Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 5 December 2024** at 10.00am in the Lecture Theatre, Headquarters/Education Centre and via MS Teams.

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**DECLARATIONS OF INTEREST**	Chair	*Verbal*
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 03.10.24	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**STRATEGY**		
	5.1	Winter Plan	Director of Acute Services	Appendix-2024-78
10.30	**6**	**FINANCE AND RISK ASSURANCE**		
	6.1	Resources & Performance Committee minutes: 29.08.24	Board Secretary	Appendix-2024-79
	6.2	Endowment Fund Board of Trustees minutes: 17.06.24	Board Secretary	Appendix-2024-80
	6.3	Finance Report	Director of Finance	Appendix-2024-81
10.45	**7**	**QUALITY AND SAFETY ASSURANCE**		
	7.1	Clinical Governance Committee minutes: 28.08.24	Board Secretary	Appendix-2024-82
	7.2	Quality & Clinical Governance Report	Director of Quality & Improvement	Appendix-2024-83
	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2024-84
11.10	**8**	**ENGAGEMENT**		
	8.1	Staff Governance Committee minutes: 18.07.24	Board Secretary	Appendix-2024-85
	8.2	Area Clinical Forum Minutes: 25.06.24	Board Secretary	Appendix-2024-86
	8.3	British Sign Language (BSL) Plan 2024 to 2030	Director of Public Health	Appendix-2024-87

11.20	**9**	**PERFORMANCE ASSURANCE**		
	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2024-88
	9.2	Primary Care Improvement Plan Annual Report	Chief Officer, Health & Social Care	Appendix-2024-89
11.45	**10**	**GOVERNANCE**		
	10.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 18.09.24	Board Secretary	Appendix-2024-90
	10.2	Code of Corporate Governance Sectional Update	Board Secretary	Appendix-2024-91
	10.3	Board Committee Memberships & Quoracy	Board Secretary	Appendix-2024-92
11.55	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 6 February 2025 at 10.00am at Council Chamber, Scottish Borders Council and via MS Teams	Chair	*Verbal*

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 3 October 2024 at 10.00am in the Council Chamber, Scottish Borders Council and via MS Teams.

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

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr C Myers, Chief Officer, Health & Social Care
Mr A Carter, Director of HR, OD & OH&S
Mrs L Jones, Director of Quality & Improvement
Mr S Whiting, Infection Control Manager
Ms R Pullman, Nurse Consultant Public Protection
Mrs C Oliver, Head of Communications & Engagement
Ms S Laurie, Senior Communications Officer
Ms L Thomas, Communications Officer
Mr A McGilvray, Senior Reporter
Ms L Anderson, ITV Border
Mr P Seeley, Office for Mrs R Hamilton MSP
Mr D Knox, BBC Reporter
Mr T Kunkel, RCN Health & Safety Rep
Mr J Gaddie

1. Apologies and Announcements

1.1 Apologies had been received from Cllr D Parker, Non Executive, Mrs L Huckerby, Interim Director of Acute Services and Mr J McLaren, Non Executive.

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

1.3 The Chair recorded her thanks to Scottish Borders Council for the use of their facilities.

1.4 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** noted there were no verbal declarations.

The **BOARD** approved the inclusion of the declarations of interests for Mr Peter Moore in 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 August 2024 were approved.

4. Matters Arising

The **BOARD** noted there were no live actions on the Action Tracker.

5. Chief Executives Report

5.1 Mr Peter Moore recorded his thanks to the Board and wider organisation for his warm welcome to NHS Borders. He thanked the previous Chief Executive, Mr Ralph Roberts for his support in the handover of the Chief Executive role as well as the Executive Team who had picked up the slack during the transition phase.

5.2 Mr Moore commented that he had spent his first few weeks getting out across the system to understand the services provided and local communities and highlighted the financial and estate challenges faced by the Board.

5.3 The Chair commented that she had received positive feedback from various members of staff on Mr Moore's strategy to get out and about and meet people in person.

The **BOARD** noted the update.

6. Integrated Annual Planning Cycle

6.1 Mrs June Smyth provided a presentation on the integrated annual planning cycle covering the next three year period.

6.2 The Chair noted that the work would be resource heavy, and she was keen that the Board be kept informed on progress and any slippage.

6.3 Mrs Fiona Sandford enquired about tying it in with the Integration Joint Board (IJB) finances. Mr Andrew Bone commented that dialogue had commenced earlier that week with the Chief Financial Officer of the IJB to go through timelines and a reasonable working draft of the plan had already been produced.

6.4 Mrs Sarah Horan acknowledged the work that had been taken forward on the integrated workforce plan and welcomed the dementia nurse consultant being the first nurse consultant post across the integration space.

6.5 Mrs Lucy O'Leary enquired about the potential for real time performance and the identification of hot spots in future periods. Mrs Smyth commented that some short and medium term investment to support the BI Team had been agreed which would support the creation of dashboards and when more performance data was available a more proactive forward look and scenario planning would be able to be progressed linking to the national forward looking model.

6.6 Mr James Ayling enquired about disaster recovery planning in respect of capital infrastructure. Mrs Smyth commented that it related to digital to improve and enhance disaster recovery.

The **BOARD** noted the presentation.

7. Resources & Performance Committee minutes: 02.05.24

The **BOARD** noted the minutes.

8. Audit & Risk Committee minutes: 20.06.24, 27.06.24

The **BOARD** noted the minutes.

9. Finance Report

9.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements including: position remained on track with the current forecast; overspend of £10.3m at the end of five months gave a current run rate of £24.5m at the year end and the forecast suggested an improvement to a position of £23.5m; savings achieved in current year with full year effect of £7m of savings; brokerage target of £14.8m and unable in Quarter 1 and in the financial plan to present a plan to get to that level and unlikely to change in the Quarter 2 forecast; key performance was similar to previous months with core cost pressures in prescribing and additional beds in the system.

9.2 Discussion focused on: reduction in nursing agency staff; potential delayed impact on life expectancy and mortality; surge beds closure; areas of overspend that were as a consequence of good activity; anticipation of increased levels of community services creating a change in spend levels; and work remained on going to move towards the discharge to assess model.

9.3 Mr Chris Myers commented that a transformation lead was looking at the detail of who was in the surge wards, what their needs were and what could be done to expedite a transfer to a care setting. A new locality manager was also in post to ensure pathways were implemented as 60% of the delayed discharges within the Health Board were awaiting residential care. A review was also taking place of the criteria for residential care and how to create capacity to release flow. An action plan was also being developed which would feed into the winter plan.

9.4 Mr Peter Moore commented that he had seen a real concerted effort through the organisation to live within financial means and he took a lot of assurance from seeing that first hand. In regard to surge beds, he suggested there was something fundamental to be done over the following weeks on how it felt for the workforce moving into winter and into a period of sustained pressure and he was keen to support staff to be able to provide the best care. He further suggested that reporting should demonstrate cause and effect such as an overspend in Home First and Community services should see a reduction in acute activity.

The **BOARD** noted the contents of the report including the following:-

YTD Performance	£10.32m overspend
Outturn Forecast at current run rate	£24.76m overspend
Q1 Review Forecast (adjusted trend)	£23.53m overspend
Variance against Plan (at current run rate)	£1.0m improvement
Projected Variance against Plan (Q1 Forecast)	£1.23m overspend
Actual Savings Delivery (current year effect)	£7.22m (actioned)
Projected gap to SG brokerage	Best Case £8.73m (Q1) Worst Case £9.96m (trend)

The **BOARD** noted the assumptions made in relation to Scottish Government allocations and other resources.

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

10. Clinical Governance Committee minutes: 10.07.24

The **BOARD** noted the minutes.

11. Quality & Clinical Governance Report

11.1 Mrs Laura Jones provided an overview of the content of the paper and highlighted several elements including: emergency access; a development session with the IJB on the winter plan; risks around viability of acute services moving forward and the vulnerability of teams like Dermatology and Haematology; growth in key services such as cancers, diagnostics, drugs and outpatients; pressures in the independent contractors workforce and the influence of PCIP in driving primary care workload; Aseptic risk; HEPMA remained a key priority for medicines safety; and the health care environment.

11.2 Dr Lynn McCallum advised the Board that a new Haematology Consultant had been appointed which had made a significant difference.

11.3 Further discussion focused: quality of care reviews which was a nationally commissioned piece of work by Directors of Nursing; health care environment and a public enquiry into new builds; Health Improvement Scotland involvement in PCIP would drive a lot of data around activity in primary care as a starting point and there was a willingness of GPs to share data more readily than in the past; and complaints performance.

11.4 Mrs Lynne Livesey commented that in regard to complaints, a recent Scottish Public Services Ombudsman (SPSO) report had indicated that when a complaint had been

concluded some Boards had not fully addressed the issues raised and did not have a process in place to explore those elements further. She sought assurance that NHS Borders had a robust process in place.

11.5 Mrs Jones commented that there were a limited number of cases from NHS Borders that were escalated to the SPSO. There was however one case where there were two aspects that the SPSO had suggested we could have provided greater clarity on, and the team were looking at how to do that. She further confirmed that there was a robust process in place to interlink complaints and SAERs. She suggested providing further information to a future Board meeting. The Chair asked that the suggestion be added to the Action Tracker.

11.6 Mrs Fiona Sandford drew the attention of the Board to the number of elements within the report that the Clinical Governance Committee had taken limited assurance on.

11.7 A discussion took place to agree the level of assurance received from the report and it was agreed as limited not as a reflection of the work of clinical teams but due to the operational pressures that they worked to.

The **BOARD** noted the report.

The **BOARD** agreed to receive further information regarding the interlinks of complaints and SAERs.

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

12. Infection Prevention & Control Report

12.1 Mr Sam Whiting provided an overview of the content of the report and highlighted three key matters including: work of orthopaedic SSIT group; quality improvement work and the plan to deliver education to doctors in relation to CAUTI; and hand hygiene and the next round of audits due to commence the following week.

12.2 Discussion focused on: observations regarding the five step hand hygiene methodology; catheterisation being the main cause of e coli; the work of the CAUTI group; and consistency of catheterisation and potential alternatives.

The **BOARD** discussed and noted the report.

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

13. Public Protection

13.1 Ms Rachel Pullman provided an overview of the content of the report and drew the attention of the Board to strengthening links with public safety and clinical governance teams and particularly adult support and protection investigations. She further highlighted: improvement plans; action plans; feedback mechanisms back to the public protection committee; national work lead by the Scottish Government on adverse events; learning reviews; and challenges with information sharing and the multiple different systems navigated.

13.2 Discussion focused on: feedback from the Annual Report when navigation of the various systems was highlighted; positive improvement approach; streamlining the process; impacts of population health and health inequalities; and to schedule an update to a Board Development session in 2025.

The **BOARD** noted the report and the underpinning message that Child and Adult Support and Protection is everyone's business irrespective of role or position in NHS Borders.

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

14. Staff Governance Committee minutes: 18.04.24

The **BOARD** noted the minutes.

15. Area Clinical Forum Minutes: 02.04.24

The **BOARD** noted the minutes.

16. NHS Borders Performance Scorecard

16.1 Mrs June Smyth provided an overview of the content of the report and highlighted several elements including: planned care; mental health; delayed discharges; narrative for those off trajectory and underlying reasons affecting performance; continuing to review the format and content of the scorecard; and the BI Team were working on more interactive data and a more integrated approach as we move forward.

16.2 The Chair welcomed the use of some data to look forward as well as look back.

16.3 Dr Lynn McCallum drew the attention of the Board to cancer performance and commented that traditionally there had been excellent performance against that trajectory however there was some slippage which related to chair capacity in the SACT service. She further advised that diagnostic performance remained high although there were challenges within the radiology team.

16.4 Mrs Fiona Sandford commented that it would be helpful to have more direct reporting from the ACF into the Clinical Governance Committee or the Board as the ACF covered all independent practitioners across health services. Dr Kevin Buchan commented that it had been discussed with the Chair and Vice Chair and he would progress the ACF feeding into the Clinical Governance Committee. The Chair asked that the suggestion be added to the Action Tracker.

16.5 Further discussion focused on: ongoing positive performance of CAMHS; activity run rates for psychological therapies; urology services via NHS Lothian; supportive improvement opportunities; all centre for sustainable delivery (CfSD) work is channelled through the planned care programme board; and challenges with psychology service funding.

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

The **BOARD** noted that the ACF Chair would progress linking the ACF through the Clinical Governance Committee in terms of activities across independent practitioners.

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

17. Scottish Borders Health & Social Care Integration Joint Board minutes: 15.05.24, 24.07.24

The **BOARD** noted the minutes.

18. Board Business Plan 2025

18.1 The Chair introduced the item.

18.2 Mrs Lynne Livesey noted that the quarterly reports on Whistleblowing would be submitted to the Staff Governance Committee and the Annual Report would be submitted to the board. She enquired about the iMatter report. Miss Iris Bishop commented that the Board and organisation wide iMatter reports had been rescheduled to the Board Development session to be held in December.

18.3 Dr Sohail Bhatti noted the Director of Public Health Annual Report was an annual report but had been incorrectly noted as two yearly on the business plan.

The **BOARD** approved the Board meeting dates schedule for 2025.

The **BOARD** approved the Board Business Cycle for 2025.

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

19. Consultant Appointments

19.1 Mr Andy Carter provided a brief overview of the content of the report.

19.2 Mrs Fiona Sandford enquired if the Consultant in Emergency Medicine was an additional post and why the Consultant in Audiology would not commence in post until 2025.

19.3 Dr Lynn McCallum advised that the Consultant in Emergency Medicine was an additional post and that the Consultant in Audiology was on a fellowship and would commence in post after than had concluded.

The **BOARD** noted the report.

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

20. Any Other Business

20.1 Mrs Sarah Horan advised that there were two members of NHS Borders staff who had been nominated as finalists for the Scottish Health Awards taking place in November.

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, 5 December 2024 at 10.00am in the Lecture Theatre, Headquarters and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on

Agenda Item: Quality & Clinical Governance Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-4	11	The **BOARD** agreed to receive further information in regard to the interlinks of complaints and SAERs.	**Laura Jones**	**In Progress:** Explanation paper to be brought to the Clinical Governance Committee in January 2025 ahead of the February 2025 Board meeting.

Agenda Item: NHS Borders Performance Scorecard

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2024-5	16	The **BOARD** noted that the ACF Chair would progress linking the ACF through the Clinical Governance Committee in terms of activities across independent practitioners.	**Kevin Buchan**	

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Winter Plan**
Responsible Executive/Non-Executive:	**Lynne Huckerby, Interim Director of Acute Services**
Report Author:	**Lynne Huckerby, Interim Director of Acute Services**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to an:

- Annual Winter Plan

This aligns to the following NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper updates NHS Borders Board on our 2024/25 Winter Plan (**Appendix 1**), which has been developed using a whole system approach working in collaboration with our HSCP and across our Acute, P&CS, Mental Health, and Corporate Business Units. The plan has been informed through the whole system Seasonal Planning Group, Winter Roadshows, and professional engagement. The 2024/25 Winter Plan is being presented for approval.

2.2 Background

This Winter Plan represents a whole system approach to our readiness to respond and plan for a surge in demand for health and social care services during the period December 2024 to March 2025. While the focus of this plan is on the winter months, the

measures outlined are applicable to other times of the year when our health and social care system faces increased pressures.

This Plan seeks to address operational pressures experienced across the health and social care system, typically over winter but recognising periods of surge and pressure can happen throughout the year. We have engaged with stakeholders across health and social care including acute, primary & community services, mental health, social care, and social work as well as corporate services.

A lessons learned exercise held in May, allowed us to capture the learning from winter 2023/24 and to build on what went well. Winter planning formally began in June 2024. A Scottish Government winter readiness template was completed and submitted in October 2024. It is our intention that the Seasonal Planning group continues as part of our operational governance arrangements throughout the year to support planning for peak periods of demand, and to commence winter planning earlier.

2.3 Assessment

We have developed our planning priorities to guide our health and social care services as we put people at the heart of what we do, whilst we build our resilience to meet changing demand, recognising that surges can occur at any time of the year and not just winter.

Our 'whole system' plan considers interfaces across the health and social care system, ensuring we promote preventative and self-help options such as NHS inform, NHS 24 and local 'What Matters Hubs'. Our plan has been developed following a 'layered care' model with a focus on prevention, self-management and ensuring robust signposting to ensure our population receive the right care at the right time for their needs.

It was important to reflect on Winter 2023/24 to understand what worked well and less well recognising the importance of building on the learning of the prior year. A session was held in May 2024 and the outputs of this have informed our response to this coming winter period.

Our data modelling reflects the actual demand in the preceding two years (2022/23 and 2023/24); both planned and unscheduled care activity. In collaboration with Public Health Scotland, we have included the predicted Board level impact of covid, norovirus and seasonal illness. This is demonstrating the requirement for an additional 15 beds over and above our current bed availability at peak periods during winter. We have built in our mitigating demand through our known additional capacity through Virtual Hospital, and Discharge to Assess models of care.

2.3.1 Quality/ Patient Care

Our plan has been developed with a focus on prevention, self-management, and robust signposting to ensure our population receive the right care at the right time for their needs.

2.3.2 Workforce

Our business units and HSCP colleagues have been fully engaged in informing this plan demonstrated through the Winter Roadshows and professional team engagement.

A key element of this plan is 'winter wellness' highlighting what our staff and teams reflected to us as key areas of support. Our winter staff engagement sessions will continue throughout the winter period to give us the opportunity to check in with our staff.

2.3.3 Financial

Scottish Government winter budget is £200,000 and additional NHS Borders resource has been approved to provide the additional 15 beds, support the release of Senior Charge Nurses, and additional general services support along with a small amount of funding to develop our local winter campaign.

2.3.4 Risk Assessment/Management

This plan has been tested through our Hivernale business continuity exercises carried out on 26th November and 3rd December. **Appendix 2** provides an assessment of the key outcomes.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement, and consultation

An extensive staff engagement exercise has taken place across all our sites; BGH, all Community Hospitals, and several of the larger GP practices. Our approach to public engagement has been informed by our clinical colleagues and frontline staff who are closest to our patients and their communities. Our winter roadshows and attendance across all professional leadership groups has helped to shape and inform our winter delivery model.

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.

DATE	MEETING	FORMAT	VENUE
09 October	PNMLC	In Person	Lecture Theatre, Education Centre
10 October	Winter Roadshow	In Person	Kelso Health Centre Break Room
10 October	Winter Roadshow	In Person	Kelso Community Hospital Canteen
10 October	AHP Meeting	In Person	AHP Office
15 October	Winter Roadshow	In Person	BGH Canteen

DATE	MEETING	FORMAT	VENUE
16 October	H&SC Quad	MS Teams	
16 October	Winter Roadshow	In Person	Hawick Health Centre Break Room
16 October	Winter Roadshow	In Person	Hawick Community Hospital Canteen
17 October	Winter Roadshow	In Person	Galashiels Health Centre Break Room
17 October	Acute Quad	In Person	Ground Floor VC Room
17 October	Winter Roadshow	In Person	BGH Canteen
22 October	Winter Roadshow	In Person	BGH Canteen
22 October	Winter Roadshow	In Person	BGH Canteen
24 October	Winter Roadshow	In Person	The Knoll Staff Canteen
28 October	MH Quad	MS Teams	
28 October	Winter Roadshow	In Person	Hay Lodge Hospital Canteen
28 October	AMC Committee	MS Teams	
29 October	Board Executive Team	MS Teams / In Person	Coldingham Room, Education Centre
29 October	Joint Executive Team	MS Teams	
30 October	Clinical Directors	MS Teams	
01 November	SCN/M Forum	In Person	Tryst
05 November	Medical Unit Meeting	MS Teams /In Person	Tryst
07 November	Resources & Performance Committee	MS Teams	
18 November	Corporate Services Huddle	MS Teams	
20 November	Senior Medical Staffing Committee (SMSC)	In Person	Tryst
25 November	GP Sub Committee	MS Teams	
28 November	HM Senior Staff Meeting	MS Teams	

2.4 Recommendation

- **Decision** – approval of the Winter Plan 2024/25.

The Board is asked to **approve** the 2024/25 Winter Plan.

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 1, Winter Plan 2024/25
- Appendix 2, Output following Exercise Hivernale business continuity exercises 26/11/24 and 3/12/24. *(To Follow)*

NHS Borders

2024/25
WINTER PLAN

CONTENTS PAGE

INTRODUCTION

This Winter Plan represents a whole system approach to responding to a surge in demand for health and social care services during the period December 2024 to March 2025. While the focus of this plan is on the winter months, the measures outlined are applicable to other times of the year when our health and social care system faces increased pressures. We continue to focus on a preventative approach as far as possible to mitigate and reduce harm by ensuring people who need health and social care services are receiving the right care, at the right time and in the right place.

We have developed our planning priorities to guide our health and social care services as we put people at the heart of what we do, whilst we build our resilience to meet changing demand, recognising that surges can occur at any time of the year and not just winter.

Our 'whole system' plan considers interfaces across the health and social care system, ensuring we promote preventative and self-help options such as NHS inform, and NHS 24. When people do need care and support, we intend to care for them in their own home or in a homely setting. We want to make best use of our local community services including; pharmacy and primary care services. We will protect our Emergency Department and acute services for those who need us most. We recognise that the interdependencies of the whole patient journey can span more than one aspect of our health and care system which often leads to delays and pressures, and access to our services must consider this interdependency. Our plan has been developed with a focus on prevention, self-management and ensuring effective signposting to ensure our population receive the right care at the right time for their needs.

BACKGROUND

In May 2024, NHS Borders, along with our Health & Social Care Partnership carried out a lesson learned exercise on the preceding Winter 23/24. In June 2024, NHS Borders formed a Seasonal Planning Workstream who are responsible for a whole system and planned approach to both seasonal and surge planning.

The initial focus of this group has been on the forthcoming 2024/25 Winter season and planning for fluctuations and demand on services. This work has included the development of Business Unit planning and carrying out a critical friend review to ensure there is a whole system understanding on potential system pressures and demands during peak activity and to prepare to respond appropriately.

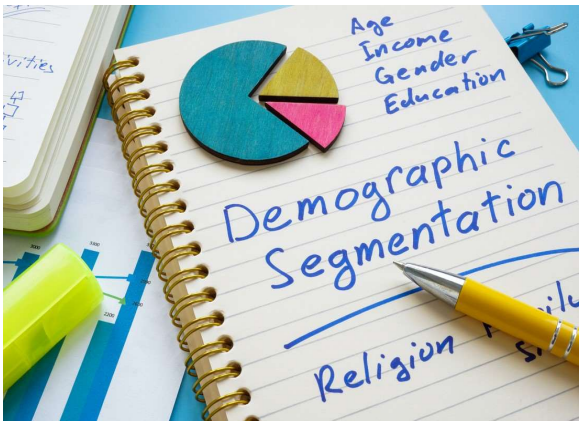
The Seasonal Planning Workstream is chaired by the Interim Director of Acute Services and the membership is whole system with representation from Acute Services, Primary & Community Services, Mental Health Services, Health & Social Care Partnership and Corporate Services.

The agreed objectives for the Seasonal Planning Workstream:

- Review the Lessons Learned outputs from previous years and embed to facilitate an evolving learning organisation.
- Provide organisational leadership and accountability to seasonal planning within parameters and resource set by surge bed project and based on normal seasons.
- Identify the key whole system activities across NHSB/SBC which will positively improve capacity and reduce the demand for additional Acute and community hospital surge beds.
- Make effective use of data and information relating to seasonal trends and apply this knowledge to planning for the continued safe and effective care during times of increased pressure and demand.
- Oversee performance management of the plan, assess the outcomes, report on performance and the overall execution of the plan.

- Define via the Whole System Operational Group, the mechanisms and command & control for effective management of escalation.
- This workstream will oversee seasonal planning across NHSB, Social Care and Social Work and report into to the Surge Bed Transformation Bundle.

KEY FACTS



NHS Borders serves a population of 116,020 (2021 figures) and continues to increase. The 45-64 age group make up a larger share of the population than is average for Scotland, and the 65-74 age group is growing the fastest which has implications on the healthcare system. As we continue to develop our model of care to ensure care is provided as close to home as possible, it is evident that our resources continue to be stretched and not always in the right place.

Geography of the Scottish Borders also has its own unique set of challenges due to the rurality of some areas and the distance required to reach the different localities. Therefore, making the most of the services people have local to them is key to our transition to a preventative care delivery model.

NHS Borders continues to experience prolonged and persistent pressures across the services, particularly in relation to our delayed discharges across our Acute and Community Hospitals meaning that without timely access to rehabilitation and step-down care we are causing harm and deterioration of health. Our long waits in the Emergency Department (ED), and increased turnaround times for ambulances create significant risks for those who are unable to access timely assessment. Our acute hospital is currently operating on many days above full capacity, with an additional 22 surge beds open consistently throughout the year.

As at the time of writing in November 2024, there are currently 77 delayed discharges within the Borders General Hospital. A key organisational priority is to reduce our delays through a rigorous and robust process involving escalation to executive leadership daily.

Our Primary & Community Services also continue to face increased pressure, with Community Hospital beds at maximum capacity and the demand for support in the community as high as it has ever been.

APPROACH TO WINTER

LESSONS LEARNED

It was important for us to reflect on Winter 2023/24 to understand where there were successes, or shortcomings of the planning and implementation of the 2023/24 Winter Plan within NHS Borders. A session was held in May 2024 and the outputs of this have been included in planning for and responding to 2024/25 Winter.

An overview of the areas that went well, suggestions for improvements and recommendations have been outlined below in Figure 1.

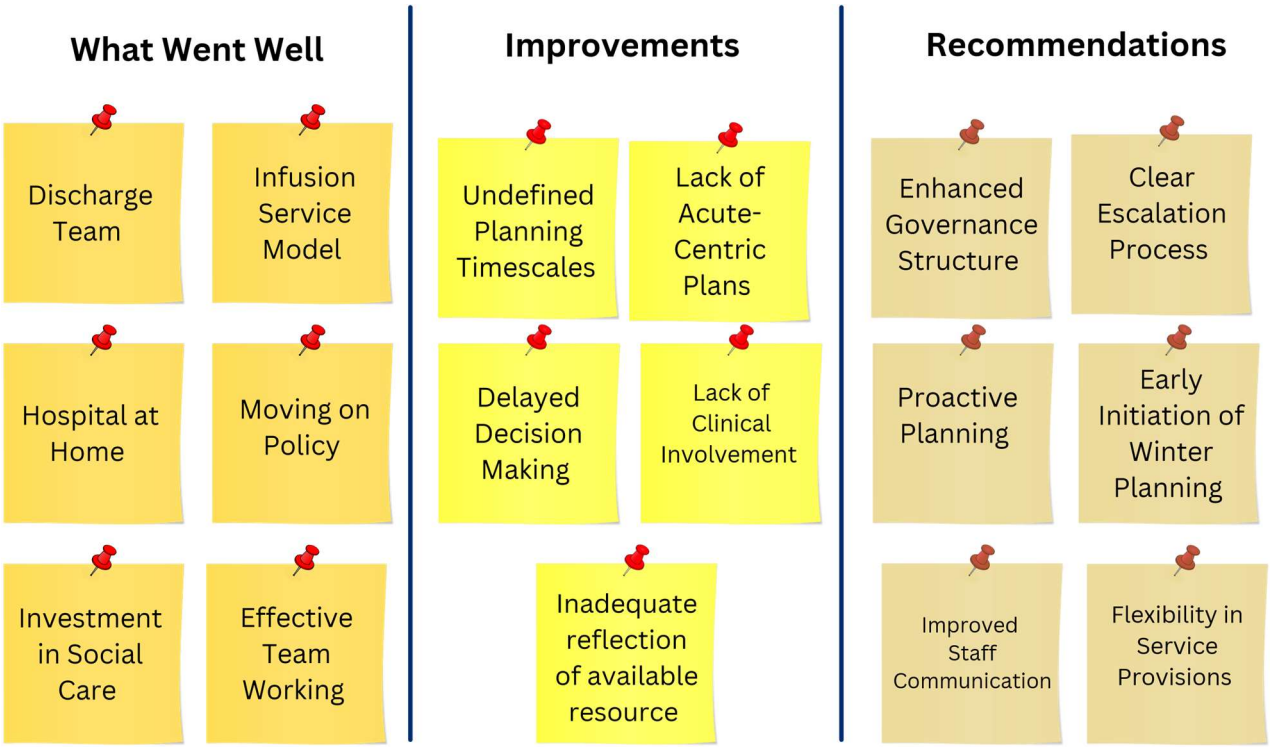


Figure 1: Lessons Learned from 2023/24

WINTER WORKSHOP

In our planning for Winter 2024/25, we have ensured engagement takes place as a Whole System, across all our professional groupings, including medical, clinical, AHP and corporate management.

A Winter Planning Workshop was held on the 23 September 2024 which had wide representation from across the Whole System. The purpose of this workshop was to build consensus on the model and approach for winter delivery, ensuring continued safe and effective delivery of frontline services.

The key objectives for the session were:

- Understand the needs of all key stakeholders from frontline delivery to support service functions
- Provide a critical friend approach to understanding and analysing plans in the content of the whole system
- Develop a winter model for delivery

KEY PRINCIPLES

Key principles were developed and agreed by the seasonal planning group to facilitate effective development and execution of our winter plan 2024/25. These are:

- Always living our Values, and being particularly observant to this during period of heightened pressure
- Winter is 'everyone's business'
- 'One team' approach across the whole system
- Collective ownership of development and execution of the winter plan
- Early warning approach/proactive response
- Routine monitoring and adjustment of plan – level of flex
- Lessons Learned – live capture throughout the winter period

PREPARATIONS & PLANNING

The seasonal planning group has met fortnightly since June 2024 to develop plans, assign the small winter funding allocation, develop the winter delivery model, undertake data modelling to plan for the demand on services over the period, and to stress test the plan through our business continuity exercise.

BUSINESS CONTINUITY

NHS Borders is holding two tabletop exercise sessions in November/December to bring together services across NHS Borders and Borders HSCP. Our “Exercise Hivernale”, is designed to enable services to collectively test their winter plan and strengthen our collective response to potential winter challenges. Exercise Hivernale will help to test NHS Borders preparedness for severe winter pressures, specifically focussing on the challenges posed by increased demand on services due to a significant respiratory virus surge and the operational disruptions that would arise in the event of a severe weather. As part of this exercise, we will also test our OPEL escalation framework which has been developed as a single system wide escalation response. Our escalation framework is attached as an Appendix to this plan.

Following the exercise, we will conduct a comprehensive debrief and lessons-learned session for both scenarios, gathering insights from all participants to identify strengths and areas for improvement. This session will inform refinements to the winter plan, ensuring NHS Borders can continue to adapt, improve, and deliver high-quality care in challenging winter conditions. The feedback and actionable improvements identified in the debrief will be integral to enhancing the resilience and responsiveness of NHS Borders throughout the winter period and beyond.

The chosen scenarios to be tested against are:

- **Surge in admissions due to heightened levels of respiratory illnesses in the community**

- **Disruption of operations due to severe weather**

STAFF ENGAGEMENT

As part of our 2023 Winter Lessons Learned, staff engagement and communication are key to continuing the delivery of safe, quality and effective services throughout the Winter period.

Taking this into account we have undertaken an extensive engagement exercise across our Acute Hospital, Community Hospitals and also GP Practices to hear from the staff that are delivering frontline services, to find out what their concerns are around the approaching Winter period and what support could be put in place to mitigate some of these concerns.

In addition, we have also engaged with professional medical, clinical, AHP and corporate teams in the development of the plan. These opportunities to engage our leadership teams have helped to inform and shape the plan.

The engagement sessions took place through October and November scheduled at varying times to capture as many staff in the discussion as possible. We held 11 frontline staff sessions, and a range of 12 medical, clinical and business management sessions where he heard from a range of stakeholders across our frontline services, as well as our operational and senior clinical and management leadership groups. Across the period we have engaged more than 100 staff who have helped to shape and inform this plan.

The four questions we discussed with staff during the engagement sessions were:

1. What are your concerns about Winter; these could be operational and/or about your personal wellbeing?
2. Are there any actions you or your colleagues have taken to address these?
3. Do you have any ideas about approaching winter differently?
4. How can your colleagues support you?
5. How can the public support you?

Our engagement with frontline staff will continue throughout the winter period, so we can use this as a ‘check in’ with staff to allow us to flex and be responsive to staff and organisational needs. This will be communicated through our internal staff share route.

YOU SAID	WE DID
Staffing & Resources Concerns about morale, higher sickness rates and staffing shortages. Worsened by the increased workload during winter months, with difficulty in coordinating staffing for evening shifts or adverse weather.	We recognise that our resources are stretched and we are asking teams as part of our winter plan to prioritise patient related activities over the winter period, over projects, unless they will have an impact on winter.
Winter Wellbeing Strong emphasis on staff wellbeing, training and team support.	We know that staff are working hard every day. Your wellbeing is important to us as we face the pressures of winter. We have put in place a range of measures to support staff wellbeing.
Public Messages There is a growing sense of entitlement among patients, who expect immediate care or access to medication and treatment, putting additional strain on our services. Patients' frustration with delays or service limitations is noted, with some becoming rude or demanding.	We have developed a winter campaign 'Accessing Healthcare' which will be used all year round to begin to change patient behaviour. This has a focus on ‘right care, right place' and encourages the public to take responsibility for their own wellbeing, and signposting to the right services at the right time for their healthcare needs.

Additional Capacity Better cover during winter and staff shortages, including purchasing extra staff time for cover. Advocacy for more flexibility and support in managing unexpected absences, such as for childcare or illness.	A small amount of winter funding has allowed us to focus on providing the additional bed capacity required for our predicted demand, and for additional General Services support. We expect that the expansion of our Virtual Hospital and our Discharge to Assess model of care will help to reduce pressure on our hospital services.
Hospital Flow Concerns about delayed discharges and patients in the wrong care settings. The discharge process is fragmented, with inadequate communication and coordination, leading to delays and inefficient use of resources.	We know that we have a significant number of patients delayed across our bedded areas. Our number one organisational priority is reducing this number to ensure that we reduce harm to patients and improve their experience of our care system.
Business Continuity Adverse weather (snow, cold) impacts staff travel, which has a knock on effect on delivering services. Concerns about issues with transport and accommodation for staff.	We are testing our plan at an upcoming 'Hivervale' business continuity exercise where we will test two scenarios on 26 November and 3 December. This will ensure our plan is ready for implementation.

WHAT IS THE DATA TELLING US?

Our data modelling in Figure 1 considers the preceding two years of planned care and unscheduled care activity and demonstrates the seasonal trends. The winter predictions also include impact of Covid, Flu and seasonal illness. This models the predicted bed requirement within NHS Borders. There is a clear rise in predicted required beds between November 2024 - end of February 2025. The March data is awaited from Public Health Scotland, and this will be updated once available.

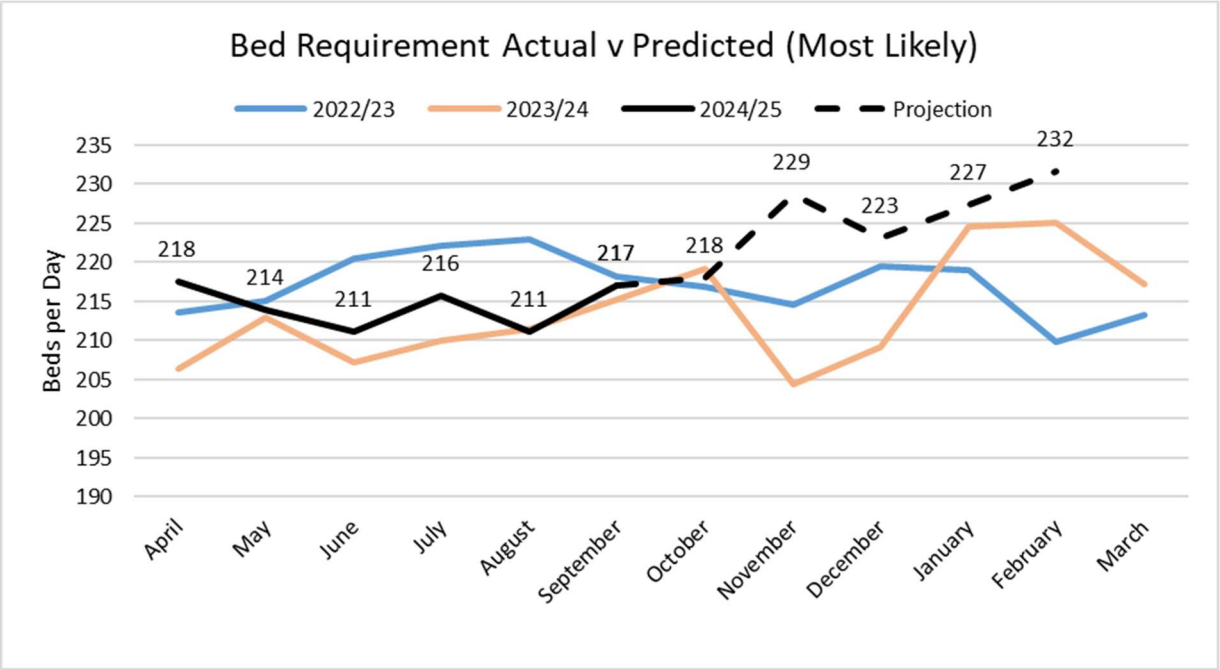


Figure 2: Annual bed requirement actual v predicted (most likely)

NHS Borders has a baseline bed model of 196 beds and since March 2023 has been operating with an additional 22 unfunded beds. As is demonstrated by Figure 2 above the demand on our beds has been consistently higher this year (black line) than that of 2023/24 (peach line).

The predicted demand for beds this winter is higher than that of the last two years. The modelling has been carried out with the support from our Business Intelligence team and Public Health Scotland. In addition to the existing operational surge, we are predicting in the 'most likely' of our scenarios the requirement for an additional 15 beds. Acute Services are preparing and executing the use of 5 beds in Borders View and 10 beds in Ward 8.

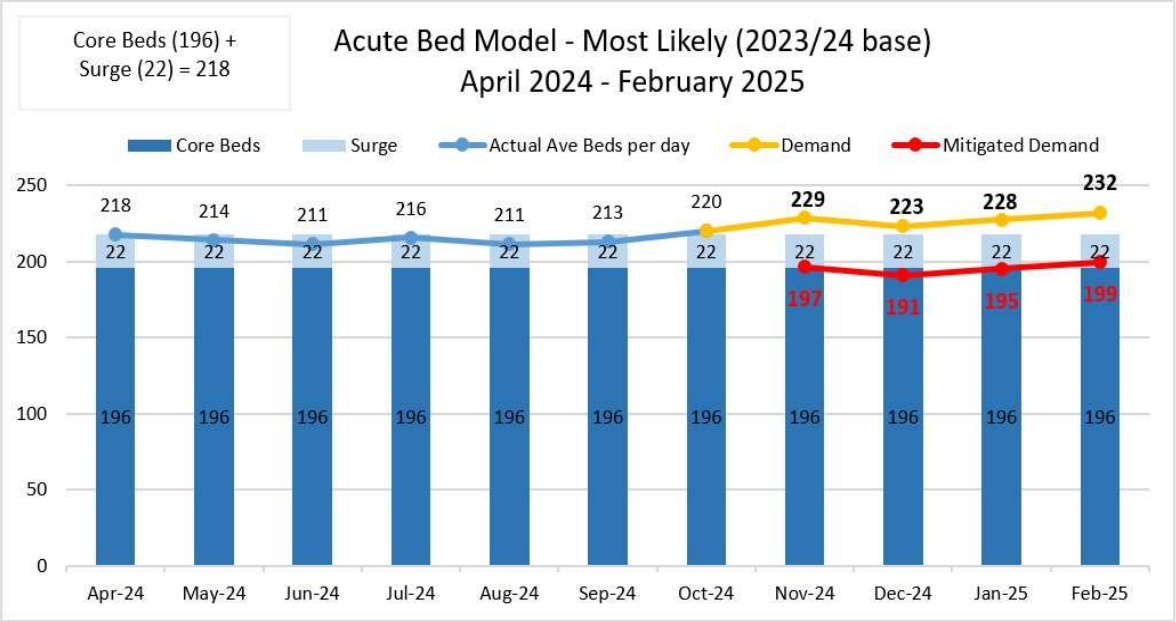
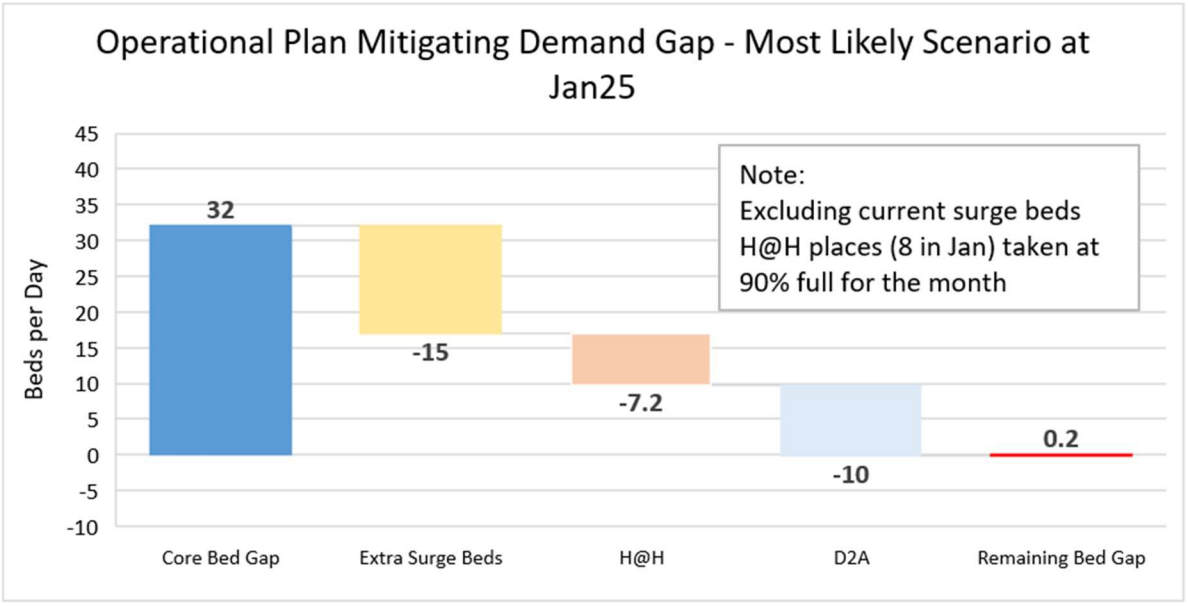


Figure 3: Acute Bed Model Winter 2024/25

As part of our modelling exercise, we have considered those services which operate outwith our bed bases in the community and across Primary & Community Services. These include our Virtual Hospital expansion from February and Discharge to Assess model from end January. It has not been possible to include Home First services due to the service pressures and existing caseload.



The detail is captured in Figure 4 below.

Figure 4: Mitigating Demand 2024/25

WHOLE SYSTEM DELIVERY

We have worked collaboratively across our Health and Social Care Partnership (HSCP) and NHS Services to define, shape and develop our Winter Plan 2024/25. There are specific areas which will be strengthened through this period in accordance with the pressure and demand on the system.

We highlighted the increase in bed requirements in the data modelling on page 11 and have therefore directed much of our winter funding towards ensuring we have sufficient beds and staffing to accommodate the rise in predicted demand.

Our Plan on a Page as outlined below (Table 1) provides an overview of the key themes of the winter plan and our approach to delivery as well as expected outcomes. The four key themes are:

- Supporting and enabling **Prevention**
- A robust approach to **Redirection**
- An expected **Reduction** in our delays across the system
- Ensuring our ability to **Respond** to care needs in the 'right place, right time'

The table below outlines our whole system response to winter delivery in accordance with the themes presented above. The four key strategic priorities are:

1. ***Surge Beds*** Increasing our surge beds by 15 to cope with the winter demand and associated nurse and health care support worker staffing complement. These beds will form part of our surge closure plan where it is our intention to reduce the total of 37 surge beds from April 2025.
2. ***Discharge to Assess*** when our patients are medically fit to leave the hospital our new discharge to assess model will ensure patients are assessed at a facility (Garden View) out with the hospital setting to ensure we can assess their needs is as homely a setting as possible.

3. ***Front door*** of our hospital will present alternative pathways of care as relevant for our patient needs. Our recently established Acute Admission Unit will divert patients away from our Emergency Department (ED) for our medical, surgical and GP pathways of care. Throughout the winter period we anticipate increasing the throughput through an expansion of hours.

   In addition, we will also be robustly signposting people away from the ED if their care needs are not life threatening to alternative services which will best serve their needs.

4. ***Improving hospital flow*** work is underway to address our hospital delays. Since October we have increased the rigour and focus to managing our delayed discharges. This involves daily meetings with representation from social care, social work, primary care, acute services and mental health. Daily escalations to executives are assisting in addressing and unlocking process issues.

5. ***National assets*** as part of our local winter campaign we will be encouraging the use of our NHS 24 national infrastructure with a specific focus on access to:

   - **111** is available at anytime day or night for urgent and unscheduled advice and signposting;
   - **Mental Health 'hub'** – psychological wellbeing practitioners are available at any time to speak to people, of all ages and services include; listening, offering advice and signposting (inc Breathing Space, Distress Brief Intervention and Living Life Services) to further help if required;
   - **Paediatric video consultations** will be available as part of a winter test of change offering services to 2-12 years for common winter ailments.

Area	What do we want to do?	What priority actions will we take?	How will we know we have achieved?
Prevention	Promote access to self-help, and self-management to keep people well. Encourage waiting well for secondary care consultations and treatment. Raise awareness of alternative sources of support and routes for healthcare.	• Winter/Seasonal Communication Strategy and Implementation Plan • Promoting national assets such as NHS 24, NHS inform and national helplines	• Increased access to alternative services (NHS 24, NHS inform) • Reduction in GP attendances • Reduction in ED attendances
Redirection	Consistent messages of signposting, redirection to 'right care, right time'. Robust model of signposting and redirection from our Emergency Department to encourage behaviour change. Redirect inappropriate attendance to suitable alternatives across all our services.	• Establishment of Acute Assessment Unit (AAU) and extension to 8 pm • Increased promotion of Pharmacy 1st service, and minor ailments service • Application of communications strategy across social, print media, and radio	• Increased use of Pharmacy • Increased attendance at AAU • Increased demand for Virtual Hospital • Reduced ED attendance • Reduced hospital admissions
Reduction	Reducing our hospital delays and non-delay length of stay (LOS) to improve hospital flow Reducing hospital admission and attendances through prevention and redirection actions above.	• Daily review of delayed discharges with relevant escalation in place • Non-delay LOS review • Increase Senior Charge Nurse capacity to facilitate improved ward ownership • Review failed discharges	• Improved process and efficiency through opportunities to remove delays • Improved hospital flow • Reduction in Occupied Bed Days • Improved EAS • Reduced delayed discharges
Respond	Facilitate rapid discharge through Discharge to Assess to embed the 'home is best' approach Respond to support our population who are vulnerable or in crisis	• Implement whole system OPEL framework • Agree whole system escalation framework (command approach) • Pre-noon discharge planning in place • Implement PDD improvement and compliance plan	• PDD compliant discharges • Reduction in LOS • Reduced delayed discharges • Improved flow across BGH and Community Hospitals

Table 1: Key themes of the winter plan

WINTER / SEASONAL ENGAGEMENT & COMMUNICATION MODEL

Our approach to public engagement has been informed by our clinical colleagues and frontline staff groups. Our winter roadshows and attendance across all professional leadership groups has helped to shape our model. We know that public behaviour change takes time and so this framework will be applied all year round.

The fundamentals of this approach are embedded in our three-stage model outlined below:

1. Encouraging our local population to manage and take responsibility for their own health and care through our **prevention** approach;
2. Building awareness of **local** access to services in the community;
3. Protecting our **acute services** for those who need us most.

Figure 5: Communications and Engagement Model

The winter communications landscape can be cluttered with overlapping and sometimes contradictory messages, such as advice on stocking up on self-help medicines versus ordering unnecessary prescriptions.

It is the role of the communications team to ensure that there is a clear plan in place which focuses attention on the timing and consistency of messaging, whilst retaining the ability to react at short notice when required. We will communicate key messages based on data and experience to signpost the public and highlight any call to action when required.

A clear and concise campaign has been created which aligns with the Winter Engagement Model above which focusses on prevention through self-care, community support including getting the right care, in the right place at the right time and when to access acute services. Additionally, it also covers key information about how to wait well whilst on our waiting list, engaging with our health professionals to make informed decisions and what to expect when admitted or discharged from hospital. While aimed at winter, this campaign will continue to help the community navigate health services year-round.

WINTER WELLNESS

Many of our teams, departments and business units have a strong ethos of team working and support to one another and so this will continue throughout the winter period. We will be encouraging the following aspects of wellness across our workforce.

STAFF FLU VACCINATIONS

In 2023/24, NHS Borders was the highest-performing mainland board for health care worker influenza vaccination uptake, achieving a final rate of 49.9%. By November 2023, uptake was already at 40.9% with 1,608 health care workers vaccinated. In comparison, as of November 2024, uptake stands at 29.5% with 1,183 vaccinated so far, at present NHS Borders remains the top-performing mainland board for all health care worker influenza vaccination in 2024/2025 season.

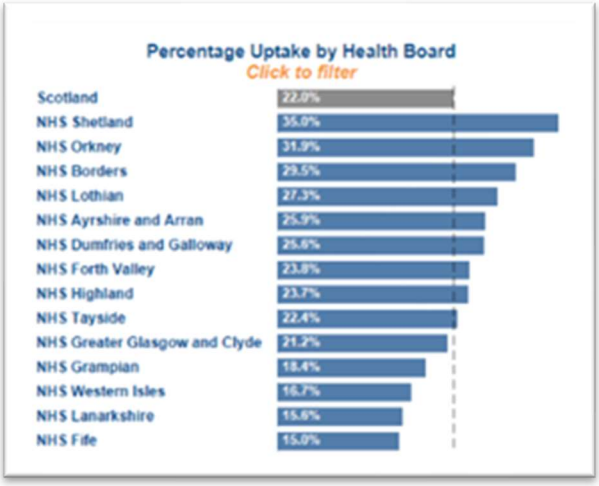


Figure 6: PHS Discovery Data (as at 08/11/24)

The decrease in flu uptake this year reflects a broader national trend, influenced by several factors. There is a sense of a lack of "vaccine confidence" among the public due to misinformation across various social media platforms. Unfortunately, this has led to reduced understanding, urgency and motivation for many routine vaccinations.

Below is a comparison of vaccination figure from 2023/24 with our current progress in the 2024/25 programme. Note: PHS have indicated that the denominators for eligible staff are not correct and being investigated.

Season	Eligible Number	Total Vaccinated (as of November)	% Uptake (as of November)	Final Total Vaccinated	Final % Uptake
2023/24	3,925	1,608	40.9%	1,957	49.9%
2024/25	4,005	1,183	29.5%	-	-

Table 2: Flu Vaccination comparator 2023/24 and 2024/25

BREAKS

We will be encouraging staff wellness through promotion of physical activity through local gyms, and local clubs as well as making the most of the outdoors when staff are off duty. When staff are working we are encouraging healthy breaks which could include lunch with team members and friends, or taking a brisk walking around the campus/local community.

REVIEWING ESSENTIAL MEETINGS

Our key priority is the safe and effective delivery of our services through winter. In managing the expected additional demand for our services we will be encouraging our teams to review and reduce any meetings considered to be non-essential during this period.

MENTAL HEALTH FIRST AID

The darker and shorter days can cause lower mood, especially if we are less active during the winter months. Supporting our colleagues and co-workers is crucial as we face a potentially demanding winter period. We continue to encourage colleagues to seek mental health first aid support through our group of practitioners, and if interested to encourage staff to undertake the course.

WELLBEING NEWSLETTERS

A monthly staff wellbeing newsletter is circulated. Topics over the winter period will include Coping with darker mornings, Importance of taking breaks and social interactions with colleagues, Challenges of the festive period and financial wellbeing.

SELF HELP RESOURCES

A range of resources are available to staff via the Occupational Health &Safety microsite including Self Care Matters booklet, Relaxation skills guidance, and a Staff Mental Health and Wellbeing Resources guide providing details of researched based interventions and apps.

Information on national wellbeing resources are also available promoting the workplace Specialist service, the National wellbeing Hub and the National wellbeing helpline.

TRAINING

Stress and resilience training is available for all staff, and we are currently scoping the option to make similar training available in e-learning format with modules on LearnPro.

Working Health Matters course - this course helps staff develop a toolkit to manage challenges in or out of work. The content focuses upon relaxation, time management, improving sleep, coping with stress, assertiveness and how our thoughts might impact on our behaviours. This course is delivered via Teams and incorporates self-directed learning.

LIVE MANAGEMENT & LEARNING LESSONS

Our winter plan will be a live document, and we will adjust and adapt our plan according to patient demand across the period. We will monitor this through our seasonal planning group ensuring that we are responsive to the system pressures. We also intend to undertake a live capture of lessons through the period, which will also allow us to adjust the plan in the live environment. A more formalised lessons learned session will be held in April with representation from across the system.

We will apply the Gold/Silver/Bronze command structure to managing the day-to-day demands in order that we balance the risk across the system.

Our seasonal planning group will transition to managing the known peaks of demand across the year and will enable our winter planning activity for 2025/26 to commence early.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**Peter Moore, 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 7 November 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 29.08.24

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 29 August 2024 at 9.00am via MS Teams.

Present:
Mrs F Sandford, Non Executive (Chair)
Mrs L O'Leary, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Dr K Buchan, Non Executive
Mrs L Livesey, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mr A Carter, Director of HR
Mrs J Smyth, Director of Planning & Performance
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Mrs L Huckerby, Interim Director of Acute Services
Mrs K Lawrie, Partnership Representative

In Attendance:
Miss Iris Bishop, Board Secretary
Mrs L Goodman, Head of IM&T
Mr M Clubb, Director of Pharmacy
Mrs C Oliver, Head of Communications
Mrs S Swan, Deputy Director of Finance
Mr K Bryce, IM&T Manager

1. Apologies and Announcements

1.1 Apologies had been received from Mrs K Hamilton, Chair, Cllr D Parker, Non Executive, Mr J McLaren, Non Executive, Dr L McCallum, Medical Director, Mrs C Myers, Chief Officer and Mrs S Horan, Director of Nursing, Midwifery & AHPs.

1.2 Mrs F Sandford, Vice Chair, chaired the meeting in the absence of Mrs K Hamilton, Chair.

1.3 The Chair welcomed Mr M Clubb, Director of Pharmacy and Mrs L Goodman, Head of IM&T to the meeting.

1.4 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 2 May 2024 were approved.

4. Matters Arising

4.1 **Action 2023-3:** It was noted that LIMS was a substantive item on the meeting agenda and the item could be closed on the action tracker.

4.2 **Action 2024-1:** It was noted that LIMS was a substantive item on the meeting agenda and the item could be closed on the action tracker.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Actions 2023-3 and 2024-1.

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

5. Performance Scorecard

5.1 Mrs June Smyth provided an overview of the content of the report and highlighted several elements including: the format of the report in relation to the signed off ADP; extended content of the report to the Resources & Performance Committee towards the end of the financial year to include the 15 box grid, the programme of work that reported through the Quality and Sustainability Board and what services wished the Board to be sighted on; and a refresh of the performance framework.

5.2 Discussion focused on: outpatients waiting times and a comparison of current performance compared to 2019 activity; cancellation rates for operations were 8% nationally and 10% locally; some challenges in performance were driven by issues in particular specialties such as dermatology; those waiting over 52 weeks had continued to rise since January 2024 and at what point would the gap close and not get any worse; and the difference between staffing levels and productivity needed to be made clear for the public.

5.3 Mrs Lynne Huckerby commented that the value and sustainability of the services across the patch was being explored. The right resources and skills were required and that was a challenge around recruitment and retention as could been seen with the difficulties in dermatology and urology, where the inability to recruit senior staff to those services and the funding from the Scottish Government was to ensure the delivery of 2023/2024 levels of activity. A deeper dive into the matter at a future Board Development session would help to bring the Board up to speed with the challenges and how they were being addressed such as through the outpatients programme.

5.4 Mrs Lucy O'Leary enquired given the continued numbers and volumes presenting at the Emergency Department, if there was any evidence of what proportion of that business was the product of other pressures in the system such as deferred meetings, outpatients waits or readmissions.

5.5 Mrs Huckerby commented that it was something that was being looked at. In terms of the Emergency Department (ED) there were lots of workstreams looking at pathways from attendance at the ED and flow through the rest of the hospital and there was a challenge in that with readmission rates. Work was progressing on unpicking the back story to of the patient being an appropriate admission to the ED as there were many frail ill elderly with high levels of acuity presenting in the ED.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of July 2024.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received limited assurance from the report.

6. LIMS Update

6.1 Mrs Lynne Huckerby provided an overview of the content of the report and highlighted that in July there had been an external support provision put in place to progress the work on developing a resource plan around a "go live" with the product to deliver safe and effective laboratory services locally. The national position in terms of the Citadel/Magentus solution had slipped by 6-9 months and it was suspected that the March 2027 "call off contract" was no longer viable. NHS Tayside and the Golden Jubilee had also made the choice to stay with Clinysis and they had also had challenges with them.

6.2 Mrs Laine Goodman provided a presentation on the LIMS programme.

6.3 Mr James Ayling enquired if there would be a breach in contract and a financial penalty if there was a need to contractually drawdown under the framework and go to Citadel in April 2026.

6.4 Mr Ayling also enquired about the implications of the framework agreement and the contract with Citadel given the organisation had chosen to remain with Clinysis at the present time.

6.5 Mrs Huckerby commented that in terms of the framework agreement around Citadel/Magentus the development of that product was not as advanced as had been anticipated. Given the slippage neither NHS Borders, NHS Tayside nor the Golden Jubilee had been asked to be part of the programme at present. At some point in the future a formal agreement would be required to be put in place.

6.6 Mr Ralph Roberts reminded the Committee that part of the decision made at the time to remain with Clinysis was in relation to mitigating risk, with the intention of moving to the national product Citadel/Magentus in the future.

6.7 The Chair sought clarification of the number of WTE staff required for the project.

6.8 Mrs Lynne Livesey enquired if the team was confident that given the problems to date, that Clinysis could deliver a fully functioning system within the timescale.

6.9 Mrs Goodman confirmed that to date there had been no discussions about penalties from Citadel. In terms of slippage she suggested there was an expectation of cost apportionment to change which was dependent on all Boards going live at their

scheduled time. In terms of a call off against Citadel/Magentus, she explained the complexities involved in the LIMS implementation and its integrations with other systems and the need to match what colleagues in other Boards were doing.

6.10 Mrs Goodman explained that Laboratory staff were key to the project and both they and the digital team were exhausted and disheartened about the slow progress. She was in discussions with the Scottish Government about change fatigue and the cost to the organisation and explained that if there was a move to Citadel/Magentus, NHS Borders would not be able to call off against it in 2026 and she had asked them to extend the programme and advised that NHS Tayside and the Golden Jubilee were in the same position.

6.11 In terms of the 4 WTE posts she confirmed that they were required. The potential to pull project staff from other projects would result in delays to other programmes of work and she was concerned at the wellbeing of those staff.

6.12 Mrs Goodman then commented that unfortunately she was not confident that spending up to £1.5m would produce a fully functional viable product as the end result and she had been speaking to other Health Boards across the UK who were moving to Winpath Clinysis and only one Trust had gone live with one module in 4 years.

6.13 Mrs Huckerby commented that it could not be underestimated the pressure in Labs who delivered a 24/7 service whilst also supporting the project and staff wellbeing in that team was of a real concern. She suggested it was important to fix a date for completion as the project had not be expected to run on as long as it had.

6.14 Mr Andrew Bone reflected that it had been 2 years since the start of the project and the complexities around it had not been understood at that time. In terms of resources they had been provided for in the Financial Plan Q1 forecast and he suggested it remained affordable within a deficit forecast overall.

6.15 Mrs Livesey commented that she was broadly supportive of the investment and resource to be put into the project and urged the Executive Team to engage with Clinysis and build in legal financial consequences for the provider should any faults in delivery lay with them.

6.16 Mrs Harriet Campbell suggested that the current position was initially due to poor contract management and she sought assurance that it would not happen again with other contracts.

6.17 Mr Roberts suggested the Committee commission the Executive Team to have robust conversations with Clinysis about timescales and to seek assurance that a complete and viable system would be realised within the timeline and to agree to include Scottish Government digital colleagues within that conversation. He further suggested Mrs Huckerby and Mrs Goodman formally work with Scottish Government digital colleagues to build on the option appraisal to get to a point where a decision could be made on if there was another viable option that both NHS Borders and the Scottish Government could buy into and then undertake a lessons learned piece of work.

6.18 Mr Ayling assured the Committee that the Audit and Risk Committee had undertaken a contract management review and had received a lessons learned outcome from it.

6.19 The Chair commented that reluctantly the resource was necessary. She recorded the thanks of the Committee to the Teams involved in the project for the work they were doing under very difficult circumstances. She further supported push back against Clinysis and agreed that colleagues should continue to work closely with the Scottish Government Digital Team.

The **RESOURCES & PERFORMANCE COMMITTEE** reluctantly approved the extension of the LIMS project timeline to May 2025, recognising that the date was approximate and subject to the timely completion of testing, data migration, and validation exercises.

The **RESOURCES & PERFORMANCE COMMITTEE** approved the extension of contracts for the Test Manager and Compliance Specialist, and the appointment of a LIMS delivery specialist Project Manager, 2 Project Support Officers with LIMS delivery experience, and 4 Locums to backfill Laboratory Staff aligned to the LIMS project.

The **RESOURCES & PERFORMANCE COMMITTEE** considered the financial implications and approved the necessary resource allocations to ensure the safe and effective delivery of the LIMS project.

The **RESOURCES & PERFORMANCE COMMITTEE** considered the broader context of the slippage in the National Magentus Implementation and the experiences of other Boards and Trusts across the 4 Nations in implementing WinPath Enterprise. It was important to remain mindful of the possibility of additional delays, which would be closely monitored and managed to minimise impact.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received no assurance from the report.

7. Aseptic Dispensing Fabric and Staffing requirements 2024-25

7.1 Mr Malcolm Clubb provided an overview of the content of the report and highlighted that either a brand new unit, modular unit or to tender via a national procurement for products would be required. An intention to tender had been issued and 15 declarations of interest had been received with 5 meetings held and 3 parties withdrawn. In order to maintain cancer services on the Borders General Hospital footprint aseptic products were a necessity. He further explained the risks associated with the current unit and the challenges in resourcing pharmacy services.

7.2 Dr Sohail Bhatti enquired about the outcomes and Mr Clubb explained that all patients were managed under the same protocols, regimes and treatments wherever they were in Scotland, so the patient would always get the best outcome.

7.3 The Chair enquired in regard to risk tolerance if there were any incidents due to being noncompliant. Mr Clubb confirmed there were no incidents, there was a risk from using a unit incorrectly and risk mitigations were in place, however there was a clear need for a different solution to the organisations long term requirements.

7.4 Mr Andrew Bone commented that aseptics was currently the single highest clinical risk identified for a future capital planning priority.

7.5 The Chair sought clarification on the status of the modular unit and increased staffing levels and timeframes. Mr Clubb commented that an exit date was required to stop using the current unit and if a modular unit was not used it would need to be short term as there was no evidence to confirm it would be safe to carry on using the current unit.

7.6 Mr Bone advised that it would be 12 months minimum from the point of commissioning. In regard to workforce, Mr Bone commented that any increase in staffing would be via a saving from elsewhere in the organisation.

7.7 Mrs Harriet Campbell enquired if new staff could be attracted to the posts. Mr Clubb commented that he already had some staff who could be ringfenced for the posts to protect the cancer team.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed the Board's long term commitment to providing cancer treatment services within the Borders General Hospital and recognised that it would require access to aseptically prepared products.

The **RESOURCES & PERFORMANCE COMMITTEE** acknowledged that the risk outlined was outwith the Pharmacy directorate's risk appetite and agreed that the Board accept risk ownership until such time as mitigation was in place to address the issues outlined.

The **RESOURCES & PERFORMANCE COMMITTEE** supported a switch to using national procurement prefills unless a product was required to be made bespoke as it was not available on the national procurement tender. That was likely to be the case in around 75% of cases. That would include an increased expenditure for products on a temporary basis.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed a preferred approach to address the infrastructure risk based on the assessment of options which was to pursue a modular unit which would be QAAP compliant.

The **RESOURCES & PERFORMANCE COMMITTEE** supported the increase in staffing for verification of SACT and to support safe dispensing or manufacture as per DL 2023 15 [Revised] Guidance For The Safe Delivery Of Systemic Anti-Cancer Therapy. Additional workforce costs circa £225k recurrently of circa £113k in year.

The **RESOURCES & PERFORMANCE COMMITTEE** approved the inclusion of relevant costs within the 2025/26 financial plan and recognised the implications that it would have for the Board's financial deficit and savings targets.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

8. Finance Report

8.1 Mr Andrew Bone drew the attention of the Committee to the £8.63m overspend position after 6 months, that there had been a savings delivery of £5.91m to date and that the run rate comparison to get to £25.8m.

The **RESOURCES & PERFORMANCE COMMITTEE** noted

YTD Performance	£8.63m overspend
Outturn Forecast at current run rate	£25.88m overspend
Q1 Review Forecast (adjusted trend)	£23.53m overspend
Variance against Plan (at current run rate)	£0.12m adverse
Projected Variance against Plan (Q1 Forecast)	£2.23m improvement
Actual Savings Delivery (current year effect)	£5.91m (actioned)
Projected gap to SG brokerage	Best Case £8.73m (Q1) Worst Case £11.08m (trend)

The **RESOURCES & PERFORMANCE COMMITTEE** noted the assumptions made in relation to Scottish Government allocations and other resources.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

9. Quarter 1 Review Update

9.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements to the Committee including: no changes to the numbers presented in the forecast to the Board at the start of August; a brief summary of the 15 box grid; Scottish Government response to the Q1 review; Scottish Government information on support and intervention framework; and feedback from the Scottish Government on the choices submission.

9.2 Discussion focused on: the Quarter 1 feedback; financial support made available to Mr Bone and the finance team to help support delivery of the overall programme; progress against the audit recommendations; category 3 choices; international recruitment; and continue to pursue measures and potentially add exceptions where clinical and patient safety issues were a concern.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update provided in relation to the Q1 review, which included feedback from the Scottish Government and actions to be implemented in advance of the Q2 review.

The **RESOURCES & PERFORMANCE COMMITTEE** considered actions to be implemented in relation to the Level 3 choices set out in Table 9 (section 2.3.3) and agreed the Executive Team should continue to pursue the measures and in terms of staffing that exceptions be written into it where clinical and patient safety was concerned.

The **RESOURCES & PERFORMANCE COMMITTEE** requested that the Audit & Risk Committee undertake a detailed review of the Board's position in relation to the NHS Scotland Support & Intervention Framework (section 2.3.4).

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

10. Capital Plan Update

10.1 Mr Andrew Bone provided an overview of the report and highlighted: progress against planned expenditure; completion of legacy projects; aseptics will come

forward in 2025/26; digital portfolio and community hospital RAAC; and estates backlog and preventative maintenance planning.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update provided in the paper and recognised the risk in relation to slippage on the programme and the actions in place to mitigate the risk, including further dialogue with the Scottish Government.

The **RESOURCES & PERFORMANCE COMMITTEE** confirmed it had received moderate assurance from the report.

11. Any Other Business

11.1 The Chair recorded the thanks of the Committee to Mr Ralph Roberts and wished him well in his retirement.

12. Date and Time of Next Meeting

12.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 7 November 2024 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 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 7 October 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 17.06.24

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 17th June 2024 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee
Mrs K Hamilton, Trustee (Chair)
Mrs L Livesey, Trustee
Dr L McCallum, Trustee
Mrs L O'Leary, Trustee
Cllr D Parker, Trustee

In Attendance:
Ms C Barlow, Charity Development Manager
Ms R Egan, Fundraising Officer
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 Mr R Roberts, Trustee, Mrs S Horan, Trustee, Mr J McLaren, Trustee, Mr M McLean, Investment Advisor and Mrs J Smyth, Director of Planning & Performance.

2. **Declaration of Interests**

James Ayling declared an interest in item 5.3 (Perinatal Mental Health Borders) as he was a member of the Mental Health Board which was referenced within the paper.

3. **Minutes of Previous Meeting : 6th May 2024**

James Ayling referred to his query around core/non core elements for a project in the pipeline for resuscitation trolleys and asked if there was any update on this. Colleen Barlow advised that this was still in development and would come forward as an application to the Endowment Advisory Group meeting in August.

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker
Karen Hamilton referred to the first action regarding an Innovation Fund and updated that a document had been pulled together and that she, Fiona Sandford, Lucy O'Leary and Colleen Barlow would meet to discuss this further and bring back to the Board of Trustees if necessary.

Lynn McCallum referred to the action on feedback being given to Trustees at the October meeting following the Palliative Care workshops and asked for an update on this as she had not been present for previous discussions. Colleen Barlow provided the background and assured that there would be no duplication with the other work being undertaken in

this area and that all information arising from the workshops would be fed back to Trustees.

Harriet Campbell referred to the market test exercise for the Investment Advisor contract and asked if there was a timeframe for this as she was keen to see this progressed as soon as possible. Susan Swan advised that the timeline would be discussed and agreed at the August Endowment Advisory Group meeting.

The Board of Trustees noted the action tracker.

Adult Changing Facility
Colleen Barlow spoke to this item which provided a timeline for the development of this project. Colleen highlighted that the Head of Communications and Engagement would be picking up the action regarding stakeholder engagement and would be consulting around the proposed plan with Ability Borders and Borders Carers Centre. Karen Hamilton enquired if there was a timescale for this work to allow a decision to be made on this project. Colleen asked Trustees if they were content to give approval pending feedback from the engagement exercise. No objections were raised providing key stakeholders were content with the proposals.

In the current financial climate James Ayling stressed the importance of any communications being explicit that the project is being funded by charitable monies. Colleen agreed to feed this back to the Head of Communications and Engagement.

The Board of Trustees noted the summary and timeline relating to the project.

The Board of Trustees gave approval for this project to proceed on the proviso that key stakeholders were content with the proposals.

5. **Strategy & Fundraising**

5.1 *Charity Plan 2024/25*
Karen Wilson spoke to this item and advised of a proposed amendment made to the plan since it was presented at the May meeting. Karen W explained that the previous version included an objective to plan a Firewalk fundraising event for later in the year, however following discussion at the previous meeting it had become apparent that a much wider strategy was required to maximise the unrestricted income generated. It was therefore proposed that this objective be changed to develop an Unrestricted Income Generation Strategy which would be presented to the October Endowment Fund Board of Trustees meeting. Harriet Campbell was very pleased to see this added to the plan as she wished to see as much unrestricted income being generated as possible.

The Board of Trustees approved the amendment to the 2024/25 Charity Plan.

5.2 *Staff Awards 2024 - Feedback*
Karen Wilson spoke to this item which provided feedback from the event held on Friday, 19th April 2024. Karen W highlighted that the event had been successful overall and had come in under budget. It was noted that the cost equated to £39.22 per person which was under the "benefit in kind" £50.00 threshold. Karen W referred to the feedback received and in particular to where some had felt there had been inappropriate and anti-social behaviour from some of the attendees.

Karen W advised that a paper would be presented to the Board Executive Team to consider the format of future events as well as the issue regarding the taxable benefit in kind which was £50 per head per annum which she highlighted would be difficult to monitor.

Lynn McCallum enquired if any of the issues incurred on the evening had been addressed retrospectively with individuals involved via their line management. Karen W was not aware of this to her knowledge. Lynn suggested that this be picked up outwith the meeting by the Board Executive Team as some of the behaviour witnessed was not in line with the organisation's objectives.

Lynne Livesey enquired if the format had been different at this year's event or if anything could be changed in future to prevent this sort of behaviour. Karen W felt that the format had been largely the same as previous years.

Harriet Campbell noted her thanks to Peter Lerpiniere for his compering of the evening which she felt had been excellent. Harriet was also in agreement that management should discuss with those who had behaved inappropriately at the event.

Andrew Bone highlighted that staff were attending in a social capacity and no required behavioural conduct had been set out prior to the event which may be something that required to be looked at in future.

James Ayling felt that those attending were representing NHS Borders and should have behaved accordingly. James also felt that the obligation may have been on Trustees, as funders of the event to have set out the conduct expected beforehand, and that Trustees should perhaps reflect if the correct decision to fund the event had been made and when looking at the format of any future events consider it being alcohol free.

Karen W advised that any future proposals would be brought back to Trustees in due course.

The Board of Trustees noted the report.

5.3 *Perinatal Mental Health Borders*

Colleen Barlow spoke to this item. Colleen provided background on the charity Perinatal Mental Health (PMH) Borders who provide psychological, emotional and educational support to families living in the Scottish Borders. It was noted that most referrals are made by Health Visitors, GPs, Midwives and Family Nurses.

Colleen went on to explain that the charity had asked for a financial contribution towards purchase of the premises where they are based as they had been offered the property at a price substantially lower than the valuation. It was noted that the charity had secured other contributions towards this from local trusts.

Colleen confirmed that the request met with "the difference" charity's purpose.

Colleen also highlighted available funding she had identified within various areas, namely Women's Health, Children's Services and Mental Health, however there

were competing demands against some of these funds so proposed that all applications for funding be brought forward to the August Endowment Advisory Group so they can be prioritised.

Karen Hamilton reminded that all Trustees are welcome to attend meetings of the Endowment Advisory Group.

James Ayling declared an interest in this item as he sat on the Mental Health Board.

Lynne Livesey supported the proposal to see all bids together so comparisons and a decision could be made. Lynne also enquired if the other sources of funding already secured by the charity had any timescales attached to them. Colleen was not aware of any but agreed to check this.

Harriet Campbell also agreed with the proposal to review all bids together. Harriet felt it would be helpful to see more information within the application that comes forward, particularly around the number of clients seen throughout the course of a year.

Lucy O'Leary noted the statement about "the value added of this donation on acute services" and reminded that the value should be across all business units and not just acute.

The Board of Trustees provided approval in principle to give financial support towards PMH Borders and that a formal application should be taken to the Endowment Advisory Group for prioritisation against other bids.

5.4 *Charity Regulations Update – June 2024*

Coleen Barlow spoke to this item which provided an update on recent changes to the Scottish Charity Law and Regulations. Colleen advised that these changes would provide greater transparency and accountability with more powers being given to the Office of the Scottish Charity Regulator (OSCR) which were detailed within the appendix.

Colleen explained that the changes were subject to a public consultation in 2019 and that a further consultation was being undertaken with technical workstreams taking place alongside. It was noted that one such technical workstream would focus on the reorganisation of statutory and royal charter charities which may facilitate the necessary legislative changes to implementing the recommendations from the governance review of NHS Endowment Funds.

Colleen highlighted the response being proposed by the Scottish Endowment Network Group in favour of the reorganisation technical workstream to include the requirements of the Scottish NHS Charities and asked Trustees for their agreement to this. It was also noted that Trustees could respond individually to the consultation if they so wished.

The Board of Trustees noted the update and agreed to a formal response being submitted in favour of the reorganisation technical workstream to include the requirements of the Scottish NHS charities.

6. **Endowment Fund Annual Accounts 2023/24**

6.1 *Final 2023/24 Report from Trustees and Annual Accounts*
Susan Swan spoke to this item which provided an updated pack to that seen at the last meeting for the 2023/24 Report from Trustees and Annual Accounts. Susan was pleased to report that a clean audit opinion had been received and that the audit memorandum would be circulated to Trustees when it was received.

Susan advised of two recommendations which would be detailed within the memorandum, namely the tracking of income as per the policies in place and continuing the work on the restricted funds.

Susan referred to the list of changes made to the previous document received, and in particular to the update to the total revenue and investment income due to interest confirmed from the United Trust Bank. Susan confirmed that this change had been fed through the individual financial notes and had been signed off by External Audit.

It was noted that the annual accounts would be issued as part of the Board's consolidated accounts and would be presented to Borders NHS Board at its meeting on 27th June 2024.

As the audit memorandum had not been received James Ayling assumed that Trustees were being asked to approve the annual accounts subject to receipt of this. Susan confirmed that this was correct.

James also referred to a change around the Duchess of Sutherland's monies being reported as a grant rather than a legacy and asked who had the authority to change this. Susan advised this change was made following a recommendation from External Audit. Following discussion Susan agreed to investigate this further and make the necessary update if required.

The Board of Trustees approved the 2023/24 Endowment Fund Annual Report and Accounts subject to receipt of the audit memorandum.

7. **Any Other Business**

None.

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

Monday, 7th October 2024 @ 2 p.m.

BE
24.06.24

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Finance Report – October 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 NHS Scotland 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 climate change 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, 12th November 2024
- Board Executive Team, 26th November 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 October 2024

FINANCE REPORT FOR THE PERIOD TO THE END OF OCTOBER 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 October 2024.

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** the contents of the report including the following:

YTD Performance	£12.06m overspend
Outturn Forecast at current run rate	£20.67m overspend
Q2 Review Forecast (adjusted trend)	£22.64m overspend
Variance against Plan (at current run rate)	£5.09m improvement
Projected Variance against Plan (Q2 Forecast)	£1.97m underspend
Actual Savings Delivery (current year effect)	£7.68m (actioned)
Projected gap to SG brokerage	Best Case £5.87m (trend) Worst Case £7.84m (Q2)

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 October 2024.

Table 1 – Key Financial Indicators

	Financial Plan £m	Month 7 £m
Summary		
Year to Date (forecast/actual)	(15.03)	(12.06)
Core Operational	(12.30)	(0.40)
Savings	(13.46)	(12.46)
Average Monthly Run Rate	(2.15)	(1.72)
Outturn Forecast – trend (pro-rata)	(25.76)	(20.67)
Updated Forecast – Q2 Review	(25.76)	(22.64)
Recurring Savings		
Full Target	(28.11)	(28.11)
In year target	*(11.24)*	*(11.24)*
Forecast Delivery	14.64	14.64
Schemes Implemented	-	6.71
Planned/Mandated Schemes	7.93	0.98
Cost Avoidance Measures (forecast)	2.00	*2.00*
Non Recurring Savings (Forecast)	-	0.98
Schemes in development	4.71	3.97
Slippage against Plan	-	-
Scot Gov Support		
Brokerage Cap	14.80	14.80
Forecast Overspend after brokerage (Q2)	(10.96)	(7.84)
Accumulated Brokerage Mar-24	35.53	35.53

4 Summary Financial Performance

4.1 The board's financial performance as at 31st October 2024 is an overspend of £12.06m. This position is summarised in Table 2, below.

Table 2 – Financial Performance for seven months to end October 2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	287.43	351.13	205.50	205.66	0.16
Revenue Expenditure	287.43	351.13	183.28	195.50	(12.22)
Surplus/(Deficit)	**-**	**-**	**(22.22)**	**(10.06)**	**(12.06)**

4.2 Core Operational Performance

4.2.1 The core operational performance excluding savings is £4.08m overspent. This position has been adjusted to £0.40m (underspent) in anticipation of additional resources not yet implemented within operational budgets.

4.2.2 The overall impact of these adjustments is a £4.48m improvement included within the position reported above. These adjustments are summarised as follows.

4.2.3 Anticipated release of reserves held in respect of areas such as non-pay growth, and any flexibility identified within the reserves. Work is ongoing to establish the basis for release of areas such as non-pay growth into the revenue budgets. The level of funding assumed to be released is £1.41m YTD.

4.2.4 Financial flexibility in respect of balance sheet items to be reviewed at Q2 has released £3.07m into the position YTD with a full year balance of £5.27m. This is an increase of £0.35m against the level of release expected during the Q2 review. This excludes further flexibility generated through non-recurrent slippage in revenue budgets. The level of assumed flexibility included in the year to date position is £2.01m.

4.3 Savings Delivery

4.3.1 As noted in Table 1 (key financial indicators), the overall financial performance at Month 7 is £12.06m overspent, of which £12.46m 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 7 this would project a shortfall of £7.85m.

4.3.3 The year to date position of £12.46m 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 £6.71m. This is higher than the total savings delivery in 2023/24, however, in line with previous agreement, 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 October 2024.

Table 3 – Income by Category, year to date October 2024/25

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
SGHSCD Allocation	266.47	326.27	190.32	190.32	-
Family Health Services	10.24	13.81	9.54	9.54	-
External Healthcare Purchasers	4.93	4.33	2.60	2.76	0.16
Other Income	5.79	6.72	3.04	3.04	-
Total Income	**287.43**	**351.13**	**205.50**	**205.66**	**0.16**

5.1.2 Income in relation to external contract is slightly over recovered due to the inclusion of additional patient income from NHS Lothian Mental Health service were support was provided on a short term basis in previous months and has continued to over recovery due to a high cost one off emergency patient from out with Borders.

5.2 Operational performance by business unit

5.2.1 Table 4 describes the financial performance by business unit at October 2024.

Table 4 – Operational performance by business unit, October 2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets Business Units					
Acute Services	80.07	83.48	47.85	49.47	(1.62)
Acute Services - Savings Target	(6.79)	(4.49)	(2.65)	-	(2.65)
TOTAL Acute Services	**73.28**	**78.99**	**45.20**	**49.47**	**(4.27)**
Set Aside Budgets	32.24	33.71	19.28	20.63	(1.35)
Set Aside Savings	(4.17)	(3.94)	(2.30)	-	(2.30)
TOTAL Set Aside Budgets	**28.07**	**29.77**	**16.98**	**20.63**	**(3.65)**
IJB Delegated Functions	109.56	154.90	84.96	86.10	(1.14)
IJB – Savings	(8.32)	(5.86)	(3.42)	-	(3.42)
TOTAL IJB Delegated	**101.24**	**149.04**	**81.54**	**86.10**	**(4.56)**
Corporate Directorates	22.38	25.99	14.49	14.08	0.41
Corporate Directorates Savings	(2.36)	(1.91)	(1.12)	-	(1.12)
TOTAL Corporate Services	**20.02**	**24.08**	**13.37**	**14.08**	**(0.71)**
Estates & Facilities	22.92	24.90	14.14	14.55	(0.43)

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
Estates & Facilities Savings	(2.26)	(2.23)	(1.30)	-	(1.30)
TOTAL Estates & Facilities	**20.66**	**22.67**	**12.82**	**14.55**	**(1.73)**
External Healthcare Providers	36.17	34.88	20.25	20.36	(0.11)
External Healthcare Savings	(4.21)	(2.86)	(1.67)	-	(1.67)
TOTAL External Healthcare	**31.96**	**32.02**	**18.58**	**20.36**	**(1.78)**
Board Wide					
Depreciation	5.87	5.87	3.42	3.42	-
Year End Adjustments	-	(13.11)	(13.11)	(13.11)	-
Planned expenditure not yet allocated	6.32	17.36	1.89	-	1.89
Board Flexibility	-	5.27	3.07	-	3.07
Financial Plan 25-26 Pre-Commitments	-	(0.83)	(0.41)	-	(0.41)
Total Expenditure	**287.43**	**351.13**	**183.28**	**195.50**	**(12.22)**

5.2.2 **Acute Overall**. The position is £7.92m overspent. £2.97m relates to operational overspend and £4.95m 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 continues with full year recurring saving of £2.7m either retracted or ready for retraction from budget. The operational overspend of £2.97m in the first seven months of the year an increase of £0.6m over the September position. The monthly increase in overspend is in line with the ongoing expenditure trend which will lead to a forecast e year-end of £5.7m excluding savings. It is assumed that 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 will continue until the end of 24/25. Cancer drugs continue to overspend (£670k) with activity increasing in the region of 8% per annum and no additional funding allocated over the 23/24 budgeted level. Instruments in theatre and diabetic services continue to overspend (£688K). While the diabetic overspend is fully understood in relation to the increased number of new pump allocated by SG with the recurring costs now having to be picked up by the NHSB the theatre requires further investigation. Discussion is ongoing with SG around the diagnostic allocation (£467k in 7 mths) in relation to diagnostic waiting times. This allocation has not been recognised in the position as it does not appear on the allocation letter and is leading to a significant reported pressure. 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 £4.27m including seven months of the 10% savings requirement over 3 years. The operational element of the overspend is £1.62m on core budgets. Ward 7/9 are overspent by £0.47m which is related to the additional surge beds which have been open consistently during April to October and Ward 8 has been open on a number of occasions during this period. Cancer drugs show an overspent by £0.7m due to increased activity in the SACT service. Theatre supplies continue to affect the overall position adversely. Also negatively affecting the overall position is diagnostic waiting times currently not allocated as this has not received the funding via Scottish Government, we will include this funding and it will improve the position.

5.2.4 **Set Aside.** The set aside budget is overall £3.65m overspent, including seven months of the 10% saving requirement over three years. The operational element of the overspend on core budget is £1.35m. There continues to be an overspend relation to the additional beds in "blue ED". These beds remain open to deal with the long waits in the department due to lack of flow into the rest of the hospital due to the high number of delays blocking beds in the remainder of the hospital. Maternity leave cover in ED medical staffing continues to put pressure on the budget due to the use of a high cost agency medic. Also 15 unfunded surge beds have remained open consistently between April and September contributing to the high level of overspend within this area. Also drugs pressure continues in neurology and respiratory as no drugs uplift has been allocated for 24/25

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 £1.14m. Within Mental Health, medical agency use (locums) continues to be a pressure (£0.317m), largely offset by a small underspend (£0.038m) in the MH Drugs budget and savings arising from vacancies across Mental Health Nursing pay budgets (£0.293m). Primary Care Prescribing pressure has decreased from £0.800m last month to £0.637m at the end of M07. This is due to further information on the volumes prescribed over the summer months and their associated costs now having been made available, within which we have seen a small reduction from the levels experienced during the first quarter of this financial year.

5.2.6 There are a small number of other areas where some financial pressures are currently being experienced such as in Home First (£0.102m), Sexual Health drug costs (£0.087m) and in Community Nursing equipment and supplies (£0.181m). A significant proportion of these are currently offset non-recurrently by ongoing vacancies across all areas, including nursing workforce models (£0.237m), Allied Health Professionals (£0.164m) and Dental services (£0.137m).

5.2.7 In relation to Home First specifically, the service continues to operate at a level beyond the agreed funding plan and will continue to overspend throughout this year until an alternative solution is found to operate the service within the agreed funding envelope or further investment is made to fund to current operating levels. Home First therefore remains the main area, other than Prescribing, contributing to the net adverse position reported for IJB delegated functions.

5.2.8 **Corporate Directorates** are reporting a net under spend of £0.41m on core budgets. The over spend is mainly due to equipment costs linked to e-Health where funding is still to be confirmed.

5.2.9 **Estates & Facilities** are reporting an operational overspend of £0.43m. This is mainly related to the ongoing requirement to main the estate with only high-risk work being undertaken. Service contracts are also an area of concern and work is being carried out to ensure that all contract are appropriate and place at the correct level for service requirement. Patient travel continues to be an issue in Facilities with increased number of patients requiring to be transported to Edinburgh for treatment. A review of patient transport services is in train and likely to report out during December.

5.2.10 **External Healthcare Providers.** Excluding savings there is an over-spend of (£0.11m). This mainly related to contracts with NHS Lothian for both Primary Care and ECCM (Acute) Contract. The commissioning Team are currently working through the patient level information and are in discussion with the NHS Lothian team to validate the data but there appear to have been a significant increase in expenditure and this has been reflected in the position. draft until actual 24/25 activity is available.

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 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 incorporates expectation of additional savings of £3.4m to be delivered above the level of in year delegated savings targets. This includes schemes remaining in development which present a risk to delivery of the planned level of savings (see para 6.6, 'potential slippage').

6.3 Actual Savings Delivery

6.3.1 Table 5 below shows actual level of savings achieved to date, representing the current year value for the 12 months to end March 2025.

Table 5 – Savings achieved as at October 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)	2.17	0.00	2.17	(0.34)	(4.62)
Set Aside	(1.67)	0.37	0.00	0.37	(1.30)	(3.80)
IJB Directed Services	(2.30)	1.23	0.00	1.23	(1.07)	(4.53)
Prescribing	(1.03)	1.16	0.00	1.16	0.13	(1.39)
Corporate Directorates	(1.16)	0.40	0.23	0.63	(0.53)	(1.72)
Estates & Facilities	(0.91)	0.04	0.04	0.08	(0.83)	(2.18)
External Healthcare Providers	(1.68)	1.34	0.70	2.05	0.37	(2.16)
Total	**(11.26)**	**6.71**	**0.98**	**7.68**	**(3.58)**	**(20.42)**

6.3.2 Against the 2024/25 target, £7.68m 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.

6.3.3 The balance of savings to be delivered in 2024/25 is £3.58m. Within this figure is some elements of non-recurrent savings target against which offsetting actions are in place but which are not directly reported against target. The level of unmet savings remaining against the three-year target (10%) is £20.42m.

6.3.4 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.

6.4 Cost Avoidance Measures

6.4.1 A number of cost avoidance measures are in place through FIP and grip & control schemes. In general, these measures are not tracked except where there is material impact over the medium term. The largest element of these schemes is in relation to Agency cost avoidance and Table 6 outlines the year to date and average monthly trends in relation to these measures. Based on M07 year to date, the projected savings identified in the Q1 review remain achievable (£2m full year effect).

Table 6 - Agency Use by Staff Group

	Apr-Oct			Ave Monthly (FYE)		
	2023/24 £k	2024/25 £k	Movement (increase/ -decrease) £k	2023/24 £k	2024/25 £k	Movement (increase/ -decrease) £k
Medical	2,018	1,100	-918	267	157	-110
Nursing	570	168	-402	79	24	-55
Other	594	287	-308	74	41	-33
	3,182	**1,555**	**-1,627**	**421**	**222**	**-198**

6.5 Progress towards Implementation

6.5.1 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.

6.5.2 Additional measures have been introduced for 2024/25 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.

6.5.3 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.

6.5.4 Table 7 summarises the recurrent plans currently identified by business units for 2024/25 as at October 2024. 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	38	(3.13)	3.22	2.87
Commissioning	9	(1.26)	1.35	1.34
Corporate	29	(0.87)	0.65	0.61
Estates	2	(0.30)	0.04	0.04
Facilities	5	(0.38)	0.12	0.09
IJB - MH/LD	21	(0.65)	0.69	0.52

	Number of Schemes	3% Target	FYE	PYE
IJB - PACS	36	(1.84)	1.31	1.14
Organisation Wide	34	0.00	1.33	1.20
	174	**(8.43)**	**8.70**	**7.81**

6.5.5 This position shows a significant decrease in projected savings against the position reported in the September (M06) finance report. The reduction in the value of projected FYE savings and PYE savings is £0.81m and £0.47m respectively. The number of schemes has decreased by 2 (from 176).

6.5.6 Movement has occurred partly as a result of actions implemented at MYR, specifically the request that all services review the phasing of plans not yet implemented and provide update to PMO to confirm any changes in projected impact to March 2025. As evidenced in Table 8, below, the main shift has been in the level of schemes recorded at Gateway 1.

Table 8 – Recurring Plans 2024/25: Progress by Gateway

	Last Month			This Month		
	FYE £m	PYE £m	Total Schemes	FYE £m	PYE £m	Total Schemes £m
At planning stage	-	-		-	-	
Gateway 1	1.29	0.94	26	0.44	0.32	18
Gateway 2	0.84	0.44	13	0.74	0.50	13
Gateway 3	0.19	0.17	6	0.22	0.16	7
Gateway 3 - Blue	7.19	6.74	131	7.30	6.83	136
Total Schemes	**9.51**	**8.28**	**176**	**8.70**	**7.81**	**174**

6.5.7 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.

6.5.8 Where there has been reduction in individual business unit plans this will be addressed through FIP steering group meetings; additional actions will be sought to secure delivery at least to the level of savings target in year.

6.5.9 It is likely that this situation will increase the reliance upon non-recurrent savings in place in 2024/25 and may therefore leave a shortfall against recurring savings thus impacting on the opening deficit at April 2025. This will be reviewed by end December through the development of the draft financial plan.

6.5.10 As noted in paragraph 6.5.5 above, there has been a reduction in the number and value of schemes identified. Table 8 however demonstrates that there continues to be progress towards implementation. The proportion of schemes which are now at GW3 is 90% (86% FYE).

7 Key Risks

7.1 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.

7.2 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).

7.3 Risks to the forecast are described in more detail within the Q2 review.

Appendices

- N/A

Author(s)

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 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 6 November 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 28.08.24

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 28 August 2024** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non-Executive Director (Chair)
Dr K Buchan, Non-Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Director of Quality & Improvement
Dr S Bhatti, Director of Public Health
Dr J Manning, Associate Medical Director, Acute Services
Mr M Clubb, Director of Pharmacy
Mr P Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs C Cochrane, Head of Psychological Services
Mr S Whiting, Infection Control Manager
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance

1 Apologies and Announcements

Apologies were received from:

Mrs H Campbell, Non-Executive Director
Lynne Livesey, Non-executive Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr A Cotton, Associate Medical Director, Mental Health Services
Dr I Hayward, Associate Medical Director, Acute Services
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mrs L Huckerby, Interim Director of Acute Services
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services

The Chair welcomed:

Mrs R Pulman, Nurse Consultant Public protection (item 6.2)
Ms C Wilson, General Manager - Primary Care & Community Services (item 7.2)
Mr A Carter, Director of HR - shadowing
Mrs E Cameron, Head of Organisational Development - shadowing

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.

2.2 The **CLINICAL GOVERNANCE COMMITTEE** noted there were no new declarations and previous declarations stood.

3 Minute of Previous Meeting

3.1 Following correction to wording at 5.2.7 on Action Tracker the minute of Clinical Governance Committee meeting held on Wednesday 28 August was approved.

4 Matters Arising/Action Tracker

4.1 There were no Matters Arising from the previous minute. Action Tracker was discussed and updated accordingly

5 Effectiveness

5.1 Clinical Board update Mental Health Services

5.1.1 Mr Lerpiniere provided a brief overview of the report. He noted that the ECT standards audit were included in the report as previously requested and the Committee should be assured with the results. NHS Borders had fared well when benchmarked against rest of Scotland recognising that we are a small service so any failure would have a significant impact on overall percentages.

5.1.2 Mr Lerpiniere noted the Scottish Patient Safety Programme (SPSP), Mental Health reports. Positive work is ongoing in Huntlyburn and Lindean showing significant impact on inpatient care. He is keen to encourage monitoring and for the SPSP to reach out beyond the inpatient units as vast majority of Mental Health work takes place in the Community.

5.1.3 Staffing challenges continue, particularly around Medical staffing they continue to strive to find the best way to support this staffing group.

5.1.4 Following closure of Cauldshiels challenges to support complex care needs and dementia assessment needs within Border specialist had continued, leading to problems with delayed discharges and the continued need to support those who no longer need to be in dementia unit but have not specialist dementia provision in the Community. Mr Lerpiniere will keep the Committee informed on results of Commissioned services review.

5.1.5 There had been an increase in the number of falls, the service is being supported by Falls Quality Improvement Facilitator to review these falls. He was happy to report that these were predominantly without harm and noted as a natural consequence of rehabilitation and mobilisation. The increase had been attributed to a change in observational practice.

5.1.6 The Chair enquired if Mr Lerpiniere had dates relating to completion of redesign, he gave a brief update and agreed to include some narrative in report for next Committee meeting in November.

5.1.7 Mrs Jones commented on the Neurodiversity pathway in CAHMS on behalf of Mrs H Campbell. She recognised the good progress being made in relation to first appointments but targets don't appear to stretch beyond this appointment. She asked that he include some information on subsequent appointments along the pathway, particularly in terms of impact on patients waiting for treatment. Mr Lerpiniere commented that further communication had come from Scottish Government which had caused some confusion and they are working on addressing what impacts this communication might have on pathway. He will keep the Committee informed.

5.1.8 ACTION: Mr Lerpiniere to include further information on redesign in next paper.

5.1.9 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed moderate assurance.

5.2 Clinical Board update Learning Disabilities Services

5.2.1 Mr Lerpiniere discussed the content of the report. He drew attention to work around how the service can demonstrate improvements following Mental Welfare Commission visit. He also noted that they were happier with the updated report following discussions with the inspectors.

5.2.2 Improvement on care planning is ongoing and progress is being made on annual health checks with the main hold up being resources.

5.2.3 Mr Lerpiniere commented that push continues on progress against the coming home programme. Discussion followed relating to the complexities as reported previously.

5.2.4 Mr Clubb commented that he is keen to work with the service to ensure that medication checks are done alongside the annual checks to save two appointments and improve patient journeys. Mr Lerpiniere will contact Mr Clubb to put this in place.

5.2.5 Mrs Jones enquired about the progress and outcomes on the individuals in out of area placements in relation to the lives through friends project on Mrs H Campbells behalf. Mr Lerpiniere commented that not all patients in out of area placements require hospital care as quite a lot are supported through social care. He commented that there were no firm dates as yet and they continue to work towards ensuring all resources are in place before this happens. This may take some years to complete particularly within the current financial restraints.

5.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **moderate assurance.**

5.3 Clinical Board update Acute Services

5.3.1 Mrs Dickson provided a brief overview of the content of report. She noted the site had continued to work under extreme pressure with ED at some points operating at 214% capacity. She reported a number of delays were still being seen in the system but position had improved slightly, surge beds had been closed with an aim to hold this position. Dr Manning added this level was unprecedented. Work is ongoing looking at the front door model and GP Expect patients to help coordinate and improve impact and provide appropriate flow through ED. He commented that the issue is not just related to the front door but a whole system issue.

5.3.2 Stroke performance remained a concern. Meetings are continuing monthly and a new Stroke Liaison Nurse had been appointed giving traction in resolving some issues. Mrs Dickson will continue to update the Committee with progress. She noted that our first patient on thrombectomy pathway was transferred from ED to Edinburgh with a really positive outcome for that patient.

5.3.3 New SAER process across unscheduled care is being trialled, a positive impact on addressing action plans had been seen. Process will be rolled out across the acute services. Anything not closed down will be fed back through governance processes for further monitoring.

5.3.4 Pressure continued across women and children's services, particularly with staffing in SCBU resulting in unit being closed at times. Mums are being redirected up to Lothian with work is ongoing towards resolution.

5.3.5 Mrs Dickson commented infection control audits had shown a marked improvement in all areas except ED, they are working on actions to improve on results.

5.3.6 Mrs Dickson noted there had been issues recruiting to Healthcare Support Worker posts. Some related to AI applications with interviewees proving not the be to standard of the application presented. She noted that some of the applicants were not eligible to work in the UK. Discussion followed relating to this issue. Two HR colleagues were in attendance, Mrs Dickson was invited to discuss further with HR out with meeting. Mr Carter commented they were aware of this issue and had raised it with East Region recruitment service.

5.3.7 Appraisals still not completed as had been expected, partly due to challenges already noted above and additional sickness seen over last two months. Work continues toward completing these. She did note despite difficulties the position had improved from last year.

5.3.8 Mrs Dickson ended on a good news story not included in the report. Noting first same day knee replacement had been completed.

5.3.9 Discussion relating to difficulties in protecting bed for elective cases followed a question from the Chair. Mrs Dickson assured the Committee there had been a slight reduction in late notice cancellations due to lack of bed availability.

5.3.10 The Chair enquired about low level of outpatient activity, Mrs Dickson noted it was largely due to staffing pressures and having to prioritise clinics, she commented the position was improving. New room booking system is underway with better utilisation being expected.

5.3.11 Discussion regarding swallow screen fails of 82%, the Committee feel this is too much. Mrs Dickson noted their focus will be on driving up performance with the introduction of new stroke nurse.

5.3.12 Dr Bhatti requested more detail on equality characteristics in reports as well as more on patient experience. Discussion took place regarding Dr Sohail's expectations from reports in terms of quality and impact on patient care. Mrs Dickson noted that discussions were ongoing between the QI and Operational teams.

5.3.13 Dr Bhatti requested clearer detail and correlation between the infection control issues in Acute and the Infection Control report to the committee. Mrs Jones commented that this discussion could be picked up with Mr Whiting, noting that some of this detail is provided to the Infection Control Committee.

5.3.14 Discussion took place on concerns raised by Dr Bhatti that the focus appeared to be on acute services. He commented that a topic for the Board should be around whole system when discussing flow. There should also be some time to discuss waiting times and outpatients. Mrs Sandford and Mrs Jones will discuss and raise with the Board.

5.3.15 Mr Clubb noted a comment relating increase in use of opioids and gabapentanoids for those awaiting surgery await surgery and the need to be aware that this could be an issue if it continued.

5.3.16 ACTION: Discuss issues relating to AI applications with HR
Discuss infection control reporting to the Committee in Acute paper

5.3.17 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

5.4 Clinical Board update Primary & Community Services

5.4.1 Mr Grieve provided an overview of the report. He noted significant pressure remains in Community hospitals.

5.4.2 He noted that Health Visiting services are back to normal but had a slight setback in not being successful in their bid for gold infant feeding award through UNICEF, although feedback was positive and the team are able to submit an action plan to progress towards gold award later in the year.

5.4.3 Sickness absence remained high but a downward trend had been seen, return to work completion remains an issues this had been highlighted in performance review with the board. They are looking at a more targeted approach with individualised reports being sent to Direct Line managers for completion with a view to reducing outstanding paperwork.

5.4.4 Mr Grieve commented on the crowd strike which affected EMIS web, this had caused some concern but Business Continuity plans kicked in allowed continuation of service delivery. The reliance on paper diaries is being discouraged due to financial constraints but Mr Grieve noted that these diaries are part of their business continuity and helped ‘save the day.’

5.4.5 AHP activity level still remains very high and they continue to prioritise service provision when they can.

5.4.6 A PIN was published relating to Duns Medical Group in July, the services will progress towards a formal tendering for Duns Medical Group, once the 35 day lead time has passed. Mr Grieve will keep the Committee informed on progress.

5.4.7 Pressures remain under general anaesthetics within Public Dental services, he reported that work is in progress to address a way forward to mitigate pressures and see an improvement.

5.4.8 Mr Grieve reported on a clinical issue that arose through C TAC implementation and governance surrounding INR results and adjustment of medication. This was paused temporarily to address governance which is now complete and service had been resumed.

5.4.9 There has been some concern around registered Leaderfoot virtual surgery patients. Mr Grieve is linking with Dr Manson to offer additional support, they are also working closely with PMAV to ensure systems and processes are slicker providing a safer working for clinicians and ensuring there is no discrimination against the individuals who require this service for their healthcare needs.

5.4.10 Mr Grieve highlighted the positive returns in hand hygiene citing resent spot checks had produced high performance rates between 95-100% within the four community hospitals.

5.4.11 Mr Grieve had raised concerns around the increase in falls, he liaised with senior charge nurses and clinical nurse managers and established the flash points appear to be at points of transfer. He noted that bed and chair sensors are often at fault so he had asked the organisation to look at alternatives to these sensors to work towards mitigating what is a high risk for the organisation

5.4.12 Dr Buchan enquired it the reported absence related to anxiety & depressions is related to work environment. Mr Carter commented that there is a mix of work, domestic, and financial. Discussion followed on how this could be addressed. Mrs Cameron added that this was not unique to Health and these issues were being seen in other industries.

5.4.13 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance**

6 Assurance

6.1 Psychological Services annual report

6.1.1 Dr Cochrane attended to give a brief overview of the report. The service is stretched at present and work against standards is slow with a reluctance to start new services when existing ones are struggling. Discussion followed relating to the gaps in services, Dr Cochrane commented work had been undertaken to see if these gaps were noted in any SAERs. Psychological Services are commencing a service review in September to address any of these issues and will keep the Committee informed once completed.

6.1.2. Dr Cochrane did note to the Committee she had concerns in particular around rehabilitation, she is having discussions with the Medical Director relating to these concerns. They are also working closely with the rehab and mental health teams.

6.1.3 There followed discussion on training needs and EMDR, training had been difficult to address when capacity and funding constraints are issues. Dr Cochrane will explore this further. She is concerned that the lack of availability to some training is a risk and detrimental to patient's long term recovery.

6.1.4 Mrs Jones enquired about work on the psychological traumatic event pathway. Dr Cochrane gave a brief overview of progress, they continue to work closely with Occupational Health and are exploring whether training provided met expectations as uptake was poorer than expected.

6.1.5 Dr Cochrane highlighted her concerns around vacancies, ongoing resilience issues and limited training budget, she will keep the Committee citied on these issues.

6.1.6 Dr Bhatti commented that he would like to see a measure of the impact on services and peoples mental health given the gap issues. Dr Cochrane noted that there are nationally agreed measures and these will be considered during the service reviews.

6.1.7 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

6.2 Public Protection

6.2.1 Mrs Pulman provided a brief overview of the content of report. She commented they had two learning reviews in relation to adult support and protection which had now been completed. Meeting is to take place to develop and improvement plan in relation to the findings. It is recognised there is a need to strengthen links between processes to avoid duplicating reviews unnecessarily. National work is ongoing to look at interfaces in public protection. This will enable better feedback and learning and provide stronger assurance. Mrs Pulman did not have a timeline but is working alongside Patient Safety team and is waiting to hear about National learning review group from Scottish Government.

6.2.2 Dr Bhatti enquired about engagement with public health in relation to public protection issues. Mrs Pulman commented the previous Director of Public Health sat on the Public Protection Committee so would welcome Dr Bhatti to take up that place.

6.2.3 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Significant Assurance**

6.3 Public Health Annual Report

Report was not submitted. Paper to be tabled in January 2025 prior to submission to the Board.

7 Patient Safety

7.1 Infection Control Report

7.1.1 Mr Whiting provided a brief overview of the content of the report. He gave an update on Mpox incidence and how NHS Borders will deal with any cases should they arise including ensuring all staff have current correct fitting of required face masks.

7.1.2 He gave and update on the most recent Prevention of CAUTI group who are concentrating on outcomes and interventions, in particular staff training and education on management of various types of catheters and how rationale is recorded. Action plan had been devised and the group will continue to work on these actions

7.1.3 Mr Whiting updated the committee on data relating to compliance with hand hygiene and capacity within the infection control team. He reported that they had recovered some capacity so Quality Improvement work can continue. Dialogue with SCN in ED is planned once they return from leave to address compliance in that location.

7.1.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance**

7.2 Significant Risks Relating to Primary & Community Services and Independent Contractors

7.2.1 Ms Wilson provided an overview of the content of the report. She commented that individually each section that sits under this umbrella is extremely resilient but do carry a certain amount of fragility particularly within the workforce. NHS Borders has second highest vacancy rate in Scotland, particularly GPs. Retention & recruitment within optometry, pharmacy and dentistry has also been difficult. Ms Wilson noted various pieces of work to implement primary care programme with capacity being released by Health Board to support GPs to delivery contract. An exit plan will need to be considered beyond October 2026.

7.2.2 The chair enquired as to the evidence of success the Scottish Government is looking for. Ms Wilson commented that the Scottish Government are testing to see if their support is having meaningful impact on GP services so looking at quantitive and qualitative data relating to improvement. There are teams of data analysts working with NHS Borders to capture all that is necessary.

7.2.3 The Scottish Government will be reaching out to GPs as part of the evaluation framework to ascertain if the work has been having a meaningful positive impact on delivery of contract. The results of the evaluation will be fed back to NHS Borders in due course. Dr Buchan commended the commitment PACS had towards the contract. He felt the impact making lives better was not always being considered by the Scottish Government and engagement from them was not always great. The Committee discussed delivery of contract, exit plans and ongoing impact and risks associated with non-delivery.

7.2.4 Ms Wilson highlighted dental position, the committee is well cited on this issue but she gave an update on the sustainability concerns and mitigations in place.

7.2.5 Dr Buchan enquired about measures around mental health of Primary Care estate in particular relating to absence. Ms Wilson noted there was not a huge amount of data on this due partly to GPs being independent contractors who are under no obligation to share this information with the Board, they are looking at developing a scorecard, she would welcome any input into taking this forward. Discussion followed on how this might be achieved and the Committee look forward to seeing this develop.

7.2.6 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Limited Assurance.**

7.3 Duty of Candour Annual Report

7.3.1 Mrs J Campbell provided a brief overview of the content of the report. She noted there had been 37 Significant Adverse Events which enacted duty of candour. These had all been addressed within the correct procedure and align with local adverse event policy. She noted these is room for improvement but there is a robust local process in place.

7.3.2 Dr Buchan commented on progressing duty of candour in general practice. This prompted discussion on how this might be achieved. Mrs J Campbell commented that there had been some discussion relating to complaints and adverse events in GP practices and offered to pick this up with Dr Buchan. Discussion should align with a previous action on tracker around robust integration and sharing of data between primary and secondary care.

7.3.3 ACTION: Discuss data sharing relating to DOC in GP practices

7.3.4 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed the **Moderate Assurance.**

8 Person Centred

8.1 Claims Report

8.1.1 Mrs Jones provided a brief overview of the report. The report is high level, therefore difficult to go into any specific details due to its' nature. Most claims tend to sit in the Acute service as expected due to the level of interventional work, along

with staff injury claims. Triangulation is performed to ensure claims across care assurance areas relating to patient safety are not missed.

8.1.2 Discussion followed regarding whether all claims were a result of previous complaints or SAERs. Mrs Jones noted not all claims make it through claim process but all are logged against NHS Borders, she commented that although not all are result of SAER or Claim the organisation was generally aware prior to claim.

8.1.3 Dr Bhatti requested inclusion of a trend over time in subsequent reporting. Mrs Jones commented claims can stay open for years, so trends are not easily quantified, she will look for a way to include trends in future reports. The Chair asked if it would be possible to look at new claim trends in the interim.

8.1.4 Discussion followed on the level of assurance for this report as it is a position statement and difficult to take assurance stance on it. A degree of assurance can be taken from the systems and processes to investigate and mitigate harm are in place but not all claims have been through these processes.

8.1.5 The **CLINICAL GOVERNANCE COMMITTEE** noted contents of the report and confirmed **Moderate Assurance.**

9 Items for Noting

There were no items were put forward for noting.

10 Any Other Business

10.1 Dr Bhatti commented that a public governance report relating to public health should come to the Committee. Miss Laing will discuss where this item would fit into the Committee Workplan with Mrs Jones.

10.2 The Secretariat made a request that papers be returned by submission date as far as possible to allow for preparation and sending to members to allow for appropriate scrutiny.

10.3 Mrs Cameron thanked the Chair for allowing Mr Carter and herself to sit in on the meeting.

10.4 ACTION: Discuss public health public governance report for future workplan

11 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 06 November 2024** at **10am** via Teams Call.

The meeting concluded at 12:26

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Quality & Clinical Governance Report - November 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** **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 NHS Scotland 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 06 November 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 (IJB) for further collective action.

2.3.2 The CGC received a report from Primary and Community Services. The CGC considered the extensive report noting the developments across health visiting, school nursing, district nursing and community nursing and treatment rooms. The committee had previously requested that work to understand the impact of gaps in the Allied Health Professional workforce were having across the system and were pleased to note a paper on this has been taken through the Joint Executive for the Health and Social Care Partnership with a set of resulting actions. The CGC were keen for a continued focus in this area as the work is progressed. Dental services were discussed including the fragility and challenges facing dental teams. The CGC recognised there is extensive work underway in this area but were keen to have assurance around the plan between dental and acute services to address the paediatric patients awaiting day case treatment. The CGC took limited assurance from the report.

2.3.3 The CGC received a report on Mental Health and Psychological Services. The CGC noted the positive reduction in drug deaths. Overall, the committee agreed limited assurance based on the workforce pressures in mental health services and the continued delays in mental health beds. The committee took moderate assurance from the Psychological services report.

2.3.4 The CGC received a report on Learning Disability Services. The CGC recognised the great work in this area and also the continued focus on delivering the aims of the Coming Home Report and were keen to see a clear plan for delivery in this area acknowledging the complexity involved. The committee took moderate assurance from the report.

2.3.5 The CGC considered a paper from Acute Services. The committee remained concerned about the pressure on patient flow in acute services necessitating significant additional surge beds. The committee noted the continued work to improve flow with multiple improvement efforts underway across the health and social care system. However, remain concerned about the significant impact on patients waiting for access to specialist acute beds and for elective care and the harm that comes as people wait to access the correct place of care. The CGC have previously escalated this to the Board and IJB for further action but feel that progress has been limited due to the constraints across our local health and social care system. The CGC feel this is an area the requires continual focus within the Board and IJB and consideration of what further action the Board require. The CGC have requested a deep dive into outpatient waiting lists which is

scheduled for the Board in December 2024. The CGC want to understand the progress specialties and consider expectations for 2025/26 and associated resources. The committee gave the acute services paper a no assurance position in recognition of the points above.

2.3.6 The CGC considered the Cancer Services Annual Report. The CGC took significant assurance from the report. The CGC noted the expected challenges ahead in the delivery of cancer services relating to specialist workforce, complexity of treatment regimes and pressures on regional pathways. The CGC were assured that the Board has been briefed on this area for consideration in financial planning discussions.

2.3.7 The CGC considered the GP sustainability paper and the positive work underway through the Primary Care Improvement Programme (PCIP) to modernise primary care delivery in support of the delivery of the new GMS contract. The CGC recognised the ongoing financial risk in this area which remains unclear following the national demonstrator funding and the continued pressures in filling GP vacancies. The CGC were keen to see a continued focus on primary care data to bring greater focus to the work carried out in general practice and how PCIP was impacting on this. There was a discussion on the potential impact on waiting list backlogs on primary care particularly in relation to prescribing practice and the Primary and Community Services work agreed to look into this further with colleagues from acute services and pharmacy. A Prior Information Notice is currently live on Public Contracts Scotland for Duns Medical Practice. The practice is currently operating under health board management on a short term basis with the aim of returning this to the normal Independent Contractor model as soon as possible. The CGC heard of the intension to build a programme work alongside PCIP to focus on long term sustainability of primary care and the CG were keen for the Board to be aware of the scope of this work and deliverables linked to the detail provided in the paper about population projections and likely demand on primary care. The committee agreed a position of moderate assurance.

2.3.8 The CGC received the research governance annual report. The CGC noted the reduction in national funding for research this year and the risk this presents to the same core research infrastructure but noted the encouraging work to build research in new areas which would have the potential to bring additional resources. The CGC noted the excellent innovation work which has taken place in the summer in Stroke services and as part of the UK wide Future Flight Programme to test the use of Drones in the NHS. The committee noted the report and took significant assurance from the report.

2.3.9 The CGC noted Strategic Risk Report relating to Mental Health & Learning Disability Services. The paper detailed the risks presented and the work underway to address these. Most notably the CGC considered the ongoing workforce pressures in Psychiatry which are mirrored across the country but present significant local challenge. Workforce pressures extend into occupational therapy and nursing. The Medical Director advised that NHS Borders have appealed for this to form part of the national focus work. The committee discussed access to specialist beds across the country and on occasions this presents local pressures where beds can’t be accessed in a timely fashion. Whilst mitigations are in place for this to ensure patient safety the CGC were keen this area remains a focus on regional and national planning work. The CGC have previously highlighted these issues to the Board with a resulting plan for additional resources to support the workforce position but are keen for close monitoring of this area recognising the workload strain on the mental health team. The CGC took limited assurance from the paper recognises the fragility in the workforce.

2.3.10 The CGC received the quarterly Hospital Standardised Mortality Report (HSMR) report. The committee noted the report and took moderate assurance from the report. The CGC noted the continued theme of patient delay and the impact this continues to on the number of patients dying in a hospital setting as opposed to community.

2.3.11 Patient Safety and Care Assurance

2.3.12 EiC Quality of Care Reviews

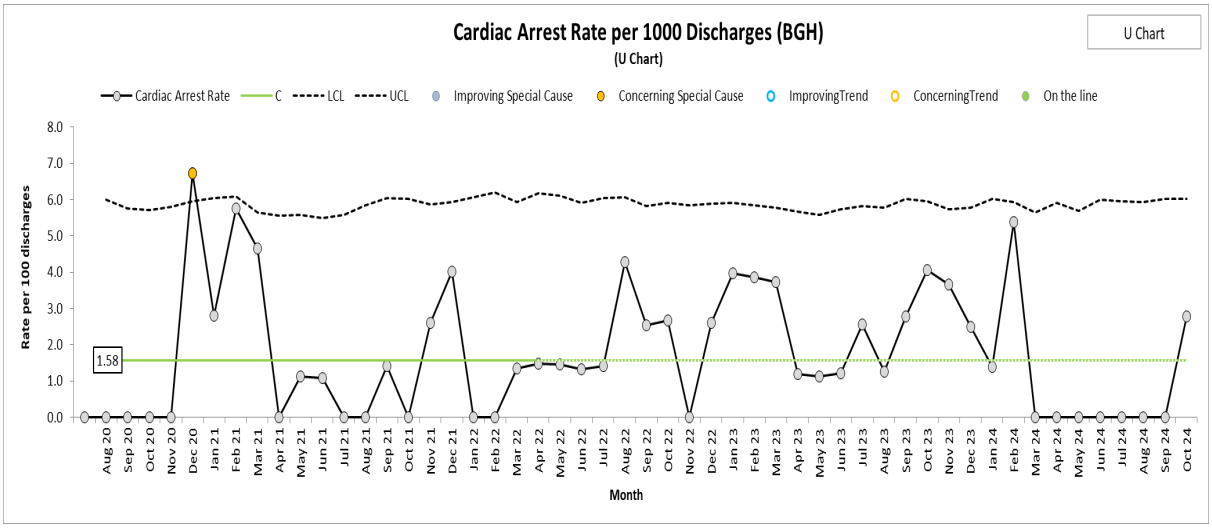
A Quality of Care (QoC) review was commissioned within Ward 14, Department of Medicine for the Elderly and was undertaken on 03 October 2024. The Scope of the QoC review was to complete all 16 elements of the Excellence in Care (EiC) QoC review framework to provide assurance of quality and safety and to generate an achievable learning and improvement plan for future Care Assurance Visits (CAV's). The QoC Review Guidance was followed to ensure that a structure was used to plan the QoC review.This process forms part of the national approach to care assurance.

2.3.13 The Lead Nurse for Patient Safety and Care Assurance led the team through the new process drawing on data within the ward quality dashboards and intelligence from staff feedback, patient feedback and adverse events. Priority areas for continual improvement have been identified in a final report and displayed within an action tracker that will be reviewed at monthly Care Assurance Visits (CAVs) and monitored by the Clinical Nurse Manager (CNM) and Senior Charge Nurse (SCN).

2.3.14 NHS Borders Care Assurance Structure has been discussed within the Quality and Safety Steering Committee, with a workshop planned for 03 December 2024.

2.3.15 Deteriorating Patient

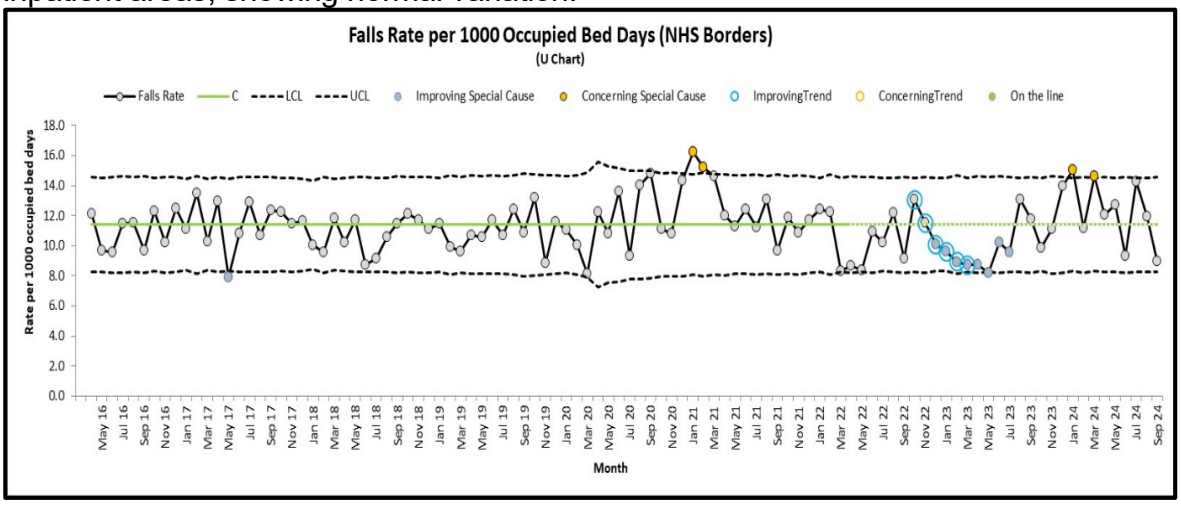
Figure 1 shows normal variation in the cardiac arrest (CA) rate per 1000 discharges in the acute adult in-patient areas (excluding ITU and ED) of the Borders General Hospital (BGH):



2.3.16 A review of the NHS Borders Observation Policy has been undertaken. The Policy signposts clinical staff to the relevant clinical observation chart and includes reference to the three early warning systems in place (NEWS2 for adults, PEWS for paediatrics, MEWS for use in maternity).

2.3.17 Falls

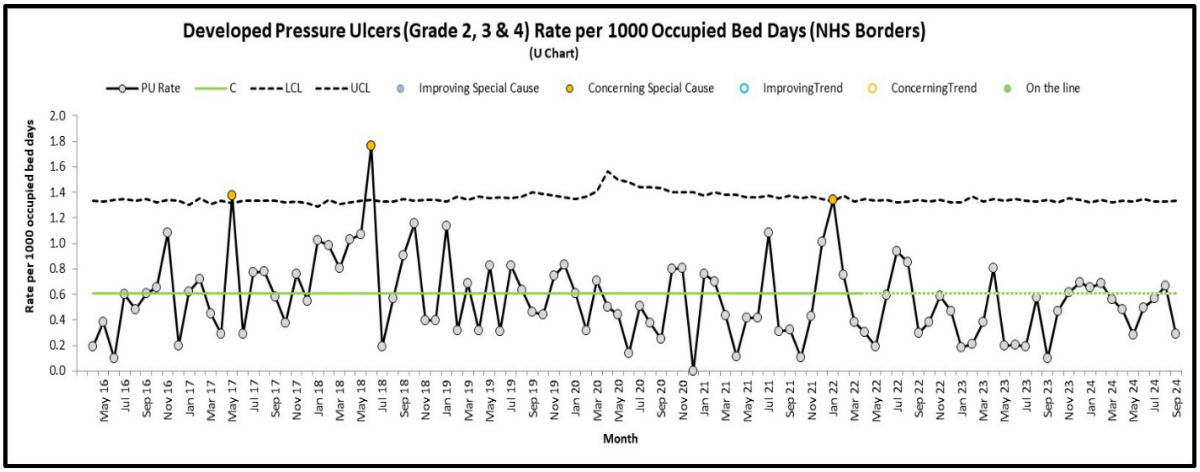
Figure 2 shows the falls rate per 1000 occupied bed days across NHS Borders adult inpatient areas, showing normal variation:



2.3.18 Following collaboration with NHS Highland the Quality Improvement Facilitator for Patient Safety started testing a Daily Care Plan (DCP) in the Medical Assessment Unit on the 14 October 2024 using quality improvement methodology. Implementation of the DCP aims to reduce documentation burden and improve person centred care.

2.3.19 Pressure Damage

Figure 7 shows normal variation of developed pressure ulcers Grade 2 and above rate per 1000 occupied bed days across NHS Borders adult inpatient areas:



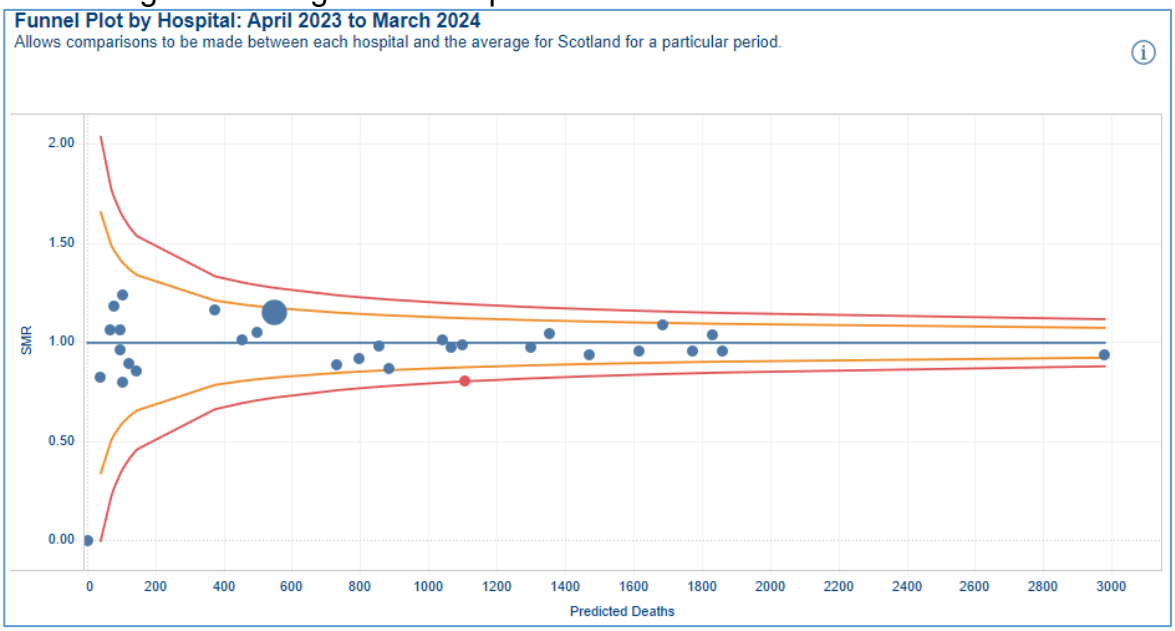
2.3.20 A total of 269 developed Grade 2 pressure damage events were reported on the Adverse Event Reporting System. The Patient Safety Team have reviewed developed avoidable pressure damage over the last 2 years in NHS Borders. It has confirmed that there have been 48 avoidable events. The Tissue Viability Steering Group are focusing on continual improvement in this area.

2.3.21 Hospital Standardised Mortality Ratio

2.3.22 Hospital Mortality

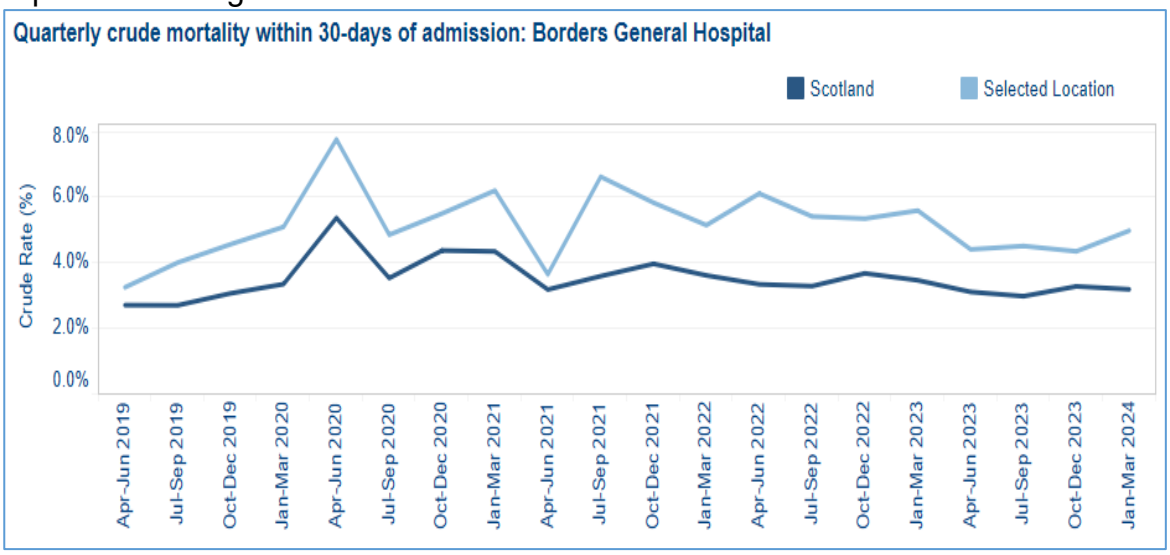
NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 21st data release under the new methodology is 1.15. This figure covers the period April 2023 to March 2024 and is based on 632 observed deaths divided by 549 predicted deaths. The

funnel plot in Figure 10 shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.23 NHS Borders crude mortality rate for quarter January 2024 to March 2024 was **5.0%** and is presented in figure 11 below:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.24 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.

2.3.25 Deaths occurring in COVID waves continue to contribute to the periods of elevated crude mortality. Figure 12 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 11 August 2024:

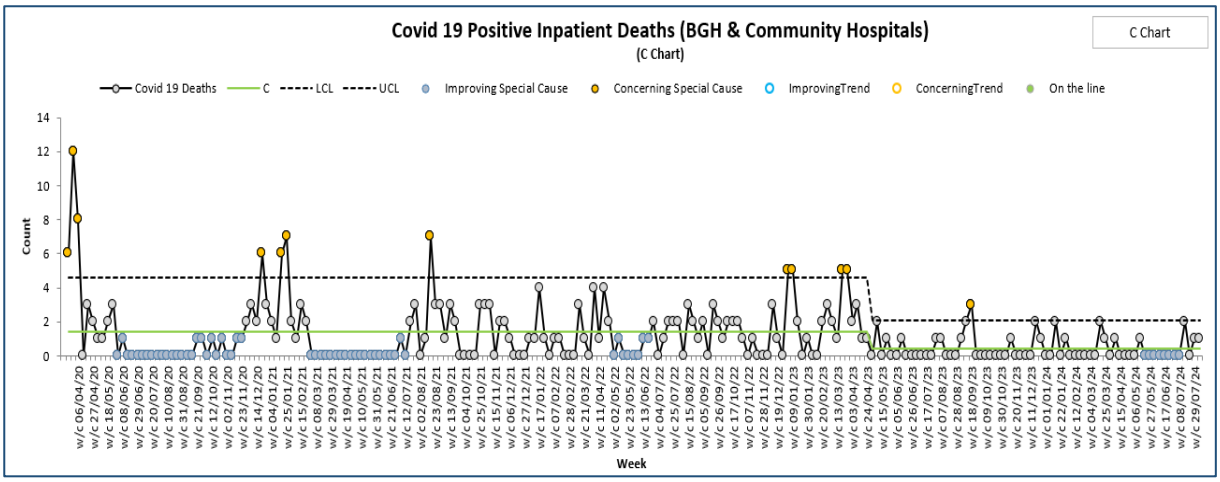
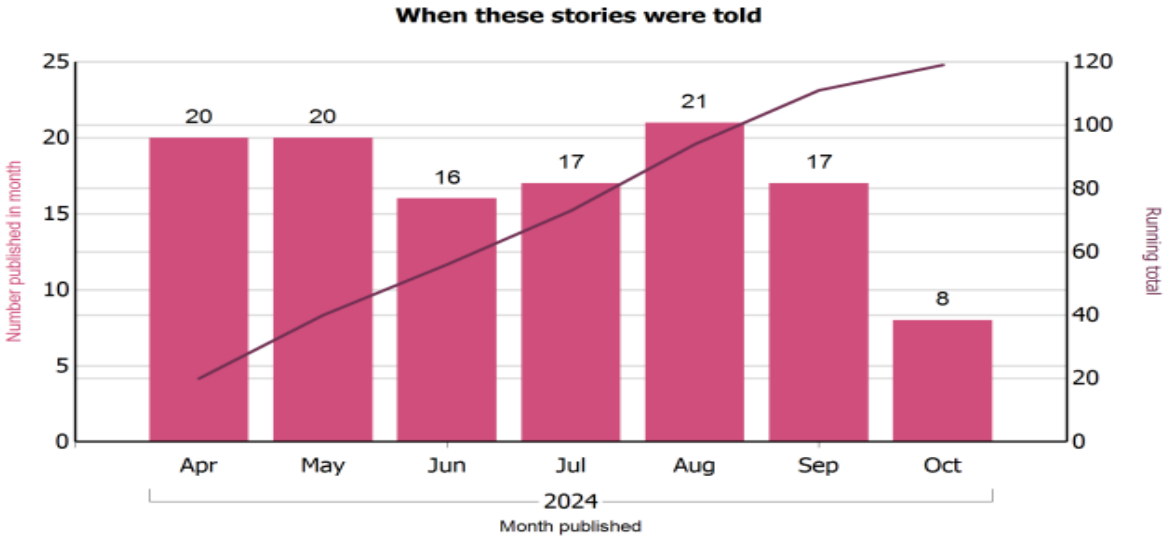


Figure 12 *From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this patients were counted as covid positive for 28 days after a positive test.

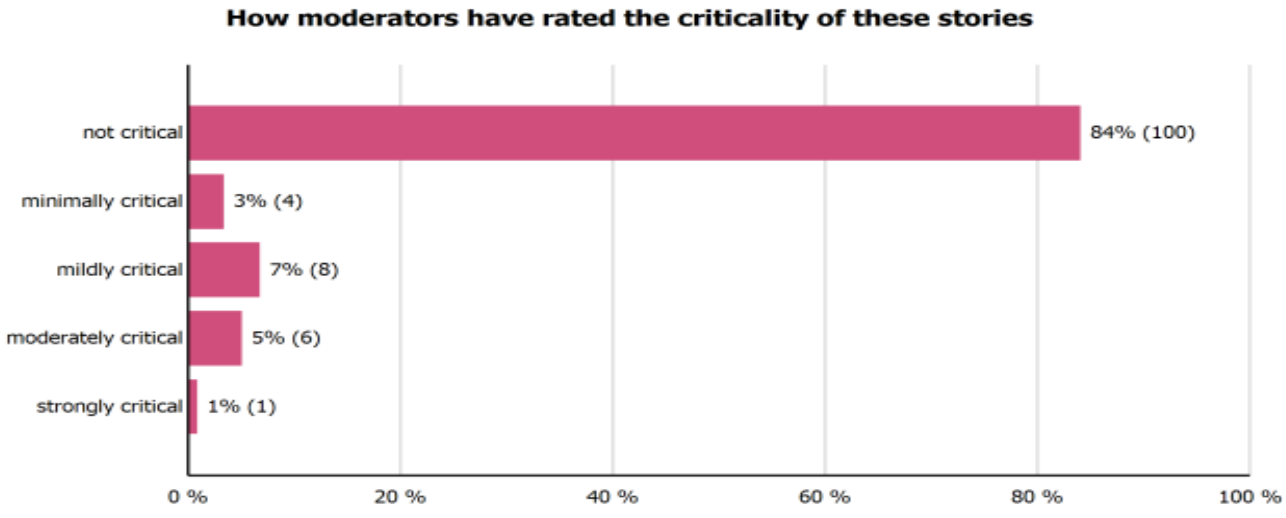
2.3.26 Patient Experience

2.3.27 Care Opinion

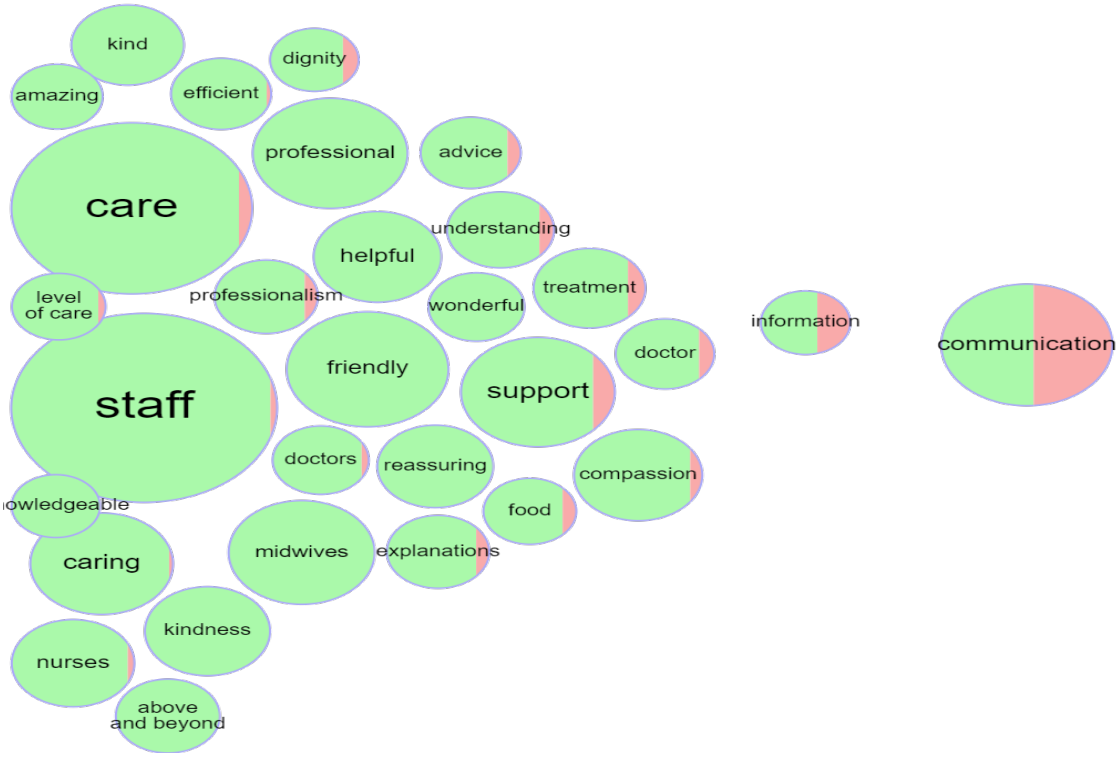
For the period 1 April 2024 to 5 November 2024 119 new stories were posted about NHS Borders on Care Opinion. Figure 13 below shows the number of stories told in that period. As of 5 November 2024, these stories had been viewed 14,374 times:



2.3.28 Figure 14 provides a description of the criticality of the 119 stories:



2.3.29 The diagram and word clouds below summarise what was good and what could be improved in Care Opinion posts for this period:

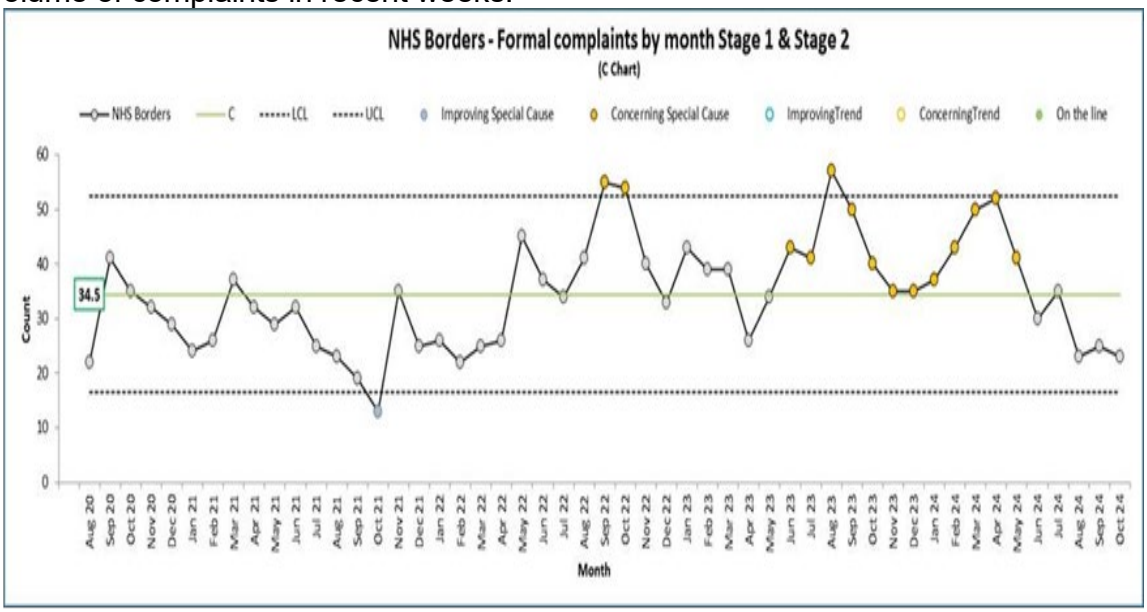


What was good?

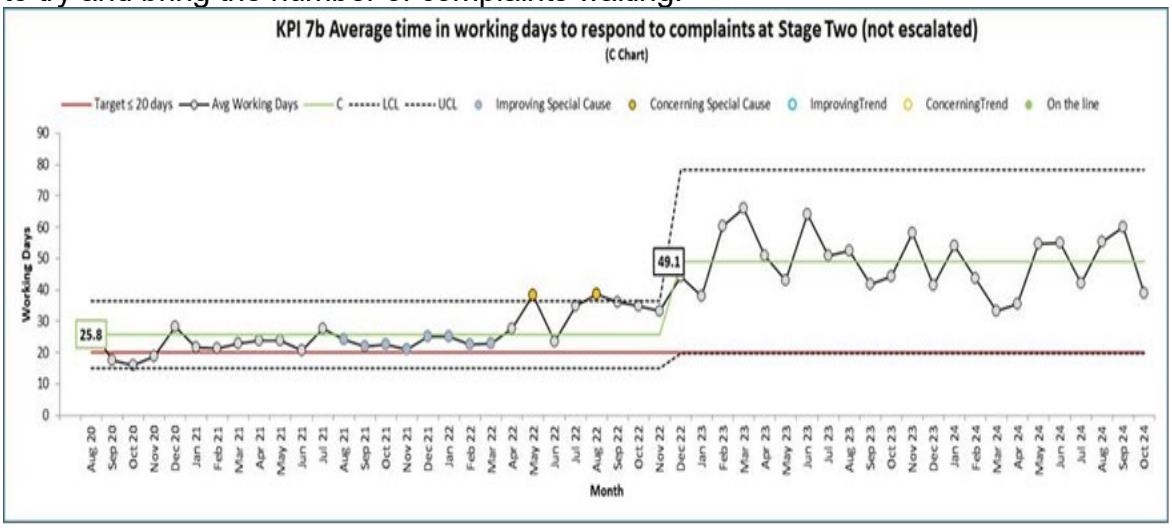
What could be improved?

2.3.30 Complaints

Figure 15 gives the number of formal complaints received by month. There has been an extended period of increased demand for both formal complaints and informal inquiries. NHS Borders has noticed a drop in the number of complaints received in the last three months. This has enabled the Patient Experience Team (PET) to close a much higher volume of complaints in recent weeks:



2.3.31 Figure 16 shows the average response time for complaints which has increased during the period of heightened demand. The PET have been doing targeted work in this area to try and bring the number of complaints waiting:

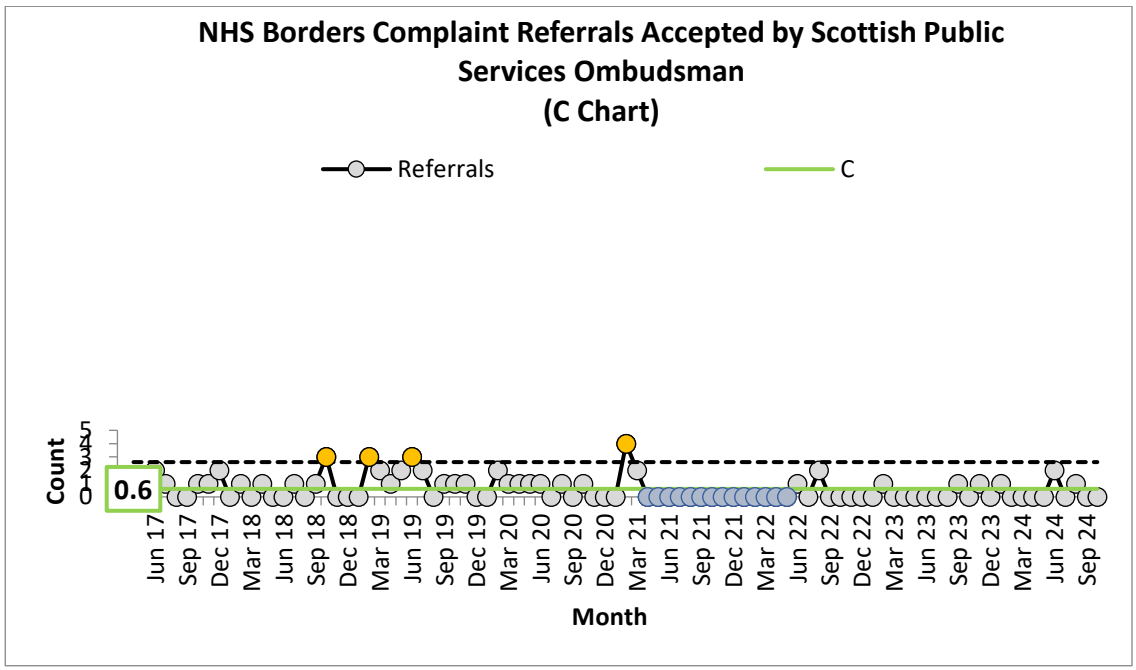


2.3.32 The Scottish Public Services Ombudsman (SPSO) are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the 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.

2.3.33 We regularly receive requests from the SPSO following contact from a complainant for more information to assist them to provide an independent review on our decision making when responding to the complaint.

2.3.34 We are seeing a high percentage of complaints that are investigated by the SPSO not upheld. The feedback we are receiving is that the Board, often after a response has been provided and the complainant contacts us again as not satisfied, we are going back out to the service and providing further information. In essence what the SPSO would do but we have taken proactive steps so there is no further action, and they close the complaint.

2.3.35 Figure 17 shows complaint referrals to the SPSO to 31 October 2024:



2.3.36 COVID Inquiries update

The Scottish Covid-19 Inquiry's hearings investigating the impacts of the pandemic on education and certification (Portfolio 4) will begin on 4 November 2024. When these hearings have finished, it will then investigate the impact of the pandemic on Portfolio 2 (business and welfare). It is anticipated that, subject to scheduling of witnesses, these hearings will end by 20 December 2024. All hearings will be broadcast on the Scottish Covid-19 Inquiry's YouTube channel: https://www.youtube.com/@covidinquirysco.

2.3.37 In 2025, the Scottish Covid-19 Inquiry will publish summaries of evidence for Portfolio 4 (education and certification) and Portfolio 2 (business and welfare).
In Spring 2025 the Scottish Covid 19 Inquiry will publish a narrative record of the health and social care impact hearings (Portfolio 3). All narrative records will be published on the Scottish Covid Inquiry's website (https://www.covid19inquiry.scot/)

2.3.38 The UK Covid-19 Inquiry's public hearings for Module 3 - Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK are currently taking place and are due to end on 28 November 2024.

2.3.39 There are 10 modules within the UK Covid-19 Inquiry:

Completed:

1 Resilience and preparedness

Currently active:

2. Core UK decision-making and political governance
    A. Scotland
    B. Wales
    C. Northern Ireland
3. Impact of Covid-19 pandemic on healthcare systems in the 4 nations of the UK
4. Vaccines and therapeutics
5. Procurement
6. Care sector
7. Test, Trace and Isolate
8. Children and Young People
9. Economic response

10. Impact on society

2.3.40 Quality/ Patient Care

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.

2.3.41 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.

2.3.42 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.

2.3.43 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.

2.3.44 Equality and Diversity, including health inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.45 Climate Change

No additional points to note.

2.3.46 Other impacts

No additional points to note.

2.3.47 Communication, involvement, engagement and consultation

This paper is for awareness and assurance purposes and has not followed any consultation or engagement process.

2.3.48 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, based on the level of assurance taken at the clinical governance committee overall a level of limited assurance is proposed to the Board.

3 Glossary

Clinical Governance Committee (CGC)
Integrated Joint Board (IJB)
Primary Care Improvement Programme (PCIP)
Hospital Standardised Mortality Ratio (HSMR)
Excellence in Care (EiC)
Quality of Care (QoC)
Care Assurance Visits (CAV)
Clinical Nurse Manager (CNM)
Senior Charge Nurse (SCN)
Cardiac Arrest (CA)
Intensive Therapy Unit (ITU)
Emergency Department (ED)
National Early Warning Score (NEWS2)
Paediatric Early Warning Score (PEWS)
Maternity Early Warning Score (MEWS)
Daily Care Plan (DCP)
Patient Experience Team (PET)
Scottish Public Services Ombudsman (SPSO)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Infection Prevention & Control Report – September 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 NHSScotland quality ambition(s):

- Safe

2 Report summary

2.1 Situation

This report provides an overview for NHS Borders Board of infection prevention and control with particular 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 16 *Staphylococcus aureus* bacteraemia (SAB) cases between April and August 2024, 8 of which were healthcare associated infections.

1.2 The Scottish Government 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). We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target which equates to no more than 20 healthcare associated SAB cases. We are on target to achieve this as shown in figure 1 below.

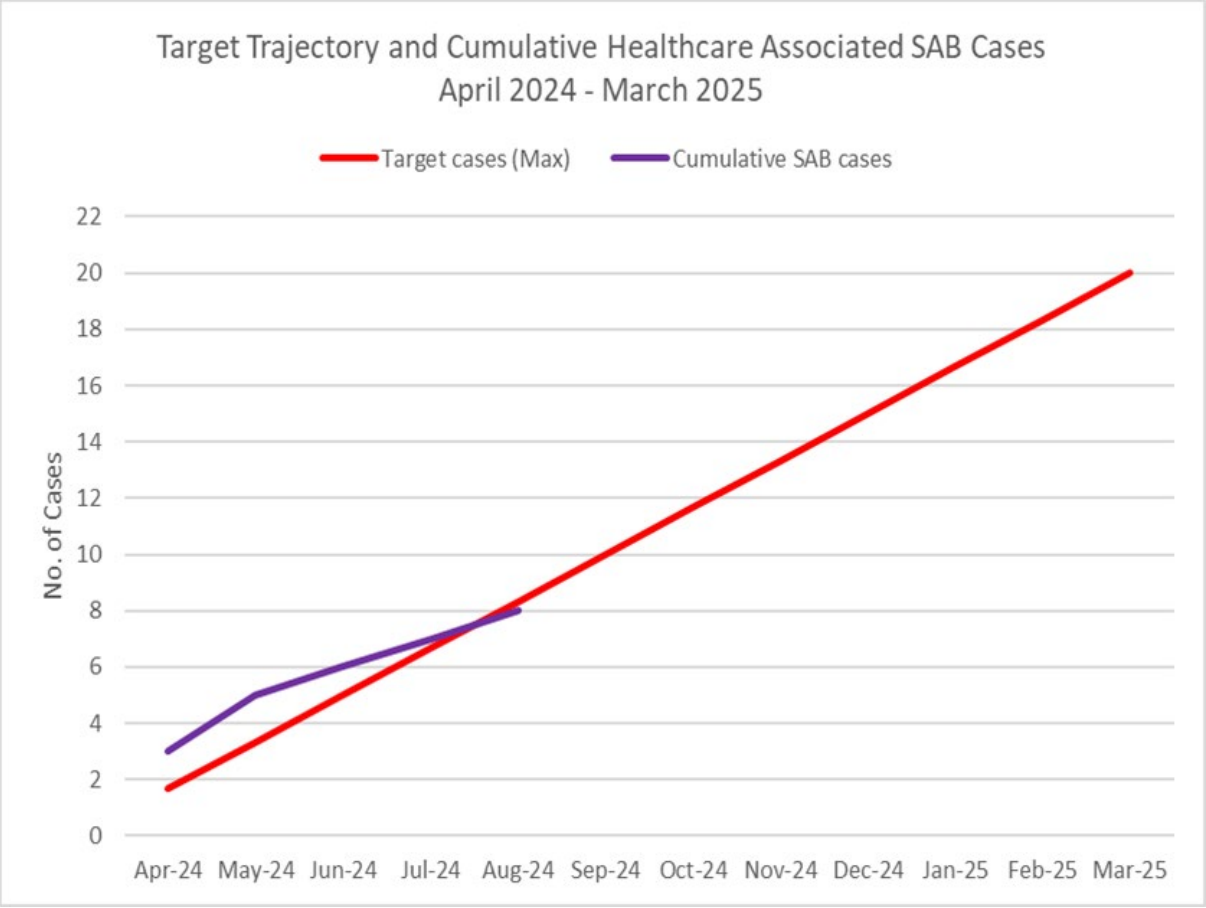


Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

- ***Clostridioides difficile Infection* (CDI)**

1.3 NHS Borders had a total of 9 *C. difficile* Infection (CDI) cases between April and August 2024; 5 of which were healthcare associated infections.

1.4 As with SABs, the Scottish Government 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).

1.5 We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target which equates to no more than 12 healthcare associated CDI cases. We are currently on target to achieve this as shown in figure 2 below.

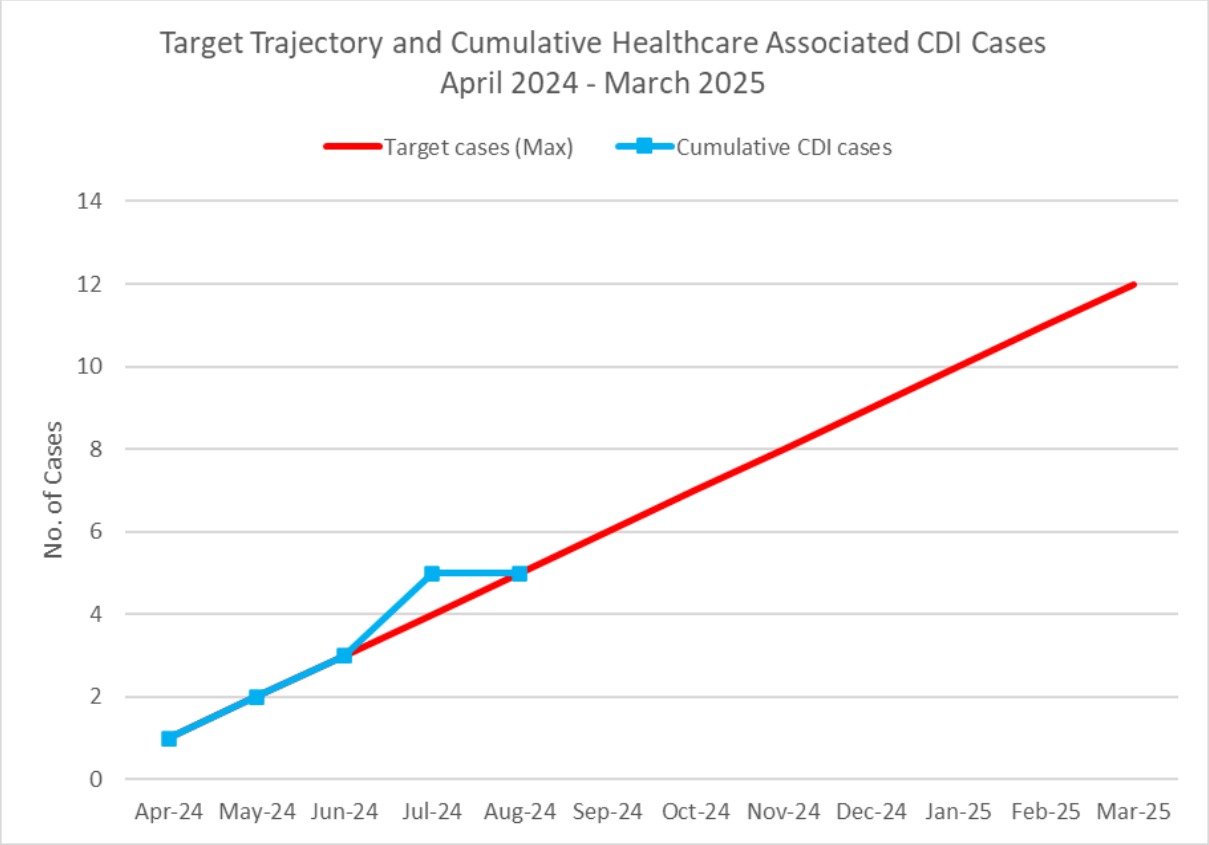


Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

- ***Escherichia coli* bacteraemia (ECB)**

1.6 NHS Borders had a total of 60 *Escherichia coli* bacteraemia (ECB) cases between April and August 2024; 27 of which were healthcare associated infections.

1.7 The Scottish Government previously 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).

1.8 Our target for 2023/24 equated to no more than 32 healthcare associated ECB cases. We are awaiting updated Scottish Government targets for 2024/25. Until then, we will continue to use our 2023/24 target as illustrated in Figure 3 below. We are currently not on target to achieve this.

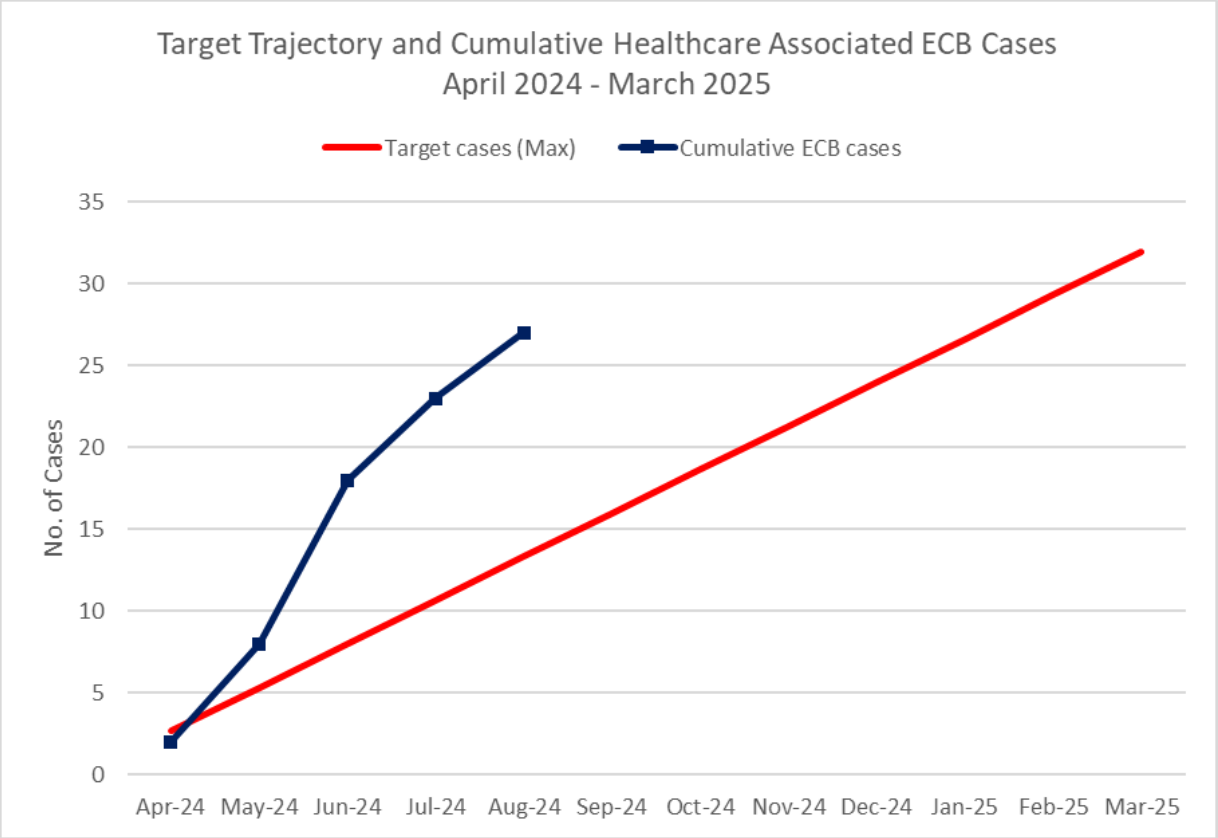


Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

2.0 Infection Surveillance

• ***Staphylococcus aureus*** **Bacteraemia (SAB)**
(Background information provided in Appendix A)

2.1 All of the SAB cases between April and August 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.

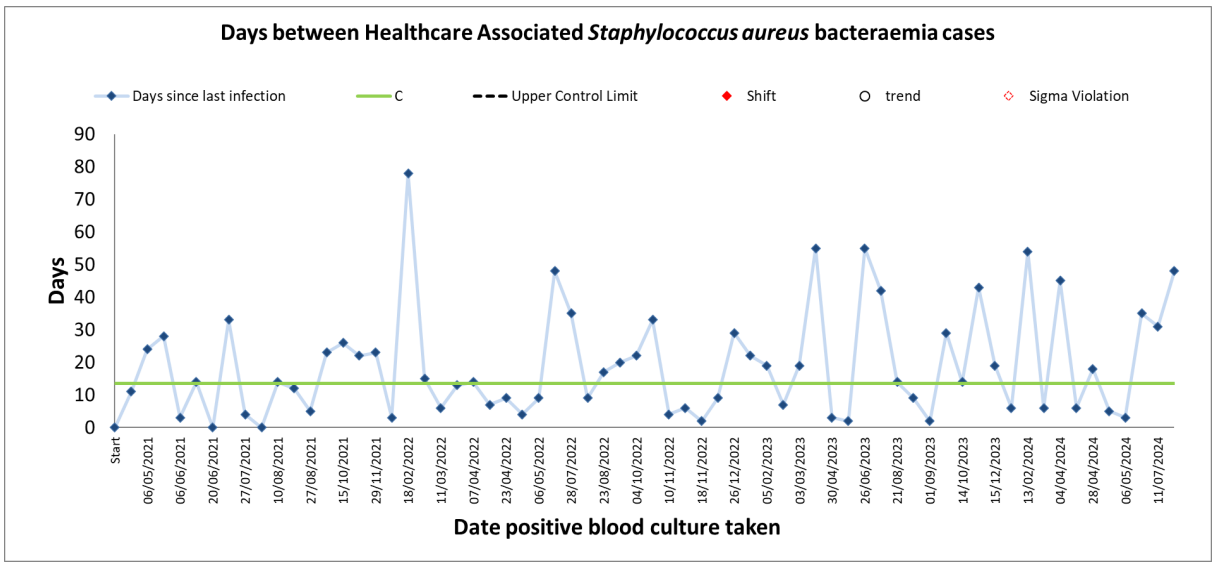


Figure 4: NHS Borders days between healthcare associated SAB cases

2.6 Over the last 2 years, the primary cause of preventable healthcare associated SAB cases has been Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 5 below.

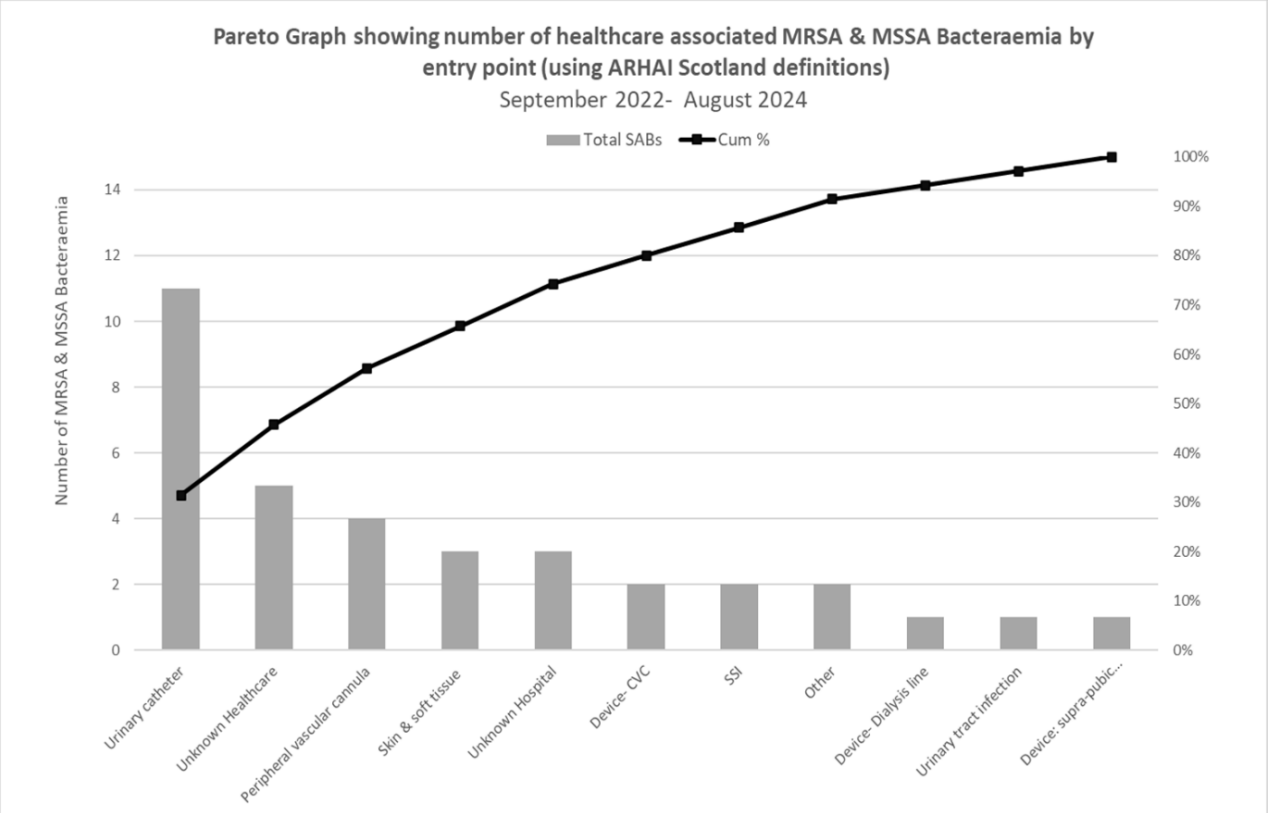
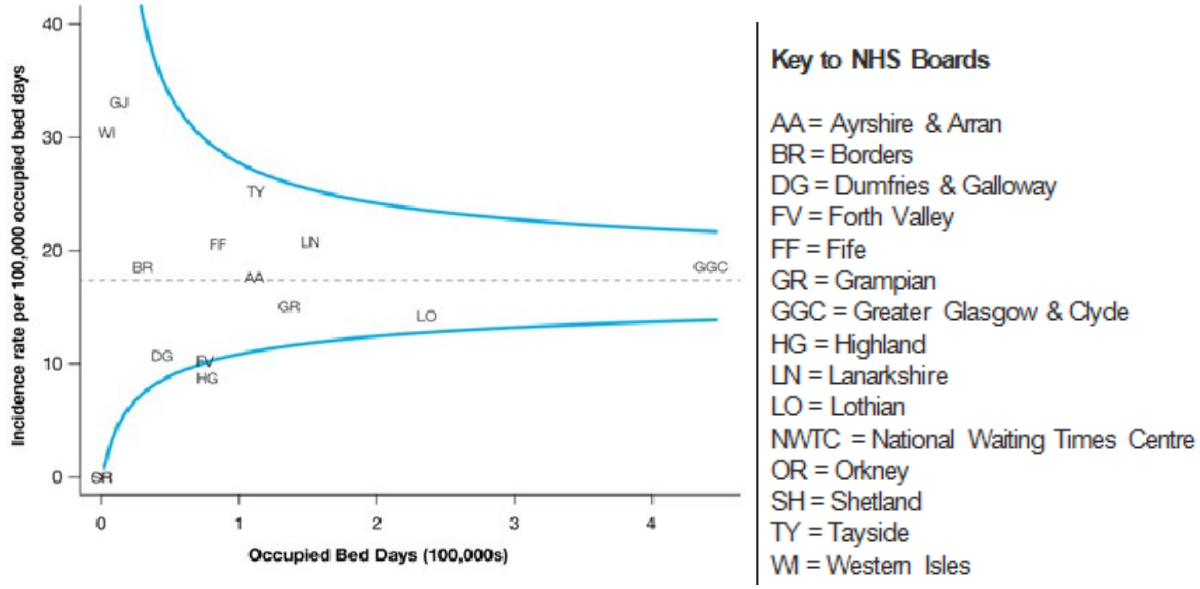


Figure 5: Pareto chart of NHS Borders healthcare associated SAB cases by entry point

2.7 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 6 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 2 2024 (Apr 2024 – Jun 2024).

2.8 During this period, NHS Borders (BR) had a rate of 18.6 which was above the Scottish average rate of 17.3. We are not a statistical outlier from the rest of Scotland.



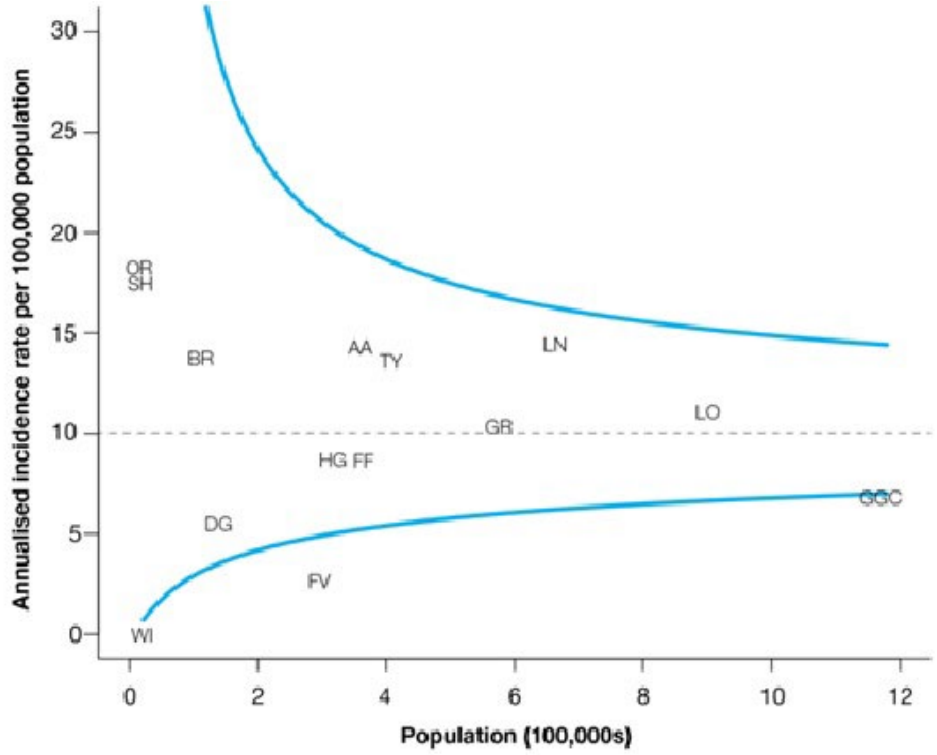
1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.
2. NHS Orkney and NHS Shetland overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 6: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q2 2024

2.9 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.

2.10 Figure 6 shows that NHS Borders was within the blue funnel which means that we are not a statistical outlier.

2.11 Figure 7 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q2 2024.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 7: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2024

2.12 During this period NHS Borders (BR) had a rate of 13.8 per 100,000 population which was above the Scottish average rate of 10.0. 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)**

2.13 NHS Borders had a total of 9 *C. difficile* Infection (CDI) cases between April and August 2024; 5 of which were healthcare associated infections.

2.14 Figure 8 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.

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

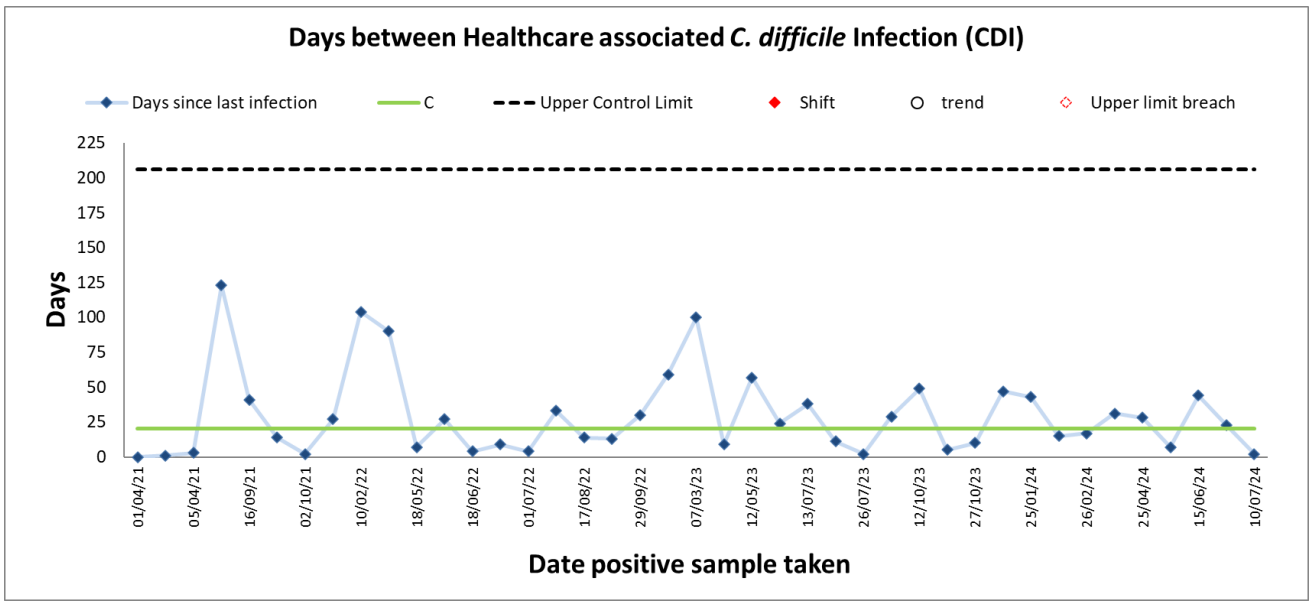
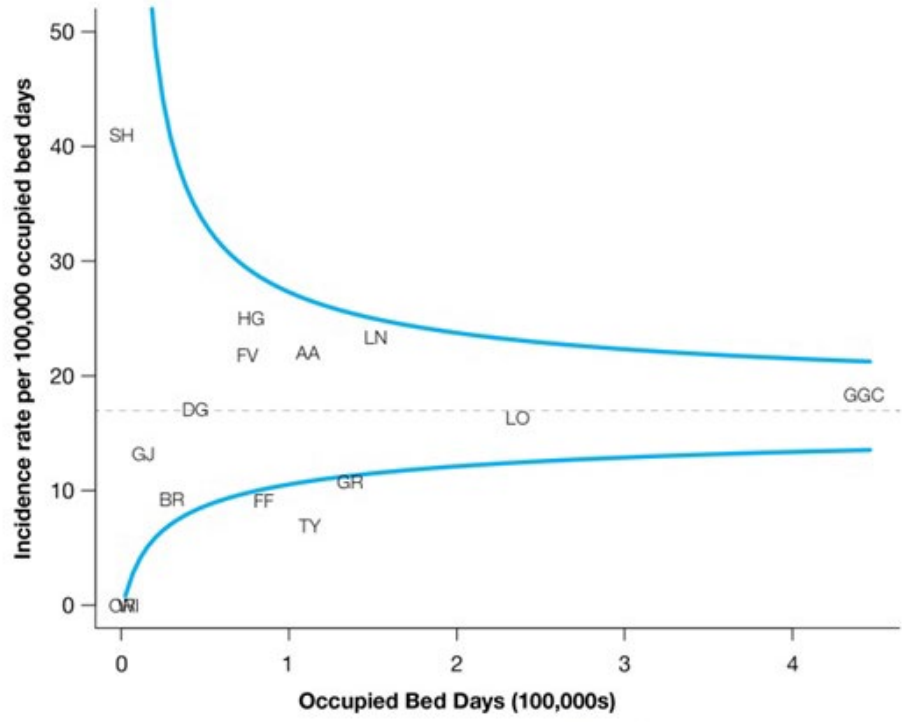


Figure 8: Days between healthcare associated CDI cases

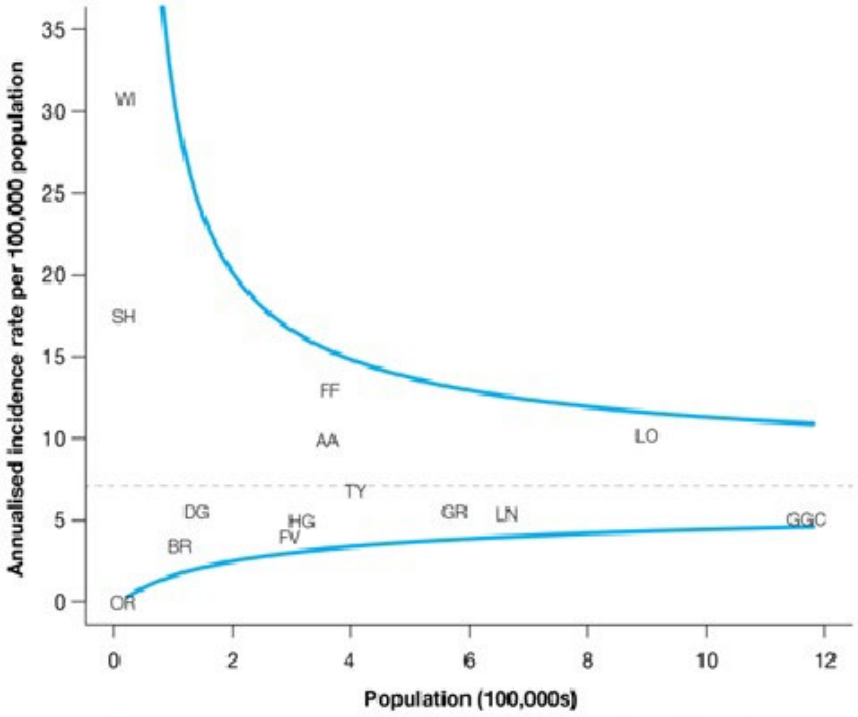
2.16 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 9 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q2 2024. The graph shows that NHS Borders (BR) had a rate of 9.5 which was below the Scottish average rate of 17.0.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.
2. NHS Orkney and NHS Western Isles 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 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q2 2024

2.17 Figure 10 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 Q2 2024. The graph shows that NHS Borders (BR) had a rate of 3.4 which was below the Scottish average rate of 7.1.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 10: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2024

- ***Escherichia coli* bacteraemia (ECB)**

2.18 NHS Borders had a total of 60 *Escherichia coli* bacteraemia (ECB) cases between April and August 2024; 27 of which were healthcare associated infections.

2.19 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 11 below.

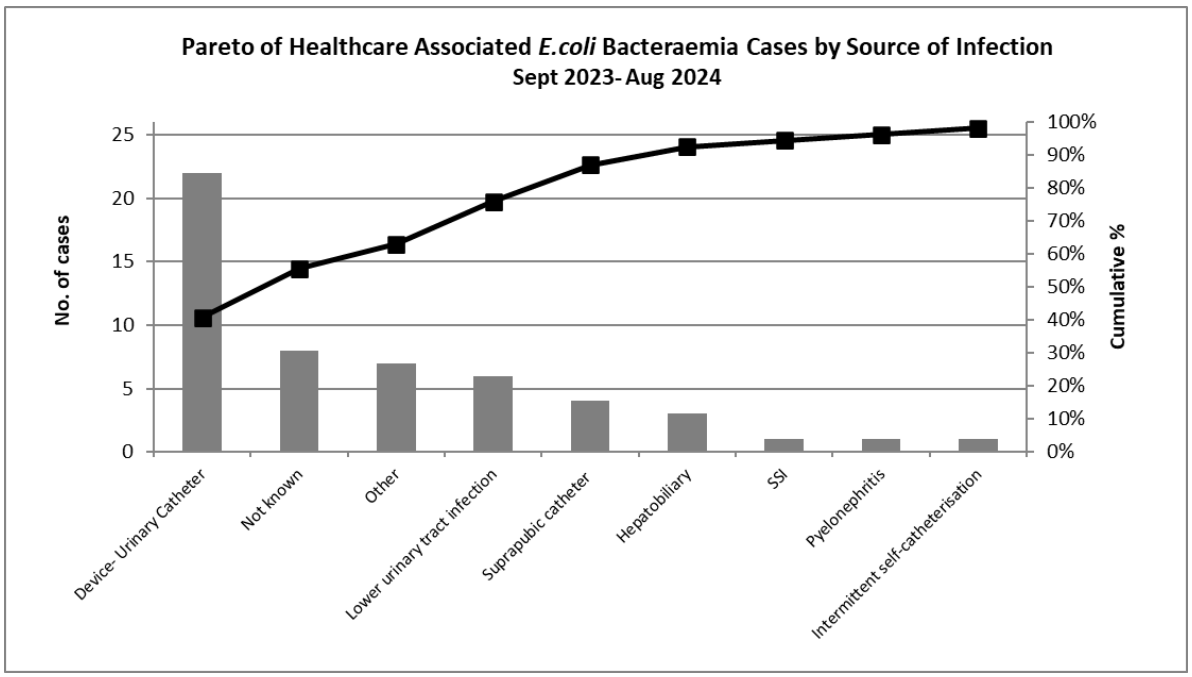


Figure 11: Pareto chart of healthcare associated ECB cases by source of infection

2.20 Figure 12 shows a statistical process chart of the total number of healthcare associated *E.coli* bacteraemia cases per month. The chart shows that there was a statistically significant increase in cases in the month of June 2024. This had not been previously apparent but reflects the mean average adjusting due to subsequent data points. The cases were reviewed and no cause for the increase or link between the cases could be identified.

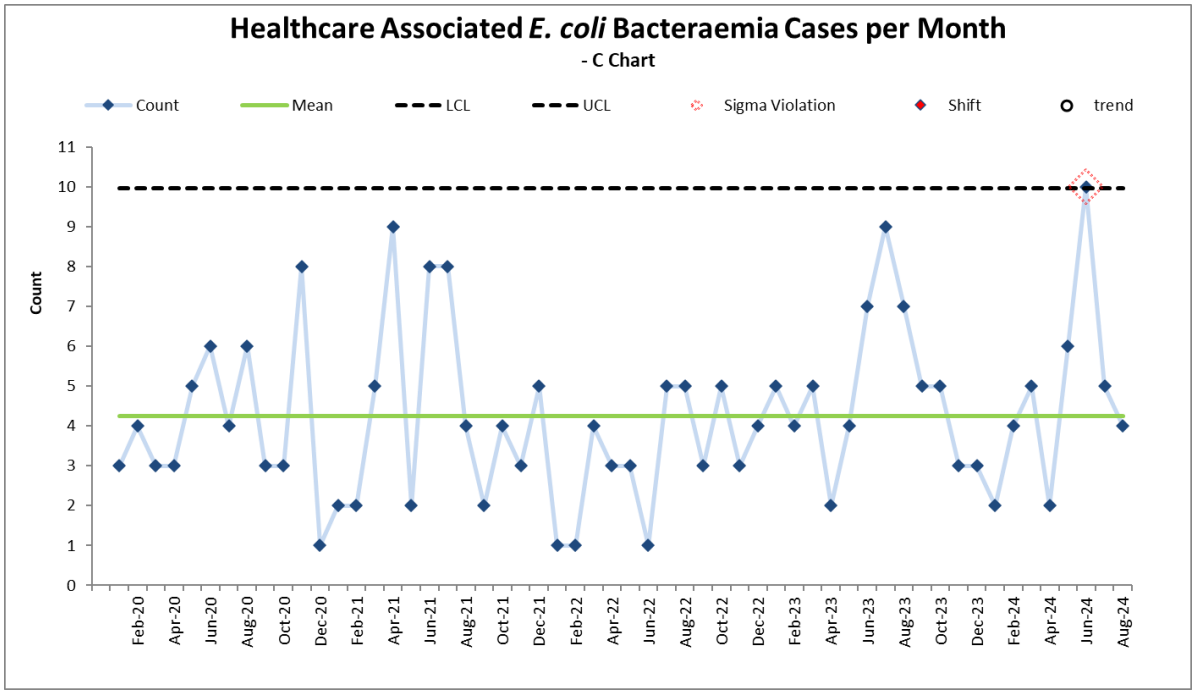
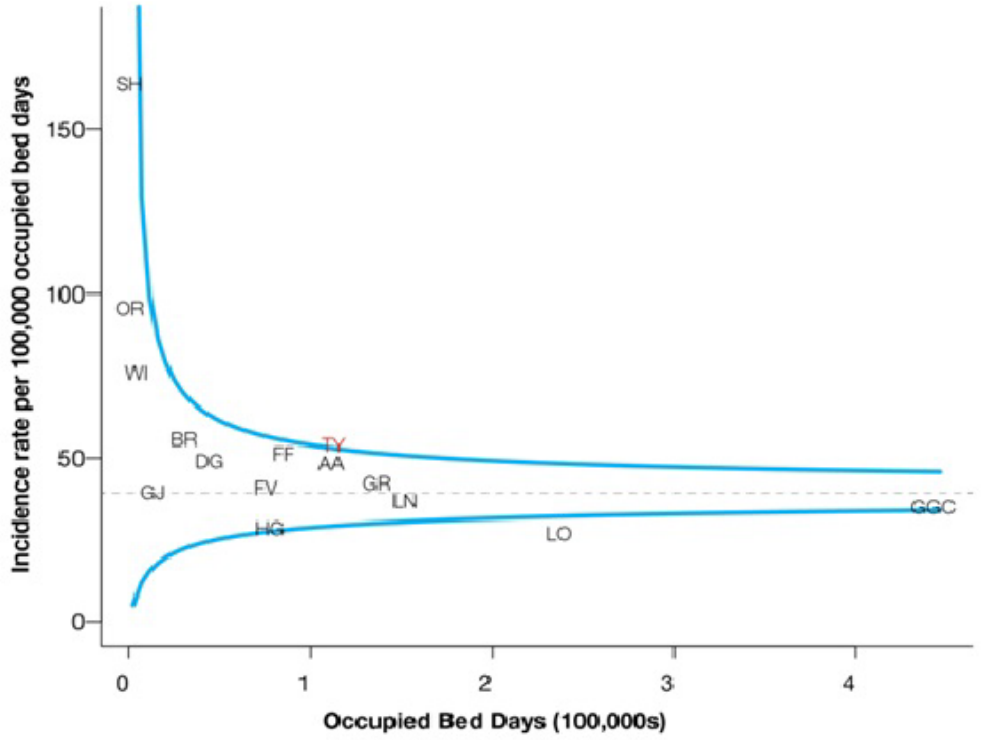


Figure 12: Statistical process chart (SPC) of healthcare associated *E.coli* bacteraemia cases per month

2.21 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 13 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2024. NHS Borders (BR) had a rate of 55.7 for healthcare associated infection cases which was above

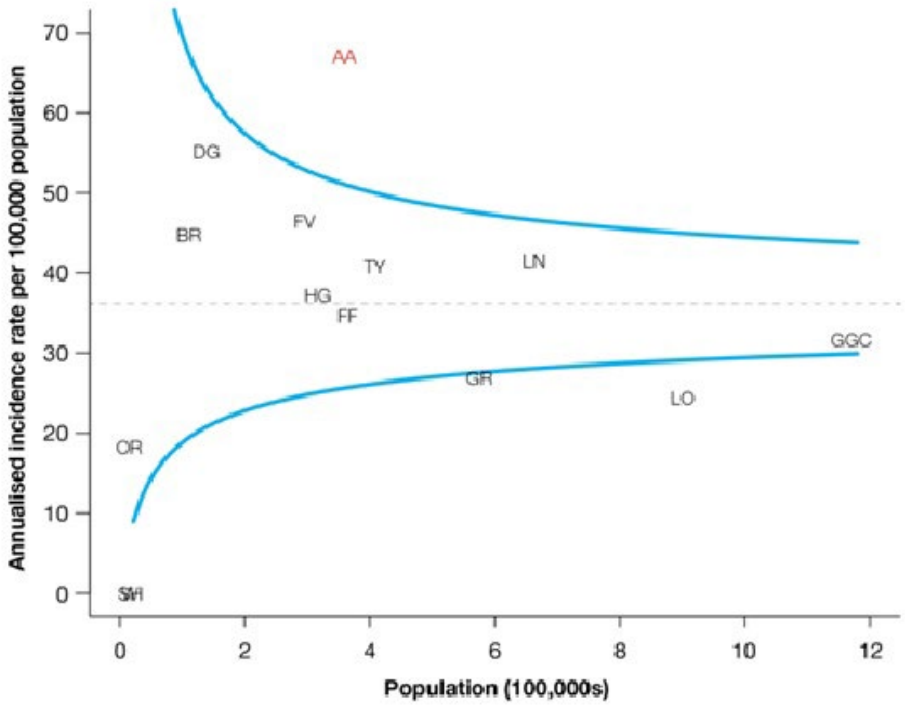
the Scottish average rate of 39.4 but we are not a statistical outlier from the rest of Scotland.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Public Health Scotland ISD(S)1.
2. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 13: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2024

2.22 Figure 14 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2024. NHS Borders (BR) had a rate of 44.8 for community associated infection cases which was above the Scottish average rate of 36.2 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 Orkney and NHS Western Isles overlap.
3. NHS boards above the 95% confidence interval upper limit are highlighted in red.

Figure 14: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2024

- **Surgical Site Infection (SSI) Surveillance**

2.23 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.

2.24 In July 2023 NHS Borders resumed local SSI surveillance for hip and knee arthroplasty and C-section surveillance was recommenced in January 2024. The latest data is provided in the tables below. Figures 15 and 16 show statistical process control charts (G-charts) which plot the number of surgical procedures between infections. The reason for using this type of chart is to account for fluctuations of the case load due to cancellations or other external factors. The higher the line on the graph, the better we are performing.

Table 1

Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) **(January - August 2024)**			
Procedure	**Total ops**	**Total SSIs**	**SSI Rate**
Hip arthroplasty	101	5	4.95%
Knee arthroplasty	84	1	1.19%
C-section	244	4	1.64%

Table 2

SSIs per month with category of infection (Using ARHAI Scotland definitions) (January - August 2024)			
Procedure	**Month**	**SSI category**	**Type**
C-section	January	Superficial	Elective
Knee arthroplasty	February	Superficial	Elective
C-section	March	Superficial	Emergency
Hip arthroplasty	May	Deep	Elective
C-section	May	Superficial	Emergency
C-section	May	Deep	Emergency
Hip arthroplasty	June	Superficial	Emergency
Hip arthroplasty	June	Deep	Emergency
Hip arthroplasty	July	Deep	Elective
Hip arthroplasty	August	Deep	Emergency

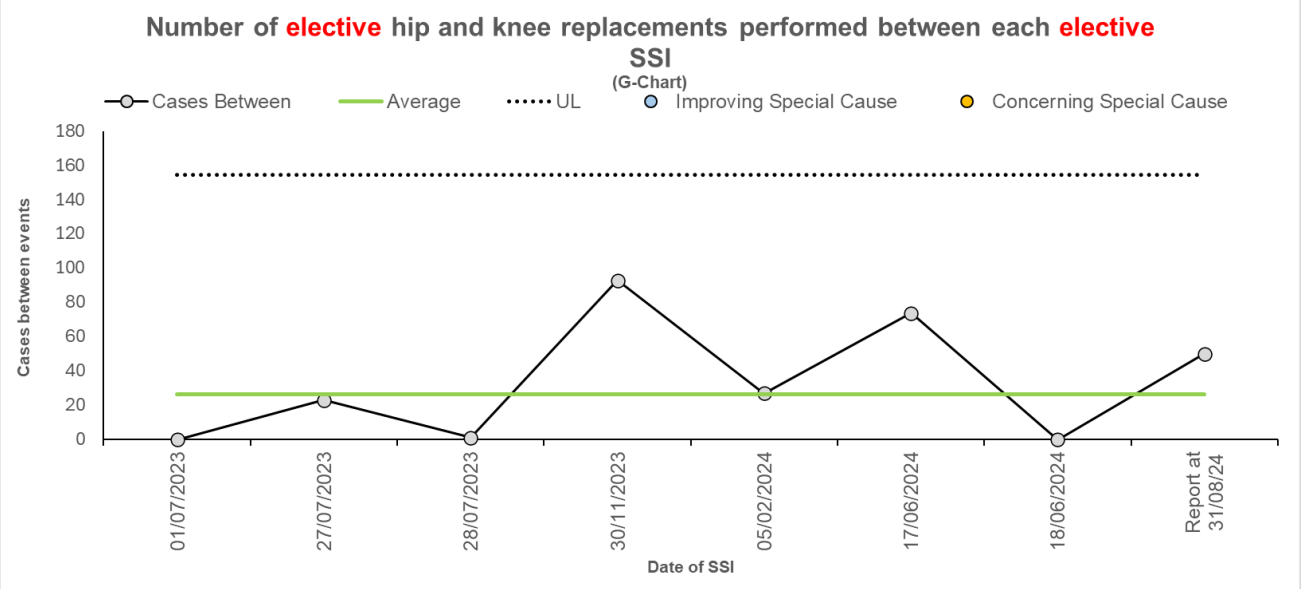


Figure 15: G-chart of elective hip and knee arthroplasties performed between each SSI

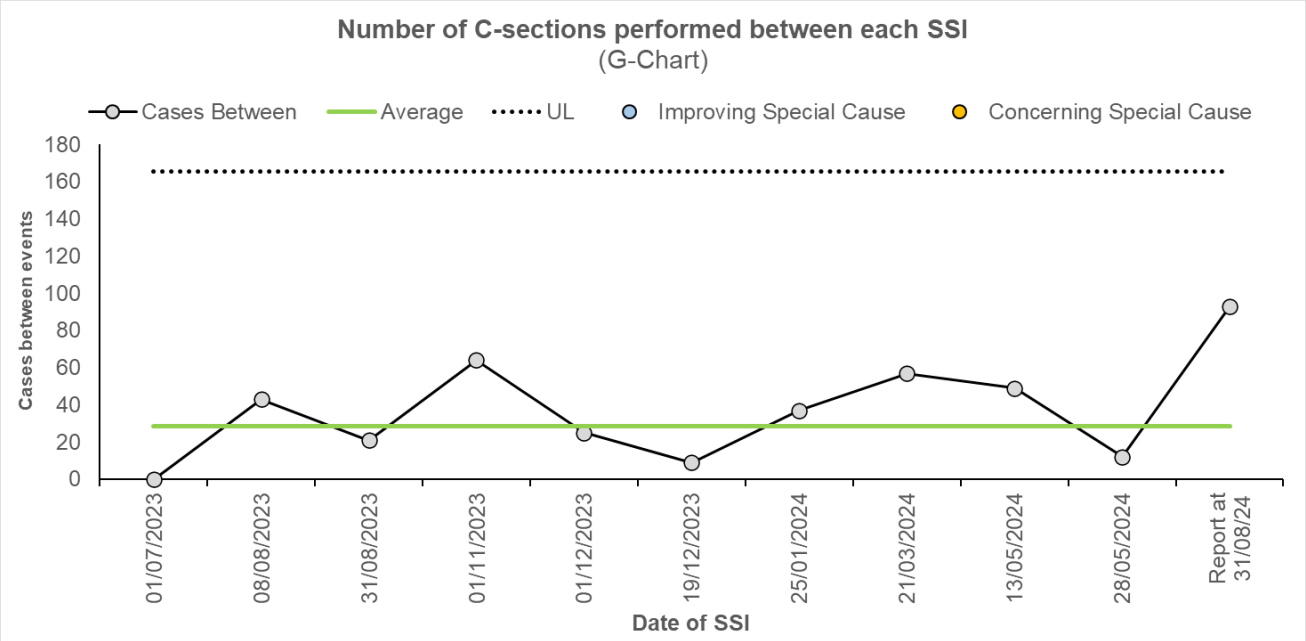


Figure 16: G-chart of C-sections performed between each SSI

2.25 An Orthopaedic SSI Task and Finish Group has completed a review of the post-operative patient pathway against national guidance. This informed the development of an action plan which was presented to the Infection Control Committee with a further update requested in early 2025.

2.26 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.

3.0 Incidents and Outbreaks

- **Respiratory outbreaks**

3.1 Since the last Board update, there have been 7 respiratory clusters which were all due to Covid-19. A summary for each closed cluster as at 13th November 2024 is detailed in Appendix B.

3.2 Learning from each incident is captured and acted upon in real time where appropriate.

- **Estates Incidents**

3.3 There have been two recent incidents relating to Estates refurbishment projects where local Infection Control advice and national guidance were not followed.

3.4 The first incident related to a service using temporary accommodation whilst the usual location had a significant refurbishment. After moving into the temporary accommodation, a joint inspection was conducted by the Infection Prevention and Control Team (IPCT) and Estates in accordance with national guidance (Healthcare Associated Infection Systems for Controlling Risk in the Built Environment – HAI

SCRIBE). The formal Stage 4 review (review of completed project) was not written up or signed off and the infection control advice to reduce an identified risk was not actioned. A Datix event has been logged and Estates and Infection Control are scheduling a joint review to identify and address the learning.

3.5 The second incident related to a different service moving back into a recently refurbished area. Although IPCT had been involved in the planning stages related to the work, IPCT were not informed prior to patient services being delivered in this area. After moving into the area, water safety concerns were identified and mitigations put in place. A formal Stage 4 HAI SCRIBE review has not yet been completed and NHS Borders Water Safety Plan was not followed. This required sign-off by the IPCT and Authorised Engineer for water prior to occupation of the area which was not completed. A Datix event has been logged and a learning review will be undertaken.

4.0 Infection Control Compliance Monitoring Programme

4.1 In August and September 2024, spot checks were undertaken in 16 clinical areas with an average compliance of 94.9%.

4.2 The new audit programme for 2024/25 commenced in April 2024. 5 areas were audited in August and September 2024 and all achieved ≥91% compliance.

4.3 IPC review themes from spot checks and audits on a monthly basis to identify improvement actions. This data also informed the focus for local staff communications for International Infection Prevention Week in October 2024.

5. Quality Improvement Update

- **Hand Hygiene**

5.1 The Medical Director accompanied one of the Infection Prevention & Control Nurses during a recent hand hygiene audit. This was a positive shared learning experience and demonstrated the commitment to improving hand hygiene compliance. Following this, the Medical Director has written to all doctors sharing her reflections on this experience and expectations.

5.2 On the 25th September, the Director of Nursing, Midwifery and AHPs wrote to the Chair of each of the divisional governance Groups seeking confirmation that hand hygiene compliance is considered at governance meetings.

5.3 Four locations with the poorest compliance have been offered Quality Improvement support. The HAI Quality Improvement Facilitator has met with each of the Senior Change Nurses in those areas and provided a data summary for staff detailing local compliance by staff group and the World Health Organisation 5 moments of hand hygiene. Separate discussions will take place with AHP and General Services leads who have a transient role across all areas.

5.4 In conjunction with the Clinical and Professional Development Team, IPCT have launched a pilot Programme to develop Infection Prevention & Control Champions. This programme will provide staff with an introduction to Infection Prevention & Control and

fundamentals of Quality Improvement as well as giving participants opportunity to shadow IPCT and participate in hand hygiene observations. A significant component of the programme is provided by the Organisational Development Team to support the individuals to grow in confidence and gain skills to affect change in their workplace.

5.5 The Infection Prevention and Control Team are in the process of completing hand hygiene audits across NHS Borders. The outcome of these audits will be shared in the next report.

- **Catheter Associated Urinary Tract Infection (CAUTI)**

5.6 The Prevention of CAUTI Group continues to oversee progress against the action plan and review data at each meeting to consider further areas for improvement.

5.7 A catheter count carried out earlier in 2024 focussed on reason for catheterisation and type of catheter. Services across Borders submitted data which has informed improvement activity as well as prompt further questions and analysis of the data to better understand variation.

5.8 An example of an output from the review of the data is an action to develop educational resources relating to supra-pubic catheters.

5.9 A test of change is being considered to support nurse led catheter removal across Community Hospitals and Care Homes.

5.10 As shown in the graph below, the highest proportion of catheters in situ relate to retention. Two of the data points highlighted in the graph are not typical indications for a catheter. Each of these cases are currently being explored further with individual services for each of the patients / residents. Where no indication for catheterisation was reported, each of these cases is also being reviewed.

5.11 The majority of individuals where the reason provided for catheterisation was ‘incontinence’ were care home / nursing home residents and each of these is being reviewed by the Care Home Support Team.

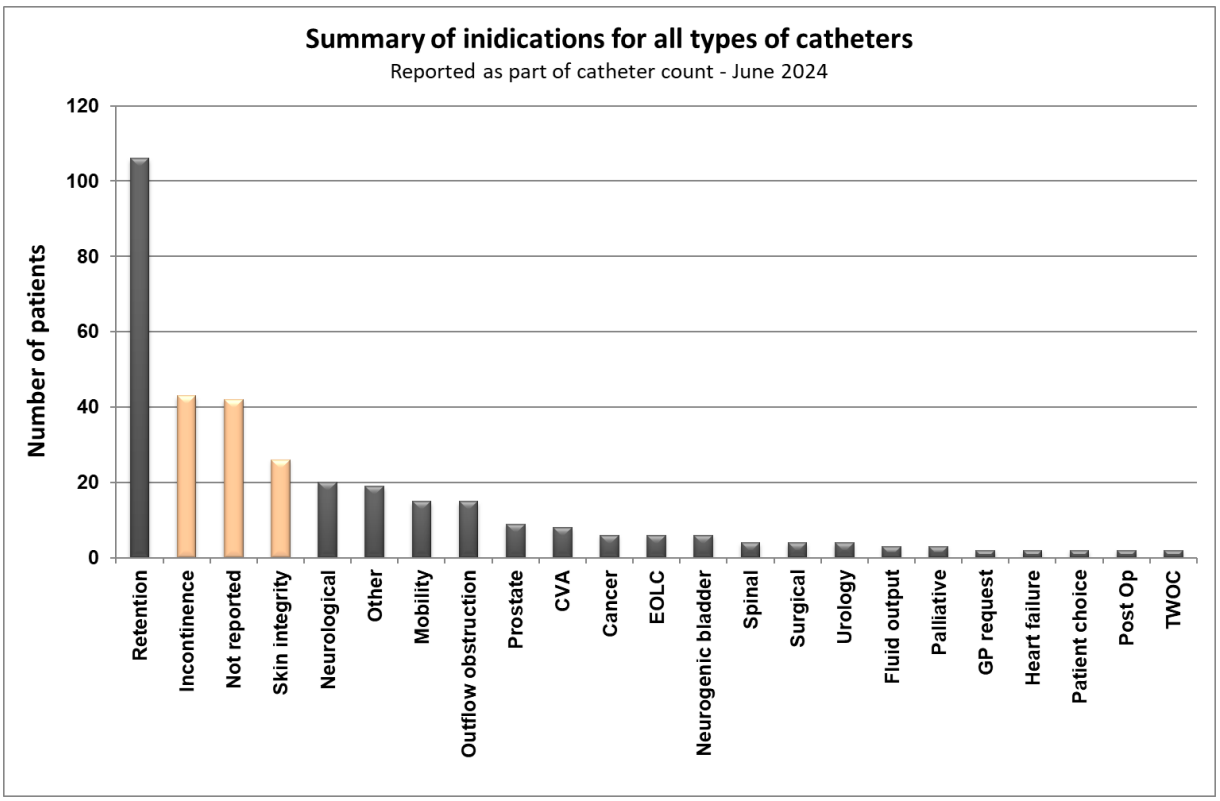


Figure 17: Number of individuals with a catheter by reason for catheterisation (June 2024 data)

5.12 Further updates on the work of the Prevention of CAUTI Group will be provided to the Infection Control Committee and Clinical Governance Committee.

6.0 Infection Control Work Plan 2024/25

6.1 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.

6.2 There are currently six overdue actions in the 2024/25 Infection Control Work Plan of which one is assessed as high risk, two are assessed as medium risk and the remainder are low risk. The high risk action is to establish a governance process for derogating from national guidance relating to the built environment. This action is on target to be completed by early December 2024.

7. 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 April to June 2024. Figure 18 below shows the cleanliness score for NHS Borders Apr-Jun 2024 was 95.8%. In the same period, the estates score was 98.5%.

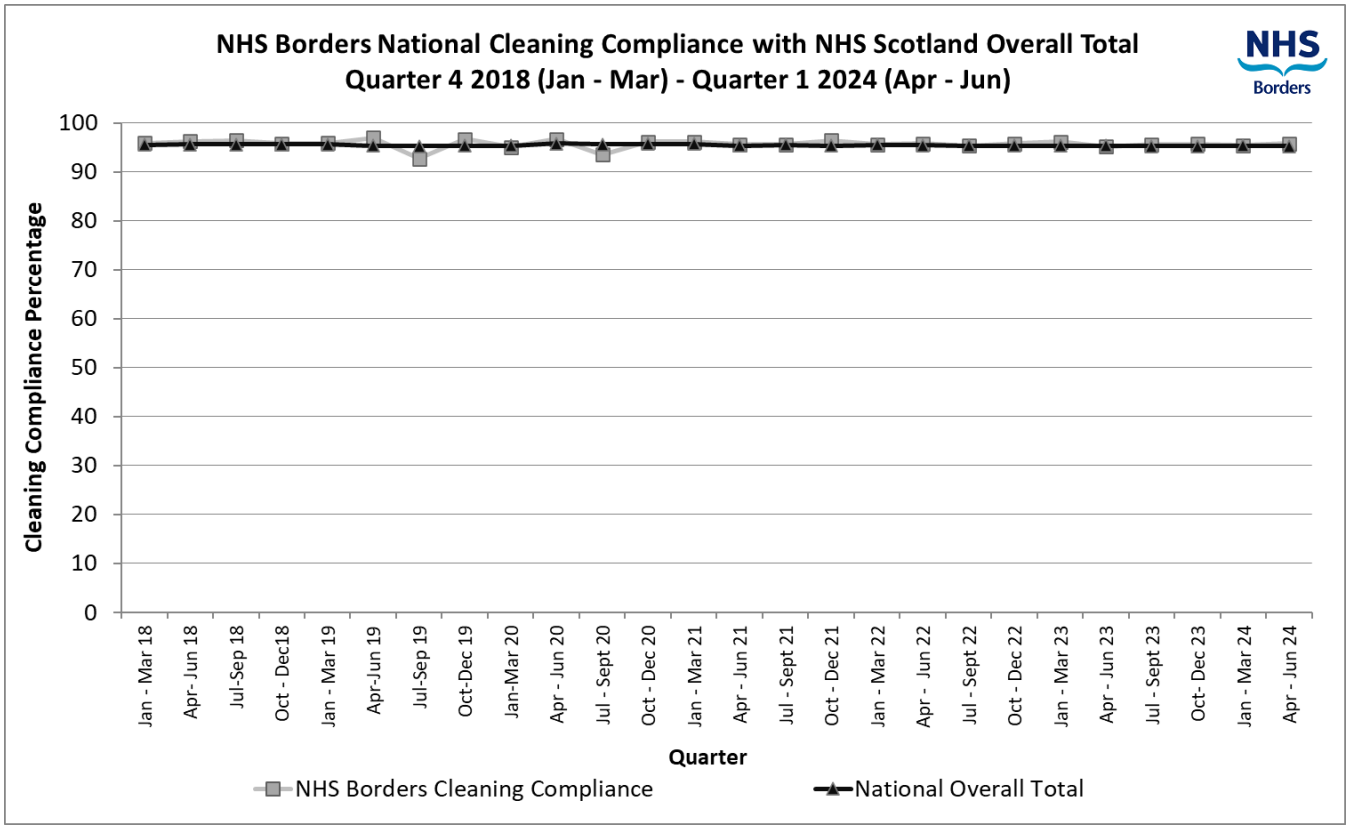


Figure 18: NHS Borders cleaning compliance against the NHS Scotland average by quarter

8.0 National guidance

- **Antimicrobial Resistance**

8.1 The new UK Antimicrobial Resistance National Action Plan 2024-2029, (NAP) was published on 8 May 2024. The new UK-wide plan builds on previous work under the 2019-2024 plan, forming part of the overall longer-term UK 20-year vision to contain and control antimicrobial resistance and to ensure that antimicrobials remain effective against infection.

8.2 The plan has a One Health focus and recognises the importance of close cross-sectoral collaboration to meet its objectives. It sets out 30 commitments over 9 outcomes (Appendix C) across human health, animal health and the environment to invest in innovation, optimise the use of antimicrobials, and promote collaborative working internationally. The NAP includes 5 human health targets.

8.3 It should be noted that NHS Borders has the fewest Infection specialists of any territorial Scottish board. The need for good diagnostics is emphasised in the NAP.

There is a human element to diagnostics, particularly when it comes to interpreting microbiology and susceptibility information, and therefore access for clinicians to advise on results is often as important as the result itself. Locally responsive laboratory services are also part of this.

8.4 A Scottish implementation plan is anticipated which will set out the precise actions and targets for Scotland.

- **Launch of the new 'water' section in chapter 4 of the National Infection Prevention and Control Manual**

8.5 On 5th August 2024, the Scottish Government wrote (DL 2024 17) to Boards to notify of new content added to the national Infection Prevention and Control Manual. The Scottish Government has set an expectation for the new content to be fully implemented by 1st January 2025.

8.6 The national infection control networks (Infection Control Managers Network and Infection Control Doctors Network) in Scotland have raised significant concern to ARHAI Scotland and the Scottish Government about the new content which is focussed on water.

8.7 The concerns relate to aspects which may not be possible to implement, proportionality of the content, and significant costs to fully implement.

8.8 A further meeting between ARHAI Scotland and the national infection control networks is scheduled for November.

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

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	2	4	2	5	1	5	3	2	2	4
Total SABS	1	2	4	2	5	1	5	3	2	2	4

Clostridioides difficile infection monthly case numbers

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Ages 15-64	2	0	0	0	0	0	1	0	0	2	0
Ages 65 plus	2	0	1	1	2	1	1	1	1	2	1
Ages 15 plus	4	0	1	1	2	1	2	1	1	4	1

Cleaning Compliance (%)

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Board Total	95.5	95.9	96.18	96.42	95.14	96.1	95.2	95.9	96.3	96.0	96.0

Estates Monitoring Compliance (%)

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Board Total	98.0	98.09	98.62	97.86	95.37	98.61	98.7	98.5	98.6	97.1	98.1

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	1	2	0	1	0	2	0	1	1	0
Total SABS	0	1	2	0	1	0	2	0	1	1	0

Clostridioides difficile infection monthly case numbers

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Ages 15-64	1	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	1	2	1	0	0	1	0	0
Ages 15 plus	1	0	0	1	2	1	0	0	1	0	0

Cleaning Compliance (%)

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
BGH Total	98.4	99.0	98.1	98.4	98.0	98.3	95.2	95.1	95.5	95.6	95.5

Estates Monitoring Compliance (%)

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
BGH Total	98.4	98.4	98.0	98.3	99.0	98.1	98.7	98.3	98.5	98.3	98.3

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

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 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

Clostridioides difficile infection monthly case numbers

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 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

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	2	2	4	1	3	3	1	1	4
Total SABS	1	1	2	2	4	1	0	3	1	1	4

Clostridioides difficile infection monthly case numbers

	Oct 2023	Nov 2023	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024
Ages 15-64	1	0	0	0	0	0	1	0	0	2	0
Ages 65 plus	2	0	0	0	0	0	1	1	0	2	1
Ages 15 plus	3	0	0	0	0	0	2	1	0	4	1

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

The paper refers to a Scottish Government expectation to fully implement new water safety guidance by 1st January 2025. The implementation cost has not been assessed and national discussions reflecting concerns with the guidance continue.

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. Much of the data was included in the monthly infection control report 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 has been presented to the Clinical Governance Committee.

2.4 Recommendation

Board 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:

- **Moderate Assurance**

3 List of appendices

The following appendices are included with this report:

Appendix A: Supplementary information and definitions
Appendix B: Outbreak summary
Appendix C: Summary of the 2024 to 2029 NAP (copied from the Executive 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 13/11/2024 (CLOSED INCIDENTS ONLY)					
Outbreak start date	**Outbreak location(s)**	**Organism**	**Positive patient cases**	**Patient deaths** (COVID recorded on DC)	**Suspected/ confirmed staff cases**
23/08/2024	Ward 7 Bay 3	COVID	3	0	0
06/09/2024	Hawick Room 5	COVID	2	0	0
10/09/2024	MAU (Bay 4)	COVID	4	0	0
08/10/2024	MAU (Bay 3)	COVID	6	0	0
09/10/2024	Ward 4 (Bays 1, 2 & 4)	COVID	9	0	0
12/01/2024	Ward 7 (Bays 1&3)	COVID	6	0	0
16/10/2024	Ward 9 (Bay 4)	COVID	3	0	0

Learning identified from incidents:
Ensure results are checked prior to patients being admitted to multi-bedded bays

Appendix C

Summary of the 2024 to 2029 NAP (copied from the Executive summary)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 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 21 November 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 18.07.24

STAFF GOVERNANCE COMMITTEE (SGC)

Minute of the meeting held on Thursday 18th July 2024, 13:00-15:00 via Microsoft Teams

Present:
Councillor David Parker, Non-Executive Director (Chair);
Mrs Lynne Livesey, Whistleblowing Champion (Non-Executive);
Mrs Karen Hamilton, Chair of the Board (Non-Executive).

Ex Officio Members
Mrs Vikki MacPherson, Partnership Lead (Support Services) Staffside (Unite).

In Attendance:
Mr Andy Carter, Director of Human Resources, Organisational Development, Occupational Health & Safety;
Dr Rebecca Devine, Consultant in Public Health;
Mrs Michelle O'Reilly, Head of Clinical & Professional Development;
Miss Kirsty McLachlan, Interim Head of Occupational Health;
Ms Edwina Cameron, Head of Organisational Development ;
Mrs Claire Smith, Head of Workforce Systems / Human Resources Manager;
Mr Robin Brydon, Interim Head of Health & Safety;
Mrs Lynne Boyle, Senior Nurse in Workforce Planning;
Mrs Josie Gray, Personal Assistant to Employee Director (SGC Administrator).

Apologies:
Ms Harriet Campbell, Non-Executive Director;
Mr Ralph Roberts, Chief Executive;
Dr Sohail Bhatti, Director of Public Health;
Mr John McLaren, Employee Director (Non-Executive);
Mrs Ailsa Paterson, Deputy Director of Human Resources;
Miss Iris Bishop, Board Secretary / INWO Liaison Officer;
Mrs Karen Lawrie, Partnership Lead (Acute Services) Staffside (Unison);
Mrs Yvonne Smith, Partnership Lead (Primary & Community Services) Staffside (RCN);
Ms Gail Russell, Partnership Lead (Mental Health & Learning Disability Services) Staffside (Unite).

1. Welcome, Introduction and Apologies

The Chair welcomed everyone to the meeting and the apologies were noted.

It was noted that the meeting was not quorate.

2. To Agree Minute of Previous Meeting

The minute of the last Staff Governance Committee (SGC) held on 18th April 2024 were agreed by those present as an accurate reflection of the discussion.

The SGC agreed that the previous minute would require ratification at the next meeting due to today's meeting not being quorate

2.1 Matters Arising

There were no outstanding actions to address.

A request for actions to be highlighted in bold after each item within the SGC minutes of meetings was made and this was agreed, alongside continuation of an Action Log from each meeting.

3. STANDING AGENDA ITEMS

3.1 Workforce Planning Update – Integrated Workforce Plan

Claire Smith confirmed that in terms of the Health and Social Care Partnership Workforce Plan NHS Borders (NHSB) were currently in year two of the three-year cycle. There is continuing engagement with partners across the partnership to implement some of the actions that were identified recently; with a re-launch meeting where areas of focus were agreed in order to jointly work towards the included training and development, wellbeing, and recruitment and retention of staff; noting the financial position and capacity has been quite a barrier. Areas of focus will enable the progression of actions with an integrated approach to improve efficiency across the sector by working together towards a two year update by the end of October 2024.

Claire asked the SGC to recognise that many influencing factors have changed some of what will be included in this plan, such as; assessing the impact of the introduction of the Agenda for Change (AfC) Pay elements: Reduced Working Week (RWW), Protected Learning Time, and Band 5 Nursing Review; and the intelligence that e-Rostering and Safe Care can bring, providing and enabling managers to access this information once they are *live* within the system to support them with operational workforce planning and importantly evidence compliance with the Health and Care Staffing legislation. Claire went on to explain that another influencing factor is partial retirement becoming easier to access since the rules changed in October 2023. NHSB has already had a number of employees take up this opportunity with more planned before the end of the year, noting also the potential impact of the remedy pension changes which are likely to lead to more staff considering retirement over the next few years.

With regards to next steps, Claire confirmed the need to bring back a two-year update of the Workforce Plan Actions to the SGC, incorporating the aforementioned elements and noting we may have a further outline of the national requirements for the development of future workforce plans by then.

Andy Carter wished to briefly touch on the pension remedy side of things, further, explaining that a recent court case known as ‘McLeod’ or ‘Sergeant’ where High Court judges said that the change that took place around normal retirement age was age discriminatory and had the effect of moving people on to a career averaged re-valued earnings pension scheme over a seven-year period (2015-2022). Andy highlighted there are a few people who are quite long serving who will have the opportunity between December 2024 and March 2025 to decide whether they want to have their pensionable service linked to the final salary scheme.

Karen Hamilton thanked Andy for articulating the point around pension remedy and reflected that there was a sense of irony here, explaining that in terms of cost saving

the most expensive element is workforce, and therefore with less staff we would save money; however, this then goes against patient safety and the safe delivery of services. It is importance of fully understanding the potential impact in terms of both finance but also the services and care NHSB provides.

Andy Carter agreed with Karen's point, noting the pension remedy has almost created a voluntary severance programme and worried that NHSB could potentially lose organisational memory due to people leaving early.

The SGC were asked to note this update.

ACTION:

- *Include impact of influencing factors (AfC Pay Elements, eRostering, Health & Care Staffing Act, Pension Remedy) within a future Workforce Planning Update to the SGC –* ***Claire Smith / Andy Carter***

3.2 Whistleblowing Update 12:46

Lynne Livesey directed the SGC's attention to the Whistleblowing papers previously circulated by Iris Bishop, explaining that both the Annual Whistleblowing Report and the Improvement Plan had been pulled together by the Whistleblowing Governance Group to build upon and make improvements on the systems that are currently in place. Lynne confirmed the Whistleblowing Annual Report has already been submitted and has been circulated to this committee for information and any comments. She noted that the cases are very small in number, and that Lynne understood that cases from previous years have now been completed. In terms of data, NHSB has one new case which is currently moving to Stage 2 within the current year and is being put through the appropriate process, with reports on this expected as it goes through in terms of the Action Plan and updates.

Lynne explained that with herself and Iris Bishop having moved into their new positions, respectively as Whistleblowing Champion and Independent National Whistleblowing Officer (INWO) Liaison Officer, they have reviewed whistleblowing elements and identified that there are some improvements to be made around processes. They are making sure that we have a renewed effort to ensure people are aware of the whistleblowing process and how it is accessible to everyone, not just staff within the hospital and immediate environment but also within the wider health service, volunteers and contractors' etc. She indicated that more work around website presence and the promotion of this so that we are confident that if people do feel there are issues that they know how to progress that. Lynne went on to state that part of this is also highlighting to staff where there have been cases and to share any learning. She noted this has been difficult due to the small number of cases and that there has not yet been a great deal of changes prompted by these cases coming through but agreed we could draw on wider reports from across Scotland to identify other learning which we could use in our Speak Up Week to show that feedback is valued, that we take it seriously and actions are taken as a result of the effort happening that does not come to light through the process. Lynne confirmed this will be the focus of the Whistleblowing Governance Group over the coming months.

Edwina Cameron stated that she had found the Whistleblowing Improvement Plan really reassuring and suggested that communications to wider staff would be

beneficial. The report to shows a good news story to prove that we are *listening* and we are *doing*, acknowledging that some of the detail may be confidential. In terms of this idea Lynne welcomed this approach and did not think there was anything contained within the Whistleblowing Improvement Plan that would breach confidentiality and agreed to put this alongside the Annual Whistleblowing Report on the NHSB intranet microsite and include details within Speak Up Week and within other planned communications to staff.

Karen Hamilton agreed that the Whistleblowing Improvement Plan was helpful and echoed Edwina's comments that we need to make sure people understand what we are doing. Karen stated the timelines on the Whistleblowing Improvement Plan were tight in terms of what can be achieved and expressed she would be content with some of the target dates being shifted in terms of prioritisation to make the plan more achievable. Karen went on to comment, that in terms of the small number of cases, one of the consequences has been a certain amount of attrition of Confidential Contacts, in that people who had previously engaged have now slipped off the list because they are not being used; people get de-skilled and lose confidence. Karen understood that there has been some work around refreshing the list of Confidential Contacts and some skill set focus so that people feel comfortable to stay on the list even though they may not be being contacted frequently.

The Chair and Karen welcomed the work progressed so far by Lynne and Iris and agreed they had really grasped whistleblowing and offered their thanks. Lynne confirmed in terms of timelines for the Whistleblowing Improvement Plan that a lot of things can be done quickly and were not going to require a lot of work but acknowledged points around appropriate time to achieve certain aspects of the plan and agreed to reflect on this, to make sure we are prioritising the right areas and pushing back ones that are likely to take longer. Lynne agreed with Karen's comments around the Confidential Contacts and stated there were some ideas being considered around how to keep this group of contacts going, to make sure they are kept involved in whistleblowing by offering training and other elements that might be helpful, confirming that some meetings have been arranged with the Confidential Contacts to talk about what they would value to keep their interest going, noting they are performing an important function within the organisation.

Andy Carter reiterated the importance of the function of the Confidential Contacts, confirming that there had been on average about three to four whistleblowing cases every year over the last five years and acknowledged that this did not offer a lot of work for the Confidential Contacts. Andy confirmed that ring-round emails were sent to the Confidential Contacts when there was a new case, asking who could take it on and noted a couple of very skilled Confidential Contacts had taken on about six cases between them. Andy went on to comment that these experienced Confidential Contacts are very busy people who have committed themselves to the process and have done an excellent job. However, we also have some other Confidential Contacts who were trained three years ago but who are less confident and a little bit reticent about coming forward but agreed that we need to encourage them with perhaps some coaching alongside the experienced Confidential Contacts.

The SGC was asked to note this update.

ACTIONS:

- *Share and promote learning from Whistleblowing Annual Report & Whistleblowing Improvement Plan with staff -* ***Lynne Livesey / Iris Bishop***
- *Up-skill and further train the less experienced Confidential Contacts to keep their interest in this important function and encourage uptake of future cases, with peer support from experienced Confidential Contacts –* ***Lynne Livesey / Iris Bishop***

3.3 Strategic Risks: Workforce

Andy confirmed that four strategic risks have been identified, namely; Industrial Action, Workforce Sustainability, Health & Safety Training around the management of aggression and violence; and Statutory & Mandatory Training. Andy confirmed he had agreed with Lettie Pringle (Risk Manager) to go along to the Clinical Governance Committee to shadow the way they deal with strategic risk. He also confirmed that Lettie has kindly offered up some training to any member of the SGC around how, as our Risk Manager, Lettie would like to see the SGC address the Workforce Strategic Risk to ensure a standardised approach across the Board's sub-committees.

Edwina Cameron wished to refer to the SGC Self-Assessment Effectiveness Survey Feedback item on the agenda, stating that as part of this survey there was a desire to have some development and suggested including something around understanding Strategic Risks as part of this development. Andy agreed with Edwina, explaining that as the overall strategic risk owner for this it was a large piece of work and that they were in the process of unpicking this in order to get elements aligned to more appropriate risk owners.. Andy reiterated the need to align with the other sub-committees of the Board and offered to liaise around some Strategic Risk training with Lettie.

Karen Hamilton agreed with the need for continuity across the sub-committees of the Board, to ensure each committee is tasked with a particular area of work, with the principles and processes remaining the same and referred to previous short development sessions within the SGC, agreeing that this would be a good place to re-start these development sessions.

The SGC agreed to a development session around Strategic Risk.

The SGC was asked to note this update.

ACTIONS:

- *Liaise with Lettie Pringle around a Strategic Risk Development Session for SGC members and Non-Executives –* ***Andy Carter / Edwina Cameron***

4. Health & Care Staffing Update

Lynne Boyle presented on the Health & Care (Staffing) (Scotland) Act 2019, what it means for us and current progress within NHSB to the SGC. Lynne explained that the Heath & Care (Staffing) (Scotland) Act 2019 came into being in 2019 and that it became *live* as of 1st April this year. It is in the process of its first reporting period with reports expected to the Scottish Government by the end of April 2025, and that NHSB has local reporting into the Board that is expected throughout the first year of

implementation. Lynne highlighted the key messages around this are: to enable safe and high-quality care; to make provision around staffing in the NHS and Care Services; and to support the health, wellbeing and safety of patients and staff; noting that the requirements of this Act are not new concepts but rather to build on processes that are already in place. The reporting requirements will support local and national workforce planning; encourage service redesign and innovation where appropriate; promote transparency in decision making processes around staffing; and create a more open and honest culture where staff feel empowered to feedback on staffing decisions that are made. Most clinical and professional roles are within scope of this legislation.

Lynne confirmed several duties associated with the legislation that each NHS Board has to comply with: the guiding principles over health and care staffing and planning for staffing, highlighting specifically the appropriateness of staffing. Each Health Board will report into the Scottish Government, where ministers will then collate these reports and present to Parliament on an annual basis. Alongside these duties, Lynne confirmed that NHSB must have some localised considerations where each individual and clinical lead will have to consider what they are doing as part of the system, how and through which governance groups they can gain assurance that they are compliant with this legislation, and what systems and processes do they need to put in place to gain that assurance.

Lynne briefly touched on the Real Time Staffing Assessment, highlighting that there are several resources developed by the Scottish Government for Adult Inpatient, Maternity, Mental Health, Critical Care areas, as well as a generic resource. These resources allow identification of risk and how you might mitigate that, how to escalate and to be able to document this in a concise way that provides assurance. The Real Time Staffing Assessments take cognisance of the workforce; the numbers, skills and any deficits as well as the workload including patient acuity and environmental factors; to ensure these are fed back to colleagues; noting if clinical advice is sought and a discrepancy occurs between this advise and any action taken that this is also recorded and fed back to the person providing the advice. Lynne reiterated as a health care organisation we need to ensure that we identify where there are severe or recurring risks.

eRostering and Safe Care are linked to the safe staffing legislation, with eRostering being rolled out across Scotland. NHSB are currently in our implementation pathway which is expected to take a couple of years to complete overall. Lynne explained this is a daily staffing software based on care hours and the requirements of patients with descriptors within this that use the Adult Inpatient Tool calculators to match staffing levels to patient acuity to increase safety, efficiency and to allow better informed decisions around staff management and deployment. Within Safe Care there is an option to have a helicopter view at various levels of the site / departments / wards which assists in trying to make staffing decisions; the caveat being that we need to ensure accurate and timely input.

Within the legislation, mandated for a two-week run annually, are the Staffing Level Tools; where there are a number relating to specific areas; some go alongside the Quality Tool; and all work alongside the Professional Judgement Tool. These tools look at staffing in retrospect, to review clinical activity and workload, and to identify

what the recommended staffing requirements would be. Where there are specific staffing level tools there is also a need to use the Common Staffing Method which looks at the local context and wider issues that impact staffing when doing any kind of workforce planning and the way in which to deliver care. This Common Staffing Method takes elements into account such as sickness absence, training ability and capacity, appraisals, and safety and quality issues in each area as a holistic view of care.

Lynne went on to explain that Commissioning was another area where there is a duty under the legislation. Boards need to be assured that any Commission services comply with the duty to ensure appropriate staff and to comply with the guiding principles, noting it is the Health Board's responsibility to ensure this rather than the Commission service; highlighting the need to gain that assurance from any third party provider.

To summarise the reporting structure for this legislation Lynne confirmed the previous requirement for quarterly reports to the Scottish Government throughout the last financial year. Our first quarterly report due to the Board, as stipulated in the law, is due for submission next week and this will feed into our annual Board Report to the Scottish Government due at the end of April 2025. In addition to this we are also expected to produce quarterly reports to the Scottish Government on the use of high-cost agency spend. Healthcare Improvement Scotland (HIS) are the overarching monitoring and compliance managers for this programme, looking at the monitoring and compliance of staffing alongside their Quality Care Inspections, including the monitoring and reviewing of staffing tools. The duty is on health boards to assist HIS when they visit, to provide the information requested; and importantly noting that HIS have made a formal request for quarterly Board Reports to be submitted to them as well as part of their engagement process with boards.

Lynne confirmed there has been a lot of national activity which is continuing, refreshing staffing tools and developing new generic Real Time Staffing resources, and noting that metrics are being fed into the safe care staffing software being rolled out. Guidance chapters on the legislative duties are now in the public domain and have been out for consultation prior to the legislation going *live*. NHSB have developed their own range of quick guides which are available locally alongside various SWAY presentations and Turas resources.

Locally we have a schedule for staffing tool completion set out for next year which includes the training of staff, ensuring staff take this responsibility upon themselves to ensure all professions are self-assessing in readiness to comply with this legislation, and the need to define the processes around documentation, risk escalations etcetera for their areas that must be put in place. It is essential to ensure multi-professional engagement and that we comply with the reporting requirements, moving this into business-as-usual going forward.

Karen Hamilton requested for the slide-pack to be circulated to the SGC membership. Karen noted this was in relation to Health and Care staff and asked whether there were similar activities and processes going on within care settings as well as our own. Lynne confirmed the Care Inspectorate is the overarching body that is looking after Care Services so, like HIS, is responsible for this; noting that Care

Services have duties within the legislation as well which are based upon existing laws and principles within care services, although these are not as in depth as the duties for Health Care and not as much reporting is expected. Lynne also confirmed that Prisons, Hospices, Nurseries etcetera also fell within Care Services.

Lynne confirmed that HIS have a system of unannounced inspections but that part of this in future will incorporate safe staffing and workforce planning. She did not think that HIS involvement with boards and engagement sessions would lead to more inspections or a different schedule of inspections, unless of course there was something really worrying within a submitted report. There may be greater focus on inspections in the future, however, boards have been assured by HIS that even in this first year of compliance and monitoring it is there as a very much non-punitive and supportive system to come in and speak with boards to look at their quarterly reports and see what shared learning there can be.

Locally Lynne reported things are improving although some services are slow to engage or not fully engaged. Some areas are much more complex, such as Public Health which covers a range of services with some regional. Due to NHSB being a rural board with remote services and small teams, some services which cannot get a handle on safe staffing may need to consider re-design and may include some unsavoury decisions. Examples of this are being discussed across the board, noting not only the new legislation but also improving the quality and safety of care for our patients, alongside sustainability under the current financial constraints.

The SGC was asked to note this update.

ACTION:

- *Circulate the Health & Care Staffing presentation slides to SGC membership –* ***Lynne Boyle / Josie Gray***

5. To Agree SGC Terms of Reference

6.

Edwina Cameron presented the SGC with the latest version of the Terms of Reference, noting they had already been circulated to the membership on more than one occasion and no comments had been received back. It was therefore assumed that the SGC were happy to accept these Terms of Reference.

Karen Hamilton queried the quoracy, stating it was different to other sub-committees of the Board. Edwina explained that four non-executives were required for quoracy of the SGC, including the Employee Director and the Whistleblowing Champion, based on the Staff Governance Standard and legislation. Karen acknowledged that the SGC has a mandate from these standards.

The SGC agreed these Terms of Reference.

The SGC was asked to note this update.

7. To Agree SGC Work Plan 2024-25

The Chair asked members of the SGC for their views on what they would like to see on the SGC Work Plan for this financial year.

The Development Session around Strategic Risk was again referred to and agreed as a sensible opportunity for development. The Chair went on to suggest that the SGC needed to think about the five key Staff Governance Principles, in terms of staff; being kept well informed; appropriately trained; involved in decisions which affect them; treated fairly and consistently; and with an improved and safe working environment. Andy Carter agreed with the Chair, in that the five principles were the anchor points of the SGC.

Andy Carter wished to make the SGC aware that the government are communicating with health boards around the need to establish Anti-Racism Plans, suggesting we could look at this from the way we design and deliver our clinical services and whether they are fit for purpose. Karen Hamilton referred to our Employment Status Capability in terms of people with protected characteristics, and suggested this may perhaps be something for the SGC to progress. Andy Carter agreed we had previously done some work around the disability protected characteristics and around disclosure levels of having a disability, alongside help from our Communications and Occupational Health teams, and confirmed that this level had increased from around under half a percent up to around two or three percent; approx another fifteen to twenty people disclosing to Occupational Health that they had a disability. Andy went on to credit Linda Clotworthy, a Unison and Staffside colleague, for establishing the Disability Staff Network, which has successfully grown over a number of meetings and gained a voice between management and staff around the unique challenges that people with a range of different disabilities face, some visible and some not. Andy reiterated that we need to keep going and agreed more work could be identified in this area, specifically mentioning Occupational Health Passports, whereby people move between different organisations and there is full awareness of the extent of their condition and how it affects the workplace, considering reasonable adjustments.

Edwina Cameron referred the SGC to the Agenda Plan at the end of today's SGC Agenda, explaining that these elements were active within the organisation; Quality Management System (QMS), the Staff Pillar, and the Staff Wellbeing Group; suggesting that the SGC can gain assurance that these are functioning in a way that is linked to the Staff Governance Standards. Edwina suggested we put out the suggestions to the SGC membership, asking for them to consider points particularly linked to the Staff Governance Standards to create a fuller agenda for the SGC.

With regards to a further Development Session, Edwina suggested one around what the Staff Governance Standard is and how this links into iMatter, and from an Executive perspective how you get assurance from this. The SGC agreed for Edwina Cameron to work with Andy Carter and the Chair around a draft SGC Work Plan, with an email communication to the SGC membership and Non-Executives about what they would like to see on the SGC Work Plan.

Claire Smith added that now we were at the stage of reporting against Safe Staffing legislation, it would be good to bring any progress back to the SGC for assurance.

The SGC agreed with this approach and was asked to note this update.

ACTION:

- *Pull together a draft SGC Work Plan based on suggestions from today's meeting (SGC 18.07.2024) and circulate to SGC membership and Non-Executives for their views* - ***Edwina Cameron / Andy Carter / David Parker***

8. SGC Self-Assessment Effectiveness Survey Feedback

Edwina Cameron explained that the Self-Assessment Effectiveness Survey of the SGC was one of the things that the SGC had previously requested and noted when the survey was initially run there was a lack of feedback; therefore, it was agreed at the last SGC to re-run this survey. Edwina confirmed responses had now been collated, noting two members had declined to comment due to either being new to the committee or not having attended enough meetings.

Edwina referred the SGC to the shared report on the agenda pack which pulled together from the responses to the survey, particularly to the questions asked around committee membership, support and information, and the role of the SGC; and confirmed there was nothing detrimental in relation to the performance of the SGC.

Evaluation of the *free text* within the survey indicated some important information to build upon in relation to organisational development. In relation to membership and dynamism, a need was identified to focus more on training aspects, specifically around the Staff Governance Standard, and it was proposed for a development session to be undertaken by the SGC and Non-Executives annually. In relation to the role and work of the SGC, it was proposed that a report on staff governance around policy updates comes from the Area Partnership Forum (APF) to the SGC, noting the Policy And Conditions of Employment (PACE) Group reports into the APF. Edwina commented that finance currently gets a greater hearing within the Board and reminded the SGC that the Staff Governance Standard was legislated to balance discussion and that it was critical to get this right in relation to changes within the Board and the responsibilities of the SGC.

Edwina summarised by stating it had been a worthwhile exercise and that the survey had gathered some important information which will help influence the work of the SGC going forward.

Karen Hamilton agreed that it was a good observation around development sessions which would be more informative and to broaden out to a number of Non-Executive Directors, rather than just the SGC membership. She suggested this approach could also be transferred into other governance committees.

The Chair agreed with colleagues that the survey had been a very useful exercise and suggested it would undoubtedly be repeated in the future.

The SGC was asked to note this update.

ACTIONS:

- *Progress Development Session for SGC and Non-Executives around Staff Governance Standard –* ***Edwina Cameron / Josie Gray***
- *Report around Policy Updates from the APF / PACE Group to be compiled for the SGC –* ***Edwina Cameron / Andy Carter***

9. iMatter Update

Andy Carter confirmed we had the start of reports coming into NHSB at the very end of June 2024, and referred the SGC to an email he had circulated with a brief presentation on iMatter.

Andy reminded the SGC that iMatter comes from the means of testing the staff experience, what it feels like to work in a particular team, your level of job satisfaction, and how committed and engaged you are to your team, your team leader and NHSB as a whole; noting that the 28 statements asked in iMatter are all wrapped around and anchored in the five staff governance commitments.

In relation to participation, Andy reported a good news story in that NHSB have gone from 52% in 2021 to 57% in 2024 (just under 2,400 respondents), which is the same 5% increase as the Scottish average; and noting Social Care colleagues are now engaged with this. In terms of the employee engagement index, we have seen a dip of 1%, from 77% last year to 76%, which is also in-line with the Scottish average.

On review of performance against the 28 statements Andy confirmed that last year we had seen an improvement in 24 of the 28 statements, noting some only by 1% and some by 3 or 4%, statistically a significant improvement. Looking at iMatter 2023 we were seeing an upwards trajectory in performance, however, this year we have seen a deterioration in 20 of those 28 statements; with the remaining 8 at roughly the same and no improvement in any of the statements; and iterating that for 20 out of 20 statements we saw a percentage drop of 2-3%.

Andy highlighted that NHSB had dropped 3% on 'I feel my organisation cares about my health and wellbeing', 'our confidence and trust in Board members who are responsible for my organisation', and dropped 2% on 'I'd be happy for a friend or relative to access services here', 'I'd recommend my organisation as a good place to work', 'I feel involved in decisions relating to my job and confident my ideas and suggestions are acted upon', and 'I'm confident performance is managed well in my organisation'. Andy stated these are all important statements in terms of a barometer of how people are feeling and believed we need to be alert to this with a suggestion for a more comprehensive paper coming back to the SGC, assuming that much of this reflects the Scottish Budget in December 2023 and increased financial pressures, and high demand within our health and social care system.

Andy posed the question to the SGC of the need for a full analysis report on iMatter at the next, or a dedicated, meeting. Andy also proposed this could be done as a development session, to think about the sharing of iMatter as a Board and consider what we communicate out to the workforce; as a classic *you told us / we did* exercise, to reinforce the message that iMatter is taken seriously by the senior management team and want to embrace it to bring about positive change.

Andy went on to remind the SGC that individual teams now also need to go on to develop their iMatter Action Plans by mid August.

The Chair congratulated NHSB on achieving a 57% response rate, stating that within

local government nothing like this level of engagement is achieved. Edwina Cameron confirmed that our colleagues within Health & Social Care had a response rate of 49% which was the highest they have ever achieved.

Lynne Livesey made comment that engagement in similar surveys within the sector she comes from is usually much higher, but noted the survey was normally open much longer and there had been more opportunity to promote it across management structures. Lynne stated that she would be interested in more detail around participation to understand if this was from an even spread across areas or whether there has been significant non-engagement from areas, such as digitally excluded groups of the staff population. Lynne also expressed an interest around the level of deterioration in several areas and asked if this was mirrored across Scotland. Lynne went on to support the notion to address iMatter in more detail sooner than the next scheduled SGC meeting in October.

Andy referenced a report to the Board and SGC last year with comparisons to the national average in performance and stated that this analysis for this year's iMatter had not yet been done. Andy noted that the smaller organisations, under one roof, tended to have much higher performance levels, whereas more dispersed workforces see lower levels, such as bed-holding directorates which might only have one computer on the ward and therefore less engagement due to the staff's inability to get access to a computer and were not inclined to complete the iMatter questionnaire in their own time.

Andy agreed to try and drive-up participation levels and to look at iMatter in more detail sooner rather than later.

Edwina Cameron explained that the national report had not yet been released and that there were still health boards running their iMatter, stating we could expect a national report around the end of September 2024. Edwina went on to note that there was a degree of confidentiality within iMatter, in that we cannot see individual team results but that we could see into directorates; stating there was variation across directorates and particular concern around our Estates and Facilities, referring to potential digital exclusion. In relation to this Edwina confirmed that paper copies of the iMatter questionnaire had been provided for teams to encourage completion, although the Scottish Government was not keen for us to continue using paper copies. An area of suggested focus was around the use of SMS, noting this works very well with our Carers and the Scottish Borders Council; and offered the SGC a level of assurance around addressing digital exclusion, to come up with some solutions.

Karen Hamilton pointed out that a lot of Board development sessions were around finance and agreed that a development session for the SGC around iMatter would be a good starting point and agreed that it would be clearer once we have seen some further data, to understand the pressures on the organisation in terms of how staff are feeling.

Edwina Cameron sought clarification from the SGC that they were looking for a single-item meeting with a development session around iMatter in mid-September 2024. This was agreed with the proviso of an extension of the invitation to non-

executives as well, in line with regulations.

In terms of iMatter Action Plans, Edwina explained that this is done at team level and encouraged Directors to engage with their own directorates.

The SGC was asked to note this update.

ACTIONS:

- *Circulate National iMatter Report to SGC membership (once published – August / September 2024) –* ***Andy Carter / Edwina Cameron***
- *Arrange a single-item SGC meeting with a development session around iMatter in mid-September 2024 –* ***Edwina Cameron / Josie Gray***

10. FOR NOTING

10.1 Temporary pause for Staff Governance Monitoring

Andy Carter informed the SGC that there had been a temporary pause in staff governance monitoring by the Scottish Government, explaining there had been a bit of an exchange between HR Directors and the Scottish Government around the expectation for boards to carry out this monitoring process annually and highlighting the amount of effort this takes, with no feedback being received by boards from the Scottish Government for a long time, therefore no added value; and on this basis the Scottish Government have agreed to a temporary pause.

The SGC was asked to note this update.

10.2 APPROVED Occupational Health & Safety (OHS) Forum Minutes – 11th March 2024

Andy Carter referred the SGC to the shared minutes on the agenda pack expressing that this had been a vibrant meeting touching on points such as: Reinforced Autoclave Concrete and related inspections of NHSB localities; and the quality of our water supply etcetera.

The SGC was asked to note this update.

10.3 APPROVED Training Education & Development (TED) Board Minutes – 25th April 2024

Andy Carter referred the SGC to the shared minutes on the agenda pack explaining that this meeting focused on a range of things around the Education Policy, expenses for training, and around Statutory & Mandatory Training compliance. Andy exclaimed that the TED Board was now gaining traction on some issues and commended Michelle O'Reilly's performance in relation to this to the SGC.

The SGC was asked to note this update.

10.4 DRAFT Area Partnership Forum (APF) Minutes – 26th April 2024

Andy Carter referred the SGC to the shared minutes on the agenda pack and noted these are going to the APF tomorrow for final sign-off.

The SGC was asked to note this update.

10.5 DRAFT Area Partnership Forum (APF) Annual Report 2023-24

Andy Carter referred the SGC to the shared report on the agenda pack and noted it is going to the APF tomorrow for final sign-off.

Andy stated that this report had inevitably picked up on the RWW for the AfC side of the workforce; Protected Learning Time, noting NHSB have just received some frequently asked questions in relation to this from the Scottish Government around how staff will be afforded time to do their learning and noted this will be closely monitored; and the Band 5 Nursing Review, noting there is a national portal and matching process created for staff to enjoy some uplift for time in which they had performed at a higher level.

The SGC was asked to note this update.

11. Any Other Competent Business

No other competent business was raised.

Date of the next meeting

The Chair confirmed that the next Staff Governance Committee meeting was scheduled for Thursday 31st October 2024 from 13:00-15:00 via Microsoft Teams.

The Chair also reminded the SGC of the aforementioned agreed single-item agenda meeting and development session around iMatter, for SGC members and non-executives, planned for mid-September 2024.

The Chair thanked those in attendance for their contributions and closed the meeting.

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 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 1 October 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 25.06.24

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 25 June- 13:00 – 14:00
Via Microsoft Teams

Present: Kevin Buchan (Chair), Rachel Mollart, Philip Grieve, Martin O;Dwyer, Caroline Thompson, Gerhard Laker, Nicky Hall\,

In Attendance: Meeting recorded to be transcribed thereafter.

1. APOLOGIES and ANNOUNCEMENTS
Caroline Cochrane

2. Draft Minute of previous ACF – April 2024
Approved as correct record

Action Tracker
Kevin email Sohail and Rebecca Devine and also discussed at AMC. Rachel as chair of AMC will write to Sohail and Rebecca. Pending Scottish Government Guidelines

3. Clinical Governance Committee

Kevin provided an update as noted below:

- Sickness absence remains high – health visiting and district nursing.
- Review of primary care nursing skill mix.
- Philip Grieve intimated red rag status sickness absence for 6 months delivering only partial pathways. Eildon Nursing – 40% sickness absence to secondment to hospital at home – both decided to return to substantive posts. This combined with large proportion of people going into BGH managing insulin/diabetes and coming out unable to manage has impact on district nurses.
- DN and HV review – looking at realigning responsibilities to ensure specialist nurses providing more specialist.
- How ACF feed into the Board: Position of independent contractor status into Clinical Governance. Laura Jones, Fiona Sandford and Kevin Buchan to look at how feed in. ACF should be voice into Board.
- Coming Home Programme – complex learning difficulties – repatriation ongoing. CAMHS achieved HEAT target – good news. People in between CAMHS and lower level care 2 – risk to the Board of people not being seen – significant amount of underserved young people not having needs met – perhaps ACF voice into Clinical Governance.
- Promotional death at home: Moving away from medical model to national model to allow people to pass away at home.

4. **Non Exec Input to ACF**

Kevin spoke with Ralph Roberts and Karen Hamilton regarding how interact with both the Board and Clinical Governance and how we don't use role of ACF currently to inform Board. It was noted that the Chair and CE were keen to discuss this further and formalise a process

Action: Agreed email conversation regarding how write to Board around expectations and highlighted the need to have formalised decision making process.

Following the above, Paul Williams referred to an example, in Health & Social Care partnership discussions around FIP and savings and discussion around clinical prioritisation and what this should look like and how this would be a great example of what should come to ACF as the Clinical voice to the Board in particular decisions around clinical risks. It was noted that previously during covid there had been a Clinical Prioritisation Group established

5. **National ACF Chairs Meeting**

No update provided. Kevin will endeavour to locate minutes and circulate to ACF members in due course.

6. **Annual Review: Non Ministerial**

August 22nd. Looking for attendees and key themes for discussion. Themes previously:

- Patient safety
- Effective Clinical Governance
- Health & Equalities
- Realistic and value based medicine
- Health innovation
- Work force planning
- Influence cohort of NHS Board

Rachel Mollart confirmed she would be able to attend and referred to NHS public/private interface under patient safety heading.

Kevin was reflective of last year's discussion and where we are currently. He highlighted the need for open and honest conversations to be had with the Board. In addition, it was further noted how it was difficult for clinicians to make decisions around financial cuts. Good opportunity to highlight areas of good work e.g. preventative work in primary care, mental health etc. Patient safety issues – bring some examples of issues on the ground.

Following a query from Nicky Hall regarding the IJB and it's role – it was noted that NHS contribution to the IJB fell short of around £8m and IJB cannot have a deficit. The challenges faced by IJB were noted.

7. **NHS Board Papers**

All to look at papers before Thursday and feedback any comments to Kevin Buchan

8. **Professional Advisory Committees:**

Area Dental Advisory Committee (ADC)

Gerhard Laker provided an update as below:

- New NHS Remuneration system introduced in November working well
- Dental – (Community and hospital) - Staff shortages across board. Waiting lists to reduce theatre time etc.
- NHS Borders Oral Health Improvement Plan – awaiting implementation
- Recruitment & retention including dental nurses, managers etc – difficult issue

Area Medical Committee (AMC) & GP Sub Group

Rachel Mollart provided an update as below:

- Public/Private NHS treatment
- GP Role Document – now agreed. Has gone to GP Committee National Conference as well as being sponsored by Medical Director, Lynn McCallum as a good piece of work. Would be helpful for other IC groups be made aware of this document. Rachel agreed to circulate document for wider dissemination as other areas may wish to pick this up.
- Clinical Interface Group: Aware of recent example of issue between optician and GP – need to share problem
- P&CS looking at launching OPAL escalation process – to help identify when services are at red, amber, green and identifying escalation processes to ensure patient and clinicians safe.

Area Ophthalmic Committee (AOC)

Nicky Hall provided an update as noted below:

- Next meeting tonight.
- Reference to GP document: Rachel happy to attend any Committee meeting/or provide any narrative to assist.
- AOC slightly different as part health care and part retail

Area Health Professionals (AHPs)

Paul Williams provided an update as follows:-

- AHP Professional Advisory Forum slightly changed. Relaunched approach – not only people in recognised leadership roles, opened up to wider staff groups including health and social care staff. First two meetings very positive – genuine enthusiasm from staff. Next step how to put some things into practice – some smaller pieces of work e.g. some small level clinical projects and some larger pieces of strategic work e.g.work around frailty and prevention.
- Staffing workforce issue – Healthcare staffing act – how demonstrating – working from an AHP perspective. Can bring more information to next meeting.

Area Pharmaceutical Committee (APC)

Martin O'Dwyer provided an update as follows:

- Workforce issues – Llyods – most now changed hands – bedding in process still ongoing – better received by public.
- Supply chain under pressure – lots of medicines not easy to provide alternatives e.g. ADHD medicines – constantly juggling which brands are available, types of insulin are two
- No contract framework – level of uncertainty
- Pharmacy First working well – Pharmacists able to prescribe - increasing number of PGDs
- Minor ailments service now pharmacy first working well
- Morale still quite low. National picture v UK picture – number of pharmacies closing concerning

Professional Nursing & Midwifery Leadership Council (PN&MLC)

Philip Grieve provided an update as follows:

- Safer staffing legislation – HIS asking for Q3 return
- Implementing Reduced working week – proving a challenge – P&CS, Acute and Mental Health all submitted papers to OPG separately identifying decifit of WTE over 3 year period which will manifest itself. SG provided funding – NHS B received an allocation of that funding.
- Nursing & Midwifery Council progressed and agreed have a local nursing midwifery and AHP Strategy. Will be led and worked on jointly through Paul's professional forum and Nursing forum
- Good news story: Lynsey Russell received National Nurse of Year Award. Rachel Gardiner team lead LD also received an award.
- Will speak to John Fyfe – regarding associated risk with people who have been liberated from prison. To ensure reviewed/refreshed to ensure clinicians not placed under significant risk. Philip will also raise this issue for GP group.

Medical Science Update:

Caroline Thompson had to leave meeting early

Psychology

Caroline Cochrane returning to work soon. Will be good to welcome her back

NHS Borders feedback to Board

Any feedback please inform Kevin who will feed back.

9. **Any Other Competent Business**

None

10. **Date of Next Meeting**
1 October 2024

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**British Sign Language (BSL) Plan 2024 to 2030**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti, Director of Public Health**
Report Author:	**Sarah Downie, Health Improvement Practitioner (Public Health) in partnership with Sylvia Mendham, Senior Business Services Officer (Scottish Borders Council)**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Attendees at this meeting are being asked to approve the Scottish Borders BSL Plan, which was approved by SBC in June 2024. NHS Borders has a legal duty as a Public Service to publish a BSL Plan as per the BSL (Scotland) Act 2015. This is the first NHS Borders BSL Plan.

2.2 Background

The BSL (Scotland) Act 2015 requires public bodies in Scotland to publish plans every 6 years, demonstrating how they will promote and support BSL.

The BSL (Scotland) Act 2015 aims to:

1. Promote awareness and use of BSL
2. Improve access to services for Deaf and Deaf- blind people

This BSL Action Plan was put together to support the BSL National Plan, published on 6th November 2023. The BSL Plan 2024 - 2030 will have six key priorities. These priorities are consistent with the ten long term goals of the National BSL Plan in Scotland. These are: education (family support, early learning & childcare, school education, post school education); training; work and social security; health care (including social care); mental health and wellbeing; transport; culture and arts; justice and democracy.

These goals represent the Scottish Government's current aim, "To embed BSL further in other relevant government policies, plan & strategies". This document outlines the joint Scottish Borders BSL Plan to ensure that people whose first or preferred language is BSL are empowered to exercise their rights in accessing Public Services they need and that staff are fully responsive to their needs. Thus, help "to make Scotland the best place in the world for BSL users to live, work, visit & learn".

NHS Borders and SBC will work in partnership to:

1. Consider establishing a BSL Action Plan Group for 2024 to 2030 with the help of the Deaf Community, Council, NHS Borders, See Hear Group, who will act as a reference group to monitor and review the actions laid out within the plan
2. Continue to be supported by the BDA, Helen Morgans-Wenhold, BSL Equality and Inclusion Officer – Local Authorities, The See & Hear Group and the South of Scotland Deaf Children's Society
3. Review the plan in light of the Scottish Government's National Plan and the Inclusive Communication regulation proposal, due to be implemented in 2025.

2.3 Assessment

This is NHS Borders' first BSL Plan designed to meet the needs of the local BSL community by working in partnership with the community themselves and partner organisation across the Scottish Borders. If the Plan is not published, the risk to the organisation is reputational damage/loss of trust and a failure in NHS Borders' legal duty as per the BSL (Scotland) Act 2015.

The evidence base used to inform the priorities and actions considered with the BSL Plan is the consultations and meetings with the local BSL community as well as taking the lead from the National BSL Plan as approved by the Scottish Government. In the Scottish Borders, the key priories were a lack of local interpreters, education (especially in the early years) and transport (lack of information in BSL).

2.3.1 Quality/ Patient Care

The BSL Plan aims to have a positive impact for members of the local BSL community accessing services. Where needs are met, this allows for open communication and better health outcomes. There are also likely to be improvements in quality of care by continuing to work in partnership with SBC who provide support for BSL users in the community through the Sensory Services Team.

2.3.2 Workforce

The key action for NHS Borders is to investigate options for a system where BSL users accessing services are 'flagged' as 'potentially requiring an interpreter'. This would prevent a BSL users arriving for an appointment only to find an interpreter has not been booked and then having to wait for another appointment which could delay treatment. The suggestion made at the consultation was to have a pop-up on TrakCare where the colleague sending out the appointment letter would be reminded to check whether an interpreter was needed. There would also be scope to add information about Contact Scotland BSL to the pop-up message on TrakCare to avoid communication issues. This would require colleagues from Medical Records to link in with SBC Sensory Services Team who hold the patient information for every BSL user in the Scottish Borders.

Staff health and wellbeing should not be negatively affected by the BSL Plan however it is recognised that learning something new can be great for wellbeing. It is not feasible to train every NHS Borders staff member BSL however a suggestion at the consultation was that all Public Services staff could learn how to introduce themselves. Another suggestion made at the consultation was to have Deaf Awareness included in the Mandatory Learning Equality and Diversity module which should also include information about Contact Scotland BSL. This would require a review and update of the current module.

2.3.3 Financial

There is potential for the interpreting/translation budget to be utilised more, however this can be managed by asking the Service User for their preferred option for communication. Where reasonably practical, Contact Scotland BSL (Video Relay System) could be used to replace a face-to-face appointment to allow for an interpreter to be present on screen if an in-person interpreter was not available. This is not ideal due to the 3D nature of BSL however is free at point of use.

2.3.4 Risk Assessment/Management

Greatest risk to NHS Borders is reputational damage caused by a failure to meet the organisation's legal duty by not having a BSL Plan in place. This is mitigated by approving the BSL Plan, following through on agreed actions and working in partnership across the Scottish Borders to improve access to BSL for all.

2.3.5 Equality and Diversity, including health inequalities

The BSL Plan supports the Public Sector Equality Duty, Fairest Scotland Duty and the Board's Equalities Outcomes by being proportionate and relevant and meeting the needs of the local BSL community. The BSL Plan, in part, aims to address the health inequalities experienced by the local BSL community, primarily linked to accessing Public Services in BSL.

An Equalities and Human Rights Impact Assessment is in progress. Stage 1 is attached as an appendix. Stages 2 and 3 are nearing completion.

From the Stage 2 consultations, we have learned that if we achieve greater access to fully trained and registered interpreters when required, more Public Services

information readily available in BSL and grow our own local BSL user community (both deaf and hearing users) by working in partnership with organisations across the Scottish Borders, then we will meet the equalities-focussed concerns raised by our local BSL community.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

"Working together in partnership with SBC [and partner organisations across the Scottish Borders], we share the responsibility to ensure that BSL users and the deaf community have the same, and equal, opportunities as their hearing peers." [Dr Sohail Bhatti, Director of Public Health – Foreword to the BSL Plan]

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate:

NHS Borders and Scottish Borders Council held four face-to-face consultations throughout January to April 2024. These consultations have shaped the proposed actions contained in this current plan. NHS Borders and Scottish Borders Council carried out an online consultation in May 2024. BSL interpreters were present at every in-person meeting and a video link with BSL interpretation of the plan was available alongside the online consultation.

Meetings:

- Local BSL Community and Partner Organisations, 16 January 2024
- Local BSL Community and Partner Organisations, 4 March 2024
- Local BSL Community and Partner Organisations, 6 March 2024
- Local BSL Community and Partner Organisations, 13 April 2024
- See Hear Group, April 2024
- Local BSL Community and Partner Organisations, 4 September 2024 (equalities and human rights focus with Contact Scotland BSL in attendance)

In partnership with, the Council and NHS Borders, we will continue to engage with the Deaf Community developing, reviewing and monitoring the action plan and we will continue working with stakeholders to:

1. Ensure BSL users are able to access the services they need;
2. Implement the actions proposed;
3. Provide updates on progress and
4. Evaluate what is working and develop further actions when required.

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.

- Scottish Borders Council Executive Committee, 27 June 2024 – supported the BSL Plan with positive feedback

2.4 Recommendation

- **Decision** – Reaching a conclusion after the consideration of options.

The Board is asked to **approve** the plan.

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 1, British Sign Language Plan 2024-2030
- Appendix 1, BSL Equalities and Human Rights Impact Assessment Stage 1

SCOTTISH BORDERS COUNCIL &
NHS BORDERS:

British Sign Language (BSL) Plan 2024 to 2030

NHS Borders

Scottish Borders COUNCIL

CONTENTS

FOREWORD BY SCOTTISH BORDERS COUNCIL'S CHAMPION FOR THE DEAF COMMUNITY

I am honoured to be asked to present the Scottish Borders Council British Sign Language 2024 –2030, a joint plan between Scottish Borders Council and NHS Borders.

BSL is an amazing and an incredibly visually expressive language and I am really lucky that I can sign albeit slowly and carefully nowadays.

I can hear and use sound communication devices with ease. People whose first language is BSL cannot, but they have the same rights to services, participation, support, and engagement that those of us who have hearing do.

This is Scottish Borders Council's refreshed plan and NHS Borders first plan is to ensure that BSL users are able to live, work and play in their communities.

I want to extend my thanks to every single person who participated in the consultation process to formulate the refreshed plan and look forward to this being a live document we all refer to regularly and measure the improvements against.

Cllr. Elaine Thornton-Nicol
Scottish Borders Council's Champion for the Deaf Community
3rd June 2024

FOREWORD BY NHS BORDERS DIRECTOR OF PUBLIC HEALTH - DR SOHAIL BHATTI

I am pleased to present the Scottish Borders BSL Plan 2024-2030, a joint plan between NHS Borders and the Scottish Borders Council.

As the NHS Borders Director of Public Health, my role, and the role of the Public Health Directorate, is to promote good health, prevent poor health and proactively work towards closing the Health Inequalities gap here in the Scottish Borders. Our THISBorders Health Inequalities Strategic Plan has recently been published. NHS Borders also has a legal duty and responsibility in terms of protecting Equality and Diversity.

This British Sign Language Plan aims to ensure that our BSL users, and the deaf community, who live and work in the Scottish Borders are able to fully access information and services in their first language and fully participate in every aspect of their lives across the life stages as is their Human Right.

Working together in partnership with Scottish Borders Council, we share the responsibility to ensure that BSL users and the deaf community have the same, and equal, opportunities as their hearing peers.

Dr Sohail Bhatti
NHS Borders Director of Public Health
17th June 2024

INTRODUCTION TO SCOTTISH BORDERS COUNCIL'S AND NHS BORDERS BRITISH SIGN LANGUAGE (BSL) PLAN 2024-25

The Scottish Government wants to make Scotland the best place in the world for (British Sign Language) BSL users to live, learn, work and visit. This means that people whose first or preferred language is BSL will be fully involved in daily and public life in Scotland, as active, healthy citizens, and will be able to make informed choices about every aspect of their lives.

The BSL (Scotland) Act 2015 requires public bodies in Scotland to publish plans every six years, showing how they will promote and support BSL. This is the first BSL Local Plan for Scottish Borders Council (SBC) developed in co-ordination with NHS Borders, Borders College and the local BSL community.

Throughout the plan, we refer to 'BSL users. This covers all people whose first or preferred language is BSL, including those who receive the language in a tactile[1] form due to sight loss.

BSL is a language in its own right, with its own grammar, syntax, and vocabulary. It has its own dialects and rich variation. Most importantly, it is a language which enables many of our D/deaf (D - people born deaf, d - those who become deaf) and Deafblind citizens to learn, work, parent, be creative, live life to the full, and to make their contribution to our communities, our culture and our economy.

This plan follows on from the Council's previous BSL Plan, covering the period 2018 to 2024. The current BSL Plan has been put together in conjunction with NHS Borders and contains the actions that Scottish Borders Council and NHS Borders will take between 2024 and 2030 to comply with the BSL (Scotland) Act 2015.

A BSL version of the Scottish Borders Council BSL Plan can be found on the Council's website.
The Council & NHS Borders BSL Plan 2024 to 2030

Key Contact for Scottish Borders Council' & NHS Borders BSL Plan are:

- Sarah Downie, NHS Borders & Sylvia Mendham, Scottish Borders Council
- Public Health Email (PublicHealth@borders.scot.nhs.uk)
- Scottish Borders Council: smendham@scotborders.gov.uk
- Public Health Telephone number (01896 825 560) & Scottish Borders Council (01835 824000)

British Sign Language (BSL) users can contact us via contactSCOTLAND-BSL

Contact Scotland BSL

[1]**Tactile BSL** is used by those whose first and preferred language is BSL. It has its own BSL grammatical structure, syntax, lexicon, vocabulary, and emanates from the BSL community, for use by those BSL users who can no longer see and have to adapt to using tactile means.

DEVELOPMENT OF SCOTTISH BORDERS COUNCIL'S AND NHS BORDERS BRITISH SIGN LANGUAGE (BSL) PLAN 2024-25

The Scottish Government published the second British Sign Language (BSL) National Plan 2023-2029 in November 2023, as a requirement of the British Sign Language (Scotland) Act 2015. Scottish Borders Council, like other public bodies specifically NHS Borders and Borders College are required to produce a BSL Plan 2024-2030 by May 2024. These plans must:

- Involve BSL users (including those who use the tactile form of the language) and those who represent them.
- Ensure that the consultation on the draft plan is accessible to D/deaf and Deafblind BSL users; and
- Be published in BSL as well as in English in both draft forms, and in final form.

The legislation says that BSL plans should 'try to achieve consistency' with the BSL National Plan 2023 to 2024.

According to the 2011 Census, the Scottish Borders had 228 people aged 3 and over that identified that BSL was a language used at home.

Given that the BSL community in the Scottish Borders is very small, the three local public bodies (Scottish Borders Council, NHS Borders, and Borders College) agreed to have joint approach to BSL Plan development.

To help develop of the local plans with the BSL community in the Scottish Borders there a number of briefings held so that the BSL community and other interested parties could contribute to the BSL Plan, and these are as follows:

- Tuesday 16th January 2024, the purpose of the meeting was to review the first draft of the BSL plan. The meeting was attended by representatives (adults and young people) from the Deaf Community, British Deaf Association (Scotland), Councillor Thornton Nichol, Education representatives, Police Scotland, staff from Scottish Borders Council and NHS Borders.

- Monday 4th March 2024, the purpose of this meeting was to concentrate of the actions in regard to Education and Transport. The meeting was attended by representatives of the Deaf Community, Scottish Borders Council, NHS Borders, and British Deaf Association (Scotland). Wednesday 6th March 2024 Saturday 13th April 2024.

- Wednesday 6th March 2024, a joint meeting with Borders College, Scottish Borders Council and NHS Borders. This meeting was open to anyone who wished to be involved.

- Saturday 13th April 2024 Scottish Borders Council and NHS Borders held an open event in Eyemouth, so that people unable to attend the previous events due to work, were afforded an opportunity to contribute on the Council's and NHS Borders BSL plan.

- Consultation with the See Hear Group, who are comprised of representatives of the Scottish Borders community planning partnership and people with sensory impairment (primarily those that are deaf / hearing impaired and blind / partially sighted).

  Support from the BDA (British Deaf Association – Scotland) was made to ensure SBC's & NHS Borders BSL plan was consistent with the plans from other Councils and following guidance from the Scottish Government.

- There was also a full public link to consultation for the Local BSL Plans that ran between 14 May 2024 and 27 May 2024. There were 19 respondents to the consultation all of which were positive to the proposed actions of SBC, and NHS Borders.

NATIONAL BRITISH SIGN LANGUAGE (BSL) PLAN

The actions within Scottish Borders Council & NHS Borders BSL plan support the 10 long-term goals in the National BSL Plan, and these are:

Symbol	Goal Name	Goal Description
	**Across all our services**	Across the Scottish public sector, information and services will be accessible to BSL users.
	**Family Support, Early Learning and Childcare**	The Getting it Right for Every Child (GIRFEC) approach will be fully embedded, with a D/deaf or Deafblind child and their family offered the right information and support at the right time to engage with BSL
	**School Education**	Children and young people who use BSL will get the support they need at all stages of their learning, so that they can reach their full potential; parents who use BSL will have the same opportunities as other parents to be fully involved in their child's education; and more pupils will be able to learn BSL at school
	**Post-School Education**	BSL users will be able to maximise their potential at school, will be supported to transition to post-school education if they wish to do so, and will receive the support they need to do well in their chosen subject(s)
	**Training, Work and Social Security**	BSL users will be supported to develop the skills they need to become valued members of the Scottish workforce, so that they can fulfil their potential, and improve Scotland's economic performance. They will be provided with support to enable them to progress in their chosen career
	**Health (including social care), Mental Health and Wellbeing**	BSL users will have access to the information and services they need to live active, healthy lives, and to make informed choices at every stage of their lives
	**Transport**	BSL users will have safe, fair, and inclusive access to public transport and the systems that support all transport use in Scotland
	**Culture and the Arts**	BSL users will have full access to the cultural life of Scotland, an equal opportunity to enjoy and contribute to culture and the arts, and are encouraged to share BSL and Deaf Culture with the people of Scotland
	**Justice**	BSL users will have fair and equal access to the civil, criminal, and juvenile justice systems in Scotland
	**Democracy**	BSL users will be fully involved in democratic and public life in Scotland, as active and informed citizens, as voters, as elected politicians and as board members of our public bodies

SCOTTISH BORDERS COUNCIL AND NHS BORDERS BRITISH SIGN LANGUAGE (BSL) PLAN 2024-2030

SBC British Sign Language (BSL) Plan 2024 -2030 has ten actions which are consistent with the ten long term goals of the National BSL plan. These actions were identified for Scottish Borders Council and NHS Borders following consultation with the BSL community, Borders College, British Deaf Association (Scotland), the Scottish Borders See Hear group, Scottish Borders Council departments, Live Borders, and the public.

The actions in the Scottish Borders Council and NHS Borders British Sign Language (BSL) Plan 2024-2030 focus on embedding BSL within its approach to customer services, communication, and training. The actions are listed in the table below.

Across Our Services

Action	Comment
1. Delivering the BSL National Plan – 2023 to 2029 the Council and NHS Borders will: • Ensure records hold accurate information about BSL Users. • BSL Users can engage with services in the manner they choose (interpreter, Contact Scotland, written format etc). • Ensure that staff of the Council and NHS Borders are afforded opportunities to train in BSL awareness (this includes training in basic BSL).	Improving information about who uses BSL in Scotland.
2.1 BSL Accessibility – improving access to, and the use of BSL by Scottish Borders Council & NHS Borders **2.2 To continue to engage with the Deaf Community throughout the duration of the BSL Plan** **2.3 Consider setting up a working group to monitor the BSL plan during 2024 to 2030**	To review BSL videos on the Council website Improving access to, and use of, BSL by Scottish public services. Contact ScotlandBSL British Sign Language (BSL) | NHS inform Addressing the shortage of BSL interpreters and other professionals in Scotland Currently through HA Sensory Team requires 3 weeks' notice (min)

Action	Comment
3.1. To raise awareness of BSL as part of the 1 + 2 package and support schools wishing to include this as part of their curriculum. **3.2 Promote and support learning in BSL across schools/ELC in the Scottish Borders** **3.3 Consideration of nominating a BSL lead in schools, to work with BSL user to promote BSL learning in schools.** **3.4 To look at compiling a list of Deaf BSL users who would like to be Deaf role models for Deaf children & young people. To help them become more confident in having BSL identity and having access to BSL culture.** **3.5 Work in partnership with Borders College to look at options for further qualifications in BSL for staff and students.** **3.6 Consideration towards making deaf awareness training mandatory.** **3.7 Consider working with other agencies in the Scottish Borders to provide BSL/ Deaf awareness classes.**	Children and Young People & their families. In relation to BSL from our Teachers of the Deaf Service we offer an Introductory Session to BSL 1+2 languages. Support for deaf children and their families learning BSL in the early years. Gap identified for under 5. Contact Scotland Accessing social care and wellbeing services in BSL.GIRFEC
4. Access to employment Support BSL Users in the workplace/access work grant to provide Interpreters, adaptations to ensure their health & wellbeing.	ATW grant – Focus on CYP GIRFEC No one left behind. To make any job opportunities service accessible in BSL so Deaf BSL users could feel confident to apply. Consider staff training in BSL to mentor a Deaf BSL user
5. Health & Wellbeing. Appropriate support to access relevant services – apps available – Contact Scotland	Key – communication NHS Borders will improve identification of when an interpreter is to be booked ahead of an appointment so appropriate provision can be made. There are a range of options available to BSL users in accessing services, e.g., an interpreter, Contact Scotland, written format, etc. Depending on BSL Users preferred method of communication.

Action	Comment
6. Celebrating BSL Culture – supporting access to culture and promoting Deaf heritage	Promoting Deaf heritage and culture in BSL. Grants to deaf clubs?
7. BSL Data – That data on BSL users is used to inform statutory services to provide services - (with consent) Continue to collect feedback and information from Deaf BSL users via face-to-face engagement as part of Data collection.	
8. Transport- support access for BSL users to access transportation they require - – to work in partnership with other agencies to share resources to make transport more accessible to people and young people when they require it.	Accessibility to information in BSL- sign in real time proposed (so people know when bus is due) – look at text alerts /other options for young people when services are cancelled.
9. Access to justice – provision of interpreters/ translation into BSL for anyone BSL user requiring access – Police app	As above
10. Democratic participation – Support to vote, information in BSL format.	As above

CONCLUSION

The Scottish Borders Council & NHS Borders British Sign Language (BSL) Plan 2024-2030 will be implemented and monitored by the Resilient Communities & Human Resources Directorates. It is important to note that the Scottish Borders Council & NHS Borders BSL Plan 2024-2030 has been developed with the help of the Scottish Borders Deaf Community, with a focus on children and young people, to encourage the take up of BSL within schools & College. To encourage young people to celebrate their culture and most importantly so that BSL users' access to the services they need.

The local See Hear Strategy Group and the Deaf Community will continue to act as a reference group for the BSL Plan and implementation.

Scottish Borders Council & NHS Borders will contribute to the national progress report in 2025.

Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 1 Proportionality and Relevance

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Scottish Borders Council and NHS Borders British Sign Language Action Plan

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (clients, customers, people using services, employees) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity Neurological Condition	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
x	x		x		x	x	x	x

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (highlight those that apply)

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings Occupational segregation Forced Labour and trafficking*	Poverty Housing Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health* Palliative and end of life care*	Conditions of detention Hate crime, homicides and sexual/domestic abuse Criminal civil justice Restorative justice Reintegration, resettlement and rehabilitation*	Political and civic participation and representation Access to services Privacy and surveillance Social and community cohesion* Family Life*

*Supplementary indicators

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
The Scottish Borders Council and NHS Borders BSL Action Plan aims to improve opportunities and outcomes for people whose first or preferred language is BSL. This plan will commit to improving access to key information and services in BSL to ensure that our Deaf/Deaf-blind BSL Users have the same access to opportunities as their hearing peers.	Positive impact	Significant
Protected characteristics and associated Human Rights (Adults and Children) will be significantly and positively impacted by the Scottish Borders Council and NHS Borders BSL Plan as follows:	Positive impact	Significant
Age: all ages are given equal opportunity to learn BSL, especially young people and older adults who are adversely affected by the lack of BSL tutors in the Scottish Borders	Positive impact	Significant
Disability: the correct interpretation/translation requirements of people with sensory impairments and other disabilities are met by Public Services to ensure full communication and access to services; people with a disability have equal opportunity to learn BSL	Positive impact	Significant
Sexual Orientation/Gender Reassignment: LGBTQIA+ community have confidence that BSL interpreters are suitably trained	Positive impact	Significant

Pregnancy and Maternity: the correct interpretation/translation requirements of people accessing pregnancy and maternity are met by Public Services to ensure full communication and access to pregnancy and maternity information	Positive impact	Significant
Race: the correct interpretation/translation requirements of people who use non-BSL Sign Languages are met by Public Services to ensure full communication and access to services	Positive impact	Significant
Religion and Belief (including non-belief): people from all religious and beliefs have confidence that BSL interpreters are suitably trained	Positive impact	Significant

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes
E&HRIA to be undertaken and submitted with the report – Yes	**Proportionality & Relevance Assessment undertaken by:** **Sarah Downie** **Date: 10.06.2024**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**NHS Borders Performance Scorecard October 2024**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Authors:	**Carol Graham, Planning & Performance Officer** **Matthew Mallin, BI Developer**

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 October 2024 against the targets from the 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 ADP.

In July 2024, a new approach to quarterly monitoring of progress against plans for 2024/25 was issued by Scottish Government to Health Boards. Boards were requested to share a copy of their own local Delivery Plan progress or performance report which they present to their own Board to inform them on progress on delivery against their plans. The intention is that this will provide assurance around delivery in a way which ensures that the Scottish Government is receiving information consistent with that received by the Board itself, whilst also reducing workload and duplication of reporting. In light of this request, it has been proposed that we will submit a copy of this performance report to Scottish Government on a quarterly basis throughout 2024/25. We submitted our quarter 2 report to Scottish Government on Monday 11 November 2024.

2.3 Assessment

Index	New Outpatient (NOP)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	31/10/2024	109	0	0	0	0
2	Over 78 Weeks	31/10/2024	360	300	260	220	200
3	Over 52 Weeks	31/10/2024	1739	1411	1230	1019	850
4	Total List Size	31/10/2024	12018	10115	9450	8810	8310

Index	Inpatient/Day Case (TTG)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	31/10/2024	42	10	10	5	5
2	Over 78 Weeks	31/10/2024	160	250	229	210	200
3	Over 52 Weeks	31/10/2024	433	645	617	595	575
4	Total List Size	31/10/2024	2638	3165	3240	3330	3310

Trajectories for Delivering Unscheduled Care Targets

Index	Emergency Access	Current Month	Current Performance	30/08/2024	30/09/2024	31/10/2024
1	Emergency Access Standard	October 2024	60.00%	63.00%	64.50%	67.40%

Index	Delayed Discharges	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Delayed Discharges Actual	11/11/2024	82	69	50	46	0
2	Additions	11/11/2024	19	16	16	16	0
3	Removals	11/11/2024	19	21	16	16	0

As outlined above, we are not meeting some of the trajectories. A narrative providing further detail can be found within the scorecard where available updates have been added. To clearly demonstrate where we are achieving or under achieving on standards, a summary of met targets for Planned Care and Delayed Discharge has been included within the scorecard.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 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 provided by the relevant service area and collated by the Planning & Performance Team.

2.4 Recommendation

- **Awareness** – To note Board performance as at the end of October 2024.

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 31 October 2024

Month 7

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.

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 July 2024, a new approach to quarterly monitoring of progress against plans for 2024/25 was issued by Scottish Government to Health Boards. Boards were requested to share a copy of their own local Delivery Plan progress or performance report which they present to their own Board to inform them on progress on delivery against their plans. The intention is that this will provide assurance around delivery in a way which ensures that the Scottish Government is receiving information consistent with that received by the Board itself, whilst also reducing workload and duplication of reporting. In light of this request, it has been proposed that we will submit a copy of this performance report to Scottish Government on a quarterly basis throughout 2024/25.

Performance is measured against a set trajectory or standard. To enable current performance to be judged, colour coding is being used to show whether the trajectory is being achieved. A tolerance of 10% is applied to the standards to enable them to be given a RAG status. For standards where the trajectory is 0, the tolerance level is 1, anything higher the RAG status is red (for example waiting times and delayed discharges).

Current Performance on Annual Delivery Plan (ADP) Targets

Index	New Outpatient (NOP)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	31/10/2024	109	0	0	0	0
2	Over 78 Weeks	31/10/2024	360	300	260	220	200
3	Over 52 Weeks	31/10/2024	1739	1411	1230	1019	850
4	Total List Size	31/10/2024	12018	10115	9450	8810	8310

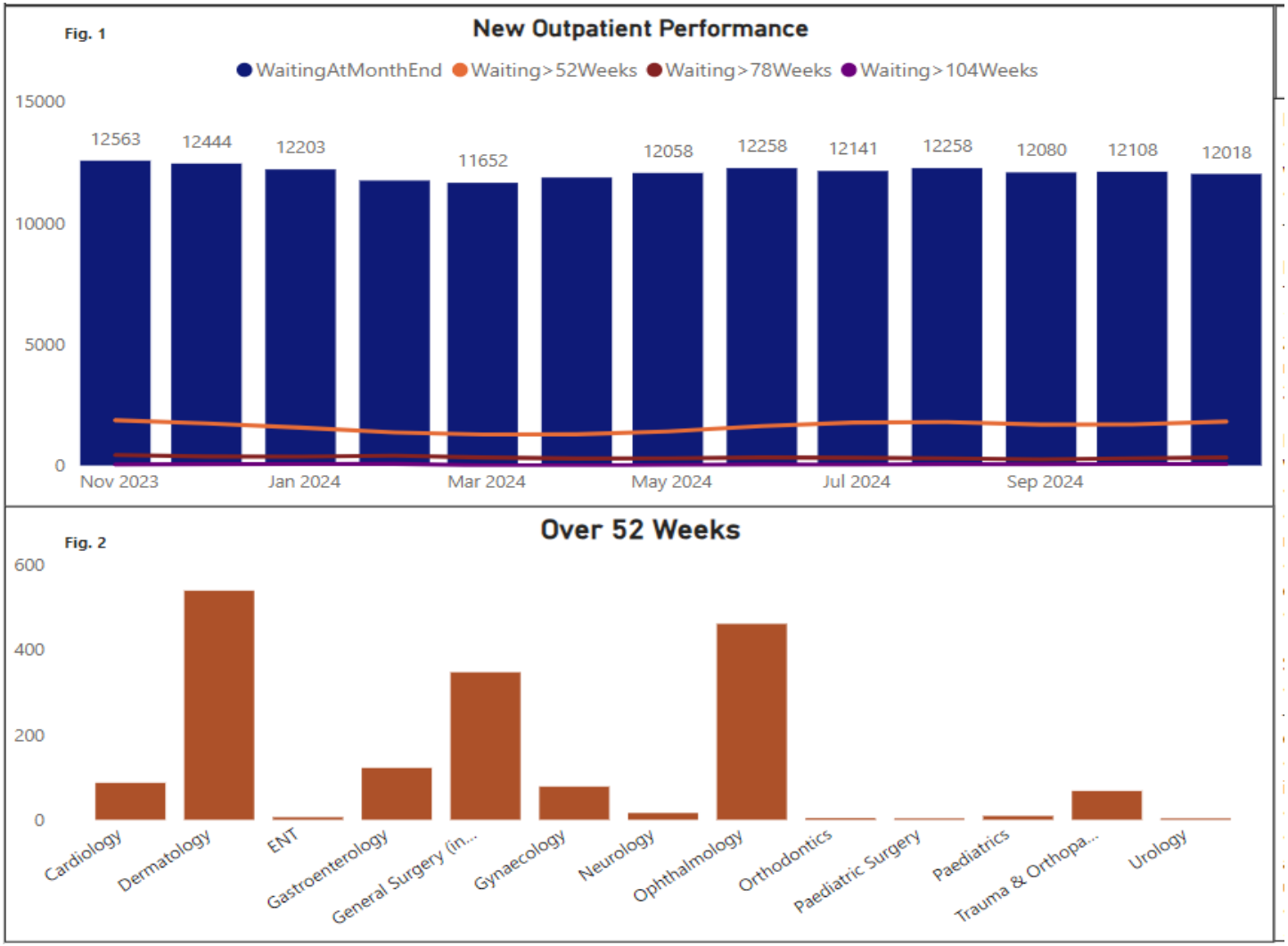
Index	Inpatient/Day Case (TTG)	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Over 104 Weeks	31/10/2024	42	10	10	5	5
2	Over 78 Weeks	31/10/2024	160	250	229	210	200
3	Over 52 Weeks	31/10/2024	433	645	617	595	575
4	Total List Size	31/10/2024	2638	3165	3240	3330	3310

Trajectories for Delivering Unscheduled Care Targets

Index	Emergency Access	Current Month	Current Performance	30/08/2024	30/09/2024	31/10/2024
1	Emergency Access Standard	October 2024	60.00%	63.00%	64.50%	67.40%

Index	Delayed Discharges	Current Month	Current Performance	30/06/2024	30/09/2024	31/12/2024	31/03/2025
1	Delayed Discharges Actual	11/11/2024	82	69	50	46	0
2	Additions	11/11/2024	19	16	16	16	0
3	Removals	11/11/2024	19	21	16	16	0

Outpatients waiting times



Performance:

- The overall new outpatient waiting total list size remains broadly stable.
- We are seeing the number of patients waiting over 52 weeks trending upwards due to capacity issues in General Surgery, Ophthalmology, Gynaecology, and GI services. These are related to a combination of specific skills deficits for some routine procedures (vasectomies, minor skin lesions and eye operations), and ongoing vacancies despite recent attempts at recruitment.
- Activity levels overall are being maintained at levels at least consistent with those achieved last year, and during October activity showed an increase when compared to the same period 12 months ago.
- Capacity across all specialties is being challenged around the high volume of "urgent" referrals resulting in limited capacity to see the long waiting "routines". This is extending some absolute routine waits while total numbers waiting is the same.

There are 2 main issues contributing to the specialties with patients waiting over 52 weeks:

- As noted, a higher-than-expected number of referrals are being clinically prioritised to "urgent" with limited capacity therefore to see more routine waiting patients.
- Additionally, we have ongoing workforce issues and challenges in key services due to unfilled long-term vacancies. This is most apparent in Dermatology and Ophthalmology. The outcome of a recent recruitment process is awaited for a Consultant Orthodontist.

Plan for Q4:

- General Surgery – A National Elective Coordination Unit (NECU) campaign is being organised alongside a plan for additional vasectomy lists (longest waiting patients). We are planning for regular local vasectomy lists in New Year by retaining a specialty doctor to undertake this activity. Ophthalmology – We are planning for minor operation lists with the support of a locum; there is a skills deficit within the current workforce. The service has successfully secured approval to receive medical trainees for the first time and were allocated one trainee. However, due to accommodation issues in NHS Lothian, we have other trainees registered with the department who will be seeing long waiting patients and undertaking cataract surgery along with our consultants. These posts will provide additional activity. Another key piece of work the service is progressing, is reviewing the Glaucoma pathway. The new way of working will be introducing optometry-led and nurse-led clinics. This will release consultant time for "new" long waiting patients.
- Dermatology – NHS Borders has been approached by the Centre for Sustainable Delivery (CfSD) to pilot high volume image clinics. The delivery of first test of change is due in November. This Scottish Government funded campaign is focused on long waiting patients on the Dermatology waiting list, initially concentrating on lesions where the model has been successfully delivered in other areas. We await our allocation of resource which will include end of end pathway support (includes face to face review or surgery).
- Cardiology – additional capacity will be coming online during November and will be targeted to longer waiting routine patients.

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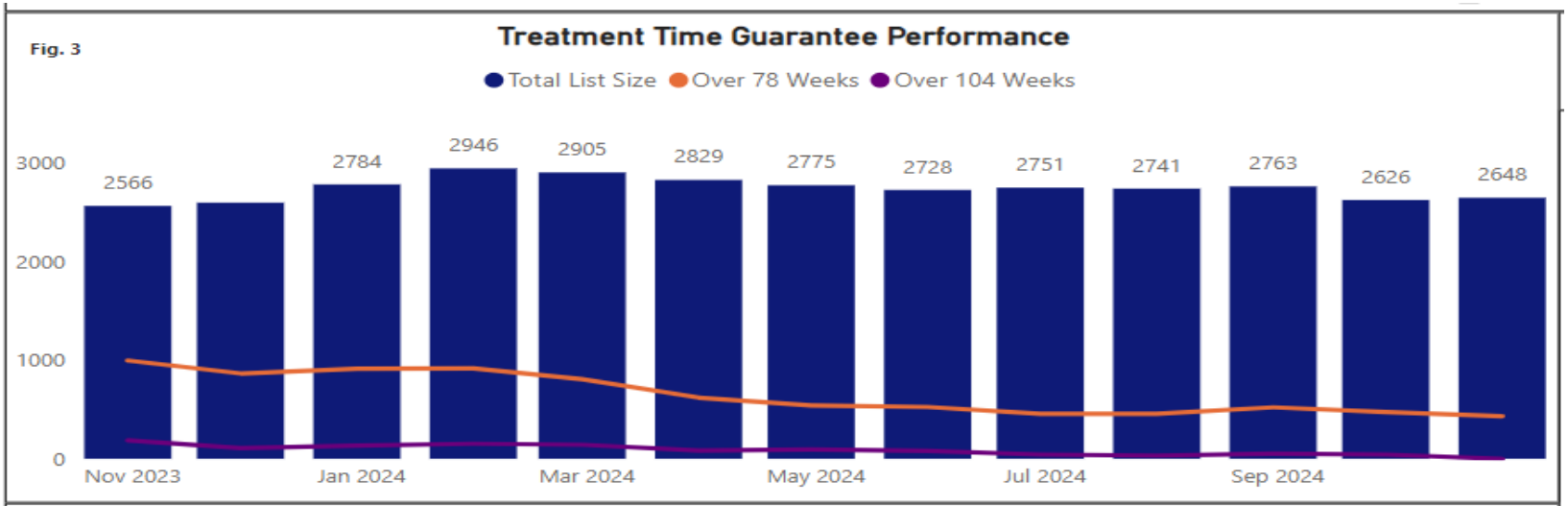
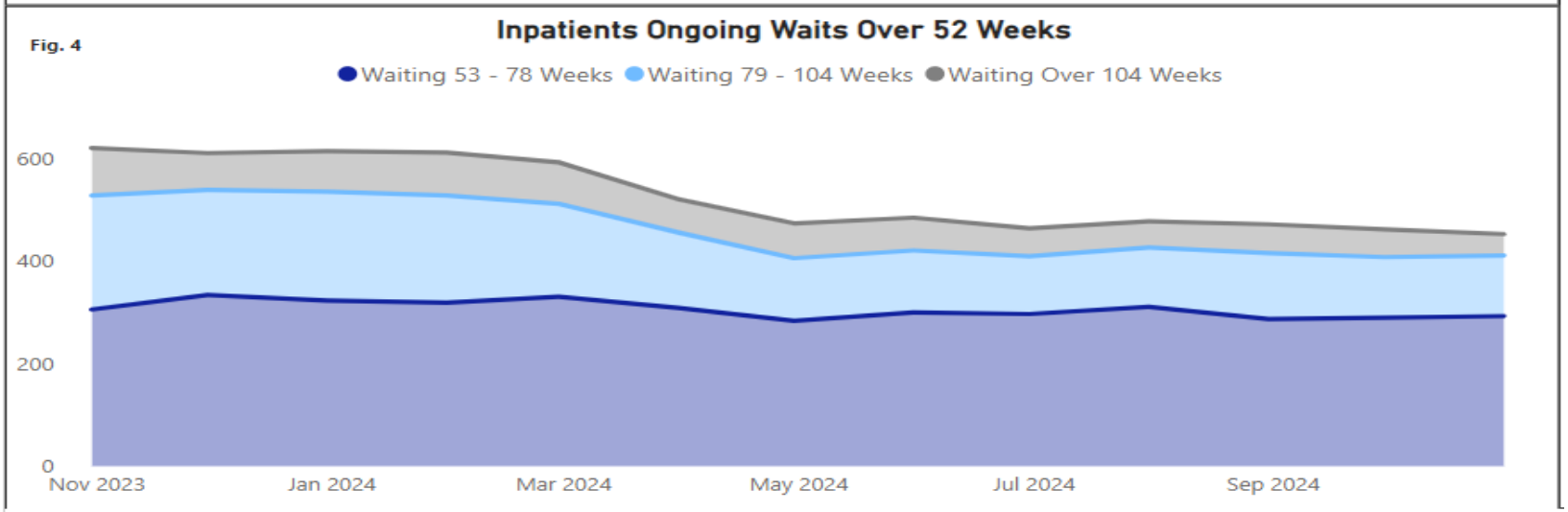
TTG Performance Against Trajectory- All Specialties





Performance:

What is the data telling us.

- The size of the Inpatient Waiting List increased by 22 patients compared to the previous month. Patients waiting over 104 weeks decreased by 12 from 54 patients to 42 and patients waiting over 52 weeks decreased by 9 from 462 to 453.

Why is this the case?

- Elective activity in October was relatively disappointing at 95% of 2023 levels. However, it is at 108% of 2023 levels when compared to the last 3 months and 105% compared to the last 6 months.
- Activity in October was impacted by 6 cancelled lists, down from 10 in September. All of these lists were in DPU (2 Ophthalmology lists due to no surgeon available and 4 Orthopaedic lists due to no recovery staff available to undertake GA lists)
- There was a 9.6% cancellation rate in October, which equates to 37 patient cancellations. These were for a variety of reasons, the top 3 being 'cancelled by patient' (8), 'Nursing Staff not available' (6) and 'Procedure no longer required' (5). This compared to a 9.4% cancellation rate in September, or 36 cancelled cases.

What is being done to improve performance?

- Maintaining the Elective Bay in Ward 9 is key to mitigating cancelled cases due to lack of In-Patient Ward beds. In October there were 37 Orthopaedic IPs who received surgery compared to 24 in August. It is important that continuous access is maintained for Elective patients to this bay over the Festive / Winter Period.
- A decision remains pending on the implementation of Infix in BGH which is expected to deliver a step change in efficiencies. Infix is a Theatre Scheduling Tool that is being rolled out across NHS Scotland and has been shown to deliver a 26% increase in theatre efficiencies.
- The Making Theatres Great project is currently turning focus towards Orthopaedic Surgery to deliver further improvements in theatre utilisation and reduce cancellations.

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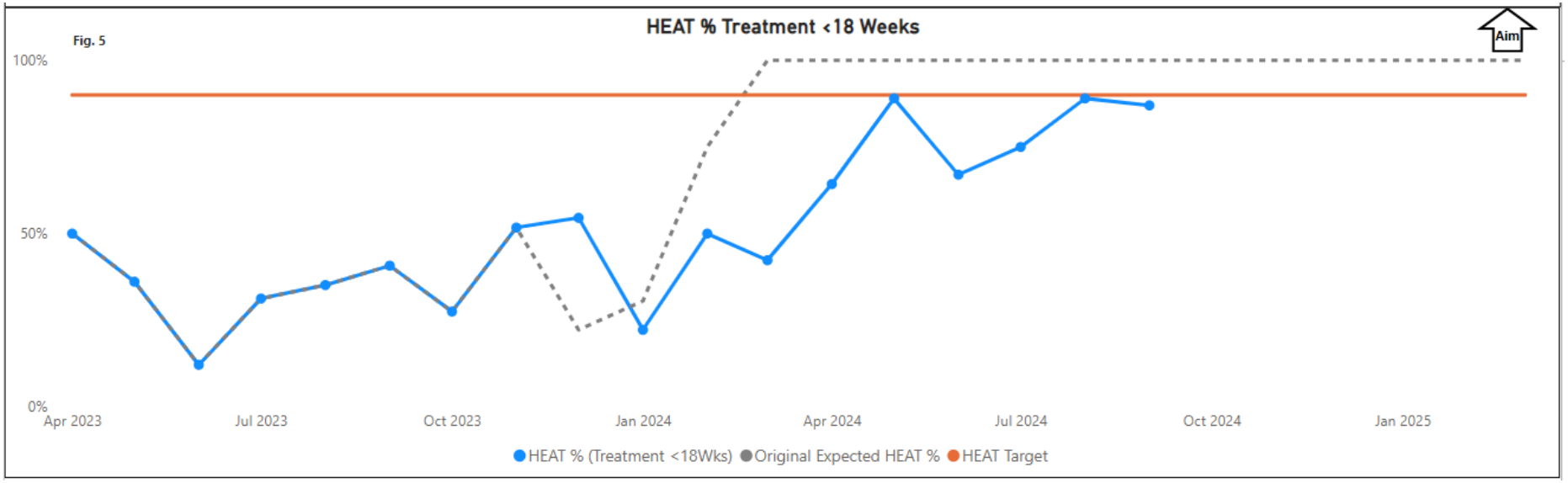
Mental Health Waiting Times – CAMHS



Achievement towards the CAMHS Treatment Trajectory

During September 2024, CAMHS achieved 100% HEAT Standard of patients being seen within 18 weeks from referral to first appointment.

We continue to see 12 new patient appointments per week and urgent/emergency appointments out with these. Now that we are meeting the LDP (HEAT Standard) the referrals and number of treatments are being weighted in favour of 90% Category 1 and 10% Category 2 due to the increase in the number of Neurodevelopmental referrals. This is being monitored weekly to maintain the Heat Target for Category 2's.

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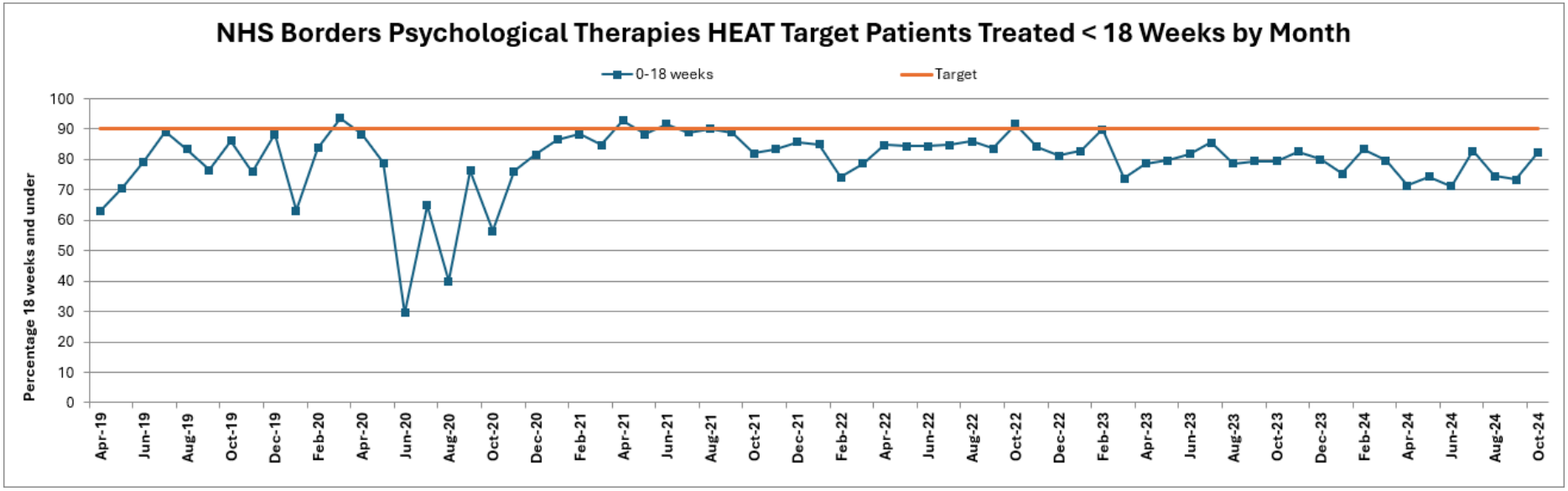
Mental Health Waiting Times- Psychological Therapies



What is the data telling us?

Performance against the LDP target is improving. In October 2024, we started treatment with 125 people, 103 within 18 weeks and 21 of whom had waited between 19-35 weeks. One person had waited 52 weeks but this was due to non-attendance of previous appointments. Our LDP performance this month means that in October 82.40% people started psychological therapy treatment within 18 weeks, which is an improvement from last month (73.5%).

In October 2024, we accepted 260 referrals – a slight increase from the previous month (256); We currently have 471 people on our waiting lists for psychological therapy, 90% of whom have been waiting under 18 weeks. 47 people are waiting over 18 weeks, with 4 people waiting between 36 and 52 weeks and no one is waiting over 52 weeks.

Why is this the case?

In some areas we have capacity gaps or waits for specialist treatment that can cause delays. In other areas we have had staff sickness or gaps where people have gone on maternity leave and we have been unable to backfill these posts, or where some have left the service where delays to recruitment have impacted on flow. In the past we utilised in year slippage for fixed term or locum posts to help with this but are unable to do so currently due to the financial situation, which does impact performance.

What is being done to improve performance?
We continue to closely monitor and work hard to reduce all waits, especially those over 18 weeks, but do expect some fluctuations in performance over the next 6-12 months.

We have started our service review where we will be looking at productivity and how we deliver our service to maximise our efficacy and ensure people have the right treatment as soon as possible. We do however anticipate that performance may fluctuate over the next year due to the pressures described above.

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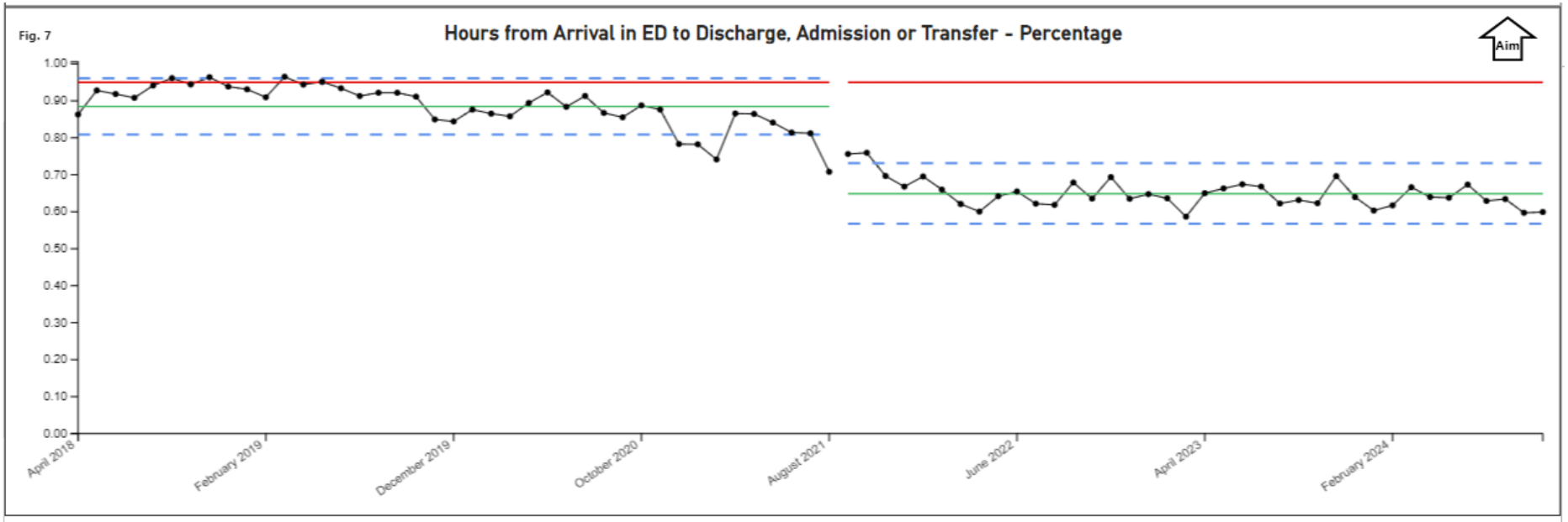
Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance



Note: December 2020 ED significant facility 32 MIU opened. EAS calculated on unplanned attendances only. The board is required to ensure that the maximum length of time from arrival at Accident & Emergency to admission, discharge or transfer is four hours for at least 95% of patients.

In October 2024 there were 2668 unplanned attendances to the Emergency Department (ED), with 1069 breaches. Performance against the standard was 59.93% vs. 59.87%% in September 2024. There remain significant challenges in delivering, safe, effective patient flow. The reasons behind this are long standing and historic.

The BGH continued to face significant pressures throughout October associated with attendances, acuity, and flow with additional surge open for patients waiting longer than 4hrs for an inpatient bed.

Following NHS Board approval for the ED Workforce Review, a programme of recruitment remains underway to implement the recommendations across Nursing and Medical workforce.

On 30th September the Acute Assessment Unit (AAU) went live, the unit is situated in the Borders Urgent Care Centre (BUCC).

Many patients arriving at the ED could be safely treated in a more appropriate environment, freeing up ED resources for those requiring the highest level of care. The goal is to improve patient safety, experience, and staff satisfaction by identifying patients referred from Primary Care who can safely follow this approach. It will also include urgent specialty cases where ED attendance or hospital admission can be avoided, or where a hospital discharge can be safely followed up with an urgent review.

This work is in its infancy reporting measures will track progress, helping us ensure positive changes and make real-time adjustments when needed. Data has shown that between 30th September and 31st October 111 patients avoided ED and we treated as part of the AAU approach.

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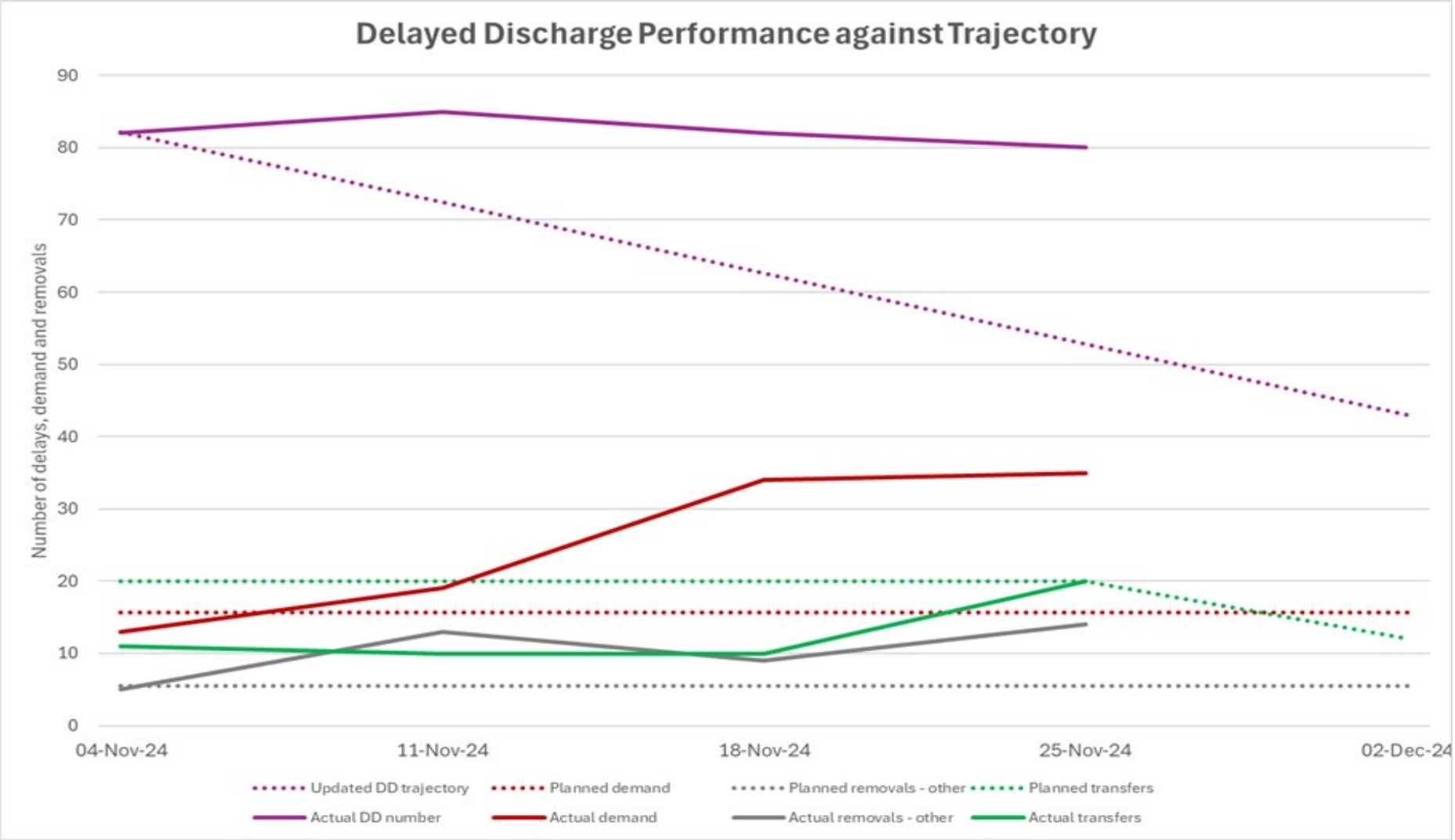
Delayed Discharge



Delayed Discharge Performance

Due to concerns about the number of people in the hospital system who were classified as delayed discharges and the harm that was coming to these individuals, at the end of October a new more challenging trajectory was set in order to reduce harm, and to provide enhanced resilience for other patients who required acute care over the winter period and for staff.

To support this new trajectory, staff in the BGH and across the HSCP have adopted an enhanced and intensive collective focus to reduce the harm in the system and the number of people who are classified as delayed discharges.

What is the data telling us?

What is the data telling us?
On Monday 25th November, 80 people delayed against the new trajectory of 53 by the 25th November.

Why is this the case?
Total demand for care from the hospital system based on previous levels of demand was 101 over the 4 week period and higher than the expected forecast over the period of 63 referrals to care.

Over the period, we required a total of 102 removals (80 transfers and 22 removals for other reasons) in order to deliver the trajectory based on the forecast demand of 63. There were 92 removals over the period (51 transfers and 41 removals for other reasons).

What is being done to improve performance?
Significant work is being undertaken by the Ready for Discharge Action Group which meets daily to review each person who is referred to care and who is delayed, and who work collectively to problem solve, reduce length of stay and expedite transfer arrangements.

Action cards have been developed to optimise and standardise processes for staff, with an Action card for the Ready for Discharge Action Group and Social Work assessment now being in place. Further action cards are being developed for:

- Adults with Incapacity
- Ward teams
- The choices policy
- Moving on policy

New dashboards and datasets have been created to track progress, identify trends and improve our planning approach in order to support improvements in performance.

As of Monday 25th October, 47 of the 80 people (59%) were delayed with their primary reason as being process (19 social work assessment, 15 adults with incapacity, and 13 choices / moving on policies).

33 of the 80 people were awaiting social care capacity (41%), with 13 awaiting residential care, 11 requiring extra care / specialist housing capacity, 5 awaiting homecare and 4 awaiting nursing care.

8 additional residential care beds have been created by converting underutilised capacity in St Ronan's and Saltgreens Care Homes, and these are now in the system.

The approach of collecting capacity information from residential, nursing care and care housing has improved with a new daily form that has been sent out by the Director of Health and Social Care to all 'bed based' care providers. The information returns are then completed by providers and shared with the Ready for Discharge Group to ensure that any capacity is allocated promptly. A daily sitrep is escalated from the group to the Director of Acute Services and Director of Health and Social Care. This is reviewed and acted upon and then shared with the Chief Executives of NHS Borders and the Scottish Borders Council for awareness on a daily basis. In addition, the Director of Acute Services and Director of Health and Social Care escalate when required for support from the Chief Executives.

The Medical Director, Director of Nursing Midwifery and AHPs, Associate Medical Directors, Associate Nurse Directors and Associate Director of AHPs have visited a number of wards and services to support staff with discharge process improvements, and identify opportunities.

There will continue to be a focus on delayed discharges, and we will extend this to focus on ward process, including strengthening ward MDTs and increasing the amount of time that ward charge nurses are supernumerary to support ward discharge planning, and enhance local quality and clinical governance.

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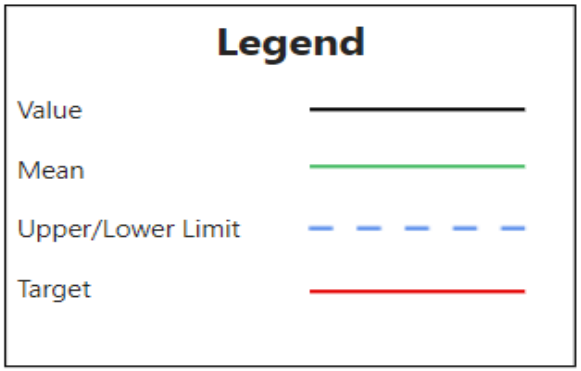
Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

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

Index	Measure	Target/Standard	Last Period	Last Position	Current Period	Current Position	Performance
1	Cancer Waiting Times - 62 Day Target	95% patients treated following urget referral with suspicion of cancer within 62 days	01 August 2024	76.00	01 September 2024	81.80	↑
2	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	01 August 2024	100.00	01 September 2024	100.00	→
3	New Outpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	30 September 2024	7,924.00	31 October 2024	7,993.00	↓
4	New Inpatients - Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	30 September 2024	1,761.00	31 October 2024	1,718.00	↑
5	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	30 September 2024	294.00	31 October 2024	158.00	↑
6	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	01 September 2024	60.20	01 October 2024	59.40	↓
7	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	01 August 2024	277.00	01 October 2024	394.00	↓
8	CAMHS - % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	01 August 2024	88.90	01 September 2024	87.50	↓
9	A&E 4 Hour Standard - % patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	01 September 2024	60.00	01 October 2024	60.00	→
10	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	30 September 2024	63.00	31 October 2024	69.00	↓
11	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	01 August 2024	74.60	01 September 2024	73.50	↓
12	Drug & Alcohol - % treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	01 June 2024	97.00	01 September 2024	99.00	↑
13	Sickness Absence Rates (%)	Maintain overall sickness absence rates below 4%	01 August 2024	5.62	01 September 2024	6.24	↓

Cancer Waiting Times

Fig. 10

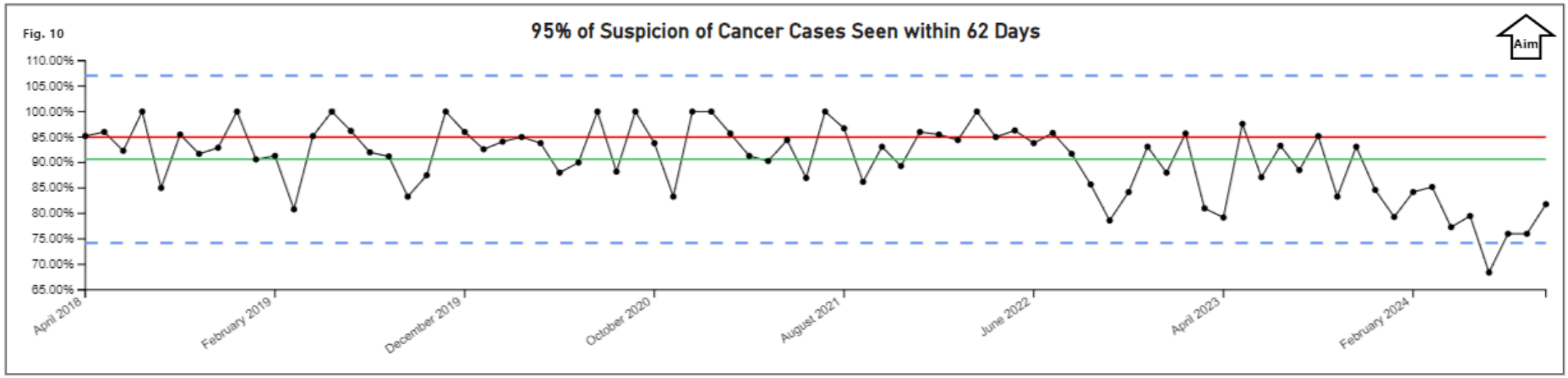
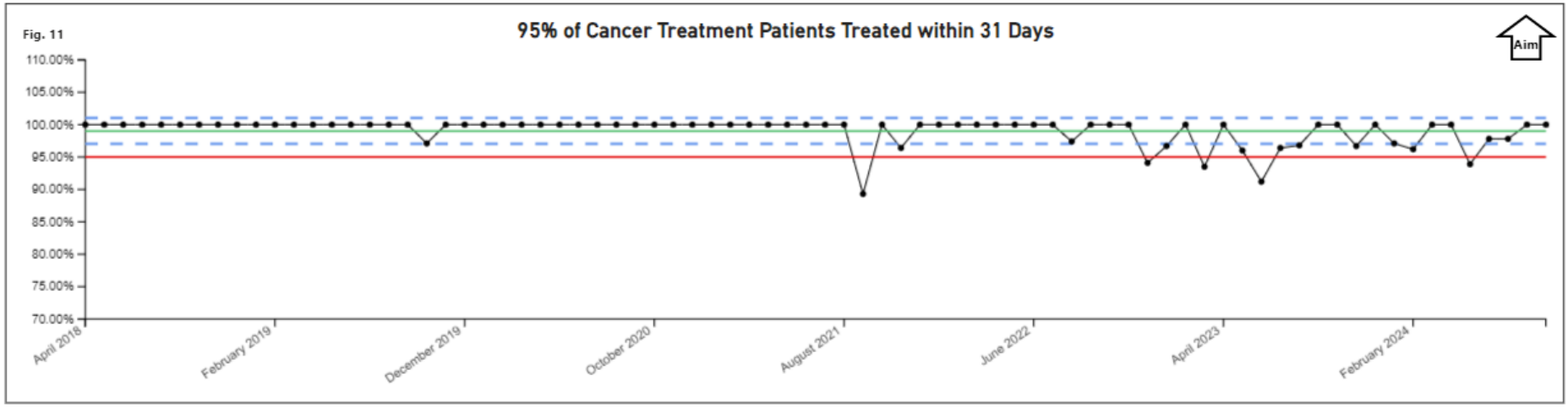
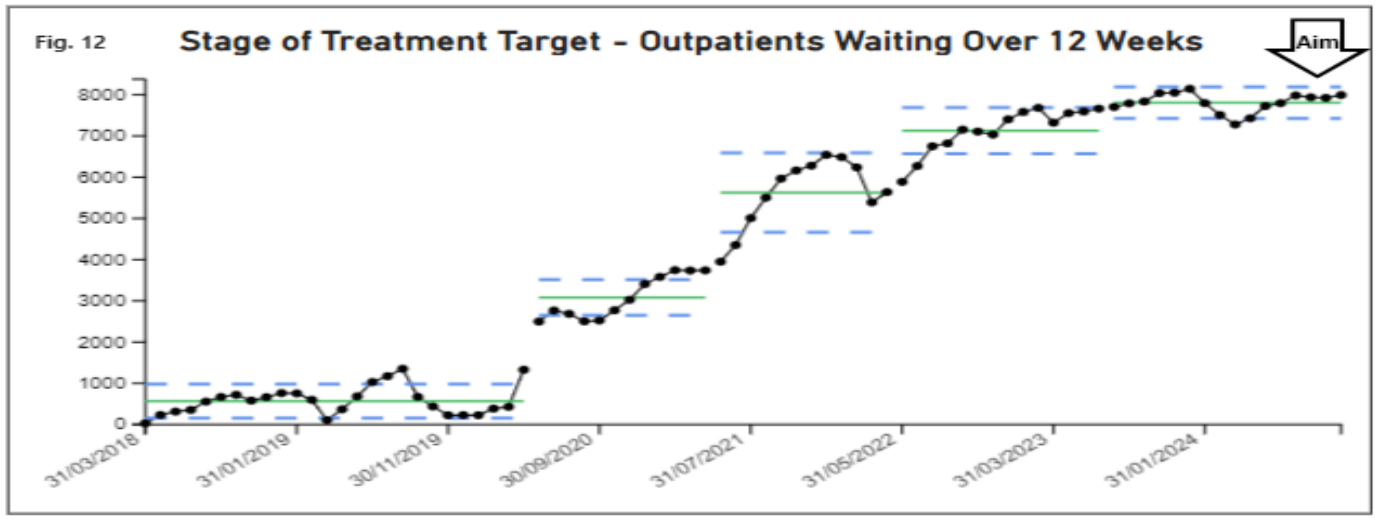


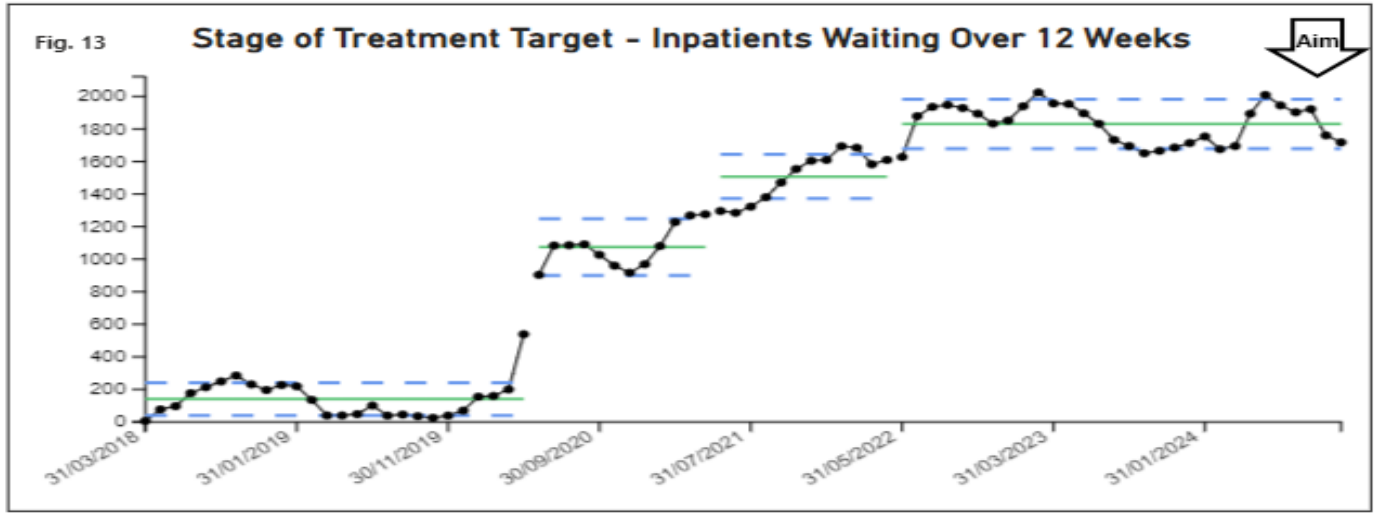
Fig. 11



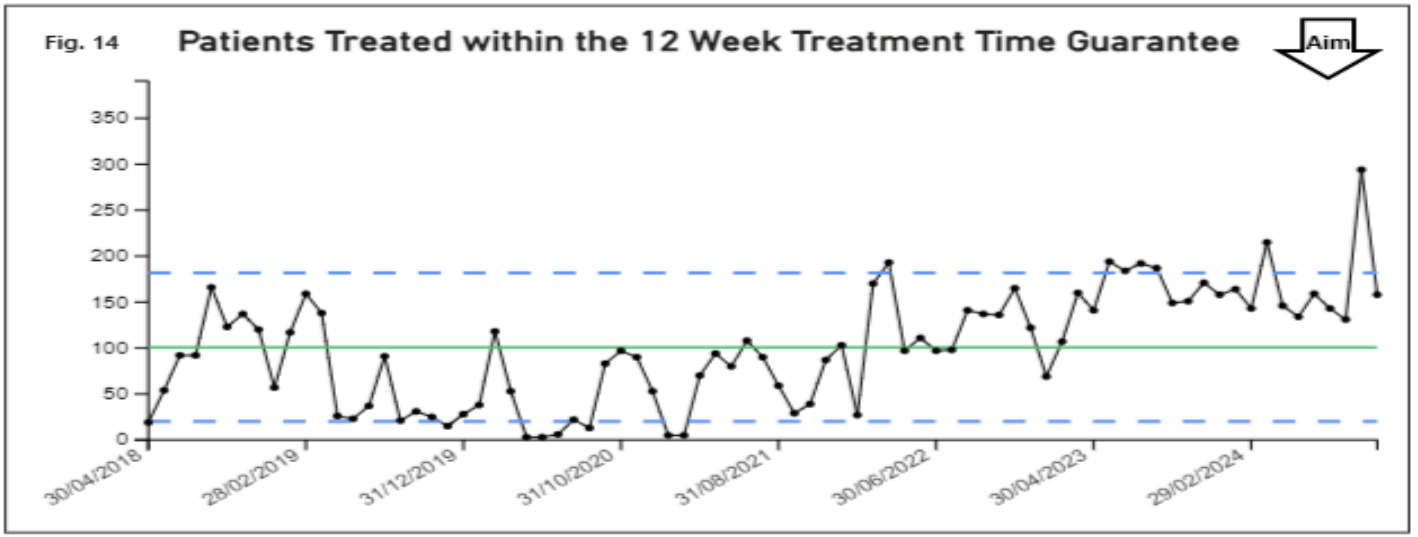
Please Note: There is a 1 month lag time for data.

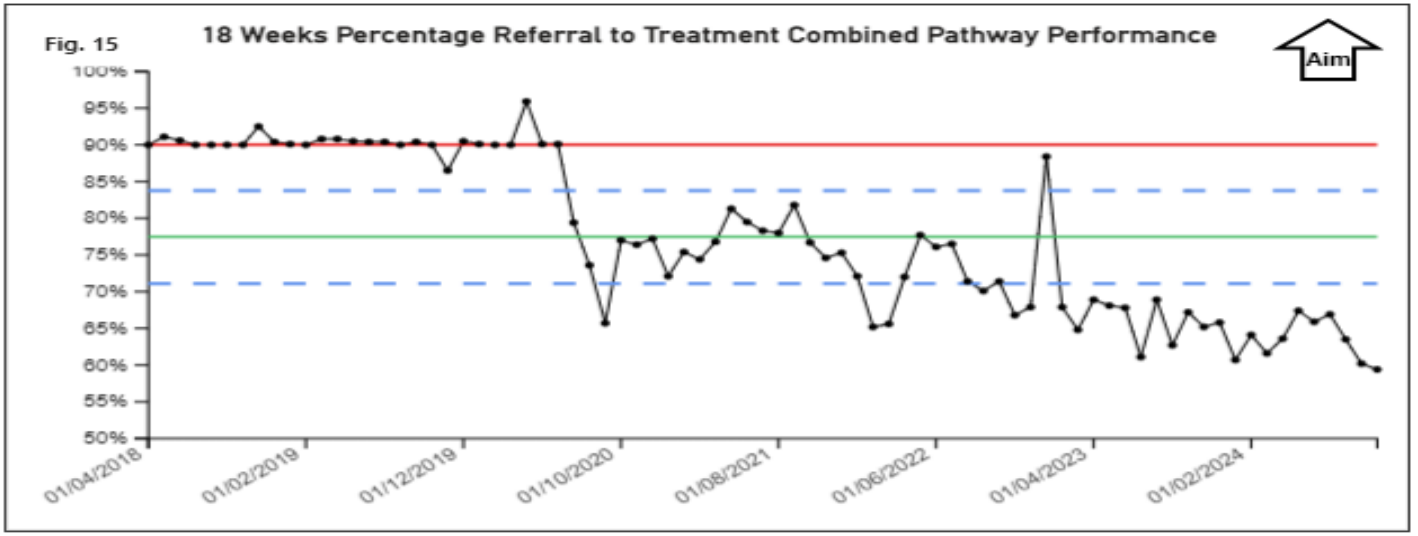
Stage of Treatment- Outpatients/Inpatients waiting over 12 weeks



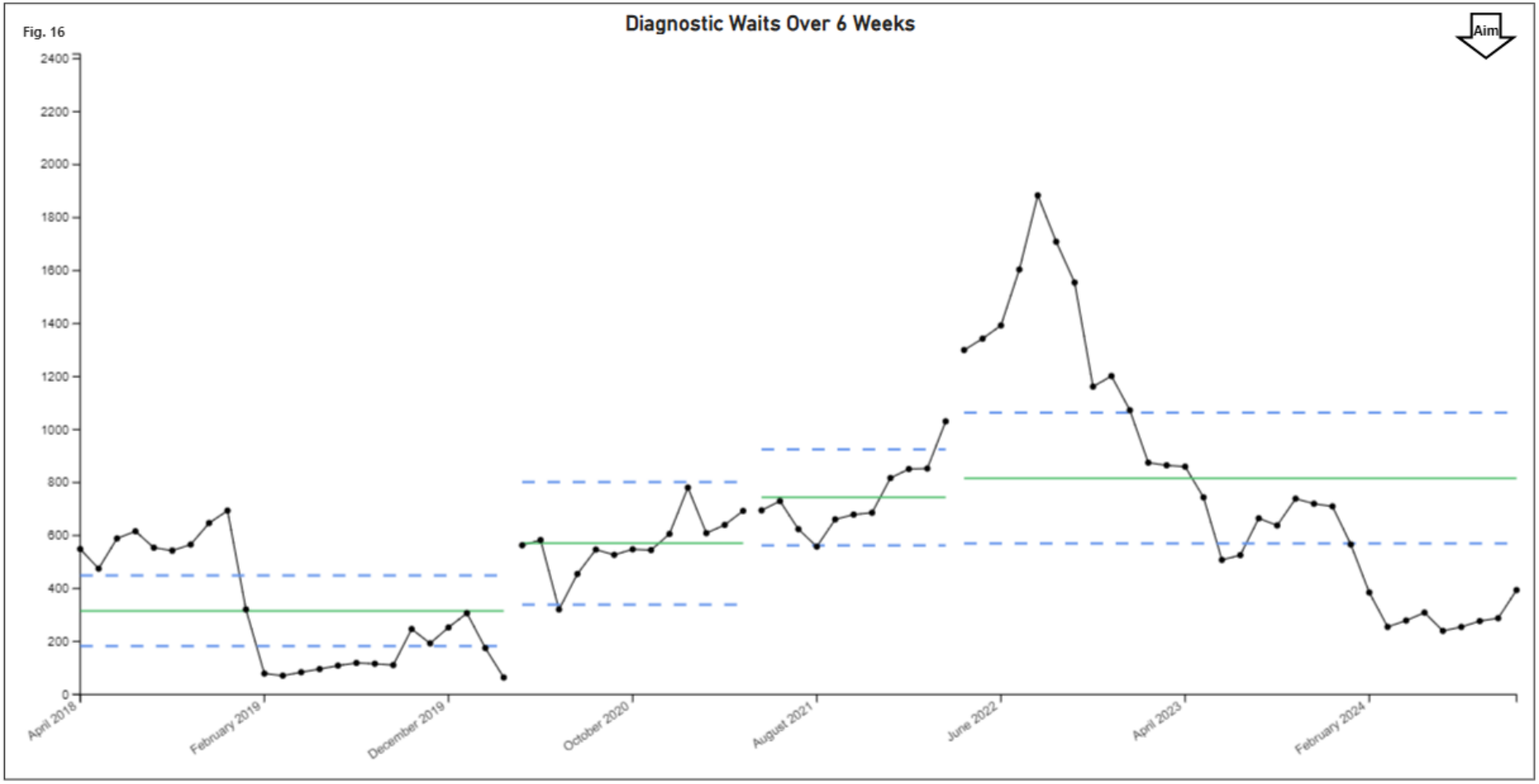


Treatment times

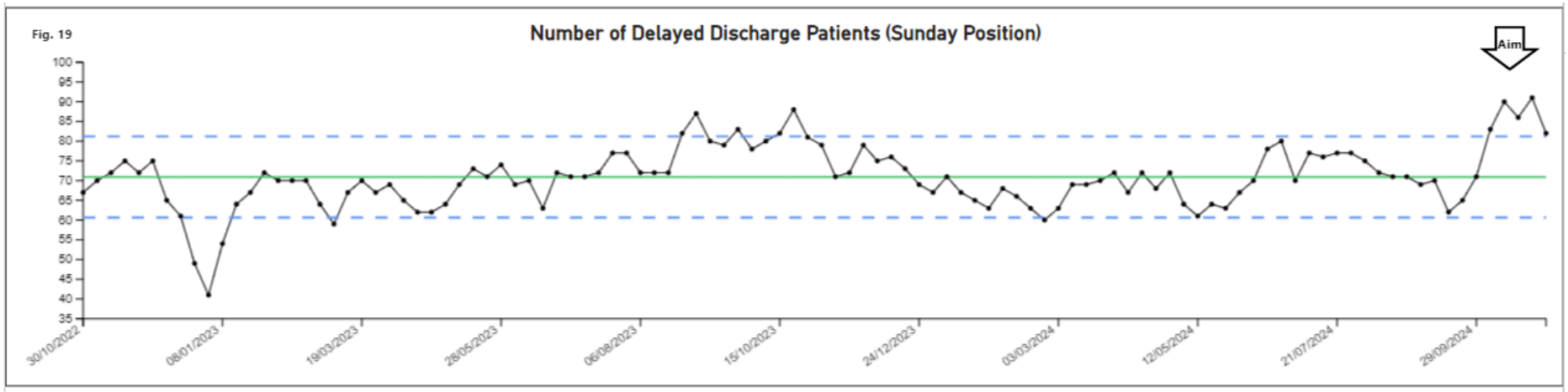


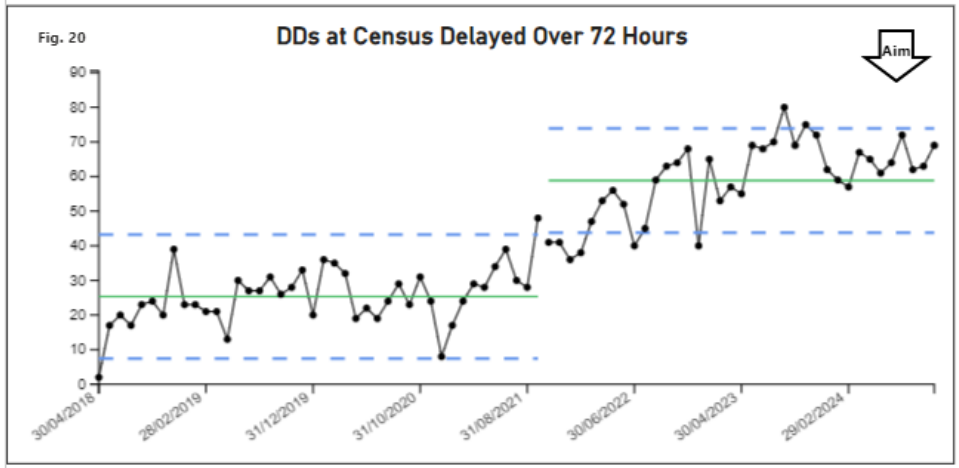


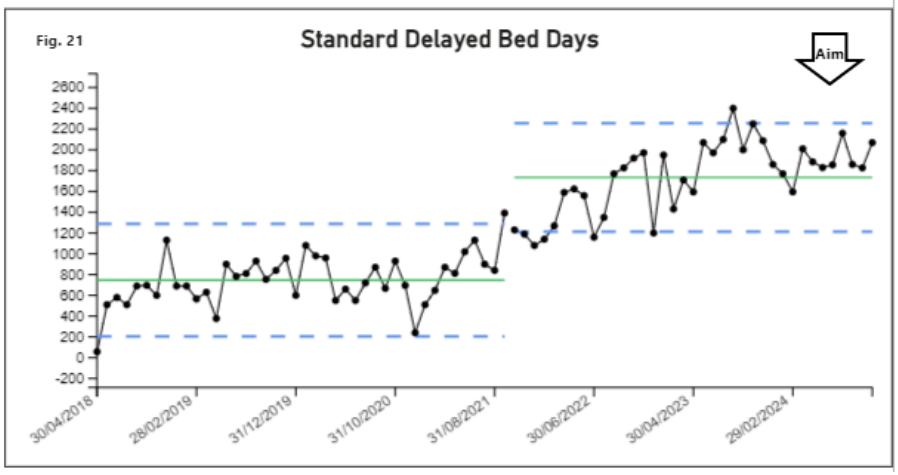
Diagnostic Waits



Delayed Discharges

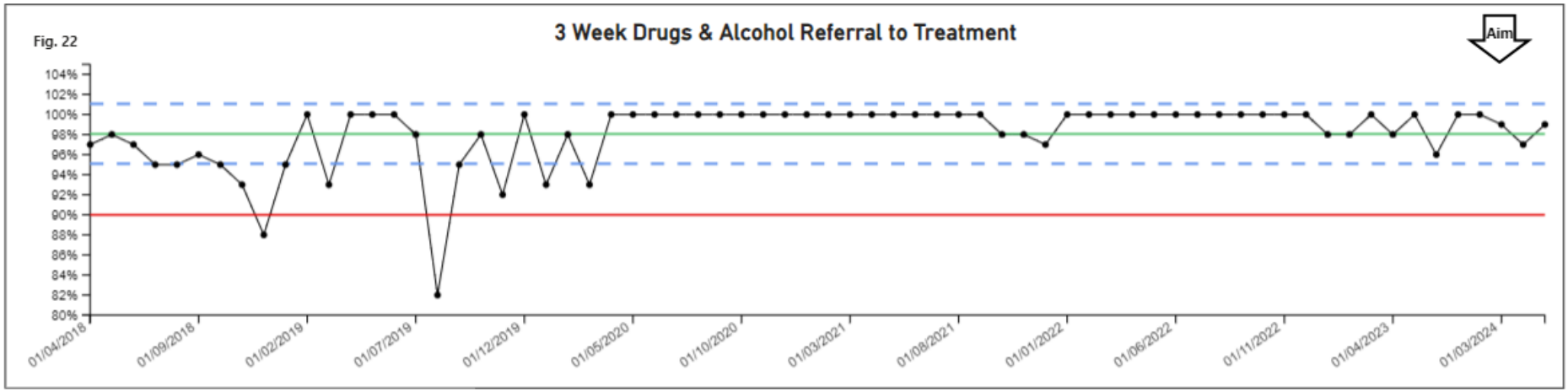






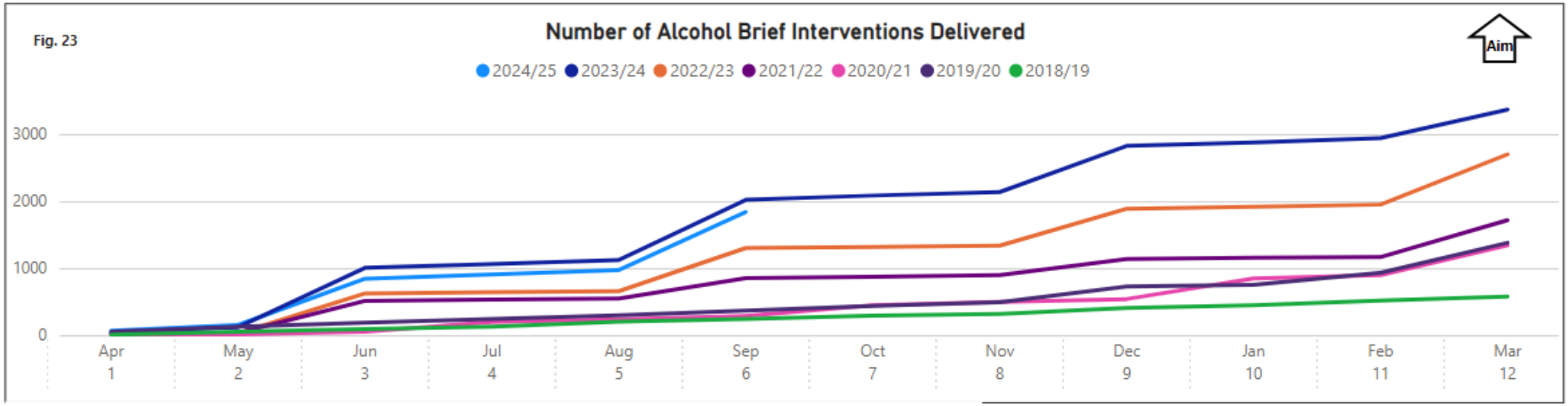
Drugs & Alcohol

Fig. 22



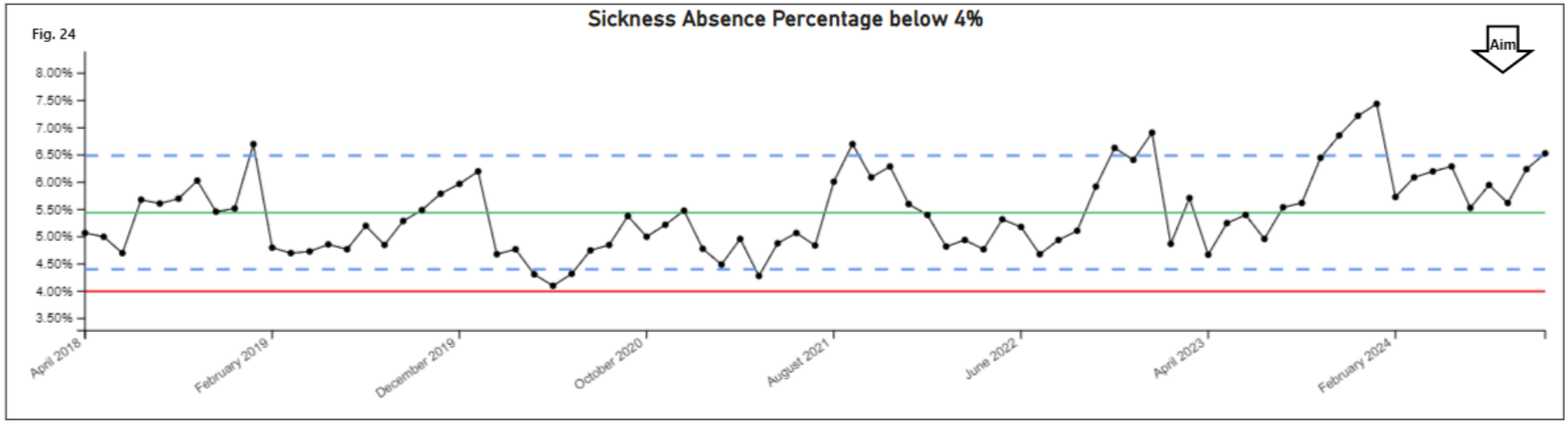
Note: Updates provided Quarterly

Fig. 23

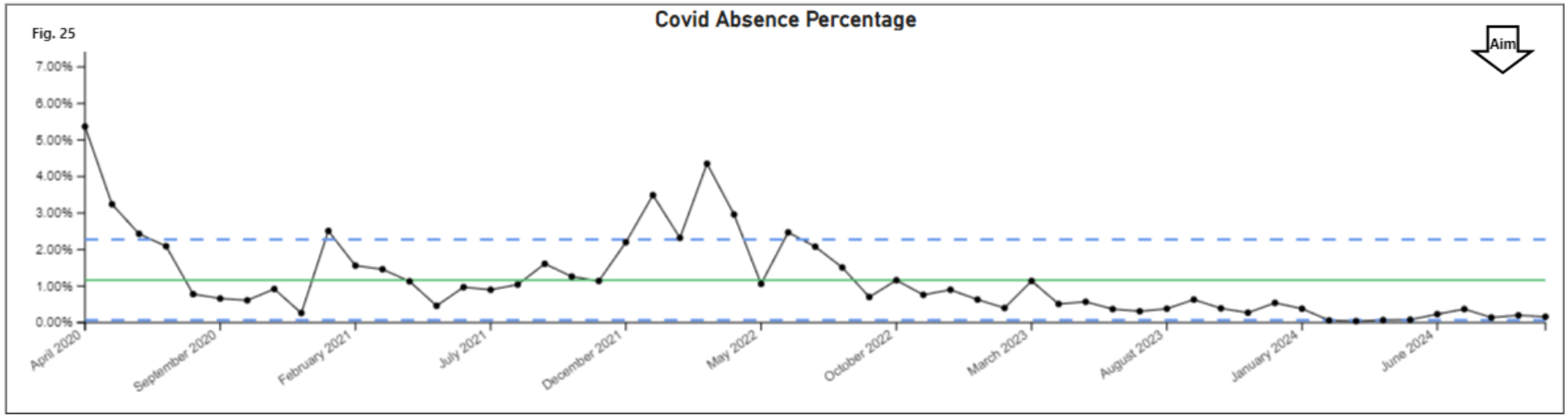


Please Note: Standard is 1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again.
There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.

Sickness Absence

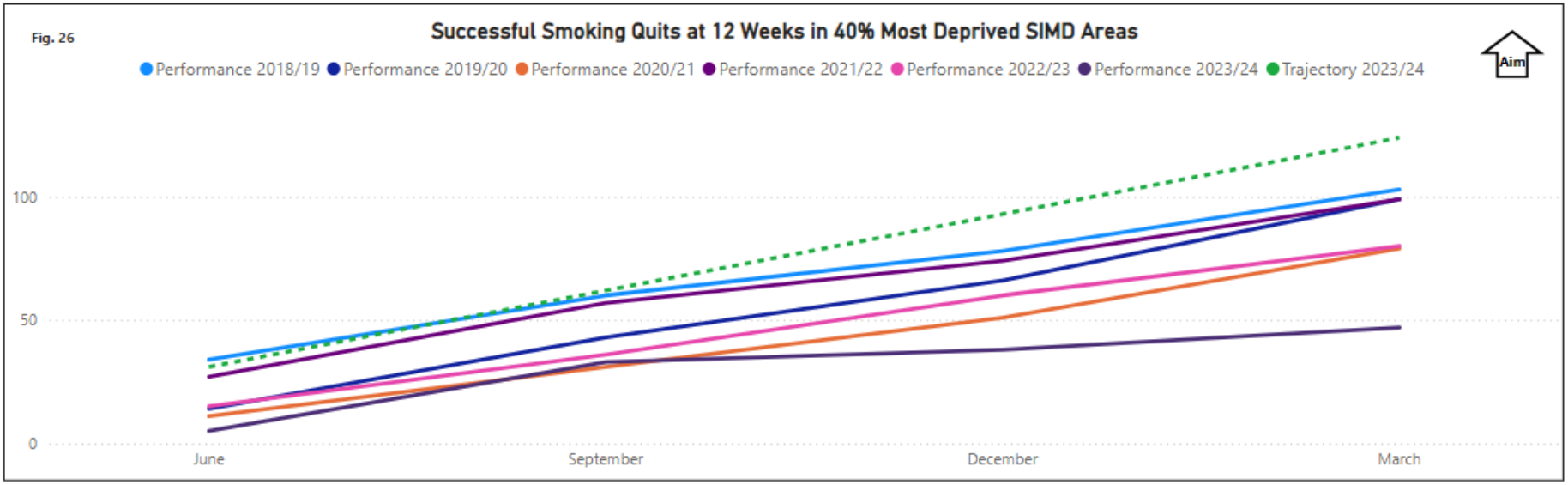


Note: Sickness absence data does not includes any COVID-19 related absences.



Smoking Quits

Latest NHS Scotland Performance (2019/20)	NHS Borders Performance (2019/20)
97.20	77.40



(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)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Primary Care Improvement Plan Annual Programme Report**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Cathy Wilson, General Manager P&CS**

1 Purpose

To update the Health Board on progress made with implementation of the 2018 GMS contract (PCIP) for the period April 2023 – October 2024.

The purpose of this report is to provide a comprehensive overview of the achievements, challenges, and future goals pertaining to the delivery on the commitments outlined in the General Medical Services (GMS) 2018 contract.

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Legal requirement
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The Board is asked to note the contents of the report attached and consider the issues raised in the report.

2.2 Background

New GMS GP Contract – 2018

2.2.1 In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals. The New GMS GP Contract refocused the role of GPs as Expert Medical Generalists (EMGs) working within a Multi-disciplinary Team (MDT). The aim of this is to reduce GP and GP Practice workload. New staff will be employed by Health Boards and will work with practices and clusters.

2.2.3 The Health Board would be required to shift GP workload and responsibilities to members of a wider primary care multi-disciplinary team when it is safe and appropriate to do so, while also demonstrating an improvement for patient care.

2.2.4 It is a requirement of the MoU that Integrated Authorities develop and review a local Primary Care Improvement Plan (PCIP). The aim of the plan is to identify and integrate key areas to be transformed to achieve the GP contract goals with the expectation that reconfigured services will continue to be provided in or near GP practices.

MoU2

2.2.5 SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflected gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

2.2.6 This revised MoU2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans.

2.2.7 SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agreed that the following services should be reprioritised to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

2.2.8 It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

November 2021

2.2.9 In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.

March 2022

2.2.10 By March 2022 the Health Board had delivered VTP in full, partially delivered Pharmacotherapy (level 1 Acute Prescriptions) and CTAC was a still to be delivered. Modelling and planning were complete and implementation was waiting for funding allocation before it could go ahead.

August 2022

2.2.11 Allocation from Scottish was released in August 2022 and was insufficient for fully implementing CTAC. This triggered a review of the strategic plan as a new model was required to fit within the financial envelope. This led to a reduced model, CTAC Phase 1, providing only phlebotomy services.

March 2023

2.2.12 As a direct result therefore and without any dialogue with the Board / Partnership regarding how the position on these reserves may have changed since they were brought forward on 01 April 2022 or any legal, contractual or strategic commitments that may have been entered into during the year, the SG has unilaterally deducted the full £1.523m from Scottish Borders 2022/23 PCIF allocation, resulting in no Tranche 2 payment being made.

July 2024

2.2.13 In July 2023 - PCIP Exec had their proposal approved to combine funding streams from a range of Health Board and PCIP sources as well as releasing savings from a Programme of Polypharmacy in order to bridge the gap between PCIF funding for GMS Contract implementation and what was agreed would be as close as we could achieve to full delivery of the contract.

January 2025

2.2.14 NHS Borders applied to be a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme over November and December of 2023. We were notified of our success and the programme was kicked off by the Cabinet Secretary for Health in January. The programme includes £4.3million in funding for a full CTAC service and steps to increase Pharmacotherapy provision over 18 months up to October 2025.

2.3 Assessment

2.3.1 Financial

There are no costs attached to any of the recommendations contained in this report.

2.3.2 Risk Assessment/Management

This report is not a proposal and so there is no Risk or Mitigation considerations for the IJB. However, the report does include all the elements of risk that have been identified in relation to this project and no specific additional concerns need to be addressed.

2.3.3 Equality and Diversity, including health inequalities

A Stage 1 Equalities and Human Rights Impacts Assessment has been completed (attached).

Stage 2 and 3 are in progress but we have not yet completed due to a lack of resource and the significant capacity required for this task. We have a new member of staff who will lead on engagement for the programme and they will resume this process when they come into their role on the 25th of November 2024.

2.3.4 Climate Change

Reduced travel in provision of Pharmacotherapy and continued provision of CTAC locally in the community and making this sustainable long terms will mean reduced travel to for associated staff and patients respectively. This will have Carbon reduction impacts and will also decrease impacts of transport on air quality.

2.3.5 Other impacts

Not Applicable.

2.3.6 Communication, involvement, engagement and consultation

We will be consulting with all groups identified in Stage 1 of the Equalities and Human Rights Impacts Assessment. As mentioned there we have not undertaken consultation with these groups to date.

2.3.7 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.

- Scottish Borders Health and Social Care Partnership Integration Joint Board, 20 November 2024

2.4 Recommendation

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

The Board is asked to **note** the content of the attached report and consider the issues raised in 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 List of appendices

The following appendices are included with this report:

- Appendix 1, Primary Care Improvement Plan Annual Programme Report
- Appendix 2, IIA

PCIP Borders
Primary Care Improvement Plan

2024

Primary Care Improvement Plan

Annual Programme Report

PCIP Executive Committee Report

“

With an expanding PCIP, further delivery of services and use of resource, we aim to start this shift working towards building a primary care team that is resilient and provides high quality care for the population of the Scottish Borders.

”

- Dr Rachel Mollart

GP Sub-Committee Chair

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Foreword

Notes from the PCIP Executive Chair – Cathy Wilson

This past year has marked a pivotal moment for the Scottish Borders Primary Care Improvement Plan as we embarked on an exciting new chapter, being recognised as one of four demonstrator sites across Scotland. This achievement, secured through a competitive selection process, has provided additional resources to accelerate our efforts in reshaping primary care services. With this support, we are successfully expanding key services such as Community Treatment and Care (CTAC) service and Pharmacotherapy, driving forward our vision of patient-centred, accessible healthcare.

These developments have also strengthened our collaboration with Healthcare Improvement Scotland (HIS) in data collection and analysis, enabling our teams to improve efficiency and meaningfully assess the impact of our work. Our multidisciplinary team (MDT) approach continues to be central to our efforts, with each core workstream—Vaccinations (VTP), Urgent Care, Mental Health (Renew), and First Contact Physio (FCP)—playing a vital role in delivering integrated, comprehensive support within GP practices to effectively meet patient needs each day.

While challenges remain, particularly around workforce availability and recruitment—issues heightened by rurality, deprivation, demographic pressures, and health inequalities—our vision remains clear: to advance primary care and bring services closer to our communities, reducing reliance on hospital-based care. Though the 2018 GP contract is only partially delivered and future funding post-October 2025 is yet unconfirmed, we remain focused on making the most of the expanded PCIP and maximising our resources to build a resilient, high-quality primary care team that can serve the diverse needs of the Scottish Borders population.

My deepest thanks go to our patients, GPs, healthcare teams, and community partners. Your dedication and collaboration are the backbone of our progress, and together, we are making a profound impact on primary care in the Scottish Borders. As we look to the future, we remain fully committed to transforming primary care, fostering a sustainable, accessible, and exceptional healthcare experience for all.

Notes from the Chair of GP Sub-Committee – Dr Rachel Mollart

During 2024, the Scottish Borders Primary Care Improvement Plan (PCIP) has seen some exciting development. Scottish Borders was one of 4 areas across Scotland to be selected as a demonstrator site by Scottish Government. This was following a successful bid within a highly competitive process. With additional resource we have been able to further develop our PCIP allowing delivery of CTAC (phlebotomy) and expansion of Pharmacotherapy services. We are continually looking at ways to improve efficiency in our teams and this year have received additional support in data collection and analysis from Health Improvement Scotland (HIS). Our pharmacotherapy team are moving to a hybrid hub model. In addition to the new developments, our previously established work streams of Vaccinations (VTP), Urgent Care, Mental Health (Renew) and First Contact Physio (FCP) are mainstreamed and business as usual. These work streams are embedded within GP practices and are involved in day to day multidisciplinary team working.

We still face difficulties. We have significant issues with availability of work force and difficulty recruiting to some posts. Rurality, deprivation, demographic and health inequalities exacerbate issues locally. The fiscal position nationally remains challenging. The 2018 GP contract is only partially delivered. There is no confirmation of additional funding after October 2025 with completion of the demonstrator site. Without the supporting structures in place to allow rerouting of some workload, GPs are having to complete tasks which are no longer their contractual responsibility. This is resulting in less available time for GPs to provide care in their role as the expert medical generalist, having an impact on access to GP appointments for patients, on GP well-being and GP recruitment and retention. A further concern for GPs has been the pausing of Sustainability Loans by Scottish Government in May 2024. The scheme provided vital support to ease financial risks of owning GP premises and increased the stability of these practices. There is no information as to when this scheme might restart.

Moving forwards, the emphasis is on further development of Primary Care and General Practice. The focus is to move services into the community, away from hospital based care. With an expanding PCIP, further delivery of services and use of resource, we aim to start this shift working towards building a primary care team that is resilient and provides high quality care for the population of the Scottish Borders.

Notes from the Chief Officer of the Integration Joint Board – Chris Myers

We are making significant strides in developing primary care and community services in the Scottish Borders. Despite challenges in resourcing, recruitment, retention, rurality, and responding to increased demand, the Primary Care Improvement Plan has driven rapid progress. We were thrilled to be one of four Primary Care Phased Investment Programme Demonstrator Sites, recognising our proactive and collaborative approach with General Practices, the Health and Social Care Partnership, and our communities.

Despite our challenges and the fact that we have further work to do, our patients have told us through the latest Health and Care Experience survey that their experiences in GP practices and the wider community multidisciplinary team was on the whole overwhelmingly positive. This reflection is a testament to the hard work of everyone involved, and I am deeply grateful to our GP Practices, to our community teams and to the public for their ongoing support in improving access to and the sustainability of primary care.

“We will continue to transform primary care, fostering a sustainable, accessible, and exceptional healthcare experience for all. “

Cathy Wilson – Chair of PCIP Executive Committee

Journey

PCIP Timeline

In 2018, a new GP contract was introduced. A new primary care model was to be rolled out to make it easier for people to access care from a wide range of healthcare professionals.

Funding was to be provided for the streamlining of services and for new staff who would be employed by NHS Health Boards to help maximise the time GPs can spend for caring for those who require their expertise.

It was hoped that this transition would take place over the course of 3 years – this would be locally agreed through Primary Care Improvement Plans (PCIPs) .

2018

PCIP is part of the GP Contract. It is defined through an agreed national Memorandum of Understanding (MoU) between the Scottish Government (SG), the Scottish General Practitioners Committee of the British Medical Association (SGPC), Integration Authorities (IAs) and NHS Boards.

This MoU mandated the delivery of specific priorities aimed at supporting people to access more easily the most appropriate healthcare to meet their needs to in turn release GP Clinical time to allow GPs to focus on their role as Expert Medical Generalists.

SG funding to support the implementation of the MoU has been allocated to IAs through the Primary Care Improvement Fund (PCIF), and locally agreed PCIPs would set out in more detail how implementation of the 6 priority service areas will be achieved.

PCIP Executive April 2019

The PCIP Executive Committee (created in April 2019) is the body which overseas and directs the development and implementation of the PCIP programme in the Borders. Its membership is at senior level and represents the 3 partner organisations – a tripartite agreement between GPs, NHS Borders and the Integration Joint Board (IJB).

A revised version of the Borders PCIP Plan 2018-2021 would be published later in the year.

COVID-19 Pandemic

The PCIP Executive notes the impact of COVID on service delivery. GP Executives of the GP Sub Committee would work closely with NHS Borders to mitigate risks and focus on the recovery and remobilisation progress.

Journey

December 2021

Joint letter SG/SGPC

In December 2021, the Government issued a letter announcing an implementation change order of workstreams recognising which streams would be of more benefits to GP workloads, also the extended deadline for workstreams and also highlighting the contractual burden on Health Boards for non-delivery of these workstreams.

July 2021

MoU2

SG issued an updated Memorandum of Understanding (MoU2) to Health Boards in July 2021. The revised MoU for the period 2021-2023 recognised what had been achieved on a national level but also reflects gaps in delivering the GP Contract Offer commitments as originally intended by April 2021.

This revised MoU2 acknowledges both the early lessons learned as well as the impact of the Covid-19 Pandemic and that the delivery of the GP Contract offer requires to be considered in the context of Scottish Government remobilisation and change plans.

SG advised that all 6 MoU service areas should remain in scope, however following the SG/SGPC letter of December 2020, they agree that the following services should be reprioritized to the following three services:

- Vaccination Transformation Programme (VTP)
- Pharmacotherapy
- Community Treatment and Care Services (CTAC)

It is important to note that prior to the MoU2 announcement, other PCIP Borders workstreams were well underway and PCIF commitments attached.

November 2021

GP Sustainability Payment

In recognition that nationally several HBs were struggling with the March 2022 deadline, a GP sustainability payment was offered to help cover costs- giving an additional year for implementation of both CTAC and Pharmacotherapy.

March 2022

Position

The position at the end of March 2022, against the three priority areas from MoU2, was as follows:

- Vaccination Transformation Programme (VTP) – delivered in full (supported by non-recurrent funding)
- Pharmacotherapy (level 1 Acute Prescriptions) – partially implemented
- CTAC – not yet implemented

Modelling and planning were complete for final implementation however this was paused pending confirmation of resources to support further investment.

August

2022

Scottish Government Annual Allocation

Scottish Government confirmed the 2022/23 PCIF allocation in August 2022. In common with the position across NHS Scotland, the level of funding available to primary care within Scottish Borders was insufficient to meet the projected costs outlined within the local PCIP.

At this stage a strategic review was undertaken which identified a revised CTAC Phase I model to deliver a minimum PCIP commitment. Discussions on implementation were predicated on use of non-recurrent resources held within the IJB reserves to bridge investment pending confirmation of future Scottish Government allocations.

March

2023

Adjustment to Health Board's Funding Allocation

In March 2023 Scottish Government made adjustment to the Health Board's RRL funding allocation to offset slippage on prior year PCIF allocations against funding allocated in 2022/23. This adjustment had the effect of reducing non-recurrent IJB reserves held for PCIP by £1.523m – this triggered a review of Scottish Borders' PCIP strategic plan.

July

2023

IJB and Health Board Approve PCIP Bundle for fuller GMS Contract Delviery

In July 2023 - PCIP Exec had their proposal approved to combine funding streams from a range of Health Board and PCIP sources as well as releasing savings from a Programme of Polypharmacy in order to bridge the gap between PCIF funding for GMS Contract implementation and what was agreed would be as close as we could achieve to full delivery of the contract.

January

2024

NHS Borders successful in bid to become a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme.

NHS Borders applied to be a demonstrator site on the Scottish Governments Primary Care Phased Investment Programme over November and December of 2023. We were notified of our success and the programme was kicked off by the Cabinet Secretary for Health in January. The programme includes £4.3million in funding for a full CTAC service and steps to increase Pharmacotherapy provision over 18 months up to October 2025.

PCIP Borders
Primary Care Improvement Plan

PCIP Vaccination

Delivered March 2022

Community PCIP Care & Treatment

PCIP Pharmacotherapy

Due by since April 2022

MoU 2 Priorities

PCIP Community Mental Health

PCIP Urgent Care

PCIP Musculoskeletal

Community PCIP Links Worker Service

Additional Professional Roles

PCIP Premises

PCIP Communications

PCIP Data

Enablers

Primary Care Phased Investment Programme

As already shown in the timeline, we were successful in our application to become a Demonstrator Site as part of the Primary Care Phased Investment Programme (PCPIP). This programme is being delivered locally in tripartite agreement between the Scottish Government, NHS Borders and Healthcare Improvement Scotland. The other demonstrator sites on the programme are Edinburgh City, Shetland and Ayrshire and Arran. The programme aims to evaluate fuller implementation of the 2018 GMS contract to inform the next steps for Scotland for the start of 2026.

In the Scottish Borders the new services and models for provision that have been funded are as follows:

- A Full clinical workforce to provide Community Treatment and Care in each Health Centre in the Borders
- A centralised admin hub for the booking and administration of the CTAC service
- A centralised Pharmacy Hub to provide Pharmacy Technician Support to every GP practice in the borders 5 days a week.
- A centralise High Risk Medicines Service to monitor all patients on a predefined list of medications – previously known as DMARDs.

In our work with Healthcare Improvement Scotland as the local delivery team for this programme we are undertaking the change following quality improvement methodologies. Whilst being a proven way of developing sustainable and meaningful positive outcomes when implementing change, this will facilitate the collection of data on impact and outcomes of the increase GMS Contract implementation and help to inform Scottish Government on where GMS contract implementation is bring the best value for GP practices, patients and the public.

Our initial period of work with Healthcare Improvement Scotland has been to 'Understand the System' this has meant the collection of significant amounts of data to build up context and a baseline to compare against as we monitor the changes these new services bring. Then culmination of this has been to undertake a week of care audit across 9 practices in the Scottish Borders.

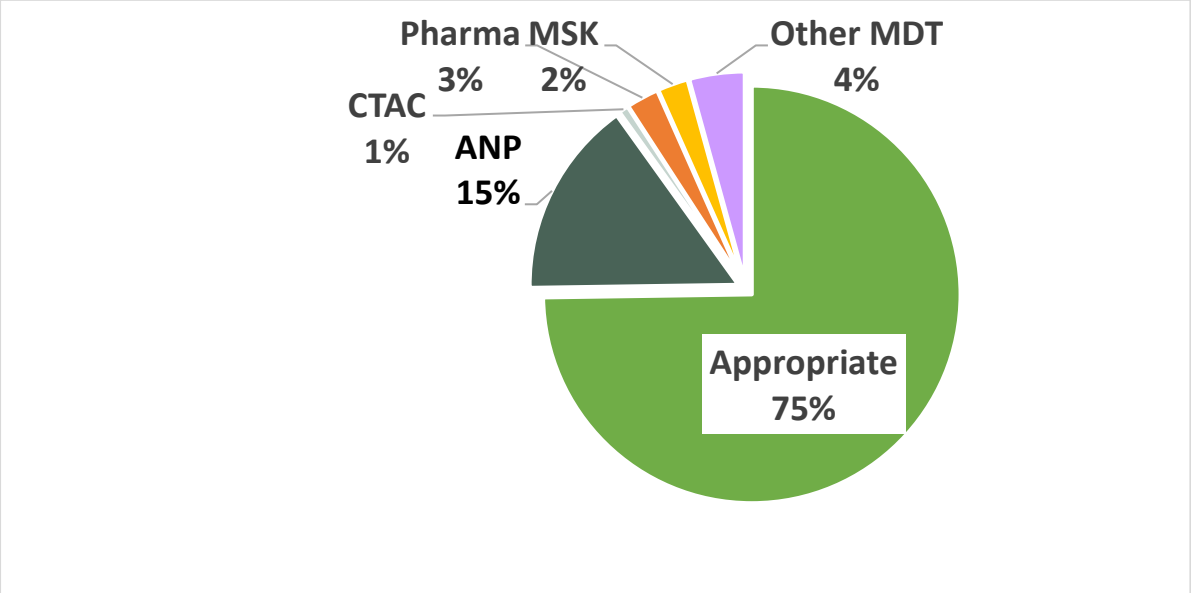
Week of Care Audit Summary

- **9 Practices collected data for 5 consecutive days each between 29th of July and the 18th of September 2024**
- This covers 56,774 registered patients – **46.7% of Borders registered patient population**
- Number from each practice cluster:
  - 3 Central
  - 3 East
  - 2 South
  - 1 West
  - Practices were selected for invitation to participate by HIS.
- Selection was based on trying to balance a range of variables - creating a **representative sample for the Borders.**

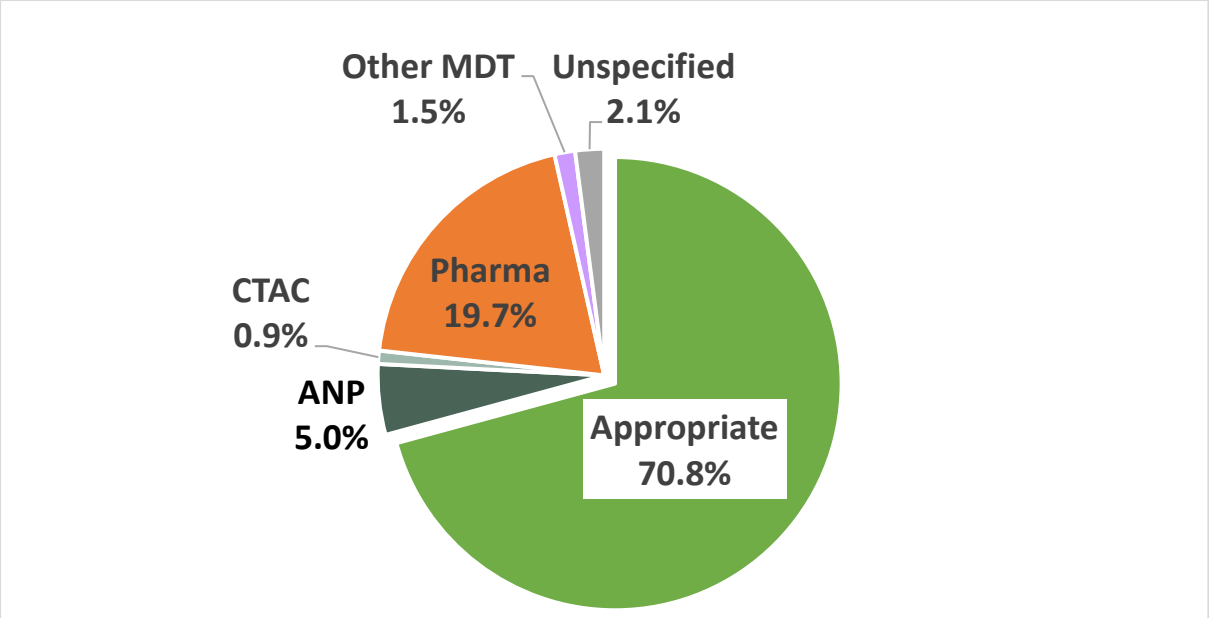
This Data collection exercise has allowed us to quantify demand fully for Pharmacotherapy, CTAC and ANP Urgent Care for the first time as well as quantify time spent by GPs on tasks that could have also gone to mental health or to Physio.

This can be shown below for first Patient facing activity and then non patient facing activity. This data highlights some of the key services that are most likely to reduce GP's time on tasks appropriate for other professional groups.

GP time spend in Patient Facing Activity – split by who the best person to see the patient would have been:



GP time spend in non- Patient Facing Activity – split by who the best person to see the patient would have been:



Next Steps in PCPIP

Between September 2024 and March 2025, the focus will be on implementing the above services in practices and establishing sustainable and high impact changes. This will be monitored throughout with Healthcare Improvement Scotland undertaking an independent evaluation of the programme both qualitatively and quantitatively. After this period the analysis and write up of the changes and their impacts will be made and go to Scottish Government for consideration of next steps.

What we set out to deliver

The GMS Contract (2018), subsequent Memorandum of Understandings and the draft directions released in April 2023 outlined a commitment to the development of HSCP (Health and Social Care Partnership) led pharmacotherapy services to support GP workload. Acute prescribing makes up a significant part of day-to-day workload in primary care services and this programme provides solutions to support rapid sustainable improvement.

The programme aims to deliver improvements that:

- enable staff involved in prescribing to work together effectively, and
- enable pharmacotherapy and practice staff to fully utilise their skills sets.

Service Delivery

The original service plan in 2018 for Pharmacotherapy was for 28 whole time equivalent (WTE) completing work raging from the original Level 1 – 3 as per the GMS 2018 contract. NHS Board allocated staff funded prior to PCIP were later removed early on in the plan to refocus on efficiencies, reducing the workforce to 21 WTE with further funding cuts leading to a current workforce of 16.6wte (Pharmacists and Technicians).

In March 2022, faced with concerns around the delivery of Levels 1, 2 and 3, a survey was sent to all GP practices to better understand which areas could make a significant difference at reducing GP workload. The results indicated that GP Practices prioritised Level 1 work. A technician led service was organised mainly focusing on supporting Level 1 prescribing, hospital discharge letters, clinic letters and repeat prescribing (increasing serial prescribing). This service has continued up until now.

The release of the draft directions in April 2023 and being successful with a bid submitted to Scottish Government and Health Improvement Scotland to become a demonstrator site, has prompted a change in direction of service delivery

The Pharmacotherapy service is now defined as 'Management of all acute and repeat prescriptions, medicines reconciliation, performing polypharmacy reviews and serial prescribing (GP to only provide immediate care to prevent injury of a patient or the worsening of a patient's clinical condition). Making available sufficient staff to ensure that an adequate service continues to be available, during annual leave, sickness absence or parental leave taken by the staff who routinely operate the service.'

Workforce

Based on our 2018 original plan we would have had 1wte member of pharmacy team per 5000 patients, with the reduction in funding available the ratio is now 1wte to 7500 patients. The team consists of staff ranging from Band 3 Pharmacy Support Workers to Band 8a pharmacists which provide a good spread of skill mix to complete the levels 1-3 pharmacotherapy work.

What has been achieved by October 2024

Workload

Data collection has been a focus of work. The project began by creating task sheets for staff members to use as a guide in completing assigned work. These sheets include the necessary read codes that need to be referenced. A new read code template includes all the codes required to record the daily work completed by each staff member to maximize the data collected for review.

We have used the software EMIS Enterprise, to automatically pull this data from the practices, and create dashboards, demonstrating the quantity of work completed by the team in a more aesthetic manner

We have learned that practice workload for Level 1 tasks is subject to wide variation (complexity of work assigned to the team, level of experience, skill mix and different practice demographics are key components of this). To minimise variation this is being addressed by standardisation of practice work using SOP's developed by the team and future agreement of a MOU.

Service Delivery

A wide variance in the work that each practice would like the team to complete, that is the skill set of the team and how work is completed in practice, has led to significant challenges in delivering an equitable service.

As part of the demonstrator site funding provided by Scottish Government/ HIS, premises for a Pharmacy Team HUB has been acquired. All the Pharmacotherapy Technicians and Pharmacy Support Workers will work here daily, completing Level 1 work and in particular increasing serial prescribing, while the Pharmacist remain in practice. The HUB working will provide a better Team ethos and peer support, while allowing work to be evenly shared across the team, rather than individuals being allocated to a practice on a session basis (based on list size)

In September 2024, GP practices were sent a survey again, asking what work within the practice they would like to be completed by the Pharmacist. The results of this survey have still to be shared.

Acute Requests

Acute requests are in many practices the main workload assigned to the Pharmacists. Although difficult to ascertain exact numbers, the team are beginning to take active steps to reduce the quantity by utilising other services available, for example serial prescribing and use of limited repeats. We have taken steps to collaboratively work with Health Improvement Scotland to reduce the numbers, which will increase safety of prescribing and equity in the service.

Serial Prescriptions

Managing the medicines to treat chronic disease is part of the service delivery plan and serial prescribing is key to this. Work is continuing over 2024/5 to maximize the number of repeat medications that are managed via the serial prescribing route, currently we average at 4% over the

Board. With the addition of a Band 3 Pharmacy Support worker to the team, this percentage should increase.

Workforce Development

Over the past 48 months, we have been developing our service and are continually reviewing skill mix. Recognising the lack of technician workforce at a national level. The 5 trainee technicians that were being trained within the team have now qualified However, of these trainee pharmacy technicians, we only have permanent positions for two due to budget demands on the service. The others have been employed in other sectors of pharmacy within NHS Borders.

The pharmacist team (4.1wte) consists of 75% Band 8a pharmacists, of which 2.71wte are >55yrs old, reducing the progression available for less experienced pharmacists in years to come.

Community Pharmacy

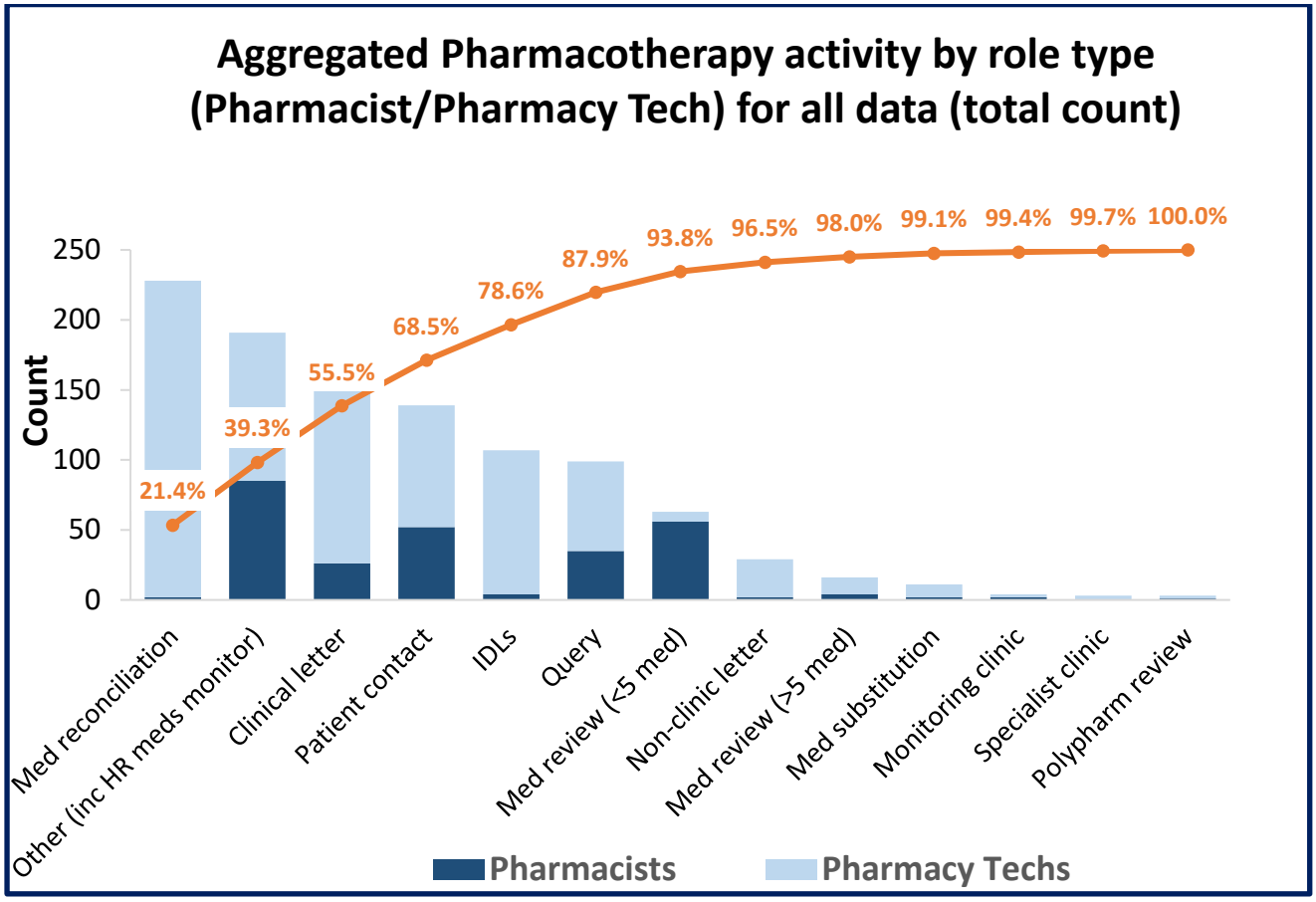
The links between practice teams and community pharmacy teams are very important. Community pharmacy provides supports to general practice in a number of areas (Pharmacy First and Pharmacy First plus) as well as working alongside the team to provide Serial prescribing.

Learning form the Week of Care Audit - Pharmacotherapy

As covered in the section on the PCPIP we undertook a week of care audit of 9 Practices collected data for 5 consecutive days each between 29th of July and the 18th of September 2024.

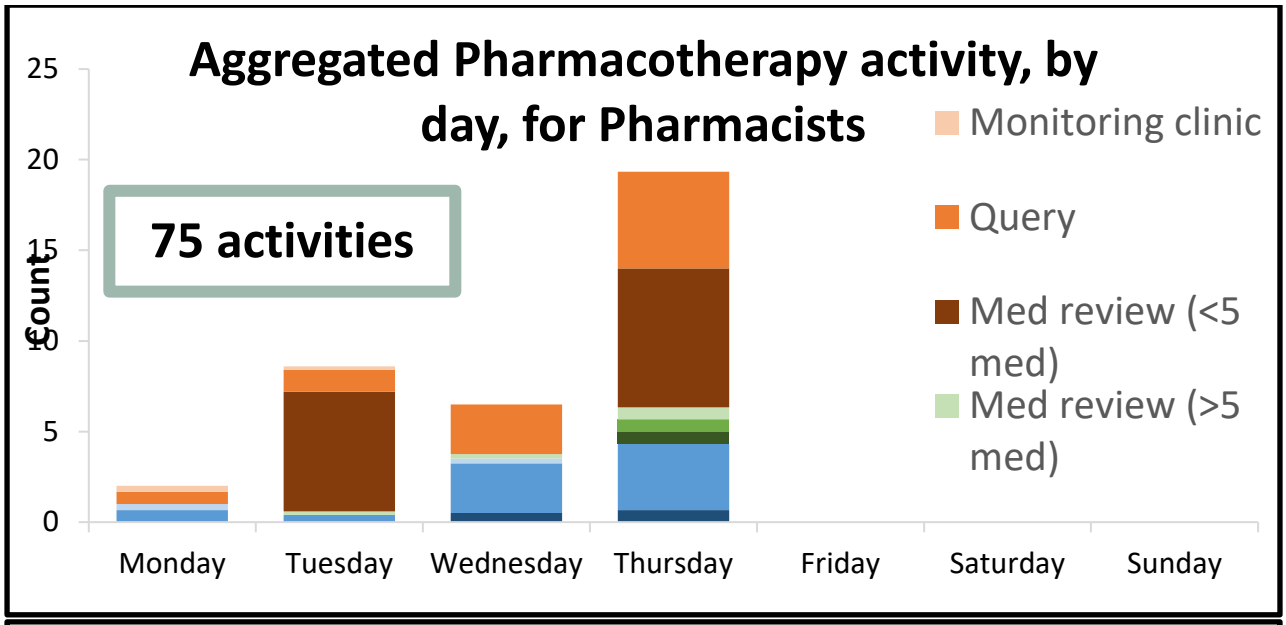
The findings from the audit indicate that Pharmacotherapy could provide a significant benefit to reducing GP workload if we were able to provide more capacity within the service – almost 20% of time spent on non-patient facing tasks could have been undertaken by Pharmacotherapy.

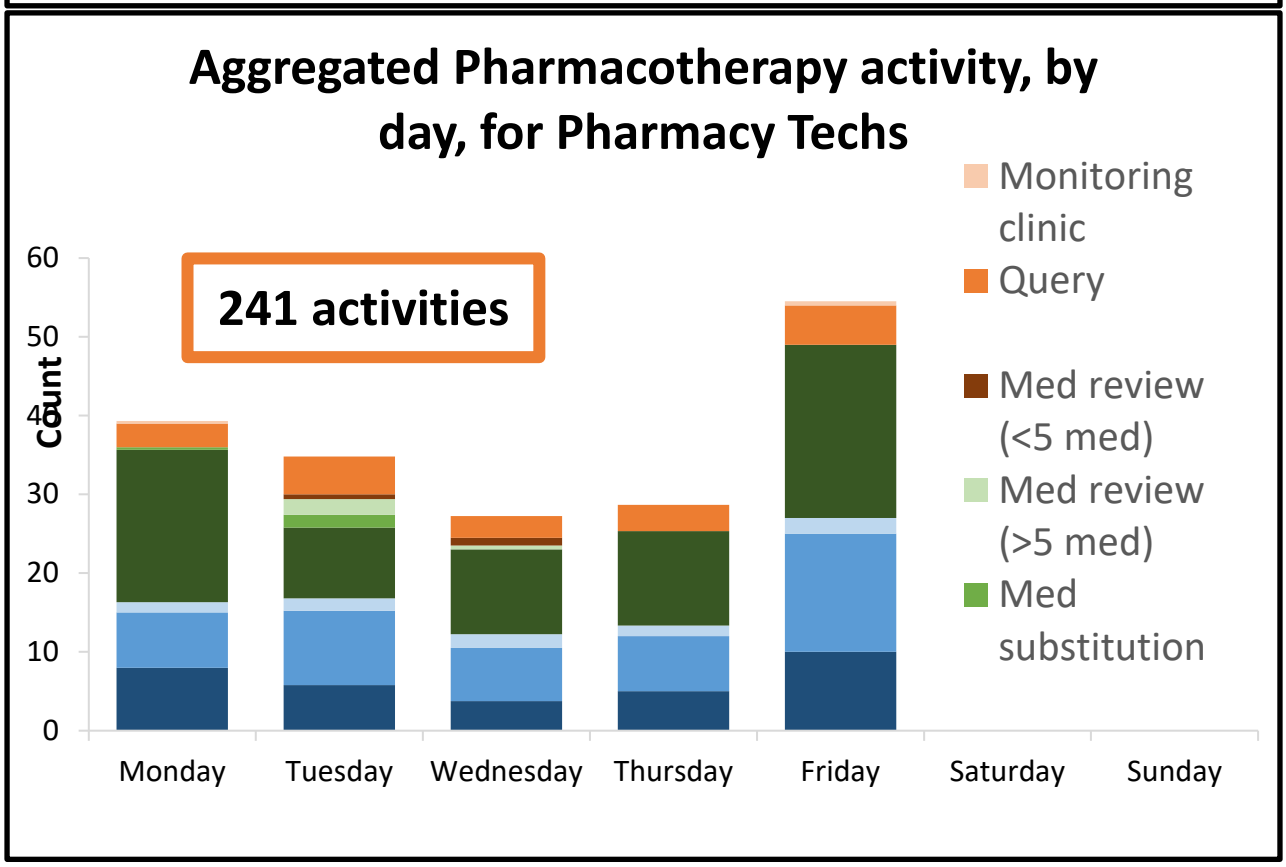
The Pharmacotherapy team also recorded their activity in practices:



In the above Pareto chart we see a breakdown of the workload of the pharmacotherapy team, split by Pharmacists and Pharmacy technicians. This clearly outlines that almost 100% of activity is being spent covering level 1 tasks in the practices that took part in the Week of Care Audit.

In the following charts we show the breakdown of the two staff groups, Pharmacists and Pharmacy Technicians by days of the week. We would hope that as we move towards hub working we can smooth out coverage from the pharmacy technicians even further to ensure that patients prescriptions from discharges and outpatient appointments are actioned faster and therefore patient safety is improved.





What gaps do we still have to deliver on the MOU?

Within NHS Borders the attention is focused on delivering the Level 1 tasks only and how we deliver this given the current budget constraints around staffing. This means that delivery of MoU2 is not attainable due to Level 2 and 3 not being delivered by the Pharmacy Team.

With the proposed draft directions from Scottish Government the model of pharmacotherapy in NHS Borders will need to respond to support delivery of the directions.

Key Risks:

Service resilience has been challenging, trying to maintain a service with vacancies is not possible. The definition of Pharmacotherapy previously quoted, includes covering annual leave, sickness and parental leave. The difficulty with this ask is that with low team numbers there is very limited flex in the allocations to move staff without leaving other noticeable gaps in practices. However, moving to the HUB premises in November 2024 will assist in alleviating these gaps along with the addition of defining safe staffing levels and an improved annual leave authorisation process.

Remote working from hubs is the way to improve resilience. This streamlining of staff to a central area can reduce inefficiencies in travel as well as resolve issues with space within practices. Progress with this plan has been influenced heavily by the availability of work stations and available areas to work in.

Staff training and ongoing support for staff development in line with the national direction led by NES to ensure that staff have the necessary skills and competence to carry out these new roles safely and effectively does impact on service delivery to some extent and requires negotiation with practices. Practice pharmacist specific frameworks have been developed by NES (both at foundation and advanced practice level) but the team find the workload at present does not afford them the opportunity to engage with these frameworks and future staffing models need to take this into account (staff given between 10% and 20% of their time to complete training and admin). Frustration is felt by the team that there is no time to undertake these frameworks. The pharmacists are also becoming deskilled in previous clinical areas of work due to only completing level 1 work, which reduces moral and uptake of vacancies in the team. Also, only completing level 1 work, does not produce the evidence required to match competencies within an Advanced practice framework.

Vacancy Management is an ongoing issue, not only locally but also nationally. Within the rural setting of NHS Borders, trained Pharmacy Technicians (not already employed by the Board) are becoming harder to find. Newly qualified staff (particularly pharmacists) are also moving away to the cities for a large part of their career. This is causing movement within teams and sectors rather than new employees joining the NHS. Vacancies are being advertised for considerable periods of time with no candidates applying that meet the essential criteria which is causing delays in service development.

Leadership As teams grow in size, more time is required to lead the changes required within practices and support the less experienced staff. We are currently introducing a technician led service, they will support leadership, training and service delivery in the team.

Travel Time was a major concern for the service management, due to less central placed practices losing clinical hours on a regular basis. With all the team (excluding the Pharmacists) moving to a HUB, this will significantly reduce travel time lost as this will be their new base.

What do we still need to enable this?

Understanding the workload challenges and practice systems has led to the realisation both locally and nationally that there needs to be a significant piece of quality improvement work embedded into practices to get them “pharmacotherapy ready” where the Level 1 tasks can be devolved to the pharmacy team. The required resource as well as skill mix to deliver a pharmacotherapy service is being modelled nationally based on experience to date from various boards.

Our original modelling of a total resource of 1 WTE pharmacotherapy team member per 5000 patients has been shown over the past 2 years to be inadequate and this finding is supported across Scotland. A national view is awaited regarding an optimum staffing model but this will be difficult to deliver due to current funding and workforce availability.

The outcomes from the demonstrator site projects will assist in defining delivery of the contract, but unfilled vacancies may mean that we are delayed in demonstrating this.

The Primary and Community Services (P&CS) Team within NHS Borders Health Board are responsible for delivering a robust, efficient and sustainable CTAC service which will enable people to live safely and confidently in their own homes and communities, supporting them and their families and carers to effectively manage their own conditions whenever possible.

The CTAC delivery model will delivery Treatments included in the GMS contract in each practice across Scottish Borders to maximise access for all Borders residents.

The CTAC project will also put in place the required infrastructure and workforce so that in future, an enhanced CTAC service can be offered to assist with shifting the balance of care from acute settings to the community.

The CTAC implementation plan builds on the current 10 treatment room services in a phased approach;

- Phase 1 – all phlebotomy services transfer to health board
- Phase 2 – an administration hub takes on booking of appointments
- Phase 3 – all treatments and care delivered in all sites

Phase 1 was completed by September 2024 and a plan has been devised to outline the steps needed to deliver phase 2 and 3 simultaneously. The planned completion date is end of March 2025.

Core CTAC treatments *(as per GMS contract list)*	**Current Treatment Room Provision beyond Core CTAC** *(as currently provided in limited number of existing HB Treatment Rooms)*
Ear Care	Assisting minor surgery
ECG	Catheterisation
INR checks (phlebotomy or near patient testing)	Continence Assessment
Minor Injuries*	Complex wound Management (including leg care and Dopplers)
Monitoring chronic conditions (BP-including 24 hour monitoring / active stand / Weight / Height / Urinalysis / Diabetic Foot Screening)	Medicine Administration
Phlebotomy (primary care)	Phlebotomy (secondary care)
Suture removal	Resus trolley and equipment maintenance
Wound Dressings	24 hour heart rate monitoring removal
	24 hour urine collection

The project is now part of the national Primary Care Phased Investment Programme which is testing the effectiveness of the new GMS contract in alleviating GP workload pressure. The successful bid to allow us to take part in the programme has attracted additional funding which has accelerated our ability to deliver services.

A full staffing model was submitted as part of the Pathfinder bid and is as follows:

Job Title(s)	Band	WTE Staff (in post)	WTE Staff (to recruit)
Senior Charge Nurse	7	1	0
Registered Nurse	6	2.42	4.88
Registered Nurse	5	9.16	5.44
Healthcare Support Worker	3	6.04	23.16
Admin Supervisor	4	0	1.21
Call Handler	2	0	12.1

Engagement activity

Work has been undertaken to engage with GP practices and current treatment room staff about the planned changes to treatment room provision. This has involved one to one meetings with practices and members of NHS Borders staff. Written communication and drop in sessions have also been provided.

Appointments per cluster

Staffing and available appointments has been developed using available data from GP practices and the health board. A ratio has been used to ensure fair allocation of resources.

For phase 1, a ratio of 1 WTE HCSW per 11,000 was used. Details below

Sites	Population	Band 3 WTE	Band 3 WTE +21% uplift	Number of 10 min appointments per week	2hr clinics required per week	2hr clinics to offer per week
West	**20,634**	**1.88**	**2.27**	**393**	**39.30**	**40.00**
Peebles Hay Lodge	11,918	1.09	1.31	227	**22.70**	**23**
Innerleithen St Ronan's	4,739	0.43	0.52	90	**9.00**	**9**
West Linton	3,977	0.36	0.44	76	**7.60**	**8**
South	**26,309**	**2.40**	**2.89**	**502**	**50.20**	**51.00**
Hawick Health Centre	11,276	1.03	1.24	215	**21.50**	**22**
Hawick Mairches	6,114	0.56	0.67	117	**11.70**	**12**
Selkirk	7,343	0.67	0.81	140	**14.00**	**14**
Newcastleton	1,576	0.14	0.17	30	**3.00**	**3**
Central	**33,372**	**3.03**	**3.67**	**636**	**63.60**	**66.00**
Galashiels health centre	**14,906**	**1.35**	**1.64**	**284**	**28.40**	**29**
Galashiels Roxburgh Street	3,575	0.33	0.39	68	**6.80**	**7**
Melrose Eildon	6,932	0.63	0.76	132	**13.20**	**14**
Earlston	3,231	0.29	0.36	62	**6.20**	**7**

Stow & Lauder	4,728	0.43	0.52	90	**9.00**	**9**
East - Berwickshire	**16,384**	**1.49**	**1.80**	**313**	**31.30**	**32.00**
Duns Knoll	9,849	0.90	1.08	188	**18.80**	**19**
Eyemouth	6,535	0.59	0.72	125	**12.50**	**13**
East - Cheviot	**23,976**	**2.18**	**2.63**	**458**	**45.80**	**48.00**
Kelso	11,810	1.07	1.30	225	**22.50**	**23**
Jedburgh	6,914	0.63	0.76	132	**13.20**	**14**
Coldstream	3,852	0.35	0.42	74	**7.40**	**8**
Greenlaw	1,400	0.13	0.15	27	**2.70**	**3**

Newcastleton model

Due to the remote and rural classification of Newcastleton, a different approach is being taken. This will deliver all services but in an integrated nursing model including District Nursing, ANP, GPN and Treatment room nursing.

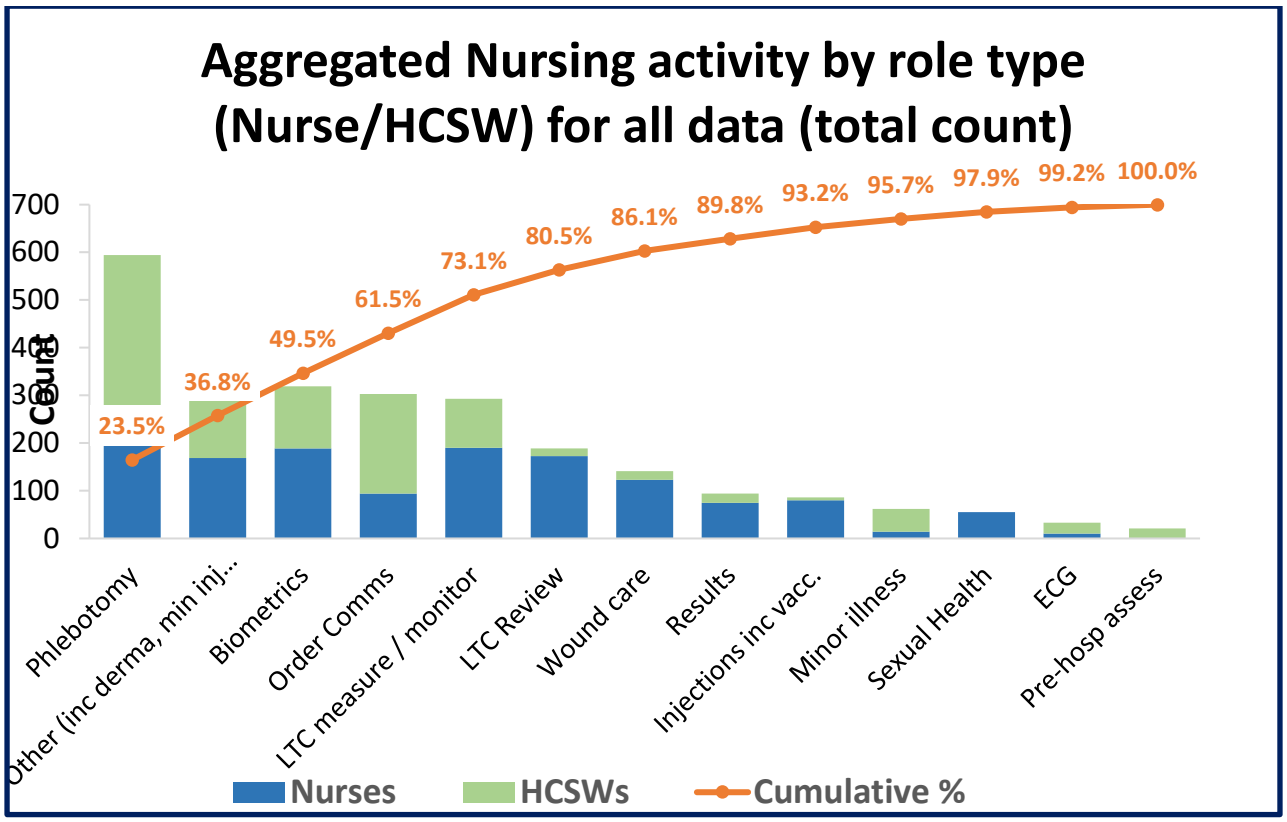
Key Risks

Risk	Details
Finance - long term sustainability	Roughly 50% of our core Healthcare Support Worker staffing allocation have been recruited on a fixed term basis due to the fact that this service has not ben allocated recurrent funding. This lack of sustainable finance is the key risk for the service, and for NHS Borders as this is a permanent transfer of work out of GP practices into a non-permanently funded service.
Recruitment	Recruitment processes can take up to 12 weeks. Delivery of CTAC service is dependent on staffing being available to run clinics and provide treatments. Temporary posts – current experience shows that recruitment to Fixed Term Posts reduces successful recruitment in RN and HCSW posts. Some types of staff e.g. Band 4 associate practitioners may not be available due to a lack of suitably trained personnel.
Standardisation of delivery	Each of the 22 practices in the Scottish Borders has differences in processes related to recall of patients with LTC and requests for treatment and care. A standardisation of processes is required to give the maximum flexibility in how services are staff and run. This requires careful negotiation and may not be deliverable at all sites.
IT infrastructure and changes	Health board and GP services operate on different EMIS patient record systems. In addition, Trakcare is used to request and action blood test results. The lack of a joined up patient record and simple interfaces between systems creates clinical risk. In early 2024 all GP practices are moving to a system called Vision,

	this requires a 12 week programme involving GP admin time. This may reduce capacity of practices to engage with CTAC developments.
Data assumptions	Data used to create the original CTAC staffing and financial planning model was based on 2019 activity and broad assumptions have been applied rather than a full analysis of demand/capacity across all GP practices. The assumptions will have an impact on the reliability of the model. A ratio approach has now been used and tested against existing workforce used to deliver CTAC tasks.
Project delay risk	Project timelines have slipped considerably and delivery by the new 2023 deadline will not be met. Without a clear agreement for financial funding the project team are unable to create a timeline for the rollout of these services.

Learning from the Week of Care Audit - CTAC

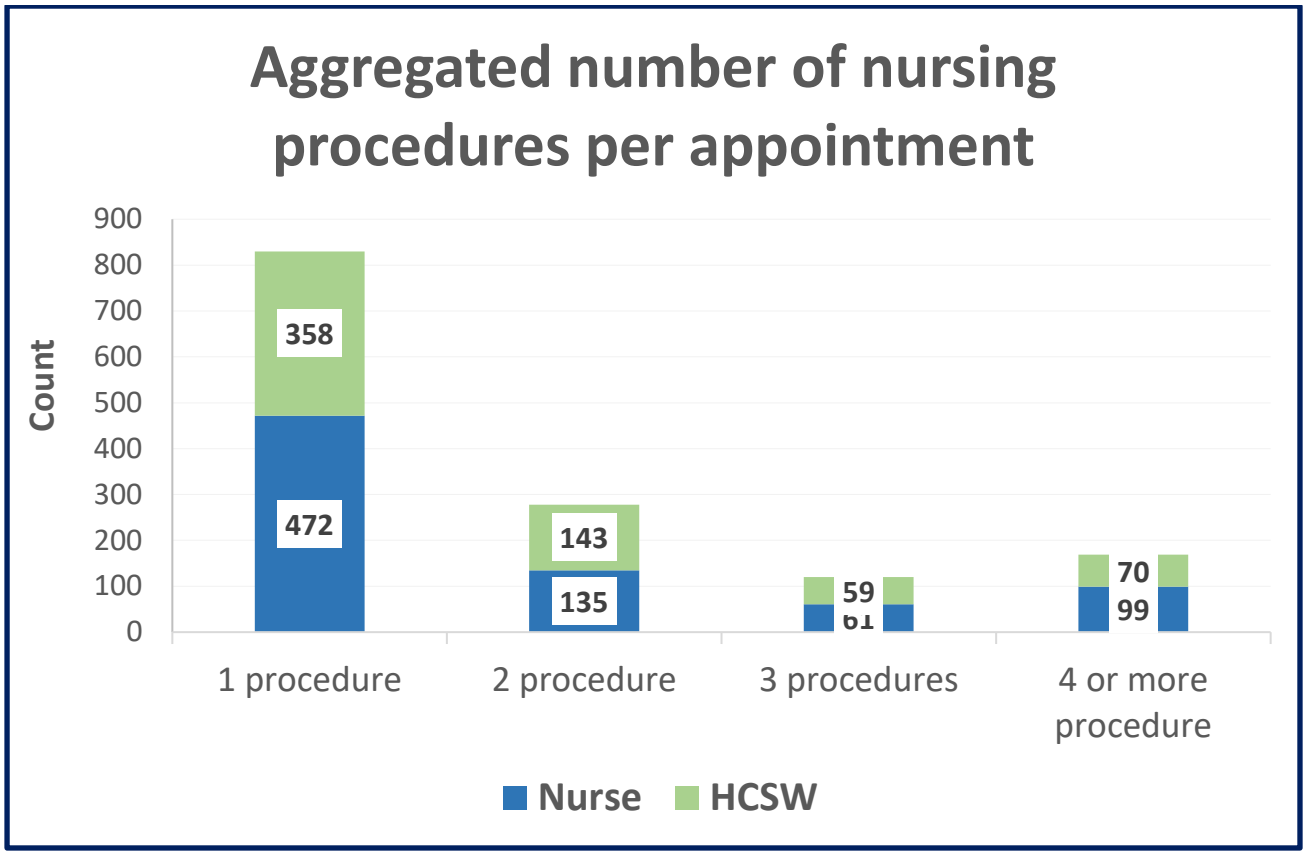
Nursing activity was monitored across ANPs, Practice Nurses, District Nurses and Healthcare Support Workers during the Week of Care Audit. This was an attempt to quanitfy demand for activities that fall into CTAC as well as to map out some of the roles that will remain with practice nursing.



In the above Pareto chart we can see that Phlebotomy and other HCSW tasks are already being undertaken by a proportion of HCSWs. As we complete the implementation of full CTAC we will have shifted the skill mix across practice treatment rooms from roughly 1/3 Healthcare Support workers versus 2/3 Registered nurses to the reverse proportions. So we would aim to be reportin next year

that all Phlebotomy and other tasks aligned to HCSWs job roles are being done upwards of 95% of the time by HCSWs.

In the graph below we have recorded the number of appointments were multiple treatments were provided within a single appointment. This can often improve patient experience and it is a risk for the implementation of CTAC and the accompanying admin hub that we may see fewer multi-treatment appointments. This also creates more admin demand and is a less efficient use of clinicians time. It is a control measure for the programme that we do not fractuce the patient journey further through the implementation and transfer of these services from practices.



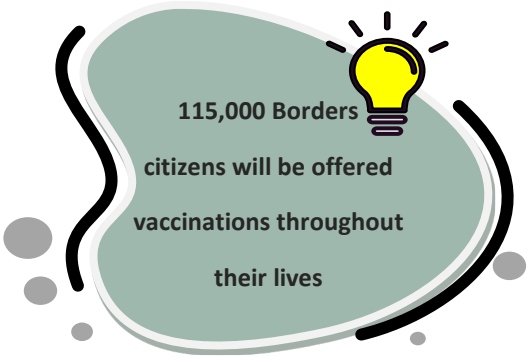
WHAT WE SET OUT TO DELIVER

As per the outcomes of the 2017 GMS contract negotiations, NHS boards and local partners are required to plan, manage and deliver vaccinations rather than the longstanding arrangement of contracting delivery through general practice.

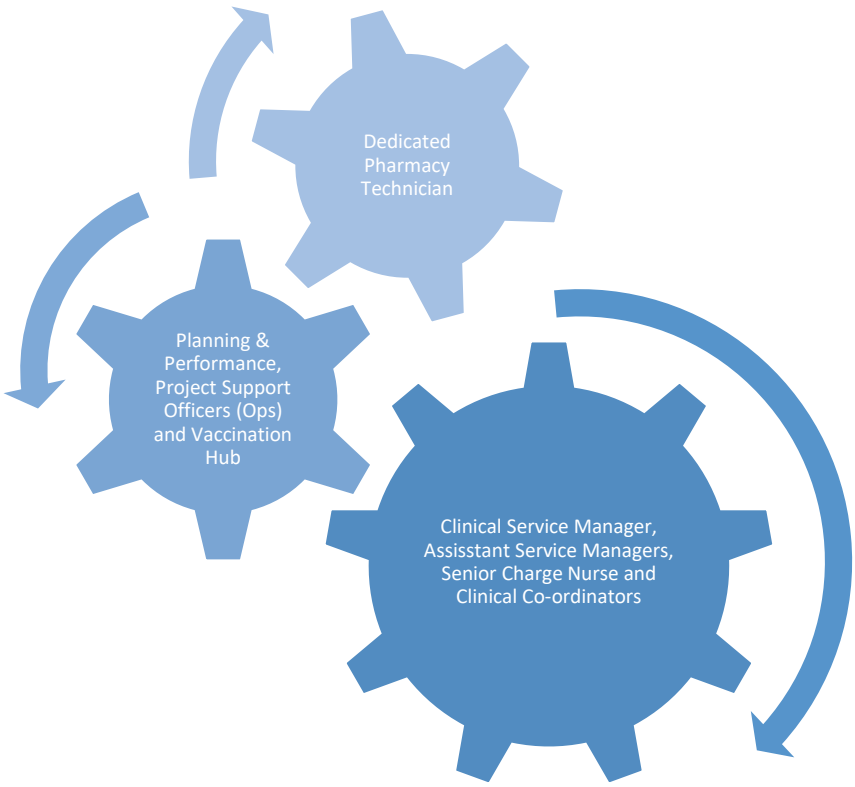
While the UK Joint Committee on Vaccination and Immunisation (JCVI) and Public Health Scotland (PHS) will continue to guide national policy and vaccination programmes, delivery must be managed and implemented by NHS health boards and their local partners to suit their local population, geography and workforce.

Between September 2021 and April 2022, NHS Borders Vaccination Transformation Programme created a dedicated Vaccination Service with responsibility for vaccinations and immunisation, and successfully transitioned all outstanding programmes from GPs to the health board by the required deadline.

NHS Borders Vaccination Service leads the delivery of programmes in partnership with public health, school immunisation, community nursing, occupational health, maternity services, child health, general practice, acute services and the wider Scottish Borders Health and Social Care Partnership.



Vaccination clinics take place on an ongoing basis in health centres, schools, hospitals and community venues across the Borders. Provision is also in place for patients who are housebound or live in residential care.



The service is led by a dedicated Clinical Service Manager, supported by Assistant Service Managers (Planning and Operational) and the following staff:

- Senior charge nurse, Clinical Co-ordinators, vaccinators (nurses) and healthcare support workers.
- Planning and Performance Project Support Manager to assist with planning, uptake monitoring, change and improvement.
- Project Support Officers manage clinic set up, logistics, kit and vaccine transport.
- Vaccination Hub for patient contacts, admin and staffing, including a coordinator, supervisors, admin officers and call handlers.
- A dedicated pharmacy technician to manage vaccine provision.

DELIVERY APPROACH

The Vaccination Transformation Programme delivered patient journeys, operating processes, policies, workforce, communications, resources, systems and reporting from scratch to support a new service.

A dedicated “Vaccination Hub” was developed following its introduction during the 2020 flu programme, evolving to provide a single centre of expertise for:

- Call handling and patient appointment booking line (inbound and outbound)
- Clinic administration (registering patients, arriving patients, liaising with clinical staff)
- Staffing support (recruitment, rostering and training support)
- Dedicated administration and operational support
- Clinical operational support (e.g. clinic kit boxes, printing documentation, ad hoc transport requests)
- Caseload and patient list management (e.g. housebound patients, care homes)
- Records management (devolved management, record amendments, issues and data quality)

Covid-19 and other non-PCIP vaccinations

The Vaccination Programme was integral in the successful delivery of Covid-19 Vaccinations. It is important to note that this vaccine along with other non-PCIP vaccines introduced after the PCIP specification was agreed are funded with a separate additional funding stream.

The Vaccination Transformation Programme capitalised on innovations and new technologies to create a streamlined, resilient, people-centred service introducing:

- A cloud-based telephone system, increasing call capacity, improved patient routing, call queues, options for patient call back, and the capability for call handlers to answer calls remotely.
- Vaccination Management Tool, a national web-based application to support the recording of vaccinations at point of care.
- iPads to support the recording of vaccinations ‘on the move’ and in varied clinic settings.
- National Vaccination Scheduling System to support the appointing of patient en mass by cohort, and a web-based portal allowing patients to book and reschedule appointments online.
- National Clinical Data Store and COVID status app, allowing patients to view their own vaccination status online and automatically pushing data into GP systems.
- Reporting dashboards – sharing concise, visual summaries of uptake, performance and planned appointments.
- Dedicated vaccinations webpage for patients http://www.nhsborders.scot.nhs.uk/vaccinations
- Dedicate vaccinations intranet for NHS staff and partners.

CLINICAL STAFFING BREAKDOWN (31 March 2023)	Permanent		Fixed Term		As & When	
	In Post	Vacant	In Post	Vacant	In Post	Vacant
Clinical Management	2.0	0.0	0.40	0.0	0.0	0.0
VTP (Babies, Pre-School, Travel & Selective)	3.6	0.00	0.00	0.00	0.00	0.00
Adult Vaccinations (Shingles, Pneumo, Flu & CV-19)	4.0		4.00	0.00	0.54	0.00
School Immunisations	5.06	0.00	0.53	0.00	0.00	0.00
Total:	14.66	0.00	0.53	0.00	0.54	0.00

VACCINATION ACTIVITY & UPTAKE- As of March 2023, the Vaccination Service has given over 493,000 vaccinations, including over 347,00 COVID vaccinations (since December 2020), and 146,00 vaccinations across routine childhood, pneumococcal, shingles, flu, selective and travel programme.

Programme	Vaccinations given	Uptake range
Routine childhood (baby/pre-school)	30,000	94 – 97%
Pneumococcal	12,500	75 – 85% (all cohorts)
Shingles	11,000	51 – 76% (all cohorts)
RSV	5,000	55% overall uptake
Non-Routine & Travel	4,000	-
Flu	194,000	55 - 93% (all programmes)
COVID	402,000	86 – 99%

Taken from the Renew Annual Report 2023/24, September 2024

Introduction and highlights

The Renew service was established in NHS Borders in October 2020, utilising funding from PCIP, Action 15 and psychology services with the aim of offering a "see and treat" model for model for mild to moderate anxiety and depression for those aged 18 and above, using evidence based psychological therapies in primary care.

In the last year we have continued to note high demand for our service, Renew is receiving more referrals for people who have more complex mental health problems, whose needs are not met through low intensity interventions, but not severe enough to warrant secondary care services.

In the past year, we have reviewed our service data, where the areas of demand are and monitored the types of presenting problems referred to the service. Using that data and our understanding of the psychological therapies matrix we have altered some of our service provision.

This has included:

- Reviewing and enhancing the therapeutic intensity of our anxiety and depression courses
- Reviewing the frequency of these courses
- Introducing new skills courses to meet new demand e.g. courses which address problems with emotion regulation, and people who have experienced trauma throughout their lives.
- We have also placed emphasis on ensuring people are matched with the intensity of intervention which best matches their needs at point of referral.

Renew continues to offer a psychological assessment to patients at point of referral. We aim to ensure patients are triaged appropriately within Renew and matched to the evidence-based intervention appropriate to their presentation and goals or referred appropriate to other services in a timely fashion.

This report outlines the performance of Renew against our KPIs for the period of April 2023 to June 2024 in addition to longitudinal service data for comparison purposes. Further, where appropriate we have included comparisons to the Increasing Access to Psychological Therapies (IAPT) Programme, as a comparison for national data.

Key highlights:

- We have noted a change in the type of demand in the service to increased complexity requiring additional 1:1 treatment
- Using service data, we have used quality improvement methodology to understand our referral pathway and plan for changes in order to meet changes in demand, by analysing our waiting lists and using the matrix to plan and provide evidence-based interventions.
- Our clinical response has been to reallocate our clinical resource in order to provide interventions like Survive and Thrive which meet a clinical need but also allow us to provide treatment to a number of people effectively and efficiently.
- We have updated the content of our skills courses to ensure that they are as therapeutically effective as possible.

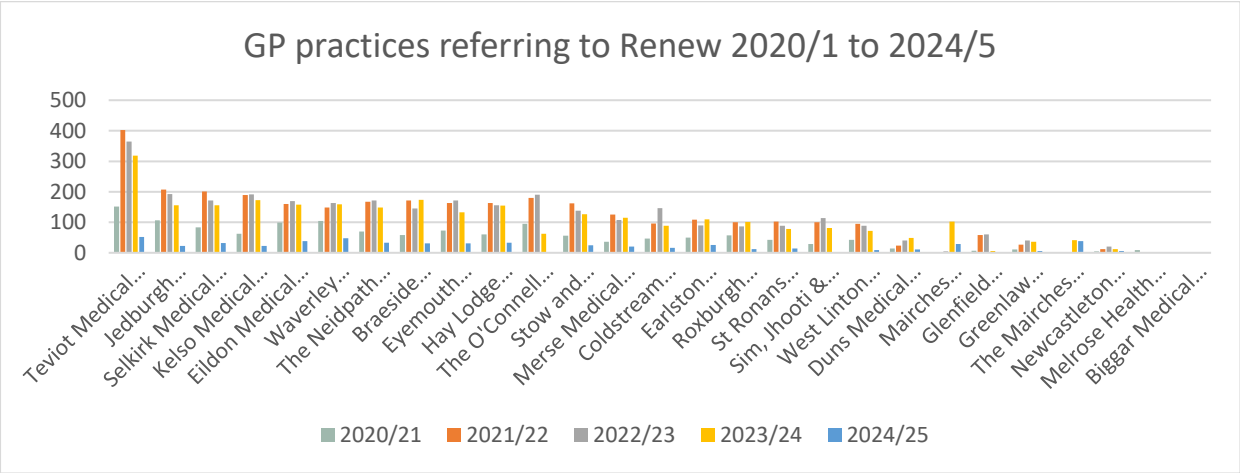
- The DBI clinical lead psychologist position, now sits within the Renew structure, ensuring good communication, shared training opportunities and effective transfer for patients between the two services.
- We continue to receive positive feedback from our GP colleagues and patients
- Our data analysis suggests our range of treatments are effective in reducing 'caseness' and bringing about reliable improvement comparable with IAPT data.

Progress as per KPI's

KPI1: Demand for service – Referrals

The service continues to experience high demand. All GP practices across NHS Borders have referred to Renew since the service opened in 2020 and the chart below indicates that this pattern has continued as the service has developed.

Chart 1: GP practices referring to Renew

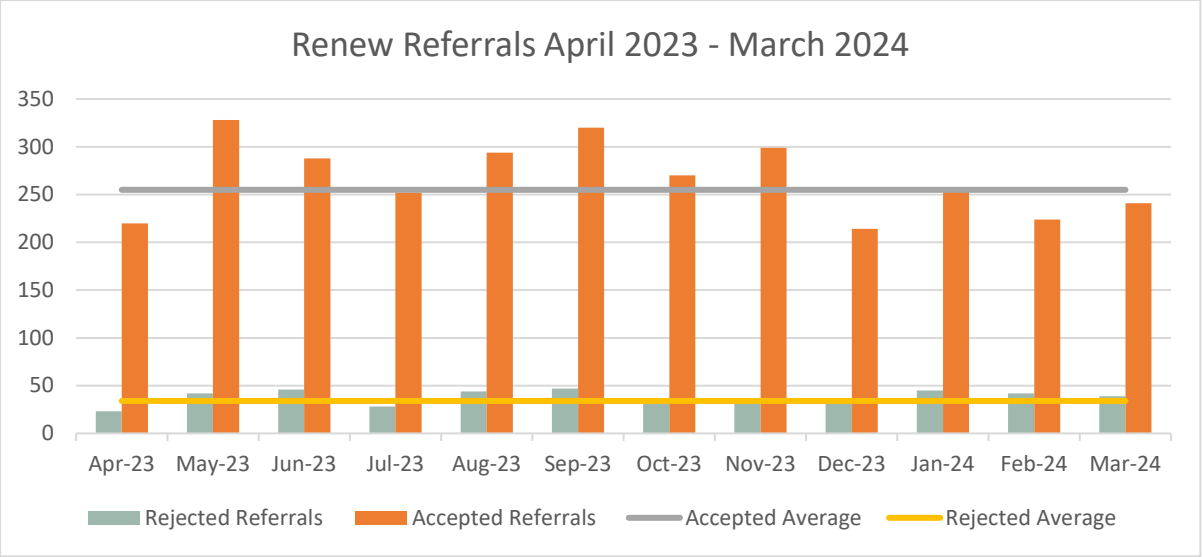


*A number of practices have merged during the reporting periods explaining a reducing in referrals from some practices and an increase in others.

We note some seasonal variation in referrals, with generally lower numbers over the holiday periods. The rate of referral has decreased over the first quarter of this year, but in this we note a declining demand for treatment of mild disorders and an increase in demand for treatment of moderate presentations of anxiety, depression and both single and complex presentations of psychological trauma.

Chart 2 below, highlights the number of referrals accepted and declined each month, with the overall mean for comparison. We aim to have a high threshold for declining referrals and therefore very few of the referrals to Renew each month are declined. We triage and monitor referrals daily, the main reasons recorded for declining referrals are as follows: significant complexity which would require a multidisciplinary approach, or the treatment approach is located in Secondary Care (eating disorder, EUPD) or the patient presents with significant risk could not be safely supported in primary care.

Chart 2: Referrals to Renew April 23-June 24



We wanted to understand the repeat referrals to the service. When the service was initially launched in 2020/2021 the community was experiencing high levels of anxiety. The service responded to this by offering high volume evidence-based CBT skills courses and whilst the data and patient feedback suggests these are effective at alleviating distress, we noted a number of return referrals to the service, suggestive that patients as the anxiety from the Covid period has reduced there are a number of patients with psychological distress which requires higher intensity interventions.

As we have understood the referral data and amended our treatment approach over the second quarter of 2023/2024, we have seen a reduction in return referrals to the service as demonstrated in Table 1 and Chart 3. We will continue to monitor this going forward.

Table 1: Percentage of New to Return Referrals 2021-2023

Year	2021	2022	2023
Percentage New referrals	88%	83%	86%
Percentage Return referrals	12%	17%	14%

KPI 2: Speed of Access/Service Efficiency to see and treat

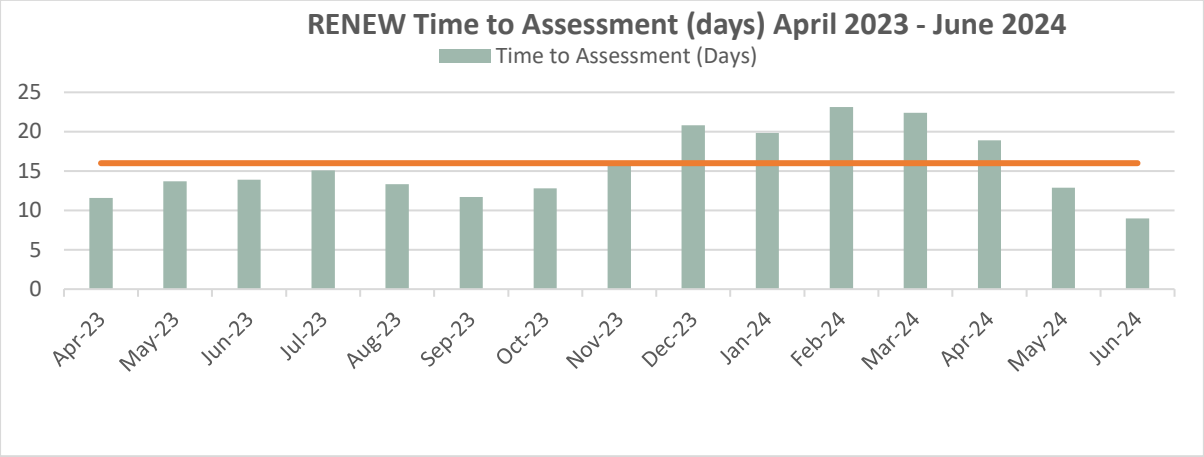
A) Assessment

In the last financial year, average time from referral to assessment was 13 days. There was an increase in the latter part of 23/24 due to increased referrals to the service, seasonal staff sickness and maternity leave. We subsequently amended the distribution of our resource to ensure that these times were improved. GP's have told us that they value us doing an assessment and giving an opinion on best treatment within a short period of time.

In Renew, we front load clinical expertise to ensure that people receive a psychological assessment and treatment outcome quickly. This may mean a psychological treatment in Renew, but it may also mean being signposted or referred on to an organisation who may more appropriately meet the person's needs e.g. Secondary Care Psychology, Cancer Services, or a third sector organisation who

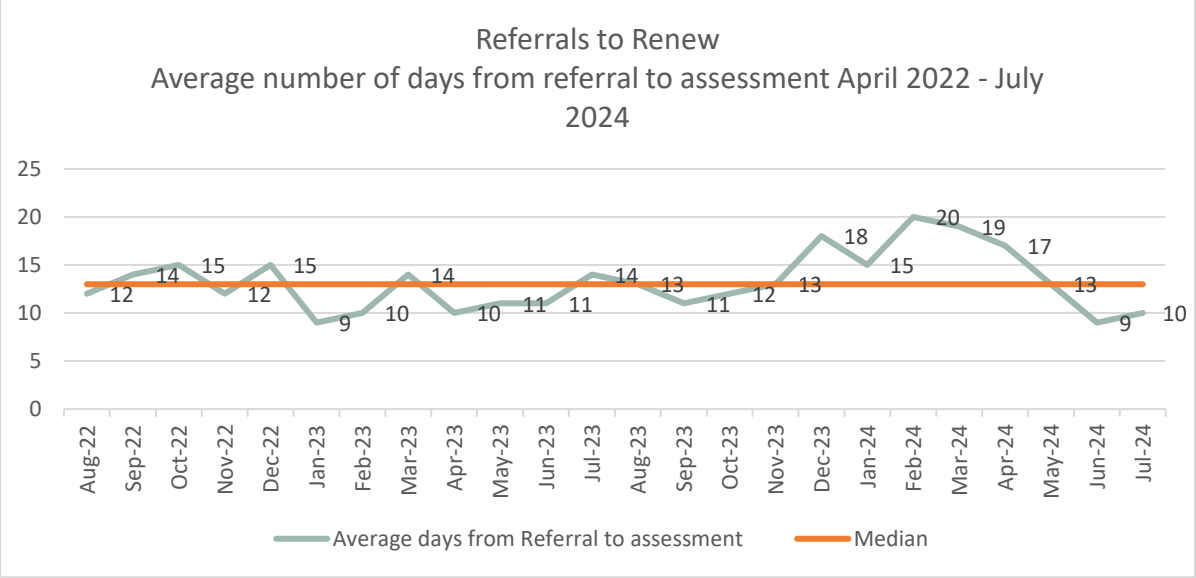
can provide mental health assistance which meets the persons goals. We note that a proportion of the people we assess don't necessarily need psychological therapy but are able to signpost them to the best option possible for them. Although this takes resource, GP's tell us they value assessment appointments with letters sent to GP's giving them recommendations.

Chart 4: Average time to assessment



We know it's important to patients and GPs that people are assessed quickly. Chart 5 below demonstrates that our referral to assessment time has been consistent across the last two years.

Chart 5: Referrals to Renew: Average number of days from referral to assessment April 2022-July 2024



B) Treatment

In the last financial year on average people started treatment within 8.7 weeks of referral. Those who access digital treatments can start immediately, those attending skills courses should wait no longer than 4 weeks till the next available course. The longest waits in the service are for those people who require individual interventions. The change in demand in types of referrals has altered the flow of patients through the system as more people wait for individual interventions. However,

the service consistently performed well against the HEAT standard of referral to treatment within 18 weeks.

Chart 6: Renew Time to treatment (days) April 2023 – June 2024

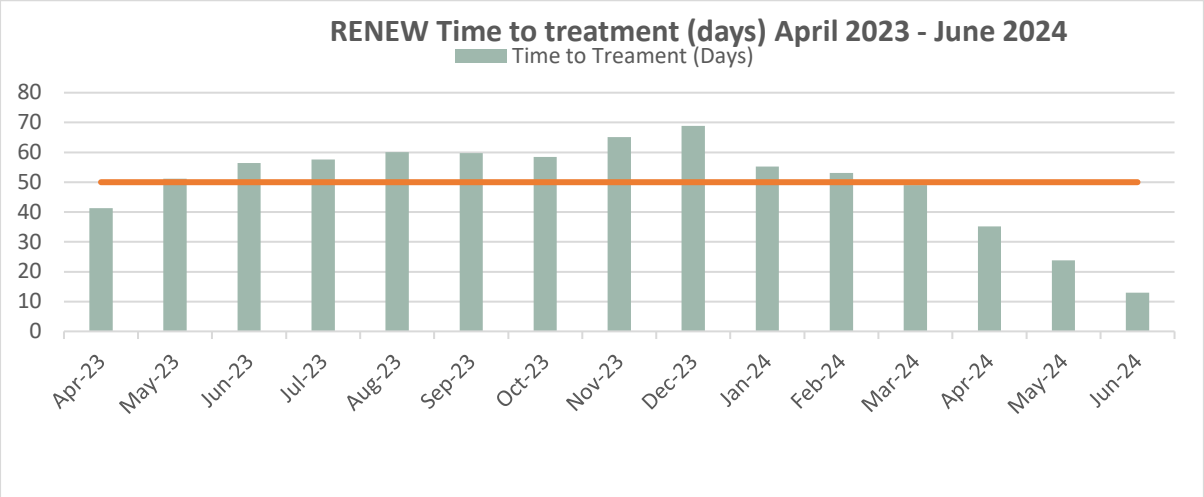
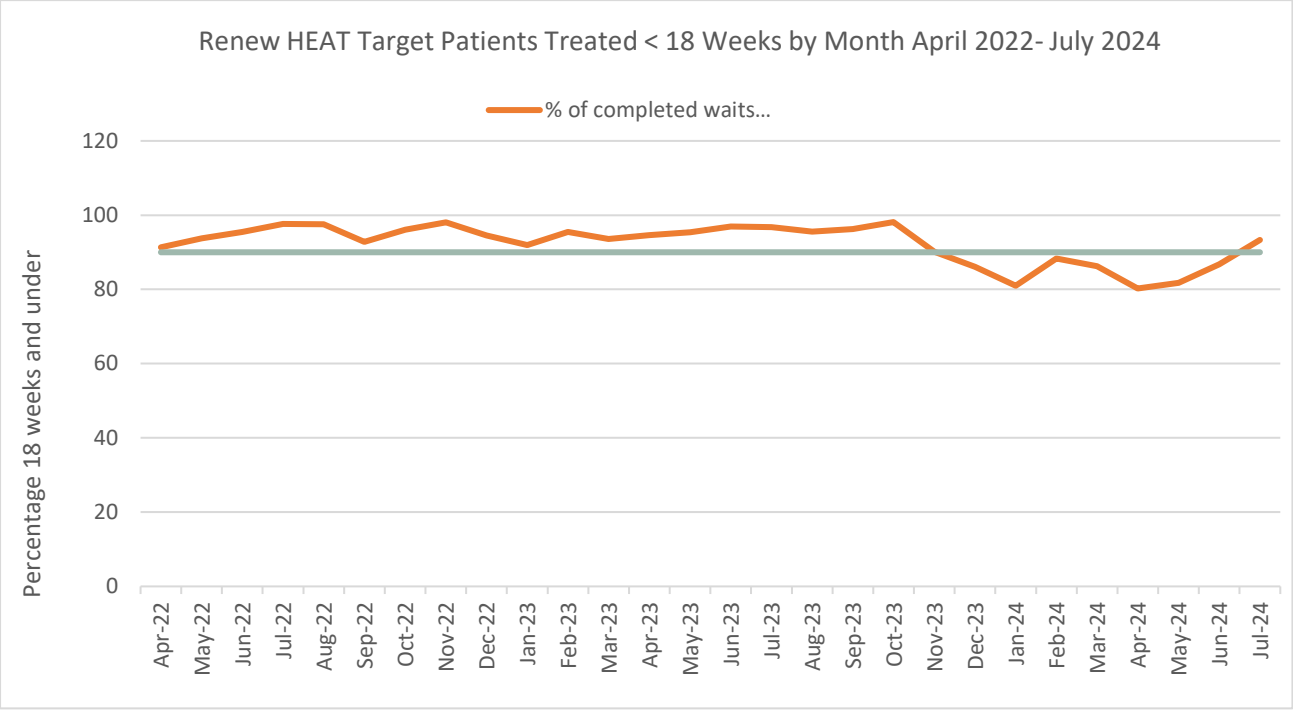


Chart 7: Renew Performance against 18 Weeks Heat Target.



Our performance against the HEAT target fell in November and December 2023 due to increased clinical demands of those waiting for treatment, staff on maternity leave and significant seasonal illness in our staff. We reviewed the delivery of skills courses, the clinical needs of those waiting on our individual treatment waiting lists and reallocated resource, including the introduction of Survive and Thrive (evidence based group intervention for those who have experienced repeated interpersonal psychological trauma). We were also able to recruit qualified psychologists to enable

throughput on our clinical psychologist individual waiting lists. This has significantly improved performance.

C) Treatment interventions offered

We currently offer psychological interventions of varying intensities in Renew to ensure we are able to offer the correct 'dose' of therapy. There are three types of individual intervention offered, EPP (brief intervention), CAAP (8-12 sessions of high intensity CBT), Clinical or Counselling Psychologist (12-16 sessions of highly specialist therapy).

Approximately 30% of the people referred to renew are suitable for treatment in a one of the skills courses; these include Anxiety, Low mood (mild to moderate symptoms of anxiety or low mood/depression), healthy self esteem for those whose psychological difficulties are impacted by their self esteem (moderate difficulties) Emotion Resources is most appropriate for people with moderate difficulties experiencing problems with emotion regulation and the most recent addition to the service is Survive and Thrive, appropriate for people who have moderate difficulties associated with having experienced repeated interpersonal psychological trauma.

The skills courses offered in Renew remain a highly popular and effective treatment option. In 2023/24 we have reviewed and updated the content of the anxiety, low mood and healthy self esteem skills courses to ensure they remain consistent with the evidence base, and they are offering the correct 'dosage' of treatment. We will continue to review the impact of these changes in terms of patient feedback and clinical outcomes.

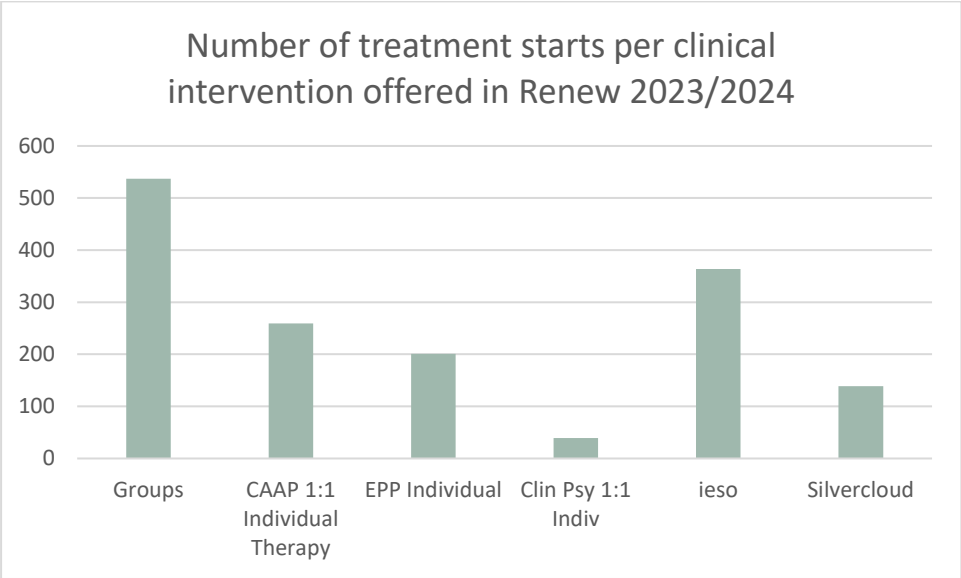
Digital interventions are also offered in the service. Silver Cloud has a range of modules for people experiencing mild to moderate psychological difficulties. These are provided with online support from our Assistant Psychologists. People work through these modules independently in their own time. IESO is a higher intensity digital intervention. This is offered by therapists who are providing a text-based appointment service People accessing the service are offered individual CBT at an appointment time of their choice which provides a flexible alternative for those people who do not wish to take time off work to attend appointments or may require flexibility for childcare.

Treatment options in Renew are outline in more detail in Appendix 1.

D) Demand and Uptake of Interventions:

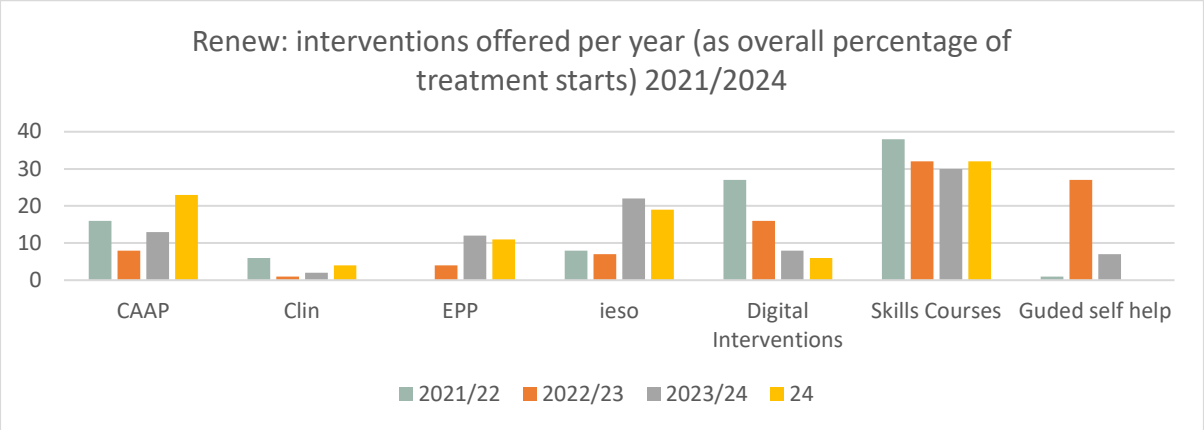
Chart 8 below shows the types of interventions offered in Renew over the reporting period as a percentage of overall treatment starts. The figure demonstrates that approximately 30% of interventions offered in Renew over the past year were 1:1 (Clin Psych, CAAP or EPP), a further 30% of interventions were via our skills courses.

Chart 8: Clinical Interventions delivered in Renew in 2023/24



As discussed earlier in the report, we have noted a change in profile for the demand for different types of interventions over the course of Renew's establishment with a focus on increased demand for interventions for moderate presentations of common mental health problems which often demand a 1:1 intervention. Charts 9 and 10 below indicate the percentage treatment starts for each intervention over the period of 2021 to 2024.

Chart 9: Type of clinical intervention offered per year (as overall percentage of treatment starts) 2021/2024



We note the graph demonstrates increasing demand for individual therapy (Clin/Counselling Psychologist, CAAP or EPP) and the number of these interventions offered within the service continues to increase. We believe this reflects the increasing complexity of presentations referred to Renew, and that people who are being referred to the service have their care appropriately matched to their presenting complaint.

There is an overall decline in demand for digital therapies, particularly Silver Cloud. IESO falls between an individual and a digital intervention, as it is a chat-based therapy provided on a 1:1 basis. We have seen increased demand and uptake of ISEO across the period 2021-2024, largely we believe due to the increased flexibility of appointment times and overall increased demand for individual therapy.

Chart 10 Renew demand for individual and group therapies (percentage of treatment starts) 2020/21 to 2023/24

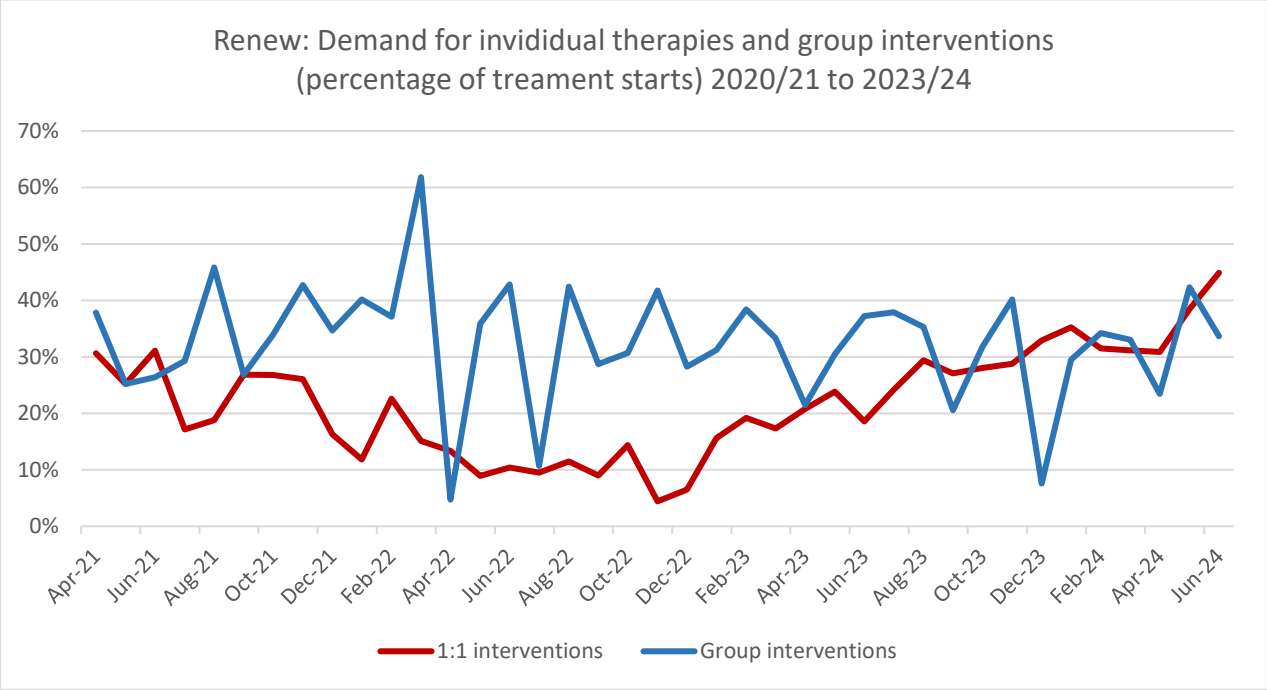
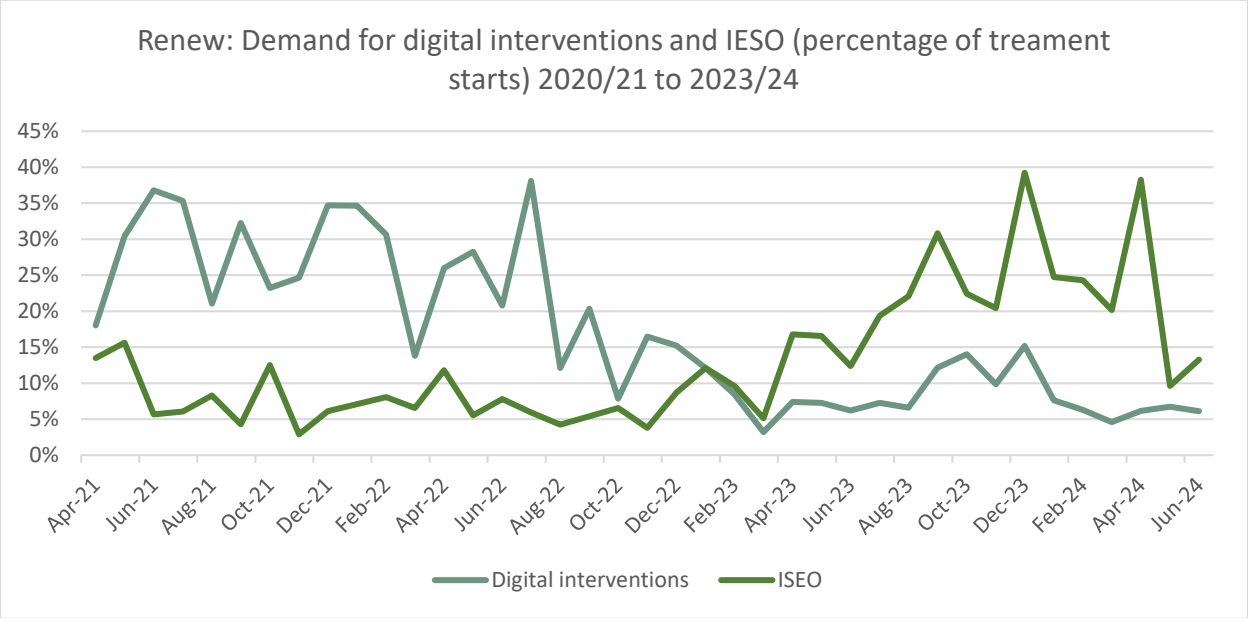


Chart 10 demonstrates the relatively stable demand for CBT skills courses across the last three years. Months where there are drops in numbers are where we tend to run fewer courses or experience changes in referral numbers. We have noted that as we have altered our treatment allocations to these courses overall compliance has also increased. Importantly chart 10 notes the significant increased demand for individual interventions in Renew and the importance of these for the people accessing our service. Typically, people requiring individual interventions experience moderate psychological distress with associated impact on functioning, common presentations include, PTSD (type 1 and 2), OCD, birth trauma, health anxiety, or more complex presentations of depression which require formulation.

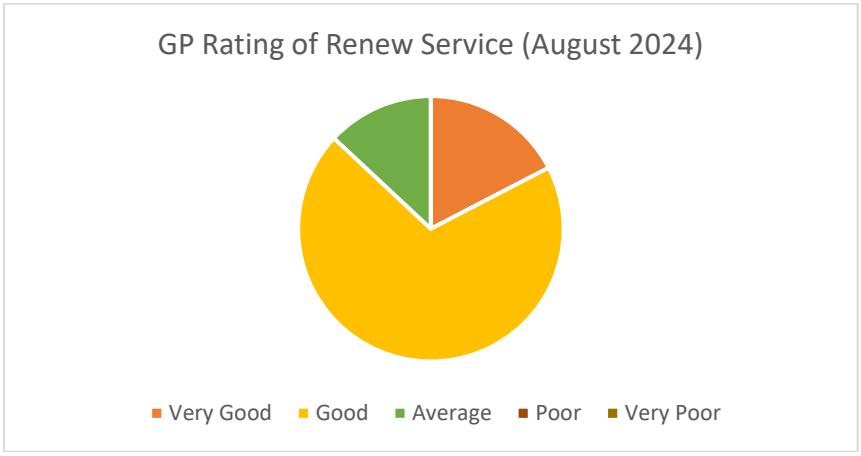
Chart 11 clearly demonstrates the significant decline in demand for self-guided digital interventions like SilverCloud with significant increased demand for 1:1 therapist chat based appointments increasing over the last 18 months. This is also attributable to increased complexity in referrals to Renew and the demand from some patients for flexible appointment times.

Chart 11: Demand for digital interventions in IESO – 2021-2023/24



KPI 3: Service Outcomes – service valued by GP's and patients and treatment effectiveness

1. GP Feedback:
   As our key stakeholders, GP feedback is an important element in understanding out service. In August 2024 we sent out a questionnaire to GP colleagues asking them their views on the service.



   We were delighted to note that 100% of the respondents rated Renew positively, also offering helpful and constructive feedback on the ongoing delivery of the service.

2. <u>Some GP comments (May 2022):</u>
   What does Renew do well?

- Contacts patients quickly
- Good initial assessment and signposting
- Many of my patients have fed back what a fantastic experience they have had with Renew and how they have really helped them
- Good service for patients, rapid triage and contact

What could Renew do better?

- Keep GPs updated about how Renew is working – so we can let patients know what to expect
- More face-to-face interventions
- Increase capacity for ongoing psychological treatments
- Signposting referrals on to secondary care or CMHT rather than passing back to GP

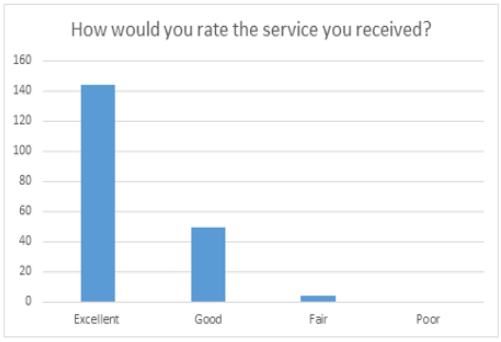
Other comments about Renew?

- Overall, I think Renew is a great service and has benefited a lot of patients
- Mental Health presentations in general practice are no longer heart sink because there is a service like this
- Good service. Has revolutionised mental health care for the Borders GP
- I am aware of the increasing complexity of cases given to Renew as CMHT push back in Borders, and am grateful your service exists

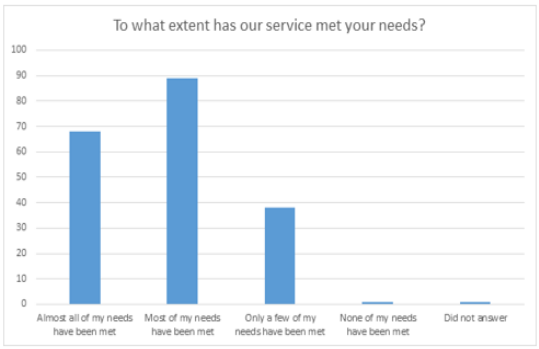
The feedback received from our GP stakeholders was positive and encouraging. Demonstrating that our focus on frontloading our service resource to provide high quality brief psychological assessments in a timely fashion is useful. We value the constructive feedback on what the service could do better and will take that forward in our delivery of the service over the next year.

3. **Service user feedback:**
   Following each intervention, we give patients the opportunity to provide feedback on the service they received. Renew uses the Client Satisfaction Questionnaire (CSQ-8) as a structured form of feedback. The following responses have been received from patients using the service from 2020-2024
   We routinely monitor this data in order to consider our patient experience and the effectiveness of interventions.

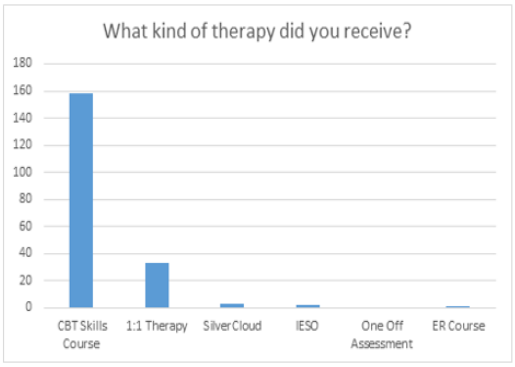
A) How would you rate the service you received?



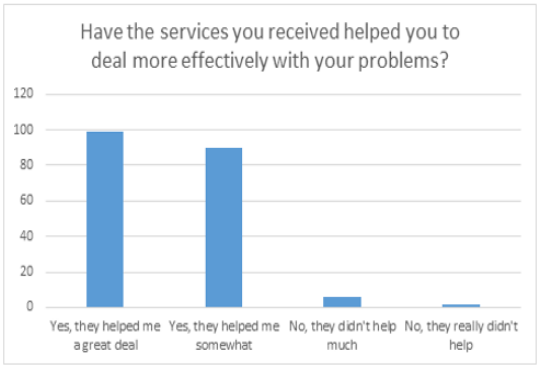
B) To what extent has our service met your needs?



C) If you were to seek help again, would you come back to our service?

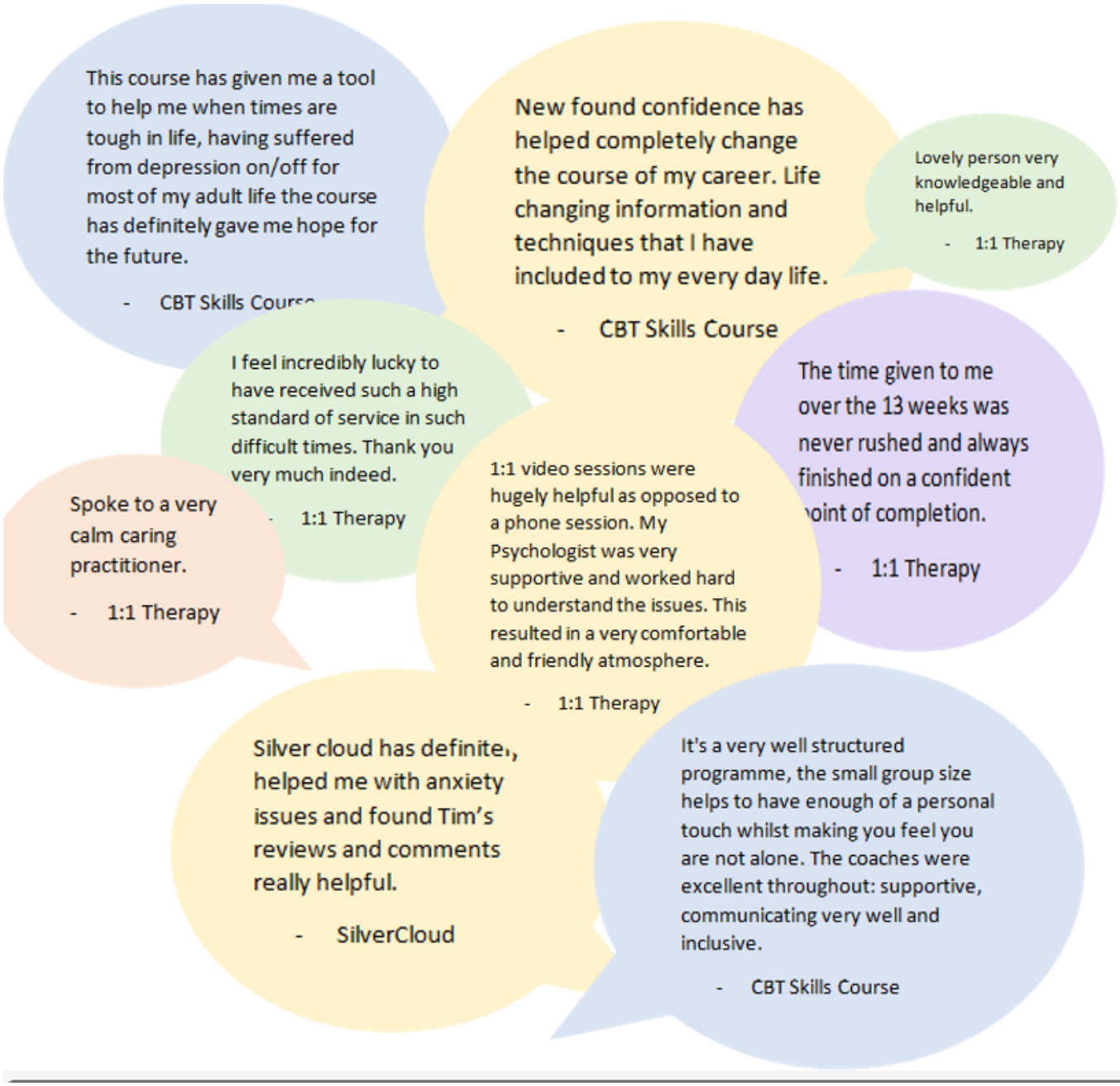


D) Did the service you received help you deal with your problems



Given the volume of patients seen in Renew and the variety of presenting problems treated, we are delighted with the feedback that most patients responding rated their treatment as excellent or good and that people would use our service again. We are further encouraged the significant majority of patients noted that the services they received enabled them to deal more effectively with their problems.

Patient comments



4. Treatment effectiveness

Renew aims to treat low mood/depression and anxiety that presents in a primary care setting. We collect routine clinical measures of depression and anxiety using nationally accepted measures called the PHQ-9 and GAD-7 which are collected pre and post intervention in order to capture this and monitor treatment effectiveness.

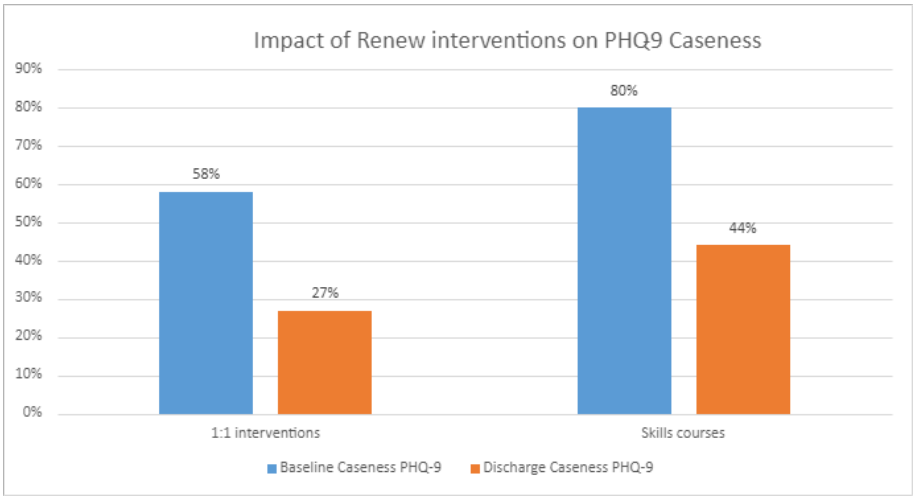
We measure what we call “caseness” using clinical cut offs, which indicate whether a person’s symptoms were significant enough to be considered a clinically significant case. When repeated, this indicator shows the proportion of people who completed a course of treatment who were considered to be a clinical case at the start of treatment (above caseness), and whose symptoms had improved to below the clinical threshold upon completing treatment, giving an overall impression of the clinical effectiveness of an intervention.

The data in Charts X and X demonstrate the percentage of patients achieving “caseness” on each of these measures pre and post intervention.

a) PHQ-9- Low mood and Depression.

The PHQ-9 is a widely accepted measure of low mood and depression which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving “caseness” pre and post intervention. Figure 8 below shows an improvement in symptoms and caseness across all interventions offered for low mood and depression.

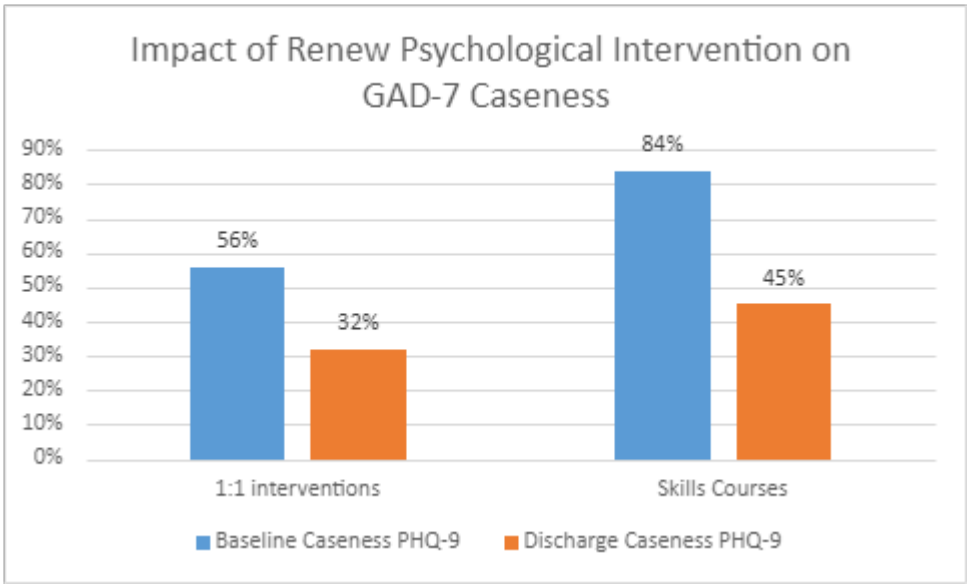
Chart 12: percentage of patients achieving ‘caseness’ pre and post intervention across Renew interventions.



b) GAD-7 – Anxiety

The GAD-7 is a widely accepted measure of anxiety which is measured at assessment and discharge. The data in this chart below demonstrates the percentage of patients achieving “caseness” pre and post intervention. Figure 9 below shows an improvement in symptoms and caseness across all interventions offered for anxiety.

Chart 12 Percentage of patients achieving 'caseness' on GAD-7 across Renew interventions



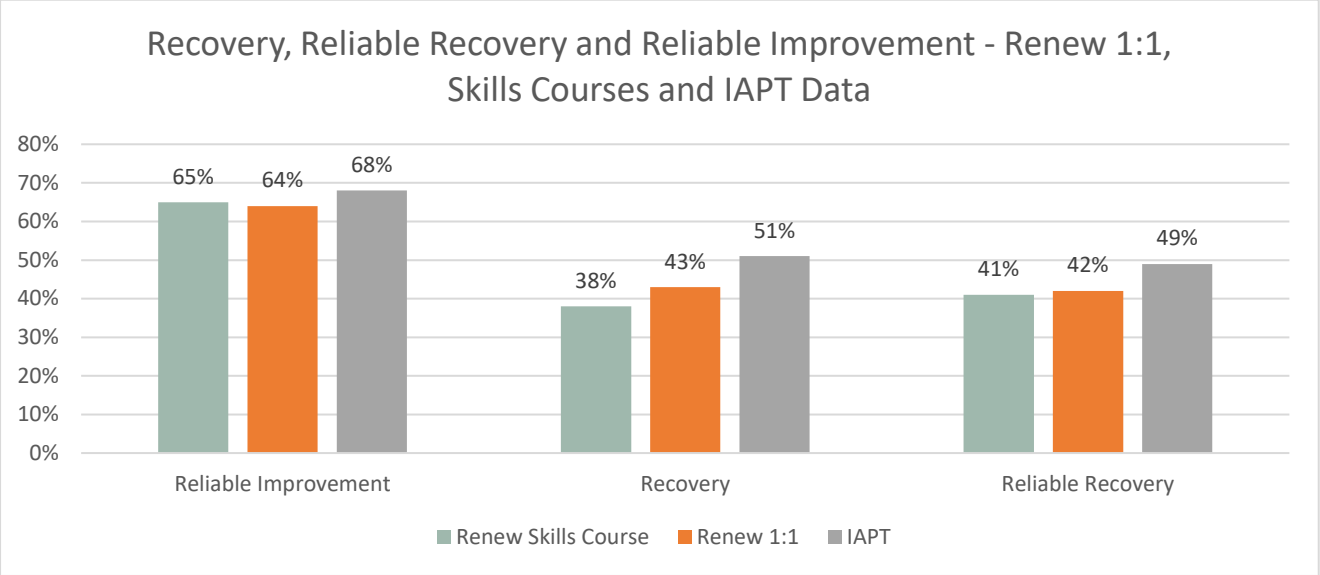
c) Recovery, reliable recovery and reliable improvement by psychological intervention in Renew

Caseness is a different metric to 'reliable recovery' recovery measured by 'casesness' simply means a change in symptoms from above to below the threshold for being considered a clinical case, regardless of the amount of change.

Reliable improvement refers to a statistically reliable improvement, whether people's scores meet clinical threshold or not. Reliable improvement therefore covers people who have recovered, and those whose improvement is significant.

Reliable recovery is achieved when symptoms improve by a significantly large margin pre and post intervention, for people who were considered a clinical case at the start of treatment.

Chart 13 : Recovery, Reliable Recovery, and Reliable Improvement 1:1 and Skills Course Interventions



The data provided above is comparable to IAPT data. In IAPT 68% of people finishing a course of treatment showed reliable improvement vs 64% and 65% in Renew for 1:1 interventions and skills courses respectively.

In reliable recovery, our 1:1 patients are those which present with the most complex difficulties when they attend for treatment. Treatments are delivered according the psychological therapies Matrix (NHS Scotland, 2023). However these individuals often present with co-morbid difficulties. Reliable recovery occurs in 44% of cases undertaken by CAAPs and 39% in cases undertaken by EPPs. EPI are a relatively new intervention in NHS Scotland, and at times people present with multiple difficulties however at a milder level, this may account for the reduced percentage of reliable recovery in that cohort.

KPI 4: Balancing Measures: Ensuring the effect of the service is positive and not creating more work for GP's or Mental Health Services.

a) GP Mental Health Appointments

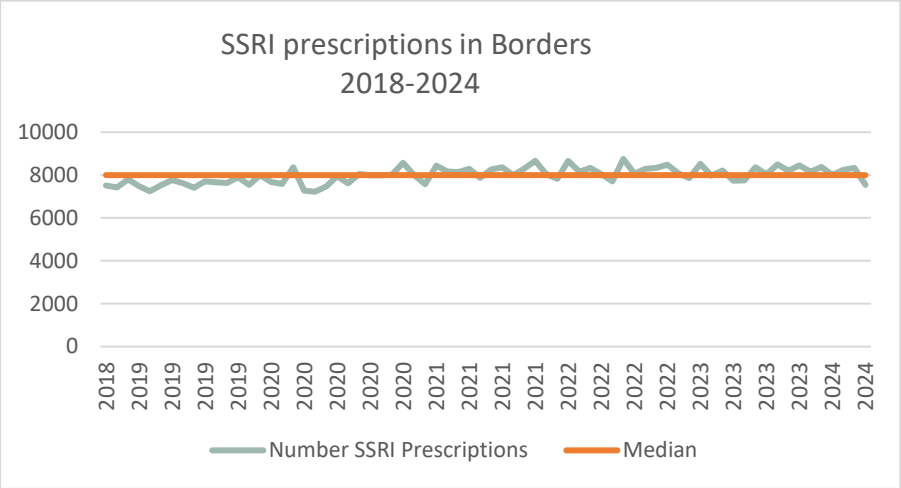
When we did our test of change, an audit on one GP Practice, revealed that for every new GP Mental Health consultation, there were three times as many return appointments. This pointed to the "revolving door" where there was no effective, evidence-based treatment available and was one of the main reasons why we tested out and adopted a "see and treat" model as opposed to usual models of distress management in primary care. With this KPI, we sought to measure whether by establishing Renew, those GP's who referred to Renew had a drop in mental health appointments, especially return appointments. Unfortunately, in spite of extensive discussions, no mechanism has been found to be able to measure GP mental health appointments and as such we have not been able to measure this KPI and recommend we remove this as a KPI unless suitable technology is developed.

b) Anti-depressant Prescribing:

Our assumption was that with different treatment options, that GPs would rely less on prescribing anti-depressant medication. We therefore proposed to monitor anti-depressant medication prescribing. This however, also proved to be difficult on a number of levels. When we consulted experts in this area, the consensus was that even if there was a drop (or increase) in anti-depressant medication, there was not current technical ability to attribute this change to Renew.

We have however, been able to review SSRI and anxiolytic prescribing in Borders between 2018 and 2024.

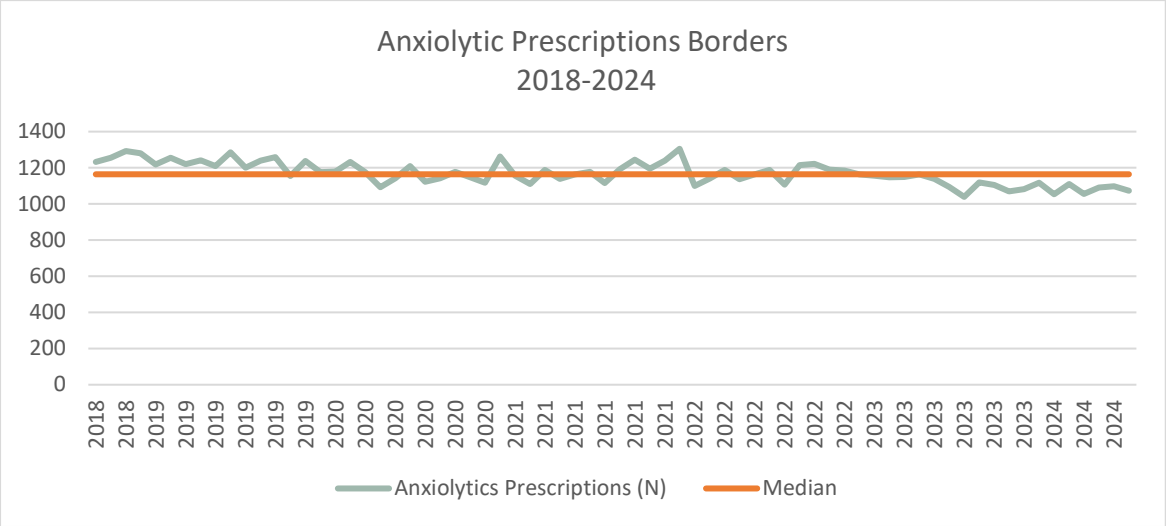
Chart 14 : SSRI prescriptions in Borders 2018-2024



Whilst during the time Renew has been established there has not been a significant impact on SSRI prescribing. National statistics suggest an overall 2% increase in antidepressant prescribing in 2022/23 (NHS England).

We also considered prescribing data around anxiolytics and there does appear to have been a reduction in Anxiolytic prescribing across the Borders area during the period Renew was established. It is interesting data to note, however, we are unable to attribute a causal relationship with the establishment of Renew. Of note, national data suggests that Anxiolytic prescribing decreased by 2% nationally; whilst anxiolytic prescribing in Borders appears to have decreased by 13% overall, this may be reflective of better opportunities to access appropriate psychological therapy in Primary Care as an alternative to prescribing for anxiety related disorders.

Chart 15: Anxiolytic Prescriptions: Borders 2018-2024



c) Impact on Mental Health Services

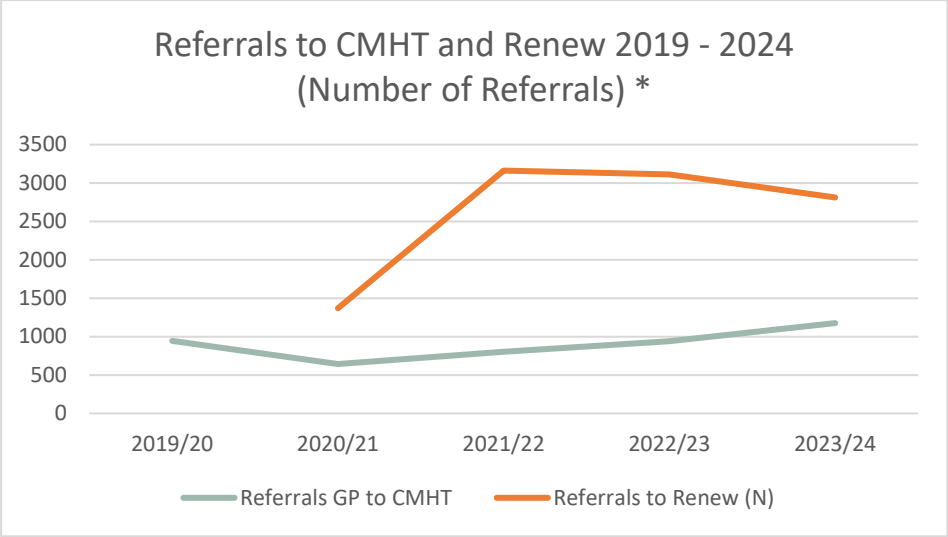
At the time, we considered a balancing measure to be that there was not an increase in referrals to other mental health services, namely the CMHT. To monitor this, we have looked at two pieces of data – total referrals from GP's to CMHT's and referral data between Renew and the CMHT.

Referrals from GP's to CMHT

Data collected between 2019/20 and 2023/24 indicates that there was an initial significant reduction (30%) in referrals to CMHT which occurred around the time Renew was launched. It was noted in earlier reports that whilst it was an interesting trend, the period coincided with the end of the Covid-19 Pandemic which may have impacted overall referral data.

Data for 2020/21 onwards demonstrates a gradual increase in referrals to CMHT, bringing the figure closer to baseline (pre-pandemic) referral numbers. This data is consistent with the recent findings of Gomes (2024) who noted a significant decreased of the number of new referrals to a specific community mental health service with the onset of Covid and a following progressive increase of referrals following on from the end of the pandemic. This is further supported by NHS England data which suggests an increase of 24% to mental health services across NHS funded secondary mental health services between 2019-2020 and 2022-23 (NHS England, 2024). We would therefore conclude that the increased referrals to CMHT is likely a multifaceted issue not directly linked to the introduction of Renew.

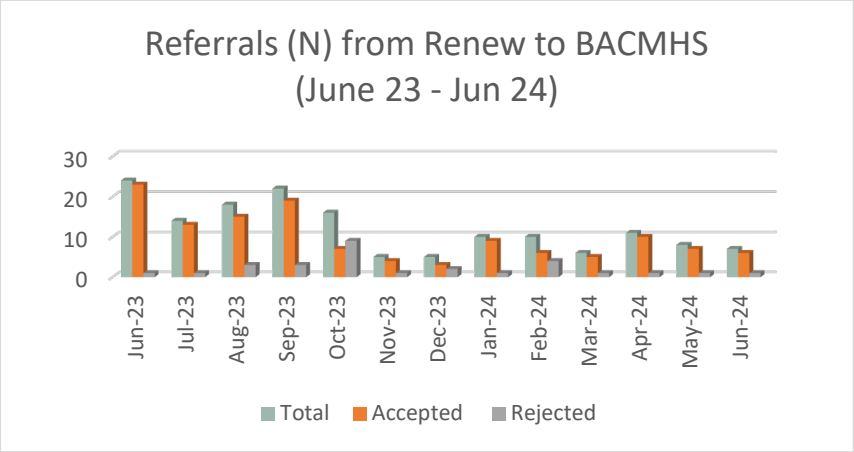
Chart 16: Referrals to CMHT and Renew period 2019 - 2024



*Renew launched in 2020

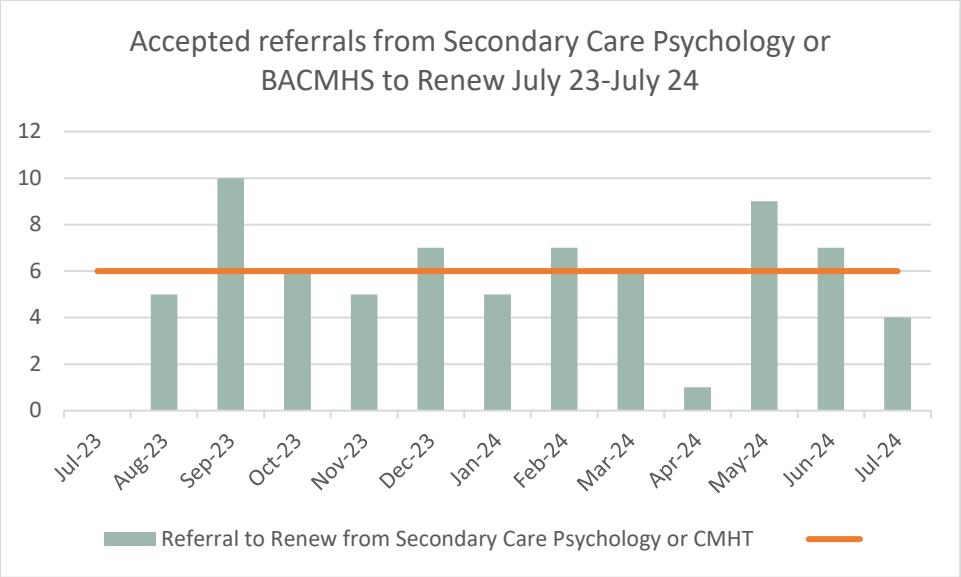
Chart 18 below indicates the referrals made to BACMHT by Renew over the last year, including the total number, those accepted and those declined during that time. There has been a significant overall decline in referrals to BACMHS from Renew over this period as referral criteria has been clarified for BACMHS and referrals to Renew have fallen within our service criteria and fewer have required additional support following referral.

Chart 17: Referrals from Renew to BACMHS (June 23- June 24)



Renew continue to work closely with our colleagues in Secondary Care Psychology and BCAMHS to provide an efficient and patient centred pathway enabling transfer between the services. We meet on a weekly basis to discuss referrals being transferred between the services. The chart below notes the number of accepted referrals transferred from Secondary Care Psychology and BCAMHS to Renew.

Chart 18: Accepted referrals (N) from Secondary Care Psychology or BCAMHS to Renew Jul 23-Jul 24



Key outcomes:

- We will continue to use QI methodology to understand the demand, activity, capacity and queues in our service.
- We will continue to seek and use the feedback of our key stakeholders and patients in their experience of the service
- Using both forms of data, alongside the psychological therapies' matrix, we will continue to adapt and reallocate our clinical resources to ensure we are providing high quality evidence-based interventions to ensure we are meeting the needs of the people referred to the service.
- The evidence suggests that there is an increasing requirement to provide individual interventions as people referred to the service having increasing complexity, including psychological trauma. We will therefore, as far as we are able continue to reallocate our resources to ensure that they are focussed on this demand whilst continuing to provide evidenced based interventions for anxiety and depression for those meeting clinical thresholds.
- Patients and our GP stakeholders value the quick access to assessment within our service, we will therefore continue ensure that people have access to timely assessment and treatment allocation.
- Following on from GP feedback in August 2024, we will deliver regular updates regarding the service with information about the types of interventions provided and what to expect from contact with the service.
- Continue the close working relationship with Secondary Care Psychology and BCAMHS in order to provide and effective and efficient patient pathway between the services.

Treatment interventions offered in Renew

1:1 intervention	Clinical and Counselling Psychologists	Proved interventions at the highest complexity and intensity in Renew. They provide interventions across psychological models and offer 12-16 sessions of psychological therapy. Typical cases for clinical psychologists in Renew involve processing of complex trauma, or presentations of anxiety, OCD or depression which are more complex in presentation and require a higher intensity of intervention
	Clinical associates in applied psychology (CAAPs)	CAAPs in Renew offer 8-12 sessions of cognitive behavioural therapy to patients presenting with mild to moderate anxiety and depression related difficulties. CAAP interventions are offered 1:1 via Near Me or face to face where clinically indicated. CAAPs also provide a central role in the design and delivery of the CBT skills courses.
	Enhanced Psychological Practitioners	Enhanced Psychological Interventions are CBT-informed, high volume approaches suitable for people presenting in primary care settings. They enable staff to help more people, who are seen for a shorter duration and time (generally 6-8 30min sessions). Their interventions are focussed on providing a single strand of CBT for people with milder presentations.
CBT Skills Courses	Anxiety	8 week evidence based CBT skills course. 2 hours per session, delivered remotely by CAAPs and Assistant Psychologists. This course is appropriate for people with mild to moderate symptoms of anxiety
	Low Mood	8 week evidence based CBT skills course. 2 hours per session, delivered remotely by CAAPs and Assistant Psychologists. This course is appropriate for people with mild to moderate symptoms of low mood or depression.
	Healthy Self Esteem	9 week evidence based CBT skills course following low self esteem treatment model. 2 hours per session delivered remotely by CAAPs in the Service. This course is appropriate for people who have mild to moderate difficulties which are largely driven by low self esteem
	Emotion Resources	9 week evidence based CBT skills course following emotion resources treatment model. 2 hours per session delivered remotely by CAAPs in the Service
	Survive and Thrive	10 week course, delivered by two clinical psychologists and a CAAP. Evidence based treatment for symptoms of complex PTSD. 2 hour course delivered remotely by CAAPs in the service
Digital interventions	Silver Cloud Modules	We offer a range of effective evidence based digital therapy offerings for patients accessing Renew. Beating the Blues has now been phased out and replaced by Silvercloud which offers 14 different modules of evidence based computerized CBT (cognitive behavioural therapy). Silvercloud is appropriate and effective for people who have mild to moderate mental health problems
	IESO	IESO is a further digital intervention offered as part of the service. Offered in three tiers from guided self-help to higher intensity interventions for depression and anxiety; patients make a 1:1 appointment and engage with a therapist via text, access is quick, usually within 2 weeks. People referred to this service from NHS Borders experience 67.7% reliable improvement following treatment. This effective treatment can be offered in evenings or weekends which suit people who have work or family commitments find it difficult to access appointments in working hours.

Workforce and footprint:

First contact Physiotherapy services were implemented in the Borders in 2019 with only 2.2 WTE B7 Physiotherapists.

The service has grown to 100% of budget allocation with a staff compliment of 9.2 WTE FCP's in service from February 2022, working at a 1:20 000 population ratio. The service has carried one 0.5 WTE vacancy from February 2023. We have been successful in international recruitment with the new member of staff to join the service in September 2023.

The service is funded for 8.7 WTE Clinically and 0.5 WTE Management. FCP services are delivered in 100% of the 23 GP practices in the Borders in a hybrid model.

- Vision:
  - First contact Physiotherapy (FCP) in the Borders will provide a trusted and direct triage service, in the GP practice, for patients presenting with musculoskeletal pathologies.
- Mission:
  - To be the Gold standard of FCP in Scotland. To inspire hope and contribute to health and well-being by providing the best first contact MSK care to every patient through integrated clinical practice, education and research.
- Slogan:
  - "Together we are the difference"

Key Focus areas:

1. Multidisciplinary teams:

The team is well integrated in all 23 of the 23 GP practices within the Borders. The FCP work-stream have been using a hybrid delivery in the last year to move away from a silo working model imbedded in the GP practices. The key priorities of FCP remain to be a service of excellence in being:

- Safe
- Person centred
- Equitable
- Accessible
- Outcome focused

- Effective
- Sustainable
- Affordable
- Value for money

2. Pathways:

The team has been working continuously on developing various pathways across the MDT for better patient care, early access and “right time-right care-right practitioner”.

FCP pathways established is with

- MSK teams
- Orthopaedics
- Community link workers incl. Mental health
- OT/Speech and Language therapist
- Podiatry and orthotics
- Third party vendors e.g. Live Borders

3. Expert Generalist role

FCP continuously work towards our four pillars of practice to enhance our skill, clinical outcomes for patients and our leadership within the developing roles and delivery of care in PCIP and the Physiotherapy profession.

4. Digital innovation:
   In April 2024 we embarked on a pilot study implementing PHIO a MSK digital solution into each and every GP practice. The digital application is set to triage all presenting MSK pathologies and direct patients to the correct outcomes as per the NHS Borders clinical pathways. Phio with high clinical safe sensitivity also directly refers onto the MSK rehabilitation team or GP practice for additional investigations, were a patient does not meet the criteria for self-management. See more on data and visualisations from PHIO below.

5. Enablers:
   1. Workforce: 9.7 Clinical WTE delivering FCP services in 23 GP practices to a 1:21 000 ratio. (1 WTE Maternity leave until September 2025)

i. GP requirement is currently 223.57 hours per week (10731.36pa – 48 weeks)
ii. 8.7 WTE FCP = 321.9 FCP hours per week
    1. 1(70% clinical time /30% time to work towards our professional four pillars of practice.
    2. N 225.33 clinical hours -10815.84 pa over 48 weeks

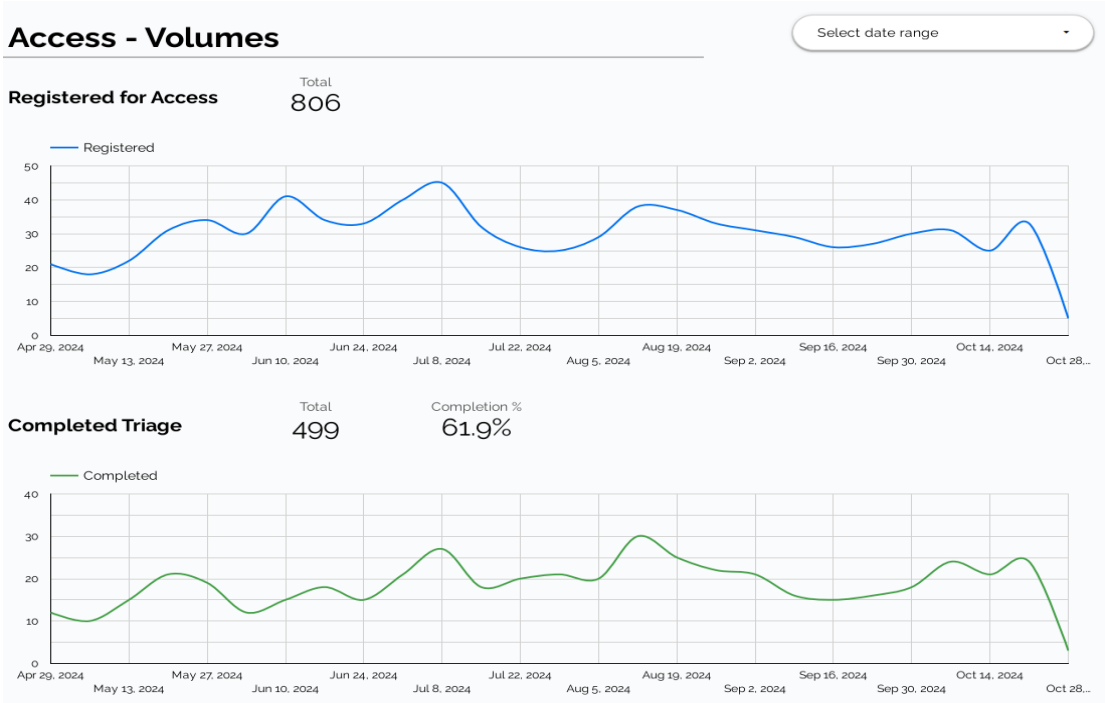
2. Education and training:
    i. 100% of the FCPs are cortisone injection therapy trained.
    ii. 100% FCP staff members are IRMER trained and refer for special investigations including MRI scans
    iii. 3 members of staff received their qualification as independent prescribers for non-medical prescribers with four more members of staff to follow in the next 24 months.
3. The APP lead represents The Borders at the National APP Primary Care Network.

6. Premises:
    1. In GP practice service delivery model for FCP in Borders are limited to certain days to do accommodation shortages in some practices.
    2. Blended working format between Face-Face / Telephone triage and Near Me consultations., with Face to face being the preferred method of service delivery to enable reduction in double appointments being used.

7. Digital:
    1. The change over from the hybrid IT system as reported on in 2023 was welcomed by all and aim to deliver the service direct, cost effective and at the point of the patient asking for an appointment. The imbedding back into the GP practice has raised the team's overall wellbeing and work satisfaction as well as the satisfaction of our patients. A greater cohesive MDT working relationship are being reported with GP /ANP and FCP sharing skills and information daily.

PHIO

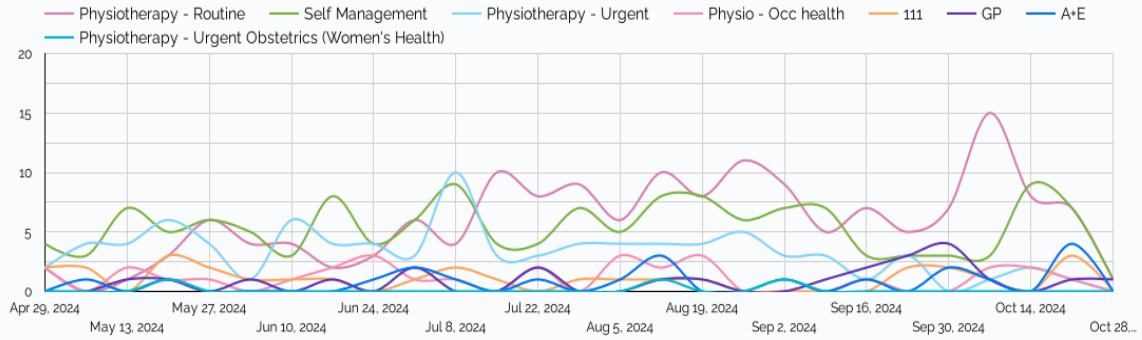
- 12 month Pilot study, sits across primary care in front of GP practice as a self-triage tool, and refers directly into MSK for ongoing rehabilitation where needed.
- Based on clinical pathways of the NHSB
- 800-1000 consultations per month for the cost of one B5 post
    - (FCP with 8.2 WTE 1350 consultations pm)
- Completed the first 100 audit and high level of confidence with more than 95% falling into predicted outcome category.
- Working with Phio to streamline patient experience and see how we can adjust for a waiting list management tool as well.



Access - Outcomes

Select date range

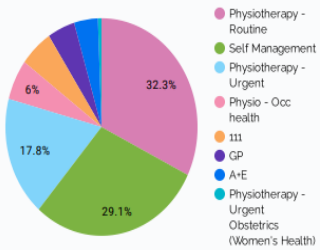
Triage Outcome over Time



EQL Clinician Review and Agreement

	Triage Outcome	Agreement Rate	Count
1.	Self Management	98.6%	144
2.	111	32.1%	28
3.	GP	56.5%	23
4.	A+E	35.0%	20

Outcome Split



Access - Reviewed Outcomes

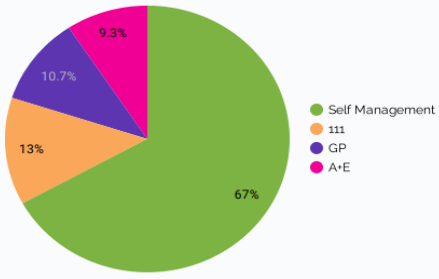
Select date range

EQL Clinician Review and Agreement

	Triage Outcome	Agreement Rate	Count
1.	Self Management	98.6%	144
2.	111	32.1%	28
3.	GP	56.5%	23
4.	A+E	35.0%	20

1 - 4 / 4

Outcome Split (Before)

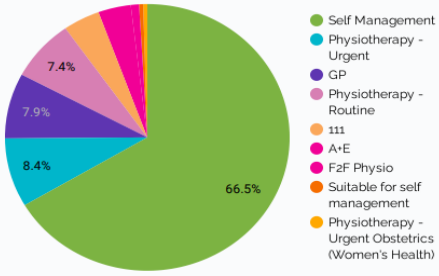


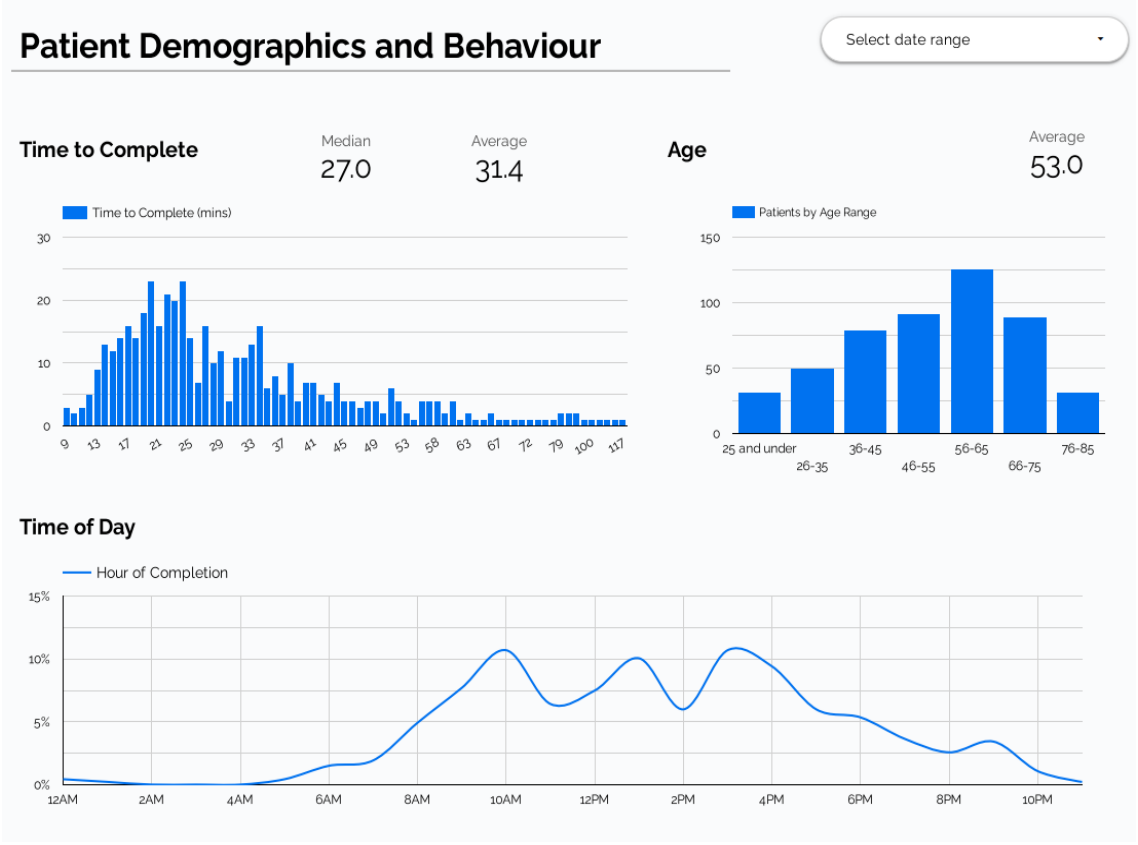
Changed Outcomes

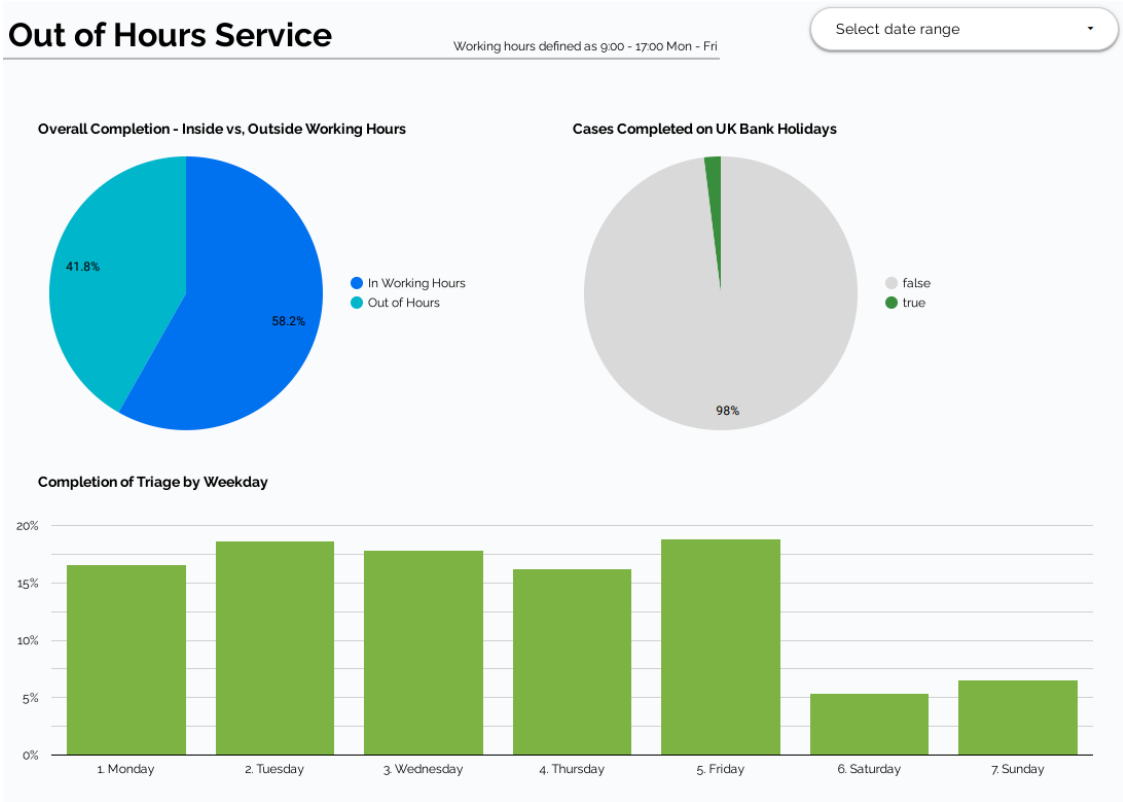
	Triage Outcome	Updated Outcome	Count
1.	111	Physiotherapy - Routine	7
2.	111	Physiotherapy - Urgent	6
3.	A+E	Physiotherapy - Urgent	6
4.	A+E	Physiotherapy - Routine	5
5.	GP	Physiotherapy - Routine	4
6.	GP	Physiotherapy - Urgent	4
7.	111	GP	3
8.	Self Management	Physiotherapy - Urgent	2

1 - 15 / 15

Outcome Split (After)

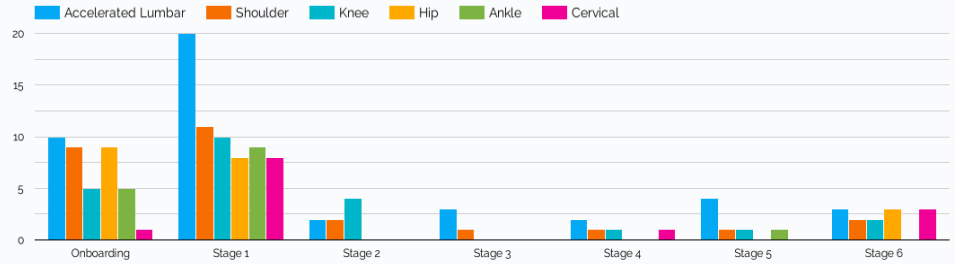



Patient Demographics and Behaviour
Select date range
Time to Complete
Median
27.0
Average
31.4
Time to Complete (mins)
30
20
10
0
9 13 17 21 25 29 33 37 41 45 49 53 58 63 67 72 79 100 117
Age
Average
53.0
Patients by Age Range
150
100
50
0
25 and under
26-35
36-45
46-55
56-65
66-75
76-85
Time of Day
Hour of Completion
15%
10%
5%
0%
12AM
2AM
4AM
6AM
8AM
10AM
12PM
2PM
4PM
6PM
8PM
10PM

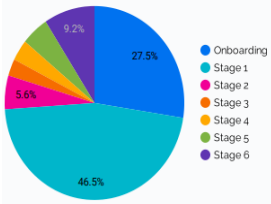

Out of Hours Service
Working hours defined as 9:00 - 17:00 Mon - Fri
Select date range
Overall Completion - Inside vs, Outside Working Hours
41.8%
58.2%
In Working Hours
Out of Hours
Cases Completed on UK Bank Holidays
98%
false
true
Completion of Triage by Weekday
20%
15%
10%
5%
0%
1. Monday
2. Tuesday
3. Wednesday
4. Thursday
5. Friday
6. Saturday
7. Sunday

Engage - Programmes and Stages

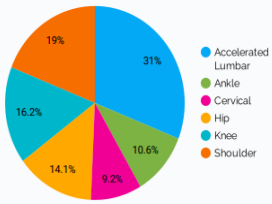
Select date range



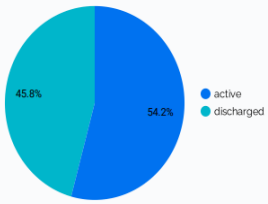
Patients by Current Stage



Patients by Programme



Patients by Current Status



Onboarding and Compliance by Programme

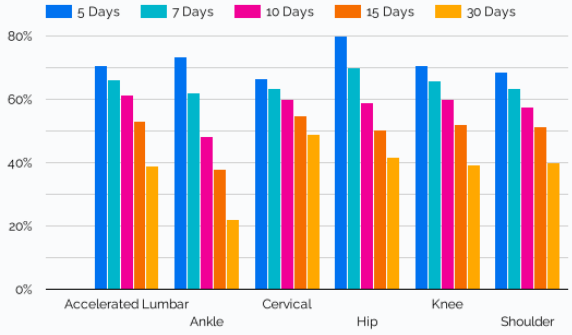
Select date range

Onboarding

	Programme	Onboarding %
1.	Accelerated Lumbar	77.27%
2.	Ankle	66.67%
3.	Cervical	92.31%
4.	Hip	55%
5.	Knee	78.26%
6.	Shoulder	62.96%

1 - 6 / 6

Compliance



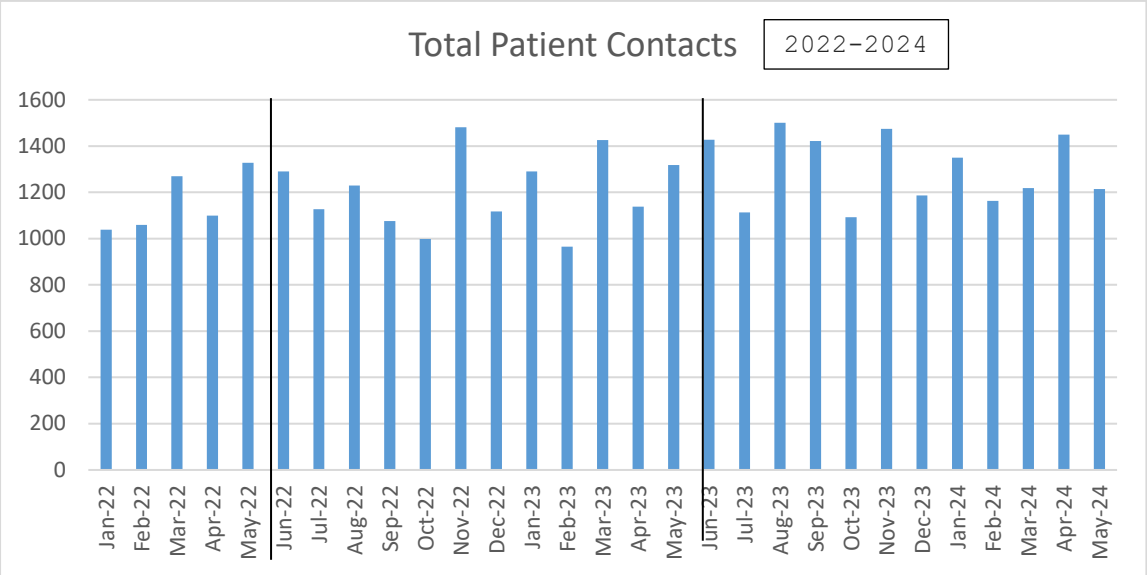
Compliance (cont.)

	Programme	First 5 Days	First 7 Days	First 10 Days	First 15 Days	First 30 Days
1.	Accelerated Lumbar	70.83%	66.07%	61.25%	53.06%	38.89%
2.	Ankle	73.33%	61.9%	48.33%	37.78%	22.22%
3.	Cervical	66.67%	63.49%	60%	54.81%	48.89%
4.	Hip	80%	69.84%	58.89%	50.37%	41.85%
5.	Knee	70.67%	65.71%	60%	52%	39.33%
6.	Shoulder	68.75%	63.39%	57.5%	51.25%	40%
	Grand total	**71.14%**	**65.28%**	**58.86%**	**51.22%**	**39.41%**

'Compliance' defined as number of Daily Assessments completed within timeframe.

What did we deliver?

1) Impact on GP workload:



- 1282.33 (2022-2023) compared to 1016.52 (2021-2022) average consultations per month with a 73% average of self-management and no further referral/intervention required.
- 15388 (2022-2023) compared to 13216 (2021-2022)total consultations for the year
- 0.9% patients referred back to GP practice for medication or fit note prescription.

2) X-ray and MRI referrals:
   - 3.7% average referral rate for x-ray views
   - 2.1% average referral rate for MRI views
3) Wider system benefits:

MSK activity:

- 6.7% average MSK (Musculoskeletal Physiotherapy department) referral rate.

Orthopaedic activity:

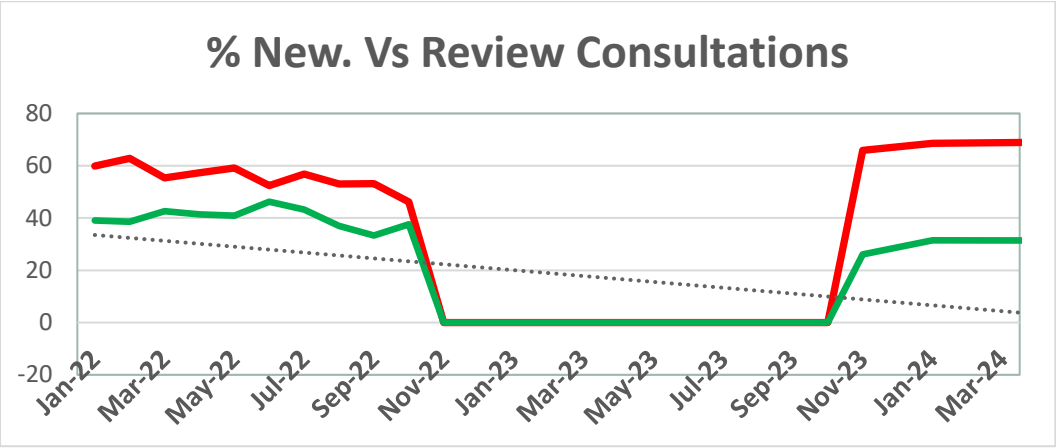
- Cortisone injection therapy in primary care setting:
  - Average of 3.7% of FCP activity is administering Cortisone injection therapy
  - 882 CSI injections administered for the year, 46% increase compared to 2022-2023 financial year.
- Orthopaedic referral rate:
  - 6.2% referrals to orthopaedic secondary services.

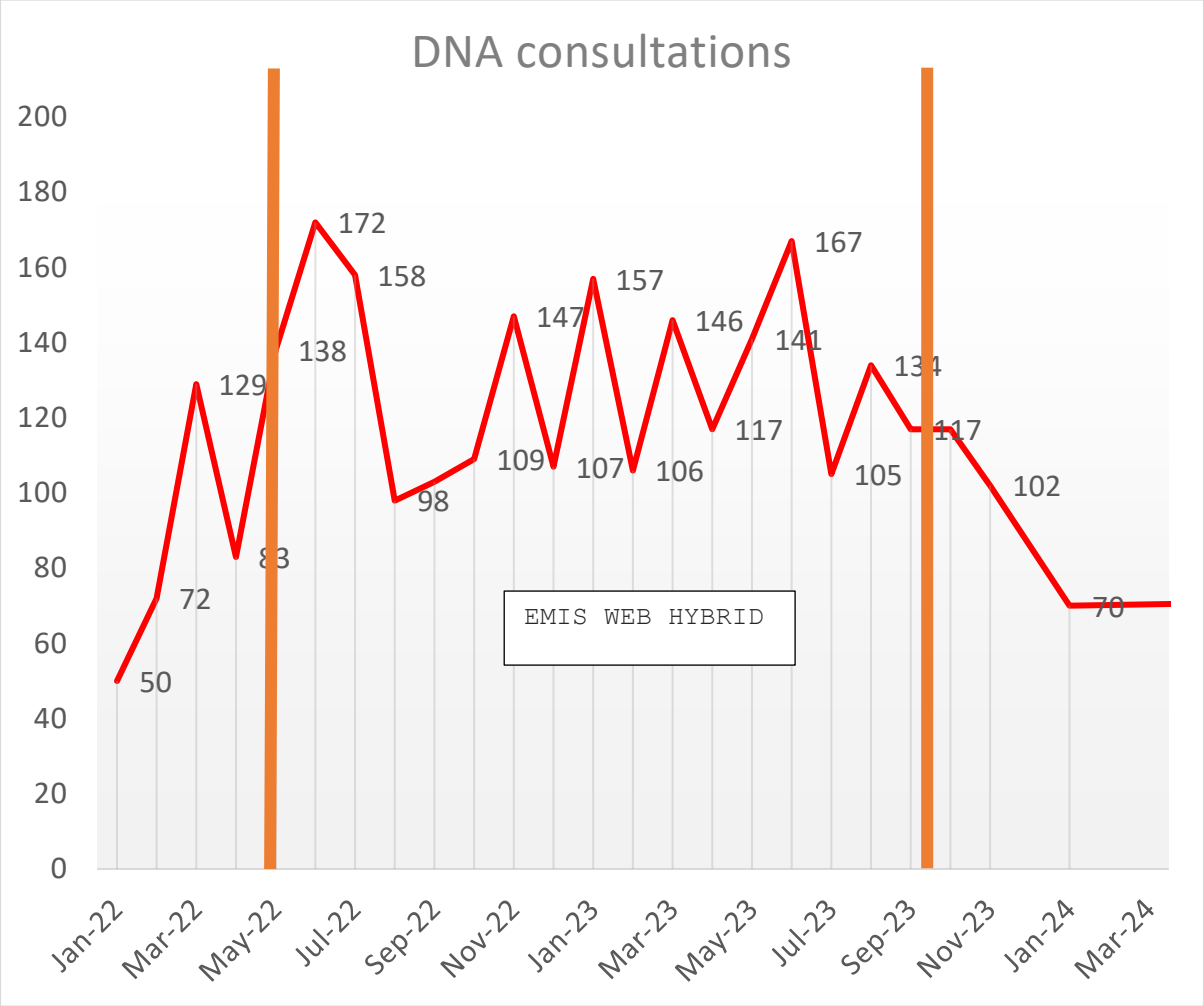
- Clinical pathway development was done with focus on the patient journey,
- Education and in service training to clinically up-skill FCPs on diagnosis and referral patterns.

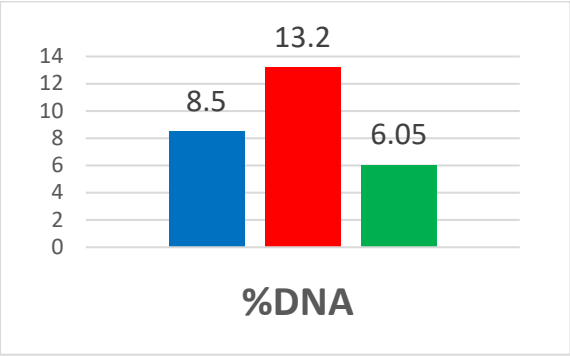
4) IT and technological considerations:
    - Use Emis PCS in the GP practice increasing MDT working to better serve the patients needs.
    - Creation of a platform for automated service audits and activity data.
    - Implement PHIO application to assist in early triage.
    - Improved Quality of care and peer review auditing to support, mentor and educate the FCP team.

Gaps in the delivery of FCP services?

1) HR: To be in line with National service delivery of 1:12 000 population ratio over a 48 week service the Borders are in need of 372.61 additional FCP hours per week.
    - FCPs to increase with 4 WTE to successfully answer to the demand.
2) IT systems:
    a. The current IT provisioning in the Borders does not communicate successfully with IT used in GP practices. To be able to render a virtual model FCPs are using one IT system that is removed from the GP IT system and duplication of clinical notes exist.
    b. Delayed times in reports for investigations due to the different IT systems and FCP need to employ a third system to search for reports.
    c. Gap in It reporting evident in below graph.
        i. Positive changes in New to review range after moving hybrid IT system back to being practice based. Lesser consultations used for reviews as more direct Face to face appointments are available.
3) Mitigation of risk:
    a. To reduce DNA and Review rate increasing access, capacity and efficiency we moved the IT system from a hybrid model to be imbedded in the GP practice.







137 DNA slots = 68, 5 hours in 2022-2023 on hybrid system.

83 DNA Slots = 41.5 hours for 2023-2024

Executive Summary:

- Mean of 985 Face to face consultations per annum = 492.5 Consultation hours away from GP per month.
- 27 hours reduced DNA rate with service imbedded into the GP practice
- 70/30 New to Review ratio compared to 60/40. Being imbedded into the GP practice is a more efficient, convenient and cost effective way to deliver the service while maintaining high standards of patient satisfaction, employee satisfaction and overall better MDT working.

The initial focus of the Scottish Borders Primary Care Improvement Plan 2018-2021 was the development and establishment of an Advanced Nurse Practitioner model. As there was a shortage of trained ANPs nationally and within the rural Borders demographic, NHS Borders undertook to recruit a cohort of untrained ANPs.

Prior to PCIP roll out there was no workforce supply of trained primary care ANPs and in 2019 a successful pilot of five trainees Advanced Nurse Practitioners (ANP) was carried out across South and West GP Clusters.

The ANP service is highly valued and supports PCIP to meet the urgent care pathway to provide a service to GP practices for `urgent care`, delivering on the day presentations: face to face consultations, telephone consultations and home visits. This releases the GP to take on a more holistic view of patient care and clinical expert role, and improving patient access to care and treatment.

The ANPs are autonomous practitioners and manage the comprehensive clinical care of their patients, including prescribing and onward referral. Independent prescribing is an integral component of advanced practice which allows easier and quicker access to medications for patients and increases patient choice in accessing medication, and there is a growing body of evidence to support the positive impact of independent prescribing by ANPs.

Service User Experience

Patients have embraced the role of advanced practitioners in primary care and they have reported high levels of satisfaction with the care they receive. They have commented on their surprise at the autonomous ability of advanced practitioners to include assessment, diagnosis and treatment. Many patients request to see the ANP again. This allows for continuity of care.

Positive feedback on the referral of patients to secondary care has also been received.

Where are we now?

Our newly appointed clinical lead has been in place since May 2024. The lead has been able to strengthen morale and job satisfaction within the PCIP urgent Care workstream and forge positive working relationship between practice managers where PCIP ANPs have been allocated.

Together with the Clinical Service Manager, their leadership will be instrumental in ensuring the success of our urgent care service.

Urgent Care Workstream has significantly matured. A key aspect of this development is the commitment we have made to our trainee Advanced Nurse Practitioners (ANPs) all trainee ANPs have been contracted through a bonding arrangement to remain with NHS Borders for a minimum of two years post-qualification. This agreement has been vital in stabilising our workforce and ensuring consistency in care delivery.

Additional ANP have been recruited to replace natural movement within the service.

Documentation which elaborates on our current position and future plans have been distributed to practices in the PCIP. These documents are working documents and will be subject to change as the process develops

Challenges and Key Risks:

Recruitment of qualified advanced practitioners continues to be challenging, particularly due to the rural geographical area of the borders and in light of the reduction of nurses entering the profession and retiring from the profession.

What do we aim to achieve in the coming year?

- Clinical lead to continue to stabilise and improve moral and job satisfaction for current ANPs
- Continue development of ANP academy
- Collection of data to further understand the impact that ANPs have in urgent care.

Community PCIP Links Worker Service

Please Note: We have no new update to this workstream from the 2023 report

On the 8th September 2022 PCIP Executive decided to discontinue funding for the Community Link Workers (CLW) due to inadequate funding from the Scottish Government for PCIP. The workstream was prioritised for deep evaluation as it was operated under a model that was considered inadequate for its intended purpose. Additionally, the service was set during the pandemic, which presented challenges in fully integrating it with practices due to staff proximity restrictions in back offices in GP surgeries. This hindered the optimisation of information sharing and coordination, impacting the effectiveness of the service.

Despite these constraints, the dedicated team of 2.5 full-time equivalent community link workers and two full-time equivalent Local Area Coordinators continues to serve the community. Over a two-year period, while funded with through PCIF, they managed to identify and attend to 40 GP patients in need. However, the available data did not demonstrate a significant easing of GP workloads as a direct result of CLW. Despite efforts made, the overall impact on alleviating pressures and reducing the workload of GPs was limited.

Nevertheless, Local Area Coordination services continue to be available as part of the broader service offered under our Health and Social Care Partnership.

Recent premises projects have brought significant benefits to CTAC, Pharmacotherapy and Vaccination services. CTAC phlebotomy clinics have been accommodated on 20 sites across the Borders, a dedicated pharmacotherapy hub for 36 staff is launching in November 2024 and the Vaccination Service is making widespread use of health board premises to run clinics instead of paying for external venues.

Premises constraints remain a risk to ongoing PCIP delivery. Pressures on 25 community sites are increasing from more than 50 P&CS, Acute and Mental Health services using health centres and community hospitals. The transfer of PCIP work from GP practices to NHS Borders is further increasing demands, and no single approach has ever been agreed as to whether work should be accommodated in health board rooms or whether GP practices should transfer rooms with work.

NHS Borders Capital Investment Group has committed to a strategic community premises programme to tackle risks associated with capacity, functional suitability and physical condition of premises. Work would deliver recommendations outlined in the Buchan Report (2021) but timelines and resources remain unconfirmed to progress capital works.

Resource constraints within NHS Borders Estates, Capital and IM&T services continue to limit operational and tactical change and improvement works required to implement PCIP workstreams.

Key achievements & priorities

- NHS Borders Capital Investment Group commitment to a community premises improvements programme (timelines and resourcing TBC).
- Launch of a dedicated pharmacotherapy hub with 36 desks in a large, open plan office at Scottish Borders Council headquarters. Modern, bright, fit for purpose furniture, encouraging collaboration, support and supervision. Newly installed IT infrastructure and desktop hardware, cloud telephony service with advanced call handling.
- CTAC phlebotomy service launch - 425 hours of morning clinics accommodated in 20 health centres across the Borders.
- Vaccination service clinics brought into health centres and community hospitals instead of paying for community venues (town halls etc).
- Interim office arranged for CTAC appointment booking team at SPPA, Tweedbank, running alongside the Vaccination Service. Progressing towards a single Primary Care admin Hub.
- Transformation of offices at Newstead site to create accommodation for 55 staff across 8 services.
- Improved utilisation of health centre rooms, prioritising clinical rooms for patient care. Creation of more shared bookable spaces with standard furniture and equipment.
- Work in progress to introduce room utilisation sensors to health centres to identify capacity, tackle poor room booking behaviours, support with redistribution of space

between health board and GP practices and to help prioritisation of capital investment.

- Patient access telephone pilot in Coldstream health centre – if health board reception desk is unstaffed, patients may lift the telephone handset to automatically connect with a staffed reception on another site. Planning rollout across nine further sites.
- Ongoing investment in clinical and non-clinical equipment, furniture and IT equipment with a cautious approach to spending given financial grip & control measures.
- P&CS premises governance linked into board-wide management groups including capital investment, transport, security, chemical safety, water safety, ventilation safety, period poverty.

Key challenges and risks

- No progress on capital investment programme for community premises. Timelines and resources remain unconfirmed, dependent upon Capital, Estates and IT resources.
- Increasing PCIP demands on existing health board rooms (ANPs, vaccinations, CTAC, pharmacotherapy). Work is transferring from GP practices to the health board but GPs are retaining rooms. No single, agreed approach to PCIP rooms across sites.
- Competition for rooms – more than 50 services across P&CS, Acute and Mental Health make use of 400 rooms across 25 community sites. Clinical prioritisation of services vs available rooms will be required. Risk to patient equity if services withdrawn from certain health centres.
- Financial grip and control measures scrutinising, limiting or denying spend.
- NHS Borders has committed to freezing GP rent until premises improvements have been delivered, throttling potential source of income. GPs paying significantly below market rates for utilities and resources.
- Scottish Government has paused funding of construction projects (new health centres and hospitals) until 2026 at the earliest, advising health boards to make better use of existing resources.

PRIMARY CARE IMPROVEMENT FUND OVERVIEW

Background

Each month, a PCIP budget monitoring report is made to the PCIP Executive. This report outlines:

- Latest known information with regard to expected / actual PCIF allocation;
- Conditions over its use;
- How the recurring PCIF allocation has been directed / allocated across PCIP workstreams by PCIP Executive;
- Expenditure against the workstream budgets created in support of this direction;
- Forecast expenditure by workstream to 31 March;
- How non-recurring slippage / allocation are expected to be utilised during the financial year;
- Proposed revisions to the PCIP and their financial impact; and
- Risks to delivery and overall affordability.

The majority of PCIP activity is funded entirely by Scottish Government Primary Care Improvement Fund allocation, with a relatively smaller amount of resource coming from NHS Borders baseline and other funding sources, primarily within the CTCS (Treatment Rooms Budget), MH Renew (Action 15 Allocation) and VTP (Vaccination Allocation). Additionally, from 2023/24, NHS Borders made an additional recurring investment of £0.500m in order to fund the shortfall overall.

2023/24

Funding Allocation

In July 2023, NHS Borders and Scottish Borders Health and Social Care Partnership (the Board / Partnership) received its Annual PCIF funding letter and tranche 1 of its allocation. This was followed by a second tranche of in January 2024.

The overall national resource envelope on which allocations were based increased to £190 million pounds and notably, for the first time in the life of PCIF, included a specific allocation of £19.5m to fund the significant pay inflation that has been experienced in both financial years 2022/23 and 2023/24. As a result of the increase in national funding envelope, Scottish Borders Integration Authority's PCIF share increased to **£4.109m** in 2023/24, representing 2.15% share of the national allocation. This consisted of **£3.660m** core allocation (broadly the same as in 2022/23) and an additional **£0.449m** pertaining to pay inflation. Reserves brought forward at 01/04/23 of **£0.383m** were already deducted at source from this allocation by the Scottish Government however. With the exception of the additional allocation for pay inflation, this allocation has remained broadly at the same level and can be summarised per the table below:

	2023/24 PCIF Allocation £'000
2022/23 NRAC Allocation	**3,660**
2022/23 + 2023/24 Pay Allowance	**449**
Less: SG noted Reserves b/f	(383)
Less: Baselined Funding	(161)
Tranche 2	(215)
2023/24 Tranche 1 Allocation	**3,350**

2023/24 Expenditure

In 2023/24, the Scottish Borders Partnership's PCIF allocation was directed and spent in full. No reserves were carried forward at the end of the financial year.

Workstream	PCIP 3-Year Recurring Investment £'000	Forecast Expenditure to 31 March 2024 £'000	Surplus / Slippage / (Deficit) at 31 March 2024 £'000
VTP	438	603	(165)
Pharmacotherapy	1,141	1,033	108
CTAC	62	62	0
Urgent Care	949	922	27
FCP	628	624	4
Mental Health	849	821	28
Community Link Workers	0	0	0
Central Costs	42	43	(1)
Total Expenditure	**4,109**	**4,109**	**(0)**
Funded by:			
Core Allocation	(3,660)		3,660
2022/23 + 2023/24 Pay Allowance	(449)		449
Forecast Expenditure		(4,109)	(4,109)
Total	**(4,109)**	**(4,109)**	**(0)**

The position reported above fully utilised the 2023/24 PCIF allocation. It did not however, fund any additional progress towards the delivery of CTCS nor was it sufficient to cover the forecast cost of VTP in full.

2024/25

The Scottish Government Primary Care Improvement Fund allocation to Health and Social Care Integration Authorities is calculated using the NHS Scotland Resource Allocation Committee (NRAC) formula. NHS Borders' / Scottish Borders H&SCP's allocation letter for 2024/25 was issued by the Scottish Government on 05 July 2024 within which, NHS Borders' NRAC proportion in 2024/25 has remained at 2022/23 levels - 2.15% of the national quantum of £190m less £10m which has currently been withheld by SG pending review later in the financial year . As advised by the Scottish Government, this funding is to be treated as recurring, primarily to support permanent recruitment necessary to deliver agreed Primary Care Improvement Plan (PCIP) workstreams. The 2024/25 allocation does not yet include any uplift for Agenda for Change (AfC) pay increases.

The funding is ring-fenced and the Scottish Government continues to emphasise that it must not be subject to general savings requirements and cannot be used to address any wider funding pressures of the Health Board or Integration Joint Board (IJB). At the end of 2024/25, the Partnership carried forward no reserves into the current financial year Where previously underspends through slippage would have been carried forward enabling PCIP Executive to direct the use of any non-recurring funding of this nature in the following financial year.

The table below reconciles to Annex A of the Scottish Governement 2024/25 allocation letter. It details that including the allocation for historic pay inflation (but excluding any allowance for 2024/25 pay inflation), the total allocation for 2024/25 is again **£4.109m**. This is the full level of allocation available to support the delivery of PCIP during 2023/24 but acknowledges that:

- **£0.161m** of the allocation is already in NHS Borders' baseline funding which requires to be used to support PCIP. This is no different from recent previous years;
- Unlike previous years' allocations, the full **£3.948m** has been allocated in full as part of Tranche 1.

	2024/25 PCIF Allocation £'000
2024/25 NRAC Allocation	**3,660**
2022/23 + 2023/24 Pay Allowance	**449**
Less: SG noted Reserves b/f	0
Less: Baselined Funding	(161)
Tranche 2	0
2023/24 Tranche 1 Allocation	**3,948**

PCPIP Pathfinder

NHS Boards and Health and Social Care Partnerships were invited by the Scottish Government to submit bids, by the end of October 2023, to host a phased investment programme demonstrator site, in order to demonstrate what a model of full implementation can look like in practice. Demonstrator sites will be supported to achieve full delivery of pharmacotherapy and CTAC services, utilising improvement methodologies to support the approach, over an initial 18 months, while maintaining full delivery of VTP.

The Scottish Borders bid has been successful and over the Spring of 2024, discussions commenced with regard to planning and refinement of workstream models. Following this work, Scottish Government issued formal allocation letters to successful Boards / HSCPs in early May 2024.

Scottish Borders' allocation amounts to a total of **£4.340m** relating to 18 months' pathfinder pilot over financial years 2024/25 and 2025/26. For 2024/25, the allocation is **£2.870m**.

	2024/25	**2025/26**	**Total**
HSCP	**£'000**	**£'000**	**£'000**
Scottish Borders	2,870	1,470	4,340
Ayrshire and Arran	3,320	1,300	4,620
Edinburgh City	1,200	690	1,890
Shetland	730	310	1,040
Healthcare Improvement Scotland	1,800	1,400	3,200
	9,920	**5,170**	**15,090**

“

We were thrilled to be one of four Primary Care Phased Investment Programme Demonstrator Sites, recognising our proactive and collaborative approach with General Practices, the Health and Social Care Partnership, and our communities.

”

- Chris Myers

Chief Officer of Integration Joint Board

Acknowledgements

PCIP transformation work would not be possible without the dedicated support and involvement of the various workstreams highlighted in this report. Although it is not possible to name everyone individually, PCIP Executive Committee would like to thank everyone who has contributed to the drafting, testing, implementation and refining of Scottish Borders' Primary Care Improvement Plan.

Workstream Leads

Workstream	Lead
Vaccination Transformation Programme	Nicola Macdonald – Clinical Service Manager
Community Treatment and Care Services	Kathy Steward – Clinical Nurse Manager
Pharmacotherapy	Malcolm Clubb – Lead Pharmacist Primary and Community Services
Community Mental Health "Renew"	Dr Caroline Cochrane – Director of Psychological Services and Head of Psychology Speciality
Urgent Care Services	Lisa Hume – Lead Advanced Nurse Practitioner
Musculoskeletal Services "First Contact Physio"	Wilna-Mari Van Staden – Clinical Lead Advanced Physiotherapy Practitioner
Premises	Rob Cleat – Primary and Community Services Premises Lead
Communications	Clare Oliver – Communications Manager
Finance	Paul Mcmenamin–Deputy Director of Finance / Finance Business Partner (IJB)

PCIP Executive Committee

GP Executives	Dr Rachel Mollart Dr Kevin Buchan Dr Kirsty Robinson Dr Robert Manson
NHS Borders	Cathy Wilson – General Manager Dr Tim Young – Associate Medical Director
Integration Joint Board	Chris Myers – Chief Officer Hazel Robertson – Chief Finance Officer

PCIP Team

Senior Project Manager	Owain Simpson
PCIP Information Analyst	Fiona Grant

November 2024

Scottish Borders

PCIP Executive Committee

Scottish Borders Health and Social Care Partnership

Equality, Human Rights and Fairer Scotland Duty Impact Assessment – Stage 1 Proportionality and Relevance

.

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

Primary Care Improvement Plan (PCIP) Bundle Proposal

In completing this Impact Assessment, considerations will be applied to the following components of The Bundle:

- Transfer of Disease-Modifying Anti-rheumatic Drugs (DMARDS) from GPs to the Pharmacotherapy Service;
- The transfer treatment-room related services provided by GPs to the Health Board;

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation
x	x	x	x	x	x	x	x	x

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	Work	Living Standards	Health	Justice and Personal Security	Participation
Higher education Lifelong learning	Employment Earnings	Poverty Social Care	Social Care Health outcomes Access to health care Mental health Reproductive and sexual health* Palliative and end of life care*		Access to services Social and community cohesion* Family Life*

*Supplementary indicators

1. Transfer of DMARDS from GPs to the Pharmacotherapy Service

This proposal would see a shift of existing DMARDs workload from GP practices to a new Pharmacy Hub

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
Age	Positive	DMARDS are currently offered via a Local Enhanced Service – which is optional for GPs as a result some areas in the Scottish Borders may not offer local reviews of DMARDS. This approach would offer an equitable access of DMARDS for all applicable Scottish Borders patients. As GPs are independent contractors, there are local variations of DMARDS application across the Borders. By transferring these reviews to the Health Board, this would standardise DMARDS via a single Pharmacotherapy service. When paired with CTAC Phlebotomy service, improved accessibility for essential diagnosis tests – equitable service across Scottish Borders with enhanced convenience for people with a reliance on transport. More frequent monitoring of long-term conditions with ability to discuss issues in detail with Pharmacotherapy services remotely or in person via appointment in local setting.

	Negative	Juvenile arthritis patients will have different pediatric pathways as assessed by their GP/Secondary Care consultant. However, this proposal would mimic current arrangement to allow local monitoring where possible. Younger patients with small veins may not be suitable for monitoring in local CTAC and may need to travel further to see a qualified practitioner. When accessing Pharmacotherapy Hub, patients may be first advised to contact by telephone which is an unfamiliar process and with different staff who may need additional time to understand their health needs. Confusion and upset because the service is now provided by a different healthcare professional than the one that patients knew and was familiar with. Perception that service provided by non-GPs is not as good as the service they received previously.
Disability	Positive	Health Board run service would improve equitable access to services for all. Compatible with NHS Borders Values - recognising the need for person-centred approach, where required, monitoring of conditions could be offered via CTAC domiciliary visits.

	Negative	Main service would be offered via telephone consultations, however, we are retaining some in-clinic capacity in all Health Centres on request and to accommodate those that may not be able to easily communicate via telephone due to a disability. There may be an increase in barriers to accessing Pharmacotherapy Hub as patients may be first advised to contact by telephone which is unfamiliar and with different staff who may need additional time to understand their individual health needs. Confusion and upset because the service is now provided by a different healthcare professional than the one that patients knew and was familiar with. Perception that service provided by non-GPs is not as good as the service they received previously.
All protected characteristics (Age, Disability, Gender, Gender Re-assignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief (including non-belief) & Sexual Orientation)	Positive	The transfer of DMARDS to the Pharmacy team will ensure that individuals receive care from the appropriate a multi-disciplinary team (MDT) by the 'right person, right place, right time', improving overall service delivery. By involving MDTs with the most suitable skills, individuals will receive enhanced continuity of

		care tailored to their specific needs – eliminating varied GP approach across the Scottish Borders. Additional capacity time will be released for better access to GPs and application of Realistic Medicine principles (e.g. Polypharmacy reviews). Staff will take more responsibility for the clinical care of patients they are treating – upholding NHS Borders' values of patient-centred care, ensuring that the diverse needs of all individuals are met in an inclusive manner.
Work/Education	Positive	DMARDS monitoring to Pharmacy Hub presents an opportunity for the Pharmacy team to utilise their advanced skills and knowledge in a more focused and impactful manner: • Aim to provide staff with fulfilling roles that align with their training and enable them to contribute significantly to patient care. • The shift in responsibility has the potential to enhance staff retention by offering the pharmacy team an avenue for professional growth and the opportunity to expand their expertise.

2. Transfer of treatment-room related services from GPs to the Health Board

Main Impacts	Are these impacts positive or negative or a combination of both	Are the impacts significant or insignificant?
Age	Positive	Health Board treatment-room services are not currently available to 8 GP practices causing inequitable access to services across the Scottish Borders. This could be disproportionally affecting older people or adults unable to travel further distances for treatment or may experience longer waiting times for treatment via their GP. This proposal will enhance the delivery of an equitable access to treatment room service and safeguard locally accessible services for all adults. Peripatetic/Domiciliary Health Board Services available where needed.
	Negative	We will not be able to offer complete CTAC (especially pediatric phlebotomy) service for children due to variable workforce skill set. Different pathways will need to be arranged for some pediatric treatment services. Children may need to travel further to access these services. Additional work will need to be made in developing these pathways. Although known/local GP staff transferred (via TUPE) to the health board, some confusion and upset may be caused by a service that is provided

		by a different healthcare professional than the one that patients knew and was familiar with. Clinical risks may be increased as primary care staff in CTACs may not have robust GP back-up.
Gender/Gender Re-assignment/Religion and belief	Negative	There may be a lack of male nurses or health care professionals to see patients who request this.
All protected characteristics (Age, Disability, Gender, Gender Re-assignment, Marriage and Civil Partnership, Pregnancy and Maternity, Race, Religion and Belief (including non-belief) & Sexual Orientation)	Positive	Improve access to healthcare services for people with protected characteristics by promoting consistency and standardisation of care across the Health Board. Equitable access to treatment room facilities may be better distributed and equipped to accommodate the needs of diverse populations, ensuring equitable access for individuals with protected characteristics. Under health board framework, access to training modules supporting the provision of culturally competent and inclusive care. Introduction and use of GP Order Comms - seamless electronic blood ordering form. Resulting in paperless system and reducing harm caused by errors. Staff will be enabled to adopt a patient-centres approach, placing the patient at the centre of their healthcare decisions – treatment plans/schedules can be tailored to their unique

		needs and preferences, empowering them to take an active role in managing their health. By equipping patients with knowledge about their conditions, treatment options, and self-care strategies, they can become active participants in their own healthcare, fostering a sense of control and empowerment.
Work / Living Standard	Positive	People in Scottish Borders with variable work shift patterns or with employment/education further away from home will have the choice to access treatment such as phlebotomy in a health center of their choice and will no longer be restricted to their GP based practice. Increased opportunities for training, education, and professional development (especially for TUPE GP Staff) for treatment room staff. TUPE staff will be transferred onto NHS Scotland's agenda for change contracts – securing Living Wage. Improved workplace policies – could offer greater job security in a culture that promotes wellbeing and inclusive work environment.
Poverty	Positive	Individuals experiencing poverty may have better access in areas with higher poverty rates, reducing transportation and financial barriers. The Health Board can prioritise the provision of high-quality care to individuals experiencing poverty, ensuring they receive equitable

		treatment and support, promoting inclusivity and reducing potential biases.

Is the proposal considered strategic under the Fairer Scotland Duty?	Yes
E&HRIA to be undertaken and submitted with the report – Yes or No **If no – please attach this form to the report being presented for sign off**	**Proportionality & Relevance Assessment undertaken by:** **Name of Officer** **Date:**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 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.

- Integration Joint Board 20 November 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 18.09.24

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 18 September 2024** at **10am** as a hybrid meeting in the Council Chamber, Scottish Borders Council and via Microsoft Teams

Present:

(v) Cllr R Tatler
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicoll
(v) Mrs L O'Leary, Non-Executive (Chair)
(v) Mr J Ayling, Non-Executive
(v) Mrs F Sandford, Non Executive
Mr C Myers, Chief Officer
Mrs L Turner, Interim Chief Financial Officer
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mrs J Smith, Borders Care Voice
Ms L Gallacher, Borders Carers Centre
Ms L Jackson, LGBTQ+
Mrs G Lennox, Head of Adult Social Work
Mr D Bell, Staff Side, SBC
Ms V MacPherson, Partnership Rep, NHS Borders
Ms J Amaral, Chief Executive, Borders Community Action
Mr N Istephan, Chief Executive, Eildon Housing Association

In Attendance:

Miss I Bishop, Board Secretary
Mr D Robertson, Chief Executive, Scottish Borders Council
Mr P Moore, Chief Executive, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Mr A Bone, Director of Finance, NHS Borders
Dr S Bhatti, Director of Public Health, NHS Borders
Mrs L Jones, Director of Quality & Improvement
Mr A Carter, Director of HR, OD & OH&S, NHS Borders
Ms I Thomson, MH&LD
Mr S Burt, General Manager, MH&LD
Ms S Henderson, MH&LD
Mrs F Doig, Head of Health Improvement
Ms S Elliot, Drug & Alcohol Partnership
Ms L Thomas, Communications Officer
Mrs W Henderson, Scottish Care
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Mr D Knox, Reporter BBC Scotland

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr D Parker, Elected Member, Cllr N Richards, Elected Member, Mrs K Hamilton, Non Executive, Mr J McLaren, Non Executive, Mr P Grieve, Chief Nurse Health & Social Care Partnership, and Dr R Mollart.

1.2 The Chair welcomed to Mr Peter Moore, Chief Executive, NHS Borders to the meeting.

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

1.4 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 July 2024 were approved.

4. MATTERS ARISING

4.1 **Action 2024-6:** It was noted that the item had been postponed to the IJB Development session to be held on 20.11.24 due to the availability of those involved.

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 Myers provided a presentation on the delivery report and highlighted several key elements of it including: delayed discharges; social work assessments; what matters hubs; vaccination programmes; challenges in relation to the delivery of the Home First and Adult Social Care Direction and the Delayed Discharge and Hospital Occupancy Direction.

5.2 Discussion focused on several key issues including: delayed discharges trajectory; reducing length of stay; successful recruitment to the hospital social work team; prevention of admission; providing access to social work early in the discharge pathway; data on outcomes including waiting times for packages of care; links to community support and third sector support; work to be done on qualitative outcomes; and community led support.

5.3 Ms Linda Jackson commented on the accessibility of the document to the general public and suggested a shortened summary or plain English version would be helpful.

5.4 Cllr Elaine Thornton-Nicol commented on the complications with the guardianship process and suggested a process be formulated with a “move once rule” to enable those stuck in the guardianship process to be placed in a more appropriate setting, such as an enhanced bed setting, when the hospital setting was clearly not the most appropriate setting for them. Dr Lynn McCallum commented that unfortunately there were limited powers within the legislation to be able to move people on when they were stuck in the guardianship process.

5.5 Mrs Gwyneth Lennox advised that the teams were continuing to work to optimise the use of powers of attorney.

5.6 Mr David Robertson commented that it was useful to see the figure of 92.3% for those patients discharged without a delay the previous week (145 discharges) and that 7.7% had been discharged from the delayed list (12 discharges). Whilst a focus was required on the problem areas the statistics showed that the vast majority were discharged well without a form of delay and it was important to balance the positives with the challenges.

5.7 Dr McCallum suggested it would be useful to see a break down of data on those removed from the delayed discharge list due to ill health and then re-added to the list. A breakdown by re-referral aspects and how many were re-referred to social work having been ill and removed from the list. A total length of time on a social work list would also be useful as it was all important in terms of patient experience.

5.8 Dr Sohail Bhatti suggested that data on the protected characteristics should also be collected.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed that a plain English, easy read version of the report should be produced for the public website.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

6. DIRECTION: LOCAL AREA COORDINATION SERVICE REVIEW

6.1 Mr Simon Burt provided an overview of the content of the report and highlighted several elements including: extremely high level of stakeholder satisfaction with the current service; staffing model; PCIP funding; budget reduction; and vacancy freeze.

6.2 Discussion focused on: level of demand; eligibility criteria including those with low and moderate needs; communications plans for those who were likely to received a reduced service; inclusion of PCIP funding removal for transparency purposes; benefit in the LAC approach and working across local intelligence; links into remote communities and the third sector; teaching people to solve their own problems in groups enables them to learn from each other; robust education and supervision model; staff training and supervision by Team Managers to maximise benefit of resource.

6.3 Mr James Ayling suggested there was little evidence to show that the approach would work and he enquired if there was enough resource to deal with a potentially larger number of issues.

6.4 Mrs Irene Thomson advised that all the research studies undertaken had demonstrated that the model worked very well and caseloads of 60 people were manageable. The research studies looked at population sizes of around 10,000 per LAC and the Scottish Borders offering was slightly above that, which was partly due to budgetary constraints. However the point of linking with other community

resources was a key element of the work that had previously drifted but would help with the local development of resources.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** supported the implementation of staffing model 2a (Table 1) and associated recommendations set out in section 8.

7. COMING HOME PROGRAMME

7.1 Mr Simon Burt provided an overview of the content of the report and highlighted several key elements including: reduced delayed discharges and provide care closer to home; dynamic support register; legal duty to provide appropriate care; learning disability service analysed spending practices and provided evidence of due diligence for resource allocation; and 24 in the service and some supported outwith the area.

7.2 Discussion focused on several matters including: Kelso supported housing; staffing requirements to enable the model to succeed; assurance on achieving value for money; regional opportunities for in patient beds; and a review of respite services for adults with learning disabilities next year.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the predicted increase in demand for the Lives Through Friends approach based on data from young people's services and the ongoing implications for the Learning Disability Service.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to the increase in clinical staff required to support the return home of the 4 Lives Through Friends service users at a recurring cost of £211k to be permanently funded through reduced spend on placements.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that there is an anticipated reduction in costs of £0.239m resulting from the placement changes outlined in the paper but significant workforce challenges associated with this programme.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** remitted the IJB Chief Officer to commission a needs assessment to determine need / demand and inform the planning approach of the Integration Joint Board. This will be presented back to the Integration Joint Board for future consideration.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Learning Disability Service is exploring Regional Solutions to provide accessible Learning Disability in-patient services and will bring an update back to the Integration Joint Board in due course.

8. ALCOHOL AND DRUGS PARTNERSHIP - ANNUAL SURVEY FOR SCOTTISH GOVERNMENT - ADP STRATEGIC PLAN 2024-2027

8.1 Mrs Fiona Doig provided an overview of the content of the report and highlighted several elements including: annual survey - training on alcohol workshop and pilot car navigator role; community recovery; areas for improvement; supporting local communications; highlight report from the service: strategic plan – prescribed remit

from Scottish Government; impact assessments and purposeful engagement; feedback to those who engaged in the process; and next steps and update on actions.

8.2 Dr Sohail Bhatti commented that alcohol related issues were a significant priority for the Scottish Government as Scotland had the highest rates in western Europe. He advised that the Scottish Borders ADP was regarded as high performing.

8.3 Cllr Elaine Thornton-Nicol congratulated everyone involved and enquired about the impact of stigma on those willing to come forward for support.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved final sign off of the ADP Annual Survey

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the ADP Strategy and associated Equality and Human Rights Impact Assessment (E&HRI).

9. BOARD MEETING DATES & BUSINESS CYCLE

9.1 Miss Iris Bishop provided a brief overview of the content of the paper.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2025.

10. QUARTER 1 UPDATE

10.1 Mrs Lizzie Turner provided a presentation on the Quarter 1 update and highlighted several elements including; 24/25 approved budget; revised budget – delegated services; financial position – health delegated services - social care – IJB delegated services – set a side services; ongoing financial risks; NHS savings; SBC savings; and reserves update.

10.2 The Chair thanked Mrs Turner for the evolving clarity of the report.

10.3 Ms Lynn Gallacher requested sight of the allocation for carers support services within the adult social care services. Mr Chris Myers commented that the full allocation and spend on carers was detailed within the Annual Report.

10.4 Dr Sohail Bhatti commented that it was helpful to see the reduction in prescribing pressure.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation.

11. INTEGRATED WORKFORCE PLAN UPDATE

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the Chief Officer was now the chair of the Integrated Workforce Plan's Implementation Board. This was in direct response from the Implementation Board to appoint an executive lead in the paper presented to the Joint Executive Team in September 2023.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the outcome of the Implementation Board's meeting in April 2024.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the observations in relation to the Scottish Government's draft Workforce Planning Guidance.

12. STRATEGIC PLANNING GROUP MINUTES 10 JULY 2024

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

13. ANY OTHER BUSINESS

13.1 No further business was raised.

14. DATE AND TIME OF NEXT MEETING

14.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 20 November 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:	**5 December 2024**
Title:	**Code of Corporate Governance Refresh**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Committee for:

- Decision

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

To provide the Board with a sectional refresh of the Code of Corporate Governance (CoCG) for formal approval.

2.2 Background

The Code of Corporate Governance details how the Board organises and governs its business.

The Code of Corporate Governance is required to be updated every 3 years.

The Board on 4 April 2024 reviewed and approved a refresh of the CoCG.

2.3 Assessment

Section A – How business is organised. This section has now been refreshed to remove reference to the Public Governance Committee that was disbanded earlier in the year.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Once approved the Code of Corporate Governance will be available through the NHS Borders website under the Corporate Information section, as well as the Finance microsite on the intranet.

2.3.9 Route to the Meeting

This report has been prepared directly for the Board.

2.4 Recommendation

The Board is asked to **approve** the refresh of Section A of the Code of Corporate Governance.

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, Section A Code of Corporate Governance

SECTION A

How business is organised

1. THE BOARD AND ITS COMMITTEES (DIAGRAM)

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

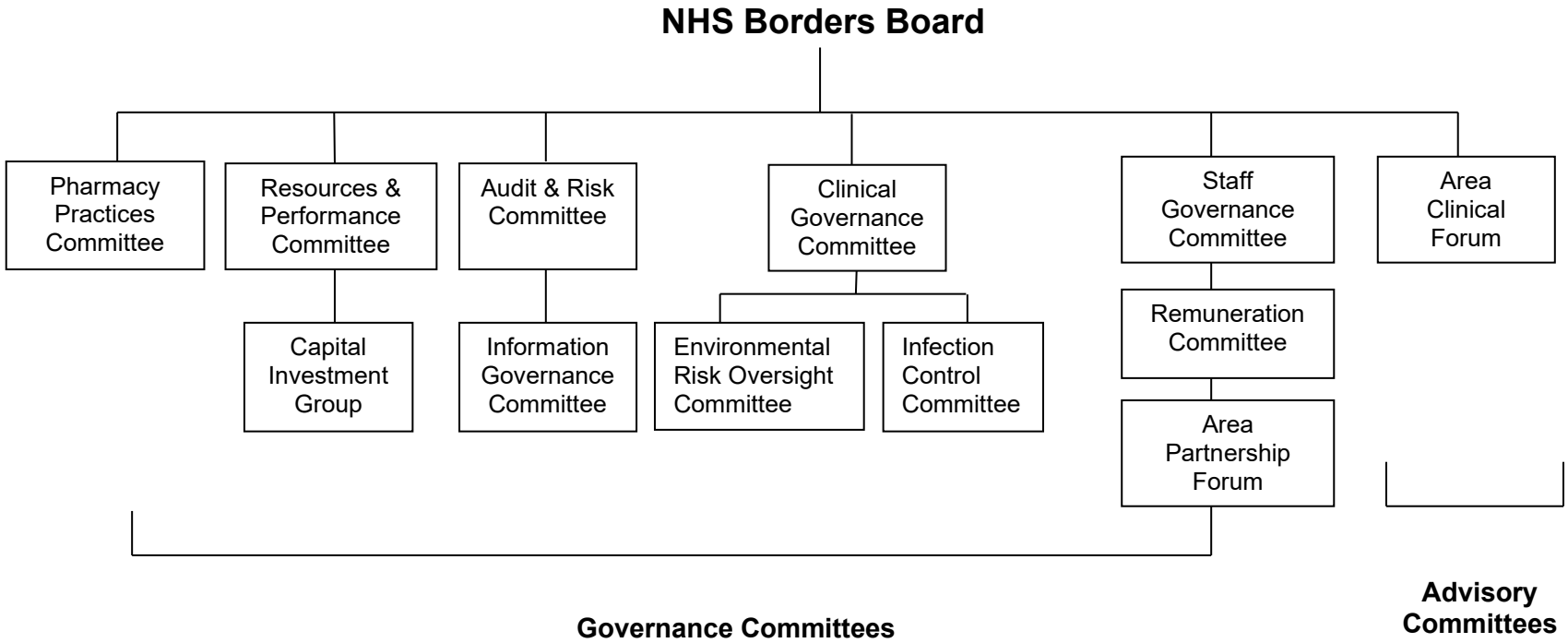
1. General
   Board Members – Ethical Conduct
2. Chair
3. Vice-Chair
4. Calling and Notice of Board Meetings
   - Deputations and Petitions
5. Conduct of Meetings
   - Authority of the Person Presiding at a Board Meeting
   - Quorum
   - Adjournment
   - Business of the Meeting
   - Board Meeting in Private Session
   - Minutes
6. Matters Reserved for the Board
7. Delegation of Authority by the Board
8. Execution of Documents
9. Committees
10. Guidance to exemptions under the Freedom of Information (Scotland) Act 2002
11. Records management

3. STANDING COMMITTEES

1. Establishing Committees
2. Membership
3. Functioning
4. Minutes
5. Frequency
6. Delegation
7. Committees
8. Purpose and Remits
   A. Resources and Performance Committee
   B. Capital Investment Group (sub-committee of Resources & Performance Committee)
   C. Audit & Risk Committee
   D. Information Governance Committee (sub-committee of Audit & Risk Committee)
   E. Clinical Governance Committee
   F. Infection Control Committee (sub-committee of Clinical Governance Committee)
   G. Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
   H. Staff Governance Committee
   I. Remuneration Committee (sub-committee of Staff Governance Committee)
   J. Area Clinical Forum
   K. Area Partnership Forum
   L. Pharmacy Practices Committee

Section A - Appendix 1: The Heath Boards (Membership and Procedure) (Scotland) Regulations 2001

1. THE BOARD AND ITS COMMITTEES



* The Pharmacy Practices Committee has delegated authority from the Board to meet when there are applications to consider in line with Statutory Instrument 1995 NO 414 (S28)
The National Health (Pharmaceutical Services) Service (Scotland) - Regulations 1995

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 confirms the matters to be included in the Standing Orders. This is attached for reference at Appendix 1 of this section. The following is NHS Borders' practical application of these Regulations.

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF BORDERS NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Borders NHS Board, the common name for Borders Health Board, and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development)

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations and any request to co-opt member(s) to the Board. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified from taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting

of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Borders NHS Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board Secretary shall provide a copy of these Standing Orders to all members

of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. The non-executive member of the Board with the whistleblowing portfolio is excluded from being Vice-Chair. A member who is an employee of the Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Chief Executive or Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason) the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least five times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be

considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member at which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

Deputations and petitions

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has concluded their presentation. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of the Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees

will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be

adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute which will be held electronically.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Delivery Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Delivery Plan, the Board should receive it at a public Board meeting.)

f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: This must be considered in private by the Board. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The Audit and Risk committee should advise the Board on the appointment, and the Board may delegate to the Audit and Risk committee oversight of the process which leads to a recommendation for appointment.)

Within the above the Board may delegate some decision making to one or more executive Board members.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions (Section G) and the Scheme of Delegation (Section F).

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members include some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally, Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects to consider certain items as restricted

business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Borders NHS Board and is not to be counted when determining the committee's quorum.

10. Freedom of Information (Scotland) Act 2002

10.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective, so that it includes all records held by the Board prior to 2005 as well as since that date.

10.2 Under FOI(S)A NHS Borders is required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale;
- Maintain a publication scheme of information to be routinely published;
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information.

10.3 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents;
- committee minutes and notes;
- correspondence including e-mails;
- statistical information.

10.4 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

10.5 All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.

10.6 Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002 which is available on the NHS Borders intranet Information Governance site at

http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

10.7 Briefings on how to apply exemptions can be found on the Scottish Information Commissioners website at http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

10.8 For further advice on the Freedom of Information (Scotland) Act 2002, processes and application contact the Freedom of Information Officer or Communications Team.

11. Records management

11.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

11.2 Separate guidance has been produced for records management. The NHS Borders Records Management Policy can be found on the NHS Borders Intranet Information Governance site at http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

3. STANDING COMMITTEES

1. Establishing Committees

1.1 The Board on the recommendation of the Chair shall create such Committees, as are required by statute, guidance, regulation and Ministerial direction and as are necessary for the economical efficient and effective governance of the Boards' business.

1.2 The Board shall delegate to such Committees those matters they consider appropriate. The matters delegated shall be set out in the Purpose and Remits of those Committees detailed in Paragraph 8, Purpose and Remits

1.3 The Chair may vary the number, constitution and functions of Committees at any meeting by specifying the proposed variation.

2. Membership

2.1 The Board on the recommendation of the Chair shall appoint the membership of Committees on an annual basis. By virtue of their appointment the Chair of the Board is an ex officio member of all Committees except the Audit & Risk Committee.

2.2 The Board on the recommendation of the Chair shall appoint the Chairs of the Governance Committees of NHS Borders Board.

2.3 Any Committee, shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.4 In recommending to the Board the membership of Committees, the Chair shall have due regard to the Committee purpose, role and remit, and accountability requirements as well as the skills and experience of individual Non Executives and any requirements associated with their recruitment. Certain members may not be appointed to serve on a particular Committee as a consequence of their positions. Specific exclusions are:

- Audit & Risk Committee - Chair of the Board together with any Executive Member or Officer.
- Remuneration Committee - any Executive Member or Officer.

2.5 The Board on the recommendation of the Chair has the power to vary the membership of Committees at any time, provided that this is not contrary to statute, regulation or direction by Scottish Ministers and is in accordance with the paragraph 2.4 above.

2.6 The Board on the recommendation of the Chair shall appoint Vice-Chairs of Committees. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

2.7 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Chair recommend to the Board the appointment of a Chair of a Committee who is not a Non-Executive Member, such circumstances are to be recorded in the Minutes of the Board meeting approving the appointment.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be practical by the Chair after the vacancy takes place.

3. Functioning

3.1 An Executive member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek the approval of the Chair to appoint Sub-Committees for such purposes as may be necessary.

3.3 Committees may from time to time establish working groups for such purposes as may be necessary.

3.4 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted members who are not members of the Board, are deemed to be acting on behalf of the Board.

3.5 During intervals between meetings of the Board or its Committees, the Chair of the Board or the Chair of a Committee or in their absence, the Vice Chair shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the terms of reference of the Committee and require a decision which would normally be taken by the Committee. All decisions so taken should be reported to the next full meeting of the relevant Committee. It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

4. Minutes

4.1 The approved Minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information, and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee meeting shall also be submitted to the next meeting of the Committee for approval as a correct record.

4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

5. Frequency

5.1 The Committees of the Board shall meet no fewer than four times a year.

6. Delegation

6.1 Each Committee shall have delegated authority to determine any matter within its purpose and remit, with the exception of any specific restrictions contained in Section F, Section 1 (Reservation of powers and delegation of authority – Matters reserved for Board agreement only).

6.2 Committees shall conduct their business within their purpose and remit, and in exercising their authority, shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the purpose and remit, or in these Standing Orders, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Borders policies and the Code of Corporate Governance.

6.4 The Chair may deal with any matter falling within the purpose and remit of any Committee without the requirement of receiving a report of or Minute of that Committee referring to that matter.

6.5 The Chair may at any time, vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Chair in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to a number of Committees, and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation, which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

7. Committees

- Resources and Performance Committee
  - Capital Investment Group (sub-committee of Resources & Performance Committee)
- Audit & Risk Committee
- Information Governance Committee (sub-committee of Audit & Risk Committee)
- Clinical Governance Committee

    - Infection Control Committee (sub-committee of Clinical Governance Committee)
    - Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
- Staff Governance Committee
- Remuneration Committee (sub-committee of Staff Governance Committee)
- Area Clinical Forum
- Area Partnership Forum
- Pharmacy Practices Committee

8. Purpose and Remits

A) RESOURCES AND PERFORMANCE COMMITTEE

1.1 Purpose

The Resources and Performance Committee (R&PC) is established in accordance with NHS Borders Board Standing Orders and Scheme of Delegation.

The Resources and Performance Committee is a Standing Committee of the NHS Board.

The overall purpose of the Resources and Performance Committee is to provide assurance across the healthcare system regarding resources and performance, ensure alignment across whole system planning and commissioning, and to discharge the delegated responsibility from the NHS Board in respect of asset management.

The Committee will receive reports, and draft plans for review and response in respect of; Finance, Performance, Capital, Asset Management, national and regional planning groups and the Health and Social Care Partnership strategic plan.

The Committee will oversee the development of a Financial Strategy for approval by the Board that is consistent with the principle of Patient Safety as our number one priority, but with reference to all other national and local priorities.

The Committee will act as the Performance Management Committee of the Board, the Service Redesign Committee of the Board and influence the early development of the strategic direction of the Board.

The scope of resource will include finance, workforce, property and technology.

1.2 Composition

Membership of the Committee shall be:

- Chair of the Board (Chair)
- All Non Executive Directors
- Chief Executive
- Director of Public Health
- Medical Director
- Director of Nursing, Midwifery & AHPs
- Director of Acute Services
- Director of Quality & Improvement
- Director of Finance
- Director of Workforce
- Director of Planning & Performance
- Chief Officer Health & Social Care Integration (accountable for the performance of the partnership and the delivery of the delegated services).
- Partnership Representative

Attendees shall be:

- Board Secretary (Secretariat)

Attendees may be invited to the Committee at the discretion of the Chair and it is anticipated, depending on the issues to be discussed, that other key individuals from the wider organisation will be asked to attend.

The Lead Officer for the Resources and Performance Committee shall be the Chief Executive.

1.3 Meetings

Meetings of the Resources and Performance Committee will be quorate when one third of the whole number of members, of which at least two are Non Executive Members are present.

The Committee will be chaired by the Chair of the Board.

The Committee will meet no less than 4 times per year and conduct its proceedings in compliance with the Standing Orders of the Board.

The Chair of the Committee, in conjunction with the Chief Executive shall set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business or through the Committee Chair.

The agenda and supporting papers will be sent out by the Board Secretary, at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The Committee will be supported by the Board Secretary who will submit the minutes for approval at the next Resources and Performance Committee meeting, prior to submission to the Board.

To avoid the Committee's agenda becoming over-burdened and unmanageable specific pieces of work may be delegated to the appropriate Director, sub group or short-life task and finish groups reporting to the Committee with very specific remits, objectives, timescales and membership.

1.4 Remit

The remit of the Resources and Performance Committee is to scrutinise the following key areas and provide assurance to the Board regarding:

- Whole system strategic planning including oversight of the healthcare services delegated to the IJB;
- Whole system financial planning, including an overview of budgets delegated;
- Compliance with statutory financial requirements and achievement of financial targets;
- Such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- The impact of planned future policies and known or foreseeable future developments on the underlying financial position of the Board;

- To review the development of the Board's Financial Strategy over a three year period and the Board's Annual Financial Plan making recommendations to the Board;
- The Property and Asset Management Strategy and Capital Plans of NHS Borders.
- The Board's performance against relevant targets and key performance indicators linked to the Scottish Outcomes framework.
- Whole system technology planning.
- Whole system workforce planning.

Appropriate governance in respect of risks, as allocated to the Committee by the NHS Board and/or Audit & Risk Committee relating to finance, planning, performance and property, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

1.5 Property and Asset Management

To ensure that the Property & Asset Management Strategy is in line with the Board's strategic direction and;

- that the Board's property and assets are developed, and maintained to meet the needs of 21st Century service models;
- that developments are supported by affordable and deliverable Business Cases with detailed project implementation plans with key milestones for timely delivery, on budget and to agreed standard;
- that the property portfolio of NHS Borders and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework, including assessment of backlog maintenance;
- that there is a robust approach to all major property and land issues and all acquisitions and disposals are in line with the Property Transaction Handbook (PTHB);
- to review the Capital Plan and submit to the NHS Board for approval and oversee the overall development of major schemes, including approval of capital investment business cases. The Committee will also monitor the implications of time slippage and / or cost overrun and will instruct and review the outcome of the post project evaluation;
- to review all Initial Agreements, Outline Business Cases and Full Business Cases and recommend to the NHS Board in line with the Scheme of Delegation.

To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance.

1.6 Arrangements for Securing Best Value

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for:

- The planning, appraisal, control, accountability and evaluation of the use of current and future resources.

- Reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements.
- The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.7 Allocation and Use of Resources

The Committee has key responsibility for:

- Reviewing the development of the Board's Financial Strategy in support of the Integration Joint Board Strategic Plan, Annual Delivery Plan and Regional Delivery Plans, and recommending approval to the Board.
- Reviewing and agreeing the level of budget to be provided to the IJB for the functions delegated and make recommendations to the Board.
- Reviewing the H&SCI Strategic Plan to ensure the outcomes can be delivered within the Board's revenue and capital plans.
- Reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board.
- Monitoring the use of resources available to the Board.
- Reviewing the Property Strategy (including the acquisition and disposal of property) and make recommendations to the Board.

Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment); the review of the Property Strategy (including the acquisition and disposal of property); the review of all business cases coming forward for recommendation to the Board; and for making recommendations to the Board as appropriate on any issue within its terms of reference.

1.8 Strategy Development

The Committee will review the development of the NHS Board's Strategic Plan, ensuring that strategic planning objectives are aligned with the NHS Board's overall strategic vision, aims and objectives.

The Committee will scrutinise the development of all strategies which require approval by the Board, including the Annual Delivery Plan.

The Committee will ensure that strategies are compliant with the duties of the Board in respect of meeting legislative and good practice requirements.

The Committee will also ensure that there is an integrated approach to planning ensuring that workforce, finance and service planning are linked.

The Committee will ensure appropriate inclusion of National and Regional Planning requirements and monitor overall progress with the East of Scotland planning agenda.

The Committee will ensure NHS Borders input, at an appropriate level, to the draft IJB Strategic Plan, and promote consistency and coherence across the system highlighting issues which may impact the delivery of NHS Board aims and objectives.

1.9 Service Redesign/Transformation

The Committee will provide appropriate oversight to significant service redesign including security for cases for change and to ensure this is progressed in a collaborative way working across health, social care and other organisations, with explicit links between service redesign, service improvement, workforce planning and the strategic priorities for NHS Scotland.

The Committee will review and scrutinise all business cases coming forward and recommend for approval by the Board as appropriate.

1.10 Performance Management

The Committee will review the NHS Board Performance Management Framework ensuring it is in line with the National Performance Framework and make recommendations to the NHS Board.

The Committee will review the NHS Board's overall performance and planning objectives, and ensure mechanisms are in place to promote best value, improved efficiency and effectiveness and decision making across the healthcare system

The Committee may, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost-effective level.

The Committee will seek assurance on a rigorous and systematic approach to performance monitoring and reporting across the whole healthcare system to enable more strategic and better informed discussions to take place at the NHS Board.

The Committee will seek assurance as to the adoption of a risk based approach to performance management through routine review. This will focus on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against whole system performance targets.

The Committee will maintain oversight of progress with the implementation of the financial improvement programme, receive reports, receive assurance on effective engagement, and provide support and advice.

1.11 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee.

In order to fulfil its remit the Resources and Performance Committee may obtain whatever professional advice it requires, and require other individuals to attend meetings as required.

1.12 Reporting Arrangements

The Resources and Performance Committee reports to the Board.

The minutes of the Resources and Performance Committee meetings will be submitted to the next meeting of the Resources and Performance Committee for approval.

The minutes will then be presented to the following Ordinary Meetings of the Board for noting.

1.13 Review

The Terms of Reference of the Resources and Performance Committee will be reviewed on an annual basis.

The Resources & Performance Committee shall undertake an annual self assessment of the Committee's work.

B) CAPITAL INVESTMENT GROUP

1.1 Purpose

The group is established in order to provide a vehicle for management to address the requirements of the Board and its Committees with respect to the development of infrastructure strategy and related capital investment.

The NHS Borders Capital Investment Group (BCIG) will be responsible for the development and management of the Board's Property and Asset Management Strategy (PAMS) and associated capital plan, including prioritisation of resources available to the plan, and the monitoring of progress against same. The group will also undertake review and approval of capital business cases in line with the revised governance framework (to be developed).

The group will be responsible for ensuring that there are appropriate governance arrangements in place in relation to property and asset management, including compliance with the mandatory requirements of 'A policy for property and asset management in NHS Scotland', the Scottish Capital Investment Manual (SCIM), Scottish Public Finance Manual (SPFM) and the NHS Scotland Property Transactions Handbook (PTH).

1.2 Key Principles

In undertaking its business, the group will seek to meet the following functions:

- To provide **assurance** to the Board via the Resources& Performance Committee, on the strategic fit, appropriateness and value for money of capital investment, property and asset management proposals presented to it.

- To provide **accountability** by fulfilling its role as a decision-making body of the Board in respect of matters delegated to BCIG under the Board's scheme of delegation, and in making recommendations to the Board in relation to capital investment, property and asset management.

- To provide an **advisory** role to the Board in relation to capital investment or disinvestment issues.

1.3 Membership

- Director of Finance (Chair)
- Director of Planning and Performance (Vice-Chair)
- Head of Estates
- Head of Estates Projects
- Head of IM&T, or deputy
- Head of Planning & Performance
- Deputy Director of Finance
- Head of Procurement
- Acute Services Representative
- Primary & Community Services Representative
- Mental Health & Learning Disabilities Representative
- Corporate Services Representative
- Partnership Representative
- Medical Director (or Representative)
- Finance Business Partners

It is the responsibility of members to nominate a deputy if they are unable to attend any meeting.

1.4 Decision Making

For matters of prioritisation or approval, the meeting must be quorate.

To be quorate each meeting will have a minimum of 1 Director and no less than a total of six members, which must include:

- A member, or nominated deputy, from each Clinical Board (Acute services, PACS, Mental Health/LD) and from Corporate Services
- Head of Estates or Head of Estates Projects
- A Finance representative (if Director of Finance not present)
- A Planning & Performance representative (if Director of Planning & Performance not present)
- Head of IM&T (if Director of Planning & Performance not present)

Decisions will be made by consensus. A veto may be exercised by agreement of both Chair and Vice-Chair.

The Group may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

It is the responsibility of the member to read all papers prior to the meeting to ensure the agenda is followed in a timely manner.

1.5 Frequency of Meetings

A full meeting will be undertaken quarterly in line with the preparation of the Board's annual plan and its quarterly review cycle. Meetings will be scheduled to align with the business cycle of the Resources & Performance Committee.

Additional meetings will be scheduled according to need during those months where there is no full meeting scheduled. Where no decisions are required attendance at these meetings will be determined on the basis of business need.

The agenda and papers will be issued at least seven working days in advance of the meeting.

1.6 Remit

The remit of the group is:

- To ensure that the Board's Property & Asset Management Strategy (PAMS) is prepared in line with the requirements of CEL 35 (2010), is aligned to the Board's clinical and other relevant strategies, and is subject to review on a regular basis.

- To ensure there are arrangements in place for the monitoring of property transactions and compliance with the NHS Scotland Property Transactions Handbook, including acquisition and disposal of assets by purchase, sale or lease.

- To provide challenge and scrutiny to the development of business cases in relation to the suitability, feasibility and acceptability of the plans described.

- To ensure that business cases are prepared in line with the requirements of the Scottish Capital Investment Manual (SCIM).

- To review and/or approve business cases for capital investment within the limits of delegated authority.

- To review proposed applications for funding, including external and charitable funding, in order to assess and make recommendations as appropriate.

- To make recommendation to the Board (and its Committees) in relation to the prioritisation of capital resources through the development of a five year capital plan.

- To make recommendation and/or approve the utilisation of in year slippage arising from the Board's capital plan.

- To ensure that arrangements are in place for the post-project evaluation of capital investments.

1.7 Reporting Arrangements

The NHS Borders Capital Investment Group will report to the Board's Resources & Performance Committee.

A Capital monitoring report will be prepared quarterly for review by the group prior to submission to the Resources & Performance Committee.

Specific pieces of work will be delegated to an appropriate officer or to short-life working groups, where appropriate.

1.8 Sub Groups

The group may constitute such sub-groups as required to meet the requirements of its workplan.

1.9 Review

Membership and frequency of the Group will be reviewed annually.

The NHS Borders Capital Investment Group shall undertake an annual self-assessment of the Committee's work.

C) AUDIT & RISK COMMITTEE

1.1 Purpose

To assist the Board in the delivery of its responsibilities for issues of risk, control and governance and associated assurance including the conduct of conduct of public business and the stewardship of funds under its control.

To provide assurance to the Board that:

- An appropriate system of internal control is in place
- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Governance arrangements are in place to cover the NHS functions which are delegated and the resources which are provided to the IJB are satisfactory, fully utilised, regularly reviewed and updated
- Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities
- Effective processes and systems of Risk Management are in place
- Assurance from risk owners that review and mitigation is undertaken for very high risks.
- Effective systems of Information Governance are in place

1.2 Membership

Non Executive Members
4 core members from the non-executive members, excluding the following:

- Chair of the Board

Chair of the Committee
A core non-executive member of the Audit & Risk Committee shall be appointed as the Chair of the Committee by the Chair of the Board.

Ordinarily the Audit & Risk Committee Chair cannot be the Chair of any other Governance Committee of the Board. The Governance Committees are the Staff Governance Committee, Clinical Governance Committee, Information Governance and Public Governance Committee.

In Attendance
Executive Directors

- Chief Executive (as Accountable Officer)
- Director of Finance, Procurement, Estates and Facilities (as Chief Finance Officer)
- Director of Quality and Improvement (as Lead for Risk Management)
- Director of Acute Services

Other Attendees

- Chief Internal Auditor
- External Auditor
- Deputy Director of Finance – Head of Finance

Other officers of the board may be invited to the Committee at the discretion of the Chair.

The Lead Officer for the Audit & Risk Committee shall be the Director of Finance, Procurement and Estates and Facilities.

The committee will be supported by a nominated P.A.

1.3 Meetings

The committee will meet at least four times a year. The Chair of the Committee may convene additional meetings as he/she deems necessary;

The Board or Accountable Officer may ask the committee to convene further meetings to discuss particular issues on which they want the committee's advice;

The Audit & Risk Committee Chair will have the power to exclude all others except members from a meeting.

The quorum for the Audit & Risk Committee shall be two non-executive members.

The Chair of the Committee, in conjunction with the Director of Finance as Lead Officer for the Committee, will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under AOB ('Any Other Business') or through the committee chair.

A workplan approved on an annual basis by the Committee will identify the key items of business to be discussed at each meeting.

The agenda and supporting papers will be sent out at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The minutes will be submitted for approval at the next Audit & Risk Committee meeting, prior to submission to the Board.

The Chief Internal Auditor and the representative of the appointed external auditors shall have free and confidential access to the Chair of the Audit & Risk Committee.

1.4 Remit

The main objectives of the Audit & Risk Committee are to ensure compliance with NHS Borders's Code of Corporate Governance and to seek assurance on the effectiveness of the Board's systems of governance, internal control and risk management.

The duties of the Audit & Risk Committee are in accordance with the Scottish Government Audit & Risk Committee Handbook and are as detailed below.

Internal Control and Corporate Governance

To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment (including financial and non-financial controls).
- Information Governance and communication.
- Risk Management.
- Control procedures.
- Decision making processes.
- Monitoring and corrective action.
- Annual review of the Governance Framework and the Governance Statement (as included within the Board's Annual Report and Accounts), including review of assurance statements from Executive directors and Board Committees.

To review the system of internal financial control, including:

- Safeguarding of assets against unauthorised use and disposition
- Maintaining proper accounting records and the reliability of financial information used within the organisation or for publication
- Ensuring that the Board's activities are within the law, regulations, Ministerial Direction and the Board's Code of Corporate Governance.
- Presenting an annual Statement of Assurance on the above to the Board, in support of the Governance Statement by the Chief Executive.

Internal Audit

- Make recommendation to the Board for the appointment of its Chief Internal Auditor and Internal Audit service following appropriate procurement.
- Review and approve the arrangements for delivery of Internal Audit.
- Review and approve the Internal Audit Strategic and Annual Plan.
- Review all Internal Audit reports and disseminate to the relevant Board Committees in line with the Internal Audit Protocol.
- Ensure that executive leads are held accountable for the delivery of actions arising from audit recommendations within agreed timescales; review any actions where completion date falls due outwith the financial year within which the report has been prepared.
- Consideration of the Chief Internal Auditor's Annual Report and Assurance Statement.
- Review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
- Ensure that there is direct contact between the Audit & Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors.
- Collaboratively work with the other partner bodies in support of the functions delegated to the IJB.

External Audit

- Note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors.
- Review the annual Audit Plan including the Performance Audit programme.
- Consideration of all statutory audit material for the Board, in particular:
    - Audit reports (including Performance Audit studies)
    - Annual Report
    - Chief Executive Letters
- Monitor management action taken in response to all External Audit recommendations, including VFM studies
- Review of matters relating to the Certification of the Board's Annual Report and Accounts (Exchequer Funds), Annual Patients' Private Funds Accounts, Annual Endowment Funds Accounts and the Annual IJB Accounts
- Meet with the External Auditors at least once per year and as required, without the presence of the Executive Directors
- Review the extent of co-operation between External and Internal Audit.
- Annually appraise the performance of the External Auditors
- Review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds and Patient Funds Accounts

Code of Corporate Governance

- Review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation, Standing Financial Instructions and recommend amendments to the Board;
- Examine the circumstances associated with each occasion when Standing Orders have been waived or suspended;
- Review and assess the operation of any Schemes of Delegation;

- Monitor compliance with the Members' Code of Conduct.

Annual Report and Accounts

- Undertake scrutiny of the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- Review and recommend for approval the Health Board Consolidated Annual Report & Accounts;
- Review the Annual Accounts for the NHS Borders Endowment Funds;
- Review and recommend for approval the Annual Accounts for Patients' Funds;
- Review schedules of losses and compensation payments.

Other Matters
The Committee shall:

- Review the arrangements that the Board has in place for the prevention and detection of fraud, and will receive regular reports on the business activities progressed by the Board's local Countering Fraud Operational Group.
- Monitor how the Board addresses risk in relation to potential litigation;
- Review the effectiveness of arrangements in place for the development, implementation and monitoring of directions issued by the Scottish Borders Integration Joint Board.
- Promote the use of audit reports as improvement tools by ensuring that they are directed for the attention of appropriate individuals or groups;
- Review and report on any other matter referred to the Committee by the Board;
- Review its own performance and effectiveness, including its running costs and terms of reference on an annual basis;
- Keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention;
- Review any arrangements in place for special investigations, where these arise.

1.5 Best value

The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, may seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Audit & Risk Committee reports to the Board;
- Following a meeting of the Audit & Risk Committee, the minutes of that meeting should be approved at the next Committee meeting and then presented at the following Board meeting;
- The Audit & Risk Committee should annually, and within three months of the start of the financial year, approve a work plan detailing the work to be taken forward by the Audit & Risk Committee;
- The Audit & Risk Committee will produce an Annual Assurance Statement which describes the outcomes of work undertaken by the Committee during the year in order to provide assurance to the Board that the Committee has met its remit. This statement must be presented to the Board meeting considering the Annual Accounts.

1.8 Review

The Terms of Reference of the Audit & Risk Committee will be reviewed on an annual basis.

D) INFORMATION GOVERNANCE COMMITTEE

1.1 Introduction

NHS Borders hereby resolves to establish a committee to be known as the Information Governance Committee (the Committee).

1.2 Role

To provide assurance to NHS Borders Audit & Risk Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

1.3 Membership

Committee membership

- Medical Director, Chair
- Caldicott Guardian, Vice chair
- Senior Information Risk Officer [SIRO]
- Chief Clinical Information Officer (CCIO)
- Acute Services representative
- Primary & Community Services representative
- Mental Health & Learning Disability representative
- General Practitioner
- Area Partnership Forum representative
- Finance representative
- Head of IM&T
- Director of Quality and Improvement
- Information Governance & Cyber Assurance Manager

In attendance

- Information Governance Lead
- Data Protection Facilitator
- Freedom of Information Officer
- Cyber Security Manager
- Committee Administrator

Meetings will not be quorate and no business will be transacted if less than 50% of the members or their representatives are present. Members are to nominate a deputy if they are unable to attend.

Others will also be invited to attend as the Committee sees fit.

1.4 Frequency

Meetings shall be held not less than 4 times per annum.

In the event of a planned meeting not being quorate, the recommendations of those who attended will be circulated within 7 days of the meeting for agreement by the majority of the Committee.

The Chair may convene a meeting of the Committee at any time, or when requested by the Audit Committee, and has the authority to exclude all others except members from a meeting.

If an event of significance to the Committee arises between meetings, the Director of Planning & Performance (as executive lead for Information Governance), or their nominated deputy, will bring this to the attention of the chair of the Committee.

The agenda and supporting papers will be sent to members at least 5 working days before the date of the meeting.

Any additional papers can be circulated via email.

1.5 Authority

The Committee is authorised by the Audit Committee to investigate any activity within its Terms of Reference. It is also authorised to seek any information it requires from any member, employee or agent of NHS Borders. All members, employees and agents of NHS Borders are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Audit Committee to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

1.6 Scope

The Information Governance Committee to provide assurance to NHS Borders Audit Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

The duties of the committee are to:

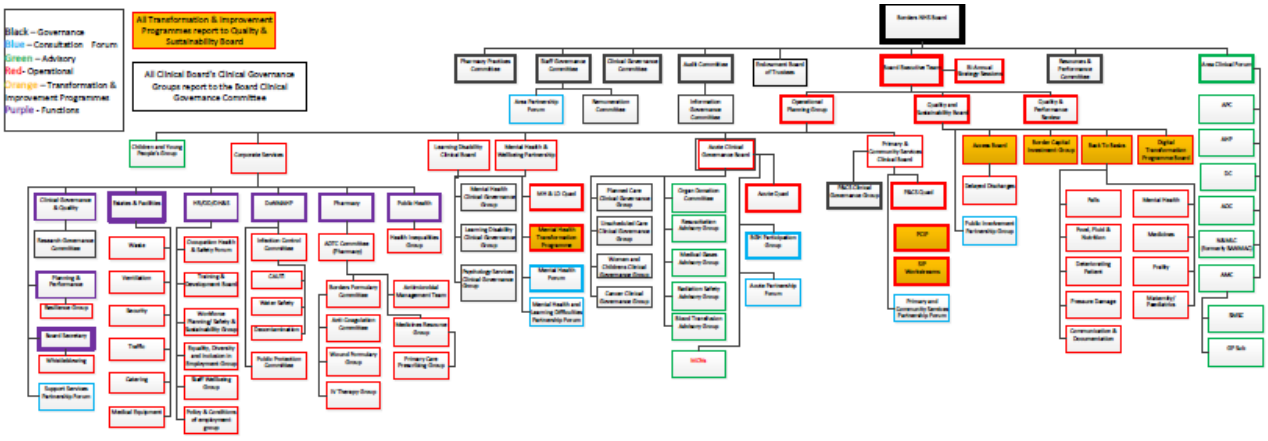
- Ensure that appropriate structures and systems are in place to support and deliver Information governance.
- Assure NHS Borders Audit Committee that these structures are operating effectively
- Ensure NHS Borders complies with UK and Scottish legislation in respect to Information Governance.
- Assist in the development and review of Information Governance policies
- Approve Policies and supporting guidelines as required
- Provide a vehicle for dissemination of Information Governance information with the aim of applying continuity and consistency across NHS Borders.
- Highlight to the Clinical Executive-Operational Group identified trends and developments in Information Governance that may affect the workforce, patients and others.
- Ensure NHS Borders complies with NHS Scotland Information Governance and policies and procedures
- Promote best practice throughout NHS Borders in all Information Governance matters.
- Provide regular reports to NHS Borders Audit Committee by submission of the approved minutes, and report any specific significant problems as they emerge.

These duties will be discharged through a standing agenda, which will include reporting on the following key activities:

- Caldicott / Confidentiality
- Data Protection
- Education, training and staff awareness on Information Governance
- Freedom of Information
- Incident review and monitoring
- IT Security and Cyber Security
- Records Management

These key activities will be amended as required and formally reviewed annually.

Reporting Arrangements



The committee is operationally accountable to the Clinical Executive with scrutiny and assurance resting with the Board's Audit Committee.

Minutes will be kept of the proceedings of the Committee. The draft minutes are to be circulated, within ten working days to the Chair of the Committee, and within five working days thereafter to members.

The Chair of Committee shall provide assurance on the work of the Committee and the approved minutes will be submitted to the Operational Planning Group meeting for information.

The Committee will conduct an annual review of its role and function

Appendix 1

Definitions

Information Governance means handling information in a confidential and secure manner to appropriate ethical and quality standards. Information Governance is a key issue for all NHS organisations and is fundamental to the effective delivery of health services, particularly as we move towards an electronic health record.

IT Security protects the information and also the physical infrastructure that supports the information from theft or damage to the hardware, software or electronic data, as well as from disruption or misdirection of the services they provide. IT Security also covers the creation of policies and standards to ensure all information is protected.

Cyber Security is solely concerned with preventing electronic attacks against electronic data.

Key Business Areas / Legislative

- Data Protection Act 2018
- Networks and Information Systems Regulations 2018
- UK General Data Protection Regulation
- EU General Data Protection Regulation
- Freedom of Information (Scotland) Act 2002
- Confidentiality: NHS Scotland Code of Practice
- Public Records (Scotland) Act 2011 – Records Management
- Information Security Standards
- Caldicott Guardianship

E) CLINICAL GOVERNANCE COMMITTEE

1.1 Purpose

To provide the Board with the assurance that clinical governance controls are in place and effective across NHS Borders.

1.2 Composition

a) Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of four Non-Executive Board members, one of whom shall be the Chair of the Area Clinical Forum. One of these members shall be appointed as Chair. Membership will be reviewed annually.

b) Appointment of Chair

The Chair and Vice Chair of the Committee shall be appointed by NHS Borders Board Chair.

c) Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The following NHS Board officers or their representatives will normally attend meetings.

- Director of Quality & Improvement
- Chief Executive
- Director of Acute Services
- Medical Director
- Director of Public Health
- Director of Nursing, Midwifery & Allied Health Professionals
- Director of Psychological Services
- Director of Pharmacy
- Associate Medical Directors
- Lead Nurse for Patient Safety and Care Assurance *Associate*
- Directors of Nursing
- Associate Director of Allied Health Professions
- Associate Director for Midwifery and General Manager for Women & Children Services
- Infection Control Manager
- Risk Manager

Others will also be invited to attend as the Committee sees fit.

All Board Members have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

1.3 Meetings

a) Frequency

The Clinical Governance Committee will meet six times a year to fulfil its remit.

b) Agenda and Papers

The Chair of the Committee, in conjunction with the nominated lead Executive and the Director of Quality & Improvement will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business (AOB) or through the Committee Chair.

The agenda and supporting papers will be sent out by the Committee Administrator, seven days in advance of the meetings to allow time for members' due consideration of issues.

c) Quorum

Two members of the Committee, including the Chair, will constitute a quorum. If the Chair is not available, the Vice-Chair will chair the meeting. If neither the Chair nor Vice-Chair is available, the other members will decide who will chair the meeting.

d) Minutes

Formal minutes will be kept of the proceedings by the Committee Administrator and submitted for approval at the next Clinical Governance Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Clinical Governance Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

e) Other

In order to fulfill its remit, the Clinical Governance Committee may, within current financial constraints, obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of board staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

1.4 Remit

The main duties of the Clinical Governance Committee are to receive assurances that clinical governance controls are in place and effective across NHS Borders, on behalf of NHS Borders Board; and that the principles of clinical governance are applied to the health improvement activities of the Board.

a) General

- assure the Board that appropriate structures are in place to undertake activities which underpin clinical governance;
- review the systems of clinical governance, monitoring that they operate effectively and that action is being taken to address any areas of concern;
- review the mechanisms which exist to engage effectively with healthcare partners and the public;

- encourage a continuous improvement in service quality;
- ensure that an appropriate approach is in place to deal with clinical risk management, including patient safety, across the NHS Borders system;
- review performance in management of clinical risk.
- monitor complaints response performance on behalf of the Board;
- promote positive complaints handling, advocacy and feedback including learning from adverse events;
- monitor the processes whereby infections are monitored and controlled;
- monitor mortality in and out of hospital with specific reference to unexpected or unusual deaths;
- receive reports on child and adult protection activities;
- produce an Annual Clinical Governance Report;
- ensure that appropriate action plans are developed, implemented and monitored as a result of published national reports and inquiries; and
- assure the Board that appropriate structures are in place to ensure robust links to the Healthcare Quality Strategy

b) Internal Monitoring

- review the Internal Clinical Governance annual audit priorities;
- make recommendations to the NHS Borders Audit Committee on the requirements for internal audit to support clinical activities;
- receive and consider Clinical Audit Reports along with regular Progress Reports;
- review the actions taken by the Chief Executive, Medical Director and Director of Nursing, Midwifery and Allied Health Professionals on any recommendations or issues arising from Audit Reports; and
- review the effectiveness of the Clinical Audit Programme.

c) External Monitoring

- review Audit Reports from external monitoring bodies in relation to clinical governance; and
- monitor and report to the Board that appropriate actions in relation to external review and monitoring of clinical governance are being taken.

1.5 Risk Reporting

The Committee shall receive reports from relevant service leads within the areas of its remit. As a result of these reports, and considering areas of interest to the Committee, any areas of risk shall be highlighted and reported.

An action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out.

1.6 Best Value

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis. The outcome of this review shall be included in the Annual Report.

1.7 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.8 Reporting Arrangements

The Clinical Governance Committee is a standing committee of the Board and is accountable to the Board and shall formally report to the Board through the Annual Report. Otherwise reporting shall be by exception reporting.

The Chair of the Committee shall submit an Annual Assurance Statement on the work of the Committee to the Board. The timing of this will align to the Board's consideration of the Chief Executive's Statement of Internal Control for the associated financial year.

The Clinical Governance Committee shall undertake an annual self assessment of the Committee's Work.

F) INFECTION CONTROL COMMITTEE

1.1 Purpose

This committee fulfils the requirements of the Scottish Government Health Directorates (SGHD), outlined in HDL (2001) 53 and HDL (2005) 8, for all NHS Boards to establish an Infection Control Committee.

The Infection Control Committee (ICC) exists to maintain an overview of infection control priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that infection control issues are managed and escalated appropriately.

1.2 Composition

The Committee includes appropriate representation from across NHS Borders as detailed below:-

Committee Member	Named Deputy	Quorum - Committee Requirements
Director of Nursing & Midwifery and AHPs (HAI Executive Lead) (Chair)	Associate Directors of Nursing (ADON) as nominated	Minimum of 1 Committee Member or Deputy
Medical Director	Associate Medical Directors or Clinical Director as nominated	Minimum of 1 Committee Member or Deputy
Consultant Microbiologist (ICD)	Not applicable	Minimum of 2 or more of the ICD, ICM or IPCN
Infection Control Manager (ICM)	Senior Infection Control Nurse	
Infection Prevention & Control Nurse (IPCN)	Not applicable	
Consultant in Public Health	Health Protection Nurse	

Medicine (CPHM)	(HPN)	
BGH Representative (Associate Director of Nursing) (Deputy Chair)	General Manager, Clinical Service Manager or Clinical Nurse Manager	Minimum of 1 Committee Member or Deputy
Primary and Community Services Representative (Clinical Nurse Manager)	Primary and Community Services Representative (Clinical Nurse Manager)	Minimum of 1 Committee Member or Deputy
Mental Health and Learning Difficulties Representative (Operational Manager)	Mental Health Representative and Learning Difficulties (Operational Manager)	Minimum of 1 Committee Member or Deputy
Head of Estates	Estates Manager	
Head of Soft FM (Facilities)	Facilities Team Lead	
Head of Quality and Clinical Governance	Clinical Governance and Quality Facilitator	
Antimicrobial Pharmacist	Pharmacist as nominated	
Head of Occupational Health	Occupational Health Nurse Manager	
Head of Health and Safety	Safety Advisor	
Member of public	Not applicable	
Staff Side Representative	Staff Side Representative as nominated	

1.3 Meetings

Frequency of Meetings

The ICC meets every 6 weeks. Patient specific details will not be discussed. If there is a high level of interest from members of the public in joining the Committee, selection will be through an interview process.

Secretarial Support and Minutes

The Infection Control Administrator will provide admin support to the ICC.

At least seven days notice will be given of the agenda. Minutes will be ratified at each meeting and agreed and noted as a correct record by the Committee.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Committee meeting or support working sub-groups.

Quorum and Voting

Quorum of the Committee is as indicated under section 1.2.

Circulation of Minutes

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

1.4 Remit

- Approves the national and local objectives and priorities for targeted surveillance of infection.
- Approves the annual Infection Control Workplan.
- Monitors the progress of the annual Infection Control Workplan
- Responsible for assessment of levels of compliance with National HAI Standards.
- Receives reports and monitors action plans following HEI inspections.
- Critically review infection control surveillance data and evidence of actions implemented to reduce the incidence of HAI
- Provide guidance and support in the development of actions specific to Infection Prevention & Control.
- Consider risks to be added to the risk register and monitor
- Monitors infection related incidents and oversees related actions
- Provide assurance to NHS Boards Board in relation to Infection Prevention & Control.
- Provides advice and support on the implementation of policies/ procedures /guidelines.
- Delegated authority to approve all infection control policies.
- Approves the annual infection control audit programme and monitors progress, actions and learning from audits.

- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of infection control is in place.
- Tasks the Infection Prevention & Control Team and Health Protection Team to investigate and manage outbreaks of infection. Reports will be presented to ICC following an outbreak incident.

Duties of membership:

Chair

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to infection control.
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.
- Formally write to Committee members and their line manager if they fail to attend 3 consecutive meetings.

Committee Members:

- Nominate deputy if unable to attend
- Provide advice and support to the Infection Control Team (ICT) and the Health Protection Team (HPT).
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

1.5 Risk Reporting

The Committee will routinely review infection control risks and escalate as appropriate.

1.6 Best Value

Membership and frequency of the Committee meetings will be regularly reviewed.
Clear description of agenda items, and opportunity provided to public representatives to a pre-meeting briefing.

1.7 Authority

As detailed in the remit, the Committee monitors progress against the Infection Control Work Plan, provides assurance and escalates risks and issues, and approves Infection Control Policies.

1.8 Reporting Arrangements

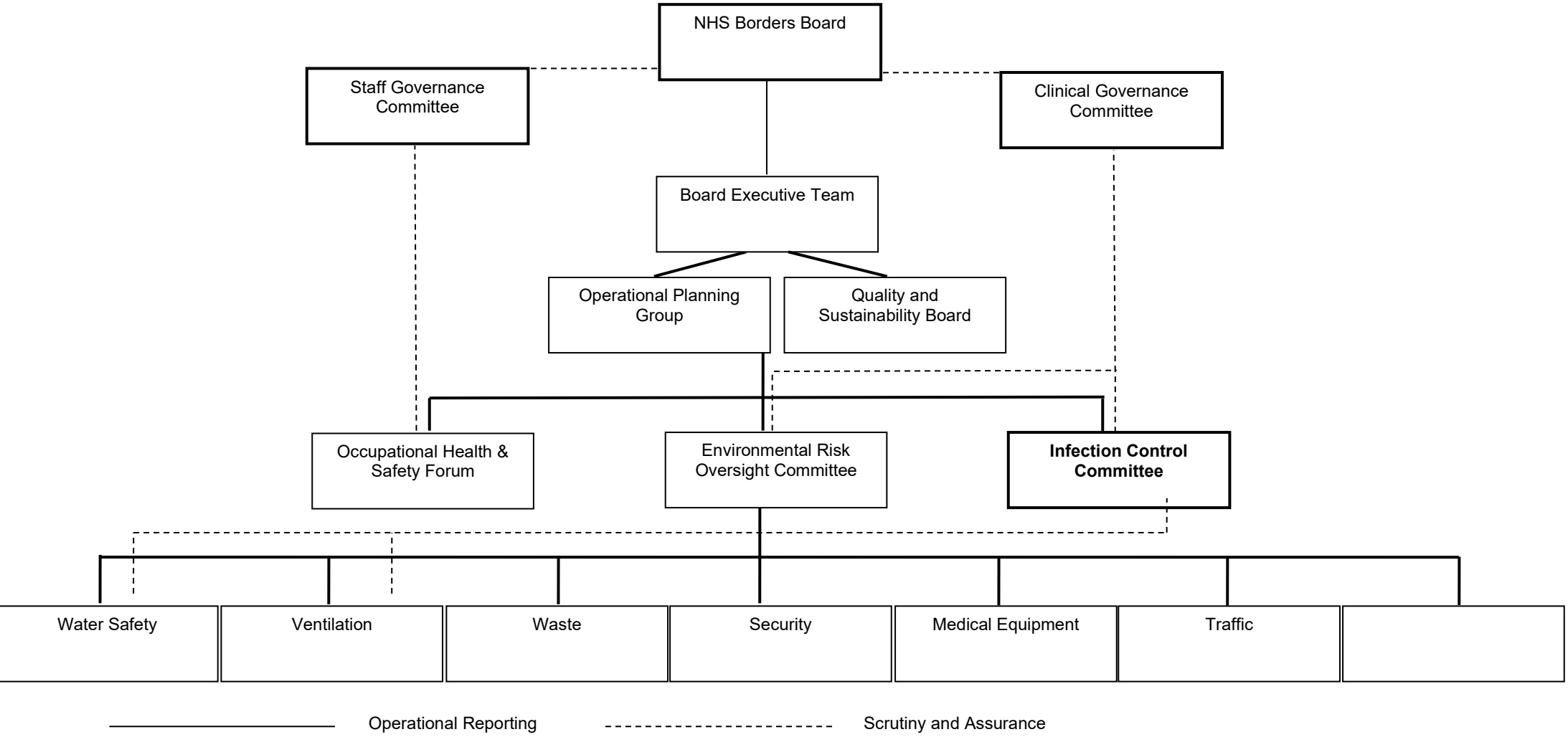
The ICC formally reports to the Operational Planning Group with a dotted line to the Clinical Governance Committee for scrutiny and assurance.

1.9 Accountability Arrangements

Refer to Appendix 1

Infection Control Committee – Reporting Structure

Appendix 1



G) ENVIRONMENTAL RISK OVERSIGHT COMMITTEE

1.5 Purpose

This Group fulfils the requirements of CEL35 (2010), the Scottish Health Technical Memorandums and Notes and Health and Safety Legislation. Statutory compliance relating to inspection, operations and management of assets.

The Environmental Risk Oversight Group (EROG) exists to maintain an overview of environmental risk priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that environmental risk issues are managed and escalated appropriately.

This group is constituted to provide specialist technical oversight to areas of risk relating to the built environment. It does not replace the existing risk management functions performed by other groups including: Infection Control Committee, Occupational Health & Safety Forum, Operational Planning Group (OPG).

1.6 Composition

The Group includes appropriate representation from across NHS Borders as detailed below:

Group Member	**Named Deputy**	**Quorum - Group Requirements**
Director of Finance	Director of Quality and Improvement	Minimum of 1 Group Member or Deputy
Director of Quality and Improvement	Director of Finance	
Consultant Microbiologist (ICD)	Not applicable	Minimum of 1 Group Member or Deputy
Infection Control Manager (ICM)	Senior Infection Control Nurse	
Head of Hard FM (Estates)	Estates Programme Manager	Minimum of 1 Group Member or Deputy
Estates Programme Manager	Head of Hard FM (Estates)	
Head of Soft FM (Facilities)	Not applicable	
Risk Manager	Not applicable	
Head of Health and Safety	Health and Safety Lead Advisor	Minimum of 1 Group Member or Deputy
Partnership Representative*	Not required	N/A

*Partnership attendance is optional. All risks under review will be considered through separate forums in line with risk management policy.

a) Frequency of Meetings

The EROC meets every 6 weeks.

b) Secretarial Support and Minutes

The BET administrative team will provide admin support to the EROC.

At least seven day's notice will be given of the agenda.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Group meeting or support working sub-groups.

c) Quorum and Voting

Quorum of the Group is as indicated under section 1.2.

d) Circulation of Minutes

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

1.7 Remit

- Provide oversight of environmental risks outwith risk appetite to assess further actions needed and make recommendations to the organisation where further resources are required
- Monitor levels of compliance with statutory and other guidance and for maintaining a record of non-compliance and the mitigating actions
- Monitor risk around the built environment including considering, recording and recommending derogations to any standards
- Develop and maintain the Board policy for derogations
- Receives and considers escalation from sub-groups
- Receives reports and monitors action plans following inspections or internal/external audit
- Provide assurance to NHS Boards Board and sub-committees in relation to Environmental Risk.
- Monitor compliance with the annual statutory audit and compliance risk tool programme and monitors progress
- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of control is in place.

1.4 Duties of membership:

Chair

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to Estates and Environmental Risk
- Escalate very high risks, as considered from the Board risk appetite approach to the Operational Planning Group
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.

- Formally write to Group members and their line manager if they fail to attend 3 consecutive meetings.

Group Members:

- Nominate deputy if unable to attend
- Provide advice and support to the Estates and Facilities Teams
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

1.10 Risk Reporting

The Group will routinely review environmental risks and escalate as appropriate.

1.11 Best Value

Membership and frequency of the Group meetings will be regularly reviewed.

1.12 Authority

As detailed in the remit, the Group monitors progress against the Estates Work Plan, provides assurance and escalates risks and issues.

1.13 Reporting Arrangements

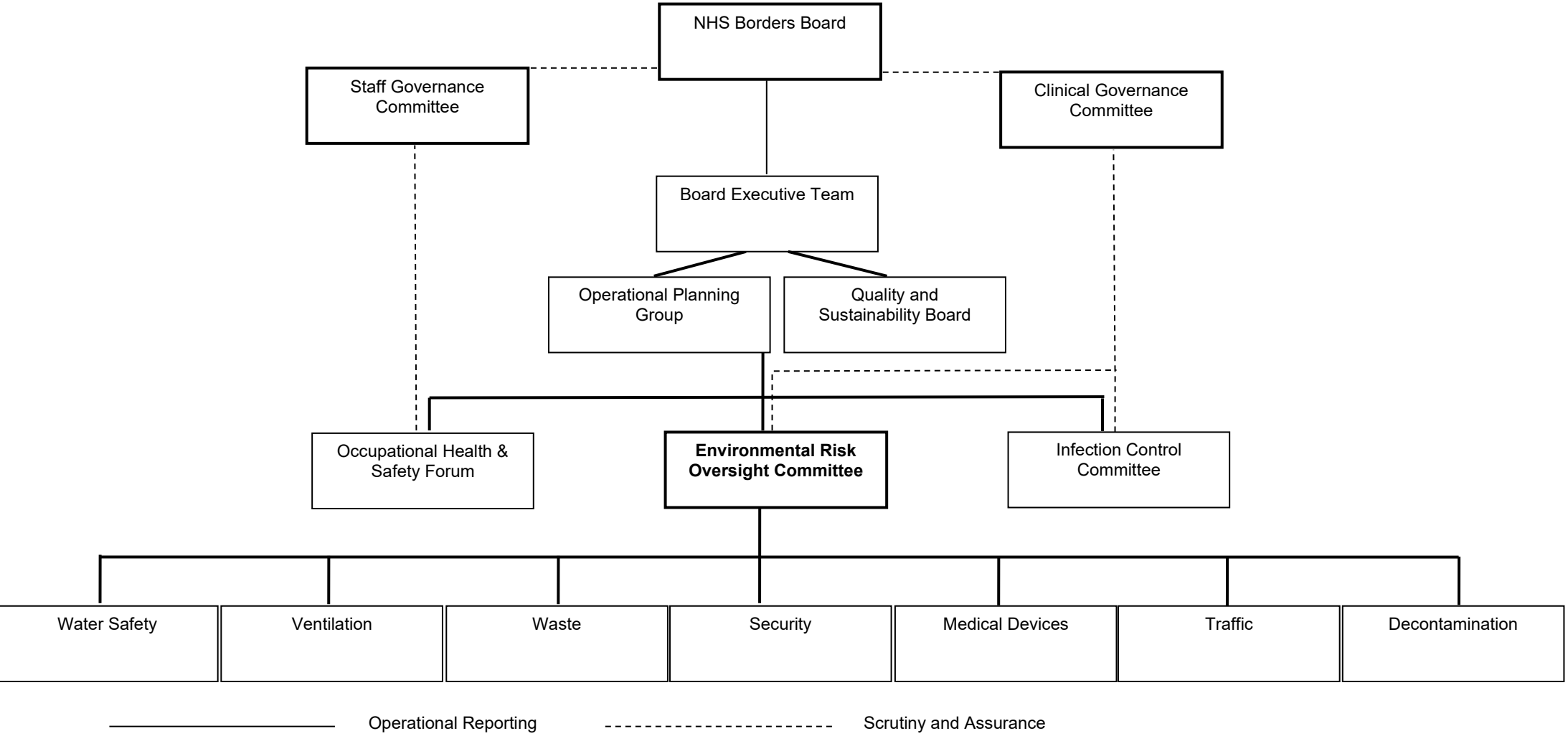
The EROC formally reports to the Operational Planning Group on matters relating to operational performance, risk and financial control. The EROC will provide assurance through the Operational Planning Group.

1.14 Accountability Arrangements

Refer to Appendix 1

Environmental Risk Oversight Group Reporting Structure

Appendix 1



H) STAFF GOVERNANCE COMMITTEE

1.1 Purpose

To advise the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard and Whistleblowing Standards; addressing the issues of policy, targets and organisational effectiveness. The NHS Reform (Scotland) Act requires Boards to put and keep in place arrangements for the purpose of improving the management of the officers employed, monitoring such management, and workforce planning. This will be demonstrated through achievement and progress towards the Staff Governance Standard through:

- Scrutiny of performance against individual elements of the Staff Governance Standards.
- Data collected during the self-assessment audit conducted under the auspices of the Area Partnership Forum.
- The action plans submitted to, and approved by, the Staff Governance Committee.
- iMatter / Everyone Matters / Collecting Your Voices results.
- Whistleblowing activity data.
- Data and information provided in statistical returns reports to the Committee.

1.2 Membership

Membership of the Staff Governance Committee will be:

- A minimum of four Non-Executive Members, one of whom must be the Employee Director and one the Whistleblowing Champion.

In addition there will be in attendance:

- Partnership Leads - Staff-side, from Local Partnership Forums
- Director of HR, OD & OH&S and Deputy Director(s) of HR
- Other Directors (as appropriate)
- Head of Work & Wellbeing
- OD Lead
- Health & Safety Advisor
- Practice Development Lead

The Chief Executive and Chair will attend at least one Staff Governance Committee meeting per year.

The Committee may invite additional attendees as required by the agenda.

1.3 Meetings

Meetings of the Committee will be quorate when two Non-Executive Members are present.

A Non-Executive Member will act as Chair to the meeting.

1.4 Remit

- To monitor performance of the Health Board against the Staff Governance Standard.
- To fulfil a monitoring, promotion and assurance role with Whistleblowing activity within NHS Borders and ensure compliance with the Once for Scotland/Independent National Whistleblowing Officer Standards.
- To monitor and evaluate Workforce strategies and implementation plans.
- To monitor pay modernisation processes.
- To monitor compliance with Statute and encourage best practice around equality, diversity & inclusion in employment.
- As appropriate, to work collegiately with the Area Partnership Forum (APF) which has the responsibility for ensuring effective partnership working between management and staff at all levels in NHS Borders.
- To receive and note annual reports from the Remuneration Committee.
- To ensure implementation of Once For Scotland Workforce Policies.
- To provide timely Staff Governance information required for national monitoring arrangements.
- To provide Staff Governance information for the Statement of Internal Control.
- To approve and monitor any NHS Borders Workforce Plan.
- To monitor and challenge against the Staff Governance Committee Dashboard data.
- To receive and note National reports on whistleblowing and give assurance to Board on this or escalate concerns to same.
- To receive and note annual report/updates from the OH&S Forum.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Borders NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Staff Governance Committee reports to Borders NHS Board.
- Following a meeting of the Staff Governance Committee, the Minutes of that meeting should be presented at the next Borders NHS Board meeting.
- The Staff Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Staff Governance Committee.

- The Staff Governance Committee will produce an Annual Report for presentation to Borders NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year. The Annual Report must be presented to a Board meeting prior to the Audit & Risk Committee considering the Annual Accounts.

I) REMUNERATION COMMITTEE

1.1 Purpose

The fourth edition of the Staff Governance Standard made clear that each NHSScotland Board is required to establish a Remuneration Committee, whose main function is to ensure application and implementation of fair and equitable pay systems on behalf of the Board as determined by Ministers and the Scottish Government and applies to Executives and Senior Managers only.

1.2 Composition

- The Chair of the Board (who will be the Chair);
- The Vice Chair of the Board
- The Employee Director
- Two other Non-Executive Members

In addition there will be in attendance:

- Board Secretary
- Chief Executive
- Director of HR, OD & OH&S
- Associate Director of Workforce

At the request of the Committee, other Senior Officers may also be invited to attend.

All members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

1.3 Meetings

The Committee will meet no less than 3 times per annum**.**

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of HR, OD & OH&S. The Chair may call a special meeting of the Remuneration Committee to address the issue.

Meetings of the Committee will be quorate when three Non-Executive Members are present.

1.4 Remit

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Manager Pay Systems and also to discharge specific responsibilities on behalf of the Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Borders Performance Assessment Agreement and Scottish Government direction and guidance for determining the employment, remuneration, terms and conditions of employment for Executive Directors, in particular:-

- Approving the personal objectives of all Executive Directors in the context of NHS Borders's Annual Delivery Plan, Corporate Objectives and other local, regional and national policy

- receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors.

Ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for other staff employed under the 'Executive Cohort' and 'Senior Manager' pay systems. The Committee will receive formal reports annually providing evidence of the effective operation of these arrangements.

Promote the adoption of an NHS Borders approach to issues of remuneration and performance assessment to ensure consistency.

Undertake reviews of aspects of remuneration/employment policy for Executive Directors (e.g. Relocation Policy) and other Senior staff (e.g. special remuneration), when requested by NHS Borders Board.

The Remuneration Committee shall approve, reject or seek amendment to proposed severance packages ie financial packages to incentivise an employee leaving the employment of NHS Borders by mutual consent. These are usually progressed through use of a Settlement Agreement which is a legal document which requires ultimate sign off by Scottish Government. Where matters are time critical, the proposal may be circulated around the Remuneration Committee by email, if there is no upcoming formal meeting.

Consider and keep under regular review the arrangements for those NHS Borders staff on external secondments.

To be assured as to the proper processes of the Discretionary Points Committee in the award of discretionary points to eligible specialist, medical and dental staff based on competent recommendations from the appropriate advisory bodies, and to receive reports from the Committee for approval.

To have oversight of the consultant recruitment process on behalf of the Board, who are responsible for the recruitment, and authorisation of appointments of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009.

1.4.1 Confidentiality and Committee Decisions

Decisions reached by the Committee will be by agreement and with all Members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a second and casting vote.

1.4.2 Minutes and Reports

Reports issued to Members will contain full details of the issues to be considered with clear recommendations to the Committee. The minutes will record the decisions reached by the Committee with due regard to confidentiality in relation to individuals.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from the Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference, and in doing so, is authorised to seek any information it requires about any employee.

In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and it may require Directors or other officers of NHS Borders to attend meetings.

1.7 Reporting Arrangements

The Remuneration Committee reports through the Staff Governance Committee to the Board;

Following a meeting of the Remuneration Committee the minutes of that meeting shall be marked as “confidential” and made available to the Non Executive Directors.

The Remuneration Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Remuneration Committee.

The Remuneration Committee will produce a high level Annual Report for presentation to the Staff Governance Committee to provide assurance that the Remuneration Committee is addressing appropriate business in line with due process.

The Remuneration Committee will through the Staff Governance Committee provide an annual assurance that systems and procedures are in place to manage the pay arrangements for all Executive Directors and others under the Executive Cohort and Senior Manager pay systems so that overarching Staff Governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential

employment issues that are considered by the Remuneration Committee; these can only be considered by the Non-Executive Members of the Board.

The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Staff Governance Committee. This is to ensure that the Staff Governance Committee is in a position in its annual report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Borders.

1.8 Review

The Terms of Reference of the Remuneration Committee will be reviewed on an annual basis. The Remuneration Committee will undertake an annual self assessment.

J) AREA CLINICAL FORUM (ACF)

The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- Draw on the full range of professional skills and expertise in their area for advice on clinical matters both locally and on national policy issues;

- Promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process to support the NHS Board in the conduct of its business.

1.1 Purpose

To formulate comprehensive clinical advice to the Board on matters of policy and implementation. The Committee will consult widely with its constituency and the Board. It will be pro-active in:

- reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups;

- the provision of a clinical perspective on the development of the Local Delivery Plan and the strategic objectives of the NHS Board;

- sharing best practice and encouraging multi-professional working in healthcare and health improvement;

- ensuring effective and efficient engagement of clinicians in service design, development and improvement;

- providing a local clinical and professional perspective on national policy issues;

- Ensuring that local strategic and corporate developments fully reflect clinical service delivery;

- Taking an integrated clinical and professional perspective on the impact of national policies at local level;

- Through the ACF Chair, being fully engaged in NHS Board business; and

- supporting the NHS Board in the conduct of its business through the provision of multi-professional clinical advice.

At the request of Borders NHS Board, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- Investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi- disciplinary advice.

- Advise Borders NHS Board of the impact of national policies on the integration of services, both within the local NHS systems and across health and social care.

Authority: The Area Clinical Forum is an Advisory Committee of the Borders NHS Board.

Reporting Arrangements: The Area Clinical Forum will report to Borders NHS Board and submit an Annual Report on its activities to the NHS Board.

The approved minutes of the ACF will be presented in to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken.

Membership: The Area Clinical Forum will consist of the chair, vice chair and another identified representative of each of the statutory Area Professional Committees as follows:-

- Area Allied Health Professionals Committee
- Area Medical Committee
- Area Dental Committee
- Area Optical Committee
- Area Nursing and Midwifery Committee
- Area Pharmaceutical Committee
- Healthcare Scientists Advisory Committee
- Psychologists Team

Others in Attendance: The Committee may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

Sub Committees: The Committee may appoint ad hoc Short Life Working Sub-Committees as appropriate to consider and provide advice on specific issues.

Tenure: Individual members tenure will be determined by the constitution of their parent Committee. If a member resigns or retires, the appropriate Advisory Committee will choose a replacement. Individuals shall cease to be members of the Area Clinical Forum on ceasing to be the Chair, Vice Chair or identified representative of their professional committee.

Officers

Chair: The Committee shall elect a Chair. This shall be on the basis of one vote for each of the Committee members. The Chair shall be elected for 4 years in line with the appointment tenure of Non Executives to the Board. He/she will be eligible for a maximum of 2 consecutive terms of office.

Selection of the Chair will be an open process, and all members may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot (Annex A).

The Chair of the Area Clinical Forum will, subject to formal appointment by the Cabinet Secretary for Health and Wellbeing, serve as a Non-Executive member of Borders NHS Board.

Membership of Borders NHS Board is specific to the office rather than to the person. The normal term of appointment for Board members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

Where the members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Non-Executive member of Borders NHS Board, the new Chair will have to be formally nominated to the Cabinet Secretary as a Non-Executive member of Borders NHS Board for approval.

In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a member of the Area Clinical Forum.

Vice-Chair: The Committee shall then elect a Vice-Chair. The tenure shall be the same as for the Chair.

A Vice Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all members may put themselves forward as candidates for the position. If more than one person puts themself forward an election will be held by secret ballot.

The Vice Chair will deputise, as appropriate, for the Chair, but where this involves participation in the business of Borders NHS Board, they will not be functioning as a Non-Executive member.

Secretary: The Secretary shall be provided by the NHS Board.

Conditions

Interests: Members must declare any pecuniary or other interest which could be construed as influencing the advice given to the NHS Board, and must not participate in discussion leading to that advice.

Removal: An Office Bearer may be removed from office at a meeting of the Committee only if the removal has been included as an agenda item. Such removal would require the agreement of two thirds of the members of the Committee.

Executive Powers: The Chair (or in his/her absence the Vice Chair) will have discretionary powers to act on behalf of the Committee but in doing so is answerable to the Committee.

Membership of the NHS Board: The Chair will be appointed by the Cabinet Secretary as a full member of Borders NHS Board.

Conduct: All members will have due regard to and operate within NHS Borders Code of Corporate Governance.

Standing Orders

Notice of Meetings: The Secretary will ensure that the agenda and relevant papers are issued at least seven days before the meeting whenever possible.

Minutes: The Secretary will ensure that the minutes of the meetings of the Committee are sent to the each member with the agenda and papers of the next meeting.

Meetings: Meetings will be held bi-monthly although the Committee may vary these arrangements to cover holiday months or other circumstances.

Quorum: A quorum of the Committee will be one third of the members. In the event that the Chair and Vice Chair are both absent, the members present shall elect from those in attendance, a person to act as chair for the meeting.

Voting: Where the Committee is asked to give advice on a matter and a majority vote is reached the Chair or Secretary will record the majority view but will also make known any significant minority opinion and present the supporting arguments for both view points.

Alterations to the Constitution and Standing Orders: Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Committee provided notice of the proposed alteration is circulated with the notice of the meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

Any alterations must be submitted to the NHS Board for approval.

ANNEX A

ACF CHAIR ELECTION PROCESS

- Election to be carried out during ACF meeting.
- The current chair will ask for nominations from the ACF members and check nominees willingness to stand for election.
- If there is more than 1 nominee each will be asked to briefly inform the ACF what will be their approach to the role, how they will involve the members and how they will develop the ACF (no more than 5 minutes each).
- Each ACF member will have 1 vote (they may vote for themselves).

- Each member will write their chosen candidate on a paper slip and pass to the secretary.

- The Board Secretary will check the votes and announce the winner.

- In the event of a draw then the Board Secretary will announce this to the ACF.

- Candidates will be asked if they wish to add anything to their earlier statements.

- The ACF members will then vote again.

- If there is a second draw the Board Secretary will announce this and the Chair will ask the members if they are likely to change their vote.

- If not then the decision will be referred to a panel of 3 Non Executive Directors. Candidates will give a short presentation to the panel on their approach to the role, how they will involve the members and how they will develop the ACF.

- The panel will then make a decision and inform the existing Chair.

- Once a decision is made the Board Secretary will then make the appropriate arrangements.

- The ACF Vice Chair will be appointed via the same process

K) AREA PARTNERSHIP FORUM (APF)

1. Purpose

The Area Partnership Forum is a strategic body which is responsible for facilitating, monitoring and evaluating the effective operation of partnership working across NHS Borders. It further acts to endorse HR policies, procedures & protocols through the partnership process, recognising the Once for Scotland context.

1.1 Remit

The Area Partnership Forum will:

- Take a proactive approach in embedding partnership working at all levels of the organisation to assist the process of devolved decision making and to develop effective working relationships;
- Endorse, implement & monitor adherence to all HR Policies;
- Consider and comment on other corporate policies/strategies, assessing the impact of strategic decisions upon staff and making sure policies are underpinned by appropriate Staff Governance and financial planning disciplines;
- Support the work of the Staff Governance Committee;
- Ensure the best HR practice is shared across the health board;
- Contribute to the development of strategies and action plans;
- Oversee, monitor and evaluate the roll-out of staff surveys;
- Liaise with national industrial relations bodies such as the Scottish Partnership Forum and STAC;

- Contribute to local and regional planning arrangements;
- Ensure adequate and necessary Facilities Arrangements are in place;
- Making sure that the views of all Staff Side with an interest in improving local health and healthcare services, local communities and healthcare staff are appropriately heard and considered;
- Ensure the Area Partnership Forum has knowledge and understanding of national issues;
- Ensure that in its close working with the Training, Education & Development (TED) Board, that all staff are effectively trained, properly supported and performance is formally reviewed on an annual basis.

1.2 Authority

The Forum is authorised by NHS Borders to investigate any activity within its terms of reference. In order to fulfil its remit, the Area Partnership Forum may obtain whatever professional advice it requires (including that from professional/trade union/national or local representatives) and require Directors or other officers of the Board to attend meetings.

The external Auditor and Chief Internal Auditor shall have the right of direct access to the Joint Chairs of the Area Partnership Forum.

The Forum is authorised by the Board to endorse & adopt Once for Scotland HR policies and any other more localised protocols through the partnership process.

1.3 Reporting Arrangements

- The Area Partnership Forum acts as a sub-group of, and reports to, the Staff Governance Committee which in turn is a sub-committee of the Board;
- Following a meeting of the Area Partnership Forum, the approved minutes of that meeting will be presented for information at the next meeting of the Staff Governance Committee;
- The Area Partnership Forum shall annually and within three months of the start of each financial year provide, approve and agree a workplan detailing the work to be taken forward by the Forum that year;
- The Area Partnership Forum shall produce an annual report for presentation to the APF and Staff Governance Committee that will describe outcomes from the Forum during the year.

2. MEMBERSHIP

Membership of the Area Partnership Forum shall comprise representatives of management and all recognised staff organisations (Staff Side). [Appendix 1]. For any voting purposed each recognised Trades Union will have one seat/one vote. However all Staff Side representatives are encouraged to attend.

Management and Staff Side should have named members with nominated deputies. Management and Staff Side representatives, including deputies, may attend as observers with the agreement of the Joint Chairs. Full Time Officers for recognised Staff Side organisations may attend as an ex-officio member.

Membership (and Deputy Membership) is conferred without limit of time subject to acceptable record of attendance. Membership will be formally updated annually when the Terms of Reference are reviewed.

The Employee Director's Offices shall ensure that an accurate record of attendance is maintained and absence from three consecutive meetings of the Forum shall result in membership being withdrawn and alternative representation being sought.

Should there then be continued non-attendance of a nominated representative to the APF, the Joint Chairs shall contact the nominated representative and/or (in the case of a Staff Side representative) their relevant staff organisation and clarify if the nominated representative wishes to continue as a member of the APF, or if another nominated representative from that organisation will be replacing them on the APF.

2.1 Formal Sub Groups

Local Partnership Forums x 4
Pay And Conditions of Employment (PACE) Group
Joint Staff Forum, with IJB

The Area Partnership Forum will also act as a resource for other groups seeking Staff Side views / opinions relating to NHS Borders matters.

The Occupational Health and Safety Forum, as a statutory committee for Health and Safety, will communicate directly to the Area Partnership Forum and Staff Governance Committee on matters agreed in partnership with managers and health and safety representatives. The OH&S Forum is not a sub-committee of APF.

3. FORUM MEETINGS

3.1 Cycle of Meetings

The Forum will meet on an agreed basis, but routinely every 8 weeks, unless otherwise agreed by the Joint Chairs.

3.2 Chairing of Meetings

There will be Joint Chairs appointed from Management and Staff Side who will chair meetings of the Forum on an alternating basis. It is the responsibility of the Joint Chairs to agree in advance any agenda items. Tenure of the Chair of the Staffside for APF is de facto that the Employee Director is to be included at 2 successive terms as Chair as a maximum; noting non-executive directors have exception to the limit of successive terms in post. The Employee Director's Offices shall distribute an agenda and supporting papers for each Forum meeting no later than one week before the date of the meeting to all Forum members.

3.3 Quorum

The Forum will be quorate when:

- a minimum of five members of the Management and;
- a minimum of five members of the Staff Side are present.

4. VALUES

To underpin the working of the Area Partnership Forum, the following values will be adopted and govern the approach taken to consideration of issues, in line with the requirements of MEL (1999) 59:

- mutual trust, honesty and respect;
- openness and transparency in communications;
- recognising and valuing the contribution of all partners;
- access and sharing of information;
- consensus, collaboration and inclusion;
- maximising employment security;
- full commitment to the framework and good employment practice;
- the right of stakeholders to be involved, informed and consulted;
- early involvement of all staff and their trade unions in all discussions regarding change;
- a team approach to underpin partnership working.

The Forum will also promote and act in accordance with the Partnership Standards for NHS Borders.

5. DECISION OF THE FORUM

5.1 Consultation

Any party may request that a matter brought before the Forum be subject to appropriate consultation with management and Staff Side colleagues prior to any final agreement being reached.

Decisions reached by the Forum which impact on the operation of policy and practice will take effect from a date agreed by the parties and will apply to all relevant staff employed within NHS Borders.

5.2 Referral

Any matter considered by the Area Partnership Forum which is deemed to fall outwith its terms of reference, or which is subject to Board or Staff Governance Committee approval, will be referred to the Board or Staff Governance Committee on the basis of Area Partnership Forum support. Reference to the Scottish Partnership Forum may also take place as appropriate.

5.3 Failure to Agree

In the event of any failure to agree matters under consideration, the matter will be referred via the Joint Chairs to the Staff Governance Committee, who will endeavour to find a way forward.

6. Review

These Terms of Reference will be reviewed on an annual basis and before the end of June each year.

APPENDIX 1
Management Representatives

The management representatives will be drawn from the senior officers of NHS Borders and will normally include:

- Chief Executive
- Director of HR and OH&S (plus deputies)
- Director of Acute
- Chief Officer, HSCP
- Director of Planning & Performance
- Director of Finance (or deputy)
- Director of Nursing, Midwifery & AHPs (or deputy)
- Associate Director of AHPs
- Head of Soft Facilities Management
- Head of Estates General Managers
- Representative of the Communications Department

Other management representatives may attend in response to specific issues under consideration at the Forum

Staff Side Organisations

- British Association of Occupational Therapy – BAOT
- British Dental Association – BDA
- British Dietetic Association – BDA
- British Medical Association – BMA
- British and Orthoptic Society - BIOS
- Community and District Nursing Association
- Community Practitioners and Health Visitors Association
- Chartered Society of Physiotherapy – CSP
- General Municipal Boilermakers Union – GMB
- Royal College of Nursing – RCN
- Royal College of Midwives – RCM
- Society of Chiropodists & Podiatrists – SCP
- Society of Radiographers – SOR
- UNISON
- UNITE

The Chairs of the Local Partnership Forums attend using either their Trade Union seat or in an ex-officio capacity.

Fulltime Union Officials attend in an ex-officio capacity.

L) PHARMACY PRACTICES COMMITTEE

Terms of Reference

The Pharmacy Practices Committee is constituted and operates in compliance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995. Statutory Instrument 1995 No 414 (S.28).

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

Made	*6th September 2001*
Laid before the Scottish Parliament	*7th September 2001*
Coming into force	*28th September 2001*

ARRANGEMENT OF REGULATIONS

PART IV

MISCELLANEOUS

12. Revocations

SCHEDULE: Meetings and proceedings of the Board and committees

The Scottish Ministers, in exercise of the powers conferred by sections 2(10), 105(7) and 108(1) of, and by paragraphs 2A, 4, 6 and 11 of Schedule 1 to the National Health Service (Scotland) Act 1978(a), and of all other powers enabling them in that behalf, hereby make the following Regulations:

PART I

GENERAL

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and shall come into force on 28th September 2001.

(2) In these Regulations, unless the context otherwise requires–

"the 1997 Act" means the National Health Service Act 1977(b);

"the Act" means the National Health Service (Scotland) Act 1978;

"Board" means a Health Board constituted under section 2(1) of the Act;

"the Charity Commissioners" means the Charity Commissioners constituted in accordance with section 1 of the Charities Act 1993(c);

"Chief Officer" means the person or persons holding the post of Chief Executive;

"committee" means a committee of a Board and includes "sub-committee"

"contract" includes any arrangement including a NHS contract;

"health service body" means a person or body specified in section 17A(2) of the Act(d);

"meeting" means a meeting of the Board or of any committee;

"member" means a member of a Board and includes the chairperson;

"NHS trust" means a National Health Service trust established under section 12A of the Act(e).

(3) A reference in these Regulations to a numbered regulation is to the regulation bearing that number in these Regulations and a reference in a regulation to a numbered paragraph is to the paragraph bearing that number in that regulation and a reference to the Schedule is to the Schedule to these Regulations.

(a) 1978 c.29; section 105(7), which was amended by the Health Services Act 1980 (c.53) ("the 1980 Act"), Schedule 6, paragraph 5(1)(a) and Schedule 7 and by the Health and Social Services and Social Security Adjudications Act 1983 (c.41) ("the 1983 Act"), Schedule 9, paragraph 24, contains provisions relevant to the exercise of the statutory powers under which these Regulations are made; section 108(1) contains definitions of "prescribed" and "regulations" relevant to the exercise of the statutory powers under which these Regulations are made; paragraph 2A of Schedule 1 was inserted by the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), Schedule 5, paragraph 2; paragraph 4 of Schedule 1 was amended by the 1990 Act, Schedule 5, paragraph 3; and paragraph 11 of Schedule 1 was amended by the 1980 Act, Schedule 6, paragraph 7 and Schedule 7 and by the 1990 Act, Schedule 5, paragraph 7. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

(b) 1977 c.49.

(c) 1993 c.10.

(d) Section 17A(2) was inserted by the 1990 Act, section 30 and amended by the Health Act 1999 (c.8), Schedule 1.

(e) Section 12A was inserted by the 1990 Act, section 31 and amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2, paragraph 46 and by the Health Act 1999 (c.8), sections 46 and 48 and Schedule 4, paragraph 45.

PART II

MEMBERSHIP

Appointment and term of office

2.—(1) All members shall be appointed by the Scottish Ministers.

(2) The term of office of the members shall, subject to regulation 5, be for such period as the Scottish Ministers shall specify on making the appointment.

(3) After the expiration of a term of office a member shall, subject to regulation 6, be eligible for re-appointment.

University members

3. For the purposes of paragraph 2A of Schedule 1 to the Act(a) the Boards in which at least one of the persons appointed to be chairperson or a member must hold a post in a university with a medical or dental school are the Boards in Grampian, Greater Glasgow, Lothian and Tayside.

Remuneration of members

4. Remuneration may be paid, in accordance with such determination as may be made by the Scottish Ministers, under paragraph 4 of Schedule 1 to the Act(b), to the chairperson, a member appointed under paragraph 2A of Schedule 1 to the Act holding a post in a university and any of the other members, except any members holding the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Resignation and removal of members

5.—(1) A member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.

(2) If the Scottish Ministers consider that it is not in the interests of the health service that a member of a Board should continue to hold that office they may forthwith terminate that person's appointment.

(3) If a member has not attended any meeting of the Board, or of any committee of which they are a member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless the Scottish Ministers are satisfied that–

(a) the absence was due to illness or other reasonable cause; and

(b) the member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.

(4) Where a member who was appointed for the purposes of paragraph 2A of Schedule 1 to the Act ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes, the Scottish Ministers may terminate the appointment of that person as a member.

(5) Where any member becomes disqualified in terms of regulation 6 that member shall forthwith cease to be a member.

Disqualification

6.—(1) Subject to paragraphs (2) and (3), a person shall be disqualified for being a member, if–

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere than in Scotland, they have granted a trust deed for the benefit of

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(a) Paragraph 2A was inserted by the 1990 Act, Schedule 5, paragraph 2.
(b) Paragraph 4 was amended by the 1990 Act, Schedule 5, paragraph 3.

their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs;

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body;

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office;

(e) they are a chairperson, member, director or employee of a health service body;

(f) they have had their name removed, by a direction under section 29 of the Act(a), from any list prepared under Part II of the Act and have not subsequently had their name included in such a list;

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application;

(h) they have had their name removed, by a direction under section 46 of the 1977 Act(b) from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list;

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application;

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986(c); or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1)–

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when–

(i) the sequestration of their estate is recalled or reduced; or

(ii) the sequestration is discharged;

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when–

(i) the bankruptcy is annulled; or

(ii) they are discharged;

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when–

(i) that appointment is recalled; or

(ii) the judicial factor is discharged;

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

Appointment and powers of vice-chairperson

7.—(1) For the purpose of enabling the business of a Board to be conducted in the absence of the chairperson, each Board shall appoint a member who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust to be vice-chairperson and any person so appointed shall, so long as they remain a member of the Board, hold office as vice-chairperson for such period as the Board may decide.

(a) Section 29 was amended by the Health and Social Security Act 1984 (c.48), Schedule 8 and by the National Health Service (Amendment) Act 1995 (c.31), section 7 and the Schedule.

(b) Section 46 was amended by the Health Authorities Act 1995 (c.17), Schedule 1 and the National Health Service (Amendment) Act 1995 (c.31), sections 1, 2 and 3.

(c) 1986 c.46.

(2) Any member so appointed may at any time resign from the office of vice-chairperson by giving notice in writing to the chairperson and the members may appoint another member as vice-chairperson in accordance with paragraph (1).

(3) Where the chairperson of a Board has died or has ceased to hold office of where that person has been unable to perform their duties as chairperson owing to illness, absence from Scotland or any other cause, the vice-chairperson shall take the place of the chairperson in the conduct of the business of the Board and references to the chairperson shall, so long as there is no chairperson able to perform their duties, be taken to include references to the vice-chairperson.

PART III

PROCEEDINGS

Meetings and minutes

8.—(1) The meetings and proceedings of the Board shall be conducted in accordance with standing orders made pursuant to regulation 9.

(2) At every meeting of a Board, the chairperson, if present, shall preside.

(3) If the chairperson is absent from any meeting, the vice-chairperson, if present, shall preside, and if the chairperson and vice-chairperson are both absent, the members present at the meeting shall elect from among themselves a person, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, to act as chairperson for that meeting.

(4) All acts of, and all questions coming and arising before, a Board shall be done and decided by a majority of the members of the Board present and voting at a meeting of the Board and, in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

(5) The proceedings of a Board or of any committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member of such committee.

Standing orders

9.—(1) Subject to paragraph (2) and to such directions as may be given by the Scottish Ministers, each Board shall make, and may vary and revoke, standing orders for the regulation of the procedure and business of the Board and of any committee.

(2) Standing Orders under paragraph (1) should include the matters set out in the Schedule.

Appointment and functions of committees

10.—(1) A Board may, and if so directed by the Scottish Ministers shall, appoint committees for such purposes as the Board may determine, subject to such restrictions or conditions as the Board may think fit, or as the Scottish Ministers may direct.

(2) Any committee, but not including any sub-committee, appointed under paragraph (1) shall include at least one member of the Board and may include persons, including trustees of a NHS trust, who are co-opted, and may consist wholly or partly of members of the Board.

(3) Any sub-committee appointed under paragraph (1) may include persons who are co-opted and may consist wholly or partly of members of the Board or wholly of persons who are not members of the Board.

Conflict of interest

11.—(1) Subject to such exceptions and qualifications as may, with the approval of the Scottish Ministers, be specified in standing orders, if a member, or associate of theirs has any pecuniary or other interest, direct or indirect, in any contract or proposed contract (not being a contract for the provision of any of the services mentioned in Part II of the Act) or other matter, and that member is present at a meeting of the Board or of a committee at which the contract or other matter is the subject of consideration, they shall at the meeting, and as soon as practicable after its

commencement, disclose the fact, and shall not take part in the consideration and discussion of, the contract, proposed contract or other matter or vote on any question with respect to it.

(2) The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by this regulation in any case in which it appears to them in the interests of the health service that the disability should be removed.

(3) Any remuneration, compensation or allowances payable to a chairperson or other member by virtue of paragraphs 4, 5 or 13 of Schedule 1 to the Act shall not be treated as a pecuniary interest for the purpose of this regulation.

(4) A member shall not be treated as having an interest in any contract, proposed contract or other matter by reason only that they, or an associate of theirs, has an interest in any company, body or person which is so remote or insignificant that they cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(5) This regulation applies to a committee as it applies to the Board and applies to any member of any such committee (whether or not they are also a member of the Board) as it applies to a member of the Board.

(6) For the purposes of this regulation, the word "associate" has the meaning given by section 74 of the Bankruptcy (Scotland) Act 1985(a).

PART IV

MISCELLANEOUS

Revocations

12. The following Regulations are hereby revoked:–

(a) the Health Boards (Membership and Procedure) (No. 2) Regulations 1991(b)

(b) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993(c)

(c) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998(d)

(d) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999(e).

SUSAN C DEACON
A member of the Scottish Executive

St Andrew's House,
Edinburgh
6th September 2001

(a) 1985 c.66. Section 74 was amended by the Bankruptcy (Scotland) Regulations 1985 (S.I. 1985/1925), regulation 11.
(b) S.I 1991/809.
(c) S.I. 1993/1615.
(d) S.I. 1998/1459.
(e) S.I. 1999/132.

Regulation 9

SCHEDULE

MATTERS TO BE INCLUDED IN STANDING ORDERS REGULATING MEETINGS AND PROCEEDINGS OF THE BOARD AND COMMITTEES

Calling meetings

1.—(1) The first meeting of the Board shall be held on such day and at such place as may be fixed by the chairperson and that person shall be responsible for convening the meeting.

(2) The chairperson may call a meeting of the Board at any time and the chairperson of a committee may call a meeting of that committee at any time or and shall call a meeting when required to do so by the Board.

(3) If the chairperson refuses to call a meeting of the Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of members, has been presented to the chairperson or if, without so refusing, the chairperson does not call a meeting within 7 days after such requisition has been presented, those members who presented the requisition may forthwith call a meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

Notice of Meetings

2.—(1) Before each meeting of the Board, a notice of the meeting, specifying the time, place and business proposed to be transacted at it and signed by the chairperson, or by a member authorised by the chairperson to sign on that person's behalf, shall be delivered to every member or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting.

(2) Lack of service of the notice on any member shall not affect the validity of a meeting.

(3) In the case of a meeting of the Board called by members in default of the chairperson, the notice shall be signed by those members who requisitioned the meeting in accordance with paragraph 1(3).

Conflict of interests

3.—(1) A member shall be excluded from a meeting of the Board or committee in accordance with regulation 11 while any contract, proposed contract, or other matter in which they or an associate of theirs has an interest is under consideration.

(2) The exceptions and qualifications referred to in regulation 11(1) shall be specified.

Quorum

4. No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of members including at least two members who do not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Conduct of meetings

5.—(1) At any meeting of a committee the chairperson of that committee, if present, shall preside.

(2) If both the chairperson and vice-chairperson (if any) are absent from a meeting of the Board a member, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, chosen at the meeting by the members present shall preside.

(3) If both the chairperson and vice-chairperson (if any) of a committee are absent from a meeting of that committee a member of the committee chosen at the meeting by the other members present shall preside.

(4) If it is necessary or expedient to do so a meeting may be adjourned to another day, time and place.

Voting

6. Every question at a meeting shall be determined by a majority of the votes of the members present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

Records

7.—(1) The names of the members present at a meeting shall be recorded.

(2) The minutes of the proceedings of a meeting including any decision or resolution made at that meeting shall be drawn up and submitted to the next ensuing meeting for agreement after which they will be signed by the person presiding at that meeting.

Suspension and disqualification

8. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

EXPLANATORY NOTE

(This note is not part of the Order)

These Regulations supersede and revoke the Health Boards (Membership and Procedure) (No. 2) Regulations 1991 ("the 1991 Regulations") and their amendments, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998 and the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999.

The Regulations, make provision in relation to Boards established under the National Health Service (Scotland) Act 1978 as to the membership and procedure of these Boards.

Regulation 2 makes provision with regard to the terms of office of members of Boards and regulation 3 makes provision for those Boards which must have at least one member who holds a post in a University with a medical or a dental school.

Regulation 4 deals with the remuneration of the members of Boards and regulation 5 with their resignation and removal from office.

Regulation 6 provides for the circumstances in which a person may be disqualified from membership of a Board. Regulation 7 deals with the appointment of a vice-chairperson of committees and sub-committees of Boards.

In Part III there are various provisions with regard to procedure including provisions as to the meetings of the Boards. Regulation 9 makes provision for standing orders regulating the procedure of meetings of Boards and of committees and sub-committees. Regulation 10 makes provision about the appointment and functions of committees. Regulation 11 makes provision with regard to conflict of interest.

Regulation 12 revokes the 1991 Regulations and all amending instruments as mentioned above which provided for membership and procedure of Boards referred to above.

The Schedule sets out the detail of the matters that must be included in the standing orders made pursuant to regulation 9.

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**5 December 2024**
Title:	**Board Committee Memberships**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Person Centred

2 Report summary

2.1 Situation

It is good practice for Non Executives to be exposed to the full range of Committees that service the Board and at the Board meeting held on 1 February it agreed a number of membership movements across the Board Sub Committees.

Later in February 2024 Mr Tris Taylor resigned as a Non Executive Director and the Board has continued to operate with that Non Executive vacancy, which has impacted on the workload of our Non Executive cohort.

The Board also agreed to disband the Public Governance Committee earlier this year which again has impacted on the workload of the Non Executive cohort.

This paper confirms the current membership of Committees by our Non Executive cohort and that we will continue to operate with a Non Executive vacancy at this time.

This paper also provides the quoracy for each of the Board Sub Committees, as set out below, which in some cases had reduced in order to lessen the burden on the Non Executive cohort.

Committee	No of Non Executive Members	Quoracy Requirements
Resources & Performance Committee	All Non Executives	One third of the whole membership
Audit & Risk Committee	4	2
Clinical Governance Committee	4	2
Staff Governance Committee	4	2
Remuneration Committee	5	3

2.2 Background

In line with the Code of Corporate Governance the Board must approve the Non Executive membership, including the appointment of Chairs and Vice Chairs as appropriate, of its Committees.

2.3 Assessment

This report provides an update to the changes in Board memberships since those agreed by the Board on 1 February 2024.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Committees are created as required by statute, guidance, regulation and Ministerial direction and to ensure efficient and effective governance of the Boards' business.

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 report has been produced for the Board.

2.4 Recommendation

The Board is asked to **note** the changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart (Appendix 1).

The Board is asked to **note** the quoracy levels for the Board Sub Committees as set out above.

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, NHS Borders Non Executives Committee Chart.

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 27.06.2024

Name/Cttee	Vacancy	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Kevin Buchan (ACF)	Lucy O'Leary (Digital Champion)	Cllr David Parker (LA)	Lynne Livesey (Whistle-blowing Champion)	Harriet Campbell (Sustainability Champion)	James Ayling	Exec Lead & Secretariat
Borders NHS Board (All NEDs)		X	VC	C	X	X	X	X	X	X	CEO BS
GOVERNANCE											
Resources & Performance Committee (All NEDs)		X	X	C	X	X	X	X	X	X	CEO BS
Audit Committee (4 NEDs)						X	X	X		C	DoF DoF PA
Clinical Governance Committee (4 NEDs)			C		X			X	X		DoQI CG&Q PA
Staff Governance Committee (4 NEDs)		X					C	X	X		DHR DHR PA
Remuneration Committee (5 NEDs)		X	X	C					X	X	DHR BS
Area Clinical Forum (Chair ACF)					C						ACF Chair CEO PA
PARTNERSHIP											
Area Partnership Forum (Chair APF)		C									ED ED PA
Community Planning Partnership Strategic Board (Chair & Vice Chair)			X	X							SBC
CYPPP Board (1 NED)				X							SBC
Police, Fire & Rescue & Safer Communities Board (1 NED)										X	SBC
OTHERS											
Endowment Fund Board of Trustees (All NEDs)		X	X	C	X	X	X	X	X	X	DoF DoF PA
Expert Advisory Group to Endowment Cttee (4 NEDs)	X	C		X	X						DoP&P DoP&P PA
Area Drugs & Therapeutics Cttee (ACF Chair)					C						DoP DoP PA
Car Park Appeals Panel (1 NED)		C									GSM GSM

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 27.06.2024

Name/Cttee	**Vacancy**	**John McLaren** (APF)	**Fiona Sandford** (Vice Chair)	**Karen Hamilton** Chair	**Kevin Buchan** (ACF)	**Lucy O'Leary** (Digital Champion)	**Cllr David Parker** (LA)	**Lynne Livesey** (Whistle-blowing Champion)	**Harriet Campbell** (Sustainability Champion)	**James Ayling**	**Exec Lead & Secretariat**
Values Based Healthcare					**X**					**X**	MD PA
Whistleblowing Champion								**X**			Scot Gov't
Sustainability Champion									**X**		Scot Gov't
Digital Champion						**X**					Scot Gov't
OCCASIONAL/AS AND WHEN NECESSARY											
Discretionary Points Committee (Annual)			**C**								DHR DDHR
Pharmacy Practices Committee				**C**							MD DoP PA
Dental Appeals Panel (1 NED required at the final escalation stage only)											MD MD PA
ECR Panels (1 NED required at the final escalation stage only)											MD DPH PA
Dismissal Appeal Hearings (1 NED required on all dismissal appeal hearings as per NHSS Formal Hearing Guide)											DHR DDHR
LINKAGES											
Area Clinical Forum			**A**								ACF Chair CEO PA
Mental Health Partnership Board										**A**	GM MH&LD PA
Learning Disability Partnership Board						**A**					GM MH&LD PA
Medical Education Board								**A**			DoME PA
Organ Donation Committee									**C**		Hospital Management
Primary & Community Services Clinical Board											P&CS
Acute Clinical Board											Hospital Management
TOTAL	**0**	**8**	**8**	**8**	**8**	**7**	**5**	**8**	**8**	**9**	

Changes highlighted in pink.

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 27.06.2024

KEY

C	Chair	DDHR	Deputy Director of HR
VC	Vice Chair	GSM	General Services Manager
X	Member	GM	General Manager
A	Attendee	DoME	Director of Medical Education
CEO	Chief Executive	SBC	Scottish Borders Council
DoF	Director of Finance	ED	Employee Director
DoNMA	Director of Nursing, Midwifery & AHPs	PA	Personal Assistant
DPH	Director of Public Health	CO H&SCI	Chief Officer Health & Social Care Integration
MD	Medical Director	DHR	Director of HR, OD & OH&S
DoQI	Director of Quality & Improvement	CG&Q	Clinical Governance & Quality
DoP&P	Director of Planning & Performance	DoP	Director of Pharmacy
BS	Board Secretary		

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 27.06.2024

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AND ASSOCIATED COMMITTEES

Name/Cttee	**Vacancy**	**John McLaren** (APF)	**Fiona Sandford** (Vice Chair)	**Karen Hamilton** Chair	**Kevin Buchan** (ACF)	**Lucy O'Leary** (Digital Champion) **(IJB Chair 2022-25)**	**Cllr David Parker** (LA) **(IJB Vice Chair 2022-25)**	**Lynne Livesey** (Whistle-blowing Champion)	**Harriet Campbell** (Sustain-ability Champion)	**James Ayling**	**Exec Lead & Secretariat**
Scottish Borders Health & Social Care Integration Joint Board (H&SC IJB) (5 NEDs Required)		**XV**	**XV**	**XV**		**C-XV**	**VC** (Appointed in capacity as a Cllr)			**XV**	**IJB CO BS**
H&SC IJB Audit Committee (2 NEDs Required)				**XV**		**XV**					**IJB CFO BS**
H&SC IJB Strategic Planning Group **(Vice Chair of IJB, Chairs the SPG)**							**C** (Appointed in capacity as a Cllr)				**IJB CO PA**
TOTAL	**0**	**1**	**1**	**2**	**0**	**2**	**2**	**0**	**0**	**1**	

Changes highlighted in pink.

KEY

C	Chair
VC	Vice Chair
XV	Member (Voting)
XNV	Member (Non Voting)
BS	Board Secretary
IJB CO	Integration Joint Board Chief Officer
IJB CFO	Integration Joint Board Chief Financial Officer
PA	Personal Assistant