Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 24 June 2021 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr M Dickson, Non Executive
Mr T Taylor, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Ms H Campbell, Non Executive
Mr J Ayling, Non Executive
Mr J McLaren, Non Executive
Mrs A Wilson, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr L McCallum, Medical Director

In Attendance:
Miss I Bishop, Board Secretary
Mrs N Berry, Director of Operations
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of Workforce
Dr A Cotton, Associate Medical Director
Dr C Allan, Consultant Public Health Medicine
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Infection Control & Laboratory Service Manager
Mrs J Stephen, Head of IM&T
Ms C Kelly, Chief Clinical Information Officer
Ms C Anderson, Public Health Lead Children, Young People & Families/Child Health Commissioner
Ms S Flower, Associate Director of Nursing P&CS
Ms E Dickson, Interim Lead Nurse
Mrs C Oliver, Communications Manager
Mr A McGilvray, Radio Borders
Mr K Janiak, Southern Reporter
Mr D Knox, BBC Radio Scotland

1. Apologies and Announcements

1.1 Apologies had been received from Cllr David Parker, Non Executive, Dr Tim Patterson, Director of Public Health, Dr Janet Bennison, Associate Medical Director, Dr Nicola Lowdon, Associate Medical Director and Mr Rob McCulloch-Graham, Chief Officer Health & Social Care.

1.2 The Chair welcomed Dr Chris Allan, Consultant in Public Health Medicine to the meeting who was deputising for Dr Tim Patterson.

1.3 The Chair welcomed a range of attendees to the meeting.

1.4 The Chair welcomed members of the public to the meeting.

1.5 The Chair confirmed the meeting was quorate.

1.6 The Chair announced that it was the final meeting for Mr Malcolm Dickson, Non Executive, who would conclude his term of office on 31 July 2021. The Chair recorded the thanks of the Board to Mr Dickson for the support and expertise that he had brought to the Board and some of its sub Committees during his term of office.

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

2.2 Mr Malcolm Dickson declared that his sister-in-law was an executive member of the Board of Northumberland Health Trust.

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

2.4 Mrs Harriet Campbell declared that her husband had been appointed as Director of Digital Development for South of Scotland Enterprise.

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

The **BOARD** approved the inclusion of the declaration of interests for Dr Tim Patterson, Mrs Harriet Campbell, Mr James Ayling and Mr Andrew Bone in the Register of Interests.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Borders NHS Board held on 1 April 2021 were approved.

4. Matters Arising

The **BOARD** noted the action tracker.

5. COVID-19 Remobilisation Plan 2021/22

5.1 Mrs June Smyth provided an overview of the background to the matter and its route to the Board for ratification.

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

The **BOARD** ratified approval.

6. Pharmaceutical Care Services Plan 2021-2024

6.1 Mrs Alison Wilson provided background to the requirement of the plan and the regulations associated with it. She highlighted that additional commissioned services could not always be sustained due to the small size of many Pharmacies. The main focus of Pharmacies remained fulfilling their national contract with either little or no additional capacity to take on additional commissioned services.

6.2 Ms Sonya Lam commented that the plan was an annual plan and the proposal was to move to a 3 year plan and she enquired about the governance arrangements in that respect. Mrs Wilson confirmed that any minor updates would be brought back to the Board for approval on an annual basis with a major refresh taking place every 3 years. She added that the 3 year approach was in line with several other Health Boards.

6.3 Mrs Lucy O'Leary enquired if capacity for Pharmacists to take on additional work would be increased with the introduction of the Independent Prescribers. Mrs Wilson commented that the expectation was that capacity would be increased. She confirmed that there would also be a payment to Pharmacies who engaged Independent Prescribers.

6.4 Mr Tris Taylor commented that there appeared to be little service user engagement in the plan. Mrs Wilson clarified that the plan had been shared with the Public Partnership Forum for their input, however she emphasised that the plan was substantially constrained by the national contract. She reminded the Board that public representation was included in the Pharmacy Application process.

6.5 Mr Taylor commented that he would be keen to see metrics used and enquired if the Realistic Medicine programme could contain metrics. Mrs Fiona Sandford suggested Realistic Medicine be a future discussion at a Board Development session. Dr Lynn McCallum welcomed the suggestion of Realistic Medicine being a substantial discussion at a future Board Development session. She also highlighted that Realistic Medicine was about practicing clinical care as a whole general approach as opposed to a specific programme and she suggested she have a further discussion with Mr Taylor outwith the meeting.

6.6 Mr Taylor commented that he would like the Public Governance Committee to be sighted on the plan. Mr Ralph Roberts commented that he envisaged sharing with the Public Governance Committee could allow a more detailed discussion about the role and opportunities around public involvement related to Pharmacy Services and the Pharmaceutical Care Plan.

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

The **BOARD** approved the plan and the request to change from a yearly plan to every 3 years with an annual review and update as required.

7. Development of NHS Borders Digital Strategy

7.1 Mr Andrew Bone introduced the paper. Ms Catherine Kelly provided an overview of the content of the strategy and transformation of innovating services that were digitally enabled.

7.2 Mr Tris Taylor welcomed the updating of the infrastructure. He noted that there were a number of risk themes set out within Section 4 of the paper. Mr Taylor asked that when the full risk register was developed, that consideration be given to the risks for the population as equal to the risks to delivery.

7.3 Mr Bone acknowledged that there was more work to do on developing the risk register and more broadly the issue of balancing the benefits of transformation and changing how services were delivered in a digital space versus the need of maintaining the infrastructure. Most of the resource at present was directed to resilience to ensure the infrastructure was secure at the detriment of transformation, however the strategy would allow that shift of direction towards transformation through a balanced approach, whilst recognising that resource would remain a constraint overall.

7.4 Mrs June Smyth emphasised that digital services were not necessarily the solution for everyone in the local population and she was mindful that as the strategy developed engagement with the local population would be crucial.

7.5 Ms Sonya Lam enquired how the digital strategy would be aligned to the organisations vision and strategy. Ms Kelly commented that one of the challenges in formulating the strategy was that the digital strategy could not be done in isolation as it had to underpin the organisations broader objectives. She confirmed that it was also aligned to the national strategy and NHS Borders Clinical Strategy.

7.6 Mrs Smyth commented that the NHS Borders Clinical Strategy set the vision of the organisation pre pandemic and a programme of work would be drawn up and taken forward to revisit that strategy.

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

The **BOARD** noted the contents of the paper and the update on Road to Digital.

The **BOARD** noted development of the draft Digital Strategy to date, direction of travel and considered how Board members wished to engage in it moving forward.

The **BOARD** noted the risks described in this paper.

The **BOARD** noted the request for a Non Executive member as digital champion.

The **BOARD** noted that an individual had potentially volunteered subject to clarification of the extent and commitment of the role.

8. Resources & Performance Committee Minutes: 04.03.21

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

The **BOARD** noted the minutes.

9. Audit Committee Update

9.1 Mr Malcolm Dickson provided an overview of the content of the update and highlighted that no assurance had been agreed on waiting times and an action plan had been formulated.

9.2 In regard to waiting times, Mrs Nicky Berry reminded the Board that the Access Board had been stood down during the Pandemic. It had now been resurrected and a manual audit of notes were taking place on a monthly basis to ensure codes were being applied appropriately in order to address the recommendations from the internal audit.

9.3 Mrs June Smyth also advised that the internal audit had been a narrow audit on one aspect of waiting times management. A full cycle of internal audits would be included in the 3 year plan.

9.4 Mrs Harriet Campbell enquired about the role of the Access Board. Mrs Smyth advised that it was set up to have oversight of waiting times standards and involved the 3 Clinical Boards.

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

The **BOARD** noted the update from the Audit Committee meeting held on 16 June 2021.

10. Audit Committee Minutes: 22.03.21

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

The **BOARD** noted the minutes.

11. Endowment Fund Minutes: 28.09.20, 31.03.21, 17.05.21

11.1 Miss Iris Bishop provided a brief explanation in regard to the occasional timelag for the receipt of approved Committee minutes by the Board.

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

The **BOARD** noted the minutes.

12. Financial Performance

12.1 Mr Andrew Bone provided an overview of the content of the paper and advised that the financial plan was based on a lot of uncertainty in regard to the remobilisation of services and the continued impact of COVID-19. He highlighted the drivers of expenditure and the actions being taken to address those pressures. In preparing

the Quarter 1 review all funding assumptions, actions and variations against the plan would be scrutinised.

12.2 Mr Bone drew the attention of the Board to the risks arising from the planned phasing of delivery on savings plans and that funding for COVID-19 expenditure was assumed within the position in anticipation of SG allocations not yet confirmed.

12.3 The Chair commented that she and Mr Bone were in discussion regarding the presentation of the tables within the financial report in order to make those more understandable to the general reader.

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

The **BOARD** noted that the board was reporting a £2.66m overspend for two months to end of May 2021.

The **BOARD** noted the position reported in relation to COVID-19 expenditure and assumptions around funding in relation to same.

The **BOARD** noted the timescales for the board's Quarter One Review and preparation of an updated outturn forecast.

13. Clinical Governance Committee Minutes: 17.03.21

13.1 Mrs Fiona Sandford provided a brief update on the most recent Clinical Governance meeting that had taken place in May and highlighted that the Committee had undertaken a deep dive session into Elective Access and Emergency Access. They had also discussed the increase in Falls that was being seen across of NHS Scotland, potentially due to the deterioration of patients due to COVID-19 and the required donning and doffing of PPE in between patients.

13.2 In July the Committee were expecting a deep dive into Mental Health and Primary Care waiting times, particularly Dental waiting times. The Committee would also be discussing Realistic Medicine.

13.3 The Chair commented that Non Executives were welcome to observe any Board Sub Committee that they were not a member of, if there were items of interest on the agenda.

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

The **BOARD** noted the minutes.

14. Quality & Clinical Governance Report

14.1 Mrs Laura Jones commented that the focus for the Clinical Governance Committee had been on the access areas around clinical risk. She then clarified 2 points within the Q&A document: the graph in relation to COVID-19 deaths was up to the 19th May with one death of suspected COVID-19 in June; in answer to Q46 the service was funded to October 2021 and did form part of the respiratory service review and would be brought forward as part of that services long term plan.

14.2 Mr Tris Taylor recalled that the model complaints procedure had been overhauled and he enquired if a system and process for reviewing and monitoring the learning form complaints and compliments was in place and could be provided in aggregate to the Board. Furthermore he was keen to have a discussion on metrics for Realistic Medicine and for some of the elements of Realistic Medicine to be scrutinised by the Public Governance Committee as they involved equalities in decision making between the clinician and the patient.

14.3 Dr Lynn McCallum commented that she wholeheartedly embraced public involvement in the Realistic Medicine programme given the ethos of the programme was individualistic care and to ensure all parties had the knowledge they required to make their choices on their own healthcare.

14.4 She further commented that the Communications Team had produced a series of animations on Realistic Medicine which had been endorsed by the Realistic Medicine National Group in terms of content. She suggested she set up a call with Mr Taylor outwith the meeting in regard to Realistic Medicine.

14.5 Mrs Jones commented that the Patient Feedback Team provided trend data on actions from complaints and she could provide that information to the Board or Sub Committees. She was keen to get a better understanding of what the Board would like to see so that she could reflect that in the regular report going forward.

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

The **BOARD** noted the report.

15. Healthcare Associated Infection – Prevention & Control Report

15.1 Mr Sam Whiting drew the attention of the Board to section 7 of the report and the reference to the Infection Control Compliance Monitoring programme, to confirm that the new process had commenced. He also referred to section 12 of the report in regard to PPE practice and guidance, which had been updated earlier in the week and brought the organisation in line with national guidance and reduced the use of PPE for the majority of patient contacts. He advised the Board that the over use of PPE could be associated with increased infection risk.

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

The **BOARD** noted the report.

16. HIS Unannounced Inspection Report

16.1 Ms Suzie Flower reported that progress had been made in regard to the Action Plan with the majority of actions remaining on target for completion. There was some further work to be taken forward on education and person centred care planning through the Clinical Boards and back to basics programme. Monitoring was taking place through all of the Community Hospitals not just Hay Lodge as well as the Senior Charge Nurses dashboards to ensure good compliance.

16.2 Mrs Lucy O'Leary commented that in reading the report it appeared to show good service delivery of compassionate care but with less robust support processes in place and she enquired how that would be addressed in all locations. She further

commented that in terms of the digital strategy there was a fundamental gain to ensuring things worked correctly digitally for staff and patients.

16.3 Mrs Nicky Berry commented that the recommendations had been in regard to documentation, as the observations of interactions between staff and patients were very good. The documentation had been refined during the COVID-19 Pandemic and further improvements had been made in regard to training on the new documentation. Mrs Berry commented that she was proud that the care to patients had been seen as excellent and in putting the recommendations on documentation into context she advised that 2 sets of notes had been audited that day out of a potential 23 sets of notes for patients who were in the Hospital that day.

16.4 Mrs Sarah Horan commented that in regard to digitalisation, given the pressures in the system, digitalisation of records and documents would make it much easier and simpler for staff and patients in terms of risk assessments, care needs and care planning.

16.5 Ms Flower assured the Board that all 4 Community Hospitals were being reviewed in terms of care and documentation to ensure any improvements were made where identified.

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

The **BOARD** noted the Action Plan.

17. Food Fluid and Nutrition Update

17.1 Ms Elaine Dickson commented that the Food Fluid and Nutrition (FFN) Group had been paused during the first and second wave of COVID-19, however it had now been re-established and had focussed on a gap analysis. She drew the attention of the Board to Item 20 in regard to exploring developing a link with social work teams as more patients were being admitted in a deconditioned state. The link had now been established through the Eat Well, Stay Well initiative.

17.2 The Chair welcomed the multi-disciplinary team approach.

17.3 Ms Sonya Lam enquired if the organisation met the FFN standards and what work was going on nationally to understand the deconditioning of patients that were being admitted to hospital and how that might be prevented.

17.4 Ms Dickson confirmed that the organisation was meeting the FFN standards. There remained a focus on the nutritional assessment of patients on admission, by drilling down into each part of that nutritional assessment to identify any areas of concern as well as a triangulation of initiatives with care home placements, carers and the Dietetic Team.

17.5 Mrs Sarah Horan commented that in regard to Falls, there had been an increase in Falls seen across NHS Scotland since the pandemic. In NHS Borders there had been a real reduction in Falls pre pandemic across all sites. She further commented that the Feeding at Risk Policy was being reviewed and would be submitted to the Clinical Governance Committee for approval.

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

The **BOARD** noted the report.

18. Staff Governance Committee Minutes: 15.03.21

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

The **BOARD** noted the minutes.

19. Area Clinical Forum Minutes: 01.12.20

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

The **BOARD** noted the minutes.

20. End of Year Managing Our Performance Report 2020/21

20.1 Mrs June Smyth provided a brief overview of the content of the report.

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

The **BOARD** noted the 2020/21 End of Year Managing Our Performance Report (MOP).

21. Performance Scorecard

21.1 Mrs June Smyth provided a brief overview of the content of the report. She explained that it was the first of the fuller reports to be brought to the Board having stood down some of the reporting due to COVID-19 the previous year. Some targets had been reintroduced which were attached to the Remobilisation Plan and some had been attached to the previous Annual Operational Plan. Feedback from the Scottish Government in terms of performance reporting was awaited.

21.2 Mrs Lucy O'Leary enquired as the report format was developed if thought could be given to where the Board might look prospectively at where the hotspots could be. Mrs Smyth commented that she would take that suggestion on board and as part of the Remobilisation Plan there were some projections already included in the performance report and where possible she would include actual versus planned.

21.3 The Chair commented that in reference to Q63 in the Board Q&A DNAs appeared comparatively high for diagnostic tests. Mrs Smyth commented that an answer to that question was being clarified and would be supplied separately.

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

The **BOARD** noted the April 2021 Performance Scorecard.

22. Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20

22.1 Mrs Carole Anderson commented that the report was for the period 2019/20 as it had been deferred from several agendas due to the COVID-19 Pandemic. Within

the Board Q&A she had included the current 2020/21 report which had just been approved by the Community Planning Partnership on 10 June 2021.

22.2 The Chair commented that it was a fulsome report and she welcomed the inclusion of the 2020/21 report.

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

The **BOARD** noted the Local Child Poverty Action Report 2019/20 Report.

23. Board Committee Memberships

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

The **BOARD** formally approved the membership and attendance of Non Executive members on its Board and other Committees as recommended by the Chair with immediate effect.

24. Scottish Borders Health & Social Care Integration Joint Board minutes: 17.02.21, 24.03.21

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

The **BOARD** noted the minutes.

25. Any Other Business

There was none.

26. Date and Time of next meeting

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

The meeting concluded at 10.40am.

Signature: ……..
Chair

BORDERS NHS BOARD: 24 JUNE 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Appendix-2021-42 Register of Interests	**Harriet Campbell:** Since completing the form my husband has been appointed as Director of Digital Development for South of Scotland Enterprise. I can't really see any conflict of interest there, but it may need to be added. Thoughts welcomed.	**Iris Bishop:** Hi Harriet I have established through Jackie Stephen that the South of Scotland Enterprise was set up by the Scottish Government and is not a corporate company, however there may be collaboration work with them in the future. I would therefore advise that you declare this interest.
2	Appendix-2021-42 Register of Interests	**Malcolm Dickson:** As the Finance Report mentions external providers and purchasers, I make my usual declaration that my sister-in-law is an executive member of the Board of Northumberland Health Trust.	**Iris Bishop:** Thank you Malcolm I will note in the minute of the meeting.
3	Appendix-2021-42 Register of Interests	**Tris Taylor:** Andrew Bone: What is 'B' in 'B Director'?	**Andrew Bone:** A 'B' category director is a member of the board which is nominated as a representative of shareholders. In this instance the South East Hub has both private and public sector shareholders (all regional councils and NHS Boards in Lothian and Borders). There is a single board appointment representing all the public sector organisations who have an interest - this was most recently held by a member of East Lothian Council.
4	Appendix-2021-42 Register of Interests	**Sonya Lam:** I declare my partner is a temporary specialist advisor to the Scottish Government Approve	**Iris Bishop:** Thank you Sonya I will note in the minute of the meeting.
5	Minutes of Previous Meetings	**Tris Taylor:** These minutes are brilliant thank you, love the new paragraph numbering.	**Iris Bishop:** Thank you.
6	Matters Arising/ Action	**Tris Taylor:** 6.8: Please could we have the	**Ralph Roberts:** Agree minute should refer to

	Tracker	resubmission of the Risk Management Strategy to include matrices (should this be 'metrics'?) and key performance indicators (and presumably baselines & targets?) on the Action Tracker with a deadline?	"metrics" rather than "matrices". Board formally agreed Strategy at last meeting recognising that further development of Metrics / KPIs would be progressed; I would suggest that the timescale for this to be refined should be delegated to the Audit Committee as the relevant Board committee at this stage.
		14.1: looks like an action for me and Ralph – this is outstanding, can we book it or put it on the action tracker?	**Ralph Roberts:** Noted and will be scheduled
		22.5: what has been the change in the position on Delayed Discharges since the Audit Committee report? If the change has been negligible or negative, is the agreed monitoring via the Audit Committee of progress on Delayed Discharges sufficient to see actual change? What change has there been in occupancy figures for residential and nursing care homes, which stood at 84% at the last Board meeting and are targeted at 90%? What proportion of the people currently delayed relies on factors within NHS Borders' control?	**Rob McCulloch-Graham:** The position fluctuates daily, but overall the position has not improved as yet. The reports to the audit committee have demonstrated that actions have been undertaken as described within the report. The position is monitored and reported daily, and the senior steering group chaired by the two operational leads, who can respond immediately when issues are escalated through the agreed process. The occupancy rates as measured we have discovered are flawed, as they are based on places registered with the care inspectorate, and are over the actual number of available beds. We are now working with providers to gain a more accurate indication as the actual number of places available in each institution.

			Delayed Discharge performance cannot be aligned with a single partner. As has been explained in previous reports the factors that influence are many and there is a complex interplay. These factors also frequently change in degree. The ownership of performance is now seen firmly a shared accountability, and equal efforts are being made by all partners.
7	Appendix-2021-43 COVID-19 Remobilisation Plan 2021/22	**Harriet Campbell:** I am conscious that most (if not all) board papers have already been approved by other committees/individuals and I imagine most queries I have will therefore have already been addressed. Nonetheless, I am putting all my questions down... In particular I am wondering – and this will probably become clear: given that this is a public meeting, to what extent questions are needed to ensure that the public is able properly to see what is happening. If all we do is ratify papers that have already been approved in committee, then can the public really be said to know what is going on? Generally too, many of the papers refer to other reports and papers and in some cases (and papers vary) say things like 'x took the committee through the report and highlighted areas of interest'. If you weren't at the meeting, without those reports it is hard fully to understand the impact and import of the decisions taken in the relevant meetings. Can I take assurance that colleagues have approved or would others recommend that we should all be reading all	**Ralph Roberts:** This is correct, although some issues are reserved for the Board and will not therefore have gone through a sub-committee – this should be made clear on cover papers. All Committee minutes are subsequently seen in public so this provides an opportunity for oversight of issues overseen in committee. As governance committees these are normally focussed on assurance and so will only make decisions where these are clearly delegated within the Board's scheme of delegation. All committee papers are available to any Board member but it would not be expected that other Board members read all papers from Committees they are not directly involved in. Where an issue at a committee needs to be brought to the attention of other Board members, for instance because of an assurance concern or significant decision, then it is expected this is flagged to Board members

		papers behind all committee meetings?	through the Committee chair updates or when minutes are reviewed.
8	Appendix-2021-43 COVID-19 Remobilisation Plan 2021/22	**Karen Hamilton:** Approved	-
9	Appendix-2021-43 COVID-19 Remobilisation Plan 2021/22	**Sonya Lam**: Ratify.	-
10	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**Harriet Campbell:** Why are we moving to a three year plan? Are there any risks associated with the move? How have these been mitigated? As we come out of the pandemic, I would imagine that use of pharmacies will change and does a three year plan allow for that possibility. I note the 'potential loss of aseptic services'. How likely is this and when will we know? Again will this not impact on future planning – does a three year plan allow enough flexibility? Do employees of independent community pharmacies count as part of the NHS Borders workforce? Am slightly confused by employee numbers stats. Confused by pharmacotherapy numbers and practice – are these just within the 3 GP practices that offer prescribing services? Sorry, not clear from report. How are we providing these services across the full geographical area? Report (p 23) makes it clear we are below aim for ratio of such staff to patients. How are we addressing this?	**Alison Wilson:** Many of the other Boards have 3-year plans and generally there is very little change year on year. We would build in annual reviews where if we thought there was a need to update it. The aseptic business case is being prepared at the moment and will come to the Board in October. No they don't count within NHS Borders workforce. The numbers quoted refer to the staff employed through the primary care investment plan (PCIP) one. No PCIP staff cover all practices. The 3 dispensing practices employ their own staff to do this work and are not connected to NHS Borders pharmacy staff. The ratio was an arbitrary figure mentioned nationally as one to aspire to. There is no evidence to say whether this is the right number or not.

		Similarly with the independent prescriber community pharmacists, how does this work in areas (24 of the 9 pharmacies) where there is no such prescriber? Should we be aiming to increase this?	Yes this is part of a national work programme. We are supporting and encouraging pharmacies to train their pharmacists as prescribers but we cannot make them.
		Vaccination services. Given the issues highlighted (not least legislative problems) is is really likely ('on course') that these will all be outwith general practice by the end of 2021? If only 1000 flu vaccines were administered by pharmacy staff, in only half of practices, in 2020/21, is it really realistic to expect that the necessary many times that (not to mention routine childhood vaccinations etc) will be in place in the next six months. It seems unlikely to me and is this a risk we should be concerned about?	Community pharmacy vaccinations are only a small part of the solution. We are working with the overall programme board to ensure that we deliver this. It will be a multi-pronged approach and is being co-ordinated by the PMO team.
		When access is again available to the BGH, would it be possible to see how the electronic prescribing and robotics work. I am struggling to imagine these!	I can send you a link to see how it works elsewhere and gives you an idea of my asoirations locally.
		Is there a data protection/patient confidentiality issue around ECS? It doesn't seem to have been widely publicised.	There is a national agreement to enable community pharmacies to access the ECS, which will have taken into account these issues.
		Is there a significant difference from the patient perspective between the minor ailments service and PFS? If so, has the as the change been adequately highlighted to patients?	It is more of an evolution of the old minor ailments service and was launched "softly" by Scottish Government. Personally I don't think it has been promoted enough.
		More generally there are quite a few actions where it seems to me it is unclear *how* the action is going to be put in place : eg 'support the development of vaccination services'. Do we need detail on this? What about resource etc?	Many of the actions will form part of my senior team's objectives for the year to make the "live". Resource is an issue and we will have to prioritise work accordingly.

11	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**Lucy O'Leary:** (page nos refer to Board pack not indiv report) P45 - independent prescribers. Are the current IPs (including those recently coming on stream) spread across the patch or are there areas which do not have access to an IP? P 46 Has any modelling work been done to establish projected WTE requirements over time for pharmacy staff in the various settings, taking into account current workforce demography, expected changes in demand etc etc and, if so, how has this informed the planning here? P 51 Dispensing practices. The numbers and location are shown but I'm not sure whether there is any plan to change this – do we want more or fewer in future? Are there barriers to achieving whatever the "right number" is?	**Alison Wilson:** Yes there are areas within the community pharmacy network without IP pharmacists. It is an evolving picture. See response above. Only in the managed sector and this was many years ago. We were due to update this last year but it was put on hold. It should be restarted in the coming months once we know the timeline for the pharmacy robot. Dispensing Drs are historic. There are no plans to increase this number. It is likely to reduce if we get pharmacy applications in these areas.
12	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**Fiona Sandford:** Very interesting paper: 1. o deliver Right Care Right Place, are we training enough pharmacists at sufficient pace as independent prescribers? Is the delivery date of 23/24 sufficiently ambitious? 2. ow will we 'nudge' a change in behaviour of the public to make better use of our pharmacies 1WTE pharmacy technician for care homes/ care at home seems a bit meagre?	**Alison Wilson:** By 2026 all newly qualified pharmacists will be prescribers and pharmacists qualify this year will have the opportunity to become a prescriber by 2023. Lots of communication and positive feedback on patient experiences of using pharmacies. Yes we need about 2 wte which has been highlighted to IJB.
13	Appendix-2021-44 Pharmaceutical Care	**Karen Hamilton:** General info – this is replicated on a number of strategies and I wonder if we could link it	**Alison Wilson:** That would be good

	Services Plan 2021-2024	online to a suite of common info? Hyper links on Agenda – very useful!!!! Exec Summary 1.6 This year the Plan has been changed to a 3-year plan and action plans included reflect this. There will be an annual review and update of the Action Plan and any other areas required. If this is already done should we be ratifying not approving this? Rationale and impact for moving to 3 year plan? Change Log 1.6 Suggestions from Board member including to align with SB H&SC Strategic Plan and NHS Borders organisational purpose – done?	 See earlier response. It is a proposed change so probably should be approved. Yes
14	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**Tris Taylor:** Though I have a lot of questions, I hugely appreciate the clear underlying logic and referencing that appears throughout, and the quality of the writing and editing of this detailed and concise plan. Thank you to all involved. P11, bottom paragraph: the charts referred to (at appendix 7) don't tell us much about people with long term conditions except how many hospital admissions the Board makes of people with long term conditions. Hospital admissions are a very small part of people's lived experience with long-term conditions. Can we get some better data please to expand on the fourth of the five bullet points above it ('more people in the Scottish Borders report a limiting, long-term health condition (29%) compared to Scotland (24.6%)')? (I can see two workbooks are embedded, but these are not openable in the PDF.)	**Alison Wilson:** This is more for public health rather than this plan. We include it as a snap shot only.

		P13: given there is a statutory duty on NHS Boards to provide the pharmaceutical services necessary to meet local needs, to what extent can we evidence that our commissioning or provision of pharmaceutical services is driven by the needs of service users, carers, families and the broader population?	The test is whether pharmaceutical services are “necessary and desirable”. We would very much like to be able to commission other services from pharmacies but the feedback we get from contractors is that they are struggling to meet the need of their national contract and not able to take on more services.
		Please could a list of the professional and public partners consulted be provided?	Included in the cover paper
		P15: Is the % quoted in relation to Figure 6 calculated on the basis of headcount or FTE?	Sorry not sure as this is NES data.
		P16: What systems and controls are in place to audit and grade accessibility to pharmacy services, and when were providers (including the Board) last audited?	We don’t audit and grade.
		To what extent have disabled people been involved in designing and executing these systems and processes?	As pharmacies are independent contractors we can only advise. This would be for the pharmacies to do.
		Appendix 3 provides a checklist of criteria relating to accessibility and confidentiality. To what extent is that list of criteria validated by disabled people? To what extent can the Board be confident that it is sufficient to discharge the obligation to make ‘reasonable adjustments’ for any disabled person, taking into account the variety of ways in which a person can be disabled?	This is taken from the Disability and Discrimination Act. There is no definition of this so we cannot be assured. It is at the discretion of the pharmacist. In addition pharmacists are not directly funded for provision of some of the adaptations.
		Given the significant focus on access cited in the ‘Rural & Remote’ section on p11, with 16% of people	We don’t have this level of information. Many pharmacies do deliver medicines but this is an

		reporting transport issues as creating barriers to health, what is the timescale and plan for reducing that 16% to nil with regard to pharmacy services? Of that 16%, what is its demographic profile with regard to other protected characteristics, and to what extent can we regard serving this community better as a priority according to health inequalities indicators, policy and statute?	unfunded service. They offer telephone or "Near me" consultations to increase access.
		P17: Has the expansion of the Prescribing Support Team resulted in a greater or lesser proportion of the workforce having a protected characteristic?	Greater.
		P20: What proportion of community pharmacists and/or of the entire pharmacy workforce have lived experience of long-term conditions?	Information not available
		PP23 & 25: What metrics are deployed to monitor compliance with, and outcomes from, Realistic Medicine principles?	We don't have anything at the moment.
		PP23-24 and 25: What systems and processes are in place to ensure that service users (including 'complex patients) and carers are involved in the design, delivery and evaluation of learning & development/education & training activity for pharmacy colleagues?	Most of this is done through the pharmacy workforce, predominantly pharmacists. Depending on what E&T is being delivered then service users / carers may be involved. This would depend on whether you are talking about initial E&T or CPD. Pharmacist training now included experiential learning.
		P26: What systems & processes are in place to ensure the involvement of service users, carers and the wider population in quality improvement?	We have involved feedback from service users in some of the enhanced services provided.
		P27: Looking at the methodology behind the survey	Some data is available through ISD but not

		result that 80.5% of people accessing community pharmacy services are completely satisfied, it appears the sample would tend heavily toward frequent users and entirely exclude non-users. What data is available on access demographics concerning community pharmacy, either in general or in the Borders?	frequently used. As people don't register with a pharmacy it is hard to seek views of non-users.
		P32: What do we know about the impact on health of lack of access to a community pharmacy?	Very little
		P33: Please can the 'low' use of ECS be specifically quantified? What are the metrics, what is the baseline and what is the target figure, by when? What systems and processes are in place for raising usage?	ECS access was only granted during first lockdown. We are feeding back usage data to pharmacies.
		Likewise, what is the target uptake of NearMe, from what base, by when, expressed as both the proportion of community pharmacies signed up and the difference between the desired and actual volume of usage?	As above.
		P35: Against what evidence of need has the conclusion been made that current provision is adequate? To what extent is that evidence sourced directly from disabled people?	No information is sourced directly from disabled people. It is based on judgement.
		PP36-40: The Plans do not show baselines and targets and in that respect it will be difficult or impossible to account for the relative success of execution. Please could they be supplied?	This will be picked up with my team.
		Overall: what assurance is available with regard to the involvement of our Borders population in the	No assurance can be provided. Most pharmacy services are directed through the

		design, delivery and evaluation of pharmacy services? Is that assurance considered sufficient? If not, what additional action ought to be taken to provide sufficient assurance and what metric/s used to measure performance?	national contract. We would involve local communities if we get a new pharmacy application. We have included the public from time to time about enhanced services but the response has been very poor.
15	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**James Ayling:** Community pharmacies are at the front line of healthcare delivery . .....yet we appear to rely on independent providers providing them. Large pharmacy chains will presumably make decisions on potential closures based on not just local matters but national profitability etc. Small independent pharmacies will have their own issues and profit/loss considerations. Are we confident that funding packages and the like will make the setting up and maintenance of community pharmacies **in the Borders** an attractive proposition? Are there contingency plans in place to cover for a pharmacy that shuts down quickly or unexpectedly or in breach of contract ? Is there any provision that might allow a local Health Board to take over the running of a community pharmacy in extremis or potentially have a right of pre- emption (if money was available)? Why is the use of the Emergency Care Summary low? Do we investigate that? It sounds a very positive development .	**Alison Wilson:** We are receiving applications for new pharmacies so yes. The independent nature of pharmacy does mean that we have limited control over what other services they provide e.g the provision of compliance devices is usually a commercial decision. Yes we have a MOU in place with many of the pharmacies though pharmacies should have their own arrangements in place to cover this. No. We are liaising with pharmacies to understand why. They were only granted access last year.
16	Appendix-2021-44 Pharmaceutical Care Services Plan 2021-2024	**Sonya Lam:** • ppendix 9 provides a more explicit links with the NHS Borders organisational objectives 2020-2023. • hank you for adding Appendix 10 which provides high level narrative. Further consideration may be needed as to how	**Alison Wilson:** Thank you for the comments. This is something we can look to take forward.

		the actions and outcomes of Pharmaceutical Plan contribute to the strategic objectives through the 7 partnership principles. • he action plan on pages 36-40 provides useful outputs against each year but not perhaps outcomes i.e. what does success looks like in 2024. I recognise that a measurement framework is a considerable piece of work particularly with the breadth of activity covered in the plan and I understand that this will in the relevant lead pharmacist's objectives but I would like to see both a measurement framework and a finance framework so that as a Board we understand the impact and progress of transformation. • n EDI and risk assessment would be welcome too	
17	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Harriet Campbell:** I'm definitely going to need more background on this and would welcome this in due course!	**June Smyth/Jackie Stephen:** We would be very happy to arrange a further discussion and to answer any questions at a mutually convenient time.
18	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Malcolm Dickson:** It's some time since the Digital Maturity Assessment was carried out in 2019, yet I think this is the first time NEDs have seen or heard of it. I presume this is because reaction to it has been severely delayed by the more pressing need for IM&T staff to react to the needs of the pandemic? Has delay and/or our position relative to other Boards been recorded as a risk on the Strategic Risk Register? In terms of consultation and stakeholder engagement, this could make use of existing networks such as the IJB's Strategic Planning Group, and Locality Working Groups.	**June Smyth/Jackie Stephen:** While we had some informal feedback in late 2019 the final DMA results were sent to all Health Boards by Scottish Government in March 2020. Any response to that has been delayed by the pandemic. Digital is on the strategic risk register along with a separate cyber risk. There are plans to engage with stakeholders and citizens through a number of existing groups**.** We are also keen to ensure the voices of front line clinical and administrative staff of all levels of seniority are heard, as these are

			the people who are most impacted on a daily basis by our digital technology solutions. We intend to achieve this by targeting different groups and through open drop in sessions.
19	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Lucy O'Leary:** P 98 We are asked to nominate a NED as Digital Champion but the paper doesn't set out why this is necessary or what the role would be. Is it a central requirement or a local proposal? (apologies if this is included in any of the linked documents and I've missed it – I don't have online access as I am making these notes)	**June Smyth/Jackie Stephen:** This is a local proposal rather than a central requirement. We have found that non-executive interest has been beneficial in the past, generally through resilience and audit committee but feel given the importance of Digital across all our services and the leadership needs identified through the DMA might lend itself and be of interest to non-executives. How exactly this might work requires further consideration. The digital transformation journey for healthcare organisations is not easy and the investment and cultural change required to ensure successful delivery and realisation of benefits should not be underestimated. As digital increasingly underpins achievement of business objectives a number of healthcare organisations are appointing non-executive directors with digital transformation experience or identifying people who are willing to take a lead role challenging conventional ways of working and ensuring digital investment reduces strategic risk and delivers maximum value.
20	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Fiona Sandford:** Clearly critical that we do everything reasonably possible to protect against cyber attack – how does the delayed roll out of Windows 10 and Office 365 affect our vulnerability?	**June Smyth/Jackie Stephen:** An update will be provided verbally due to the security aspects of this question.

		Disappointing that we are mostly firefighting and not enhancing processes; improving digital must be a pivotal as we transform our services	As we move forward it is important that the portfolio of work is balanced between • *usiness as usual projects* e.g. essential maintenance and upgrades to existing systems; • *ptimisation of existing systems* e.g. implementation of new functionality in existing electronic health records to reduce dependency on paper based processes; • *ew innovations* e.g. implementation of new applications which help to improve the quality of care delivered or enable staff to work more productively. At present the majority of available resource is directed at urgent business as usual projects.
21	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Karen Hamilton:** Lucy volunteered for Champion – do we have any more? 1.4 It is anticipated that in autumn 2021 Scottish Government will require all Boards to update their Digital Maturity Self Assessment. How sure of this are we? 2.3 with patient and public representative groups to gather their views about how we can use digital technologies to make it easier to navigate health and care services, to access care and to be supported to keep well at home. Does this include GP's appointments system?	**June Smyth/Jackie Stephen:** 1.4 Scottish Government has confirmed that they are planning to repeat the digital maturity assessment exercise later this calendar year. 2.3 Feedback from patient and public groups will help identify where there are key challenges accessing services in acute, community, mental health and primary care settings or where there are opportunities to provide digital tools to enable self supported care. This will inform the digital transformation

			programme being undertaken with Scottish Borders Council and the digital citizen delivery plans being developed by Scottish Government. As patient pathways include care delivered by health and social care partners in Scottish Borders Council, or other territorial or national health boards, it is important that any citizen digital tools take account of this. It is likely that most of these tools will need to be procured or implemented once for Scotland.
		Feel the need to commend IMT on the huge amount of work done through Covid and recognise the impact this will have had on the strategic plan timescales?	Thank you – Yes our timescales have moved and the impact on the remaining RTD items is answered in a further question. Some timescales for actual delivery are still being developed in light of local prioritisation work and the volume of new request and changed context.
		Can this be quantified and how does it impact on risk?	The passage of time can of course change the risk profile, along with changed context, ageing equipment etc. so the breadth / volume of risks has increased and we are working with services to mitigate and prioritise some of the more localised risks and associated work. We have also seen numerous new requirements to support services as they reshape & recover, making it a challenging picture where the support of the wider organisation to prioritise and align our efforts is crucial. We have made some very welcome

			progress in engaging with colleagues to move that forward.
22	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Tris Taylor:** 2.2.1 – typo 'VODI-19'? (Sorry – seemed like it needed mentioning) 3.3 Which is due to which please? Noted and empathised with.	**June Smyth/Jackie Stephen:** 2.2.1 This should be COVID-19. 3.3 Windows 7 migration to Windows 10 - elay due to reprioritising and assigning project staff to Covid response and recovery tasks. Migration to Office 365 - elay due to reprioritising and assigning project staff to Covid response and recovery tasks. EMIS Mobile - elayed due to higher priorities for available team. - urther delays due to Covid and Covid response activities Impacted by Covid response task and placed GP IT Replacement - elayed due to National delays CHI Child Health System Replacement - ational delays. Then delayed due to Covid HEPMA - o capacity or funding in place to conclude a business case & prioritise organisationally. GP ORDER COMMS - elayed due to Covid and dependency upon multi-

			board procurement exercise.
23	Appendix-2021-45 Development of NHS Borders Digital Strategy	**James Ayling:** These comments are based on the paper in front of me as I haven't seen previous plans etc. It is a step forward and will allow us to provide an update to the Scottish government's update requirement later this year. The 6 month timeline seems tight particularly with only 8 weeks July and September for stakeholder views for such a potentially important exercise .Is this the right time to be doing important work on this project when we are remobilising ? Will there not be lessons learnt from use of digital during the pandemic that need to be teased out?	**June Smyth/Jackie Stephen:** It is recognised that the stakeholder engagement exercise is important both to gather feedback about what works well and what challenges are faced. Without dedicated resources available to support this exercise it will not be possible to complete within the proposed timescales. It is also recognised that without a digital strategy it is challenging to prioritise the large number of projects in the digital portfolio based on alignment to achievement of business objectives. The Scottish Government digital maturity assessment also noted the lack of a local transformational digital strategy therefore it is important that this work is progressed alongside service recovery. Lessons learned from the pandemic are being taken into account as the strategy develops. Although Covid-19 necessitated rapid roll out of Near Me virtual consultations and Microsoft Teams for remote meetings and multidisciplinary team collaboration there was still a requirement for large numbers of staff to work on site as many processes are still dependent on having access to paper case notes. Feedback from clinical staff indicates that virtual consultation uptake by some patients has been limited because of lack of available resource to signpost them to the correct virtual waiting. Some clinicians are reluctant to continue to use the technology for

			outpatient clinics as they wish to revert to traditional methods of delivering care. On the other hand some clinicians have embraced the technology and are able to demonstrate significant benefits to their services. Work is required to address the cultural resistance to change that exists in some parts of the organisation and to ensure that technology solutions are implemented with the ongoing support needed to promote adoption and use.
24	Appendix-2021-45 Development of NHS Borders Digital Strategy	**Sonya Lam:** • hat was the key learning from the Road to Digital i.e. since 2017? Did we successfully mitigate the risks identified? • f the digital strategy is to describe the health board's ambition and plans to digitally transform services for improved outcomes, are we talking about digitally transforming existing pathways or do we need to rethink our pathways through a digital lens? Is digital the only driver behind transformed pathways? • o we have the infrastructure in place to launch a new strategy?	**June Smyth/Jackie Stephen:** RTD Phase 1 was infrastructure and security – Most of the risks originally identified have been addressed. Phase 2 of RTD was focused on mitigation of application risk, and these are also mostly completed now. It needs to be kept in mind that RTD was the strategy for 2017 to 2020 and the events since March 2020 have significantly impacted strategic direction and priorities. The key learnings from RTD & Covid were: 1. n year 1, funding from Scottish Government became available before the full scope and solution were fully understood and planned out which led to a lot of catch up and planning and delivery under intense pressure. 2.

			ccess to the right skills and capacity is at the right point is essential for smoother delivery. 3. nsure that project scope clearly defined and fully understood. 4. reater organisational understanding & input to prioritising, aligning to outcomes and balancing across key infrastructure and front line functionality is required. 5. here is a need to consider our approach, internal organisation and reliance on FTC to create a more sustainable resource model that lends itself to faster, more responsive delivery. It is important that the default position is not just to digitise existing pathways and care processes without considering how digital technology or data can enable care to be delivered in a more person-centred, safe, equitable or efficient way. Digital can potentially be both an enabler of pathway transformation and a driver of transformational change. Digital should be considered to be a key component of all service and pathway redesign processes from the start. The infrastructure will need continual refresh and modernisation to support both current and future aspirations and ways of working. We will need to make sometimes difficult choices in what we prioritise as an organisation and align the infrastructure to support that and deliver the intended benefits, while ensuring security

			and continuity of services already in place.
25	Appendix-2021-46 Resources & Performance Committee Minutes: 04.03.21	**Harriet Campbell:** Do we not review the minutes of the 6 May meeting now too? If not, why not?	**Iris Bishop:** The public Board meeting receives the approved minutes of its sub Committees. The draft minutes of the Resources & Performance Committee held on 6 May 2021 will not be approved by that Committee until it meets again on 2 September 2021. Once those minutes are approved they will be noted by the next public Board meeting on 7 October and the approved minutes will also be made available on the NHS Borders website. All Health Boards adopted the Once for Scotland Model Standing Orders for Health boards. Those standing orders clearly state that only approved minutes should be received by the public Board meeting. This is why we also have Committee chair updates to the Board because this gives Committee chair's the opportunity to flag any significant issue that was discussed but that other Board members may not become sighted on for a number of months because of the committee / Board meeting cycle.
26	Appendix-2021-46 Resources & Performance Committee Minutes: 04.03.21	**Karen Hamilton:** Noted **Sonya Lam:** Noted	-
27	Appendix-2021-47 Audit Committee Update	**Harriet Campbell:** Will we get a further update on waiting times at the meeting? Am assuming so and would welcome this.	**Andrew Bone:** See 28 below.
28	Appendix-2021-47	**Karen Hamilton:** Noted	**Andrew Bone:** Re. above – this is same point

	Audit Committee Update	Exec summary bullet point 1 Waiting time Internal Audit – can we elaborate briefly verbally at the meeting please?	as 27, above. Would suggest Nicky Berry is best placed to give this update. The bullet refers to actions in place to address the risks highlighted within the recent WT audit.
29	Appendix-2021-47 Audit Committee Update	**Sonya Lam:** Noted.	-
30	Appendix-2021-48 Audit Committee Minutes: 22.03.21	**Harriet Campbell:** Could I have a brief (two line) explanation on what the updates to the code of corporate governance cover please?	**Iris Bishop:** The updates were to:- **Section A** "How business is organised". This section now includes the following updates:- • Replacement of the Standing Orders with the Model Standing Orders as prescribed by the Scottish Government for all Health Boards to adopt. • Revision of the Resources & Performance Committee Terms of Reference. • Inclusion of the Capital Investment Group (CIG) Terms of Reference. The CIG will be a sub-committee of the Resources & Performance Committee. **Section C** "Standards of business conduct for NHS staff". This section has been revised to reference the UK General Data Protection Regulation. **Section F** "Reservation of powers and delegation of authority". This section now includes the following updates:- • Section 2.2.1 refers to emergency powers and at page 226 we have included reference to a limit of £1m being set for the Chief Executive to authorise

			during a response to an emergency situation/major incident. • Page 243 Appointment of Consultants: The Chair has delegated authority for the Appointment of Consultants to the Chief Executive to Chair the Consultant Interview panels.
31	Appendix-2021-48 Audit Committee Minutes: 22.03.21	**Karen Hamilton:** Noted. **Sonya Lam:** Noted.	-
32	Appendix-2021-49 Endowment Fund Minutes: 28.09.20, 31.03.21, 17.05.21	**Harriet Campbell:** Are the endowment fund minutes only brought to board once a year? Just wondering why we have minutes going back to last September.	**Iris Bishop:** The public Board meeting receives the approved minutes of its sub Committees. The minutes from 2020 were approved the day before the Board meeting on 1 April and so were not available at that time for that meeting.
33	Appendix-2021-49 Endowment Fund Minutes: 28.09.20, 31.03.21, 17.05.21	**Karen Hamilton:** Noted. **Sonya Lam:** Noted.	-
34	Appendix-2021-50 Financial Performance	**Lucy O'Leary:** P 149 As I understand it the largest single component of overspend is a surge in activity in the ED in April/ May. There has been mention of work to understand the causes of this – are we yet in a position to understand more about the underlying causes?	**Gareth Clinkscale:** Increase in ED demand has been predominantly minors activity however there has been increase in all patient flows. We are also seeing examples of more deconditioned patients admitted to hospital following lockdown requiring longer rehab and more complex discharge planning.
35	Appendix-2021-50 Financial Performance	**Fiona Sandford:** 3.4, 3.5 and 5.4: Any update on Quarter One? If ringfenced resources have not yet been released, why will the adjustment not materially alter reported performance?	**Andrew Bone:** Sorry, I may be misinterpreting the question – hopefully this will answer: The reported position is our most up to date information available (to end May). We would expect to have early indication of end of June position by mid July and this will inform the

			forecast to end March to be prepared as part of the Q1 review. Clarification on ring-fenced resources: funding ***has*** been released where we have been able to confirm expenditure in being incurred; there is always a period of 'bedding in' in first quarter as some new allocations or commitments are still being evaluated. I would expect a slight correction to the level of budget by June/July but at this stage there is no expectation this will make a significant improvement to performance.
36	Appendix-2021-50 Financial Performance	**Karen Hamilton:** Noted A couple of points for clarity which I will discuss with Andrew at our 1:1 Wed 23rd. If unclear still I will raise verbally at meeting.	**Andrew Bone:** Noted (and discussed).
37	Appendix-2021-50 Financial Performance	**James Ayling:** There is a big variance within 2 months between opening annual budget and the revised annual budget for income and expenditure. Presumably there a systemic /reporting /timing reason for this?	**Andrew Bone:** Yes. The opening budget represents the 'recurring' resource available to the board, which provides the baseline of service budgets. We then amend the budget to reflect the financial plan and any in year allocations from Scottish Government. This will continue to grow throughout the year, with many allocations received later in the year. Wherever we have a degree of assurance around the funding we will anticipate income and set budgets early, but in some cases this is not possible. I intend to provide a more comprehensive overview of how the financial mechanisms of the board operate as part of a future briefing

			session to be available to board members. At this stage the intention is to align this with the cycle for preparation of the mid-year review (October) but will be happy to consider moving this forward if there is a view this would be helpful.
38	Appendix-2021-50 Financial Performance	**Sonya Lam:** • .9.7: How is the usage of agency being addressed? Will this level of expenditure in the Set Aside continue or is there a plan to pull this budget back on line? How will this impact on the progress of the plans to address unscheduled care flows?	**Andrew Bone:** The remobilisation plans agreed in March included a recognition that we needed to bolster (particularly) hospital staffing in the first part of the year in order to support a phased approach to recruitment and to mitigate risks during the transition from current (COVID19) operating model. There are however ongoing workforce recruitment and retention challenges in relation to a number of staff groups and the consideration of whether agency staff are engaged remains subject to assessment of safe staffing levels required to mitigate clinical risks. Expenditure within set aside/unscheduled care will be reviewed as part of the wider Q1 review. This will include consideration of any potential changes to existing planning assumptions.
39	Appendix-2021-51 Clinical Governance Committee Minutes: 17.03.21	**Harriet Campbell:** As above, why is the most recent set of clinical governance minutes not dealt with at this board meeting?	**Iris Bishop:** The public Board meeting receives the approved minutes of its sub Committees.
40	Appendix-2021-51 Clinical Governance Committee Minutes:	**Karen Hamilton:** Noted 1 Announcements etc – comments on late papers noted and concurred.	-

	17.03.21		
41	Appendix-2021-51 Clinical Governance Committee Minutes: 17.03.21	**Sonya Lam:** Noted	-
42	Appendix-2021-52 Quality & Clinical Governance Report	**Harriet Campbell:** Local press was reporting a recent Covid-19 death in the Borders. Is that correct? I suspect, even if it is, that it will be outwith the period covered (ie after 31 May), but please can you confirm? If within the period, why is this not reflected in the report? Of the critical stories on Care opinion are there words or issues that recur – it might be informative to have a wordle of these too?	**Laura Jones:** This is correct Harriet it was outwith the reporting period on the graph up to the 31 May 2021 but there has been 1 death from COVID 19 since this graph was prepared. This death occurred on the 1 June 2021. This is possible and has been provided below for the period 01/04/2020 to 31/03/21. Happy to include in future reports: What could be improved? 
43	Appendix-2021-52 Quality & Clinical Governance Report	**Malcolm Dickson:** I think I've asked at least once a year for 4 years for assurance that data on types of complaints is used to learn lessons and I've seen nodding heads but no evidence offered. This is valuable intelligence for the organisation's management. The Board doesn't necessarily have to see this data analysis but the Clinical Governance	**Laura Jones:** Trend data is shared with clinical board governance groups and improvement actions are drawn out from complaints responses onto shared improvement trackers for each clinical board. The main themes from complaints remain the same. Each clinical board provides

		Cttee may want to?	a routine report to each Board Clinical Governance Committee and could provide examples of how actions from complaints have been implemented.
44	Appendix-2021-52 Quality & Clinical Governance Report	**Karen Hamilton:** Noted 4. Realistic medicine – what progress is being made here? 9 Volunteering- Impact of Volunteer co-ordinator post currently vacant? New raft of volunteers potentially – how do we do this?	**Laura Jones:** There are several workstreams contributing to the overall realistic medicine workplan a detailed overview of progress of each project could be provided if helpful. We are currently filling the remaining contract for the Volunteer Coordinator post for 2 years. A paper will also be considered at the next Endowment Committee to consider the longer term plan for the volunteer role. In the meantime the team lead for the person centred care function continues to provide advice on the remobilisation of volunteers against the national guidance on reinstating volunteer roles. The majority of volunteer roles were stood down during the wave 1 and 2 pandemic response for the protection of volunteers, unless roles where able to be delivered remotely.
45	Appendix-2021-52 Quality & Clinical Governance Report	**Tris Taylor:** 4.2: What are the specific actions in the plan regarding increasing dialogue with patients and the public? What are the associated metrics, targets and baselines?	**Laura Jones:** Realistic medicine video targeted at the public through social media channels, describing broad principles. Key messages relating to realistic medicine have been woven into text used for radio interviews targeted at the public. Realistic medicine questions now included in all outpatient letters sent to patients in preparation for their appointments and is presented visually in clinical environments with

			the aim of encouraging a discussion between the patient and clinician to inform decision making about their care and treatment: 1. s this test, treatment or procedure really needed? 2. hat are the potential benefits and risks? 3. hat are the possible side effects? 4. re there simpler, safer or alternative treatment options? 5. hat would happen if I did nothing? We do not yet have specific metrics but group being formed to build approach to this and to agree key areas from realistic medicine workstreams where NHS Borders would like to build a dialogue with the public over the coming year. This conversation is being supported by the communications and engagement team.
46	Appendix-2021-52 Quality & Clinical Governance Report	**Sonya Lam:** • oint 5.3. Can I clarify whether the NHS Borders Pulmonary Rehabilitation service is mainstreamed and permanent now? • hat does Datix data tell us about the safety environment? Are there any trends in data?	**Laura Jones:** I will get details of this to provide at the meeting. I have asked Sonya for clarity on this question and will prepare a response.
47	Appendix-2021-53 Healthcare Associated Infection – Prevention &	**Harriet Campbell:** At 2.3 we have a chart showing days between SAB cases (and the same at 3.1 for C Diff). Given therefore that a high number is a good	**Sam Whiting:** Any statistically significant events (sigma violation, shift, trend) are automatically applied. There can be wide

	Control Report	number, why are the occasions where there are 0 or 1 days between infections not sigma violations? What is the acceptable level here (other than merely 'above the green line')? Presumably as soon as there is one case in the hospital it becomes more likely there will be others, and hence seeing clusters below the green line?	fluctuation without necessarily being statistically significant. To date, the graphs show natural variation. Although we haven't seen linked clusters of SAB cases, every case is investigated to identify any learning or themes to target improvement. Invasive devices such as peripheral venous catheter (PVC) are a particular risk factor for patients developing a SAB with implementation of best practice safety bundles being a previous focus of improvement activity. In the last 12 months there has only been one SAB case where the cause was associated with a PVC. As with SAB cases, every CDI case is also reviewed to identify learning. For CDI we also map patient location to look for any potential cross transmission. Where there is a potential association (for example, if 2 cases had been on the same ward at the same time), the laboratory samples are sent to a reference lab for further typing to see if organisms are indistinguishable which could be indicative of cross transmission.
		Are there any initial indicators from the study into validation of cleaning results? Are similar validations carried out re hand hygiene and infection control compliance monitoring?	Five peer audits were conducted in May 2021 with a member of the infection control team accompanying the Domestic Supervisor during the audit. On average, the cleanliness score dropped by 12% across the five locations compared with

			the previous audit that had been conducted in April 2021. In the same locations, the Estates fabric scores dropped by an average of 21%. Estates and Facilities colleagues are reviewing the approach to audits. Pre-COVID-19, our supplier of hand gel conducted periodic hand hygiene audits for us. The nurse employed by the supplier to conduct audits and deliver staff hand hygiene training is retiring in June 2021 and we will be discussing with her successor about resuming these audits in the future. Infection Control compliance monitoring has always been conducted by the Infection Control Team in the past to provide assurance by being independent from the wards. Work is progressing on a new process with Infection Control Nurses training Clinical Nurse Managers to undertake audits of each other's areas.
		I'm sure we will have an update on Covid 19 given recent increases in cases in the Borders, but if we haven't had one by this point in the meeting, please may we have one? Please may we have an update on the meeting re endopthalmitis?	There have not been any recent COVID outbreaks in NHS facilities. Public Health would be best placed to update on wider community prevalence and clusters. No epidemiological link between the two cases has been found. The cause(s) of the cases is unclear. There have been no further cases. This clinical activity continues to be undertaken in theatres. An options appraisal will be developed to identify the best location for these

			procedures to be undertaken in the future.
48	Appendix-2021-53 Healthcare Associated Infection – Prevention & Control Report	**Karen Hamilton:** Noted **Sonya Lam:** Noted.	-
49	Appendix-2021-54 HIS Unannounced Inspection Report	**Karen Hamilton:** Noted.	**-**
50	Appendix-2021-54 HIS Unannounced Inspection Report	**James Ayling:** Given my lack of experience on the Board to date It would be interesting to know how this report is rated on a RAG type analysis or the like just to let me put the findings into context.	**Sarah Horan/Susie Flower:** HIS have adapted their current inspection methodology for safety and cleanliness, and care of older people. NHS boards are measured against a range of standards, best practice statements and other national documents, including the Care of Older People in Hospital Standards (2015) and Healthcare Associated Infection (HAI) standards (2015). During inspections, HIS identify areas where NHS boards are to take actions and these, are called requirements. A requirement sets out what action is required from an NHS board to comply with national standards, other national guidance and best practice in healthcare. A requirement means the hospital or service has not met the standards, and as such HIS are concerned about the impact this has on patients using the hospital or service. HIS that all requirements are addressed and the necessary improvements are made**.** If we were to attempt to RAG I would suggest **Green -** No requirements **Amber-** Requirements **Red-** requirements and escalations required

			plus a follow up inspection.
51	Appendix-2021-54 HIS Unannounced Inspection Report	**Sonya Lam:** • am presuming that the Improvement Action Plan (Page 213) is specific to Hay Lodge. After a visit, do we consider whether any of the improvement plans that are applicable to other community settings? What mechanism do we use to share the learning from such visits?	**Sarah Horan/Susie Flower:** The action plan is specific to Haylodge however a number of requirements are applicable across all 4 CH. The action plan has been shared with all 4 CH and is discussed at SCN meetings with a number of the actions being rolled out across all 4 sites. (eg making meal times matter,, ward audits and education relating to care planning).
52	Appendix-2021-55 Food Fluid and Nutrition Update	**Harriet Campbell:** I'm sure there is a historical and clear reason for this (and it may be that those who were on the Board then will already understand this) but if the original report on this was presented to the Board in January 2019 this seems a rather long time ago (pandemic notwithstanding). Why was more progress not seen between 2019 and 2020?	**Sarah Horan/Elaine Dickson:** The report was due to be submitted early 2020 which the pandemic then put paid to. It felt important to acknowledge that essentially a holding pattern was in effect 2020 – 2021 with this report based on a Gap analysis to capture the improvement work and that a refresh of FFN standards was required.
53	Appendix-2021-55 Food Fluid and Nutrition Update	**Karen Hamilton:** Noted Can progress against the action plan be shared – via email if necessary.	**Sarah Horan/Elaine Dickson:** The action plan has updates included. Please advise if you are looking for further detail, Thank you
54	Appendix-2021-55 Food Fluid and Nutrition Update	**Sonya Lam:** • an I clarify whether Appendix 1 (Page 4) relates to 2019? If so, what are the most up to date percentages? What are the target percentages? • o we currently meet the standards for FFN and the Complex Nutritional Care Standards?	**Sarah Horan/Elaine Dickson:** I can confirm that Appendix 1 relates to data from 2021, and should have been highlighted as an Appendix further through the document. The Target percentage for recording of MUST is 100%. As per standard 2 states a nutritional assessment should be undertaken and recorded within 24 hours of admission. Nutritional screening was previously identified as an area which required improvement to meet the standards. In an attempt to gain greater understanding of whether there were specific aspects of the

			assessment process which were more or less compliant than others, each specific step was audited individually. This has provided some baseline data which will help inform improvement work required moving forward.
55	Appendix-2021-56 Staff Governance Committee Minutes: 15.03.21	**Harriet Campbell:** Again, why do we not consider the more recent SGC meeting minutes at this Board Meeting?	**Iris Bishop:** The public Board meeting receives the approved minutes of its sub Committees.
56	Appendix-2021-56 Staff Governance Committee Minutes: 15.03.21	**Karen Hamilton:** Noted Item 4 Whistle Blowing – paper to come to Board? Remind me if this has happened	**Iris Bishop:** It is scheduled for the 7 October Board meeting.
57	Appendix-2021-56 Staff Governance Committee Minutes: 15.03.21	**Sonya Lam:** Noted	**-**
58	Appendix-2021-57 Area Clinical Forum Minutes: 01.12.20	**Harriet Campbell:** What is BANMAC?	**Iris Bishop:** BANMAC is the Borders Area Nursing & Midwifery Advisory Committee which is a professional advisory committee for the Board via the Area Clinical Forum.
59	Appendix-2021-57 Area Clinical Forum Minutes: 01.12.20	**Karen Hamilton:** Noted. **Sonya Lam:** Noted.	**-**
60	Appendix-2021-58 End of Year Managing Our Performance Report 2020/21	**Malcolm Dickson:** Cover Report page 1/237. Good to see that 100% of patients requiring Treatment for Cancer were seen within the 31 day target throughout the year, especially since Audit Scotland have stated that this target was adversely affected during the pandemic in other health board areas. Page 10/249 (and page 258): Does the TTG Improvement Plan have a target trajectory and, if so, when do we anticipate getting anywhere near the	**June Smyth:** Feedback noted thank you The TTG improvement plan has three areas of focus for 2021/22; (1) to ensure urgent capacity is maintained and the most clinically

		zero target?	appropriate patients are seen/treated, (2) to return activity to pre-pandemic levels and (3) to work to reduce all waits over 52 weeks to zero by the end of March 2022. Our ability to achieve zero patients > 12 weeks will be dependent on external resource and constrained by workforce and infrastructure. We do not yet have a definitive timeline for returning waiting times to pre-pandemic levels.
		Page 14/253 "To understand the multifactorial causes for delayed discharges – a deep dive data analysis has been undertaken that demonstrates that there is no one single cause of delayed discharges" - presumably there must be one or two factors more common in delays than others and so these can be focussed on for improvement?	That's correct – the following are areas of focus to reduce delayed discharges 1. Rate of admission – reduced rates convert to reduced delays. Work on admission prevention will be explored further as part of the HSCP Localities Operations Group 2. Step (process) delays - Delays due to assessment/discharge planning are being reviewed 3. Delays in access to care homes (45% of bed days) – inappropriate assessment (ie, nursing when could be residential) – Waiting times for care home placement – Care home capacity (incl type and locality) 4. Packages of care (33% of bed days) - availability and spread of packages of care. 5. Delays due to legal discharge issues (19% of bed days).

61	Appendix-2021-58 End of Year Managing Our Performance Report 2020/21	**Lucy O'Leary:** Is the format for this report centrally prescribed? If not – paragraph numbering please, and a table of contents that matches the actual structure of the report P 248, top chart. The narrative further on makes clear that the Jan/ Feb low number of TTG breaches is only because there were extremely low levels of treatments being carried out in the first place. As it stands, this chart adds little to the report and is potentially misleading if it's not clear that a low number isn't necessarily a good thing. Again, if it's not centrally prescribed, could it be junked, improved or rethought in future? See below re note on p 259	**June Smyth:** Not centrally prescribed or required by SG. Noted for inclusion in next report. I agree Lucy; this chart isn't helpful without the context beside it. We will revisit for future reports.
62	Appendix-2021-58 End of Year Managing Our Performance Report 2020/21	**Karen Hamilton:** Noted Exec Summary 1.3 Of course O/P figures over 12weeks are concerning. Other areas of significance outwith trajectory also noted. Can we have some comment as to how we are managing and supporting our staff with this and how are we communication with SG colleagues about improvements?	**June Smyth:** We have a programme of work underway to increase remobilise and increase Outpatient activity. This includes a number of key activities: 1. afe return to pre-pandemic Outpatient list sizes using extended waiting area space and managing arrival times 2. epurposing of clinical space to increase clinic capacity 3. ecruitment to Quality Improvement post to extend good practice seen in specialties such as Orthopaedics and Gynaecology where this will support reduction in backlog. This role will prove critical in increasing the number of specialties that offer Active Clinical Referral Triage (enhanced vetting), Patient Initiated

			Return, Near Me and Clinical Waiting List validation. 4. aiting list initiative and external provider capacity targeted at specialties with the longest waits. We are meeting with the Scottish Government Waiting Times team on a monthly basis to consider these activities and review progress against monthly trajectories.
63	Appendix-2021-59 Performance Scorecard	**Harriet Campbell:** If we compare patients waiting longer than 12 weeks at the end of March (given in End of Year Managing Our Performance Report) which was 3493 and those waiting at end of April 3508, the increase is small although we are told they 'continue to increase'. Is this small increase a positive sign (things are stabilising and we are turning the tanker around) or a worrying one – numbers are continuing to increase. The report implies the latter... What do the numbers look like for end of May? The predicted trajectory on p6 is very worrying – not least because we are already above the predicted levels which expect numbers to remain static until August (why?) before rapidly increasing (although I note that actual figures for April were below the trajectory). What is the reasoning behind the projections?	**June Smyth/Nicky Berry:** The increase in the Outpatient waiting list between March and April reflects reduced capacity associated with COVID-19 mitigating activities and Outpatient referral activity beginning to increase following the second COVID-19 wave over the winter period. The latest report (22nd June 2021) has 4081 patients > 12 weeks. The predicted Outpatient trajectory assumes a return to pre-pandemic referral levels from the beginning of the financial year (these have been reduced through the pandemic) and several conservative assumptions around how quickly we can return to pre-pandemic capacity. This trajectory also assumes a lower level of external funding from Scottish Government to reduce the Outpatient backlog. Progress with the Outpatient remobilisation programme and funding confirmed by Scottish Government this week will improve this trajectory. The figures for the end of May 2021 are 3489 for outpatients waiting over 12 weeks.

		Question I should have asked long ago – if there is a 12 week target for an outpatient appointment and a 12 week TTG are these cumulative? Ie a patient should be seen within 12 weeks and then (if further treatment then required) expect to wait no more than a further 12 weeks? So it is actually 24 weeks from referral to treatment?	The OP and TTG targets are separate and so yes, if you were to wait the maximum for each then your wait would be 24 weeks
		Do we have any understanding of why DNAs are comparatively high for diagnostic tests?	We will review with the acute team and provide a separate response once this work has been undertaken
		What are the factors that impact on ED waiting times? Is this Covid (eg social distancing etc) or are there other factors that need to be considered?	There are several factors impacting on poor Emergency Access Standard performance and works to improve the position: 1. OVID-19 safe pathways, such as GP assessment services in the Emergency Department (ED), are still in for a number of services which increase activity going through the ED. Plans to move this activity out have been delayed due to workforce pressures. 2. here is evidence of patients arriving to hospital more deconditioned and with greater need following lockdown. Length of stay has increased. 3. ood practice established pre-pandemic in the management of discharge has had to be restarted following the disruption to BGH wards and teams in the creation of 5 COVID-19 wards over the previous 15 months. BGH length of stay was reduced by one day in the two years

			prior to the pandemic. Work is underway to remobilise those factors that helped achieve this. 4. orkforce challenges limit capacity with increased vacancy levels and sickness absence associated with the pandemic. 5. elayed discharges have increased to 2019 levels. There are a number of pieces of work under way to reduce this including the appointment of a Delayed Discharge Coordinator and the introduction of the daily Whole System Huddle. 6. nfrastructure challenges such as the design of the Emergency Department, which existed pre-pandemic, still impact on consistent performance. There has been an increase in Minor Injuries attendances since lockdown eased. The expansion of scheduled Minor Injury appointments at BGH and reopening of local GP Minor Injury services should reduce pressure here.
64	Appendix-2021-59 Performance Scorecard	**Malcolm Dickson:** Page 2/257 Para 1.1: "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" - very pleased to see this commitment. It will help the Board see the wider context in which performance operates, and which inevitably affects performance to greater	**June Smyth:** Noted thank you

		and lesser degrees.	
65	Appendix-2021-59 Performance Scorecard	**Lucy O'Leary:** Noted that the format is work in progress. Please could the final version include section numbering of the individual performance measures to facilitate ease of reference in the covering paper to the measures being highlighted? P 259 Reference to the MOP report containing comparisons to other Boards in future – assume this is omitted in the report above because of the reduced reporting regime under Covid? P 279 Standard reads: *Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% SIMD areas* Should this read "the 40% most deprived SIMD areas"?	**June Smyth:** Comment Noted – we will do this for the next report. Yes reporting was reduced to support operational pressures. Yes it does mean this - we will amend the wording to be more precise.
66	Appendix-2021-59 Performance Scorecard	**Fiona Sandford:** Good to see Treatment for Cancer targets being met. Obviously concerning how many targets are red or amber Look forward to hearing more on A7E 4 hour standard at the meeting Delayed Discharges and CAMHS waits particularly concerning	**June Smyth:** Thank you the positive feedback will be relayed to the team through the access board. Performance Scorecard - ahead of the next publication the format of the scorecard is being updated to clearly distinguish, where applicable, performance against traditional AOP standards and performance against RMP3 trajectories - this will enable a clear distinction. Emergency Access Standard performance is a concern. A meeting was held last week between members of the Executive team and senior leaders across Health and Social Care to explore what more can be done. A number

			of key actions were agreed to be progressed at pace to improve patient flow, reduce long waits for admission in the Emergency Department and subsequently improve EAS and delayed Discharge performance. Those actions include: • Expanding the BGH Integrated Huddle to include Community Hospitals creating a twice daily whole system huddle that will focus on reducing delayed discharges no matter where they occur • Realigning project support to increase the pace of delivery of Emergency Department process work • Restarting the Daily Whole System Control Room to ensure senior operational leadership of patient flow • Realign operational nurse capacity to increase leadership at a ward level in support of discharge • Balance workforce challenge across clinical boards CAMHS - recruitment continues to be progressed and in early April clinicians increased the number of face to face appointments in response to clinical need. The service continues to work with Scottish government on the enhanced support that has been provided.
67	Appendix-2021-59 Performance Scorecard	**Karen Hamilton:** Noted 1.9 Delayed Discharge – are we recruiting to post here within the SW team BGH to improve this?	**June Smyth:** A 1 year Fixed Term Discharge Coordinator post has been approved by 50:50 funding from SBC and NHS Borders via the winter board. In addition, a whole system

			escalation process has also been developed. There is significant work underway in relation to developing defined pathways for patients as part of the work on the Older People's Pathways, and on establishing a whole system integrated huddle to review delays.
68	Appendix-2021-59 Performance Scorecard	**James Ayling:** I have seen a letter to an outpatient (podiatry) asking that patient if he/she/they feel that they still require treatment and if not to let Podiatry know .If no response is received within 2 weeks then it is assumed that the patient no longer requires treatment .Is this the process referred to as "Discharge Patient Initiative Review (PIR)? I assume some conditions will clear up themselves but overall is this widely used? Presumably this would not be used for eg Cardiac outpatients ?	**June Smyth:** 'Patient Initiated Review' is when a patient is offered the option of not progressing with treatment or follow up but instead offered advice on alternative (often self) care. The patient can self refer back into service to pick up where they left off if they later decide treatment is indeed required. This avoids the patient having to be referred back through their GP. PIR would only be used where deemed clinically safe to do so.
69	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**Harriet Campbell:** A fascinating, and in some cases worrying, read, but I would appreciate more detail on what NHS Borders can and should be doing to improve things (outreach, education etc?)	**Carole Anderson:** The Health Inequalities programme will be considering the role of participating services in how to raise socio-economic issues (e.g. housing, finance, employment) within clinical settings **Increase knowledge of Child Poverty across the workforce** • Promoting Health Scotland's Increase uptake Public Health Scotland Child Poverty, health & Wellbeing e-Learning module • Increase awareness of the Challenging poverty stigma - learning hub LINKS: https://elearning.healthscotland.com/enrol/index.php?id=523 https://elearning.healthscotland.com/course/vie

			w.php?id=577 **Remove Financial barriers** Remove the financial barriers that families with children staying in hospital can experience. The 'Young Patient Family Fund' for all children up to 18 years old; will reimburse travel, subsistence and some of the accommodation costs associated with visiting. **NHS Borders Money Worries App** Promote SB Money Worries App: Provides information & signposting support on areas of Health, Money, Housing, Work. The Money Worries App was successfully launched on 16th March 2021, following a period of testing and improvements. Launch week communications has demonstrated a combined social media reach of 21,594. Reporting processes are currently being agreed with MTC. Please find further information:  Money Worries App Update.docx **Financial Inclusion in Early Years** The HVs are asking about financial inclusion at all core visits and signposting and referring to SBC FI Early Years Service. Data is recorded on EMIS - quarterly data report in place. Within the Scottish Borders Pregnant women and families with young children have had

			increased benefits equated to £1.3 million In total from March 2020 - March 2021 1,925 Best Start and Best Foods Grants applications were made, 73% were authorised in Scottish Borders this is above the average for Scotland. March 2020 - March 2021 total claim for Scottish Borders families £458,545
70	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**Malcolm Dickson:** Good report, packed with data. (There is a misprint on Page 37/317 - colour code 4 is said to represent 15% to under 10%, when the latter should be 20%.)	**Carole Anderson:** Thank you, misprints noted
71	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**Fiona Sandford:** Very interesting report. Given the anticipated K-shaped recovery from COVID, we could expect this situation to deteriorate. When might we get a report covering 20/21?	**Carole Anderson:** Please see the 2020/21 CP Report attached. Approved with no amendments by the CPP on the 10th June 2021, and not in time for this agenda  ChildPoverty_Action Report_2021.pdf The impact of COVID 19 has been highlighted within the **National Context in Relation to Covid-19 and Child Poverty Report:**  National Context Covid-19 and Child Pc **Income from Employment** • One quarter of adults concerned about providing for their families. • One in five households with dependent children

			reported serious financial difficulty. • Lower income households are twice as likely to have increased debts • Ethnic minority groups with high representation in lower paid and high in-work poverty sectors eg accommodation and food services. Single parents, most likely female, more likely work in these sectors, also working part time resulting in higher poverty rates **Income from Benefits** • Difficulties in navigating a complex social security system can result in delays to payments of benefits. • Families who do not have digital devices may be disadvantaged from claiming benefits as face to face support became limited **Cost of Living** • One quarter of adults reported being very or somewhat worried about affording enough food for themselves or households • People spending more time at home, is likely to increase costs of heating and electricity, causing fuel poverty. • Scottish Government financial support contributed to a further 53,000 children becoming eligible for free school meals (FSM) during pandemic. With additional £12.6 million available to provide support during summer holidays
72	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**Karen Hamilton:** Noted This is a 19/20 report which is read with interest. I would however be more interested to read the 20/21 report when it is available	**Carole Anderson:** Apologies, this agenda item has been delayed from August 2020. 20/21 Report attached above.

73	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**James Ayling:** A very informative document . Its now getting close to almost a year old however . The view is that COVID will have had a deeply prejudicial effect financially and psychologically on children and young people and I presume therefore that the next report may show a bleaker picture and therefore despite the progress reflected in this report there will be even more significant challenges to face. I was surprised that there is no reference to Borders College in the document.	**Carole Anderson:** Please see 2020/21 report attached. Borders College is referenced in the 2020/21 document.
74	Appendix-2021-60 Scottish Borders Local Child Poverty Action Report - Annual Progress Report 2019/20	**Sonya Lam:** Noted.	-
75	Appendix-2021-61 Board Committee Memberships	**Karen Hamilton:** Approved.	-
76	Appendix-2021-61 Board Committee Memberships	**Sonya Lam**: Approve. What is the plan for the vacancies highlighted in green? What is an ESR panel?	**Iris Bishop/Karen Hamilton:** **Vacancies:** We are clarifying the justification of these groups requiring a Non Executive as a member. **ECR:** Extra Contractual Referral panel – GPs can make an ECR to a panel to consider where treatment for an individual is outwith the scope of what we provide, sometimes this is an operation or the provision of expensive drug treatments.
77	Appendix-2021-62 Scottish Borders Health & Social Care	**Karen Hamilton:** Noted. **Sonya Lam:** Noted.	-

	Integration Joint Board minutes: 17.02.21, 24.03.21		