Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 7 October 2021 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr T Taylor, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Ms H Campbell, Non Executive
Mr J McLaren, 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
Dr T Patterson, Joint Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr G Clinkscale, Director of Acute Services
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Dr J Bennison, Associate Medical Director
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Infection Control Manager & Laboratory Service Manager
Mrs L Pringle, Risk Manager
Mr P Williams, Associate Director of AHPs
Mrs J McClean, Director of Regional Planning East Region
Mrs C Oliver, Communications Manager
Mr A McGilvray, Radio Borders

1. Apologies and Announcements

1.1 Apologies had been received from Mr James Ayling, Non Executive, Mrs Alison Wilson, Non Executive, Mr Andy Carter, Director of Workforce, Dr Amanda Cotton, Associate Medical Director and Dr Tim Young GP, Associate Medical Director.

1.2 The Chair confirmed the meeting was quorate.

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

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

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

2. Declarations of Interest

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

2.2 The declarations of interest for Gareth Clinkscale were tabled.

The **BOARD** approved the inclusion of the Declarations of Interest for Mr Gareth Clinkscale in the Register of Interests.

3. Minutes of Previous Meeting

The minutes of the Extra Ordinary meeting of Borders NHS Board held on 2 September 2021 were approved.

4. Matters Arising

The **BOARD** noted the action tracker.

5. Strategic Risk Register Report

5.1 Dr Tim Patterson introduced the report and Mrs Lettie Pringle highlighted several elements including: the new governance structure; and the responsibility of governance groups to provide assurance to the Board.

5.2 Mr Tris Taylor raised 4 queries: was it the Executives responsibility to identify further risks; should that be a whole Board responsibility; the underlying logic for the allocation of risks to committees to monitor; the broadness of culture such as compassionate leadership, kindness, enabling staff, did not seem to fit into the single risk identified; and was there enough organisational capacity to manage risk under the current circumstances.

5.3 Dr Patterson commented that allocation of risks to Board Committees had been an agreed direction from the Audit Committee. In terms of the identification of risk, the Board Executive Team collectively agreed the strategic risks to be included in the register taking into consideration the current risk environment. The issue around culture change was something for the various risk owners to consider and the issue of organisational capacity was an important point given the extremely difficult times faced by staff with pressures on services. The Risk Management Board was aware of capacity issues and had a plan to support Clinical Boards through the identification of risk champions and a review of the risk management team to support services and risk owners to develop risks.

5.4 The Chair suggested the discussion on the cross referencing of risks across the Board Sub Committees be remitted back to the Audit Committee.

5.5 Ms Sonya Lam commented that whilst the majority of risks could be aligned to the corporate objectives, however the strategic risks were not aligned to the strategy as it remained unclarified.

5.6 Mrs Harriet Campbell enquired if the overarching way in which risks were managed required review. Dr Patterson confirmed that the process followed was the British Standard for Risk Management which was about identifying risks, their impact on the organisation and developing plans to address the risks. He assured the Board that operationally the system worked well.

5.7 Mr Ralph Roberts suggested that the Executive Leads revisit their strategic risks and be explicit as to whether the risks were being managed or tolerated. Executive Leads should also ensure they had the risks and actions well documented and described, to enable the respective Board Governance Committees to reassure themselves when they reviewed their risks in more detail.

5.8 Mr Andrew Bone commented that the Quality & Sustainability Board would be supporting the development of an updated organisational strategy and this would support the future identification of Strategic risks.

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

The **BOARD** noted the report.

6. Regional Health Protection Service

6.1 Dr Tim Patterson explained to the Board that Health Protection was really about communicable disease and environmental health.

6.2 Mrs Jan McClean provided the background to and an overview of the report.

6.3 The Chair advised that she had been asked to raise a point by Mr James Ayling in his absence, which was that governance should be a consideration from the outset and not just in the setting up period.

6.4 Ms Sonya Lam commented that she was happy to endorse the approach proposed and enquired if more assurance would be required in terms of operating within the financial framework considering NHS Borders remained on the NHS Board Performance Escalation Framework for financial matters.

6.5 Mr Ralph Roberts commented that he was supportive of the proposal as it also supported resilience. He further advised that it was expected to be delivered within the existing resource, however if that were not possible then a further discussion would take place with the Board. He fully expected the proposal to mitigate as far as possible any long term financial implications and accepted that there could be long term financial implications for heath projection in the future given the COVID-19 pandemic.

6.6 Mrs McClean commented that the working assumption was that there would not be any additional costs and until the details of the model were understood and the potential issues of inter-operability, she could not say definitively that there would be no additional costs. She assured the Board that the work was present and there were already staff in place, the proposal was about the way the workload was organised, whilst continuing to work within the context of the pandemic.

6.7 Further discussion focused on: the engagement process with the staff and public around the proposal; the sustainability of nurse led models given recruitment difficulties; confirmation of staff side representation on the Programme Board; potential for the nurse led model to be more attractive to nurses and provide more opportunities for their development; and the quality and resilience of the local service should improve.

6.8 The Chair suggested an update paper be provided to the Board in advance of the model being operational in March 2022 and that the update paper include assurance on public engagement, staff engagement, finance and risk.

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

The **BOARD** endorsed the approach to the implementation of a regional model for Health Protection services.

7. Resources & Performance Committee Minutes: 06.05.21

The **BOARD** noted the minutes.

8. Audit Committee Minutes: 15.06.21, 20.07.21

The **BOARD** noted the minutes.

9. Endowment Committee Minutes: 07.06.21

The **BOARD** noted the minutes.

10. Financial Performance - August 2021

10.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: the deficit of £3.7m; the section in blue in the report explained the changes from the previous report; the reset of the budget in line with the quarterly reviews which in turn reset the deficit; COVID-19 expenditure of £3.65m which was slightly lower than anticipated; quarter 1 review meeting with Scottish Government; Scottish Government intention to support Boards with the non delivery of savings in a similar manner to last year; and additional resource for winter included social care monies to be transferred via the Integration Joint Board.

10.2 Ms Sonya Lam noted the additional funding and commented that the challenge remained in terms of attracting and retaining the workforce. Mr Bone commented that whilst Boards were given additional resource for recruitment, it remained a challenge to attract staff as all Boards were seeking the same levels of staff. He suggested there was a need to understand what the recurring capacity was in terms of workforce and how that might be secured and financed recurrently by aligning both jobs and resources.

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

The **BOARD** noted that the board was reporting a £3.70m deficit for five months to the end of August 2021.

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

11. Clinical Governance Committee Minutes: 19.05.21, 21.07.21

The **BOARD** noted the minutes.

12. Quality & Clinical Governance Report

12.1 Dr Lynn McCallum described the Clinical Prioritisation section of the report and focused on the bringing together of clinicians into difficult decision making forums and empowering clinicians to bring forward their creative and innovative ideas to do things differently.

12.2 Mrs Fiona Sandford reflected on the discussion held at the Clinical Governance Committee and welcomed the update that structures were now in place and sought a further update. Mr Gareth Clinkscale explained the plans to expand COVID-19 patient capacity, the staffing models and the pressures on non COVID-19 patients in terms of longer lengths of stay. He spoke of the workforce pressures and cessation of routine operating with a plan to restart operations from 18 October 2021.

12.3 Mrs June Smyth highlighted the pressures in primary care and mental health services and the steps being taken by those services to ensure they were safe and specifically in mental health some of their activities had had to be put on hold.

12.4 Dr McCallum emphasised the pressures across the whole health and care system and the work being taken forward with Scottish Borders Council in relation to moving patients who were medically fit to leave hospital to a more appropriate setting.

12.5 Mrs Sandford commented that what was often heard by the Board was different to what was heard in the street and that there did seem to be a disconnect of the public view of the situation. She suggested she had noted a slight change in the tone of communications being released by the Scottish Government over recent weeks where there appeared to be more of a recognition of the long term impact of the pandemic on people with other health conditions.

12.6 Ms Sonya Lam enquired in regard to pages 6 and 7 of report if there was any analysis of Serious Adverse Events (SAE) and any other changes in parameters, such as staffing changes, complaints increasing and any annual trends. Mrs Laura Jones commented that the graph on SAEs had been reissued as the shift that had been included in the paper was incorrect. There were a number of cases recorded on DATIX, which was a live reporting system, and one of the issues in the pandemic in the most recent months had been the timeliness of review and response from front line services and that had led to a shift in data which meant there were more events of minor or near miss. She assured the Board that the SAE data remained in normal limits.

12.7 In terms of HSMR data, Mrs Jones commented that it remained within normal limits. There had been an elevation in the crude mortality level and that was expected to

continue, however when the COVID-19 deaths were removed from the data the crude mortality data remained within the normal range.

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

The **BOARD** noted the report.

13. Healthcare Associated Infection Prevention and Control Report

13.1 Mrs Sarah Horan drew the attention of the Board to sections 1.9 and 10.3 of the report and highlighted; limited single room provision; steps in place to mitigate risk; patients swabbed on admittance; re-swabbing of patients who were negative but asymptomatic for COVID-19; impact on nosocomial (healthcare associated); and increased intelligence Scotland wide on the genome and mutations of the COVID-19 virus.

13.2 Mr Sam Whiting explained the steps taken to reduce the risk of spread to patients in multi bedded bays through testing prior to admittance; filling the corner beds first in 6 bedded bays and then the middle beds last; supporting patients to wear face masks; clean hands; twice weekly lateral flow tests for staff; providing support to staff; and the safe use of PPE.

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

The **BOARD** noted the report.

14. Care of Older People in Hospitals: Update on Falls

14.1 Mr Paul Williams provided an overview of the content of the report and highlighted: the increase in incidents of inpatient falls and falls with harm, primarily in the Borders General Hospital and Community Hospitals which followed a national trend; piloting of a new falls initiative in MAU which had seen a 20% to 86% improvement in a short space of time; on-going work of linking pathways to ensure people linked to the most appropriate service at the most appropriate level; and resourcing of the physiotherapy service.

14.2 The Chair enquired if there was any work undertaken in looking across services and social care in relation to the Falls Strategy and the broader elements. Mr Williams confirmed that partners from social work, care homes and care at home were all involved in the Falls Strategy Group and were integral to producing any kind of pathway across the partnership.

14.3 Mrs Harriet Campbell enquired who was responsible for ensuring consistency and what might be slipping between the teams. Mr Williams advised that he, Mrs Laura Jones and Mrs Sarah Horan all had accountability for falls. He highlighted that it was a challenge in Borders as there was no dedicated team of people whose sole responsibility was falls.

14.4 The Chair sought a flow diagram of accountability and reporting for sharing with the Board.

14.5 Mrs Lucy O'Leary enquired about the role of public facing communications in the strategy. Mr Williams confirmed that the communications approach to the public would include safe handling techniques.

14.6 Ms Sonya Lam enquired if there was sufficient funding and what would need to be done if there wasn't. Mr Williams recognised that resource was a potentially limiting factor especially given members of the clinical governance function had been redeployed to patient facing roles when they had focused on falls work previously. Mrs Jones commented that across Scotland there was a pattern of deterioration in falls and falls with harm and nationally colleagues were trying to understand the wider impact of the pandemic on the deconditioning of the elderly. She commented that Ms Zoe Spence had been dedicated to falls work and was currently redeployed to a COVID-19 ward but would be protected from redeployment to continue with the inpatient falls and wider falls work. Mrs Jones suggested she would provide an update to the next meeting on the bid for national funding and how resource could be put around the wider agenda.

14.7 Mr Tris Taylor recognised the challenges of capacity and referred to the earlier discussion on risk and enabling risk owners to be supported by a Board wide acceptance of additional risks.

14.8 The Chair commented that the pressures the organisation was under linked to the recent statement by the Cabinet Secretary and the follow up letter received by all Health Boards.

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

The **BOARD** noted the current situation and strategic approach being taken by NHS Borders in relation to falls prevention and management.

The **BOARD** noted the on-going challenges facing clinical teams, clinical governance improvement facilitator capacity and staff capacity to engage in strategic and quality improvement work.

15. Public Governance Committee Minutes: 23.02.21, 05.05.21

The **BOARD** noted the minutes.

16. Area Clinical Forum Minutes: 23.03.21

The **BOARD** noted the minutes.

17. NHS Borders Performance Scorecard

17.1 Mrs June Smyth provided a brief overview of the content of the report. She recorded her thanks to Mr Gareth Clinkscale who had personally answered several of the questions within the Board Q&A.

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

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

18. Borders NHS Board – Business Cycle 2022

18.1 Miss Iris Bishop provided an overview of the content of the report.

18.2 The Chair encouraged the Board Governance Chairs to feed into Board agenda setting.

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

The **BOARD** approved the Board meeting dates schedule for 2022.

The **BOARD** approved the Board Business Cycle for 2022.

19. Consultant Appointments

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

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

20. Scottish Borders Health & Social Care Integration Joint Board minutes: 26.05.21, 28.07.21

The **BOARD** noted the minutes.

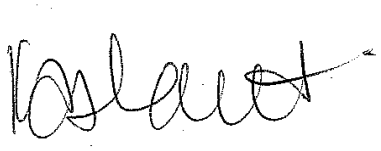
21. Any Other Business

21.1 Mr Ralph Roberts reminded the Board that it was the last meeting for Mr Rob McCulloch-Graham who was retiring as Chief Officer Health & Social care at the end of the month. Mr Roberts thanked Mr McCulloch-Graham for all he had achieved and driven forward to further the integration of services since his appointment in 2017.

22. Date and Time of next meeting

The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 2 December 2021 at 9.00am via MS Teams

The meeting concluded at 10.57am.



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Chair

BORDERS NHS BOARD: 7 OCTOBER 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Declarations of Interest	-	-
2	Minutes of Previous Meetings	**Harriet Campbell:** Just wondering if we should note on the meeting on 2 September that a number of members of the public and press were also in attendance but did not speak?	**Iris Bishop:** The members of the public in attendance are listed at 1.3 on the minutes.
3	Matters Arising/ Action Tracker	-	-
4	Appendix-2021-68 Strategic Risk Register Report	**Harriet Campbell:** P15 and p34 of the pack – 'Destabilisation of clinical services'. Should this risk not be renamed to make it clearer that it focuses on recruitment and retention of staff? My first reading was that it seemed like a bit of a vague 'catch all' P 16 and P44 While I note and accept all the detailed and well-thought out comments on the paper, is grading 'failure to implement remobilisation successfully' as 'medium' not a little optimistic given the potential seriousness of the impact and the difficulty of predicting what remobilisation will look like in an ever-changing situation? Even the controls in place for this risk acknowledge that plans may need to be amended.	**Tim Patterson/Lettie Pringle:** The title has been updated to reflect this request and will show in reports as: 'Destabilisation of clinical services due to ability to recruit and retain medical workforce.' With the current, robust control measures in place this risk is currently graded as a medium risk. This has been graded using the organisational risk matrix: • Consequence: Moderate outcome (late delivery of key objectives, some disruption in service with unacceptable impact on patient care, temporary loss of ability to provide a service, challenging recommendations that can be addressed with appropriate action plan);

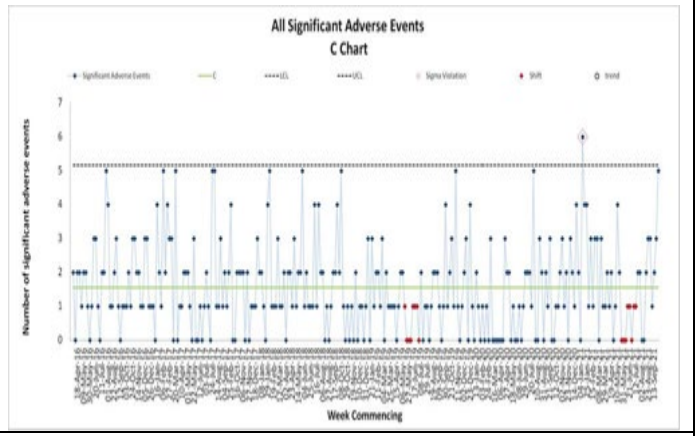
		More generally what concerns me is the relatively high number of risks for which the controls in place are considered to be inadequate. What, if anything, can and should be done about this – in a global sense rather than a risk-specific one?	• Likelihood: Possible (reasonable chance of occurring); Following the matrix this risk level is calculated as a medium risk. As the risk register is a live system, as actions become controls or situations escalate the expectation is the current risk level will be reflective of these changes. The gap analysis column of the risk report addresses why the controls are not managing the risk to an acceptable level and considered as being inadequate. The gap analysis should inform the action plan to minimise these gaps as far as reasonably practicable, thus reducing the overall risk level. In some cases the gap may involve external factors and this is something that has to be accounted for within NHS Borders remit (for example, COVID virus mutations is not something NHS Borders can control however there is regular national and local modelling undertaken to identify increases/decreases in cases, NHS Borders remobilisation plan and local contingency plans in place for increased COVID numbers and admissions should this occur).
5	Appendix-2021-68 Strategic Risk Register Report	**Karen Hamilton:** I appreciate the way the risk management is described within the governance structures. Risks 23, 18, 16 and 17 – noting that these have	**Tim Patterson/Lettie Pringle:** Newly identified risks show up as no previous grading within the report.

		come from nowhere/medium to 'very high'. Why is this? (now noting table on P8 this is clearer as to why!) – however – consequences of these additions?	The increase in risks should not be seen as a negative but as a positive showing the Board Executive Team are proactive in ensuring risks are identified and our risk register reflects our current strategic risks. This allows the board to be risk aware and manage risks to ensure they have appropriate controls and actions in place to minimise impact should they occur.
6	Appendix-2021-68 Strategic Risk Register Report	**James Ayling:** The new risk :Failure to implement remobilisation successfully (No.21) is wrongly labelled No 20 in the detailed analysis.	**Tim Patterson/Lettie Pringle:** Apologies, report will be updated to correct this error.
7	Appendix-2021-68 Strategic Risk Register Report	**Fiona Sandford:** P9: Scrutiny and Assurance: Clinical Governance Committee: "Committee not assured that some risks were being managed appropriately and proportionately. This was because some risks are still in development and appeared not to be managed in a timely manner." I'm not sure this is an accurate picture, perhaps we might change this to '…some risks are still in development, or there was insufficient information at this time, or a small number of risks appeared not to be managed in a timely manner' Happy to discuss further	**Tim Patterson/Lettie Pringle:** Discussed with Fiona and agreed rewording of 'A small number of risks appeared not to be managed in a timely manner. Insufficient information available to be assured that risks in development are being managed in a timely manner.' Agreement that a further report will be presented to the next CGC providing more information and progress of these risks.
8	Appendix-2021-69 Regional Health Protection Service	**Karen Hamilton:** 7 Exec Summary - Intention described as Dec 2020 which is past? I appreciate the benefits of streamlining service in terms of efficiency and presumably cost saving. Are there any staffing implications over and above described in cover paper section on this? And likewise implications for patients? Finally are we potentially disadvantaged by being on the periphery of the Region?	**Tim Patterson:** The main objective of the workstream is to improve the quality and resilience of health protection services within the EoS region and not to specifically reduce costs. However as the workstream develops, efficiencies should become apparent e.g. less duplication of effort and fewer on call rotas. There are currently no plans to reduce staffing capacity. Indeed it is a specific SG objective to strengthen public

			health teams and to develop a 'First Class' public health service for Scotland. As the workstream should lead to a more efficient and resilient health protection service, patients should also benefit. Although a small contributor to the network in terms of staffing, NHS Borders should benefit in the future due to: • the regionalisation of specialist work • greater service resilience particularly for health protection nursing • more time to develop and strengthen regional/local quality assurance work • improved local authority relationships • better health protection training opportunities and career pathways.
9	Appendix-2021-69 Regional Health Protection Service	**James Ayling:** This appears to be a very sensible and timely project for all Boards and in particular for us. I see the current project structure has now been revised to take account of project implementation with the establishment of an oversight board, liason group,clinical reference group and an operational delivery group. While I appreciate the current paper is an update it would be good to have some idea of the proposed governance arrangements once the project is up and running. Who will have final responsibility for this regional service ? Will the oversight body remain in place/report to all four Boards? What happens if there is a proposal which suits 3 Boards but not us given our demographics and rurality? How do we as the Borders NHS Board retain our say over these services in our area or are we delegating these services (risks)?	**Tim Patterson:** Decisions on the governance of the future regional services will be taken by the programme board as the workstream develops.

10	Appendix-2021-69 Regional Health Protection Service	**Fiona Sandford:** Seems very sensible, happy to endorse	-
11	Appendix-2021-70 Resources & Performance Committee Minutes: 06.05.21	**Harriet Campbell:** P90 Perhaps not for this meeting but is there any update on Lucy's question on the Q&A which as far as I know still hasn't been answered.	**Iris Bishop:** The update has now been issued.
12	Appendix-2021-71 Audit Committee Minutes: 15.06.21, 20.07.21	**Harriet Campbell:** Perhaps not my place to say so but for readability (particularly on-screen) it would be nice to have a few more paragraphs. If a session on internal audit is run (p102) it would be very helpful if I could join it (albeit not on the audit committee) if possible.	**Andrew Bone:** We are always happy to receive feedback and suggestions for improvement. We'll take this point on board and consider what we can do to improve readability of future minutes. Noted re. Internal Audit. We'll make future session(s) available to non-committee members where they may be of interest.
13	Appendix-2021-72 Endowment Committee Minutes: 07.06.21	**Harriet Campbell:** Given that the Endowment Committee and the NHS Board are two entirely different bodies – albeit with overlapping membership – I'm just wondering what the rationale is for the NHS Board seeing these minutes? (Although as I write I suppose there's no real reason why they shouldn't as long as the Endowment Committee has approved their being shared.).	**Iris Bishop:** We publish them for the purposes of transparency, the same as we publish the IJB minutes which is another separate body with overlapping membership. More than happy to relook at this if the Board wish.
14	Appendix-2021-73 Financial Performance - August 2021	**Harriet Campbell:** P115 are we in a position to be able to comment on the assumptions around savings which were to be reviewed at the end of September? (may be too soon I realise).	**Andrew Bone:** It is a little too early unfortunately. I will provide update when available. I would envisage we can provide update to Resources & Performance committee in November.
15	Appendix-2021-73 Financial Performance -	**Karen Hamilton:** Nice clear report Andrew and the Team, well done.	**Andrew Bone:** We are just beginning to model the full year

	August 2021	3.6.7 Spend by business unit is clearly going to be all over the place due to cancelled electives and added pressures on ED, locum and bank staff etc . Do you have any modelling on the full year impact of this? (apologies if I have missed this in th report!)	impact as we start to prepare our financial plan for 2022/23 and beyond. I will provide an update to the Resources & Performance committee in November around timescales for the plan. I think it is likely to be January before we are able to present modelling for full year effect of in year trends.
16	Appendix-2021-73 Financial Performance - August 2021	**Fiona Sandford:** Clear paper, thank you. No questions at this stage but look forward to discussions	-
17	Appendix-2021-74 Clinical Governance Committee Minutes: 19.05.21, 21.07.21	-	-
18	Appendix-2021-75 Quality & Clinical Governance Report	**Harriet Campbell:** P140 Is there any update on duty of candour? P143 There were 'plans to launch the collaborative September 2021'. I think there may be a word missing here and so I'm not sure what it means, but did this happen and if so how did the launch go? This seems to relate to falls and if so how is it linked with the internal multidisciplinary falls team (and the paper at 7.4)?	**Lynn McCallum/Laura Jones:** We still await feedback from Scottish Government as to the recommended approach for Duty of Candour in the context of the COVID 19 pandemic. There was a re-launch of the adult acute Scottish Patient Safety Programme in September 2021 with a priority focus on Falls and Care of the Deteriorating Patient. These areas both form core priorities in our local NHS Borders Back to Basics Improvement Programme. Our local inpatient fall's work and working group (detailed in paper later on Board agenda) is informed by this national workstream and NHS Borders are represented in the national expert group guiding this work.
19	Appendix-2021-75 Quality & Clinical	**James Ayling:** Section 2.3.9 states that the number of serious	**Lynn McCallum/Laura Jones** The shift in significant adverse events has

	Governance Report	adverse events has increased, evidenced by the 8 week shift above the current average. Are there any obvious reasons for this?	been under review in the last week. There are a number of cases where further information is now available in relation to the outcome for the patient which has led to event being downgraded on the Adverse Event Management System based on the actual harm which was caused. There revisions are likely to change the shift reported. However, the cases which remain span all 3 clinical boards and there is no specific pattern or trend to note. 
20	Appendix-2021-75 Quality & Clinical Governance Report	**Fiona Sandford:** Much of this was discussed at length at CG. A lot of concerning information, but no questions at this point	-
21	Appendix-2021-76 Healthcare Associated Infection – Prevention & Control Report	**James Ayling:** What sort of incident is defined as a COVID-19 related incident for which a Problem Assessment Group and/or Incident Management Team requires to be convened? The increase in numbers in July /August coincides with the rise in community COVID-19 prevalence. Is there any other internal identifiable reason or pattern?	**Sam Whiting:** A Problem Assessment Group (PAG) may be convened if we have a concern that requires further review but before it is known if there is an incident. An example could be a single COVID-19 case occurring in a non-COVID-19 area such as a surgical ward. An Incident Management Team (IMT) would be

		I note the lack of single rooms to accommodate all admissions for five days for COVID-19 may have resulted in a number of instances where patients in multibedded bays with a negative COVID-19 test on admission subsequently developed symptoms and tested positive prior to their day 5 inpatient screen, or were asymptomatic and tested positive on their day 5 screen and that multiple contacts may have become COVID-19 positive. This is of course very concerning. I do note we are constrained in this regard by our bed layouts. The gap analysis for the risk of healthcare associated infection (Risk 17 in Risk Register) says that *Ultimately, the only way to mitigate this risk is to increase spacing between patients either by reducing the number of patients in multi - bedded rooms or re - provision of inpatient services in more spacious accommodation*. Can assurances be given that the aforesaid mitigation has been considered in each case ? Is there any provision for trying to send a patient to say Lothian NHS for treatment if we know that we cannot mitigate the risk at the BGH ..or will Lothian be similarly challenged? I presume that the 10 resultant deaths indicated in 10.2 make up those categorised as probable or definite hospital onset in terms of the reporting to ARHAI. Scotland COVID-19 Hospital Onset Definitions?	convened in response to a recognised incident. An example would be multiple COVID-19 cases identified in an area in a specified time period which could be indicative of cross transmission within that area. Here is the link to the national guidance we follow which includes a definition of healthcare associated infection outbreaks and also describes the role of PAG and IMT meetings. With the wide range in the incubation period, routes of transmission for COVID-19 are often unclear (visitor to patient, patient to visitor, patient to patient, staff to patient, patient to staff, staff to staff). Increases in community prevalence increase the likelihood of staff, patients and visitors coming into hospital whilst incubating COVID-19 from a community acquired source which could contribute to multiple introductions into hospital. Following introduction to hospital we know the risks and have evidence of nosocomial hospital infection. NHS Borders COVID-19 Gold Command has approved criteria for considering reducing the number of beds in multi-bedded bays taking account of wider system bed pressures using indicators such as the Emergency Access Standard, delayed discharges and waits for community hospital beds. I understand that the risks we have associated with multi-occupancy inpatient rooms and bed pressures are not unique to NHS Borders.

		Interesting to note that whilst five days is recognised as the average incubation period for COVID-19 the ARHAI definitions show day 8 to 14 as only being *probable* hospital onset.	Not all of the deaths were classified as probable or definite hospital onset. The national standardised definition of probable or definite hospital onset does not always exactly correlate with the more detailed information considered during the management of an outbreak. For example, if a patient were exposed during their inpatient stay and identified as a contact, if they subsequently become COVID-19 positive after discharge home within a specific timeframe, the IMT would consider this case as being linked with the outbreak. The national definition would classify this case as community onset as the patient became positive in the community.
22	Appendix-2021-76 Healthcare Associated Infection – Prevention & Control Report	**Fiona Sandford:** Much of this was discussed at length at CG. Clearly nosocomial COVID must be a serious concern. Any information available on other Health Boards?	**Sam Whiting:** I'm not aware of any published data by health board. However, the table below shows figures for the whole of Scotland for the same time period as I reported in my paper for NHS Borders:-

			Cumulative COVID-19 Cases by Hospital Onset Status **Summary** For Scotland, the total number of COVID-19 cases reported to National ARHAI Scotland, with specimen dates from week-ending 4 Jul 2021 to week-ending 29 Aug 2021, when including the community onset infections, was 155612. % of total / n = Community onset 99.0% 154,105 Non-Hospital onset 0.8% 1,178 Indeterminate Hospital onset 0.1% 120 Probable Hospital onset 0.0% 56 Definite Hospital onset 0.1% 153 Grand Total 100.0% 155,612 **COVID-19 Cases by Hospital Onset Status - by week Scotland**
23	Appendix-2021-77 Care of Older People in Hospitals: Update on Falls	**Harriet Campbell:** See above – why no mention of the Scottish Patient Safety Programme in here? Am I misunderstanding what this is or should it not be impacting on falls policy? There seem to be lots of different groups – SPSP, Multidisciplinary falls team (is this the same as the Falls Strategic Group?), Back to Basics, community prevention, Inpatient falls group, Falls Strategic Group... – looking at this. Are these sufficiently joined up and what oversight is there to ensure this? This may be the role of the Strategic Group but that isn't clear from the paper (to me anyway).	**Sarah Horan/Paul Williams:** The inpatient falls group and community prevention group are workstreams which report into the Falls Strategic group. The Falls strategic group reports to the 'Back to Basics' Governance group and Board Clinical Governance Group to ensure appropriate oversight. Both the Falls strategic group and 'Back to Basics' group are linked to the SPSP work to ensure that NHSB is in step with the national approach.
24	Appendix-2021-77 Care of Older People in Hospitals: Update on Falls	**Lucy O'Leary:** Work on falls prevention is welcomed. Can I check that independent care home/ home care providers are engaged and involved in the work on strategy development/ early intervention? (paper references third sector and SBC).	**Sarah Horan/Paul Williams:** The care home governance team is represented on the strategic group alongside representation from SBCares. We will reach out to independent partner colleagues for

		In future updates, could information on the strategy development work come before the inpatient falls strand? This paper could perhaps be read as giving the I/p work higher priority but I am sure that is not the case	additional representation. I can confirm that the Falls Strategy Group is leading and directing the inpatient workstream. Apologies if this was not clear.
25	Appendix-2021-77 Care of Older People in Hospitals: Update on Falls	**Fiona Sandford:** P5 3.3: compliance with falls documentation due to unprecedented workforce pressure – understandable, however is it also likely that the same workforce pressure might be resulting in sub-optimal falls prevention? Board might want to keep a watch on this?	**Sarah Horan/Paul Williams:** You are correct Fiona that workforce pressures will no doubt be having an impact on falls prevention. Our clinical governance team are working hard to support clinical teams at a ward level in this regard. We will continue to monitor not only documentation but also engage with ward staff regarding current challenges and support.
26	Appendix-2021-78 Public Governance Committee Minutes: 23.02.21, 05.05.21	**Harriet Campbell:** I know our board meeting cycle often ends up with there being a delay in minutes being brought to the Board but February is a very long time ago. P174 How is the current dialogue with/about carers (which was clearly causing concern in Feburary)? For my understanding are these unpaid carers or care sector workers? And to what extent is this an NHSB issue and to what extent an SBC one (or IJB?) P176 I think there's a critical typo in here (at 6.1). Surely suicide, drugs and inequalities are *avoidable* causes and not 'unavoidable' as the minutes have it.	**Iris Bishop:** The minutes have been delayed due to a PGC meeting not being quorate. The membership and quorum requirements are being reviewed. **June Smyth:** A carer's workstream has been set up under the direction of the Chief Officer. There is Carer representation on the Public Governance Committee. Apologies the text should read 'avoidable.'
27	Appendix-2021-78 Public Governance Committee Minutes: 23.02.21, 05.05.21	**James Ayling:** Good to see the many activities and projects being reviewed and discussions taking place.	-
28	Appendix-2021-79	**Harriet Campbell:**	**Alison Wilson:** Timely communication around

	Area Clinical Forum Minutes: 23.03.21	P191 what progress has been made on issues raised here regarding feedback to/from (12) and use of (13) the ACF?	the professional advisory groups (PAGs) is challenging. The ACF meets the Tuesday before the Board so it can feed into the Board. Most of the PAGs meet bimonthly so to get timely feedback to and from the groups doesn't work. Most requests for feedback have a short turnaround. It is something all the ACFs grapple with and comes up regularly at the national group.One of the other Boards is look to run a workshop on engagement with ACF. The Chair is due to attend the next ACF meeting so it would be good to pick up a discussion about this at that meeting.
29	Appendix-2021-79 Area Clinical Forum Minutes: 23.03.21	**Fiona Sandford:** 4. good to see that Olive is to attend November meeting to update on Realistic Medicine (would be great to hear how that is received)	**Alison Wilson:** Happy to feedback after the session.
30	Appendix-2021-80 NHS Borders Performance Scorecard	**Harriet Campbell:** Cancer times remain faultless. Well done everyone. Should be highlighted every time! Nice to have positive performance highlighted too. P193. Is the increased number of clinically urgent outpatients the result of the increased waiting times? Ie are these people who have been waiting for so long that their need has become urgent? And if so, is this the sign of major issues to come (which i imagine may well then have an impact on inpatient figures)? And if so what is being done about this? Feels like a big bubble waiting to burst...	**June Smyth:** Thank you and will share with operational teams involved This is correct Harriet. We are seeing more patients re-prioritised to urgent classification due to the length of wait for a routine appointment. This is likely to continue while we are holding this level of backlog of appointments. We are continuing to work to increase the amount of Outpatient capacity we can deliver. This work has been delayed due to a decision made in August to divert operational capacity to support unscheduled care, ITU and COVID-19 pressures. Remobilisation activities are starting again

			focussed on several areas: • Returning final outpatient clinics to pre-pandemic patient numbers (per clinic) • Exploring alternative physical capacity for displaced Outpatient clinics • Implementing demand management best practice from the rest of Scotland to aid reduction of the backlog The Outpatient backlog will translate to an increase in patient numbers converting to surgery as more patients are seen in Outpatients.
		P194. Noted under CAMHS that they are 'targeting their longest patients waiting and this doesn't prevent continual referrals being made to the service'. I had understood that clinical need was the priority in other service areas. Why is this not the case in CAMHS (noting that urgent cases are seen urgently). I don't necessarily think this is the wrong approach, I just wonder why it seems to be different from, eg, outpatients above. P202 Why is ophthalmology particularly struggling with 12 week outpatient times and what can be done about this?	CAMHS prioritise referrals based on the clinical information provided. Routine referrals that are on the referral to treatment waiting list are provided with assessment appointments and are treated in turn. Urgent and Emergency referrals are provided with assessment appointments based on the clinical information provided within the appropriate time scale. Ophthalmology has been a particular area of challenge for Outpatients due to several factors. Locum support had been secured to cover the gap between previous substantive consultant workforce finishing and new consultant posts starting. Unfortunately this capacity fell through due to unplanned absence. Social distancing has been a particular problem in the Eye Centre that has reduced clinic capacity. Following new guidance on social distancing in Outpatients, clinic templates will return to pre-pandemic

			patient numbers from October. We are currently exploring opportunities for external capacity to support the Ophthalmology position.
		P204. I see that performance against trajectory on the 12 week TTG has been good, but I also see that the trajectory jumps this month. Why is that and what can/is being done to keep the numbers comparatively low. (PS can I also check I am reading these right – these are numbers of breaches of the TTG, so low is good?! If that is right, incidentally, why show in this way rather than as a percentage which is what the standard requires? Are the low numbers just the result of fewer referrals?)	This isn't a simple answer. The chart indeed shows we have fewer patients who have breached their 12 week waiting time at point of operation than we had modelled as a trajectory. However we are also delivering a higher proportion of urgent operations and fewer overall operations than we had planned; therefore a low number is not necessarily a good thing. As our case mix has a higher proportion of urgent cases, these will all be within 12 weeks waiting time. When we get to the point of delivering more routine operations then the number of 12 week breaches will increase dramatically.
		P205. I note that endoscopy is particularly affected here. I believe that specific measures were being put in place to address this backlog and it would be helpful to have an update on this.	Additional weekend capacity has been put in place to reduce urgent Colonoscopy waiting times (which are now below 4 weeks and stable). Endoscopy continues to be a challenge due to a substantive consultant vacancy and cancellation of planned activity to ensure safe medical staffing levels in Unscheduled Care. Further external capacity is being sought to reduce waiting times.
		P208 The trajectory on the A&E standard is downward and has been since March. Do we have any clear information on why this is and what is being done about it?	The deterioration in Emergency Access Standard performance is multi-factorial. One of the key drivers behind the deterioration in performance since March has been workforce

		I'm sure I should know this but what are Flow 1,2,3 and 4 and why the marked difference in performance?	pressures due to vacancy levels and sickness absence. We have also reduced the number of medical beds in response to nursing capacity challenges. A further factor has been the continued need for a COVID-19 inpatient response. The closed beds were repurposed as a COVID-19 ward which is currently caring for 12 inpatients. Our physical infrastructure also limits our ability to manage COVID-19 infection without limiting non-COVID-19 capacity. Another factor that developed during the pandemic was the increase in the length of stay (LOS) in the BGH. In the two years prior to the pandemic we reduced the LOS through both work in Acute Services and across the wider Health and Social Care system by one day. This LOS benefit has been lost during the pandemic. There is anecdotal evidence of patients arriving more deconditioned and we are seeing a greater number of complex discharges. This alongside workforce pressures across social care has also resulted in a dramatic increase in Delayed Discharges with 9.7% of adult BGH beds filled with delays and 56 delays across all inpatient areas. There is a plethora of work underway to improve performance across the system. In the BGH improvement work has stalled due to operational pressures with operational managers having to work on wards to support safe staffing levels. Improvement work is now being restarted with a focus on re-establishing basic patient flow management principles. We

			are trialling additional consultant cover in the Emergency Department out of hours to support senior decision-making. A new Discharge Coordination Team is being recruited to focus on reducing LOS in complex discharges. The Older Person's Assessment Area in the Medical Admissions Unit is planned to restart their trial. Across Primary and Community Services, Home First is expanding its opening hours and criteria. We are investing in the Community Care Review Team (review levels of packages of care in the community) to create more capacity. The Community Treatment and Assessment Centres will offer minor injuries capacity outside the BGH ED. The fortnightly winter board provides and overview and leadership of these works. Flow 1 minor I injury Flow 2 medical assessment (non-admitted) Flow 3 medical admitted Flow 4 surgical admitted
		P211 similarly sickness absence is getting more significance. Why is this and what is being done to mitigate this as we move into Winter?	We are seeing an uptick in sickness absence levels which is likely related to the operational pressures currently being experienced, on the back of an exceptional year and 1/2 period for staff. John McLaren chairs a Wellbeing Board which is focussed on staff support in a number of areas such as protected areas for staff and free tea/coffee. We are also focussing on ensuring basic management principles such as supportive return to work discussions are in place.

31	Appendix-2021-80 NHS Borders Performance Scorecard	**Karen Hamilton:** DD. 1.7 cover paper. Fully acknowledge the joint work and pressures in relation to this ever growing concern. We must ensure we adhere to the policies in place as a whole system measure across all aspects of NHS and LA. Can we further clarify data shared at Weekly updates? Harriet raised this with Iris and I think it might be worth covering here for newer NXD's? Iris could you share email?	**June Smyth:** Thank you for raising this. Our weekly HSCP delayed discharge performance meeting focuses on delivery against trajectory, risks, mitigating actions and escalation. As part of this, there is a significant amount of data and associated narrative available.
32	Appendix-2021-80 NHS Borders Performance Scorecard	**Fiona Sandford:** Treatment of Cancer and Suspicion of Cancer figures very good to see. (great press statement on this from us, pity that the coverage focused only on the negatives from other Boards) Good to see Diagnostic waiting times improving slightly, clear concern that other waiting times must snowball resulting in more deconditioned patients. Look forward to hearing about a coherent plan / funding proposition from SG	**June Smyth:** We are in the process of developing (the next iteration) of the elective recovery plan. This will include the redesign of elective inpatient pathways to increase capacity within workforce constraints, theatre utilisation improvement activities, session productivity work in Ophthalmology, outpatient clinic capacity changes, mobile MRI backlog recovery and several projects taking forward best practice in line with the new Centre for Sustainable Delivery (CfSD) Heat Map. Scottish Government are funding both outpatient and surgery additional activity to help with the position.
33	Appendix-2021-81 <u>Borders NHS Board – Business Cycle 2022</u>	**Karen Hamilton:** Should we mention and approve Q&A processes with timescales? Timetable – can we clarify colour coding at lines 55-57	**Iris Bishop:** I am happy to confirm the timescales for the Q&A process at the meeting. My apologies for not being clear on the colour coding. It is blue items for the public meetings and orange items for the Board Development sessions.
34	Appendix-2021-82 Consultant Appointments	**Lucy O'Leary:** For information – what is the breakdown of the Board's consultant cohort by gender (including these	**Andy Carter:** The current breakdown is 45% male / 55% female.

		4 appointments)?	The gender balance has moved significantly over the years with the increased female graduates from medical schools.
35	Appendix-2021-82 Consultant Appointments	**Fiona Sandford:** Good!	-
36	Appendix-2021-83 Scottish Borders Health & Social Care Integration Joint Board minutes: 26.05.21, 28.07.21	**James Ayling:** The July 28 minutes state that the partnership under-spent by £6.236m during the financial year relating entirely to slippage in the use of ring-fenced funding and planned investments, in addition to unutilised funding allocations for Covid-19 costs and that this has been carried forward to 2021/22 as part of the IJB earmarked reserve. I understand that these funds are ring fenced but given this significant reserve fund…. are there any options here?	**Rob McCulloch-Graham/Andrew Bone:** Expenditure plans against the IJBs ring-fenced reserves are currently being reviewed and an update will be presented to a future IJB meeting. Any slippage in expenditure plans against ring-fenced resources will normally require to be carried forward for future commitments however the reserves do include some elements which will offset cost pressures within the partnership. Any further scope for funds to be used flexibly will be subject to agreement between IJB and partner organisations.