Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 27 June 2024** at 9.30am in the Lecture Theatre, Education Centre and via MS Teams

AGENDA

Time	No		Lead	Paper
9.30	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.31	**2**	**DECLARATIONS OF INTEREST**	Chair	*Verbal*
9.32	**3**	**MINUTES OF PREVIOUS MEETING** 04.04.24	Chair	*Attached*
9.33	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.35	**5**	**STRATEGY**		
9.35	5.1	2024/25 Annual Delivery Plan	Director of Planning & Performance	Appendix-2024-35
9.45	5.2	Borders Child Poverty Report	Director of Public Health	Appendix-2024-36
10.00	**6**	**FINANCE AND RISK ASSURANCE**		
10.00	6.1	Resources & Performance Committee minutes: 07.03.24	Board Secretary	Appendix-2024-37
10.01	6.2	Audit & Risk Committee minutes: 25.03.24	Board Secretary	Appendix-2024-38
10.02	6.3	Endowment Fund Board of Trustees: 06.05.24	Board Secretary	Appendix-2024-39
10.03	6.4	Annual Report & Accounts 2023/24 *(Restricted to Board members only)*	Director of Finance	Appendix-2023-40
10.15	6.5	Annual Audit Report 2023/24 from Audit Scotland *(Restricted to Board members only)*	Audit Scotland	Appendix-2023-41
10.25	6.6	Endowment Fund Annual Report and Accounts 2023/24 *(Restricted to Board members only)*	Director of Finance	Appendix-2023-42
10.35	6.7	Audit & Risk Committee Assurance Report *(Restricted to Board members only)*	Audit Committee Chair	Appendix-2023-43

10.45	6.8	Finance Report	Director of Finance	Appendix-2023-44
10.50	6.9	Audit & Risk Committee Chair Update Report on Financial Sustainability.	Audit Committee Chair	Appendix-2023-45
11.00	**7**	**QUALITY AND SAFETY ASSURANCE**		
11.00	7.1	Clinical Governance Committee minutes: 13.03.24	Board Secretary	Appendix-2024-46
11.01	7.2	Quality & Clinical Governance Report	Director of Quality & Improvement	Appendix-2024-47
11.20	7.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2024-48
11.30	**8**	**ENGAGEMENT**		
11.30	8.1	Staff Governance Committee minutes: 29.11.23	Board Secretary	Appendix-2024-49
11.31	8.2	Area Clinical Forum Minutes: 23.01.24	Board Secretary	Appendix-2024-50
11.32	**9**	**PERFORMANCE ASSURANCE**		
11.32	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2024-51
11.45	**10.**	**GOVERNANCE**		
11.45	10.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 20.03.24, 17.04.24	Board Secretary	Appendix-2024-52
11.46	10.2	Whistleblowing Annual Report	Whistleblowing Champion	Appendix-2024-53
11.59	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 1 August 2024 at 10.00am in the Lecture Theatre, Education Centre and via MS Teams	Chair	*Verbal*

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 4 April 2024 at 10.00am in the Lecture Theatre, Headquarters/Education Centre and via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Ms L Livesey, Non Executive
Mrs L O'Leary, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, Non Executive
Dr K Buchan, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr S Bhatti, Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mr A Carter, Director of HR, OD & OH&S
Mrs L Jones, Director of Quality & Improvement
Mrs S Errington, Head of Planning & Performance
Mr S Whiting, Infection Control Manager
Mrs K Kiln, Consultant in Public Health
Mr M Clubb, Director of Pharmacy
Miss L Henderson, Communications Officer
Mr T Luke, Infection Control Nurse
Ms C Anderson, Infection Control Nurse
Ms F Doig, Head of Health Improvement/ADP Strategic Lead
Ms J Reid, Health Improvement Team
Ms L Ponton, Health Improvement Team
Ms N Sewell, Health Improvement Team
Ms N White, Health Improvement Team
Mr R McMoran, PA to Director of Public Health
Ms S Wayness, ADP Project Officer
Ms S Elliot, ADP Partnership Coordinator
Mr A McGilvray, Senior Reporter
Mrs R Hamilton MSP
Mr C McLean, Public Involvement Partnership Group member
Ms A Elton
Ms L Jackson
Ms Arlene, Psychology Student

1. Apologies and Announcements

1.1 Apologies had been received from Mr G Clinkscale, Director of Acute Services, Mrs J Smyth, Director of Planning & Performance, Mrs L Huckerby, Interim Director of Acute Services and Mr C Myers, Chief Officer Health & Social Care.

1.2 The Chair welcomed a range of attendees to the meeting including members of the public and press.

1.3 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

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

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 1 February 2024 were approved.

4. Matters Arising

The **BOARD** noted the Action Tracker.

5. Pharmaceutical Care Services Report

5.1 Mr Malcolm Clubb provided an overview of the content of the report and drew the attention of the Board to the 6 neighbourhoods with expressions of interest, the work of the contracts committee and the hearing that had taken place regarding a Tweedbank application for a pharmacy practice at the end of 2023.

5.2 Dr Sohail Bhatti commented on the increase in independent prescribers. Mr Clubb advised that non medical routes were used before any prescribing route was undertaken and that was part of the underpinning principles and good practice in prescribing.

5.3 Further discussion highlighted: pharmacy consultation rooms; potential of more prescribers to allow for deprescribing; starting dialogue with patients on the values based healthcare approach of being prescribed medication that they may not want or wish to take; national discussions were progressing on the potential repurposing of medications returned in tact; and social prescribing to community pharmacists.

5.4 Mrs Harriet Campbell enquired about the impact of the polypharmacy review and Mr Clubb advised that the report pertained to community pharmacy services only. Dr Lynn McCallum assured the Board that the polypharmacy work continued to progress at pace in both primary and secondary care.

5.5 Mrs Lynne Livesey enquired if incentives to pharmacy practices were geared towards prescribing or other options. Mr Clubb advised that there were monthly

peer review sessions to discuss prescribing and ensure choices were appropriate. Consultations did not need to end in a prescription they could end in a referral to a GP or some simple advice with homely remedies and so there were consultation based results and pharmacies would receive an appropriate levy.

The **BOARD** endorsed the Pharmaceutical Care Services Plan report 2024-27.

The **BOARD** noted the challenges and that any updates or concerns would be escalated via relevant channels including OPG as required.

The **BOARD** confirmed it had received significant assurance from the report.

6. Health Inequalities Strategy

6.1 Mrs Kirsty Kiln provided a presentation on health inequalities that focused on: differences in life expectancy; accessing better quality data; wider determinants of health; inequalities in childhood, amongst working age adults, older adults; and engagement.

6.2 Mr James Ayling enquired when the Board could expect to receive regular progress reports on the metrix of KPIs as outlined with the recommendations from the internal audit report. Mrs Kiln commented that it was a priority and it was a challenge where data was collected that provided tiny changes over a short period of time. The intention was to pursue a live dashboard of data.

6.3 The Chair enquired if there was a programme or concept of when the Board would receive regular updates and feedback.

6.4 Further discussion focused on: activity on fair living wage and period poverty; hidden inequalities; years of life lost at a more micro level; how to proceed with little or no funding; support a change in direction to move to a preventative health system away from the reactive health care system provided; in social prescribing it suggested there were 1 million contacts or conversations per year which would equate to 10 per patient of which 5 were for social care reasons; GPs could provide the life lost data with support and how would support be provided to get the vital information and data gathering for preventable deaths; an acknowledgement that many wider social determinants impacted on health inequalities such as housing; and an acknowledgement of the work done through UNICEF.

6.5 Dr Sohail Bhatti confirmed that there was a need to capture all of the disadvantaged groups and move the strategic direction from being reactive to being preventative.

6.6 Mr Ralph Roberts welcomed the report and the need to focus on population health, service delivery and health inequalities. He commented that there were on-going discussions at a national level on reform of the health service in Scotland and health inequalities needed to be centre to those discussions.

6.7 Mr Laura Jones enquired if the board underestimated the resources it committed to primary and secondary prevention and suggested it would be helpful if there was an action for a map of services and funding provided to be shared with the Board. The Board could then review if the funding and services were positioned in the way experts would recommend and maybe some of that resource would need to be

adjusted and repositioned. The Chair commented that the suggestion be added to the Board action tracker as an Action for the Board to receive an update on progress, scoping of what was already in place, what worked well and what was being progressed.

6.8 Dr Bhatti commented that a Programme Board had been established to lead on Health and Inequalities and he was keen to expand the membership to include a Non Executive. The Chair advised that she would give consideration to the request outwith the meeting.

The **BOARD** noted the presentation.

The **BOARD** agreed to place an action on the action tracker that would read "The Board would receive an update on progress, scoping of what was already in place, what worked well and what was being progressed."

The **BOARD** confirmed it had received significant assurance from the report.

7. Resources & Performance Committee minutes: 18.01.24

The **BOARD** noted the minutes.

8. Audit Committee minutes 11.12.23

The **BOARD** noted the minutes.

9. Endowment Fund Board of Trustees minutes 04.10.23

The **BOARD** noted the minutes.

10. Financial Plan 2024/25 Update

10.1 Mr Andrew Bone provided an update on progress with the financial plan. The overall summary before savings included: a £45m financial gap identified; savings of £14.6m identified; the level of brokerage would be limited to about £15m from the Scottish Government; a shortage of identified savings plans for delivery in year; the risks and work required to move forward; and the inability to provide a balanced financial plan for approval by the Board.

10.2 Mr Bone commented that in terms of the financial plan, dialogue continued with the Scottish Government on the implications of not having a balanced financial plan.

10.3 Mr Ralph Roberts commented that it was a significant position for the Board to be in and whilst the scale may vary, all Health Boards were in a similar position. He advised there was a need to be honest with the Board, staff, communities and the public on the scale of change required and that it would impact on services.

10.4 Dr Kevin Buchan commented that table 4 appeared to show that the Primary and Community services and Mental Health services had achieved the goals set and other units had not. He enquired how those were achieved and what impact was on patient care.

10.5 Mr James Ayling commented that the level of savings required would be hard to achieve and if they were not achieved and further savings were not identified, then potentially the Board would have a requirement for £64m of brokerage over the 3 years of the plan and at March 2027 it would be in the region of £100m brokerage required. He enquired if that should be factored into the current plans.

10.6 Mr Bone commented that in terms of the achievement of targets, all detailed savings plans from business units were being reviewed to understand the delivery risk and consequential impact on other parts of the system. In terms of the process overall and progress towards the identification of savings, all Business Units that had not identified savings had been approached to ask them to continue to work on plans to release savings.

10.7 In regard to brokerage and savings, Mr Bone commented that the Scottish Government had specifically asked for 3 year plans that would show a recurring balance by the end of year 3 and any brokerage would be payable after that term. It was anticipated that at the end of year 3 the health board would require in the region of £100m brokerage and at that point it would be difficult for the health board in terms of ongoing viability. He suggested as the financial plan was developed that in order to describe what it would take to achieve financial balance, there would be a need to develop a 5-10 year plan to describe the actions over the medium and longer term to get to a balanced position and repay the brokerage.

10.8 Cllr David Parker enquired if the health board were safe to set a budget as it looked like an exponential issue. A 3 year plan to show balance had been requested by the Scottish Government and it was clear it could not be delivered. The challenge of delivering recurring savings previously and in the future was significant. He enquired if the organisation was viable for the future and what the view of the Scottish Government was.

10.9 Mr Roberts commented that the reality was that it was unclear what the response of the Scottish Government would be to an unbalanced 3 year plan. The question of viability was a fundamental question for the Scottish Government. A plan to pay back brokerage would be worked up once a balanced position could be achieved and it would paid back over a period of 10 years.

10.10 Mrs Fiona Sandford commented that all health boards in Scotland were facing financial difficulties and the worst performing, including NHS Borders, were the remote and rural health boards with older populations. She suggested it should be made clear to the Scottish Government that however much progress might be made it would not be possible to manage the demographic challenge along with remoteness and rurality and that was the key reason the organisation would struggle financially for a considerable amount of time. Mr Roberts commented that nationally a piece of work was being taken forward on the reform of the health service in Scotland which would encompass issues in relation to rurality, remoteness, geography and demography.

10.11 Mrs Livesey enquired if the Board were minded to set an interim budget for the year, given there was further work to be done, and it would enable services to function for that period but would not remove the pressure of requiring the delivery of savings.

The **BOARD** approved the proposed issue of an interim (revenue) budget for 2024/25 aligned to the expected opening deficit at April 2024. This deficit is aligned to the recurrent savings targets set for individual business units over the medium term and excludes any provision for growth in expenditure during 2024/25 pending identification of actions to address this growth (including any additional resources, where available).

The **BOARD** confirmed it had received limited assurance from the report.

11. Provision of Resources to the Scottish Borders Integrated Joint Board

11.1 Mr Andrew Bone advised that a letter had been issued to the Chief Officer and Chief Financial Officer of the Integration Joint Board (IJB) setting out the budget offer which had been made contingent on the approval of the Board. He acknowledged that the delay in an offer had been the source of frustration for the IJB members. He assured the Board that an improved process would be followed for the future.

11.2 The paper detailed the budget offer and the IJBs' share of increased pressures and savings. Mr Bone explained the intricacies of the Scheme of Integration in relation to budgeting and the requirement of the respective partners to provide funds to reach a balanced position if savings could not be delivered.

11.3 Cllr David Parker thanked Mr Bone for the offer received by the IJB and commented that the IJB had to operate within a balanced budget and there would be challenges for the IJB to deliver the savings targets identified.

11.4 Mr Ralph Roberts commented that he expected the IJB to get into a conversation about the right balance between health and social care.

11.5 Mrs Lucy O'Leary commented that the role of the IJB was to commission the integration of services which effectively required the issue of directions to enable change.

The **BOARD** noted the report.

The **BOARD** approved the budget offer to the IJB.

The **BOARD** confirmed it had received moderate assurance from the report.

12. Finance Report

12.1 Mr Andrew Bone provided an overview of the content of the report and advised that it reflected the same position as had been reported for a number for a number of months with the organisation on course to deliver the forecast position. He advised that the Board was not in line with what was expected from the Scottish Government and that dialogue was on-going.

12.2 In terms of general risk he advised that the one thing likely to impact on the forecast on the closure of the March position was the continuous backlog of reporting of prescribing results, as it would be June before the actual end of year position for primary care prescribing would be known. He clarified that the delay was due to processing delays at a national level.

The **BOARD** noted that the Board was reporting an overspend of £15.92m for eleven months to the end of February 2024.

The **BOARD** noted the updated M11 forecast outturn to £16.3m deficit and the risks to the forecast.

The **BOARD** noted the position reported in relation to recurring savings delivered year to date (Section 5).

The **BOARD** confirmed it had received moderate assurance from the report.

13. Clinical Governance Committee minutes: 17.01.24

The **BOARD** noted the minutes.

14. Quality & Clinical Governance Report

14.1 Mrs Laura Jones provided an overview of the content of the report which included: the Clinical Governance Committee taking partial assurance from the Clinical Boards on availability of workforce in particular areas ie general practice, dermatology, haematology and cancer pathways; urology and endoscopy had been compounded by additional capacity; unscheduled demand and impact on stroke unit and elective beds; regional beds for the Mental Health & Learning Disabilities services; the Clinical Governance Committee taking positive assurance for Obstetrics & Gynaecology; issues with local diagnostics; full assurance provided on all areas of children's services; continued interaction with the COVID Inquiries; and criminal investigations were underway.

14.2 Mrs Fiona Sandford drew the attention of the Board to the difficulties being experienced in primary and community services in regard to medical staffing cover at the Community Hospitals.

14.3 Dr Lynn McCallum commented that there had been and issue in finding medical staff to cover the Kelso and Knoll Community Hospitals as the contracted GPs had handed back the medical cover contract. If a solution could not be found it was likely that the beds would close temporarily to comply with patient safety requirements. A solution was being sought for the longer term and in the immediate an interim plan would be put in place until the end of July 2024.

14.4 Dr Kevin Buchan commented that a long term plan was required as GPs continued to look to see which areas they could move away from to cope with their continually increasing workload.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report.

15. Infection Prevention & Control Report

15.1 Mr Sam Whiting provided an overview of the content of the report and highlighted several points including: standard reporting for the covid inquiries; the challenge in

reducing ecoli; the work of the Cauti Group in quality improvement and the triangulation of data; improvement in data for care homes; deep dive into catheter data prevalence in the Borders General Hospital and Community Hospitals; and a public facing hydration campaign.

The **BOARD** noted the report.

The **BOARD** confirmed it had received moderate assurance from the report.

16. Future of the Public Governance Committee

16.1 Mrs Steph Errington provided an overview of the content of the report and advised that following the resignation of the Non Executive Chair of the Public Governance Committee (PGC) and in light of pressures faced by the Board it had been agreed to review the Public Governance Committee. The review had focused on 2 key objectives which were to make sure the Board retained scrutiny in relation to public involvement and engagement and to see more efficient and effective ways of working. She confirmed that all of the existing public involvement groups would remain in place with a different reporting route.

16.2 The Chair had been assured on the level of mapping of activities from the PGC to the different areas in the organisation and that the Public Involvement Partnership Group (PIPG) had been consulted.

16.3 Mr James Ayling enquired how the Board would be assured on health inequalities as it would be split across a range of governance committees. Dr Sohail Bhatti commented that it was the oversight of governance and accountability of health inequalities that would be lost, however there was a need for less meetings.

The **BOARD** paused the recommendation from the Chair of NHS Borders that the Public Governance Committee be formally disbanded.

The **BOARD** agreed the discharge of remits as set out in Table 1 of the paper and that it should set out how it linked to the health inequalities agenda to ensure all those elements were captured.

The **BOARD** confirmed it had received limited assurance from the report.

17. NHS Borders Performance Scorecard

17.1 Mrs Steph Errington provided an overview of the content of the report and highlighted that overall performance levels were similar to the last report with pressure points in specific areas such as Dermatology, Cardiolgy, A&E and Cancer waiting times. Some improvements were shown across new Outpatient appointment times.

17.2 Mr James Ayling enquired about the TTG 12 week target and the reference to risk created due to a lack of capacity at the Golden Jubilee and the Band 3 post and he enquired if that was a example of grip and control procedures. Mrs Errington commented that the post was going through the grip and control process.

The **BOARD** noted Board performance as at the end of February 2024.

The **BOARD** confirmed it had received moderate assurance from the report.

18. Scottish Borders Health & Social Care Integration Joint Board minutes: 24.01.24

The **BOARD** noted the minutes.

19. Code of Corporate Governance Refresh

19.1 Miss Iris Bishop drew the attention of the Board to the potential for a revised Members Code of Conduct (Section B) being issued by the Standards Commission later in 2024.

The **BOARD** approved the refreshed Code of Corporate Governance.

The **BOARD** confirmed it had received significant assurance from the report.

20. Any Other Business

The **BOARD** noted there was none.

21. Date and Time of next meeting

21.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 27 June 2024 at 10.00am in the Lecture Theatre, Education Centre, Borders General Hospital and via MS Teams (hybrid) and that the meeting would be extended to 12.30.

Borders NHS Board Action Point Tracker

Meeting held on 4 April 2024

Agenda Item: Health Inequalities Strategy

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-1	6	The **BOARD** agreed to place an action on the action tracker that would read "The Board would receive an update on progress, scoping of what was already in place, what worked well and what was being progressed."	**Sohail Bhatti**	**In Progress**

Agenda Item: Future of the Public Governance Committee

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-2	16	The **BOARD** paused the recommendation from the Chair of NHS Borders that the Public Governance Committee be formally disbanded.	**Steph Errington**	**In Progress**

Agenda Item: Future of the Public Governance Committee

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-3	16	The **BOARD** agreed the discharge of remits as set out in Table 1 of the paper and that it should set out how it linked to the health inequalities agenda to ensure all those elements were captured.	**Steph Errington**	**In Progress**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**2024/25 Annual Delivery Plan**
Responsible Executive/Non-Executive:	**June Smyth Director of Planning & Performance**
Report Author:	**Hayley Jacks, Planning & Performance Officer**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan
- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper updates Borders NHS Board on the submission of our 2024/25 Annual Delivery Plan (ADP) and the formal sign off of the ADP by Scottish Government.

2.2 Background

On 04 December 2023, a joint commissioning letter setting out the Finance and Delivery Planning Approach for 2024/25, sent on behalf of John Burns, Chief Operating Officer NHS Scotland and Richard McCallum, Director for Health and Social Care Finance, Digital and Governance was emailed all NHS Boards.

The submission date for the Annual Delivery Plan was the 15 March 2024.

The plan is attached as **Appendix 1** and was signed off by the Chief Executive and Chair on behalf of NHS Borders Board prior to submission.

2.3 Assessment

The previously issued NHS Delivery Plan Guidance 2023/24 took planning forward from the volatility of the previous three years and helped make further progress along the path towards recovery and renewal as set out in Re-mobilise, Recover, Re-design: the framework for NHS Scotland. It asked all NHS Boards to produce both Annual Delivery Plans for 2023/24 and Medium Term Plans covering up until 2026.

Last year's 2023/24 plans were a significant step forward in moving towards a greater level of coordination across NHS Scotland, to progress along the path towards recovery and renewal as set out in Re-mobilise, Recover, Re-design: the framework for NHS Scotland. Looking to the year ahead, the intention is to build on the effective planning already underway, and in particular, to ensure that delivery planning for 2024/25 took place within the context of the current Medium Term Plans.

Therefore, the core aim of this year's guidance is to support Boards in updating their Medium Term Plans into Three Year Delivery Plans with detailed actions for 2024/25 and aligned to their Financial Plans, and to the ministerial priorities for NHS Scotland as set out in the guidance document.

The planning priorities set out in the guidance intended to give clarity on the high level priorities which Boards should deliver in 2024/25, whilst remaining flexible enough to allow Boards to appropriately plan and prioritise within their own financial context.

The Business Units worked collaboratively with the Planning & Performance Team to develop our ADP. The Interim Director of Planning & Performance, along with the Planning & Performance Manager, met with Scottish Government representatives on Wednesday 27 March 2024 for a discussion of initial reflections and next steps before formal sign off from Scottish Government. Formal sign off from Scottish Government was received on Monday 03 June 2024 and is attached as **Appendix 2**.

As noted in the approval letter, we have no specific priority areas to feedback to Scottish Government on but a wider range of *"Development and Improvement Areas"* for some of the sections which we have been encouraged to reflect on in order to drive improvements in future planning and delivery. These improvement areas are detailed from **page 3** of **Appendix 2** and the Planning & Performance Team will continue to work with services to ensure the comments are factored into future discussions.

As set out in the NHS Scotland Delivery Planning Guidance 2024/25 (issued by Scottish Government on 04 December 2023) a key mechanism against which the progress and impact of the Delivery Plans will be reported in 2024/25 is via a forthcoming NHS Board Delivery Framework. The Delivery Framework has been received in draft format (**Appendix 3**) and is still going through internal Scottish Government review and governance. It aims to set out a clear set of agreed indicators for which delivery against

plans are reported, monitored and discussed with Boards, such as the quarterly progress reporting against the NHS Board Delivery Plans.

Our Board Scorecard, which is brought for information to the Board or Resources & Performance Committee (R&PC) meetings, depending on the Committee meeting cycle, will be developed to reflect the 2024/25 Framework indicators and performance against the national standards.

Any plan and monitoring updates will also be brought for information to the Board or R&PC meetings respectively.

2.3.1 Quality/ Patient Care

Each key deliverable has been prioritised using scoring criteria which considers, amongst other criteria, patient safety and quality improvement including impact on health inequalities.

2.3.2 Workforce

The ADP has been developed in conjunction with the Scottish Borders Health and Social Care Partnership (HSCP) Workforce Plan 2022-25.

2.3.3 Financial

This plan has been developed in conjunction with the 2024-25 Three Year Financial Plans that has been submitted to Scottish Government.

2.3.4 Risk Assessment/Management

This will be continually assessed by the business units as we progress the key deliverables.

2.3.5 Equality and Diversity, including health inequalities

Services will carry out Health Inequalities Impact Assessments (HIIAs) as part of delivering 2024/25 ADP priorities.

2.3.6 Climate Change

None identified.

2.3.7 Other impacts

None noted.

2.3.8 Communication, involvement, engagement and consultation

The ADP has been co-produced with individual services and senior management teams. As part of this co-production the plans have been presented to various committees for noting or appropriate action.

Specifically, the plans have been shared for review and comment with the Area Partnership Forum, Area Clinical Forum, Operational Planning Group, the Health & Social Care Partnership Joint Executive Team and members of NHS Borders Board.

As the individual programmes of work referenced in the plans are activated, the appropriate level of involvement will be agreed upon; including specific communications plans.

2.3.9 Route to the Meeting

The submitted plans have been noted by the Operational Planning Group (OPG) and the Board Executive Team (BET). This paper is brought forward to the Board today for awareness purposes. Both plans have been taken through the appropriate governance processes.

2.4 Recommendation

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, ADP1: Narrative response to ADP
- Appendix 2, ADP sign off letter from SG
- Appendix 3, NHS Board Delivery Plan Guidance 2024/25 Supplementary Advice: Delivery Progress Reporting

2024 – 2025

DRAFT Delivery Plan

NHS Board: NHS Borders

March 2024

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Glossary	
ABR	Auditory Brainstem Response
ACRT	Active Clinical Referral Triage
ADP	Annual Delivery Plan **also**: Alcohol and Drugs Partnership in Public Health
AHP	Allied Health Professional
ANIA	Accelerated National Innovation Adoption
ANP	Advanced Nurse Practitioner
BAS	Borders Addiction Service
BECS	Borders Emergency Care Service
BGH	Borders General Hospital
BMS	Building Management System
CAMHS	Child and Adolescent Mental Health Service
CCIO	Chief Clinical Informatics Officer
CCT	Certificate of Completion of Training
CESR	Certificate of Eligibility for Specialist Registration
CfSD	Centre for Sustainable Delivery
CGS	Community Glaucoma Service
CMHT	Community Mental Health Team
CPAG	Child Poverty Action Group
CPD	Clinical Professional Development
CPP	Community Planning Partnership
CTAC	Community Treatment and Care
CT	Computerised Tomography
CV	Cardiovascular Disease
CYPPP	Children and Young People Planning Partnership
DPH	Director of Public Health
DME	Department of Medicine of the Elderly
DOCA	Day of Care Audit
DPI	Dry Powder Inhaler
DWD	Discharge Without Delay
DWP	Department for Work & Pensions
ED	Emergency Department
EHRIA	Equalities & Human Rights Impact Assessment
EPA	End Point Assessment
EV	Electric Vehicles
FIP	Financial Improvement Programme
FME	Forensic Medical Examination
GA	Graduate Apprenticeship
GDS	General Dental Service
GDP	General Dental Practitioners

GDPR	General Data Protection Regulation
GI	Gastrointestinal
GMS	General Medical Services
GP	General Practitioners
H&S	Health & Safety
HCSA	Hospital Consultants and Specialist Association
HCSW	Healthcare Support Worker
HIS	Health Information Systems
HISES	Health Innovation South East Scotland
HR	Human Resources
HSCP	Health & Social Care Partnership
ICJ	Improving Cancer Journey
IDA	Innovation Design Authority
IG	Information Governance
IIA	Integrated Impact Assessment
IJB	Integration Joint Board
IPC	Infection Prevention and Control
ITS	Intensive Home Treatment Service
LD	Learning Disability
LDP	Local Delivery Plan
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, or Asexual
M365	Microsoft 365
MAU	Medical Assessment Unit
MAT	Medication-Assisted Treatment
MDI	Metered Dose Inhaler
MDT	Multidisciplinary Team
MHO	Mental Health Officer
MRI	Magnetic Resonance Imaging
NECU	National Elective Co-ordination Unit
NESGAT	NES Glaucoma Award Training
NTC	National Treatment Centres
NUI	New User Interface
OD	Organisational Development
OH	Occupational Health
OH&S	Occupational Health & Safety
OOH	Out of Hours
OPAT	Outpatient Parenteral Antibiotic Therapy
P&CS	Primary and Community Services
PCIP	Primary Care Improvement Plan
PDD	Planned Date of Discharge

PDS	Public Dental Service
PIR	Patient Initiated Review
PMO	Programme Management Office
PT	Psychological Therapies
PWLE	People with Lived Experience
qFIT	Quantitative Faecal Immunochemical Tests
RAD	Rapid Assessment Discharge
RCDS	Rapid Cancer Diagnostic Service
RDS	Right Decision Support
RTT	Referral to Treatment Time
RVS	Royal Voluntary Service
SABA	Short Acting Beta-2 Agonist
SACT	Systemic Anti-Cancer Therapy
SAS	Scottish Ambulance Service
SBC	Scottish Borders Council
SCI	Scottish Care Information
SDAI	Scottish Dental Access Initiative
SPA	Supporting Professional Activities
SPoC	Single Point of Contact
SSO	Single Sign On
THIS	Tackling Health Inequalities in the Scottish Borders
TTG	Treatment Time Guarantee
UCR	Unified Care Record
UGI	Upper Gastrointestinal Series
VBH&C	Value Based Health & Care
VDI	Virtual Desktop Infrastructure
V1P	Veterans First Point

Introduction

NHS Borders provides healthcare services to our local population of 116,020 people (National Records of Scotland, as of June 2021) as well as working to improve the overall health of the population. We take great pride in the delivery of healthcare to our local communities and all our staff who work within NHS Borders and across our Health and Social Care Partnership, carry out their role with the aim of improving the lives of our patients and the health of people within our local communities.

Our vision, along with that of our wider Health and Social Care Partnership, is that all people in the Scottish Borders are able to live their lives to the full. We aim to be a leader in the quality and safety of care we provide, doing this by the continual improvement and development of local services to meet the needs of our population. This will require innovation in the design of our services ensuring they are sustainable, equitable and fit for purpose to meet the demands of the future.

However, we acknowledge that there are very significant challenges ahead of us, linked to rurality, demographics, workforce availability, and financial resources. We also need to adapt to the changing health technologies and treatments, including their impact on our workforce and financial resources. These challenges require us to think differently, with our partners and communities, about the way we deliver our services across the Scottish Borders including what level of service offering we can deliver within the resources available. We will need to be realistic and honest with our communities about whether, with these challenges, we are able to meet our aspirations and the immediate demand on our services.

We intend to grasp this challenge and use it as an opportunity to innovate for the future. We believe that by ensuring the services we provide are sustainable, as well as transforming the traditional models of delivery, that we can deliver quality health services to the people of the Borders. Through the relentless pursuit of quality within our organisation we have driven down costs and improved the effectiveness and safety of our services and will continue to do so. We are focussed on delivering value for every individual patient by a focus on person centred care. Values based health and care forms a critical part of our organisational strategy.

The scale of the challenges faced in planning and delivering health and social care services to meet need are unprecedented and if we are to continue to provide safe, high-quality care within the financial resources that we are allocated, then we will have to take decisions that change the level, type and distribution of our services. Our priorities in this Delivery Plan are therefore heavily focused on delivering financial sustainability.

NHS Borders is currently escalated at Stage 3 of the Scottish Government Performance Escalation Framework in relation to financial sustainability. The Board's financial plan for 2024/25 describes an opening deficit of £41m therefore we are required to deliver savings and other remedial actions consistently within 2024/25.

The Scottish Government has requested the submission of NHS Borders Financial Plan outlining the minimum expectations regarding current and future affordability requirements. This sets two key financial planning requirements:

1. Our Financial Plan should detail a clear programme of work and supporting actions to deliver a minimum target of 3% recurring savings on baseline budgets.

2. Plans should demonstrate an improved forecast outturn position for 2024/25 compared to the forecast outturn position presented in the medium-term plan submitted in March 2023.

For NHS Borders, a third requirement is set out in relation to the Board's accumulated deficit and brokerage requirements. This requirement is:

3. The level of brokerage available in 2024/25 will be capped at £14.9m. Over the medium term (2024/25 to 2026/27) plans should be put in place to eliminate this requirement.

As per our draft financial plan, as at 15 March 2024, this currently demonstrates that over the next 3 year period the underlying (recurring) deficit is expected to reduce from £41m (March 2024) to £19.3m (March 2027). The minimum savings delivery is projected at 3% per annum (a total of £28.1m over three years).

It must be noted that even if the financial performance described in the plan, including the delivery of savings, is achieved this will still leave the Board needing to deliver significant further savings to address our current deficit. Beyond this there will then be the need to identify further actions to meet the repayment of the total brokerage that will be accumulated once the Board returns to financial balance.
The assumptions underpinning the plan remain subject to significant uncertainty, with limited modelling undertaken so far on future demographic and policy impacts, and wider economic forces.

Our draft financial recovery plan highlights that traditional cost improvement measures and productivity gain, while essential, will not be sufficient to achieve financial balance. The necessary actions required to sustainably reduce costs will require whole system transformation and reform to Health & Social Care delivery within the Scottish Borders. While we have scoped and commenced the implementation of a major transformation programme, there remains a significant gap between the level of savings identified and the target required to meet financial balance.

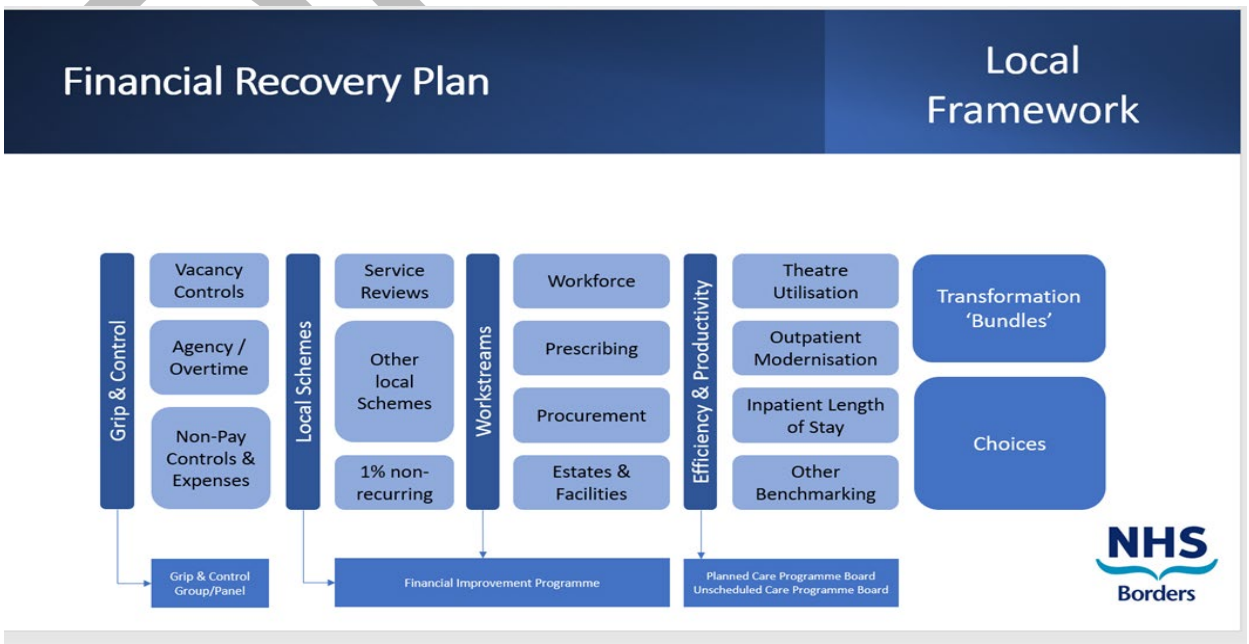
We have an appetite to develop the way in which we use digital solutions and believe that investment in this area will enhance operational efficiency and yield cost savings. Through the strategic deployment of digital tools and platforms, we could streamline processes, enhance service delivery, reduce overhead costs, mitigate operational inefficiencies, improve our patient engagement, and reduce the administration burden on staff at all levels. Harnessing the power of data analytics, artificial intelligence, and automation, can unlock actionable insights, optimise resource planning and allocation, and facilitate informed data-driven decision-making. We recognise that we are at the start of our digital journey, and over the next year intend to further develop our understanding of the opportunities, benefits and costs through our return-on-investment modelling. We also recognise that in the current financial situation, the availability of capital to invest in digital initiatives will be extremely limited. Any investment will therefore only be possible where this can

clearly demonstrate a significant financial return. Any investment will therefore need to be phased over a number of years and we will continue to carry significant risks which will require robust maintenance and business continuity plans to continue operational business as usual.

We also have a significant workforce challenge with a local ageing workforce and national shortages of many staff groups including Registered Nurses, some Allied Health Professionals (AHPs), Medical Consultants in certain specialties like Psychiatry & Dermatology and General Practitioners (GPs). The proportion of Nursing and Midwifery Staff in NHS Borders aged over 55 is 26.6%, compared to 19.6% for the East Region, and 20.6% for Scotland overall. While projected retirements are difficult to predict due to a high degree of flexibility around age of retirement, type of retirement, chosen timing, different pension schemes, personal circumstances and choice, the older age profile within NHS Borders is likely to lead to turnover of posts which can be difficult to recruit to through local or national supply lines. The number of Nursing and Midwifery undergraduate places going unfilled in Scotland and the attrition rate with some courses is cause for some concern.

We have developed a local framework as an approach to the development of our Financial Recovery plan which is consistent with the NHS Scotland Planning & Delivery Board "15 box grid". It must be stressed that this approach covers a range of activities and will require significant assessment as areas are considered and implemented. As the plan is implemented a number of decisions and choices will be required in relation to the impact financial savings will have on service delivery. While a number of these will be within NHS Borders decision making powers, given the scale of savings required and the significant risks that implementation may pose, means that we will also need to engage with local and regional partners, as well as the Scottish Government. This will be particularly important in relation to areas where we may need to implement actions for financial reasons that are inconsistent with the current policy or strategic intent of the Board or Scottish Government.

Each section of our framework and approach is summarised below:



Grip & Control

Grip & Control is a key component of our approach in delivering more immediate savings. This should enable budget retraction in some cases and there are workstreams to cover this as part of our programme. A robust Grip & Control Framework has been issued to cover the broader agenda that includes cost pressure and cost containment.

Our local Grip & Control framework includes robust scrutiny at a senior level within the organisation and covers the following key areas:

- Vacancy control
- Agency & overtime usage
- Non-pay controls & expenses

The scope and objectives of our Grip & Control process and procedures are as follows:

1. To support and enhance the Financial Improvement Programme (FIP) through improved cost control, both against budgetary spend and actual expenditure.
2. To get clarity and focus on managing the following:
    a. In Year external cost pressures
    b. Budget overspends and financial discipline
    c. Areas where the policy and controls are inadequate to meet the needs of the organisation
3. To standardise the controls and financial scrutiny across all business groups, directorates and corporate departments of the organisation so the overall measurement and tracking can be consolidated easily.
4. To ensure the Grip & Control measures delivered are sustainable and recurrent.

Local Schemes

Our recovery plan has set out clear key expectations for all services, across the organisation. This includes a requirement to set out plans for a reduction of 10% against their base budget over a number of years. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is delivered in 2024/25.

To enable a standardised and consistent approach to local schemes, a strategic steer for all services to undergo a service review is in place with a set of minimum standards that must be followed. These include the following:

1. A plan for the future provision of the service, including proposed changes to service model and expected outcomes
2. A renewed focus on efficiency, value and financial sustainability, to deliver the best possible patient care within the resources available. Design of services within two funded service models: 100% of current budget, 90% of current budget. A 10% reduction in budget is likely to require a reduction in service scope, service delivery and workforce. Associated risks will need to

be fully understood to allow informed decision making at both a local and national level depending on the permission required to implement
3. Reducing risks - particularly ones 'outwith organisational tolerance'
4. Evidence of the inclusion of the principles of value-based medicine
5. Opportunities in innovation, climate and sustainability
6. Workforce using the Six Step Methodology
7. How a service engages with staff and public / patient and Equalities & Human Rights Impact Assessment (EHRIA)

Expected outputs from our local schemes are likely to include reduction in workforce costs, reductions in service offerings, enhanced criteria and thresholds for referrals and treatment and feasibility into regional and national shared service provision as an alternative to local delivery where there is an opportunity for cost reductions and overheads.

Workstreams

A number of specific whole system workstreams have also been identified for areas of significant spend to ensure there is a high level of focus.

Workforce – This workstream will focus on setting a longer-term workforce strategy in line with a target reduction in headcount in the region of 10%. This area will incorporate the impact of the local schemes and other whole system programmes. The key activities in scope for this workstream include skill mix reviews specifically in community nursing, specialist nursing and allied health professions. Medical – on call and out of hours models, allocation of End Point Assessment (EPA) and Single Point Assessment (SPA) and rota compliance will also be a focus along with assessment and implementation of alternatives to replacement of roles through natural turnover. There will be a number of key dependencies to this workstream given new policy and legislation around Safe Staffing, recent pay awards etc and these will have to be assessed to determine financial consequences.

Prescribing - Prescribing spend across the organisation, in line with all health Boards, is rising at a high and unaffordable rate. This workstream aims to address a number of areas and to evidence a reduction in medications not adding value to patients and Improving NHS Borders sustainability agenda in line with "Sustainable Care" and supporting the implementation of Value Based Healthcare. Key activities will include opportunities across Polypharmacy reviews, product switching, Biosimilars and Homecare.

Procurement - To provide oversight to supplies & procurement expenditure within NHS Borders, including activities undertaken directly by the Procurement department as well as other contract and non-contract expenditure committed through their delegated authority by individual line managers. This workstream will assess all areas of non-pay expenditure and map existing spend to contract and non-contract, identifying how each area of spend is governed and assessing whether these arrangements are fit for purpose. Policy and related operating procedures will be established for each area of expenditure, including controls in place in relation to product selection, new product introduction, product standardisation. All areas of opportunity will be looked at for savings through benchmarking, variance analysis, and other relevant methods and by considering relevant cost drivers (volume, mix, price, wastage). The workstream will develop

triggers and escalation points in relation to changes in product use and/or price and establish a contract register for NHS Borders which is comprehensive and includes contracts held out with the procurement department. A communications strategy for increasing price awareness will be central to this work.

Estates & Facilities – This workstream focusses on rationalising the number of sites within NHS Borders to deliver a 20% reduction in cost base and mitigate estates risk profile. A workplan is being established to review baseline for each site (property costs, current occupancy, etc.) and then identify options for displaced staff, including any changes to staff working practices. A phased approach will be undertaken with identified sites to commence during 2024/25. In line with the recent Scottish Government guidance in relation to Whole System Infrastructure Planning, NHS Borders will commence the first planning phase to develop a maintenance-only business continuity plan based on a risk-based assessment of the Board's existing infrastructure. This plan will outline options to mitigate against inherent risks associated with existing infrastructure, meet environmental sustainability standards, and provide the necessary accommodation for service delivery needs. This will thereafter need to be prioritised against the funding envelope available to the organisation.

Efficiency & Productivity

Ensuring NHS Borders is as efficient and as productive within the resources it has available is an essential part of our approach. As part of our local framework robustly assessing and responding to all potential / productive opportunities is essential. A range of data sources will be used including, NHS Scotland benchmarking data to identify opportunities as well as participation in regional and national workstreams. This will allow the organisation to ensure we optimise models of care, identify potential areas for exploration, increase our productivity and therefore maximise the provision of care to our population.

Theatre utilisation, modernising Outpatients and Inpatient length of stay will be key areas of focus during 2024/25.

Transformation

Given the size and scale of the challenge ahead transformation is a key component of our approach to ensuring affordable, safe and sustainably services. The planning work for transformational change has begun to ensure we deliver outputs across all 3 years of the plan. However, it is likely that the greatest benefit will be delivered in years 2 and 3 of the plan.

A number of large-scale transformational change opportunities are currently being assessed and will cover the following areas:

- Alternative funding models and opportunities for some services to improve the quality and quantum of care
- Assess options and feasibility of local, regional and national shared services including clinical and non-clinical services
- Redesign of patient pathways and flow to ensure the right care is provided in the right place at the right time by the right person

- Enhancing community capacity in peoples' homes
- Redesign of our Inpatient footprint ensuring alternative care pathways within community settings and a reduction in our hospital beds.
- A targeted programme of prevention to divert and substantially prevent need for healthcare through a targeted set of interventions

A number of these will require changes in practice and policies and many will require local, regional and national negotiation and Scottish Government approval to proceed. There may also be the need to secure non-recurring funding sources to support the transition to new models of delivery.

Choices

Significant and radical choices and decisions will require to be made over the lifetime of this plan and these will have an impact on the services we currently provide. While the Board will mitigate the impact as far as possible it must be recognised that our services will feel different for our staff, patients and communities.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

We are committed to involving the public and our partners in the development of options and the decision-making process. It is crucial that everyone using NHS resources understands the context within which we are operating, and that the decisions they (staff, patients, partners and communities) make have a financial impact.

We launched our Time for Change engagement programme in October 2023 which was designed to help get our messages across to our staff and the public. It took place as a series of conversations across the five localities of the Borders over a three month period, allowing both staff and the public to attend drop-in sessions, both in person and online. The themes that emerged from the Time for Change conversations have informed the content in developing this plan, identifying what is important to our staff and public.

The remainder of this delivery plan articulates the national Drivers of Recovery and how NHS Borders will, if we are able to within the resources available, address the priorities outlined by the Scottish Government. At the time of writing this plan there remains a number of uncertainties and therefore planning assumptions have been made and detailed under each driver where necessary. As this plan, along with our financial recovery plan, is implemented levels of commitment and associated performance agreements may require to be reassessed and therefore this plan remains responsive with continual assessment over the coming months.

2024/25 DELIVERY PLAN
Drivers Of Recovery

1	**Primary & Community Care**	Improve access to primary and community care to enable earlier intervention and more care to be delivered in the community.

Delivery of core primary care services

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Primary & Community Care all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Primary & Community Care this equates to in the region of £1.8 million recurring and £0.6 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £5.6 million recurring across the following 2 years.

Across Primary & Community Care key areas of focus will look across the following areas:

- Models of palliative care provision and opportunities for mixed funding sources to ensure quality provision across our communities
- Rationalising NHS Borders sites to deliver a 20% reduction in cost base and mitigate estates risk profile
- Reviewing and redesigning our community hospital inpatient model
- To set longer term workforce strategy in line with a target reduction in headcount
- Exploring digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology
- To divert and prevent need for healthcare by 10% through a targeted set of interventions delivered systemically including social prescribing, network of neighbourhoods and falls prevention/response through enhanced partnership working

It must be noted that as a delegated area of health delivery, these plans will be subject to the consideration and approval of the Health and Social Care Integration Joint Board.

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of

Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

The rest of this section describes areas of progress and aspirations in line with the national recovery drivers. However, given our financial context and savings targets set out realistic boundaries must be placed on expected deliverables, timescales and performance levels as our financial recovery schemes progress.

Primary Care and Community Services (P&CS) will continue the development of its multi-disciplinary teams (MDT). We were pleased to be selected as a Primary Care Improvement Plan (PCIP) Demonstrator Site. This upcoming work will further progress the implementation of both Community Treatment & Care (CTAC) and Pharmacotherapy services to complement our existing MDTs. This recognition affirms our commitment to enhancing primary care delivery in the Scottish Borders. Once scope is agreed locally the programme will run for 18 months taking a quality improvement approach to rollout of the planned changes. This collaboration will involve rigorous evaluation and analysis on the outcomes and effectiveness of PCIP and its contribution to addressing health inequalities by strengthening the overall resilience of all primary care services.

The longer-term sustainability of services is affected by various factors, including the ageing population, retaining equitable access under the limitations of rurality, and the availability and retention of skilled workforce in primary care. We continue to develop a GP Sustainability Strategy to address these challenges and establish a proactive framework that facilitates the sustainability and adaptability of primary care services. This will be an ongoing programme throughout 2024/25 and will be designed within the 10% less cost model that is required.

Ongoing development of Community Treatment and Care (CTAC) services, supporting more local access to a wider range of services.

Following the announcement of the PCIP Demonstrator Funding, the imminent implementation of CTAC services will begin this year. CTAC service will provide patients with access to various sites for testing and treatment room care closer to where they live, work, or go to school. The successful implementation of a fully integrated CTAC service will significantly contribute to the proactive management of long-term conditions. As part of a key enabler for MDTs, the service will be specifically tailored to focus on early intervention- aimed at preventing harm and enhancing the quality of life for patients, for example through better monitoring and collaboration with the Pharmacotherapy service.

To ensure that the impact of our CTAC service implementation is captured effectively, we are committed to working alongside HIS to develop a comprehensive evaluation framework. The framework will enable us to collect and analyse data regarding the effectiveness and efficiency of CTAC service and the impact it will have on other services within both primary and secondary care.

Implementation of the work described above will only be possible following suitable funding allocation as part of the demonstrator site. Any long-term recurring costs associated with implementation will require to be fully funded through this programme and redesign of the service.

Ensuring there is a sustainable Out of Hours service, utilising multidisciplinary teams.

NHS Borders has been reviewing the Out of Hours service and clinical workforce model to ensure we provide a safe, resilient, and effective service for the population of the Scottish Borders within the funding allocation available. Following an option appraisal process, a preferred model has been agreed. The preferred option is to maintain a central Service with an Advanced Practitioner Led Service Model and Collaborative GP On-Call. The implementation of this model is likely to be phased. The first milestone for 2024/25 will be to develop this phasing plan before beginning implementation.

Early detection and improved management of the key cardiovascular risk factor conditions, primarily diabetes, high blood pressure and high cholesterol.

Work is being undertaken to develop ways of better identifying health inequalities within our population. This will require engaging several stakeholders and the development of data dashboards showing where the greatest need is within our population. This in turn will allow targeting of resource to allow efficient early intervention and prevention work.

As health trajectories are set in early life it is important that children and young people, along with their families, are supported to make healthy decisions. Services such as child healthy weight are key in that regard and should be tailored to need. Similarly adult weight services will be required to divert individuals from these pathways later in life. Our health inequalities strategy will identify and develop plans to address early disadvantage including obesity and health risk behaviours. Changes to regional allocation of adult weight management and child healthy weight programmes have necessitated a 66% reduction in service. Whilst service redesign is attempting to mitigate this reduction, the clinical impact will inevitably lead to increased waiting times for tier 3 patents and a reduction in preventative service delivery for individuals accessing tier 2.

NHS Borders will continue to support initiatives such as “Know your numbers” to allow people to make informed choices about their health and will use our position as an Anchor Institution to case find. The formation of a local Food Plan will aid in the management of risk factors for a number of these conditions. We will also incorporate within our Health Inequalities Strategy, primary and secondary prevention methods to address Cardiovascular Disease (CVD), respiratory and other chronic diseases such as diabetes. Ideally, we will need to identify people in the early stages of disease development which underlines the importance of case-finding e.g. for hypertension (“know your numbers”), and successful interventions for overweight and obesity which we will link with peer supported activities of common interest. By aggregating into population cohorts, we will be able to reach

significantly greater numbers of people than through a pure 1:1 individual patient care approach.

Dental Sustainability

Despite access to NHS dentists remaining a challenge, we have seen positive developments with an increase in the number of General Dental Practitioners (GDPs) and therefore improved NHS General Dental Service (GDS) access in Borders. Given this positive increase in GDS access the opportunity has arisen to rebalance the Public Dental Service (PDS). The rebalancing process will involve the transfer of patients that do not have additional needs to a GDP practice. The GDP practice will continue the NHS registration of these patients who will be entitled to the same NHS treatments, at the same cost as when registered with a PDS dentist.

The Public Dental Service (PDS) has for many years supported dental access and has a significant number of routine GDS patients registered with the service. PDS are also impacted by recruitment challenges, with several posts vacant. There is no capacity in PDS to accept further patients for routine GDS care, with priority given to those who fall within the core remit of PDS (patients with additional needs or vulnerabilities). Pressures in GDS have had a knock-on effect on PDS and it will be essential that the service retains the ability to provide care for vulnerable patients who cannot be treated in GDS.

Rebalancing will allow the PDS to focus on the core responsibilities of the service, namely by:

- Improving access by increasing capacity to manage the growing number of unregistered patients presenting with a dental emergency.
- Enabling an offer of a “single course of treatment” to render unregistered patients dentally fit while seeking registration, particularly targeting:
  - people who have presented to the emergency dental service who have treatment needs beyond the acute problem managed in the emergency appointment
  - children identified through the school dental inspection as having severe decay or abscess who are not registered with a dentist
  - children identified at a Childsmile fluoride varnish visit as having a need for dental care and who are unregistered
- Building the Special Care Dentistry function with in PDS to meet the needs of vulnerable and complex patients who cannot be managed in routine general dental practice, ensuring they are able to be seen timeously and promoting early intervention.
- Increasing the focus of PDS on inequalities, meeting our duties under the Equality Act and enabling prioritisation of care of those most in need and at greatest risk of poor oral health.
- Providing opportunities for “shared care” in situations where a patient may be suitable for most of their dental care to take place in general dental practice but with PDS input to support and deliver aspects requiring a more specialised approach.

The recent designation of the whole of NHS Borders for the Scottish Dental Access Initiative (SDAI) is a positive development and over the coming months/years we hope this will attract new practitioners to the area, enable expansion of existing practices and to increase the availability of NHS Dental Care. Recruitment and

retention to the area will be crucial to building capacity within dental services, and we plan to actively promote the Borders as an attractive area to work within the dental profession.

In addition, we are keen to explore innovative solutions to overcome current challenges and would welcome an opportunity to engage in discussion with Scottish Government regarding the potential, for example, of introducing alternative models and incentives such as a “salaried plus bonus” payment model and a review of the recruitment and retention allowance, with a particular focus on retaining the existing workforce.

While dental access is our main concern, we recognise the importance of maximising the oral health of our population to prevent oral conditions which contribute to pressure on dental services and, through their impact on general health, knock on effects on colleagues in the wider health and social care system. The Oral Health Improvement Team will continue to drive local delivery of the national oral health improvement programmes with a focus on reducing oral health inequalities for children and the “dental priority groups”. In addition, we will work across dentistry and with partners to promote and improve oral and general health.

During 2023/24, a Strategic Plan for Oral Health and Dental Services was developed and will be presented to the Integration Joint Board (IJB) for approval in March 2024. This is a 12-year plan to be implemented from the start of 2024/25 and is based on recommendations from a comprehensive needs assessment. The plan will set our strategic direction, guiding longer term planning to improve oral health and develop and build resilience in dental services. It is envisaged that this plan will help steer us through the current challenges and as it progresses will be a vehicle to build on the good work already happening in the Scottish Borders. In conjunction with the plan, there will be a series of 3-year implementation plans produced to support delivery of the high-level objectives.

Non-emergency patient transport services

NHS Borders works with Royal Voluntary Service (RVS), Scottish Ambulance Service (SAS) and our in-house team to provide essential non-emergency transport services. This includes Cancer cars, Dialysis appointments and Outpatients appointments where appropriate. The service is currently carrying a significant cost pressure and we will need to review the scope, scale and delivery of the service to address this. This is a key area of focus to reduce costs and work across our local partners to enable this.

Delivery of hospital-based eyecare

During 2023, we have been in discussions with the Dentistry & Optometry Division at the Scottish Government regarding the roll out of the Community Glaucoma Service (CGS) across Scotland. For Community Optometrists to provide CGS they are required to be Independent Prescribers and must have completed NES Glaucoma Award Training (NESGAT). In addition, practice owners must agree with their employed Optometrists providing this service.

We were unable to deliver this during 2023/24 as there were no Community Optometrists able to progress with the required NESGAT course. During 2024/25 as we are alerted to Optometrists completing their prescribing course, we will make direct contact with them to gauge interest in them undertaking the NESGAT course. Only once we have willing and qualified Optometrists will Primary Care be able to pick up the delivery of CGS in the community.

Community Pharmacy

The implementation of Pharmacy First in NHS Borders has supported management of patients for self-limiting conditions through community pharmacy.

This service supports the patients to self-manage care with access to assessment and treatment for a wide range of conditions such as Urinary Tract Infection, Shingles and Cellulitis. This care can be received in patients' local communities and gives access to treatment without accessing a GP directly or out-of-hours care at the weekend.

We have also seen the evolution of Pharmacy First Plus with community pharmacists training to become independent prescribers, the presence of an independent prescriber in the community pharmacy allows treatment to patients who cannot be managed based on the complexity of their care needs using Patient Group Directions. We expect to see growing numbers of pharmacists providing the service during 2024/25. To harness the availability of this service provision, work needs to be done to develop care navigation where patients are shared between their GP and community pharmacist.

2	**Urgent & Unscheduled Care**	Access to urgent and unscheduled care, including scaling of integrated frailty services to reduce admissions to hospital.

Ensuring patients receive the right care in the right place by optimising Flow Navigation , signposting and scheduling of appointments to our Front Door where possible and increasing the routes for professional-to-professional advice and guidance with a specific focus on frailty pathways and care home support. Improve urgent care pathways in the community and links across primary and secondary care.

This area remains a key pressure point both in terms of service delivery and financial cost. The Borders General Hospital continues to operate significantly out-with its funded bed base due to patients experiencing higher lengths of stay associated to treatment, and a corresponding increase in the length of stay for many patients waiting for social care provision. This has a detrimental impact on Planned Care delivery.

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Urgent & Unscheduled Care all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Acute Services including Urgent & Unscheduled Care this equates to in the region of £3.1 million recurring and £1 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £7 million recurring across the following 2 years.

Across Urgent & Unscheduled Care key areas of focus will look across the following areas:

- Models of palliative care provision and opportunities for mixed funding sources
- Explore opportunities for regional and national services
- Redesign the front door to introduce a flow navigation senior decision maker model which directs patient flow from SAS/Care Home/Falls/GP Expect onto the correct pathways including service signposting to deliver productivity gain within set resources
- Explore options to develop hospital at home and virtual capacity in order to reduce inpatient hospital based beds
- Closure of all unfunded surge beds
- To set longer term workforce strategy in line with a target reduction in headcount
- Explore digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology
- To divert and prevent need for healthcare by 10% through a targeted set of interventions delivered systemically including social prescribing, network of neighbourhoods and falls prevention/response through enhanced partnership working

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

The rest of this section describes areas of progress and aspirations in line with the national recovery drivers. Given our financial context and savings targets realistic boundaries must be placed on expected deliverables, timescales and performance levels as our financial recovery schemes progress.

In 2023/24 work has been developed in preparing the conditions for change: establishing pilots, building cross-boundary relationships and building staff engagement towards a period of more significant and sustained change. In preparation for 2024/25, we have reset our Urgent and Unscheduled Care Programme Board which will have a targeted approach to delivering change both in terms of service redesign and financial improvement. At the end of this year with the measures we are putting in place, we believe that we will see improved flow through our hospital, improved navigation with the aim of getting more people to the 'right care, right place, right time' and an improvement in our prevention of admission and early supported discharge.

The out of hours workforce model has been agreed and progression of the implementation plan has commenced. This will provide a multi professional workforce delivering advanced practice supported by onsite and remote GP. This is a significant part of the redesign and transformation work planned for 2024/25. Outcomes from implementing this new workforce model include providing a more sustainable GP workforce alongside providing a platform for staff development across all disciplines.

The Flow Navigation Centre in the out of hours is well established and with the appointment of a Strategic Lead for Urgent and Unscheduled Care will enable us to consider other opportunities to extend this beyond the current scope. The scope of our Urgent and Unscheduled Care Programme Board is exploring a collaborative approach to displaced pathways which include: acute assessment for GP referrals to Medical, Surgical and Gynaecology and Medical Ambulatory Care. The primary focus of this work is to consider how to consolidate these pathways to generate sustainability over the short to medium term (3-5 years). In delivering this model it is anticipated that as much as 20-25% of Emergency Department (ED) activity could be redirected to urgent (not emergency) care pathways. If successful, and sustainably staffed, this will in turn reduce overcrowding/congestion in the ED

department and support improvement against handover times, delays to care and patient experience. Centre for Sustainable Delivery (CfSD) benchmarked 2022 data shows that care home attendances to ED per 100k population ranged from 195 per 100k in Aberdeenshire, to 680 per 100k in the Scottish Borders, with the median point being 419 per 100k in West Lothian. As part of our 'Front Door' focus we will develop an understanding of how flow navigation could appropriately support a reduced attendance rate. Work is also being undertaken to focus on admission reduction under our Health & Social Care Partnership (HSCP) Strategic Care Home Oversight Group.

Improving access to Hospital at Home services across a range of pathways including OPAT, Respiratory, Older People, Paediatrics and Heart Failure.

Hospital at Home

The Hospital at Home pilot launched in April 2023. It has an inclusive patient criterion encompassing all adults over the age of 18, primarily residing in the central area of the Scottish Borders. The programme is versatile and skilled in overseeing various conditions, including (but not limited) to Outpatient Parenteral Antibiotic Therapy (OPAT), Heart Failure, Frailty and General Older People related illness. In its development, the service has also managed to provide some respiratory care (separate to Virtual Respiratory Ward) via ad-hoc support from the Respiratory Specialist Nurses. Our Hospital at Home Test of Change gained national recognition for its exemplary collaboration, methodology, governance, data collection and rapid implementation.

Whilst still in its testing phase, the benefits of the service have been observed by measuring the impact on:

- Contributing to reducing delays across the entire system
- Avoiding unnecessary hospital admissions
- Reducing length of stay
- Additional discharge pathway leading to increased flow through Borders General Hospital (BGH).

Hospital at Home is also currently collaborating with the Respiratory Virtual Ward service (see below) team to ensure best practice is aligned and that both services are providing the best care for patients being treated in the community during the period of testing and developing each model.

Whilst benefits have been seen national funding for the service is due to finish at the end of June 2024. A business case setting out the options for the future of the service is going to the IJB in March 2023. In the current financial climate this will only be affordable if the case is made for the closure of Inpatient beds and the transfer of resources into the Hospital at Home service or towards financial savings given the significant deficit position.

As hospital occupancy levels remain high associated to increased levels of need in our system, and as we need to deliver this service by shifting existing financial resource, in our current financial environment we are exploring whether we can afford to continue with the pathfinder within an extremely challenging financial

context. If non-recurring resource can be identified to support a year of testing at scale our Virtual Respiratory Ward (RVW) and Hospital and Home would come together in an integrated service model and opportunities for further alignment to localities and community nursing teams would be maximised.

Respiratory Virtual Ward

Following a successful bid for non-recurrent monies from Scottish Government, the respiratory service team developed the infrastructure and pathways for a respiratory virtual ward by using remote monitoring equipment supplied through a third-party company – Current Health. NHS Borders are the first Board in Scotland to utilise this equipment in this way. Following rapid planning and development, the virtual ward became operational on Tuesday 23rd January 2024. The respiratory virtual ward has 10 beds available. We remain on trajectory to offer five additional beds by the end of February, increasing to 15 virtual ward beds in total. Achievement of 20 virtual ward beds in March will be dependent on the ability to cover current gaps in the clinical rota during this period. We have also submitted a further order to purchase additional remote monitoring kits, which were costed in the proposal submitted to SG.

The virtual ward team are now working more closely with Hospital to Home. A key area of focus in 2024/25 is our 'Joint capacity model for virtual hospital at home which will evaluate the feasibility of a combined hospital at home and virtual respiratory offering. The current funding for the RVW test of change is only adequate to support operation until end of March 2024. Extension of this service will need to be linked to the Business case for the extension of virtual Hospital at Home capacity and the linked reduction in Hospital beds.

Optimising assessment and care in Emergency Departments by improving access to 'same day' services, the use of early and effective triage, rapid decision-making and streaming to assessment areas.

A key area of focus in 2024/25 is our 'Front Door'. Our work-packages will include signposting and the development of robust urgent care pathways (those pathways previously displaced during the pandemic). The work will seek to separate urgent from emergency care to decongest the ED and will include the option of single point of referral. This has already shown to reduce the ED attendances by ensuring patients are signposted to the right care, right place at the right time. This service will be provided by a senior clinical decision maker, but long term sustainably is dependent on funding.

Reducing the time people need to spend in hospital, increasing 1-3 day admissions and reducing delays over 14 days, by promoting early and effective discharge planning and robust and responsive operational management.

The Integrated Discharge without Delay (DwD) Programme Delivery Group takes a whole system approach to identify key areas of improvement through parallel and collaborative working across our Health and Social Care Partnership to implement Discharge without Delay.

The Programme Delivery Group aims to:

- Standardise the processes and practices of Discharge without Delay
- Educate all staff on the principals of Discharge without Delay
- Agree data set for monitoring and associated reporting periods
- Develop the appropriate governance for the scrutiny, challenge and supportive discussion to improve effective discharge;

Locally we have also invested a significant amount of quality improvement time in developing our Discharge Kaizen, and there are lessons from this that are part of our 2024/25 improvement plan. In addition, there have been three national self-assessments against the agreed DWD principles. The learning from these assessments is considered in line with local approaches around Plan Do Study Act and test of change cycles - such as a recent test of change in Ward 9 around board round principles and effective real time decision making, referrals and Trak. This year we will be developing a Target Operating Model for Discharge that will help us to target further areas for improvement including live updating of the patient database – Trak, further promoting weekend and pre-noon discharges and ongoing focus on Planned Date of Discharge (PDD) and DWD within ward Huddles.

Discharge folders are now live on wards to support the Multi-Disciplinary Teams using the Discharge without Delay principles when planning for discharge.

With the above work, the delivery group aim to continue the roll out of education on Trak to ensure that PDD is correct on the patient system. This will support accurate recording at clinical board safety briefs and in turn give us an overview of the whole system discharges.

Embedding the DWD principals from admission gives teams better time to plan for discharge and engage with other teams, such as the Discharge Team and Pharmacy. Reducing duplication of referrals, ensuring that all areas are following the same processes will enable us to promote pre-12 discharges which we know are important to support flow within all sites across NHS Borders.

A National Day of Care Audit (DOCA) is being discussed for late April. However further to discussion with the Discharge Team and the National Lead there is a local appetite to utilise NHS Lanarkshire's Criteria to Reside to better understand internal processes and identify patients who meet the criteria to reside an acute ward. This will be trialled by a member of the management team and discharge team on one ward initially to fully understand the process and benefits.

Local Discharge Events are being organised to support the engagement with staff with DWD and to run through patient scenarios. Topics that will be covered are:

- Effective conversations to support discharge planning
- Patient pathways and how they link with Strata
- Understanding Delayed Discharges
- Moving on Policy

These will be delivered as 1 hour bite size sessions as the Planning Group understand current staffing pressures. A slide pack will be developed with QR code links to documentation as well as printed versions of information for staff.

Work is also underway to optimise pathways for patients who have had a stroke or fracture. We recognise that length of stay has increased in inpatient areas caring for these patient groups because of poor flow into downstream care and rehabilitation settings. This work is aligned with our community hospital planning and work to build our capacity in home first provision for reablement and early support discharge.

Reduce unscheduled admissions and keep people's care closer to home through reconfiguring existing resource to accelerate rapid assessment and evolve to implement Frailty Units.

Currently, the Borders General Hospital is operating a non-acute ward which has been established to support care of those patient whose discharge is delayed and who would ideally be cared for in the community by social care. This has reduced the overall Department of Medicine of the Elderly (DME) acute footprint. Early consideration needs to be given, as part of our Elderly transformation work, to the long-term approach to these beds.

Exploration of the feasibility of a Borders-wide Health and Social Care Partnership Integrated Reablement Service, which combines the NHS Borders Home First Team with the Scottish Borders Council Adult Social Care is ongoing. The purpose of this work is to improve outcomes for people, reducing care at home packages and enable people of the Borders to remain independent at home. This in turn reduces admissions into the Acute hospital and supports discharges. An implementation plan is being developed and we will continue to monitor progress. This work needs to be progressed in the context of the scale of delays in the system, as well as the unsustainability of the Health investment in this service.

Within the Acute setting AHP services support frailty assessment with dedicated short stay input through the Rapid Assessment and Discharge (RAD) team within ED and Medical Assessment Unit (MAU). This holistic AHP assessment seeks to reduce length of stay, facilitate discharge and prevent admission from ED when possible. Community AHP services are reviewing current service structures to develop a locality approach to service delivery, working closely with colleagues across the statutory and non-statutory elements of our HSCP. This will enable a single point of access, reduce service duplication, and make best use of staff resource.

A Public Health approach across AHP services will be crucial over the next 5-10 years. Focussing on a preventative and early intervention approach by seeking to reduce the impacts of frailty within our communities by promoting physical activity, healthy nutrition, and mental wellbeing. We will partner with third sector and community groups to promote a health improvement approach across the Borders. Workforce and financial constraints are key limiting factors to our ability to get upstream.

National workforce challenges continue to limit AHP services ability to deliver across all clinical areas and ongoing work to review workforce structure, skill mix and service delivery models is underway.

3	**Mental Health**	Improving the delivery of mental health support and services, reflecting key priorities set out in the Mental Health and Wellbeing Strategy.

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Mental Health all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Mental Health this equates to in the region of £0.6 million recurring and £0.2 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £1.5 million recurring across the following 2 years.

Across Mental Health key areas of focus will look across the following areas:

- Review the mental health bed base and optimise inpatient processes to reduce operating costs.
- Opportunities for colocation of services and rationalisation of sites; potential shift in regional/local service provision.
- Rationalising NHS Borders sites to deliver a 20% reduction in cost base and mitigate estates risk profile
- To set longer term workforce strategy in line with a target reduction in headcount
- Explore digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology
- To divert and prevent need for healthcare by 10% through a targeted set of interventions delivered systemically including social prescribing, network of neighbourhoods and falls prevention/response through enhanced partnership working

Again, as Mental Health services are delegated to the Integration Joint Board (IJB), these plans are subject to approval by the IJB.

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person centred approach.

The rest of this section describes areas of progress and aspirations in line with the national recovery drivers. However, given our financial context and savings targets set out realistic boundaries must be placed on expected deliverables, timescales and performance levels as our financial recovery schemes progress.

It is worth noting that a significant level of funding for mental health services has come from national funding allocations, including in the region of 17-20% of the service being non-recurrently funded. In the context of our current local financial constraints, with additional challenges relating to reductions in national funding allocations for mental health, this does significantly increase the risk to mental health service delivery.

Improving Access to Mental Health Services

Child and Adolescent Mental Health Service (CAMHS) continues to look at new ways to improve access by children and young people to the service it provides. These improvements have and will include career development structures within nursing, psychology and psychiatry with a focus on clear patient flow designed to meet the broad range of needs for referred patients to the service. Stakeholder engagement both formal and informal will continue to be established within the service this will enable the service to reach a wider audience and work in co-production.

Establishing the service as multiagency working with colleagues in SBC and third sector organisations will also improve access to the service. Close links with school nurses and working collaboratively with Borders College has forged links to enable more children and young people to access the CAMHS service. CAMHS has significantly reduced its longest waits for referral to treatment as well as the overall number of patients on the waiting list. Future planned activity includes:

- Improving the referral quality to the service. This will be achieved by a Borders wide roll out of a school referral route for neurodevelopmental queries. The new referral template is continuing to benefit the service and the pilot continues to support if any interventions can be established prior to the first appointment.

- Expanding the range of support materials and integration with other communication platforms. Development of an in-house Urgent Emergency/Intensive Home Treatment Service (ITS).

- Working with colleagues across Scotland to support and deliver an Out of Hours (OOH) CAMHS service provision.

- Working with colleagues across Scotland to examine inpatient services acknowledging that access to specialist young person beds continues to be challenging placing demands on the adult acute inpatient service.

Key priorities in relation to CAMHS Specifications include continuing to carry out new patient assessment appointments with a focus on reducing the Referral to Treatment Time (RTT). Historically CAMHS within NHS Borders has reported both

core mental health patients (CAT 2) and Neuro-developmental patients (CAT 1) waiting over the 18 weeks Heat target as combined data for publication in national returns. CAMHS now report specifically on the core mental health data. This is in line with guidance and the approach in other health boards in Scotland. The current projected trajectory will meet the 90% Referral to treatment target by the end of February 2024 with plan in place to continue to meet the 90% target moving forward.

The delivery of Psychological Therapies in Scotland has an 18-week referral to treatment Heat target (RTT) / Local Delivery Plan (LDP) access standard of the wait from referral for psychological therapies and intervention to treatment of a maximum of 18 weeks.

The key focus areas across psychology services in order to support meeting the HEAT/LDP target are:

- Develop standard operating procedures clear rules consistency and effective administration
- Improve flow and timely treatment and meet the Heat target
- Improve the patient journey through psychology services to work in a more joined up way to provide better access and fewer barriers
- Recruit and retain staff creating a positive, attractive service
- Establish an eCBT digital team
- Support well-being growth professional development for everyone working in psychological services
- Coproduce with people with lived experience
- Review services in line with Scottish Government Psychological Therapies (PT) PT specification document 2023
- Lead trauma informed training and development across the Borders

Psychology services in NHS Borders continue to review demand and capacity to respond to changes in demand for the service and to ensure we can offer treatment to those referred to the service within 18 weeks. Part of this exercise is to identify backlogs and ensure services are resilient, with as few barriers as possible. This is especially relevant as due to the current national recruitment situation, financial and workforce challenges such as vacancies, reductions in core staffing and identified gaps in services.

Each speciality within psychology services is working to ensure they have appropriate skill mix and staffing to ensure the delivering of evidence-based interventions in an efficient, safe and cost-effective manner.

We have undertaken trajectory modelling for 2024/25; this is updated on a regular basis to reflect changes in staffing and service demand. We anticipate our

performance against the PT Heat target will average 80% in the next financial year with a range of 67-87%.

As noted above, due to the financial challenge facing NHS Borders, all services are reviewing their budgets with a view to a reduced financial envelope going forward and this includes CAMHS and Psychological Therapies. As result of this we are not able to invest in any new posts or alleviate any gaps. If enacted, it is likely core services will be impacted in terms of service provision and waiting times.

Tackling Inequalities in Mental Health

There are plans underway to review current services in line with strategies and the forthcoming secondary mental health standards to improve the delivery of mental health services within NHS Borders. This will involve redefining pathways into and within our services to ensure they meet needs of patients and carers. The identified areas for reviews are our working age adult services, older adults' services, medical workforce and commissioned services. The reviews will include a review of workforce and demand to ensure we are meeting required standards and maximising workforce capacity.

In addition, in line with local savings plans where there is a change to policy or practice, we are legally required to undertake an Integrated Impact Assessment (IIA) to understand and best mitigate social and health inequalities. For areas where there have been national reductions in funding (e.g. mental health), it would be helpful to have a copy of the national IIA so as to help frame our local discussions around the IIA.

One area identified in our scoping exercise has been access to services to ensure that our services have clear treatment pathways and referrals that come into service that are appropriate and timely. Having the correct access should prevent unnecessary waits or delay in referrals. This has included directing those whose needs will not be best met by our services to alternative sources of support.

We are working closely with social care and third sector agencies to map out mental health services that are available with aim of supporting more people in the community, including adults concerned they may have neurodevelopmental disorder who are no longer being assessed within the adult mental health service unless additional secondary care mental health criteria are met. This is in line with our individualised approach to values based health and care.

Within our mental health rehabilitation service, we have introduced grade 5 supported accommodation, defined as Intensive community rehabilitation, providing early discharge from grade 6 or an alternative to admission. This has increased the capacity of our service through integration with social care and third sector and will continue to develop so we can support those with complex needs in the community.

Primary Mental Health Teams

In October 2020 the Renew primary care mental health service was established using a combination of funding from Action 15 and the PCIP. This service, for those

aged 18 and over was developed in partnership with GP's and psychology services and offers a range of evidence-based interventions for mild to moderate anxiety and depression. A centralised model was agreed as a "one stop shop – see and treat model" and this has worked well in the Borders. Since its establishment, demand has grown strongly to an average of 300 referrals per month.

Renew works closely with other services in primary care including those developed/developing under the PCIP. We are considering how referrals between Renew and the secondary care mental health service can be improved to ensure patients access the right service in a timely fashion. We will be reviewing the service this year as part of the review of psychology services with the aim of ensuring that the service is continuing to meet the needs of primary care, is as productive as possible and that pathways to step up those who need secondary care intervention are as seamless as possible. No major expansion is planned due to funding constraints.

Forensic Mental Health Services

NHS Borders does not serve a prison population or have secure accommodation under our service. Our Forensic Mental Health care is all provided either in the community or is in partnership with external providers. Our previous provider has withdrawn from their Service Level Agreement and we have no in-house access to specialist Forensic Psychiatric expertise for our adult service, where absolutely necessary we require to commission externally, and within the Learning Disability (LD) Service this is provided by a 'generic' LD consultant.

When required we work closely with partner agencies to appropriately plan and deliver a person-centred repatriation model for people who, for forensic care, have been placed out of area but remain under our care. We can access ad-hoc telephone advice only from Lothian.

We are working with Police Scotland, Scottish Ambulance Service (SAS), Mental Health Officer's (MHO's) and other partners to update our Psychiatric Emergency Plan to reflect and include the recommendations identified in the Ending the Exclusion report.

Mental Health Workforce

We have developed senior leadership teams within all our services across mental health, this was done to improve our governance structure and workforce involvement. The remit of the senior leadership team is to be proactive in managing strategic issues and to have a focus on objectives to ensure the workforce plays a part in the strategic planning process. We are holding in-house careers and Clinical Professional Development (CPD) events to strengthen and develop our workforce to assist with challenges with recruitment and retention of staff.

There is an overall deficit of fully trained, substantive consultant psychiatrists across our services. In some areas there is heavy reliance on agency locums, some of whom do not hold a CCT (full training as a consultant doctor), in order to allow continuity of service. This is particularly significant in the adult service where discontinuity of medical leadership has affected our teams over a prolonged period.

A medical workforce plan seeks to expand non-consultant level medical staffing, creative use of wider Multi-Disciplinary Team (MDT) roles and to support consultants in taking on larger areas of responsibility. There are limited levers to additionally recruit to NHS Borders or to retain doctors who are relied upon to cover gaps.

Quality & Safety Challenges

There are ongoing challenges with the Mental Health Estate in relation to:

- CAMHS accommodation
- Borders Addiction Service (BAS) accommodation
- Access to appropriate community clinic space
- Accommodation for the Veterans First Point (V1P) service

Utilising the Scottish Government grant for improving Mental Health Estates, we have now identified suitable alternative accommodation for V1P. Work continues to look at alternatives for additional clinical space and CAMHS accommodation.

NHS Borders has also commissioned a review of the Mental Health Estate including space requirements and surveys of existing sites to support planning moving forward. In the current financial context, we will scope the potential to rationalise our mental health estate.

Learning Disabilities

There are currently <5 people with Learning Disabilities (LD), located outside of the Scottish Borders, delayed in out of area hospital placements at an extremely high cost of circa £2.3million per year for the care and support.

The LD Service commissioned Lives Through Friends to lead the assessment and commissioning process, thereby enabling the individuals to return to Scottish Borders in line with the Coming Home Implementation report and live closer to family and friends within robust models of support. This option is anticipated to cost considerably less, at circa £1.2m per year. It is likely this will take a long time and whilst better for patients may cost in the short term.

4	**Planned Care**	Recovering and improving delivery of planned care

Delivering year on year reductions in waiting times and tackling backlogs focusing on key specialities including cancer, orthopaedics, ophthalmology and diagnostics.

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Planned Care all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Acute Services including Planned Care this equates to in the region of £3.1 million recurring and £1 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £7 million recurring across the following 2 years.

Across Planned Care key areas of focus will look across the following areas:

- Explore opportunities for regional and national services
- To set longer term workforce strategy in line with a target reduction in headcount
- Explore digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

In alignment with our Planned Care Template response, our commitment to achieving results, particularly in relation to cancer performance and improving our 23 hour stay facilities in order to increase throughput will rely on waiting list funding as committed in previous years. Without this financial source will significantly impede our Treatment Time Guarantee (TTG) performance in these areas and have a potentially detrimental impact on the outcomes for our patients.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

The rest of this section describes areas of progress and aspirations in line with the national recovery drivers and should be read in conjunction with our planned care template response. However, given our financial context and savings targets set out realistic boundaries must be placed on expected deliverables, timescales and performance levels as our financial recovery schemes progress.

During 2023/24 the number of patients waiting for more than 1 year for an outpatient appointment steadily reduced. We have eliminated 2 year waits in all specialties and have less than 18-month waits in all but a small number of problematic services. A significant majority of service will be working to a maximum routine wait of no more than 1 year by 31 March 2024.

We have seen activity levels recover gradually during the year and are now consistently delivering activity at or above 90% of pre-pandemic levels. Capacity issues in 2-3 high volume outpatient services, related to ongoing vacancies are holding back full recovery. These Specialties will remain an area of specific focus for innovation and redesign during 2024/25.

This includes a focus on new and review activity in Outpatient Ophthalmology, and a continuing focus on maintaining accelerated access for our most urgent referrals including cancer. While access has remained good for those on cancer pathway, we are seeing both an increase in suspicion of cancer referrals and consequently urgent waits. This in turn is putting pressure on diagnostic capacity and cancer performance.

We are reviewing referral data to understand the rate of subsequent cancers identified. Where there is no correlation between increased referrals and identified cancers, we will look at our referral guidance and vetting process. Utilising information provided via Specialty Delivery Groups we have started a review of both Breast and Urology/prostate pathways in the first instance.

Services are currently exploring different workforce models to increase capacity, i.e. Ophthalmology is currently training technicians and nurse specialists to take on new roles.

For the Inpatient TTG we are seeing a growth in the total number of patients on our waiting lists, while at the same time seeing a reduction in those waiting for more than 1 year. Longer waits of more than 2 years are proving persistent and this is related to prioritisation of urgent and cancer pathways, and bed capacity issues. We took steps in 2023 to move our short stay surgical unit to protect elective capacity. However, elective inpatient beds continue to remain under significant pressure due to delays across the health and social care system and unscheduled demand. Work will be undertaken to reduce those who have waited more than 2 years by March 2024, and we plan to eliminate these during Q1 2024/25 with the support of our Short Stay surgical unit.

We will continue to see waits of 18+ months reducing during 2024/25 but we are unlikely to see these eliminated in total given the priority we will continue to give to those on cancer pathways. We are also likely to see TTG waiting list numbers increasing as we recover outpatient and cataract waits. We have increased capacity in cataract surgery by 50% through a combination of productive improvements and targeted waiting lists funding investments and have also secured an increase in

funded National Treatment Centres (NTC) capacity for cataract surgery from 400 to 600 cases in 2024/25. We recognise that given the financial context in which we are operating, this may mean we need to make different choices in the use of waiting times monies. We will seek advice from Scottish Government on our approach via our parallel Planned Care submission.

Enabling a "hospital within a hospital" approach in order to protect the delivery of planned care.

A proposal to ring fence existing elective beds (nominally 16 beds) was developed and approved during 2022/23 with a planned investment of £350k from our recurring waiting times allocation. This has proved challenging to implement during 2023/24 due to the increase in delays across our care system and the increase in risk to unscheduled flow associated with a reduction in available beds.

Without dedicated and protected capacity, we have over the last 12 months seen 3% (100 cases) of scheduled procedures cancelled at short notice due to bed capacity issues. Many of these cancellations have been in our orthopaedic and urology services where we continue to see long prospective waits for routine inpatient/short stay procedures.

A proposal to amend existing plans and create a 23 hour or short stay elective unit will be considered as part of planning for elective capacity during 2024/25. This would increase the level of required investment to £630k but would mitigate risks associated with a reduction in overall bed numbers while improving pathway consistency and elective capacity. We are aiming for an overall increase of 10% (300 cases) in list productivity via a higher number of scheduled procedures given improved capacity and removing avoidable cancelations. At the present time this is unaffordable within our Financial plan and therefore we may not be able to support this investment.

This will complement work being undertaken to improve the prospective length of stay for fracture patients. Initial scoping work started in Q3 2023 and will continue during 2024/25 with the objective of recovering an elective bed footprint sufficient to support planned orthopaedic inpatient surgery.

Maximising capacity to meet local demand trajectories.

Alongside plans for an "elective hospital within a hospital" and proposals to increase bed capacity, we will continue improvements in respect of overall theatre capacity and productivity as part of our "Making Theatres Great" programme. During 2023/24 we have seen available operating capacity increase by 24% when comparing elective operating sessions in Q3 2023/24 with capacity for the same period from the year previous.

This increase is associated with our theatre workforce recovery plan, and we will see a further capacity increase during Q4 of 15%, or 4 elective sessions a week. That will bring NHS Borders up to pre-pandemic capacity levels.

Alongside this we have also seen a corresponding increase in both completed surgeries and cases per operating session. This equates to an increase of 34% in

activity and a movement from 2.0 cases per sessions to 2.13 comparatively for the same Q3 period. We will see overall activity during 2024/25 at or even above comparative levels delivered during 2019.

There will be a continued focus during 2024/25 on improving list scheduling and improving session productivity. Implementing a short stay ward on the BGH site will open further improvements on both day case and short stay pathways and improve confidence in scheduling additional cases. There will also be renewed focus on process improvement, specifically list start times and turnaround times between cases on lists.

As noted, we are anticipating a further 10% improvement in productivity in 2024 once we have improved access to inpatient capacity and resolved intraoperative delays consequently. It is currently projected that this will reduce long waits but will not reduce the overall number on our waiting list, because of increased patients converting from our increasing Outpatient activity.

Match outstanding demand with available capacity across Scotland through regional and national working including through the National Treatment Centres (NTCs).

NHS Borders has been working closely with NTC's and the National Elective Coordination Unit (NECU) to improve access and resolve some persistent and underlying backlog and capacity issues. During 2024/25 we will:

- Increase capacity for Cataract Surgery, Arthroplasty and General Surgery at the Golden Jubilee National Hospital for 2024/25. We have also secured capacity for colorectal surgery given some capacity issues associated with prospective cover.
- Continue with additional support received via NECU for skin cancer/lesions removals. We are exploring additional support for Vasectomies for 2024/25 given local capacity issues.
- Further support for administrative and patient validation for long waiting outpatients, and review appointment backlogs. This has worked successfully during 2023/24 and we will engage on further list validation on high volume lists during 2024/25.

Detailed demand and activity profiling has been undertaken for all outpatient and Surgical lists. This will be supplemented with a review of expected capacity as the basis for detailed performance management and productivity improvement planning as we move into 2024/25. While we have recovered back to or above pre pandemic activity levels in most areas, there are a small number of specialty area (Orthopaedic outpatients, Ophthalmology outpatients, Dermatology and Cardiology) where recovery has proved sticky. These will be areas of initial focused work during 2024/25.

Extending the scope of day surgery and 23-hour surgery to increase activity and maximise single procedure lists.

We have reviewed theatre schedules and where possible moved to single specialty all-day operating lists given the productivity gain this promotes though list continuity.

Additionally, we are exploring scheduling tools that promote a more evidenced based approach to time/procedure-based list allocations.

Alongside proposals to implement a short stay surgical ward we will also undertake a comparative review of elective length of stay data to ensure our pathways are consistent with best practice nationally for post operative recovery.

Urology and Breast Surgery are areas that have been highlighted for particular attention once we have our short stay unit approved and open.

Implement outcomes of Specialist Delivery Groups including reducing variation.

Generically across all specialty groups are the endorsed outpatient initiatives/toolkit, including Active Clinical Referral Triage (ACRT), Opt In and Patient Initiated Review (PIR). There is currently a Standard Operating Procedure in place across all specialities. General Surgery and Ear, Nose & Throat have implemented Opt-In pathways and Orthopaedics are in the planning stages to implement 3 Opt-In pathways in Q1 & 2. All specialties, to varying degrees, have implemented ACRT and PIR. Focussed work based on Heatmap and local data is being progressed and will continue in early 2024/25.

The Urology, Ophthalmology and Orthopaedic Peer Recommendations are currently being developed into local action plans so that the services can prioritise based on high impact changes. The Board welcomes the regular support of the Peer Support Teams. Clinicians and operational managers will continue to attend the national specialist groups to listen to new practice and share ideas.

Linking to the national pathways, we have also recognised that we have a local gap in good referral information for primary care colleagues and there will be a collaborative piece of work with primary and secondary care ensuring good referral information is available with the pathways and set referral criteria. Recent agreement has been sought from Right Decision Service (RDS) to host NHS Borders RefHelp under our work on Value Based Health and Care.

Undertake regular waiting list validation

NHS Borders has established routine administrative validation of new outpatient waiting lists, and this includes regular communication with those on waiting lists to ensure that only patients requiring an appointment are offered this.

Alongside this, NHS Borders will review referral management and clinical vetting systems during 2024/25 with GP partners to ensure only patients who meet specific criteria for secondary care assessment are referred, and the quality of referral information allows for virtual assessment/management where appropriate to support appropriate prioritisation and rapid assessment.

We will also undertake administrative validation of those on review lists following a pilot review of Respiratory Medicine undertaken during 2023/24 that demonstrated the potential for significant benefit in terms of managing and mitigating risks given backlogs in these appointments. This work will be scoped and a target approach to

benefits in key specialty areas taken. As previously mentioned, this will include a review of treatment pathways (where available implementing Specialist Group agreed pathways). Services (such as cardiology) continue to experience long waits for routine and urgent outpatient appointments. The service has recently successfully recruited a permanent third consultant who will take up post in 25/26. This will bring much needed stability to the service. We are also looking at improvements across the heart failure pathway with specific focus on referral into Echo. This improvement has been worked through in collaboration with primary care; The aims of the referral process would be a single referral from primary care that will give sufficient information for physiological medicine to book the echo, but also contain the patients' background history and medication, so that if the patient does subsequently require onward referral into cardiology, there is no delay in required information to treat.

We are continuing to book long waiting surgical patient “in person” to ensure that procedures are still required by patients, and that reassessment or reviews are undertaken where there may be uncertainty. We are seeing this reducing avoidable cancellations, and we will develop this approach into 2024/25 alongside reminder services. We have instigated a management review of all avoidable cancellations to ensure that systems are adapted to ensure issues are identified early and adjustment made to avoid losing capacity.

NHS Borders is also scoping the implementation of electronic patient communication systems to improve appointment scheduling efficiency. This initial scoping work will be completing with an assessment of likely benefits established and a timescale for implementation considered.

Delivery of CfSD / NECU waiting times initiatives and productive opportunities

There has been a specific focus on improving performance in respect of our cataract pathway. This pathway includes some of our longest waiting elective patient. With support from CfSD we have moved to clinically vetting cataract referrals directly to surgical waiting lists, and pre-assessing patients to coincide with planned surgery. This avoids pre-assessments becoming obsolete while patients are waiting and requiring a second assessment pre-operatively. This is a more efficient pathway and increases capacity overall.

During 2023/24 we have moved from an average of 5 cataract patients on a cataract specific list, to a group average of between 6-7 cases per list, and for one surgeon we are routinely achieving 8 cataracts on planned lists. We will continue to work during 2024/25 to move to a group average of 8 primary cataracts per list. We are also planning to move to some bilateral surgeries which will increase session productivity further. This is not likely to be introduced until the end of Q2.

We have worked closely with NECU on the administrative and patient validation of the longest waiting outpatients, this achieved a 10% removal rate for those included. We will engage with the NECU team in 2024 to undertake a similar validation in support of a review of those on review waiting lists.

We are working closely with CfSD on Endoscopy productivity, validation and innovation. This has included systems that support the administrative validation for those on surveillance lists, the use of Cytosponge in ongoing assessment for

Barretts Oesophagus patients, colon capsule technologies. Computerised Tomography (CT) colon referral guidance, and the use of Quantitative Faecal Immunochemical Tests (qFIT) for surveillance list management and assessment where appropriate. We will continue to work alongside CfSD to manage capacity as effectively as possible given ongoing capacity challenges.

Our focus will be on demand/referral management with clinical pathways and robust validation.

Optimise theatre utilisation and implement digital solutions

As described above, NHS Borders has a well-established theatre productivity and improvement programme. This has delivered significant improvement during 2023/24 and there are further opportunities scheduled in 2024/25.

We are trialling electronic systems in support of scheduling and their overall cost effectiveness will be determined during 2024/25 and a decision on value established to see if a recurring investment would be justified.

5	**Cancer Care**	Delivering the National Cancer Action Plan (2023-2026)

NHS Borders is reviewing our cancer strategy in line with the requirements outlined in the national care action plan and current performance challenges in respect of both 31 and 62-days targets. This will need to be considered within the context of available resources, both current and any additional support that may be available in future.

In common with most Boards, the Prostate pathway is particularly challenging in NHS Borders, and we are working to improve this. Pathway co-ordination and capacity for Prostate Biopsy have been issues for us during 2023 and we are planning to extend capacity for these during 2024 through the recruitment of a local Consultant Urologist.

We will continue to work with our Diagnostic teams on plans aimed at addressing underlying capacity issues in both CT and Magnetic Resonance Imaging (MRI). There is currently a reliance on additional staffed mobile capacity to support waiting times consistent with cancer pathways and this is not financially sustainable in the long term. We are developing plans that demonstrate we are maximising value from our investment in existing equipment and provide best value in addressing any residual capacity requirements. This is likely to include proposals for further capital investment in equipment at some point in the future.

We are working with Gastrointestinal (GI) and Surgical teams on proposals aimed at increasing operator capacity for both Upper Gastrointestinal Series (UGI) and Colonoscopy. The longer-term sustainability of both new urgent and surveillance waiting times is dependent on a sustainable work force plan that addresses existing capacity issues.

Colonoscopy waiting times particularly impacts on reported performance against the Colorectal pathway, and we will continue to run weekend lists in the interim to maintain these waits.

The Dermatology service is under significant pressure at present due to vacant Consultant posts, and this will impact on the Melanoma pathway. We continue to work with the service to ensure that this runs as well as possible within the current constraints.

Other pathways, including Breast and Lung, generally run well in Borders and during 2024/25 we will work to ensure that this remains the case.

We have one Nurse Specialist undergoing training in Endoscopy, which we expect to be completed by the end of 2024. This will be supplemented by a review of referral pathways to ensure appropriate patient selection and the continued development of both Colon Capsule and Cytosponge use in NHS Borders.

A Rapid Cancer Diagnostic Service (RCDS) pilot has been operational in NHS Borders since April 2023, and is currently funded until September 2024. To date the pilot has been successful, with 16% of referrals being diagnosed with cancer, and a further 30% referred on to a Speciality after being diagnosed with a non-cancer

condition, but extension beyond the pilot will require additional external funding to be provided.

NHS Borders is participating in national work around optimal pathways and will implement these when realistic and achievable.

Our Single Point of Contact (SPoC) service is now fully established and supporting all tumour sites, from the point of referral for patients referred as 'suspicion of cancer' and from the point of diagnosis for others. Patient and staff feedback has been very positive, and we continue to refine processes to ensure that the SPoC service will run in harmony with the HSCP Improving Cancer Journey (ICJ) service when this commences in Borders during 2024.

We continue to review services to ensure that these are in line with national guidance and frameworks such as Effective Cancer Management, Prehabilitation and Psychological therapies and support.

A structured review will be undertaken of existing prehabilitation services available for those on cancer pathways during 2024/25 and will be used as the basis for future proposals aimed at addressing any identified shortfall. This will be taken forward in collaboration with regional and national partners to achieve equity and consistency across Scotland.

We are participating in the National Oncology Transformation Programme and continue to undertake workforce planning to ensure that the local staffing model will support future requirements from both safety and capacity perspectives.

Building works are due to be completed during the first half of 2024 to extend the treatment and drug preparation areas used for the delivery of Systemic Anticancer Therapy (SACT) treatments to ensure that these can continue to be delivered safely. This represents the first stage of developing the facility, with further works required to ensure that there is sufficient treatment capacity for the next 5-10 years.

SACT Treatment capacity is under significant pressure, due to increasing complexity of the treatments being offered, increased demand for treatment and vacancies within the team due to a combination of challenges in recruitment and maternity leave.

Borders currently operates a nurse-led model for SACT treatments, but it is felt that this is no longer sustainable. In conjunction with colleagues from the regional centre a proposal has been developed for the recruitment of Specialty Doctors to be based in Borders; this proposal is currently under consideration by the Board, but this would require a substantial investment and there is currently no identified funding to support it.

We have been unable to recruit to the Senior Charge Nurse post within the team, and the lack of medical oversight described above is believed to be a contributory factor to this. We also have a number of experienced staff members on maternity leave, and a number still in training. This will make delivery of treatment during 2024 challenging, particularly in the context of demand increasing by an average of 9% annually.

To mitigate this as far as possible we have made changes to the way that toxicity assessments and some non-SACT treatments are carried out to maximise capacity, and are developing a workforce plan to determine the expected required staffing numbers over the next 5-7 years.

Our Health and Social Care Partnership is working closely with MacMillan and our Acute service to develop the MacMillan Improving Cancer Journeys approach for people with cancer in the Scottish Borders. This should provide a more holistic approach to cancer care, recogising that cancer affects not just physical health, but also emotional, financial and practical aspects of life.

6	**Health Inequalities**	Tackling health inequalities with a preventative approach

We will be launching our first health inequalities strategy this year: Tackling Health Inequalities in the Scottish (THIS) Borders. Since the pandemic, we know that health inequalities have widened, and it is vital that we seek to understand and address the fundamental causes of these avoidable and unjust differences in health outcomes. This is an important aspect of our Values Based Health and Care approach ensuring resources are distributed equitably according to population need. Development of the strategy has involved deep data review of our population needs and takes account of the Joint Strategic Needs Assessment. Data from the strategy has been communicated and presented to multiple audiences, including at a conference of the wider public health workforce in October 2023 and another for third sector colleagues in March 2024. It is important that the strategy reflects the experiences and insights of our workforce in NHS Borders and the wider community that we serve. We know that limitation of resources may necessitate an extension to the current timescales for delivery.

The Community Planning Partnership (CPP) will also play a key role in enabling us to identify and take actions to address health inequalities across the Scottish Borders. The links of this work within the CPP is currently under development.

Our Anchors Strategy fits under the umbrella of THIS Borders strategy. We will continue to involve and engage stakeholders, complete our baseline assessment, and intend to form an Anchors Development group with workstreams as per the Anchors Strategic Plan 2023-26, however, we know that limitation of resources may necessitate adaptation to the current timescale.

As noted previously, the general equality duty requires that an Integrated Impact Assessment is undertaken when the need for a new policy or practice is identified, or when an existing one is reviewed. This is particularly pertinent in the context of the work required to continue to transform and reform NHS Borders within our current financial constraints, so that we understand the level of impacts that the change will have, and where possible, optimise in advance of the change. To assist this process, where national policy changes are undertaken, we would appreciate a copy of the impact assessment, which we can then use to inform our local impact assessment.

NHS Borders will continue to provide leadership to the Alcohol & Drugs Partnership. Our Director of Public Health chairs the Alcohol & Drugs Partnership and manages the Alcohol & Drugs Partnership Support Team. We are progressing with MAT delivery and access to residential rehabilitation has increased, including two referrals to family rehabilitation. To support Medication Assisted Treatment (MAT) 9 a series of Trauma Informed Walkthroughs are taking place to identify improvements. This will be included as a case study in the Experiential Evidence for MAT 9.

Borders will be reporting ‘0’ on its numerical return for MAT 7 – access to shared care with Primary Care due to the nature of service provision in Borders where all prescribing takes place within our addiction service. We will work with colleagues to further develop knowledge and confidence in Primary Care staff teams to effectively support our clients using the learning generated from our MAT 7 pilot.

We are engaging in 'support to report' meetings with MIST and on track to submit all required data in April. We are currently surveying colleagues across the system to inform our workforce training directory for 2024-25.

As outlined in our Department of Public Health Annual Report we are focussing on prevention and mobilising a preventive system in NHS Borders. We will be starting to support self-referral to our Wellbeing Service as part of Waiting Well. The Wellbeing Service provides support in relation to healthy weight, being more active, smoking cessation and emotional wellbeing. The Service is extending links to wider partners to encourage more referrals. For example, we are training Student Support staff at Borders College to enable them to signpost students to the service. We are working closely with colleagues in dietetics to adapt our delivery model for adult weight management.

We are developing a partnership action plan in response to the Tobacco and vaping framework: roadmap to 2024 and are working with colleagues in education to review our local materials and policies in relation to vaping based on current evidence and best practice.

In partnership with the Borders Children and Young People's Planning Partnership we will continue to take action to prevent people experiencing problem drug use through providing whole family approach services; supporting curriculum development in relation to alcohol and drugs and implementation of the young person's framework once published.

We will reduce risk for people using drugs through ensuring naloxone training and provision across key services in Borders and the non-fatal overdose pathway.
We will seek to achieve 'blue' RAG status across standards 1-5 and 'green' across 6-10 through provision and evaluation of new ANP roles for mental health and primary care.

We will test additional approaches to enhance our performance for MAT 7.

We will increase the numbers of people accessing Residential Rehabilitation through further communicating with key partners about our new pathway and aim to involve people with lived experience in the assessment process where feasible. We will build increasing awareness of the needs and barriers for people with problem drug use through ongoing communications and workforce development.

There is no prison within the Scottish Borders however this does not mean we abdicate our responsibilities regarding people from the Scottish Borders who are in prison and who we expect to return to their home. Our Associate Director of Nursing for MH will continue engagement with the Forensic Executive Leads network to ensure NHS Borders follows best practice for people released from prison. We do have a custody suite in Hawick Police Station. People in custody with healthcare needs are supported in the first instance by our Service Level Agreement with NHS Lothian.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new

medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

7	**Women and Children's Health**	Take forward the actions in the Women's Health Plan and support good child and maternal health, so that all children in Scotland can have the best possible start in life.

Maternity and neonatal services, and in particular continuing delivery of 'Best Start; policy, with ongoing focus on delivery of continuity of carer and the new model of neonatal care, and that that all eligible families are offered child health reviews at 13-15 months, 27-30 months and 4-5 years.

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Woman and Childrens Health all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Acute, including Woman and Childrens Health, this equates to in the region of £3.1 million recurring and £1 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £7 million recurring across the following 2 years.

Across Woman and Childrens Health key areas of focus will look across the following areas:

- Explore opportunities for regional and national services
- To set longer term workforce strategy in line with a target reduction in headcount
- Explore digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

The rest of this section describes areas of progress and aspirations in line with the national recovery drivers. However, given our financial context and savings targets set out realistic boundaries must be placed on expected deliverables, timescales and performance levels as our financial recovery schemes progress.

We are progressing well with implementation of the recommendations outlined in the Best Start Framework. We currently have 60% of recommendations implemented at the time of writing. We are on track to have implemented 76% of recommendations by the beginning of 2024/25 year. NHS Borders will adopt a flexible approach to delivery of a continuity model to best realise benefits whilst acknowledging local constraints to full delivery of all recommendations.

Our focus during 2024/25 will be to have robust processes in place to support Best Start being business as usual within the service as Best Start concludes by November 2024. Another focus that will continue into 2024/25 will be obtaining our

Baby Bliss Accreditation and we have a group of identified staff that are working through the recommendations within each principle.

We will also be continuing to engage in discussions with the East Region team which includes NHS Lothian & NHS Fife to define appropriate pathways to accommodate the pre-term deliveries of babies less than 27/40 gestation, less than 800grams and the sick term babies that require intensive care. Within these pathways the review of repatriation and transitional care is progressing. Although these discussions are at an early stage, this work will be a key focus during 2024/25 within Women and Children's Service.

All eligible families are offered child health reviews at 13-15 months, 27-30 months and 4-5 years.

All the reviews are integral to the Universal Health Visiting Pathway and the Child Health Surveillance Programme, and it is our intention that NHS Borders Health Visiting Service will offer these to all eligible families. However, when staffing levels are compromised for extended periods it becomes necessary to prioritise service delivery to families and children who are most in need or are at risk of harm.

Taking forward the relevant actions set out in the Women's Health Plan

The proposed implementation of Women's Health Plan for NHS Borders is as follows below. We are keenly aware that limitations on resources may necessitate an extension on delivery of this plan.

Phase 1

i. We will carry out a baseline assessment of NHS Borders performance against the overarching indicators of the national plan and on the short-, medium- and long-term priorities on each of the specific areas.
ii. We will produce a Women's Health Needs Assessment, both to inform the prioritisation of actions to be included in the implementation plan, and to assist in discussions with stakeholders such as our staff, local women, and partner organisations including SBC. This work will be led by Public Health.

Phase 2

i. Using the learning and recommendations from Phase 1 actions, the Steering Group should agree leadership, governance and project management support and produce options for the scope and remit of the implementation plan. These options will include a risk assessment of the options and relationship to other plans such as Equally Safe and choice in patient access and digital accessibility to ensure no duplication of effort.
ii. The Steering Group should then develop the implementation plan, with time limited task and finish groups to progress work on different topics and to develop actions with SMART targets. These are likely to include groups on the following:

- Workforce development
- Primary prevention in localities
- Sexual and reproductive health
- Endometriosis and pelvic pain

- Menopause and menstrual health
- Heart disease
- Screening

iii. Given the emphasis that is placed on women's lived experience within the plan, consideration needs to be **given to how female staff and local women are included in agreeing th**e scope and prioritisation of the work. Reducing inequalities, communications, and hearing and learning from women's lived experience, will be themes for all the groups.

Setting out how they will work with their local authorities to take forward the actions in their Local Child Poverty Action Report

The Child Poverty (Scotland) Act 2017 sets out the Scottish Government's statement of intent to eradicate child poverty in Scotland by 2030. The Act requires Local Authorities and Health Boards to jointly prepare a Local Child Poverty Action Plan Report and an Annual Progress Report. The Act places the duty to report with the Community Planning Partnership.

The Child Poverty Action Group (CPAG) has been formed to focus solely on the Child Poverty agenda and drive the implementation of the Child Poverty Action Plan for the Scottish Borders. The group consists of key strategic stakeholders who have responsibility for services which impact on child poverty in the Scottish Borders and/or who represent groups affected by child poverty.

The CPAG provides:

- Strategic leadership and direction on child poverty to the Community Planning Partnership (CPP).
- Works to develop the Child Poverty Action Plan which contributes to the CPP priorities and outcomes.
- Seek opportunities for strategic developments to address the drivers of poverty and to mitigate the impact of poverty on children and families in the Scottish Borders.
- Ensures robust communication across communities, key agencies and to the relevant accountable bodies in relation to areas of work overseen by the group.
- Provides opportunities for children, young people and their families to be actively involved in the planning, design and delivery of services and programmes through specific engagement with them.

The Child Poverty Action Group provides regular updates on progress to the Anti-Poverty Members Reference Group, Scottish Borders CPP, NHS Borders Board, Children and Young People's Planning Partnership (CYPPP) and to other organisations as required.

Delivering high quality paediatric audiology services, taking into account the emerging actions arising from the Independent Review of Audiology and associated DG-HSC letter of 23 February 2023.

NHS Borders has only recently resumed 2nd tier paediatric audiology assessment following several years during which a full comprehensive paediatric service was

provided from NHS Lothian. This followed specialist training provided to specific members of NHS Borders Audiology Staff who undertake paediatric audiology in children. This service is currently limited to children over the age of 7 years and in time will be extended to include children over the age of 5 years.

All Auditory Brainstem Response (ABR) assessments following newborn screening, and specialist aiding support for children under 5 years of age will continue to be provided from our tertiary Paediatric Audiology Service based in Lothian. The annual number of children from NHS Borders who require ABR assessment varies year on year but is approximately 6 to 10 per year and we have approximately 5 children under the age of 5 who are hearing aid wearers and require ongoing support from NHS Lothian. This number of children is insufficient for any clinician within NHS borders to develop clinical competency and maintain the specialist skill associated with delivering the highest quality specialist paediatric audiology care for this patient group.

However, we are working through recommendations identified in the Review of Audiology Services to ensure that NHS Borders is taking action where required. There has been a particular focus on ensuring that ongoing supervision and governance is integrated into wider assurance systems.

NHS Borders is also committed to delivering neonatal hearing screening and are currently in the process of implementing a new way of delivering this service.

8	**Workforce**	Changes to improve efficiency & productivity, reduce costs and maintain a healthy workplace culture

These are challenging times for Health & Social Care across Scotland, both in terms of satisfying demand and achieving financial balance. Under current forecasts (February 2024), NHS Borders will be required to take out costs equivalent to around 300 whole-time equivalent posts over the next 3 years and this will stress-test the system and its safe & effective functioning. Effort is going into redesign and transformation to mitigate against the anticipated reduced staffing levels.

Achieve further reductions in agency staffing use and optimise staff bank arrangements

NHS Borders is seeing a downwards trend in Nursing Agency usage/expenditure. Between August and December 2023 this reduced by almost 75%. NHS Borders' aim is to eradicate agency usage through optimal use of the Lothian & Borders Staff Bank, although this will be significantly dependent on whether surge beds are closed (taken out of the system) or not. In the last 2 months we have seen an increase in agency use, as we have had to open new surge beds to meet service pressures. Nurse Bank requests have increased following the opening of surge beds with the fill rate (roughly 50%-56% over the 6-month period) fluctuating depending on the volume of supplementary requests. A robust mechanism for approval of agency requests was introduced in August 2023 requiring Executive Nurse Director sign off for off framework requests. This will be required for all agency requests from April 2024.

NHS Borders Nursing and Facilities banks are provided as a managed service by NHS Lothian, with Bank Staff able to work across both Boards, increasing flexibility and widening access, particularly in specialist areas. Consideration is being given to offer newly recruited substantive staff an opportunity to join the Lothian & Borders Bank to increase capacity and improve the overall fill rate.

Achieve reductions in Medical Locum Spend

NHS Borders is well connected into national Medical Staffing discussions and is making every effort to comply with the targets for reducing reliance and spend on medical locums. In the past 6 months we have re-established (post pandemic) the process for approval and monitoring of all locum posts, through our Medical Oversight Group which is chaired by the Medical Director. Executive approval is required for exceptional locum appointments, beyond agreed pay rates. There is monthly monitoring of locum appointments and trends including benchmarking with other Health Boards, with involvement of the key clinicians in seeking alternatives.

NHS Borders has enjoyed success in appointing to multiple Clinical Development Fellow roles and has employed International Medical Graduates from Myanmar, which has reduced our locum requirement and spend on junior and middle grade doctors. However the highest level of agency locum spend is to cover consultant vacancies and other consultant long term absences, NHS Borders is particularly vulnerable due to a prevalence of dual or single-handed specialties. Appointment of an agency locum is often the only option to sustain safe services locally. Attempts to find regional solutions (mutual aid) continue to be pursued and re-design,

including the use of physician associates, SAS Grade doctors, use of Certificate of Eligibility for Specialist Registration (CESR) doctors and non-medical workforce solutions have been/are being explored to improve resilience of services as an alternative to agency engagement.

Deliver a clear reduction in sickness absence by end 2024/25

NHS Borders has seen an increased level of absence during the last 12 months. During 2024/25 we shall be focussing on ensuring that the Once for Scotland Attendance Management policy is being applied appropriately and consistently across all our service areas. The content of our line manager training is being refreshed and a return to classroom-based training is being introduced. Our local reporting is being reviewed to ensure managers have meaningful real time data to support the management of staff absence effectively. We are also planning on introducing absence panels where line managers present to senior managers on how they are managing absence in their areas. These panels will provide support but also scrutiny to ensure the appropriate and consistent application of policy. There are also plans to run and evaluate a series of interventions to support staff to return to work/reduce the need to take time off using improvement methodology. We are currently evaluating the data we collect in a different way to help support this approach. It is hoped that we will be able to report on this in late 2024/early 2025. These interventions will be supported by our Area Partnership and monitored via our Staff Governance Committee. Both committees remain active in monitoring the wellbeing and working conditions of Staff. Management of attendance is an important part of a line manager's role & remit. Services like Human Resources (HR), Occupational Health and Health & Safety will support managers to optimise attendance. It does however have to be recognised that the current public sector financial climate, strained personal finances caused by inflationary pressures in the economy, reduced staffing levels in quarters, ageing workforce and increase in long-term conditions does affect resilience levels and makes the job of a manager to motivate good attendance and high level of productivity, a challenge.

Business Services Transformation / Increasing efficiencies across administrative and support services

As described in the introductory section above NHS Borders requires to focus on implementing a number of schemes to contribute to significant savings targets as set out by the Scottish Government. Within Corporate Services all areas are expected to set out plans for how a reduction of 10% against their base budget can be delivered. This includes a requirement that a minimum of 3% recurring and a further 1% non-recurring is planned to be delivered in 2024/25.

Across Corporate Services this equates to in the region of £0.9 million recurring and £0.3 million non-recurring to achieve the required 3% (recurring) and 1% (non-recurring) reduction during 2023/24 followed by a further estimated £2 million recurring across the following 2 years.

Across Corporate Services key areas of focus will look across the following areas:

- Explore opportunities for regional and national shared services
- To set longer term workforce plan in line with a target reduction in headcount

- Explore digital opportunities where a clear efficiency and modern approach can be delivered through the use of technology
- Rationalise NHS Borders sites to deliver a 20% reduction in cost base and mitigate estates risk profile

We recognise that the scale of savings required will not be achievable without consideration of options which may impact on the capacity of services, as well as how they are designed and delivered. As these are developed, we will need to evaluate options and present the details of choices and associated risks together with identifying any appropriate mitigations and dependencies.

In recognition of the challenging financial position, services are reviewing resources in line with service review methodology. There is a specific focus on increasing efficiencies across administrative and support services, and NHS Borders will set out actions to support achievement within NHS Borders/Integrated Scottish Borders HSCP Strategic Workforce Plan updates scheduled to be delivered in Summer 2024.

Within administrative services, one recent example has been the decision to host the e-Rostering service within HR, recognising synergies with existing HR Systems, Medical Staffing, HR Policies and Workforce Planning/Safe Staffing. We see e-Rostering, and specifically Safe Care as an enabler to evidence progress against the Health and Care Staffing Act 2019 and deliver opportunities to enhance staff and patient safety.

Operational and strategic Workforce Planning is optimised through e-Rostering, with access to robust real time staffing data to inform decision making, monitor trends, and measure compliance. Through close working with our finance colleagues, e-Rostering will give leaders access to key workforce indicators to efficiently plan their workforce, including budgets, funded establishment, supplementary spend, alongside the ability to record professional judgement, real time staffing and raise patient safety concerns. That said, this national initiative has had to be resourced adequately and in getting underway has diverted time & energy away from core services.

Delivering sustainable improvement in Terms and Conditions

While it is hoped that the Non-Pay elements of the 2023/24 pay negotiations will support workforce recruitment, sustainability, productivity and retention there is significant concern about the funding of these changes and the potential workforce implications (Management/Staff-side/individual staff time & energy) at a time when we are also implementing the Safe Staffing legislation. The priority areas of a reduced working week, protected learning time and a review of band 5 job nursing profiles will be progressed in partnership as the national guidance and timelines are developed. It is important to recognise that implementation of these initiatives will require significant workforce and management capacity. This will have a knock-on impact on our ability to deliver other elements of our Financial and Delivery plan.

e-Rostering Progress

With great effort and at the expense of other existing priorities, NHS Borders has managed to exceed the target of 6 rosters built on Health Roster by November 2023, with 11 currently live and 6 in development since August 2023. A key achievement has been the roll out across Women and Children's Services, which includes Nursing, Midwifery and Medical units. Whilst the benefits are quickly realised for Agenda for Change staff with shift-based rostering, the medical implementation is more complex. The introduction of activity-based rostering through activity manager presents a higher administrative burden, particularly in areas where job plans are annualised, with less predictability around regular activities. In the current financial climate, serious consideration around resources is required to weigh up the benefits of Activity manager against basic shift-based rostering. Service areas are having to dismantle existing roster systems to make way for e-Rostering.

Our Plan for 2024/25 is to focus on areas that will benefit most from e-Rostering, e.g. professions that come under the Health and Care Staffing Act 2019, areas with high bank and agency usage, and areas that regularly re-allocate staff because of patient acuity/staff availability. Completion of service areas to enable visibility of all units under a Service Manager's responsibility will be a priority to improve efficiency, minimising the requirement to access/report from multiple systems.

An updated implementation plan for e-Rostering is in development for approval at our local programme board. The current team are responsible for preparation and implementation of new rosters, supporting business as usual queries, systems set up and maintenance, and roster reviews. As the number of live areas increases the capacity to implement new areas will reduce, impacting roll out timescales.

Work is underway to protect resources required to implement and support e-Rostering based on the following scenarios;

- Projected proportion of the organisation that can realistically introduce e-Rostering by March 2026 with existing resources.
- Projected resources required to implement in all areas which fall within the Hospital Consultants and Specialists Association (HCSA) (2019) by March 2026.
- Projected resources required to fully implement across all of NHS Borders by 2026.

Should resources not be secured/sustained, the successful implementation of the new system will be jeopardised and the whole roll-out will be at risk.

Improving working cultures

NHS Borders remains committed to improve the working culture. To support this, we have a planned programme to roll out the Values and Behavioural Framework to all staff during 2024/25. These sessions also introduce the concepts of Civility Saves Lives/communication tools and personal responsibility to challenge and address poor behaviours within the workplace. This work will be supported by our ongoing Compassionate Leadership training which is open to leaders at all levels

within the organisation. We also plan to introduce a suite of communication training and management support to implement our change programme.

We will also be running another Wellbeing Week following the success of our previous event in 2023. This event will encourage and support staff to take a holistic approach to wellbeing and will address physical, mental, and emotional wellbeing. The steering group for this event brings together a wide range of staff across the organisation. We will also use our previous evaluation to ensure that lessons learned are addressed. Our monthly Wellbeing newsletter has now become established and supported by staff. We continue to offer staff direct access to our Occupational Health service for support with both work and personal issues, including access to counselling and physiotherapy. The coaching network continues to work to provide a confidential service to staff at all levels. Both services are well used and evaluated by individuals who use the service. The Head of Occupational Health and the Head of Organisational Development work closely to ensure that the services are developed in a way that ensures they are complementary.

Our Wellbeing group has a workplan for 2024/25 and will continue to communicate its achievement to staff. This is a Partnership group with an active, all organisation, membership.

NHS Borders are committed to ensure that all staff are treated equitably and that we celebrate the equality and diversity of all staff. To support this our Equality and Diversity and Inclusion group is chaired by the Director of HR, Organisational Development (OD), Occupational Health & Safety (OH&S). The organisation has also supported the development of our Minority Ethnic, Disability and Lesbian, gay, Bisexual, Transgender, Queer, Questioning, Intersex or Asexual (LGBTQIA+) groups. A woman's group is also under discussion with a hope of introducing this soon. We have also run a series of Equality and Diversity Training for staff and have actively supported the development of the national offering within TURAS.

Equality & Diversity matters are increasingly seen as core business in NHS Borders but there is a risk that as the health board has to streamline its services, then the time and energy able to be afforded to this important agenda could be put under considerable strain, as people are required to do more with less.

Employability

NHS Borders continue to support employability schemes, enhancing local supply pipelines, and providing opportunities for young people and disadvantaged groups. Modern Apprenticeships (MAs) are supported in line with the requirements of the Young Person's Guarantee, and the Prince's Trust Programme continues, which aims to prepare students for a Health Care Support Worker (HCSW) role. We are also currently looking to support Graduate Apprenticeships (GAs) within the next Financial Year.

In addition to this we are working to implement a Train to Care program in Spring 2024 along with a further Train to Gain programme for facilities staff in late Summer 2024. Both programs are developed to give those furthest removed from the labour market a 2-week work placement in NHS Borders as part of an intense employability programme. We have also committed to working with our partners at Department of Works & Pension (DWP) to provide Mock Interview workshops to people seeking

employment and support them with completing the NHS Jobtrain application process.

Project Search which supports young people with a learning disability or autism into work continues, with the 2023/24 cohort entering their final rotations. We have worked with Borders College to create a Promotional Video for Project Search and have an information evening taking place in February 2024 for potential applicants for the 2024/25 Cohort. This Event will allow the Public to engage with us and learn from our current interns about the course and skills they learn. Interns attend 3 different placements throughout the year with the aim of successfully achieving employment. The program allows them to make significant progress building their confidence, skills, and experience in preparation for further training/employment.

A key priority is engaging the younger workforce and significant effort has gone into working more closely with our local schools over the past year. NHS Borders staff have committed to attending Careers Fairs in all 9 Secondary schools. We will also be working with the schools to hold NHS insight days showcasing the variety of careers available. We will once again be running the accredited virtual work experience program, this gives pupils an opportunity to learn about the variety of careers available, meet clinicians and research their findings in a presentation. Workplace Tours resumed last year and we now have requests from 5 of the Secondary Schools. This is a generic work experience week for S3 pupils, where young people rotate across 10 departments. We have introduced 3 rotational Medical Work Experience weeks for Students in S5/S6. Last year we introduced Mini Medical Mock Interviews for S6 Students who applied to study medicine, and this was a great success and will run again late autumn. We have also engaged with Primary schools in the Scottish Borders and will be hosting an NHS Future Pathways session providing them with details of all the careers within the NHS.

A co-ordinated approach to work experience placements is taking place for requests from senior school pupils, and 18+ and we work with the organisation to fulfil these placements for all.

Progress on employability matters is dependent upon organisational capacity (including line manager time) and funding.

9	**Digital Services Innovation Adoption**	Optimise use of digital & data technologies in the design and delivery of health and care services for improved patient access and fast track the national adoption of proven innovations which could have a transformative impact on efficiency and patient outcomes

We aim to have our new Digital Strategy in place for early in 2024/25, however the current capital and resource constraints facing the Board will have an impact upon both the scale and pace of implementation for any newly developed strategy, which will require phasing of strategic delivery in some areas.

With the current challenges in mind, we are working closely with our services to make greater use of what we have, focusing on digital system optimisation and consolidation to maximise our existing investment in technology, and investigating efficiencies in current processes to ensure we're maximising the value for money from our current digital systems. To achieve this goal, we have made some changes in the Digital Services structure, and continue to identify new ways to improve our collaborative engagement with key stakeholders. This will allow us to identify areas for improvement and opportunities for digital technology to aid service re-design and improvement. We are currently working with teams to work collaboratively to maximise the use of digital and data technologies across the organisation in the design and delivery of services to improve patient and staff experience.

When services are re-designing, they include Digital colleagues in the projects and consider the Digital options that might assist. A collaborative approach to review all aspects of the Digital impact as solutions are developed, including consideration of the impact on patients and staff. A test of change or pilot will be established and evaluated prior to a full implementation if appropriate. We are also establishing additional clinical capacity to support the Digital team and Chief Clinical Informatics Officer (CCIO) as they design and implement Digital solutions. This is a particularly critical factor in the development and optimisation of new and existing clinical systems.

We have a well-established Digital Portfolio process where all work and projects are assessed and prioritised, including national programmes and local aspirations to develop our plans. The process assesses the importance, organisational fit with objectives, commitments, and performance as well as the benefits of delivering the scheme. This includes considering risks in the underlying infrastructure, security, architecture, any data sharing, and service that must be mitigated.

Across both IT infrastructure and the application domains a significant element of our yearly plan is focused on mitigating risks leaving limited capacity to pursue projects that innovate, increase our digital maturity or support redesign of services in the timescales and at the pace we would wish. We are looking at options for how we address the balance of resources, so that any unexpected work does not impact on project delivery. The process is collaborative and transparent, with clinical and service input to aspects of prioritisation when choices and flexibility are available, rather than essential risk mitigation.

In that context, we will review how we can further contribute and participate in the national priorities set out in 'Care in the Digital Age' Delivery Plan as our local plans are developed.

This work on delivery of national programmes will evolve further as plans and any available resources are refined. We are significantly impacted by the increasing demands on our local infrastructure, whether through ageing infrastructure that needs to be refreshed, increased security requirements or service need for improved performance and functionality. We face challenges within the local context of small teams, skills gaps, recruitment and retention issues, and funding constraints – both capital and revenue. Our capital is extremely limited and insufficient to implement an adequate refresh programme.

In the 2024/25 delivery year the IT Infrastructure team will be mitigating several key risks, including replacing Direct Access for circa 1,400 remote access users, consolidating all end point protection on Windows Defender, and implementing the full suite of Microsoft Security products in line with National Cyber Security Centre recommendations. IT Infrastructure will also be implementing Single Sign On (SSO) for Primary Care users, delivering the IT infrastructure and end user computing requirements for the CTAC Programme, initiating a Service Desk redesign, and expanding Virtual Desktop Infrastructure (VDI) from 350 users to circa 1,000 users.

A key focus during the 2024/25 delivery year is to continue to work collaboratively with our HSCP partners in SBC to move forward our ambitions of an integrated health and care record as resources allow. As part of this we will follow closely developments within the national arena and product set for their availability and functional fit with the architecture we aspire to deliver. Key components are likely to include identity management, national digital platform, and digital front door. There may be challenges in the timing of functions being readily available and the capacity and priority of work in the national programmes that will require us to make some tactical choices to progress, though we are committed to leveraging Once for Scotland approaches and products where we can. In addition to the ongoing work on HealthShare implementation, we are also working with SBC to implement Federated Services to enable secure Microsoft 365 interoperability between NHS Borders and SBC, enabling staff to collaborate via MS Teams, share Mailboxes, collaborate via SharePoint and OneDrive.

Our teams participate and share knowledge and learning through the Digital forums available to us whether digital leads, Information Governance (IG) & Cyber Security forums, Infrastructure leads and regional Digital groups etc. As far as possible we adapt, and re-use content and solutions developed nationally or in other NHS Boards to minimise the effort required locally.

We continue to work with the Cyber Security Operations Centre setup nationally in partnership with Abertay University. We will look to contribute and benefit from a national Cyber Security strategy which will involve adoption of common technologies to support and protect the Digital Infrastructure within local boards. This will provide NHS Borders with additional Cyber Security expertise which will assist in developing and monitoring our security posture.

Individual roadmaps for national products such as National Digital Platform, Identity Management and Digital Front Door developed collaboratively around an architecture would assist local Digital teams to develop plans and strategies to increase their digital maturity and level the offering to staff and patients across all Boards. It would also be helpful if these focused on providing the essential functions

that support Boards to interact with the public and streamline their service delivery e.g., appointments and letters interaction with patients, or integrated records and referral management across health and social care and cross board boundaries.

There are many Digital initiatives that come from policy areas outside the Digital Directorate, often via NSS commissions, and having a more coordinated view of these and how they fit together with a national architecture would assist Boards to be more prepared and plan for implementation and take advantage of these offerings. This applies equally to programmes already established where clarity of plans and approach in a single coordinated view would be beneficial.

Regarding the Microsoft 365 (M365) programme, it is important that the national programme implements the agreed resource model to create the capacity to support Boards by giving guidance and clarity of the steps necessary to build the foundations that will allow us to safely deploy the functionality available to us through SharePoint, Power Apps, PowerBI & Viva Engage. Boards like NHS Borders who have very small teams find it hard to plan and support the desire from local service leads to exploit Microsoft 365 without clarity of security components, IG and how to gain the skills and knowledge of the product to leverage it for services. At a local level NHS Borders will be rolling out Microsoft SharePoint, PowerBI and Microsoft OneDrive to staff during the 2024/25 delivery year. NHS Borders are currently in the process of training existing digital staff in essential Microsoft 365 skills, in Power Platform development, Power Automate, Microsoft SharePoint and PowerBI Development, so that we can start leveraging the benefits available through process automation, internal and external collaboration, real time information and improved customer and employee engagement and collaboration.

Our approach locally will be to leverage the current systems we already have whether Microsoft 365 (M365), or TrakCare to deliver more value from money already being spent. As part of this we plan to work towards a comprehensive electronic patient record that can be shared across health & social care systems and with individuals so they can interact with our services and have access to appropriate information and transact with us. We will achieve that through leveraging the functionality within TrakCare and are in the process of implementing a Unified Care Record (UCR), using the HealthShare product to facilitate the sharing of information across staff groups in our HSCP in NHS Borders and SBC social care teams, with the long term aim of expanding the HealthShare platform capability to enable NHS Borders to ultimately share information directly with the public.

The next major upgrade for the TrakCare Patient Management System is to upgrade to TrakCare 2023 (T2023), in Q1 of the 2024/25 Delivery Year. The T2023 upgrade will be followed in Q2 of 2024/25 with the implementation of the New User Interface (NUI). Not only does this give a more modern look and feel to the system but it will allow NHSB to utilise new functionality enabling an electronic health record within the TrakCare system. The Encounter Record functionality is a problem-oriented medical record, providing a centralised workspace enabling a care provider to document an encounter with a patient as well as providing a solution for viewing and storing patient information. Observations can be recorded electronically and the NUI scales to multiple types of devices allowing more options for mobile working within our settings. Our delivery roadmap for TrakCare contains thirty-eight enhancements and pieces of additional functionality, which we are working with the clinical teams to prioritise and phase in over a two-year period.

InterSystems HealthShare is a comprehensive Health Information System (HIS) and healthcare data platform that enables the sharing and exchange of healthcare data between different healthcare organisations and systems. Overall, InterSystems HealthShare aims to improve the quality of care, increase efficiency, and reduce costs by enabling healthcare organisations to share and exchange healthcare data in a secure and interoperable manner.

This project is a joint HSCP venture with SBC and is initially focusing on providing a Unified Patient Record which will aggregate data from multiple Health and Social Care systems to allow clinicians to view all relevant patient data in one place. After the initial twelve-month test of change, HealthShare could be developed further to enable NHS Borders to provide a patient portal giving our patients the ability to access aspects of their care record, book appointments and receive letters electronically. The development of a patient portal would be considered only after the successful completion of the test of change period, in January 2025, should funding and local prioritisation support this future phase of HealthShare.

We are in the process of developing a strategy for removing paper health records and developing digital solutions for electronic data capture into a full Electronic Health Record. This will improve access to information, which is currently stored in paper notes, accuracy of records and allow sharing of relevant patient data.

In Information Governance, we are in the process of implementing OneTrust, which will support management of our Information Assets, provide a log of Records of Processing agreements, create workflows for completion and approval of Data Protection Impact Assessments and allow us to document data flows to streamline and enhance processes under General Data Protection Regulation (GDPR) Regulations.

NHS Borders supports the use of innovation to drive change in services, which can be transformative and make an impact on delivery of care improving patient outcomes and experience. As a result, innovation is now embedded in all service reviews to encourage innovative ways of working and scoping of potential projects including transferrable learning from other services.

The Health Innovation South East Scotland (HISES) innovation hub is established and provides opportunities for regional collaboration with our partners, NHS Lothian and NHS Fife. However some potential solutions can only be tested in Lothian due to access to digital platforms such as Lenus, and their larger digital and e-health team who have funded time to support innovation. As a small health board with significant financial pressures, NHS Borders must prioritise projects and utilise resources to best effect. An innovation steering group was established in 2023 to facilitate this to provide a local pathway for the approval of innovation projects with representation from the Project Management Office (PMO) and Digital team to ensure correct communication and identification of prioritisation for the organisation. This includes considering innovation projects identified by the Innovation Design Authority (IDA) to be part of the Accelerated National Innovation Adoption pathway (ANIA). These projects follow a process managed by the Centre for Sustainable Delivery (CfSD) with recommended value cases being presented to Board Chief Executives for implementation. As part of the ADP in 2023/24 a scoping exercise was undertaken to identify resources required for consideration of these projects. In

2024/25 NHS Borders will continue to engage with national teams managing ANIA projects to seek information flow to the Innovation Champion to ensure all relevant stakeholders are involved in the review, so that these projects can be added to the local Innovation pipeline for steering group approval. This will ensure the questionnaires from the national project teams are completed fully with accurate information whilst also identifying any local barriers to implementation such as financial onboarding costs to health board that require escalation to the Chief Executive for feedback to IDA.

In 2024/25 NHS Borders will continue to work with HISES colleagues to develop regional and national challenges and input to national demand signal challenges funded by Scottish Government. Where resources allow, NHS Borders will continue to work with awarded companies to develop solutions that align to NHS Borders priority areas as laid out by the ADP. Local innovation projects will also be encouraged to meet these priorities including the further development of the RVW including seeking funding from organisations such as Innovate UK to provide resource for testing innovation to bridge the funding gap caused by current financial deficit. In 2024/25 NHS Borders will continue to develop the pipeline to encourage innovation focussing on clinical prioritisation and not limited to projects that require Digital input. Where digital input is required, the steering group will ensure that projects are fed into the digital pipeline prioritisation process. Work will also be undertaken based on service reviews and outputs from Quality Improvement projects to scope more innovative solutions. This will include developing data driven solutions and developing relationships with Data Loch and academic partners for co-collaboration in developing local solutions.

NHS Borders has already adopted the Right Decision Support (RDS) tool as part of our work on Values Based Health and Care. The RDS tool hosts our suite of local clinical guidelines to support clinical decision making and this will be further expanded in 2024/25 to host all NHS Borders patient information. Work is also underway to scope out our current ref help resources to bring these over into the RDS tool, in doing this there will be a continued focus on Values Based Health and Care and ensuring effective referral pathways are in place between primary and secondary care services.

10	**Climate**	Climate Emergency & Environment

We have not identified any additional resources available to support delivery of the strategic and policy commitments within this area and our existing capacity is fully directed to operational service delivery. Wherever possible we are progressing plans through existing resources. We have developed our local action plan aligned to the national strategy and this will consider the extent to which we are able to meet the objectives set out by Scottish Government below.

Greenhouse gas emissions reductions in line with national targets

Transport & Travel & Fleet Decarbonisation

Replacing vehicles without funding will be a challenge for NHS Borders

Given the rural setting of the Board, whilst we endeavour to move to Electric Vehicles (EVs) the infrastructure within the region and cost of longer-range vehicles needs to be balanced with provision of service.

We will:

- Launch our Active travel plan policy
- Work with Scottish Borders Council to further improve transport infrastructure
- Support the introduction of the amended bus timetable – collaboratively revised to better to support shift times
- Improve access to Electric pool vehicles across NHS Borders
- Work collaboratively across Scottish Borders with Public Sector organisations to improve EV infrastructure
- Support decision making for journey planning to be lowest carbon option

Inhaler Propellant

NHS Borders clinicians have adopted the approach agreed through national Respiratory pharmacy networks. It is the opinion of the Scottish Respiratory Pharmacist SIG, that the best inhaler is 'the one the patient can use [most] effectively'. The cost (financially and environmentally) of Dry Powder Inhalers (DPI) is significantly greater than normal use of Metered Dose Inhalers (MDIs). There are two new (environmentally better) propellants coming to market in the next couple of years and it was agreed the greatest immediate gain clinically and environmentally would be to focus on patients' over-use of Short Acting Beta-2 Agonist (SABA) inhalers rather than any scheme switching to DPI.

Nitrous Oxide

The main Nitrous Oxide Manifold has already been decommissioned; the Green Theatre team and Medical Gas committee will continue to review areas for improvement.

Building Energy Use

We will continue to reduce our Energy use in 2024/25 by:

- Rolling replacement programme of fluorescent light fittings with LED fittings (internal and external)
- Rolling replacement of inefficient heating boilers – various locations.
- Rolling maintenance programme – extract roof fans (replace with efficient direct drive fans where possible).
- Replacement of 3 laundry washers with new efficient units (including water recovery systems).
- Pressure systems replacement - efficiencies in steam system.
- Improve our condensate units.
- Upgrade our Steam Traps
- Upgrades to Building Management System (BMS).
- Feasibility of new efficient fans being utilised for roof extraction and supply ventilation.
- Rolling programme of insulation upgrades (inclusive of insulation jackets).

Adapting to the impacts of climate change

NHS Borders has completed the first version of our Climate Adaptation Plan in Collaboration with all key stakeholders in 2023/24

In 2024/25 we will:

- Review all actions and ensure the relevant action owners are making progress against the plan.
- As the teams responsible and involved with adaptation planning gain competence and understanding, they will routinely review to add and amend the plan to capture further risks and actions to support.
- Work collaboratively with Scottish Borders Council and other partners to seek areas for partnership and collaborative working to manage adaptation plans.

The Achievement of National Waste Targets

NHS Borders will build on the good progress in 2023/24 as we move into 2024/2025.

We will fully implement the Waste route map (developed by National Scenic Areas & Zero Waste Scotland) for NHS Scotland.

We will continue to focus on delivering the targets set out under the section resource and Waste Management in DL (2021) 38 ensuring full compliance by 2025.

The progress will be monitored through the Waste Management steering group with representatives from across the organisation and IPC and H&S colleagues to ensure the Waste Strategy is delivered collaboratively and to ensure it complies with IPC & H&S guidance too.

We are currently reviewing our recycling and general waste contractor and expect to appoint a contractor who can provide more accurate data in 2024/25.

Clinical Waste

In the last 12 months we have continued to reduce our Clinical waste tonnage by 11.91%. This has been achieved through education, communication and engagement on the wards. This work will continue in 2024/25 alongside working in collaboration with IPC and Clinicians to review any additional changes that can be made.

Local Procurement

The Head of Procurement sits on the Sustainable Procurement Steering Group and also on the NHS Borders Sustainability and Climate Change steering group as well as the Waste Management Steering Group. This cross-group oversight supports the communication in this key area.

Local procurement assists in projects that support the removal of single use items – for example the replacement of single use scrub hats with reusable ones

Circular Economy

We will:

- Continue to repurpose furniture and equipment across the organisation through effective networks
- Fully utilise Warpit
- Further embed recycling behaviours across the organisation

Food Waste

We will:

- Use the Waste Route map to identify good practice to reduce food waste
- Investigate ways to commence food waste recycling

Environmental Management

We will continue to work collaboratively, through Public Health, with Scottish Borders Council to capitalise and build on our green spaces.

We will develop our Green space and Biodiversity strategy, bringing together the good work already in progress into one umbrella document.

Reducing the Environmental Impact of Healthcare

Work in both Green Theatres and Polypharmacy continue, and the teams are committed to delivering sustainable change as part of their day role. These initiatives align closely with our local Value Based Health and Care work with a focus on sustainability.

We will implement all “Bundle 2” green theatre deliverables.

Summary

Significant changes are required to ensure the financial sustainability of NHS Borders. Growing demand, operational challenges and increasing costs have added to the financial pressures the organisation was already facing.

We continue to face significant increases in demand on our services from demographic change (an increasing elderly population, higher than the rest of Scotland) and the continued development of new treatments, procedures and new medicines. An ageing population means more people in the Borders will be living with one or more complex conditions and therefore will require more support from health and social care as they age. There will also be fewer people of working age within the population to offer that support. It is critical that we continue to build a focus on Value Based Health and Care ensuring resources are deployed with a person-centred approach.

Looking ahead, our focus will continue to be on pursuing the sustainability of our services within the context of workforce and financial pressures, and therefore any previous commitments of deliverables set nationally will need to be revisited and re-assessed in line with our financial recovery plan. There remains a number of uncertainties and therefore this plan remains draft, responsive and continual assessment over the coming months.

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28 May 2024

Dear Ralph

NHS BORDERS DELIVERY PLAN 2024/25

Many thanks for submitting your NHS Board Delivery Plan 2024/25. May I take this opportunity to thank you and your team for all the hard work that has gone into the preparation of this plan over recent months.

Whilst great progress has been made, our NHS continues to face significant challenges as we recover from the ongoing impacts of the Covid pandemic, coupled with a related period of ongoing financial challenge. We welcome the approach being taken by your Board to develop your service delivery and financial planning in an integrated way and to ensure that patient safety and front line services are appropriately prioritised whilst working within agreed budgets.

We fully recognise the significant and ongoing challenge this represents and acknowledge that planning is currently set within a landscape of uncertainty and risk. Most recently, the letter from the Scottish Government to all Chief Executives on 8 May regarding *NHS Boards Financial Position and Service Delivery* emphasised that the target for 3% recurring savings against baseline funding must be achieved, and the requirement to reach financial balance through further choices and actions.

In support of this, Boards have been asked to complete, by 31 May, a schedule of further Board level choices and decisions you have assessed to reduce financial deficit, but which require further discussion and clearance to move forward with due to the impact on performance or service delivery. This return will also help us understand the impact on your Delivery Plan.

Within this context, we are satisfied that your current Delivery Plan broadly meets our requirements and provides appropriate assurance under the current circumstances, and we are therefore content for you to proceed to seek final approval from your Board. However, even more so than in previous years, whilst these Delivery Plans provide an agreed way forward, they must also remain dynamic and responsive to the fluid situation in which we find ourselves.

To help support this continuous improvement, we have included a range of feedback arising from our review of your plan, which can be found in **Annex A**. This covers a small number of '*Priority Areas*' where, as part of our ongoing engagement with your Board, we will be seeking assurance that actions are being undertaken to address. Alongside these, there are a wider range of *"Development and Improvement Areas"* which you and your colleagues will wish to reflect on in order to drive improvements in your future planning and delivery.

Our approval of the plan as whole is contingent upon the understanding that your Board will continue to work closely with the Scottish Government around its delivery and implementation over the coming year. In particular, reducing planned care waiting lists remains a key Government priority, and we will continue to work with you to refine and deliver your Planned Care Plans, supported by the additional funding announced last month, to ensure that we can maximise performance within the available resource envelope.

Where elements of your plan may involve reforming the way in which services are delivered, we will wish to work closely with you to understand the nature of any changes and ensure it fits with the priorities of NHS Scotland as a whole.

Once again, many thanks to you and all your colleagues, and we look forward to continuing to work with you as we plan and deliver the highest possible quality of care for patients, improve the experience of our staff and ensure the best possible value for citizens. If you have any questions about this letter, please do not hesitate to get in touch.

Yours sincerely

PAULA SPEIRS
NHS Scotland Deputy Chief Operating Officer

Annex A – Scottish Government Feedback

Recovery Driver	Improved access **to primary and community care** to enable earlier intervention and more care to be delivered in the community

Priority Areas

- None

Development and Improvement Feedback

Community Link Workers

There is no reference to Community Link Workers within the plan, and NHS Borders have previously advised the Scottish Government that this workstream would no longer be prioritised for funding from the PCIP Executive. However they advised the IJB and LA would continue to fund and provide the service. They had also said they had agreed a planned review of their HSCP local area coordination and CLW service and that this had started when corresponding in October 2023 and they had placed a recruitment freeze on the service. It would helpful to understand the number of CLW posts, if any, and from a health inequalities lens what services are available to patients requiring support for social and economic issues (debt, social isolation, housing), which impact on health and wellbeing.

NHS Borders has been reviewing the Out of Hours service and clinical workforce model to ensure we provide a safe, resilient, and effective service within the funding allocation available. Following an option appraisal process, a preferred model has been agreed. The preferred option is to maintain a central Service with an Advanced Practitioner Led Service Model and Collaborative GP On-Call. The implementation of this model is likely to be phased. The first milestone for 2024/25 will be to develop this phasing plan before beginning implementation. This appears to be realistic and achievable and it will be useful to follow up on progress.

There is reference to the Community Glaucoma Service and the Board's current challenges in having sufficient numbers of interested Independent Prescribing optometrists willing to undertake the NESGAT qualification. It is welcome that the Board plans to have discussions with newly qualified IP optometrists about CGS, and it would be useful to explicitly set out the importance of maintaining an active ongoing dialogue with their existing IP optometrist population and optometry practices to hopefully persuade some to change their minds about CGS.

The Plan sets out a successful bid to increase the availability of SDAI to encompass the whole of Borders region. The aim being to encourage the expansion of existing NHS practices, or the setting up of new NHS practices to register new NHS patients. This on its own may be insufficient to improve access, and it would be helpful to see more detail on this.

Recovery Driver	**Urgent & Unscheduled Care** - Provide the Right Care, in the Right Place, at the right time through early consultation, advice and access to alternative pathways, protecting inpatient capacity for those in greatest need

Priority Areas

- None specific to the plan itself; however the Board should continue to work closely with the Scottish Government *Unscheduled Care Policy and Performance Team* to drive improved performance.

Development and Improvement Feedback

The plan sets out cuts to unscheduled care services in the region of £3.1 million followed by a further £7 million of the next two years. They have not set out the options which will create the efficiencies required and it is unclear what the impact will be on service delivery / performance, and this will need to be followed up on.

There is clear understanding of the financial and workforce/resource context and also alignment to the Urgent and Unscheduled Care improvement portfolios. However, the plan does not provide performance trajectories at present.

Recovery Driver	Improve the delivery of **mental health** support and services

Priority Areas

- None immediately specific to the Delivery Plan; however the Board should work with the Scottish Government *Mental Health Team* to drive improved performance.

Development and Improvement Feedback

The plan indicates significant savings targets must be met in mental health. The scale of savings will likely have some impact on capacity of services, design and delivery, however it would be helpful to include more details on what this will actually look like for mental health services, and it is recognised that further work is required around how each area will go about planning for 10% reduction against their base budget. It appears there is still work to be done on the consideration of options, choices and associated risk mitigation and dependencies.

NHS Borders highlight that core services in mental health (including CAMHS and PT) will be impacted in terms of provision and waiting times as they review budgets, and it will be important to work with the Scottish Government to monitor and manage these impacts.

The plan notes that a number of reviews are to take place looking at pathways, patient flow, timely access to services, use of wider sector support and partnership working in addition to reducing estates all in line with strategies and forthcoming secondary MH standards and cost saving, and it will be helpful for the Board to engage with the Scottish Government on how the outputs of these reviews will impact on future planning.

Recovery Driver	Recovering and improving the delivery of **planned care**

Priority Areas

- None immediately specific to the Delivery Plan; however the Board should work with the Scottish Government *Planned Care Policy and Performance Team* on actions needed on their associated Planned Care Plan.

Development and Improvement Feedback

The delivery plan notes concerns around long waits for cardiology appointments which may impact delivery of timely and equitable access to diagnosis treatment and care for people with heart disease as set out in the Heart Disease Action Plan (2021).

More widely, due to the significant financial pressure that all Boards are facing, there may be a consequent impact on waiting times performance. The Scottish Government will work with Boards to maximise options that bring most return for minimal cost.

Recovery Driver	Delivering the National **Cancer** Action Plan (Spring 2023-2026)

Priority Areas

- None immediately specific to the Delivery Plan; however the Board should work with the Scottish Government *Cancer Access Team* to drive improved performance.

Development and Improvement Feedback

A Rapid Cancer Diagnostic Service pilot has been operational since April 2023 but is only funded until September 2024. The service has been running successfully, but NHS Borders will require additional funding to allow this service to continue after September 2024. It would be useful to see more detail on what the plans are following clarification of the funding position.

The plan clearly sets out the plans to improve Cancer Waiting Times for each challenged tumour group. More could be said about the Optimal Cancer Diagnostic Pathways for Lung and Head & Neck – the plan references these will be implemented 'when realistic and achievable' and it would be useful to have more detail as to how the Board is working towards this.

There is acknowledgment of the single point of contact initiative and prehabilitation, including the psychological therapies and support framework. It is reassuring to see that consideration is being given to how SPoC and ICJ will augment each other to ensure best use of resources and maximise impact on both patients and the wider system.

There is positive reference to the Oncology Transformation Programme with involvement in national programme and a review of local service design and delivery. However, staffing challenges and the resource required to deliver against targets etc., are noted. The transformation programme should help to address workforce issues and we welcome NHS Borders support in delivering this. The SACT pressures are recognised for 2024.

Recovery Driver	Enhance planning and delivery of the approach to **health inequalities** and improved population health
Priority Areas	
• None	
Development and Improvement Feedback	
It's not clear that the section below adequately reflects the intention or spirit of MAT Standard 7, which not only aims to provide more options for the delivery of drug and alcohol services, but also seeks to ensure that further wrap-around care for accompanying ailments, and it would be helpful to have further clarification on this. *"Borders will be reporting '0' on its numerical return for MAT 7 – access to shared care with Primary Care due to the nature of service provision in Borders where all prescribing takes place within our addiction service. We will work with colleagues to further develop knowledge and confidence in Primary Care staff teams to effectively support our clients using the learning generated from our MAT 7 pilot."*	

Recovery Driver	Take forward the actions in the Women's Health Plan and support good **child and maternal health**, so that all children in Scotland can have the best possible start in life.

Priority Areas

- None

Development and Improvement Feedback

NHS Borders' plans to deliver Child Health Reviews in the context of changing resource are reasonable and deliverable.

In the primary care chapter there is an effective section on early detection and improved management of the key cardiovascular risk factor condition. As this is a key priority in the Women's Health Plan (WHP) it would be good to see these WHP actions or at least reference to WH made here.

It is positive to see the intentions towards implementation set out and the commitment to 'carry out a baseline assessment of NHS Borders performance against the overarching indicators of the national plan and on the short-, medium- and long-term priorities on each of the specific areas. It is stated that this will be 'led by public health' there is no acknowledgment of the role of their Women's Health Lead in this. It would also have been good to see how the Board are building on work already achieved as at present it suggests nothing will be done towards the implementation of the WHP until their baseline assessment has been completed.

Recovery Driver	Implementation of the **Workforce** Strategy

Priority Areas

- None immediately specific to the Delivery Plan; however the Board should continue to work with the Scottish Government to drive closer alignment between workforce and delivery planning.

Development and Improvement Feedback

The workforce related objectives appear to be realistic and achievable. The Board has a number of initiatives including short life groups and action plans. It will be useful to see progress updates on these through the year.

The Board include financial savings considerations in the context to their workforce related objectives and recognize the current budget savings asks. In relation to reduction in use of supplementary staffing, NHS Borders have set out clear process to monitor the use and spend on supplementary staffing, and in the reduction in admin services spend.

Recovery Driver	Optimise use of **digital & data technologies** in the design and delivery of health and care services for improved patient access and fast track the national adoption of proven **innovations** which could have a transformative impact on efficiency and patient outcomes

Priority Areas

- None

Development and Improvement Feedback

NHS Borders plan is very detailed in what programmes of work are being continued to the 2024/25 Plan and what are new programmes of work for 2024/25.

The ADP highlights NHS Broders has developed a Digital Strategy which they are hoping to implement although funding and resourcing are an issue. The ADP also highlights a general financial position and how this could impact on delivery of all programmes, and it will be useful to follow up on this when the funding position is clearer.

The plans clearly set out their plans regarding delivery of the National Digital Programmes, *National digital programmes: CHI, Child Health, GP IT, eRostering, LIMS, HEPMA, M365, endoscopy reporting system, Diagnostics (PACs), Near Me, Connect Me, Scottish Vaccination Immunisation Programme (SVIP)

Future iterations of plan should set out how the Board will implement the NHS Scotland Scan for Safety Programme by March 2026 as mandated in the Scottish Government's Directors Letter (2024) 3

Recovery Driver	**Climate** Emergency and Environment

Priority Areas

- None

Development and Improvement Feedback

It is welcome to see a positive stated intention made to planning a strategic approach to deliver greenspace and biodiversity action, with reference made to umbrella document bringing progress together. Aware that the board have changed the lengths of their grass cuttings to pursue more sustainable grassland management practices, though this has not been mentioned.

Detail on the implementation of Environmental Management Service (EMS) was not included, which may be a missed opportunity to showcase the work that NHS Borders are doing in this area. Although there has been no resources identified, some EMS work has been progressed, the Rio platform is being used and progress is being made on the compliance register.

It is welcome that the Board have developed an Adaptation Plan and have mentioned that it will be implemented in the next years. The Board also recognise the importance of collaborating with local partners and main stakeholders.

NHS Borders have clearly stated decarbonisation measures to address building energy they will put into place in 2024/25 given the current financial situation. They will progress with 'no regret' measures such as upgrades to lighting, inefficient boilers, fans, BMS, and insulation. They are currently in line with ministerial priorities, however, it is recognised that it will need longer term capital funding to address larger heating system upgrades.

Intended actions around a dedicated travel plan, increased collaboration, and consideration of bus timetable routes are welcome. However, the financial implications of continued fleet decarbonisation are noted and it is recognised that this will limit what is able to be achieved.

The Board have intimated that they will follow the waste route map recommendations, however, it may be useful to include more detail on the delivery of that piece of work. The Board have advised that they will continue to progress on targets going forward but also note that they are going to review the current waste contractor locally; however, this should be done via the national framework to take benefit from the work done via the route map. Encouraging to see the reduction in clinical waste and the ongoing work in this area.

Supporting Theme	Finance & sustainability
Priority Areas	
• None immediately specific to the Delivery Plan; however, the Board should continue to work with the Scottish Government *Health Finance Team* on their Financial Plan and ensure that this is fully aligned with updates to the Delivery Plan.	
Development and Improvement Feedback	
As above.	

Supporting Theme Value Based Health & Care
Priority Areas
• None
Development and Improvement Feedback
While the Delivery Plan mentions value based health and care and contains a few actions and commitments, there is no mention of how the Board intends to support delivery of the Value Based Health and Care action plan. Practising Realistic Medicine to deliver value based health and care should be viewed by Boards as a key enabler of the ten drivers of recovery and fundamental to achieving a more sustainable healthcare system, and it would be helpful for this to be a stronger theme throughout the plan.

NHS Board
Delivery Plan Guidance
2024/25

Supplementary Advice:
Delivery Progress Reporting

Scottish Government
Riaghaltas na h-Alba
gov.scot

Context

1. As set out in "*NHS Scotland Delivery Planning Guidance 2024/25*" (issued on 4 December 2023) a key mechanism against which the progress and impact of the Delivery Plans will be reported in 2024/25 will be via a forthcoming "NHS Board Delivery Framework". The purpose of this supplementary guidance is to set out how this will support the development of the draft NHS Board Delivery Plans due for submission on 7 March 2024.

2. The Delivery Framework aims to set out a clear set of agreed indicators for which delivery against plans are reported, monitored and discussed with Boards. This included both quarterly progress reporting against the NHS Board Delivery Plans, as well as support for ministerial and executive level discussions with Boards.

3. **Annex A** sets out the draft Delivery Framework Indicators for 2024/25. A key principle for the metrics included for 2024/25 reporting is that they should all already be data which Boards and the Scottish Government regularly monitor performance against. The aim is to provide a coherent, clear and consistent Framework which provides a shared understanding against which delivery will be monitored against and not place an additional burden on Boards.

Setting Board-Level Delivery Aims and Subsequent Reporting and Monitoring

4. Some of the Delivery Framework indicators have associated **national** Standards which overall progress is measured against. As far as possible these are framed as improvement aims rather than a fixed target (for example, 'year on year improvement' versus ' achieve 95%'). However, for some metrics there are existing statutory targets in place (for example, waiting times) and where this is the case, the national Standard is framed in terms of the established target.

5. Within that context, when developing their Delivery Plans, Boards should consider for each of the indicators what a **realistic** local standards to achieve would be as a result of the impact of the actions undertaken in the Delivery Plan. The Scottish Government will engage with Boards via both workshop sessions and individual meetings throughout February to support Boards in developing what realistic aims and trajectories against each of these indicators would be.

6. Some of the Delivery Framework indicators outlined in **Annex A** are publicly available as official statistics or are available via dashboards e.g. **ScotPHO** and the **Whole Systems Dashboard**. Work will be needed to develop these indicators and dashboarding over the next year to set up a new way of monitoring progress. The Scottish Government's engagement with Boards in February will also cover the use of this Dashboarding, and other sources, to ensure they are able to access all the necessary data.

7. The intention is that rather than asking Boards to submit data every quarter, a report will be generated from the Dashboarding (and other sources while this

is being developed) which will be used to support discussions between the Scottish Government and Boards as to the impact of plans on delivery and progress being made against the Delivery Aims set out alongside their Delivery Plans.

8. Following agreement of this initial set of delivery aims in support of the draft Delivery Plans, the Scottish Government will continue to work with Boards to develop this approach over the spring and summer of 202 to support future delivery planning.

Next Steps

9. In summary:

- **Annex A sets out draft Delivery Framework Indicators against which Boards should consider what realistic local standards to achieve would be as a result of the impact of the actions undertaken in their Delivery Plan.**

- **The Scottish Government will engage with Boards throughout February to support development of their delivery aims and trajectories for 2024/25, 25/26 to 26/27, as well as access and use of the Dashboarding, and other data sources.**

- **Monitoring of progress against these delivery framework in 2024/25 will be based on quarterly meetings between the Scottish Government Health Planning Team and NHS Board Directors of Planning based on reports generated from dashboarding, and other sources, including the *Whole Systems Dashboard and ScotPHO*.**

Annex A – Draft delivery Framework indicators for 2024/25

Recovery Driver	Indicator	National Standard	Source and Definition
Primary & Community Care	GP Access	GPs to provide 48 hour access or advance booking to an appropriate member of the GP team for at least 90 per cent of patients.	Data Source: Health and Care Experience Survey Frequency: Biennial Latest figures: In 2021/22, 89 per cent of survey responses were positive for 48 hour access to an appropriate healthcare professional. In 2021/22, 48 per cent of survey responses were positive for booking an appointment with a GP more than 48 hours in advance.
Urgent & Unscheduled Care	SAS turnaround times	100% patients turnaround within 60 minutes	Data Source: SAS MI Frequency: Weekly Data available: Will be added to Whole System & Winter dashboard
	Accident and Emergency Waiting Times	95% of patients to wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment. Boards to work towards 98%.	Data Source: A&E waiting times Frequency: Monthly Latest figures: Nov 2023 some 67% of A&E attendances were seen and resulted in a subsequent admission, transfer or discharge within 4 hours.
	Accident and Emergency Waiting Times	Patients wait less than 12 hours to admission, discharge or transfer from A&E.	Data Source: A&E waiting times Frequency: Monthly Latest figures: In November 2023, 6,133 patients spent more than 12 hours in A&E.

Recovery Driver	Indicator	National Standard	Source and Definition
	Unplanned Care - Occupancy	Ensure that acute receiving occupancy is 95% or less	Data Source: Scottish Government MI Frequency: Weekly Data available: Whole System & Winter MI dashboard
	Unplanned Care – Emergency Length of Stay	Reduce estimated average length of stay for emergency admissions to acute hospitals.	Data Source: RAPID Frequency: Weekly Data available: Whole System & Winter dashboard
Mental Health	CAMHS Waiting Times	90 per cent of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.	Data Source: CAMHS waiting times Frequency: Quarterly Data available: Care & Wellbeing Dashboard (shinyapps.io) Latest figures: For the quarter ending September 2023, 75.6% of children and young people were seen within 18 weeks of referral.
	Psychological Therapies Waiting Times	90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.	Data Source: Psychological Therapies waiting times Frequency: Quarterly Data available: Care & Wellbeing Dashboard (shinyapps.io) Latest figures: For the quarter ending September 2023, 79.4% of people started their treatment within 18 weeks of referral.
Planned Care	Treatment Time Guarantee	100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment (Treatment Time Guarantee).	Data source: Frequency: Quarterly Data available: Latest figures: During quarter ending September 2023, 56.1% were completed in 12 weeks or less

Recovery Driver	Indicator	National Standard	Source and Definition
	Planned Care - 12 Weeks First Outpatient Appointment	95 per cent of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). Boards to work towards 100 per cent.	Data source: NHS waiting times – stage of treatment Frequency: Quarterly Data available: Latest figures: At end September 2023, 42% waiting less than 12 weeks .
	Delayed Discharge - Delivering good discharge processes to reduce delayed discharge levels and improve hospital occupancy flow	Reduce average number of beds occupied per day due to people delayed in hospital	Data source: Delayed discharges in Scotland Frequency: Monthly Data available: Latest figures: In November 2023 the average number of beds occupied per day due to people delayed in hospital was 1,894.
Cancer	Cancer Waiting Times	95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	Data Source: Cancer Waiting Times Frequency: Quarterly Data available: Latest figures: In quarter ending September 2023, 94.9% of patients started treatment within the 31-day standard. In quarter ending September 2023, 72.0% of patients started treatment within the 62-day standard.

Recovery Driver	Indicator	National Standard	Source and Definition
	Cancer Screening	Increase the uptake of cancer screening	Date sources: Scottish breast screening programme statistics Frequency: Data available: Care & Wellbeing Dashboard (shinyapps.io) Latest figures: In 2019-22, 74.5% were invited and attended a routine breast screening appointment. In 2020-22, 69% of females and 64% of males attended bowel cancer screenings.
Health Inequalities	Asthma	Reduce asthma related hospital admissions	Data source: Acute Hospital Activity and NHS Beds Information Frequency: Quarterly Data available: Care & Wellbeing Dashboard (shinyapps.io) Latest figures: 85 per 100,000 asthma-related hospital admissions in 2021/22
	Drugs and Alcohol	90 per cent of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Data source: National drug and alcohol treatment waiting times Frequency: Quarterly Data available: Latest figures: During the quarter ending 30 September 2023, 92.3% of referrals to community-based services started treatment with a wait of 3 weeks or less.

Recovery Driver	Indicator	National Standard	Source and Definition
	Vaccinations	Increase vaccination uptake for all groups year on year (including influenza, Covid, RSV and Shingles) and for children specifically to ensure: 95% of children have completed all of the recommended vaccination programmes by 24 months: 90% of girls fully vaccinated with HPV vaccine by the age of 15	Source: Care & Wellbeing Dashboard (shinyapps.io) Percentage (%) uptake of COVID-19 vaccinations in eligible population by NHS Board based on monthly figure Percentage (%) uptake of influenza vaccinations in eligible population based on annual figure
	Smoking	Increased smoking cessation services across Scotland and successful quits year on year, including during pregnancy	NHS Stop Smoking Services in Scotland Statistics published on annual basis and dashboard Dashboard - NHS stop smoking services Scotland - April 2022 to March 2023 - NHS Stop Smoking Services Scotland - Publications - Public Health Scotland
	Weight	Increased referrals for Tier 2 and Tier 3 weight management services for (1) adults and (2) children and young people year on year.	Data source: Referrals to NHS Boards commissioned weight management services
Workforce	Sickness Absence	NHS Boards to achieve a reduction in sickness absence.	Percentage of total NHS staff sickness absence based on fortnightly figures available via the Whole Systems Dashboard
Climate	Climate Change – Greenhouse emissions	Year on year reduction in total greenhouse emissions (including medicines) for those emissions sources which form part of the NHS Scotland 2040 net-zero target.	Annual Climate Emergency and Sustainability Report Access climate change and sustainability tools | National Services Scotland (nhs.scot)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Borders Child Poverty Report**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti, Director of Public Health**
Report Author:	**Fiona Doig, Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Person Centred

2 Report summary

2.1 Situation

The Child Poverty (Scotland) Act 2017 requires Local Authorities and Health Boards to jointly prepare a Local Child Poverty Action Plan and an Annual Progress Report.

A report has been prepared to update on progress in Scottish Borders in relation to the Action Plan for 2023-24 and outlines the planned actions for 2024-25. This report (Appendix 1) has been endorsed at the Community Planning Partnership on 6.6.24 and submitted to Scottish Government.

2.2 Background

The Child Poverty (Scotland) Act 2017 sets out the Scottish Government's statement of intent to eradicate child poverty in Scotland by 2030. Local Authorities and Health Boards are required to jointly prepare a Local Child Poverty Report (including an Action Plan) and submit an annual progress report each year. The annual progress

report should describe activities undertaken and planned locally to contribute towards tackling child poverty.

Tackling child poverty in the Scottish Borders is governed through the Community Planning Partnership (CPP). A Child Poverty Action Group steers this work and consists of Scottish Borders Council, NHS Borders and key partners.

Scottish Government's tackling child poverty delivery plan 2022-26 (Best Start, Bright Futures) sets out an approach to delivery of the national mission to tackle child poverty. It focuses on:

- Action to support families
- Sustained action to create the integrated support that families need to move into work
- Changing the system to provide the support parents need
- Investing long term in both children's outcomes and economic transformation that will create a fairer, more equal Scotland.

The Borders report aligns with this approach.

Best Start, Bright Future outlines that almost 90% of children in poverty in Scotland live within these six priority family types:

1. Lone parents
2. Families with a disabled child or parent
3. Families with 3+ children
4. Minority ethnic families
5. Families where the youngest child is under 1
6. Mothers aged under 25

The report outlines the challenges faced in Scottish Borders including:

- There has been in increase in the proportion of children in low income families (after housing costs) from 19.5% in 2021-22 to 19.7% in 2022-23 with some localities having over 22% of children in this situation.
- 23% of our children live in poverty (after housing costs) in the Scottish Borders.
- In 2022, the gross weekly full-time workplace-based wage in the Scottish Borders was £51 less per week than the average for Scotland. This is, however, a much improved figure since the previous year.
- The proportion of employees (18+) earning less than the 'real living wage' in the Scottish Borders was 13.8% in 2022-23, higher than the Scottish average of 9% although a reduction from the previous year's figure of 24.2 and is at its lowest level recorded.
- 13.8% of Scottish Borders Households receive Universal Credit

The report also outlines some headlines in relation to tackling child poverty including:

- There is an improving trend for school leavers from our most deprived areas (SIMD Quintile 1) entering positive destinations after leaving school. This has increased over time reach8ing 96.7% in 2022-23.
- Increase in provision of support for income maximisation. Across Borders two staff within the team have generated over £1million in financial gains for families.

The Report outlines the local approach to developing a Scottish Borders Child Poverty Index (SBCPI) to use alongside the Scottish Index of Multiple Deprivation (SIMD). The

SBCPI uses components including DWP/HMRC income data; free school meals; clothing grants and Educational Maintenance Allowance to provide further insights. Data is presented for individual data zones of which there are 143.

Key observations from the SBCPI include the following:

- All datazones in Borders have children in low income families and all localities had a least one datazone with 40% or more children in Low Income Families
- There is an increase over time in the proportion of datazones with mid/high/higher levels of child poverty from 66% in 2017 to 92% in 2022. However, in 2023 there is a return to pre-covid levels of 68%.

2.3 Assessment

The Report provides an overview of a range of initiatives (Appendix 2) delivered through partnership working during 2023-24 alignsed agains the Best Start, Bright Futures framework of:

- Employability
- Education
- Information and advice
- Housing and energy
- Health and wellbeing
- Digital exclusion
- Fuel related activity
- Financial inclusion
- Money worries

An overview of progress on all actions is included in Appendix 2 of the Report. Specific actions for NHS Borders include:

- Working with partners including Borders college to support training opportunities in health and social care
- Working with third sector children and families services to increase skills and capacity for staff and families in healthy eating
- Promotion and co-ordination of the Healthy Start Vitamins and Vitamin D scheme
- Co-ordination of Money Guiders training

Highlighted actions for 2023-24 are presented on page 28 of the Report and detailed actions are included in Appendix 1E. These align with Best Start, Bright Futures as follows:

- providing the opportunities and integrated support parents need to enter, sustain, and progress in work
- maximising the support available for families to live dignified lives and meet their basic needs
- supporting the next generation to thrive

Specific actions for NHS Borders include:

- Building staff capacity through training (e.g. food training for Breakfast Club staff; mental health awareness, Money Guiders training)
- Provision of breastfeeding groups; healthy start vitamins and weaning groups for families

Joint priorities for 2024/25 are set out below in four key themes. These themes have been identified by the Child Poverty Group Partners and demonstrate a commitment to working together to deliver differently in order to tackle child poverty going forward. A workshop is planned for the summer whereby Partners will work together to create specific actions for these priorities.

The priorities are:

- Understanding local need – including developing a shared data and intelligence resources and ensuring the work reflects the voices of people with direct experience of poverty and staff working with low income households
- Use of policy levers and resources – use a whole systems approach to poverty reduction and prevention; ensure streamlined pathways and focus on engagement in early years
- Understanding our progress- develop a shared outcome framework to allow all partners to understand progress
- Ways of working – develop stronger and clearer relationships between the Child Poverty Group, the Children and Young People's Planning Partnership and the CPP.

It is expected that challenges associated with the cost of living crisis will continue to impact disproportionately on families with children and there is a role for NHS Borders to continue to equip staff to provide signposting to services for families experiencing poverty.

2.3.1 Quality/ Patient Care

This report outlines a positive impact on families experiencing hardship. It could be anticipated that ongoing hardship for families will impact on service demand.

2.3.2 Workforce

Actions outlined for NHS Borders in 2023-24 are provided through existing resource, however, it could be anticipated that increasing hardship and distress in our communities could impact negatively on staff health and wellbeing.

2.3.3 Financial

Actions outlined for 2024-25 are provided through existing resource. Impact on families will be positive where support is accessed.

2.3.4 Risk Assessment/Management

It is recognised the inability to support anti-poverty actions is likely to increase demand on services. This impact is also likely to be experienced by staff. The actions within the 2024-25 are intended to mitigate the impact of child poverty.

2.3.5 Equality and Diversity, including health inequalities

By providing targeted interventions and supports to mitigate or address child poverty this report contributes to the Fairer Scotland Duty to reduce inequalities of outcome caused by socio-economic disadvantage when making strategic decisions.

It contributes to our Equality Outcomes and in particular outcome 5: We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.

An impact assessment has been completed and is available at Stage 1 Scoping and Assessing for Relevance (scotborders.gov.uk)

2.3.6 Climate Change

There is no impact on climate change as a result of this report.

2.3.7 Other impacts

n/a

2.3.8 Communication, involvement, engagement and consultation

This joint report has been prepared on behalf of NHS Borders and Scottish Borders Council by local authority colleagues. In collating the report key stakeholders including NHS Borders, Youth Borders, Department of Work and Pensions, Borders College, Skills Development Scotland, Inspiring Scotland, Volunteer Centre Borders and Third Sector children and young people's services were invited to update on their progress on actions for 2023-24 and confirm actions for inclusion in the 2024-25 Action Plan.

2.3.9 Route to the Meeting

This has been previously endorsed by the Community Planning Partnership on 6.6.24.

2.4 Recommendation

This report is for **Awareness.**

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- Significant Assurance

3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Scottish Borders Child Poverty Report 2023-24 and Action Plan.
- Appendix No 2Local Child Poverty Data and Statistics
- Appendix No 3, Document Scottish Borders Chid Poverty Annual Progress Report 2023-24

SCOTTISH BORDERS

LOCAL CHILD POVERTY ACTION REPORT 2024/25

AND INCLUDING

PROGRESS UPDATE ON THE 23/24 PLAN

Scottish Borders COUNCIL

Contents

Foreword and Introduction

This report covers progress made in tackling child poverty in the Scottish Borders in 2023/24 and sets out planned actions for 2024/25.

Scottish Borders Council, NHS Borders, Community Planning Partners, and the partnership Child Poverty Group recognise the importance of tackling child poverty, and are determined to make a difference to children, young people, and families in the Scottish Borders.

The Child Poverty (Scotland) Act 2017 sets out the Scottish Government's statement of intent to eradicate child poverty in Scotland by 2030.

The Act requires that Local Authorities and Health Boards jointly prepare a Local Child Poverty Action Plan Report and an Annual Progress Report. The reports should describe measures taken to contribute to meeting child poverty targets and proposed measures for the purpose of contributing to meeting the targets. It should also describe any income maximisation measures taken to provide pregnant women and families with children with information, advice and assistance about eligibility for financial support and assistance to apply for financial support.

This Plan sets out our strategic approach and commitment to undertake priority areas of work and key actions to alleviate child poverty. We will work with partners at both a national and local level as we take action throughout 2024/2025.

Child Poverty levels in the Scottish Borders continue to be challenging, for example:

- **19.7%** of our children still live in poverty (before housing costs)
- **23%** of our children still live in poverty (after housing costs)
- **8.2%** of our children in P7 to S6 state that they always or often go to bed feeling hungry.

However:

- The regional pay gap between the Scottish Borders and Scotland has greatly improved since 2021 for workers who live in the region. In 2023, the median gross weekly pay (residence based) was £673. This is £29 below the £702 for Scotland.
- There is an improving trend in the percentage of school leavers from quintile 1 (the most deprived areas) entering positive destinations after leaving school in the Scottish Borders. In 2018/19, 87.18% of quintile 1 school leavers entered a positive destination. This figure has steadily increased each year, reaching an impressive 97.65% in 2022/23.

We continue to align to Scottish Government's tackling child poverty delivery plan 2022 to 2026, Best Start, Bright Futures. This sets out how we will work together to deliver on Scotland's national mission to tackle child poverty. It is a plan for all of Scotland and recognises the contribution that all parts of society must make to deliver the change needed for children and families. Another important national plan is The Promise. Poverty is one of the five fundamentals contained in The Promise plan and organisations must be able to demonstrate how they are playing their part in mitigating the impacts of poverty. We continue to align with the Promise.

We recognise that partnerships are key to the achievement of the outcomes we plan for our children, young people and families in the Scottish Borders and thank the Child Poverty Group and the Community Planning Partnership for their contributions to the Plan.

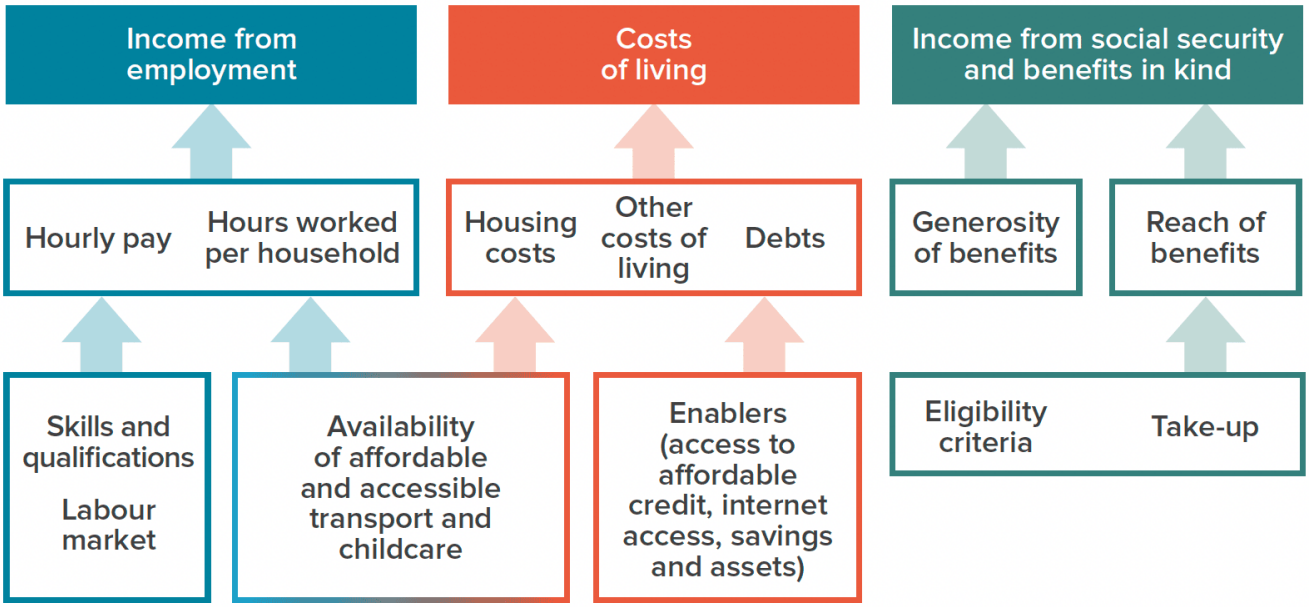
Councillor Caroline Cochrane – Chair of Community Planning Partnership
David Robertson – Chief Executive, Scottish Borders Council
Ralph Roberts – Chief Executive, NHS Borders

National Context

Best Start Bright Futures
Scottish Government's tackling child poverty delivery plan 2022 to 2026, Best Start, Bright Futures sets out how we will work together to deliver on Scotland's national mission to tackle child poverty.

Drivers of Child Poverty
The direct drivers of poverty fall into three main categories – income from employment, costs of living and income from social security. We remain focused on actions around these themes, as summarised in Figure 1 below.

Figure 1 – Drivers of child poverty



Source: Best Start, Bright Futures

Fairer Scotland Duty
The Fairer Scotland Duty (the Duty) places a legal responsibility on named public bodies in Scotland to actively consider ('pay **due regard**' to) how they can **reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions.** Therefore, it is crucial that public bodies consider the impact that their decisions have on socio-economic disadvantage and the inequality of outcome that both adults and children may experience as a result.

Families at greatest risk of poverty
The national Child Poverty Delivery Plan continues to focus on supporting the six priority family types. Almost 90% of all children in poverty in Scotland live within these six priority family types. We remain focused on actions to help these families.

1. Lone Parents
2. Families where a member of the household is disabled.
3. Families with 3 or more children
4. Minority ethnic families
5. Families where the youngest child is under 1.
6. Mothers aged under 25.

Source: Best Start, Bright Futures

Local Context

What do we know about Child Poverty in the Scottish Borders

The headlines below show that we face significant challenges in the Scottish Borders.

- Our children in low-income families (before housing costs) has **risen** from **19.5%** in 2021/22 to **19.7%** in 2022/23.
- 23% of our children still live in poverty (after housing costs) in the Scottish Borders
- 13.8% of Scottish Borders Households receive Universal Credit.

Appendix 1A shows more detail, including data relating to the nationally identified high priority family groups.

Households receiving Universal Credit

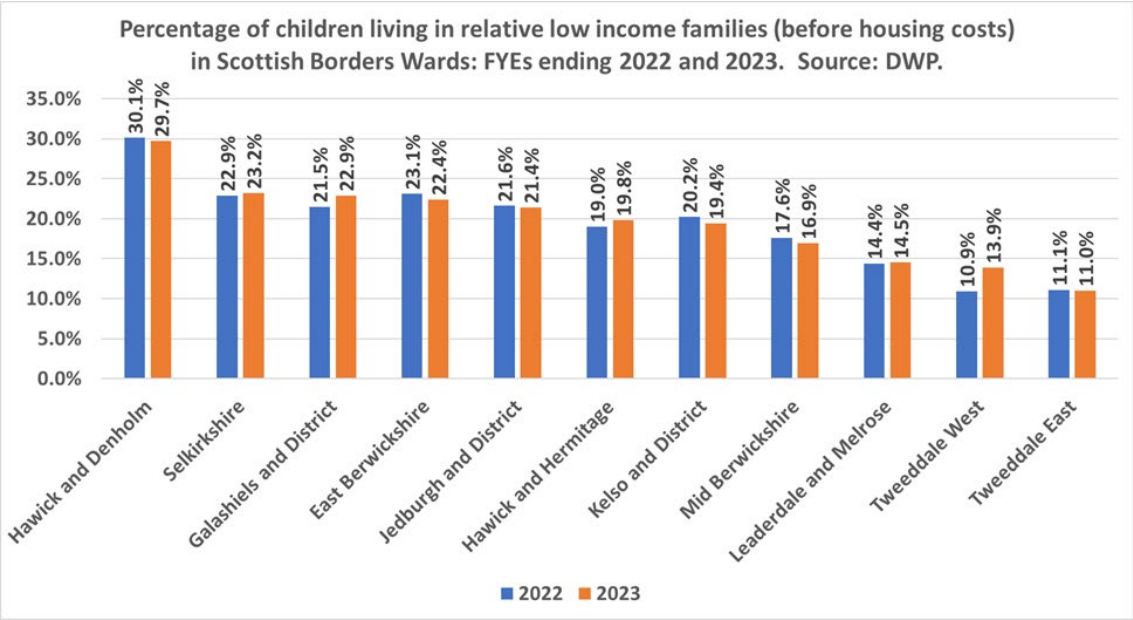
The table below shows the number and proportion of households in the Scottish Borders receiving Universal Credit (UC) compared to Scotland. Overall, the Scottish Borders has a lower proportion of households receiving UC (13.8%) compared to 17.1% for Scotland. In the Scottish Borders there were 3,233 households claiming the 'Child Entitlement' or 5.8% compared to 6.9% for Scotland.

Universal Credit Households November 2023 (provisional figures)	Scottish Borders No of Households	% of All Occupied Households	
		Scottish Borders	Scotland
All Occupied Households	55,858	100%	100%
All Universal Credit Households (UCH)	7,709	13.8%	17.1%
UCH with Children	3,427	6.1%	4.6%
UCH claiming Child Entitlement	3,233	5.8%	6.9%
UCH Lone Parent	2,390	4.3%	5.5%
UCH with 3+ Children	686	1.2%	1.4%
UCH with Child Under Age 1	263	0.5%	0.5%
UCH with Children - Child Disability Entitlement	348	0.6%	0.9%
UCH with Children - Adult limited capacity for work entitlement	566	1.0%	1.3%
UCH with children - adult carer entitlement	505	0.9%	1.2%
UCH with children with a UC entitlement due to disability or incapacity of a family member	1419	2.5%	1.1%

Source: DWP/NRS

Children in Low-income Families in Scottish Borders Electoral Wards

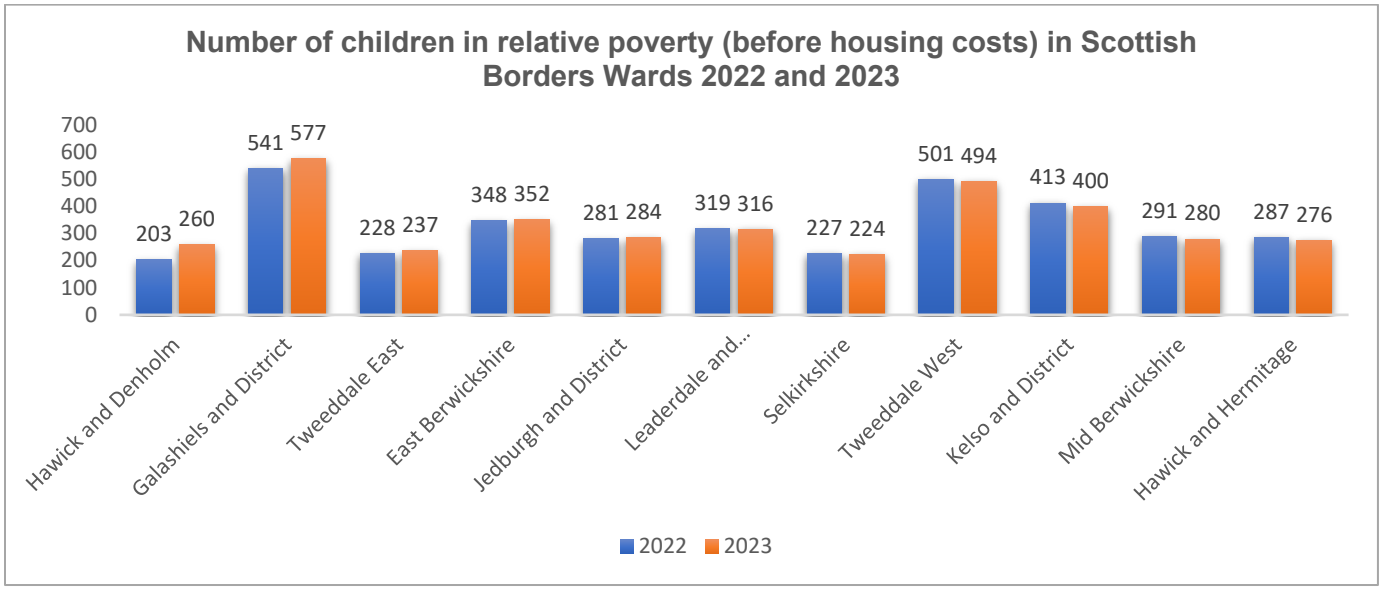
The chart below shows the Relative Child Poverty data at Scottish Borders Electoral Ward level for the financial years ending 2022 and 2023.



Child poverty is highest in the Hawick and Denholm Ward, which contains one of the region's areas of highest Multiple Deprivation. Selkirkshire and Galashiels and District also contain deprived areas, indicating that child poverty is strongly linked with deprivation, as we would expect.

Numbers of children in relative low-income families, Electoral Wards

The following chart gives an indication of the numbers of children who are estimated to be living in relative low-income families in the financial years ending 2022 and 2023.



The Scottish Borders Child Poverty Index

The Scottish Borders Child Poverty Index (SB CPI) provides additional insight into Child Poverty in the Scottish Borders. The SB CPI was created to work alongside the Scottish Index of Multiple Deprivation (SIMD). SIMD

provides a way of looking at deprivation in an area, covering the whole population and does not specifically reflect child poverty.

The SB CPI is a summary of two components, which are:

- Children in Low Income Families (**CiLIF**) – Source is DWP/HMRC[1]. Relative low-income is defined as a family whose equivalised income is below 60 per cent of contemporary median income. Gross income measure is Before Housing Costs (BHC) and includes contributions from earnings, state support and pensions. The SB CPI uses the most recent available year's data, currently there is a one-year lag e.g., for SB CPI 2022 uses the CiLIF data for 2021-22.
- Clothing Grant (**CLG**) - Source is SBC. The proportion of pupils recorded for Clothing Grant of all pupils in area for school year.

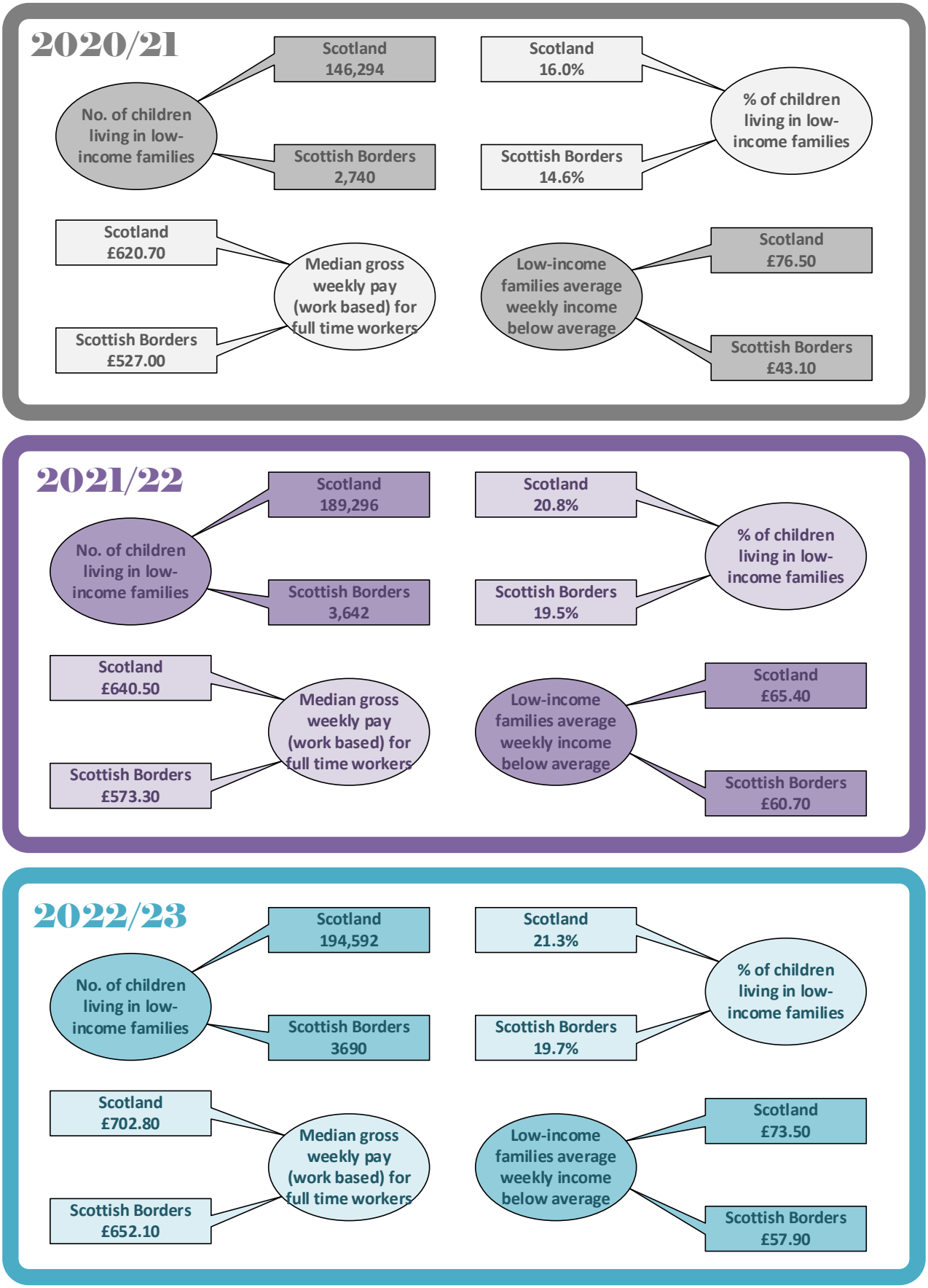
The table below shows the results for the Scottish Borders for 2017 to 2023

Child Poverty Index Component / Year	SB CPI 2017	SB CPI 2018	SB CPI 2019	SB CPI 2020	SB CPI 2021	SB CPI 2022	SB CPI 2023
Children in Low Income Families - CiLIF (DWP)*	19.0%	20.7%	20.5%	22.0%	18.0%	23.8%	**23.9%**
Clothing Grant - CLG (SBC)	14.6%	15.1%	15.2%	18.1%	18.0%	18.8%	**16.7%**

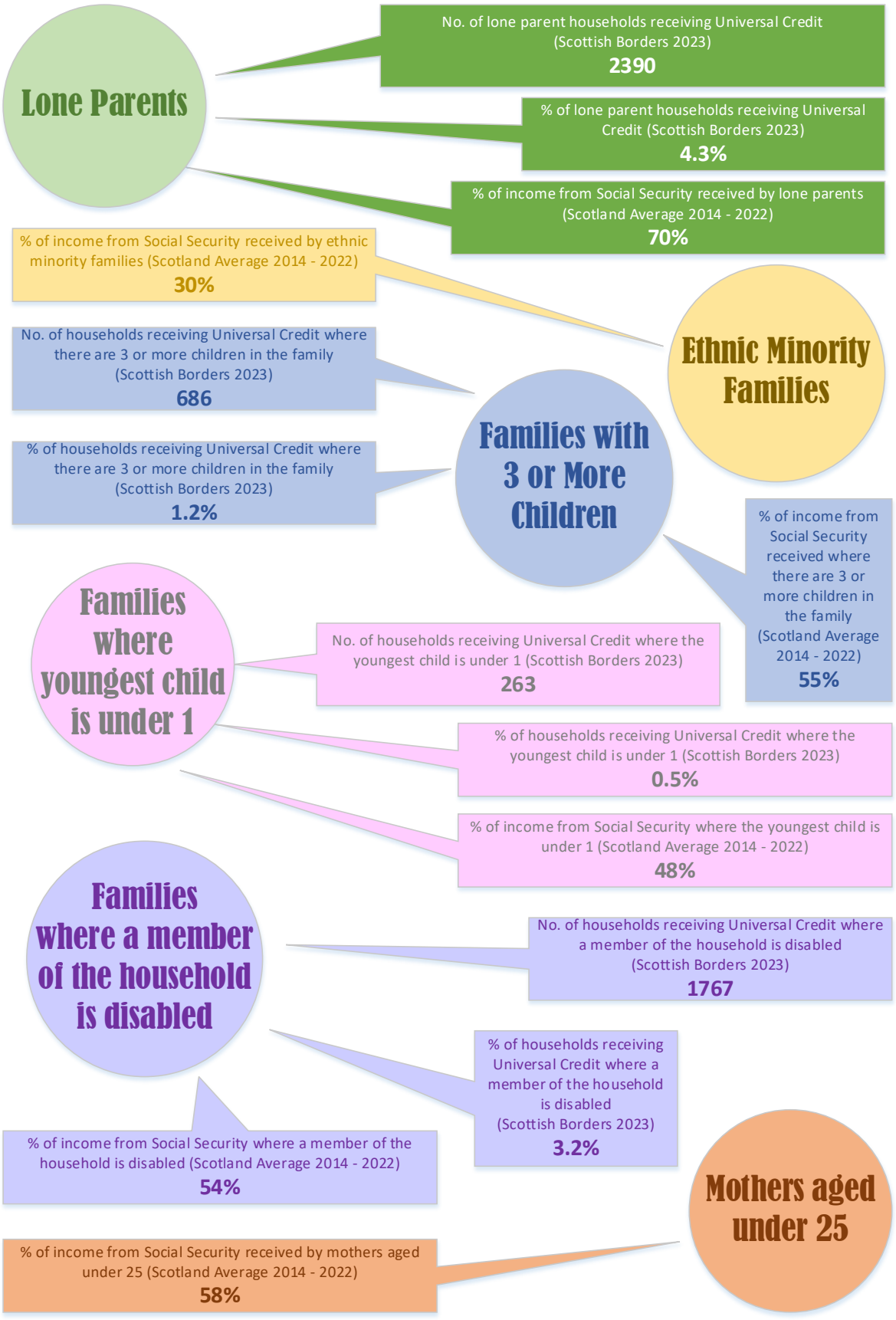
The impact of Covid19 and the cost of living crisis was seen in the number/proportion of data zones with Mid/High/Higher levels of child poverty. In 2017, 66% of data zones had Mid/High/Higher levels of child poverty. That increased to 71% in 2020 and then to 92% in 2022. However, for 2023 the proportion of data zones with Mid/High/Higher levels of child poverty returned to pre-covid levels at 68%.

Understanding Child Poverty in the Scottish Borders

[1] *The calculation of proportion of Children in Low Income Families for the purpose of the Scottish Borders Child Poverty Index differs to 'official statistics' due to the availability of the data from Stat-Xplore. The children in Stat-Xplore are defined as dependent individuals aged under 16; or aged 16 to 19 in full-time non-advanced education or in unwaged government training. (Not just those aged under 16 – unable to group into age bands). The figure for all children is then expressed as proportion of those aged 0 to 15 as published by NRS. It is recognised that this calculation is imperfect, but practical for the purpose of the SB CPI.


2020/21
No. of children living in low-income families
Scotland 146,294
Scottish Borders 2,740
% of children living in low-income families
Scotland 16.0%
Scottish Borders 14.6%
Median gross weekly pay (work based) for full time workers
Scotland £620.70
Scottish Borders £527.00
Low-income families average weekly income below average
Scotland £76.50
Scottish Borders £43.10
2021/22
No. of children living in low-income families
Scotland 189,296
Scottish Borders 3,642
% of children living in low-income families
Scotland 20.8%
Scottish Borders 19.5%
Median gross weekly pay (work based) for full time workers
Scotland £640.50
Scottish Borders £573.30
Low-income families average weekly income below average
Scotland £65.40
Scottish Borders £60.70
2022/23
No. of children living in low-income families
Scotland 194,592
Scottish Borders 3690
% of children living in low-income families
Scotland 21.3%
Scottish Borders 19.7%
Median gross weekly pay (work based) for full time workers
Scotland £702.80
Scottish Borders £652.10
Low-income families average weekly income below average
Scotland £73.50
Scottish Borders £57.90

Understanding Key Drivers and Priority Groups data in the Scottish Borders



What are we doing about Child Poverty in the Scottish Borders?

Tackling child poverty in the Scottish Borders is governed through the Community Planning Partnership (CPP). The CPP has oversight and approval duties associated with the Local Child Poverty Report and Action Plan but delegates the delivery of it to the Child Poverty Group. The Child Poverty Group is a multi-agency partnership made up of Scottish Borders Council, NHS Borders, and other key partners. They meet to discuss and support the local approach and respond where appropriate to national developments.

Local Plans outlined below all make a contribution to tackling child poverty in the Scottish Borders.

The Scottish Borders Council Plan
The Council Plan from April 2024 sets out a strategic framework for Council decision-making and operations.

Anti-Poverty Strategy
The Scottish Borders Anti-Poverty Strategy sets out the way in which the Council and its partners will aim to work together to help reduce poverty across the region and recognises that Child Poverty is included in this aim.

Children & Young People's Services Plan 2023-2026
Child Poverty features as a priority within the Children & Young People's Services Plan 2023-26. The whole family support network outlined in the Plan works with the Child Poverty Group towards the following aim:

- *Reduce the number of children in poverty and reduce the impact of living in poverty on families. Ensure that children and their families are given the opportunity to contribute to shaping local policy and actions to reduce the social and economic impact of poverty.*

Scottish Borders Community Plan
'Working together with our communities and through targeted partnership action, will enable all people in the Scottish Borders to live their lives to the full'. The Scottish Borders Community Plan works with four priority themes to support communities. These themes support our child poverty agenda.

T.H.I.S Borders (Tackling Health Inequalities in the Scottish Borders 2024-2030)
This report describes systemic differences in people's health that are thought to be avoidable and unjust and outlines how these can be tackled in practice.

Children's Rights
Our Children's Rights Report 23-26 reports on the steps we have taken to fulfil the requirements of the United Nations Convention on the Rights of the Child (UNCRC).

Equity Strategy
Our Education Equity Strategy 2021-2026 has been developed to ensure increased excellence, accelerated progress and embedded equity in our schools and settings to reduce the poverty related attainment gap and improve outcomes for care experienced children and young people (CECYP). The strategy coordinates the Attainment Scotland Funding streams; Pupil Equity Funding, Strategic Equity Funding and CECYP Funding to ensure maximum impact.

Local Housing Strategy
The Local Housing Strategy (LHS) 2023-2028 is the key strategic document for housing in the region. The LHS sets out how we and our partners plan to address housing and housing related opportunities and challenges in all tenures over the five-year period.

Budgets and Funding

Significant Scottish Borders Council budgets and funding are attributed to tackling child poverty in the Scottish Borders. The table below sets these out for 2024/25. Additional child poverty funding streams are also expected, as set out in Best Start, Bright Futures, for No one left behind, employability projects, reducing barriers and childcare.

Budget/Funding	2024/25
Crisis grants	£156,000
School clothing grants	£390,800
Free sanitary products in schools	£44,000
Free sanitary products in public bodies	£50,000
Educational Maintenance Allowance*	£237,070
Pupil Equity Funding*	£1,919,000
Strategic Equity Fund*	£448,171
Care experienced Children and Young People Fund*	£159,250
Whole Family Wellbeing Fund	£661,000
TOTAL	**£4,065,291**

*based on 2023/24 funding

Scottish Borders Council is proud to be an accredited real Living Wage employer (current rate £12 per hour) and they remain committed to encouraging the wider adoption of the real Living Wage by partners, local employers, and suppliers. The Council has adopted the *Scottish Government Best Practice Guidance on Addressing Fair Work Practices*, including the Real Living Wage in Procurement for relevant contracts.

Key areas of Work in 2023/24

During 2023/24**, child poverty partners have been involved in a** number of key areas of work that have had a significant effect on tackling child **poverty and** making a difference for children and their families.

Your Family Your Voice: Whole family support

Scottish Government recognised the need for a Child Poverty Employability Coordinator who could:

- Create and Adopt a Whole systems approach
- Support strong communications between relevant partners and services locally
- Identify and promote key changes to local policy and practice that will contribute to child poverty targets.
- Design referral pathways between services, or improve those already in place if they are not effective
- Link between child poverty work and other related policy initiatives
- Ensure a clear understanding of the causes and solutions of child poverty is shared and informs action undertaken within Scottish Borders
- Engage nationally to share learning and identify what works in relation to tackling child poverty through employability.

The plan to enable the aims to be met were set out in four phases:

Phase 1	Parental engagement – Your family, Your voice Practitioner engagement – Whole Family Support-Child Poverty(employability)
Phase 2	Gathering & Collation of our conversations Planning and agreed Action Plans with partners & stakeholders – How do we make a difference? Agree measurable and achievable outcomes and data capture
Phase 3	Framework to embed policy, practice and referral pathways Staff support & training

	Delivery
Phase 4	Measurement & reporting Reflection and review

A number of events were held with young people, through the Cost of the School Day, Youth Voices Network, parents within Early Years Centre identified as being in the highest areas of deprivation and with Practitioners from both within and outwith the Local Employability Partnership. A total of 16 partner agencies took part in the Whole Family Approach conversations.

Conversation themes for Parents and Young People were around:

- Income
- Wellbeing
- Potential
- Attainment, (education, training, career)
- What can we do differently?

Conversation themes for Practitioners were around:

- Barriers
- Support
- Referral Pathways
- Lifespan Interventions
- What can we do differently?

From these conversations, parents and young people told us about the following areas in which services could work differently to best support their needs:

The outcomes:

Income	**Wellbeing**
❖ Advice around budgeting ❖ Help with fuel debt ❖ Benefits advice ❖ Income maximisation ❖ Benefits advice delivered locally ❖ Information in spoken and visual form ❖ Provide childcare for attending training etc ❖ Cost of travel options for families	❖ Create time and space to talk ❖ Book club for parents ❖ Teatime clubs for parents and children ❖ Buddy bench for parents ❖ Exercise classes – Zumba, Pilates, kick boxing (in localities) ❖ Groups for parents with older children ❖ Support with parenting techniques ❖ Taster sessions for parents
Attainment	**Potential**
❖ Aspirational support ❖ Offer training in localities ❖ Support the whole families wellbeing ❖ Provide employability skills taster sessions ❖ CV building ❖ Support with dyslexia ❖ Provide courses that parents want ❖ Provide training mentors (local) ❖ Provide funding & technology to access online learning	❖ Funded out of school club places ❖ Support groups for parents and children ❖ Literacy support for children (no ipads) ❖ Provide learning opportunities within school times ❖ Provide flexible learning opportunities ❖ Provide learning opportunities taster session ❖ Childcare provision

Practitioners identified the following areas in which services could be delivered differently, to best support family's needs and make a difference:

❖ Improve accessibility to buildings ❖ Offer locality based support ❖ Improve partnership working – in person where possible ❖ Upskilling tutors ❖ Waive college fees ❖ Tackle Mental Health needs	❖ Challenge stereotypes ❖ Public sector work experiences ❖ Make the small changes early enough ❖ Earlier interventions and conversations ❖ Taster sessions ❖ More inspirational conversations with parents

Early Years

All Early Years settings, including the Early Years Centres, have reducing child poverty embedded within their practice. The provision of funded Early Learning and Childcare (ELC) for eligible 2-year-olds and all 3-and 4-year-olds and the expansion of hours to 1140, is a key national policy driver in reducing child poverty.

The Early Years Centres have a particular role in enabling families to be supported in maximising their income. An additional Early Years Centre has been opened using Mental Health and Wellbeing Funding. This Centre is in Kelso (chosen based on data from the NHS 27-30 Month Check). It is open part time during term time and data on its use and outcomes for families will be available for next year's report.

Equity and Excellence Leads play a critical role in supporting children to close the poverty-related outcomes gap by being an additional resource over and above usual staffing for a setting.

- Equity and Excellence Leads placed in settings with high deprivation (SIMD data) and lower attainment to plan interventions and support high quality pedagogy and practice.
- Impact of EE Lead role tracked and monitored over year by QIO and EYISO team.
- Additional SEYOs with Equity and Excellence remit placed in priority quintile 1 settings to plan and lead interventions to target identified cohort/individuals with gaps in learning and /or development
- All EE Leads work collaboratively with partners to support families to access benefits and support the actions of the SBC Child Poverty Action plan.
- EE Leads are all trained in Psychology of Parenting Programme (PoPP) and delivering to targeted groups of parents in areas of deprivation.

Housing

Housing Emergency – The Scottish Government declared a national housing emergency in May 2024.
In May 2024 Scottish Borders Council considered a report which outlined the significant challenges that the Council and partners are experiencing in ensuring residents in the Scottish Borders have access to a home which meets their needs. It was agreed that SBC should consider declaring a local 'Housing Emergency' and a report will be brought to Council for further consideration.

<u>The provision of new homes</u> - the programme has delivered 183 general needs homes in 2023/24 and 38 of these were particular needs homes.

<u>Homelessness</u> – over the past 18 months SBC homeless service has been experiencing unrelenting demand from applicants – particularly from the private rented sector. This has increased the demand for temporary accommodation. There is a shortage of new build private supply, few starter and smaller homes for purchasing or downsizing and little opportunity for family accommodation. The lack of supply is increasing the demand on the service.
<u>Demand for homes</u> – the demand for homes over the past few years has increased significant with many contributing factors:

- Supply of homes cannot keep pace with demand;
- There has been a significant increase in property values, at a rate well above national and local wage inflation;

- There is a smaller percentage of housing stock available as socially rented accommodation;
- Construction prices have increased significantly since 2021;
- The latest Scottish Government Quarterly Housing Statistics publication highlighted the lowest level of site starts in the social new build programme across Scotland since 1988.

These issues have a direct impact on property prices, rental levels, and general housing availability which contributes to wider economic and social challenges. We are seeing the demand in all sectors of housing:

- The average number of bids per available social rented property has doubled over the last 5 years – particularly in large family homes. For example, SBHA 's new homes in Kelso this year had 100 bids for 5 family size homes.
- More people are staying in their current homes. The number of RSLs let available has continued to decrease – meaning less availability of homes.
- Shortage in private new build. Over recent years there has been limited appetite from market house builders to develop in the Borders.
- Despite successful delivery of the Strategic Housing Investment Programme over recent years and delivery of affordable housing, it remains challenging to deliver new build social rented stock at the necessary volume. The Borders is faced with high construction costs, often significant infrastructure requirements, labour and contractor shortages and increasing finance costs. The Affordable Housing Supply Programme Funding allocation for the Borders has been reduced by 26% for 2024/2025 which will have a detrimental impact on the delivery of new affordable homes.

It is important to note that notwithstanding the issues and challenges highlighted above, a significant amount of progress is already being made. Some examples include:

- The Council's empty homes service has expanded to bring disused properties back in to use.
- The Empty Homes Grant Scheme launched in 2022 is currently supporting 20 empty homes to be brought back into use. 13 of these homes will be made available for rent at an affordable level.
- The demolition phase for Upper Langlee is complete and Phase 1 of delivery started in early 2024.
- 221 affordable homes were delivered during 2023/2024. 177 of these were new supply affordable homes.
- South of Scotland Community Housing are working with Community groups across the Borders to support them to potentially deliver their own housing developments.
- £1.8m in 2022/23 invested in improving private housing stock energy efficiency with a further £1.8m in 2023/24. Measures installed included - Solar PV & Battery: 50 completions, Air Source Heat Pumps: 10 completions and Internal Wall Insulation: 25 completions.
- There have been 5,444 referrals and interactions with households through Home Energy Scotland
- Key worker housing has been provided in Galashiels for NHS & SBC Social Care staff.
- Expansion of Homes for Good into the South of Scotland.
- Introduction of the licensing of Short Term Lets.
- Increased proportion of RSL lets to Homeless households (target 50%; currently 41%).
- Established the Housing Options Protocol for Care Leavers

Below we have set out some examples of the work undertaken to demonstrate how we are making a difference in the areas that are considered the key drivers for tackling child poverty.

Income from Employment

Positive Destinations

Data shows an improving trend in the percentage of school leavers from quintile 1 (the most deprived areas)

entering positive destinations after leaving school in the Scottish Borders. In 2018/19, 87.18% of quintile 1 school leavers entered a positive destination. This figure has steadily increased each year, reaching an impressive 97.65% in 2022/23.

Several initiatives have contributed to this success, including targeted support for young people, close collaboration with partners such as Skills Development Scotland, employability services, Developing the Young Workforce, and Borders College. We have also focused on enhancing the curriculum to expand opportunities for students, including more work-based learning and courses. The established 14+ partnership, where schools and partners work together to plan supports for young people transitioning from school to their chosen destinations, has been instrumental in this progress. Furthermore, setting ambitious local stretch aims as part of the Scottish Attainment Challenge has driven positive change.

Meanwhile, the rate for quintile 5 leavers (the least deprived areas) has remained consistently high, hovering around 97-99% over the past 5 years. In 2022/23, 95.77% of quintile 5 leavers entered a positive destination. Notably, the gap between quintile 1 and quintile 5 positive destination rates has significantly narrowed over time in Scottish Borders. In 2018/19, there was a 12.12 percentage point gap between the two quintiles. By 2022/23, not only had this gap closed, but quintile 1 actually surpassed quintile 5 by 1.88 percentage points (97.65% vs 95.77%).

This remarkable progress demonstrates the effectiveness of the targeted initiatives and strong partnerships in Scottish Borders aimed at improving outcomes and opportunities for school leavers from the most disadvantaged backgrounds. The concerted efforts of schools, the council, and various partners have created a supportive ecosystem that enables young people, regardless of their background, to transition successfully into positive destinations such as employment, further education, or training after completing school.

Parental Employability Service
Parental Employability Support (PES) uses a holistic keyworker approach to upskill and/or re-train, increasing family income, lifting themselves and their family out of poverty. PES workers provide personalised support for parents who face barriers to progressing in their careers. PES are currently supporting 135 parents within the Scottish Borders.

The Intensive Family Support (IFSS) takes a holistic whole family approach to working with families, supporting each individual within the family to progress as well as implementing whole family activities that build a support network. IFSS aims to improve family dynamics to enable families to provide effective support for each other. IFSS are currently supporting 29 families within the Scottish Borders.

Within the Scottish Borders PES and IFSS work together to ensure that all referred families and parents can identify their barriers and holistic support to reach their potential. Below is a case study from a Parent who has received tailored support from both services, and it showcases the work delivered by both teams and positive outcomes achieved through the support.

Bogdan moved to the Borders from Romania in 2019. He met his partner in 2020 and they moved in together 2021. His partner was referred to IFSS in 2021 whilst pregnant due to social isolation, financial hardship and health issues. He had limited English with no permanent employment, unstable housing and poor living conditions. Bodan and his partner hoped for financial stability, a secure and safe home and permanent employment.

<u>Support Pre-Employment</u>
Financial Stability

- *Register with Universal Credit*
- *Apply for Child Benefit*
- *Apply for Scottish Child Payment*

Secure and Safe Home

- *Register with Social Housing, SBHA, Waverley and Eildon, contact Housing Officers to discuss family needs*
- *Contact current landlord regarding poor living conditions*
- *Apply for Community Care Grant including removal costs*
- *Apply for Fresh Start pack*
- *Liaise with Housing Officer to secure social housing tenancy*
- *Discretionary Housing Payment Application to cover dual rent*

Permanent Employment

- *Enrol on ESOL course at Borders College*
- *Connect Scotland Device and MiFi Device*
- *Register on My World of Work*
- *Create CV*
- *Register on My Job Scotland*
- *Support Bogdan to apply for jobs*
- *Contact SBC re Modern Apprentice Positions and ask that Bogdan be considered*
- *Support Bogdan to interview location*
- *Assist with pre-employment checks*

The family are now living in a SBHA tenancy, which is fully furnished. The family are in receipt of child benefit, Scottish Child Payment (and Universal Credit pre permanent employment) Bogdan has gained employment on a 4-year Mechanic Apprenticeship with SBC, earning the living wage and his English has improved.

Quote from Bogdan:
'I could not do it alone without your help
Thank you for everything, I will not forget all the things you do to help us'

The Cost of Living

Holiday Provision
The partnership offered funding for holiday programmes in 2023/24.

Live Borders
Through the summer holiday period of 2023 (1st July – 16th August 2022), Live Borders worked in partnership with Scottish Borders Council and other key providers to deliver the "Summer 2023" Holiday Activity Programme. Live Borders delivered a comprehensive programme of sport, physical activity, and cultural opportunities and continued to offer free places for identified children through discount codes and in some instances, making whole offers free of charge.

Activities included a variety of holiday camps in all school clusters (multi activity and sport), a Family Activity Pass for families referred by professional staff, free cinema access for targeted individuals, a range of museum and galleries activities, library workshops, and a partnership disability camp with a local third sector group. Key findings from the programme are as follows:

- Over **3500** visits made by children and young people to Live Borders activities.
- Activity camps (all) averaged **92**% occupancy with **52%** of places free of charge for targeted children and young people.
- 542 families accessed activity camps. 182 families were identified as low income and in need of targeted support.

- **47**% of children reported an increase in their resilience when having to deal with day-to-day problems through the summer holiday programme.
- **44**% reported an improvement in their self-confidence through participation in the summer programme.
- **61**% reported that they were more likely to be active in the future as a result of holiday activity participation.
- **82**% reported that they had greater confidence to attend further sport and physical activity opportunities in their schools and wider communities.

Children & Young People feedback
- 97% of children and young people reported having fun at holiday camp activity.
- 59% of children and young people felt that they had made new friends as a result of their involvement through the summer programme
- 64% stated that they had learned new skills.
- 57% reported that they were interested in new things.
- 27% reported that they had reduced their feelings of loneliness as a result of their participation in the summer programme.

Parents
Following the camps, parents were e-mailed an online survey to obtain feedback and further evidence the impact that the programme has had:

- *"My daughter is from Ukraine, and despite little practice of English, she felt very comfortable. Every day she wanted to run to the camp. We would like to thank everybody from the Live Borders team".*

- *"Thank you. So rare for her to come home raving about going back. Well done!"*

- *"We REALLY appreciated the support and opportunity offered to SEN children. This made the difference between attending or not. Please provide more activities with your wonderful staff".*

- *"My two had such an amazing time when they were there, and it made their summer 1000 times better".*

- *"As a parent, to watch him grow in confidence through the week as he told me stories of new friends made and activities he had enjoyed was positive to see and hear".*

Youth Borders
A total of **1,141 young people directly benefitted** from Summer 2023 funding by attending **285 youth work activities**. Young people enjoyed **2,924 snacks and 1,599 meals** during these summer activities. 22 YouthBorders members organisations delivered this programme.

People living in households on low incomes, young people undergoing transitions, followed by larger families were the top three factors targeted by YouthBorders member organisations.

Specific Households / Families	**No.**
People living in households on low incomes	539
Children undergoing transitions	238
Larger families (3+ children)	205
Children with a disability or ASN	185
People living in households with a disabled family member	85
Children supported by a child's plan	85
Minority Ethnic Families	75
Children under 1	49
Mothers under the age of 25	44
Children in need of protection	42
Young Carers	33

Family Tea Group

Working with partners in Burnfoot Community Futures, our Community Learning and Development (CLD) team identified a need for families to work and have fun together and be fed to reduce rising costs in fuel and food costs. They planned and delivered a 6-week block of family fun/teatime activities for families who they were aware of in the community who would benefit from this intervention. Different family groups, single parents, large families, dads and kids, teenagers and high school families attended.

Activities included art and crafts, cooking, board games, junk modelling, gardening, STEM activities and the last session delivered party food and time in soft play (whatever the age).

Funding was provided through Burnfoot Community Futures (Bring Back Better Borders) and the CLD budget.

Families learned to work together, had the opportunity to play games together and value quality time together. Families were fed, thus reducing household costs in heating and food. Recipes were shared so that families were able to make affordable meals at home.

Families accessed wider support through conversations with CLD/Hub and were signposted to local services and support where relevant/required e.g., housing, access to Councillors, foodshare, etc. Adults from each group progressed into volunteering in the community garden, or further CLD learning opportunities and felt more able to participate having had the opportunity to build relationships and trust in this group in the first instance.

Cyrenians
Cyrenians are a charity who tackle the causes and consequences of homelessness. The first cook club and pantry in the Borders was set up in May 2023, closely followed by 3 others. They are currently operating in the following locations:

- Cheviot Youth, Kelso
- Oakwood Park, Galashiels
- Philiphaugh Community Centre
- Walkerburn Public Hall

The aims of this project are to get good, affordable food into communities that may be experiencing food insecurity and to bring the community together over food. They do this by using a dignified, community focused approach.

Uptake has been good and people are enjoying both the pantries and the cook clubs. Between May and October 2023, they had 86 people signing up for a pantry membership and the pantries were used a total of 1,149 times. They also distributed 7,765kg of food from Fareshare, equating to around 18,500 meals.

The pantry at Walkerburn is currently at full capacity and there are a few people on the waiting list. The Philiphaugh Pantry is also often at capacity and Kelso has a good uptake, identifying that there is a real need in these areas.

"*The pantry has been very helpful, great choice, friendly staff and helpful. Appreciate the support during these difficult times*"

"*The pantry helps me and my wee boy immensely. The staff make me feel really welcome and we get a good chat too, which helps a lot being a single parent. The food really helps me out as I have to budget my food shop. Great service!*"

"*The pantry has been great in the community. It is very helpful feeding a large family. It has helped to save on cost considering inflation in supermarkets etc. Very grateful. Thank you*"

The Cook Clubs see regular multi- generational audiences and each venue has its own characteristics based on the people who attend:

- Oakwood Park in Galashiels works with a teenager with an absent parent who is not attending school who comes to join this group each week.

- Kelso has a group of young adults with learning difficulties who seek the skills to live independently. Our users are supported to gain skills for healthy eating, managing food to reduce waste and associated cost and being able to afford to feed themselves independently. The cross over with Local Area Coordinators (LAC) has been very positive here.
- The Walkerburn group has as many as 25 attending, 12-15 of which are children. This is a loud and social environment and they sit down to eat the meal together at the end. Everyone is involved in preparation, laying the table, serving and clearing away. A relationship with the Citizens Advice bureau has been established at Walkerburn and this offers an invaluable opportunity to offer services to people who would otherwise find it impossible to access the advice and support they need.

Warm Welcome Spaces across the Borders
The cost-of-living crisis continued to have a negative impact on our rural communities in 2023/24. This issue becomes more exacerbated in the winter months when opportunities for social connections are reduced and the cost to eat and heat homes increases.

Funding of £40,000 was awarded from the National Lottery Community Fund and Scottish Borders Health and Social Care Partnership to Borders Community Action who created a joint approach to support local communities, and the idea of Warm, Welcome Spaces emerged. The grant benefitted a wide range of community groups and organisations across the Scottish Borders with a varied spread across the 5 localities. It is estimated that a total of 3,900 people benefitted from activities, such as arts and crafts, food, cafes, games and youth activities.

Feedback was positive:
It helped me make new friends within our village
It's hard for my mum at home, free food on Friday evening's is a real help
Things like this make a big difference to me
I lost my Young Scot card and haven't eaten since breakfast (boy aged 13)
Can we come along just for food? (boy aged 14, family now connected to foodbank)

Food / Breakfast
Jedburgh Grammar Campus offers:
- The Filling Station (breakfast club before school) for targeted young people in primary and secondary
- Snacks for break in all primary classrooms, the Pupil Support Base and Science
- Prelim breakfasts for senior pupils offered by Home Economics staff

In Secondary: Young people experiencing poverty have the option to attend each morning. The aim is for every child to start the school day having eaten a healthy breakfast so that they…

- Have increased focus.
- Have higher energy levels.
- Are ready to learn.
- Can develop their social skills.
- Can make friends.
- Arrive in good time.

There is also a box of food in the Pupil Support Base and Science department which can be accessed by any young person who is hungry at any time of the school day.

In Primary: There is a Breakfast Club Supervisor. Children are referred via regular Health and Wellbeing Partnership Meetings. The Filling Station provides a nurturing and supportive environment for some of our more vulnerable children to check-in each morning. There is also a P4-7 Soft Start intervention group each morning for 5 primary pupils in this area and they have a healthy breakfast which helps them to be ready to

learn. A ‘Wee Filling Station’ is in each learning area for children who need a snack at break. While we target those children experiencing poverty, any child can access a snack if they are hungry.

Funding has come from book sales in the community, donations from local supermarkets, a donation from Jedburgh Rotary, funding application and the PEF fund. PEF Youth Worker *‘The children in Soft Start don’t get breakfast at home due to family circumstances. It’s a healthy start to the day as the food on offer meets the guidelines and the breakfast gives them energy for learning.’*

Bumps, Babies and Toddlers Breakfast Club
A number of parents identified the need for a Group that could be held at their local community centre. It was imperative that the Group could accommodate pregnant women, those with babies and those with toddlers. They had already connected to other parents in the community who agreed that they would like to go ahead but needed support from CLD to make this happen. From these conversations, Langlee Bumps, Babies and Toddler Group was born.

CLD met with NHS Borders Joint Health Improvement Team (JHIT) to request their involvement for the provision of breakfast given prior knowledge of families and their circumstances i.e., the impact of the cost living crisis. CLD were aware of the various stages of pregnancy of some of the parents.

Aims and Objectives:
Provide a bumps, babies and toddlers group for the local community in response to their need
Provide a nutritious breakfast and raise awareness of good nutrition
Provide information and signpost families to relevant organisations
Emphasise the need for bonding, routine, boundaries, nurture and play
Peer learning and support
Work in partnership with Borders Community Action to build capacity of the parents by encouraging and supporting them to become a sustainable, funded community-led group

What We Did:
A mapping exercise was facilitated with parents to find out what they would like on the programme of activities
Key partners were contacted to see if they were willing to provide an input, and from there a 12-week pilot was developed and delivered and subsequently extended. Key partners positively engaged with parents: Weaning, Infant Nutrition, Social Security Scotland, DWP, Multiply, Social Work
A nutritious breakfast was provided reflecting the EatWell Guide
Resources were shared resources on behalf of key partners, including Money Worries App, 6 ways to be well and PND information booklets, healthy eating guides and recipes
A safe space was provided for parents to bond with their child through free play, nursery rhymes and stories and engage in peer learning and support
Applied for funding to extend the sessions for 1 year and worked with parents to set up a committee – this learning is ongoing

Outcomes:
Partnership team successfully met all of our aims and objectives
Parents have improved knowledge and clearer understanding of weaning and infant nutrition organisations available to support nutritious breakfast options and the benefits to their child(ren)’s development
Parents have a clearer understanding of bonding, routine, boundaries, nurture and play and can link these to their child(ren)’s positive growth and development
Parents have developed a network for peer support and feel better connected to their local community

The parents attending reported that the Group has had a positive impact on them and their children. It is hoped that the Group will become sustainable, grow and develop with the parents at the helm. This work has now taken place and a committee has been formed. CLD applied for funding, and this was awarded to the Group through the Cost-of-Living Fund (SBC) following this successful 12-week pilot. The funding will provide breakfast for the group for the next year and by then the hope is that the group will be self-sustaining.

Closing the Poverty Attainment Gap
Over the last 2 years the local authority has made progress in narrowing poverty-related outcomes in attainment, attendance and positive destinations. Locally designed approaches to addressing the gaps are being designed and implanted in Clusters. The cluster model in the Scottish Borders is a commitment to working across a range of services, including third sector organisations and community partners working together with families, maximising local resources. This initiative aims to empower communities to take ownership of change, enabling them to adapt and thrive. The focus is on collaboration, consultation, and shared responsibility among stakeholders. This work is also a key part of the SBC Equity Strategy.

Clusters have adopted a range of approaches. For example, one cluster has employed a home school link worker with a focus on improving levels of engagement, attainment and attendance with targeted families. Another cluster has created a Wellbeing Team and a Family Wellbeing Hub which will deliver universal and targeted wellbeing activities for families.

Cost of the School Day
The local authority is making good progress in building a framework to ensure a consistent approach to tackling the costs associated with school. The community of practice (CoP) has received support from Child Poverty Action Group (CPAG) Scotland and Education Scotland. Partners from educational psychology, Citizens Advice Service, Quarriers mental health service, Social Security Scotland, CPAG Scotland, NHS Borders, Community, Learning and Development (CLD) and employability services have been included in the CoP. A ‘champion’ from each cluster has been identified who will have a lead role in gathering and sharing examples of effective practice. There is recognition that some schools and settings have already taken significant action in reducing costs to families so a collation of case studies from the within the local authority will be gathered and highlighted locally and shared with CPAG Scotland.

Pupil Equality Funding (PEF)
PEF funding was used to create a “Snug” within Wilton Primary School. The Snug was to be used as a space to nurture young people identified as displaying increased distressed and deregulated behaviours, that were having a negative effect on their attainment and achievement especially in reading, writing and numeracy.

A junk room space in the school was given a makeover and a local supplier provided the furniture at generously reduced prices. The parents at the school also volunteered to help makeover the space.

The Snug has been running since April 2023. In just under a year, the Snug has run a number of groups, supporting over 60 children.

All of the children complete the Glasgow Motivation and Well-being questionnaire twice over the course of the academic year. Once in October and again in April. The data from the questionnaire is analysed, and then discussed with class teachers. From this Snug groups are formed.

The children are in groups of no more than eight. The school runs two sessions a day, four times a week and

the sessions are now run by two Additional Needs Assistant's (ANA's).

The Snug has been such a success that the school are now supporting young people from other schools within the Hawick cluster. It is truly becoming a shared resource. The school have also had professionals from outside agencies and from other schools across the Borders observe the nurture groups in the Snug.

The model is working well and the ANA's have been upskilled and trained using the Nurture groups in School Principles and Practice. They have also worked closely with Speech therapists, CAMHS and Education Psychologist to meet the needs of the pupils.

Outcomes:
100% of the children made improvements in both developmental and diagnostic strands.
98% of children improved their attendance as a result of attending the Snug.
100% of class teachers noticed a positive change in behaviours, relationships, communication and regulation.
Parents and carers have been very supportive of their children attending the Snug, with 100% of them agreeing to their children being selected for a nurture group.

Income from Social Security and benefits in kind

Financial Inclusion
A dedicated resource is now part of the Financial Inclusion Team supporting the Employability and Community Learning Teams. Benefit checks and advice are now available for parents who are looking to maximise their income or improve their employment prospects. Along with staff dedicated to Early Years Financial Inclusion (who already has strong links with SBC's Early Years Service, NHS Health Visitors and Midwives), they will provide an increase in support to a wider group of families in the Borders.

The work undertaken by these two staff resulted in over £1 million in financial gains for families in the Scottish Borders during 2023/24.

The Financial Inclusion Team, along with the Digital Innovation and Systems Team, have developed a new case management system which will improve reporting and day to day case management. It will offer improved reporting to monitor demand, identify trends and influence future take up campaigns. The team will also use Council data to maximise free school meal and clothing grant eligibility as well as encourage take up of Scottish Child Payment.

Post COVID and cost-of-living issues were less relevant within referrals in 2023-24, however there were more residence related issues reflecting an increase in job seekers arriving from overseas many who had no "access to public funds" and therefore unfortunately no rights to benefits.

The case studies outlined below clearly demonstrate the immense value that the joint SBC referral system and NHS Pathway Initiative bring to young families in the Borders. The support provided by Financial Inclusion staff can significantly increase the income of families, but the positive outcomes can extend much further than just an increase in income:

Case 1 A referral was received for a young person after concerns were raised by a key worker. This led to a conversation with their parent who was struggling to support the young person and their two siblings. After a benefits check was completed, Best Start Grant, Best Start Foods, Council Tax Reductions, Child Benefit, Universal Credit and Carers Allowance were awarded. The young person was awarded Educational Maintenance Allowance and the support provided an increase of over **£7,000** per year in additional household income.

Case 2 A single parent lived with their teenage child in a poorly maintained private let. They had not worked for over 8 years and was offered a job but were concerned about losing their benefits. They received support from

the team to apply for Universal Credit, Scottish Child Payment and Discretionary Housing Payment which meant they would be over £100 per week better off. Once the parent settled into the post, they received advice which led to them working overtime and starting a second job. They were also signposted to support regarding their tenancy which led to several repairs being carried out on the property.

Case 3 A single disabled mother with two disabled children was living in a very rural area in the Borders. A Health Visitor immediately recognised that the family were living in extreme poverty and had never claimed any benefits so contacted the Early Years Financial Inclusion team. A full benefits package was immediately arranged including many disability elements for both the mother and the children. In the end this amounted to an increase in income of over **£20,000** a year and the family were able to enjoy a much more fulfilling life.

Case 4 A single parent with two children had their benefits cancelled by HMRC and ordered to pay back over £30,000. Her physical and mental health deteriorated, and she was encouraged by her Health Visitor to get assistance. The Early Years Financial Inclusion team provided support, and the benefits were eventually reinstated resulting in the overpayment being cleared and a backdated payment of over **£8,000** being made.

Case 5 concerned a young mother with two young children who had failed to escape from an abusive relationship with her husband. This was found to be an extreme example of coercive control and she thought that because of this she would not be entitled to any support from the authorities. The health visitor reported that the mother was understandably terrified to leave her husband with no money and no alternative accommodation. In a joint effort with the Parental Employment and Homeless Teams they managed to find her alternative accommodation, a full benefit package and not least a small part time job and she and her children were finally able to safely move away from her abusive husband. This was an excellent outcome and a great example of joined up working.

Case 6 involved a couple with 6 children where the Health Visitor reported that she had been dismayed at the condition the family were living in. The Financial Inclusion team visited them and were very concerned to discover that the unemployed father was in fact claiming all the benefits and using the money to host drug parties with his friends leaving his own family in an almost destitute condition. The Child Protection Team were made aware of the situation and subsequently they involved the police who took the necessary action to remove the father. In the meantime, all of the benefits were transferred to the mother and the homeless team managed to get her alternative accommodation in another area of the Borders. All this took a while, but the mother reported later to the health visitor that she had never been happier.

At the time of referral, the incomes of each family were well below the Scottish Governments guide on poverty levels. On completing the referrals, all of them were over these limits so every family had been effectively lifted out of poverty following the health visitors and Financial Inclusion Team's intervention.

Other Activity During 2023/24

Throughout 2023/24 Scottish Borders Council, NHS Borders, Community Planning Partners, and the Child Poverty Group have progressed a significant range of activity geared towards tackling child poverty in the Scottish Borders.

Detail on that activity can be found in **Appendix 1B.**

Looking Forward – Priorities for 2024/25

Our priorities for 2024/25 are set out below in four key themes. These themes have been identified by the Child Poverty Group Partners and demonstrate a commitment to working together to deliver differently in order to tackle child poverty going forward. A workshop is planned for the summer whereby Partners will work together to create specific actions for these priorities.

Understanding local need
Develop a shared data and intelligence resource across services, departments and organisations so that there is a more in-depth understanding of the drivers and impact of poverty in the Scottish Borders
Develop our work with people with direct experience of poverty so that they are meaningfully involved in service development and delivery. Ensure that membership of the Child Poverty Group reflects the voices of those who have experienced poverty and those who work closely with low-income families.

Use of policy levers and resources
Use a whole systems approach to poverty reduction and prevention, including high level strategic engagement from housing, economic development, transport and childcare in the child poverty agenda.
Ensure that our pathways are simple and intuitive so that families at risk of financial crisis are supported in a timely and dignified way.
Increase our focus on engagement in the early years so that low-income families receive the wrap-around, whole family support they need.

Understanding our progress
Create a shared outcome framework for child poverty, which allows all local partners to understand their progress towards shared goals in the short, medium and long term. This should include understanding the impact of key interventions on priority families.

Ways of working
Build stronger, clearer relationships between the Child Poverty Group, the CYPPP and ultimately the CPP. Ensure that the Child Poverty Group is empowered and resourced to take a strategic role in action to tackle child poverty in the Scottish Borders.

Glossary

CECYP	Care Experienced Children and Young People
CILIF	Children in Low Income Families
CLD	Community Learning and Development
CLG	Clothing Grant

COP	Community of Practice
DWP	Department for Work and Pensions
IFSS	Intensive Family Support Service
JHIT	Joint Health Improvement Team
NIF	National Improvement Framework
NRS	National Records of Scotland
PEF	Pupil Equity Funding
PES	Parental Employability Support
PND	Post-natal Depression
SB CPI	Scottish Borders Child Poverty Index
SB	Scottish Borders
SBC	Scottish Borders Council
SBHA	Scottish Borders Housing Association
SIMD	Scottish Index of Multiple Deprivation
UC	Universal Credit
UCH	Universal Credit Households
UNCRC	United Nations Convention on the Rights of the Child

Appendix 1A

Local Child Poverty Data and Statistics

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Children in Low Income Families

Information provided shows evidence on drivers of child poverty, along with information on the groups of people who are more at risk of experiencing child poverty.

The information in the Headlines section contains indicators that can be used as 'proxy' measures of child poverty locally.

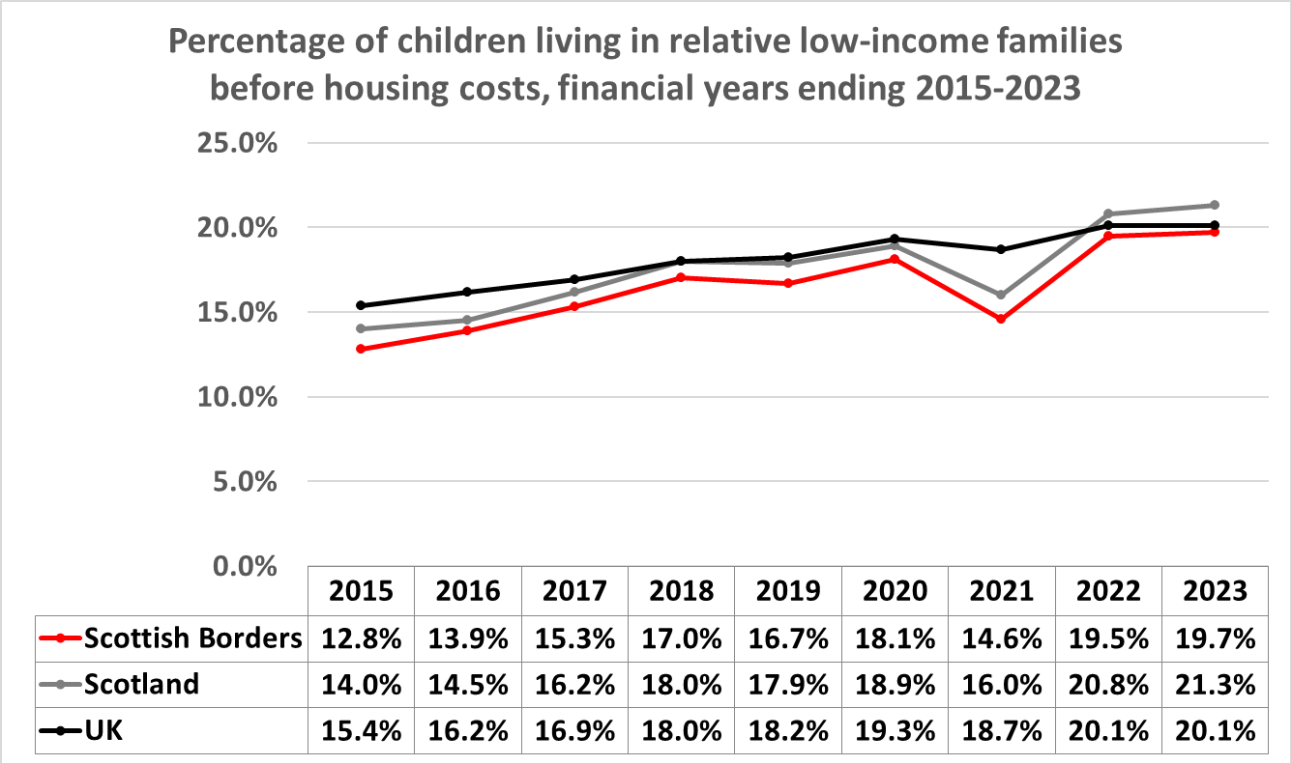
The Department of Work and Pensions (DWP) publication "Children in low income families: local area statistics 2014 to 2023" provides information at local authority and ward level to help monitor child poverty and its drivers locally.

Children in Relative Low-income Families, before housing costs

Relative child poverty in a given year is when a family is assessed as having a low household income by the median income standards of the given year. The family must also claim Child Benefit and at least one other household income benefit (Universal Credit, tax credit or Housing Benefit) at any point in the financial year.

The chart below shows the DWP figures for the Financial Year Ending (FYE) 2023. **19.7%** of children aged 0-15 in the Scottish Borders live in relative low-income households. This is below the Scottish average of 21.3% and is unchanged from the previous year. The Scottish figure has increased since the previous year, indicating that child poverty in Scotland is getting worse but child poverty in the Borders is not so much. These are provisional findings, as the figure for Scottish Borders may be revised in due course.

Children in Low-income households over time, FYEs 2015 to 2023 before housing costs

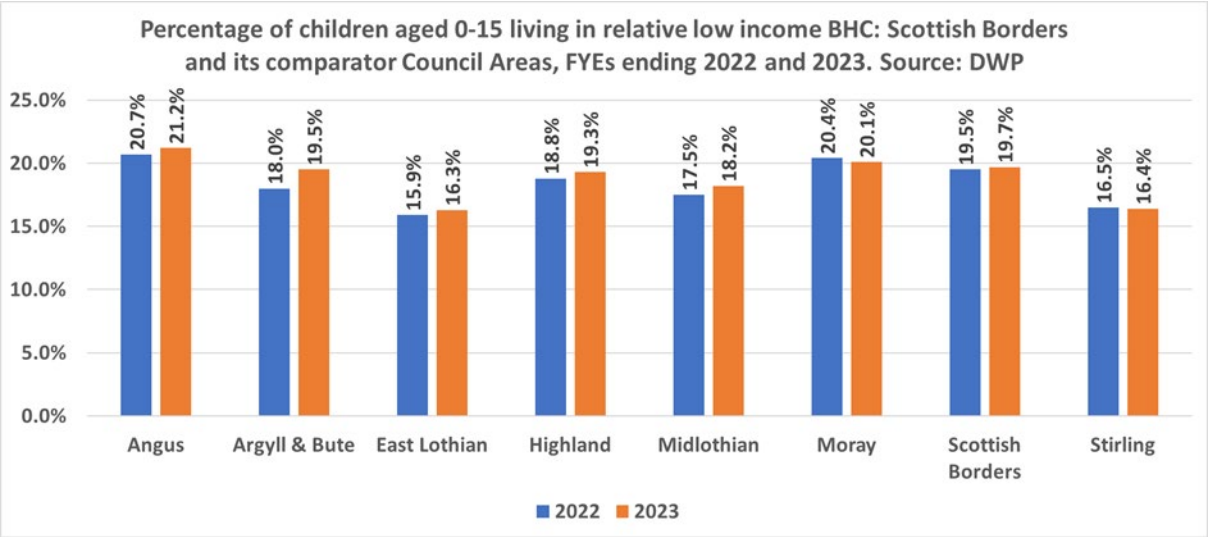


	2015	2016	2017	2018	2019	2020	2021	2022	2023
Scottish Borders	12.8%	13.9%	15.3%	17.0%	16.7%	18.1%	14.6%	19.5%	19.7%
Scotland	14.0%	14.5%	16.2%	18.0%	17.9%	18.9%	16.0%	20.8%	21.3%
UK	15.4%	16.2%	16.9%	18.0%	18.2%	19.3%	18.7%	20.1%	20.1%

The line graph above shows the timeline of this measure since FYE 2015.

Changes since the previous year: Scottish Borders and comparator Local Authority areas

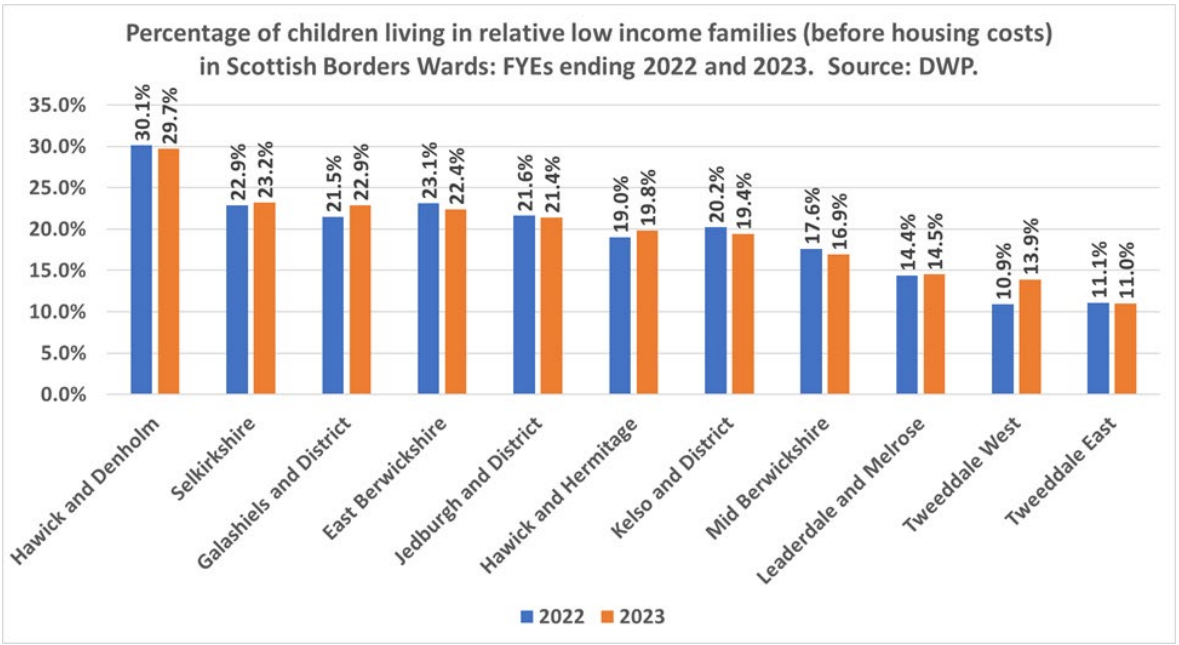
The Scottish Borders is in a benchmarking group with seven other Scottish Local Authorities.
The bar chart below shows how relative child poverty in 2022 and 2023 compares with the position in these comparator areas.



Relative child poverty BHC in Scottish Borders is on the high side compared with its "family" of comparator Local Authorities. Only Angus and Moray have higher levels. This shows there is still work to do in Scottish Borders to reduce child poverty.

Children in Low-income Families in Scottish Borders Electoral Wards

The chart below shows the Relative Child Poverty data at Scottish Borders Electoral Ward level for the FYEs 2022 and 2023.



Child poverty is highest in the Hawick and Denholm Ward, which contains one of the region's areas of highest Multiple Deprivation. Selkirkshire and Galashiels and District also contain deprived areas, indicating that child poverty is strongly linked with deprivation, as we would expect.

Numbers of children in relative low-income families, Electoral Wards

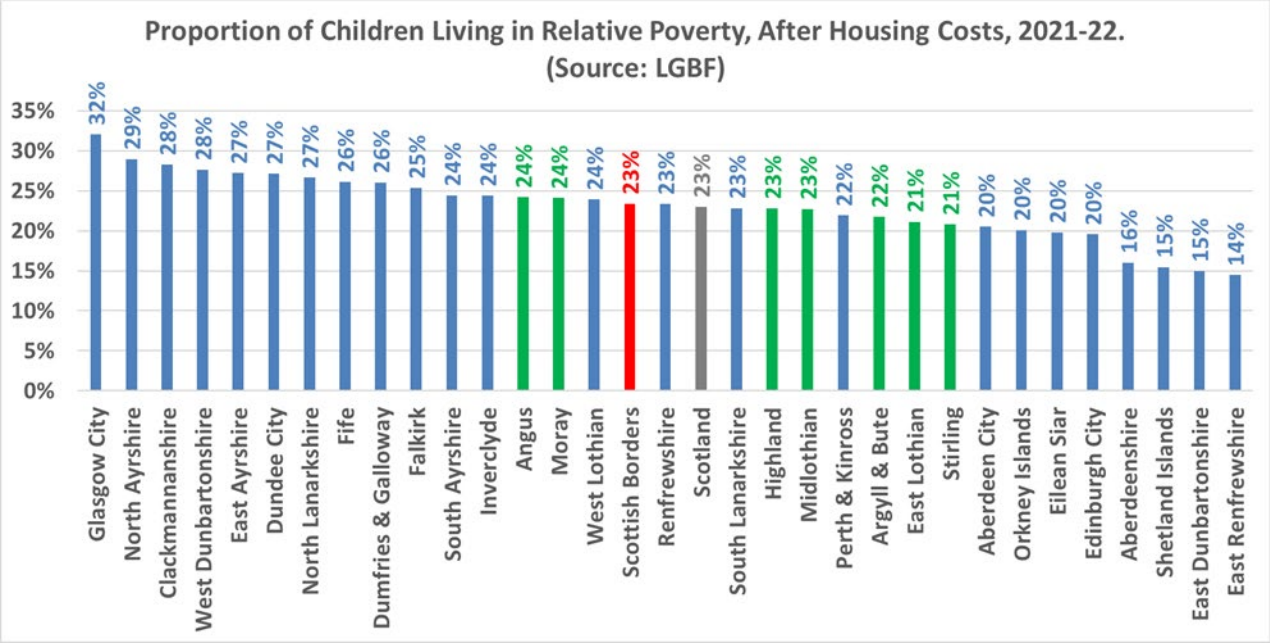
The following table gives an indication of the numbers of children who are estimated to be living in relative low-income families in the financial years ending 2022 and 2023.

Number of children in relative poverty (before housing costs) in Scottish Borders Wards				
Ward	2022	2023	% change 2022-23	No. of children 0-15, 2021
Hawick and Denholm	203	260	28.1	1,632
Galashiels and District	541	577	6.7	2,534
Tweeddale East	228	237	3.9	1,981
East Berwickshire	348	352	1.1	1,762
Jedburgh and District	281	284	1.1	1,455
Leaderdale and Melrose	319	316	-0.9	1,880
Selkirkshire	227	224	-1.3	1,489
Tweeddale West	501	494	-1.4	1,818
Kelso and District	413	400	-3.1	1,401
Mid Berwickshire	291	280	-3.8	1,582
Hawick and Hermitage	287	276	-3.8	1,188

Apart from having the highest levels of relative child poverty BHC, Hawick and Denholm has also seen the biggest increase in numbers of families living with child poverty since the previous year. Interestingly, the other Hawick ward has seen a decrease in child poverty, showing that there is a complex situation with a lot of inequality within the town.

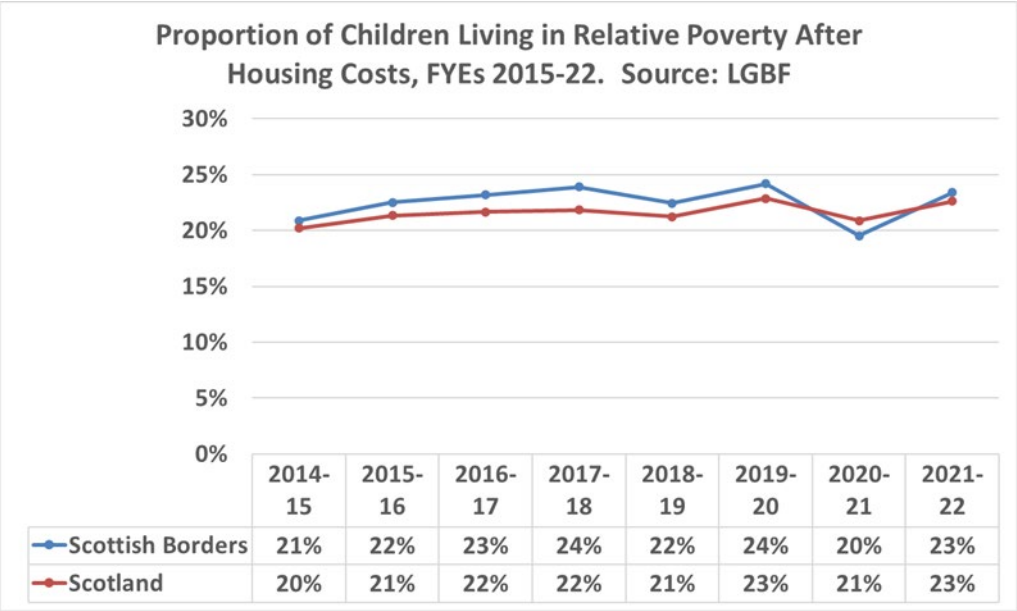
Children in Low-income Families (Relative poverty), after housing costs

The Local Government Benchmarking Framework (LGBF) presents child poverty estimates (after housing costs) at local authority level, which are produced by the End Child Poverty Coalition. This measure is for relative poverty after housing costs, which provides important alignment with the targets set out in the Child Poverty (Scotland) Act 2017 and is therefore regarded as the "key" statistic on child poverty. This data shows the period following the introduction of the Scottish Child Payment and during the cost-of-living crisis. The 2022-23 data are not yet available from LGBF.



The chart above shows that the Scottish Borders (red bar) had 23% of children living in child poverty in 2022-23 – that is to say, they were in households with a household income that was 60% below the median for that year, after rent or mortgage has been paid. This is worse than the previous year's figure of 19.1% and is now similar to the Scottish average (grey bar). Child poverty after housing costs is higher than before housing costs, as we would expect, and shows that the burden of paying high rents and mortgage repayments is pushing more families into poverty. Scottish Borders is one of the less well-performing Council Areas compared with its comparator Local authorities (green bars). The comparator Local Authorities were chosen by LGBF as they share certain population, rurality, and deprivation characteristics with the Scottish Borders.

Children in Low-income households over time, FYEs 2015 to 2022 after housing costs



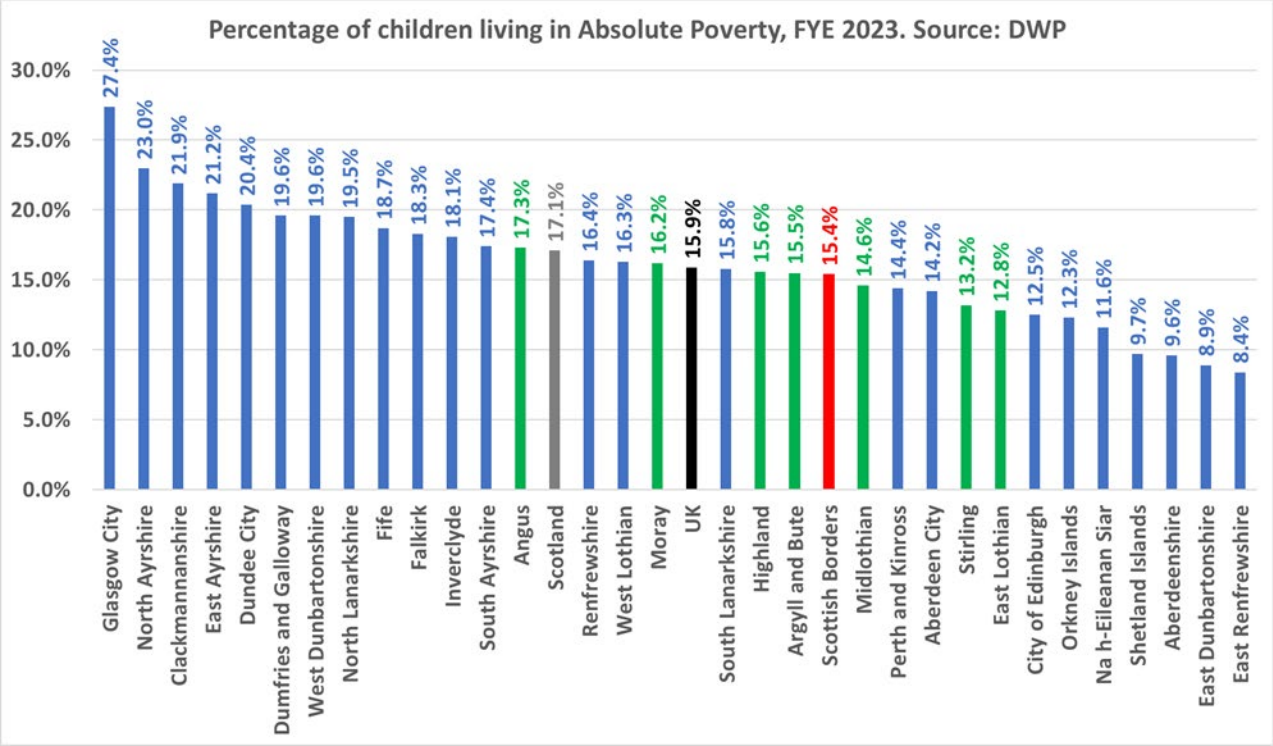
	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Scottish Borders	21%	22%	23%	24%	22%	24%	20%	23%
Scotland	20%	21%	22%	22%	21%	23%	21%	23%

The trend in the Scottish Borders is similar to the Scottish average but has always been marginally higher, reflecting the higher impact of housing costs on relatively lower wages in the region. In 2020-21 the proportion of children living in poverty (after housing costs) had dipped down to below the Scottish average, but the 2021-22 dataset shows that it is now rising again, reflecting the rising cost of living. The Scottish Child Payment rose in December 2022 so this mediating effect should be reflected in next year's statistics.

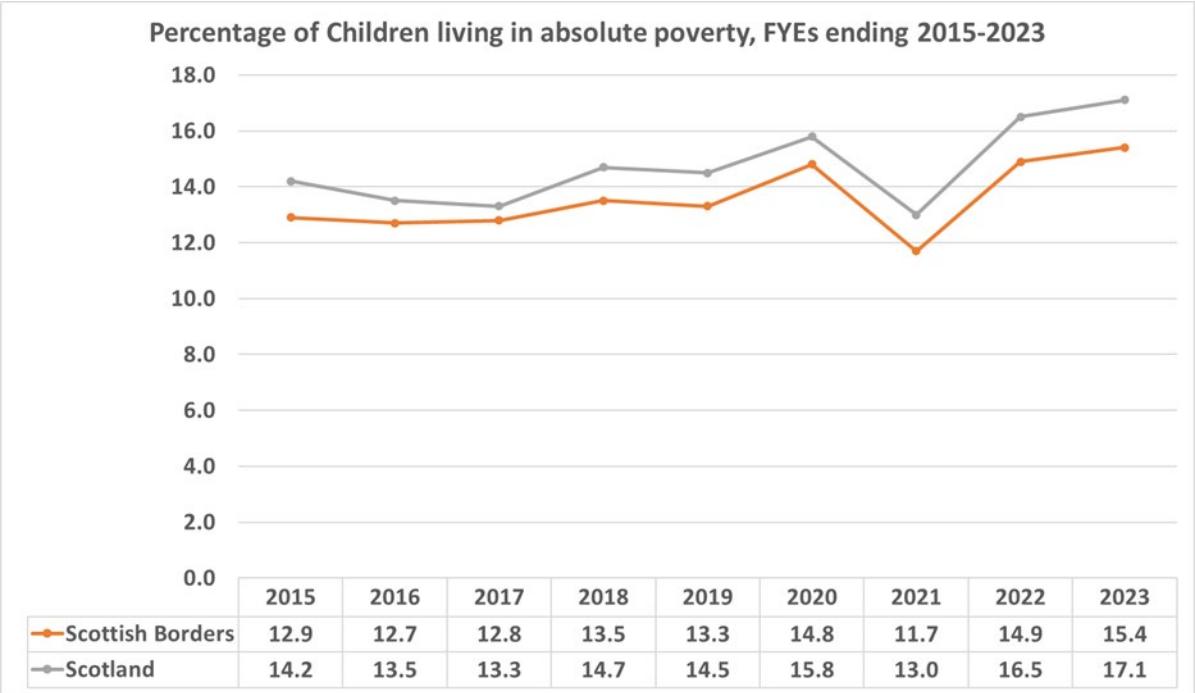
Children in Low-income Families living in Absolute poverty

Absolute low income is defined as a family in low income Before Housing Costs (BHC) in the reference year in comparison with incomes in financial year ending 2011. A family must have claimed Child Benefit and at least one other household benefit (Universal Credit, tax credits, or Housing Benefit) at any point in the year to be classed as low income in these statistics.

The chart below shows the DWP figures for the Financial Year Ending (FYE) 2023. **15.4%** of children aged 0-15 in the Scottish Borders live in absolute low-income households. This is below the Scottish and UK averages of 17.1% and 15.9% respectively. The green bars show the comparison with Scottish Borders's "LGBF family group" and shows that Scottish Borders is performing around average in this measure compared with its "family" of demographically similar Local authority areas.



Children in Absolute Low-income households over time, FYEs 2015 to 2023 before housing costs

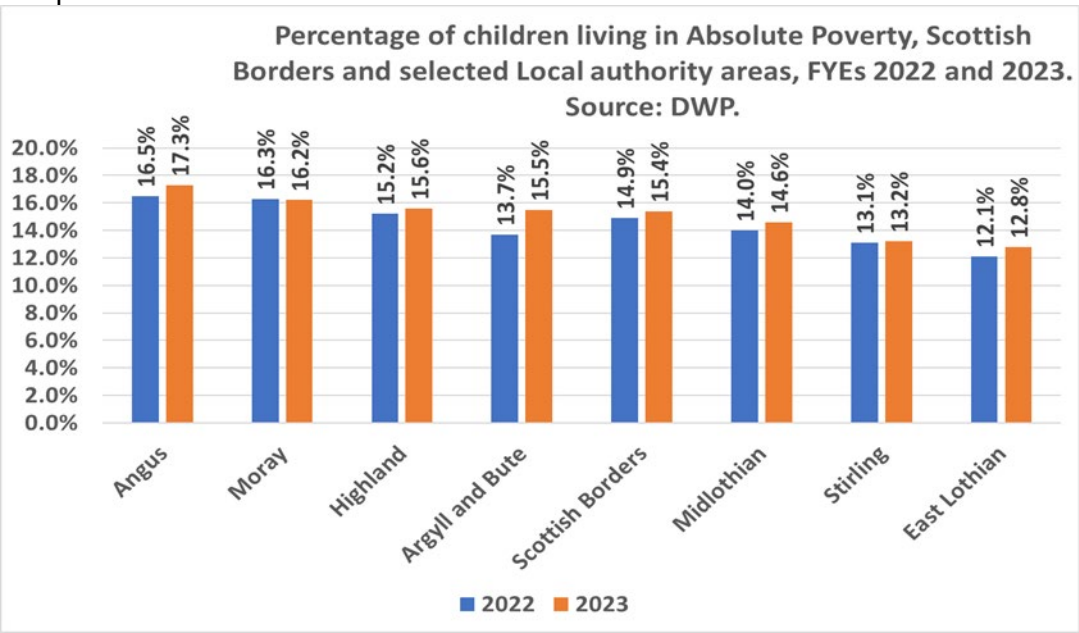


	2015	2016	2017	2018	2019	2020	2021	2022	2023
Scottish Borders	12.9	12.7	12.8	13.5	13.3	14.8	11.7	14.9	15.4
Scotland	14.2	13.5	13.3	14.7	14.5	15.8	13.0	16.5	17.1

The line graph above shows the timeline of this measure since FYE 2015. Absolute poverty in Scottish Borders has always been below the Scottish Borders average but otherwise mirrors the Scottish pattern. It increased last year and is continuing to increase as the cost-of-living crisis continues to have an impact on living standards when compared with what they were in 2011.

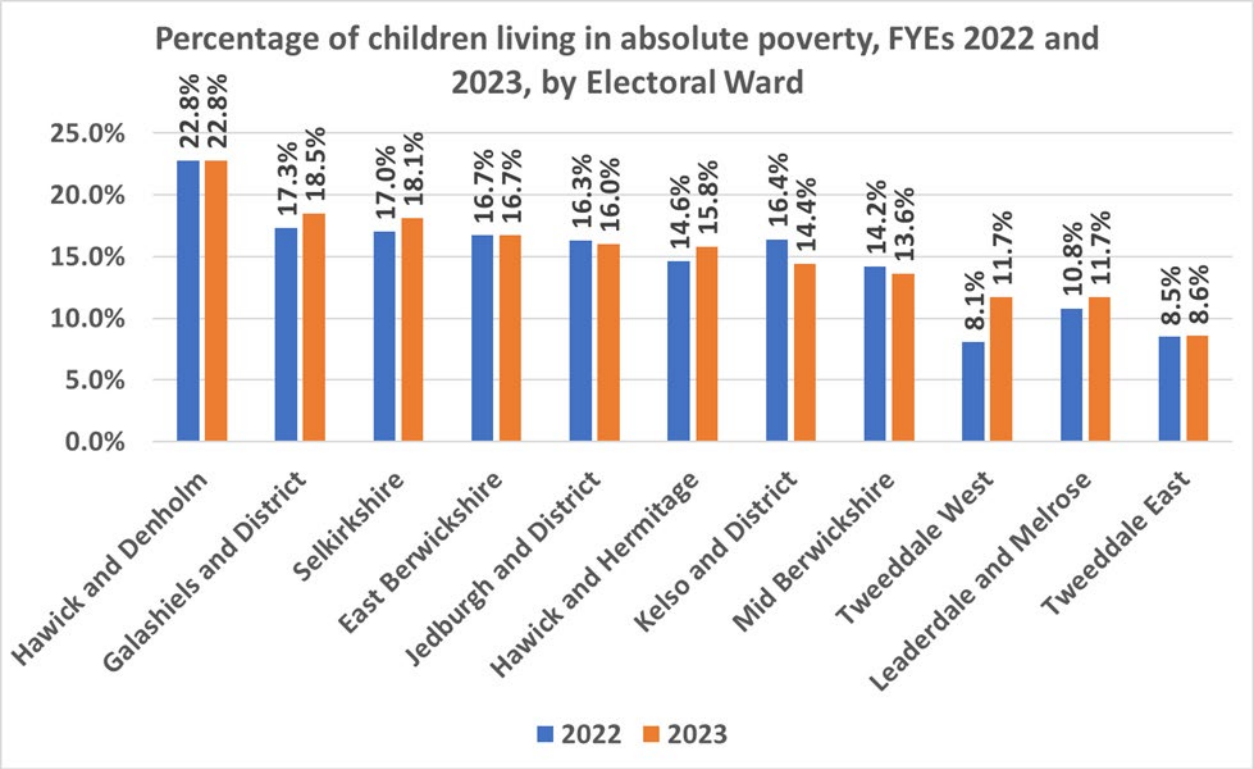
Absolute poverty since the previous year: Scottish Borders and comparator Local Authority areas

The Scottish Borders is in a benchmarking group with seven other Scottish Local Authorities.
The bar chart below shows how absolute child poverty in 2022 and 2023 compares with the position in these comparator areas.



Children in Absolute Poverty in Scottish Borders Electoral Wards

The chart below shows the Absolute Child Poverty data at Scottish Borders Electoral Ward level for the FYEs 2022 and 2023.



Numbers of children in absolute low-income families, Electoral Wards

The following table gives an indication of the numbers of children who are estimated to be living in relative low-income families in the financial years ending 2022 and 2023.

Number of children in relative poverty (before housing costs) in Scottish Borders Wards				
Ward	2022	2023	% change 2022-23	No. of children 0-15, 2021
Tweeddale West	151	219	45	1,818
Leaderdale and Melrose	211	229	9	1,880
Hawick and Hermitage	175	189	8	1,188
Galashiels and District	437	466	7	2,534
Selkirkshire	258	274	6	1,489
Tweeddale East	174	176	1	1,981
Hawick and Denholm	380	380	0	1,632
East Berwickshire	298	298	0	1,762
Jedburgh and District	240	236	-2	1,455
Mid Berwickshire	231	221	-4	1,582
Kelso and District	236	207	-12	1,401

Scottish Borders Child Poverty Index 2023

SB CPI: Purpose and Scoring

The purpose of the **Scottish Borders Child Poverty Index (SB CPI)**[1] is to provide additional insight into Child Poverty in the Scottish Borders. It is an *experimental* tool that may be used as a proxy for understanding the level of child poverty within the Scottish Borders.
The SB CPI was also created to work alongside the Scottish Index of Multiple Deprivation. SIMD provides a way of looking at deprivation in an area, covering the whole population and does not specifically reflect child poverty.

The SB CPI is a tool to help inform the Local Child Poverty Action Plan and which is a requirement of the Child Poverty Act (Scotland) 2017. The SB CPI is a summary of four components, which are:

- Children in Low Income Families (**CiLIF**) – Source is DWP/HMRC.[2] Relative low-income is defined as a family whose equivalised income is below 60 per cent of contemporary median income. Gross income measure is Before Housing Costs (BHC) and includes contributions from earnings, state support and pensions. The SB CPI uses the most recent available year's data, currently there is a one-year lag e.g. for SB CPI 2023 uses the CiLIF data for 2022-23.
- Clothing Grant (**CLG**) - Source is SBC. The proportion of pupils recorded for Clothing Grant of all pupils in area for school year.

The table below shows the score that an area will receive based on the result for each component. The SB CPI allows an area to have a score ranging from 0 to 11, where 0 indicates no element of child poverty and 11 the highest levels of child poverty.

Children in Low Income Families (DWP)	Clothing Grant (SBC)
0: None	0: None
1: Under 10%	1: Under 5%
2: 10% to Under 20%	2: 5% to Under 10%
3: 20% to Under 30%	3: 10% to Under 15%
4: 30% to Under 40%	4: 15% to Under 20%
5: 40% or More	**5: 20 to Under 30%**
	6: 30% or More

SB Child Poverty Index (revised)	
Points	**Level**
0 to 2	1: Lower
3 to 4	2: Low
5 to 6	3: Mid
7 to 8	4: High
9 to 11	**5: Higher**

[1] Revised November 2023

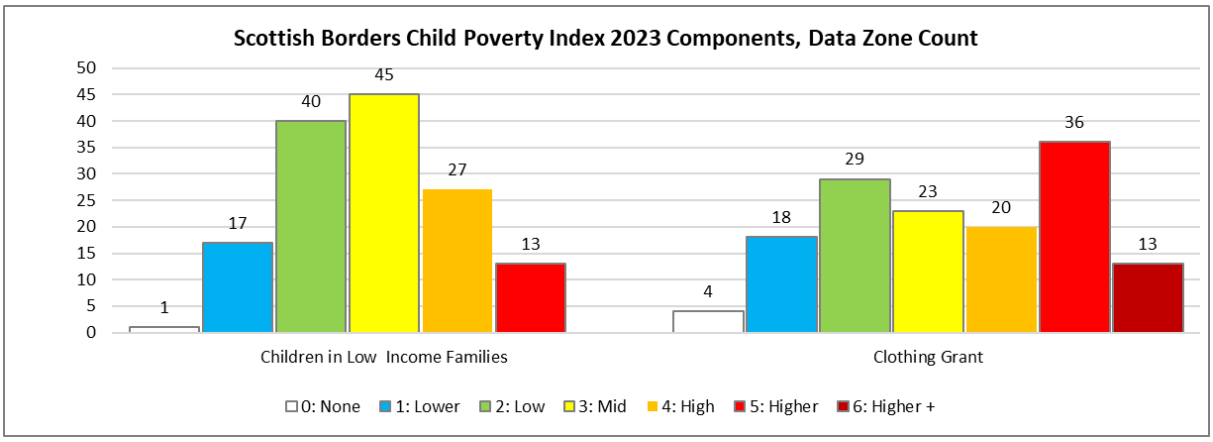
[2] *The calculation of proportion of Children in Low Income Families for the purpose of the Scottish Borders Child Poverty Index differs to 'official statistics' due to the availability of the data from Stat-Xplore. The children in Stat-Xplore are defined as dependent individuals aged under 16; or aged 16 to 19 in full-time non-advanced education or in unwaged government training. (Not just those aged under 16 – unable to group into age bands). The figure for all children is then expressed as proportion of those aged 0 to 15 as published by NRS. It is recognised that this calculation is imperfect, but practical for the purpose of the SB CPI.

Scottish Borders Child Poverty Index 2023 Components

The table below shows the allocation of data zones in the Scottish Borders for each of the components by count and proportion within each grouping.

Component Points	Children in Low Income Families		Clothing Grant	
	Count	Percent	Count	Percent
0: None	1	1%	4	3%
1: Lower	17	12%	18	13%
2: Low	40	28%	29	20%
3: Mid	45	31%	23	16%
4: High	27	19%	20	14%
5: Higher	**13**	**9%**	**36**	**25%**
6: Higher +		**0%**	**13**	**9%**
SBC Data Zones	**143**	100%	**143**	**100%**

The graph below shows the count of data zones for each componet by grouping.

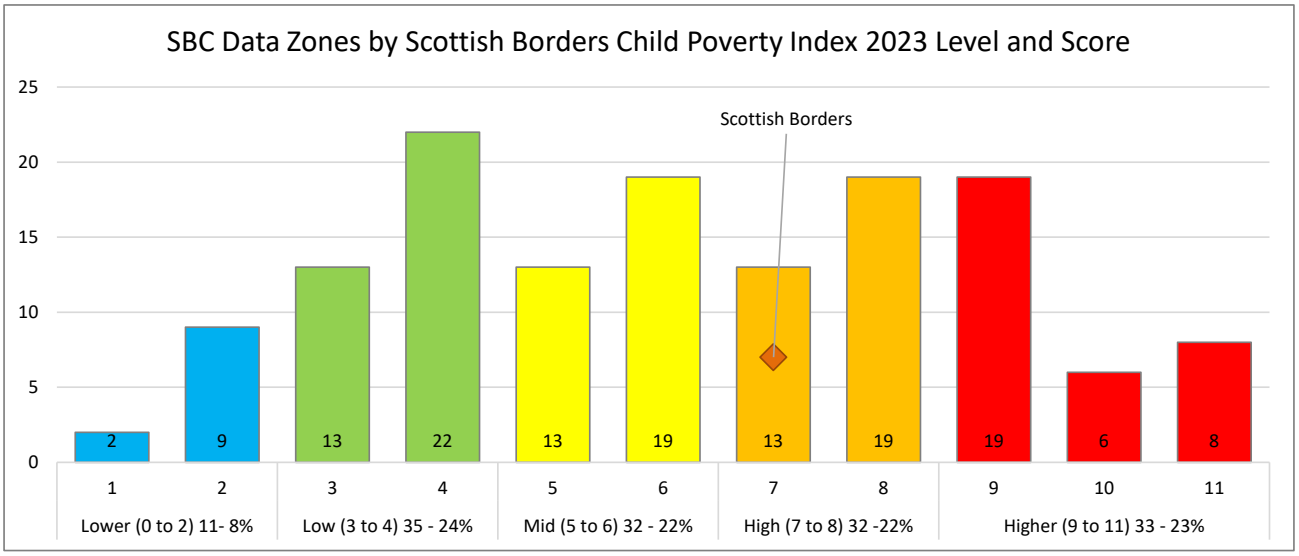


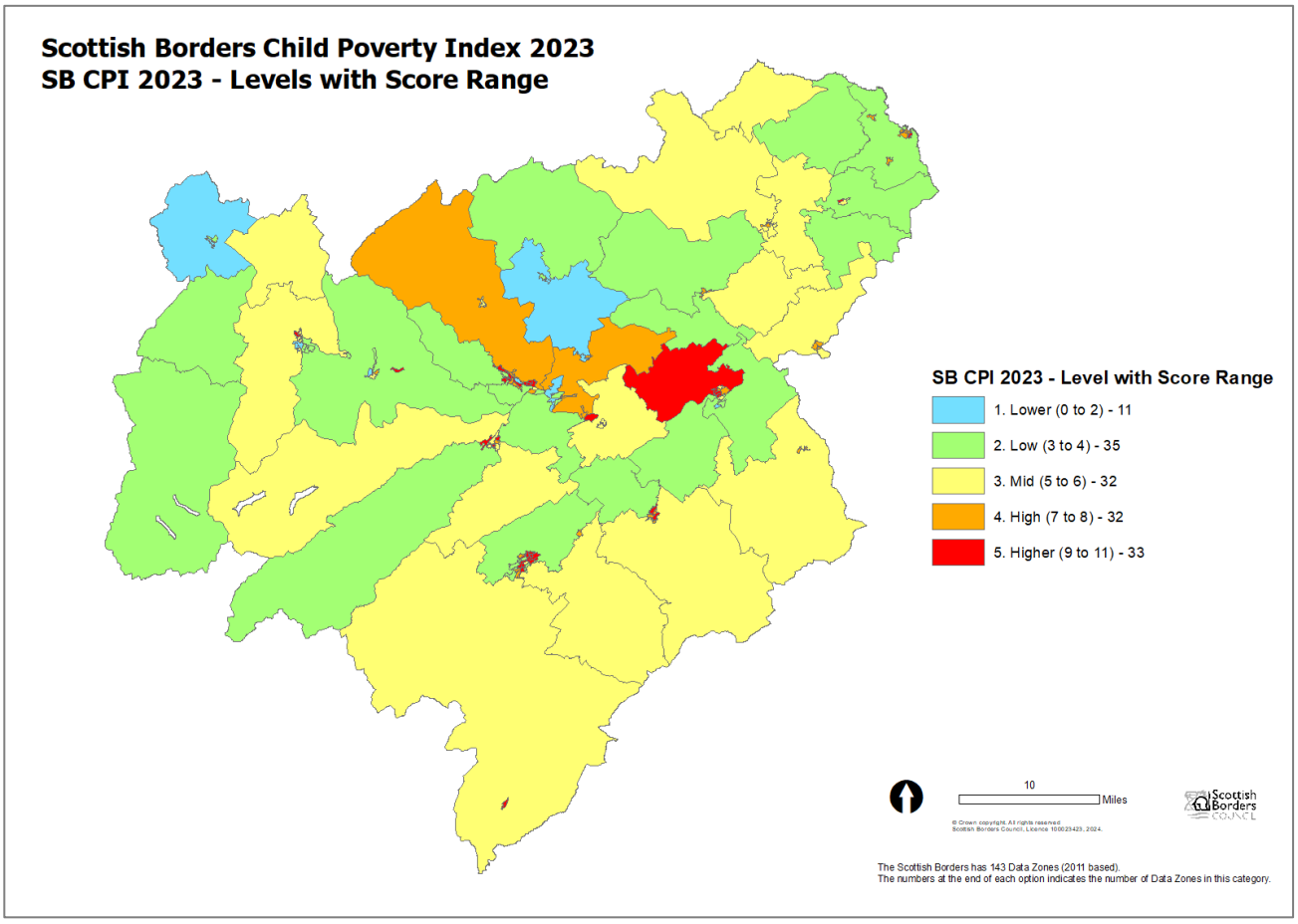
The table below shows the proportion of data zones by their Children in Low Income Famlies group and Clothing Grant group.

Clothing Grant Group	Children in Low Income Familes Group						
	0: None	1: Lower	2: Low	3: Mid	4: High	5: Higher	Scottish Borders
0: None		1%	1%				3%
1: Lower		5%	5%	1%	1%		13%
2: Low		4%	12%	4%			20%
3: Mid		1%	3%	8%	2%	1%	16%
4: High	1%		5%	6%	2%	1%	14%
5: Higher			1%	10%	11%	2%	25%
6: Higher +				1%	2%	6%	9%
Scottish Borders	1%	12%	28%	31%	19%	9%	100%

Scottish Borders Child Poverty Index 2023 Results

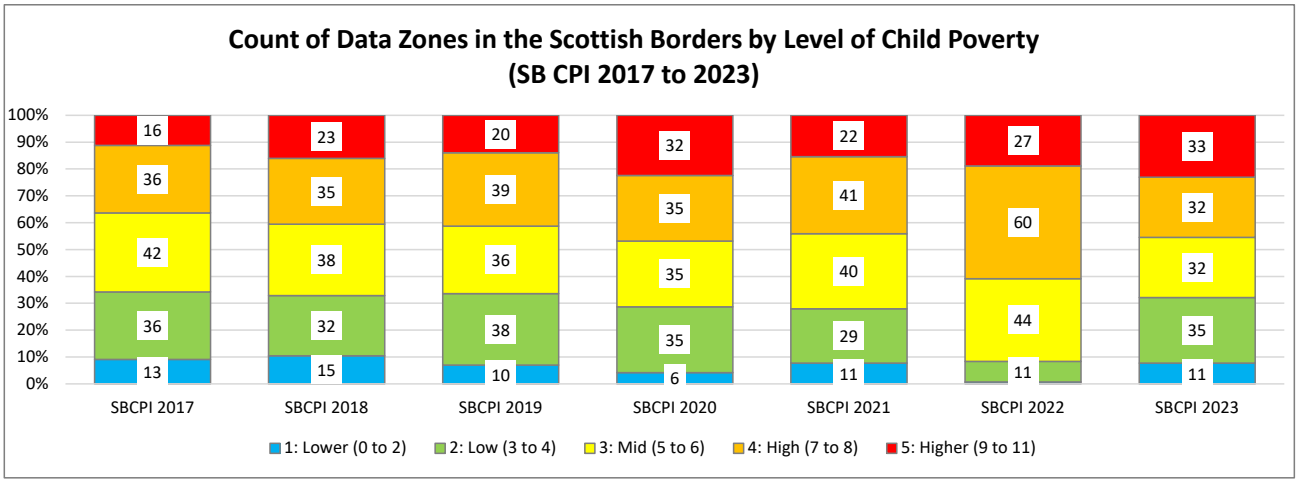
The graph and map below show the Scottish Borders data zones based on the SB CPI score, grouped into levels of Child Poverty. Higher level (33 data zones) has a score of 9 to 11; High level (32 data zones) have a score of 7 or 8; Mid level (32 data zones) have a score of 5 or 6; Low level (35 data zones) have a score of 3 or 4; and Lower level (11 data zone) has a score of 0 to 2. Every data zone in the Scottish Borders has some element of child poverty. The Scottish Borders SB CPI score for 2023 was 7 in the High level.





Scottish Borders Child Poverty Level Change Over Time 2017 to 2023

The graph below shows the distribution of data zones by level of child poverty for between 2017 and 2023.



The impact of Covid19 and the cost-of-living crisis can be seen in the number/proportion of data zones with Mid/High/Higher levels of child poverty. 66% of data zones had Mid/High/Higher levels of child poverty in 2017 that increased to 71% in 2020 and then to 92% for 2022, reflecting the impact of the cost-of -living. However, for 2023 the proportion of data zones with Mid/High/Higher levels of child poverty return to pre-covid level with 68%.

Scottish Borders Child Poverty Level Change Over Time 2017 to 2023 - Wards

The table below shows the Scottish Borders Child Poverty Index level (SBCPI) for the Scottish Borders and each ward between 2017 and 2023.

Area	SB CPI 2017 Level	SB CPI 2018 Level	SB CPI 2019 Level	SB CPI 2020 Level	SB CPI 2021 Level	SB CPI 2022 Level	SB CPI 2023 Level
Scottish Borders	**3. Mid**	**4. High**	**4. High**	**4. High**	**3. Mid**	**4. High**	**4. High**
East Berwickshire	4. High	4. High	4. High	4. High	3. Mid	4. High	4. High
Mid Berwickshire	3. Mid	3. Mid	3. Mid	3. Mid	4. High	4. High	3. Mid
Jedburgh and District	3. Mid	3. Mid	4. High	4. High	4. High	4. High	4. High
Kelso and District	3. Mid	3. Mid	4. High	4. High	4. High	4. High	4. High
Galashiels and District	4. High	4. High	4. High	4. High	4. High	4. High	**5. Higher**
Leaderdale and Melrose	2. Low	2. Low	2. Low	2. Low	3. Mid	3. Mid	2. Low
Selkirkshire	4. High	4. High	4. High	4. High	4. High	4. High	4. High
Hawick and Denholm	4. High	**5. Higher**	**5. Higher**	**5. Higher**	4. High	**5. Higher**	**5. Higher**
Hawick and Hermitage	4. High	4. High	4. High	4. High	4. High	4. High	4. High
Tweeddale East	2. Low	2. Low	2. Low	2. Low	3. Mid	3. Mid	2. Low
Tweeddale West	2. Low	2. Low	2. Low	3. Mid	3. Mid	3. Mid	3. Mid

Child Poverty Drivers

The three drivers of child poverty considered in this report are:

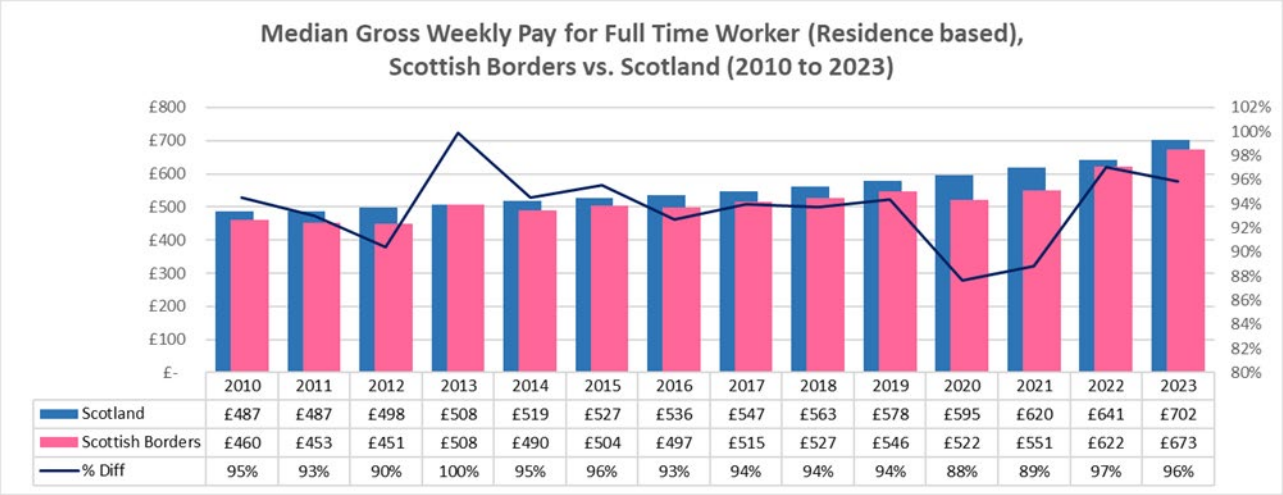
1. Income from employment
2. Costs of living
3. Income from social security and benefits in kind

Income from employment

The following section presents evidence from official statistics on topics such as earnings and jobs, particularly in households with children. This does not measure child poverty directly but helps to provide some background context to the current position.

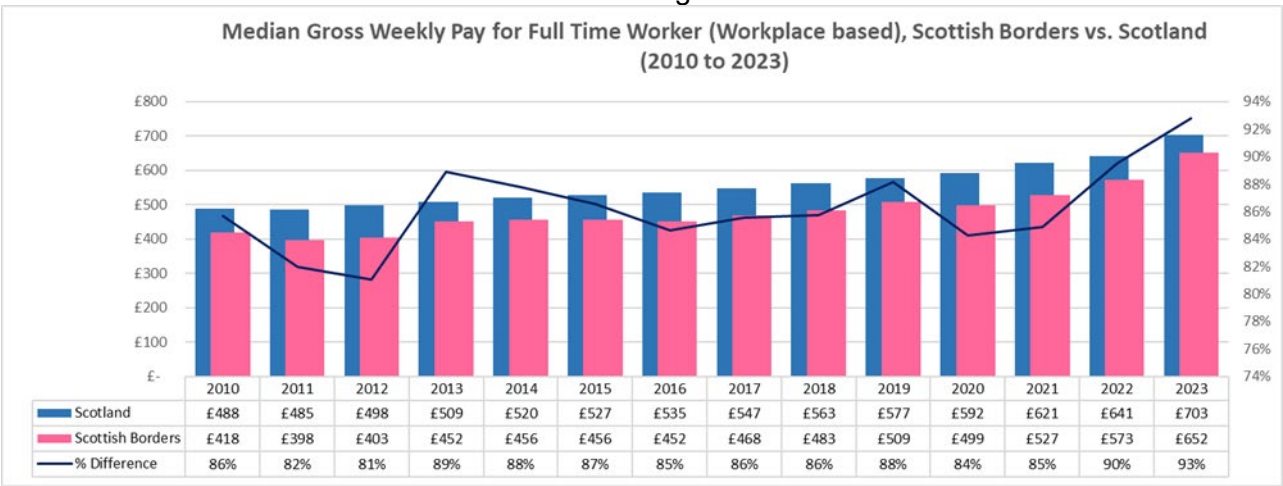
a) Average weekly Earnings

In 2023, the **median gross weekly pay** for full time workers living in the Scottish Borders (residence based) in the Scottish Borders was £673, **£29 below** the £702 for Scotland or **96% of the Scottish figure**. The regional pay gap between Scottish Borders and Scotland has greatly improved since 2021 for workers who live in the region.
(Annual Survey of Hours and Earnings - NOMIS)



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Scotland	£487	£487	£498	£508	£519	£527	£536	£547	£563	£578	£595	£620	£641	£702
Scottish Borders	£460	£453	£451	£508	£490	£504	£497	£515	£527	£546	£522	£551	£622	£673
% Diff	95%	93%	90%	100%	95%	96%	93%	94%	94%	94%	88%	89%	97%	96%

In 2023, the **median gross weekly pay** for full time workers working in the Scottish Borders (workplace based) was £652, £51 less than the £703 for full-time workers working elsewhere in Scotland. This is 93**% of the Scottish figure**. The pay gap for workplace-based earnings has improved since 2021 due to recent pay awards for Borders workers in the wake of the cost-of-living crisis.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Scotland	£488	£485	£498	£509	£520	£527	£535	£547	£563	£577	£592	£621	£641	£703
Scottish Borders	£418	£398	£403	£452	£456	£456	£452	£468	£483	£509	£499	£527	£573	£652
% Difference	86%	82%	81%	89%	88%	87%	85%	86%	86%	88%	84%	85%	90%	93%

b) Percentage of employees (18+) earning less than the real living wage

The Living Wage, also known as "the Real Living Wage", refers to the hourly salary that is deemed by the Living Wage Foundation to be the minimum necessary for an employee's basic needs to be met.

The current Real Living Wage is £12 per hour for the UK (£13.15 for London). **The Real Living Wage is not compulsory** but is paid by over 14,000 businesses in the UK who call themselves a "Living Wage employer".

It is not to be confused with the **National Living Wage, which is the compulsory Government minimum for over 23s** and is currently £10.42 per hour. The statutory National Living Wage is calculated as a percentage of median earnings, whereas the voluntary Real Living Wage is calculated according to the cost of a basket of household goods and services at current prices. Therefore, the **Real Living Wage better represents the cost of living** during times of high inflation.

Figures are workplace-based, so include all those who work in the region, regardless of where they live.

The data in the chart below were sourced from the Annual Survey of Hours and Earnings (ASHE) for Scottish Government's December 2023 Local Child Poverty Dashboard.

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Scottish Borders	25.8%	21.2%	21.7%	26.5%	24.5%	23.6%	25.6%	22.5%	24.2%	22.4%	13.8%
Scotland	18.8%	18.6%	19.3%	19.6%	20.1%	18.4%	19.4%	16.8%	15.2%	14.5%	9.0%

The above chart shows why Scottish Borders is often referred to as a "low wage economy." The proportion of full-time workers who are paid less than the Real Living Wage has always been higher than the Scottish average. Out of the 17 Council Areas which provided valid data to the 2022 Annual Survey of Hours and Earnings (ASHE), Scottish Borders had the second-worst rate of low-pay, with only South Ayrshire having a worse rate. Rates of low pay are lowest in the city Council areas, where salaries are more competitive.

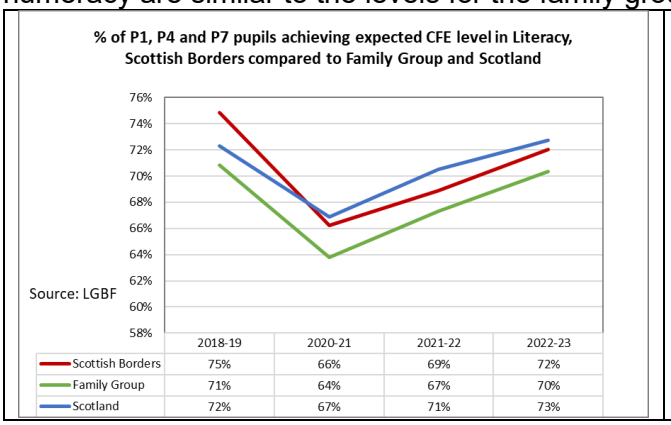
More encouragingly, there has been a significant increase in wages in 2021-22 across Scotland in response to the cost-of-living crisis and this has benefitted the region substantially. The proportion of over 18s who are paid less than the Real Living Wage in the region is at its lowest ever level.

c) Child poverty and Education Outcomes

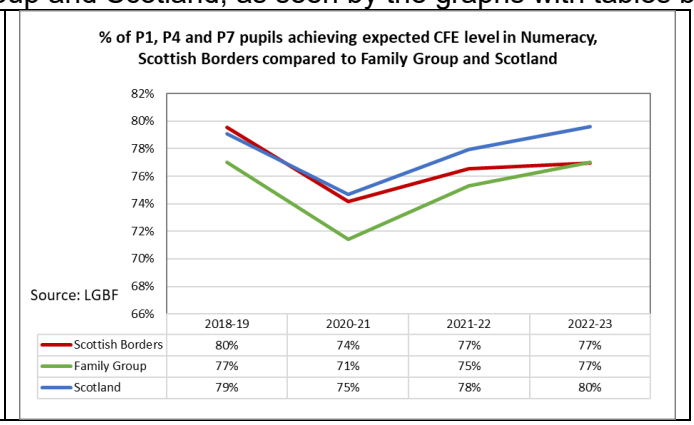
The link between poverty and educational attainment is complex. The aim is for educational attainment for those in the most deprived areas to be similar those in the least deprived areas. The Local Government Benchmarking Framework (LGBF) has several indicators that highlight the attainment of those pupils from the most deprived areas.

Literacy and Numeracy in primary school pupils

The pupils in the Scottish Borders are achieving the expected Curriculum For Excellence[3] level for literacy and numeracy are similar to the levels for the family group and Scotland, as seen by the graphs with tables below.

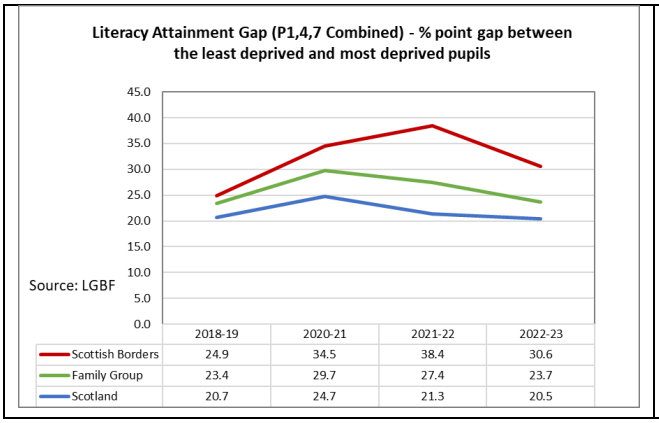


	2018-19	2020-21	2021-22	2022-23
Scottish Borders	75%	66%	69%	72%
Family Group	71%	64%	67%	70%
Scotland	72%	67%	71%	73%

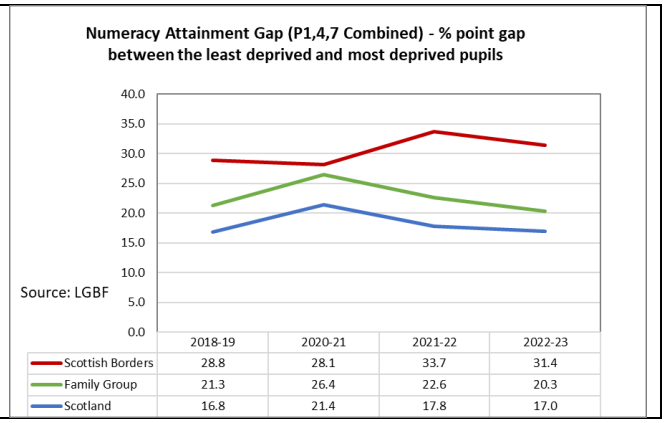


	2018-19	2020-21	2021-22	2022-23
Scottish Borders	80%	74%	77%	77%
Family Group	77%	71%	75%	77%
Scotland	79%	75%	78%	80%

However, when looking at the % gap between the least deprived and most deprived pupils there is a bigger gap in the Scottish Borders compared to the family group and Scotland. In the most recent years the gap for both literacy and numeracy in the Scottish Borders has reduced, but still bigger than the family group and Scotland.



	2018-19	2020-21	2021-22	2022-23
Scottish Borders	24.9	34.5	38.4	30.6
Family Group	23.4	29.7	27.4	23.7
Scotland	20.7	24.7	21.3	20.5

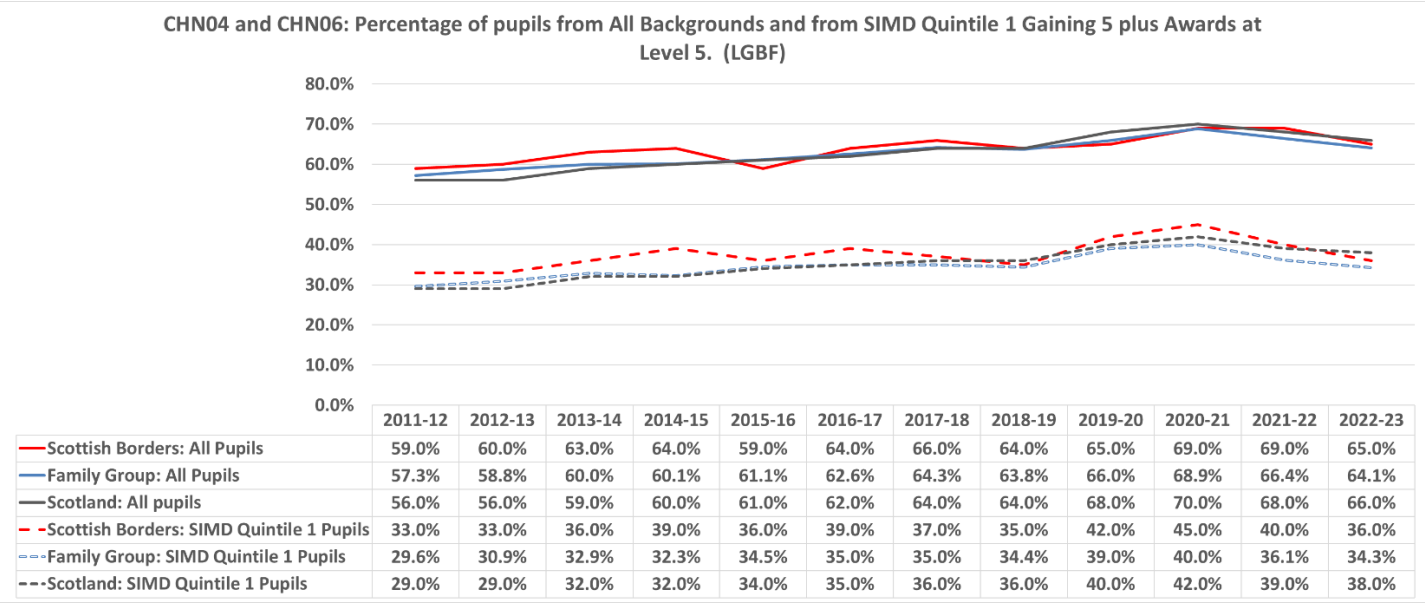


	2018-19	2020-21	2021-22	2022-23
Scottish Borders	28.8	28.1	33.7	31.4
Family Group	21.3	26.4	22.6	20.3
Scotland	16.8	21.4	17.8	17.0

[3] CFE = Curriculum for Excellence

Senior phase: impact of deprivation on Gaining 5+ Awards at Level 5 and Level 6

The graph below shows the proportion of pupils gaining 5+ awards at level 5 (SQA National 5) for all pupils and those from the 20% most deprived areas in Scotland (a.k.a. “SIMD Quintile 1”). It compares Scottish Borders, its family group of comparator Council areas and Scotland.



	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Scottish Borders: All Pupils	59.0%	60.0%	63.0%	64.0%	59.0%	64.0%	66.0%	64.0%	65.0%	69.0%	69.0%	65.0%
Family Group: All Pupils	57.3%	58.8%	60.0%	60.1%	61.1%	62.6%	64.3%	63.8%	66.0%	68.9%	66.4%	64.1%
Scotland: All pupils	56.0%	56.0%	59.0%	60.0%	61.0%	62.0%	64.0%	64.0%	68.0%	70.0%	68.0%	66.0%
Scottish Borders: SIMD Quintile 1 Pupils	33.0%	33.0%	36.0%	39.0%	36.0%	39.0%	37.0%	35.0%	42.0%	45.0%	40.0%	36.0%
Family Group: SIMD Quintile 1 Pupils	29.6%	30.9%	32.9%	32.3%	34.5%	35.0%	35.0%	34.4%	39.0%	40.0%	36.1%	34.3%
Scotland: SIMD Quintile 1 Pupils	29.0%	29.0%	32.0%	32.0%	34.0%	35.0%	36.0%	36.0%	40.0%	42.0%	39.0%	38.0%

The graph clearly shows the difference in attainment between the 20% most deprived (dashed lines) and all pupils (solid lines) for all three selected areas. The deprivation attainment gap for National 5-level pupils is worse in Scottish Borders than its comparator Council areas, and both are worse than Scotland as a whole.

SQA National 5 Attainment gap between All pupils and SIMD Quintile 1	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Scottish Borders	33.0%	40.0%	29.0%	42.0%	34.0%	40.0%	30.0%	33.0%	35.0%	28.0%	31.0%	34.0%
Family Group	25.8%	27.9%	24.9%	26.7%	25.1%	23.5%	23.7%	24.0%	21.1%	21.4%	22.5%	25.1%
Scotland	23.0%	21.0%	21.0%	20.0%	20.0%	19.0%	19.0%	18.0%	19.0%	17.0%	18.0%	16.0%

Deprivation Gap at Level 6 (Scottish Higher) Level

Although a lower proportion of pupils gain 5+ awards at level 6 (Scottish Higher) compared to level 5, the pattern comparing all pupils to those from the 20% most deprived areas is similar

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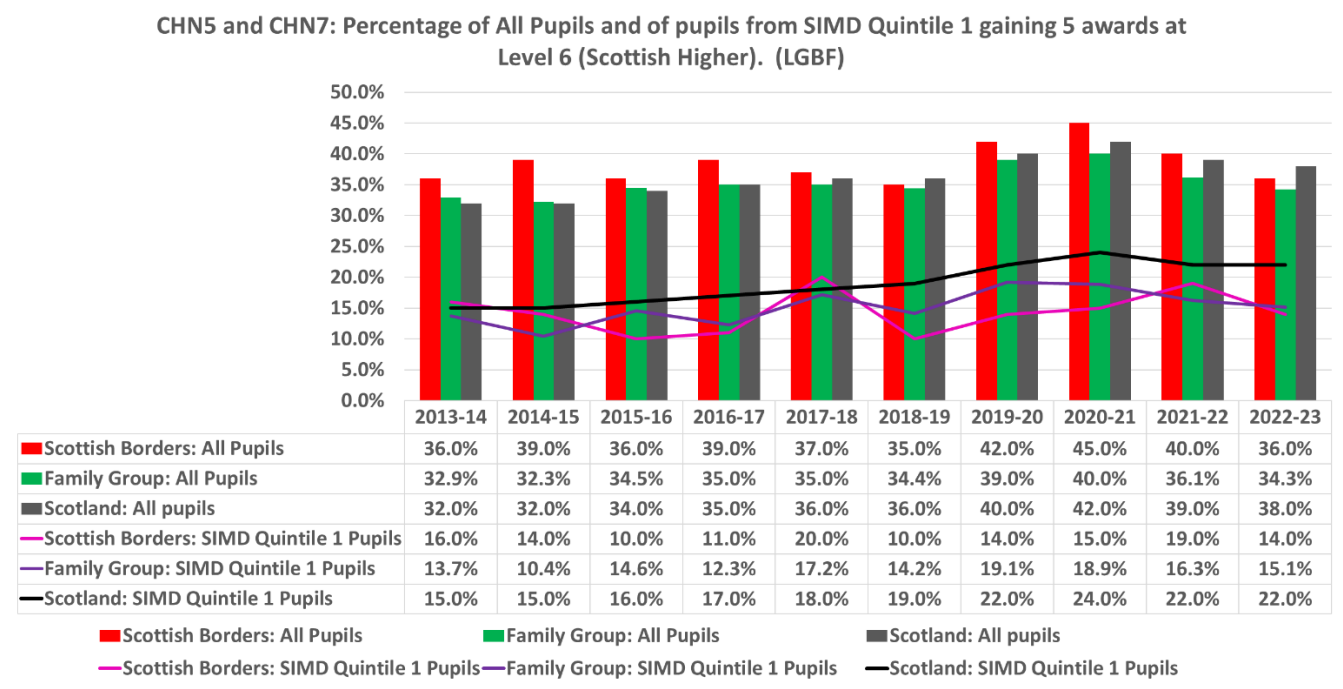


	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Scottish Borders: All Pupils	36.0%	39.0%	36.0%	39.0%	37.0%	35.0%	42.0%	45.0%	40.0%	36.0%
Family Group: All Pupils	32.9%	32.3%	34.5%	35.0%	35.0%	34.4%	39.0%	40.0%	36.1%	34.3%
Scotland: All pupils	32.0%	32.0%	34.0%	35.0%	36.0%	36.0%	40.0%	42.0%	39.0%	38.0%
Scottish Borders: SIMD Quintile 1 Pupils	16.0%	14.0%	10.0%	11.0%	20.0%	10.0%	14.0%	15.0%	19.0%	14.0%
Family Group: SIMD Quintile 1 Pupils	13.7%	10.4%	14.6%	12.3%	17.2%	14.2%	19.1%	18.9%	16.3%	15.1%
Scotland: SIMD Quintile 1 Pupils	15.0%	15.0%	16.0%	17.0%	18.0%	19.0%	22.0%	24.0%	22.0%	22.0%

There is a persistently larger Deprivation Attainment Gap in Scottish Borders than in both its family group and the Scottish average at Scottish Higher level, and this deprivation gap tends to fluctuate depending on the cohort of pupils, which is relatively small.

CHN5 and CHN7: Attainment Deprivation Gap at Scottish Higher Level	2013 to 14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Scottish Borders	20.0%	25.0%	26.0%	28.0%	17.0%	25.0%	28.0%	30.0%	21.0%	22.0%
Family Group	19.2%	21.8%	19.9%	22.8%	17.8%	20.2%	19.9%	21.1%	19.9%	19.1%
Scotland	17.0%	17.0%	18.0%	18.0%	18.0%	17.0%	18.0%	18.0%	17.0%	16.0%

Costs of Living

Information from Institute For Government states that the "Cost of living Crisis" refers the fall in "real" disposable incomes (adjusted for inflation and after taxes and benefits) that the UK has experienced since late 2021. This is triggered by the failure of wages and social security benefits to keep up with inflation but is also exacerbated by external factors such as the Ukraine war and escalating energy prices.

Inflation peaked at 11.1% in October 2022 and has come down since then. This does not mean that food prices have come down, only that they are rising less rapidly. Since then, there has also been a round of public sector pay awards and a lowering of energy prices, which has reduced the crisis. However, domestic, and small business finances, which were already running off savings due to the pandemic, are now stretched so thin that many families and businesses have no reserves left.

It is estimated that household incomes will finally catch up with living costs and Real Household Disposable Incomes (RDHI) will return to pre-2021 levels by 2027. For some households, the damage done by the erosion of their financial resilience during the previous 8 years will be felt for a long time.

a) Fuel Poverty

According to research carried out for the 2021 Scottish House Conditions Survey, a household is in fuel poverty if, in order to maintain a satisfactory heating regime, total fuel costs necessary for the home are more than 10% of the household's adjusted net income (after housing costs) and the household's remaining adjusted net income is insufficient to maintain an acceptable standard of living – the so-called "heating or eating" debate.

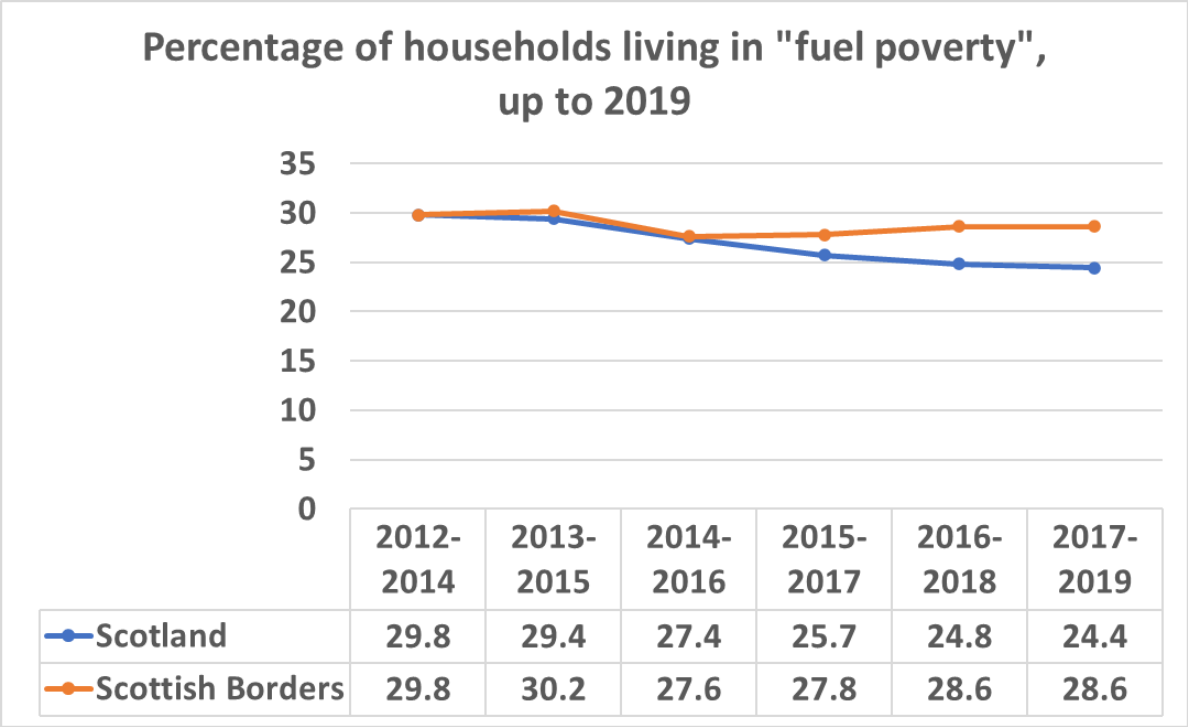
Where a household is in fuel poverty, the "fuel poverty gap" is the annual amount that would be required to move the household out of fuel poverty.

Definitions of all these terms, and exclusions to what is counted as income, are set out in the Fuel Poverty (Scotland) Act 2019.

The Fuel Poverty (Scotland) Act 2019 also set targets to eradicate fuel poverty. The 2040 targets are that:

- no more than 5% of households in Scotland would be in fuel poverty
- no more than 1% of households in Scotland would be in extreme fuel poverty
- the median fuel poverty gap of households in Scotland in fuel poverty would be no more than £250 at 2015 prices (adjusted to take account of changes in the value of money).

Tools for measuring this well-legislated aspect of poverty are currently very poor. Estimates of fuel poverty rates are available up to 2019 for Local Authority areas. The Covid-19 pandemic forced temporary changes in the way that the SHCS was gathered, meaning that 2020 and 2021 data are missing for Council Areas and that the Council Area measure for fuel poverty will not return to normal until after the 2022-24 three-year averages are produced, which will be in 2026.

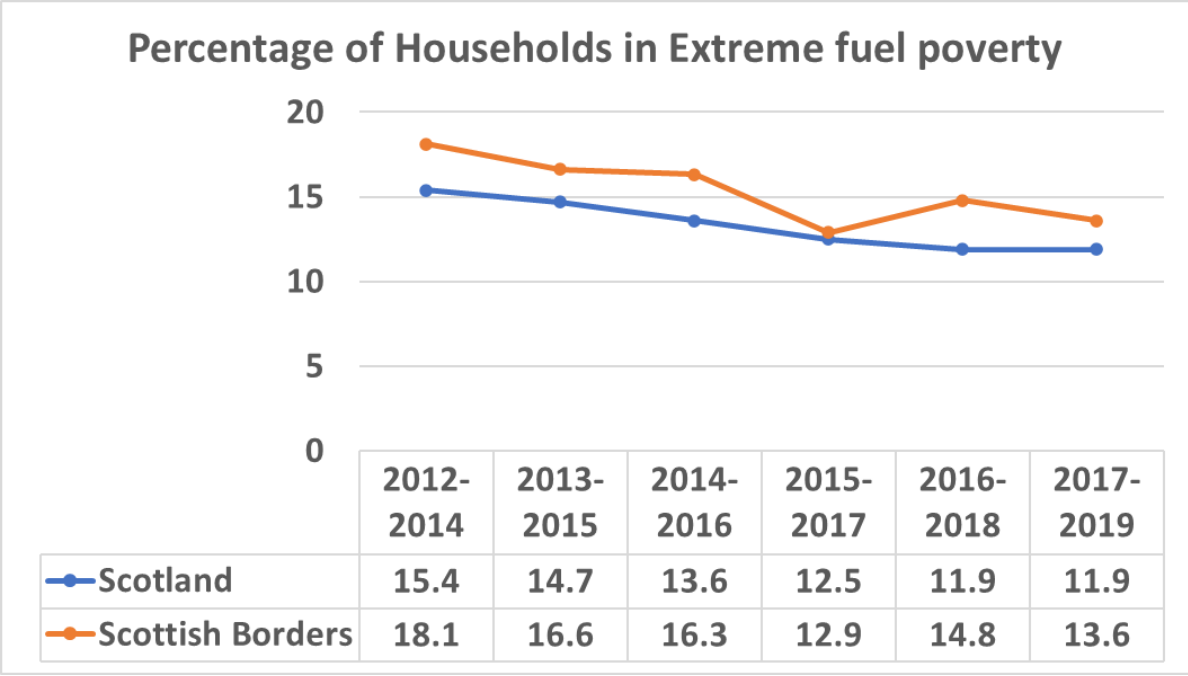


	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Scotland	29.8	29.4	27.4	25.7	24.8	24.4
Scottish Borders	29.8	30.2	27.6	27.8	28.6	28.6

The chart above shows that fuel poverty in Scotland was gradually decreasing up to 2019, but it remains higher in Scottish Borders. There has not been any change since the previous set of figures.

Extreme fuel poverty

Extreme fuel poverty follows the same definition as fuel poverty except that a household would have to spend more than 20% of its adjusted net income (after housing costs) on total fuel costs to maintain a satisfactory heating regime, rather than 10%. To the statistics, extreme fuel poverty is a subset of fuel poverty and is not mutually exclusive.



	2012-2014	2013-2015	2014-2016	2015-2017	2016-2018	2017-2019
Scotland	15.4	14.7	13.6	12.5	11.9	11.9
Scottish Borders	18.1	16.6	16.3	12.9	14.8	13.6

The previous chart showed that 28.6% of Scottish Borders households are estimated to be in fuel poverty. Just under half of these are estimated to be in extreme fuel poverty, according to the most recently available figures. Extreme fuel poverty is estimated to affect 13.6% of households in Scottish Borders, although this

does seem to be coming down since the previous set of figures.

The 2021 and 2022 Scottish updates on fuel poverty
The 2021 SHCS update found that 19.6% of households in Scotland were estimated to be in fuel poverty, but that was very likely to be an underestimate. The initial observations from the 2022 data show that the fuel poverty rate has risen to 31% in Scotland, which is a more credible increase on the 24.6% 2019 revised figure for Scotland. We would expect the rate in Scottish Borders to be about 4 percentage points above the Scottish average, meaning that it could now be as high as 35% in Scottish Borders.

The median fuel poverty gap for fuel poor households was estimated to be £690 in 2021 but is likely to be higher now. This is the additional annual amount that the average fuel-poor householder would need to bring them out of fuel poverty.

Respondents were more likely to be fuel poor if they:

- Lived in the social rented sector
- Used electricity as their primary heating fuel
- Had a prepayment meter
- Lived in a property with a low energy efficiency rating
- Had a low income

Some of these correlations might seem obvious, but it is stressed in the SHCS that low income is not the only cause of fuel poverty.

The 2022 initial observations showed that the long-term trend in energy efficiency of housing stock continues to show improvement, as do the levels of critical disrepair observed for the survey.

The Borders Housing Network have allocated over five thousand vouchers since 2021.
In 2023/24, a total of 2,122 vouchers helped 2,789 adults and 1,332 children.

Year	Number	People	Cost
2021/22	1,026	2,034	£52,793
2022/23	2,247	4,251	£101,990
2023/24	2,122	4,121	£100,939
Total	**5,395**	**10,406**	**£255,722**

Income from social security and benefits in kind

Issues around social security benefits for families with children are listed as the third driver of child poverty. The Children in Low-Income Families indicator shows that most families are already living in at least relative poverty to qualify for welfare benefits. Official Statistics around use and take-up of welfare benefits fall into two categories:

1. Families who qualify for benefits and are supported by social security to meet their basic needs
2. Families who fall through the gaps in the social security system or receive inadequate support, and are in crisis

Families living in crisis due to insufficient social security support tend to be undocumented and are therefore very difficult to measure. These figures tend to present in different ways, such as food insecurity and foodbank use, housing insecurity and homelessness, chaotic lifestyles, crisis grants and mental and physical health problems.

Universal Credit (UC) is a single payment for each household to help with living costs for those on a low income or out of work. It is replacing six benefits, commonly referred to as the legacy benefits:

- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance
- Income Support
- Working Tax Credit
- Child Tax Credit
- Housing Benefit

Support for housing costs, children and childcare costs are integrated into Universal Credit. It also provides additions for people with a disability, health condition or caring responsibilities which may prevent them from working.
Claimants are at risk of not receiving the correct amount of Universal Credit, or being refused UC, if their circumstances or household income change frequently, or their living situation is unstable, or if they are not able to produce the correct paperwork, or if they are sanctioned or deducted for any reason. These households who fall through the safety net are then at risk of severe poverty, which is insufficiently documented, and which can manifest itself in other ways, such as debt, food bank use, homelessness, mental health problems, substance misuse and crime.

Although there is almost certainly a level of under-claiming due to households stumbling over the claims process or still awaiting transfer from legacy benefits, the statistics for Households receiving Universal Credit provides an insight into priority families in relative poverty.

a) Households receiving Universal Credit

The table below shows the number and proportion of households in the Scottish Borders receiving Universal Credit compared to Scotland. Overall, the Scottish Borders has a lower proportion of households receiving UC (13.8%) compared to 17.1% for Scotland. In the Scottish Borders there were 3,233 households claiming the 'Child Entitlement' or 5.8% compared to 6.9% for Scotland.

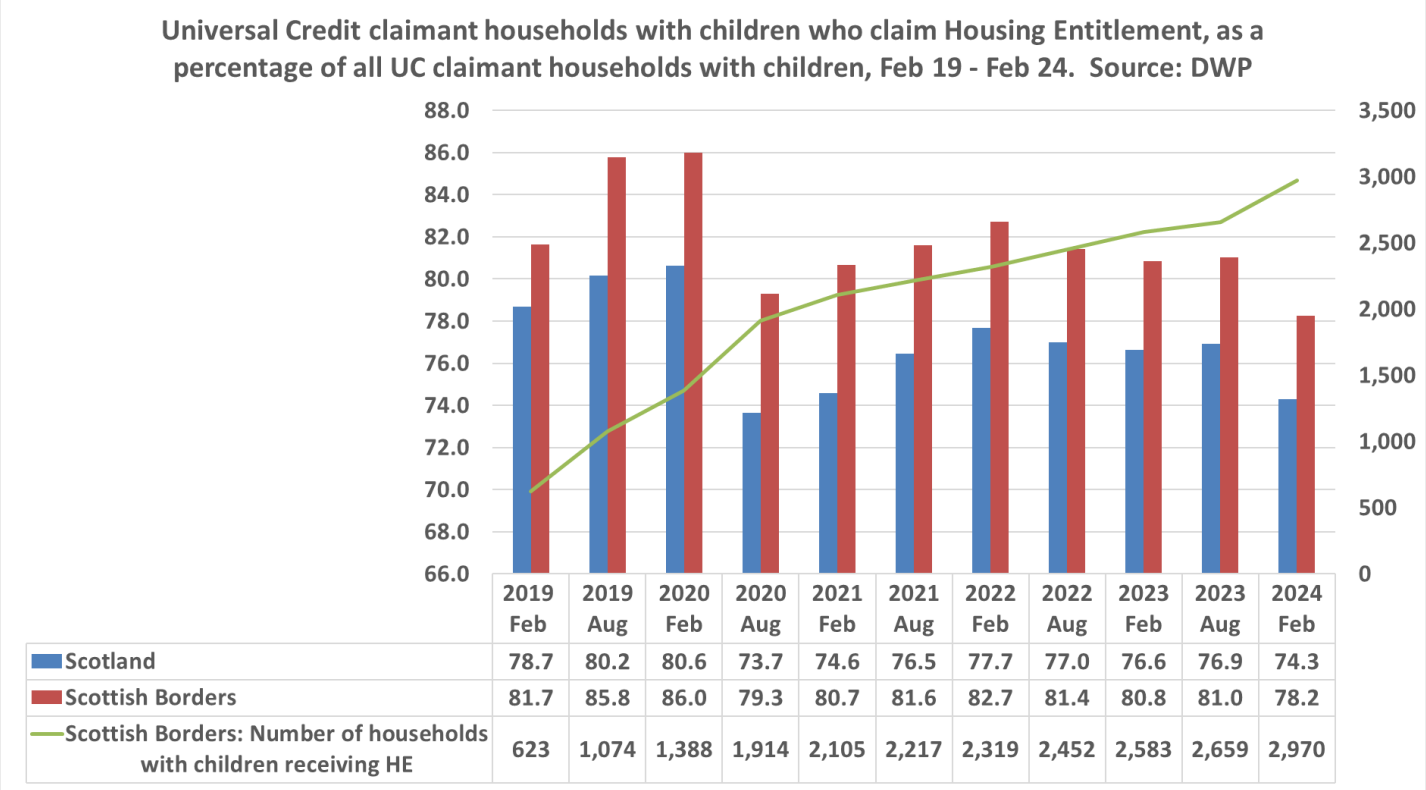
Universal Credit Households November 2023 (provisional figures)	Scottish Borders No of Households	% of All Occupied Households	
		Scottish Borders	Scotland
All Occupied Households	55,858	100	100
All Universal Credit Households (UCH)	7,709	13.8	17.1
UCH with Children	3,427	6.1	4.6
UCH claiming Child Entitlement	3,233	5.8	6.9
UCH Lone Parent	2,390	4.3	5.5
UCH with 3+ Children	686	1.2	1.4
UCH with Child Under Age 1	263	0.5	0.5
UCH with Children - Child Disability Entitlement	348	0.6	0.9
UCH with Children - Adult limited capacity for work entitlement	566	1.0	1.3
UCH with children - adult carer entitlement	505	0.9	1.2
UCH with children with a UC entitlement due to disability or incapacity of a family member	1419	2.5	3.4

Source: DWP/NRS

b) Households with Children who claim the Housing Entitlement of Universal Credit

The chart below indicates that the majority of households with children who interact with the Universal Credit system need help with their housing costs, and that housing unaffordability is affecting households with children in the Scottish Borders more than on average for Scotland. As of February 2024, 78.2% of all Universal Credit-claiming households with children, or 2,970 households in Scottish Borders, claim the entitlement formerly known as Housing Benefit.

The numbers below do not provide a full picture of housing insecurity. Housing Benefit is still in operation for some categories of claimant, and people who live in hostels or temporary accommodation are not eligible to apply for help with their housing costs. Applicants to Universal Credit must provide documentary proof of their housing costs. This means that the applicant must have paid their first instalment of costs for the housing before they are able to apply for welfare benefits, to be paid in retrospect, which is very difficult for families already in financial and housing insecurity to do. There is inevitably an unknown number of undocumented families who are unable to claim help with their housing costs and are at risk of homelessness.



	2019 Feb	2019 Aug	2020 Feb	2020 Aug	2021 Feb	2021 Aug	2022 Feb	2022 Aug	2023 Feb	2023 Aug	2024 Feb
Scotland	78.7	80.2	80.6	73.7	74.6	76.5	77.7	77.0	76.6	76.9	74.3
Scottish Borders	81.7	85.8	86.0	79.3	80.7	81.6	82.7	81.4	80.8	81.0	78.2
Scottish Borders: Number of households with children receiving HE	623	1,074	1,388	1,914	2,105	2,217	2,319	2,452	2,583	2,659	2,970

c) Food insecurity

Foodbanks and community food redistribution outlets

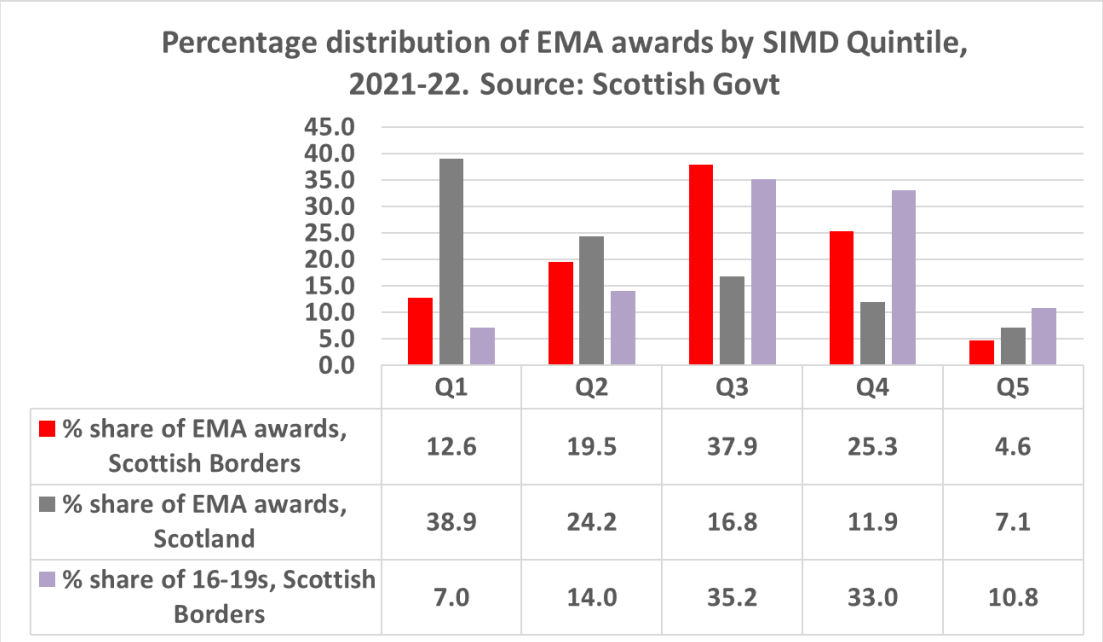
Information available on the SBC website indicates that there are 31 **food redistribution outlets** in the Scottish Borders in 2024, including: food banks, FareShare providers, Early Years Centres, Community cafes and food larders.

The locations were:

- 11 in Berwickshire
- 3 in Cheviot
- 7 in Eildon
- 3 in Teviot & Liddesdale
- 7 in Tweeddale

d) Education Maintenance Allowance
Education Maintenance Allowance (EMA) is a UK Government benefit of £30 per week, paid to eligible students aged 16-19 from low-income households, who choose to continue with their education, in an attempt to close the deprivation attainment gap between the most-deprived and the less-deprived areas.

According to the SBC SEEMIS Management Information System, there were 239 pupils receiving EMA in the 2023-24 academic year.



	Q1	Q2	Q3	Q4	Q5
% share of EMA awards, Scottish Borders	12.6	19.5	37.9	25.3	4.6
% share of EMA awards, Scotland	38.9	24.2	16.8	11.9	7.1
% share of 16-19s, Scottish Borders	7.0	14.0	35.2	33.0	10.8

Scottish Government information breaks EMA awards down by Local Authority and SIMD Quintile. The graph above shows that 7% of 16- to 19-year-olds live in Quintile 1, the most-deprived 20% of neighbourhoods in Scotland. Senior pupils from Quintile 1 neighbourhoods in Scottish Borders are proportionally somewhat more reliant on EMA to remain in education (12.6% of all claimants) than pupils in Quintile 5.

This is, in fact, a much lower proportion than on average for Scotland: if it was in line with Scotland, we would expect 39% of EMA recipients to be living in Quintile 1 neighbourhoods. It indicates that take-up of the education incentive is somewhat lower than expected in Scottish Borders' most deprived neighbourhoods: either they do not qualify for it, or, more likely, they choose not to stay on in education despite the incentive. This is concerning, as there is already an education outcomes deprivation gap in Scottish Borders, which EMA was designed to address.

Interestingly, take-up of EMA is well above Scottish average in Quintiles 3 and 4 in Scottish Borders, meaning that more students from neighbourhoods with average and below-average deprivation live in low-income households and are eligible (and keen) to take up EMA in order to stay on at school. This means that senior school pupils' futures are being impacted by low household incomes throughout a wider demographic group in Scottish Borders, and this impact is not confined to pupils from the more deprived areas.

e) Free School Meals are available to all P1-5 children in the Scottish Borders, regardless of circumstances. A separate means-tested Scottish Government-funded scheme of free school meals for P6-S6 pupils is available to eligible households and is administered by the Local Authority.

According to the SBC SEEMIS Management Information System, there were 2,066 pupils receiving means-tested Free School Meals in the 2023-24 academic year, or 14.7% of the school roll.

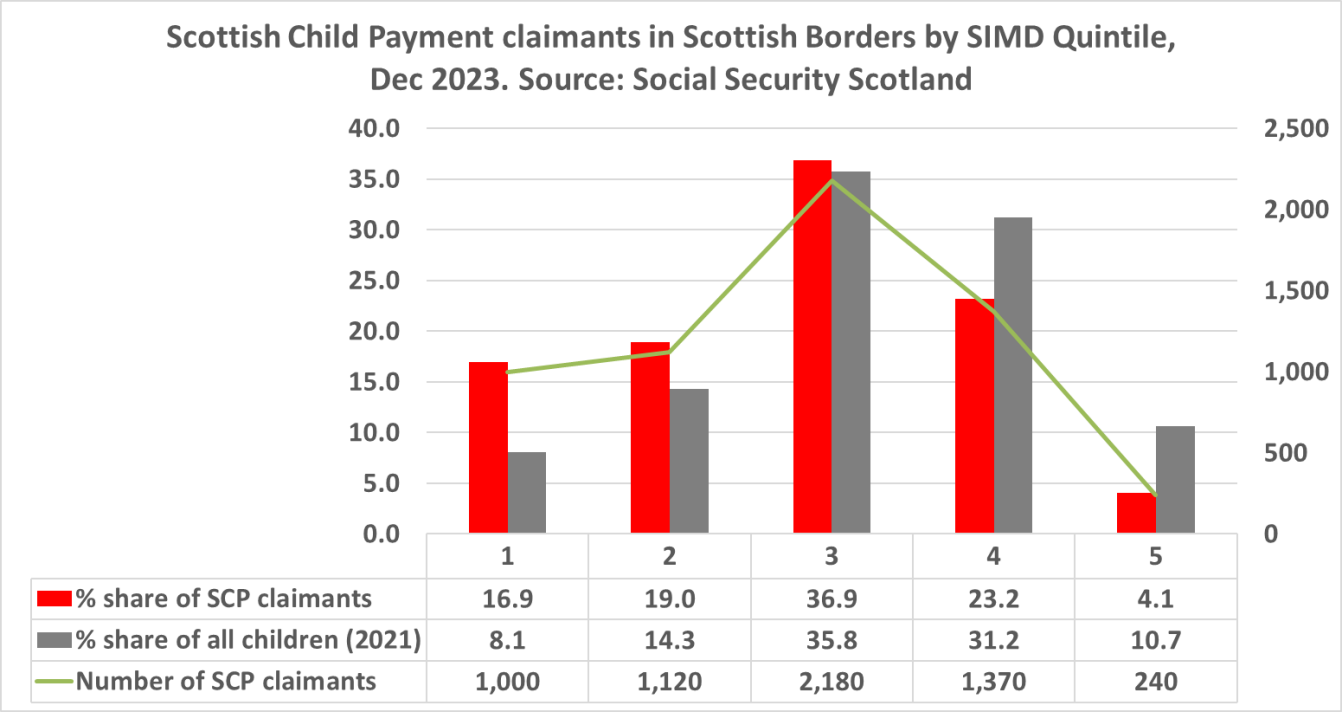
f) School Clothing Grant - in 2023-24 this was an annual payment £120-£150 per pupil to assist with the cost of school clothing and footwear. According to the SBC SEEMIS Management Information System, there were 2,453 pupils receiving Clothing Grant in the 2023-24 academic year, or 17.3% of the school roll.

g) Scottish Child Payment

The Scottish Child Payment is a Scottish Government top-up benefit for households with children that was introduced in February 2021. Initially the weekly payment of £10 was awarded to families claiming universal credit with children aged 0-5.

Since December 2022, the weekly payment was increased to £25 per week and expanded to all children aged 0-15. The first set of Official Statistics for this new benefit are shown below.

In total, there were 5,910 claimants of Scottish Child Payment in Scottish Borders in December 2023.



	1	2	3	4	5
% share of SCP claimants	16.9	19.0	36.9	23.2	4.1
% share of all children (2021)	8.1	14.3	35.8	31.2	10.7
Number of SCP claimants	1,000	1,120	2,180	1,370	240

The grey bars in the chart above show the distribution of the child population in Scottish Borders by SIMD Deprivation Quintile. 8.1% of children in Scottish Borders live in the most-deprived Quintile, i.e., the most-deprived 20% in Scotland – these include Langlee, Burnfoot, other parts of Hawick and Galashiels, and parts of Selkirk. The red bars show that a disproportionate share of Scottish Child Payment recipients (16.1%, or 1,000 claimants) live in these neighbourhoods.

10.7% of children live in the least-deprived Quintile, such as the southern part of Peebles, Innerleithen and Lauder, but only 4.1% of SCP claimants live in these areas. Nevertheless, there are still 240 claimants, which shows that there is evidence of child poverty in the most affluent areas.

The largest cohort of SCP claimants live in Quintiles 3 and 4 (average or below-average deprivation), which is where the majority of all Scottish Borders children live. This shows that there is child poverty wherever there are children. However, as expected, there is a concentration of child poverty in the areas of highest Multiple Deprivation.

Priority Groups

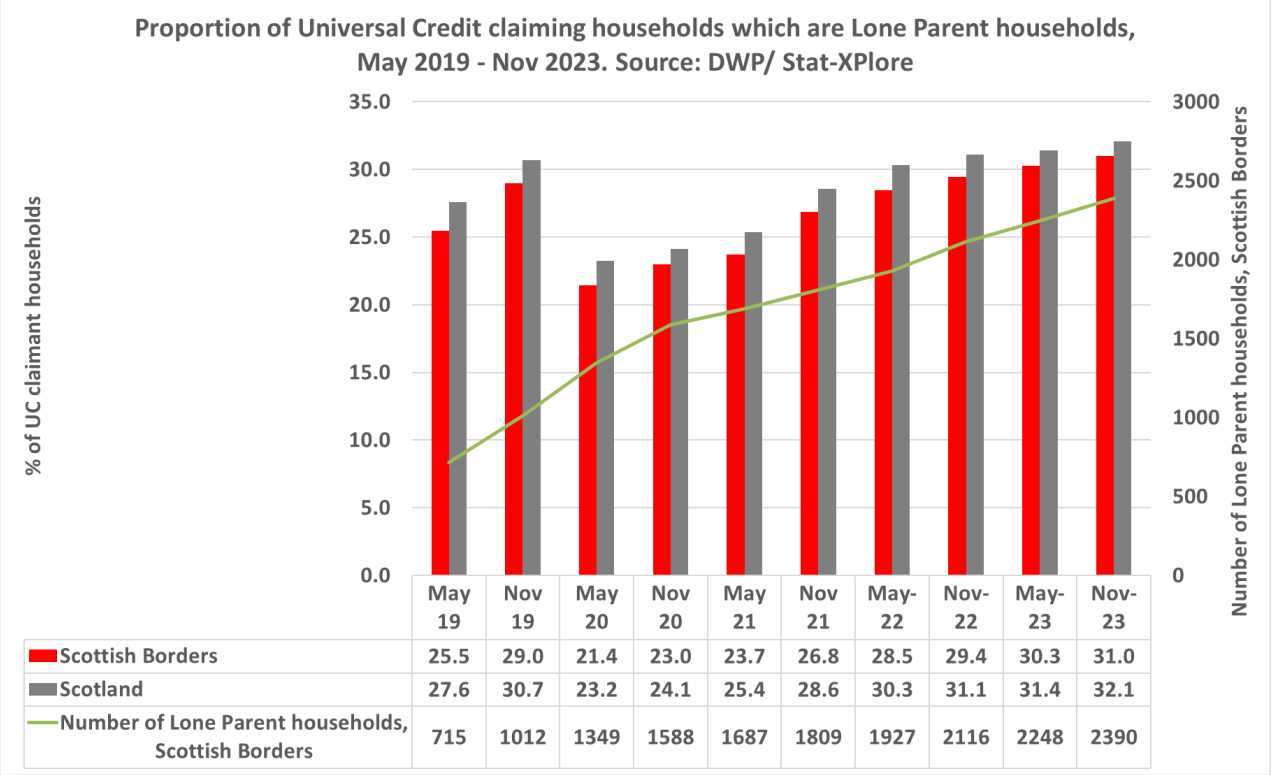
This section provides context on the priority groups identified in 'Best Start, Bright Futures' and profile information on child population. According to Public Health Scotland, more than 8 out of 10 children in relative poverty in Scotland are in at least one of these priority groups:

1. lone-parent families
2. a household where someone is disabled
3. families with three or more children
4. minority ethnic families
5. families with a child under one year old
6. families where the mother is under 25 years of age.

Priority Group 1: Lone Parents

a) Lone Parents claiming Universal Credit

The chart below shows that 31% of Universal Credit claiming households were Lone Parent Households in the Scottish Borders, in November 2023. This is equivalent to 2,390 households. The proportion has always been below the Scottish average, but it is increasing, indicating that more Lone Parent households which were previously managing without Universal Credit are now finding themselves in financial difficulties due to the cost-of-living crisis. The numbers of Lone Parent Households claiming Universal Credit is also increasing, in the Scottish Borders and Scotland.



	May 19	Nov 19	May 20	Nov 20	May 21	Nov 21	May-22	Nov-22	May-23	Nov-23
Scottish Borders	25.5	29.0	21.4	23.0	23.7	26.8	28.5	29.4	30.3	31.0
Scotland	27.6	30.7	23.2	24.1	25.4	28.6	30.3	31.1	31.4	32.1
Number of Lone Parent households, Scottish Borders	715	1012	1349	1588	1687	1809	1927	2116	2248	2390

Priority Group 2: Disabled

Households where the householder or a family member has a disability are more at risk of poverty in a number of ways:

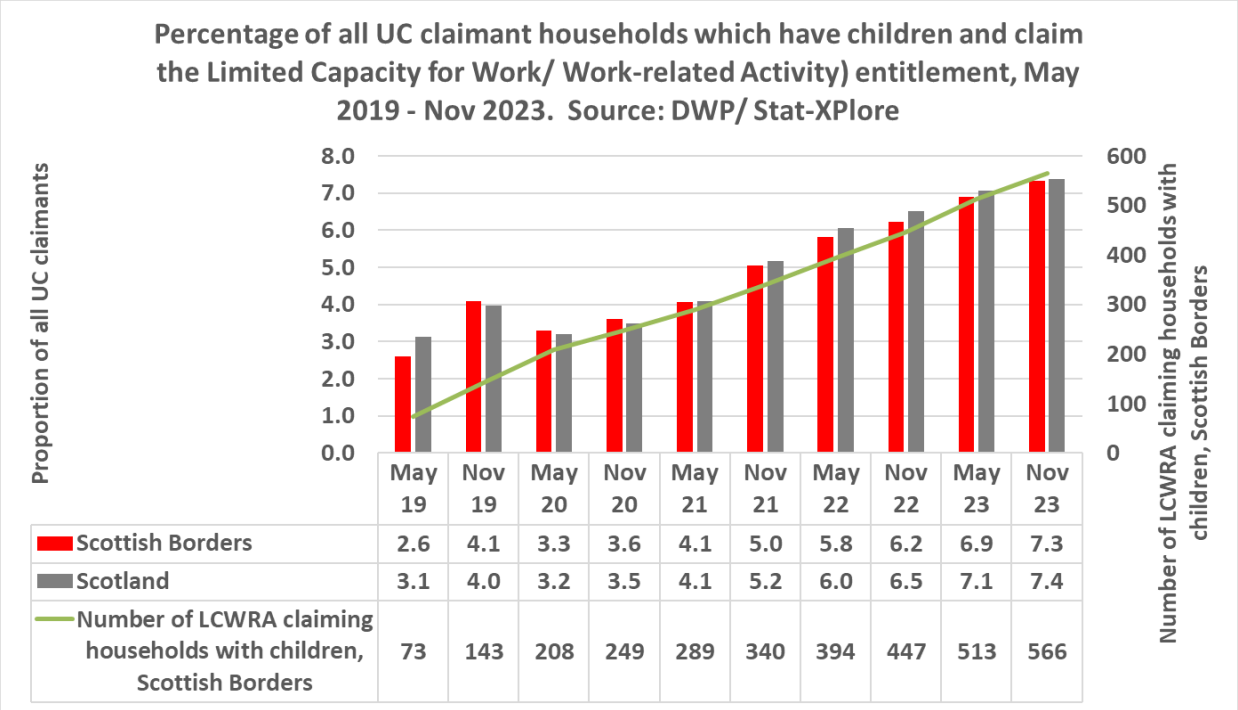
- Difficulty in accessing suitable, well-paid work and reduced work capacity due to the disability
- Difficulty in accessing well-paid work with suitable hours, due to unpaid caring responsibilities towards a disabled family member
- Additional costs incurred directly or indirectly by the disability

a) Universal Credit – Claiming households with children that claim the limited capacity for work element

The chart below shows the numbers and percentages of households with children where an adult has been awarded the limited capability for work/ work related activity (LCW(RA)) entitlement of Universal Credit. 7.3% of Scottish Borders UC-claiming households are families with dependent children who receive this entitlement, similar to the Scottish average and showing a similar trend. The number of awards and the proportion of households with children who receive it is steadily increasing, indicating both:

- a steady increase in the number of parents who are being diagnosed with a work-limiting health condition since the pandemic and are struggling to cope financially
- an increase in the proportion of adults with a work-limiting illness who are struggling financially, who had been managing better before the pandemic.

In November 2023, there were 566 family households with children claiming this entitlement in the Scottish Borders.



	May 19	Nov 19	May 20	Nov 20	May 21	Nov 21	May 22	Nov 22	May 23	Nov 23
Scottish Borders	2.6	4.1	3.3	3.6	4.1	5.0	5.8	6.2	6.9	7.3
Scotland	3.1	4.0	3.2	3.5	4.1	5.2	6.0	6.5	7.1	7.4
Number of LCWRA claiming households with children, Scottish Borders	73	143	208	249	289	340	394	447	513	566

b) Young Carers

According to information from Social Security Scotland, Young Carer Grant is a payment that can be applied for annually by young carers aged 16, 17, and 18 who care for someone normally paid a qualifying disability benefit. The payment is a flat rate of £326.65 that can be applied for once a year.

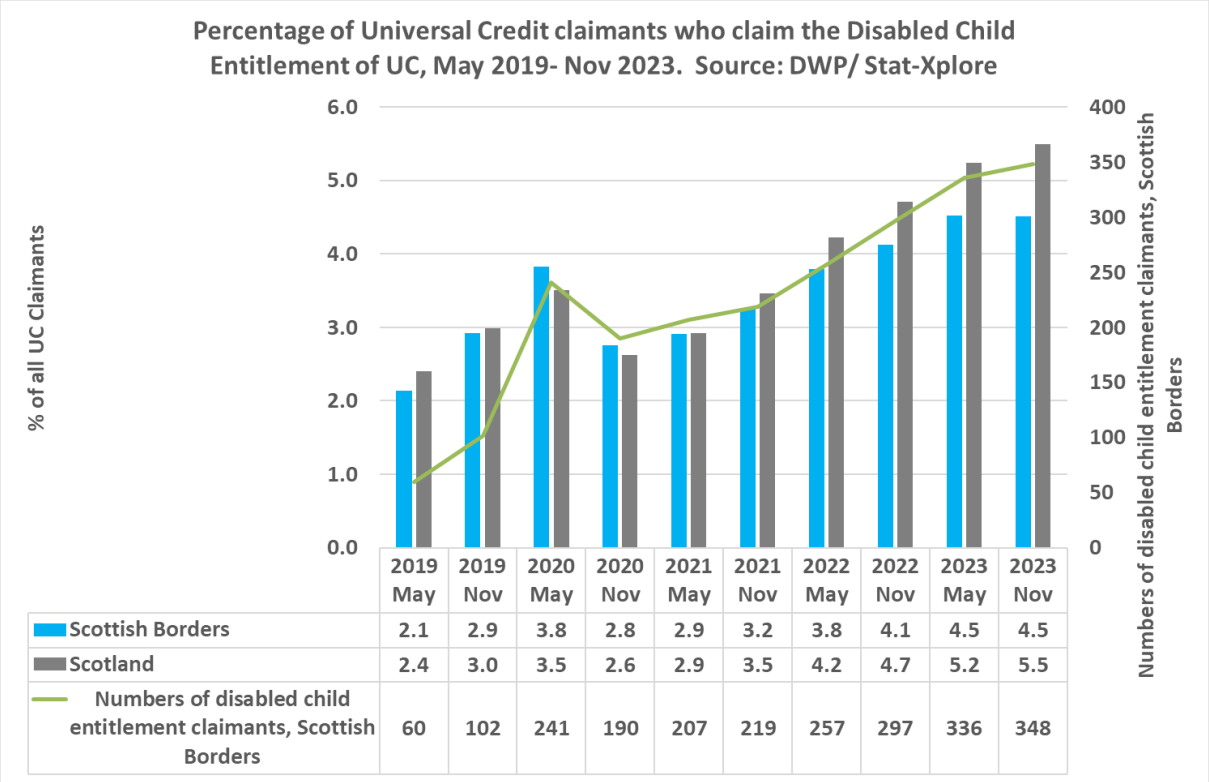
The payment is in acknowledgement of the young person's carer role and is intended to help them access life opportunities that are the norm for many other young people. Young carers can spend this money as they choose. On 1 April 2022, the value of payment for Young Carer Grant was uprated from £308.15 to £326.65.

In the 2022-23 financial year, there were 15 applications for Young Carer Grant in Scottish Borders, representing 1% of all applications received in Scotland. By contrast, 15% of all Scottish applications were received in Glasgow City, and the urban Local Authority areas account for the highest share of applications. Applications from rural Council areas are generally fairly low. Of the 15 applications received in Scottish Borders, 54% of them were approved.

According to the SBC SEEMIS Management Information System, there were 93 Young Carers in Scottish Borders schools in the 2023-24 academic year. This means that the majority of Young Carers in the region either do not, or are not able to, apply for Young Carer Grant.

c) Universal Credit - Claiming households with children that have a disabled child

The chart below shows that the percentage of UC-claiming households with children that claim the Disabled Child element affects an estimated 348 households in the Scottish Borders, who are already living in relative poverty. The numbers of Disabled Child Entitlement claiming families have steadily increased, since the entitlement was rolled out from legacy benefits.



	2019 May	2019 Nov	2020 May	2020 Nov	2021 May	2021 Nov	2022 May	2022 Nov	2023 May	2023 Nov
Scottish Borders	2.1	2.9	3.8	2.8	2.9	3.2	3.8	4.1	4.5	4.5
Scotland	2.4	3.0	3.5	2.6	2.9	3.5	4.2	4.7	5.2	5.5
Numbers of disabled child entitlement claimants, Scottish Borders	60	102	241	190	207	219	257	297	336	348

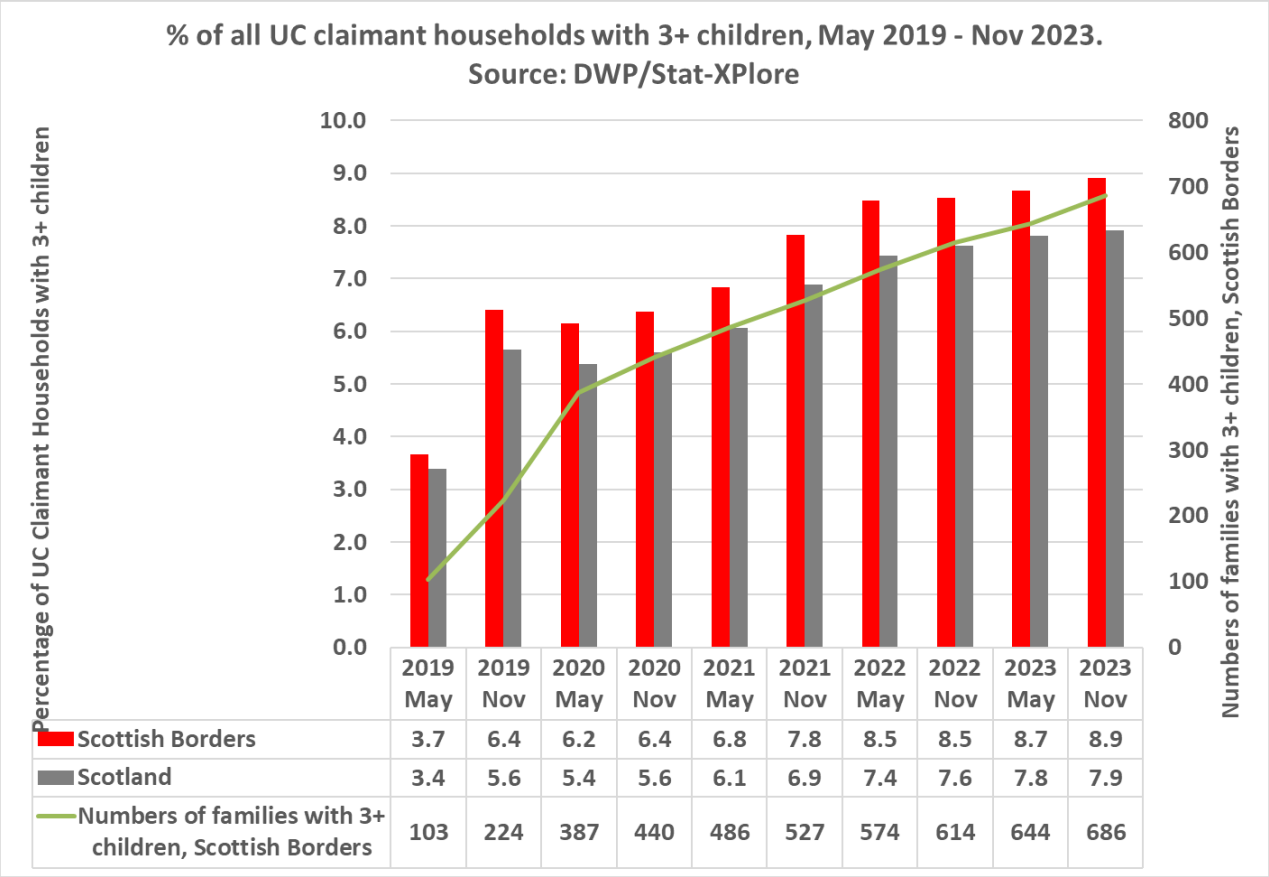
Priority Group 3: Households with 3 or more children

According to Public Health Scotland, 12% of all families in Scotland have three or more children. They are more at risk of being affected by child poverty because:

- they are disproportionately affected by the two-child Child Benefit policy and the benefits cap, which ensures no household receives more in welfare benefits than the average wage
- they face higher costs of living, even before the current crisis
- they are more likely to report they do not manage well financially and are more likely to be living in overcrowded conditions

a) Universal Credit claimants with 3+ children

The chart below shows that the proportion of all UC claimant households that have three or more children, is increasing, although the numbers are fairly small. Only 686 households were in this category in November 2023. This is a small proportion of families but is increasingly represented in the Universal Credit statistics. This indicates again that families who were able to manage financially before the pandemic and the cost-of-living crisis are now finding themselves needing to claim Universal Credit in order to get by. The proportion of larger families in the Universal Credit statistics is consistently larger in Scottish Borders than in Scotland, due to lower household earnings in the region.



	2019 May	2019 Nov	2020 May	2020 Nov	2021 May	2021 Nov	2022 May	2022 Nov	2023 May	2023 Nov
Scottish Borders	3.7	6.4	6.2	6.4	6.8	7.8	8.5	8.5	8.7	8.9
Scotland	3.4	5.6	5.4	5.6	6.1	6.9	7.4	7.6	7.8	7.9
Numbers of families with 3+ children, Scottish Borders	103	224	387	440	486	527	574	614	644	686

Priority Group 4: Minority ethnic families

According to recent Scottish Government information, minority ethnic adults make up 12% of the population in Scotland. Minority ethnic people are more likely to suffer from poverty and child poverty because:

- they are more likely to live in a larger family with younger parents, which are also priority groups for child poverty
- they face additional barriers applying for, and working in, the better-paid jobs, despite often outperforming their White British peers at school
- as a consequence, they are more likely to be forced into low-paid work with irregular hours, which is contrary to a healthy family work-life balance
- they are also more likely to live with housing insecurity and higher rents in the private rented sector

There is very little information about the correlation between minority ethnic households and child poverty in the Scottish Borders. The uptake of Universal Credit is recorded by age and gender, but not by ethnic group.

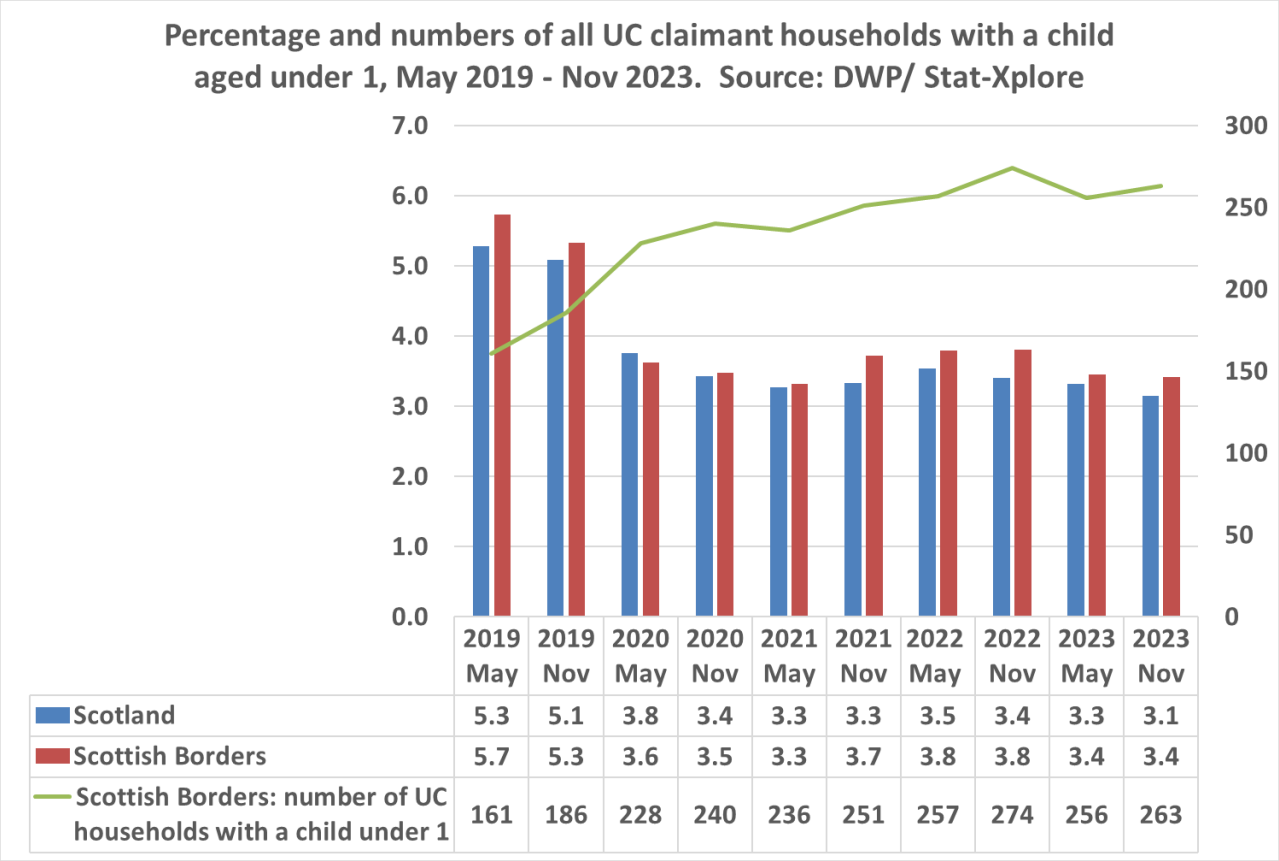
Priority Group 5: Youngest child aged under 1

Families with a child under 1 are more at risk of child poverty, due to the income deprivation caused by at least one of the parents taking maternity or paternity leave for up to a year.

National Registers of Scotland estimated that there were 847 births in Scottish Borders in 2022. The birth rate is decreasing in the region, which is a warning marker for the future sustainability of the population. If couples are putting off having children due to financial concerns, then this will exacerbate the long-term sustainability issue even more.

a) Universal Credit – families with children under 1

The chart below shows that there were 263 families with babies under 1 claiming Universal Credit in November 2023, which is about 31% of all recorded births in 2022 (the most recently available figure). The number of families claiming help with costs has increased in the Scottish Borders, despite the flat birth rate in the region. However, the proportion of UC claimant households that had children under 1 dropped sharply at the start of the pandemic, due to the system being swamped with larger numbers of other claimant types. Since the end of the pandemic and the start of the cost-of-living crisis, the proportion of claimants with a new baby has been higher in Scottish Borders than the average for Scotland, reflecting the lower wages and lack of job opportunities in the region.



	2019 May	2019 Nov	2020 May	2020 Nov	2021 May	2021 Nov	2022 May	2022 Nov	2023 May	2023 Nov
Scotland	5.3	5.1	3.8	3.4	3.3	3.3	3.5	3.4	3.3	3.1
Scottish Borders	5.7	5.3	3.6	3.5	3.3	3.7	3.8	3.8	3.4	3.4
Scottish Borders: number of UC households with a child under 1	161	186	228	240	236	251	257	274	256	263

Priority Group 6: Mothers aged under 25

According to Scottish Government information, mothers aged under 25 are a diverse, relatively small and shrinking group but are more likely to live in a low income household, and more likely to live in a deprived area than older parents, for a number of reasons including:

- Less financial security and fewer savings
- Lower earnings from work, and being trapped in a cycle of in-work poverty
- Housing insecurity – less likely to afford own home and more likely to still be living with parents or in

unsuitable conditions
- A higher likelihood of also being in another priority group, e.g., lone parents, child aged under 1, disabled household member, which undermines their ability to work their way out of poverty even more.

These issues are magnified the younger the mother. Parents aged under 20 are more vulnerable than parents aged 20 to 24. The journey out of poverty for a young, disadvantaged parent is complex, and requires a lot of support from public services and welfare support.

Figures are provided by DWP on the age of individual claimants of Universal Credit, but it does not link them to which entitlements of UC they claim or whether they have children. The stats on Households claiming Universal Credit do not give information on the age of the claimant who is claiming on behalf of the child.

Appendix 1B - Scottish Borders Child Poverty Annual Progress Report 2023/24

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Employability **Through these actions we will increase support available to parents, and uptake and awareness of that support, as well as giving parents access to skills, training and opportunities. This will strengthen the employment offer to parents and create new fair work opportunities, plus tackling inequalities which stop parents from entering and participating in the labour market.**						
Financial Support						
Offer assistance with benefit appeals and specialist advice.	1, 3	SBC Financial Inclusion Team	Number of benefit appeals and specialist advice provided	Children and Families	A2	This is an ongoing service action.
Signposting for help with childcare (aged 2+), travel, digital skills and information on financial support through welfare benefits and Scottish Social Security Benefits.	1, 3	CAB	Increased take up of services and benefit entitlements	Parents	A2	This is an ongoing service action. Signposting provided for help with childcare, travel and digital skills as well as referrals and support to access financial support.
Increase awareness and accessibility of HMRC's Childcare Account for both working families and childcare providers.	1, 3	SBC Early Years	Increased number of families receiving support	Children and Families	A1	This service is regularly promoted so that parents are aware of the support available.
Provide support to parents to help them to take up, extend or sustain employment and maximise their income.	1, 2, 3	SDS	Uptake or extension of employment to maximise income	Parents	B3	Continue to deliver all age career, information, advice and guidance services across the region and lead on PACE (Partnership Action for Continuing Employment) to support individuals who have been made redundant. SDS are supporting the work of the Local Employability Partnership (LEP) with a particular focus on parents.
Administer a client intervention fund to assist with the removal of barriers to employment and support individuals to complete funding applications including Independent Living Fund.	1, 2, 3	SDS	Usage of funding	Families	B3	Barrier removal fund approved by the LEP and administered by the Council. In financial year 23/24 £100k was committed. £28,441 was awarded to 35 clients supported through the Parental

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						Employability Service (PES), £30,749 to 40 No on Left Behind (NOLB) clients and £18,485 was spent on Chromebook and reader pens.
Positive Destinations						
Increase skills and the likelihood of young people impacted by poverty achieving a positive destination.	1	SBC Education SDS DYW Borders Borders College SBC CLD	Increased skills of young people and achievement of positive destinations	Children and Young People	A3	The 2nd annual 3 day event "SkillsQuest" for Care Experienced Young People, Young Carers and invited others was held for S2 and S3 pupils. 80 pupils attended from 8 secondary schools. This was supported by 25+ partners. Schools continue to widen their senior phase curricula, one example being the Level 6 construction course partnership between Galashiels Academy, Morrisons Construction, Borders College and Powering Futures.
Ensure care experienced learners receive ongoing support through transition from school to positive destinations. Increase positive destination rate of learners living in quintile 1 and reduce the poverty gap.	1	SBC Education	Increased positive destination rate of learners	Young People	C3	Ongoing support continues for care experienced learners, this includes the 14+ planning process, partnerships with Borders College and employability services. The poverty related outcome gap in positive destinations continues to narrow.
Fair Work Nation						
Work with employers to ensure they are aware of their responsibilities to employees/workers in line with the principles of a Fair Work Nation.	1	CAB	Increased awareness of workforce challenges and Fair Work Nation	Families	A3	Work with the Employment, Rights & Advice Service, signposting clients who have employment concerns. Attend forums when requested and advise clients on their rights.
Engage with employers to ensure fair, rewarding and sustainable work opportunities are promoted and supported.	1	SBC Employability Service	Increased engagement with employers	Families	A3	Through organised events and outreach activities, we (will) actively engage with local businesses and employers, to ensure we are promoting and supporting fair and sustainable opportunities for people of the Scottish Borders, in accordance with employment laws. Our Employability Service offers in work

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						support and, in accordance with the equalities act, we can assist employers in ensuring appropriate, reasonable adjustments are in place where required.
Work with employers to support delivery of apprenticeship programmes and encourage Fair Work practices including payment of the Living Wage.	1, 2	Borders College SBC Employability Service Interest Link Borders	Number of apprenticeship programmes	Young People	C3	
Childcare						
Offer options for parents to engage in work and access to appropriate childcare.	1	Child Poverty Group Employability Service SBC Early Years	Engagement in work for parents accessing appropriate childcare	Parents	A2	Options provided through SBC Employability Services as part of their ongoing service actions.
Provision of support funding to cover Childcare requirements to enable students to fulfil their attendance, study and work placement requirements.	1	Borders College	Increased attendance levels	Families	A2	Depending on the circumstance, funded students may be entitled to support with childcare costs. This gives the option to place children into nursery or with a registered childminder. The award is based on timetables hours, with flexibility built in to manage study around the everyday challenges families encounter. Those studying a Further Education course can request help with childcare when completing the online funding application. Childcare support is also available through SAAS for eligible HE students. The colleges discretionary fund also provides additional support for childcare costs for FE students in financial hardship.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Volunteering						
Promote volunteering roles within the CAB Service to support parents/carers returning to the workplace.	1	CAB	Increase of parents returning to work	Parents	A1	Our Volunteer Training & Development Project Team have attended roadshows and groups. Team have attended parent groups and community events.
Develop volunteer peer mentoring to build confidence, responsibility and help with career decisions.	1	Interest Link Borders	Number of members & families supported, volunteers involved and sessions provided.	Families	B1	50 young peer mentors from local schools were involved in our befriending groups. These were mainly in Peebles, Galashiels & Hawick.
Create pathways into youth work and offer opportunities for learning and on the job training through volunteering.	1	Tweeddale Youth Action	Number of young people supported	Young People	C3	We continue to support pathways into youthwork through volunteering opportunities and access to training and learning. Three former service users are now part of our staff team.
Information and Support						
Signposting and provision of information to parents will be done through the library service.	1	Live Borders	Number of parents supported	Parents	A1	Literature available in the library. Staff provide support using information from SBC, DWP, Citizens Advice website.
Signpost or refer parents to local specialist services who are looking for support back into employment.	1	CAB	Increased referrals	Parents	A1	Signposting and referrals completed to specialist services for parents who are looking to re-enter employment.
Provide learning opportunities to support parents into employment.	1	SBC Employability Service	Take up of increased learning opportunities	Parents	A1	This is an ongoing service action within the Employability Service.
Promote employability and other relevant projects across social media channels and through referrals from frontline staff.	1, 2	BHA	Increased employability promotion	Parents and families	A1	Borders Housing Network are members of the Local Employability Partnership and BHA promotes various employability projects via social media channels.
Provide advice, assistance and benefit checks to parents of young children.	1, 2, 3	SBC Employability Service	Provision, value and uptake of benefits and support	Parents	A1	This is an ongoing service action which has been extended to those engaging with Employability and Community Learning and Development Services.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Offer employability training to those requiring support, including young people and parents.	1	SBC ESS	Increased number of participating parents and young people at training	Parents and Young People	A1	Our Pre-employability programme is designed to assist individuals in gaining skills, confidence, and resilience. The Key-Worker support assists people who face challenges and barriers into employment, education, or training, by implementing individualised, strengths-based programmes. Each bespoke programme can include a variety of workshops, learning opportunities, work experience, personal and wellbeing support, and guidance to become more independent and active within the community, at a pace determined by each individual and their personal circumstances. Our Employability Training provides individuals the opportunity to obtain accredited qualifications in employability, personal development, core skills and customer care. Training can be delivered to individuals, small groups, or within a workplace environment. As part of or training, work closely with local businesses and employers to provide opportunities to participate in workplace tasters, to speak to employers through engagement presentations and to explore opportunities in further education.
Grow the BookBug Programme to support young parents and develop signposting alongside "return to work" schemes.	1	Live Borders	Increased parental participation of BookBug programme	Parents and families	A1	Bookbug sessions are available in every Live Borders Library apart from Earlston (opening times restrict at present). Literature is available in all libraries. Staff are available to help with enquiries.
Develop partnership approaches to jointly run events with roadshows/leaflets.	1	Live Borders	Increased participation at jointly run events	Parents and families	A1	Library staff attended the Scottish Borders School Employment Fair to promote employment opportunities within Live Borders.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Collaborate with partners to offer digital skills in library spaces.	1	Live Borders	Usage of Connecting Borders devices	Parents and families	A1	Technical issues with Wi-Fi in libraries has prevented progress.
Offer activities, respite and unlimited support for family members to develop friendship networks, confidence and communication skills.	1	Interest Link Borders	Number of family carers benefitting and sessions provided	Families	A1, B1, C2	115 children and young people with learning disabilities and autism have been supported. 200 family carers benefited through respite. Two new groups for ages 18+ focused on skills development.
Expand outreach Careers guidance and employability support activities.	1	SDS Job Centre	Increased engagement from customers including parents and carers	Parents and families	A1	SDS closed their public access centre at Waukrigg Mill, Galashiels and now co-locate with the Job Centre at New Reiver House, Galashiels. Community delivery included all secondary schools, Borders College, SDS Hawick Public Access Centre, Abbey Row Community Centre, Eyemouth Community Centre, Southfield Community Centre, Food Punks and various cafes and community venues across the Borders.
Monthly drop-ins at EY centres to provide Parental Employability Support (PES) for parents who are entitled to Eligible 2's placements. Fortnightly drop in support from the Parental Employability Service (PES).	1	SBC ESS DWP	Take up of training opportunities Eligibility of parents entitled to support	Children and Families Parents	A1	Parental employability support workers visit and offer support to parents and families who attend the Early Years Centres across the Scottish Borders, on a monthly basis.
Provide numeracy courses for parents through the Government's Multiply initiative.	1	SBC ESS	Increased number of participating parents	Parents	A1	The service is working closely with Multiply to identify gaps within localities where Multiply programmes can be delivered to our families.
Offer 1-1 employability support to care experienced young people and engage with support services to ensure wrap around support is provided.	1	SBC ESS	Number of care experienced young people supported	Young People	C1	The service works closely with agencies and partners, including Social Care, Education and NHS Borders, to support young people with care experienced backgrounds, in accessing and sustaining employment. They offer a dedicated Employment Support Worker to provide

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						ongoing support and mentoring to individuals to find, and sustain, positive opportunities and destinations.
Projects and Programmes						
Shape a delivery plan and actions through the provision of local skills training and targeted interventions, including travel vouchers to ensure accessibility.	1	Borders College Local Employability Partnership SBC ESS DWP	Formulation of delivery plan and actions	Young People	A1	Those who qualify for funding support are eligible for free travel. This is available to anyone living more than 3 miles from their College base. Those between 5-21 years old are eligible for free bus travel.
Develop a Community Pop Up Hub employability programme.	1, 3	SDS DWP SBC	Increased engagement from individuals	Families Parents Disabled Minority Ethnic Mothers	A1	A community pop up model was piloted in 2022 on a weekly basis in the Burnfoot Community Café involving partners SBC, SDS, DWP and NHS. Due to low footfall accessing the services, this was paused in March 2023 with partners exploring the option of working with Community Officers to offer employability support and wellbeing information across the region working closely with established community groups. Most recent focus has been on individual partners supporting the Social Work What Matters Hubs.
Deliver programmes promoting independence/life skills and offer awards in volunteering to support participants to gain the skills required to enter paid work.	1	Borders College	Number of volunteering awards	Young People	C3	Through the Department of Business and Enterprise, Borders College delivers a range of leisure and community courses including National 4, 5 and Higher certificated courses. They also deliver a range of employability courses in partners with DWP and SBC. Skills for Life and Work programmes are designed to equip candidates with skills they need to lead successful and fulfilling lives. Awards within these programmes start an entry level and can progress to level 4. These include courses like 'Ready for Life', 'Tenancy' and 'Employability'.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Develop physical and mental health, mindfulness and meta skills through an employability boot camp.	1	Borders College SBC	Increased physical and mental health skills	Families	A3	In partnership with SBC, Utility Warehouse and DWP, Borders College ran the Employability - Developing Skills for Employment course. This course, which is aimed at people who are unemployed, provided opportunities including upskilling, recognised certificated, confidence building and interview experience. A further 'Train for Life' course provides training in customer service, data science, employability, health living and IT skills.
Provide an all age employability service (16+), including travel pass and digital connectivity access.	1	SBC Employability Service	Number of young people supported	Young People	C3	This is an ongoing service action within the Employability Service.
Work with local partners to provide targeted employability skills training and support people into ancillary roles in the NHS.	1	Borders College SBC NHS	Improved target employability skills	Families	A3	Borders College, SBC, SBCares and NHS Borders work together to deliver an integrated health and social care partnership through the Care Career Academy, which provides a range of flexible training opportunities. This enables individuals to learn while they earn, develop a range of skills and offer progression on to chosen career pathways into health, nursing, care and social care.
Undertake meaningful industry insight visits over the summer to a broad range of key industry sectors.	1	SDS DYW	Visits conducted	Young People	A3	12 SDS industry insight placements took place across the South of Scotland over the summer of 2023 with 61 individual visits. Formal evaluation of the visits scored 8.8/10. Planning is underway with the DYW Regional Group for further visits in summer 2024.
Support partnership planning for poverty related issues by producing labour market information including Regional Skills Assessments.	1	SDS	Evidence from Regional Skills Assessments conducted	Families	A3	Regional Skills Assessments and Sector Skills Assessments are published by SDS on an annual basis and are available to support planning. Most recent publication was February 2024 - www.skillsdevelopmentscotland.co.uk/wh

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						at-we-do/skills-planning/regional-skills-assessments
Break the intergenerational cycle of poverty by working with partner agencies to target hard to reach families.	1, 2, 3	SBC ESS Social Work Early Years	Take up of services	Families	B1	Targeted advice and support focusing on the 6 priority family groups, and offering generational support is being developed with providers including Housing and 3rd Sector.
Education **Through these actions we will continue to tackle the poverty related attainment gap and support the health and well-being of children and young people. This will in turn help children and young people to achieve better lifelong outcomes, thus helping to break the cycle of poverty.**						
Attainment						
Achieve medium term outcomes of Scottish Attainment Challenge strategy to improve outcomes whilst closing the poverty-related attainment gap.	1	SBC Education	Achievement of medium term outcomes	Children and Young People	C2	All short and medium term outcomes of the Equity Strategy have been achieved. Work continues to narrow poverty related outcome gaps, including the setting of stretch aims in schools and the local authority.
Narrow the poverty attainment gap through resourcing improvements in pedagogy, curriculum development and learning teaching and assessment by utilising Strategic Equity Funding.	1	SBC Education	Narrowing of poverty attainment gap	Children and Young People	C2	Equity is at the heart of the new SBC Way breakthrough curriculum. All schools are engaging in the 3-year implementation plan. Strategic Equity Funding (SEF) has been devolved to clusters to support enhance initiatives to narrow the poverty related attainment gap. This is planned and monitored to ensure impact.
Develop a curriculum reflecting the aspirations of the OECD Review of Curriculum for Excellence as well as The Hayward Review on national qualifications and assessment.	1	SBC Education	Evaluation of practices, approaches and experiences of staff and children	Children and Young People	A2	Our new 3-year plan of the SBC Way, includes all schools engaging in improvements to the curriculum in literacy, numeracy and pedagogy. We await further national guidance on the Hayward review and the future of national qualifications and assessments.
Ensure Learning for Sustainability, UNCRC and The Promise are integral to our new curriculum and culture.	1	SBC Education	Evaluation of practices, approaches and experiences of	Children and Young People	A2	Work continues to ensure these areas are embedded in our schools, including rights respecting schools and the BrightSpots improvement programme.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
			staff and children			
Plan and lead interventions with children and parents/carers to close poverty related attainment gaps.	1	SBC Early Years	Attainment gap improvements	Children and Families	C2	This is an ongoing service action within the Early Years Service and Early Years Centres.
Transport and Travel						
Ensure all young people have access to the Young Scot website, support to apply for their Travel Card and free bus travel for under 22s is promoted.	1	SBC CLD Borders College SBC EES Tweeddale Youth Action CAB	Increased applications for Travel Cards Increased uptake of travel entitlement Increased bus travel applications	Young People	A2, C3	All pupils who have Ipads have a tile on their desktop to access Young Scot. All young people are encouraged by CLD and our 3rd sector partners to access travel cards.
Students who do not qualify for national travel entitlement schemes are provided with bus or train tickets where they meet the eligibility requirements of student bursary.	1	Borders College	Increased distribution of bus and train tickets	Young People	A2, C3	All students living within 3 miles of a College base are offered free travel as part of bursary support.
Digital Support						
Identify children and young people with learning disabilities and autism who would benefit from devices and connections.	1	Interest Link Borders Connecting Scotland Connecting Borders	Increased uptake in digital devices	Children and Young People	A2	4 Ipads have been given to eligible individuals
Student advice, guidance and support is available to all students and supported by a comprehensive student information portal to support successful learner outcomes.	1, 2, 3	Borders College	Positive learner outcomes	Families	B3	The Student Advice Centre is open to students Monday-Friday and offers a range of support including advice and guidance on travel, finances, academic issues and wellbeing. The college's student portal provides links to a range of

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						information to support their studies, including assessment information, learning support, student support, IT support and funding information. We are currently in discussions to develop a careers tile to support students with employability skills and are about to launch 'Report for Support' which is an accessible internal bullying and harassment reporting tool
Information and Support						
Provision of support funding to cover Childcare requirements to enable students to fulfil their attendance, study and work placement requirements of college qualifications.	1	Borders College SBC CLD	Increased attendance levels Increased access to childcare	Families	A2	Funded students may be entitled to support with childcare costs. This gives the option to place children into nursery or with a registered childminder. The award is based on timetables hours, with flexibility built in to manage study around the everyday challenges families encounter. Those studying a Further Education course can request help with childcare when completing the online funding application.
Libraries offer drop in craft and reading sessions and the 'summer ready challenge' for children.	1	Live Borders	Number of children supported	Children	C2	The summer reading challenge was available to all children during the summer holidays. A programme of activities was offered alongside the challenge to encourage children to visit the library and take part in the scheme.
Identify and support pupils, in partnership with schools, whose education may be affected by poverty factors.	1, 2, 3	SDS Schools	Number of young people supported	Young People	C3	SDS deliver a targeted service offer in schools. Careers Advisers work with school guidance staff to identify those pupils most at risk of not progressing to a positive and sustained destination. Validation activity takes place twice a year and SIMD is a contributing factor. The school leaver destination publication shows an improving picture of the gap between the 20% most and least deprived.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Ensure all young volunteers qualify for Saltire Awards.	1	Interest Link Borders	Number of volunteers	Young People	C3	All young volunteers achieved their Saltire Award in 2023/24.
Projects and Programmes						
Provide a mentoring programme specifically aimed at supporting, advocating and coaching young people who are most at risk of not sustaining a successful learning journey.	1	Borders College	Number of students supported	Families	C2, C3	The Borders Young Talent Mentor scheme provides mentoring support to care experienced students and student carers. Our student wellbeing coordinator provides dedicated wellbeing support for students who are struggling with their wellbeing. We also have two partnerships with external mental health organisations who support targeted interventions, including the delivery of counselling sessions.
Deliver enhanced inclusive economic growth through the Regional Economic Partnership, whilst continuing to adopt and embed the Fair Work approach.	1, 3	SOSE	Number of organisations funded whose activities indirectly or directly address child poverty	Families	A2	Sharing prosperity and inclusive growth are established as key values within the Regional Economic Strategy. The Regional Economic Partnership are reviewing their delivery plans but will continue to adopt and embed the Fair Work approach.
Information & Advice **Through these actions we will help to ensure families receive the support they are entitled to. We will provide support to help overcome barriers to accessing this support, as well as improving the quality and availability of advice services.**						
Transport and Travel						
Signpost to relevant services where it appears there is an entitlement to support with transport e.g. free bus pass.	1	SBC Financial Inclusion Team	Uptake of Travel Cards	Families	A2	This is an ongoing service action which has been extended to those engaging with Employability and Community Learning and Development Services.
Advertise and promote free bus travel for under 22s and Job Start Payment.	1, 2, 3	SBC Financial Inclusion	Number of young people supported	Young People	C3	Independent, sustainable travel forms an integral part of the work done with young people seeking opportunities for work, education and/or training. As part of our intervention, we support all participating young people in applying for, and utilising, free bus travel, available through Young Scot.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Signposting and Advice						
Signpost specialist support, including mental health and drug and alcohol services to young people attending youth club.	1, 2, 3	Tweeddale Youth Action	Number of Young People signposted	Young People	B1	Signposting continues through visible posters at our youth clubs, social media and our website as well as through targeted inputs/conversation at sessions.
Provide a holistic and whole family support library service by signposting and provision of authoritative sources of information.	1, 2, 3	Live Borders	Uptake in signposting	Families	B1	Information available in libraries from SBC/NHS staff helps to signpost customers using information from SBC and Third sector websites.
Signpost or refer to local and national employment support if relevant.	1, 2	CAB	Number of young people supported	Young People	C3	CAB provides advice, information and support to all 16+. Income maximisation advice and support to apply for all benefits. Social Security Scotland also provide assistance with Scottish Child Payment applications.
Available Support						
Develop and produce a service directory which outlines available support for children and young people, families and professionals.	1, 2	SBC Financial Inclusion Team	Increased available support	Families	B1	Scottish Borders Council's website has been updated with a page showing support for families. Parents, children and young people | Benefits and Financial Support | Scottish Borders Council (scotborders.gov.uk)
Proactively promote free school meals (FSM) and clothing grant provision, conduct benefit take up campaigns and provide linked advice and support.	2	SBC Financial Inclusion Team	Increased uptake	Children and Young People	A3, B3	A take-up exercise is undertaken every summer before the start of the new school year
Students are supported to ensure that they access the maximum and appropriate funding sources available to them.	1, 2, 3	Borders College CLD	Uptake of funding sources	Families	B3	The Student Funding team provide ongoing support to students to access the funding available to them. The team are available to meet with students. They also provide workshops, 1-1s, drop ins and intro to funding sessions at various points throughout the academic year. The funding team is supported by the wider student services team who can also offer information and advice in relation to funding, support students to meet with the funding team, and complete applications to relevant community funds.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Housing & Energy **Through these actions we will help to keep housing costs low, provide support with rising energy bills and tackle homelessness for families.**						
Tenancy Sustainment						
Support families to secure settled, mainstream housing as part of the Rapid Rehousing Transition plan.	1, 2	SBC Homelessness	Reduction in homelessness	Families	A1, B4	A budget is assigned to our RRTP in Funding to Families with Children in the form of the Housing Intervention Fund (HIF) and the Crisis Intervention Fund (CIF). The team seeks to identify the needs of families and children at the initial point of contact, so that they can assist quickly. They also offer a Deposit Guarantee Scheme to help families and individuals attain the deposit they need for private rented accommodation, so that they are not missing out on opportunities, as well as supermarket gift cards as well as bus vouchers to access transport. The service aims to house families and individuals as quickly as possible, taking into account all their needs, determining appropriate access to amenities, school, work, other family networks etc.
Parents are signposted for advice and support on housing or tenancy related matters.	1, 2, 3	SBC Financial Inclusion SBC Homelessness	Number of families supported	Families	B4	Referrals are made between the financial inclusion team and the homelessness team. The service also engages with CAB where needed.
Use social media and campaign marketing to encourage people facing homelessness to engage early with a view to set up repayment options and/or other suitable debt remedies.	1, 2, 3	CAB Landlords	Number of families supported	Families	B4	Relevant information is shared on social media. A specialist energy project was undertaken in 2023/24 to assist with complex cases. Money advice workers assist with debt issues and fuel bank and discretionary funds requests are made when appropriate.
Fuel and Energy						
Award Crisis Grants or signpost to external partners to assist with fuel costs.	1, 2, 3	SBC Financial Inclusion CAB Changeworks	Number of families supported	Families	B4	Referrals are made between partners to address specific issues for clients.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
		Home Energy Scotland RSL's				
Utilise funding from the Scot Govt Fuel debt fund 2023/24 to support tenants with their heating costs and reduce their fuel debt.	2, 3	SBHA	Number of tenants supported, monetary gains	Families	B4	Since June 2021, the Borders Housing Network has distributed £1,543m in funds received from the Scottish Government's Fuel Debt Fund to over 5,000 social rented Tenants across the Scottish Borders who are in fuel poverty. This funding has reduced their heating costs and cleared their fuel debt. Of the 5,000 social rented Tenants supported, a total of 2,300 children are residing within these homes.
Support 2,000 social rented tenants through continued funding of the Warm and Well Co-ordinator and Energy Advisor.	2, 3	SBHA	Number of tenants supported, monetary gains	Families	B4	Over 5,000 social rented Tenants have received support from the Borders Housing Network's 2 x Warm and Well Coordinators, with 2,481 Tenants supported in 2023-24, against a target of 2,000. The increase in support over the past year can be attributed to the cost-of-living crisis and increased energy costs. Following an additional award from SBC's Cost of Living Fund for £40,000, the Borders Housing Network have been able to retain 1 x Warm and Well Coordinator to continue the service for another year, with an aim to support 1,000 social rented Tenants, reflecting a reduction in the service provision. The Network will continue to explore funding opportunities with partners to continue this invaluable service beyond 31 March 2025.
Warm Affordable Homes						
Creation of new social housing though warm, affordable housing and infrastructure.	2	BHA	New social housing creation	Families	B1	Berwickshire Housing Association (BHA), recognise the profound impact of safe, secure homes on families and children. In 2023-24 they expanded their commitment by developing 21 new homes in Duns at Springfield Drive. Through increased

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						investment, they are enhancing heating systems and improving thermal efficiency to reduce costs for customers. Partnering with WarmWorks has enabled them to implement Air Source Heat Pumps, along with PV and battery storage systems, ensuring that customers benefit from reduced heating expenses. They also remain dedicated to acquiring new sites for development to bolster housing stocks.
Information and Support						
Engage with support services to ensure they are easily accessible and available to all, as well as funding information.	1, 2, 3	SBC ESS	Number of families supported	Families	B4	Key worker support is a mandatory element of the delivery of employability services. This ensures parents and clients are aware and able to access the opportunities available. Engagement with RSL energy advisors as well as Sustainable Selkirk offer professional advice and support to those in fuel poverty.
Health & Wellbeing **Through these actions we will provide financial, practical and emotional support, helping to tackle and mitigate the impact of poverty as well as preventing it.**						
Food and Healthy Eating						
Secure funding to continue to support families with vouchers and continue to provide food at evening drop-in sessions.	1, 2, 3	Tweeddale Youth Action	Number of vouchers distributed Food provided	Young People	B1, B2	Tweeddale Youth Action continue to offer a free evening meal at drop-ins and school holiday activities and distribute occasional vouchers.
Invest in estates and community facilities including community food gardens.	1, 2, 3	BHA	Uptake in accessing benefits assistance	Families	B1	BHA continues to provide land and support for two community food gardens in Duns and Ayton in partnership with Abundant Borders. Various activities take place in the gardens to encourage the local community to participate and become involved in food growing and preparation, including children and families. BHA's community programme supports community groups with modest funding for activities that will benefit the

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						whole community including support to local foodbanks and larders.
Work with third sector services providing family support to build capacity in relation to health and wellbeing (eg healthy eating on a budget).	1, 2	JHIT		Families	B1	Community Food Workers (CFW) delivered several cooking on a budget sessions in the community including super snacks/meals on a budget. Approx numbers attending were 29 adults and 20 children. Support in the Summer Programme included 'fussy eaters fund with food' family lunch and food activity with 42 parents and 72 children participating. Additional cooking sessions were delivered for Post Natal Depression Group and via drop ins.
Offer students a free breakfast, supermarket vouchers, lunch/breakfast bars and provide regular drop in 'Wellbeing' cafes.	1, 2, 3	Borders College	Number of students supported	Families	C1	Breakfast packs and supermarket vouchers are available from the student services teams. Themed wellbeing cafes provide opportunities to discuss and raise awareness for key equalities themes, including corporate parenting, mental health and wellbeing and menopause.
Provide training to support Breakfast Clubs to deliver nutritious food for children.	2	JHIT	Number of children supported	Children	C2	A Breakfast Club Guide in line with current guidance was developed to support staff delivering breakfast clubs with examples of suitable foods to offer at clubs both to fit with the guidance and in keeping with a health promoting school/community ethos. JHIT and SBC delivered training to all 20 recipients of Breakfast Club funding. All participants were provided with supporting documentation.
Promote 'Ride Pingo' for its customers in Berwickshire and enable older people to attend lunch clubs and social community events.	1	BHA Berwickshire Wheels	Number of transport users	Families	A2	Ride Pingo is promoted via BHA social media and attendance to lunch clubs and local events is a key aim of BHA Befriends group activities. A total of 976 invites were made to befriends to attend 65 plus events with 64 individuals attending one or more of these local

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						events. The project also supported 96 lonely and isolated older people with individual befriending via 26 volunteer Befrienders. BHA Befriend was awarded a further three years funding by the National Lottery in January 2024.
Mental Health						
Offer Books on Prescription and signpost to mental health services.	1	Live Borders	Increased uptake Increased signposting	Families	B1	Books on prescription are available for loan. Free requests mean customers can access books from any library, offering them a greater choice.
Provide of tenancy sustainment services, direct and intensive support to prevent tenancy failure including financial inclusion and BeWell mental health project.	1, 2, 3	BHA	Uptake of sustainment services Number of families supported	Families	B1, B4	Total annual benefit gains generated for BHA customers amounted to £785,208 secured in the last financial year. This includes over £18k in Child Benefit and Scottish Child Payment awards. BeWell capacity expanded and extended to work with more customers under age 25. By December 2023 the project had supported 34 people since April 2023 and over 70 BHA customers since BeWell was initiated in November 2021.
Lobby for renewed funding for the student mental health counselling service. Continue to work with local third sector providers to provide collaborative interventions that will support student mental health and wellbeing.	1, 2	Borders College	Uptake in mental health counselling services	Families	B1	Scottish Government committed to a further allocation of mental health and wellbeing transitional funding in 2023-24. This funding was used to continue counselling provision while upskilling current staff, building on partnerships with the third sector and developing internal services.
Co-deliver Continuous Professional Development training on Mental Health Awareness including Trauma Informed Practice and Self Harm and Suicide Prevention.	1	NHS Borders SDS	Increase of trained SDS Advisors	Families	B1	The SDS leadership team and NHS Borders Mental Health Practitioners co-delivered Trauma Informed Practice training in March 2023 followed by Mental Health First Aid training in May 2023. This was complemented with an online module and signposting materials.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Information and Support						
Provide five fortnightly peer-age befriending groups for children and young people with learning disabilities & autism aged 8-25. Also fifteen 1:1 befriending links.		Interest Link Borders	Number of members & families supported, volunteers involved and sessions provided.	Children and Young People	B1	16 groups for children and young people operated in the community, in-school and by Zoom. Young people aged 18-25 took part in a further 17 intergenerational groups. Fifteen 1:1 links operated.
Provide information on maternity rights, additional support offered, benefit checks and claim support.	1, 2, 3	CAB	Number of families supported	Families	C1	Benefit checks offered to all clients with information on maternity rights and support to make any relevant applications.
Provide local breastfeeding support groups.	1	JHIT	Number of parents supported	Parents	C1	Evaluation of Breastfeeding in the Borders is in progress. There are noted improvements in breastfeeding rates between women living in most and least deprived communities. Breastfeeding groups running in 8 areas across the Borders.
Provide Healthy Start Vitamins.	1	JHIT	Number of children supported	Children	C1	Evaluation of Health Start Vitamins and Vitamin D is in progress. The reach of distribution has increased over the last year supported by a new promotional campaign.
Provide weaning and healthy groups for families.	1	JHIT	Number of families supported	Families	C1	Weaning groups are taking place face-face, on-line and within breastfeeding groups. Face to face weaning sessions were provided to 73 people and virtual weaning to 28. The service have also piloted 'weaning on a budget' resources.
Projects and Programmes						
Implement the Team Around The Cluster approach in our school communities.	1, 2, 3	SBC Education	Uptake of families supported	Children and Families	B1	The Team Around the Cluster approach continues to be embedded in school communities with more resource being devolved to clusters (e.g Strategic Equity Funding). Cluster Lead 'pathfinders' have been appointed in each of the 9 clusters.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Increase the number of school and settings evaluating themselves as good or better for QI 3.1. Provide training for child protection coordinators and designated managers on aspects of The Promise and roll out play pedagogy.	1	SBC Education		Children and Young People	C1	A new 'Sharing the Standard' programme of activities has been launched with school leaders. Designated Managers have received input on The Promise. Schools have engaged with the Bright Spots programme. Further work in this area will be identified through the Bright Spots Action Plan and the Scottish Government's proposed Promise Education Outcomes strategy when this is published. All school leaders have received input on play pedagogy.
Monitor and evaluate whole family support provided to ensure it continues to meet the needs of the families.	1, 2, 3	SBC Early Years	Evaluation of support provided	Families	B1	This is an ongoing service action and is reviewed as part of the wider Early Years service alongside the Whole Family Support Network of the CYPPP.
Provide a programme of Bookbug for babies and toddlers.	1	Live Borders	Number of children supported	Children	C1	Bookbug sessions are available in all libraries (apart from Earlston) Duplo sessions and under 5 story times are available in larger libraries.
Support delivery of School Holiday programmes.	1	JHIT	Number of families supported	Families	C1	Participation in Christmas Grant Allocation Process & Easter Assessment Panel to review, discuss and agree funding awards. Draft submission to PHIRST For PH Funded Evaluation of programme, awaiting outcome.
Undertake core work with families on playing with their children through a number of sessions, ie Bookbug, Stay and Play, Tots Time.	1	SBC Early Years	Number of families supported	Families	C1	This is an ongoing service action within the Early Years Service. All nurseries and Early Years Centres offer stay and play sessions as part of core business.
Tackling Digital Exclusion **Through these actions we will expand the Connecting Scotland Programme and help to provide devices for families in poverty to enable access to appropriate services and support.**						
Utilise Connecting Scotland, NOLB and SPF resources to ensure all parents gain access to a device and appropriate IT training.	1	SBC EES	Access to digital devices	Parents	A2	Through the Barrier removal fund and key worker support, advice and support is provided to ensure parents/clients have the access they require to engage in support services and training.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Provide a laptop loan system whereby anyone who requires a laptop, digital device or broadband access receives this.	2	Borders College	Uptake of digital devices	Families Young people	C2, C3	All students who do not have their own laptop are provided with one via our loan laptop scheme. We have further laptops available across our campuses within laptop lockers. These can be loaned our short-term to students, which they access with their student card.
Communities & Partnerships **From these actions we will work with partnership, third sector and community organisations to provide holistic and whole family support.**						
People and Place						
Deliver our vision for place and regeneration and support communities to form Place Plans.	1, 2	SBC Communities	Partnership working with third sector and community organisations	Families	B1	60+ place plans are under development in communities
Provide library membership for every baby born in the Scottish Borders.	1	Live Borders SBC Registrars	Number of families supported	Families	C1	ECALM (Every child a library member) is progressing in partnership with SBC registrars.
Support the delivery of play park programmes through the Capital Investment Scheme and Sport and active living funding opportunities.	1	SBC Communities	Delivery of play parks Number of children and young people supported	Families	C1, C2	The Play park investment programme has involved a number of engagement sessions with communities. Seven playparks have been completed in 2023/24 with a further 3 scheduled to be completed. Improvements to playparks in Newcastleton, Heiton, Broughton, Kelso and Burnfoot is planned.
Develop new partnerships, in both the third sector and community organisations to gain improved outcomes for our clients.	1, 2, 3	CAB	Number of families supported	Families	B1	The CAB are engaged in a pilot project with Social Security Scotland to ensure clients are supported to apply for Scottish Benefits. Pilot project completed ensuring clients are applying for Council Tax Reduction when appropriate.
Funding						
Initiate and support community projects through community funds, some of which are now social enterprises.	1	BHA	Increased community projects	Families	A3	BHA continues to support community groups where possible, including seed funding, endorsement of larger funding applications and other partnership work,

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						including ad hoc support to local foodbanks and larders
Work in partnership with third sector and community organisations, attend fortnightly/monthly community meetings and co-deliver warm and well grant funding.	1, 2, 3	SBC Communities	Partnership working with third sector and community organisations	Families	B1	Funding was awarded to Borders Community Action from the National Lottery Fund and Scottish Borders Health and Social Care Partnership. A total of £40k was obtained to support local communities.
Work with strategic partners to ensure there is help with heating costs through Cost of Living Support initiatives.	2	SBC Planning & Strategy	Cost of Living initiatives	Families	B2	The cost of living support initiatives continue to provide help with heating costs where appropriate
Support the roll-out Money Guiders Training Programme in partnership with Money and Pensions Service.	1, 2, 3	JHIT	Response to Money Guiders Training Programme	Families	B3	Staff from Health Improvement and Borders Addiction Service have taken part in the Money & Pensions Service National Evaluation and shared the partnership approach by working with SG Improvement Service and the Money & Pensions Service and facilitating presentations to share learning with the Scottish Money Guiders Network & the MAPS team in Bedford.
Holistic and Whole Family Support						
Provide holistic support through the Stepping Stones project and signpost to other organisations.	1, 2, 3	Tweeddale Youth Action	Number of referrals received	Young People	B1, B2	Stepping Stones delivery and signposting continues to have a significant positive impact on highly vulnerable young people.
Work cohesively in family assessments to provide a package of support as part of a shared 'whole family approach.'	1	SBC ESS	Increase to packages of support delivered	Families	B1	Initial meetings with referred families examine possible referral routes such as: Housing, Mental Health, Income maximisation. The service ensures that appropriate links are made with all services supporting the family to enable everyone's needs and wellbeing to be considered. Families are actively engaged in the process and work within a robust support plan which has a multi-agency and family focus.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Projects and Programmes						
Explore the possibility, working in collaboration with NHS, to ensure timely mental health support is offered to clients accessing employability services.	1	SBC ESS NHS	Delivery of collaborative working with NHS	Families	B1	Conversations are continuing with NHS but there are some resource issues to provide NHS mental health specific support to employability clients. The week of Wellbeing is being delivered by the NHS Wellbeing Team – A taster session and additional support is offered if required.
Work in collaboration with Peebles High School to offer daytime, vocational support for disengaged young people. Work towards PHS using SQA framework to recognise achievement through this support and tie in with business and enterprise.	1	Tweeddale Youth Action	Number of young people supported	Young People	C2	Food and Bike Punks are currently supporting cohorts of school refusers and those on blended timetables during the school day. PHS have recently allocated a teaching resource to support accreditation of young people accessing provision at TYA during the school day. Collaboration with CLD supports accreditation through youth awards.
Attend school career fairs to raise awareness of all types of support could be available depending on their circumstances.	1, 2, 3	CAB	Number of children supported	Children	C2	CAB attend local groups, pensioners groups, U3a, school and career fairs and parent groups. Energy training is offered and provided to both external groups and partners and resources provided.
Inform and shape provision based on the Annual Participation Measure, focusing on areas with poor participation.	1	SDS LEP YPG	Number of families supported	Families	C2	Use of data from school leaver follow up activity and participation data for 16–24-year-olds to target provision in areas of greatest need. For example, delivery of NOLB Stage 2 and 3 in Eyemouth and Hawick. Annual Participation Measure 2023 for the Scottish Borders was 95.6% versus 94.3% nationally and was an increase of 2.4% in 2022.
Improve the effectiveness, consistency and impact of 14+ meetings through a refreshed framework and event for core partners.	1	SDS LEP YPG	Number of young people supported	Young People	C3	The 14+ framework was updated and an online session held with all 14+ leads in March 2024, co-delivered by SDS and Education and covering SLDR, data hub completeness and use and overview of LEP. 14+ meetings are being held regularly in all schools and the improvement in school leaver destinations

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						is evidence of impact. In the most recent publication 96.8% of 22/23 school leavers were in a positive destinations versus 95.9% nationally.
Engage fully in identifying, supporting and addressing child poverty throughout the Local Employability Partnership key themes of transitions, barriers, employer engagement, skills and leadership.	1, 2, 3	SBC Employability Service	Number of young people supported	Young People	C3	Parental and practitioner engagement events have been held across the 3 most deprived areas in the region with clients and the following partners: Borders Housing Network, SDS, DYW, DWP, SOSE, Employability, CLD.
Fuel related activity **Through these actions we will tackle fuel poverty and provide support with rising energy bills.**						
Warm and Well						
Offer libraries as warm spaces during autumn and winter 2023/24. Signpost to the SBC Cost of Living Crisis website.	2	Live Borders	Number of participants Number of families supported	Families	B2, B4	Cost of living literature and information to help support people available in the library. All Libraries registered on warm spaces website and available as a warm space during opening hours.
Allocate Warm and Well funding to support the operation of warm spaces in communities during the winter period.	1, 2, 3	SBC Communities	Number of families supported	Families	B4	A total of 30 grant applications were received and 22 were awarded funds. The grants benefitted a wide range of community groups and organisations spread across the 5 localities. Approx 3,900 people benefitted from activities.
Attend Warm Spaces and other community groups to be pro-active to discuss energy saving ideas, schemes and funds available to help families.	1, 2, 3	CAB	Number of families supported	Families	B4	Energy training offered & provided to local groups and stakeholders in order to share knowledge & resources. Discretionary funds made available and referrals to crisis energy support provided.
Fuel and Energy						
Provide ongoing support to mitigate fuel poverty including distribution of SG Fuel Support funding, Fuel Bank vouchers and energy saving advice.	2	BHA	Funding and voucher allocation	Families	B2	BHA has supported 85 customers with large fuel debt amounting to £31,960 averaging £374 per household. Fuel Bank vouchers continue to be dispensed with BHA allocating 605 vouchers last year, helping 887 adults and 476 children. Borders Housing Network (BHN) collectively allocated 2,122 vouchers in the last year. BHN has distributed 5,395

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						FB vouchers in the Scottish Borders since 2021 helping 10,406 people.
Signpost clients to Housing Providers as part of Initial Assessment to ensure eligibility of all additional funds for Fuel costs.	2	SBC ESS	Increased eligibility identified from Initial Assessments	Families	B2	The service works with the Housing network to create a referral pathway, which will be consistent across all 4 RLSs and homelessness services, this will include referral to PES/IFSS and to Welfare Benefits for income maximisation.
Partnership Working						
Work in partnership on specific projects such as Low and Slow and provide energy training in local communities.	2	SBC Communities Changeworks CAB	Uptake of Low and Slow Project	Families	B2	The Low and Slow project has delivered a 6-week programme where families learned a new way of working, shared recipes and enjoyed good food.
Work in partnership with Borders Home Energy Forum members to support fuel poverty interventions.	2	JHIT	Number of families supported	Families	B4	Ongoing sharing of information with/from the partnership. Contribution to the LHEES Strategy Consultation through co-ordination and submission of a PH response.
Continue the partnership delivery of the Warm & Well Scheme in 2023/2024, including the services of an Energy Advisor.	2	SBC CAB	Monetary gains and support given	Families	B4	Specialist energy advice & support provided with delivery of the Warm & Well project.
Financial Inclusion **Through these actions we will help maximise income of low income households, lifting children out of poverty and combatting the cost of living crisis.**						
Education Settings						
Students under the age of 18 are assisted to apply for Education Maintenance Allowance and to ensure that they maximise the student income streams they are eligible for.	1, 2, 3	Borders College	Number of students supported	Young People	C2	Students are provided with support via our student funding team and student support team to apply for EMA.
Schools will work more collegiately in clusters on the cost of the school day, using pupil equity funding to support it.	2, 3	SBC Education	Monetary gains	Families	B2	A new cost of the school day network has been formed and collation of effective practice has taken place. Each cluster has an identified person to lead on COSD. CPAG Scotland have engaged with the network to enhance our knowledge. The network's focus moving forward will be aimed at establishing relationships with partners, developing a framework for schools/settings, including

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						recommendations and encouraging professional learning for staff.
Support parents to be more confident as parents and co-learners in the education of their children and help their child flourish as a member of the school and wider community.	1	SBC CLD	Number of families supported	Families	C1	CLDS delivers parental support programmes such as Living with Parents.
Income Maximisation						
Work in partnership with other local authority and third sector organisations to support families with income maximisation and access to benefits and grants.	1, 2, 3	SBC Education	Uptake of families supported	Children and Families	B3	Clusters are building relationships with partners through various means, including the Cost of the School Day Network.
Provide Financial Inclusion and signposting to relevant services including child specific welfare support, access to food resources and clothing grants. Maximise take up of child related benefits and resources.	1, 2, 3	BHA	Uptake in accessing assistance Update of benefits	Families	B2, B3, B4, C1	BHA tenancy support service generated an annual benefit gain for BHA customers amounting £785,208 in the last financial year. Regular referrals to foodbanks and clothing resources are made as part of ongoing support provided.
Provide a comprehensive Income maximisation assessment to clients to ensure all funding streams are explored for families both unemployed and in work. Ensure all eligible families are in receipt of the package of 5 family benefits.	1, 2, 3	SBC ESS	Volume of Income Maximisation Assessments	Families	B2	Recruitment of a welfare benefits assistant has provided the offer of an in-work Benefit calculation to all participants engaging with Employability services. The delivery of a Parents Programme includes the offer of a welfare benefits check to each parent to ensure income maximisation.
Provide benefit checks and advice (including referrals from Employability Team) and signposting	1, 2, 3	SBC Financial Inclusion SBC Early Years	Uptake of referrals Updates in benefits checks	Families	A3, B2, B1	Dedicated support is now in place within the Employability Service which will make a difference to families in providing benefit checks.
Provide support and signposting for applications for disability benefits and assist with appeals if required.	1, 2, 3	SBC Financial Inclusion	Uptake in benefits applications	Families	B2	This is an ongoing service action.
Projects and Programmes						
Provide pilot pop up welfare/employability hubs offering wellbeing and employability support and advice.	1, 2, 3	SBC ESS SBC Communities	Attendance at hubs	Families	B3	In collaboration with LEP partners and external agencies, such as housing and NHS Borders, the service will provide opportunities for individuals and communities, to engage in hubs

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
						promoting and supporting wellbeing and employability.
Undertake take-up campaigns to encourage people to apply for benefits or support where parents might not have been aware of their potential entitlement.	1, 2, 3	SBC Financial Inclusion	Referral intake	Families	B3	Specific campaigns have included free school meals, clothing grants and Scottish Child Payment.
Money Worries **Through these actions we will put money directly in the pockets of low income households, lifting children out of poverty and combatting the cost of living crisis.**						
Cost of Living						
Provide funds to run free breakfast clubs across 20 schools.	2	SBC Communities	Attendance at breakfast clubs	Children and Families	B2	£50k was made available to 16 schools/organisations to enhance or start a breakfast club. Feedback is currently being gathered.
Ensure all students eligible to receive student funding have received additional cost of living payments to help mitigate the cost-of-living crisis in the 22-23 academic year.	2	Borders College	Continuation of Scottish Government funding	Families	B2 B4	Cost of living payments continue to be provided to students at Borders College, of up to £5,000 per year. This is provided in installments across the year. Students are invited to apply for this payment by e-mail (they just need to respond saying they would like to receive it). All students who made an initial application will automatically be provided with further instalments throughout the year.
Support families 1:1, liaison with housing, vouchers available for supermarkets, linking with and referrals on to charities. Hold clothing swap shops.	1, 2, 3	SBC Early Years	Number of families supported	Families	B4	This is an ongoing service action within the Early Years Service.
Income and Benefits						
Increase awareness of benefits among parents of primary and secondary pupils through continued campaigning.	3	SBC Financial Inclusion Team	Monetary gains, support given	Families	B3	Specific campaigns have included free school meals, clothing grants and Scottish Child Payment. Where appropriate, referrals are sent to CAB for money advice.
Work with people and families to maximise their income in person, by telephone, near me digital service and mail, attending community events and outreach services.	1, 2, 3	CAB	Increase to number of families supported	Families	B3	Income maximisation is provided in person, by telephone, email and near me video call. Debt advice provided to clients with debt issues and attended community events to raise awareness.

Action	Poverty Driver*	Partners Involved	How will impact be assessed?	Intended beneficiaries or target groups	Best Start, Bright Futures Indicator**	Update
Provide support with Housing Benefit and Discretionary Housing Payment applications to assist with rent payments.	1, 2, 3	SBC Financial Inclusion	Number of families supported	Families	B4	A campaign to identify parents affected by the Benefit Cap was undertaken and awareness sessions with other partners delivered.
Promote welfare benefits and Scottish Government benefits relevant to the young person.	1, 2, 3	CAB	Number of young people supported	Young People	C3	Benefit checks are offered to all clients to ensure they are receiving full entitlement. Clients are also encouraged to attend Social Security Scotland drop-in service in bureau.
Information and Support						
Promote the Money Worries App to increase uptake	1, 2, 3	JHIT CAB NHS Borders	Usage of Money Worries app Number of families supported Monetary gains	Families Parents	B3, C1, A2	The Money Worries App continues to be promoted to clients.

*Poverty Drivers
1 – Income from Employment
2 – Costs of living
3 – Income from Social Security and benefits in kind

**Best Start, Bright Futures Indicators
A1 – A strengthened employment offer to parents
A2 – Connectivity and childcare
A3 – Transforming our economy
B1 – A transformational approach to People and Place
B2 – Enhanced support through social security
B3 – Income maximisation
B4 – Access to warm affordable homes
C1 – Best start to life
C2 – Supporting children to learn and grow
C3 – Post school transitions

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**Ralph Roberts, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Resources & Performance Committee 2 May 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Resources & Performance Committee minutes 07.03.24

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 7 March 2024 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mrs L O'Leary, Non Executive
Mr J Ayling, Non Executive
Mrs H Campbell, Non Executive
Dr K Buchan, Non Executive
Cllr D Parker, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mr A Carter, Director of HR
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement

In Attendance:
Miss Iris Bishop, Board Secretary
Mrs C Oliver, Head of Communications
Mrs L Huckerby, Interim Director of Acute Services
Mrs S Errington, Interim Director of Planning & Performance
Mrs S Swan, Deputy Director of Finance
Mrs L Goodman, Head of IM&T
Mrs R Devine, Consultant in Public Health

1. Apologies and Announcements

1.1 Apologies had been received from Mrs L Livesey, Non Executive, Dr L McCallum, Medical Director, Dr S Bhatti, Director of Public Health, Mrs J Smyth, Director of Planning & Performance and Mr G Clinkscale, Director of Acute Services.

1.2 The Chair welcomed Mrs R Devine, Consultant in Public Health who deputised for Dr Sohail Bhatti.

1.3 The Chair welcomed Mrs S Errington, Interim Director of Planning & Performance in the absence of Mrs J Smyth.

1.4 The Chair welcomed Mrs L Goodman, Head of IM&T to the meeting who presented item 5.1 on the agenda.

1.5 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there were none declared.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 18 January 2024 were approved.

4. Matters Arising

4.1 **Minute 5.9:** The Chair enquired if the elective treatments trajectory had changed. Mrs Steph Errington confirmed that the updated performance levels had been included in the performance scorecard.

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

5. Strategic Risk: Digital Infrastructure Resiliency and Security

5.1 Mrs Steph Errington drew the attention of the Committee to the inability to be able to provide full assurance around the strategic risk element and advised that outlined within the report was the position statement on all of the areas. Also within the report were the mitigations and opportunities across the key groups that would continue to be worked through and developed. One of the key next steps would be the establishment of a Digital Governance Committee and Digital Strategy.

5.2 Mrs Fiona Sandford enquired of the timeline for the strategies and prioritisation of various elements that had been highlighted to enable NHS Borders to be a proper digital organisation.

5.3 Mrs Laine Goodman advised that a draft digital strategy was already being drawn together along with costings for different pieces of work. Skill sets were being explored and the SEC would be used as the network structure vendor, as there were concerns around the vetting of vendors and the transparency of procurement process for new technologies.

5.4 Discussion focused on: need in acute services to sweat the assets available in order to become more efficient and productive; driving change nationally; the potential to use technical expertise on a regional basis; resources currently available and how to develop resource to enable delivery of the strategy; much work to be done on contracts management across the organisation; investment required in training to grow our own talent in IM&T; reviewing options for next year to potentially break some smaller services away from Microsoft to other companies; potential impact of a lack of digital infrastructure and literacy on patient safety; prioritisation in the plan for internal audit, disaster recovery and business continuity; high level cost assessment of not doing it; cost of bank and agency staff versus recruiting our own; cost of staff time in working with inadequate systems; high level assessment of what is being done badly and what it is costing; the cost of not doing anything; digital governance and anything that touched clinical activities; and the resilience data facility is not really a resilient data facility as it is on the same site and system, another off site facility is required in order to be fully resilient.

5.5 Cllr David Parker suggested given the scale and extent of the issues, that a Non Executive should be a member of the proposed Digital Governance Committee.

5.6 The Chair reminded the Committee that Mrs Lucy O'Leary was the Non Executive Digital Champion and would be the obvious choice to join the Digital Governance Committee.

5.7 Mrs Errington advised that she would ask that Mrs L O'Leary was co-opted onto the Committee. She further advised that the Digital Governance Committee was more of a transformational programme would be report through to the Quality & Sustainability Board and then on to the Resources & Performance Committee.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that only partial assurance could be given at that time against the Strategic Risk.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the establishment of a Digital Governance Committee.

The **RESOURCES & PERFORMANCE COMMITTEE** supported the development of a Digital Strategy.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed a future development session take place as part of the development of the Digital Strategy

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from the report was Limited Assurance.

6. 324-LIMS LabCentre Replacement - WinPath Enterprise Go Live and Migration to the National LIMS

6.1 Mrs Lynne Huckerby summarised the key points, challenges and the impact of how it was being addressed. She highlighted the challenges with suppliers and the failed implementation of go live dates; the belief that only clinical staff who delivered the day to day service could test the new system; potential delivery by 31 May, however Clinysis can't support a go live until 10 June; and the potential for financial penalties.

6.2 Mrs Harriet Campbell raised concern over the failure to install the replacement system and prepare for the 2027 deadline, as well as the potential for significant clinical risks. Mrs Huckerby assured the Committee that there would be a balance to ensure the testing did not impact patient safety and create any clinical risks.

6.3 Mr Ralph Roberts commented that with Mrs Huckerby now leading the project and being able to bring her background experience to the table the Committee had a far better oversight of the programme and he suggested a robust lessons learning exercise should take place at the conclusion of the project.

The **RESOURCES & PERFORMANCE COMMITTEE** supported the recommendation that NHS Borders through the Project Board create the urgency to addressing and concluding this project. This comprises IT, Labs, service, and senior management resource who are assessing and planning mitigation for all risks, both operational and financial, associated with delays in completing the current WPE project.

The **RESOURCES & PERFORMANCE COMMITTEE** supported the recommendation that the Project Board assess the feasibility and impacts of NHS Borders ether proceedings with their obligations and commitments under the current national LIMS framework and had cognisance that it might choose to withdraw from the national framework until after March 2027.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from the report was Limited Assurance.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to add the item to the Action Tracker in order to receive a brief verbal update on progress at each meeting.

7. 2024/25 Delivery Plan Submission

7.1 Mrs Steph Errington provided an overview of the content of the report and highlighted several updates including: East Region Programme Plan; CAMHS neurodiversity pathways; and digital strategic risk assessment.

7.2 She further highlighted that the plan was heavily caveated within the resources available and the level of commitments within the plan would be reassessed and change as the financial plan was implemented. The Scottish Government had also extended the submission timeline for the planned care trajectory and planning assumptions.

7.3 Mrs Lynne Huckerby described the planned care element of the delivery plan and the assumptions made on funding in terms of waiting list funding to support ongoing activity around planned care. She highlighted spend in relation to Ward 17 and it's use as a day case service, dermatology, cancer care, colonoscopy and cataract surgery. Mrs Huckerby also drew the attention of the Committee to the spend on Synaptics for dermatology, colonoscopy and cataracts which created an issue in terms of it being high cost, however without that support continuing there would be a significant impact on the ability to meet waiting times especially in regard to cancer patients.

7.4 Mrs Fiona Sandford enquired about the out of hours workforce model and available funding for the consultant post. She commented on the comparative care home attendances at the Emergency Department per head of population and enquired if the delivery plan was too optimistic and the tone needed to be more realistic given both the financial and resource challenges.

7.5 Mr Chris Myers commented that in regard to the care home attendance rate at the Emergency Department, it had just over the past few days been recognised that there was a data issue in how that data was derived and the business intelligence team were investigating.

7.6 Mrs Sarah Horan commented that the national 111 system often lead to people being conveyed to the hospital. The previous system of the BECS service staff taking phone calls from local care homes often lead to people being able to stay in the care home or their own home and avoided a trip to hospital and potential admission.

7.7 Mrs Errington advised that she would feedback on the consultant post funding and also review the tone of the draft plan. She further advised that once submitted the Scottish Government would provide feedback on the plan and it would also be subject to the financial plan being supported.

7.8 Further discussion focused on: the positive narrative should be rephrased to be more pessimistic which is a more honest tone; theatres utilisation and theatres dashboard; respiratory virtual ward work and funding sources are being withdrawn; delay in submitting the Annual Delivery Plan; and the Board Chief Executives speaking to the Scottish Government about high cost services and funding.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from the report was Limited Assurance.

8. Financial Plan

8.1 Mr Andrew Bone provided a presentation that gave an overview of the content of the plan and highlighted several elements including: approach to savings; current deficit; continuous level of requirement for brokerage over the medium term; aiming for maximum level of brokerage of £14m; reaching an agreement with the Scottish Government on any investments that are new ie Emergency Department investment; financial recovery plan framework; 15 box grid; savings plan – planned savings and schemes in development; business as usual savings without redesign or restriction to services; and hard choices.

8.2 Mr Bone further commented that the Health Board Directors of Finance had been developing propositions based on 3-4 key areas including, access and performance, workforce, agency use and medicines, a consistence to the use of premium rate services ie Synaptics and looking at the expansion of NHS units like the Golden Jubilee and national treatment centres.

8.3 Mrs Fiona Sandford commented that controlling the front door was critical to so many of the schemes that were in development and enquired if the new ED consultant post was in the savings plan. Mr Bone commented that he had not included the front door as a scheme as it was not cash releasing and the financial plan assumed the investment would happen and contribute to the financial gap.

8.4 Mrs Lucy O'Leary enquired about the size of the gap to be filled with the choices year on year.

8.5 Mr John McLaren enquired why the review of management structures wasn't being fast tracked when the downsizing of corporate functions was. The Chair commented that it was a fair point.

8.6 Mr Ralph Roberts commented that the Board was £30m short to get back to a balanced budget and he suggested if the organisation achieved all of the schemes it would still not deliver enough savings.

8.7 Mr Bone committed to reviewing the language to ensure effective communication before the plan was published.

8.8 He further reflected that the challenge was to describe the actions necessary to get to brokerage in 2024/25 and over the 3 year plan to a break even position (£15m year one, £15m over years 2 & 3). He advised that he was conflicted as he did not believe that it was deliverable.

8.9 The Chair reminded the Committee that the Board owned the deliverability of the plan and that it was for the whole Board to take responsibility for delivery or not.

8.10 Mr Roberts commented that the Board did not have a plan to deliver what it needed to do and needed to describe what it could do and be clear on what was on the list as deliverable over and above planned savings. There would then need to be a list of other stuff to be done in order to deliver the financial plan and those things would have to be done with the caveat

that the Board did not think they were the right thing to do and were not supportive of doing them.

8.11 Mrs Sandford reminded the Committee of the need for honesty with the public and that the communications need to set out what would have to be done, what else might have to be done and finally what would need to be done to achieve the savings but that the Board were not supportive of doing them.

8.12 Dr Kevin Buchan enquired where the assessment of impact on patients, care, wellbeing, etc was, or if it was not being considered.

Rebecca Devine left the meeting.

8.13 Mr Chris Myers supported Dr Buchan's view and emphasised that it was important consideration was given to everything for all possible savings and the challenge in that approach was that there would be areas more disproportionality impacted than others and gave the example that the mental health and learning disability service had already identified savings before the Scottish Government had advised they would withdraw funding, so there was a need for the overall strategic view as well.

8.14 Mr Bone commented that in terms of the clinical impact the financial plan had not been impact assessed. The schemes would be developed into an action plan and then be risk assessed and if there was a risk arising that could not be mitigated the board would be asked to tolerate those risks.

8.15 Cllr David Parker suggested the plan was published and delivery was made within parameters with good wrap around communications, whilst being clear the Board did not believe it was wholly deliverable.

8.16 Mrs Sandford agreed with Cllr Parker's view and commented that it was about language and if there were 3 sections and the third section contained items that would achieve financial targets but were unacceptable to the Board, then the language needed to be clear, open and transparent for the

8.17 The Chair suggested the BET review the ADP in light of the financial plan to get a synergy between the 2 documents so that they sat side by side on the challenges of delivery.

8.18 The Chair suggested the financial plan be submitted with changes in language and confirmation that it was being submitted against the Boards better judgement. She asked that both the ADP and Financial Plan be submitted together as one did not exist in isolation from the other.

The **RESOURCES & PERFORMANCE COMMITTEE** considered its position with regard to the following issues in order to set direction for the finalisation of the Medium Term Financial Plan:

Issue	**Recommendation**
Presentation of Savings within Financial Plan (SG Template)	▪ The committee is asked to support the general approach outlined under 'Financial Plan Savings Template' (page 4) ▪ The committee is asked to endorse the proposed inclusion of schemes within each heading based on further presentation*
Enhanced Grip & Control Measures	▪ The committee is asked to consider the additional grip & control measures set out under 'Grip & Control Measures' (page 7) and

	confirm which measures should be progressed for 2024/25.
Vacancy Controls	▪ The committee is asked to consider the scope of future vacancy control measures as set out under 'Vacancy Controls' (page 8).
Workforce Reduction Targets	▪ The committee is asked to approve the introduction of a workforce reduction target as set out under 'Workforce Targets' (page 8).
Financial Operating Principles	▪ The committee are requested to review and approve the proposed financial operating principles (page 9).

The **RESOURCES & PERFORMANCE COMMITTEE** requested the financial plan be submitted with changes in language and confirmation that it was being submitted against the Boards better judgement.

The **RESOURCES & PERFORMANCE COMMITTEE** requested that both the ADP and Financial Plan be submitted together as one did not exist in isolation from the other.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from the report was Limited Assurance.

9. Finance Report

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from this report as Moderate Assurance.

10. Performance Report

10.1 Mrs Steph Errington provided a brief overview of the content of the report.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of January 2024.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from this report as Moderate Assurance.

11. R&PC Annual Report 2023/24

The **RESOURCES & PERFORMANCE COMMITTEE** noted the current draft report and approved final sign off by the Chair after the elements from the 7 March 2024 meeting were included.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the level of assurance it had received from this report as Significant Assurance.

12. Any Other Business

12.1 There was none.

13. Date and Time of Next Meeting

13.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 2 May 2024 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Audit & Risk Committee 20 May 2024
- Audit & Risk Committee 20 June 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit & Risk Committee minutes 27.03.23
- Appendix No 2, Audit & Risk Committee minutes 20.05.24

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 25th March 2024 @ 1 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director (Chair)
Mrs L Livesey, Non Executive Director
Mrs L O'Leary, Non Executive Director

In Attendance: Miss I Bishop, Board Secretary (Item 7.4)
Mr A Bone, Director of Finance
Mr J Boyd, Director, Audit Scotland
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs L Goodman, Head of IM&T/Digital Services (Item 7.2)
Mrs K Hamilton, Chair
Mrs L Huckerby, Interim Director of Acute Services
Ms E Mayne, Health Value for Money Director, Grant Thornton
Mr I Lochhead, Audit Manager, Audit Scotland
Mrs C Oliver, Head of Communications and Engagement (Item 6.2)
Mrs L Pringle, Risk Manager
Mr R Roberts, Chief Executive
Mrs S Swan, Deputy Director of Finance (Head of Finance)

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those present to the meeting.

Apologies were received from Cllr D Parker, Non Executive Director, Mrs L Jones, Director of Quality Improvement and Ms H McKellar, Manager, Grant Thornton.

James confirmed that today's meeting was quorate.

2. **Declaration of Interest**

James Ayling declared that he was now a member of the Integration Joint Board and Lucy O'Leary declared that she was Joint Chair of the Integration Joint Board.

3. **Minutes of Previous Meeting – 11th December 2023**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

Andrew Bone referred to the two actions on page 1 of the tracker regarding the IJB directions tracker and advised that he had met with Hayley Jacks, who would not be attending today's meeting for this item later on the agenda, however she would be undertaking a full review and a paper would be available for the May meeting.

James Ayling highlighted that two items within the minutes of the last meeting were not included within the tracker and he was keen that these were not lost sight of, namely that Whistleblowing was considered for inclusion in the 2025/26 audit plan. The other was regarding the Infection Control HAI Scribe Internal Audit report and the recommendation to use the national e-tool for future projects. James reminded of the request for an update to be provided at a future Committee meeting should the decision be made not to proceed with the use of this.

The Committee noted the action tracker.

Assurance Levels

James Ayling noted that for the purpose of strengthening assurance within Committees, new assurance levels had been introduced and going forward would be included within papers asking the Committee to confirm the level of assurance they had received from the report, namely significant, moderate, limited or none.

James highlighted that Internal Audit used different terminology for their assurance levels which could make it more difficult to decide which level of assurance can be taken should it fall between two levels. Emily Mayne confirmed that Internal Audit had been consulted around this and had mapped this against their assurance levels and were content with the ones proposed. Andrew Bone suggested using Internal Audit's levels of assurance for their reports. Lynne Livesey agreed that this would make more sense to have one set of terminology for these reports.

The Committee noted the update and agreed to use the level of assurance provided by Internal Audit for each of their reports.

Audit & Risk Committee Terms of Reference

James Ayling advised of recent changes in membership to the Board Sub Committees and took this opportunity to thank Tris Taylor and Fiona Sandford for all their input over previous years as they would no longer be members of the Audit & Risk Committee. James went on to welcome Lucy O'Leary, David Parker and Lynne Livesey to the Committee.

James highlighted that the current Terms of Reference excluded some Non Executive Members from being members of the Committee, namely the Chair of the Board, Scottish Borders Council member, Chair of the Area Clinical Forum and the Employee Director. James advised that the Board Secretary had checked with other Boards and had confirmation that the only exclusion they had was the Chair of the Board, therefore proposed removal of the other exclusions as this would allow the Scottish Borders Council member to join the Committee. Lucy O'Leary and Lynne Livesey both agreed with this amendment.

The Committee approved the amended Terms of Reference for inclusion in the Code of Corporate Governance refresh which would be going forward to the Board the following month.

Amendment to Workplan – Financial Recovery
James Ayling noted that this would now be covered within the report at item 6.4.

5. **Risk Management**

5.1 *Risk Management Quarterly Report*
Lettie Pringle spoke to this report which was for the third quarter to 31st December 2023. Lettie highlighted the key items from the report where it was noted strategy and policy objectives have remained static and that it was hoped for these to all be green within the quarter 4 report. Lettie advised that the corporate objectives had been updated to reflect the Health and Social Care Partnership's Strategic Framework. Regarding risks outwith the organisational risk appetite, it was noted that the Operational Planning Group had given agreement to tolerate 10 of these and escalated 3 to the Board Executive Team for decision. Lettie also highlighted that there had been a marked improvement in risks being approved within the 104 day target.

James Ayling was pleased to see that things had moved forward since the quarter 2 report and enquired if there was improvement in the overall trend. Lettie advised that there had been improvement in some areas, with more required in others, however it was moving in the correct direction overall.

James noted there were 31 very high risks within the operational risk register, the majority of which related to staff shortages and funding issues, and questioned if there would be any improvement to these in the current financial climate and if there was a mitigation plan. Ralph Roberts confirmed that some elements of risks were going to continue as high risk due to the workforce issues etc, however it was hoped that some could be mitigated with the transformation work which would be taken forward.

James referred to section 6.3 of the report and asked for an update on the deep dives undertaken by the Governance Committees and if these were adding any value. Lettie agreed to check this and provide an update which would be circulated around the Committee for information.

James also asked for an update on the risk fund and the implications for risk going forward if there was going to be less money to mitigate risk. Andrew Bone stressed that the process which is put in place would be more important than the budget level since this was intended to promote a risk-based approach to management of service issues.

The Committee confirmed it had received limited level of assurance from the report.

The Committee noted the report.

5.2 *Horizon Scanning Report*

Lettie Pringle spoke to this report and advised it was to identify emerging risks which could affect the delivery of NHS Borders' business. Lettie went on to highlight the three key publications which support in the local horizon scanning process, namely the National Risk Register, the Scottish Risk Register and the World Economic Forum Global Risk Report. Lettie referred to the chart at the bottom of the report detailing each global emerging risk which had been mapped to the appropriate strategic risk and risk owner.

Lucy O'Leary enquired if there were any risks which could be missed that had not been identified in this report or the previous one. Ralph Roberts highlighted that there were elements which could not be mitigated by NHS Borders and these would require interaction nationally as part of the broader strategic response with Scottish Government.

Lettie advised that the Board Assurance Framework would be commencing on 1st April and that the Committee would receive a quarterly report prior to presentation to Borders NHS Board.

The Committee confirmed it had received limited level of assurance from the report.

The Committee noted the report.

6. **Internal Audit**

6.1 *Internal Audit Plan Update Report*

Emily Mayne spoke to this report which provided a summary on delivery of the 2023/24 Internal Audit plan. Emily highlighted that 127 days had been delivered against the 135 days within the plan. It was noted that the final 3 audit reports were being presented at today's meeting. Emily also referred to page 3 of the report which set out the assurance opinions given for all the work undertaken during the course of the year.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee noted the report.

6.2 *Internal Audit Report – Community Engagement*

Emily Mayne introduced this report which had an overall rating of reasonable assurance with some improvement required. The findings ratings were noted as 1 medium and 1 low.

It was noted that the audit had assessed the arrangements in place for conducting community engagement initiatives and to evaluate their alignment with established good practices. Three engagement projects had been selected which was a hundred percent sample and it had been found that the current arrangements were sufficient and there were no issues raised with the processes and controls in place.

Clare Oliver confirmed that she was content with the findings and highlighted that the Involving People Framework had only been in place since July 2023 so was pleased that this had been found to be satisfactory. Clare accepted the areas which had been highlighted for improvement and advised these would be taken forward within the workplan during the coming year.

The Committee confirmed it had received reasonable level of assurance from the report.

The Committee noted the report and that it would be referred to the Resources & Performance Committee.

6.3 *Internal Audit Report – Radiology Productivity*

Emily Mayne introduced this report which had an overall rating of reasonable assurance with some improvement required. The findings ratings were noted as 5 low and 1 improvement.

It was noted that the review had focussed on a number of key risks areas, namely referral processes, scheduling processes, reporting arrangements and monitoring and reporting of waiting times and activity for CT, MRI and Ultrasound.

Emily confirmed that good practice had been identified throughout the audit and hoped that the recommendations would be seen as a positive in moving forward.

Lynne Huckerby advised that she would be discussing this with the Director of Quality & Improvement to ensure there was clarity around ownership of the actions.

The Committee confirmed it had received reasonable level of assurance from the report.

The Committee noted the report and that it would be referred to the Clinical Governance Committee.

6.4 *Internal Audit Report – Financial Sustainability*

Emily Mayne introduced this draft report which had an overall rating of partial assurance with improvement required. The findings ratings were noted as 4 high, 3 medium, 5 low and 3 improvement. Emily explained that it had taken longer to get to the current position and that a decision had been made with management that the draft report should come forward to this meeting without management responses rather than wait until the next meeting.

It was noted that the review was to assess that there was an effective system of control in place and to assess the processes and controls in place around financial sustainability with a view to identifying where further focus could be directed.

Emily highlighted that the audit had identified some recommendations which did not fit within the scope but which were still fundamental and these were noted as improvements. Emily explained that they had looked at the 4 areas of the

saving process, namely identification, taking forward, delivery and reporting. Emily felt that NHS Borders would not necessarily get better results for some parts of the current process in place. Emily also referred to the Project Management Office (PMO) which she felt were currently being directed to lower value savings schemes which could be deemed as business as usual when they should be working up the ideas that will deliver more substantial savings.

Andrew Bone felt that this had been a helpful review and accepted the findings. Andrew explained that it had been agreed that the report should come forward to the Committee at the earliest opportunity in draft and confirmed that they were working on the management responses for the recommendations. Andrew felt that the timing of the review was good to take these recommendations on board and build into the plan. Andrew also expected there to be shorter timescales for implementing the actions.

Ralph Roberts also welcomed the report and agreed that the recommendations needed to be progressed at pace. Ralph stressed the need for the process to focus on what will achieve the biggest benefit. In regard to the PMO, Ralph explained that some of this resource has been used as backfill within the organisation and agreed that they needed to focus on the larger scale projects rather than the business as usual ones.

Lynne Livesey felt that it was helpful to see the report in draft format but it would be beneficial to have sight of the management responses as soon as possible. Lynne referred to the recommendation which stated that there was a lack of recognition from senior leadership on the part they needed to play in supporting the overall financial position and asked for an update on this as it would be central to savings being identified.

Andrew advised that there were two challenges around this, namely people's ability to undertake the leadership role and the capacity required to deliver as savings plans were more ambitious than what had previously been seen across the organisation.

Ralph Roberts assured that the level of the challenge was recognised and reiterated that it required to be moved forward at pace.

Lucy O'Leary noted that the report and actions had huge potential to drive forward the organisation's culture. Ralph advised that getting the correct balance between finance and service input to deliver these would be crucial.

The Committee agreed that the report, when complete with management responses, should be circulated via email when available.

The Committee awaited the final report before agreeing the level of assurance it provided.

The Committee noted the draft report and that the final version, when available, would be referred to the Resources & Performance Committee.

6.5 *Draft Internal Audit Annual Report 2023/24*

Emily Mayne spoke to this item which provided a draft of the annual report for 2023/24. Emily referred to page 8 of the report which detailed an overview of the assurance ratings and number of recommendations, noting the ratings for these, for the audits undertaken during 2023/24.

Emily also referred to the Head of Internal Audit's opinion on page 11 which was currently proposed as partial assurance with improvement required. Emily stressed that if any of the recommendations highlighted within the report could be progressed before the report is finalised it could have an impact on the overall opinion.

James Ayling noted that the high risk findings would be highlighted within the Annual Governance Framework. James also noted the timeliness of the implementation of the recommendations varied, with some being completed promptly and others significantly delayed. James stressed the need to prioritise the completion of overdue actions, particularly where they are rated as high risk.

Lynne Livesey enquired about the 3 high risk recommendations arising from the use of bank and agency audit which were due on 31st December 2023. Andrew Bone was aware that there had been a delay due to nurse leadership changes for a period of time and that the SLA had been rewritten and was being discussed with NHS Lothian.

The Committee confirmed it had received partial level of assurance from the report.

The Committee noted the draft annual report for 2023/24 and that the final report would come forward to the May meeting.

6.6 *Internal Audit Report – Draft Internal Audit Plan 2024/25*

Emily Mayne spoke to this item and highlighted pages 6 and 7 which detailed the reviews proposed to be undertaken during 2024/25. For transparency Emily highlighted the areas where there was no coverage within the plan, namely consultant job planning, revisiting pharmacy risks and how the Board receives messages which may indicate poor clinical practice (e.g. Letby case). Emily then went over the risk mapping exercise undertaken in producing the proposed plan. It was noted that this had been discussed with the Board Executive Team and feedback received had been incorporated.

Andrew Bone confirmed that the draft plan had been circulated to the Chairs of the Governance Committees for comment but no significant feedback had been received. Andrew also advised of a request received from the IJB seeking a review to be undertaken by Grant Thornton in regard to the financial management of the financial resources associated with set aside functions to ensure compliance.

Lettie Pringle referred to the governance and risk management audit which had the Director of Finance as the named lead as she felt this should be the Director of Quality & Improvement. Andrew advised that it had been debated how this was managed and that he was content for this to be changed to the Director of Quality & Improvement.

James Ayling referred to the areas where there was no coverage within the plan and noted his concern that there was no assurance around how the Board receives messages which may indicate poor clinical practices. James felt a Board development session may be appropriate for this. Andrew was aware that this was on the radar to come forward to a future Board development session around the lessons learned but was not aware of the timescales.

James also noted that 10 days had been allocated to undertake the property transaction monitoring audit and queried if this was too many days. Andrew did not envisage they would all be required but as it was currently unknown what would happen over the next 12 months this would evolve during the course of the year.

James asked Committee members if they had any thoughts around there being nothing within the plan for pharmacy and maternity. Lynne Livesey felt that it would be helpful, due to the recent case, for there to be something on maternity.

James asked for a discussion to take place around this before the plan is finalised.

Emily referred to the 2 audits identified for quarter one as she had the resources in place to undertake these. Agreement was given to proceed with these audits.

The Committee noted the draft plan and that they would receive the final version at the next meeting.

The Committee agreed that the audits identified for quarter 1 should proceed.

7. Governance & Assurance

7.1 *Audit Follow Up Report*

Emily Mayne referred to discussion under item 6.5 and re-iterated that a final push to complete the recommendations highlighted could have a positive impact on the overall opinion.

James Ayling noted that there were several overdue high risk recommendations which the Clinical Governance Committee (CGC) had oversight of and as Fiona Sandford, Chair of CGC, no longer sat on this Committee he would write to her to ensure she was aware.

James referred to the aged action for the Committee's attention regarding the Estates and Facilities audit and the update reported with a suggestion to combine two actions and close the other as it has been superseded. Andrew Bone explained that the migration of the Strategic Assessment Management System, used nationally over Scotland, had been delayed so the timescale required to be extended to be in line with this. The Committee agreed to the revised implementation date of 31st March 2025.

The Committee noted the report.

7.2 *Audit Follow Up Process*

IM&T

James Ayling welcomed Lainé Goodman to the meeting, who had recently taken up the post of Head of IM&T/Digital Services, to provide an update on the recommendations arising from the IT Resilience and Recovery audit which had a revised timescale of 31st March 2024.

Lainé Goodman went on to provide an update on the recommendations where it was noted that NHS Borders were still quite weak around resilience and disaster recovery. This was attributable to a number of factors, such as lack of resource or the ability within teams. It was noted that there were still single points of failure throughout various teams.

Lainé commented on the recent cyber attack within NHS Dumfries and Galloway.

Lynne Livesey noted the major risk this was to the organisation and asked if Boards could work together to draw on expertise. Lainé advised that as much as possible had been done on a national basis.

James enquired what would be reasonable timescales to expect for completion of the actions. Lainé was unable to provide this at the present time as there were a number of issues around the resources required for implementing these, however assured that keeping patient data secure is a top priority.

James asked that Lainé attend the May Committee meeting to provide a further update and that the monthly updates continue.

The Committee confirmed it had received no assurance from the update.

The Committee noted the update.

Although not on the agenda, James asked for an update on ventilation as he was aware from the last monthly update received that there had been good progress. Andrew Bone advised that he was not aware of any deviation against the previous timescales reported. Andrew advised that there had been a specific issue on the BGH site which has since been resolved but it had been disruptive over a 2 – 3 week period.

The Committee noted the update.

7.3 *Debtors Write Off Report*

Susan Swan spoke to this item and highlighted that as at 29th February 2024 a total of £0.23m was being followed up as part of the Board's internal credit control processes. It was noted that a number of debts are pursued through the debt recovery agency and when this proves to be unsuccessful a request is put forward to the Director of Finance to write these debts off.

James Ayling noted that a total of £73k of income had been deemed irrecoverable and presumed that this was for the period being reported and that there was not any large amounts amongst the invoices written off. Susan

confirmed that there was not and agreed to provide a range of debts written off within future reports.

The Committee noted the report.

7.4 *Review of Code of Corporate Governance*
Iris Bishop spoke to this item and advised that all proposed changes had been highlighted within the document and that she had no issues to raise.

Susan Swan referred to sections F and G and advised that there was still work to do on these so a further update would be provided in due course.

James Ayling referred to a proposed change on page 22 regarding the appointment of consultants where it now read like the Chair had delegated this to the Chief Executive. Iris confirmed that this was not the case and agreed to clarify the wording.

The Committee confirmed it had received moderate level of assurance from the report.

The Committee recommended that the Code of Corporate Governance refresh be put forward to NHS Borders Board for approval.

8. **External Audit**

8.1 *External Audit Annual Audit Plan 2023/24*
John Boyd spoke to this item which summarised the workplan for the 2023/24 audit. It was noted that this was the second year of a 5 year appointment. John went on to take the Committee through the report which outlined the proposed approach for the annual audit and highlighted key points. John referred to the timetable which noted the aim of having sign off by 30th June 2024. John appreciated this timescale would be challenging as it had slipped previously and advised that some interim testing would be taking place prior to the year end as well as there being additional resource within the audit team to support the delivery date.

John referred to the audit fee which is set centrally by the appointments team and allows an uplift of 10% from the baseline fee. John did not foresee any uplift from the baseline fee at present but would keep the Committee updated should this change.

Andrew Bone advised that there is ongoing dialogue collaboratively between Directors of Finance and Audit Scotland about the audit fee and that Audit Scotland's Chief Executive had attended the last Directors of Finance meeting.

James Ayling referred to the 3 significant risks of material misstatement to the financial statements and enquired why there was an increase this year. John explained that one of the risks was consistent with previous years, in relation to fraud caused by management of controls and that there were two new risks added. The first of these was in relation to property valuations, where a full revaluation was undertaken at March 2023 and was not planned for March 2024 in line with the Board's valuation policy. This creates a risk that 'book' value

may differ from 'market' value and audit would test this. A particular area of focus would be in relation to properties with RAAC present. The third risk was in relation to the potential for management to misstate expenditure in order to achieve a financial target; this risk is increased because of the challenge presented by the Board's current financial performance. John also stressed the huge financial challenge faced by the organisation, particularly due to there no longer being the flexibility of brokerage from Scottish Government.

The Committee confirmed it had received significant level of assurance from the report.

The Committee noted the report.

8.2 *Audit Scotland Reports*
Andrew Bone spoke to this report which highlighted where it was suggested relevant Audit Scotland reports are distributed across the organisation.

No issues were raised.

The Committee noted the report.

9. **Fraud & Payment Verification**

9.1 *Countering Fraud Operational Group Update*
Susan Swan spoke to this item which provided a copy of the draft Annual Fraud Report for 2023/24 which would be included in the Annual Governance Framework that would come forward as part of the annual accounts process. It was noted that the Director of Finance would sign the annual report as Counter Fraud Champion for NHS Borders.

The Committee noted the update.

9.2 *NFI Update*
Susan Swan spoke to this item which was a standard exercise across the UK undertaken by public sector bodies. It was noted that there was 1 payroll match which was ongoing and that the other NHS Board involved was investigating.

The Committee noted the update.

9.3 *Fraud Allegations*
Susan Swan advised that there were currently 3 fraud allegations at investigatory stage which CFS have been involved in for advice. It was noted that Police Scotland were also involved with one of the cases.

James Ayling queried if the Director of Counter Fraud Services should be invited to attend the Committee at some point. Susan felt that as he was due to attend the Countering Fraud Operational Group for the annual review and he attended the Board development session on a regular basis this should suffice.

The Committee noted the update.

10. **Integration Joint Board**

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

10.1 *IJB Directions Tracker*
Andrew Bone referred to earlier discussion that a report would be presented to the May meeting once the review has been undertaken.

The Committee could not take a level of assurance and awaited the report which would be coming forward to the next meeting.

The Committee noted the report and tracker.

11. **Annual Accounts 2023/24**

11.1 *Annual Accounts 2023/24 Timetable*
Susan Swan provided the Committee with the proposed timetable for production of the 2023/24 annual accounts. Susan advised that additional resource had been secured within the Finance Department and the interim audit is currently underway. It was noted that a date had yet to be identified for the Non Executive and Executive Directors session on the accounts and this would be communicated in due course.

James Ayling enquired if there was confidence in meeting the timescales outlined. Susan advised that this would be dependent on the level of queries received, however if consistent with the previous year then she anticipated that with the additional level of resource that these could be met.

Andrew Bone provided an update regarding the IJB resource where it was noted that an interim CFO was now in place.

Karen Hamilton asked for assurance that there was a mechanism in place should there be any slippage on the timescales. Andrew confirmed that they had key milestones within the timetable and should there be any slippage around these it would be brought to the Committee's attention.

The Committee confirmed it had received limited level of assurance from the report.

The Committee noted the timetable.

12. **Items for Noting**

12.1 *Information Governance Committee Minutes: 25th January 2024 (Draft)*
James Ayling felt that there were some areas of the minutes where there was insufficient information to provide the Committee with assurance. James appreciated the Committee received the annual report from the Information Governance Committee which gives assurance but felt more detail in future minutes would be helpful.

The Committee noted the draft minutes of the Information Governance Committee.

13. **Any Other Competent Business**

None.

12. **Date of Next Meeting**

Monday, 20th May 2024 @ 1 p.m. via MS Teams.

BE
04.04.24

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 20th May 2024 @ 1 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director (Chair)
Mrs L Livesey, Non Executive Director
Mrs L O'Leary, Non Executive Director
Cllr D Parker, Non Executive Director

In Attendance: Mr A Bone, Director of Finance
Mr J Boyd, Director, Audit Scotland
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs L Goodman, Head of IM&T/Digital Services (Item 7.3)
Mrs L Huckerby, Interim Director of Acute Services (Left at 2.30 p.m.)
Mrs L Jones, Director of Quality Improvement
Ms E Mayne, Health Value for Money Director, Grant Thornton
Mrs A McCloy, Senior Finance Manager (Item 9.1)
Ms H McKellar, Manager, Grant Thornton
Mr G McLaren, Head of Estates (Item 7.3)
Mr T Little, Cyber Risk and Compliance Manager (Item 7.1)
Mrs L Pringle, Risk Manager (Item 5.1)
Mr R Roberts, Chief Executive
Mrs S Swan, Deputy Director of Finance (Head of Finance)

1. Introduction, Apologies and Welcome

James Ayling welcomed those present to the meeting and in particular to David Parker as this was his first meeting.

Apologies had been received from Mrs K Hamilton, Chair.

James confirmed that today's meeting was quorate.

2. Declaration of Interest

There were no declarations of interest.

3. Minutes of Previous Meeting – 25th March 2024

James Ayling advised that he had omitted to clarify the level of assurance for a number of items at the last meeting and had circulated proposed levels of assurance to Committee members, to which there had been no objections received. These were noted as follows:

Item 6.6 - Draft Internal Audit Plan 24/25 – Moderate level of assurance
Item 7.3 - Debtors Write Off Report - Moderate level of assurance
Item 8.2 - Audit Scotland Reports – Significant level of assurance
Item 9.1 - Countering Fraud Operational Group Update - Moderate level of assurance
Item 9.2 - NFI Update – Moderate level of assurance
Item 12.1 - Information Governance Minutes – Limited level of assurance

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The Committee noted the action tracker.

5. **Risk Management**

5.1 *Risk Management Quarterly Report*
Lettie Pringle spoke to this report which was for the fourth quarter to 31st March 2024. Lettie went over the key points and highlighted that 2 strategic objectives and 1 policy objective had moved from an amber RAG status to green. It was noted that 2 policy objectives remain at amber and related to stakeholders and risk owners being inconsistent with the use of the risk management framework.

In regard to the risk appetite, Lettie advised that 8 risks were being tolerated by the Operational Planning Group, with 2 risks being escalated to the Board Executive Team.

Lettie went on to highlight that Key Performance Indicators (KPIs) had not been fully met by Clinical Boards, with the exception of the Primary & Clinical Services Board, at the end of quarter 4 but assured that actions had been put in place to fully achieve these during 2024/25.

James Ayling was pleased to see there had been improvements with some objectives moving from amber to a green RAG status, however noted that a number of risks are unmonitored and enquired how this would be resolved. Lettie advised that a monthly report is issued to managers to highlight risks within their areas outwith review dates. It was noted that although progress was slow some improvement had been made. James enquired how this would be followed up. Laura Jones highlighted the significant improvement in quarter 4 with risks awaiting review and going through the approval process which was due to the Risk Team proactively working with management to flag these. Laura added that each Director was responsible for their own areas to drive forward improvement.

James enquired if the team were satisfied that issues around risk were being adequately identified and considered in relation to savings ideas. Laura explained that part of the process in place was to complete a risk assessment as part of each FIP scheme and that they were working across the full programme to ensure that risks are articulated and well understood.

Andrew Bone added that they have incorporated a risk section within the FIP template, however explained that it would not be possible to drill down into every

risk to scrutinise these so are reliant on exception reporting. Risks which cannot be mitigated through the project are then escalated via the FIP steering group meetings. Andrew stressed that risks should continue to be managed using the standard risk management process.

James noted that the new risk management system was due to be implemented during 2024/25 and enquired about rollout and migration of data. Lettie confirmed that they had recently started phase 1 which was migration across to the new system, with the 25th November 2024 being the proposed go live date. Phase 2 would be looking at the additional modules offered by the system and this would be undertaken in 2025.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the report.

6. **Internal Audit**

6.1 *Internal Audit Report – Financial Sustainability*
Emily Mayne introduced this report which represented completion of the 2023/24 audit plan. It was noted that this report had been presented in draft at the last meeting and had an overall rating of partial assurance with improvement required. The findings ratings were noted as 4 high, 3 medium, 5 low and 3 improvement.

Emily stressed that the controls and processes which the Board are using to achieve savings did not need to be changed, however a higher level strategic review was required. Emily also highlighted that the Project Management Office, who appear to be directed to assist with business as usual projects, could be utilised in a different way.

James Ayling noted reference within the report that the Board and Executive Team required to have stronger leadership for making decisions and advised that he would be taking the report to the next Board meeting for further discussion.

Emily explained that the feedback received from the interviews with middle management was that they felt they were in a difficult position and required a clear steer around what was to be delivered and support with the unpalatable decisions which would come forward in due course. Emily stressed the need for a clear and consistent message.

Lucy O'Leary felt this was a very valuable piece of work and noted that there seemed to be a theme emerging around uncertainty of expectations and agreed with the report going forward to the Board for discussion.

Andrew Bone welcomed the report and recognised the challenge around uncertainty as he felt that there had been occasions when clarity had not been provided. Andrew advised that some of the recommendations had already been progressed through the 2024/25 planning round and that others would be in place in advance of the 2025/26 process.

Ralph Roberts referred to the timing of the audit which had been undertaken at the end of 2023 and hoped that the current position would show progress having

been made. Ralph agreed that it was correct to escalate to the Board for further discussion and reminded of a previous decision made by the Board not to have focus purely on finance, however felt that this decision needed to be kept under review.

James referred to page 4 of the report where it stated that pre-Covid around £7m of savings had been delivered with a strong focus on financial accountability and queried why this had not continued post-Covid. Emily explained that there had been an external team driving forward savings and delivery prior to Covid and advised that from the interview feedback staff were not keen to go back to that regime.

Ralph added that at that point in time 75% focus was on finance and a very intense process had been in place. This has had to be balanced against service pressures during and post-Covid to deliver an acceptable level of service.

Emily stressed the need to get the correct balance in place so it is not purely finance focussed which would put patient's safety at risk.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the report and that it would be referred to the Resources & Performance Committee and the Board.

6.2 *Internal Audit Annual Report 2023/24*

Emily Mayne spoke to this report which had been seen in draft at the last meeting and confirmed that no substantive changes had been made. It was noted that all progress made had been taken into account within the report received today and that the overall rating remained as partial assurance with improvement required.

James Ayling noted that the timeliness and implementation rate for actioning recommendations was lower than expected and felt that the Executive Team needed to focus on prioritising this. Andrew Bone recognised this would be a concern for the Committee and advised that a new process had been put in place whereby the Executive Team review these on a monthly basis. Andrew confirmed that there had been an improvement from the position at June 2023 and he hoped this would continue to have a positive impact.

James asked if Internal Audit could provide an update in 6 months to see if there had been an improvement in trends due to the new system that has been put in place.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the annual report for 2023/24.

6.3 *Internal Audit Plan 2024/25*

Hannah McKellar spoke to this item and advised that the draft plan had been presented to the last meeting and no significant changes had been made since. Hannah advised that they would work with managers should any changes be required and the Committee would be kept updated. Hannah also highlighted that should there be any additional requests this would incur additional days.

Lucy O'Leary referred to the Service/Department Productivity audit and noted that the Director of Acute Services was the executive lead so assumed this meant that it would be undertaken within Acute Services. Hannah explained that the high level scope would be agreed with the Director of Acute Services and this would determine if any other areas would be required to be brought under the review. Andrew Bone added that whilst it was assumed that the focus would be within Acute Services this year the Executive Team was keen to focus on other areas going forward.

James Ayling queried the order of some of the audits, in particular why Property Transaction Monitoring was in the first quarter and Infection and Control was in the third quarter. Emily Mayne explained that for the Infection and Control audit they required to use a clinical governance specialist and this was the first availability they had.

James noted that there was no reference to maternity/midwifery as suggested by him at the last meeting and he further noted from the action tracker update that the Executive Team had discussed this and had not felt it was required. He was aware however that it would be covered at a Board development session in due course. James asked for an update on this. Laura Jones explained that the Clinical Governance Committee have an intensive focus on this area and undertake an annual review on maternity services. It was noted that a deep dive had also been undertaken the previous year which had been benchmarked against the Ockenden report to highlight any improvements required.

Regarding the Letby case Laura advised that the Clinical Governance Committee felt that this needed to be more general focussed hence the suggestion of a Board development session which would cover other clinical areas and not just maternity.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the annual report for 2023/24.

7. Governance & Assurance

7.1 *Network and Information Systems Regulations Audit Report*

Tom Little spoke to this item which provided an update on the findings from the national Network and Information Systems Regulations audit undertaken in February 2024. It was noted that this was a statutory audit and this was year 1 of a 3 year rolling cycle. Tom highlighted that there were a number of strong areas of performance, however some sub-categories had not fared well. Tom explained that to meet the Key Performance Indicators (KPIs) over 60% was required and was pleased to report that this had been achieved for 2 of the KPIs (KPI 1 and KPI 2). Tom advised that NHS Borders had failed on KPI 3 and went over the sub-categories which included disaster recovery policies and procedures, BC/DR testing policies and procedures and business continuity, amongst other things. Tom felt that the organisation as a whole struggles with contingency planning and this required to be addressed or will continually fail.

Tom confirmed that some of the actions under KP1 3 were being undertaken but they were not adequately documented and this would be addressed prior to the next audit. Regarding the testing of software, Tom explained that there were underlying issues with the management of security credentials and they would be looking to firm up on this.

James Ayling felt that the overall trend of improvement was encouraging, however noted that the findings reported the same concerning themes as the audit undertaken on IT Recovery and Resilience which would require focus.

James noted his concern as reference was made in the report to improvements which would require more funding which would be difficult in the current financial position. Tom advised that it would be possible to undertake some of the improvements without additional financial input and was confident performance would continue in an upward trend based on the current action plan.

James enquired about the use of contractors/suppliers and asked if escrow arrangements were in place. Tom explained that this is in place for some and would be put in place for new contracts going forward.

Lynne Huckerby felt assurance was required around priorities and what would be targeted first given financial constraints versus the risk on the infrastructure as if there was going to be more reliance on digital solutions the infrastructure would need to be ready for this and it did not appear to be. Lynne felt it would be useful to have sight of the action plan when it was in a position to be shared.

Andrew Bone acknowledged the risk carried around the digital infrastructure and appreciated it is unlikely to be fixed within current resources. Andrew felt that the options available, including costs and the risks that can be tolerated, would require review from the Board/Executive Team to reprioritise funds if the risks could not be tolerated.

James asked for a copy of the full report to be circulated around the Committee for information.

The Committee confirmed it had received limited assurance from the report.

The Committee noted the report.

7.2 *Audit Follow Up Report*

Hannah McKellar spoke to this item and reported that since the last meeting 16 actions have been implemented, 41 recommendations (11 high, 25 medium and 5 low risk) were overdue from the due date originally agreed and 18 had not yet reached the original date agreed. Hannah recommended that management focus on reducing the number of outstanding actions before the next meeting (c.f. minute item 6.2).

James Ayling referred to the aged actions for the Committee's attention and noted that they were unable to take any assurance from the actions relating to IT Recovery and Resilience and appreciated that although the action from the GDPR and Information Governance Arrangements audit was rated as low it still required to be completed.

The Committee confirmed it had received limited assurance from the report.

The Committee noted the report.

7.3 *Audit Follow Up Process*
IM&T Recovery & Resilience
Lainé Goodman referred to the recent update circulated where it noted that progress had been made in creating documentation for the disaster recovery and business continuity report which was expected to be complete by the end of June. A meeting had also taken place with the Resilience Manager who had committed to produce the necessary documentation and liaise with services.

James Ayling was pleased to see there had been progress made with the documentation and asked for the monthly updates to continue and for Lainé to attend the next meeting to provide an update.

Lainé advised that she was due to attend the Board meeting on 27th June 2024 to present the digital strategy which would focus on the priorities going forward.

The Committee confirmed it had received limited assurance from the update.

The Committee noted the update.

Ventilation Systems
Gavin McLaren referred to the recent update circulated where it noted that 4 out of 5 risk areas were either complete or in progress. Of the outstanding actions Gavin advised that this included 2 high risk recommendations and went on to provide an update on these where he indicated that he hoped for these to be complete by the end of June.

Andrew Bone highlighted that whilst the audit dealt with the control environment in place, there will continue to be a significant amount of operational risk due to the age of the ventilation plant. It was noted that this is also being discussed as part of the backlog programme.

James Ayling referred to the intimated completion date of June 2024 and asked if it would be possible to circulate an update on completion dates for the Committee's information. Gavin agreed to do this as he would have a better understanding following an imminent site visit to undertake a review of all critical ventilation.

The Committee confirmed it had received moderate assurance from the update.

The Committee noted the update.

8. **External Audit**

8.1 *Audit Scotland Reports*
Andrew Bone spoke to this report which highlighted where it was suggested relevant Audit Scotland reports are distributed across the organisation.

No issues were raised.

The Committee confirmed it had received significant assurance from the report.

The Committee noted the report.

James Ayling asked for an update from External Audit on the annual audit.

John Boyd advised that the audit was still in the early stages and there were currently no matters to be brought to the Committee's attention. John also explained that some of the year end testing had been undertaken earlier than usual so that had put them in a better position.

The Committee noted the update.

9. **Corporate Governance Framework**

9.1 *Review of Corporate Governance Framework 2023/24*
Susan Swan introduced this item and advised that the document formed part of the overall annual accounts process.

Anita McCloy went on to take the Committee through the document and explained that she receives information from a number of Committees across the organisation to provide assurance. Anita described the process involved in reviewing the evidence received. Anita also referred to the governance statement which is signed by the Chief Executive as Accountable Officer. It was noted that some information was still awaited and this was highlighted within the report.

Anita advised that since the draft had been issued the third party audit had been received for the National Single Instance of the Finance System which she was pleased to report was unqualified. The remaining third party audits for Practitioner and Counter Fraud Services and National IT Services were still awaited.

It was noted that the Endowment audit was currently underway and the audit opinion would be included within the final document.

James Ayling referred to appendix 2, statement of assurance from the Audit & Risk Committee to the NHS Board, which stated that "on the basis of the Committee's work controls were considered to be overall satisfactory with one exception". James highlighted the audits referred to throughout the year where there had been no assurance received and noted there was no reference to the IT Recovery and Resilience audit and suggested that this also be included as it had been escalated to the Board.

James also referred to the last page of the Committee's assurance statement which noted that post 31st March 2024 a further 5 high risk recommendations had

passed their due date as he felt that these should also be included within the governance statement signed by the Chief Executive.

James enquired how it is determined what needs to be treated as a disclosure. Andrew explained that this is broadly a matter of judgement primarily made by himself following discussion with key personnel. In general, disclosure is made on any significant issues raised through assurance statements made by individual officers or within committee annual reports and with addition of any high rated recommendations raised by audit teams. Andrew also advised that it had previously been agreed that there would be specific statement made within this section in relation to the Board's financial and workforce sustainability, and its operational performance. It was noted that opinions would be sought from Internal / External Audit should anything arise which required this.

John Boyd added that the requirements of the Financial Reporting Manual (FreM), which is a key part of the annual audit, required to be adhered with and can result in a degree of duplication between the performance report and the governance statement.

Anita advised that any further changes would be tracked for ease of reference and it was noted that the document would not be finalised until the audit is signed off.

Ralph Roberts noted his thanks for the work undertaken and considered it was a robust process which allowed him to sign the governance statement as Accountable Officer.

Susan reminded that the informal session on the accounts would take place on the 6th June 2024 at which the document, completed at that point in time, would be presented.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the Corporate Governance Framework for 2023/24.

10. **Integration Joint Board**

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

James Ayling advised of a request from the IJB's Internal Auditor to have sight of 3 Internal Audit reports, including that relating to Financial Sustainability, to provide assurance to the IJB Audit Committee. No issues were raised in sharing these reports.

Andrew Bone also advised of a request from Scottish Government to have sight of the Financial Sustainability audit report. No issues were raised in sharing this report.

10.1 *IJB Directions Tracker*

Andrew Bone advised that a full update, in terms of implementation of the directions, was detailed within the report.

The Committee confirmed it had received moderate assurance from the report.

The Committee noted the report and tracker.

11. **Any Other Competent Business**

James Ayling asked for an update on the annual accounts. Andrew Bone advised that the audit had recently commenced and was progressing. Andrew advised that the clearance meeting was currently scheduled for the 7th June 2024 and there was no reason at present to believe there was any jeopardy to this.

James also advised that the private meetings with External Audit and Internal Audit had been scheduled to take place on the 13th June 2024 and 18th June 2024 respectively.

12. **Date of Next Meeting**

Thursday, 20th June 2024 @ 1 p.m. via MS Teams.

BE
23.05.24

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Endowment Fund Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Endowment Fund Board of Trustees 6 May 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Endowment Fund Board of Trustees minutes 05.02.24
- Appendix No 2, Endowment Fund Board of Trustees minutes 06.05.24

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 5th February 2024 @ 2 p.m. via Microsoft Teams.

Present: Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee (Arrived 2.08 p.m.)
Mrs K Hamilton, Trustee (Chair)
Cllr D Parker, Trustee (Arrived 2.05 p.m.)
Mrs F Sandford, Trustee

In Attendance: Ms C Barlow, Charity Development Manager
Ms R Egan, Fundraising Officer
Mr M McLean, Investment Advisor
Mrs S Swan, Deputy Director of Finance (Head of Finance)
Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting. Apologies had been received from Mrs L O'Leary, Trustee, Mr R Roberts, Trustee, Dr L McCallum, Trustee, Mrs S Horan, Trustee, Dr K Buchan, Trustee and Mr J McLaren, Trustee.

2. **Declaration of Interests**

James Ayling referred to the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

3. **Minutes of Previous Meeting : 4th October 2023**

The minutes were approved as an accurate record.

4. **Matters Arising**

James Ayling referred to the item under AOB on the minutes of the last meeting regarding the Investment Advisor contract and noted there was no update on this within the papers for today's meeting. Susan Swan advised that she would be arranging a meeting of the small group as previously discussed to progress this.

Action Tracker
In regard to the Palliative Care Terms of Reference Susan Swan advised that this was still in discussion and an updated version was due to come forward to the next meeting in May.

5. **Strategy & Fundraising**

5.1 *Charity Plan 2023/24 – Progress Update*
Karen Wilson spoke to this item which provided a progress update on the 2023/24 Charity Plan. Karen highlighted specific items to Trustees, namely the Big Tea campaign which had taken place in the summer and had been successful in terms of engagement. Karen referred to an NHS Charities Together webinar where it

had been acknowledged they would be coming to the end of their three year sponsorship with Morrisons, who was the corporate partner for the charity campaign. As the performance had been less than expected they had taken the decision not to run this as a national campaign in future and would retain as an "off the shelf product" for member charities to use at a local level should they wish. Karen advised that the Fundraising Team would be looking at the format of this for the 2024 event but did not envisage it being ran as it previously had been.

Karen also referred to the Tree of Light campaign which had proved to be a huge success with the most donations received to date. Karen advised that they were also hoping to reintroduce a request for sponsorship towards the cost of the tree and felt that there was potential for this campaign to grow year on year.

Karen also referred to Beacon CRM, the new database installed the previous year, and noted that the additional functionalities would help the team with day to day operations as well as be of benefit to the finance team with the aid of a bank transfer form which donors are being encouraged to use as this will help with the reconciliation of the accounts. An added benefit would also be the targeted communications using the donor data stored within the system for future campaigns which Karen hoped would see an uplift in donations in campaigns run by the charity.

Karen referred to the work undertaken on the website to give it better navigation and make it more visually appealing. It was noted that the content had been brought up-to-date with the additional policies and governance. Karen advised that a staff area had also been added which included grant criteria and the process for applying for endowment funding which meant staff didn't need to be on site to access this information.

Harriet Campbell referred to the Beacon CRM and enquired how long the contract was for and if there was a way to evidence over the course of the contract that it was providing value for money. Karen advised that it was a rolling contract rather than a fixed term contract and that there was an option to only purchase the elements which would be of benefit to the charity. Karen assured that a review would be undertaken to ensure that all the elements subscribed to were being utilised and providing value for money. Should there be any of these not being fully utilised there would be an option to remove them from the package. As part of the review the overall cost benefit would be looked at, however this would be harder to gauge initially as the benefit would primarily be associated with time and resource.

Harriet also noted her concern regarding fund managers as she was aware that there were some funds which did not have a manager as well as a lack of engagement by fund managers at the drop in sessions which was referred to within the grants update report. Harriet appreciated the current stresses on the system and felt that the fund managers may require more support. Karen advised that this would be covered by the Charity Development Manager under item 5.2 and confirmed that they would be looking into the reasons for the low uptake at the drop in sessions and would be trying to increase engagement with the charity.

James Ayling reiterated his comments from the last meeting on the successful migration to Beacon CRM and complimented on the website update, particularly

the introduction of the section for staff. James also referred to the previous point made regarding fund managers as he felt that 1:1 meetings would be more productive.

James referred to the objectives on page 6 regarding administrative and operations procedures as he noted that there was still reference to there being significant duplication in the process for accepting donations in wards. James noted his concern around this as it linked back to the audit findings about systems of internal control and being able to evidence that there is a system in place for reducing the potential of fraud and felt that this required to be prioritised. Karen advised that this hadn't been taken forward due to capacity issues in both the fundraising team and BGH admin but confirmed that this was a priority to progress and would be initiated prior to the financial year end.

The Board of Trustees noted the update.

5.2 *Grants Update*

Colleen Barlow spoke to this item and referred to the comments raised about fund managers at the previous item. Colleen advised that work had commenced producing enhanced guidance for fund managers to support spending and provide awareness of the fund manager role. Colleen went on to provide feedback from fund managers who had attended the drop in sessions. It was noted that there would be direct engagement with wards and services asking them for suggestions on what would make a difference with the process. Colleen highlighted that it was apparent from the work undertaken that more required to be done to provide awareness of the charity.

Colleen went on to explain that the larger funds do have fund managers and that she has been working with them and they are all engaged and spending funds, albeit not as much as she would like to see.

Coleen referred to the proposal within the paper that funds with a value of less than £10,000 and which have either no/very little spending or no/very little income and no legal restrictions are fed into the small grants programme. It was noted that an application would be made to OSCR on those with a legal restriction to request they are closed and funds then transferred to a general non restricted fund. Colleen highlighted that there were some very small dormant funds, which had the potential to release a cumulative total of £300,000 into an unrestricted fund.

Colleen also advised that work had been undertaken with the Clinical Board Quads which had proved helpful as some of the members are fund managers for some of the larger funds and their awareness and engagement to support this will be critical to its success.

Fiona Sandford felt that there was an understandable resistance to apply for endowment funds with the current grip and control measures in place and reminded of previous discussion about having an innovation fund. Fiona suggested adding to the staff section on the website that the charity is up for spending funds on innovative applications as there would be a requirement to transform and innovate in order to meet financial targets.

Harriet Campbell stressed the need to be very careful with the messaging so as not to give a conflicting message to that already given out by the Board.

Harriet noted her support on the proposal to move the smaller dormant funds into a general non restricted fund.

Harriet asked if it would be possible to receive a collated list on an annual basis of everyone who receives funds as she felt that Trustees were aware of those who received larger amounts but not the smaller ones. Colleen confirmed that she would be able to provide this information.

In regard to Fiona's point, Colleen advised that she had an application form and guidance for "advancing health grants" which realistically would be over £10,000 and would relate to innovation to make improvement to services.

The Board of Trustees noted the update and approved the process outlined in the paper for the next phase of the Small Grants Programme.

5.3 *Haemodialysis Fund Spend Plan*

Colleen Barlow spoke to this item. Colleen explained that the reason this was coming forward to Trustees was because there would be a slight change to the principles when approving items, in this case the service was asking to replace chairs and other equipment which had originally been funded as part of a public appeal undertaken by the charity in 2009 to improve and enhance the dialysis ward. Colleen explained that this was an exception to the rule due to there being monies remaining from the original appeal which are restricted funds.

Colleen highlighted that the cost of the chairs was just under £30,000 and that she would like to go back to the service and ask them to look at what required to be replaced or repaired and to provide a more detailed spend plan.

Karen Hamilton felt that given this was part of the initial fundraising appeal and would be a spend down from the initial fund it did set it apart from the usual principles. Karen advised that as Chair of the Endowment Fund Board of Trustees she was content in approving this and asked for any other views to the contrary. Trustees noted their agreement with the proposals.

The Board of Trustees approved the replacement of the patient chairs in the Dialysis Ward in the first instance and would accept a spend plan at a future date from the service.

5.4 *Staff Awards 2024*

Karen Wilson spoke to this report which provided an overview of the event and confirmed that planning was currently on target. It was noted that a record number of nominations had been received across the categories and the judging was now complete.

Karen referred to the budget for the event and highlighted that they had managed to get quite a few elements at no charge. The cost was noted at £17,985 which included at 10% contingency. There were also a few income generation opportunities so it was hoped that the overall figure would still come down.

Karen went on to advise of a situation in NHS Lothian, whereby HMRC had made a pronouncement on the tax status of staff awards events, deeming it to be a benefit in kind for employees, which would ultimately result in a tax bill for the Board. Karen's understanding was that the charity itself had no employees, therefore it was not a benefit to our employees as the charity was funding it for the Health Board which meant that any tax implications would not be for the Board but the employees themselves. This would only be the case if the benefit was over £50 per head which at present it was not. Karen hoped that the final cost would be approximately £40 per head which would be considered a trivial benefit to staff and would not have the same tax implications.

Karen advised that she had alerted the Chair, Chief Executive and Director of Finance via an SBAR of the situation when it had arisen. Karen confirmed that her recommendation was to continue with the event giving assurance that the cost would not rise above £50 per head. Karen noted that Ralph Roberts, who was unable to attend today's meeting, supported the recommendation with the caveat that the budget per head is kept under the threshold.

Karen Hamilton noted that some of the budget figures were still estimates and suggested there may be scope to reduce further in these areas to make sure with absolute certainty that the cost per head remains under £50. Karen also highlighted the importance of being able to clearly evidence the costs.

James Ayling enquired if the £50 threshold was per event or over the course of the year as if over the year there could be something else which could push this over. Karen W advised that it was her understanding that it was over the year and highlighted the difficulty they would have in identifying whether attendees at this event had attended another event which would constitute as a benefit.

Harriet Campbell queried why this was now an issue when it clearly hadn't been previously. Karen W advised that the decision was down to HMRC as to her knowledge it had not been pursued previously with any other Board's awards event. Harriet also enquired if the Central Legal Office (CLO) had been approached about this. Karen confirmed that they had asked CLO for advice but as they were not tax specialists they were unable to comment.

Karen W explained that they are trying to speak with NHS Charities Together to see if there was anything they could do in collectively approaching HMRC.

Fiona Sandford noted her support to proceed with the event and ensure costs were kept under £50 per head.

Andrew Bone referred to Harriet's query on why this was an issue now and advised that it has always been an obligation of the employer to pay the correct tax based on the benefits and earnings of an individual and confirmed there has been no change in the law around this. Andrew noted that there was now clearer guidance from HMRC in terms of what is relevant in terms of "trivial" and "non trivial" with the addition of a £50 threshold. Andrew stressed the importance of both the Board and charity keeping appropriate records for all events so they can be crossed referenced should an individual attend more than one. Andrew confirmed that he was relatively comfortable with proceeding on the grounds that it does not cost more than £50 per head.

It was agreed for the benefit of the minutes the SBAR referred to would be attached as an appendix.

The Board of Trustees noted the update and approved proceeding with the event with the proviso that it came under the £50 per head threshold.

5.5 *Financial and Governance Services Provided to the Board of Trustees of the Endowment Fund*

Susan Swan introduced this item and advised that the request being made to Trustees was to seek approval to utilise the accumulative funds within the Finance and Governance Support Fund to appoint a band 7 charitable finance post. Susan highlighted the difficulty in continuing to support the level of development within the charity from a finance team perspective. It was noted that the team has only been able to undertake their statutory requirements and went on to highlight areas they were not able to support.

Susan went on to highlight the types of tasks which would be undertaken by the postholder.

From an investment perspective Susan confirmed that there was sufficient money within the accumulative funds and advised that they currently still apply the 1% admin charge, however this would be looked at should the post be appointed to as they would be looking to evidence a potential increase in this charge to recover monies on a recurring basis.

Susan advised that she would be looking to apply the same principles as previously undertaken for the permanent recruitment of other post holders, i.e. an underwrite situation which protects both the individual and the Board.

Harriet Campbell asked for clarification that if the post was approved the charity would be paying approximately £67,000 for this plus the 1% admin charge. Susan confirmed that this was correct.

Harriet also asked for assurance that this additional post would be in the charity's interest as it would clearly be an advantage for the Board and stressed the need to look at this from a charity perspective. Susan assured that this would be in the charity's interest as the postholder would be solely assigned to the charity and that there would be a workplan so Trustees would have evidence of the tasks being undertaken.

Karen Hamilton referred to the 1% admin charge which would be in addition to the £67,000 for the post and asked for more detail on why the 1% would be reviewed. Susan explained that this charge had not been increased along with national pay increases and clarified that the postholder would not be doing any of the tasks within the 1% admin charge, the role would an addition in totality.

James Ayling stressed the need to be cautious when matters arise which relate to both the Health Board and Trustees, particularly given the dire financial situation with the Health Board and ensure that there is no suggestion that Trustees of the charity are in any way underwriting a financial or a human resource deficit in any

way. Susan gave assurance that this would be a new post and did not currently sit within the finance establishment.

James enquired if there had been any market research undertaken to ensure that the level of salary proposed for this role was justifiable. Susan advised that the grading of the post had been reviewed against the qualifications required to undertake the role and deliver the duties required. Susan also referred to a recent benchmarking exercise undertaken across NHS Scotland's finance teams and this post was noted as a band 7. It was noted that a job evaluation had not yet been completed so the final banding would be dependent on that so although detailed as a band 7 within the paper there was a possibility it could come back a lower grade. The initial request being made today was to get approval from Trustees to proceed.

Karen Wilson also reassured that the benefit of the role would be to the charity and highlighted that any changes required as part of the improvement work is tied into Finance and takes time and resource. Karen reiterated that much more work could be undertaken to benefit the charity with this additional resource.

Fiona Sandford noted her support to the proposal and asked if the £67,000 included on costs. Susan confirmed that it did.

Karen H noted that there was approval from Trustees on the proposal and asked that there is absolute clarity that this is not underwriting a post which already exists within the Board as well as the need for sensitivity when the post is advertised and ensure that that this post is being recruited to the charity and not the Board given the current situation.

The Board of Trustees approved the recruitment of a WTE Band 7 Charity Finance post at a cost of approximately £67k, including on costs, from the Finance & Governance Endowment Fund.

The Board of Trustees agreed that should this cost rise significantly a paper should be brought back for approval.

6. **<u>Financial Report</u>**

6.1 *Primary Statements and Fund Balances*
Susan Swan spoke to this item. Susan advised that she did not have anything to highlight to Trustees other than the finance system had reported off the quarter 2 information which reports a loss on investment. It was noted that the Investment Advisor's report reported the position to 29th December 2023.

Susan reminded that within the operating procedures there is the ability to allocate any cumulative investment gain and proposed that no allocation be made as this was the first quarter where there has been a net gain within the portfolio. This would be held going into 2024/25 and would be kept under review. This was agreed.

The Board of Trustees noted the report.

6.2 *Register of Legacies and Donations*
Susan Swan spoke to this item which provided Trustees with an update on all legacies and donations over £5,000 received to 31st December 2023. It was noted that the fundraising team continue to have a significant involvement and work with fund managers around the spend plans.

The Board of Trustees noted the report.

6.3 *Audit Completion Report – Update on Recommendations*
Susan Swan spoke to this item which provided Trustees with an update on action taken to date in response to the recommendations made in the External Audit completion report from Thomson Cooper Accountants. Susan highlighted the recommendations regarding the central log for donations and the control log for income and confirmed that these were both in progress and an update would be provided to the External Auditor at the planning meeting which would be taking place in the coming week.

The Board of Trustees noted the update.

7. **Funds Management**

7.1 *Investment Advisor Report*
Mark McLean spoke to this item and referred to the bullet point summary and advised that at the end of December the portfolio value was just under £5.3m. It was noted that since the last meeting the portfolio was up by 6.2%, net of fees, against the benchmark of just under 5.5%.

Mark highlighted that there was still some ground to be made up as the 3 year performance indicated that the portfolio was up by 6.37% net against the benchmark of 15%. Mark appreciated that it would take some time to claw this back, however noted it was reassuring that the markets have started to stabilise from an interest rate perspective in the last quarter.

Mark reminded of the outside influences on markets at the moment, such as the conflict in the Ukraine and the current situation in the Middle East.

Mark highlighted that the portfolio is producing income at just under a 3.5% yield which equated to £183,000.

Mark felt that 2024 was going to continue to be volatile with some uncertainty but hoped to see some recovery with the fixed income and infrastructure holdings within the portfolio.

Mark also noted that an investment decision made the previous year had not been the correct call, namely the portfolio was light in US equities as it had been felt that a US recession was looming but did not materialise. The underperformance of the portfolio was in part due to this.

James Ayling referred to the poor performance of the portfolio for the previous year and appreciated this could not be judged on one year, however noted that the 3 year performance was worse with a significant difference against the benchmark. James enquired if there was an in-house process to review

performance individually with the fund managers. Mark confirmed that every portfolio is bespoke and that he was responsible for managing the portfolio. Mark went on to explain that the portfolio is built around recommendations from the research team and based on individual client's objectives.

James also noted that the portfolio currently had around 12% of investments from the US and enquired if this level would be maintained. Mark advised that he would be looking to increase the US exposure.

The Board of Trustees noted the report.

7.2 *ESG Status Annual Report*
Mark McLean spoke to this item and highlighted from an ESG and SDG perspective the portfolio was sitting favourably against the benchmarks. Mark noted that there were 2 outlier stocks, namely BP and the mining company BHB, which pushed the scores up slightly.

Harriet Campbell felt that receiving this annual report provided Trustees with an opportunity to review the investments from a preventative health perspective and decide whether or not to make any changes to the companies being invested in, examples being coca-cola or companies selling alcohol.

Mark referred Trustees to the ESG policy attached to the report which provided detail on how collective investments are screened to give assurance of the work undertaken prior to making a commitment to invest.

The Board of Trustees noted the report.

7.3 *Review of Investment Portfolio Benchmark*
Susan Swan advised that the Governance Framework requires Trustees to review the investment portfolio benchmark on an annual basis. Susan advised that she had discussed this with the Investment Advisor and recommended that no changes were made to the benchmark being reported at the present time.

The Board of Trustees approved the recommendation to continue to report the Investment Portfolio performance on a combined benchmarking approach using the primary benchmark of the Investec bespoke Strategic Asset Allocation (SAA), inflation data and ARC benchmarks for the period 1st April 2024 to 31st March 2025.

8. **<u>Governance Framework</u>**

8.1 *Draft Endowment Fund Board of Trustees Workplan 2024/25*
Colleen Barlow spoke to this item and advised that the workplan which Trustees were currently working against was last approved in 2020/21 so an update was being presented which reflected ongoing work. It was noted that there were workplans for 2024/25 and 2025/26 for both the Board of Trustees and the Endowment Advisory Group. Coleen flagged that it was hoped to work towards Trustees discussing the draft annual report and accounts at an extraordinary meeting rather than having the May and June meetings so close together as this would ensure that other regular reports are spread over the year.

Colleen advised that there were no significant changes to highlight to Trustees.

The Board of Trustees approved the draft Workplans for the Endowment Fund Board of Trustees and the Endowment Advisory Group.

8.2 *Endowment Fund Governance Framework – Annual Review*
Colleen Barlow spoke to this item and advised that the annual review is a key element in ensuring that the governance policies and supporting documents are kept up-to-date. It was noted that the report provided a summary of the changes undertaken over the past year. Colleen noted that historically the review was undertaken when moving from one financial year to another, however going forward proposed any changes would go through the Endowment Advisory Group and the Board of Trustees, with a summary report of the changes coming to the January meeting of the Board of Trustees. Colleen explained that formal approval to the changes to the Charter was required before being submitted to OSCR.

Harriet Campbell referred to the Endowment Fund Charter and the addition noted within section 7 (Agreed principles for the use of Endowment Funds), namely "An employee of the Board or the Trustees may only benefit from the charity, where the grant or award conferring the benefit satisfies the "public benefit" element of the charity test, as set out in the Charities and Trustee Investment ("Scotland") Act 2005, and the guidance on "Meeting the Charity Test" published by OSCR. The expenditure must be aimed at improving health, or the prevention, diagnosis or treatment of illness for the Board's residents and any benefit to the employee must be incidental to (and necessary for) that public benefit to be realised". Harriet asked how this would work when providing staff with tea and coffee etc, which she agreed with but did not appear to be for the benefit of the public.

Colleen referred to the pandemic when staff were not able to leave the wards for a break so tea and coffee had been provided for a limited time to boost staff morale.

Colleen reminded of a paper which had come forward to Trustees in 2022 around spend on the wellbeing of staff to try and initiate these kinds of conversations which would be taken forward on a case by case basis.

Karen Wilson also reminded about the tea trolley going round the wards as a way of engaging with staff around the charity. Karen also advised that she hoped to bring forward a paper to Trustees in the future around engagement and promotion with the charity so there is a plan rather doing things on an ad hoc basis.

Karen Hamilton recalled previous discussion around getting a better correlation between the Board of Trustees and the Endowment Advisory Group so that one fed into the other to avoid duplicating discussions. Colleen advised that the Terms of Reference for the Endowment Advisory Group was within the Endowment Fund Charter and highlighted that the most significant change is to give greater delegated authority to the Endowment Advisory Group to allow them to approve applications up to £100,000. It was noted that Endowment Advisory Group papers are made available to all Trustees ahead of meetings to allow them to comment or to attend should they wish to.

The Board of Trustees approved the continued use of the existing Governance Framework and supporting policies during 2024/25.

The Board of Trustees approved the Endowment Fund Charter.

8.3 *Palliative Care Fund Update*

Colleen Barlow spoke to this item. Colleen advised that work is in progress around the governance to enable the Palliative Care Committee to create a spend plan which would be presented to Trustees. It was hoped that this would be available for the next meeting.

The Board of Trustees noted the update.

9. **Capital Spend**

9.1 *Capital Projects Update*

Andrew Bone spoke to this item which provided an update on the current position with the Macmillan project. It was noted that the tender for the contract had been awarded and it was hoped that the project would be delivered over the next few months.

Andrew went on to provide an update regarding the adult changing facilities where it was noted that a study undertaken by an external company had looked at 4 locations within the BGH, namely one at the front door and 3 on the first floor. All options were regarded as being suitable in principle and there was ongoing discussion with managers/clinicians at the BGH on their preferred option from a service perspective.

It was noted that the front door option was probably most preferable in terms of patient access, however it was not the most suitable in terms of design and if adopted as the preferred option it would be slightly restrictive around the amount of space available with no option to expand. Andrew advised this option did not also fit within the guidance criteria so it would be brought back to Trustees for a full assessment should this be the option of choice. It was noted that the other 3 options did fit within the guidance, however 2 of these had an impact on office accommodation and the remaining option would mean repurposing an existing toilet facility which on paper was the most preferrable option.

Harriet Campbell asked if views had been sought from individuals who would be using the facility. Andrew advised that this could be picked up when they have more a definitive option.

Karen Hamilton was pleased to see the positive progress as this had been ongoing for a long time and asked that a paper with next steps be brought to the next meeting. Karen added that the rough estimate of costs was coming in at £110,000/£120,000 which was affordable within the financial envelope.

The Board of Trustees noted the update.

11. **Any Other Business**

None.

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

Monday, 6th May 2024 @ 2 p.m.

BE
14.02.24

Appendix

Situation
HMRC recently pronounced NHS staff awards events as a taxable "benefit in kind" in a neighbouring board which may have implications for the NHS Borders event currently in planning.

Background
In Lothian, HMRC recently made a pronouncement on the tax implication of a 'benefit in kind' for those attending a staff awards event, the tax bill for which would be charged to the NHS body.

The bill was based on the per/head value and the tax bracket of attendees. For it not to be taxable it would need to be under £50/head to be considered 'trivial' benefit.

Although NHS Borders is not funding the event for their employees, Lothian received advice from Turcan Connell that because of the status as a corporate trustee, the charity is not a separate legal entity therefore the NHS board would still be liable for the tax bill.

NHS Lothian are likely to significantly change how they deliver this kind of event in future as a result.

In light of this information, Susan Swan contacted the CLO however was advised that they are not tax specialists therefore didn't feel suitably placed to offer guidance.

NHS Borders Celebrating Excellence Staff Awards event is due to take place on 19th April therefore is at an advanced stage of planning. From the outset the aim has been to keep costs below £50/head for the event in recognition of the "trivial benefit" threshold and current projections have this figure at £40/head, even using the full contingency allocation would only bring this figure to £45 based on full capacity of 400.

Crucially, stage 2 judging is due to be concluded today (Thursday) therefore no finalists have yet been contacted however this is due to take place in the next few days.

The Charity Board of Trustees are meeting on Monday 5th February at which an update paper on the Staff awards event is being presented.

Assessment
Finalists have not yet been informed and places at the event have not yet been opened up to staff. The only investment to date is the deposit paid for the venue (a 25% cancellation fee would also apply for the AV hire) therefore there currently exists a short window of opportunity if the event is to be cancelled, postponed or significantly altered with minimum impact.

Current projections suggest this event can be delivered under £50/head therefore any benefit in kind would be classified as trivial and consequently the tax implications described should not apply to this event.

Recommendation
Planning for this year's staff awards event goes ahead as intended ensuring the costs remain under the "trivial benefit" threshold of £50/head and the event structure and content is re-evaluated prior to decision about future events.

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 6th May 2024 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee (Left meeting at 3.45 p.m.)
Mr A Bone, Trustee
Mrs H Campbell, Trustee
Mrs K Hamilton, Trustee (Chair)
Mrs L Livesey, Trustee
Dr L McCallum, Trustee (Left meeting at 4.05 p.m.)
Mrs L O'Leary, Trustee
Mr R Roberts, Trustee
Mrs F Sandford, Trustee

In Attendance:
Ms C Barlow, Charity Development Manager
Ms R Egan, Fundraising Officer
Mr M McLean, Investment Advisor (Left meeting at 3.20 p.m.)
Mrs S Swan, Deputy Director of Finance (Head of Finance)
Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting and in particular to Lynne Livesey as this was her first Board of Trustees meeting.

Apologies had been received from Cllr D Parker, Trustee, Mrs S Horan, Trustee, Mr J McLaren, Trustee and Mrs J Smyth, Director of Planning & Performance.

2. **Declaration of Interests**

James Ayling referred to the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

Harriet Campbell declared an interest in the estate of the late Miss Macmillan as she had been the solicitor who had dealt with this case, although this was now closed and she no longer worked for the company.

3. **Minutes of Previous Meeting : 5th February 2024**

The minutes were approved as an accurate record.

4. **Matters Arising**

Fiona Sandford noted her disappointment, following discussion at the last meeting, that there was nothing regarding the innovation fund under matters arising. Fiona did not feel there was any clear advice available in this area and would very much like to see this. Colleen Barlow recognised the importance of this and advised that she was looking to arrange workshops for managers and should any Trustees be willing to join the short life working group to look at the format of these they would be very welcome.

Lynn McCallum supported this way forward as she was aware that it could be challenging for clinicians when applying for endowment funds. Lynn added that clinicians are also disheartened by the number of applications which have previously been turned down.

Ralph Roberts also agreed with the benefits of doing this as a way forward and stressed the need to encourage innovation to be included as part of bids being put forward and then try to ascertain if a separate fund will be required.

Andrew Bone reminded that there is a large proportion of monies tied up in restricted funds highlighting the need to encourage donations to be unrestricted. Andrew enquired if there was any information available on the applications from clinicians which have been turned down. Colleen advised that where applications have been unsuccessful the reasons are detailed within the grants update report and that she would be happy to discuss further outwith the meeting if required.

Fiona agreed to discuss further with the Fundraising Team to allow a proposal to come forward to a future meeting.

Action Tracker

The Board of Trustees noted the action tracker.

5. **Strategy & Fundraising**

5.1 *Charity Plan 2023/24 End of Year Report*

Karen Wilson spoke to this item which provided a year end update on progress of the 2023/24 charity plan. Karen confirmed that progress had been made on all objectives, however some would be carried forward into 2024/25 as they had not been fully achieved. Karen went on to highlight some of the successes of 2023/24, namely the Tree of Light campaign, implementation of the new Beacon Customer Relationship Manager (CRM) and migration of data, redesign of the website which now included a staff section. Work had also been undertaken by the Charity Development Manager to reduce the number of restricted funds and provide improved guidance and support for fund managers.

Karen Hamilton commented that there was still a section on the website for Covid19, and whilst recognised that this had not gone away, queried when it would be updated to be less prominent. Karen also referred to the innovation section on the website which still had to be populated and suggested that this be prioritised following earlier discussion. Karen also showed concern regarding engagement with the community hospitals as she noted that this had not taken place during 2023/24.

Karen W advised that the Covid19 section of the website was due to be removed in the near future and agreed that the innovation section required to be populated at pace. Regarding visits to the community hospitals, Karen explained that the team had not had the time required to do this in the manner that they wished to and assured that focus would be given to this.

The Board of Trustees noted the report.

5.2 *Draft Charity Plan 2024/25*

Karen Wilson spoke to this item which provided the plan for the year ahead. Karen highlighted the items which had been brought forward from 2023/24 which had not been fully achieved. Karen went on to highlight key objectives for 2024/25 which included developing targeted comms for potential donors, looking at the charity's brand, undertaking more proactive fundraising and developing Beacon CRM. Karen highlighted that the new Finance post would be key in achieving some of the objectives and that they would be supporting in the recruitment of this post. Work would continue with grant making, grants awarded to NHS Borders' staff which fulfil the charity's purpose, with an end of year report on all grants awarded during 2024/25 being produced for Trustees' attention.

James Ayling referred to the rebranding of the charity, which he noted could be time intensive and expensive, and enquired if there was any indication of timescales for the national review as it may be more appropriate to hold off doing this until new Trustees were appointed to allow them to shape this. It was noted that no timescales have been confirmed. Karen went on to explain that they were not necessarily looking to rebrand but were planning to undertake a review and would bring forward recommendations to improve the brand to Trustees for approval.

Harriet Campbell suggested that it may also be worth reaching out to solicitors, particularly regarding the unrestricted issue. Harriet stressed that the objectives relating to fund manager support and grant making were crucial for everything else to fall into place.

The Board of Trustees approved the Charity Plan for 2024/25.

5.3 *Grants Update*

Colleen Barlow spoke to this item which was an update on progress over the last three months. Colleen advised that in addition to engagement with fund managers, additional sessions had been developed for Finance and Procurement colleagues to raise awareness around recent developments and went on to provide feedback from these sessions.

Colleen also highlighted the grants which had been supported since the last meeting. It was noted that since the implementation of the Grant Making Framework there had been a 15% reduction in the overall number of funds in the charity's portfolio and it was expected that the actions supporting the Small Grants Programme would see an additional 44% reduction. This would also help with more effective evaluation and monitoring of funds.

James Ayling referred to a project in the pipeline to purchase three advanced resuscitation trolleys for acute wards to improve response times in delivering care and queried how this compared in respect of core/non core. Colleen advised that she had received information from the Resuscitation Officer and was working with clinicians and managers to work through what can come forward as non core. James commented that this highlighted the general lack of understanding for those putting forward applications.

The Board of Trustees noted the report.

6. **Endowment Fund Annual Accounts 2023/24**

6.1 *Draft 2023/24 Report from Trustees and Annual Accounts*
Susan Swan spoke to this item. Susan referred to the new format of the report and highlighted the annual accounts section which provided the draft set of accounts, with the final version coming forward to the June meeting. It was noted that these were currently being audited by Thomson Cooper, the External Auditor, who had noted the marked improvement in the standard of the document, with only minor comments being received to date.

Susan highlighted the increase in investment income and due to this being in a more positive position felt it may be appropriate to look at apportioning this across funds at a future meeting. Susan added that there was a significant amount of money tied up in a number of restricted funds and explained that these would receive greatest benefit from apportionment of the investment income.

Karen Hamilton referred to the apportionment of the investment income across funds and asked whether it would be appropriate to consider changes to this approach. Susan explained that the current policy was set in line with advice following the Turcan Connell review in 2022 and suggested that any changes would need to take into account previous advice. Susan proposed that a discussion is held with the Endowment Advisory Group in the first instance to identify any implications to Trustees for consideration in due course.

James Ayling referred to page three of the report headed “our year at a glance” and queried if it was appropriate to say “we raised £784,729” as he felt it may be more appropriate to say that the charity had “received”.

Karen Hamilton referred to the issues incurred regarding restricted and unrestricted funds and stressed the need to ensure that the website is clear around this for potential donors.

Karen Wilson referred to the remainder of the document and hoped that it had captured all the work undertaken, including that of the fundraisers, as she expected it to be used extensively to promote what the charity does in a wider sense to a variety of audiences.

Trustees felt that the new format of the report was a great improvement.

The Board of Trustees noted the draft Report from Trustees and Annual Accounts for 2023/24.

7. **Funds Management**

7.1 *Investment Advisor Report*
Mark McLean spoke to this item and referred to the bullet point summary and highlighted that at the end of March the portfolio value was just over £5.1m. It was noted that since the last meeting the portfolio had increased by +1.99%, net of fees, against the comparable benchmark of +3.93%. Mark felt that the portfolio was currently in a positive position with an increase in UK government bonds and US weightings. Mark advised that the portfolio was currently shaped to benefit from a

cut in interest rates which he hoped to see in the near future as this would hopefully recoup some of the recent underperformance.

Mark also noted the £180k of income generated, providing a dividend yield of 3.5%.

Harriet Campbell noted her disappointment around not outperforming the benchmark and consistently not doing so. Mark appreciated that the portfolio had underperformed against competitors and felt that it being underweight in US equities was primarily attributable to this.

Fiona Sandford queried if consideration should be given to having a passive tracker fund which would also be cheaper as there would be no fee payable to an Investment Advisor. Fiona also stated that she did not envisage the Bank of England cutting interest rates in the near future and noted her concern if the performance of the portfolio was reliant on this. Mark agreed that a passive tracker fund would be cheaper than active investing, however this would be a discussion for Trustees to have.

James Ayling noted that as well as the underperformance reported, the statistics within the last report also noted poor performance which he felt was a disappointing theme.

Mark referred to the recent joining up of Investec Wealth and Management with Rathbones Investment Management and advised that consent would be required to transfer clients' investments from one investment portal to another and this request would come forward in due course.

The Board of Trustees noted the report.

Mark McLean left the meeting.

7.2 *Investment Advisor Contract – Recommendations to Extend*

Susan Swan referred to the recent email circulated recommending Trustees continue the contract with Rathbones Investment Management, incorporating Investec Wealth and Investment, until the contract end date of 31st March 2025 and to request a tender exercise be conducted during 2024/25 for the award of contract from 1st April 2025.

Susan advised that she had spoken with the Investment Advisor as the break clause date had passed and had received confirmation that this could be done at any point in time. Following discussion at the previous item Susan advised that she could take forward a tender exercise earlier if Trustees wished and this could be undertaken through the Endowment Advisory Group with recommendations coming forward to Trustees.

Following discussion Trustees agreed to progress to a market test and to also look further into a passive tracker fund as per discussion at the previous item.

Lucy O'Leary and James Ayling both suggested using an external company to review the charity's requirements and structure of the portfolio if there was appropriate funding to do this.

The Board of Trustees agreed that a market test should be undertaken and would be taken forward by the Endowment Advisory Group.

8. **Governance Framework**

8.1 *Palliative Care Fund Update*
Colleen Barlow provided an update and advised that two workshops had been arranged with key stakeholders for "blue sky thinking" and proposed that Trustees await the outcome of these before options are brought forward. This was agreed.

Lynn McCallum went on to provide some background where it was noted that Highland Hospice had undertaken a similar project and have offered to provide support. Lynn explained that the workshops would also look at how to work towards a combined NHS/charity funded service. It was noted that data collated suggested that patients would rather die at home rather than in hospital but are currently unable to do this.

Andrew Bone supported this in principle but noted his concern around developing a service which is both NHS and charitably funded.

The Board of Trustees noted the update and would receive feedback from the workshops at the October meeting to agree a way forward.

9. **Capital Spend**

9.1 *Capital Projects Update/Adult Changing Facility*
Andrew Bone spoke to this report which sought approval on the preferred option to proceed with implementation of an adult changing facility within the Borders General Hospital. It was noted that no funding had been earmarked against this project so if agreed to proceed this would require to be identified.

Andrew advised that a feasibility study had been undertaken at the end of last year to look at an in building solution. It was noted that four options were detailed within the paper with one preferred option (option two). Andrew referred to the first option, which was the only one on the ground floor, and highlighted that the door was not wide enough which could restrict access to larger type wheelchair users and that this had been confirmed as a barrier to Changing Places accreditation. As such Andrew proposed that this option did not meet the requirements of the Trustees and should be discounted.

Andrew explained that there was an opportunity to reduce time to implementation through extension of an existing contract for minor works should a decision be made timeously. This would avoid the requirement for a full tender exercise. It was noted that the costs detailed were indicative based on the feasibility study and the recommendation would be to progress through the procurement route described at the costs identified, should funding be identified to meet this cost.

Karen Hamilton agreed that the preferred option made most sense.

Harriet Campbell reminded of the importance of reaching out to users for feedback to ensure that the preferred option would be a satisfactory solution.

James Ayling left the meeting.

Fiona Sandford was keen to see this project progressed and queried if the investment income referred to earlier could be used to fund this. Susan Swan advised that the investment income would be apportioned, in the main, amongst the restricted funds. Harriet suggested exploring the use of restricted funds where the scope might be aligned to the aims of this project.

Ralph Roberts recognised Trustees' commitment to progress but also noted the need to challenge if this should be prioritised due to the increased costs.

Colleen Barlow advised that following the reorganisation of funds there were some grants which could be clawed back as the projects were no longer being taken forward. External grants could also be looked at and Colleen suggested that she work with Andrew and Susan around the funding proposals to allow Trustees to make an informed decision. This was agreed.

Lynne Livesey noted that knowing where the funding would come from was key and if this information could be made available to Trustees as soon as possible then there would perhaps still be an opportunity to use the current contractor.

Andrew advised that regarding stakeholder engagement there had been none on any of the options, albeit the first floor options were the only feasible ones. It was noted that to extend the contract with the current contractor a decision would require to be made within the next two weeks. Regarding financing of the project, and due to the unique set of circumstances, Andrew suggested there might be an option to make commitment against future income to the general fund to underwrite the project to allow it to progress whilst grants and restricted funds were investigated.

Lynne McCallum left the meeting.

Following discussion Trustees agreed that the project should proceed but in general were not supportive of the suggestion to underwrite from the general fund and that an alternative source of funding be sought.

Andrew agreed to discuss with relevant parties and would request virtual approval from Trustees if this was appropriate.

The Board of Trustees agreed that option two was the most appropriate solution and that stakeholder input was required for this option.

The Board of Trustees noted that work would be undertaken to source funding for this project and further information would be circulated in due course.

11. **Any Other Business**

None.

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

Monday, 17th June 2024 @ 2 p.m.

BE
15.05.24

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Finance Report – May 2024**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Janice Cockburn, Finance Business Partner** **Paul McMenamin, Finance Business Partner**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

This aligns to the following NHSScotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The report describes the financial performance of NHS Borders and any issues arising.

2.2 Background

NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This framework lays out the requirements for submission of Financial Performance Reports (FPR) to SG which include comparison of year to date performance against plan with full review of outturn forecast undertaken on a periodic basis (i.e. both monthly and through formal quarterly reviews).

NHS Borders has determined that regular finance reports should be prepared in line with the SG framework (i.e. monthly).

The board has remitted the Resources & Performance committee to "review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements".

The board continues to receive regular finance reports for reporting periods where there is no scheduled committee meeting.

2.3 Assessment

2.3.1 Quality/ Patient Care

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.2 Workforce

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.3 Financial

The report is intended to provide briefing on year to date and anticipated financial performance within the current financial year.

No decisions are required in relation to the report and any implications for the use of resources will be covered through separate paper where required.

2.3.4 Risk Assessment/Management

The paper includes discussion on financial risks where these relate to *in year* financial performance against plan. Long term financial risk is considered through the board's Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the report is presented for awareness and does not include recommendation for future actions.

2.3.6 Climate Change

There are no relevant impacts identified in relation to the matters discussed in this paper.

2.3.7 Other impacts

There are no other relevant impacts identified in relation to the matters discussed in this paper.

2.3.8 Communication, involvement, engagement and consultation

Not Relevant. This report is presented for monitoring purposes only.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Senior Finance Team, 18th June 2024
- Board Executive Team, 25th June 2024

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Finance Report for the period to end May 2024

FINANCE REPORT FOR THE PERIOD TO THE END OF MAY 2024

1 Purpose of Report

1.1 The purpose of the report is to provide committee members with an update in respect of the board's financial performance (revenue) for the period to end of May 2024.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** the contents of the report including the following:

YTD Performance	£4.68m overspend
Outturn Forecast at current run rate	£28.08m overspend
Variance against Plan (at current run rate)	£2.32m adverse
Actual Savings Delivery (current year effect)	£4.16m (actioned)
Potential Slippage on Forecast Savings (current year effect)	£1.80m
Projected gap to SG brokerage	Best Case £10.96m Worst Case £13.28m

2.1.2 **Note** the assumptions made in relation to Scottish Government allocations and other resources.

3 Key Indicators

3.1 Table 1 summarises the key financial targets and performance indicators for the year to date performance to end May 2024.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 2 £m
Summary		
Year to Date (forecast/actual)	(4.29)	(4.68)
Core Operational	(12.30)	(0.49)
Savings	(13.46)	(4.19)
Outturn Forecast (pro-rata)	(25.76)	*(28.08)*
Average Monthly Run Rate	(2.15)	(2.34)
Savings		
Full Target	(28.11)	(28.11)
In year target	*(11.24)*	*(11.24)*
Forecast Delivery	14.64	*12.84*
Schemes Implemented	-	4.16
Planned/Mandated Schemes	9.93	4.97
Schemes in development	4.71	3.71
Slippage against Plan	-	1.80
Scot Gov Support		
Brokerage Cap	14.80	14.80
Forecast Overspend after brokerage	(10.96)	*(13.28)*
Accumulated Brokerage Mar-24	35.53	35.53

4 Summary Financial Performance

4.1 The board's financial performance as at 31st May 2024 is an overspend of £4.68m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for two months to end May 2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	(287.43)	(288.63)	(48.38)	(48.31)	(0.07)
Revenue Expenditure	287.43	288.63	46.23	50.84	(4.61)
Surplus/(Deficit)	**0.00**	**0.00**	**(2.15)**	**2.53**	**(4.68)**

4.2 Core Operational Performance

4.2.1 The core operational performance excluding savings is £2.49m overspent. This position has been adjusted to £0.49m (overspent) in anticipation of additional resources not yet implemented within operational budgets.

4.2.2 The overall impact of these adjustments is a £2.0m improvement included within the position reported above. These adjustments are summarised as follows.

4.2.3 As at end May 2024 no Scottish government allocations had been confirmed. As such, operational budgets at service level remain unadjusted for a number of items where funding is expected to be received (including ongoing commitments from prior years). The overall impact of this adjustment is £0.83m. This position is consistent with previous years and is expected to be resolved by quarter one review.

4.2.4 Further adjustment is made to the position to anticipate release of reserves held in respect of non-pay growth, including prescribing, where budget setting has not yet been completed. This work will be concluded for month 3 reporting and Q1 review. The level of funding assumed to be released is £0.72m.

4.2.5 Adjustment is made in respect of assumed financial flexibility included within the financial plan forecast. This flexibility is expected to be identified through review of balance sheet and reserves as part of the Q1 review and is anticipated pending confirmation. The level of assumed flexibility included in the year to date position is £0.45m.

4.3 Savings Delivery

4.3.1 As noted in Table 1 (key financial indicators), the overall financial performance at Month 2 is £4.68m overspent, of which £4.19m represents unmet savings.

4.3.2 The financial plan assumes delivery of £14.64m savings during 2024/25 which would result in a residual balance of unmet savings to be carried forward of £13.46m. Pro-rata to Month 2 this would project a shortfall of £2.24m.

4.3.3 The year to date position of £4.19m unmet reflects the savings profile of business unit plans which anticipates a greater level of delivery to be achieved within later financial periods.

4.4 Recurring savings delivered to date have a current year effect of £4.16m. This is higher than the total savings delivery in 2023/24, however this figure does include £1.0m retention of Waiting Times core funding following confirmation of additional Scottish government allocation which offsets expenditure in current plans.

4.5 Despite this level of savings delivery, the overall forecast savings position remains at risk and is discussed further in Section 6 of the report.

5 Financial Performance – Budget Heading Analysis

5.1 Income

5.1.1 Table 3 presents analysis of the board's income position at end May 2024.

Table 3 – Income by Category, year to date May 2024/25

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Income Analysis					
Revenue Resource Limit	266.47	266.46	44.41	44.41	-
Family Health Services	10.24	11.25	2.72	2.72	-
External Healthcare Purchasers	4.93	4.93	0.82	0.73	(0.09)
Other Income	5.79	5.99	0.43	0.45	0.02
Total Income	**287.43**	**288.63**	**48.38**	**48.31**	**(0.07)**

5.1.2 There is a small over recovery on other income which is linked to over recovery of patient related income.

5.1.3 The shortfall on income relating to External Healthcare Purchasers relates to a continuation in the reduction of levels of activity through the Northumberland SLA. Budgets were adjusted for 2024/25 to address this issue however the shortfall reported at M02 is beyond the level anticipated. This position will be monitored during 2024/25 and adjusted at Q1 forecast if required.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit at May 2024.

Table 4 – Operational performance by business unit, May 2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	73.44	80.10	13.22	13.55	(0.33)
Acute Services - Savings Target	(0.16)	(4.89)	(0.99)	-	(0.99)
TOTAL Acute Services	**73.28**	**75.21**	**12.23**	**13.55**	**(1.32)**
Set Aside Budgets	32.24	31.73	5.37	5.93	(0.56)
Set Aside Savings	(4.17)	(3.94)	(0.68)	-	(0.68)
TOTAL Set Aside budgets	**28.07**	**27.79**	**4.69**	**5.93**	**(1.24)**
IJB Delegated Functions	106.09	115.62	22.72	23.66	(0.94)
IJB – Savings	(47.85)	(7.81)	(1.30)	-	(1.30)
TOTAL IJB Delegated	**101.24**	**107.81**	**21.42**	**23.66**	**(2.24)**
Corporate Directorates	44.18	47.66	7.60	8.03	(0.43)

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
Corporate Directorates Savings	(3.49)	(4.28)	(0.71)	-	(0.71)
TOTAL Corporate Services	**40.69**	**43.38**	**6.89**	**8.03**	**(1.14)**
External Healthcare Providers	36.17	35.02	5.61	5.77	(0.16
External Healthcare Savings	(4.21)	(3.08)	(0.51)	-	(0.51)
TOTAL External Healthcare	**31.96**	**31.94**	**5.10**	**5.77**	**(0.67)**
Board Wide					
Depreciation	5.87	5.87	0.98	0.98	-
Year-end Adjustments	-	(7.08)	(7.08)	(7.08)	-
Planned expenditure yet to be allocated	6.32	3.71	1.55	-	1.55
Board Flexibility	-	-	0.45	-	0.45
Total Expenditure	**287.43**	**288.63**	**46.23**	**50.84**	**(4.61)**

5.2.2 **Acute Overall**. The position is £2.56m overspent. £0.9m relates to operational overspend and £1.67m relates to non-delivery of the three year saving targets of £10.3m. The proportion of saving anticipated in 24/25 is £3.1m recurring and good progress has been made to date with fully year recurring saving of £2m having been retracted from budget in the first 2 months of 24/25. The operational overspend of £0.9m in the first two months of the is reflective of the additional 22 unfunded beds which are open across the Acute site to deal with the significant number of delayed in the system and the additional staffing required in the ED department to staff "blue ED" while patients wait for onward admission to an appropriate bed. Further areas of overspend relate to drugs, instruments and diagnostic supplies these are currently under investigation to ensure that all funding has been allocated according or to understand the drivers behind the overspend. Budget reporting is categorised as 'Acute Services' covering health board retained functions including planned care and women & children's services, and 'Set Aside' representing unscheduled care functions under strategic direction of the Scottish Borders IJB.

5.2.3 **Acute services** (excluding Set Aside) are reporting overspend of £1.32m including two months of the 10% savings requirement over 3 years. The operational element of the overspend is 0.33m on core budgets. Ward 7/9 are overspent by £0.1m which is related to the additional surge beds which have been open consistently during April and May. Cancer drugs are overspent by £0.15m due to increased activity in the SACT service. There is also the need for waiting times funding to be allocated to a number of areas which will be input during month three reducing the current level of overspend.

5.2.4 **Set Aside.** The set aside budget is overall £1.24m overspent, including two months of the 10% saving requirement over three years. The operational element of the overspend on core budget is £0.56m. The overspend relates to the additional staffing in ED to deal with the long waits in the department for beds and increased pressure on medical staff resulting in a high cost locum being utilised during April and May £0.2m. The additional 15 unfunded surge beds have remained open consistently during April and May and have contributed to the overspend by £0.3m.

5.2.5 **IJB Delegated.** Excluding non-delivery of savings, the HSCP functions delegated to the IJB are reporting an over spend on core budgets of £0.94m. The main drivers for the overspend are Medical agency use (Mental Health locums), continued growth in GP Prescribing, and further pressures in Mental Health prescribing. This position is partly offset by ongoing vacancies across all areas.

5.2.6 The spend on GP Prescribing at M02 is already reporting an overspend of £0.82m. An element of this overspend is expected to be offset by release of funds from reserves following completion of non-pay budget setting at Month 3. Continued increases in costs and volumes continues to drive the actual spend up, and shows no signs of easing in the coming months. The impact of costs and volumes is not limited to NHS Borders but is an impact being felt across all boards in Scotland. As previously reported, primary care prescribing expenditure is reported two months in arrears and therefore the position is based upon forecast trends as at end March, and adjusted for prescribing volumes in April.

5.2.7 **Corporate Directorates** are reporting a net over spend of £0.43m on core budgets. The over spend is mainly due to equipment costs linked to e-Health where funding is still to be confirmed, as well as increased spend in patient travel (supporting hospital discharge and increasing number of patients requiring transport to NHSL from the Borders McMillian Unit). Estates expenditure remains above budgeted levels as a result of actions in place to mitigate high risks across the built environment.

5.2.8 **External Healthcare Providers.** Excluding savings there is an small over-spend of (£0.16m). Currently no in year activity has been received and therefore expenditure is predominantly based on estimates of 23/24 activity. This position remains draft until actual 24/25 activity is available. The main area of overspend is within Scottish UNPACs where the estimated activity for both Lothian and Glasgow is higher than budget.

6 Savings Delivery

6.1 The savings targets set within operational budgets represent 10% of the Board's overall baseline expenditure (£28.1m). These targets are expected to be delivered over a three year period and targets set for 2024/25 are £8.43m recurring and £2.81m non-recurring.

6.2 Table 5 sets out the operational savings targets set for 2024/25 and cumulatively to 2026/27.

Table 5 – Delegated Savings Targets

	2024-25			Cumulative 3 year target 10% £m
	Recurring 3% £m	Non-Recurring 1% £m	Total £m	
Acute Services	(1.88)	(0.63)	(2.51)	(6.26)
Set Aside	(1.25)	(0.42)	(1.67)	(4.17)
IJB Directed Services	(1.72)	(0.58)	(2.30)	(5.76)
Prescribing	(0.77)	(0.26)	(1.03)	(2.55)
Corporate Directorates	(1.55)	(0.52)	(2.07)	(5.15)
External Healthcare Providers	(1.26)	(0.42)	(1.68)	(4.21)
Total	**(8.43)**	**(2.81)**	**(11.24)**	**(28.10)**

6.3 The financial plan sets out an expected level of savings delivery in 2024/25 of £14.64m, of which £2.07m is expected to be non-recurring. The expected delivery is therefore in excess of savings targets (by £3.40m) and reflects the overall impact of both budget reduction and cost avoidance measures which mitigate against operational cost pressures.

6.4 Within this position, the plan describes planned savings identified by business units at £7.93m with a further £2.0m expected to be delivered through enhanced grip & control measures, including reduction of Agency use. Schemes in development identified within the plan represent a further £4.71m and incorporate c.£2m in relation to reduction to hospital beds (including unfunded 'surge' beds).

6.5 **Actual Savings Delivery**

6.5.1 Table 6 below shows actual level of savings achieved to date, representing the current year value for the 12 months to end March 2025.

Table 6 – Savings achieved as at May 2024

	Savings Target £m	Recurring Savings Achieved £m	Non Recurring Savings Achieved £m	Total Achieved £m	Unmet Savings (current year) £m	Unmet Savings (against 3 year target) £m
Acute Services	(2.51)	1.90	0.00	1.90	(0.61)	(4.36)
Set Aside	(1.67)	0.24	0.00	0.24	(1.43)	(3.93)
IJB Directed Services	(2.30)	0.38	0.00	0.38	(1.92)	(5.38)
Prescribing	(1.03)	0.13	0.00	0.13	(0.90)	(2.42)
Corporate Directorates	(2.07)	0.30	0.08	0.38	(1.69)	(4.77)
External Healthcare Providers	(1.68)	1.13	0.00	1.13	(0.55)	(3.08)
Total	**(11.26)**	**4.08**	**0.08**	**4.16**	**(7.10)**	**(23.94)**

6.5.2 Against the 2024/25 target, £4.16m has been delivered to date. This reflects actual adjustments reported through the finance systems and impacting on service budgets and does not include any cost avoidance measures which do not result in budget retraction.

6.5.3 The balance of savings to be delivered in 2024/25 is £7.1m. The level of unmet savings remaining against the three year target (10%) is £23.94m.

6.5.4 As noted separately, the financial plan assumes that savings delivery in year will exceed the in year savings target by £3.40m inclusive of cost avoidance measures.

6.6 **Cost Avoidance Measures**

6.6.1 Monitoring of cost avoidance measures presents a level of complexity to the FIP programme and tracking measures are not yet fully in place for all such schemes. As such, it is expected that there may be some under-reporting of delivery during the first quarter, however the actual impact of these schemes will be reflected in operational performance therefore there is no expected impact to the overall financial position as reported.

6.6.2 This situation is expected to be addressed from July reporting onwards.

6.7 Progress towards Implementation

6.7.1 The Project Management Office (PMO) maintains a register of all schemes which are included within agreed plans. Schemes in development do not appear within this register until such time as they are developed to Gateway 1.

6.7.2 Additional measures have been introduced for 2024/25 in order to ensure that performance is monitored against plan. Targets have been set for progress against each gateway and this is reported monthly to the Financial Improvement Programme (FIP) Board. This includes escalation of individual business units to more frequent steering group meetings and implementation of local vacancy control measures where necessary.

6.7.3 Schemes which are expected to be cost avoidance (i.e. do not impact on budget but result in a reduction to overall expenditure) are not presently reported through the mandate process. Reporting of such schemes is being reviewed as noted under 'Cost avoidance measures' above.

6.7.4 Table 7 summarises the recurrent plans currently identified by business units for 2024/25. This is set against the 3% recurring target.

Table 7 – Recurring Plans 2024/25 by Business Unit

	Number of Schemes	3% Target £m	FYE £m	PYE £m
Acute	37	(3.13)	3.45	2.85
Commissioning	7	(1.26)	1.13	1.13
Corporate	36	(0.87)	0.99	0.94
Estates	6	(0.30)	0.39	0.13
Facilities	10	(0.38)	0.09	0.09
IJB - MH/LD	27	(0.65)	1.07	0.74
IJB - PACS	78	(1.84)	2.71	2.61
Organisation Wide	1	0.00	0.35	0.35
	202	**(8.43)**	**10.17**	**8.83**

6.7.5 The above table indicates a potential over-recovery against target. This does however present a risk to the overall forecast where schemes indicate phasing on a fully year basis which is unlikely to be achieved. This situation is being discussed via local FIP steering group meetings with individual business units and any specific delivery risks arising from these discussions will be escalated as they arise.

6.7.6 Table 8 describes the same information as Table 7 in terms of the progress towards implementation through the Gateway mandate process. Schemes which are reported as 'Gateway 3 Blue' are fully implemented.

Table 8 – Recurring Plans 2024/25: Progress by Gateway

	FYE £m	PYE £m	Total Schemes
At planning stage	1.04	0.42	30
Gateway 1	3.86	3.36	76
Gateway 2	0.58	0.47	9

	FYE	PYE	Total Schemes
Gateway 3	0.68	0.60	30
Gateway 3 - Blue	4.02	3.98	57
Total Schemes	**10.17**	**8.83**	**202**

6.7.7 Appendix 1 provides analysis of gateway progress by business unit.

6.8 **Potential Slippage.**

6.8.1 At this stage there remain significant risks in relation to delivery of the forecast £14.64m savings; in particular those elements which fall outwith the current PMO gateway monitoring arrangements, including cost avoidance measures including any impact of grip & control and schemes remaining in development.

6.8.2 As at May 2024 there is a shortfall of £1.8m noted against the overall business unit schemes identified (including non-recurring schemes) and schemes in development. This is attributed mainly to the grip & control measures which are expected to impact as cost avoidance. It is likely that this situation will be addressed in future reporting.

6.8.3 Work to understand phasing plans and the actual risk to delivery is ongoing and an update will be provided at Quarter One Review.

7 Scottish Government Oversight

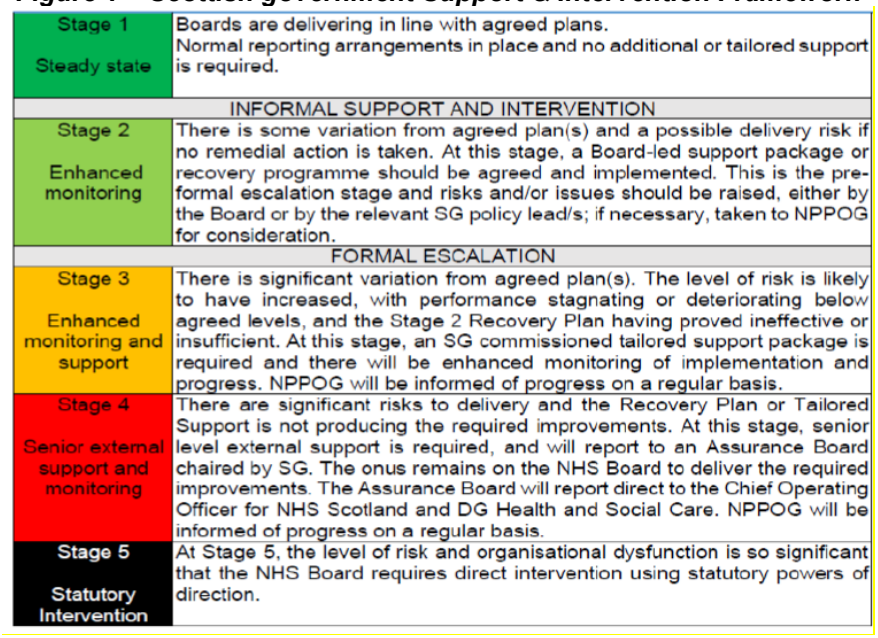
7.1 The Board's medium term financial plan was submitted to Scottish Government (SG) in March 2024 and was not accepted on the basis that it does not meet two of the three key tests set by SG for NHS Boards: firstly that the plan fails to demonstrate improvement on the 2024/25 financial plan position set out in the 2023/24 plan; secondly, that the projected deficit in 2024/25 exceeds the brokerage limit set by SG. The third test requires Board's to identify a minimum of 3% recurring savings within their plan and this test has been met.

7.2 The Scottish Government has set NHS Borders a brokerage limit of £14.8m for 2024/25. The current outturn position forecast within the Board's financial plan indicates a projected deficit of £25.76m. On the basis of run rate at M02 this position would deteriorate further to c.£28m. This however does not reflect the expected step increase in savings delivery during the remainder of the financial year.

7.3 The gap against brokerage limit outlined in the plan is £10.96m. Actions to address the gap will be discussed with the Board in advance of the completion of the Quarter One Review.

7.4 The Health Board remains at Stage 3 of the Scottish Government's Support and Intervention Framework. This framework is described below.

Figure 1 – Scottish government Support & Intervention Framework



Stage 1 Steady state	Boards are delivering in line with agreed plans. Normal reporting arrangements in place and no additional or tailored support is required.
INFORMAL SUPPORT AND INTERVENTION	
Stage 2 Enhanced monitoring	There is some variation from agreed plan(s) and a possible delivery risk if no remedial action is taken. At this stage, a Board-led support package or recovery programme should be agreed and implemented. This is the pre-formal escalation stage and risks and/or issues should be raised, either by the Board or by the relevant SG policy lead/s; if necessary, taken to NPPOG for consideration.
FORMAL ESCALATION	
Stage 3 Enhanced monitoring and support	There is significant variation from agreed plan(s). The level of risk is likely to have increased, with performance stagnating or deteriorating below agreed levels, and the Stage 2 Recovery Plan having proved ineffective or insufficient. At this stage, an SG commissioned tailored support package is required and there will be enhanced monitoring of implementation and progress. NPPOG will be informed of progress on a regular basis.
Stage 4 Senior external support and monitoring	There are significant risks to delivery and the Recovery Plan or Tailored Support is not producing the required improvements. At this stage, senior level external support is required, and will report to an Assurance Board chaired by SG. The onus remains on the NHS Board to deliver the required improvements. The Assurance Board will report direct to the Chief Operating Officer for NHS Scotland and DG Health and Social Care. NPPOG will be informed of progress on a regular basis.
Stage 5 Statutory Intervention	At Stage 5, the level of risk and organisational dysfunction is so significant that the NHS Board requires direct intervention using statutory powers of direction.

7.5 It is likely that without further progress to address the level of deficit outlined in the plan that the Health Board's status on this framework will be reviewed during the course of 2024/25.

8 Next Steps

8.1 A Quarter One Review will be undertaken following reporting of the M03 (June) position. This will assess the impact of expenditure trends and cost pressures within the core operational position, as well as review of financial plan assumptions on growth and other economic impacts.

8.2 The Q1 review will also encompass a full assessment of projected savings and any opportunities for financial improvement not already identified within the plan. Where actions are not expected to deliver in line with plan the review will set out options for mitigation against this position, including increased grip & control measures where necessary.

8.3 Improvements to financial reporting including monitoring of cost avoidance measures are expected to be in place from July 2024.

9 Key Risks

9.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 3588). This risk has been updated to reflect the Board's medium term financial plan and financial recovery plan for the period 2024/25 to 2026/27.

9.2 Where identified, risks are currently reported on an individual basis through the DATIX system. A financial risk register detailing individual risks held both operationally and on a corporate basis remains in development and is expected to be in place by end of quarter two (i.e. in advance of 2025/26 financial planning round).

Appendices

- Appendix 1 – Recurring Savings Plans 2024/25: Progress by Gateway

Author(s)

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Appendix 1 - Recurring Savings Plans 2024/25: Progress by Gateway

		Total Schemes			At planning stage			Gateway 1			Gateway 2			Gateway 3			Gateway 3 - Blue		
	24/25 Target	FYE	PYE	Total Schemes	FYE	PYE	Total Schemes	FYE	PYE	Total Schemes	FYE	PYE	Total Schemes	FYE	PYE	Total Schemes	FYE	PYE	Total Schemes
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Acute	(3,129)	3,449	2,851	37	562	215	7	698	482	15	16	16	1				2,173	2,139	14
Commissioning	(1,261)	1,127	1,127	7										54	54	1	1,073	1,073	6
Corporate	(868)	989	941	36	28	17	4	574	539	12	13	13	1	113	113	6	262	260	13
Estates	(296)	391	130	6	390	129	5	0	0	0				1	1	1	0	0	
Facilities	(382)	93	93	10	57	57	8	0	0	0				36	36	2	0	0	
IJB - MH/LD	(652)	1,068	735	27	0	0	0	662	416	15	52	39	1	354	279	11	0	0	
IJB - PACS	(1,844)	2,705	2,605	78	0	0	6	1,574	1,574	33	499	399	6	121	121	9	512	512	24
Organisation Wide	0	350	350	1	0	0	0	350	350	1									
	(8,432)	**10,172**	**8,832**	**202**	**1,037**	**418**	**30**	**3,858**	***3,360***	**76**	**580**	**467**	**9**	**679**	**604**	**30**	***4,019***	***3,983***	**57**

N.B. Recurring target is set at 3%. Table excludes non-recurring savings plans to be reported separately.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Audit & Risk Committee Chair Update Report on Financial Sustainability.**
Responsible Executive/Non-Executive:	**James Ayling, Chair ARC ,Non Executive Director**
Report Author:	**James Ayling, Chair ARC, Non Executive Director**

1 Purpose

This is presented to the Board for:

- Awareness and decision as set out in para 2.4.

This report relates to a:

- Legal requirement

This aligns to the following NHS Scotland quality ambition(s):

- Effective

2 Report summary

2.1 Situation

The Chair of the Audit & Risk Committee (ARC) wishes to bring to the Board's attention a recent Internal Audit report on Financial sustainability which ARC considers is a matter of significance for consideration of the Board . In accordance with practice the said report is referred to the Resources and Performance Committee but it does not meet again until September.

2.2 Background

ARC, at its meeting on 20th May 2024, was presented with an Internal Audit report on Financial Sustainability by the Board's Internal Auditors which provided Partial Assurance with improvement required .

2.3 Assessment

ARC is bringing this report to the Board's attention now as the efficient management of the Financial Improvement Programme is key for NHS Borders and the report highlights a number of areas requiring immediate attention including the following which are assessed as higher risk:

- Senior leadership recognises the part they need to play in supporting the overall financial position, but more work is required to drive collective ownership of the strategic decisions
- Savings and opportunities are identified from across the directorates but there is scope to use a more strategic and methodical approach
- The process for identifying savings should be widened to ensure that the scale of savings required can be identified at pace
- Governance is in place to support Board oversight of the delivery of savings but the FIP Programme Board needs to increase accountability for staff performance in delivering savings

Overall, the review identified that accountability at all levels needs increasing The report indicates that the FIP programme does not yet meet the Board's financial deficit and that decision making and leadership on this, at Board and Executive Team level should be stronger.

A copy of the report is appended hereto.

2.3.1 Quality/ Patient Care

Any implications for this topic are identified within the relevant Internal Audit report, as referenced in the body of the paper.

2.3.2 Workforce

Any implications for this topic are identified within the relevant Internal Audit report, as referenced in the body of the paper.

2.3.3 Financial

Any implications for this topic are identified within the relevant Internal Audit report, as referenced in the body of the paper.

2.3.4 Risk Assessment/Management

Internal Audit is an essential function within the Board's framework for governance and assurance. The report was presented as part of the Board's Internal Audit work plan which aims to assess the effectiveness of the Board's systems of internal control and how these controls will mitigate risks faced by the organisation.

Each report provides details of any risks identified, together with recommendations for how any weaknesses in controls might be improved, where identified.

2.3.5 Equality and Diversity, including health inequalities

There are no immediate issues identified in relation to this topic.

2.3.6 Climate Change

Any implications for this topic are identified within the relevant Internal Audit report, as referenced in the body of the paper.

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement and consultation

Internal Audit reports are prepared through engagement of auditors with relevant stakeholders identified by the Board's designated executive lead for the audit topic.

2.3.9 Route to the Meeting

The report referred to herein was discussed by ARC on 20 May 2024.

2.4 Recommendation

The Board requires to consider the findings of the report referred to herein and decide how it can best assist in implementing the recommendations of said report relevant to its function and responsibilities and in particular how it can strengthen its decision making and leadership on matters relating to the financial deficit all as referred to in said report.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1: Grant Thornton (Internal Auditors) Financial Sustainability Report dated May 2024.

NHS Borders

Internal Audit 2023/24

Financial Sustainability – FIPs

May 2024

FINAL REPORT

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Contents

This report is confidential and is intended for use by the management and directors of NHS Borders. It forms part of our continuing dialogue with you. It should not be made available, in whole or in part, to any third party without our prior written consent. We do not accept responsibility for any reliance that third parties may place upon this report. Any third party relying on this report does so entirely at its own risk. We accept no liability to any third party for any loss or damage suffered or costs incurred, arising out of or in connection with the use of this report, however such loss or damage is caused.

It is the responsibility solely of NHS Borders management and directors to ensure there are adequate arrangements in place in relation to risk management, governance, control and value for money.

Report Distribution

Executive Lead:

- Andrew Bone, Director of Finance

For action:

- Stephanie Errington, Interim Director of Planning & Performance

For Information:

- Ralph Roberts, Chief Executive
- Iris Bishop, Board Secretary
- Audit and Risk Committee

Executive summary

Background

All NHS bodies are experiencing financial pressure and ensuring that resources are directed appropriately and efficiently to deliver in-year organisational objectives and meet the longer-term health needs of the local population is becoming more challenging. In February 2023, the Auditor General for Audit Scotland reported that "The general trend of health spending in Scotland is one of growth. Despite this, NHS Scotland faces significant and growing financial pressures making a financial position that was already difficult and has been exacerbated by the Covid-19 pandemic, even more challenging."

In 2024/25 Territorial Health Boards, including NHS Borders, have been set a minimum 3% savings target under the sustainability and value framework by the Scottish Government. This equates to £9 million. It is recognised that this target will not meet the overall deficit that is expected in 2024/25 and NHS Borders would need to deliver a significantly higher percentage of savings to deliver a balanced budget. The scale of this is being worked through in the Medium Term Financial Plan (MTFP). The Scottish Government has shared communication with the Board stating their expectations including additional controls around expenditure to be taken in 2023/24 and into 2024/25 as the current position is not sustainable.

Objectives

Our review focussed on the following key risks:

- Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.
- The quality of the process for identifying savings to be taken forward is insufficient.
- For agreed savings schemes, roles and responsibilities, timescales and anticipated benefits are not clearly identified and not monitored against.
- Appropriate action is not taken where necessary to ensure that planned savings are delivered in full and to agreed timescales and the Board does not have appropriate sight of the overall position and any reasons for variances.

Limitations in scope

Please note that our conclusion is limited by scope. It is limited to the risks outlined above. Other risks exist in this process which our review and therefore our conclusion has not considered. Where sample testing has been undertaken, our findings and conclusions are limited to the items selected for testing.

Delivering savings is a continual process which, when broken down, has four specific stages, all of which must work effectively, or the pipeline is broken. There is no single approach to delivering savings and organisations have to build and develop a culture where all employees take responsibility for their part in delivering savings. We will not assess the quality of the overall financial plan and the assumptions made within that. Nor the assessment of whether saving plans have delivered their longer-term benefits.

This report does not constitute an assurance engagement as set out under ISAE 3000.

Acknowledgement

We would like to take this opportunity to thank your staff for their co-operation during this internal audit.

Headline messages

Conclusion

Partial assurance with improvement required

We have reviewed the processes and controls around the management of the Financial Improvement Programme (FIP) and have concluded that the processes reviewed have provided PARTIAL ASSURANCE WITH IMPROVEMENT REQUIRED. This was confirmed through testing in specific areas of the organisation, review of documentation and discussions with key individuals and management.

The objectives reviewed are set out on the following page with the assurance rating we have assessed for each one and the number of recommendations raised. We have reported by exception against the areas where we consider that Management and the Audit and Risk Committee should focus their attention.

The scale of the financial challenge is such that further action from management is required to deliver financial balance. The Board is aware of this and is taking actions to drive additional saving opportunities where possible. The scope of this review is to assess controls and processes in place during 2023/24. However, we have highlighted areas in this review where we consider processes should be strengthened going forward and have reported these future actions as improvement recommendations.

All staff interviewed were aware of the controls and processes. Whilst there were some areas where we identified good practice, we also recommend that existing controls and processes should be strengthened in a number of areas. We are not proposing that controls and processes should be changed as this focuses staff on the process again, and they should now be focused on delivery. The areas which have been assessed as higher risk are summarised below:

- Senior leadership recognises the part they need to play in supporting the overall financial position but more work is required to drive collective ownership of the strategic decisions required – the financial position is driving the need for difficult and potentially unpalatable decisions to be made. During such times, Executive leadership needs to be decisive to ensure that staff are empowered to deliver against their directions.
- Savings and opportunities are identified from across the directorates but there is scope to use a more strategic and methodical approach – the longer-term service delivery model should be informing which Business Units can deliver a higher value of savings and how pathway redesign can be worked towards to create efficiencies.
- The process for identifying savings should be widened to ensure that the scale of savings required can be identified at pace – a blend of top-down thematic savings and bottom-up efficiency savings should be used to achieve the savings targets required.
- Governance is in place to support Board oversight of the delivery of savings but the FIP Programme Board needs to increase accountability for staff performance in delivering savings – we identified an appetite for the FIP Programme Board having more 'teeth' and helping staff overseeing FIP projects to retain more grip and control over projects, holding them to timescale and delivering the level of savings required.

Overall, our review identified that accountability at all levels needs increasing. Several people interviewed commented that pre-Covid c.£7 million of savings were delivered with a strong focus on financial accountability. From March 2020, as a consequence of the Covid-19 Pandemic and in line with Scottish Government requirements, greater priority was placed on clinical service delivery, Covid service response and Covid recovery. This approach needs to be urgently rebalanced to allow the Board to make the decisions which deliver the savings required to regain financial balance.

Headline messages

Conclusion

We have raised 15 recommendations. The grading of these recommendations based on risk, is summarised in the table below.

Risks	Assurance rating	Number of recommendations			
		High	Medium	Low	Imp
Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.	Partial assurance with improvement required	2	-	1	2
The quality of the process for identifying savings to be taken forward is insufficient.	Partial assurance with improvement required	1	1	1	-
For agreed savings schemes, roles and responsibilities, timescales and anticipated benefits are not clearly identified and not monitored against.	Partial assurance with improvement required	-	1	2	-
Appropriate action is not taken where necessary to ensure that planned savings are delivered in full and to agreed timescales and the Board does not have appropriate sight of the overall position and any reasons for variances.	Partial assurance with improvement required	1	1	1	1

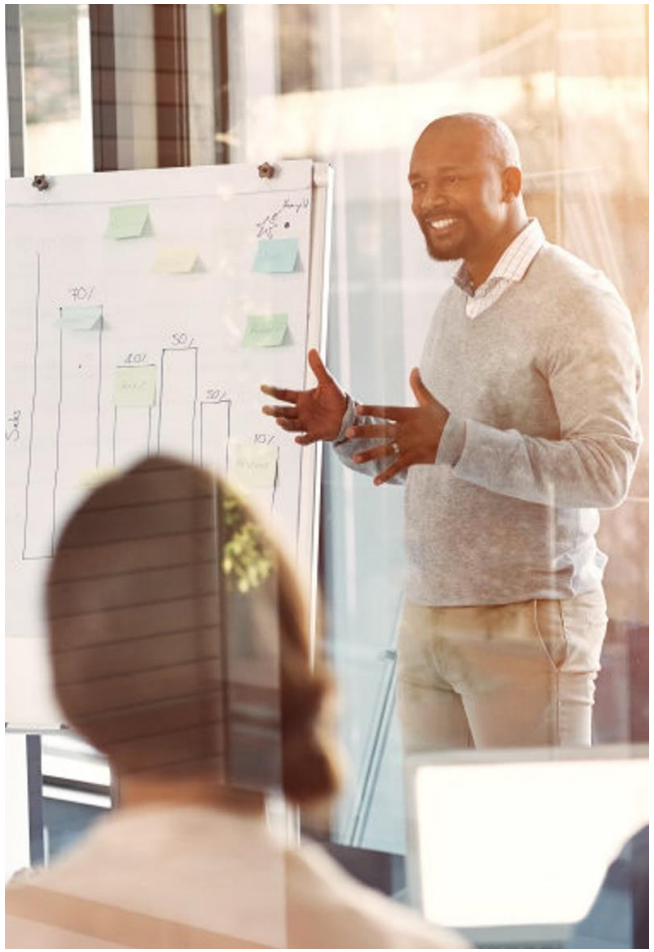
Summary of findings

Examples of where recommended practices are being applied

- There is a good level of resource to oversee the development and delivery of the FIP programme, including a dedicated PMO team , a planning team, a FIP Board, sub-committees of the FIP Board and roles within the Finance Department and responsibilities with the Business Units Quadrumvirates.
- Project Management documentation is developed including a set of core documents which will support the delivery of larger-scale saving projects and initiatives.
- The identification of savings is seen as a continual, all year process, and not an annual exercise, although there is still work to do to identify sufficient savings to be where the Board needs to be.

Areas requiring improvement

- The organisations FIP programme does not yet meet the Board's financial deficit. Decision making and leadership on this, at Board and Executive Team level should be stronger.
- Identification of savings should be more strategic and methodical working through all data available and looking at themes across the organisation.
- There is no standardised process or criteria for assessing and selecting ideas as FIP projects. The ideas spreadsheet should be cleansed to allow focus on the most promising ideas.
- The FIP Board, sub-committees to the FIP Board and Business Unit Quadrumvirates do not have agreed and ratified Terms of Reference.
- PMO resource should be used more efficiently to support larger-scale projects and initiatives rather than managing small-scale projects.
- Key documents required should be consistently used to support oversight.
- Accountability for delivering savings is lacking and should be strengthened through the role of the FIP Programme Board. Information to support this should be reported.



Detailed findings & action plan

1.	Partial assurance with improvement required	Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.

Finding and implication	Audit recommendation	Management response, including actions
<u>The strategic direction for service delivery in the long term needs to be set to support decision making which impacts the delivery of savings</u> Senior Leadership has a role in setting the strategic decision and then taking actions which enable the organisation to deliver against these. The setting of a strategic vision, underpinned by aligned strategies, including a Medium-Term Financial Plan, remains a work in progress at NHS Borders and the Board is aware that this remains a priority. Balancing quality, safety and performance in a dynamic and financially challenged environment continues to be a national issue for all NHS bodies. Work is in progress to develop what the future delivery plan should look like, but until this is concluded, and whilst managing current risk, it is difficult for the Executive Team to make financial decisions which work towards this. The Board met in December 2023 to identify 'big ticket' organisational changes to deliver savings to bridge the gap. From our interviews, we have confirmed recognition at all levels that savings on a larger scale are required which will need to include changes in service delivery models. Staff we spoke to are keen that the Senior Leadership Team identifies larger scale savings, which is likely to involve unpalatable decisions, but will provide a financially sustainable direction for the Board in the medium to longer-term. Regular meetings with Scottish Government and internal workshops are in progress to help drive these decisions, but action is required to ensure that a medium-term financial plan is in place as soon as practically possible with any final decisions being supported by data and evidence. We have raised an improvement recommendation as whilst this is outside the scope of this review, it is a key inhibitor for delivering financial savings and underpins the risks identified in this review.	**Improvement Recommendation 1** The Board should develop a Medium-Term Financial Plan which is • linked with an overall set of strategic objectives to deliver the Board's strategic vision • aligned with key strategies (clinical, operational, workforce and estates) • underpinned by analysis which is sufficiently detailed to enable the spread of savings according to areas of disinvestment, changes in patient pathways or where services need to grow This will enable financial decisions, including where investments and savings should be made, to drive the Board to its future service delivery model whilst continuing to deliver safe and effective care.	**Actions:** A revised financial framework will be developed in advance of the 2025/26 financial planning round which sets out the linkages between board strategy and operational plans and how information in support of these plans will be prepared. **Responsible Officer:** Andrew Bone **Executive Lead:** Andrew Bone, Director of Finance **Due Date:** 30/09/2024

Detailed findings & action plan

1.	Partial assurance with improvement required	Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.

Finding and implication	Audit recommendation	Management response, including actions
<u>Senior leadership recognises the part they need to play in supporting the overall financial position, but more work is required to drive collective ownership of the strategic decisions required.</u> The Board is currently operating beyond its means. The 3% efficiency target set by Scottish Government will not address the deficit position. Clinical engagement for delivering financial savings was considered strong pre-Covid by those we interviewed, but operational and workforce pressures mean that whilst there is still support from senior Clinical staff, there is also a strong focus on patient safety, staff impacts and clinical delivery within the organisation which opposes the financial decisions needed to deliver financial balance. There is therefore tension with the competing priorities which is preventing key financial decision making from happening. Review of the minutes for the December 2023 Board meeting highlights these conflicting pressures. The Board was sighted on the clinical and staffing challenges and the longer-term requirement for transformation required for any financial investment as required by the Scottish Government. Recognising the risk and the need to sustain a safe Emergency Department (ED) within the current system, the Board agreed the additional spend of £1.9 million could be included in the draft financial plan, alongside support for the work required to develop a strategic vision and redesign of Unscheduled Care pathways to deliver the future model of ED service delivery. The Board agreed the release of the additional funds should not take place until the overall Financial plan could be agreed. There was no timescale set for the further consideration of future service models. Financial risk should have as much focus as clinical and staffing risks.	**Recommendation 2** Decisions made by the Board require sufficient financial focus, balanced against clinical and staffing pressures, to ensure that the longer-term ambition of delivering financially sustainable services can be met. Increased and sustained engagement from the whole Board to deliver savings at the scale and pace required should be achieved, with better collective ownership of the strategic decisions the Board needs to make across services to achieve the longer-term service delivery model, once agreed. This should then filter down to middle management and the wider staffing body.	**Actions:** 1. Balance of risk / priority discussed with Board members at Board development session on 2nd April 2024. A further discussion with Non-Executive Members will be held to determine what further action is required to address this recommendation. 2. The Board's strategic decision making framework will be reviewed in the context of the current financial position and any changes agreed in partnership with the IJB. **Responsible Officer:** As per Executive Lead(s) **Executive Lead:** 1. Ralph Roberts, Chief Executive Officer 2. Steph Errington, Interim Director of Performance & Planning **Due Date:** 1. 30/05/2024 2. 31/12/2024

Detailed findings & action plan

1.	Partial assurance with improvement required	Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.

Finding and implication	Audit recommendation	Management response, including actions
<u>Savings and opportunities are identified from across the directorates but there is scope to use a more strategic and methodical approach</u> We have assessed the process to identify the 2023/24 savings opportunities. • A 2% savings target was initially shared across all departments which was considered by those we interviewed as fair. • Steps were then taken to identify further savings from within each directorate. • Discussion was held across the whole Board so everyone was sighted on the savings required Financial pressures have increased in year, so the approach to identifying 2024/25 savings has been slightly different. • A 3% savings target has been shared across the Corporate Directorate and Clinical Board. • There has then been a focus on productivity and efficiency. This isn't always cash-releasing, but additional capacity has helped with operational performance initially and will drive capacity in the longer-term which provides opportunities for space to implement service transformation. • Service reviews remain on-going, e.g. Women's and Children's. • The CEO has set a '90% challenge' – "what would the service look like if delivered with 90% of the budget?" which all services are aware of but this has not been worked through in all areas to date and not written into the FIP programme. We have concluded that a more strategic and methodical process should be introduced to drive the increased savings now required.	**Recommendation 3** A more strategic and methodical approach is required to drive the level of savings required by the Board. Ideas for potential savings, both recurring and non-recurring, should be collated from Business Units using a consistent strategic approach, giving consideration to a range of factors, including: • Productivity and performance • Benchmarking data and information available • Size and complexity of service provision • Workforce, patient safety and other relevant issues already aware of • Transformational opportunities (90% challenge thinking).	Changes have already been implemented for the 2024/25 planning round, including scoping of transformation 'bundles' through executive led workshops. **Actions:** A revised financial framework will be developed in advance of the 2025/26 financial planning round. This will include description of how savings plans are to be identified and developed. **Responsible Officer:** Andrew Bone **Executive Lead:** Andrew Bone, Director of Finance **Due Date:** 30/09/2024

Detailed findings & action plan

1.	Partial assurance with improvement required	Savings opportunities are not identified from across the directorates with a lack of recognition from senior leadership on the part they need to play in supporting the overall financial position.

Finding and implication	Audit recommendation	Management response, including actions
<u>Savings targets within each Directorate should be identified and deliverable</u> Financial plans and budgets highlight savings required. In some cases, these savings are not identified or fully developed. There is also opportunity for the Board to communicate a higher expectation of savings, which allows for some schemes not delivering or overspends in other areas. This would provide some contingency and allow directorates to maintain a more realistic focus on achieving their overall budget. <u>Looking forward</u> One interviewee commented that staff like an exact target to work to and in some cases the message has been to 'deliver as many savings as possible' which they struggled with. Savings discussions could provide a baseline, an expected and an ambition range to support staff in managing their delivery and help day to day decision making, whilst still delivering the overall financial target. As this is a suggestion for future development, we have raised this as an improvement recommendation.	**Recommendation 4** All savings included within budgets should be identified and achievable. It is also helpful for Directorates to have additional savings plans which could be delivered over and above those needed to balance their budgets to provide some contingency.	A revised template has been implemented during 2024/25 planning round which includes additional data to support assessment of delivery risks. Targets have been set on a three year basis and business units required to set out opportunities across the medium term to support longer term planning. **Actions:** A revised financial framework will be developed in advance of the 2025/26 financial planning round. This will include description of how savings plans are to be identified and developed, including how contingency planning will be addressed. **Responsible Officer:** Andrew Bone **Executive Lead:** Andrew Bone, Director of Finance **Due Date:** 30/09/2024
	Improvement recommendation 5 Setting a range of savings targets for Business Units (must do, should do, could do style), may help those people who like to work to structured targets and may be a way of introducing stretch and some element of competition within teams.	This finding has attracted an 'Improvement Point' as opposed to a formal recommendation, and as such does not require a management response.

Detailed findings & action plan

2.	Partial assurance with improvement required	The quality of the process for identifying savings to be taken forward is insufficient.

Finding and implication	Audit recommendation	Management response, including actions
<u>The process for identifying savings should be widened to ensure that the scale of savings required can be identified at pace</u> Interviews confirmed that the identification of savings mainly uses a bottom-up approach, engaging the Business Units to meet the savings required. This relies upon staff providing ideas and having whole service thinking. The focus is on whether savings are identified, rather than 'what could we save if we did things differently' (see Recommendation 3 referencing 90% challenge). We were informed that if saving targets are achieved that is considered enough rather than providing stretch where the Board can deliver. It therefore focuses on those savings which are easier to identify and deliver, but together take a disproportionate amount of governance time which curtails the headspace for strategic thinking. Whilst there is some focus on top-down savings focusing by theme, e.g. reducing headcount, reducing premises etc. this is delivered at a business unit level and doesn't look wider for wholesale transformation and service redesign which is where the scale of the financial challenge is driving the Board. There is also no evidence that external information is being used fully to drive savings. Themes should be applied strategically and consistently across all service areas (see **Recommendation 3**). But this takes time and should enhance the bottom-up savings where operational staff see potential savings day to day. We were informed that staff focus on the smaller items which indicates a shift in thinking is required for staff to recognise the level of change which is required. Transformation will require leadership and management time which is currently used up with processing smaller, low value schemes. PMO resource and governance should be used for top-down and bottom-up should be business as usual and managed as part of budgets.	**Recommendation 6** The Board should have two dedicated strands to their savings identification, (ideas from the Business Units and thematic Board-wide programmes) to ensure that there is a blend of ideas working towards the delivering of financial savings targets. Appropriate resource and governance should be allocated to each strand.	**Actions:** A revised approach to identification of savings will be implemented which combines a 'top down' and 'bottom' up approach. This approach has been implemented for 2024/25 planning round and has supported development of transformation 'bundles' through executive workshops and local savings plans via business unit submissions. [To be embedded in the revised financial framework to be prepared for the 2025/26 financial planning round]. **Responsible Officer:** Andrew Bone, Director of Finance **Executive Lead:** Ralph Roberts, Chief Executive Officer **Due Date:** Implemented

Detailed findings & action plan

2.	Partial assurance with improvement required	The quality of the process for identifying savings to be taken forward is insufficient.

Finding and implication	Audit recommendation	Management response, including actions
<u>There is a high volume of potential savings ideas which needs to be appropriately managed</u> Interviews with senior management, and a review of the 'Ideas Log' shared by the PMO team, identified that: • there is a high number of ideas on the spreadsheet, some of which were submitted pre-Covid and are still waiting for consideration • ideas submitted during 2023/24 is not equally distributed across services, with the highest proportion of ideas coming from Acute services (20%), compared with only 2 ideas from Mental Health and Learning Disability Services • the spreadsheet also contains ideas from external reviews, e.g. Scottish Government and a review by a Consultancy firm which give areas for investigation rather than formal ideas • ideas are categorised and assigned to a workstream / project Staff informed us that they try to regularly cleanse the spreadsheet but there remains a considerable number of ideas still requiring analysis. There is a capacity issue within the PMO team to work through in the detail to determine which ideas have potential to move to the next stage of project management. We recommend a high-level exercise is undertaken to 'triage' the ideas and pass ones which are lower value and could be managed locally back to Business Units. Further analysis can then be undertaken, allowing a focus on the larger, more profitable savings. Undertaking the detailed governance process on all savings identified as having potential reduces capacity of the PMO team to focus on the larger transformational ideas.	**Recommendation 7** Ideas on the spreadsheet, and any further ideas submitted as potential savings should be triaged in a timely way to categorise as to whether they should be passed back to the Directorate to implement or taken through the PMO governance process. At this stage, there should also be consideration of whether the spread of savings is proportionate to each service across the organisation and which areas need more support to identify savings. The PMO should focus on schemes (FIPs) of higher value and with longer term timescales for transformational change.	All services/business units are subject to revised savings targets issued for 2024/25. This ensures savings targets are equitable on basis of budget size. **Actions:** 1. A monthly meeting will be established to triage all ideas submitted as potential savings to the appropriate directorate, workstream or transformation programme. 2. FIP Board and FIP Steering Group meetings will operate to standing agenda which includes review of savings plans identified against target and resources required to support identification, planning and delivery of savings. 3. PMO capacity and workplan will be reviewed. This will include consideration of how priorities are set and support available to transformation programmes. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** 1. Andrew Bone, Director of Finance 2. Andrew Bone, Director of Finance 3. Steph Errington, Interim Director of Performance & Planning **Due Date:** 1. 31/05/2024 2. 31/05/2024 3. 30/06/2024

Detailed findings & action plan

2.	Partial assurance with improvement required	The quality of the process for identifying savings to be taken forward is insufficient.

Finding and implication	Audit recommendation	Management response, including actions
<u>No standardised approach for Quadrumvirates to assess ideas has been agreed.</u> There is a quadrumvirate (known locally as 'Q') for each Business Unit which brings together representatives from middle Management, Clinical, Finance, and Quality staff). Workforce and Partnership representatives are also involved as necessary. This process assesses whether ideas have the potential to move to the next stage. These meetings are minuted to record the discussion. If not progressed, this is reported back to the PMO. We identified that there are no agreed criteria to select an idea to move forward. Our interviews revealed that some staff considered these forums to lack positivity from clinical staff who can be risk averse, or see potential for reduced headcount etc. We have not seen evidence of this within minutes, but recognise that bringing staff together with differing backgrounds will always require a level of compromise. It was also commented that any use of the word transformation is seen as investment by clinical staff rather than changing the way services are delivered which may provide savings. These views link back to **recommendation 2** where there needs to be an appropriate balance between financial, clinical and staffing risks and this should be throughout the Board, not just senior management. Our review of a sample of Q draft terms of reference (ToR) highlighted that responsibilities in relation to financial savings, the FIP programme, and assessing ideas for potential FIP projects were not included. Clear documentation of the Quadrumvirate's approach and responsibilities in relation to FIP projects and the FIP Programme would strengthen their ToR and ensure consistency across the Board.	**Recommendation 8** The Quadrumvirates approach and responsibilities for supporting the FIP process should be documented in approved and ratified ToR, including: • criteria for progressing ideas for further development • timescales for receiving, reviewing and approving ideas Any training and awareness required should be supplied by the PMO to further ensure consistency.	**Actions:** 1. Terms of Reference (ToR) for Quadrumvirates and Clinical Boards will be reviewed via the Board's Business Process review group. This will include consideration of responsibilities in relation to FIP process. 2. Guidance for FIP process will be reviewed and reissued to relevant managers to ensure that expectations are clear and support improved consistency of approach. **Responsible Officer:** 1. Steph Errington, Interim Director of Performance & Planning 2. Jess Kandulu, PMO Manager **Executive Lead:** 1. Steph Errington, Interim Director of Performance & Planning and Andrew Bone, Director of Finance 2. Steph Errington, Interim Director of Performance & Planning **Due Date:** 1. 30/09/2024 2. 30/06/2024

Detailed findings & action plan

3.	Reasonable assurance with some improvement required	For agreed savings schemes, roles and responsibilities, timescales and anticipated benefits are not clearly identified and not monitored against.

Finding and implication	Audit recommendation	Management response, including actions
<u>The PMO service provision could work more efficiently and effectively</u> The Project Management Office (PMO) is employed to support the Business Units deliver their projects within the Financial Improvement Programme (FIP). PMO capacity should be focused on areas where they can have the greatest impact. The return on investing in the PMO team should be evident. It has been reported to us that PMO capacity is at times being used for other work, such as addressing performance issues and service improvements. Discussions with senior management highlighted areas where the PMO could work differently to strengthen their support for delivery of the FIP programme. • PMO skills should be focused on larger projects including complex, transformational or cross cutting savings • a capacity limit should be set for the PMO to drive strategic decisions when larger projects are identified so the impact of ceasing support on smaller projects is understood and managed appropriately • a cap on how many projects can be managed each year should be considered and the grouping of projects into themes to gain efficiencies – too many projects dilutes the impact of the PMO • The current focus on lower value schemes reduces analytical capacity which could be directed to the ideas with greatest potential once triaged (see **recommendation 7**) • Business Partners have identified differing approaches on PMO engagement with Business Units and there is opportunity for greater consistency and good practice being shared. Inclusion of clinicians at an early stage was noted as having the best outcomes	**Recommendation 9** The PMO should be reviewed to ensure capacity and skills remain appropriate and there is effective use of the resource available. Consideration should be given to the following: • PMO capacity to be quantified and resource directed in the most effective way to support FIP projects, potentially within themes • the balance between project management and analysis of new projects to be assessed • any PMO training needs to be identified and addressed • criteria for 'just do it' projects should be introduced, e.g. projects with higher savings and requiring minimal action and management • streamlined process / documentation to be introduced for 'just do it' projects • agreed approaches to supporting Business Units to be identified and used across the PMO for consistency and sharing of good practice	**Actions:** PMO capacity and workplan will be reviewed. This will include consideration of how priorities are set and support available to transformation programmes; the review will also consider how resources are allocated, identification of business as usual activities; guidance and training. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** Steph Errington, Interim Director of Performance & Planning **Due Date:** 30/06/2024

Detailed findings & action plan

3.	Reasonable assurance with some improvement required	For agreed savings schemes, roles and responsibilities, timescales and anticipated benefits are not clearly identified and not monitored against.

Finding and implication	Audit recommendation	Management response, including actions
<u>PMO governance is considered effective by staff but we identified gaps in the paperwork</u> The PMO works closely with the Business Units and Finance, supported by the Business Partners who report into each FIP Steering Group and up to Board. There are trackers and analysis which goes to Board. Interviews with staff provided an agreed view that the process and governance around delivery plans is good once a project is live and focus should now be on delivery. Each project has a scope, timeline, project plan and risk register, four pieces of key documentation. We reviewed project documentation for three projects selected by the PMO, and instances where documentation could be improved: • Only one project scope named the full MDT supporting the project with one not naming any project or service lead • Varying templates of the project scope were used, with only one of the three documents completed • Varying levels of detail were recorded within the three project plans, with one including an action tracker and another including only key milestones • Only one project plan named all stakeholders involved with one not identifying responsible individuals or teams • Documents were filed with various titles rather than using a standardised filing structure. Review of the FIP programme tracker highlighted that only 62% of FIPs had a mandate in place. Also, the programme tracker does not indicate whether project documents are in place for each FIP. These issues support the view from interviewees that too many projects is generating excessive paperwork. (see **recommendation 9**).	**Recommendation 10** The PMO should ensure that paperwork for each project is proportionate, completed in a timely manner and supports delivery enabling key information to be easily accessed. Consideration should be given to: • Developing a standardised file structure and naming convention for key project documentation to enable easy retrieval of key information • Revising the tracker so that the development and approval of project documentation can be monitored to ensure complete • Ensuring all FIP projects have at least the core project documents and the mandate in place and these are completed in full and in a timely manner • Building a detailed action log into the project plan template document to ensure action can be monitored closely and assure progress is being made • Identifying what core information is required for 'just do it' projects	**Actions:** Develop organisational PMO standard approach to project management to include quality checks at all stages, specifically: completion of documentation, assurance of progress, tracking of actions and a pathway for low-complexity projects. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** Steph Errington, Interim Director of Performance & Planning **Due Date:** 30/06/24

Detailed findings & action plan

3.	Reasonable assurance with some improvement required	For agreed savings schemes, roles and responsibilities, timescales and anticipated benefits are not clearly identified and not monitored against.

Finding and implication	Audit recommendation	Management response, including actions
<u>There are no standardised time restraints for a FIP project to be in a Gateway</u> The project process has 4 defined gateways and savings ideas move through these as they develop into projects. We were informed that whilst most projects moved forwards there is no barrier to projects moving backwards if they need rescoping at a previous gateway. There are no time constraints for a project to sit within a single gateway. We were informed that time within each gateway is recorded but review of the FIP programme tracker supplied by the PMO Team highlighted that the time spent in each Gateway is not easily identifiable, with numerous inaccuracies found: • the date recorded that a project entered a Gateway was recorded as the same throughout the project for 52 of the 107 projects (49%) on the Tracker • for one project, no date was recorded when entering Gateway 1 causing a fault in the dates recorded for all remaining Gateways PMO resource should be directed to projects which have the greatest opportunities to deliver savings on a larger scale. Effort should not be continually directed to projects which require disproportionate time to move forward. Ensuring that accurate dates are recorded will provide one source of evidence to inform strategic decisions made by the PMO and FIP Board to divert PMO attention away from projects which are taking too long, and ensure that the focus can remain on the projects which have could have greatest success in delivering transformational savings in the shortest timescale.	**Recommendation 11** Ensure accurate information is recorded for projects moving between Gateways to provide additional information to inform strategic decisions on where PMO resource should be directed. This information should be added to the quarterly transformation progress reports to provide data in one forum and allow projects at risk of staying in one gateway for too long or missing key target milestones to be held to account more easily.	**Actions:** 1. PMO mandate paperwork will be adapted to capture target dates for project gateways. 2. FIP Steering Group meetings will operate to standing agenda which includes review of progress against milestones for Gateway progress. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** 1. Steph Errington, Interim Director of Performance & Planning 2. Andrew Bone, Director of Finance **Due Date:** 1. Implemented 2. 31/05/2024

Detailed findings & action plan

4.	Partial assurance with improvement required	Appropriate action is not taken where necessary to ensure that planned savings are delivered in full and to agreed timescales and the Board does not have appropriate sight of the overall position and any reasons for variances.

Finding and implication	Audit recommendation	Management response, including actions
Risks and Issues logs are not completed The PMO engage in bi-monthly meetings with Business Units and discuss any risks and issues relating to individual FIP projects via review of a core project document, the Risk and Issues Log. Review of examples of Risk and Issues Logs highlighted that although there was evidence that risks and issues are discussed frequently, there were gaps including: • some issues were not listed • not all risks had named owners • the current status of risks was not always clear • the potential impact a risk or issue may have was not clear There is scope to use this document more consistently and effectively to manage risk and flag areas where additional management oversight is required, including managing barriers to progress which occur.	**Recommendation 12** To enable the management of risks and issues, challenges and barriers to a FIP project, the PMO team should ensure the Risk and Issue Logs are maintained and capture all relevant information to support discussion, management and escalation of items when appropriate.	**Actions:** Develop PMO standard approach to project management to include quality assurance of risks and issue logs for all projects. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** Steph Errington, Interim Director of Performance & Planning **Due Date:** 30/06/2024
Project Closure reports are not being used Management informed us that upon completed delivery of a FIP project a closure report is shared with the Services. Review of the template Project Closure report indicated that this report is required to be produced by the Project Manager on completion of a project and shared with the project Board for formal approval. We were informed that this stage of the process has not been implemented yet due to the PMO being relatively new, and most projects still being in progress. No examples of the closure report were available for us to review.	**Recommendation 13** To enable full implementation of the project management process of delivering FIP projects, and to enable the organisation to learn from the delivery of projects as well as celebrate any successes, the Closure report should be piloted and embedded into practice.	**Actions:** The project closure report will be adopted as standard practice from April 2024. **Responsible Officer:** Jess Kandulu, PMO Manager **Executive Lead:** Steph Errington, Interim Director of Performance & Planning **Due Date:** 30/04/2024

Detailed findings & action plan

4.	Partial assurance with improvement required	Appropriate action is not taken where necessary to ensure that planned savings are delivered in full and to agreed timescales and the Board does not have appropriate sight of the overall position and any reasons for variances.

Finding and implication	Audit recommendation	Management response, including actions
<u>Governance is in place to support Board oversight of the delivery of savings but the FIP Programme Board needs to increase accountability for staff performance in delivering savings</u> The CEO is accountable for financial performance so there is clarity at an Executive level of the financial challenge facing the Board. The CEO has a high profile within governance meetings as he attends the bi-monthly Area Medical Committee (AMC), and the two sub-committees of this, to drive clinical engagement and ensure a strong profile for delivering savings. The CEO chairs the FIP Programme Board so there is a clear understanding of the current position in relation to the delivery of savings. This Board has a strategic overview and can drive savings on a wider or more transformational scale, but the financial challenge is driving shorter term thinking. It is the forum for understanding where there are gaps, what solutions are required and holding staff at all levels of the Board to account for their performance against project plans. Feedback from all interviews confirmed that there is scope, and even a strong appetite, to increase the role of the FIP Programme Board in holding those responsible for delivering savings to account within the formal meeting and not having individual conversations. The FIP Programme Board does not report directly to the Executive Team, although there is a significant overlap in membership and the Director of Finance reports progress on savings to the Executive Team as part of his report from the Performance and Resources Committee. Our attendance at Audit and Risk Committee and by inclusion of work in our annual Internal Audit Plan, we have evidence confirming their role as having oversight of the governance around delivery.	**Recommendation 14** The FIP Programme Board should increase its expectations around delivery and hold project leads to account where savings are not being delivered to plan. This could include: • setting clear expectations of thresholds for scrutinising project plans, calling leads to meetings to explain performance and redirecting resource as necessary • receiving reports on strategic themes to understand progress on projects across different Business Units • focusing on areas which have been identified as higher risk to mitigate barriers or blockages and understanding if there are themes indicating cultural issues within the Board • recognising actions which support longer-term, recurrent savings and ensuring there are realistic timescales which ensure these maintain momentum and focus • recognising success and ensuring that this is communicated throughout the wider Board	**Actions:** An accountability framework will be developed which sets out expected levels of performance, monitoring arrangements, and escalation triggers for issues arising and how these will be resolved. **Responsible Officer:** Andrew Bone, Director of Finance and Steph Errington, Interim Director of Performance & Planning **Executive Lead:** Ralph Roberts, Chief Executive Officer **Due Date:** 30/06/2024

Detailed findings & action plan

4.	Partial assurance with improvement required	Appropriate action is not taken where necessary to ensure that planned savings are delivered in full and to agreed timescales and the Board does not have appropriate sight of the overall position and any reasons for variances.

Finding and implication	Audit recommendation	Management response, including actions

Governance around the FIP Board should be strengthened
 	
Interviews with key stakeholders identified that individuals and teams are aware of their roles and responsibilities to provide oversight and management of the FIP programme. Whilst meetings are not formally minuted, an action tracker is maintained. Our review identified that it is difficult to cross-reference actions or decisions to specific projects.
 	
We identified two key areas where we consider processes could be strengthened.
• The FIP Board's Terms of Reference (ToR) are not yet ratified, and whilst people interviewed said they were clear, review of the draft document highlighted a lack of clarity in relation to the FIP Board's roles and responsibilities. We also noted that the Quadrumvirates' ToR are not consistent or ratified (see **Recommendation 8**).
• Quarterly transformation progress reports from the PMO to the FIP Board were reviewed. These appear to be more of a tracker rather than a report to hold people to account over delivery and performance, and we consider could be strengthened by:
  • preceding the tabular format of the projects, a narrative could be included to provide an overall position statement of the programmes with any highlights or exceptions for the Board to note
  • the author and recipient of the report should be added for clarity
 	
Strengthening accountability and allowing people with responsibility for delivery of savings to recognise the authority of the FIP Board will help the PMO and Business Partners to drive delivery within the Business Units.
	Recommendation 15
	
	Governance around the FIP Board should be strengthened including:
	• ensuring the ToR includes clarity on responsibilities
	• approving and ratifying the FIP Board ToR
	• providing additional information to the FIP Board in the quarterly transformation progress reports to ensure that they can more easily hold programme SIROs to account and support other groups with oversight to also hold to account
		Actions:
		
		FIP Board Terms of Reference (ToR) will be reviewed and presented to the Quality & Sustainability Board for approval. This review will include clarification of roles & responsibilities and performance reporting requirements.
		
		Responsible Officer: Andrew Bone, Director of Finance and Steph Errington, Interim Director of Performance & Planning
		
		Executive Lead: Ralph Roberts, Chief Executive Officer
		
		Due Date: 30/06/2024

Appendices

Appendix 1:
Staff involved and documents reviewed

Staff involved

- Ralph Roberts, Chief Executive
- Andrew Bone, Director of Finance
- Janice Cockburn, Deputy Director of Finance
- Paul McMenamin, Deputy Director of Finance
- Steph Errington, Head of Planning & Performance and Interim Director of Planning & Performance
- Jess Kandulu, Programme Manager

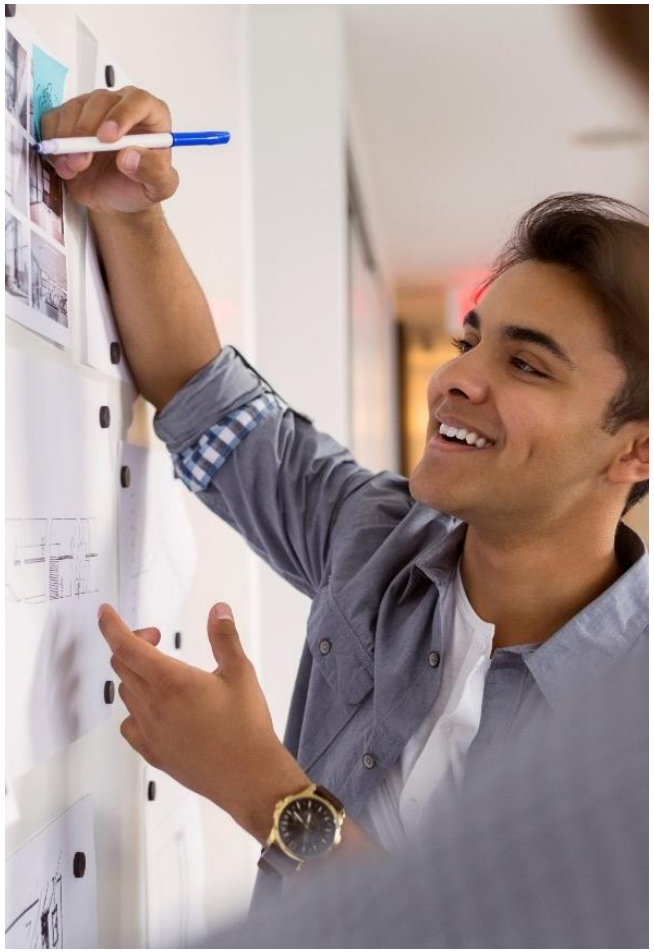
Documents reviewed

- FIP Ideas Log
- FIP Programme Tracker
- PMO reports to FIP Board
- Project Documentation (Templates)
- Project Documents (3 x Examples)
- FIP Board Terms of Reference
- Quadrumvirates Terms of Reference
- Transformation Progress Report, Q2, 2023/24
- Sub-Committees to the FIP Board meeting documentation
- FIP Board meeting documentation
- Bi-monthly meeting with Business Units meeting documentation

Appendix 3:
Good practice from other organisations

Examples of good practice identified at other NHS bodies

- Savings are kept as two separate streams for those which release cash, and those which generate efficiency / productivity savings. Only cash-releasing savings are reported through the FIP programme. The PMO supports both, but they are managed as two separate streams.
- Having a list of 'unpalatable' savings, worked up and with savings quantified in a list supports decisions should they need to be made. Staff can see the options and take these decisions should they need them. This enables difficult conversations to happen which can be helpful in bringing previously discounted ideas to fruition.
- Saving owners are those who have the greatest accountability rather than responsibility. One body always makes this the budget holder.
- Initial triage of savings works well with a proforma (so information is consistently presented) being submitted to a panel. This enables faster decision making on where resources should be focused to further develop thinking and take to the next stage.
- Encouraging staff to come forward with savings ideas from their own area, one body ran an annual Dragon's Den event. Offering a small budget for the winner for their idea to be developed, with the inventive was that any savings generated would be reinvested in their area to support further transformation.



Appendix 3:
Our assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating	Description
Reasonable assurance	Overall, we have concluded that, in the areas examined, the risk management activities and controls are suitably designed to achieve the risk management objectives required by management. These activities and controls were operating with sufficient effectiveness to provide significant assurance that the related risk management objectives were achieved during the period under review. Might be indicated by no weaknesses in design or operation of controls, only LOW rated recommendations or only IMPROVEMENT recommendations.
Reasonable assurance with some improvement required	Overall, we have concluded that in the areas examined, there are only minor weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review. Might be indicated by two or more minor weaknesses in design or operation of controls resulting in one MEDIUM rated recommendation and other recommendations being LOW rated
Partial assurance with improvement required	Overall, we have concluded that, in the areas examined, there are some moderate weaknesses in the risk management activities and controls designed to achieve the risk management objectives required by management. Those activities and controls that we examined were operating with sufficient effectiveness to provide partial assurance that the related risk management objectives were achieved during the period under review. Might be indicated by moderate weaknesses in design or operation of controls and more than one MEDIUM or HIGH rated recommendations
No assurance	Overall, we have concluded that, in the areas examined, the risk management activities and controls are not suitably designed to achieve the risk management objectives required by management. Those activities and controls that we examined were not operating with sufficient effectiveness to provide reasonable assurance that the related risk management objectives were achieved during the period under review Might be indicated by significant weaknesses in design or operation of controls and several HIGH rated recommendations.

Appendix 4:
Our recommendation ratings

The table below describes how we grade our audit recommendations based on risks:

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	• Key activity or control not designed or operating effectively • Potential for fraud identified • Non-compliance with key procedures/standards • Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	• Important activity or control not designed or operating effectively • Impact is contained within the department and compensating controls would detect errors • Possibility for fraud exists • Control failures identified but not in key controls • Non-compliance with procedures/standards (but not resulting in key control failure)
Low	Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	• Minor control design or operational weakness • Minor non-compliance with procedures/standards
Improvement	Items requiring no action but which may be of interest to management or which represent best practice advice	• Information for management • Control operating but not necessarily in accordance with best practice

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality & Improvement**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Clinical Governance Committee 29 May 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 13.03.24

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 13 March 2024** at 10am via Microsoft Teams

Present
Mrs F Sandford, Non-Executive Director (Chair)
Mrs L Livesey, Non-Executive Director
Dr K Buchan, Non-Executive Director

In Attendance
Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Director of Quality & Improvement
Dr L McCallum, Medical Director
Mrs L Huckerby, Interim Director of Acute Services
Dr T Young, Associate Medical Director, Primary & Community Services
Dr J Manning, Associate Medical Director, Urgent & Unscheduled Care
Mr M Clubb, Director of Pharmacy
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mr P Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:
Mr R Roberts, Chief Executive
Dr S Bhatti, Director of Public Health
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Mr G Clinkscale, Director of Acute Services
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs C Cochrane, Head of Psychological Services
Mrs H Campbell, Non-Executive Director
Dr I Hayward, Associate medical Director – Planned Care

The Chair confirmed the meeting was quorate.

The Chair welcomed
Mrs K Hamilton, NHS Borders Board Chair
Ms L Livesey incoming Non-Executive member
Ms L Keir, Consultant Clinical Psychologist (item 5.2 Psychological Services element)
Dr C Anderson, Public Health Lead, Child Health Commissioner (item 6.2)
Mrs M O'Reilly, Head of Clinical and Professional Development (item 6.3)
Mrs A Dickson, Infection & Prevention Control Nurse shadowing Mr Whiting
Dr R Devine, Consultant in Public Health Medicine deputising for Dr Bhati (item 7.3)
Dr J Manning, Associate Medical Director, Urgent & Unscheduled Care

2 Declarations of Interest

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

2.2 The **CLINICAL GOVERNANCE COMMITTEE** noted Mrs Horan declared interest in item 5.1, being connected with a patient awaiting repatriation. There were no further new declarations made and previous declarations stood.

3 Minute of Previous Meeting

3.1 The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 17 January 2024 were approved

4 Matters Arising/Action Tracker

4.1 There were no matters arising from the previous meeting. Action tracker was discussed and updated accordingly.

5 Effectiveness

5.1 Clinical Board update Learning Disabilities

5.1.1 Mr Lerpiniere provided a brief overview of the content of the report, giving an update on the number of people in out of area placements being supported by Learning Disability Service, plan is well under way to bring them home under coming home project. He noted that there are resource implications and challenges cause some concern, work is ongoing along with Psychology services to ensure appropriate support.

5.1.2 Discussion followed regarding the intricacies and support from the organisation to meet the expected timeline for the coming home project. Mr Lerpiniere hoped this would be completed between December 2024 and March 2025. Support is required across Health and Social Care and Housing Sector. The Chair enquired about escalating through the IJB to push forward with the accommodation being provided by Eildon Housing.

5.1.3 Mrs Horan made a late declaration of interest having a relative waiting to be repatriated.

5.1.4 The Chair raised concerns around providing intensive care at home and the strain on community staff resources. Mr Lerpiniere agreed describing challenges on providing additional support relating to health issues over and above their daily needs. He noted that support for people with a learning disability would be better provided at home rather than Huntlyburn, even with the risks this presents.

5.1.5 Mrs Horan recognised that risks associated with transition from ward to ward or service to service is a consistent theme throughout the organisation. Discussion followed relating to this theme with agreement that communication and planning is key to any transition recognising that harm can be caused to patients at each point of transition. Discussion had taken place under excellence in care relating to a dedicated workstream to focus on transition points of care across the system including social care.

5.1.6 The Chair invited the Committee to comment on level of assurance on report. Mrs Jones noted that at the next meeting we will be recording assurance differently in line with an overarching board approach introduced for the committees not previously familiar with assurance. Report authors will be invited to indicate the level of assurance expected from the Committee. 2023/24 business will be concluded with our usual approach.

5.1.7 Mr Lerpiniere informed the Committee there was a new Team Manager coming in to post.

5.1.8 ACTION: Escalate concerns regarding Accommodation being provided by Eildon Housing. Mrs Jones and Mrs Sandford will discuss with IJB/Mr Myers.

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

5.2 Clinical Board update – Mental Health Services

5.2.1 Mr Lerpiniere provided a brief overview of report. Waiting list initiative work is ongoing and due to be complete by end of March. It is expected that CAHMS HEAT targets will be met by end of March despite experiencing challenges with access to specialist inpatient beds, unfortunately the RTT target was not quite met.

5.2.2 Following investigation of two patients in other health board areas Mental Welfare Commission (MWC) reports are complete, learning points and recommendations noted. Mr Lerpiniere will give the Committee a formal update on the Mental Welfare Commission's report following annual meeting he noted the MWC had stated NHS Borders presentation was the best they had at seen.

5.2.3 Difficulties continue with recruitment, after recruiting to permanent Consultant posts, one has since withdrawn. Dr McCallum noted her significant concerns around medical staffing within Community Mental Health teams, she stated they are looking at alternative roles to work alongside the consultant rota. Mrs Horan noted her concerns relating to Nursing and Social Work roles within Mental Health. Mr Lerpiniere reminded the Committee that when considering alternatives there are particular responsibilities and limitations for staffing under the Mental Health Act.

5.2.4 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents considering the risk around staffing.

5.2.5 Psychological Services update

5.2.6 Ms Keir gave an overview of report, she noted a seasonal decrease in waiting times in December but current performance against standards had fallen. These issues were largely due to staff capacity gaps and increased sustained demand on services. It is anticipated this will stabilise by summer. The service is looking at ways to mitigate risks associated with increased waiting lists by offering assessment appointments to ensure patients are waiting appropriately for treatment. Waiting times intervention and standard definitions had been published in September, guidance on implementation is awaited.

5.2.8 Psychological Therapies National specification was launched in September 2023 by Scottish Government, the Board has been asked to nominate two representatives to

attend National meetings. Meeting findings once commenced will be included in reporting to the Committee.

5.2.9 Following review of SAERS and recommendations from these, the service is in process of establishing regular effective consultation in response to the absence of regular psychology provision in some of the mental health ward areas.

5.2.10 Ms Keir also noted that Psychological Services improvement programme is progressing albeit slowly.

5.2.11 Discussion took place regarding the amount of work the service had put in under pressure. The Committee recognised the positive developments and thanked the service for their hard work.

5.2.12 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents, recognising the amount of pressure the service is under but noting concerns regarding staffing.

5.3 Clinical Board update Acute Services

5.3.1 Mrs Dickson provided a brief overview of the report, the service continues to work under pressure with high level of delays in the system and increased waits in ED. Surge capacity continues to cause an issue relating to staffing and financial implications.

5.3.2 Diabetes services are under extreme pressure with succession planning delayed. Dermatology continues to cause concern with different models of working being explored. Surgical cancellations have remained at similar level although more patients have been through the system this year compared to last two winters.

5.3.3 Sickness absence in nursing is showing a higher rate across acute site with additional measures being put in place supported by senior managers

5.3.4 Business continuity measures had been established relating to ventilation issues in air handling unit covering Blue ED, Endoscopy and Nuclear Medicine after failing assessment. It is anticipated this could a problem for a few weeks, meeting later today will establish timescales to rectify issues.

5.3.5 Mrs H Campbell raised concerns via Mrs Jones relating to patient access to specialist beds and being inappropriately placed, there followed discussion relating to risk based judgements and potential impact on patients and on whole system. Issues relating to precarious position of dermatology and lack of response from Scottish Government relating to these concerns. This continues to be highlighted to the Board. Mrs Jones commented that there had been a modernization of the ophthalmology which showed a reduction in outpatient list but an increase in day case list.

5.3.6 Dr Manning gave an update on the position of the diabetes, dermatology and endoscopy services and the various plans for recovery, some of these involve the use of locums. The Committee discussed the reliance on use of agency and locum support which needs to be agreed and supported at Board level and any application for use needs to be agreed on a case to case basis. This will be a recommendation made to the Board.

5.3.7 ACTION: Mrs Jones and Mrs Sandford will discuss agency & locum use with board

5.3.8 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents mitigations and actions being taken

5.4 Clinical Board Primary & Community Services

5.4.1 Mr Grieve provided a brief overview of report. He noted that the health Visiting position had improved, they are looking at a better skill mix within teams. Work is ongoing in relation to community hospital staffing, Dr McCallum commented that medical staffing position remains precarious, discussions will continue and a paper is due to go to BET for consideration. Dr Ryan and Dr Young have stepped up in meantime but this is only a short term solution. Home first service is also experiencing pressures.

5.4.2 Recent increase in measles has put pressures on school vaccination team adding to their existing immunisation programme. They are also awaiting instruction from Scottish Government in relation to Respiratory syncytial virus (RSV) vaccination programme. Mrs Guthrie asked that Mr Grieve keep her informed of any developments.

5.4.3 Mr Grieve also noted there would be a detailed analysis of the increase in staff sickness across primary and community care which will be detailed in next divisional report.

5.4.4 Mrs Jones commented that AHP issues continue to be an area of concern which is highlighted to the Board. Mr Williams gave the Committee a short update on the challenges across all AHP roles, career framework is being investigated. He will add specifics to the next report to the Committee.

5.4.5 ACTION: Mr Williams will add AHP detail to next PCS meeting

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

6 Assurance

6.1 Maternity/Neonatal Services and Severe Maternal Morbidity Annual Update

6.1.1 Mrs Guthrie provided a brief overview of the report. She informed the Committee that they had successfully appointed to the obstetrics & gynaecology vacancies which will provide better resilience in the team.

6.1.2 Stillbirths and neonatal deaths remain low, to provide assurance these deaths have been reviewed under the adverse event review structure. SAER conducted following neonatal death this was shared with Healthcare Improvement Scotland (HIS) and recommendations have been received, there is an action plan in place to address these. An update on the review will be included in May's acute services paper.

6.1.3 Risks relating to Entonox have been noted on the environmental risk register and they are working with health and safety to resolve this.

6.1.4 Mrs Jones commented about HIS involvement in SAER, this is a new process for

them to assist organisations in any learning following SAER. Since paper was written the National Neonatal Death review for Scotland had been published this can be shared with the Committee, to provide some assurance there were no findings to note in relation to Borders.

6.1.5 Discussion took place relating to patient safety and work with the Deanery ensuring middle grade Doctors were appropriately trained. Mrs Horan thanked Dr McCallum on her input into ensuring the service was kept running and safe. Mrs Jones commented on Mrs H Campbell's behalf that she noted there had been an increase Nationally in C-Section rates, this may be patient choice but we should keep an eye on this through our patient safety programme.

6.1.6 ACTION: Update on neonatal deaths review to be added to acute paper for May's meeting.

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

6.2 Children's Services Network Annual Update (previously Maternal & Child Health Services)

6.2.1 Dr Anderson provided a brief overview of the report. She explained the change in name was to reflect the partnerships involved in the work. She provided assurance that the Children's Service Network are meeting the requirements around legislation of children and young people within NHS Borders. Planned improvement work is ongoing alongside working towards identified key performance indicators.

6.2.2 The Chair enquired about the RAG status being at amber for KPI's, Dr Anderson clarified this was because the KPIs were ongoing and were not yet complete nor overdue, it is expected that these will be completed within the estimated timescale.

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

6.3 Nursing, Midwifery & AHP Education annual report (including Nursing Revalidation)

6.3.1 Mrs O'Reilly provided a brief overview of the content of the report. Three areas were highlighted to the Committee, Basic Life Support, Blood transfusion completion rates and Practice Assessor/Practice Supervisor rates. Mrs O'Reilly commented that these areas all carry risk to patient safety, staff satisfaction and student experience. Non-compliance with training requirements has a knock on effect on workloads. Streamlining of development opportunities had taken place to focus on these key areas. Monthly audits are taking place and all areas of concern escalated to senior staff with bespoke sessions within clinical areas being set up to help with releasing staff from wards. Awareness of accountability, governance, delegation and responsibility to emphasise and reiterate staff's responsibility in relation to these risks and how it links to their registration is included in development days.

6.3.2 Mrs Jones recognised the work the team had done to bring the training and education agenda back in line and noted that good inroads had been made.

6.3.3 Discussion followed relating to ILS and ALS courses with suggestion from Mrs Horan that courses could be increased further .The discussion included a question

around adequate support for Resuscitation officer, Mrs O'Reilly explained that given staff population there were difficulties in training all staff but there had been mitigations put in place with some staff trained in ILS and ALS forming part of the resuscitation team.

6.3.4 Mrs Horan also commented on recruitment and staffing and ensuring students are supported through the system. Mrs O'Reilly assured the Committee that they were aware of the risks associated with student experience and solutions are in place to address these risks.

6.3.5 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents recognising the concern/risks around Basic Life Support training.

7 Patient Safety

7.1 Infection Control Report

7.1.1 Mr Whiting provided a brief overview of the content of the report. He commented that as with other Scottish Boards there had been a challenge meeting the reduction in E-Coli target imposed by Scottish Government. Urinary catheterisation remains the biggest cause of infection. CAUTI group continues to monitor this with progress made including delivery of catheter management training in care homes.

7.1.2 Review down to resident levels of data following four care homes noting a higher number of callouts relating to urinary catheters, it is hoped this will highlight areas where more targeted improvement can be done. Review of EMIS to get better understanding of District Nurse Management of urinary catheters is also underway.

7.1.3 There appears to also be an increase in non-catheterised patients with urinary tract infections. The team will look into these incidences of infection for contributory factors to explain this increase and take any learning from this information.

7.1.4 Surgical Site Infection (SSI) data is showing correlation with c-sections and work is ongoing to monitor and establish a standardised approach across the boards on how this information is collated and reported. This will inform an action plan going forward. Mrs Guthrie commented that any impacts relating to increase in c-section related SSI will be discussed at heads of midwifery meeting and any outcomes will be included in future reporting.

7.1.5 There followed a discussion regarding increased workload and impact on resources and delivery of workplan due to Police investigations into COVID deaths. The Committee acknowledged the impact this may have on the Infection Control Team and Organisation as a whole.

7.1.6 Mrs Horan commented there needs to be recognition that UTI has a significant impact not only on the patient but has financial implications for the organisation, this should be added to workplan, Mr Whiting noted that this had been recognised.

7.1.7 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents, acknowledging the increased work relating to the COVID enquiry.

7.2 Strategic Clinical Risk Quality & Sustainability Whole System Flow

7.2.1 Mrs Huckerby attended to present an update on actions relating to strategic risks associated with whole system flow. Work around re-setting programme board aligned

with financial focus is ongoing. Work on pathways and flow from front door are being focussed on in relation to the wider foot print. Meeting arranged for next week to kick this improvement programme, it is hoped this will give a clearer scope on deliverables and align work with Quality and Patient care.

7.2.2 Mrs Huckerby gave a brief description on Dr Ryan's role as strategic lead for urgent and unscheduled care in terms of understanding where improvements can be made in particular in preventing admissions, she will initially be with us for a year to push this work forward. Mrs Huckerby went on to give the Committee an overview of other strategic pieces of work with a view to reducing risks from very high to high by September initially.

7.2.3 Mrs Jones had leant Executive leadership support by highlighting to the Resource Performance Committee risks involved in relation to withdrawal of funding sources for some initiatives previously started, she commented that they are looking at sectioning some transformation monies to keep these initiatives going. Discussion followed in relation to these risks including discussion on the impact around Community Hospital bed temporary closures, work is ongoing to avoid this happening. Despite understanding that community beds cannot remain open without senior medics the Committee recognised that closure of Community Hospitals beds will have a direct effect across the whole acute site and ability to place patients.

7.2.4 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents and look forward to improved assurance by September.

7.3 Public Health Annual Report

7.3.1 Rebecca Devine gave a presentation on the report; the Committee noted that the report had already been to the Board for consideration.

7.3.2 Discussion followed relating to the report in particular around any preventative initiatives and screening work, the Chair commented that the Committee are really supportive of ongoing work recognising the importance of ensuring this is achieved within financial constraints. Mr Williams commented that often preventative initiatives get lost as impact often not visible and other immediate pressures in the system take precedence, a focus on preventative work is vital.

7.3.3 Mrs Jones noted the report was very detailed and encouraged Public Health to continue to highlight and build on the preventative local initiatives so as not to lose focus. Dr McCallum encouraged promoting and maintaining strong links with GP colleagues in order for this work to succeed. Dr Buchan further commented that often promoting healthy lifestyles and taking up screening is difficult given time and financial restraints both for Primary Care Clinicians and Patients alike. Signposting to other Primary Care services is probably key but often access to these services is limited.

7.3.4 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is encouraged to see invigorated focus on the Public Health Agenda. However it is only partially assured noting plans are in place but would like to see these working operationally before being fully assured.

7.4 Quarterly HSMR

7.4.1 Mrs Jones provided a brief overview of the content of the report there was nothing to escalate to Committee and HSMR remains within normal limits

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

7.5 Patient Safety Annual Report

7.5.1 Mrs J Campbell provided a brief overview of the content of the report noting challenges and priorities for the year ahead identified through the Scottish Patient Safety and Excellence in Care (formerly Back to Basics) Programmes. This will provide oversight of all National Programmes and give clear direction of how these are applied locally. Improvement initiative and remobilisation of leadership walk rounds will also be monitored. These will be started in acute and rolled out across the organisation along with local and national ward audit programmes.

7.5.2 Discussion followed relating to Community, Mental Health and Learning Disability services KPIs and assurance. Mrs J Campbell acknowledged that there was work to be done alongside Clinical Effectiveness team to bring all the patient safety initiatives together across the boards.

7.5.3 Mrs Jones commented a lot of the themes are reported through other reports to the Committee, this report provides an overview of what is happening organisation wide, in terms of triangulation of data across audit, mortality reviews, leadership walk rounds, complaints and adverse events to articulate what the safety priorities across the organisation are which is factored into any improvement work.

7.5.4 The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured a robust programme in place for oversight of patient safety which recognises and monitors improvement required across organisation.

8 Items for Noting

8.1 There were no changes to Committee Terms of Reference for 2024/25 and minutes from other meetings were noted.

8.2 The draft workplan was noted and will be finalised and sent to members. Mrs Jones commented that we were not able to complete all business for 2023/24 due to exceptional circumstances therefore the Medical Education and the Mortality annual reports would come at earliest point in the business for 2024/25. She noted that there were no major areas of concern to flag at present. Dr McCallum asked to note that the absence of Director for Medical Education was a risk and may be cause for concern going forward.

8.3 Draft Annual report will be updated reflecting the above and concluded for sign off, and submission in April.

9 Any Other Business

9.1 Miss Laing brought new Committee paper template and guidance for 2024/25. She asked that paper authors be aware the new template was a requirement of the Board in line with Scottish Government ‘Once for Scotland’ model. Numbering of paragraphs must be included in report for ease of scrutiny and use of copy and

pasting from an old template is discouraged. The paper template includes new assurance levels structure. Guidance will be included with call for papers.

9.2 Mrs Jones thanked the Committee for their commitment over 2023/24 and especially over the last two meetings when agenda and timings had been extended in order to conclude Committee business for the year.

9.3 There were no further items of competent business to record.

10 Date and time of next meeting

10.1 The chair confirmed that the next meeting of the Borders NHS Board Clinical Governance Committee is on **Wednesday 29 May 2024** at **10am** via Teams Call.

The meeting concluded at 12:25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Quality & Clinical Governance Report – June 2024**
Responsible Executive: /Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Author:	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance** **Justin Wilson - Quality Improvement Facilitator - Clinical Effectiveness,** **Susan Hogg - Patient Experience Coordinator** **Susan Cowe - Senior Project Officer - Covid 19 Inquiries**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 This exception report covers key aspects of clinical effectiveness, patient safety and person-centred care within NHS Borders.

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

2.2 Background

2.2.1 NHS Borders, along with other Boards in Scotland, continue to face extreme pressures on services. Demand for services remains intense and is exacerbated by significant staffing and financial challenges, across the health and social care system.

2.3 Assessment

2.3.1 Clinical Effectiveness

The Board CGC met on the 29 May 2024 and discussed papers from all four clinical boards. Each clinical board continued to raise risks which are placing pressure on the delivery of local services. Delayed discharges across the health and social care system remains a consistent issue raised by each clinical board and members were keen that this position and its impact on quality of care, access to emergency care, elective and specialist beds is not normalised and continues to be escalated to NHS Borders Board and the Integrated Joint Board.

2.3.2 The CGC received a report on Primary and Community Services. Workforce pressures and mitigating actions were described across Health Visiting, District Nursing and Allied Health professions. The CGC were keen to understand the impact of gaps in the AHP workforce which have required the daily clinical prioritisation of workload. The committee want to understand the impact on deconditioning for areas not receiving the appropriate frequency of rehabilitation input. The Associate Director of Allied Health Professions was asked to bring details back in relation to this area. There was a desire from the CGC to see more data on independent contractor services and quality of care. The Primary and Community Services team were asked to review this area recognising the constraints in access to data particularly for general practice. The CGC had limited assurance remaining concerned about demand pressures on dental services, general practice and AHPs in particular, as well as patients delayed in community hospitals and community services.

2.3.3 The CGC received a report from the Learning Disability (LD) Service. Assurance was sought on the pace of the work under the Coming Home project to bring out of area patients back to the Scottish Borders where possible. The CGC were concerned about protracted timescales for this complex piece of work requiring collaboration across agencies. The committee were briefed on progress with annual health checks for patients and the feedback from General Practice that they did not feel the current format of health checks being recommended would be feasible for GPs given workload pressures. The LD team are continuing to work on this to find a feasible local approach and the CGC were keen to receive assurance on the plan for this at the next meeting. Limited assurance was assigned to the LD report relating to the coming home timeframes and annual health checks progress.

2.3.4 The CGC considered a paper from Mental Health and Psychological Services taking moderate assurance from both reports. The CGC were assured on progress within the Borders Addiction Service relating to delivery of the Medication Assisted Treatment (MAT) standards and in relation to delivery of the Child and Adolescent Mental Health access target. The committee were also assured in relation to the recent scrutiny visits to the Borders Specialised Dementia Unit and Huntlyburn Ward from the Mental Welfare Commission. The committee recognised the work of the multidisciplinary teams in these areas who were commended for the outcomes of the visits assessing the care they deliver. Significant pressure remains in the Psychiatry workforce and the committee

remain concerned in relation to this area. The committee were briefed on a Fatal Accident Inquiry which will take place involving the mental health service and have been historically aware of the case and resulting local actions. The committee were briefed on the work commissioned to review provision across agencies to support neurodiversity and noted the growing pressure on health services for referral for specialist diagnosis. Pressure areas were noted in psychology although the service continue to make positive progress in relation to waiting times for psychological therapies and in the delivery of the renew service within general practice.

2.3.5 The CGC received a report on acute services and noted positive recent recruitment to cardiology, obstetrics and gynaecology and haematology but noted the continued pressures in dermatology and haematology and emerging pressures in radiology. The report detailed the sustained pressure on flow across the acute service resulting in delays in emergency and elective care. Several mitigations are in place including continued use of surge capacity and the extensive transformation work underway under the Urgent and Unscheduled Care programme. However, the committee recognised the impact this was having on patients and the workforce in acute services and the delays to accessing inpatient beds. The committee agreed it was critical that this is not normalised and that the Board continue to work towards solutions across the health and social care system to ensure patients can be treated and cared for in a timely manner in the correct location. The committee took limited assurance from the report.

2.3.6 An annual report on Stroke Services was discussed. The CGC noted the progress in some clinical measures within the stroke bundle but remained concerned about the ability to gain access to the stroke unit within 1 day of admission to hospital. The CGC recognised that whole system flow was impacting on this, noting the extended length of stay in the stroke unit resulting from access to downstream beds. The committee felt that the sustained problems with delays across the system must remain a focus due to the negative impact on access to specialist beds and wanted to ensure this was again escalated to the Board highlighting the CGC were not able to take any assurance in this area due to the sustained pressure and impact on performance against the stroke target.

2.3.7 The CGC received the annual report on Value Based Health and Care. The committee were pleased with the progress being made in this area recognising the significant culture and practice change involved. Work is underway on Refhelp to support referral pathways between primary and secondary care and extensive work has been done on Treatment Escalation Planning within acute and community hospitals. The CGC took moderate assurance from the report acknowledging the scale of work ahead in this area.

2.3.8 The committee considered the Patient Feedback report. The CGC noted the continued elevated demand and the resulting impact on timescales for complainants to receive a final response. The committee noted the additional capacity the Board has put in place to manage the current level of demand and took moderate assurance from the report.

2.3.9 The committee received the Hospital Standardised Mortality report taking moderate assurance from the position noting the continued excess deaths from COVID 19.

2.3.10 The committee received the annual Mortality report. The committee took time to review the impact of changes in the model of care within the acute setting resulting for system pressures and the impact this was having on the denominator of discharges from inpatient areas. The report adjusted for this to detail the trend in mortality and the findings of the core mortality review process which looks for learning to inform the local patient

safety programme. Anticipatory Care Planning remains a consistent theme, as does the impact of delays and access to inpatient beds emerging to a greater extent in the 2022/23 report. The CGC took moderate assurance from the report.

2.3.11 The CGC considered the infection control report taking moderate assurance. Concerns were noted in relation to the changes to the Health Protection Service moving to a regional approach and the changes to provision of advice for patients on discharge to care homes. The Director of Nursing, Midwifery and Acute Services and Director of Public Health were asked to provide assurance on this at the next meeting when the changes were fully understood.

2.3.12 Patient Safety

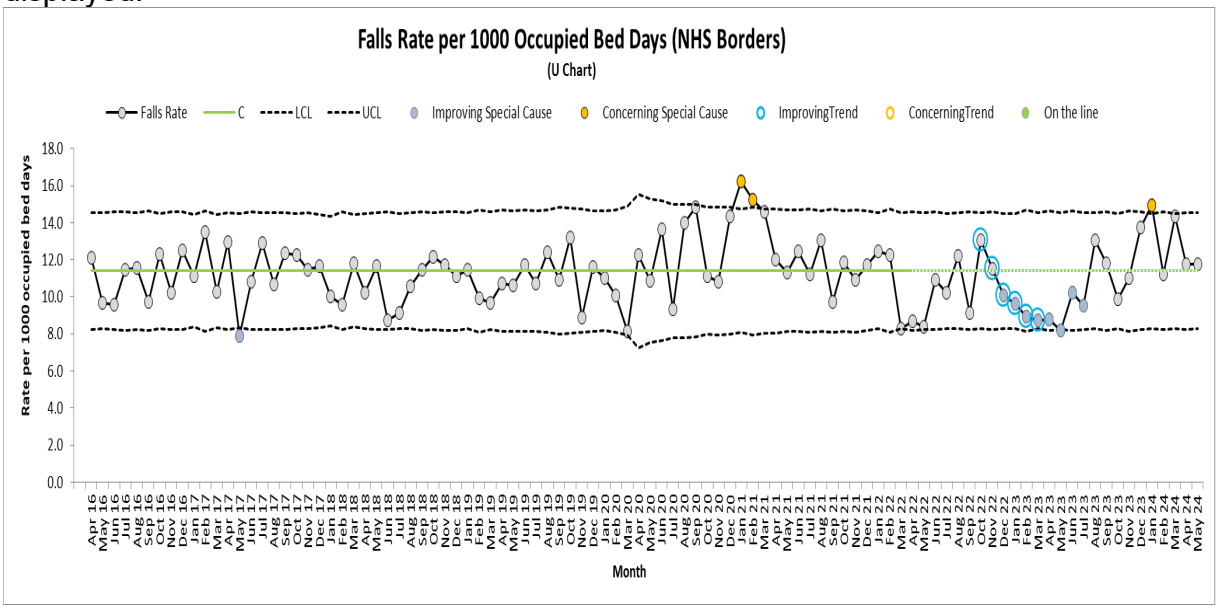
2.3.13 Scottish Patient Safety Programme (SPSP)

NHS Borders hosted a site visit for Health Improvement Scotland (HIS) in February 2024 to provide an update to include barriers, enablers and the impact of the work so far. The event gave local teams the opportunity to connect with HIS colleagues and included:

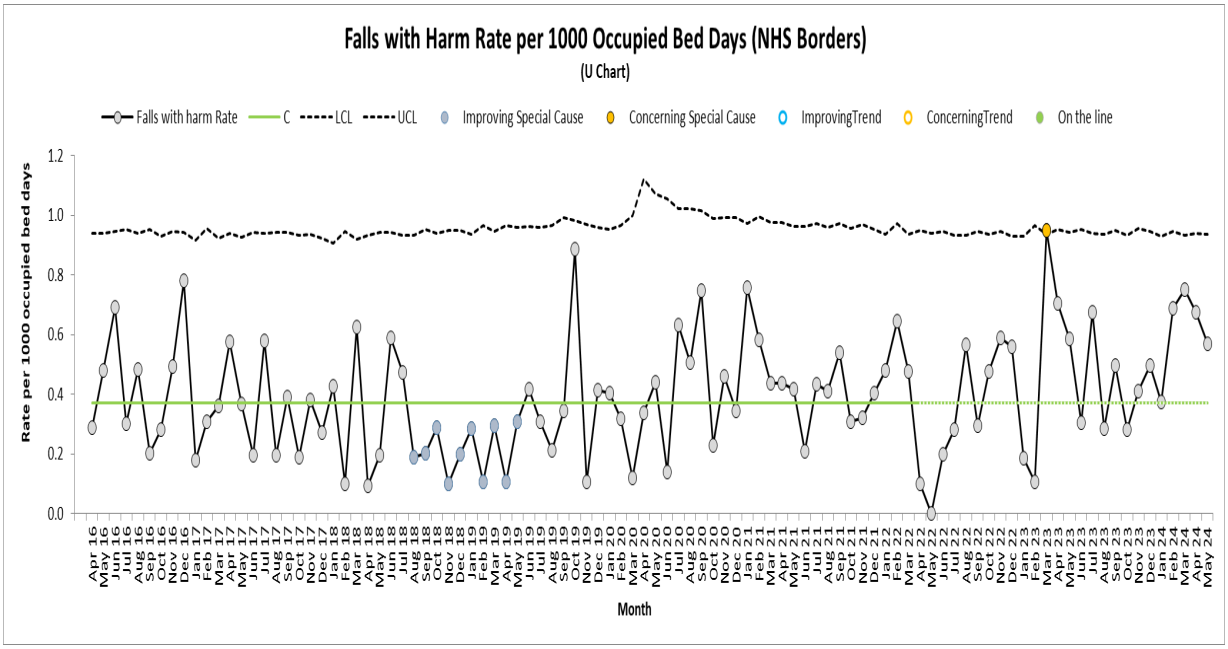
- SPSP Adult Collaborative – Falls / Deteriorating Patient
- SPSP Perinatal Collaborative
- SPSP Paediatric Collaborative

2.3.14 Falls

Graph 1 shows the fall rate per 1000 occupied bed days across NHS Borders adult inpatient areas showing normal variation with a spike in reporting in January 2024 displayed:



2.3.15 Graph 2 shows the falls with harm rate per 1000 occupied bed days for NHS Borders adult inpatient areas showing normal variation:

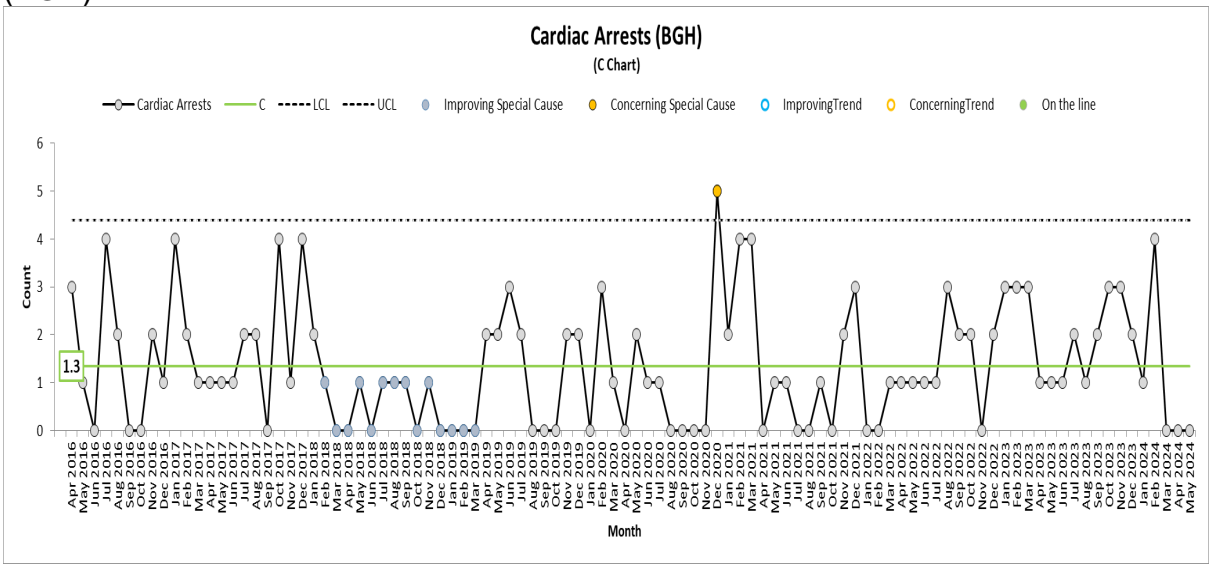


2.3.16 The Patient Safety Quality Improvement Facilitator (QIF) validates all falls within the acute inpatient areas to ensure that we have a robust process in place for the assurance of care and reports these to the falls steering group as per our local governance structure who then highlight common themes and focus on improvement and the delivery of multi-professional education with a focus on hospital acquired deconditioning and balancing the risk, falls prevention and mobility.

2.3.17 Next steps considered for falls improvement work include collaboration with NHS Highland to consider implementing their daily care plan in one identified NHS Borders ward to improve person centred care rounding and the introduction of a safe care pause to identify patients who are at risk of falls whilst incorporating falls safety checks when applicable. The Excellence in Care Programme Board have agreed the proposed testing approach for this at their June 2024 meeting to allow this work to begin.

2.3.18 Deteriorating Patient

Graph 3 shows normal variation in the cardiac arrest (CA) rate per 1000 discharges in the acute adult in-patient areas (excluding ITU and ED) of the Borders General Hospital (BGH):



2.3.19 Each CA in 2023 was validated by a senior clinician and a proforma has been completed. The Resuscitation Committee plan to review these proforma's to identify common themes or omissions in care. To reduce bias a senior clinician from an external Health Board has been invited to participate in the process. The Deteriorating Patient Group has been included in the learning to ensure a robust governance structure is in place.

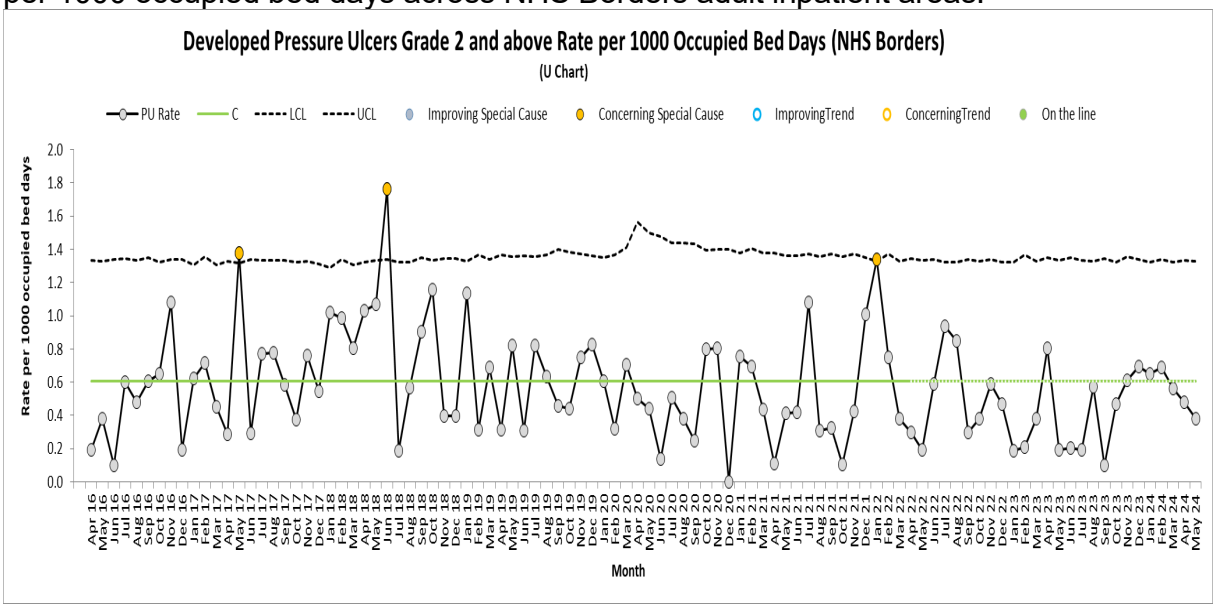
2.3.20 A review of the NHS Borders Observation Policy has been undertaken. The Policy will signpost clinical staff to the relevant clinical observation chart and include reference to the three early warning systems in place (NEWS2 for adults, PEWS for paediatrics, MEWS for use in maternity).

2.3.21 Work is also underway to continue to embed Treatment Escalation Planning (TEPs) across adult inpatient areas within acute and community hospitals. The Deteriorating Patient Group are considering criteria for priority groups where a TEP must be in place to inform the development of our local clinical policy.

2.3.22 Mortality reviews of inpatient deaths within the Community Hospitals (CH) will commence in June 2024. Development of a CH mortality review process is underway which will be similar to the current acute board system. A monthly list of all CH deaths will be generated and shared to the CH senior nursing team. The CH senior clinical teams will then aim to undertake mortality reviews of all patients to look for themes and learning from them, including length of stay and completion of TEP. Education sessions for the community hospital Senior Charge Nurses took place in May 2024.

2.3.23 Pressure Damage

Graph 4 shows normal variation of developed pressure ulcers Grade 2 and above rate per 1000 occupied bed days across NHS Borders adult inpatient areas:



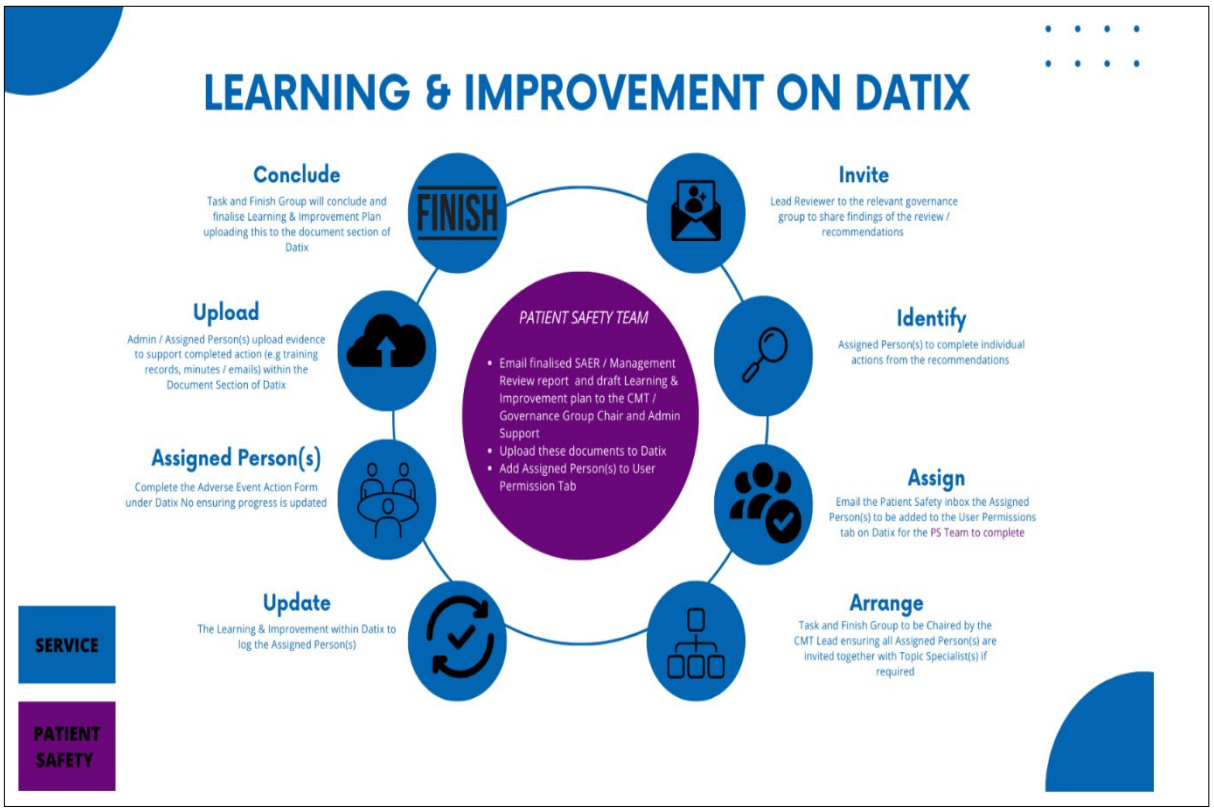
2.3.24 To support NHS Borders in reducing the number of acquired pressure ulcers developed by March 2025 the QIF for Patient Safety has liaised with the Tissue Viability Nurse to consider what additional interventions can be tested to improve processes around the prevention of pressure injuries. A proposal is being worked up for consideration by the tissue viability steering group linking with other boards in Scotland to assess where meaningful improvement has been achieved.

2.3.25 SPSP Perinatal Collaborative

SPSP have requested quarterly reporting for measures associated with the Perinatal collaborative as the programme has now remobilised across NHS Scotland. A second virtual site visit will take place in August 2024 to review improvement work underway and share learning across NHS Boards.

2.3.26 Adverse Events - Learning and Improvement Process

The implementation plan for the new Learning and Improvement process on the digital adverse event management system has commenced with a Standard Operating Procedure (SOP) and guidance developed to support Senior Management and Administration Staff. The Patient Safety Team are also facilitating training sessions to support the revisions of the learning and improvement process. Figure 1 shows the process cycle:



2.3.27 NHS Borders Excellence in Care (EiC) Programme

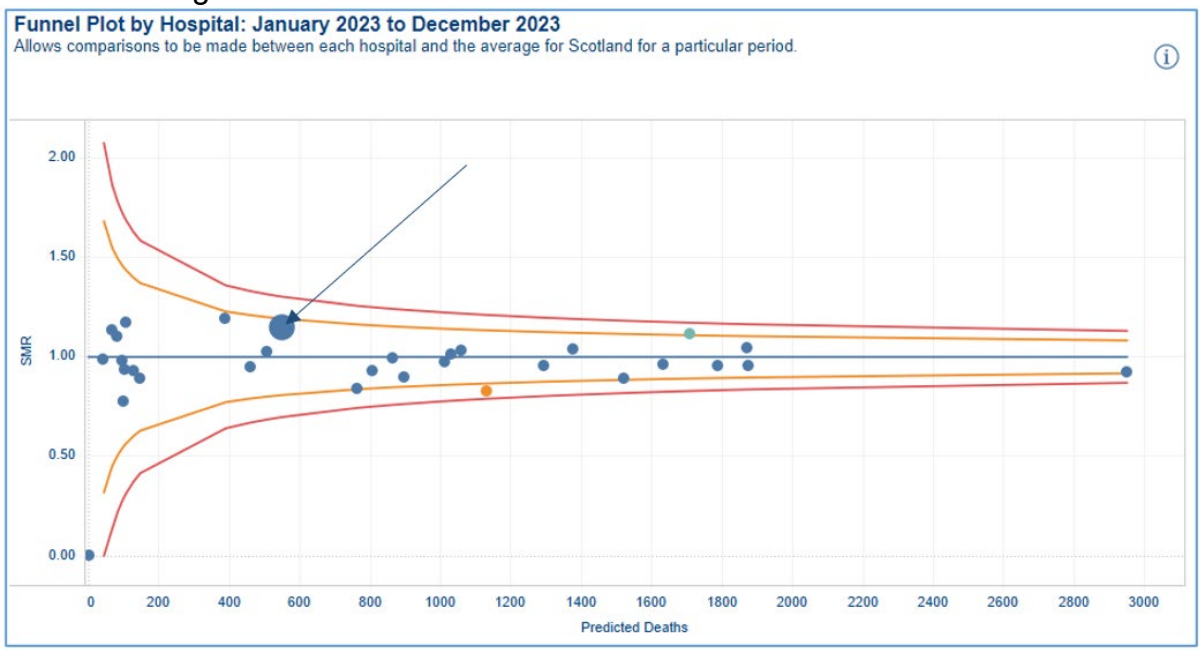
Remobilisation of NHS Borders previously named Back to Basics programme has been rebranded as NHS Borders Excellence in Care Programme in 2024. The aim of NHS Borders EiC Steering Group is to provide oversight to work underway to continually monitor and improve quality of care. Quarterly reports are submitted to Scottish Government on key quality indicators as well as the submissions to Healthcare Improvement Scotland under the SPSP programme. The Lead Nurse for Patient Safety and Care Assurance attends EiC's national short life working group to discuss the national care assurance approach and consider how Quality of Care reviews (QoC) are undertaken locally. NHS Borders have been testing a new tool as part of this national work which would replace our current Leadership Walkround approach, currently commissioned across Acute and Maternity Services. The QoC template has been tested in the Medical Assessment Unit (MAU) to date with good feedback received to the structure and expectation of the document.

2.3.28 Clinical Documentation Group

As part of our EiC Steering Group, the introduction of NHS Borders Clinical Documentation Group has commenced in May 2024 to support the scrutiny of developed and reviewed clinical documents prior to testing, approval and implementation.

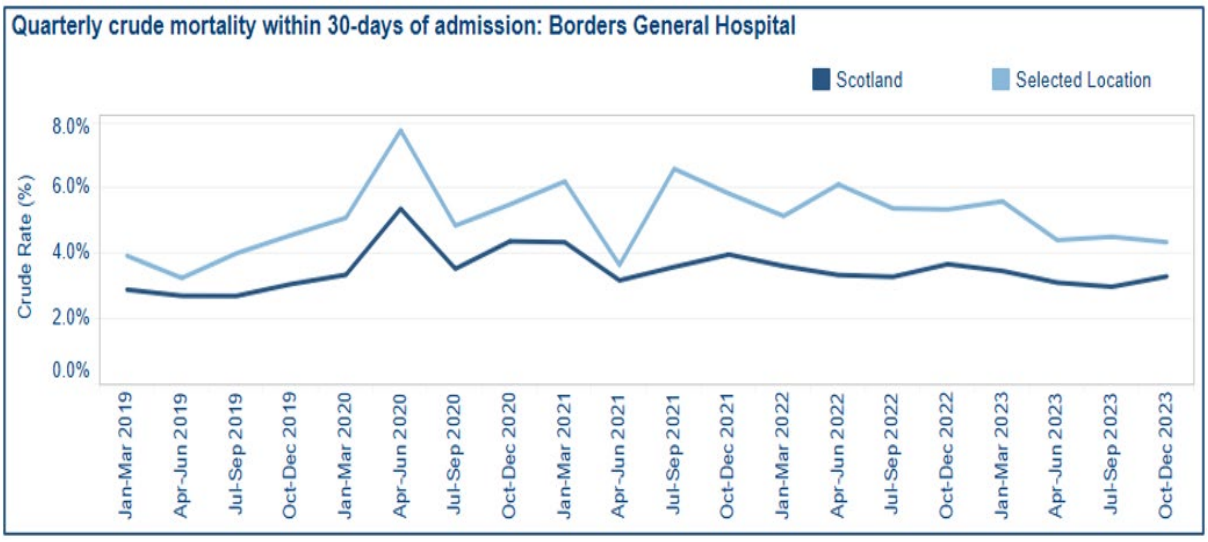
2.3.29 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 20th data release under the new methodology is 1.15. This figure covers the period January 2023 to December 2023 and is based on 629 observed deaths divided by 549 predicted deaths. The funnel plot in Figure 2 shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period therefore is not a trigger for further investigation:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.30 NHS Borders crude mortality rate for quarter October 2023 to December 2023 was **4.3%** and is presented in graph 5 below:



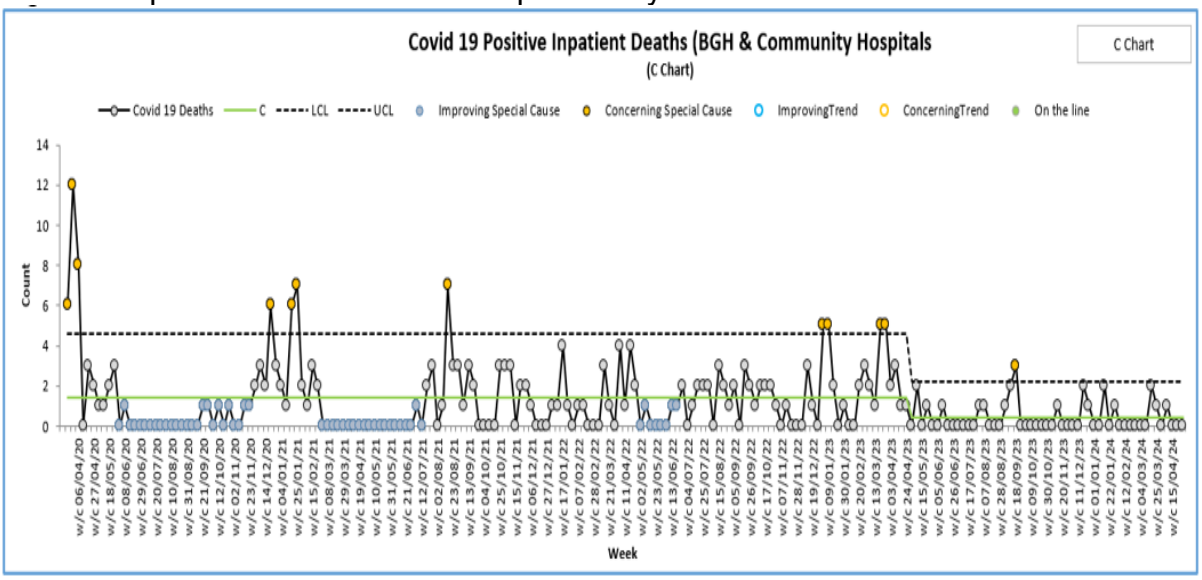
*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.31 No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the BGH by the total

number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.3.32 Deaths occurring in COVID waves continue to contribute to the periods of elevated crude mortality. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in quarter 4 of 2019/20 and quarter 1 of 2020/21.

2.3.33 Graph 6 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 4 May 2024:

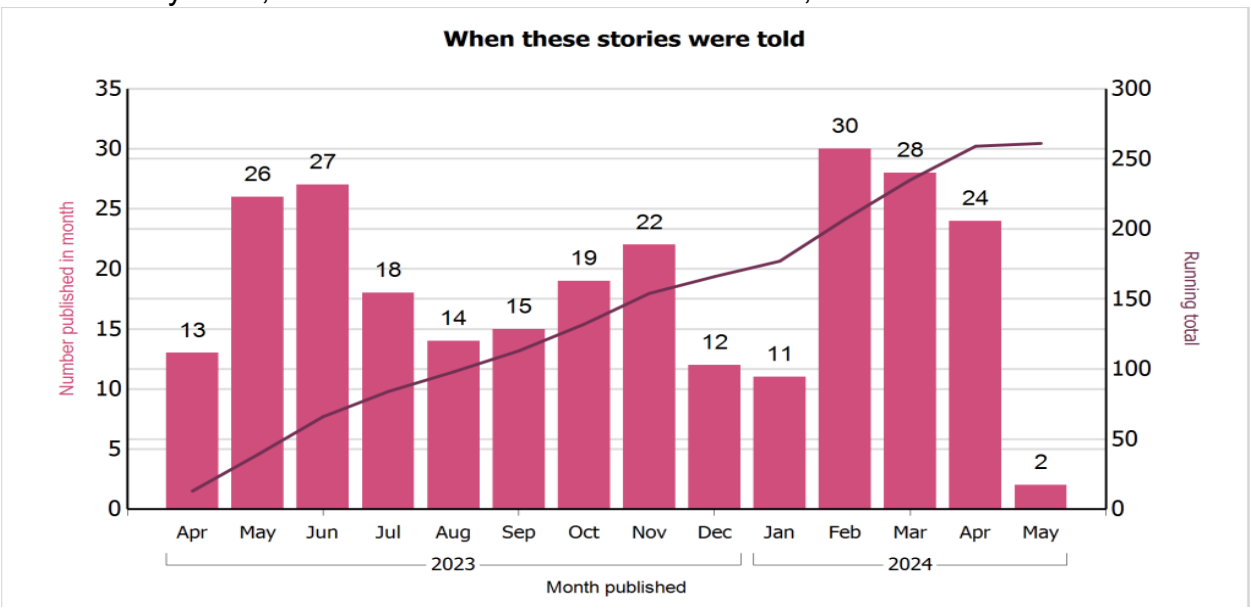


*From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this patients were counted as covid positive for 28 days after a positive test.

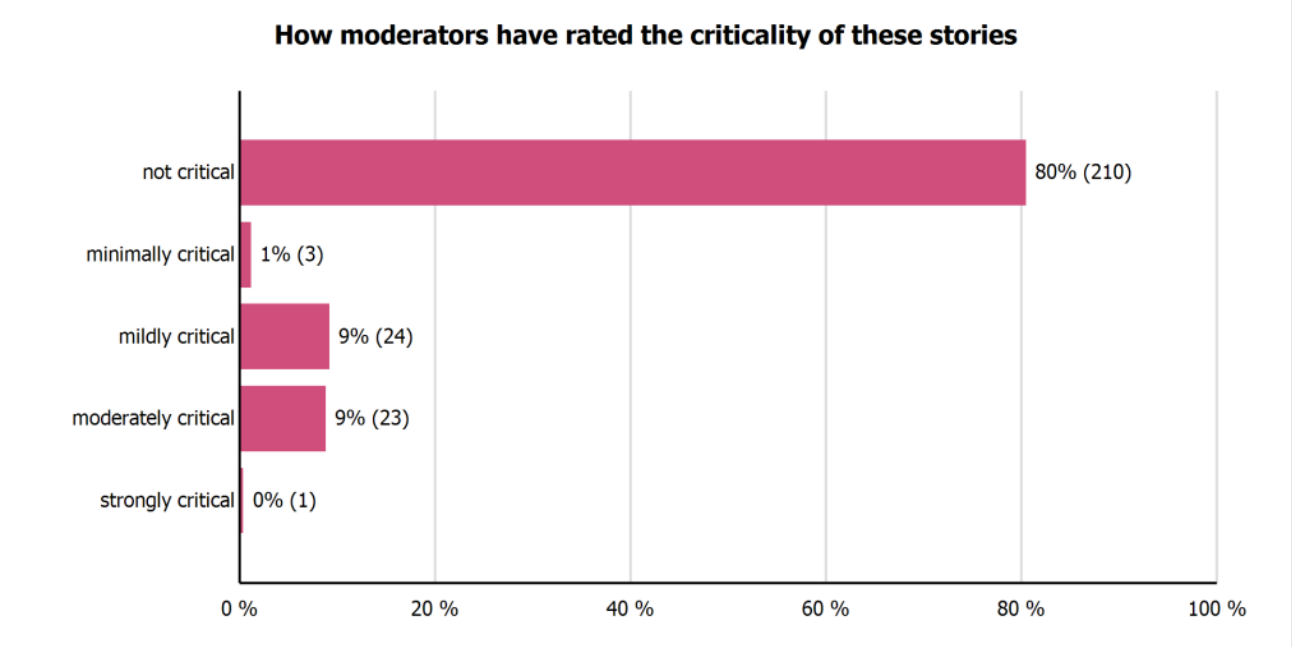
2.3.34 Patient Experience

2.3.35 Care Opinion

For the period 1 April 2024 to 15 May 2024, 261 new stories were posted about NHS Borders on Care Opinion. Graph 7 below shows the number of stories told in that period. As of 15 May 2024, these 261 stories had been viewed 27,305 times:

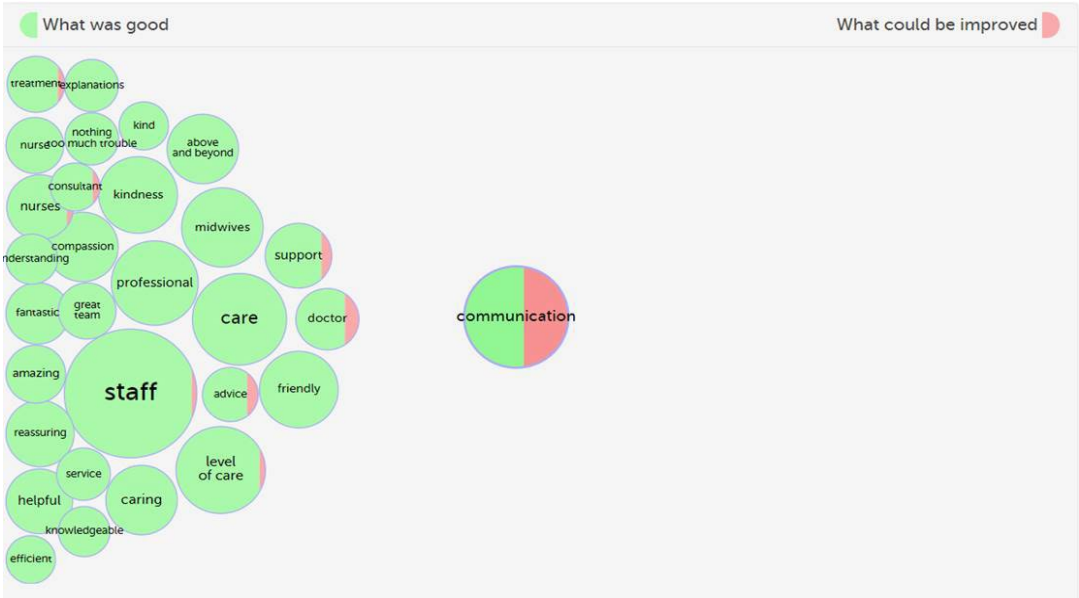


2.3.36 Graph 8 provides a description of the criticality of the 261 stories:



2.3.37 The diagram and word clouds below summarise what was good and what could be improved in Care Opinion posts for this period:

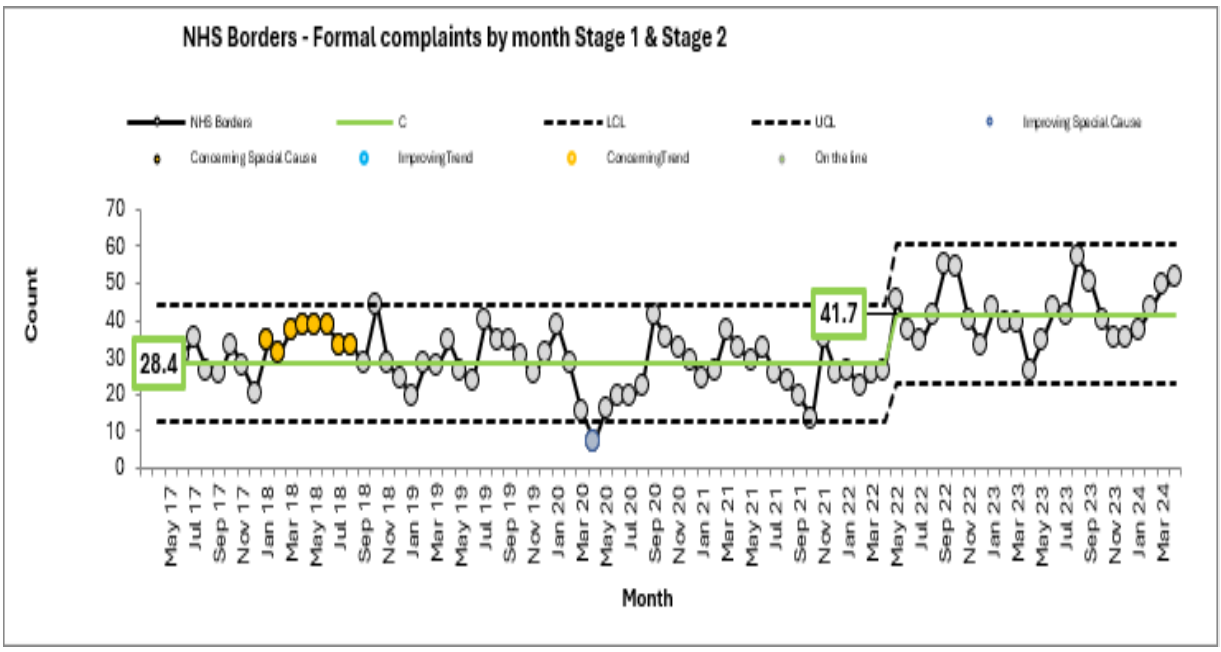
What was good?



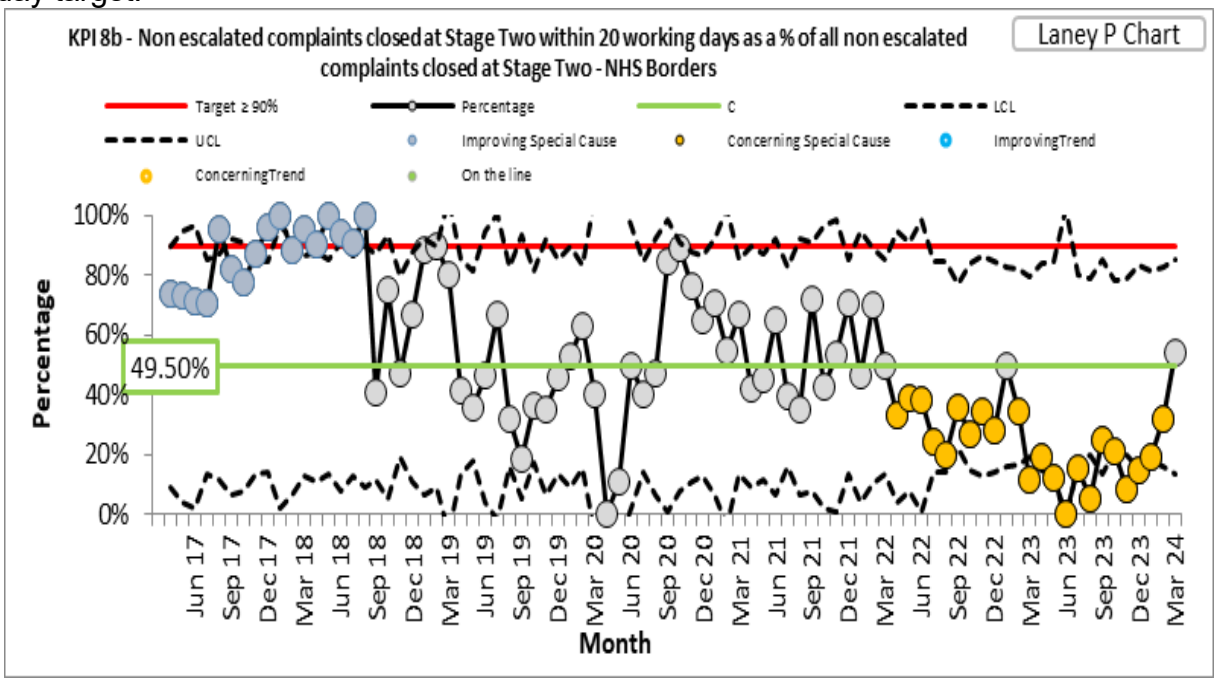
What could be improved?

2.3.38 Complaints

Graph 9 gives the number of formal complaints received by month. NHS Borders continue to observe an increased level of formal complaints as described to the Board in previous reports. Additional capacity has been added to the Patient Experience Team (PET) on a short-term basis to support this increase in workload:

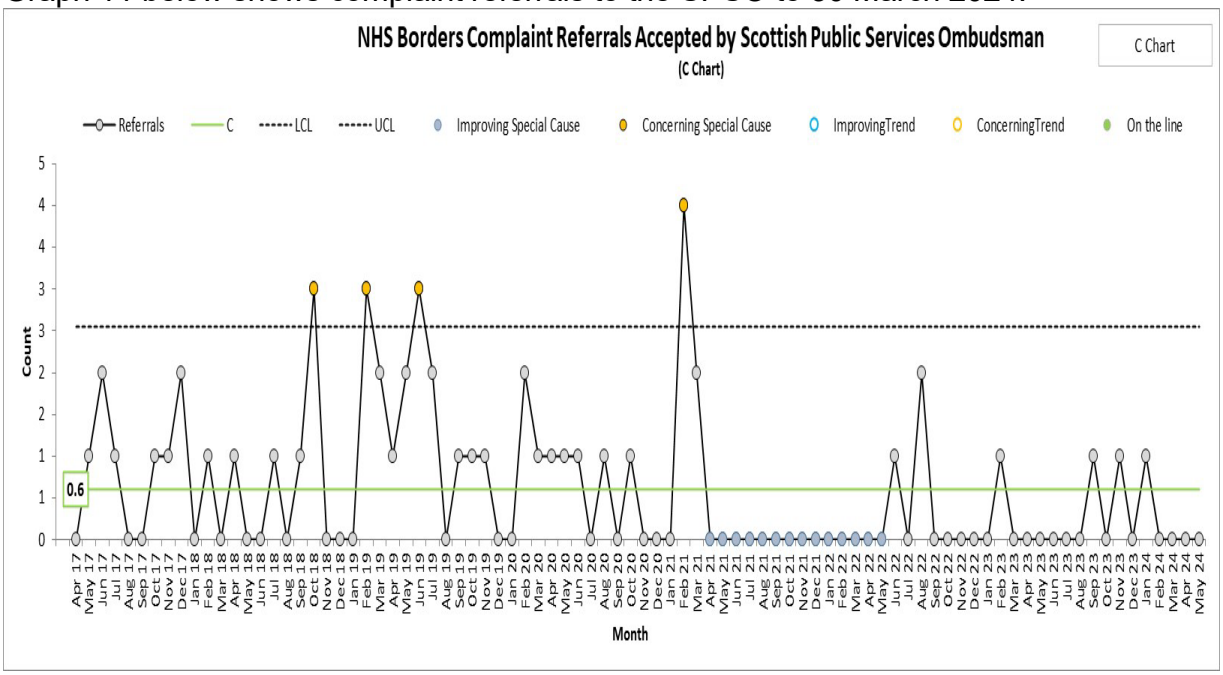


2.3.39 Graph 10 below shows the percentage of complaints responded to within 20 working days. Front line services are experiencing ongoing clinical pressures which have impacted on the ability of frontline clinical staff to respond to complaint investigations within normal timescales. This together with the increase in the number of complaints has resulted in the PET team being unable to consistently deliver against the 20-working day target:



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

Graph 11 below shows complaint referrals to the SPSO to 30 March 2024:



2.3.41 COVID Inquiries

The Scottish Covid-19 Inquiry will consider the impact of Covid, then implementation of measures and then key decision making for each theme. The Health and Social Care Impact Hearings recommenced on 15 April 2024 and will continue taking place until 1 June 2024. After completion of the Health and Social Care Impact Hearings, the Inquiry will move to Impact Hearings on Education and Young People. The inquiry is split into three themes:

(1) Health and Social Care;
(2) Education and Young People; and
(3) Finance, Business and Welfare.

2.3.42 The UK Covid-19 Inquiry is currently holding Core UK decision-making and political governance – Northern Ireland (Module 2c) public hearings in Belfast. The public hearings for Module 3 (Impact of the Covid-19 pandemic on healthcare systems in the four nations of the UK) will take place in London over 10 weeks, starting on 9 September 2024 and concluding on 28 November 2024 (2 week break 14 – 25 October 2024).

2.3.43 Quality/ Patient Care

Following the impact of the COVID-19 pandemic services continue to recover and respond to significant demand with heightened workforce pressure across health and social care. This has required adjustment to core services and non-urgent and routine care. The ongoing unscheduled demand and delays in flow across the system remain an area of concern with concerted efforts underway to reduce risk in this area.

2.3.44 Workforce

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. Key workforce pressures have required the use of bank, agency and locum staff groups and further exploration of extended roles for the multi-disciplinary team. Mutual aid has also been explored for a few critical specialties where workforce constraints are beyond those

manageable locally. There has been some progress locally in reducing gaps in the registered nursing workforce and positive levels of international recruitment. There continues to be an outstanding response from staff in their effort to sustain and rebuild local services, but many staff continue to feel the strain of workforce challenges and this needs to remain an area of constant focus for the Board.

2.3.45 Financial

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. As outlined in the report the requirement to step down services to prioritise urgent and emergency care has introduced waiting times within a range of services which will require a prolonged recovery plan. This pressure is likely to be compounding by the growing financial pressure across NHS Scotland.

2.3.46 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the need to adjust and remobilise services following the pandemic response. The NHS Borders risk profile has increased as a result of the extreme pressures across Health and Social Care services.

2.3.47 Equality and Diversity, including health inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.48 Climate Change

No additional points to note.

2.3.49 Other impacts

No additional points to note.

2.3.50 Communication, involvement, engagement and consultation

This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.51 Route to the Meeting

The content of this paper is reported to Clinical Board Clinical Governance Groups and Board Clinical Governance Committee.

2.4 Recommendation

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

3 Glossary

Clinical Governance Committee (CGC)
Learning Disabilities (LD)
Hospital Standardised Mortality Rate (HSMR)
Patient Experience Team (PET)
Scottish Public Services Ombudsman (SPSO)
Project Management Office (PMO)
Allied Health Professional (AHP)
Cardiac Arrest (CA)
Intensive Therapy Unit (ITU)
Emergency Department (ED)
Treatment Escalation Plan (TEP)
Borders General Hospital (BGH)
Community Hospital (CH)
Quality Improvement Facilitator (QIF)
Quality of Care (QoC)
Medical Assessment Unit (MAU)
Excellence in Care (EiC)
Controlled Drugs (CD)
Medication Assisted Treatment (MAT)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Infection Prevention & Control Report – May 2024**
Responsible Executive/Non-Executive:	**Director of Nursing, Midwifery & AHPs**
Report Author:	**HAI Surveillance Lead** **Infection Control Manager**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

This aligns to the following NHS Scotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

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

2.2 Background

The format of this report is in accordance with Scottish Government requirements for reporting HAI to NHS Boards.

2.3 Assessment

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

- ***Staphylococcus aureus* Bacteraemia (SAB)**

1.1 NHS Borders had a total of 32 *Staphylococcus aureus* bacteraemia (SAB) cases between April 2023 and March 2024, 15* of which were healthcare associated infections.

1.1a *NB: 2 healthcare associated cases were sampled at NHS Borders but attributed to another board. As per ARHAI Scotland definitions, these cases are still counted in our final figures.

1.2 The Scottish Government had previously set a target for each Board to achieve a 10% reduction in the healthcare associated SAB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline). Our predicted target rate for this period equates to no more than 20 healthcare associated SAB cases.

1.3 We have tentatively met this target (figure 1) but are awaiting ARHAI Scotland publication of Q1 2024 (Jan-Mar) epidemiological data in June or July 2024 which will confirm total occupied bed days and cases for the period; our rate will then be adjusted accordingly.

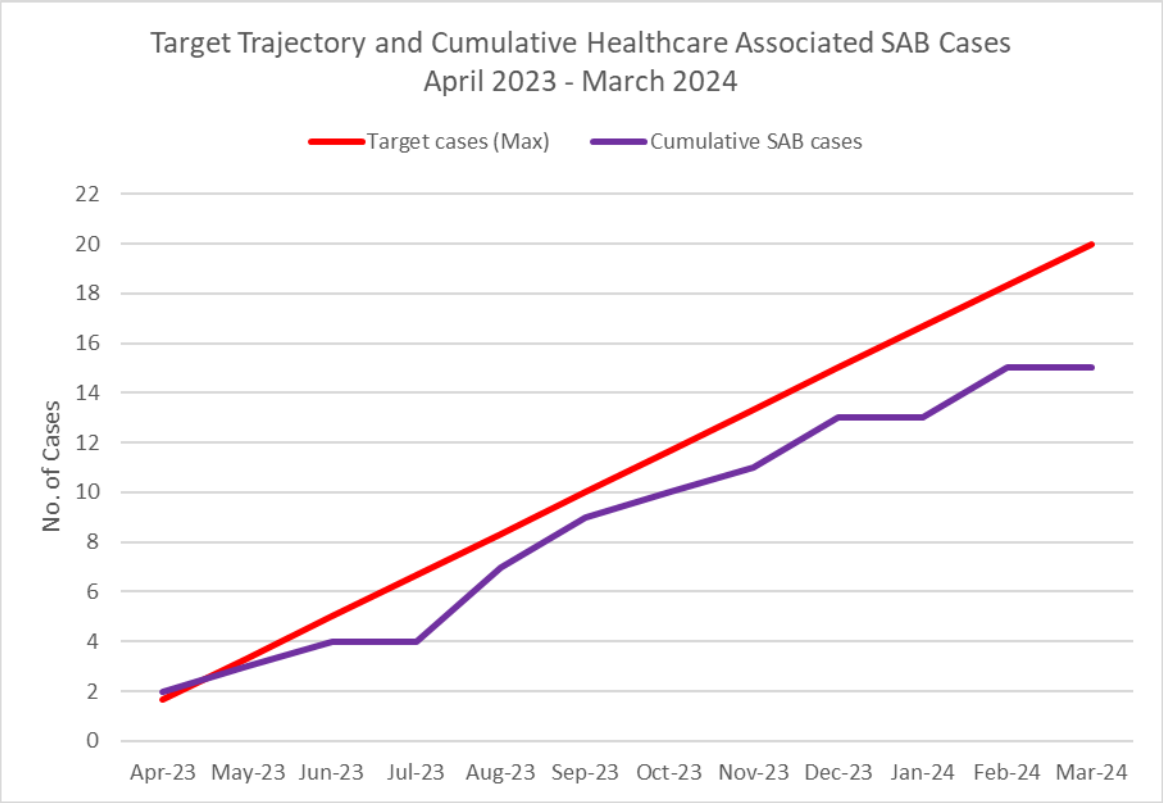


Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

- ***Clostridioides difficile Infection (CDI)***

1.4 NHS Borders had a total of 17 *C. difficile* Infection (CDI) cases between April 2023 and March 2024; 14* of these cases were healthcare associated infections.

1.4a *4 of these healthcare associated cases relate to one patient with recurring CDI. Each sample was taken >28 days apart therefore as per ARHAI definitions, these must be reported as separate CDI incidences.

1.5 As with SABs, the Scottish Government had set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline). Our predicted target rate for this period equates to no more than 12 healthcare associated CDI cases. We have tentatively not achieved this as per figure 2 but we are awaiting ARHAI Scotland publication of Q1 2024 epidemiological data in June or July 2024 which will confirm total occupied bed days and cases for the period; our rate will then be adjusted accordingly.

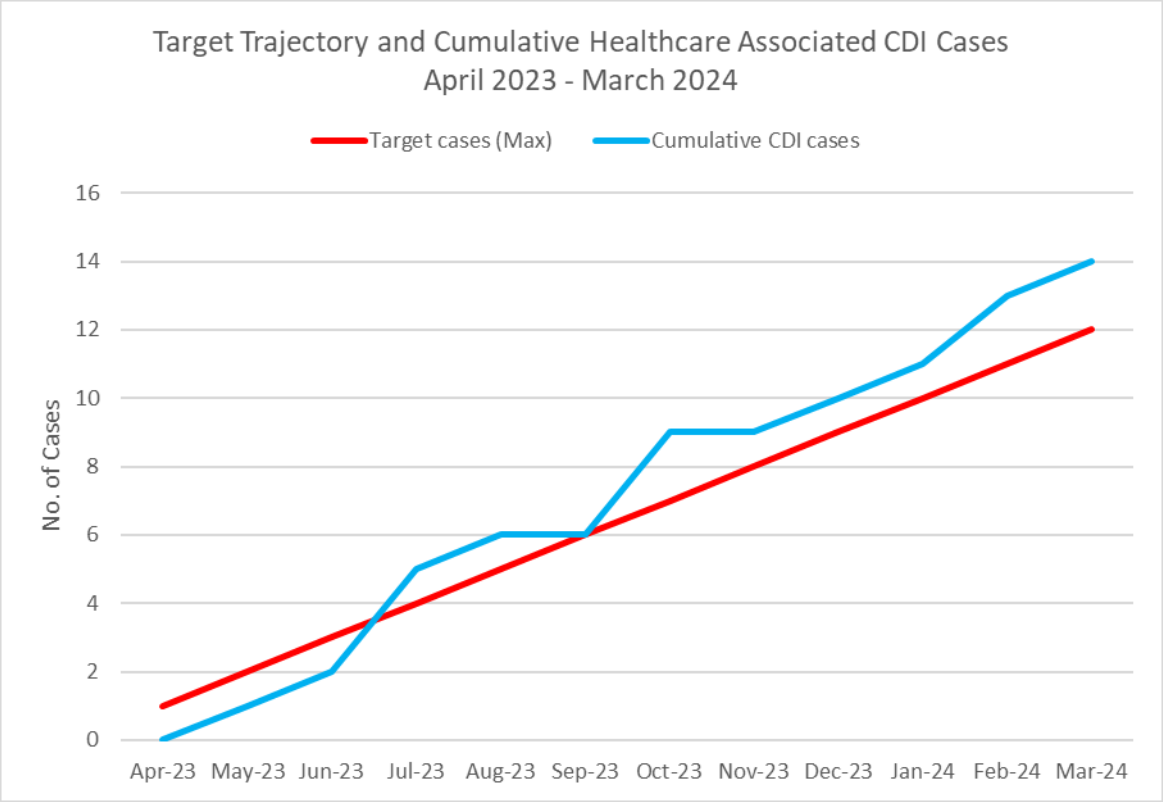


Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

- ***Escherichia coli* bacteraemia (ECB)**

1.5 NHS Borders had a total of 102 *Escherichia coli* bacteraemia (ECB) cases between April 2023 and March 2024; 56 of which were healthcare associated infections.

1.6 The Scottish Government has set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline). Our predicted target rate for this period equates to no more than 32 healthcare associated ECB cases. We have not met this target as shown in figure 3 below. We are awaiting ARHAI Scotland publication of Q1 2024 epidemiological data in June or July 2024 which will confirm

total occupied bed days and cases for the period; our rate will then be adjusted accordingly.

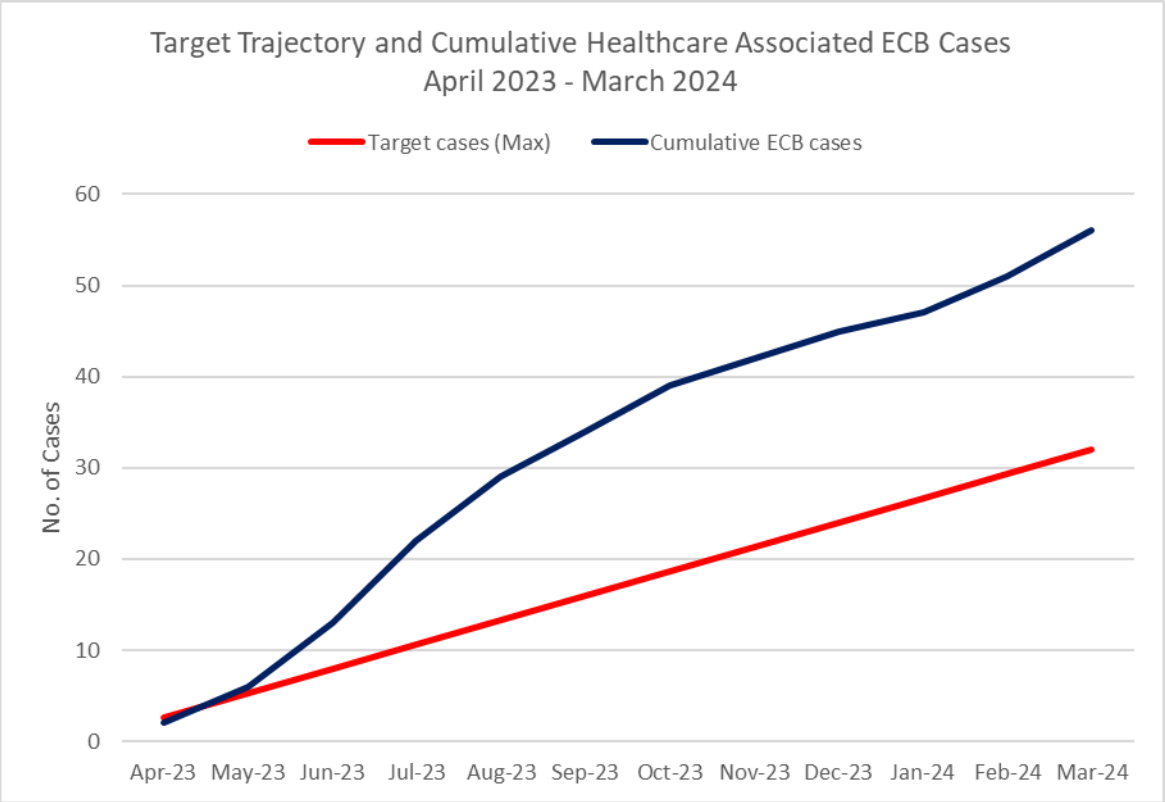


Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

1.7 We are awaiting updated Government guidance to enable us to calculate our new SAB, CDI and ECB targets for 2024-25.

2.0 Infection Surveillance

- ***Staphylococcus aureus* Bacteraemia (SAB)**
  (Background information provided in Appendix A)

2.1 All of the 32 SAB cases reported between April 2023 and March 2024 were Meticillin-sensitive *Staphylococcus aureus* (MSSA).

2.2 Figure 4 shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated SAB case. The reason for displaying the data in this type of chart is due to SAB cases being rare events with low numbers each month.

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

2.4 In interpreting Figure 4, it is important to remember that as this graph plots the number of days between infections, we are trying to achieve performance above the green average line.

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

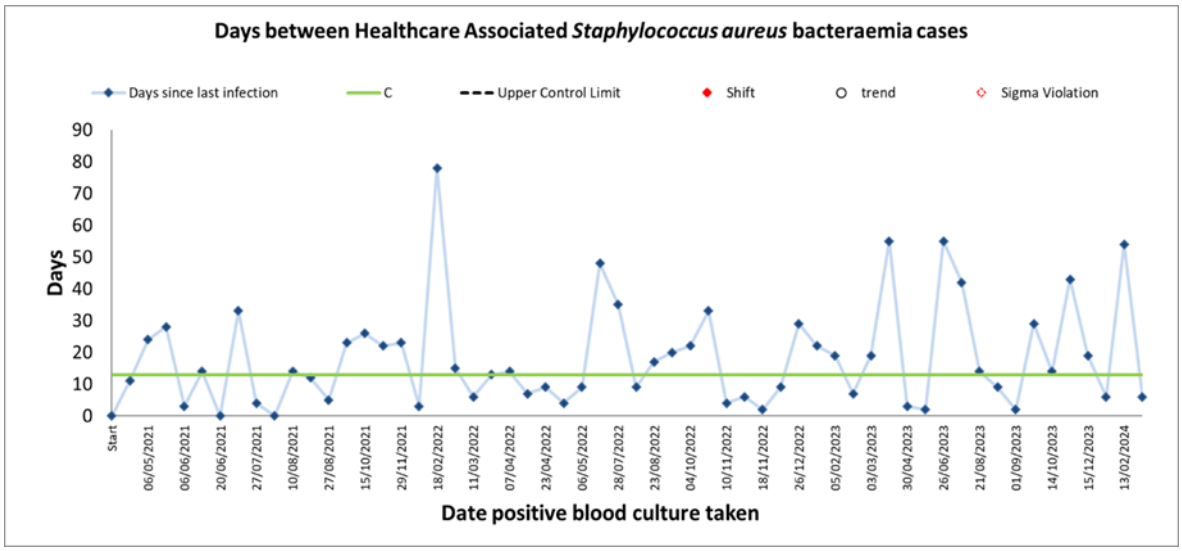
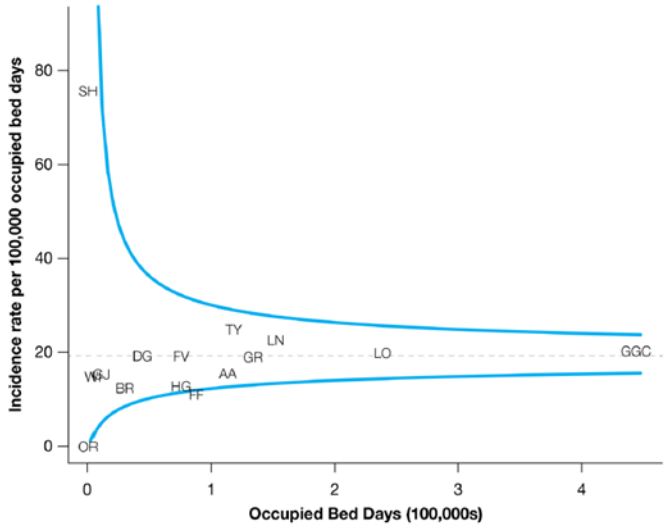


Figure 4: NHS Borders days between healthcare associated SAB cases (May 2021 – March 2024)

2.6 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows the most recently published data as a funnel plot of healthcare associated SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 4 2023 (Oct 2023 – Dec 2023).

2.7 During this period, NHS Borders (BR) had a rate of 12.4 which was below the Scottish average rate of 19.2.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Western Isles and NHS Golden Jubilee overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Key to NHS Boards

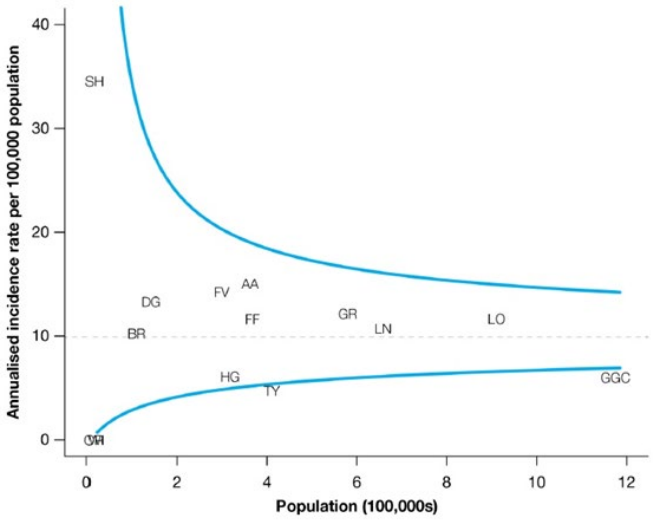
AA = Ayrshire & Arran
BR = Borders
DG = Dumfries & Galloway
FV = Forth Valley
FF = Fife
GR = Grampian
GGC = Greater Glasgow & Clyde
HG = Highland
LN = Lanarkshire
LO = Lothian
NWTC = National Waiting Times Centre
OR = Orkney
SH = Shetland
TY = Tayside
WI = Western Isles

Figure 5: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q4 2023

2.8 A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed

Days. Figure 5 shows that NHS Borders was within the blue funnel which means that we are not a statistical outlier.

2.9 Figure 6 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q4 2023.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Orkney and NHS Western Isles overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 6: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q4 2023

2.10 During this period NHS Borders (BR) had a rate of 10.3 per 100,000 population which was above the Scottish average rate of 9.9. It is worth noting that community acquired SAB cases had no healthcare intervention prior to the positive blood culture being taken. We are not a statistical outlier from the rest of Scotland.

- ***Clostridioides difficile Infection (CDI)***
  (Background information provided in Appendix A)

2.11 Figure 7 below shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated CDI case. As with SAB cases, the reason for displaying the data in this type of chart is due to CDI cases being rare events with low numbers each month.

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

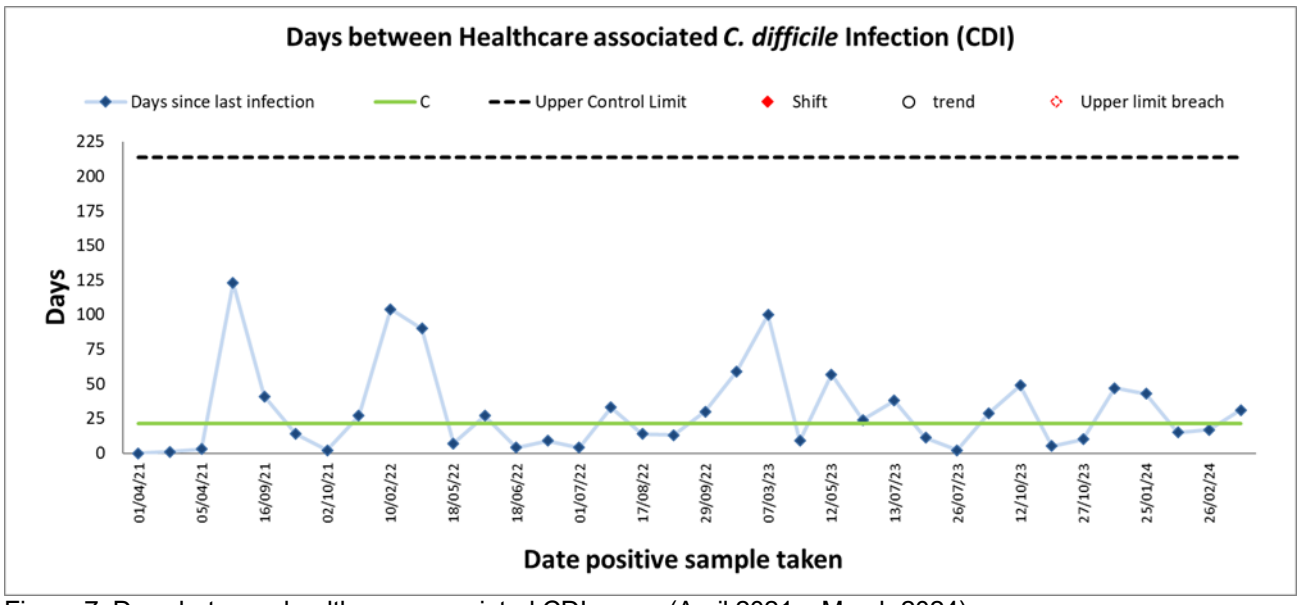
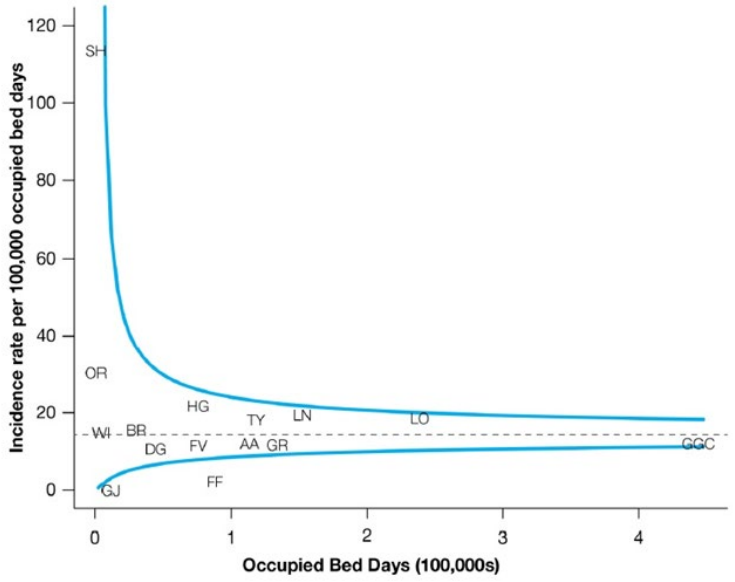


Figure 7: Days between healthcare associated CDI cases (April 2021 – March 2024)

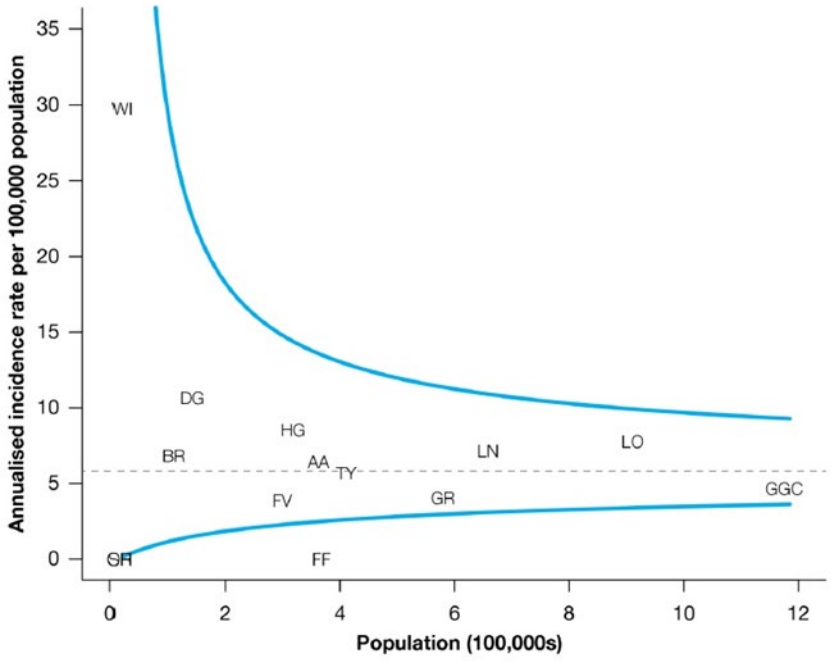
2.13 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 8 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q4 2023. The graph shows that NHS Borders (BR) had a rate of 15.6 which was above the Scottish average rate of 14.3.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 8: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q4 2023

2.14 Figure 9 below shows a funnel plot of CDI incidence rates (per 100,000 population) of community associated infection cases for all NHS Boards in Scotland in Q4 2023. The graph shows that NHS Borders (BR) had a rate of 6.8 which was above the Scottish average rate of 5.8 but we are not a statistical outlier from the rest of Scotland.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Orkney and NHS Shetland overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 9: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q4 2023

- ***Escherichia coli* bacteraemia (ECB)**
  (Background information provided in Appendix A)

2.17 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 10 below.

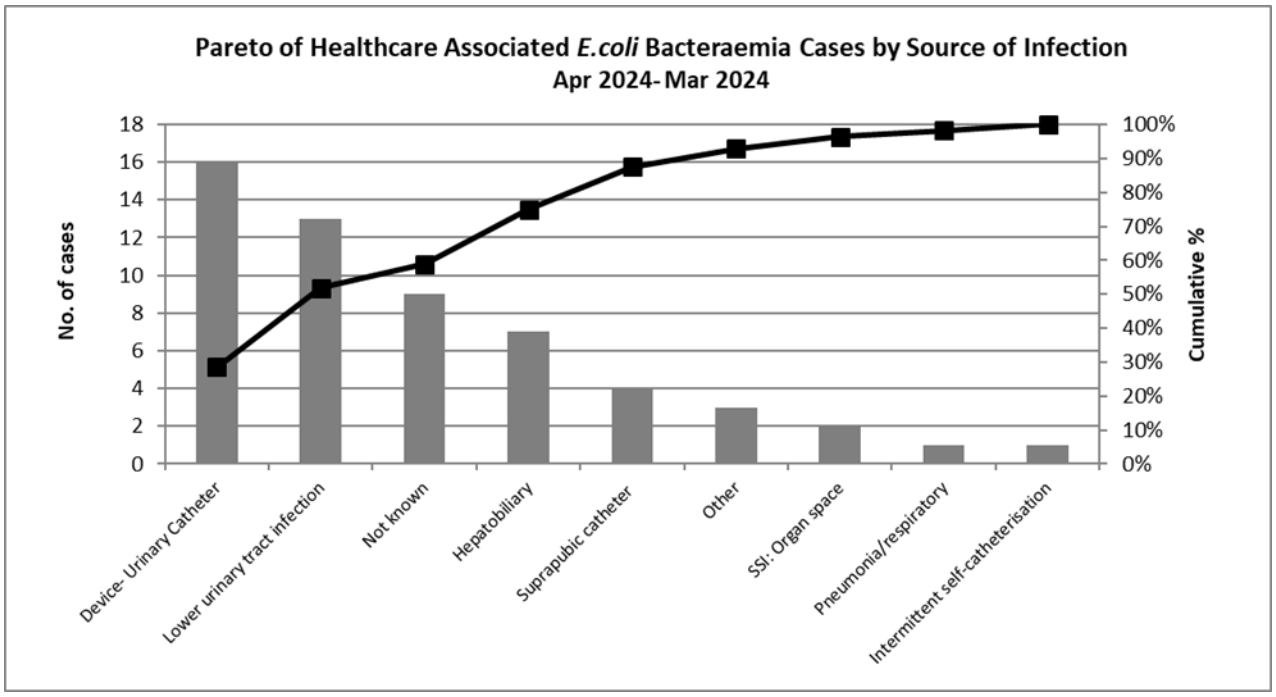


Figure 10: Pareto chart of healthcare associated ECB cases by source of infection

2.18 Figure 11 shows a statistical process chart of the total number of healthcare associated *E.coli* bacteraemia cases per month. The chart shows that the total number of cases reported per month was within expected limits and there have been no statistically significant events.

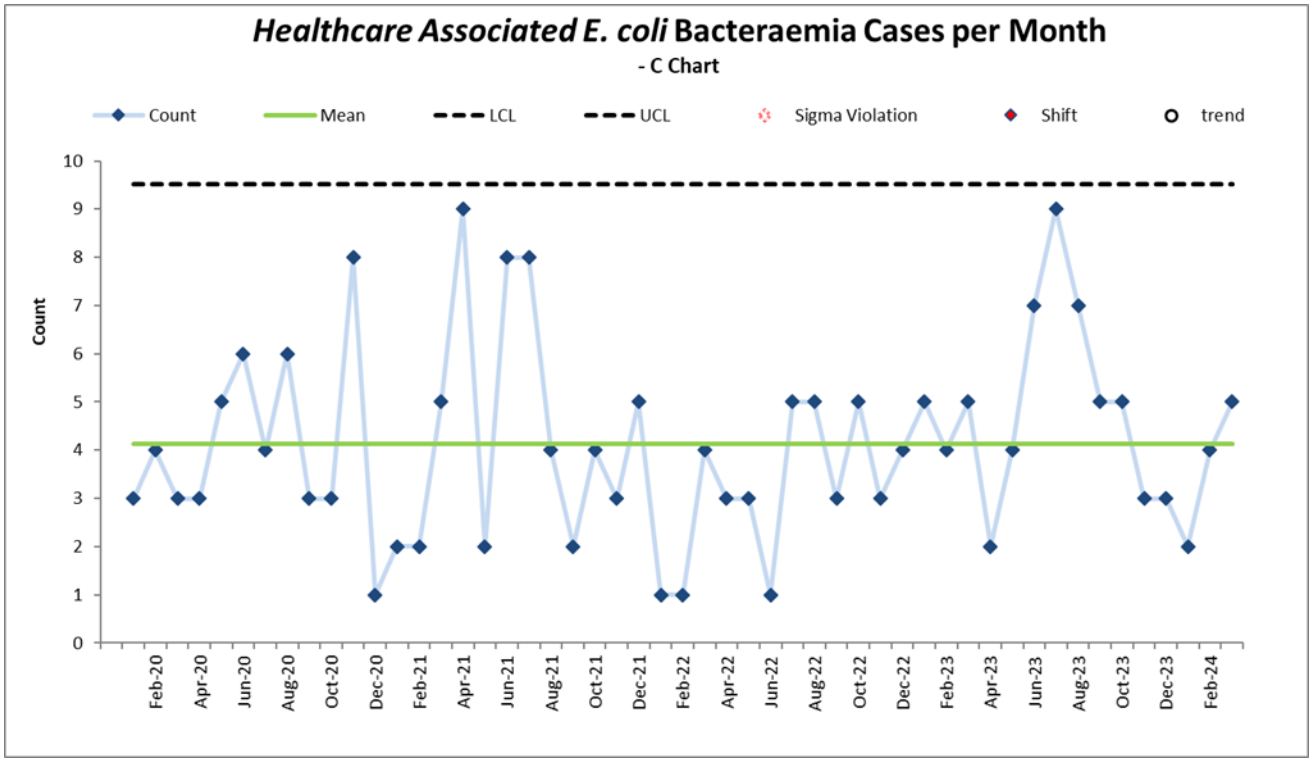
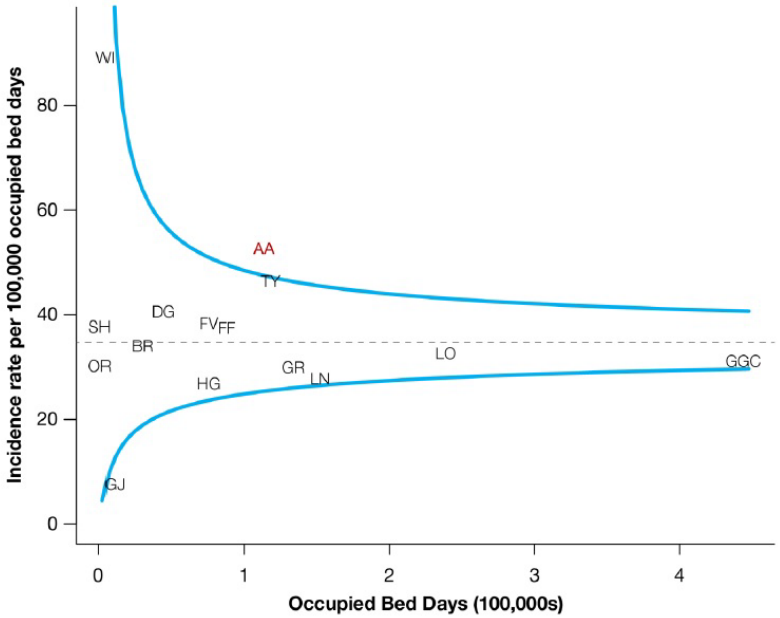


Figure 11: Statistical process chart (SPC) of healthcare associated *E.coli* bacteraemia cases per month (Jan 2020-Mar 2024)

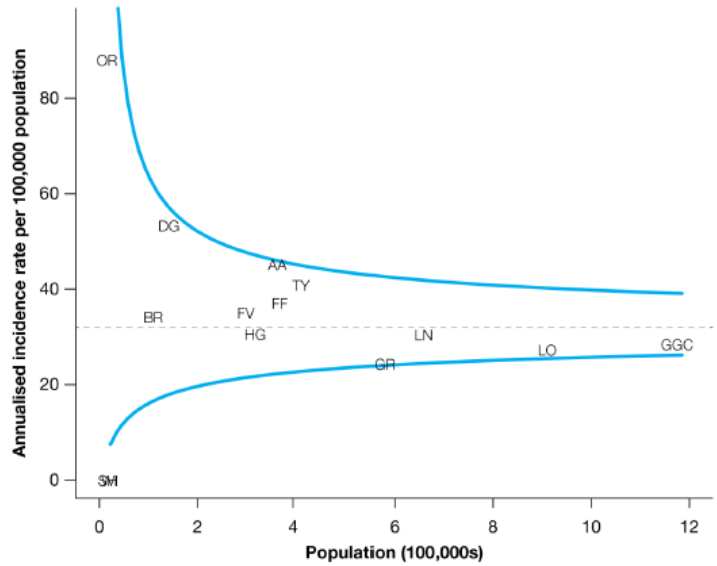
2.19 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 12 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q4 2023. NHS Borders (BR) had a rate of 34.2 for healthcare associated infection cases which was below the Scottish average rate of 34.7.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 12: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q4 2023

2.20 Figure 13 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q4 2023. NHS Borders (BR) had a rate of 34.2 for community associated infection cases which was above the Scottish average rate of 32.0 but we are not a statistical outlier from the rest of Scotland. It is worth noting that community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Shetland and NHS Western Isles overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 13: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q4 2023

3.0 NHS Borders Surgical Site Infection (SSI) Surveillance

3.1 The Scottish Government paused the requirement for mandatory surgical site infection (SSI) surveillance on the 25th of March 2020. There has been no indication of a potential date for re-starting national SSI surveillance.

3.2 In July 2023 NHS Borders resumed local SSI surveillance for hip and knee arthroplasty and C-section surveillance was recommenced in January 2024. A summary of SSI cases and rates is provided below in figures 14 and 15.

Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) **(Jan - Mar 2024)**			
Procedure	**Total ops**	**Total SSIs**	**SSI Rate**
Hip arthroplasty	27	0	0.00%
Knee arthroplasty	24	1	4.17%
C-section	99	2	2.02%

Figure 14: Summary of SSIs with SSI rate

SSIs per month with category of infection (Using ARHAI Scotland definitions) **(Jan - Mar 2024)**		
Procedure	**Month**	**SSI category**
C-section	January	Superficial
Knee arthroplasty	February	Superficial
C-section	March	Superficial

Figure 15: SSIs per month with category of infection

NB: Official SSI rates are based on a 12-month period, therefore the data presented in the table is not directly comparable to any previously published pre-pandemic data.

3.4 On 19th April, the Orthopaedic SSI Task and Finish Group completed a review of the post-operative patient pathway against national guidance. The next step will be to produce an overarching improvement plan incorporating the learning from each completed review (pre-operative, intra-operative and post-operative).

3.5 Infection Prevention and Control continue to meet with the Associate Director of Midwifery/General Manager for Women & Children Services and the Clinical Director to identify and progress actions to reduce the risk of SSI following C-section. Confirmed SSIs are also reviewed by the Core Management Team. March data is not yet available but will be published in the next Clinical Governance update.

4.0 Incidents and Outbreaks

- **Respiratory outbreaks**

4.1 Since the last Clinical Governance Committee, there have been 4 respiratory clusters for which a Problem Assessment Group (PAG) and/or Incident Management Team (IMT) has been held. A summary for each closed cluster as at 9th May 2024 is detailed in Appendix A.

4.2 Any learning from each incident is captured and acted upon in real time where appropriate.

- **Norovirus**

4.3 There have been no Norovirus incidents since the last Clinical Governance Committee update.

- **Meticillin-sensitive Staphylococcus aureus (MSSA)**

4.4 On the 19th of April, a PAG was held to discuss cases of MSSA in Hawick Community Hospital. 3 patients were confirmed via spa typing to have the same strain of MSSA, 2 of which were infections and 1 of which was colonisation. This was a coincidental finding as MSSA is not normally included in our surveillance unless the patients are in a high risk area. It was not possible to identify the origin of the cases, the transmission route or direction of transmission. No concerns were raised regarding control measures and a recent Infection Control audit in Hawick Community Hospital conducted in April scored 99%. No further cases were identified.

- **Group A Streptococcus (GAS)**

4.5 On the 12th of April a PAG was held to discuss 2 cases of GAS in Hawick Community Hospital. The 1st case had been in hospital since February 2024, this prompted screening of 3 contacts in the bay to rule out transmission. 1 further patient was found to have GAS in their throat, however they were colonised only and did not receive treatment. As with the MSSA incident, no concerns were raised regarding control measures. No further cases were identified. Local surveillance has identified an increased prevalence of GAS in the community. Origin of infection remains unknown for both of these patients.

5.0 Infection Control Compliance Monitoring Programme

5.1 In February, March and April 2024, spot checks were undertaken in a total of 29 clinical areas across NHS Borders with an average compliance of 92.8% (Appendix B).

5.2 The new audit programme for 2024/25 commenced in April 2024 following a review to ensure alignment with National and local guidance. 4 areas were audited in April 2024 and all achieved ≥92% compliance.

Ward	Date of previous FULL SICPs Audit	Previous FULL SICPs Audit Scores (%)	Date of SICPs Audit (2024-2025)	SICPs Audit Score (%)	Date Audit & Actions Sent to Ward
Margaret Kerr Unit	**04-Apr-23**	**90%**	**29-Apr-04**	**97%**	**30/04/2024**
Ward 17	**-**	**-**	**17-Apr-24**	**93%**	**17/04/2024**
Hawick	**07-Sep-23**	**91%**	**22-Apr-24**	**99%**	**29/04/2024**
BSDU	**25-Jul-23**	**91%**	**16-Apr-24**	**92%**	**18/04/2024**

5.3 Infection Prevention & Control (IPC) monitor themes from spot checks and audits on a monthly basis.

6.0 Quality Improvement Update

6.1 The Prevention of CAUTI Group last met on 30th April 2024 and continues to oversee progress against the action plan and review data at each meeting to consider additional areas for improvement.

6.2 The group plan to conduct a one off catheter count at the beginning of June 2024 across acute, community hospitals, mental health and district nursing teams. This is to identify all patients/service users with a catheter and reason for the catheter. This work will highlight areas with higher catheter use and potential focus for support in relation to management and documentation.

6.3 A short life working group is planned to develop and promote a hydration campaign across NHS Borders during the summer. The Care Home Support Team will be taking similar action across Care Homes.

7.0 Cleaning and the Healthcare Environment

7.1 Health Facilities Scotland (HFS) publishes quarterly reports on cleanliness standards and estates fabric across NHS Scotland. The most recently published report covers the period October - December 2023. Figure 16 below shows NHS October – December 2023, the cleanliness score for NHS Borders was 95.4%. In the same period, the estates score was 98.4%.

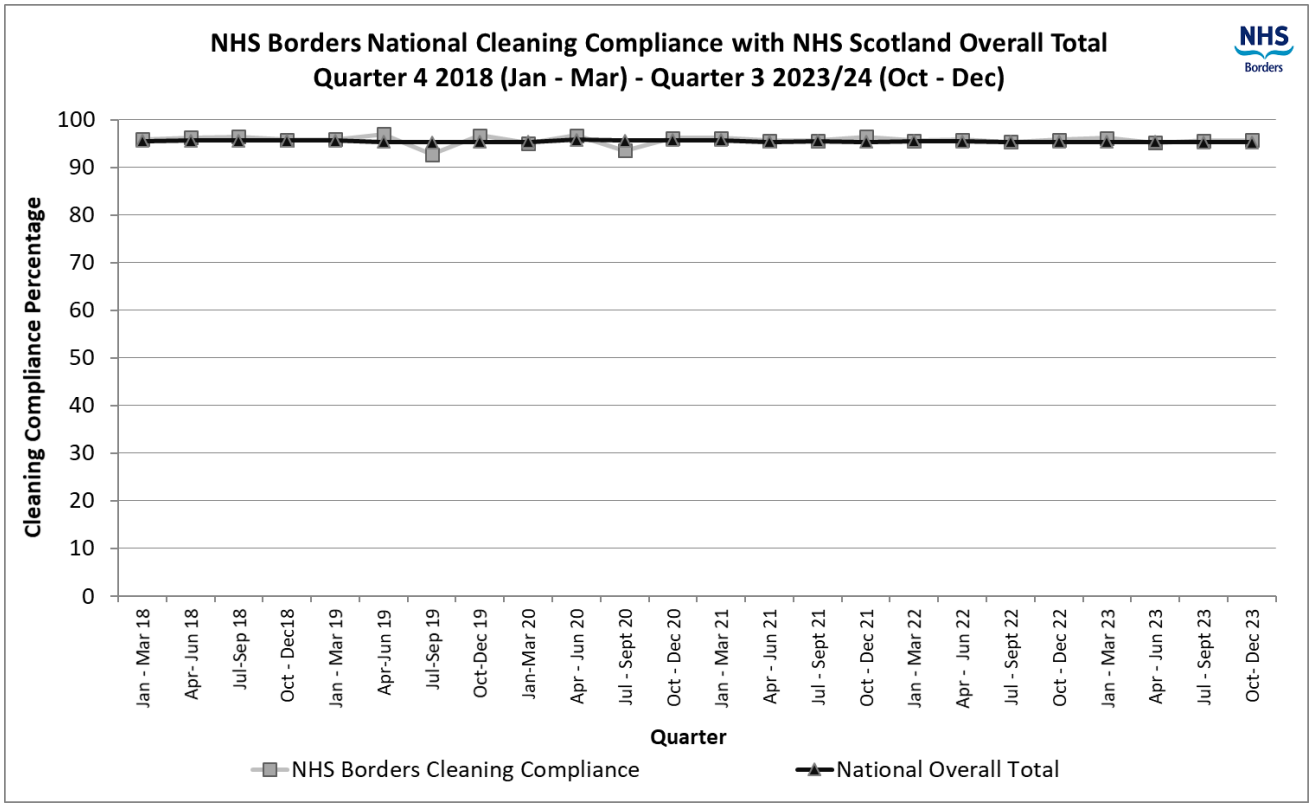


Figure 16: NHS Borders cleaning compliance against the NHS Scotland average by quarter

8.0 Hand Hygiene

8.1 NHS Borders has been informed by the National Distribution Service that GOJO Industries (our hand gel and soap supplier) has gone into administration. A short life working group is overseeing changeover to an alternative supplier with support from National Services Scotland.

8.2 The changeover process has commenced in the community and will shortly also commence in BGH. Implementation is being closely managed to ensure no area is left without hand sanitising products and to run-down existing product to minimise waste.

8.3 Since the last update to the Board, further hand hygiene audits were completed in March 2024. The outcome of the audits are detailed in Figure 17 below.

Staff Group	Opportunities Observed	Opportunities Taken	Overall Compliance by Staff Group
Nursing	198	144	73%
Medical	75	37	49%
AHP	23	21	91%
General Services / Portering	21	16	76%
Overall Compliance	317	218	69%

Figure 17: March 2024 hand hygiene compliance audits by staff group

8.4 Since this audit was completed, the Medical Director has requested provision of hand hygiene education to doctors at all levels. At the most recent meeting of the Training, Education and Development Board, a proposal to introduce role specific hand hygiene mandatory training was approved. This additional requirement is to complete a hand hygiene module developed by NHS Education Scotland and will be mandatory for all clinical staff, domestics, porters and drivers with a requirement to complete the module every 2 years.

8.5 The Infection Prevention and Control Team promoted the importance of hand hygiene in support of World Hand Hygiene Day in May. Staffed hand hygiene stalls were located at the main stairwell in BGH and the Canteen with information boards and free products and promotional items for staff to take away.

8.6 At the Canteen stall a short questionnaire was promoted to seek staff views on barriers to hand hygiene. Staff also had the opportunity to place their fingers onto agar plates which the Microbiology Laboratory then cultured to grow organisms from the prints. Staff were provided with a unique anonymous number and the cultured plates were then photographed next to the number so each individual that participated could see the germs that had been on their hands at lunch time.

8.7 A number of wards were also visited by the Infection Prevention and Control Team with staff engaging whilst swabs were taken of frequently touched items including:-

- Stethoscope
- Ward phone
- Computer keyboard
- Ward exit button
- Patient notes

8.8 Photographs of the organisms grown from these swabs were fed back to the wards and will also be used in future educational content to promote the importance of hand hygiene.

8.9 The Infection Prevention and Control Team are also working with procurement to source individual patient hand wipes to support patient hand hygiene at mealtimes. Hand wipes are already available for this purpose but it is hoped that the smaller packs being sourced will reduce waste, save money and also provide a fresh opportunity to review wards processes to ensure provision of hand wipes for patients is reliable. A patient information leaflet to accompany the hand wipes is also being developed.

9.0 Infection Control Work Plan 2024/25

9.1 The Infection Prevention and Control Team provide both a reactive and proactive service. Responding to significant unexpected events or peaks of clinical activity such as outbreak management requires flexing resources away from proactive to reactive activities impacting on Work Plan progress.

9.2 Significant Infection Prevention and Control resource continues to be diverted to support the work of the COVID Deaths Investigation Team (CDIT). This is a specialist unit within the Crown Office & Procurator Fiscal Service (COPFS) tasked with investigating the deaths of care home residents and workers related to Covid-19.

9.3 There are currently eight overdue actions in the 2024/25 Infection Control Work Plan of which three are assessed as medium risk and the remainder low risk.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

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

Understanding the Report Cards – Infection Case Numbers

Clostridium difficile infections (CDI) and Staphylococcus aureus bacteraemia (SAB) cases are presented for each hospital, broken down by month. Staphylococcus aureus bacteraemia (SAB) cases are further broken down into Meticillin Sensitive Staphylococcus aureus (MSSA) and Meticillin Resistant Staphylococcus aureus (MRSA).

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

Targets

There are national targets associated with reductions in E.coli bacteraemia, C.diff and SABs. More information on these can be found on the UKHSA website:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1081256/mandatory-healthcare-associated-infection-surveillance-data-quality-statement-FY2019-to-FY2020.pdf

Understanding the Report Cards – Cleaning Compliance

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

Understanding the Report Cards – '*Out of Hospital Infections*'

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

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	3	2	1	4	4	1	2	4	2	5	1
Total SABS	3	2	1	4	4	1	2	4	2	5	1

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Ages 15-64	0	1	1	0	0	2	0	0	0	0	0
Ages 65 plus	1	1	2	2	0	2	0	1	1	2	1
Ages 15 plus	1	2	3	0	0	4	0	1	1	2	1

Cleaning Compliance (%)

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Board Total	95.6	92.7	95.5	96.7	95.9	95.5	95.9	96.18	96.42	95.14	96.1

Estates Monitoring Compliance (%)

	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Board Total	96.9	98.5	97.5	98.3	97.5	98.0	98.09	98.62	97.86	95.37	98.61

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	0	1	1	0	1	2	0	1	0
Total SABS	1	1	0	1	1	0	1	2	0	1	0

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Ages 15-64	0	0	0	0	0	1	0	0	0	0	0
Ages 65 plus	0	1	0	0	0	0	0	0	1	2	1
Ages 15 plus	0	1	0	0	0	1	0	0	1	2	1

Cleaning Compliance (%)

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
BGH Total	98.4	98.0	98.3	99.0	98.1	98.4	99.0	98.1	98.4	98.0	98.3

Estates Monitoring Compliance (%)

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
BGH Total	98.4	98.0	98.3	99.0	98.1	98.4	98.4	98.0	98.3	99.0	98.1

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

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

Staphylococcus aureus bacteraemia monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	2	1	1	3	3	1	1	2	2	4	1
Total SABS	2	1	1	3	3	1	1	2	2	4	1

Clostridioides difficile infection monthly case numbers

	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024
Ages 15-64	0	1	1	0	0	1	0	0	0	0	0
Ages 65 plus	1	0	2	2	0	2	0	0	0	0	0
Ages 15 plus	1	1	3	0	0	3	0	0	0	0	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety.

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

This is an update paper, so a full impact assessment is not required.

2.3.6 Climate Change

None identified.

2.3.7 Other impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

This is a regular update as required by SGHD and has not been subject to any prior consultation or engagement although much of the data is included in the monthly infection control reports which are presented to divisional clinical governance groups and the Infection Control Committee.

2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the NHS Borders Board

2.4 Recommendation

Committee members are asked to:

- **Discussion** – Examine and consider the implications of a matter.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**

- **No Assurance**

3 List of appendices

Appendix A: Supplementary information and definitions
Appendix B: Outbreak summary

APPENDIX A

Definitions and Supplementary Information

Staphylococcus aureus Bacteraemia (SAB)

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

Staphylococcus aureus : https://www.nhs.uk/conditions/staphylococcal-infections/

MRSA: https://www.nhs.uk/conditions/mrsa/

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

https://www.hps.scot.nhs.uk/publications/?topic=HAI%20Quarterly%20Epidemiological%20Data

Clostridioides difficile infection (CDI)

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

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

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

https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

Escherichia coli bacteraemia (ECB)

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

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

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

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.

Cleaning and the Healthcare Environment

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

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

Healthcare environment standards are also independently inspected by Healthcare Improvement Scotland. More details can be found at:

https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

APPENDIX B

NHS Borders Clusters as at 09/05/2024 (CLOSED INCIDENTS ONLY)					
Outbreak start date	**Outbreak location(s)**	**Organism**	**Positive patient cases**	**Patient deaths** (COVID recorded on DC)	**Suspected/ confirmed staff cases**
10/04/2024	Ward 5 Bay 1 & Ward 4 Bay 4	COVID	3	0	0
19/04/2024	MAU Bay 1	COVID	4	0	0
26/04/2024	Ward 9 Bay 3 & 4	COVID	5	0	0
30/04/2024	Ward 7 Bay 1	COVID	4	0	0

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Staff Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Andy Carter, Director of HR, OD & OH&S**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Staff Governance Committee 18 April 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Staff Governance Committee minutes 29.11.23

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Wednesday 29th November 2023, 13:00-14:50 via Microsoft Teams

Present:
Councillor David Parker, Non-ExecutiveDirector (Chair)
Mr Andy Carter, Director of HR, OD, OH&S
Ms Claire Smith, eRoster ImplementationLead
Ms Edwina Cameron, Staff Involvement and OD Lead
Ms Fiona Armstrong, LD Charge Nurse/Union
Ms Harriet Campbell, Non-Executive Director
Mr Ian Ritchie, Non-Executive Director GG&C (observing)
Mr John McLaren, Employee Director
Ms Kirsty McLachlan, Interim Head of Occupational Health
Miss Marcella Malley, Personal Assistant (Minutes)
Ms Michelle O'Reilly, Head of C&PD
Ms Sonya Lam, Non-Executive Director
Mr Stasys Gimbutis, eRostering Implementation and Delivery Manager
Ms Sue Keean, H&S Lead Advisor
Ms Vikki MacPherson, Partnership Lead Staff Side

Apologies:
Mrs Ailsa Paterson, Deputy Director of HR
Ms Gail Russell, Partnership Lead Mental Health
Ms Karen Hamilton, Chair
Ms Karen Lawrie, Partnership Lead
Ms Mandy Colquhoun, OD Partner and Employability Lead
Ms Yvonne Smith, Staff Side Chair (BGH)

1. Welcome, Introduction andApologies

All committee members present at the meeting were welcomed and apologies were noted. It wasnotedthatthemeetingwasquorate. It was also stated that Items4.1, 5 and 6 on the agenda would be promoted and would be discussed following Item 1 as CS and SG would be unavailable to speak to these items later in themeeting.

2. Standing Item

2.1 Workforce Planning Update

CS noted that workforce planning progress has been limited due to resources being focussed on eRostering support. There has, however, recently been engagement from partners in the form of a workshop, where KPIs were developed and areas of mutual interest agreed.The main focus has been on training and wellbeing, with workforce plans having been looked into from an operational and strategic perspective. SL queried what the strategic aims are and how the Resources & Performance Committee can be assured of progress; HC also queried what the timescales are for any actions required. CS stated that the 3-year Integrated Workforce Plan was developed last year with a large number of actions associated with this; this is now due to be reviewed as part of the annual update. The actions currently in place are to be condensed in order to effectively measure these and focus on the most prevalent areas, such as the move from acute to community care

and how to achieve this through working closer together. AC noted that individual workforce plans also exist in addition to the integrated plan; ad hoc work is also required to tackle any further issues that arise in addition to ongoing issues that have a workforce planning component to them. HC noted that assurance needs to be provided that targets are being worked on and met in relation to workforce planning; AC responded that a paper can be brought to and discussed at the next meeting with regards to the current situation of the Integrated Workforce Plan.

3. eRostering Update

CS stated that the current eRostering system being rolled out within NHS Borders is a centralised system that is compulsory and is also being rolled out across Scotland in order to provide a consistent platform to support rostering and improve visibility and equity. The Safe Care module within the system acts as a workload tool by allowing real time comparisons of staffing levels and skill mixes, which also feeds into the Health and Care (Staffing) Act; NHS Western Isles are currently testing this aspect. As part of the eRostering process, all staff members in NHS Borders will also be given access to the Loop app, which will allow for viewing and booking of shifts and leave; it is also expected that bank shifts will be booked via this app. It was stated that this app has been well received by those areas it has been implemented in.

A demonstration of the system was provided to committee members; the auto-roster tool was shown and explained as being an unambiguous method of allocating shifts, with the ability to build rules into the background (e.g. individuals' working days); this method is being promoted as the most effective way to add rosters. eRostering resource has also recently improved with successful recruitments to the core team; SG was recruited as the Implementation & Delivery Manager, with a further 4 (3 WTE) Support Managers starting in post in December 2023. The interim team will remain in post until March 2024 and will be phased back to their substantive roles in order to aid with training and orientation of the new core team; it was noted that the programme has benefited significantly from the knowledge and background of the interim team.

There are currently 5 early adopter AfC sites where the system is live; the system is then to be rolled out to Women and Children's Services, Facilities and Ward 5 and MAU. It was noted that set-up, configuration and training is more complex for medical areas, with Child Health having been the only medical early adopter, as these areas are activity based rather than shift based, which requires further background work. The demonstration of the system also highlighted some further benefits, such as the ability for the summary page to show any roster issues (e.g. unfilled duties) and an overview of rosters and leave allocated for both managers and staff members on an individual and team basis. Duties and shifts can also be requested by staff members, with the additional ability to view personal details so that these can be kept up to date.

VM queried whether the Loop app would show whether other staff members were off sick, as a group of staff had raised this as a potential issue; CS responded that the app would only show staff members as being unavailable if they were absent. VM also noted that staff had provided feedback that the app could access their camera rolls on their phone; CS noted that this had been fed back and resolved, however it is unlikely that this is linked with the Loop app as it should not have access to any other apps. HC queried whether the rollout and use of eRostering is optional and how current training and uptake are progressing; it was also asked whether the rollout of the system would be nationwide and could be used by, for example, medics who work across different boards. CS responded that eRostering itself is mandatory, however individual staff members' use of the Loop app is optional. There has been a level of resistance in some areas to using the app, however once it was demonstrated and the benefits were highlighted, staff are now keen to use this.

It is hoped that all staff will use the app; no date has been set as yet as more clarity is required with regards to permanent resource in the first instance. There have also been various approaches to staff training, including Senior Charge Nurses cascading training to their staff and drop-in sessions to offer support to staff members with regards to using the Loop app; individual areas are being worked with to ascertain their specific training requirements.

JM echoed VM's query in chat regarding how equal access can be guaranteed if some staff members do not have access to a smartphone; CS responded that a desktop app is also available and can be accessed either at work or at home if a device is available. If staff members have no access to any IT equipment, then rosters can be printed instead and leave requests submitted directly to their line manager which can then be updated on the system; however, staff members are currently being encouraged and supported to use the app. JM also queried whether any of the identified benefits of the system are at risk due to the method of rollout and lack of resource; CS noted that it may take longer to realise some benefits due to the small size of the team. Analysis will also be conducted to determine the number of WTE staff required to successfully roll out the programme in a specific timescale, as well as value-added resource to support departments. JM added that arguably the value-added aspects of the programme could be a requirement and so the programme would be under-resourced as a result if these were to be dismissed and some benefits avoided. It was also queried how the safety aspects of the roster are decided; CS responded that much preparation work goes into the system before a unit goes live, including building parameters and rules into the system and checking these when adding future auto rosters. JM noted that the system itself, as a result, does not keep staff safe as it depends on which parameters have been entered and so an issue still exists in relation to safe staffing.

SL queried where the reports would go to provide an overview of real time information; it was suggested that as well as the Staff Governance Committee, the information could be useful for both the Clinical Governance Committee and Resources & Performance Committee. It was also asked how safe staffing is determined, as these levels are more easily calculated in certain areas compared to others, how the requirements of the Health & Care (Staffing) Act are being monitored and whether the Equality Impact Assessment has been completed for this piece of work. CS noted that as the programme is still in the early stages of rollout, reports are only being sent to the early adopter departments to ensure that rosters are accurately reflected and following this, reports will then be sent to the Programme Board and Safe Staffing Board; governance beyond this is currently being worked on.

AC noted that the system had been agreed nationally by Board Chief Executives a number of years ago, however implementation was started in August of this year and moved from the AHP/N&M directorate to HR as more synergies were seen in this area. Resources are adequate at the moment, however the process is labour intensive and so a train-the-trainer element may be introduced. An eRostering Programme Board is also in place as well as the Safe Staffing Board, so aspects between systems and legislative requirements will also need to be joined up. SL suggested that a paper could be brought to this committee to clarify how data is being used and where it is being fed into. CS noted that she will ask the Programme Manager if the EIA was completed before CS' involvement in the programme; AC added that this may have been done on a national Once for Scotland level and will determine if this is the case. The item was accepted by the committee.

4. International Recruitment Update

SG stated that prior to the start of the international recruitment campaign, there were over 60 Band 5 adult nursing vacancies in the BGH; 64 international nurses, AHPs and doctors

have since started with the organisation. It was noted that international recruitment is a costly process, due to sponsorship, preparation and housing, however NHS Borders did not need to spend anything on recruitment costs as a result of direct funding from the Scottish Government. This recruitment campaign has been a success as a result of combined teamwork from such departments as Facilities and Finance, who provided support with regards to housing (for example, by developing a unique contract with Eildon Housing).C&PD also carried out OSCE preparation and offered wider pastoral support. Other individuals and departments who provided help and support to the international recruitment campaign were thanked, including AC and Vineeth Ravindran for helping to set up the Ethnic Minority Forum, BS for starting the campaign, numerous departments for employing spouses of original international recruits and therefore aiding retention and a number of colleagues for safeguarding rental properties for international recruits. In addition, around half of new international nurses joined with UK experience and NMC registration already in place, which meant that they could start work immediately following induction. As a result of this campaign, agency use has decreased and NHS Borders now has the lowest Band 5 nursing vacancy rate in a hospital setting in Scotland at 3.4%; it is hoped that this situation will be sustained, as further recruits are scheduled to arrive and start work in January 2024.

AC thanked SG for his work on making this recruitment campaign a success story. It was also noted that Race & Equity training has been in place for staff members to aid cultural sensitivity in the workplace. HC queried whether international nurses in the community, particularly those from different ethnic backgrounds, are being welcomed and supported. It was also queried whether the UK decision to limit family immigration would affect the organisation; the 'brain drain' element of international recruitment was also noted as an ethical concern. SG responded that it only looks to be social care, rather than healthcare, that the UK government's decision on family immigration would affect, however this situation is being monitored. With regards to acceptance in the community, only positive feedback has been received from international nurses, with some nurses having noted that they specifically chose to work for NHS Borders due to positive comments received from their colleagues. A national survey for international employees has also recently been completed, the results of which will be made available in April. In relation to the 'brain drain' element, NHS Borders makes sure to comply with WHO's ethical recruitment, in that individuals are not recruited from a specified list of countries at risk.

SL queried what the issue is in terms of the attractiveness of nursing posts, as recruitment has been successful internationally, but not nationally or locally. It was also queried how staff can be retained; the fact that staff experience and learning is being taken into account to improve retention was commended. SG stated that a national shortage of NQPs and a lack of university presence in the Borders is contributing to the low local and national recruitment to nursing posts. With regards to retention, this should be improved by employment of international recruits' spouses (90% of which have been employed), which increases the likelihood of families settling in the Borders and therefore remaining in their job roles, as well as the lower cost of living in Scotland than in England and the positive feedback of the organisation and area from both colleagues and the population. It is also hoped that there will be more promotions of international staff in the future, which would aid retention further. MO noted that many universities have under-recruited this year, with the Scottish Government now having had to lift the band in relation to commission places due to this crisis. A ministerial task force is also currently looking into PAYE routes into nursing as a result of the cost-of-living concerns for students. It has also been noted that most newly recruited NQPs are from the Borders and not further afield, which is a concern. Work has also been carried out with the Florence Nightingale Foundation, as a result of which 5 international nurses have been successful in Leadership Development Programmes.

AC stated that the Ethnic Minority Forum (and its accompanying WhatsApp group) helps to

make international recruits feel welcome through regular meetings and answering of questions relating to life in the Borders. It was suggested that the potential decision to limit family immigration to the UK would be non-person-centred, and so it is hoped that this decision will not be taken forward. The attraction of national NQPs is also being worked on; it is hoped that retention will be further aided by retire-and-return opportunities and the new 36 hour working week, which should be more family-friendly. EC stated that a talent management programme for bands 3-6 is to be set up in the new year with Kirk Lakie, which should improve retention. It was also noted that employability colleagues have been working with C&PD to attract school leavers into NHS Borders posts. SL queried how to go about ensuring that people's workplaces are the best learning environment for them, as this can aid with attraction and retention. HC queried whether nursing can be studied at Borders College and whether it might be prudent to look at attracting NQPs from Northumberland, as well as simply Edinburgh and Glasgow. MO responded that a Healthcare Award course is available at Borders College, which is equivalent to year 1 of a nursing degree; HC added that students will then go to university and will be more likely to stay and look for work in their new location.

5. To Agree Minutes of Previous Meeting

The minutes of the previous meeting held on Thursday 7th September 2023 were approved without amendment. SL queried if the committee evaluation mentioned during the last meeting had been acted upon and suggested the use of an action tracker for committee meetings. AC stated that MM will circulate evaluations to committee members and create an action tracker.

6. Matters Arising

6.1 Staff Morale

KM stated that the issue of staff morale was raised recently at an HR, OD and OH&S Seniors meeting, as it had been observed that there has recently been an increased number of reports of inappropriate behaviour from colleagues in the workplace, which could potentially be explained by the current pressures in the system. Occupational Health continue to offer Respect at Work training for staff, which has a clear overlap with the LGBT+ and Race & Equity training that is also currently available. While Occupational Health is a support and advisory service that can help to guide staff through difficult situations, it is also important for managers to lead by example and help to embed a zero-tolerance culture where staff feel confident in raising any concerns. EC stated the behavioural framework is currently being rolled out to help embed the expected culture and behaviours within the organisation; 1-hour training programmes are available for staff, where the 3 Cs of communication are taught (Check in, Clarification and Chatting) to help call out bad behaviours. Coaching is also offered, which is especially helpful for managers, with a waiting list for this currently in place due to high demand. Whilst staff morale is variable, it was stated that it is important to face up to the current situation and to support staff as much as possible.

AC stated that the EEI in iMatter results has been increasing year-on-year which suggests that employees' commitment to the organisation is also increasing, however it is evident that there is upset in the system. There is ongoing work to help combat this, including increased staffing levels, Respect and Diversity training and an active Occupational Health & Safety Forum and Compassionate Leadership Programme. HC suggested that low staff morale may be a nationwide issue and that this should be addressed earlier so that staff do not feel that they need to be seen by Occupational Health; morale should therefore be assessed on a regular basis and staff checked in with. SL noted that the speak-up culture

is important in this respect and that staff should not feel intimidated to raise concerns. SK added in chat that staff should report any incidents via the adverse event reporting system to ensure that appropriate support is offered; MO noted that these issues are also covered in the Compassionate Leadership Programme and AC added that exit interview output is also utilised.

7. Standing Items
7.2 Whistleblowing Update

AC stated that there are currently 7 confidential contacts in the organisation, with 3 having actively dealt with whistleblowing cases. The Speak-Up publicity week in October garnered positive feedback, with 1 additional employee voicing interest in becoming a confidential contact. A meeting to discuss updates and training for confidential contacts has been scheduled for 6th December. There has been 1 new whistleblowing case this month regarding allegations relating to patient safety from an ex-nursing and midwifery employee who has recently left their job post with NHS Borders. This case is being managed at the moment by a confidential contact, an investigating manager and a commissioning senior manager. The whistleblowing process is also to be changed in early 2024 so that the coordinator role sits with a different senior colleague, allowing AC to provide HR advice in those cases that have an HR component.

SL noted that there is a proportionate number of confidential contacts in the organisation to allow for required experience and a possible expanding of roles. It was stated that the most recent Whistleblowing Governance Group meeting was postponed, however this has now been rescheduled for January; the Terms of Reference will be looked at and the change of governance outlined by AC will be ratified. A whistleblowing improvement plan is also being developed to improve both processes and the speak-up culture. HC queried whether the individual related to the most recent whistleblowing case felt able to speak up whilst they were in post and if speaking up now is perhaps related to the fact that they have now left employment. It was also queried what the plan is for whistleblowing once SL leaves her post. AC stated that as there are complexities with this particular case and in order to protect confidentiality, HC will be contacted outwith the meeting to discuss her queries. HC added that specific details are not required, only lessons learned in relation to speaking up in this particular case. SL noted that those who have the ability to speak up may have already done so through business-as-usual, however may not have received the outcome they were hoping for and so reverted to whistleblowing. It was also confirmed that SL will be leaving post at the end of January 2024 and a new Whistleblowing Champion has been appointed.

7.3 Strategic Risks: Workforce

AC reminded the committee that there are currently 4 main workforce strategic risks in place within the organisation; statutory and mandatory training, compliance with Health & Safety legislation, industrial action (which has now been averted in Scotland with respect to AfC staff and junior doctors) and a generic workforce risk. The former 3 risks have been entered on the risk register, however the latter requires some clarity before it can be added; this is to be discussed with the Medical Director and Director of Nursing, Midwifery and AHPs.

8. TED Board – First Full Year of Operation

MO stated that the Training, Education & Development (TED) Board was established just over a year ago with the principal aims of maintaining a strategic overview of the board's educational training and development arrangements and monitoring statutory and mandatory training compliance. The Education Policy has recently been revised and a

group has been set up to look into methods of improving statutory and mandatory training compliance rates; these rates have recently been improved across the organisation by linking training with further development. A number of rounds of funding for training courses have also been allocated through the TED Board fund and 1 new statutory mandatory core e-learning course has been added to LearnPro and mapped to the training matrix. Numerous bids have been received for training funds, with any bids received having been mapped to the training funding matrix. So far, £57,000 has been spent in 2023/24, with further bids to be shortlisted in January. The TED Board is also working with IM&T to develop an electronic study leave form to help scrutinize spending; the current paper-based form does not allow for the capture of all spending and commissioning, whereas an electronic form would allow these to be monitored and funnelled through the TED Board, therefore improving both efficiency and equitability across the board.

SL queried how the requirement for 100% compliance with statutory mandatory training has been received by staff. MO responded that the new training compliance requirement was met with some unhappiness from staff, however this is mandatory and is a board requirement, with the board also deciding that additional development cannot be funded if statutory mandatory core requirements are not met. However, it was also stated that there are only 9 core statutory mandatory e-learning modules (discounting role mandatory modules), some of which expire every 3-4 years, so the requirement is not overly onerous. Some staff groups also have CPD time built into their rotas and budgets; this new requirement has recently improved compliance rates across the organisation(MO stated in chat that ED achieved 100% compliance earlier in the summer, for example). AC added that despite the boldness of this decision and pushback having been received from some areas, RAG statuses in relation to statutory mandatory training compliance have been improving; this compliance is mandated by law and is now required before any training funding bids are submitted. SK reiterated that the 100% compliance figure is purely aligned to the 9 statutory mandatory core e-learning modules and was approved by the PACE group; it was also suggested that compliance should be viewed in terms of staff and patient safety. SL suggested that there could be a constant review of how statutory mandatory training is provided to staff and that data could be triangulated, for example, to determine how many musculoskeletal injuries have occurred and relate this to manual handling training. SK responded that practical manual handling training is role mandatory and so would not fall under the required 100% compliance, however a separate workstream is looking into increasing compliance for this training.

9. Education Policy – Final Approval

SK stated that the Education Policy was previously known as the Statutory Mandatory Training Policy; an NHS Borders internal audit from 2021/22 on statutory mandatory training made some recommendations, some of which are currently being worked on, however these recommendations have also been built into the newly reviewed Education Policy, resulting in a more strengthened policy, along with roles and responsibilities. This also ensures that staff not only attend training, but also implement this in their workplace. The study leave process has also been worked on, specifically in relation to external training courses; it is now a line manager responsibility to build external courses into LearnPro dashboards, which has also been built into the training matrix, to ensure that the organisation has a better overview of the training that is required. More emphasis has also been placed on essential training and assurance improved with regards to how funds are being spent. The governance route has also been strengthened, both regarding minutes from TED Board and Occupational Health & Safety Forum minutes, which are now added to Staff Governance Committee agendas for noting, and the Education Policy itself; this has been approved by the TED Board, Occupational Health & Safety Forum and Area Partnership Forum and is to be finally approved by this committee.

SL queried how bank staff and staff on secondment are supported, as they are outwith the scope of the Education Policy, and how compliance with annual appraisals and PDPs are monitored. SK responded that as bank staff are not employed by NHS Borders, training is to be provided by the Lothian & Borders Bank; an SLA is currently being developed between NHS Lothian and Peter Lerpiniere and Elaine Dickson from NHS Borders. In terms of compliance with annual appraisals, it is line managers' responsibility to ensure that staff are 100% compliant with their statutory mandatory training and to provide sufficient time within work for staff to complete this training. EC confirmed that performance is reported against appraisals, which is carried out as part of the workforce dashboard; it is hoped that this will be a focus from a workforce perspective next year, as performance decreased during COVID and has not improved to desired standards. AC stated that appraisal completion rates are tracked and this dataset will be brought to the Resources & Performance Committee. SK noted that it is also line managers' responsibility to ensure that their staff members' LearnPro dashboards are up to date, which are then linked to appraisals; C&PD have been training line managers to do so. DP confirmed that the Education Policy has been approved by the committee.

10. Minutes and APF Annual Report 2022/23: For Noting

AC confirmed that the minutes and APF annual report 2022/23 are simply for noting by the committee. SL queried the use of the term 'harsher tone required' in the Occupational Health & Safety Forum minutes; AC and SK confirmed that this was in relation to fire safety, where a more realistic tone and information was required in order to highlight the issue.

11. Any Other Business

DP thanked SL for her work with NHS Borders and the Staff Governance Committee and wished her well in her retirement; SL thanked the committee and wished everyone well. AC noted that IR from NHS Greater Glasgow and Clyde was present at the meeting to observe the committee's discussions.

Date of Next Meeting: The next Staff Governance Committee meeting will be held on Friday 23rd February 2024 from 13:00-15:00 in the Lecture Theatre, Education Centre, BGH.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**Kevin Buchan, Non Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Area Clinical Forum 2 April 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Area Clinical Forum minutes 23.01.24

NHS Borders - Area Clinical Forum

MINUTE of meeting held on
Tuesday 23 January 202413:00 – 14:00
Via Microsoft Teams

Present: Kevin Buchan, Rachel Mollart, Nicky Hall, Martin O'Dwyer, Gerhard Laker, Fiona Sandford, Philip Grieve, John Smith

In Attendance: Lesley Shillinglaw – Minutes/Actions

1. APOLOGIES and ANNOUNCEMENTS

Paul Williams (John Smith in attendance as deputy), Caroline Cochrane, Imogen Hayward, Mark Redpath

Kevin Buchan will contact Mark Redpath, Consultant Clinical Scientists regarding attendance at ACF meetings where possible

2. Draft Minute of previous ACF

Minutes of meeting held on 3rd October 2024 approved as a correct record. Typing error "Optometry" corrected.

Action tracker updated accordingly. With reference to Private Care Policy, it was agreed it would be useful to clarify where we are currently with this document and Kevin Buchan agreed to liaise with Rebecca Devine regarding this. **Action: KB**

In relation to action regarding the process for feedback from ACF into Clinical Governance, Kevin Buchan agreed to write to Karen Hamilton and Iris Bishop: **Action: KB**

3. Clinical Governance Committee

Fiona Sandford provided an update following the recently held Clinical Governance Committee meeting as follows:

- **Infection Control**: Good work ongoing with about ACB infections. Looking at what other Boards are doing
- **P&CS Update**: Reference PCIP Pathfinder good news. Concerned about levels of sickness across p&cs. Cover for Kelso & Knoll Community Hospitals – working group now looking at longer term
- **Acute Services**: Slight increase in improvement on emergency access standard. SBAR on women and children's services. Noted this service has been well staffed, however due to critical retirements looking fragile. Amount of creating work that colleagues in mental health and LD to cover for lack of psychiatrists. Note Interview for Consultant Psychiatrist – successful.
- **AHP Annual Report:** Lot of great work. Very high turnover of staff.
- **GP Sustainability** – report from Tim Young: PCIP Pathfinder. Had 5 applications GP Fellows. Rising patient expectations – would be helpful to gain data on this.

- **Annual Report of drug deaths** – great work ongoing. Numbers are small in Borders, however rising trend in problem of cocaine and gaopentin abuse.
- **Annual review Suicide and Prevention**: 7 last year. A lot of great preventative work ongoing
- **Estates & Infection Control:** Good report from AB.

Kevin expressed concerns noted at staff absence rate within Health Visiting – sitting at 25%. Fiona Sandford intimated the need to highlight to SG consequences of not providing certain services on staff wellbeing/absence rates.

Rachel Mollart referred to the DNA GP Safe working guidance and intimated that LMC are currently looking at which practices are using this and how.

Philip Grieve referred to safer staffing legislation coming into force in April and that hopefully this may be a supportive measure.

4. **Non Exec Input to ACF**

Fiona Sandford left the meeting for this part of the discussion. Kevin would be very keen to ask Fiona to stay on for another 6 months. She has provided incredibly helpful input/advice to the Committee. ACF members agreed Fiona to be asked to continue as Non Exec member to ACF and Kevin Buchan agreed to liaise with Karen Hamilton regarding this and update Fiona accordingly. **Action:** KB.

5. **National ACF Chairs Meeting**

Kevin Buchan provided an update as follows:

- Visit from Alison Carmichael, Head of Wellbeing and Culture for SG who updated on antivirus policy, menopause and menstrual health policy the workforce development programme and the national offer of support to clinicians.
- Separate meeting with John Burns – highlighted role of ACF and how the Committee can influence the Board. Other ACFs had more influence. JB feelings around ACF is that it should be promoted. Piece of work around a Standard Governance Framework which every Board will be required to undertake. KB will email
- Standardisation on ACF chairs/obligation to the Board. Independent contractors disadvantaged.
- Important to raise profile of ACF directly to NHS Board and not via Clinical Governance. Kevin will raise this with Karen Hamilton. **Action**: KB

6. **NHS Borders Board Papers**

Not available yet. Agreed to align ACF to the same week of the Board.

7. **Professional Advisory Committees:**

Area Dental Advisory Committee (ADC)

- Gerhard Laker provided update as follows:
- 2 months into new system of remuneration for dental practitioners. More streamlined than previous system. Will be reviewed in 4 months. Problem with access issues and

recruitment and retention. Morag Muir working on Oral Health Strategy – will keep ACF updated

- Dental Laboratory work – has lifted remuneration.

Area Medical Committee (AMC) & GP Sub Group

Rachel Mollart provided an update from SGPC/LMC as follows:

- First Minister for Health SLNC conference in September and pledged there would be movement of service and resource from secondary to primary care with funding. GP Contract- Pathfinder bid went in from PCIP Exec in December and heard on 15.12.23 successful of 4 bids therefore can now proceed with delivery of contract. We have asked for up to £4m – monies for bid not yet specified. Data collection and site visit on 6&7 February 2024.

GP Sub Update:

- GP Role document ready to be rolled out which is a helpful document to clarify remit of GPs. Has been to BET and will go to AMC and Senior Medical Committee.

Area Ophthalmic Committee (AOC)

Nicky Hall intimated meeting scheduled for end of February – will update thereafter.

Area Pharmaceutical Committee (APC)

Martin O'Dwyer provided an update as follows:

- Action plan in terms of pharmacy remuneration however payment of reimbursement and remuneration still based on estimates e.g. £60k difference between what was paid by NHS on two consecutive months – difficult for pharmacies to manage business cashflows.
- Staffing issues: Llyods takeovers all gone through now.
- Number of new contract applications in pipeline for Borders – details to be confirmed
- General: Community pharmacists struggling with volume and complexity – people don't want to go through waits in NHS 24, A&E etc. Extremely difficult to maintain safe staffing.
- Pressure on resource within hospital service continues
- Malcolm Clubb is the new Director of Pharmacy replacing the now retired Alison Wilson, but his previous role has not been filled and there are no plans to fill it
- Prescribing Support Team: Pressures due to sickness absence and recruitment & retention are high particularly for pharmacists. One pharmacist seems to split across West Linton and Gala at the minute. Whilst they are ably supported by technicians and pharmacy support workers (many of whom are now based in the central hub in Melrose) GP Team referrals into pharmacy inboxes need monitored within practices to pick up on urgent work.
- Area Pharmaceutical Committee will now meet next Tuesday so further feedback will be given at the next ACF.

Area Health Professionals (AHPs)

John Smith provided an update as follows:

- Recently submitted AHP Annual Report to CG Committee. Feedback highlighting some of risks around AHPs, including workforce challenges. Noted across rest of Scotland 17% increase in funded AHP posts – seen half of that locally. 2 in 6% increase in terms of vacancy and turnover rates locally.
- Demand and capacity issues. Site capacity issues, waiting times issues, anticipatory care planning.
- Good recognition of quality improvement work done to date. Few difficult conversations in taking stock of where AHPs are currently.
- Single point of failure where shortages of staff and managing associated risks
- Just completing Service Specification work – taking stock of where staff are, how many staff, job planning across all AHPs.
- Efficiencies and productivity work and some QI projects – need to look at things in a pathway level rather than a service level.
- Proposing change to structure of AHP Professional Leads Group: Nominated members will now join to build leadership across other parts of workforce, brings in fresh ideas from front line and re-engaging clinical teams

Professional Nursing & Midwifery Leadership Council (PN&MLC)

Philip Grieve provided update as below:

- Newly created group (in place of BANMC). Received a lot of interest. Committee now includes Health Care Support workers, Student Nurse rep and potentially a university rep and non-elected members through Education and Senior Nursing

- Two meetings to date. Working on Terms of Reference & Vision & Mission Statement

- Sarah Horan keen to have a Director of Nursing & Midwifery and AHP Strategy completed with ADoNS and AHP Lead. Philip has requested this is handed over to Leadership Council.

- Nurses are largest workforce. Mission to ensure nursing voices are heard. Now Advance Practice aligned to practices.

- Would like Council to be a forum for any views/opinions on nursing issues.

- Feed into ACF, Clinical Governance and Excellence in Care forum

- Agency spend post covid was immense nationally and it was noted that a lot of work being done to reduce this significantly. Health Care support worker agency is now non-existent. It was noted there is further scrutiny and tighter More Grip & Control measures in place around recruitment. Philip Grieve made reference to the value of PA s and admin support which allows clinicians and Managers to carry out their roles more effectively.

- Review of Care Home Support Team commissioned by Jane Douglas has now concluded. Proposed care home visiting service including Care Re-

ablement team (CCRT) and CHAD. Also examination of GP support and contact to care homes across the Borders. This is currently only available for Key Stakeholders, however will be shared in due course.

- Kelso and Knoll ANP – Important that ANP has geriatrician experience – may need support: Note this has now been recruited to

8. **Issues for Escalation to CG/Board**

Noted ACF meetings now aligned to same week as NHS Board meeting

9. **Any Other Competent Business**

None

10. **Date of Next Meeting**

Tuesday 2 April 2024 – 1pm-2pm via Microsoft teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**NHS Borders Performance Scorecard April 2024**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Authors:	**Hayley Jacks, Planning & Performance Officer** **Matthew Mallin, Developer, BI Services**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan / Remobilisation Plan

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective

2 Report summary

2.1 Situation

The main body of the scorecard sets out performance as at end of April 2024 against the targets from the 2023/24 Annual Delivery Plan (ADP). The report also includes as appendices performance as noted against some previous Annual Operation Plan/Local Delivery Plan measures, for information purposes.

2.2 Background

In 2022/23 Scottish Government moved away from commissioning any further remobilisation plans following the covid pandemic and instead commissioned a one-year ADP aimed at stabilising the system. New targets and trajectories were submitted to Scottish Government as part of the 2023/24 ADP.

As set out in the NHS Scotland Delivery Planning Guidance 2024/25 (issued by Scottish Government on 04 December 2023) a key mechanism against which the progress and impact of Health Board Annual Delivery Plans will be reported in 2024/25 is via a forthcoming NHS Board Delivery Framework. The Delivery Framework is still going through internal Scottish Government review and governance. It aims to set out a clear set of agreed indicators for which delivery against plans are reported, monitored and discussed with Boards, such as the quarterly progress reporting against the NHS Board Delivery Plans.

2.3 Assessment

We are still unable to meet certain trajectory targets however summaries for each of these can be found within the scorecard where available updates have been added.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 2023/24 waiting times trajectories and the 'hot topics' of emergency access standard and delayed discharges.

2.3.1 Quality/ Patient Care

The ADP milestones and trajectories, Annual Operational Plan measures and Local Delivery Plan standards are key monitoring tools of Scottish Government in ensuring Patient Safety, Quality and Effectiveness.

2.3.2 Workforce

Directors are asked to support the implementation and monitoring of measures within their service areas.

2.3.3 Financial

Directors are asked to support financial management and monitoring of finance and resources within their service areas.

2.3.4 Risk Assessment/Management

There are several measures that are not being achieved and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them back on trajectory. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders.

2.3.5 Equality and Diversity, including health inequalities

Services will carry out HIIAs as part of delivering 2024/25 ADP key deliverables.

2.3.6 Climate Change

None Highlighted

2.3.7 Other impacts

None Highlighted

2.3.8 Communication, involvement, engagement and consultation

This is an internal performance report and as such no consultation with external stakeholders has been undertaken.

2.3.8 Route to the Meeting

The Performance Scorecard has been developed by the Business Intelligence Team with any associated narrative being collated by the Planning & Performance Team in conjunction with the relevant service area.

2.4 Recommendation

- **Awareness** – To note Board performance as at the end of April 2024.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 31 March 2024

Month 12

Contents

Introduction

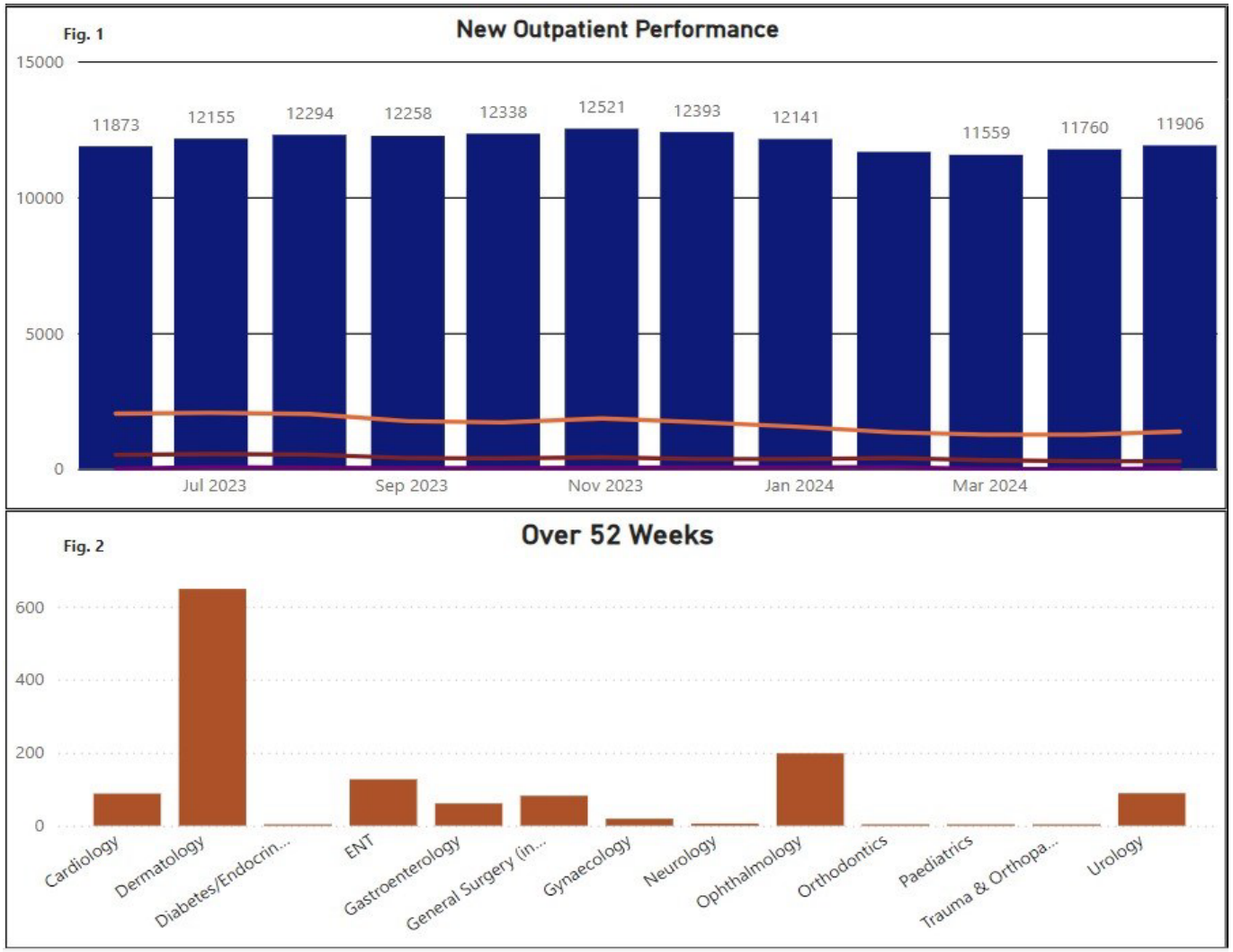
As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan (ADP) aimed at stabilising the system. As per the agreed ADP for 2023/24, which was brought to the NHS Borders Board August meeting for approval, all Boards were required to submit waiting times trajectories but no other formal performance measures were agreed.

This report contains waiting times performance and hot topic measures and an appendix which demonstrates AOP and Local Delivery Plan (LDP) measures (LDPs were in place as performance agreements between Boards and Scottish Government prior to AOPs and we retain some of the performance standards from those plans). In the current report performance is noted against waiting times trajectories in place as at March 2023.

As set out in the NHS Scotland Delivery Planning Guidance 2024/25 (issued by Scottish Government on 04 December 2023) a key mechanism against which the progress and impact of Health Board Annual Delivery Plans will be reported in 2024/25 is via a forthcoming NHS Board Delivery Framework. The Delivery Framework is still going through internal Scottish Government review and governance. It aims to set out a clear set of agreed indicators for which delivery against plans are reported, monitored and discussed with Boards, such as the quarterly progress reporting against the NHS Board Delivery Plans.

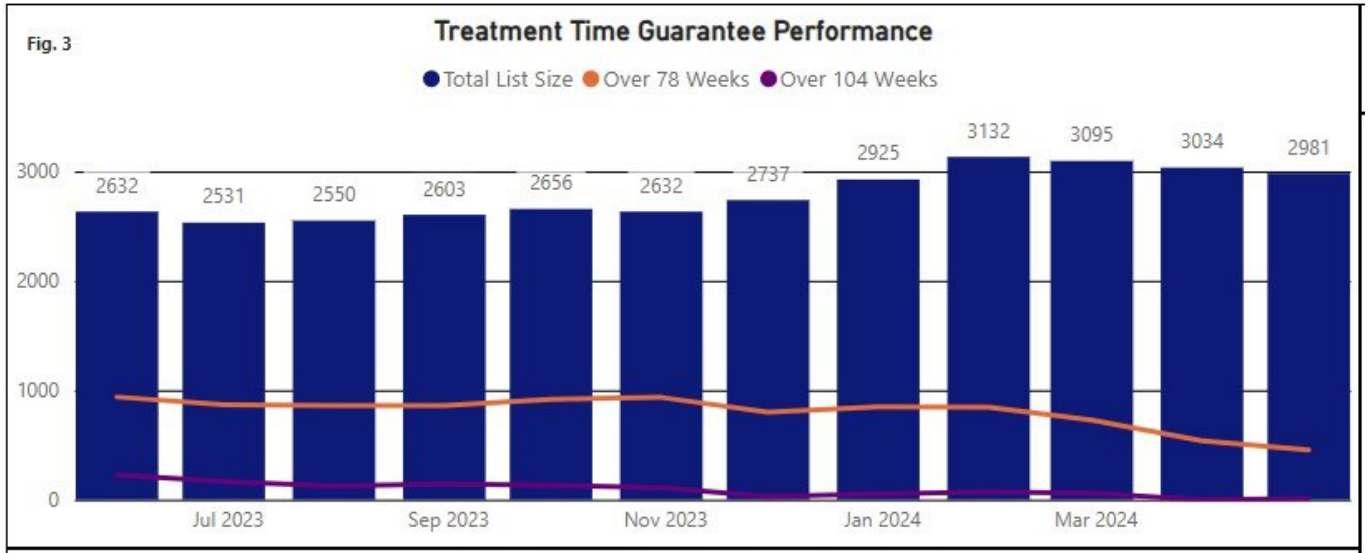
Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

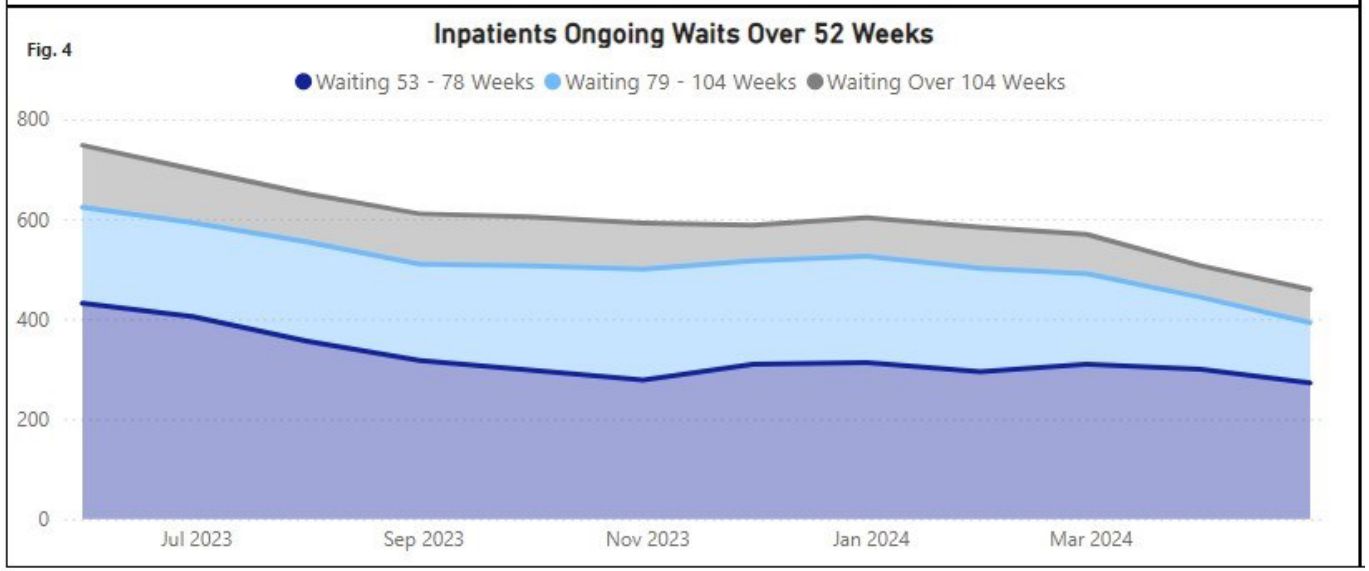
Outpatients waiting times



PLEASE NOTE: No Outpatients narrative available at time of issue 20.06.24

TTG Performance Against Trajectory- All Specialties





THEATRES

Theatres: The Treatment Time Guarantee (TTG) states that after a diagnosis is made and treatment is agreed, each health board must ensure that patients receive inpatient and day case treatment within 12 weeks. Due to the backlog of patients awaiting surgery, the current target is to ensure that there is a maximum of a 1 year wait for Inpatient / Day Cases in the majority of specialities by the end of Sep 24; this is called TTG 52.

Performance - Theatres

• The decrease in additions to the IPWL has allowed numbers on the IPWL to fall in April. Additions were 397 compared to an average of 498 over the previous 6 months.

• Average activity levels were achieved in April with elective operating at 88% of 2019 levels, a fall from 91% over the last 3 months.

Actions complete since last report

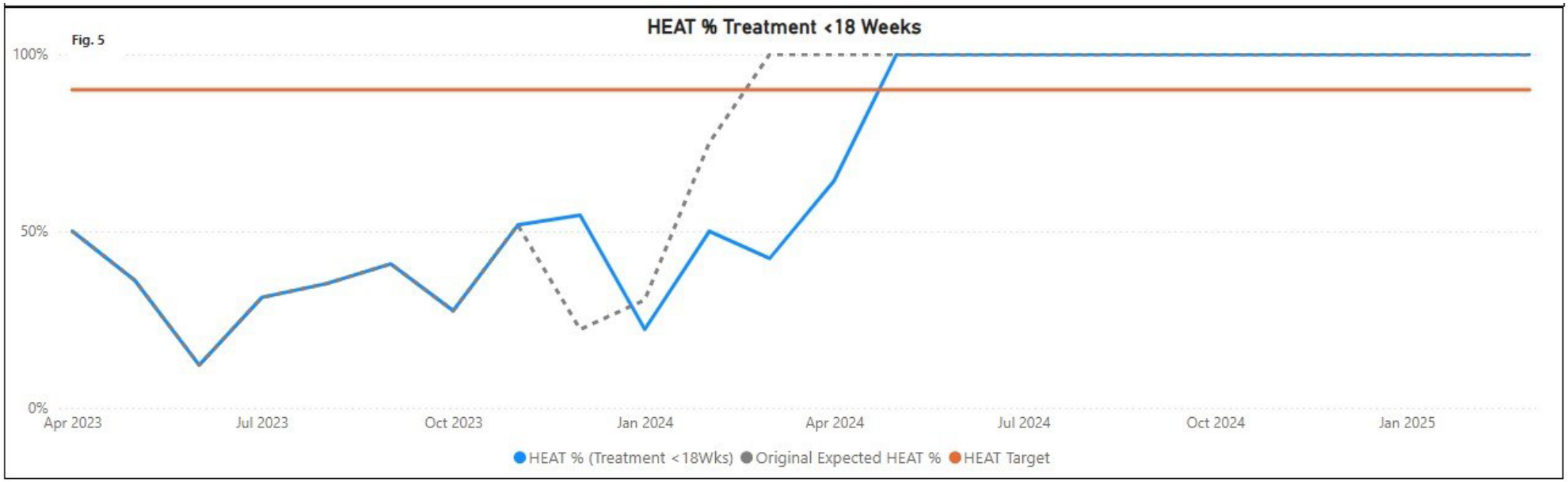
Priorities over the next month:

• Vacancy control. Posts within our Central Bookings Office have now been approved for an 18-month extension to Secondments. This development, once through the HR process, will provide welcome stability to the Team and those involved after many months of uncertainty and unwelcome stress. These extensions will buy time to confirm the structure of the team and ensure that appropriate Job Descriptions are approved for these roles.

• Theatre Scheduling - Infix. Now that SG have awarded the contract to Infix to provide a National Theatre Scheduling solution, NHSB are extremely keen, pending internal approvals, to progress with implementing this solution as quickly as is possible. Infix offers a significant increase in productivity at no cost to NHSB, but it needs to be prioritised quickly, noting the other competing demands, especially on IM&T resource. If this is not done, the roll-out to NHSB will be delayed as other Health Boards are prioritised. This outcome would be detrimental to NHSB's performance and ability to meet TTG targets (as well as to fully utilise our expensive theatre resources).

• SG funding. A bid will be developed against the £70M fund available from SG to reduce our elective waiting lists. This is likely to either be for resource to enable us to utilise empty lists in our Day Procedure Unit (DPU), for Elective operating at the weekend, or to request additional Recovery Staff to enable GA activity in DPU due to our lack of sufficient Recovery Staff to cover this location.

Updated 07.06.24

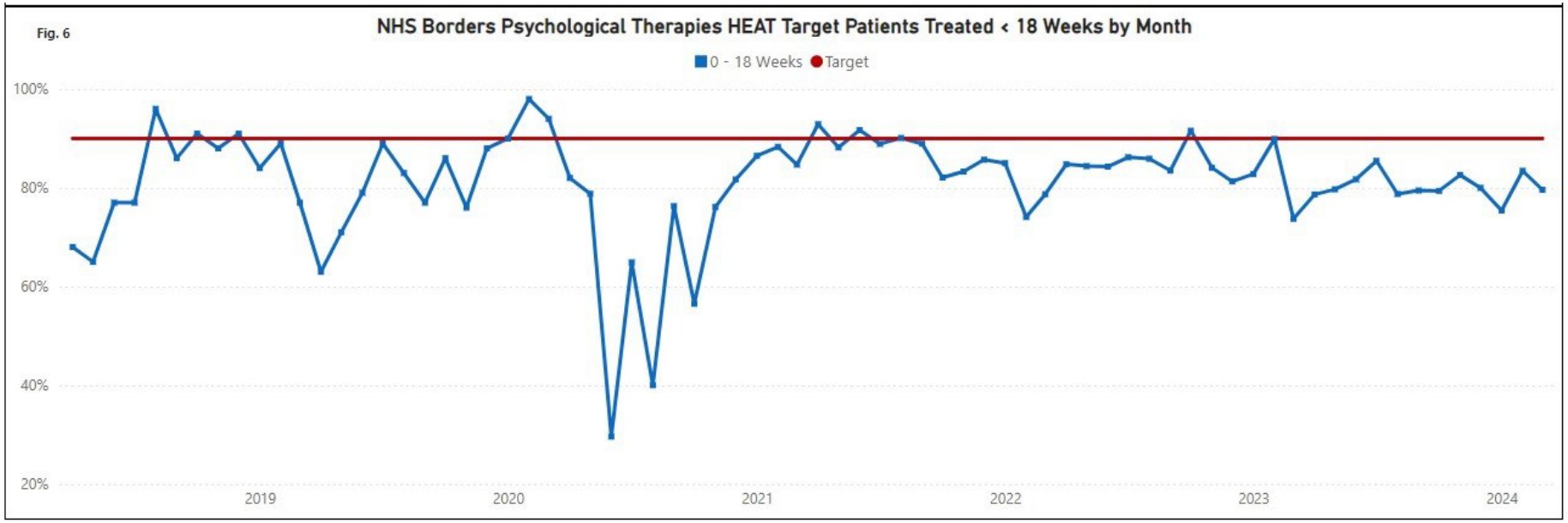


What is the data telling us?

The table shows the current trajectory based on the current projected accepted referrals and number of treatments to be completed (12 New Patient Appointments per week 51 per month). Now that we are meeting the LDP (Heat target) the referrals and number of treatments are being weighted in favour of 90% Cat 1 and 10% Cat 2 due to the increase in ND Referrals. However, this will be reviewed monthly to maintain the Heat Target for Cat 2's.

As of 1st April 2024, CAMHS have achieved the 90% HEAT Target of patients being seen within 18 weeks from referral to first appointment. On 21st May 2024 CAMHS are achieving 100% of patients being seen within 18 weeks.

Updated 07.06.24



What is the data telling us?

The 18 week RTT HEAT target for Psychological Therapies measures those people who are starting treatment and how long they have waited for this to start. The target is to see 90% of those starting treatment within 18 weeks. Performance this month towards the PT RTT standard has gone down from last month at 71.43% - last months was 79.59%. In April the service started treatment with 126 patients (147 in March 2024) of which 36 patients (30 in March) had waited longer than 18 weeks for a first treatment appointment (Figure 1).

Our LD and BAS psychology service is under great pressure with a known capacity gap. Older adult psychology is also under great pressure due to vacancies, this situation is likely to improve in the next few months as recruitment is under way. Adult mental health secondary care is under pressure due to unprecedented and sustained high referrals. In our Primary Care service, we ensured a higher number of people were able to be offered treatment starts in order to address long wait concerns which is positive but which has a negative impact on our RTT performance. There was a high level of episodic absence due to seasonal viral illness, this impacted on waiting times for both assessment and the offer of new treatment starts.

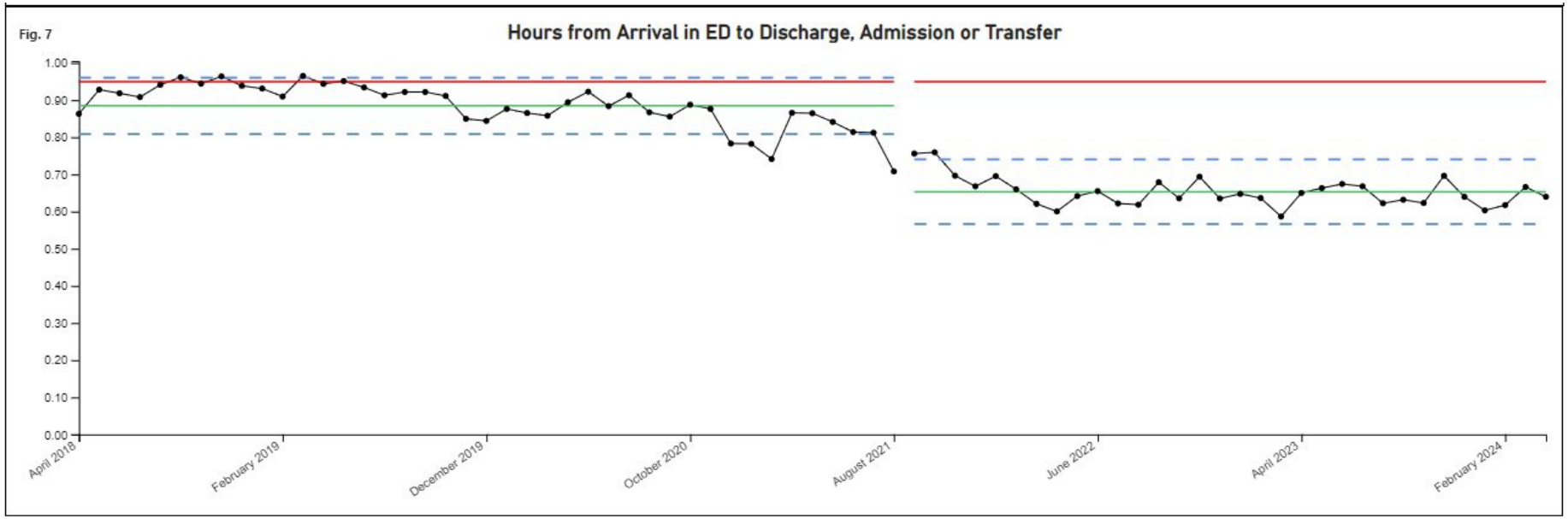
Current PT Waiting List as at 30th April 2024 we have 549 people on our waiting list, a decrease of 48 from last month, 87.25% of whom have waited less than 18 weeks. We have 15 people waiting in the 35-52 week range which represent 2.7% of those waiting. We have no patients waiting over 52 weeks. Waits over 18 weeks are mainly due to capacity issues and delays in secondary care psychology services, especially older adults, learning disability, substance misuse and adult mental health. For those areas which have had an increase in referrals, we are noticing a build-up of assessments, which will most likely impact on treatment waits.

Workforce

Our LD and BAS psychology service is under great pressure with a known capacity gap. Older adult psychology is also under great pressure due to vacancies, this situation is likely to improve in the next few months as recruitment is under way. There are a few members of staff going to be starting maternity leave in Psychology Adult Secondary Care and Renew (Primary Care).

Updated 07.06.24

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance



In April 2024 there were 2595 unplanned attendances to the Emergency Department (ED), with 937 breaches. Performance against the standard was 63.9% vs. 66.6% in March 2024 (a decrease of 2.7%).

The BGH continued to face significant pressures throughout March associated with attendances, acuity, and flow with additional surge open for patients waiting longer than 4hrs for an inpatient bed.

The Emergency Department continued to see a high volume of waits over 4 hours in March 2024 but the volume of waits over 12 hours reduced. The delays were driven by wider system pressures, such as availability of beds and cubicles, time of day discharges and delayed discharges waiting on health or social care facilities, top 3 breach reasons outlined below:

1. Wait for a Medical Bed- 316 Patients- this is driven by wider pressures within the BGH (including discharging late into the day).

2. Wait for Treatment End- 95 Patients- patients who has a clinical reason for breaching the target for patients whose care cannot be delivered within the 4 hours EAS.

3. Wait for 1st ED Assessment- 77 Patients- the loss of blue ED for a proportion of the month impacted on physical capacity to see patients in the department. However additional capacity was put in place if required across ward 7 and ward 9 and up to 10 beds for inpatient activity.

There were more days that saw 12-hour breaches in April compared to March 2024. During this month there were 7 instances when 12-hour breaches exceeded 10.

Updated 07.06.24

Delayed Discharge

Fig. 8

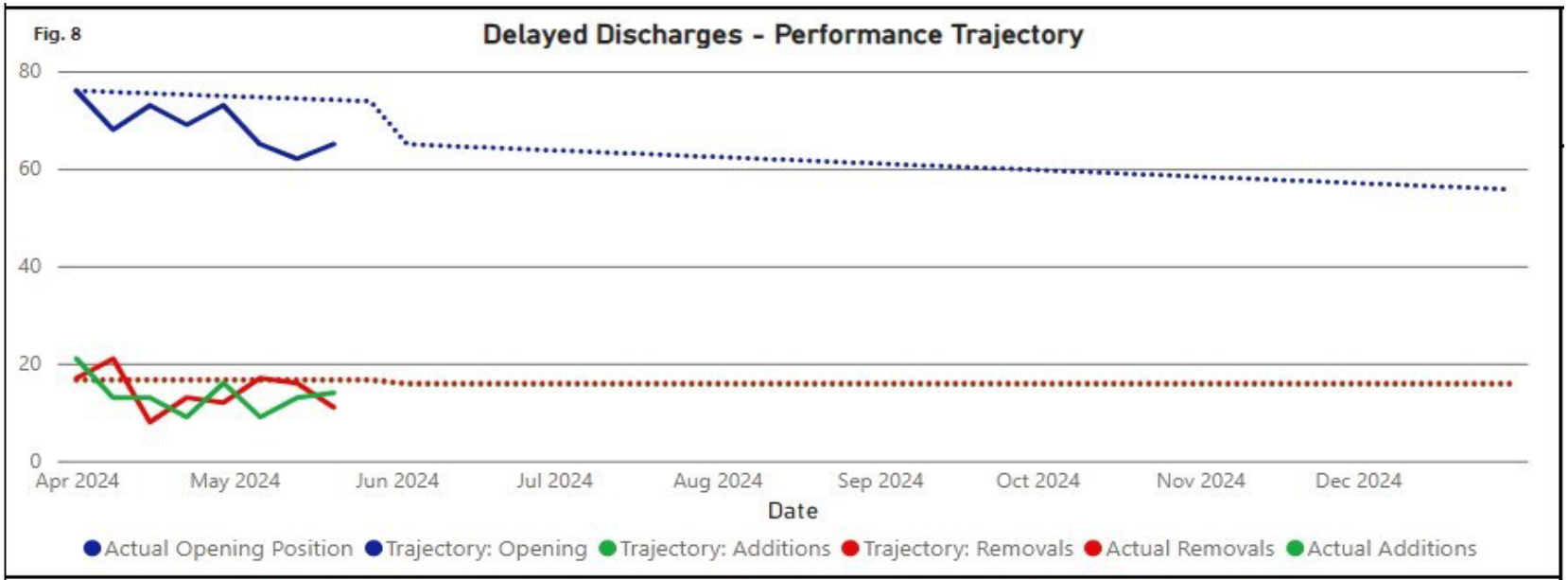
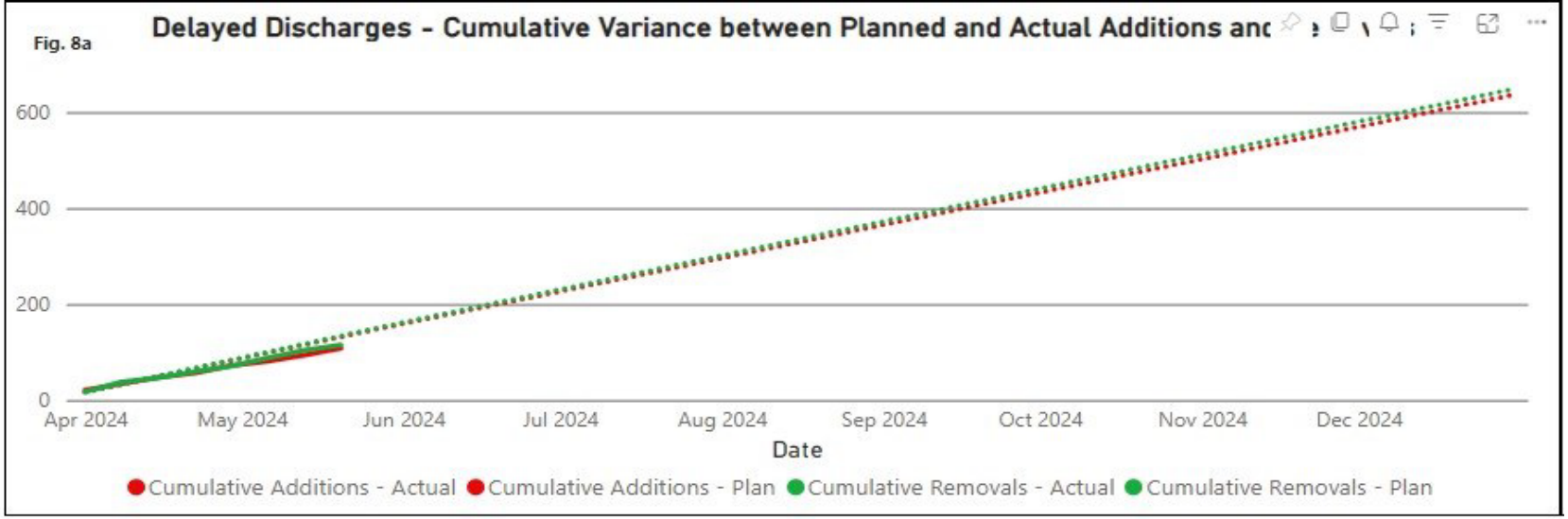


Fig. 8a



PLEASE NOTE: No Delayed Discharges narrative available at time of issue 20.06.24

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Key Metrics Report – AOP Performance

Current Performance Key

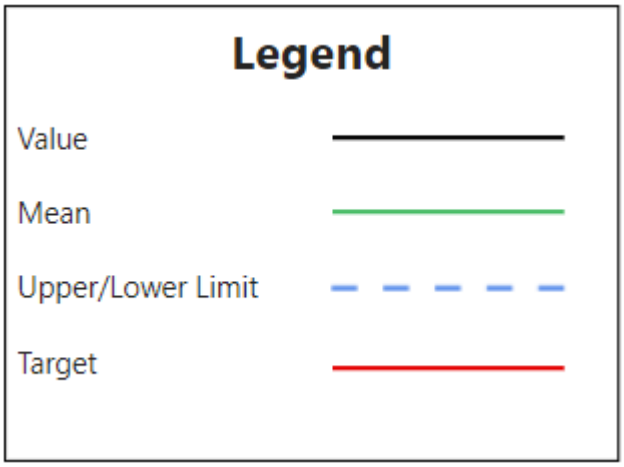
R	Under performing	Current performance is significantly outwith the trajectory/ standard set	Outwith the standard/ trajectory by 11% or greater
A	Slightly Below Trajectory/ Standard	Current performance is moderately outwith the trajectory/standard set	Outwith the standard/ trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

Key Metrics Report Annual Operational Standards

	Measure	Target/ Standard	Period	Position	Period	Position	RAG
Annual Operational Plan Measures	Cancer waiting Times - 62 Day target	95% patients treated following urgent referral with suspicion of cancer within 62 days	Feb-24	84.2%	Mar-24	85.2%	↑
	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Feb-24	96.2%	Mar-24	100.0%	↑
	New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Mar-24	7137	Apr-24	7302	↓
	New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Mar-24	2002	Apr-24	2128	↓
	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Mar-24	197	Apr-24	135	↑
	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Mar-24	61.6%	Apr-24	63.6%	↑
	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Mar-24	255	Apr-24	279	↓
	CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Feb-24	50.0%	Mar-24	42.3%	↓
	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Mar-24	66.6%	Apr-24	63.9%	↓
	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Mar-24	57	Apr-24	57	↔
	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Feb-24	83.5%	Mar-24	79.6%	↑
	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	Q3 2023/24	100%	Q4 2023/24	99%	↓
	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Mar-24	6.09%	Apr-24	6.20%	↓


Legend
Value
Mean
Upper/Lower Limit
Target

Cancer Waiting Times

Fig. 10

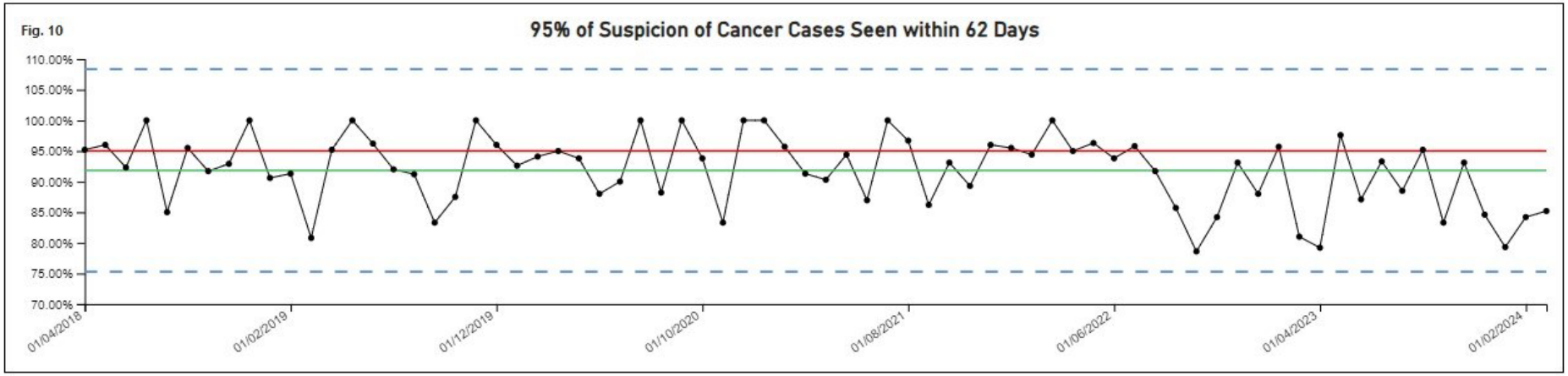
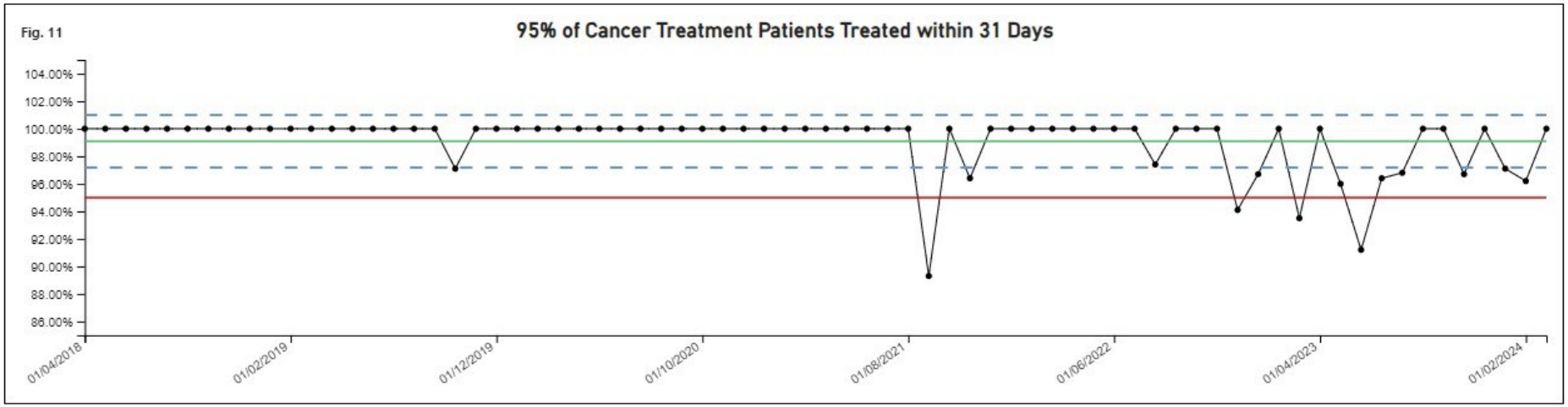
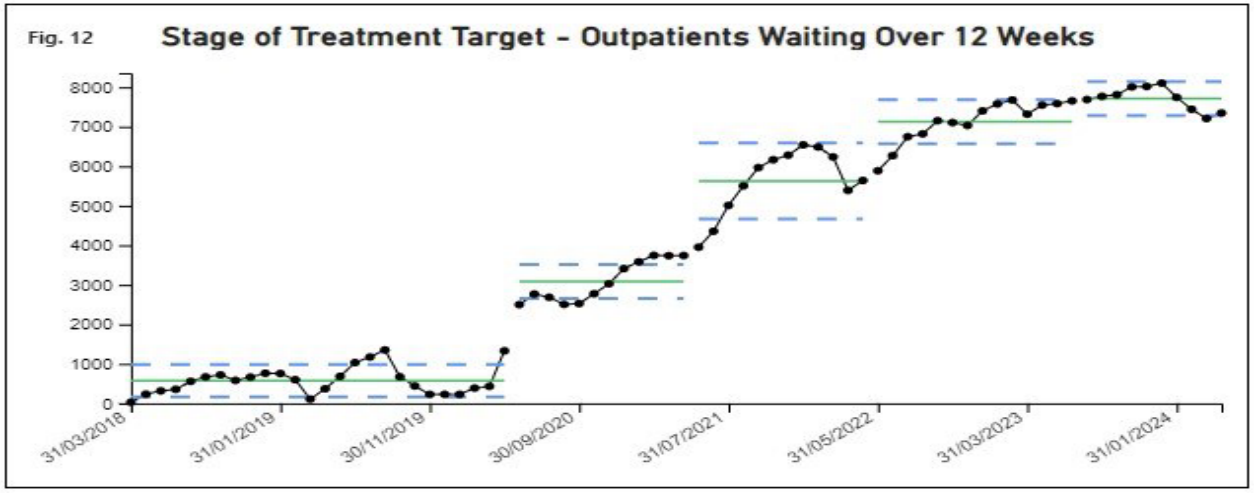


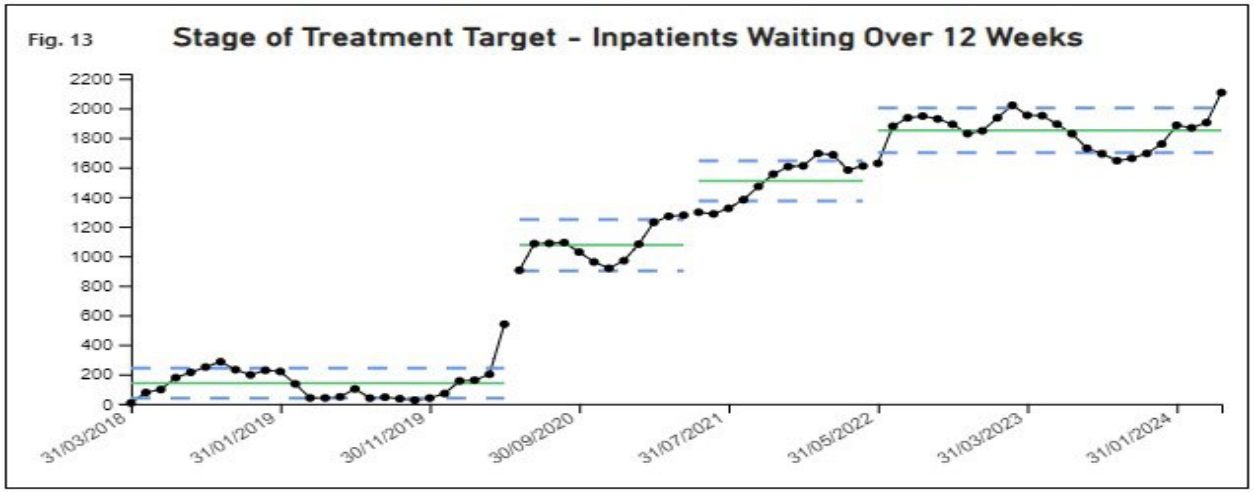
Fig. 11



Please Note: There is a 1 month lag time for data.

Stage of Treatment - Outpatients/Inpatients waiting over 12 weeks





Treatment times

Fig. 14 **Patients Treated within the 12 Week Treatment Time Guarantee**

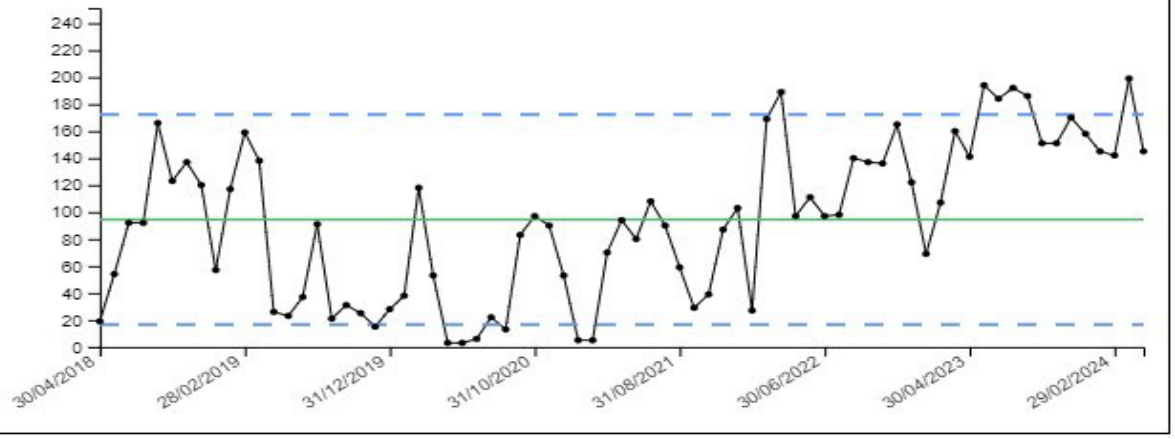
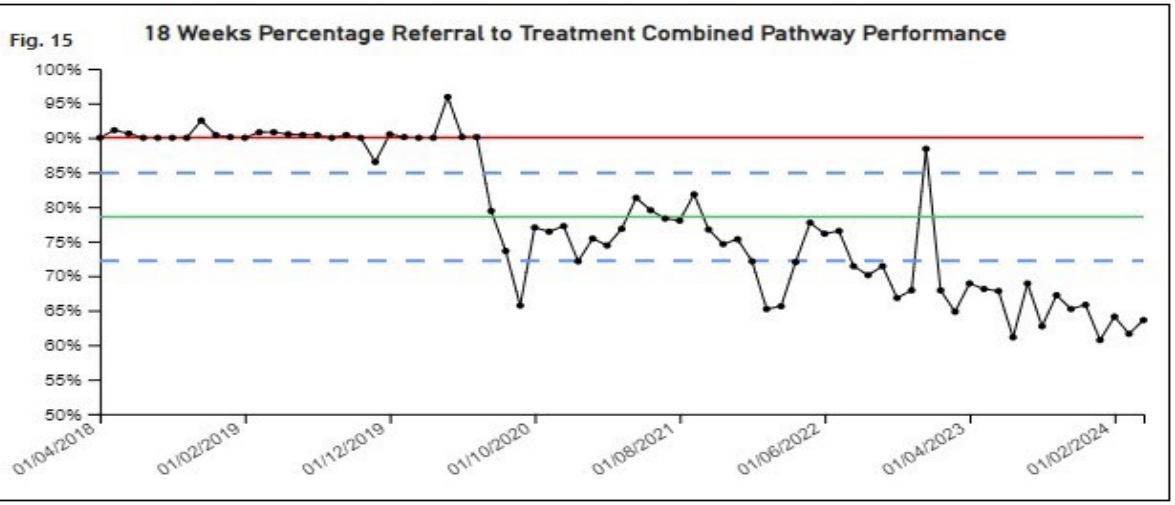
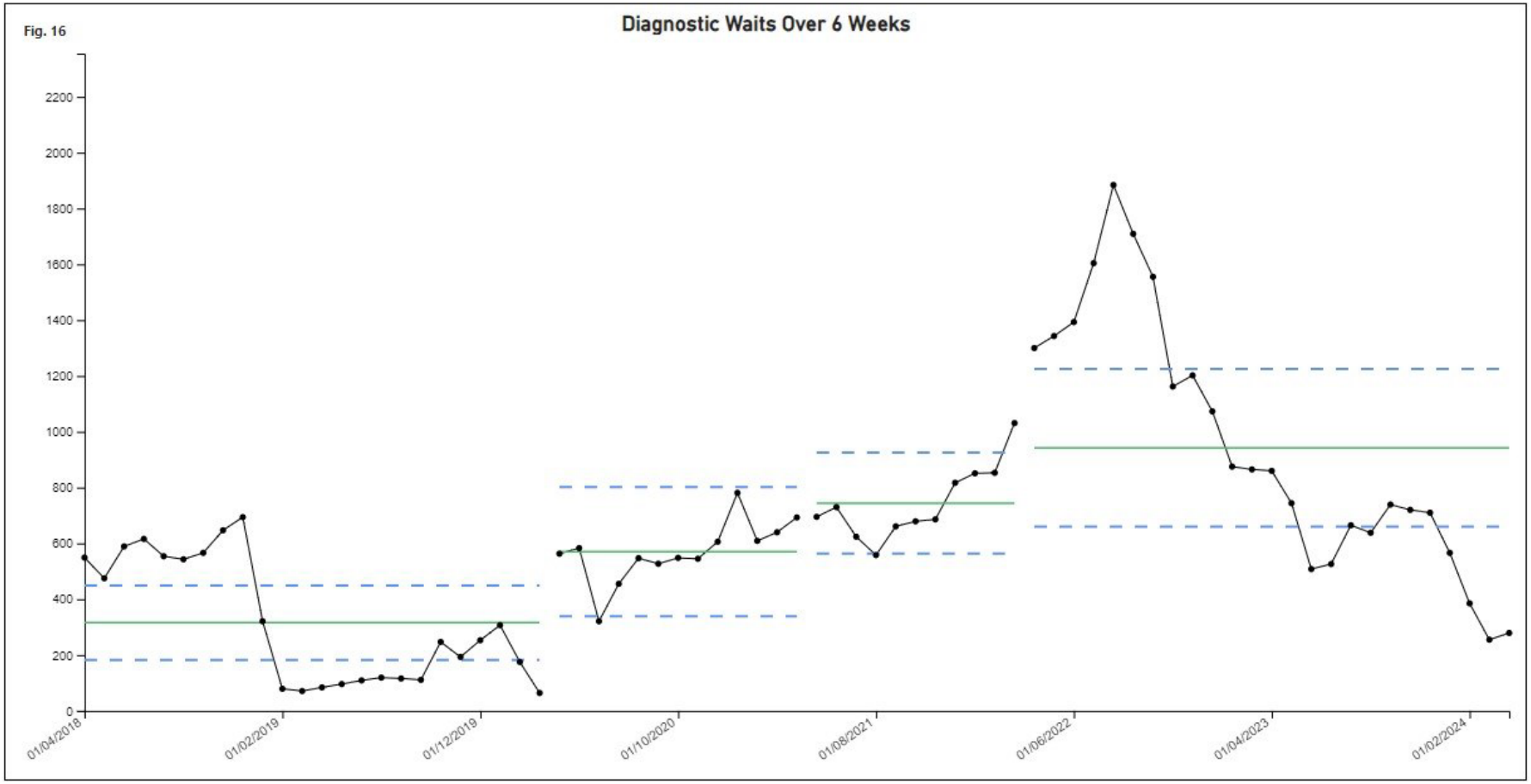


Fig. 15 **18 Weeks Percentage Referral to Treatment Combined Pathway Performance**



Diagnostic Waits



Delayed Discharges

Fig. 19

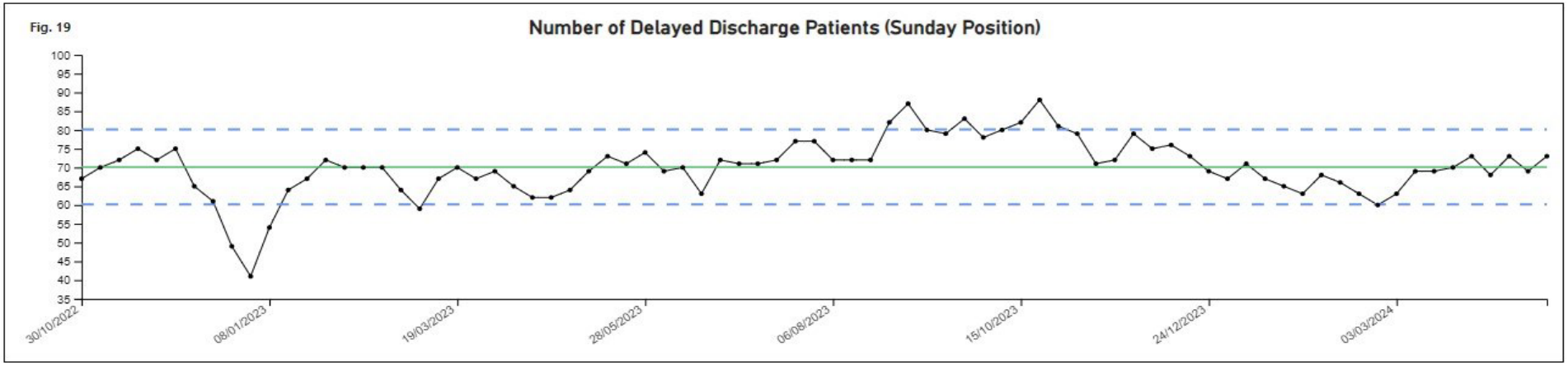


Fig. 20

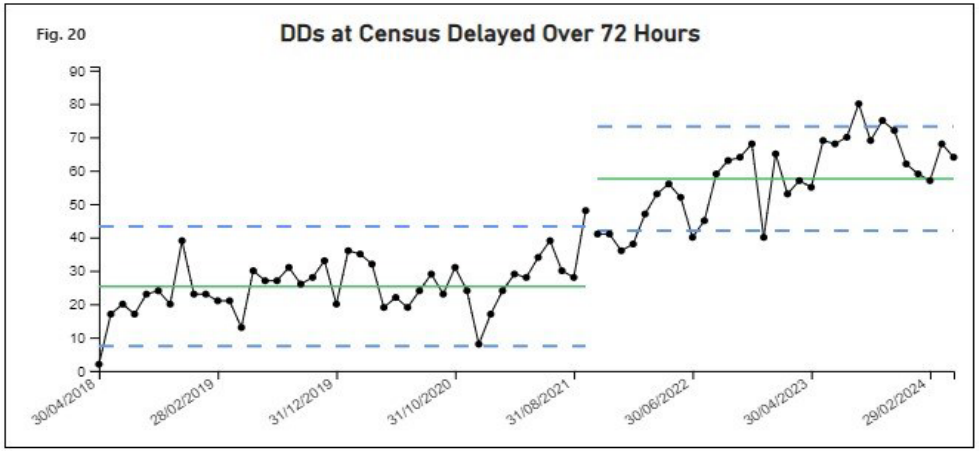
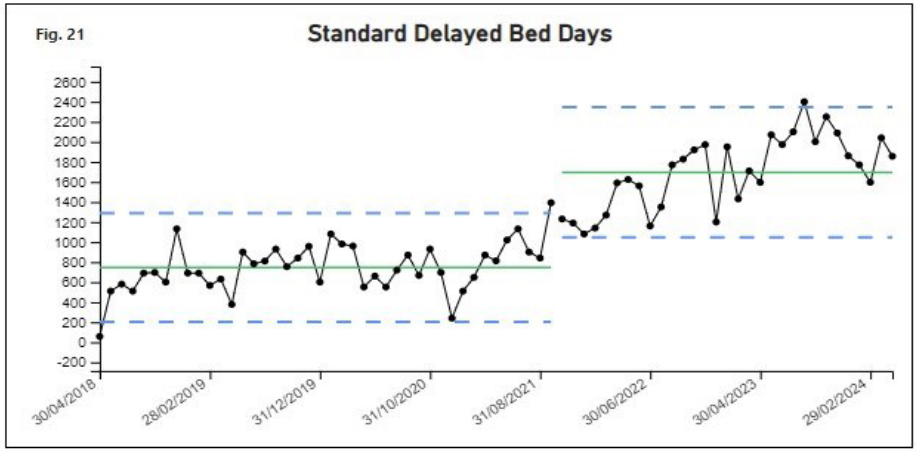
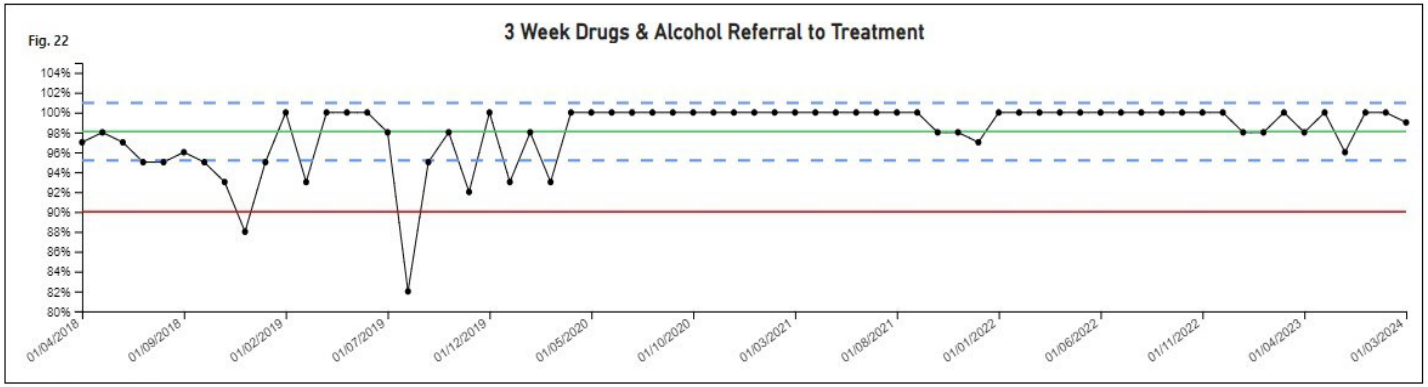


Fig. 21



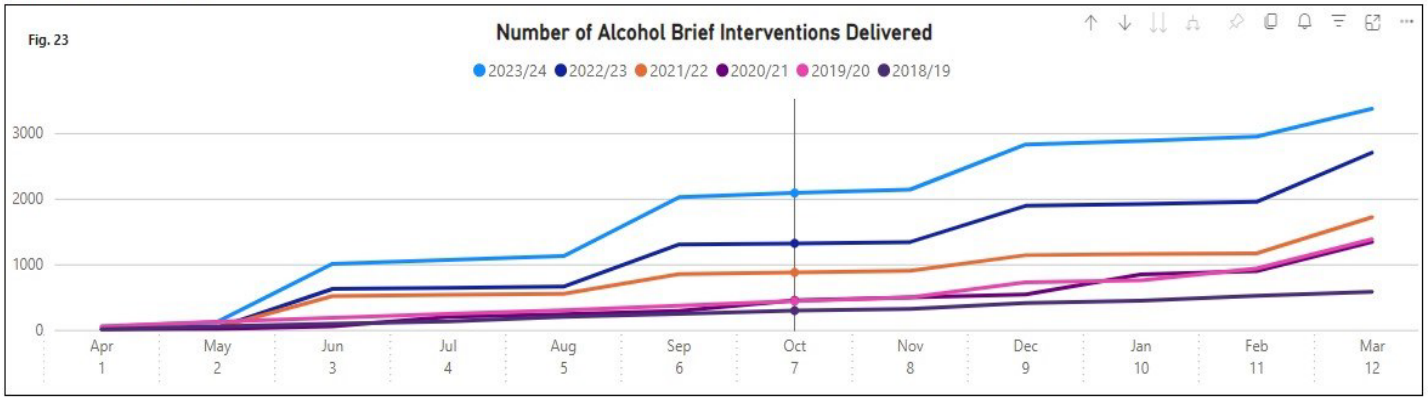
Drugs & Alcohol

Fig. 22



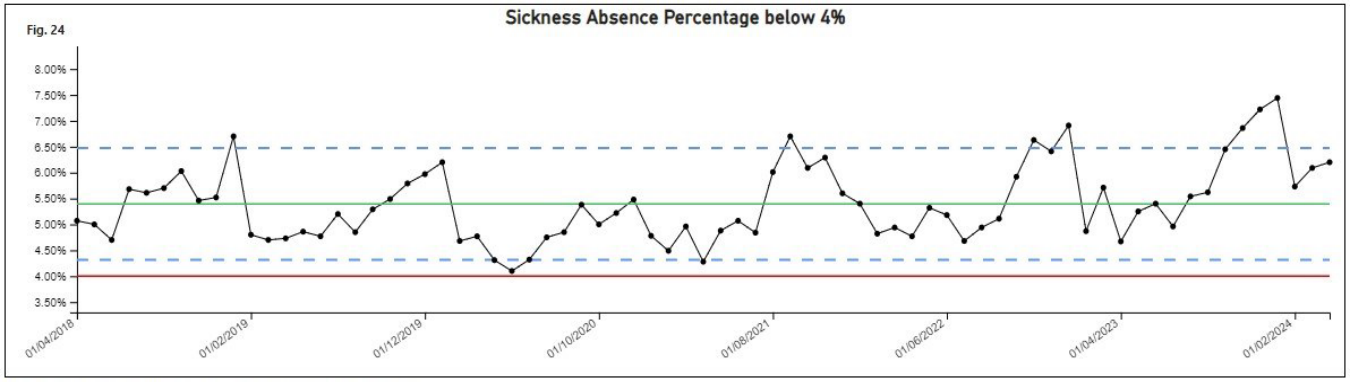
Note: Updates provided Quarterly

Fig. 23



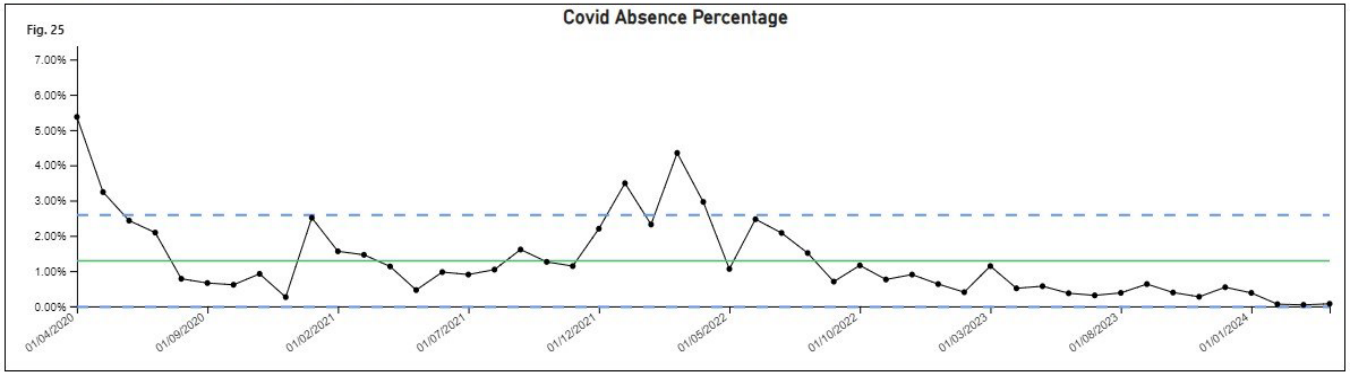
Sickness Absence

Fig. 24



Note: Sickness absence data does not includes any COVID-19 related absences.

Fig. 25



Smoking Quits

(Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12-week quit period. There is a 6-month lag time for reporting to allow monitoring of the 12 week quit period)

Latest NHS Scotland Performance (2019/20)	NHS Borders Performance (2019/20)
97.20	77.40

Fig. 26

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Extraordinary Integration Joint Board 17 April 2024
- Integration Joint Board 15 May 2024

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

- **Awareness** – For Members' information only.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**

- **Limited Assurance**
- **No Assurance**

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 20.03.24
- Appendix No 2, Integration Joint Board minutes 17.04.24

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 20 March 2024** at **10am** as a hybrid meeting in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr D Parker
(v) Cllr T Weatherston
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicoll
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mrs F Sandford, Non Executive
(v) Mr J Ayling, Non Executive
Mr C Myers, Chief Officer
Ms L Turner, Interim Chief Financial Officer
Mr N Istephan, Chief Executive Eildon Housing
Dr L McCallum, Medical Director
Mr P Lerpiniere, Associate Director of Nursing
Ms L Jackson, LGBTQ+
Ms Gwyneth Lennox, Head of Adult Social Work
Mr D Bell, Staff Side, SBC
Ms V MacPherson, Partnership Rep, NHS Borders

In Attendance:

Miss I Bishop, Board Secretary
Mr D Robertson, Chief Executive, SBC
Mr A Carter, Director of HR, OD & OH&S, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Mr A Bone, Director of Finance, NHS Borders
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Ms S Laurie, Senior Communications Officer, NHS Borders
Mr A Small, Independent Chair Scottish Borders Public Protection Committee

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr N Richards, Elected Member, Mr J McLaren, Non Executive, NHS Borders, Ms L Gallacher, Borders Carers Centre, Ms J Amaral, Borders Community Action, Mrs J Smyth, Director of Planning & Performance, NHS Borders, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Mrs J Smith, Borders Care Voice and Dr R Mollart, GP.

1.2 The Chair welcomed attendees and members of the public to the meeting including Mr A Small, Independent Chair Scottish Borders Public Protection Committee.

1.3 The Chair welcomed Mr P Lerpiniere, Associate Director of Nursing to the meeting who was deputising for Mrs S Horan, Director of Nursing, Midwifery & AHPs.

1.4 The Chair welcomed Ms L Turner, Interim Chief Financial Officer.

1.5 The Chair welcomed Mr J Ayling, Non Executive as a new voting member of the Integration Joint Board.

1.6 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 24 January 2024 were approved.

4. MATTERS ARISING

4.1 **Action 2023-2:** Mr Chris Myers advised that it was intended that a briefing session would take place in April.

4.2 **Action 2024-1:** Mr Chris Myers advised that the item was closed and explained that it had been a reporting issue and finance colleagues were considering how to present that item more accurately in future reports.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE AND DELIVERY REPORT

5.1 Mr Chris Myers gave a slide presentation which highlighted some key elements of the report including: GP access; social work waiting lists reducing; reducing community homecare unmet need; homecare trends; hospital occupancy; demand for social care from hospitals; delayed discharge surge plan and performance against trajectory; development of carers strategy; what matters hubs; and CAMHS progress.

5.2 Discussion focused on: the terminology of demand versus need; robust review of care packages to free up resource for others in need; what matters hubs and information sharing; energy consultants and the quantification of the level of money brought into the system; further work required to move forward with the integration of Home First and Adult Social Care; locality function to work more effectively at a locality level; further work progressing around the preventive agenda in regard to smoking cessation,

sexual health and health living; and planning now for next winter to manage the anticipated surge and reviewing those that impacted the surge this year to work up assumptions on expected surge requirements next winter.

5.3 Cllr Elaine Thornton-Nicoll enquired if individuals without capacity or powers of attorney were counted differently or excluded from the delayed discharges list. Mr Myers advised that there were 6 adults with incapacity and they were included in the delayed discharges figures in line with the national definition. Those individuals had longer legal processes to follow and it was important to ensure they were supported in the right setting in the right way within the legal constraints that services operated within.

5.4 Mr David Robertson reminded the Board of the amount of activity that took place across the whole system and highlighted that 96% of people admitted to hospital were effectively discharged. He suggested it would be helpful to include that fuller picture in future reports.

5.5 Ms Linda Jackson enquired about the change in process on placement of care being carried out by the community care team and commented that the Carers Centre were concerned that it might be a change in process and have a negative impact on carers in the longer term. Ms Gwyneth Lennox confirmed that the approach to the Carers Centre had not changed however the replacement care element had been aligned to the assessment review function for the cared for person.

5.6 Mrs Jill Stacey also commented that there was a planned piece of internal audit work to be carried out on support for carers.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. 2024/25 IJB FINANCIAL PLAN AND INITIAL BUDGET

6.1 Mrs Lizzie Turner provided an overview of the content of the paper and highlighted that there was not yet an offer from NHS Borders, however she anticipated that an offer would be supplied the following week. Mrs Turner drew the attention of the Board to the Scottish Borders Council offer of £81.5m and explained that the level of additional monies anticipated from the council for additional expenditure was unknown and work was taking place to provide clarity on that. She advised that the offer did meet the payment request issued in December 2023 and whilst there were new savings within the offer, there was also £1.1m of savings brought forward that were not delivered on a permanent basis.

6.2 Mr Andrew Bone commented that he appreciated how difficult it was for the IJB to be in such a position so close to the new financial year, where it was unable to set a budget due to the health budget offer not being available. He advised that circumstances surrounding the financial position in the NHS and NHS Borders had been fluid with lots of conditions being set and being subject to change and revision continually. Clarity on Scottish Government funding for a number of elements supplementary to core funding remained outstanding such as the 2023/24 and 2024/25 pay deals. The position in NHS Scotland in terms of funding remained uncertain with reviews of Health Board

budgets ongoing especially in relation to the delegated functions to the IJB. In regard to NHS Borders the biggest issue was the scale of the financial deficit and the inability to provide a balanced budget position. Overall NHS Borders faced a deficit position in excess of £40m with significant elements in relation to the delegated functions. Planning on savings continued to take place however less than 50% had been identified and the Scottish Government had offered support to identify any further savings.

6.3 Mr Bone commented that he recognised with hindsight that it would have been better to provide the IJB with an indicative budget based on the baseline of options with caveats pending progress on the NHS Borders budget. He committed to provide an indicative budget within the next 7 days.

6.4 Cllr David Parker challenged the situation and advised that the Scottish Borders Integration Joint Board was the only IJB in Scotland that was unable to set a budget. He welcomed the firm offer received from the local authority and showed his disappointment that an indicative offer had not been forthcoming from the health board. He reminded the Board that the Chief Officer had set out a clear mandate of what he had expected in terms of payment offers to the IJB. He suggested the IJB was being disrespected by the Health Board year on year in its inability to provide an indicative offer as it could not get the process right. He commented that the IJB would need to set savings targets and close surge beds, however it was unable to do any transformation work or savings work given it did not a budget offer from Health for the delegated functions. He advised that he was not happy and did not accept the excuses he had received.

6.5 Mrs Fiona Sandford commented that whilst she empathised with Cllr Parker's position she was fully aware of just how incredibly difficult it had been both operationally and financially for the Health Board. She was concerned at how the challenges faced and savings to be made by health were communicated and she highlighted the statement by the Scottish Government via the BBC that all Health Boards in Scotland had been provided with an additional 3% in real terms increase, however Health Boards did not recognise that figure as it was not new money. She was keen to have the budget position resolved and asked the IJB to recognise how challenging a position it was for NHS Borders.

6.6 Cllr Tom Weatherstone agreed with Cllr Parker and commented that with only half a budget the IJB was unable to make decisions and move forward with any kind of certainty.

6.7 Mrs Karen Hamilton recognised the comments around the table and as an IJB member suggested she was also concerned and would find it helpful to understand a bit more especially if the Scottish Borders was the only IJB in Scotland without a budget offer. She welcomed the explanation by Mr Bone and understood how difficult it was. As the Chair of NHS Borders she advised that she had pushed hard to get an offer to the IJB that day. She was keen to ensure that the same situation did not repeat itself in future as it had added to the frustration shared by members around the table. She then enquired where the IJB sat in terms of the bigger picture across Scotland as she was

aware that some of the indicative offers to IJBs were very indicative and she questioned how helpful they really were.

6.8 Mr Chris Myers commented that some IJBs had confirmed budgets or were confirming budgets by the end of the financial year and the majority had received indicative offers from health boards. He did think the IJB was an outlier in not having received a payment offer from health to date.

6.9 The Chair summarised the conversation and reflected on what it meant for the rest of the meeting agenda. She heard the message of an indicative offer being made by health within a week and looked forward to receiving that offer. She was keen that the same situation would not arise in the future and requested that a timeline be drawn up and adhered to for future budget setting. Given the IJB was not in a position of having a full budget to approve she suggested the Local Authority offer be held until the Health Board offer was received and an extraordinary meeting be organised for approval of the budget as quickly as possible.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** deferred approval of the Payment Offer from Scottish Borders Council to the extraordinary meeting.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Payment Offer from NHS Borders was outstanding and was required before the IJB budget could be finalised.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** charged NHS Borders to provide a Payment Offer by close of play Wednesday 27 March 2024.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** charged the Chief Officer with working up a timetable with the Chief Financial Officer and Director of Finance, NHS Borders for future budget offers.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested a full initial budget be brought to the IJB in April for approval upon receipt of the outstanding offer.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the risks described in the paper.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to hold an extraordinary meeting to agree the budget.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer items 5.2, 6.1 and 6.2 on the agenda to the extraordinary meeting.

7. HOSPITAL AT HOME

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer the item.

8. COMMUNITY HOSPITAL NEXT STEPS

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer the item.

9. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT UPDATE

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to defer the item.

10. STRATEGIC PLANNING GROUP MINUTES: 06.12.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

11. PUBLIC PROTECTION REPORT

11.1 Mr Alan Small, Independent Chair Scottish Borders Public Protection Committee provided an overview of the content of the report and advised that it set out the journey the Public Protection Committee was on. He highlighted that it had restructured its strategic plan and had 3 objectives and within those objectives it had sub actions that sat within the working groups of the Committee. He advised that the strategic plan had been reviewed and stretched to 2026 to bring it into line with the children's services plan.

11.2 Dr Sohail Bhatti commented that it was helpful to have the whole system overview of the public protection.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the action plan. The Underpinning message is that Child and Adult Support and Protection is everyone's business irrespective of role or position in NHS borders.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report would be circulated separately.

12. ANY OTHER BUSINESS

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there was none.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 May 2024, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

Minutes of an extraordinary meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 17 April 2024** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker
(v) Cllr T Weatherston
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicoll
(v) Cllr N Richards
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mr J McLaren, Non Executive
(v) Mrs F Sandford, Non Executive
(v) Mr J Ayling, Non Executive
(v) Mrs K Hamilton, Non Executive
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mr C Myers, Chief Officer
Ms L Turner, Interim Chief Financial Officer
Ms L Gallacher, Borders Carers Centre
Mrs J Smith, Borders Care Voice
Dr R Mollart, GP
Dr L McCallum, Medical Director
Ms L Jackson, LGBTQ+
Mr D Bell, Staff Side, SBC
Ms V MacPherson, Partnership Rep, NHS Borders

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Chief Internal Auditor
Mr D Robertson, Chief Executive, SBC
Mr R Roberts, Chief Executive, NHS Borders
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Dr T Young GP
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Mrs L Pringle, Risk Manager
Mrs C Wilson, General Manager Primary & Community Services
Mr D Knox, Reporter

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Ms J Amaral, Borders Community Action, Mrs J Smyth, Director of Planning & Performance, NHS Borders, Mr N Istephan, Chief Executive, Eildon Housing, Mrs Gwyneth Lennox, Head of Adult Social Work, Mr A Carter, Director of HR, OD & OH&S, NHS Borders and Mr A Bone, Director of Finance, NHS Borders.

1.2 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 20 March 2024 were approved.

4. MATTERS ARISING

4.1 **Action 2024-3:** Mr Chris Myers advised that work would be taken forward across the summer to develop a medium term financial planning process.

4.2 **Action 2024-5:** Although the action was closed, Mr Chris Myers advised that the Hospital at Home paper had been deferred due to the financial planning process and current uncertainty of future allocations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. 2024/25 IJB FINANCIAL PLAN AND INITIAL BUDGET

5.1 Mrs Lizzie Turner reminded the Board of the process and the offer received from NHS Borders on 27 March 2024. She drew the attention of the Board to the £81.5m offer from Scottish Borders Council (SBC) and £154m offer from NHS Borders, both of which were insufficient to deliver the strategic framework. It was noted that the NHS Borders offer was based on an offer of brokerage from the Scottish Government of £14.8m of which the Integration Joint Board (IJB) would expect to receive £6.2m. There would remain a £12m shortfall in funding for delegated services. Plans had been identified for savings of £4.3m which left a remaining gap of £8.3m across delegated and set aside services. She confirmed that the NHS Borders offer was based on baseline funding and was an indicative offer which was expected to be confirmed in July. There were challenges in both SBC and NHS Borders in regard to savings targets and SBC were undertaking a review of financial sustainability which the IJB would feed into. Mrs Turner advised that a recovery plan would be worked up and brought to the IJB along with the final budget for approval in July. She further commented that IJB reserves were being reviewed in regard to their intended purpose.

5.2 Mr Chris Myers commented on the scale of the challenge being significant with a total of 4% of savings required across the partnership and that health were looking at an 8% savings target. He noted the legal responsibility to break even financially and the need to engage and work in partnership in an open way to ensure communities were aware of the potential impacts moving forward.

5.3 Mr Andrew Bone clarified that NHS Borders was required to set a balanced budget and move to break even within the shortest possible timeframe. On the point of brokerage the paper identified assumptions which were all subject to dialogue with the Scottish Government. He confirmed that the Health Board also had recovery plans in place and suggested the work to be done through the IJB should be aligned to the NHS Borders and SBC recovery plans to ensure it was a whole system process that was as effective as possible. He commented that there would be an overlap within the partnership and non delegated functions for savings and it was imperative that work was taken forward in collaboration.

5.4 Further discussion focused on: transformation and improvements; open engagement where services may be reduced; being mindful of the shifting of pressure from one part of the system to another; focusing in the integrated space on supporting strategic change to improve outcomes and reduce costs in the more expensive parts of the system; engagement and involvement of staff in decision making; need for integrated impact assessments to be undertaken and be fully clear on the impacts on community health and wellbeing outcomes; core centre values of what will add value to people and what will cause harm should be considered at every level; growth not included in the financial plan; and demographic changes to be kept in mind when modelling any changes.

5.5 Cllr Tom Weatherston commented in regard to savings that it would be helpful to be aware of the resulting effect on the public.

5.6 Dr Lynn McCallum echoed Cllr Weatherston's comment and suggested the impact on the public was likely to be significant and she was thoughtful about the current pressures in relation to people in the wrong place that were in the whole system.

5.7 Mrs Jenny Smith urged that consideration be given to any impacts on the third sector to ensure relationships were not damaged by the financial planning process that would need to be undertaken.

5.8 Dr Sohail Bhatti commented that in looking at the totality of care being provided there was a need to move it upstream closer to the patient before the patient was admitted to hospital. He suggested more investment was required to be put into prevention.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** accepted the payment offer from the Scottish Borders Council, which was expected to allow delegated adult social care and adult social work services to break even, noting that further work would be undertaken to financially model demographic growth.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that while the initial payment offer from NHS Borders was insufficient to break even based on current expenditure and plans, it would be used as the basis for planning assumptions over the next few months, subject to further work including a final offer and further recovery actions being undertaken to ensure that they were sufficient to deliver the HSCP Strategic Framework.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that an interim, unbalanced budget be utilised until a final budget position was agreed.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested that a recovery plan would be required to be agreed for 2024/25 and that a full and final budget be brought to the IJB in July, following receipt of final information from NHS Borders.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** remitted the Chief Officer and Chief Finance Officer (Interim) to write to Scottish Government to escalate the financial position of the IJB, the impacts of any recovery actions being taken to reduce spend on the Strategic Framework, and potential use of reserves to provide in-year balance and longer term financial sustainability via transformation.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested that a three to five year financial plan be brought to the IJB in the summer, to provide a direction of travel in support of the Strategic Framework and indicative figures for future years.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue a Direction to NHS Borders and the Scottish Borders Council on the basis of the interim budget.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a short life working group be formed with representatives from the key sectors.

6. COMMUNITY HOSPITAL NEXT STEPS

6.1 Mrs Cathy Wilson and Dr Tim Young presented an update on the Community Hospitals review and provided background to the review, the outcomes of phase 1 of the review and the progress with phase 2 of the review.

6.2 A robust discussion took place on the proposed principles for the next steps with the review and several elements were highlighted including: risks in relation to the medical situation and sustainability; clarity was sought on the outcome of the Day of Care Audit (DOCA) which appeared to be inconsistent with previous DOCAs; work had been taken forward to look at the cohorts of patients admitted to community hospitals who were predominantly on stroke, palliative care and frailty pathways and how to enable a more supportive model of discharge for those patients to their own homes with supportive care; manage public expectation on what is care, safe care and community care and the various settings around that; important to agree a model on individuals needs not on a community hospital; the medical cover risk was real and had a profound impact on the model for delivery; in relation to the DOCA assurance that decisions for the future would be based on valid data; and the need to commission in line with process and take forward work to manage the medical and financial risk over the next steps with regular reports back to the IJB.

6.3 Dr Lynn McCallum advised that if there was no medical cover in place from 1 August then the clinical safety of patients would be compromised and there would need to be a plan in place ahead of August to mitigate patient safety risks. She advised that the number of discharges from community hospitals each week was very small and she suggested that beds be closed as patients were discharged in order to mitigate patient safety risks, beds could then be reopened in due course when safely staffed thereafter.

6.4 Dr Rachel Mollart advised that GPs could not continue to provide cover for community hospitals and were handing back those cover contracts, which were not part of their GMS contract. She advised that palliative care was mostly provided by primary care teams and some GPs would look after palliative care patients if they had access to beds. She advised that she was also surprised by the DOCA outcome and suggested it came down to how you defined numbers and rehabilitation needs and the overlap with social care. She suggested it was important to ensure the definition was correct and she supported the improvement of pathways to ensure better outcomes for patients.

6.5 Dr Tim Young commented that the main patient groups in Community Hospitals were those with varying levels of dementia and they were admitted and ended up in community hospitals and then required on going care that was either home based, care home or nursing and that was where the issue lay as it was a large group of patients with dementia and other illnesses who were awaiting care and the intricacies of that with guardianship issues, etc, caused the biggest issues and that was the issue to be resolved to ensure flow.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed the 12 principles for next steps.

7. DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT UPDATE

7.1 Dr Sohail Bhatti provided a presentation of the Director of Public Health annual report and highlighted several elements including: Health Improvement; Alcohol and Drugs; Joint Health Protection; screening; oral health; a focus on primary prevention; and the introduction of interventions before conditions developed.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation.

8. ANY OTHER BUSINESS

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there was none.

9. DATE AND TIME OF NEXT MEETING

9.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 May 2024, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**27 June 2024**
Title:	**Whistleblowing Annual Report 2023/24**
Responsible Executive/Non-Executive:	**Lynne Livesey, Non-Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement

This aligns to the following NHSScotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The National Whistleblowing Standards (the Standards) have been in place now since 1 April 2021. The National Whistleblowing Standards set out how the Independent National Whistleblowing Officer (INWO) expects all NHS Boards to manage, record and report whistleblowing concerns.

Where the employee remains dissatisfied, the concern can be escalated for external review to the Independent National Whistleblowing Officer .

NHS Borders supports and encourages an environment where employees, students, contractors and volunteers can raise concerns about patient safety, malpractice and any perceived wrongdoing.

2.2 Background

The National Whistleblowing Standards are underpinned by legislation and constitute formal guidance to the NHS in Scotland; guidance which has been implemented locally as *"Raising whistleblowing concerns : a guide for staff at NHS Borders"*. The Scottish Public Services Ombudsman (SPSO) and stakeholders, including NHSScotland employers and trades unions, co-produced the Standards, which were also subject to public consultation.

NHS Borders has a designated Whistleblowing Champion – Lynne Livesey, Non Executive and an INWO Liaison Officer – Iris Bishop, Board Secretary.

A range of staff from different backgrounds across the organisation act as Confidential Contacts; publicised points of contact available to staff & students to work out if their issue is indeed in the public interest and covered by the whistleblowing construct.

2.3 Assessment

The NHS Borders approach to handling whistleblowing allegations under the Independent National Whistleblowing Officer (INWO) Standards continues to evolve in line with evolving guidance from INWO.

The Standards are applicable across all NHS services**.** They must be accessible to anyone working to deliver an NHS service, whether that is through an employment, educational or commissioning arrangement. This includes current (and former) employees, bank and agency workers, contractors (including third sector providers), trainees and students, volunteers, non-executive directors, and anyone working alongside NHS staff, such as those in health and social care partnerships.

The format of the Whistleblowing Annual Report 2023/24 is in line with the June 2023 guidance received from the Independent National Whistleblowing Officer regarding what areas must be covered.

2.3.1 Quality/ Patient Care

The Whistleblowing initiative assists the organisation by creating an environment where staff who have concerns about patient safety issues and other harms will be carefully listened to and offered impartial advice, encouragement, support and protection against victimisation.

2.3.2 Workforce

The monitoring of whistleblowing concerns ensures colleagues are afforded the highest standards of governance as set out in the NHS Scotland Staff Governance hand book and a culture which supports the appropriate raising and handling of concerns.

The standards support our ambition for an open and honest organisational culture where staff have the confidence to speak up and all voices are heard. This is focused through our organisational Values of Care and Compassion, Dignity and Respect, Openness, Honesty and Transparency and Quality and Teamwork.

These standards support our commitment to making a positive contribution to organisational change. In order to maintain a healthy work environment, we believe that staff need to be empowered to speak up without fear, confident in the knowledge that their voices will be heard and taken into consideration. Our organisational values of openness, honesty and transparency are used to achieve this goal.

Whistleblowing can be stressful for the whistleblower, those who allegations are brought against and the Confidential Contact.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Risks can relate to a wrongdoing, patient safety or malpractice which the organisation oversees or is responsible or accountable for. In a health setting, these concerns could include, for example:

- patient-safety/care issues
- poor professional practice
- unsafe working conditions
- fraud (theft, corruption, bribery or embezzlement)
- changing or falsifying information about performance
- breaking any legal obligation
- abusing authority
- deliberately trying to cover up any of the above.

2.3.5 Equality and Diversity, including Health Inequalities

The Standards are underpinned by legislation and form the National Whistleblowing Policy for NHSScotland. The Scottish Public Services Ombudsman and stakeholders, including NHSScotland employers and trade unions, co-produced the Standards, which were also subject to public consultation.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Under the Whistleblowing Standards, NHS Borders must ensure that all staff have access to a ‘Confidential Contact’ whose role is to provide a safe space to discuss concerns and provide options for staff to take forward their issue.

NHS Borders Confidential Contacts are listed on the Whistleblowing microsite.

2.3.9 Route to the Meeting

This has been previously considered by the following groups as part of its development.

- Whistleblowing Governance Group on 31 May 2024.

2.4 Recommendation

- **Awareness** – For Members' information only and publication on NHS Borders external webpages.

3 List of appendices

The following appendices are included with this report:

- Appendix No1, Whistleblowing Annual Report 2023/24

Whistleblowing Annual Report 2023/2024

1. INTRODUCTION

1.1 This is the third Annual Whistleblowing Report which is presented to the NHS Borders Board for consideration.

2. KEY PERFORMANCE INDICATORS (KPIs)

Key Performance Indicator	Requirement	Local Update
1	**Statement outlining learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns**	NHS Borders designated Whistleblowing Champion changed to Lynne Livesey, Non Executive from 1 February 2024. NHS Borders designated INWO Liaison Officer also changed to Iris Bishop, Board Secretary from 1 February 2024. There has been one new whistleblowing case raised for the year 2023/24. The learning from this case has involved:- • Reminding managers and staff involved in any whistleblowing case about the need for confidentiality. • Staff will be reminded of their professional obligations under respective professional standards.

		Individuals decide who they wish to approach from the list of Whistleblowing Confidential Contacts. They may be attracted to a Confidential Contact in the same line of work or someone from a completely different job family. Geography might frame their decision one way or another i.e. speaking to someone out-with their immediate area or vice versa. Thought does need to be given as to whether there is any conflict of interest between potential whistleblower and Confidential Contact e.g. is the working relationship too close, is it unhelpful to seek assistance from someone in the same area. These things can usually be resolved between the whistleblower, Confidential Contact approached and the person who co-ordinates the Confidential Contacts. We have reminded our Independent Contractors – General Dentistry Service, General Practice, Community Pharmacy and Community Optometry of their requirements under the INWO Standards.
2	**Statement to report the experiences of all those involved in the whistleblowing procedure**	There has been one new whistleblowing case raised for the year 2023/24. Due to confidentiality we are unable to provide commentary on the experience of those involved in this case.
3	**Statement to report on levels of staff perceptions, awareness and training**	Staff Awareness – in October 2023, NHS Borders engaged in the Speak Up week, issuing Staff Involvement and Staff Share communiqués introducing each of the confidential contacts and how and why it was important to raise any whistleblowing issues. (Appendix 1). Staff Training – as at January 2024, 78 NHS Borders staff had completed the Turas whistleblowing modules, with a further 25 staff

		having accessed the training and currently progressing through it. There had been a push to double training uptake in 2023 from the 2022 position of 73 staff completed training and 23 staff were progressing training. Board Awareness – The annual iMatter survey outcomes are reviewed by the Board to seek assurance that our staff have the awareness and ability to speak up should they have any concerns. The Whistleblowing Confidential contacts have moved to six monthly meetings to share experiences and stay up-to-date with any changes to the INWO Standards. Work is planned in 2024/25 to increase the profile of whistleblowing training through the introduction of the new Whistleblowing Champion, approaching our wider workforce and ethnic minority groups for confidential contacts volunteers, again raising the profile of all of our confidential contacts and explaining how easy and valuable whistleblowing training is to individuals, the organisation and our patients. We are also commencing a review and revision of our investigations training.
4	**Total number of concerns received**	From 01 April 2023 to 31 March 2024, NHS Borders received one new set of whistleblowing concerns. During 2023/24 a complaint was received and investigated to see if it passed the definition for whistleblowing. NHS Borders did not think that it met the criteria and took advice from INWO. INWO agreed that the matter referred to internal processes rather than whistleblowing and the matter was concluded outwith the

		whistleblowing process. During 2023/24 there was also on-going engagement with INWO concerning NHS Borders first ever case under the new standards. This concerned the handling of the employee at the centre of the whistleblowing allegations. INWO and NHS Borders agreed an action plan for improving the handling and governance of whistleblowing inside the Health Board and it was adopted by NHS Borders. INWO were satisfied that NHS Borders had appropriately responded to the matter.
5	**Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed**	During 2023-24 Whistleblowing Case 3 from 2022-23 was concluded.
6	**Concerns upheld, partially upheld, and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage**	The whistleblowing case raised in 2023/24 was not upheld. Whistleblowing Case 3 from 2022-23 was not upheld.
7	**Average time in working days for a full response to concerns at each stage of the whistleblowing procedure**	For Whistleblowing Case raised in 2023/24 the total time taken from notification to resolution was 333 days. For Whistleblowing Case 3 form 2022-23 the total time taken from notification to resolution was 460 days.
8	**Number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working day**	NHS Borders Management and Confidential Contacts endeavoured to keep whistleblowers up to date with progress with their concerns.
9	**Number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1**	No cases handled under Stage One required an extension.

10	**Number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2**	No cases handled under Stage Two required an extension.

3. CONCLUSIONS

3.1 The NHS Borders approach to handling whistleblowing allegations under the INWO Standards continues to evolve in line with evolving guidance from INWO.

3.2 NHS Borders appreciates that the decision to pursue whistleblowing allegations is not taken lightly and wishes to express its thanks to those parties who took the time and effort to do so during 2023-2024, and also to staff who were involved in responding to concerns, including our network of Confidential Contacts.

3.3 In terms of improving our learning from whistleblowing cases, we have developed an improvement plan that remains live and is discussed at our quarterly Whistleblowing Governance Group to ensure progress is being made. (Appendix 2)

LYNNE LIVESEY
NHS Borders Whistleblowing Champion

IRIS BISHOP
NHS Borders INWO Whistleblowing Liaison

Appendix 1

NHS Borders

Speak Up Week 2023

2-6 October

Day	What	Where
Monday	John McLaren and confidential contacts on site	Haylodge Community Hospital
Tuesday	John McLaren and confidential contacts on site	The Knoll Community Hospital
Wednesday	John McLaren and confidential contacts on site	The BGH
Thursday	John McLaren and confidential contacts on site	Kelso Community Hospital
	Live online panel discussion: Learning from concerns	Online - register here:
Friday	John McLaren and confidential contacts on site	Hawick Community Hospital

Speak Up Week 2-6 October 2023

NHS Borders

Speak Up Week 2023

This week is Speak Up Week. We are taking this opportunity to raise the profile of our confidential contacts here at NHS Borders. Today, we hear from Iris and Gregory.

Iris Bishop,
Board Secretary

Why is whistleblowing important to you?
It is important to support each other to do the right thing when we see things going wrong either intentionally or unintentionally that pose a danger to our staff and patients.

What inspired you to be a confidential contact?
We speak of compassionate leadership and I think being a confidential contact is part of that wider compassion that we need to show each other, and if there are serious whistleblowing incidents then we need to be on the front foot to support everyone involved to deal with them as quickly as possible.

Do you have anything else you wish to add?
I think whistleblowing is a useful tool to ensure everyone benefits if concerns in the public interest can be raised early and dealt with quickly.

Iris is based in the Education Centre and can be contacted by MS Teams or by email at iris.bishop@nhs.scot

Gregory Green,
Locum Consultant Psychiatrist

Why is whistleblowing important to you?
It is a necessary process for providing staff with an effective voice for basic service improvement while ensuring the safety and confidentiality of the whistleblower.

What inspired you to be a confidential contact?
When NHS staff notice problems and feel it necessary to whistle blow, they need a confidential place to organise their thoughts, discuss their concerns, and receive ongoing direction with the process. I am motivated to provide that space and line of communication for whistleblowers so that they can safely communicate with the organisation.

Do you have anything else you want to add?
Removing fear and ensuring confidentiality and safety for whistleblowers is integral to development of our health service. When problems are noticed and the need for improvement is highlighted, whistleblowers need to be looked after, and the process needs to be as constructive as possible. NHS Borders has taken proactive steps to make this possible.

Gregory is based at the BGH and can be contacted by email at gregory.green@borders.scot.nhs.uk

If you are interested in becoming a confidential contact please get in touch with Andy Carter at andrew.carter@nhs.scot or John McLaren at john.mclaren@nhs.scot

Speak Up Week 2023

This week is Speak Up Week. We are taking this opportunity to raise the profile of our confidential contacts here at NHS Borders. Today, we hear from Lynne.

Lynne Boyle,
Senior Nurse - Workforce Planning

Why is whistleblowing important to you?
Whistleblowing is an important mechanism for staff, students, volunteers or former staff to be able to raise concerns about any aspect of safety or care that has the potential to adversely impact patients in any way. It offers protection that may facilitate individuals coming forward to share concerns that would otherwise go under the radar of the organisation. I think it is extremely important that NHS organisations are open, transparent and accountable in order to prevent harm and reduce risk to service users or employees: enabling individuals to use whistleblowing can help to achieve this.

What inspired you to be a confidential contact?
I believe strongly that individuals with legitimate concerns should be supported to raise their concerns in a way that they can feel safe and protected. Being a confidential contact means I can help to guide and support an individual through the steps that need to be taken within the Whistleblowing Standards, recognising that it can feel like a time of great stress to pursue concerns. Above all it is important that individuals raising concerns should suffer no detriment. Ensuring people are treated in a fair and consistent manner is a value that is very important to me.

Do you have anything else you want to add?
Being a confidential contact is an interesting and diverse role – supporting others to speak up can drive up safety and improve wellbeing thereby potentially benefiting everyone who comes into the organisation.

Lynne is based in the HR department and can be contacted by mobile 07747 57327, email: lynne.boyle@nhs.scot or via MS Teams

If you are interested in becoming a confidential contact please get in touch with Andy Carter at andrew.carter@nhs.scot or John McLaren at john.mclaren@nhs.scot

Speak Up Week 2023

This week is Speak Up Week. We are taking this opportunity to raise the profile of our confidential contacts here at NHS Borders. Today, we hear from Vineeth.

Vineeth Ravindran,
Cardio-respiratory/Critical care Physiotherapist
Equality rep with the Chartered Society of Physiotherapy

Why is whistleblowing important to you?
The ability to Speak Up in the public interest as well as patient safety and care aspects embodies our work culture within healthcare.

What inspired you to be a confidential contact?
The urge to improve a culture of psychological safety within myself and others around me.

Do you have anything else you want to add?
Being a confidential contact has helped me understand more about the role, improve my leadership skills and has meant I have benefited from the national network of confidential contacts.

Vineeth is based in the BGH and can be contacted on bleep 6546 (Mon-Fri 08:30-16:30) or via email: vineeth.ravindran@borders.scot.nhs.uk

If you are interested in becoming a confidential contact please get in touch with Andy Carter at andrew.carter@nhs.scot or John McLaren at john.mclaren@nhs.scot

Appendix 2

NHS Borders Whistleblowing Improvement Plan 2024-2025		Version 3: 21 June 2024		
What	Why	Who	When	Progress
	INWO Standards Part 2 and Part 3: The procedure and when to use it and the two-stage procedure			
1	Review and further develop the support for anyone raising a concern and for those who are involved in the process of a whistleblowing concern being investigated.	Staff do not suffer harm as a result of raising a concern or being part of the whistleblowing process	KM/IB	Sept 24	**Action:** Pull together a flow chart looking at who does what and what is on offer to staff which links in to the policies and procedures we already have.
	INWO Standards Part 4: GOVERNANCE: NHS board and staff responsibilities			
2	Document and inform the confidential contacts and staff about the revised procedural arrangements including the roles and responsibilities of staff involved in handling whistleblowing concerns and the change in operational leadership for whistleblowing.	Staff and confidential contacts are aware of the process and procedure if concerns are raised through the whistleblowing route.	IB IB	Sept 24 June 24	**Action:** Understanding where students, contractors fit within this. **Action:** Developing a stand-alone intranet Whistleblowing site **(Complete 14.06.24).**
3	Use of OH&S speaking up self-assessment form to be queried with Kirsty McLachlan		IB/KM	June 24	**Action:** Self Assessment Form to be circulated for reviewing.
4	Ensure there are clear procedures in place to manage whistleblowing concern raised about senior staff e.g. chief executive or a board member. Document and inform confidential contacts and staff about these procedures.	Staff and confidential contacts are clear about the procedures in place to raise whistleblowing concerns about senior staff.	IB	July 24	**Action:** Iris to ensure this is clearly documented within the system. (14.06.24 Update new manual tracking process introduced and being populated retrospectively).

NHS Borders Whistleblowing Improvement Plan 2024-2025		Version 3: 21 June 2024			
What		Why	Who	When	Progress
5	Review the Whistleblowing Governance Group Terms of Reference (ToR) for approval by the Staff Governance Committee	To ensure clarity around the governance arrangements for whistleblowing	IB	Sept 24	ToR agreed by WGG 22.01.24. Further revision made and ToR to be resubmitted to WGG 31.05.24 **Action:** Further refresh to be provided to next meeting.
6	Develop and test a template that can be used to provide assurance to the Whistleblowing Governance Group about how business units (including primary care providers) adhere to the INWO standards and how they manage concerns raised through business as usual.	To provide assurance to the Staff Governance Committee and the Board that the organisation meets the INWO standards and embeds learning from concerns into practice.	IB/EC	Sept 24	**Action***:* Edwina is happy to work with Iris on this and bring it back to the next meeting and take it to the next Staff Governance Group. IB & EC
7	Increase the number of staff undertaking the relevant modules and monitor through quarterly reporting the uptake.	Staff understand how to raise a concern through business as usual and through whistleblowing processes.	AP	Sept 24	**Action:** A check to see if the modules have been shortened to allow staff to help increase compliance. Promotion around the existence of these modules to be looked at.
8	Raise the awareness of how to raise concerns through business as usual through Speak Up week and through routine communication channels with staff.		LL	Sept 24	**Action:** levels of training to be completed by staff to be discussed at the appropriate committees/board.
9	Further develop a training/education/support programme for the confidential contacts	NHS Borders needs to ensure that the confidential contacts have the	IB/LL	Sept 24	

NHS Borders Whistleblowing Improvement Plan 2024-2025 Version 3: 21 June 2024					
What		Why	Who	When	Progress
		knowledge, skills and support to deliver the standards and support staff in raising concerns.			
10	Consider a standalone microsite on the intranet for Whistleblowing to further separate it from HR.	Staff understand how to raise a concern through business as usual and through whistleblowing processes.	AP	Sept 24	Action: to be checked if Whistleblowing resources are available and easily accessed by staff who do not have access to the intranet. This is to include contactors and students.
	INWO Standards Part 5: Governance: from recording to learning lessons				
11	Revise the structured system for recording whistleblowing concerns, outcomes and resulting action/s.	To ensure the organisation holds the relevant information in context of the need for staff confidentiality and GDPR requirements.	IB	Sept 24	**Action:** A restricted case file is held within the structure, with the move to Inphase, there is the potential for whistleblowing cases to be stored there. The cases should be recorded in the asset register by the asset owner.
12	Future-proof the organisation's ability to document concerns into any future risk reporting system.	The organisation has an efficient mechanism to record whistleblowing concerns.	IB/LP	Dec 24	
13	Ensure quarterly reporting (based on the INWO KPIs) to the Staff Governance Committee and to INWO. This should include KPI information from all primary care and other contracted service providers.	The organisation meets the INWO reporting requirements and the organisation is informed about performance against the standards and associated	IB/LL	Sept 24	

NHS Borders Whistleblowing Improvement Plan 2024-2025 Version 3: 21 June 2024					
What		Why	Who	When	Progress
		improvement plans.			
14	Develop a formal mechanism to report to the Clinical Governance Committee on lessons learned about service provision.	Lessons learned from concerns raised can be disseminated across the organisation and embedded into practice, becoming a part of service improvement.	LJ	Sept 24	Action: To make sure it is clear the reviewer is aware where the appropriate governance structure to take the complaint through would be, making sure this is implemented.
	INWO Standards Part 6, 7 & 8: Governance: NHS Board requirements for external services, primary care providers, contracted services and health & social care partnerships				
15	Explore a mechanism to ensure that primary care providers and contracted services have procedures that meet the requirements of the INWO standards.	Any organisation delivering NHS services (whether a private company, third sector organisation or primary care provider) has the same requirement to ensure access to a procedure in line with the INWO standards.	CW/TY	June 24	**Action:** Letter to be issued to independent contractors looking for a level of assurance on what procedures they have in place. **Complete:** Email issued to independent contractors.
16	Pursue how NHS Borders and Scottish Borders Council can collaborate on a single telephone number for health & social care concerns throughout Scottish Borders.	To enable staff to raise concerns when working across the health & social care interface.	LL/AC/IB	Sept 24	**Action:** Explore possibility of single telephone number for partnership concerns.
17	Data Sharing and Confidentiality	Improving confidentiality when sharing data in order to assure those staff raising concerns.	ST/IB	Dec 24	