Borders NHS Board

NHS Borders

Minutes of a meeting of the **Borders NHS Board** held on Thursday 1 April 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 Mr B Brackenridge, Non Executive Mr J McLaren, Non Executive Mrs A Wilson, Non Executive Cllr D Parker, Non Executive Mr R Roberts, Chief Executive Mr A Bone, Director of Finance Mrs 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 R McCulloch-Graham, Chief Officer, Health & Social Care Mr A Carter, Director of Workforce Dr K Allan, Associate Director of Public Health Dr A Cotton, Associate Medical Director Mrs L Jones, Head of Clinical Governance & Quality Mr S Whiting, Infection Control & Laboratory Service Manager Mrs L Pringle, Risk Manager Dr O Herlihy, Director of Medical Education Mrs C Oliver, Communications Manager Mrs F Doig, Head of Health Improvement & Strategic Lead ADP Mr P Lunts, General Manager Transformation Ms G Russell, Partnership Representative Ms K Kiln, Public Health Mr A McGilvray, Radio Borders

1. Apologies and Announcements

1.1 Apologies had been received from Dr Tim Patterson, Director of Public Health and Dr Janet Bennison, Associate Medical Director.

1.2 The Chair welcomed Dr Keith Allan, Associate Director of Public Health 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 Bill Brackenridge, Non Executive, who had been co-opted to the Board for a 9 month period under emergency powers during the COVID-19 Pandemic. The Chair recorded the thanks of the Board to Mr Brackenridge for the experience 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.

1.8 The Chair announced that a private meeting would be held at the conclusion of the public meeting to consider matters that the Board were still in the process of developing and required time for private deliberation.

2. Register of Interests

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

The **BOARD** noted there were none.

The **BOARD** approved the Register of Interests.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Borders NHS Board held on 4 February 2021 were approved.

4. Matters Arising

4.1 **Minute 13: Care of Older People in Hospitals Update:** Mrs Sarah Horan commented that she would bring an update paper on Falls to a future Board meeting.

4.2 **Action 13:** Mr Rob McCulloch-Graham commented that the intention behind the action had been to look at a reduction in hospital beds over a period of time and for the Integration Joint Board to review a business case to that effect and then issue appropriate directions to the partner bodies. However, much of the work had been delayed due to the pandemic. Mechanisms had since been put in place to look at all pathways across both NHS Borders and Scottish Borders Council to provide a robust plan for future service requirements. The Chair suggested that the matter be left to the Executives to pursue with proposals submitted to the Board at the appropriate point in the future. For the purposes of the Board Action Tracker the matter would be treated as complete at the next meeting.

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

The **BOARD** noted the action tracker.

5. Maximising the impact of NHS Borders on Reducing Health Inequalities

5.1 Mrs Fiona Doig provided a presentation on health inequalities in the Borders in support of the report and highlighted demographics of age and deprivation, as well as the impact of COVID-19 on certain population groups.

5.2 Mr John McLaren commented that in relation to advocacy, the Borders did not have an advocacy service for children/parents unless parents had a mental health issue and he sought confirmation that the approach would address that gap. Mrs Doig commented that at present advocacy for children was contained within the Children and Young Peoples Leadership Group and would link to the health inequalities work.

5.3 Mrs Fiona Sandford welcomed the presentation and cautioned around the use of language in that NHS Borders as “an” anchor was appropriate and it should not morph into being “the” anchor, which would entail many areas of responsibility that were not the primary aim or responsibility of NHS Borders.

5.4 Mrs Lucy O’Leary enquired how those service that did not self-identify were addressed and where primary care fitted into the programme.

5.5 Ms Sonya Lam enquired how staff education, understanding and training were addressed so that people understood inequalities and had it embedded in what they did to ensure inequalities assessments were meaningful. Whilst Phase 1 was around a deep dive approach she enquired if staff training could be run in parallel.

5.6 Mr Philip Lunts commented that the programme was focused on what NHS Borders could do to address inequalities, as there was potential for scope creep which was being pushed back against to ensure the focus remained on what could be achieved practically. In terms of Phase 1 of the programme it was to engage with volunteers who would be early adopters, and Phase 2 would look at groups, areas and services that would be most significant in terms of impact and then engage with those less willing to get involved. In terms of engagement with Primary Care, the GP Sub Committee were enthusiastic about the programme and keen to be engaged.

5.7 In terms of training, the actions to come out of the programme would be mapped across to direct action for a training programme.

5.8 Mr Tris Taylor commented that there was a perceived political risk of serving poor, marginalised and vulnerable people better, including the perceived risk that it might result in serving rich, mainstream and comfortable people worse. He suggested the perceived risk should be noted and mitigated where possible.

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

The **BOARD** reconfirmed its commitment to addressing Health Inequalities as a priority for NHS Borders

The **BOARD** accepted the draft framework as an approach to undertaking work

The **BOARD** confirmed the establishment of a Programme approach to delivery of this work

6. Risk Management Strategy

6.1 Dr Keith Allan provided an overview of the content of the report and highlighted that it was a 5 year over-arching strategy.

6.2 The Chair enquired in regard to the references to the COVID-19 Pandemic Committee (Gold Command) if an inclusion should be made to confirm that the Committee would be disbanded once the Pandemic had abated. Dr Allan agreed that a caveat would be included to confirm the COVID-19 risks were time limited.

6.3 Mr Malcolm Dickson commented that the Audit Committee had welcomed the overarching strategy. He further commented that much work had taken place to pull the strategy together and make it clearer and meaningful for staff to know how to identify, report and mitigate risks.

6.4 Ms Sonya Lam noted that the strategy was until 2025 and she enquired what success would look like in 2025 and how it would be measured.

6.5 Dr Allan commented that measures would be picked up through the development of key performance indicators and the Risk Management Board process. The development of processes and matrices would provide a culture shift and that cultural change would be measured and progressed through the Risk Management Board, Quarterly and Annual Reports.

6.6 Mr Tris Taylor commented he did not feel comfortable formally approving a 5 year strategy that he suggested lacked a clearly articulated vision. He would find it difficult to hold the relevant Executive to account without a matrix or quantification on what would be delivered by when. He suggested the strategic narrative required further work.

6.7 Ms Lam commented that she echoed Mr Taylor's comments, given the proposal was a risk management strategy to 2025 and other strategies such as a clinical strategy to 2025 were not available for the risk strategy to be aligned to.

6.8 Mr Ralph Roberts commented that the current Risk Management Strategy was due to expire and it was important to ensure a replacement was agreed. He recognised the point that had been made in regard to a clinical strategy and explained that the risk strategy could not be held up pending a renewed clinical strategy. He reminded the Board that the Audit Committee had accepted the risk management strategy and the Executives were aware that it was not yet perfect. He suggested the Board approve the strategy along with a request for overall matrices and key performance indicators to be developed and included in the strategy. At that point the strategy should be resubmitted to the Board for re-approval.

6.9 Dr Allan welcomed the comments and assured the Board that each Governance Committee was sighted on its own risks and processes up through the Risk

Management Board. He further commented that the Risk Policy contained a number of risks that were currently under review.

6.10 Mr Taylor commented that he was interested in understanding the need to formally approve the document against the risk of not formally approving it. Mr Roberts commented that from the point of view of emphasising that the organisation took risk seriously, promoted a cultural approach to risk and given the risk management strategy was felt by the Executives to be the correct overarching approach to risk, he suggested the Board should approve it.

6.11 Mr Taylor, Ms Lam and Mrs Lucy O'Leary lodged dissent to formal approval.

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

The **BOARD** formally approved the Risk Management Strategy for publication.

7. Resources & Performance Committee Update

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

The **BOARD** noted the update from the Resources & Performance Committee.

8. Resources & Performance Committee Minutes: 21.01.21

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

The **BOARD** noted the minutes.

9. Audit Committee Update

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

The **BOARD** noted the update from the Audit Committee meeting held on 22nd March 2021.

10. Appointment of Internal Auditors

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

The **BOARD** homologated the contract award for the board's Internal Audit function.

11. Audit Committee Minutes: 14.12.20

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

The **BOARD** noted the minutes.

12. Finance Report for the period to the end of February 2021

12.1 Andrew Bone provided an overview of the content of the report and highlighted that there were no significant issues to bring to the attention of the Board.

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

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

The **BOARD** noted that the board was reporting a small underspend for the eleven months to 28th February 2021.

13. Baseline provision of 2021/22 resource to the Health and Social Care Integration Joint Board

13.1 Mr Andrew Bone provided an overview of the content of the report and highlighted that the paper set out the principles of how the Integration Joint Board (IJB) resource turned into the actual budget of the IJB. He drew the attention of the board to: section 3.5 of the report which outlined the resources; table 2 which provided a measure of actual budget amounts; and section 3.6 which outlined the actions required by the IJB, Partnership and Health element of the IJB to achieve financial balance based on the plan.

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

The **BOARD** considered the issue as described in the paper.

The **BOARD** approved the provision of resources to the IJB as outlined in section 3.5.

14. Clinical Governance Committee Minutes: 25.11.20

14.1 Mr Tris Taylor commented that he was unsure how strategic risk was fed into the governance committees. Mr Ralph Roberts suggested he take Mr Taylor through the process outwith the meeting.

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

The **BOARD** noted the minutes.

15. Quality & Clinical Governance Report

15.1 Mrs Laura Jones drew the attention of the Board to the deaths position and in particular to those identified as COVID-19 deaths. She advised that the HSMR remained within normal limits and crude mortality had reduced. With the second wave of COVID-19 she expected to see a change in the following 2 quarters data and assured the Board that every COVID-19 death was reviewed.

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

The **BOARD** noted the report.

16. Medical Education Update

16.1 Dr Olive Herlihy provided an overview of the content of the report and drew the attention of the Board to the slippage on purchasing bikes, the bike shed and ipads for students.

16.2 The Chair and Dr Lynn McCallum welcomed such a positive report.

16.3 Mrs Nicky Berry reminded the Board that it was important to recall that progress had been made over time, as previously there had been poor feedback received on unscheduled care. It was therefore important to remember that and to see that much progress had been made and she congratulated Dr Herlihy and her team.

16.4 The Chair suggested Dr Herlihy take the Board's commendation back to the team involved.

16.5 Dr Herlihy commented that the information received had been shared and feedback had been provided and she was keen to keep the momentum going.

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

The **BOARD** noted the report.

17. Healthcare Associated Infection – Prevention & Control Report

17.1 Mr Sam Whiting provided an overview of the content of the report and highlighted that; there were zero outbreaks; and page 10, section 11.4 reference to commencing a process of reading the learning from the outbreaks that had happened. Mr Whiting commented that the learning from the outbreaks would be taken to the Infection Control Committee in the first instance and then the Clinical Governance Committee.

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

The **BOARD** noted the report.

18. Public Governance Committee Update

18.1 Mr Tris Taylor thanked Mrs June Smyth for writing the report on his behalf and made the suggestion that the original purpose of the report had been to alert the Board to any areas of concern from the Committee. However, the reports had morphed into a report from the previous meeting and he suggested was likely to be an extra burden on already busy executives. He suggested a common approach be taken to providing reports on a by exception basis.

18.2 Mr Bill Brackenridge commented that he found the reports useful. Cllr David Parker also commented that he liked the reports.

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

The **BOARD** noted the update from the Public Governance Committee.

The **BOARD** noted the report.

19. Public Governance Committee Minutes: 17.11.20

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

The **BOARD** noted **note** the minutes.

20. Staff Governance Committee Update

20.1 Cllr David Parker recorded his thanks to Mr Andy Carter who was moving the whole staff governance agenda forward.

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

The **BOARD** noted the update from the Staff Governance Committee meeting held on 15 March 2021.

21. Staff Governance Committee Minutes: 14.12.20

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

The **BOARD** noted the minutes.

22. NHS Borders Performance Scorecard

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

22.2 Ms Sonya Lam enquired if there was anything the Board should be aware of in terms of performance that was not provided. Mrs Smyth commented that the term were working through a backlog of data but were fully sighted on issues. She advised that the Access Board had been resurrected and met on a monthly basis to look back at performance and at future projections to tie into RMP3.

22.3 Mrs Nicky Berry assured the Board that Psychological Therapies and Child and Adolescent Mental Health Services (CAMHS) were represented on the Access Board. Work had been taken forward on the Emergency Access Standard and an improvement in performance had followed, however a couple of challenging days with large admissions and breaches had led to the formation of an action plan to further address performance on an on-going basis.

22.4 Mr Tris Taylor enquired in regard to delayed discharges if the choices policy was being correctly applied. Mrs Berry commented that she co-chaired a weekly Delayed Discharges meeting with Jen Holland of SB Cares, where every delayed discharge was reviewed and the next stage in their care pathway was addressed. Those that required nursing care beds were reviewed to clarify their need for 24 hour care and Ms Holland was working with external providers to secure short term private beds. Mrs Berry assured the Board that she had a daily focus on delayed discharges.

22.5 Mr Malcolm Dickson commented that the Audit Committee had received the external audit report into Delayed Discharges and would be monitoring the action plan that accompanied it. He was aware that the underlying infrastructure would need to change before any significant reduction in delayed discharges would be achieved and sustained, potentially through an increased number of residential care beds in the Borders.

22.6 Dr Lynn McCallum commented that the issue was mainly in relation to the provision of nursing care home beds as opposed to residential care home beds. In terms of national benchmarking it was clear that the Scottish Borders were at the lower end of the scale for provision of nursing care home beds.

22.7 Mr Rob McCulloch-Graham commented that occupancy figures for residential and nursing care homes in Scottish Borders were at 84% with 87% being the average across NHS Scotland. He was currently working on a target to get to 90% occupancy.

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

The **BOARD** noted the Performance Briefing for February 2021.

23. Board Committee Memberships

23.1 The Chair outlined the proposed changes in 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. Code of Corporate Governance Sectional Update

24.1 Miss Iris Bishop provided a brief overview of the content of the report.

24.2 Mr Andrew Bone clarified that a standard operating procedure would be produced in regard to the emergency powers, which would articulate how the organisation would operate in terms of emergency powers, constitution of groups, etc. The standing operating procedure would be included in the Code of Corporate Governance.

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

The **BOARD** approved the sectional updates at Sections A, C and F of the Code of Corporate Governance.

25. Scottish Borders Health & Social Care Integration Joint Board minutes: 16.12.20

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

The **BOARD** noted the minutes.

26. Any Other Business

There was none.

27. Date and Time of next meeting

27.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 24 June 2021 at 9.00am via MS Teams.

The meeting concluded at 10.45am.

Signature: …………………………………..
Chair

BORDERS NHS BOARD: 1 APRIL 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Appendix-2021-20 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 your declaration will be noted.
2	Appendix-2021-20 Register of Interests	**Sonya Lam:** I declare my partner is a temporary specialist advisor to the Scottish Government	**Iris Bishop:** Thank you Sonya your declaration will be noted.
3	Minutes of Previous Meetings	-	-
4	Matters Arising/ Action Tracker	**Karen Hamilton:** Action 13, dates from Oct 2019. Can we confirm target date or should we revisit Action altogether? Is it appropriate to remain an Action given we have so much similar slippage due to Covid.	**Rob McCulloch-Graham:** The intention behind the action had been to look at a reduction in hospital beds over a period of time and for the Integration Joint Board to review a business case to that effect and then issue appropriate directions to the partner bodies. However, much of the work had been delayed due to the pandemic. Mechanisms had since been put in place to look at all pathways across both NHS Borders and Scottish Borders Council to provide a robust plan for future service requirements. The Chair suggested that the matter be left to the Executives to pursue with proposals submitted to the Board at the appropriate point in the future. For the purposes of the Board Action Tracker the matter would be treated as complete at the next meeting.

5	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Malcolm Dickson:** Page 4 of report/64 of pack, section 11, point 1: it might be helpful to be specific here about what kind of data is required, ie data which demonstrates need rather than demand.	**June Smyth/Phil Lunts/Fiona Doig:** The data pack will be focused on population health data, including data on likely health impact on different population sectors, trends in population health and analysis of use of health services by different population groups.
6	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Malcolm Dickson:** At point 2 I suggest the programme needs to be specific about what partner engagement seeks to achieve, eg identifying hard to reach communities and the means of communicating with them, sharing personal contact details of individuals (with their prior permission) who are likely to suffer from health inequality.	**June Smyth/Phil Lunts/Fiona Doig:** We are defining the engagement we should undertake as we develop the programme. This is likely to take different forms, including high-level engagement with third sector and community groups to identify the areas and people most likely to experience health inequalities, working with service users around individual services and potentially with specific seldom heard groups. We are both keen to ensure we build on existing engagement work to avoid duplication and intend to seek external support through agencies experienced in working with vulnerable groups.
7	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Malcolm Dickson:** Overall, the report is very welcome but does not suggest how success is going to be measured.	**June Smyth/Phil Lunts/Fiona Doig:** The outcomes in the draft Programme Brief include: • Services will be designed and changed to minimise disadvantage and health inequality using a data driven approach • All staff have an awareness of Health Inequalities, opportunities to help reduce them and their role in this • Staff in identified areas have the appropriate tools and knowledge to address health inequalities in their practice • Organisational processes will have been reviewed and changed to maximise their

			impact in reducing Health Inequalities • There will be a more equitable use of services • People experiencing health inequalities will be more able to influence services The detail of the data required to monitor progress will be baselined against the data in the data pack 'Picture of Health'
8	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Karen Hamilton:** Note that there is Consultation out on the revised Guidance due for response by 7th May. Are we on track for this?	**Iris Bishop:** The Fairer Scotland Duty consultation has been put through our normal consultation process. In addition the NHS Scotland Board Chairs are formulating a response to the consultation.
9	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Karen Hamilton:** Staffing /Workforce - How will the staffing be resourced?	**June Smyth:** Directors of Planning and Performance and Finance are pursuing resourcing.
10	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Karen Hamilton:** 9. 'A group of Senior Stakeholders' – does this include anyone with lived experience? If not do we have a way of capturing this? Who is the Lead? Also echo Malcolm's comments and queries and look forward to response.	**June Smyth/Phil Lunts/Fiona Doig:** At the moment this group is comprised of NHS Borders senior managers and other interested staff. We are planning for a group event in late May/early June to which we will invite third sector and other intermediaries. Please also see question 6 above.
11	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Sonya Lam:** I agree with the principle and intent of this paper and would agree with pursuing Phase 1. This phase seems key in terms of understanding the inequality priorities of Borders and how as an 'anchor'	**June Smyth/Phil Lunts/Fiona Doig:** Thank you for your support.

		organisation we achieve consensus with partners about where we can add greatest value and impact.	
12	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Sonya Lam:** Is three months to undertake Phase 1 in partnership and engagement with partners realistic and achievable? I would want to be clear about the evidence that supports the priorities we define for the programme and what the benefits realisation will be.	**June Smyth/Phil Lunts/Fiona Doig:** We feel this is a reasonable timescale to define the scope and project infrastructure by end June 2021 assuming timely recruitment. There is further work to be undertaken in terms of prioritisation until September. To date we have already engaged with key colleagues in NHS Borders including Public Governance Committee, SBC and the Communities Groups attached to the Locality Hubs and people are keen to continue to be involved.
13	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Sonya Lam:** I wonder whether there are key foundations we need to undertake as part of Phase 1, such as (a) the undertaking of meaningful health inequalities impact assessments (and associated actions) and (b) staff understanding and training in health inequalities and the impact they can make on a daily basis.	**June Smyth/Phil Lunts/Fiona Doig:** This work will be undertaken during later phases and in association initially with prioritised service areas.
14	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Sonya Lam:** As a key employer in NHS Borders, can we be more proactive with widening access. How is the NHS Kickstart Scheme working in Borders?	**Andy Carter:** NHS Borders has signed and secured a bid for 10 Kickstart places. The adverts linked to this bid will be live within the next two weeks and thereafter interviews will take place with applicants for Kickstart posts within Facilities, Catering and HR. Further discussion is currently underway to confirm if the Health Board should submit a bid for further places.
15	Appendix-2021-21 Maximising the impact	**Lucy O'Leary:** Really welcome report, and this feels like a significant	**June Smyth/Phil Lunts/Fiona Doig:** Thank you for your support.

	of NHS Borders on Reducing Health Inequalities	step forward in changing the conversation and the centre of gravity in our system from treatment to prevention – thank you. Plans for third sector engagement are clearly a major strand for work. We may miss a trick if we only think in terms of what's already there – third sector is relatively underdeveloped/ patchy in the Borders – so it would be good to see some work as part of this on identifying what the gaps are and championing development of new third sector resources to fill those gaps	We agree that there may be potential to work differently with the third sector and this should be part of our options when looking at appropriate allocation of resources and equity of access. The Board already successfully commissions a number third sector agencies to provide support and care and this consideration may arise as part of our data collection, work with services and (potentially) HIIAs.
16	Appendix-2021-21 Maximising the impact of NHS Borders on Reducing Health Inequalities	**Tris Taylor:** What is the target please? Please can it be to achieve health equality? Full equity? To move from 'unfair 'to 'fair'? Reducing health inequalities is an unhelpful aim as it means we can claim success in a world where some inequalities persist. Finance/resources: the entry here begs the question: on what basis are resources currently allocated? And the implied split between the twin lenses of clinical need and socioeconomic need begs the question: how is socioeconomic need not clinical? What are the organisation's current attitudes and beliefs around the medical, social, biopsychosocial or other models of health? This seems to me to be an important question, the answer to which may inform how the Board may wish to frame its 'influencing culture 'work as it pertains to action on health inequalities. Risk implications: seem to me to avoid the elephant in the room, which is the perceived political risk of serving poor, marginalised and vulnerable people	**June Smyth:** This is a 2-year programme focused on the actions that NHS Borders can take to reduce health inequalities. As most health inequalities are caused by social and structural inequalities, we are not intending or able to achieve health equality. We would intend to co-produce the aim of this programme with key stakeholders, based on what we think we can achieve but ensuring that this is as ambitious and as specific and measurable as possible The current allocation of resource and use of services by different groups will be analyzed as part of the data work within the programme and will be integral to how the programme progresses. We would expect further discussion with stakeholders and the Board on this as we develop the programme further. The risk section largely related to the risks related to the programme itself, rather than the

		better, including the perceived risk that this might result in serving rich, mainstream and comfortable people worse. We should be honest about this perceived risk because we can't expect the organisation to lead with an honest and true heart if the Board won't stand up and take a position. Para 2: what has been the material impact on health inequalities to date of the organisation's commitment, endorsement and recognition described?	risks related to the outcomes of addressing health inequalities. The programme will be working at a granular level with services and groups to incrementally improve service access. The implications of this will be brought back through the Executive Team and to the Board for consideration and advice. - Impact of existing work - It is challenging to quantify the overall impact of Board's commitment, partly due to any measure in place relating to processes rather than outcomes, however, there is some success on smaller individual programmes or projects e.g. closing the gap in bowel screening services, increased uptake of breastfeeding. It is important, as Tris has indicated, that we are clear about what we are able to achieve and how we will demonstrate improvement. Breastfeeding rates 6-8 weeks June 2019 – June 2020 in Borders % of babies who have ever been breastfed by SIMD – **69%** % babies exclusively breastfed by SIMD – **38%** % drop-off in breastfeeding initiation and 6-8 weeks by SIMD – **29%**

17	Appendix-2021-22 Risk Management Strategy	**Karen Hamilton:** Note that this has been to Audit Committee and approved. Very helpful Glossary – thank you P4 Leadership and commitment to risk management throughout the organisation will be reflected through board leadership. Laudable principle which we must follow through!	**-**
18	Appendix-2021-22 Risk Management Strategy	**Sonya Lam:** Page 4. Do we mean Clinical Governance Strategy or Clinical Strategy? If Clinical Strategy, the last one finished 2020?	**Lettie Pringle:** Clinical Strategy. Error will be removed prior to publishing.
19	Appendix-2021-22 Risk Management Strategy	**Sonya Lam:** Page 4. Aims and objectives 2020-2025. What are the success criteria that we measure to know whether we achieve these aims and objectives?	**Lettie Pringle:** These objectives will inform the annual Key Performance Indicators for risk management and be agreed by the Risk Management Board. Key Performance Indicators will be reported into, and monitored by, the Risk Management Board and follow the escalation through this route of governance as required. Key Performance Indicators relating to Strategic risks will be reported and monitored by BET and governance groups as appropriate.
20	Appendix-2021-22 Risk Management Strategy	**Sonya Lam:** Page 6. If we are at Level 2 and aim to move to Level 3, where will the plans/actions to progress be outlined. What are the timescales?	**Lettie Pringle:** The culture maturity model and progress will be monitored by the Risk Management Board and follow the escalation through this route of governance. To keep the strategy realistic

			rather than idealistic, the move from level 2 to level 3 is the 5 year plan.
21	Appendix-2021-23 Resources & Performance Committee Update	**Sonya Lam:** Noted	**-**
22	Appendix-2021-24 Resources & Performance Committee Minutes: 21.01.21	**Sonya Lam:** Noted	**-**
23	Appendix-2021-25 Audit Committee Update	**Sonya Lam:** Noted	**-**
24	Appendix-2021-26 Appointment of Internal Auditors	**Karen Hamilton:** Suggest Andrew briefly explains why this is for homologation in terms of timing?	**Andrew Bone:** Contract tender was delayed (twice) over last year due to Covid. Timescales for tender agreed jointly with NHS Lothian. If we had deferred decision until board meeting then the award would have been delayed beyond end March and impacted on timing of 21/22 planning. The contract was awarded in February subject to formal standstill period (now concluded). Note that contract is from an NHS audit framework contract. This paper asks that the board formally ratify this award. The award of IA contract was previously a matter reserved to the board but is no longer required in current COCG however this is felt to be an issue where the board will wish to be satisfied that arrangements are appropriate, hence this paper is presented for approval.

25	Appendix-2021-26 Appointment of Internal Auditors	**Sonya Lam:** Confirm	**-**
26	Appendix-2021-27 Audit Committee Minutes: 14.12.20	**Sonya Lam:** Noted	**-**
27	Appendix-2021-28 Finance Report for the period to the end of February 2021	**Sonya Lam:** Assured that the board will achieve its financial target at March 2021. Note the Board is reporting a small underspend 11 months to 28 February 2021	**-**
28	Appendix-2021-29 Baseline provision of 2021/22 resource to the Health and Social Care Integration Joint Board	**Sonya Lam:** • ssues and risks noted	**-**
29	Appendix-2021-30 Clinical Governance Committee Minutes: 25.11.20	**Sonya Lam:** Noted	**-**
30	Appendix-2021-31 Quality & Clinical Governance Report	**Sonya Lam:** Noted	**-**
31	Appendix-2021-31 Quality & Clinical Governance Report	**Lucy O'Leary:** The control charts in this report pp 5-7 vary in the length of the run data – some 4-5 years, up to 8 years.	**Laura Jones:** Addressed in response 32 below.
32	Appendix-2021-31 Quality & Clinical Governance Report	**Lucy O'Leary:** Is there a rationale for the choice of X axis range for each one?	**Laura Jones:** Addressed in response 32 below.
33	Appendix-2021-31 Quality & Clinical Governance Report	**Lucy O'Leary:** Is there a reason why the data could not be shown on a consistent basis across all the charts and with some	**Laura Jones:** This is a reasonable suggestion graph's 7 and 8 reflect the time frame when these

		of the very old data truncated to avoid cramped presentation and reduced legibility in the X axis? I'm not sure there is significant added value in looking at these time series over a period of more than 4 years	performance measures were introduced nationally on introduction of the new complaints handling procedure in 2017. Graph 6 shows a trend in complaints over the years and is plotted for a longer period than we would normal plot due to historical interest from the Board in monitoring the upward trend in complaints across the NHS in Scotland and resulting impact on resources. Would agree if Board support that this could now be brought down to a standard 3 or 5 year trend which is what we would normally use akin to graphs and 5.
34	Appendix-2021-32 Medical Education Update	**Karen Hamilton:** Good to see additional support for trainees.	-
35	Appendix-2021-32 Medical Education Update	**Sonya Lam:** Comprehensive report on medical education and would welcome similar reports from other professional groups.	**Laura Jones:** The Board Clinical Governance Committee have a report scheduled on the 2021/22 committee workplan relating to education across nursing, midwifery and allied health professions. This will form part of the annual work programme for the committee from 2021/22 onwards.
36	Appendix-2021-32 Medical Education Update	**Sonya Lam:** Do we meet the requirements of the Medical ACT Performance Management Framework, if we have not made progress with the detailed measurement of Departmental support for undergraduates?	**Olive Herlihy:** NHS Borders produces an annual accountability report which is approved by NES in advance of ACT allocations. Med Ed also outlines the use of any additional funding received via ACT slippage eg upgrade to accommodation in 2020. Med Ed participates in Quality management of placement and triangulate RAG reports with local feedback.

			Med Ed has a governance forum to discuss quality or training and implement changes locally to improve and maintain standards. Med Ed complies with assuring ROT status of clinical supervisors. While we cannot be assured of actual time allocation in job plans for teaching and supervision of UG there is no doubt it is taking place as we measure indirectly from feedback and completion of supervisor reports. It would be valuable to understand the split of ACT budget within each dept in terms of teaching and supervision.
37	Appendix-2021-32 Medical Education Update	**Sonya Lam:** What plans do we have for the potential employment of the Pas?	**Olive Herlihy:** Med Ed is aware that there is interest in Physicians assistances among colleagues in surgery, trauma and orthopaedics, psychiatry, General practice and Medicine. What Med Ed cannot answer is whether there is actual posts and how these would be funded. Med Ed supports the training of this students and in addition facilitates the introduce of the PAs grade to specialities as a potential workforce.
38	Appendix-2021-33 Healthcare Associated Infection – Prevention & Control Report	**Malcolm Dickson:** Page 10/186, 12.1 Board having difficulty recruiting to 2 x WTE Infection Control Nurses. Might it be a possibility that all nursing vacancies could be mitigated to a degree by advertising south of the Border now that there is likely to be a higher rated payscale in Scotland than that in England?	**Nicky Berry:** All nursing posts are advertised on Jobtrain which is found by the search term NHS Scotland Jobs so accessible widely. Recruitment are setting up alternate SoMe pages so we can maximise coverage across the UK. It is possible that advertising south of the border will have a positive impact but the current review of the infection control service that is progressing is still necessary to ensure

			the banding of these posts reflects the needs of the organisation and the associated qualifications, skills and experience of the post holders.
39	Appendix-2021-33 Healthcare Associated Infection – Prevention & Control Report	**Sonya Lam:** Noted	**-**
40	Appendix-2021-34 Public Governance Committee Update	**Sonya Lam:** Noted	**-**
41	Appendix-2021-35 Public Governance Committee Minutes: 17.11.20	**Sonya Lam:** Noted	**-**
42	Appendix-2021-36 Staff Governance Committee Update	**Sonya Lam:** Noted	**-**
43	Appendix-2021-37 Staff Governance Committee Minutes: 14.12.20	**Sonya Lam:** Noted	**-**
44	Appendix-2021-38 NHS Borders Performance Scorecard	**Sonya Lam:** Noted	**-**
45	Appendix-2021-38 NHS Borders Performance Scorecard	**Malcolm Dickson:** 3.3 "it is anticipated going forward that 52% of outpatient appointments will be delivered virtually" - this is welcome. I presume there will be non-cashable but useable gains, ie less floorspace required for outpatients which could free up areas to either improve patient experience or for other pressing needs?	**June Smyth:** **52% Virtually-** apologies with figure should be 48% there has been an input error- 52% is face to face- report will be amended to reflect. **Gareth Clinkscale:** We completed a high-level audit last year that suggested 48% of Outpatient appointments could be delivered virtually and 52% face-to-

			face. This was copied incorrectly within the report when stating 52% virtual. That aside, 48% of activity as virtual is still a significant level of activity to work towards. We are currently working through what can be delivered on a specialty-by-specialty basis to ensure we are delivering as much activity as possible without the need for face to face contact. This work includes linking with the Scottish Access Collaborative initiatives across Scotland, where all Boards are implementing changes to the way in which they are delivering outpatient services and sharing their learning to maximise the benefits. When this works is complete, we shall have a more accurate understanding of what can be delivered virtually. Any gains made from this work are currently being used to offset the significant reductions in Outpatient capacity through social distancing. At the point at which this is no longer such a constraint then this freed capacity will be assessed to deliver other benefit (patient environment, backlog capacity, efficiency, etc).
46	Appendix-2021-38 NHS Borders Performance Scorecard	**Karen Hamilton:** 1.1 Very disappointed to see Delayed Discharge figures are creeping up again. Can I have a brief update please - despite the mitigating actions described we are not seeing an improvement?	**Nicky Berry:** DD in CH =24, BGH=9 and MH=3. Pts waiting on allocation to social worker =6 Packages of Care (POC)=10 pts Guardianship=6pts Residential=6pts Nursing care=7pts Housing/other=1pts Governance of process is in place through

			weekly meeting chaired by myself or Jen Holland Chief Officer SBcares and Adult Social Work, issues are being highlighted which are then actioned. Delays awaiting nursing beds have escalated dramatically in last few weeks. Nursing home beds commissioned by SBC; demand currently outstrips capacity. As a short term option discussions are being had with external providers regards ability to commission further beds. Medium term and longer options need to be developed across HSCP to develop capacity. Jen working with external providers regarding obtaining their privately funded beds. In addition the Dementia Nurse Consultant and Social Care Service Manager are reviewing all patients waiting for nursing care beds to ensure initial clinical assessment appropriate There is Package of care capacity issues in central and east and an urgent discussion to enable an increase in capacity is being developed with providers. Assessment of people being taken through Home First is also being reviewed to increase flow to appropriate patients to increase capacity available. In addition all Charge Nurses are being reminded that HF should be the first option for referral if appropriate.
47	Appendix-2021-38 NHS Borders Performance Scorecard	**Karen Hamilton:** 2.2. 'This is obviously a concern and diagnostic waiting	**Gareth Clinkscale:** We shall continue to keep the Board abreast of diagnostic waiting times challenges. Work is

		times will remain under regular review, with appropriate action agreed as the situation dictates in order to prioritise urgent and particularly cancer patients.' Please keep Board updated on this	underway to plan additional resource through national waiting times funding which will help this position.
48	Appendix-2021-38 NHS Borders Performance Scorecard	**Karen Hamilton:** Inpatient and outpatient waiting times are alarming but not surprising – whats the sense of SG tolerance of this?	**Gareth Clinkscale:** We meet with Scottish Government a monthly basis to review waiting times for TTG, Outpatient and Diagnostics. Our backlog is in line with what SG are seeing across the country and the national team are content with the trajectories we have submitted as part of the 2021/22 RMP.
49	Appendix-2021-38 NHS Borders Performance Scorecard	**Lucy O'Leary:** The charts in 1.2-1,6 are much clearer and I appreciate the work that's been done to clarify what's being measured in each one – thank you	**June Smyth:** Noted thank you.
50	Appendix-2021-39 Board Committee Memberships	-	**-**
51	Appendix-2021-40 Code of Corporate Governance Sectional Update	-	**-**
52	Appendix-2021-41 Scottish Borders Health & Social Care Integration Joint Board minutes: 16.12.20	**Sonya Lam:** Noted	**-**