using the co-production approach we can then start making improvements. Phillip acknowledged that there is already work underway and we are working closely with SBC and other partners to ensure that we focus on our actions.

Tris Taylor thanked Phillip for a very illuminating presentation and it is important to recognize the power and responsibilities that the health board does have in the Borders. It is good to have data reporting that can be used to aid this.

June Smyth added that there has been a shift in thinking about health inequalities as we have come through Covid and when we worked on our strategic assessment preparing services towards the second wave of Covid through our Recovery Group we are finding a lot of actions

relating to health and inequalities. Fiona Doig is a member of this group and reminded us that we all have a level of responsibilities and it's not a Public Health issue but we all have an input in to it and there should be an enhanced approach to it. Assuming that the Board is supportive of this to tackling health and equalities and taking it further than the statutory responsibilities that we have at the moment and this will require to be resourced but this will allow us to be better placed to engage with our stakeholders and public communities.

Lynn Gallacher commented that speaking from the perspective of unpaid carers and service users and people living with long term conditions, there are so many existing groups out there and they are really easy to reach now especially as people embrace technology and we do everything online now and this has made co-production much easier. People can come together through whatever platform is easiest for them, and bearing in mind that we do need to address that not everyone can do this but we can still reach a wider audience more easily than we were able to do before. Also, there are no costs involved trying to source venues etc and if meetings need to be rearranged it's so much easier to do. We are finding with our own platform that carers are more engaged online as they no longer have to leave the person they care for to attend meetings and the same applies to people who have mobility problems and can't always access public transport to attend meetings and to be able to meet people within their own homes is fantastic. Another advantage we have found is when we sent out a poll to ask carers about respite we had 60 responses within 24 hours which in the past would have taken far longer using a mail shot for example. Clare Oliver asked if carers do get a chance to get together socially using online platforms and Lynn responded that they have quizzes etc and various crafts online and these work well. Phillip Lunts asked if it would be possible to use her platforms to start asking questions regarding health inequalities and Lynn agreed that there are so many groups available in the Borders and would be happy for him to come along to a Carers meeting and speak to people.

Fiona Doig said that comments received are very helpful and there are other bits of engagement work that are going on routinely across the system. We have learned through the work with Drug and Alcohol Partnership that this is a rights based issue for people and even having a concept of right to care can be alien to people who have had least positive experience of culture within Scotland so it is work in progress. It is amazing to have the input from Public Health and happy to be involved. Tris Taylor thanked Fiona Doig and Phillip Lunts for their comments and work.

The Committee Noted the Update

6.2 Primary & Community Services Business Unit, Duns GP Practice: Chris Myers

Chris Myers updated the Committee to say that they have now concluded the process of evaluating the preferred option for the patients registered to Duns Medical Group. This has been an extensive piece of work undertaken in partnership with public and stakeholders across NHS Borders. The range of stakeholders we used included: Practice patients, wider local community/neighbouring practices and practice staff. Our communications and engagement have followed and informed the list of stakeholders, committees and Boards that we had mapped out. There were 3 phases involved from the notification of situation at end of November 2020 to informing and engaging on options in January 2021 and then informing of the outcome in February 2021. There was positive feedback received and there were concerns raised regarding having to travel to other practices, not wanting to be transferred to another practice and the extra strain being put on the other practice among others.

We asked for feedback on the 3 options of the option appraisal group that was established. The first option was any tenders received as part of the tender process and would people be in favour of a new GP practice taking over and 76.5% of the responses received said they would like a new GP practice to take over. The second option was the allocation of patients to another GP practice as close to home as possible and 0.9% of the responses showed this was the least preferred option. The third option was NHS Borders operating the practice from the existing

premises as a '2C' practice, meaning that NHSB would manage the practice and would be responsible for finding GPs to work in it, the response of 6.4% meant this was the 2nd favoured option but concerns were expressed about continuity of care and possibility of seeing a different GP each visit. The remaining 17% of patients selected both option 1 or 3 as their preferred choice.

We held an option appraisal meeting and further meetings with the public and to support them through the process and also with the voting. We did have one standing public member participating and we had seven patient representatives also. There was a lot of discussion at the meetings about the only practice that did submit a tender was from Ayrshire and would have preferred a surrounding practice, however we do need to go through the tender process for legality and the Ayrshire practice was the only bid received.

We worked with Healthcare Improvement Scotland Community Engagement colleagues and they provided a list of evaluation questions for us to ask our option appraisal participants. We are still collating this information and this will be used for any future public engagement process. An outcome letter was sent out to patients in Duns Medical Group advising that the contract was awarded to Ayrshire Medical Group from 31st March 2021. They will continue to work from the existing practice in Duns and the existing staff will be given the option to continue working there.

Tris Taylor thanked Chris for his presentation saying it was informative and useful and good to bring it back to the committee. It was really good to see the summary of the feedback from so many local people and to see it was a healthy process and it gives good assurance to this committee that the process was appropriate and well executed. He asked if Chris found any lessons identified that could be helpful in the future with any substantial engagements. Chris Myers responded that the timescales they had were challenging and there were concerns that they might not attract any bidders. It meant that we did not have the bidder presenting at any meetings and did not get the chance to interview them before the option appraisal process. This would have helped with some of the public concerns at the beginning of the process. Clare Oliver added that there had been learning with the tight timescales and they had had positive feedback. The planning team gave a lot of support to this and engaged with the public to ensure that they were clear on the options available and this was reflected in the feedback.

Lynn Gallacher commented that it was important to have transparency and communication and need to keep involving people and once they start working in partnership it is the best way to find solutions. A lot of carers can feel that they are not included and communication is important.

Committee noted the presentation

6.3 Health Improvement Scotland Community Engagement (formerly Scottish Health Council) Update – Derek Blues

Derek Blues advised the committee that they re-branded from Scottish Health Council to Health Improvement Scotland Community Engagement from April 2020. The Covid restrictions meant that plans to share the strategy and what our roles would be were slowed down. We have supported meetings in NHS Borders with Clare Oliver and Carol Graham and we still have the same staff in post in the Borders, Shelagh Martin and Sarah Cox. The restructure means we now have 3 regions and the Borders are in the East Region which covers from Tayside to the Borders taking in Fife, Lothian and Forth Valley and we have 13 staff across the 5 offices. We have had to look at engagement through a Covid lens which was new to us and to support this we have an 'engaging differently' section on our website at www.hisengage.scot This can help support a rich and diverse community and help ensure we engage with sections of the community who perhaps do not normally get asked to participate.

Nationally we have been participating in a 'gathering voices' piece of work which had relevance to the Borders around lived experience of people who have ME and the report will be available

shortly. This has given insight into living with this condition and we have spoken to Scottish Government with recommendations following this. We had good engagement with 5% of the participants coming from NHS Borders which is double what we were expecting to get which is very encouraging. We engaged using an online survey and this suited the group who perhaps were unable to take part in meetings and there was no peer group that we could have joined. The survey was easy for them to access and it worked well.

We also participated in virtual visiting and our role there was to work with partners in Boards and acute hospitals to assess what the needs were for patients who were used to getting regular visits from families and loved ones and having to adapt to the changes when Covid came along. We did a scoping exercise to source IT kit for hospitals and we are now re-visiting this with a view to look at what is required going forward.

Derek thanked the committee for allowing him to come along and stated that this set up is quite unique and he does not know of any similar committees within other Boards within his region. HIS Community Engagement would like to continue the offer of support of engagement from our staff based in the Borders. This could involve advice with signposting and expertise with the tools available. Clare Oliver expressed thanks on behalf of herself and Carol Graham for the support and advice that they have received. Clare Oliver suggested that following discussions with Lynn Gallacher that a case study could be formed regarding using technology as a carer. Derek Blues thanked Clare and said they would be grateful to use it on the website. Lynn Gallacher added that the Carers First platform would be a good forum for this and happy to discuss out with the meeting.

Tris Taylor thanked Derek for joining the meeting and his update and look forward to hearing any further progress.

The Committee noted the update

7. Any Other Business:

No other business matters were raised

Tris Taylor thanked the Committee for the contributions and added if there any concerns regarding access or if breaks need to be added into the meeting or anything else to email Marion Phillips who will pass them on.

8. Future Meeting Dates 2021

Tuesday 4 May 2.00-4.00pm
Tuesday 17 August 2.00-4.00pm
Tuesday 2 November 2.00-4.00pm

All via MS Teams

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Wednesday 5th May 2021 9.30-11.30am
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive Director

In Attendance:
Karen Hamilton, Chair NHS Borders
June Smyth, Director of Strategic Change & Performance
Margaret Simpson, Chair Scottish Borders Enterprise Chamber
Clare Oliver, Head of Comms and Engagement
Kirk Lakie, Deputy Hospital Manager – Planned Care
Philip Grieve, Service Manager, Mental Health
Sharon Bleakley, NHS Healthcare Improvement Scotland Community Engagement
Shelagh Martin, NHS Healthcare Improvement Scotland Community Engagement
Graeme McMurdo, Programme Manager, SBC (left at 10.15am)
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting. Karen Hamilton attended the meeting as Chair of NHS Borders and is mandated to attend once a year. Lucy O'Leary, Non Executive Director attended for her first meeting. Kirk Lakie and Philip Grieve were welcomed as Clinical Board representatives, and Sharon Bleakley who was deputising for Derek Blues.

Tris Taylor noted that Michael Scouler, Chaplain, has withdrawn from the committee and thanked him for his contribution over the last 3 years.

2. Apologies & Announcements

Apologies had been received from: Cllr David Parker, Non executive, Nicky Hall, Area Clinical Forum representative, Lynn McCallum, Medical Director, Laura Jones, Head of Quality & Clinical Governance: Iris Bishop, Board Secretary: Lynn Gallacher, Borders Carer Centre: Chris Myers, General Manager P&CS: Derek Blues, NHS Healthcare Improvement Scotland Community Engagement: Carol Graham, Public Involvement Officer:

The Chair advised that the meeting was not quorate. The meeting was recorded for the purpose of minutes.

3. Minutes of Previous Meeting:

The minutes of the meeting held on 23 February were noted as an accurate record and will be brought back to next quorate meeting for approval.

4. Matters Arising

Action No 41: Complaints Process: Tris Taylor has written to David Parker and will share the response when this is received. Action to be closed.

Action 41 & 42: Clare Oliver shared that Laura Jones suggest the Corporate Clinical Board could be asked to give a summary at each meeting of actions from pertinent complaints or care opinion feedback and what they have done to implement, then bring an annual overview through the annual report. This applies to both actions and to be closed.

Clare Oliver to liaise with Laura Jones and advise who will be attending future meetings. June Smyth added that Public Health is another consideration to bring updates to this meeting.

Action No 43: Internal Audit: The audit was emailed to members. Action to be closed.

Action No 44: Yetholm Surgery: Action to be closed.

Action 45: Adult Changing Facility: June Smyth updated that as agreed through the Board of Trustees they will be purchasing modular units that will be located on BGH site out with the main building. Estates are scoping the site to see where would be most accessible location. No timeline for installation as yet but will update committee to remain sited on this. Margaret Simpson asked to see the photographs, June Smyth to share with her.

Action No 49: Service Changes Affecting Carers: Philip Grieve updated that there is acknowledgement that there could have been a better process adopted at the time. There was some confusion thinking this was linked to the SBC review of Adult Care Services but this was not the case. There was a review of attendance in day services within older adults which allowed us to review and determine signpost of individuals who attended other appropriate services. Action to be closed.

Action No 50: Clare Oliver to meet with Lynn Gallacher. Clare Oliver advised that the meeting did take place with Debbie Rutherford, who is Lynn's deputy at the Carers Centre and regular meetings have been setup. In addition Clare reported that Rob McCulloch Graham has set up Carers Workstream through the Strategic Planning Group. Clare also added that she has made contact with the majority of service users and third sector partners who sit on the IJB Planning Group to make productive relationships with them.

Margaret Simpson commented on the change in working with the third sector, NHS and SBC. There have been good discussions on co-production and collaboration, and good feedback after these meetings. Action to be closed.

New Action – Clare Oliver to have discussion with Rob McCulloch Graham to find out more about the Workstream to ensure there is no duplication of meetings going on. Clare to report back to next meeting.

The Public Governance Committee noted the action tracker.

5. Business Agenda Items:

5.1 Chairs Update

Tris Taylor reported that under item 6.2 on the agenda that this is first time the individual business units have been to the meeting with updates. There are now named representatives who will attend regularly to provide information and to hold the right people accountable for the organisations public involvement and engagement, activity and processes.

5.2 Public Involvement & Engagement Update

Clare Oliver shared with the committee the quarterly update report which summarises work underway. During Covid the Public Member meetings were able to continue and are still ongoing. Our colleagues from Healthcare Improvement Scotland Community Engagement were involved with these meetings too. The Clinical Boards have had representation giving updates on areas of work and interest for members. By providing the whole system approach and involving everyone is working well.

Clare gave an update on the Here from You initiative and within the last month have had 60 individuals come forward to register their interest. This means we have representation over all localities and age groups for 20 to 85, also a mix of people with long term conditions and disabilities. This will ensure we are engaging on important issues and will grow moving forwards. Clare noted thanks to Margaret Simpson for her support with this work.

A session is being organised along with Rob McCulloch Graham to invite the people who did come forward in conversation around the future provision of health in relation to the strategic planning group and strategic planning implementation plan.

Clare reported that from an engagement perspective the Older Peoples Pathway is still in planning stage. There have been ongoing conversations with public members to look at issues they want to engage on. Margaret Simpson commented that it has been good working with Clare and that Carol Graham joined the Ability Borders working group meeting with the public members. People are interested to come forward to be part of this.

June Smyth said that the information from these conversations with public members will help inform services as they redesign their services. Good to have the patient and carer voice heard at start of conversations rather than in formal group setting. People are very honest about their experiences and the barriers and challenges to them and the people they care for, and what could help them with these issues.

Shelagh Martin commented that Health Improvement Scotland Community Engagement are grateful to be able to re-establish link with public involvement in NHS Borders, they are always very useful and productive.

Graeme McMurdo added that the conversations and engagement are very good but has concerns that the IJB agreed in February about refresh and re-provision of strategic plan so there has to engagement around this. Old People pathway is part of this. Need to be careful and conscious about speaking to various groups about same thing

Clare Oliver gave assurance to the committee that through the joint engagement group who meet fortnightly, priority is given to making sure we engage in right place with right people at right time to avoid duplication.

Tris Taylor thanked Clare Oliver for the update and the positive comments from Margaret Simpson, and added that there is potential for good blend of informal and formal engagement.

The Committee noted the update

6.1 Annual Report

June Smyth stated that the report reflects the activities of the committee in financial year 2021 and we are required to submit this to Audit Committee. The pandemic impacted on the work although the committee was restarted towards the end of the financial year. This reflects the agenda, activities and workplan that the committee followed.

Tris Taylor added that it is important to have record of activities from this committee noted in the Board Annual Report.
Karen Hamilton commented regarding the 2 meetings cancelled due to organisation being on emergency footing and will the audit committee be satisfied that this was processed through the governance procedures and was it formally accepted that we were on emergency footing. June Smyth replied that the report has been submitted to finance and they have not flagged this as an issue.

The Committee noted the update

6.2 Clinical Board Updates:

Acute: Kirk Lakie attended the meeting to give a verbal update. Due to the pandemic the majority of changes or redesigns that may have been happening over the course of the last 15 months have not been progressing to any extent. Any planning was short term and in response to the situation being faced. As we remobilise this will change and we are looking to reintroduce the discussions from 15 months ago into business as usual work. Once we know what pieces of work we need to take forward we will bring through this process.

Regarding remobilisation and due to the changes to the way we have worked over the pandemic, we will be discussing whether we will be retaining some of these changed ways of working. In particular the use of technology of how we communicate with patients and how we manage patient's with a long term condition and if we can retain this way of working. We are aware there are issues with equity of access to services and there needs to be appropriate conversations to ensure we can mitigate any potential issues.

Kirk discussed the backlog of clinical services due to the pandemic and people waiting for treatment and the uncertainty about responding to this in longer term, there are discussions happening with the Scottish Government and at Board level. There have been adjustments to the letters for patients to make them aware that they could wait for a significant length of time unless prioritised clinically. There is a clinical interface group who meet monthly and are discussing changes in clinical pathways and the balance of work between primary and secondary care. We need to engage with public and discuss what that might mean to how they access clinical services.

With regards to Cancer services, we are starting to refresh the strategy and thinking about the pressures that cancer services are facing and also using the national strategy document to look at what that means for the Borders. NHS Lothian are discussing replacing the capital infrastructure around services at the Western General Hospital. This could impact on us as they are our tertiary provider for cancer services, radiotherapy and some of the specialist inpatient chemotherapy regimes.

We have been talking to Planning & Performance team about how we engage regarding services when we are in a position to start opening up these conversations. Clare Oliver gave the assurance to the Committee that the Recovery Planning Group and Acute Services Recovery Group do discuss any issues on service changes and if required there will be early engagement with public members. From a Comms perspective we are working on a schedule of communications to be released around waiting times etc to ensure patients are informed as well as GPs

Tris Taylor thanked Kirk Lakie for his update and the appraisal of the situation. Tris asked if it is the uncertainty of the situation and recovery that is slowing down the engagement process. Kirk replied that they are only at the discussion phase and trying to assess what the services will look like and considering technology input. Kirk stated that there is realisation that it would be better to involve public members at early discussions rather than waiting until the decisions have been made.

Margaret Simpson commented that it is good to hear about early communication and this will get the public on side. Social Services are already engaging and this is making such a difference. Kirk commented that Clare's teams have been in attendance at the meetings and thanked them for their support and they give assurance that there's no need to feel anxious about open dialogue with patients and public and they are now taking that on board.

Tris Taylor commented that we need to keep talking to the public and giving them reassurance that we are working towards reducing waiting times and talking to them about any delays that have come about through Covid and our remobilisation processes. Lucy O'Leary agreed that there are a lot of uncertainties for patients regarding their treatment and good to keep talking to them.

The Committee noted the update

Mental Health: Philip Grieve attended the meeting to give an update. Mental Health services already have experience and engagement with patients with lived experience although Covid did impact ability to engage and progress any co-production. Philip highlighted the difficulties for staff working in the changing landscape and the pace that it changed. There was a co-production charter in place from 2019 and although slow to get started we are working with Borders Care Voice to get re-engaged and we included a person with lived experience and/or a carer to service meetings. The Terms of Reference to these meetings are being refreshed to ensure an appropriate representation.

Philip added that 2 peer support workers have been engaged and they are people with lived experience to work within community mental health teams. We are looking to recruit another to this post.

There is work on inclusion policy taken from good practice guidelines from Mental Health Welfare Commission. There has been input from person with lived experience which has proved really helpful and we will use this type of input within all services going forward.

Gala Resource Centre is being reviewed, this was paused during the pandemic but is now being progressed to ensure that it is fit for service. We have representation from 3rd sector organisations and carers to join us in mapping and reviewing this service at stakeholder event on 11th May.

There is representation from people with lived experience and carers on the Mental Health Programme Board.

CAMHS is going through service improvement program with support from Scottish Government and they have used feedback from service users and families and from that a stakeholder and engagement workstream has evolved to help with service use and redesign.

Mental Health transformation programme was paused for Covid and this has been reinstated and the structures and processes set behind this. We are about to embark on first workstream which is reviewing the community mental health crisis team and liaison team and again service users and people with lived experiences will be involved throughout the process.

Margaret Simpson asked if Ability Borders could be kept informed as their membership has seen an increase of mental health problems and for carers too and they could benefit from any changes and improvements to services.

Tris Taylor thanked Philip Grieve for his update.

The Committee noted the update

P&CS: Chris Myers gave apologies to the committee and June Smyth gave brief overview of the paper. The Older Peoples pathway work was highlighted and also the vaccination programme. The Covid vaccination programme will continue and the service will evolve to vaccination transformation programme to include all non covid vaccinations moving forward. June mentioned that most of the P&CS management team joined NHS Borders just before the pandemic and they have managed to respond and remobilise services as well as following guidance to include public involvement engagement. This was evident around Duns Medical Practice and the team are committed to continue this process.

Clare Oliver added that the public member involved with the vaccination programme committee has been valuable and provided good challenge. We will continue to use this format with other committees in future.

Tris Taylor commented that he agreed with the statement in the paper about the approach to setting future objectives and priorities for P&CS.

The Committee noted the update

6.3 Health Improvement Scotland Community Engagement: Sharon Bleakley attended the meeting as deputy for Derek Blues. Sharon highlighted from her update that the views of people with lived experience of M.E. was completed and the report will be published on 17th May and available on the website and people from the Borders also contributed to this.

Work is beginning on the redesign of urgent care services and this will involve whole range of people across Scotland and are awaiting confirmation of which groups from this area will be involved and we will update at next meeting.

Also will be looking at virtual visiting and gathering views of people who have used this service and how they found it and this could also include staff experience too whether they found it good, bad or indifferent. Funding was received from Scottish Government to be able to buy a number of devices for all Boards across Scotland and 46 iPads will be delivered to NHS Borders to help facilitate virtual visits. When face to face visiting is opened up there will still be patients with relatives out with the area who would benefit from virtual visiting.

The Planning with People document was published on 21st March 2021 and link was included in submitted paper. This looks at how to support the NHS Boards, Integrated Joint Board and local authorities to carry out effective engagement and how to continue to include public and people with lived experience to be involved with so many different things. This report advises on effective engagement, how to meet statutory responsibilities and continually improve engagement practice and then how to share your learning. There will be a quality framework to support self evaluation around routine engagement and specific engagement activities such as merger service changes. This is work in progress at the moment and will update at later meetings. Derek Blues can be emailed directly if there are any questions regarding the quality framework.

Clare Oliver commented that she would interested to hear more information regarding the projects mentioned and how to get involved with them. Sharon responded that they could arrange meeting to discuss further.

Tris Taylor said that the Planning with People document looks very helpful and added that progress on defining the metrics and using the evidence and engagement in terms of quantity and quality will be beneficial. Tris thanked Sharon for her update.

The Committee noted the update

7. Any Other Business:

Realistic Medicine: Clare Oliver wanted to update the committee on Realistic Medicine. This is huge area of work that transcends all clinical boards, patients and public. Dr Lynn McCallum, Medical Director, will be leading this piece of work along with Dr Olive Herlihy. There is significant element of patient and user involvement and joint decision making. This will be picked up as we move through the remobilisation phase and this is in the planning stage at the moment with ongoing meetings. There are 6 themes around realistic medicine and we will be looking to take a couple of themes and do some concentrated work around those and this will require significant engagement both internally and externally with public and patients. Clare will update the committee through her quarterly updates and as an item of business at later date. Margaret Simpson commented that this is a good piece of work and offered to help if required.

The Committee noted the item

Karen Hamilton thanked the Committee for the very useful updates from the Business units

8. Future Meeting Dates 2021

Wednesday 25th August 9.30-11.30
Wednesday 10th November 9.30-11.30

All via MS Teams

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

AREA CLINICAL FORUM MINUTES 23.03.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board as per the Area Clinical Forum Terms of Reference and also in regard to Freedom of Information requirements compliance.

Impact of item/issues on:

Strategic Context	As per the Area Clinical Forum Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 23rd March 2021 – 13:00 – 14:00
Via Microsoft Teams

Present: Alison Wilson (Chair; Area Pharmaceutical Committee) (AW)
Dr Kevin Buchan (GP/Area Medical Committee Chair/ACF Vice-Chair) (KB)
Nicky Hall (Area Ophthalmic Committee) (NH)
Paul Williams (Allied Health Professionals) (PW)
John McLaren (Employee Director) (JMcL)
Kim Moffat, Minute Secretary (KM)
Rob Cleat, Vaccination Programme Manager

Apologies: Dr Caroline Cochrane (Psychology) (CC)
Ehsan Alanizi (Area Dental Advisory Committee) (EA)
Jackie Scott (Medical Scientists) (JS)
Peter Lerpiniere (Associate Director of Nursing for MH, LD & Older People) (PL)

1 Update on Covid-19 Vaccine Rollout

Rob Cleat, Vaccination Programme Manager, kindly joined the ACF to provide a short presentation regarding the overview of the Covid Vaccine rollout for NHS Borders.

- 51,238 first dose vaccinations as of 8am on 23rd March have been administered
- By the end of Sunday 21st March, 50,000 vaccinations had been given, this equates to over 50% eligible population of the Borders being vaccinated.
- 7287 dose 2, 6000 vaccinations have been administered in last 7 days; this works out at between 500-1500 per day.
- The current 7 day average for providing vaccinations is 927 vaccs per day
- Borders performing well : dose 1 uptake 52.4% and for Dose 2 is 8.6% uptake

PW gave thanks to Rob and the team for their hard work and coordination for the vaccination updates.
JMCL reiterated his thanks to Rob for the presentation of the data, clarity of the infographics, easy to read.
AW: commendable how flexible the vaccination team and patients have been, very good to see.

ACTION:

2 APOLOGIES and ANNOUNCEMENTS

AW welcomed those present to the meeting and acknowledged the apologies listed above.

3 DRAFT MINUTE OF PREVIOUS MEETING 01.12.20

The Minute of the previous meeting, held on 1st December 2020, was read and approved as an accurate record of the meeting with no changes.

ACTION: Update and remove draft; available to IB in committees drive for NHS Borders Board (KM)

4 MATTERS ARISING AND ACTION TRACKER

Action Tracker updates:-
Drama Therapy Presentation – it was agreed to take this off the action tracker
Paul Williams advised that music and Arts therapy is done via AHP advisory committee,
John McLaren and Paul Williams to have an offline discussion regarding the benefits of drama/music therapy.

Realistic Medicine – Olive Herlihey to come to a future meeting – scheduled for November.

Advisory committee –

Clare Smith & safe staffing – Invite to Claire to November meeting

Public Protection Nurse Consultant – to attend November meeting

Decision making Framework - completed

5. ACF Terms of Reference Review – Board Sub-committee Self assessments

No comments or queries were raised at the ToR, and Kim Moffat to add in the sentence regarding annual review.

6 Survey form for Effectiveness of committees

ACF survey sent in for ACF by Kim and Alison, will send round survery next time it comes round for all ACF members to complete.

7. EU withdrawal Update

AW advised there was no update, no impact on medicines, main focus is on Covid. NHSB Brexit group and SBC Brexit group, nothing raised for healthcare. It was agreed to take this off the agenda as a standing item.

8 CLINICAL GOVERNANCE COMMITTEE: FEEDBACK – AW

The CGC met last week, and we saw some positives coming out of this, also areas for more focused work. Olive Herlihy on Medical education, positive picture, lots of good work going on there. Scottish Patient Safety Programme (SPS) is reenergising; the medicines SPSP element to be focused on and taken forward in next few months. Concerns were raised on Infection control; there is good work going on, however there has been an issue in recruiting to Infection control nursing roles, which is no different to other boards. Nicky Berry, Sarah Horan and Sam Whiting are working together to resolve this issue. Care home reviews – 7/9 had good reviews, all reviews to be completed by end of March.

JMcL commented that Covid has affected Statutory and Mandatory training significantly. How did we address medical needs for training, can we apply this to Statutory & Mandatory training? The Director of Workforce is looking to reintroduce a working group on this, however JMCL asks ACF to highlight the importance of this to their teams. PW agreed; adding that ongoing non-mandatory professional development has really been a big issue and asks how do we factor this time in within the remobilisation plan? It was suggested that Job Plans could be key to this as this can be key to staff retention. KB advised that Pre-Covid , GPs were unaware of formal education, TIME stopped, got it back online, commitment from NHSB for protected education. Job planning not used in Primary care, secondary care uses this.

AW noted that this was in relation to foundation doctors and deanery report.

NH noted no link into health board for optical staff training

8 PUBLIC GOVERNANCE COMMITEE: FEEDBACK

Meeting took place to re-establish regular cycle of meetings.

9 NATIONAL ACF CHAIRS MEETING: FEEDBACK

Met last week, no update, minutes from the last meeting have been circulated. Focus on remobilisation and starting to focus on finance.

10 NHS BOARD PAPERS: DISCUSSION

Papers not out as yet, meeting is week on Thursday, pick up issues via email when the papers come out. Should anyone have any queries, please email AW direct.

11 PROFESSIONAL ADVISORY COMMITTEES

11(a) Area Dental Advisory Committee (EA) - No update.
11(b) Area Medical Committee/GP Sub Group (KB) – GP sub met last night, increasingly important relationship with NHSB being established, flourishing of committee, clearer conversations being had.
AMC meeting: starting to gain traction and improve. Main focus is on Covid.

11(c) Area Ophthalmic Committee (NH) – No meeting, AGM planned for Teams. Everyone has had vaccinations, LFT testing in place. Issues re: comms with NHSB re: remobilisation asks, not enough time to fulfit requests for input to remobilisation plans.
11(d) Area Pharmaceutical Committee (AW) – January meeting cancelled, changed to Q&A session, fair response to that. Vaccine and LFT testing was the focus. Follow up Q&A session this month, attendance was low so no further ones planned. Next meeting in April, key focus of work was Pharmaceutical Care Services plan aiming to make this 3 year plan going forward. Chief Pharmaceutical officer to be appointed, then we expect to see a new/updated pharmacy strategy.

11(e) Allied Health Professionals Advisory Committee (PW) – re-establish AHP advisory committee, professional leads group to look at professional development for AHPs (Orthoptics/music therapy). Recruitment process for 5 of AHP professions, some appointed last week, giving more stability and resilience.

11(f) BANMAC (PL) – BANMAC didn’t meet, therefore no update.

11(g) Medical Scientists (JS) – No update as no representative was present at this meeting.
11(h) Psychology (CC) – no update as a representative was present at this meeting.

ACF noted the updates available.

ACTION: **All Advisory Committee representatives to send an update if unable to attend (KM-ALL)**

12 NHS BORDERS BOARD: FEEDBACK TO THE BOARD

- Communications to wider professions, more time for requests.
- Look into medical and wider clinical professional training.

13 ANY OTHER BUSINESS

PW asked if we get requests from Board that come via ACF. AW advised that we do not. Some other boards use ACF in a more proactive way, but Borders we used to have clinical executive group, strategy and operational group, work used to go via that.

Clinical prioritisation would be good for ACF to feed into.

DATE OF NEXT MEETING

The next Area Clinical Forum meeting is scheduled for 22nd June 2021 at 13:00 via Microsoft Teams.

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	June Smyth, Director of Planning & Performance
Author:	Gemma Butterfield, Planning and Performance Officer

NHS BORDERS PERFORMANCE SCORECARD – AUGUST 2021

Purpose of Report:

The purpose of this report is to update the Board on NHS Borders latest performance against the measures set out in the 2021/22 Remobilisation Plan (RMP3) alongside some key targets and standards that were included in previous Annual Operational Plans Local Delivery Plans (LDP).

As part of the remobilisation process following COVID-19 Scottish Government required all boards to develop and submit a remobilisation plan (RMP3) for 2021/22. As part of this plan trajectories were submitted which replaced some, but not all measures, previously contained within the Annual Operational Plan (AOP) 2020/21. The performance data presented in the attached scorecard therefore relates to:

- Trajectories contained within RMP3.
- Targets contained within previous AOPs where performance against these is still being recorded
- Performance against standards contained within previous LDPs where performance against these is still being recorded

Typically, the performance scorecard format and the measures contained within it are finalised and 'locked down' for the commencement of the financial year. However, for 2021/22 Scottish Government has yet to confirm monitoring arrangements relating to remobilisation plans, other than the routine monitoring relating to waiting times. There may therefore be a requirement to add to the performance scorecard should additional monitoring requirements be introduced by Scottish Government. In addition, as we continue to remobilise services there may be other measures or activity we would want to propose to monitor at Board level. If this is the case they will be highlighted to the Board before being included in future reports.

Recommendations:

The Committee is asked to **note** the August 2021 Performance Scorecard.

Approval Pathways:

This report has been prepared with input from the Service Leads, who have signed off their relevant sections. The cover paper has been reviewed and approved by the Director of Planning & Performance.

Executive Summary:

1.1 As highlighted previously, the monthly Performance Scorecard has been re-formatted and updated to enable members to monitor performance against the RMP3 trajectories, previous AOP and LDP measures. Reporting will continue to develop as we progress through the remainder of the year and have had the opportunity to revisit the format of the scorecard, which we plan to include key demand and activity information.

1.2 Narrative on actions being taken to achieve targets and standards are now based on exception reporting on this smaller set and is noted in this cover paper. RMP3 trajectories, LDP Standards and key local performance indicators will be measured twice yearly in the Managing Our Performance (MOP) Report which is presented to the Board. A more detailed comparison of our performance against other Boards in Scotland will be provided in the MOP.

1.3 Areas of positive performance as at 31st August 2021 are detailed below:

- 100% of patients requiring **Treatment for Cancer to be seen within 31 days** were seen in time during July 2021 (page 6)
- 100% of cases with a **Suspicion of Cancer to be seen within 62 days** were seen in time during July 2021 (page 6)
- 1325 patient breaches against **12 Week Waiting Time for an Inpatient** Appointment trajectory of 2052 in August 2021 (page 8)
- 30 patient breaches against the **12 Week Treatment Time Guarantee** trajectory of 169 in August 2021 (page 9)
- 381 patient breaches against the **Diagnostics Waiting Times** trajectory of 456 in August 2021 (page 10)

1.4 The following performance measures are reported outwith of standard/ trajectory in August 2021. As reporting develops we will revert to reporting on an exception basis and narrative will be provided for measures outwith for 3 consecutive months.

1.5 12 Week Waiting Times for First Outpatient Appointment

1.5.1 At 31st August 2021, 5172 patients were reported as waiting longer than 12 weeks for their first outpatient appointment against a trajectory of 4964, this is an increase of 470 from July 2021 (4702).

1.5.2 There was an increasing number of clinically urgent patients who had to be prioritised in August 2021 meaning that patients waiting for a routine outpatient appointment are waiting longer.

1.5.3 The acute team have an improvement plan in place however delivery against this plan is reliant on a reduction in COVID-19 activity, decreased operational pressures and financial allocation from Scottish Governments Access Support Team.

1.6 CAMHS 18 Weeks Referral to Treatment

1.6.1 Significant work has progressed within the service to address access to timely assessment. In the short term the Board will continue to show poor performance as the service is targeting their longest patients waiting and this doesn't prevent continual referrals being made to the service. However the service does still continue to respond to emergency and urgent referrals.

1.6.2 Due to increased funding made available from Scottish Government the service has progressed to enhance and increase its overall workforce specifically in the short term to address the backlog and waiting times. It is anticipated there will be a significant improvement in timely access to our service once recruitment is complete.

1.7 Accident & Emergency 4 Hour Standard

1.7.1 Our A&E department continued to faced significant pressures in August with large numbers of patients attending the front door.

1.7.2 Work remains on-going with the Re-designing Urgent Care project and our communications team continues to support with media releases.

1.7 Delayed Discharge

1.7.1 In August 2021 there continued to be delayed discharges for patients waiting for packages of care, which contributed to us not achieving the previously set trajectory. Response in relation to this from our social care partners has helped improved this position from July 2021.

1.7.2 Our focus remains on actions aimed at delivering the recommendations of the recent Delayed Discharge Audit and we continue to embed processes whilst working as a whole system.

1.8 Planned V Actual Activity Update

1.8.1 As RMP3 replaces the previously agreed AOP, all boards now have to return planned activity versus actual activity reports to Scottish Government on a monthly basis for some key areas; for July 2021 NHS Borders reported:

Activity	Planned	Actual	Variance
Key Diagnostics	1865	1660	-205
New Outpatient Activity	1325	1540	+215
TTG Activity	169	109	-60

Impact of item/issues on:	
Strategic Context	Regular and timely performance reporting is an expectation of the Scottish Government.
Patient Safety/Clinical Impact	The RMP3 trajectories, Annual Operational Plan measures and Local Delivery Plan standards are key monitoring tools of Scottish Government in ensuring Patient Safety, Quality and Effectiveness are being carried out in NHS Health Boards.
Staffing/Workforce	Directors are asked to support the implementation and monitoring of measures within their service areas.
Finance/Resources	Directors are asked to support financial management and monitoring of finance and resource within their service areas.
Risk Implications	There are a number of measures that are not being achieved, and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them back on trajectory. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders.
Equality and Diversity	Health Inequalities Impact Assessments have been completed for earlier remobilisation plans and there is one currently in production for RMP3 which is due for completion by the end of October 2021.
Consultation	Performance against measures within this report have been reviewed by each service area.
Glossary	AOP – Annual Operational Plan LDP – Local Delivery Plan RMP3- Remobilisation Plan

NHS Borders

PERFORMANCE SCORECARD

As at 31st August 2021

August 2021

Information & BI Services

Month

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Contents

INTRODUCTION

PERFORMANCE MEASURES

Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Current Performance Key

R	Under Performing	Current performance is significantly outwith the trajectory/standard set.	Outwith the standard/trajectory by 11% or greater
A	Slightly Below Trajectory/Standard	Current performance is moderately outwith the trajectory/standard set.	Outwith the standard/trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

So that the direction of travel towards the achievement of the standard/trajectory can be easily seen, the following indicators shown below are used:

Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-
Standard/Trajectory has been achieved this month	✓
Standard/Trajectory has not been achieved this month	X

Annual Operational Plan

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report was called the Local Delivery Plan (LDP) and formed an agreement on what Health Boards will achieve in the next year with SGHD. From 2018/19 Boards are no longer required to produce an LDP which have been replaced by Annual Operational Plans (AOP) that have AOP measures associated with them. Boards are also still required to monitor LDP standards which NHS Borders will do through the six month Managing Our Performance Report. As a result of the COVID-19 Pandemic the 2021/22 AOP has been replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, therefore this report contains a mix of RMP3 trajectory performance, previous AOP and LDP measures.

Please note:

Some anomalies may occur in data due to time lags in data availability and national reporting schedules.

Key Metrics- Against AOP Standards and RMP3 Trajectories where applicable

April Reported Performance - Area Achieving Standard/Trajectory

Cancer Waiting Times
62-day target

Jun 2021		Jul 2021	Target	
87.0%	↑	100.0%	≥ 95%	✓

Cancer Waiting Times
31-day target

Jun 2021		Jul 2021	Target	
100.0%	↔	100.0%	≥ 95%	✓

New Inpatients
waiting > 12 weeks target as at month end

Jul 2021		Aug 2021	Trajectory	
1233	↓	1325	2052	✓

Drugs and Alcohol clients
waiting < 3 weeks from referral to treatment

May 2021		Jun 2021	Target	
100.0%	↔	100.0%	≥ 90%	✓

Diagnostics - 8 key tests
waiting > 6 weeks target as at month end

Jul 2021		Aug 2021	Trajectory	
470	↑	381	456	✓

Inpatient/Daycase patients waiting > 84 days
TTG target as at month end

Jul 2021		Aug 2021	Trajectory	
87	↑	30	169	✓

April Reported Performance - Area Outwith Standard/Trajectory but within Tolerance

Psychological Therapy Referral to Treatment
within 18 weeks

Jun 2021		Jul 2021	Target	
91.7%	↓	88.9%	≥ 90%	X

April Reported Performance - Area Significantly Outwith Standard/Trajectory

Delayed Discharges as at census date
(last Thursday of the month) delayed over 72 hours

Jul 2021		Aug 2021	Trajectory	
31	↑	27	10	X

% of patients seen within 18 weeks
Combined Performance

Jul 2021		Aug 2021	Target	
78.3%	↓	78.0%	≥ 90%	X

New Outpatients
waiting > 12 weeks target as at month end

Jul 2021		Aug 2021	Trajectory	
4702	↓	5172	4694	X

CAMHS patients treated
within 18 weeks from referral to treatment

Jun 2021		Jul 2021	Target	
54.3%	↑	63.0%	≥ 90%	X

A&E patients discharged or transferred
within 4 hour target

Jul 2021		Aug 2021	Target	
82.3%	↓	72.4%	≥ 95%	X

Maintain Sickness Absence Rates below 4%

Jul 2021		Aug 2021	Target	
4.8%	↓	6.0%	4.0%	X

Performance Measures

Cancer Waiting Times

62 Day Cancer - 95% of all cases with a Suspicion of Cancer to be seen within 62 days

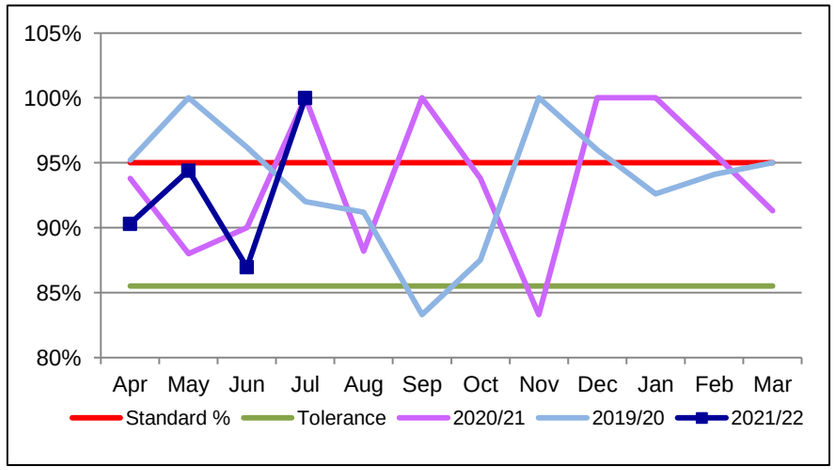
Standard
95.0%

Tolerance
86.0%

Latest NHS Scotland Performance
83.0% (Jan - Mar 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	90.3%	94.4%	87.0%	100.0%								
2020/21	93.8%	88.0%	90.0%	100.0%	88.2%	100.0%	93.8%	83.3%	100.0%	100.0%	95.7%	91.3%
2019/20	95.2%	100.0%	96.2%	92.0%	91.2%	83.3%	87.5%	100.0%	96.0%	92.6%	94.1%	95.0%

Actual Performance (higher % = better performance)



Please Note: There is a 1 month lag time for data. August data unavailable at this time.

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31 Day Cancer - 95% of all patients requiring Treatment for Cancer to be seen within 31 days

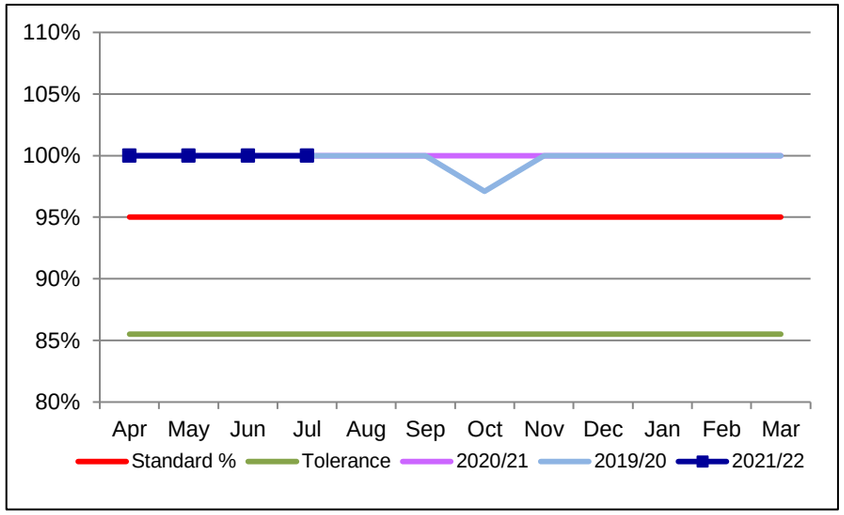
Standard
95.0%

Tolerance
86.0%

Latest NHS Scotland Performance
97.7% (Jan - Mar 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	100.0%	100.0%	100.0%	100.0%								
2020/21	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2019/20	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%

Actual Performance (higher % = better performance)



Please Note: There is a 1 month lag time for data. August data unavailable at this time.

Stage of Treatment - 12 Weeks Waiting Times

Standard - 12 weeks for first outpatient appointment

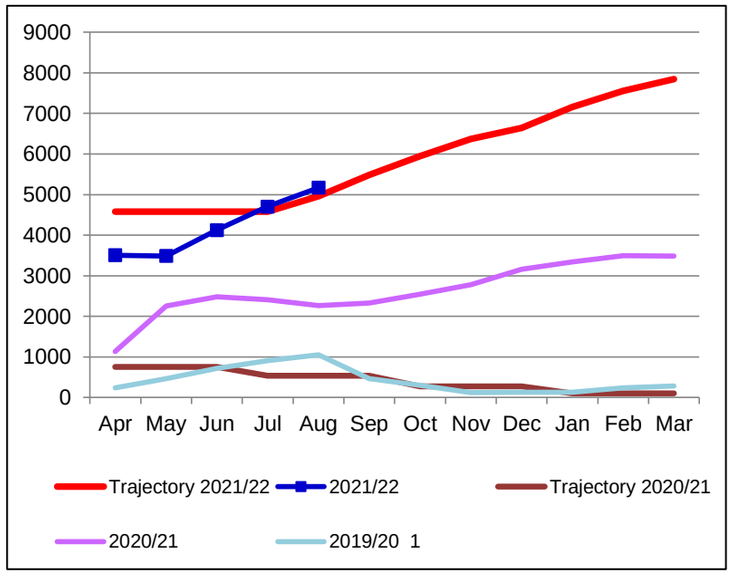
Trajectory
4580

Tolerance
5033

Latest NHS Scotland Performance	**NHS Borders Performance (as a comparative)**
48.07% (Jan - Mar 2021)	47.97% (Jan - Mar 2021)

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trajectory 2021/22	4580	4580	4580	4580	4964	5481	5949	6373	6644	7159	7553	7843
2021/22	3507	3489	4123	4702	5172							
Trajectory 2020/21	755	755	755	535	535	535	270	270	270	100	100	100
2020/21	1132	2253	2482	2406	2263	2324	2542	2783	3158	3344	3498	3489
2019/20 [1]	236	467	719	911	1055	467	301	120	128	127	240	287

Actual Performance (lower = better performance)



[1] Please note performance is measured against Trajectory not standard as per 2019/20 AOP

12 week breaches by specialty

	Feb-20	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**
Cardiology	4	1	12	53	37	43	51	66	94	108	134	151	163	162	175	162	250	273	261
Dermatology	102	150	327	460	523	524	500	526	526	550	616	562	550	534	402	534	505	597	695
Diabetes/Endocrinology	11	4	10	26	39	43	43	43	41	34	42	50	51	56	66	56	84	101	104
ENT	0	1	41	149	180	182	184	202	225	262	296	350	354	378	414	378	548	530	446
Gastroenterology	5	2	15	15	20	23	22	24	23	25	37	50	71	76	91	76	106	109	140
General Medicine	7	5	14	6	11	14	5	2	1	0	0	1	2	1	0	1	0	1	0
General Surgery	17	9	28	105	161	187	218	302	383	433	461	481	564	628	682	628	677	712	743
Gynaecology	2	3	52	131	168	148	122	80	75	93	99	101	103	90	81	90	71	98	123
Neurology	1	9	74	145	167	163	144	146	149	159	164	145	130	83	67	83	103	136	171
Ophthalmology	7	10	109	284	375	379	376	376	467	545	695	807	873	907	925	907	1120	1275	1433
Oral Surgery	12	34	141	284	335	342	299	273	272	274	251	217	148	44	25	44	19	10	8
Orthodontics	0	1	7	20	22	22	22	22	26	28	29	33	40	39	41	39	27	35	36
Other	12	16	78	134	137	123	100	98	83	66	67	73	91	97	103	97	99	96	103
Pain Management	0	2	7	26	27	23	18	5	1	0	0	0	0	0	0	0	0	0	0
Respiratory Medicine	0	2	14	8	10	9	8	24	54	74	101	114	120	130	141	130	163	181	200
Rheumatology	0	0	0	3	18	21	11	7	2	3	5	10	7	10	5	10	12	28	24
Trauma & Orthopaedics	55	30	183	328	124	32	17	5	1	3	9	17	17	9	6	9	10	141	262
Urology	5	8	20	76	128	128	123	123	119	126	152	182	214	245	283	245	329	379	423
All Specialties	**240**	**287**	**1132**	**2253**	**2482**	**2406**	**2263**	**2324**	**2542**	**2783**	**3158**	**3344**	**3498**	**3489**	**3507**	**3489**	**4123**	**4702**	**5172**

Stage of Treatment - 12 Weeks Waiting Times Continued

Standard: 12 Weeks Waiting Time for Inpatients

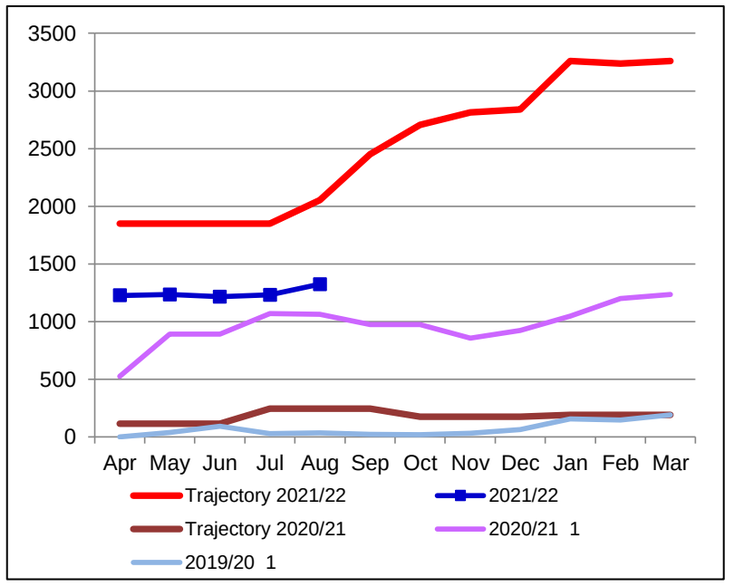
Trajectory
1849

Tolerance
2032

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trajectory 2021/22	1849	1849	1849	1849	2052	2450	2705	2814	2841	3259	3237	3260
2021/22	1227	1234	1215	1233	1325							
Trajectory 2020/21	116	116	116	245	245	245	176	176	176	190	190	190
2020/21 [1]	525	890	891	1070	1064	973	973	857	924	1048	1201	1236
2019/20 [1]	1	39	92	29	35	24	20	32	65	155	146	191

[1] Please note performance is measured against trajectory not standard as per 2019/20 AOP

Actual Performance (lower = better performance)



12 week breaches by specialty

	Feb-20	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**
ENT	0	1	24	43	43	61	62	52	36	30	25	34	39	34	32	33	37	40	39
General Surgery	2	34	90	146	147	167	161	130	120	116	122	144	163	173	160	160	154	158	195
Gynaecology	18	22	42	73	73	79	82	71	71	63	67	81	100	108	115	109	110	107	115
Ophthalmology	15	12	103	190	190	238	243	236	229	219	212	222	249	239	238	233	218	221	236
Oral Surgery	9	2	14	31	31	41	39	36	35	37	39	49	57	58	65	72	76	82	90
Trauma & Orthopaedics	2	107	223	356	356	413	402	386	342	323	389	439	503	527	526	548	547	562	590
Urology	100	13	29	51	51	71	75	62	61	69	70	79	90	97	91	79	73	63	60
All Specialties	**146**	**191**	**191**	**525**	**891**	**1070**	**1064**	**973**	**894**	**857**	**924**	**1048**	**1201**	**1236**	**1227**	**1234**	**1215**	**1233**	**1325**

12 Weeks Treatment Time Guarantee

	Trajectory
12 weeks TTG - 12 Weeks Treatment Time Guarantee (TTG 100%)	169

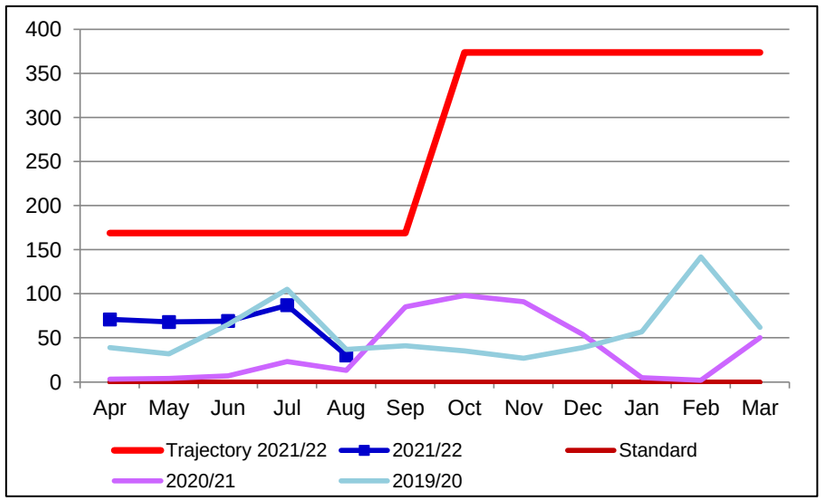
Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
71.5% (Jan - Mar 2021)	75.2% (Jan - Mar 2021)

Tolerance

186

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2021/22	169	169	169	169	169	169	374	374	374	374	374	374
2021/22	71	68	69	87	30							
2020/21	3	4	7	23	13	85	98	91	54	5	2	50
2019/20	39	32	65	105	37	41	35	27	39	57	142	62

Actual Performance (lower = better performance)



18 Weeks Referral to Treatment (RTT)

	Standard
Standard: Combined Pathway Performance	90.0%

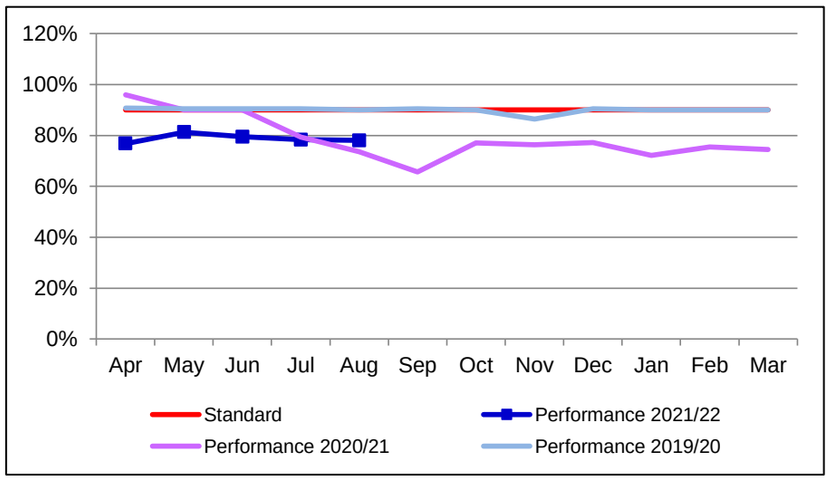
Latest NHS Scotland Performance
74.9% (Mar 2021)

Tolerance

81.0%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
2021/22	76.8%	81.3%	79.5%	78.3%	78.0%							
2020/21	95.9%	90.1%	90.1%	79.4%	73.6%	65.7%	77.0%	76.4%	77.2%	72.1%	75.4%	74.4%
2019/20	90.8%	90.5%	90.4%	90.4%	90.0%	90.4%	90.0%	86.5%	90.5%	90.1%	90.0%	90.0%

Actual Performance (higher % = better performance)



Please Note: data has a 1 month lag time to ensure it is in line with national reporting

Diagnostic Waiting Times

Waiting Target for Diagnostics - zero patients to wait over 6 weeks

Trajectory

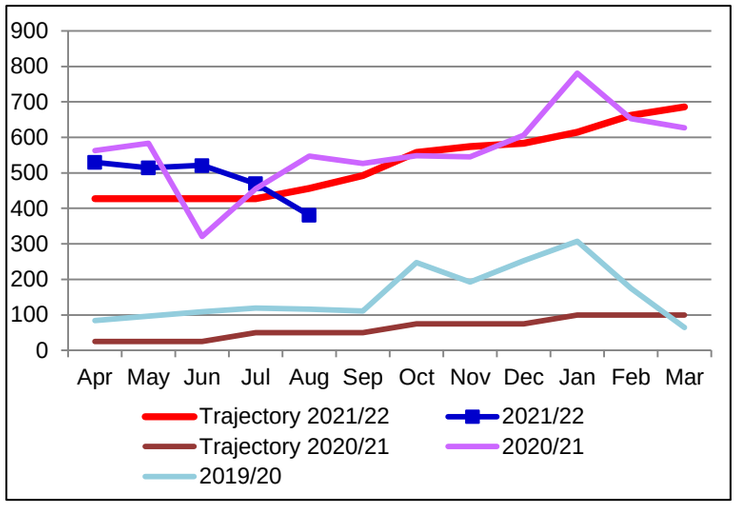
427

Tolerance

469

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory 2021/22	427	427	427	427	456	492	558	574	584	615	662	686
2021/22	530	514	521	470	381							
Trajectory 2020/21	25	25	25	50	50	50	75	75	75	100	100	100
2020/21	563	583	321	455	547	527	548	545	606	781	653	627
2019/20	84	96	109	119	116	111	247	193	253	307	175	64



The national standard is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests.
The breakdown for each of the 8 key diagnostics tests is below:

6 weeks	**Feb-20**	**Mar-20**	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**
Endoscopy	0	1	14	20	10	17	21	29	53	63	75	95	101	109	118	123	132	152	155
Colonoscopy	26	29	76	47	36	31	38	38	34	12	4	28	26	41	50	43	39	43	26
Cystoscopy	7	2	4	17	19	24	37	30	31	40	36	38	30	14	17	27	23	20	5
MRI	34	12	101	92	116	130	127	99	106	112	124	191	113	96	77	127	143	90	27
CT	4	1	88	145	132	157	199	176	139	117	132	197	221	260	168	138	151	137	107
Ultra Sound (non-obstetric)	102	19	280	245	108	82	101	138	173	195	233	232	162	107	100	56	31	28	54
Barium	2	0	0	17	19	14	24	17	12	6	2	0	0	0	0	0	2	0	7
Total	**175**	**64**	**563**	**583**	**440**	**455**	**547**	**527**	**548**	**545**	**606**	**781**	**653**	**627**	**530**	**514**	**521**	**470**	**381**

CAMHS Waiting Times

18 weeks CAMHS - 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

Standard

90.0%

Tolerance

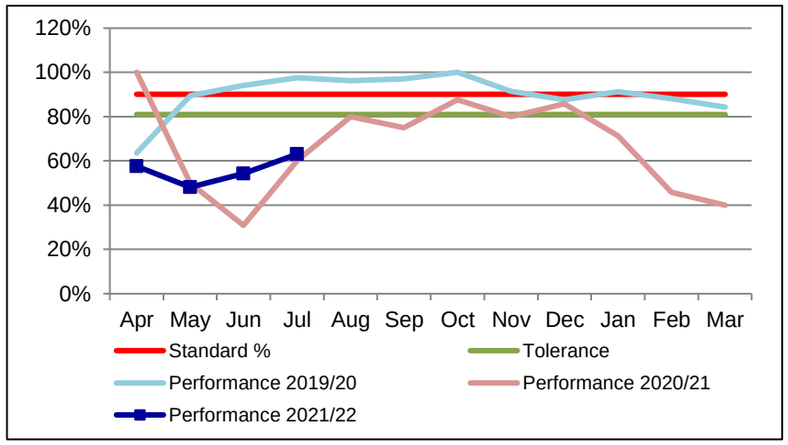
81.0%

Latest NHS Scotland Performance

72.5% (Jan - Mar 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2021/22	57.5%	48.1%	54.3%	63.0%								
Performance 2020/21	100.0%	50.0%	30.8%	60.0%	80.0%	75.0%	87.5%	80.0%	85.7%	71.4%	45.8%	40.0%
Performance 2019/20	63.5%	89.4%	94.1%	97.6%	96.2%	97.0%	100.0%	91.4%	87.5%	91.2%	88.0%	84.2%

Actual Performance (higher % = better performance)



Psychological Therapies Waiting Times

Standard: 18 weeks referral to treatment for Psychological Therapies

Standard

90.0%

Tolerance

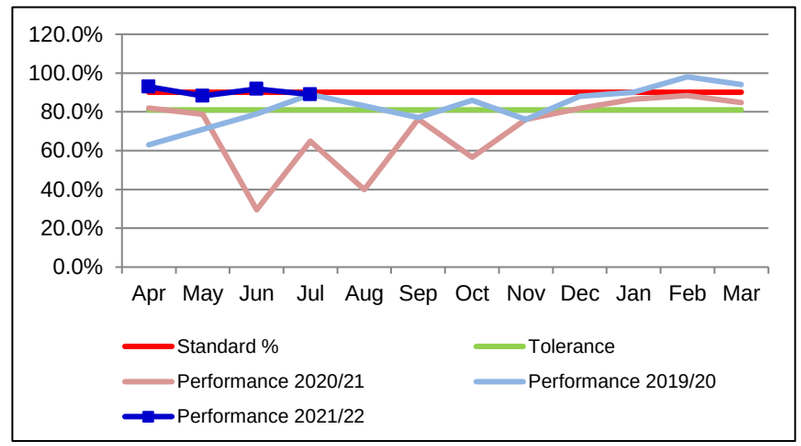
81.0%

Latest NHS Scotland Performance

80.4% (Jan - Mar 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2021/22	92.9%	88.2%	91.7%	88.9%								
Total Patients Currently Waiting >18 Weeks:	215	170	166	164								
Performance 2020/21	82.0%	78.8%	29.6%	64.9%	40.0%	76.3% [5]	56.5% [6]	76.1%	81.7%	86.5%	88.3%	84.7%
Total Patients Currently Waiting >18 Weeks:	185	225	250	271	218	180	162	157	169	156	181	201
Performance 2019/20	63.0% [2]	71.0% [3]	79.0% [4]	89.0% [4]	83.0%	77.0%	86.0%	76.0%	88.0%	90.0%	98.0%	94.0%
Total Patients Currently Waiting >18 Weeks:	162 [2]	172 [3]	159	125	125	137	158	125	135	138	140	164

Actual Performance (higher % = better performance)



[2] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay

[3] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay, but does include the Doing Well Service and DBT Team for the first time

[4] Psychological Therapy data for LD and CAMHS is NOT included (due to EMIS reporting delay and staff absence respectively). Data for Dialectical Behaviour Therapy (DBT) Team now included, as well as anxiety management patients starting treatment with the Doing Well Service

[5] Data now includes all PT Services

[6] Renew, Primary Care PT Service started in October 2020.

Drug & Alcohol Treatment

Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

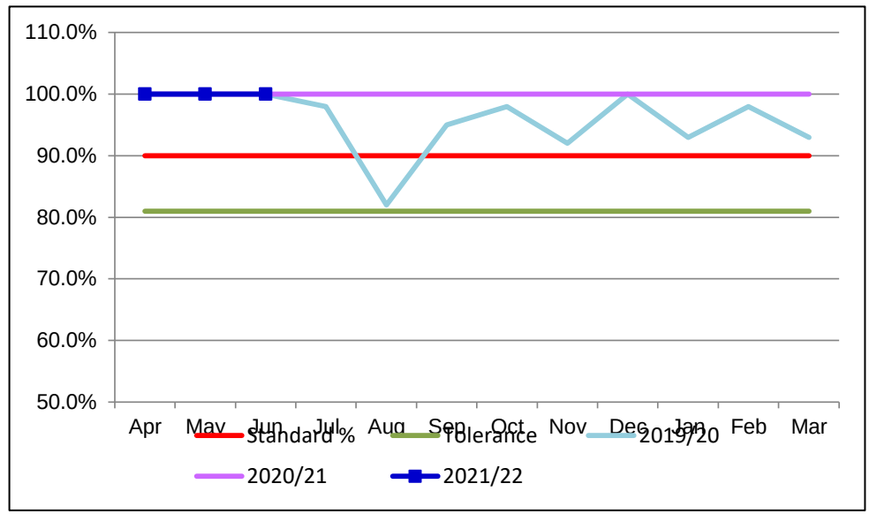
Standard
90.0%

Tolerance
81.0%

Latest NHS Scotland Performance
95.6% (Jan - Mar 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
2021/22	100.0%	100.0%	100.0%									
2020/21	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2019/20	100.0%	100.0%	100.0%	98.0%	82.0%	95.0%	98.0%	92.0%	100.0%	93.0%	98.0%	93.0%

Actual Performance (higher % = better performance)



Accident & Emergency 4 Hour Standard

4 hour A&E - 4 hours from arrival to admission, discharge or transfer for A&E treatment (95%)

Standard

95.0%

Latest NHS Scotland Performance

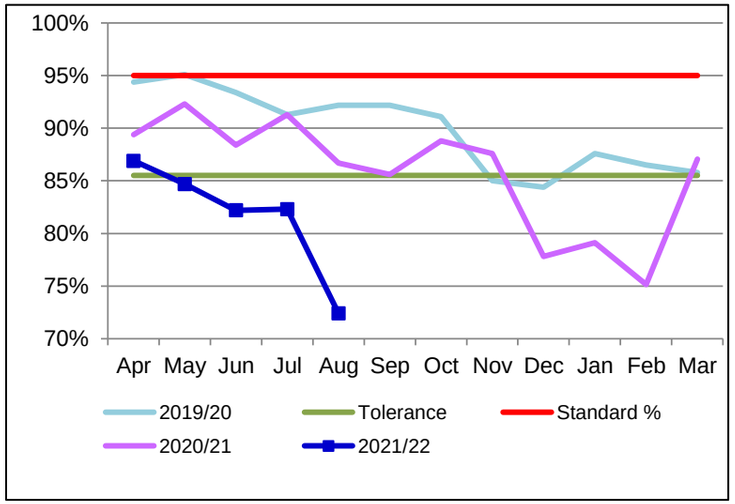
81.5% (July 2021)

Tolerance

85.5%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	86.9%	84.7%	82.2%	82.3%	72.4%							
2020/21	89.4%	92.3%	88.4%	91.3%	86.7%	85.6%	88.8%	87.6%	77.8%	79.1%	75.1%	87.1%
2019/20	94.4%	95.1%	93.4%	91.3%	92.2%	92.2%	91.1%	85.0%	84.4%	87.6%	86.5%	85.8%



The Board is required to ensure that the maximum length of time from arrival at Accident & Emergency to admission, discharge or transfer is four hours for at least 95% of patients.

Emergency Access	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Flow 1	97.3%	96.0%	96.8%	98.2%	99.3%	99.7%	98.2%	98.1%	98.0%	99.0%	97.5%	97.7%	98.1%	99.6%	97.9%	98.6%	98.0%	97.1%	97.6%
Flow 2	85.2%	82.2%	84.3%	89.4%	84.5%	84.8%	79.0%	77.3%	80.3%	80.9%	73.7%	76.3%	73.2%	81.2%	79.8%	78.5%	74.3%	77.1%	67.2%
Flow 3	73.0%	75.9%	86.7%	89.1%	80.2%	85.5%	70.5%	69.6%	81.8%	78.5%	57.7%	59.6%	50.0%	80.3%	81.3%	72.0%	67.6%	61.4%	29.4%
Flow 4	77.7%	78.1%	84.2%	81.3%	74.2%	86.1%	80.8%	78.7%	83.0%	81.8%	75.5%	74.7%	65.5%	78.3%	78.7%	75.5%	65.7%	74.2%	53.5%
Total	**86.5%**	**85.8%**	**89.4%**	**92.3%**	**88.4%**	**91.3%**	**86.7%**	**85.6%**	**88.8%**	**87.6%**	**78.7%**	**79.1%**	**75.1%**	**87.1%**	**86.9%**	**84.7%**	**82.2%**	**82.3%**	**72.4%**

Delayed Discharges

Standard: Delayed Discharges - delays over 72 hours

Standard

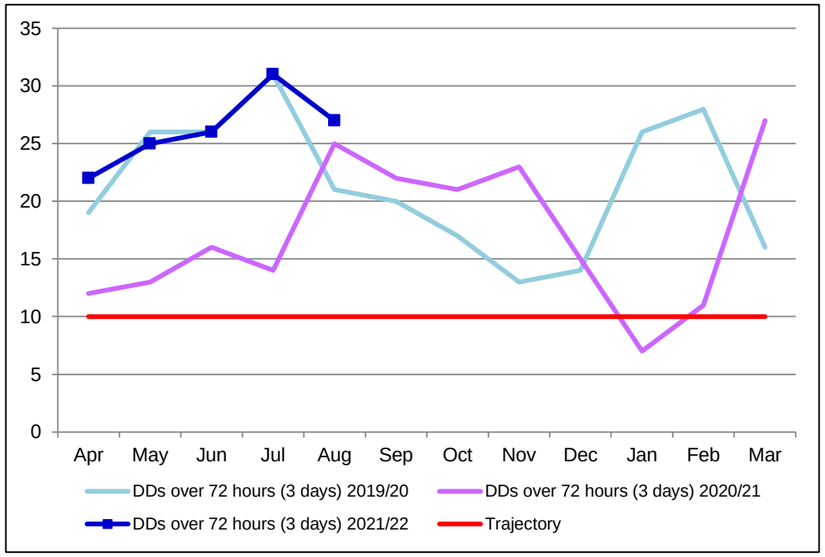
0

Tolerance

1

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory	10	10	10	10	10	10	10	10	10	10	10	10
DDs over 2 weeks 2021/22	15	15	15	21	24							
DDs over 72 hours (3 days) 2021/22	22	25	26	31	27							
Occupied Bed Days (standard delays)	852	882	947	1077	1086							
DDs over 2 weeks 2020/21	5	10	8	10	14	17	10	16	8	3	8	18
DDs over 72 hours (3 days) 2020/21	12	13	16	14	25	22	21	23	15	7	11	27
Occupied Bed Days (standard delays)	418	579	641	674	793	824	681	871	688	478	528	903
DDs over 2 weeks 2019/20	10	13	18	21	16	16	10	7	2	19	21	13
DDs over 72 hours (3 days) 2019/20	19	26	26	31	21	20	17	13	14	26	28	16
Occupied Bed Days (standard delays)	727	859	922	891	960 [1]	968	686	688	659	971	1027	859

Actual Performance (lower = better performance)



[1] Data is provisional at time of reporting

Please Note: The census date changed nationally in July 2016 from 15th of every month to the last Thursday of every month

For reference, national census data is used for monthly occupied bed days (standard delays only).

Delayed Discharges - Continued

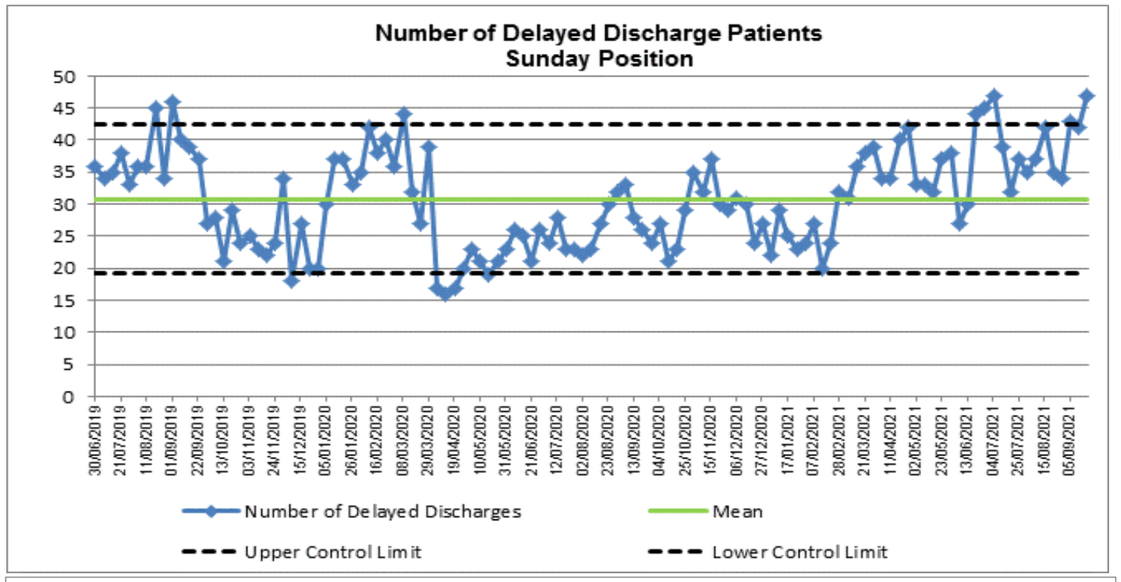
Standard: Delayed Discharges - delays over 72 hours

Standard

0

Tolerance

1

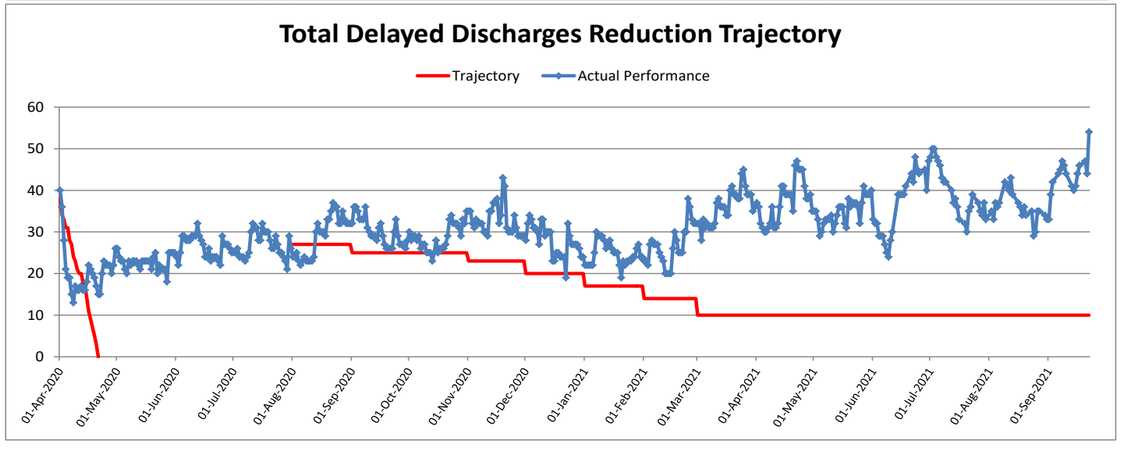


Delayed Discharges at Census Point

Type of Delayed Discharge	As at 29/04/21	As at 27/05/21	As at 24/06/21	As at 29/07/21	As at 26/08/21
Standard Cases	29	36	39	27	32
Complex Cases	2	2	3	3	0
Total	**31**	**38**	**42**	**30**	**32**

Delayed Discharges Discharged in August 2021

Reason for Delay	Cases	Average LoS
Assessment	2	3.0
Waiting Residential Home	9	28.0
Waiting Nursing Home	5	25.0
Waiting Care Arrangments to go Home	16	19.9
Patient and family related reasons	1	19.0
Complex	4	48.8
Total	**37**	**24.8**
Total Excluding Complex	33	21.8



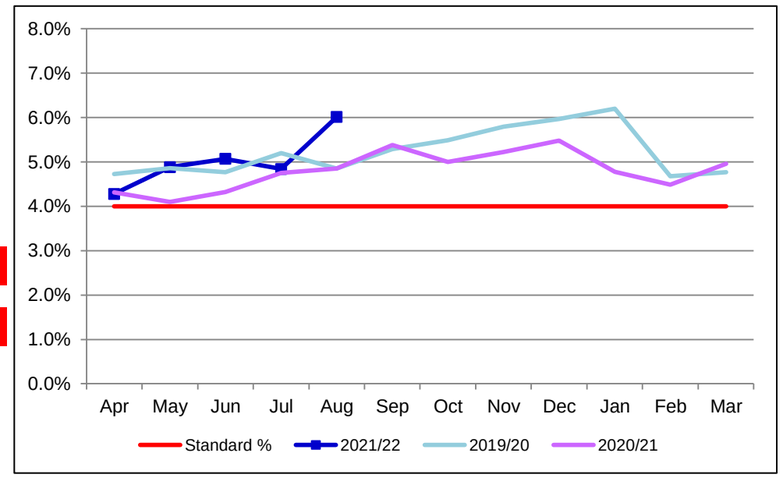
Sickness Absence

Standard: Maintain Sickness Absence Rates below 4%	**Standard** 4.0%	**Latest NHS Scotland Performance** 4.67% (2020/21) [1]

Tolerance 4.4%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
2021/22	4.3%	4.9%	5.1%	4.8%	6.0%							
2020/21	4.3%	4.1%	4.3%	4.8%	4.9%	5.4%	5.0%	5.2%	5.5%	4.8%	4.5%	5.0%
2019/20	4.7%	4.9%	4.8%	5.2%	4.9%	5.3%	5.5%	5.8%	6.0%	6.2%	4.7%	4.8%

Actual Performance (lower % = better performance)

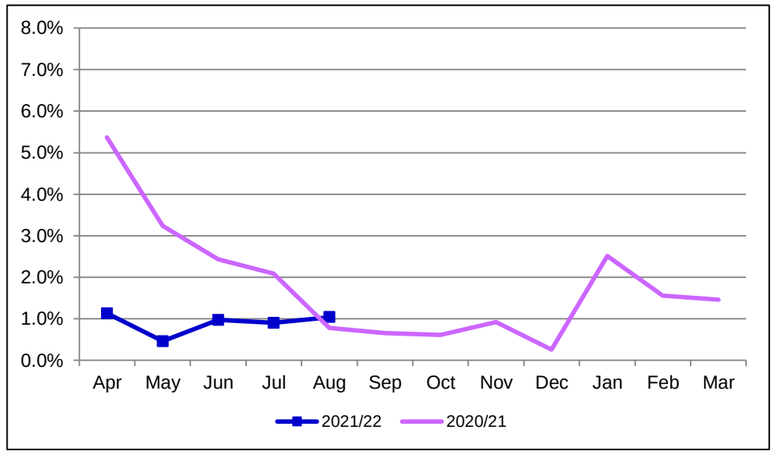


[1] Sickness absence data does not include any COVID-19 related absences.

For information: Covid Absence Rates

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	1.1%	0.5%	1.0%	0.9%	1.0%							
2020/21	5.4%	3.2%	2.4%	2.1%	0.8%	0.7%	0.6%	0.9%	0.3%	2.5%	1.6%	1.5%

Actual Performance (lower % = better performance)



Alcohol Brief Interventions (ABI)

Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

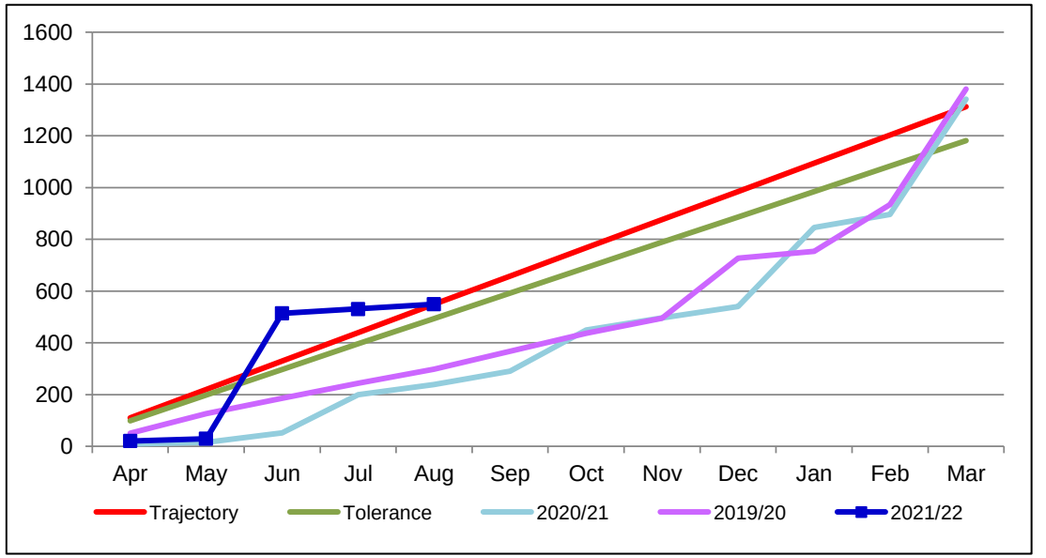
Standard	Tolerance
1312	within 10%

Actual Performance (higher = better performance)

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
123.8% (2019/20)	105.3% (2019/20)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	110	220	330	440	549	658	767	876	985	1094	1203	1312
2021/22	21	30	514	531	549							
2020/21	9	15	52	200	239	290	449	496	540	846	896	1341
2019/20	51	126	186	244	298	367	437	495	727	754	934	1381

Please Note: Standard is1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again.
There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.



Smoking Quits

Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% most deprived SIMD areas

Standard	Tolerance
173	within 10%

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

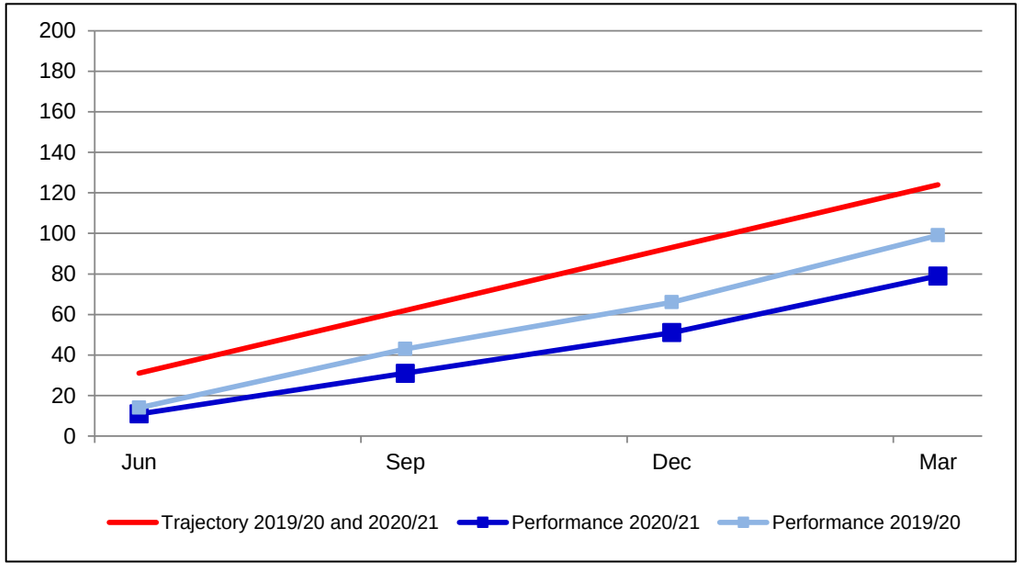
Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2020/21	31	62	93	124
Performance 2020/21	11	31	51	79
Trajectory 2019/20	31	62	93	124
Performance 2019/20	14	43	66	99
Trajectory 2018/19	33[1]	66	99	132
Performance 2018/19	34	60[2]	78	103

[1] Quarter 1 of 2018/19 target has been reduced from 43 quits to 33 quits

[2] Provisional figure provided by the service

Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12 week quit period. There is a 6 month lag time for reporting to allow monitoring of the 12 week quit period.



Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Karen Hamilton, Chair
Author:	Iris Bishop, Board Secretary

BORDERS NHS BOARD – BUSINESS CYCLE 2022

Purpose of Report:

The purpose of this report is to provide the Board with a focused and structured approach to the known business that will be required to be conducted over the coming year.

Recommendations:

The Board is asked to **approve** the Board meeting dates schedule for 2022.

The Board is asked to **approve** the Board Business Cycle for 2022.

Approval Pathways:

This report has been produced for the Board.

Executive Summary:

1. To deliver against targets and objectives, the Board must be kept aware of progress on a regular basis. The Board has a governance responsibility around performance, requiring assurance that targets will be met and that any action required to be taken to keep the organisation on course will be managed properly. The Board will seek such assurance through the Resources & Performance Committee of the Board.

2. For clarification and in the context of guidance set out in "On Board – A Guide for Board Members of Public Bodies Scotland" "How can the Board get through its business efficiently?":-

   "Board meetings should always have a manageable and prioritised agenda, an agreed duration and – perhaps – an estimated length of time for each agenda item.

   It is important that the agenda is properly focused. It must reflect the Board's two fundamental purposes – the long term (mission, strategy and planning) and monitoring performance. There will be some issues reserved to the Board, such as major capital spend decisions, and these must be on the agenda. However, it is important that the agenda is not clogged up with detail, even if it is just items "for noting". It will be all too tempting to dwell on the easy unimportant things and not concentrate on the big issues."

Public Board Meeting Agendas

3. Public Board meeting agendas should be focused on main clinical and strategic issues (apart from the standing items listed at those headings) at each meeting in order to facilitate strong debate of items.

Board Development

4. Board Development sessions have been scheduled for the afternoon after each public Board meeting. A programme of content will be worked up to ensure these sessions are used to the benefit of the Board.

5. Attached at Annex A is the Business Cycle for 2022 which has been formulated to capture the known business that the Board will be expected to address during 2022.

6. The Business Plan will remain a live document and will evolve further and flex where appropriate, to ensure the Board can meet its statutory and regulatory requirements.

7. In light of the requirements for social distancing against the background of COVID-19 the Board meetings will continue to be held via MS Teams with the intention of moving to hybrid or full in person meetings when possible.

Meeting Dates 2022

8. Tabled below are the proposed meeting dates for 2022.

- The Borders NHS Board will meet on 5 occasions.
- The Board will undertake Development sessions on 5 occasions.

- The Resources & Performance Committee (R&PC) have agreed their meeting cycle of 5 meetings per year on the dates below at their meeting held on 02.09.2021 and they are included below for information

Meeting	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Public Board		3		7		30				6		1
Development Session		3		7		30				6		1
Resources & Performance Committee	20		3		5				1		3	

- Public Board meetings – 9.00am to 11.00am – MS Teams
- Development Sessions – 2.00pm to 5.00pm – MS Teams
- Resources & Performance Committee – 9.00am to 11.00am – MS Teams

9. It is proposed that the meetings remain scheduled for the first Thursday of each month wherever possible in order to ensure reporting cycles for data collection are maximised.

10. Due to the need to ensure that the Annual Accounts are duly signed off by the Board in line with statutory requirements the June Borders NHS Board meeting will be pushed back to the last Thursday of the month (30 June).

11. In line with previous years it is proposed that there are no Borders NHS Board, Resources & Performance Committee, or Board Development sessions held in July.

Impact of item/issues on:	
Strategic Context	Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board. The SBC Full Council meetings cycle has been taken into account when identifying dates.
Patient Safety/Clinical Impact	Patient Safety/Clinical Impact implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.
Staffing/Workforce	Staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.
Finance/Resources	Resource implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.
Risk Implications	Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Board. The risks of falling outwith the financial and performance reporting cycle have been recognised and minimised.
Equality and Diversity	Compliant
Consultation	Board Executive Team
Glossary	R&PC – Resources & Performance Committee SBC – Scottish Borders Council

	A	B	C	D	E	F	G	H	I	J	K	L	M
1	**BORDERS NHS BOARD BUSINESS PLAN 2022**												
2	**Item**	**Recurrence**	**Owner**	**3 February BOARD**	**3 February DEV**	**7 April BOARD**	**7 April DEV**	**30 June BOARD**	**30 June DEV**	**6 October BOARD**	**6 October DEV**	**1 December BOARD**	**1 December DEV**
3	**Minutes**	monthly	Board Secretary										
4	**Action Tracker**	monthly	Board Secretary										
5	**Clinical Governance & Quality Update**	public	Head of Clinical Governance										
6	**Healthcare Associated Infection Control & Prevention Update**	public	Infection Control Manager										
7	**Finance Report**	public & R&PC	Director of Finance	inc: COVID, capital, year end Outturn									
8	**NHS Borders Performance Report**	R&PC & Public	Director of Planning & Performance										
9	**Statutory & Other Committee minutes**	public	Board Secretary										
10	**Consultant Appointments**	public	Director of Workforce										
11													
12	**Patient Story**	bi monthly	Head of Clinical Governance										
13	**Register of Interests**	yearly	Board Secretary										
14	**Remobilisation Plan (includes winter plan and financial plan)**	yearly	Director of Planning & Performance / Director of Finance	**feedback ?**				Final sign off					
15	**Code of Corporate Governance Refresh**	3 yearly	Board Secretary			Part Refresh Full refresh due 2023							
16	**Annual Report COPH (formerlly OPAH Overview Report)**	yearly	Director of Nursing & Midwifery									Annual Report	
17	**SB Adult Protection Committee Biennial Report**	yearly	Director of Nursing & Midwifery									Biennial Report	
18	**Child Protection Annual Report**	yearly	Director of Nursing, Midwifery									Annual Report	
19	**Child Poverty Annual Report (as per Child Poverty (Scotland) Act 2017 - Board required to publish annual report by June each year**	yearly	Director of Public Health										
20	**Strategic Risk Register**	yearly	Risk & Safety Manager			Risk Management Strategy							
21	**MOP Outturn (End of year Report 2021/22)**	yearly	Director of Planning & Performance										
22	**NHS Borders Annual Accounts**	yearly	Director of Finance										
23	**NHS Borders Endowment Annual Accounts**	yearly	Director of Finance										
24	**NHS Borders Private Patients Funds Annual Accounts**	yearly	Director of Finance										
25	**Board Committee Memberships**	yearly	Board Secretary										
26	**Board Meeting Dates & Business Cycle**	yearly	Board Secretary										
27	**Annual Review Letter and Action Plan**	yearly	Head of Performance & Planning	Dependent on timing of Annual Review						update on actions/ response to SG			

	A	B	C	D	E	F	G	H	I	J	K	L	M
28	**Alcohol and Drug Partnership Annual Report** (Goes IJB first and then NHSB for noting)	yearly FOR NOTING goes to IJB	Director of Public Health / Chief Officer									2021/22 (Goes IJB first)	
29	**Corporate Objectives**	3 yearly - FOR APPROVAL	Director of Planning & Performance								Draft 2022-2025 due 2022	2022-2025 due 2022	
30	**Community Empowerment Bill**	yearly	Director of Public Health									update	
31	**DPH Annual report**	2 yearly	Director of Public Health										
32	**Progress on Mainstreaming the Equality Duty & Equality Outcomes**	2 yearly	Director of Public Health					update					
33	**Equality Outcomes Report:** to publish on website	4 years	Director of Public Health					Due 2023					
34	**Medical Education Report** (yearly to CGC first in January each year then the Board)	yearly to CGC first	Medical Director										
35	**Pharmaceutical Care Services Plan 2022 -** The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011/32) amended regulations so that NHS Boards are obliged to publish Pharmaceutical Care Services Plans and monitor their plan annually to reflect changes in service provision or service need.	yearly (3 yearly)	Director of Pharmacy										
36	**Joint Financial Planning NHS/SBC**	yearly	Director of Finance										
37	**Financial Plan**		Director of Finance										
38	**Resource to the IJB 22/23 (Delegated Budget)**	yearly	Director of Finance			sign off							
39	**Board to formally sign off integration board membership (NEDS)**	yearly	Chair			Every 3 Years due 2022							
40	**Progress Report on the work of the CPP and the NHS contribution to Community Planning**	yearly	Director of Public Health										
41	**Counter Fraud Services**	every 2 years	Director of Finance										Due 2023
42	**Annual Audit Report**	yearly	Gillian Woolman, Audit Scotland										
43	**Logie Legacy - Zambia Twinning Partnership Annual Update**	yearly	Director of Public Health										
44	**Road to Digital 2021/22**	6 monthly	Head of IM&T									22/23 Update	
45	**Food Fluid & Nutrition Annual Report**	yearly	Director of Nursing, Midwifery							update			
46	**Primary Care Improvement Plan (PCIP)**	Yearly	Chief Officer					Update					
47	**Health Improvement Annual Report**	yearly	Director of Public Health										
48	**Blueprint of Corporate Governance Update**	yearly	Board Secretary			Awaiting National Survey - DELAYED COVID						6 month update	Prep for Self Assessment in January
49	**Health & Care (Staffing) (Scotland) Act 2019 - Annual Report on complaince for submission to Scottish Government**	yearly	Director of Workforce							Awaiting timeline from Scottish Govt			
50	**Hydrotherapy Pool**		Paul Williams taking forward, date for the Board to be identified										

	A	B	C	D	E	F	G	H	I	J	K	L	M
51	**Care Of Older People In Hospitals Update**		Director of Nursing, Midwifery & AHPs										
52	**Appointment of Internal Auditors**		Director of Finance										
53	**iMatter**		Director of Workforce										
54	**Assurance**		Board Secretary										
55	**The Board - It's Role**		Chief Executive										
56	**The Organisation - Strategy**		Chief Executive										
57													

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Andy Carter, Director of Workforce
Author:	Bob Salmond, Associate Director of Workforce

CONSULTANT APPOINTMENTS

Purpose of Report:

The purpose of this report is to notify the Board of recent consultant appointments offered by the Chair or their deputy on behalf of NHS Borders Board.

Recommendations:

The Board is asked to **note** the new consultant appointments.

Approval Pathways:

This report has been reviewed by the Board Executive Team.

Executive Summary:

Board members were briefed at its meeting in December 2017 on revisions to the NHS Borders guidance on medical consultant appointments. As a result, the Chair of the Board or his/her deputy have delegated authority to offer consultant appointments on behalf of the Board.

Since the last Board meeting, four new consultants have been interviewed, offered and accepted consultant posts.

New Consultant	Post	Start Date
Dr Lauren Smith	Consultant Paediatrician	September 2021
Dr Lucy Russell	Consultant Psychiatrist - CAMHS with interest in Neurodevelopmental Disorders	October 2021
Dr Leonie Boeing	Consultant Psychiatrist - CAMHS	November 2021
Dr Shonag Mackenzie	Consultant Obstetrician & Gynaecologist	November 2021

Impact of item/issues on:

Strategic Context	Successful recruitment to substantive consultant posts supports the sustainability of services.
Patient Safety/Clinical Impact	The Senior Medical Staffs Committee receives a

	quarterly report on forthcoming medical vacancies, new long term Consultant appointments (including locums) and consultant posts filled by long term locums.
Staffing/Workforce	Not applicable.
Finance/Resources	Not applicable.
Risk Implications	Not applicable.
Equality and Diversity	No impact assessment has been undertaken in preparation of this paper. However Equality and Diversity obligations are fully complied with in the recruitment and selection process.
Consultation	Consultation with the Remuneration Committee.
Glossary	Not applicable.

Borders NHS Board

Meeting Date: 7 October 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD MINUTES 26.05.21, 28.07.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Health & Social Care Integration Joint Board with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

The minutes are presented to the Board for information given NHS Borders is part of the Integration Joint Board and has delegated both functions and resources to the IJB.

Impact of item/issues on:

Strategic Context	Public Bodies (Joint Working) (Scotland) Act 2014
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	IJB – Integration Joint Board

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 26 May 2021** at **10am** via Microsoft Teams

Present:
(v) Cllr D Parker (Chair)
(v) Cllr J Greenwell
(v) Cllr S Haslam
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
Cllr J Linehan
(v) Mrs L O'Leary, Non Executive
(v) Mr M Dickson, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr R McCulloch-Graham, Chief Officer
Dr K Buchan, GP
Dr Lynn McCallum, Medical Director
Mrs L Gallacher, Borders Carers Centre
Mrs J Smith, Borders Care Voice
Ms Linda Jackson, LGBTPlus
Mr S Easingwood, Chief Social Work Officer
Mr D Bell, Staff Side SBC
Ms G Russell, Partnership Chair NHS
Mr N Istephan, Chief Executive Eildon Housing

In Attendance: Miss I Bishop, Board Secretary
Mrs J Stacey, Chief Internal Auditor
Mr Ralph Roberts, Chief Executive NHS
Mr D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance NHS
Mr P McMenamin, Deputy Director of Finance NHS
Mr G McMurdo, Programme Manager SBC
Mrs S Horan, Deputy Director of Nursing & Midwifery
Dr Keith Allan, Associate Director of Public Health
Mr Chris Myers, General Manager P&CS NHS
Ms S Pratt, Executive Lead PCIP
Mr B Paris, SBC
Ms J Holland, Chief Operating Officer SBCares
Mr A McGilvray (Press)
Ms J Amaral

1. APOLOGIES AND ANNOUNCEMENTS

Apologies had been received from Mrs Morag Low, Service User Rep, Mrs Nicky Berry, Director of Nursing, Midwifery & Operations, Mrs Netta Meadows, Chief Executive and Dr Tim Patterson, Director of Public Health.

The Chair noted that this meeting was the last meeting for Nicky Berry who moved to the post of Director of Operations for NHS Borders from 1 June 2021.

The Chair welcomed Sarah Horan who would take up the role of Director of Nursing, Midwifery and AHPs for NHS Borders on 1 June 2021.

The Chair welcomed Dr Keith Allan, Associate Director of Public Health who was deputising for Dr Tim Patterson.

The Chair confirmed the meeting was quorate.

The Chair welcomed guest speakers and members of the press to the meeting.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 17 February 2021 were approved.

The minutes of the Extra Ordinary meeting of the Health & Social Care Integration Joint Board held on 24 March 2021 were approved. Two minor amendments had already been made to the minutes: Linda Jackson was present as the LGBT Rep; the spelling of the word “de minimis” has been corrected on page 3 paragraph 5.

4. MATTERS ARISING

4.1 Action 8: Mr Rob McCulloch-Graham assured the Board that a new approach was being taken to co-production by amalgamating the efforts of the IJB, NHS and SBC. The action on the action tracker would be subsumed into that new approach and he suggested it be removed from the action tracker.

Mr Tris Taylor sought assurance that the coproduction model would include long-term conditions in the development and delivery of community treatment & care services. Mrs Jenny Smith commented that since the onset of the COVID-19 Pandemic many developments in coproduction had been taken forward in the third sector and she welcomed an all encompassing approach to co-production.

4.2 Action 3: Mr Tris Taylor sought a timeline for the review of the Scheme of Integration. Mr Rob McCulloch-Graham confirmed that the Strategic Commissioning Plan (SCP) would be reviewed by April 2022 and the Scheme of Integration (SoI) target date would be after that date. He explained that the review of the SCP may impact on the SoI and therefore it would make sense to complete the SoI after the SCP review had completed. He further commented that there may be changes to the SoI required as a consequence of the Derek Feeley recommendations being accepted by the Scottish Government. To date those recommendations remained with the Scottish Government for consideration.

4.3 Action 4: The item would be completed that day as it was a matter for discussion on the meeting agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. BORDERS PRIMARY CARE IMPROVEMENT PLAN: UPDATE REPORT

Mrs Sandra Pratt provided an overview of the content of the report and updated the Board on the workstreams progress to date.

Cllr John Greenwell thanked Mrs Pratt for her comprehensive report and enquired if there were any risk assessments undertaken in regard to additional funding not being received. Mrs Pratt commented that there was a risk assessment undertaken for the full programme of work and she would be happy to share that with the Board in the next PCIP update.

Cllr Shona Haslam commented that in terms of funding, there would not be enough funding to do everything, so she enquired what would not be done. She further commented that the demand on mental health services was likely to increase as the pandemic abated and she enquired if support would remain available locally for people or if services would be centralised.

Dr Kevin Buchan commented that currently there were some 300 to 320 appointments a week for community mental health services which were being filled. There was further work to be finalised in regard to appointments moving to face to face meetings in the community with video appointments being carried out centrally, when COVID-19 restrictions were lifted.

Mrs Pratt commented that the work that was not being done related to community treatment and care and vaccination programmes. The CTAC workstream was complex and contained a variety of different things that it was addressing in bite size chunks.

Mrs Lucy O'Leary enquired if there was scope for integrated health and social care roles as well as mobilising services like the breast screening mobile unit instead of relying on fixed buildings. Mrs Pratt advised that there were different models for different worksteams so not all were centralised. Due to economies of scale and COVID-19 pandemic limitations a centralised hub way of working had been developed. There were also limitations on the space in general practices. In terms of mobile units they had been used previously and tended to be expensive however they were in the mix for discussion as possible solutions.

Further discussion focused on: model specialist; confirmation that HR and vacancy processes in both NHS Borders and Scottish Borders Council were completed; partnership colleagues had been invited to attend vaccination workshops; a need for bespoke governance for the amount of staff and transformative work being undertaken; the assets available in communities were often overlooked in planning the role out of partnership services; and we should do work to better understand the totality of the assets available and the opportunities to collocate and therefore improve access.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress of PCIP to date and supported the submission of the PCIP Implementation Tracker and associated documents to Scottish Government in accordance with their regular reporting

6. OLDER PEOPLE'S PATHWAYS DELIVERY GROUP

Mr Chris Myers provided an overview of the content of the report through a presentation.

Mr Nile Istephan enquired what was not included and if enough attention was paid to pathway zero. Mr Brian Paris commented that it was a complicated and wide process when the approach taken was integrated with co-production involving stakeholders. He gave assurance that the programmes of work and workstreams sat in the localities and were connected and speaking to each other. A line had been drawn on those things that were in scope of pathway zero and a timeline had been agreed to ensure progress was made.

Mr Tris Taylor enquired about the reference to building on the findings accepted by the informative evaluation, the lessons were around the approach to what was delivered and around the systems and processes employed in setting up projects and programmes. He sought a quantification of expected benefits and suggested the same exercise were carried out as had been for the outcomes and outputs, as unless a starting point was identified there would be no baseline against which to track progress. He welcomed the presentation content of the public engagement intent.

Cllr Tom Weatherston agreed that it was a great piece of work. In terms of public engagement he commented that it had to be done correctly, potentially with a launch day and campaign to ensure the public understood it.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the approach being taken to progress with the continued development of the Older People's Pathway following on from the approval of the 'Formative Evaluation of the Discharge Programme' at the IJB's February 2021 meeting.

7. QUARTERLY PERFORMANCE REPORT, MAY 2021

Mr Graeme McMurdo presented the report and commented that concerns had been raised on the usefulness of the report as much of the data in the report was often out of date due to timelags with validated national comparison data. He drew the attention of the Board to Section 2 of the report which set out future reporting arrangements.

Cllr Shona Haslam commented that sections 4.2 and 4.3 were the same and enquired if that was an error. Mr McMurdo confirmed that it was.

Cllr Haslam enquired what the 2 strategic objectives were. Mr McMurdo commented that objective 1 was correct. Objective 2 was to make sure that when people had a health need identified, that they were diagnosed and triaged quickly and given access to the appropriate health input. If that involved hospital input they would be admitted and then discharged promptly.

Mr McMurdo commented that the regular report had been updated over the previous quarter to include extra social care measures. He also advised the Board that it had become difficult to look at performance improvement given the impact of the COVID-19 Pandemic.

Ms Lynn Gallacher commented that it was a useful report and highlighted in regard to carers, that they had managed to continue with carers support plans and to receive outcomes. However carers were becoming exhausted with the lack of access to social care and respite care. She was also aware of a reduction in packages of care being available and a longer waiting time for packages of care to be allocated. She suggested

that information on social care provisions was required. Mr McMurdo welcomed the suggestion of more information to be provided in specific areas.

Cllr Haslam agreed that the data was not inclusive of social care. She further commented that it appeared to be hospital admission focussed and not about improving the health of the population. She suggested including data on oncology, diabetes and obesity would give the Board a broad view of how population health could be improved. She further sought data on Discharge to Assess.

Mr Rob McCulloch-Graham commented that a shortage of social care indicators had been identified around pathway zero. He suggested deep dives on social care indicators; short term packages of care; allocation of packages of care; discharge to assess; discharge through Home First; and being risk averse and prescribing too much care.

Mr Tris Taylor suggested setting targets, objectives and metrics. In terms of objective 1 he suggested a need to quantify health production in the community and formulating a metrics to capture unpaid health production to assist in measuring the health of the population. In terms of objective 3 he suggested an analysis of current community capacity against a baseline was required and an understanding of whole system assets. He further commented that in terms of delayed discharge performance, it was not improving and he questioned if the choices policy was being implemented and if the strategy that was in place was being delivered and if it was, was it actually correct.

Ms Jen Holland commented that there was a performance board in Scottish Borders Council around the health & social care partnership which looked at the breadth of social work and social care performance. A piece of work on social care performance indicators should conclude in the summer and would then be brought to the IJB for consideration and inclusion in performance reports going forward.

Mr McCulloch-Graham commented that in regard to respite care, the Scottish Government were aware of difficulties with respite care provision across Scotland and he anticipated that a funding stream might be made available. Meantime further work would be taken forward through the appropriate workstream.

Mr McMurdo thanked the Board for their input to changes to the report and emphasised the need for social care measures to be included and supplementing the report with what the IJB required in order for them to make fully informed decisions.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the regular high-level quarterly performance report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposed changes to quarterly performance reporting (i.e.) to supplement the regular high-level quarterly performance report with more detailed and specific reporting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to ensure, in collaboration with the Chief Officer Health and Social Care Integration, that resource is identified for the production of performance reporting.

8. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

Mr David Robertson provided a verbal update on the budget position as it was too early in the financial year to be able to provide the usual monitoring report. He confirmed that the outturn position was in line with the information previously provided to the Board with the requirement for additional resources to be provided by both NHS Borders and Scottish Borders Council.

Mr Robertson confirmed that the process of completion of the final accounts was proceeding and report would be received by the IJB Audit Committee in due course.

Mr Robertson commented that financial reporting to the IJB in future would be through quarterly updates. They would be less retrospective and more forward looking in terms of transformational activity, delivery of savings and shifting the balance of care.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

9. ANY OTHER BUSINESS

9.1 Risk Strategy: Mr Rob McCulloch-Graham commented that there was an intention to bring a Risk Strategy paper to the next meeting of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

10. DATE AND TIME OF NEXT MEETING

The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 28 July 2021, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 12.03.

Signature: ……
Chair

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 28 July 2021** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr T Weatherston
Dr K Buchan GP
Dr L McCallum, Medical Director
Mr D Bell, Staff Officer SBC
(v) Mrs L O'Leary, Non Executive
(v) Mr M Dickson, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr R McCulloch-Graham, Chief Officer
Mr N Istephan, Chief Executive, Eildon Housing
Ms V McPherson, Partnership Chair NHS
Dr T Patterson, Director of Public Health
Mrs L Gallacher, Borders Carers
Mrs J Smith, Borders Care Voice
Mr S Easingwood, Chief Social Work and Public Protection Officer
Ms L Jackson, LGBTPlus

In Attendance:

Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mrs N Meadows, Chief Executive SBC
Mr D Robertson, Chief Financial Officer SBC
Mr A Bone, Director of Finance NHS
Ms J Holland, Chief Operating Officer SBCares
Ms S Bell, Communications Manager SBC
Ms C Oliver, Communications Manager NHS
Mr G McMurdo, Programme Manager, SBC
Ms S Flower, Chief Nurse Health & Social Care Partnership
Mrs L Jones, Head of Quality & Clinical Governance NHS
Ms S Holmes, Principal Internal Auditor SBC
Mr C Myers, General Manager Primary & Community Services NHS
Ms M Baird, Programme Manager NHS

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Shona Haslam, Cllr Elaine Thornton-Nicol, Cllr J Linehan, Mrs Morag Low, Service User Rep, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs and Mrs Jill Stacey, Chief Internal Auditor.

1.2 The Chair welcomed Mrs Sue Holmes, Principal Internal Auditor who was deputising for Mrs Jill Stacey.

1.3 The Chair welcomed Mrs Susie Flower, Chief Nurse Health & Social Care Partnership who was deputising for Mrs Sarah Horan.

1.4 The Chair welcomed guest speakers to the meeting including Mr Chris Myers and Mr Graeme McMurdo.

1.5 The Chair confirmed that Cllr John Greenwell had stood down as a voting member of the Integration Joint Board (IJB) and had been replaced by Cllr Jenny Linehan.

1.6 The Chair formally recorded Mr Malcolm Dickson, Non Executive and Vice Chair of the IJB would stand down from the IJB on the conclusion of his appointment as a Non Executive with NHS Borders on 31 July 2021. The Chair recorded the thanks of the IJB to Mr Dickson for his tenure on the IJB and chairmanship of the Strategic Planning Group and wished him a long and happy retirement.

1.7 The Chair confirmed that the Health Board at its meeting on 1 April 2021 had agreed that Mrs Lucy O'Leary, Non Executive would replace Mrs Sonya Lam as a voting member of the IJB and the IJB Audit Committee and would also be nominated as the Vice Chair of the IJB as per the Scheme of Integration on Mr Dickson's appointment conclusion. The Chair welcomed Mrs O'Leary to the meeting.

1.8 The Chair commented that the Health Board would make a further Non Executive appointment to the IJB in due course.

1.9 The Chair announced that Mrs Morag Low, Service User Rep had decided to step down from the IJB as she has decided to return to work as part of the immunisation team as a vaccinator. He recorded his congratulations to her on going back to work on the front line and wished her well for the future.

1.10 The Chair announced that Mr Rob McCulloch-Graham had decided to retire from his post as Chief Officer in the autumn and a recruitment process had been launched for a new appointment to be made.

1.11 The Chair confirmed that the meeting was not quorate and therefore no formal decisions could be made by the IJB at the meeting.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 26 May 2021 were amended to record the apologies of Mrs Netta Meadows.

The minutes would be resubmitted to the next meeting of the IJB for formal approval.

4. MATTERS ARISING

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AUDIT COMMITTEE ANNUAL REPORT 2020/21

5.1 Mrs Karen Hamilton provided an overview of the content of the report which outlined the activity of the IJB Audit Committee over the course of the past year.

5.2 Mr Tris Taylor enquired if the Audit Committee had looked at care and quality issues. Mrs Hamilton confirmed that the Audit Committee was an assurance body to review and examine audit reports and had cognisance of quality and care but would not have any direct impact.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** deferred approval of the IJB Audit Committee Annual Report 2020/21 until the next formal IJB meeting.

6. ANNUAL PERFORMANCE REPORT 2019/20

6.1 Mr Rob McCulloch-Graham recorded his thanks to Mr Graeme McMurdo for producing such a major piece of work.

6.2 Mr McMurdo provided an overview of the content of the report and highlighted that publication would take place in November and the content of the report was set by legislation as it was a report to the Scottish Government and had to include performance data. He commented that narrative had been included on the response of services during the pandemic and he had included examples at each spotlight objective.

6.3 Discussion focused on: understanding if the level of need for chronic conditions had been met and at what level; strengthening input from public health to get the needs assessment done for the next chapter; were the targets ambitious enough; page 46 tables needed amending; strengthening the “What we did section” in terms of carers, respite, older peoples survey, dementia and maternity; page 8 show “shifting the balance of care” as a movement over time; as a public facing document it required communications input to make it more short and snappy; lack of benchmarking information; what we said we would do, what we did and what we didn’t do appeared to be all mixed together leading to confusing statements; page 33 on last years’ priorities for carers support and progress made, could be strengthened; should it have a collaborative statement to show it had been coproduced by partners; and the inclusion of benchmarking data should allow a greater transparency of reporting.

6.4 Mr McMurdo commented that he would amend the tables on page 46; would work with Lynn Gallacher on the “What we did section”; as the document was a legislative requirement it did not lend itself to being easily digestible in the public domain and a short executive summary public facing document would help that; in terms of benchmarking information he agreed that it would be helpful to have benchmarking data in order to set targets and see

progress over time. He advised that the format of the report could be changed but the indicators shown had to be included and he welcomed the support to form a baseline of data.

6.5 Cllr Weatherston suggested more emphasis was given to healthy lifestyles.

6.6 Mrs Lynn Gallacher suggested more emphasis also be given to the third sector role in being a quality partner supporting the partnership to achieve its strategic aims.

6.7 Mr McCulloch-Graham commented that he was keen that comparisons in data were included in the report and more of the progress against the benchmarking data for the whole of Scotland would be emphasised. He further commented that the Annual Report was focused on the past year and the Commissioning Strategy would be the document that would focus on future years.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** discussed the draft Annual Performance Report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** wished to suggest the APR be demitted to the Strategic Planning Group and would make a formal decision on that at the next quorate meeting.

7. PRIMARY CARE IMPROVEMENT PLAN UPDATE

7.1 Mr Chris Myers presented the Primary Care Improvement Plan update to appraise the Board on the high level progress made on the implementation of the plan, progress of workstreams and a number of associated risks including financial risks.

7.2 Dr Kevin Buchan advised that services had been delivered that were helpful to GPs and highlighted physiotherapy services as an example. In terms of the Renew service he advised that there would be more people being medicated without that service and the development of the PCIP allowed GPs to get to a certain level to deliver complex care locally.

7.3 Discussion focused on: equality issues; patient experience; significant amount of underspend; and potential impact of long Covid.

7.4 Mr Myers confirmed that a Health Inequality Assessment had been undertaken for the whole programme and the individual workstreams had yet to complete them. However the Vaccination workstream given its advanced state had completed an HAII. In terms of patient feedback there had not been much received and that area would be looked at in the future. With regard to underspend the uncommitted line showed £346k uncommitted for the current financial year and the following financial year was likely to be a recurrent gap of £2.4m when the assumed £500k vaccination funding was taken off, so there was not a significant underspend for uncommitted funding. As carry forwards were not permitted all funding would be committed.

7.5 Dr Buchan commented that long Covid would revert back to GPs given it was a complex group of symptoms that GPs were best placed to recognise and advise on and the support from the PCIP would allow GPs to elevate to the Medical General experts that they were.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report, the risks, and actions being undertaken to reduce the risks.

Ms Linda Jackson left the meeting.

8. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET 2020/21

8.1 Mr David Robertson presented the formalised position as outlined at the previous meeting which reflected the financial performance of the IJB to 31 March 2021. He highlighted the financial bottom line which was wholly attributable to ring fenced funding carried forward, with the position realised after significant contributions were made to the IJB by the partners throughout the year. He further drew the attention of the Board to sections 3.3 and 3.4 of the report, set aside budge and the overall balance held by the IJB.

8.2 Mrs Lynn Gallacher noted that costs appeared to be lower than had been expected and she enquired how funding had been used and sought a breakdown of the £1.56m additional monies to the Borders for the implementation of the Carers Act. Mr Robertson confirmed that he would share the breakdown of the carers fund money and the use of the additional funding with Board members for absolute clarity of funding streams.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the final outturn position for the Partnership for the year to 31 March 2021;

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Health and Social Care partnership under-spent by £6.236m during the financial year relating entirely to slippage in the use of ring-fenced funding and planned investments, in addition to unutilised funding allocations for Covid-19 costs and that this has been carried forward to 2021/22 as part of the IJB earmarked reserve;

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the outturn position includes additional funding vired to the Health and Social Care Partnership during the financial year in order to meet previously reported pressures across health and social care functions from managed efficiency savings within other non-delegated health board and local authority services.

9. CLINICAL & CARE GOVERNANCE REPORT 2020/21

9.1 Mrs Laura Jones introduced the report and highlighted that the report sat alongside the Chief Social Work Officer report. The significant theme through the report was clinical prioritisation of services and the need to distribute professional groups across a wide range of services to support the response to the pandemic. She drew the attention of the Board to the remobilisation of services and the pressure points that remained in the system which included emergency access systems, elective pressures, community services pressures, and staffing pressures. She also highlighted the inspection of Hay Lodge and the recommendations and actions that had been progressed on the back of the inspection report.

9.2 Mrs Lucy O'Leary enquired how the pressure points could feed into the future commissioning strategy of the IJB and as a general reader she found the report difficult to navigate and would appreciate paragraph numbering in future.

9.3 Mrs Jones commented that she would be happy to change the format of the report in future. She advised in terms of the pressure points that a detailed review of the Child, Adolescent Mental Health service (CAMHS) and Psychological Therapies service had been undertaken. A long term business plan was required and would be routed through the IJB.

9.4 Mr Rob McCulloch-Graham commented that the commissioning of services around CAMHS to prevent the flow into CAMHS would assist. He suggested that could potentially be achieved by commissioning more resource into the Renew service, which currently focused on adults but could then deal with Adolescents and Children and would then reduce the impact on CAMHS. So it would be about how the IJB commissioned differently instead of doing more of the same.

9.5 Mr Malcolm Dickson enquired about the funding arrangements for support into care homes. Mrs Suzie Flower highlighted that funding was non recurrent, however there had been a commitment to support the team long term to work with care homes and support residents.

9.6 Mrs Lynn Gallacher enquired about the term "deteriorating patients", given some carers were reporting that people were being discharged from hospital with more cognitive decline then when they were admitted. Mrs Jones clarified that "deteriorating patients" referred to the state of the patient on admission to hospital as patients were more acutely ill with the need for either life saving intervention or treatment for end of life care. Patient acuity was monitored through the NEWS system which was run in all inpatient areas. Also as part of the clinical improvement work it was apparent that patients were presenting in a more deconditioned state to hospital and on discharge. It was a trend across NHS Scotland as well as increase in falls and the impact of the pandemic on patient deterioration on admission was unclear at present.

9.7 Dr Lynn McCallum welcomed the point and suggested it reinforced the need to shift the balance of care from the secondary care hospital based model into the community to get people home as quickly as possible and to provide rehabilitation in their own home.

9.10 Mr Ralph Roberts flagged to the Board that some of the issues in the report were extremely significant in terms of current service pressures on the whole system. In the context of the IJB being that whole system it was important that members understood it was the most significant pressure on the system ever seen in a summer. It was important to think about in terms of strategic commissioning going forward and also in terms of operational oversight.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

10. COLDINGHAM BRANCH SURGERY

10.1 Mr Chris Myers provided an overview of the content of the report.

10.2 Dr Lynn McCallum commented that she had spent the previous afternoon in Eyemouth at the Medical Practice and had an in-depth conversation with the GPs about the Coldingham Branch Surgery. She commented that it was evident that there had been a lot of soul searching amongst the GP partners who had worked to the best of their ability to maintain the service for as long as possible. They had been disheartened by the feedback they had received given they were working long days and missing out on family time in order to keep the branch surgery open.

10.3 The Chair commented that it could not have been an easy decision for GPs to make to withdraw from the branch surgery.

10.4 Mr Nile Istephan enquired if similar pressures existed across all Medical Practices across the region and what that would mean for the provision of services Borders wide. He also commented that he was mindful that where additional housing provision was made there was a direct read across to associated services for the population.

10.5 Mr Myers confirmed that the situation was not unique to Eyemouth and other GP practices faced other challenges such as recruitment of GPs.

10.6 Dr McCallum commented that whilst there were a number of larger GP Practices there were a significant number of smaller practices with only 3-4 GPs and if one was unwell or retired it had a massive impact on the remaining GPs and could derail those Practices. Sustainability and the current climate and workload the GPs were operating in were phenomenal and could not be underestimated. The PCIP would go some way to mitigating some areas such as assisting with workload, but there was further work to be done on retirement options, recruitment and career options.

10.7 Dr Buchan commented that currently the Borders were down by 10 partner GPs which equated to about 10% and made GP Practices fragile. GPs had been blindsided by the change in the GMS contract which made the central belt more attractive to GPs and caused difficulties with rural GP recruitment. The main key for Borders was the quality of life and work life balance that it offered. Although the language during discussion had been predominantly negative with the support of the PCIP there was still a huge positivity on where GPs were and what they could do in the future.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current situation relating to the sustainability concerns of the Coldingham Branch Surgery.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a Short Life Working Group had been established with the aim of ensuring the safe and sustainable delivery of medical and pharmaceutical service that meets the needs of Scottish Borders Population in the area. In order to do this, we will ensure that the medical and pharmaceutical needs of the population are met using a combination of reviewing the:

a. current sustainability risks;
b. current staffing levels;
c. accessibility of alternative provision of Dispensing Services including the access to the closest dispensing branch; and
d. alternative delivery models.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a public consultation was currently being undertaken and was due to close on 9th August 2021. All patients registered with Eyemouth Medical Practice had been sent a letter informing them of the situation and to invite responses to the consultation.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that an update paper would be drafted for a future Board meeting that would make recommendations on the future provision of services in Coldingham Branch Surgery.

11. STRATEGIC PLANNING GROUP MINUTES

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

12. ANY OTHER BUSINESS

12.1 No further items of business were raised.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 22 September 2021, from 10am to 12noon, via Microsoft Teams.