Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 2 December 2021** at 9.00am **via MS Teams**.

AGENDA

Time	No		Lead	Paper
9.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
9.01	**2**	**REGISTER OF INTERESTS**	Board Secretary	*Appendix-2021-85*
9.02	**3**	**MINUTES OF PREVIOUS MEETING** 29.09.21 Extra Ordinary 07.10.21	Chair	*Attached*
9.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.05	**5**	**STRATEGY**		
	5.1	Scottish Borders Council's Anti-Poverty Strategy	Director of Public Health	Appendix-2021-86
9.15	**6**	**FINANCE AND RISK ASSURANCE**		
	6.1	Resources & Performance Committee Minutes 02.09.21	Board Secretary	Appendix-2021-87
	6.2	Financial Performance	Director of Finance	Appendix-2021-88
	6.3	Climate Emergency & Sustainability Development	Director of Finance	Appendix-2021-89
9.45	**7**	**QUALITY AND SAFETY ASSURANCE**		
	7.1	Clinical Governance Committee Minutes 15.09.21	Board Secretary	Appendix-2021-90
	7.2	Quality & Clinical Governance Report	Medical Director	Appendix-2021-91
	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2021-92

10.15	**8**	**ENGAGEMENT**		
	8.1	Staff Governance Committee Minutes 14.06.21	Board Secretary	Appendix-2021-93
	8.2	Area Clinical Forum Minutes 22.06.21	Board Secretary	Appendix-2021-94
	8.3	NHS Borders Equality Mainstreaming Report 2021	Director of Public Health	Appendix-2021-95
10.30	**9**	**PERFORMANCE ASSURANCE**		
	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2021-96
10.40	**10**	**GOVERNANCE**		
	10.1	Joint Health Improvement Team Annual Report 2020-2021	Director of Public Health	Appendix-2021-97
10.50	**11**	**ANY OTHER BUSINESS**		
	11.1	Remobilisation Plan (RMP4) Feedback Letter	Director of Planning & Performance	Appendix-2021-98 To Follow
	11.2	Risk Management	Audit Committee Chair	Verbal
11.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 3 February 2022 at 9.00am via MS Teams	Chair	*Verbal*

AT THE CONCLUSION OF THE PUBLIC MEETING THE BOARD WILL RECONVENE FOR ANY MATTERS OF RESERVED BUSINESS

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Karen Hamilton, Chair
Author:	Iris Bishop, Board Secretary

REGISTER OF INTERESTS

Purpose of Report:

The purpose of this report is to include the Declaration of Interests for Mr Chris Myers to the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

The Register will be made publicly available both through the NHS Borders website and on request, from the Board Secretary, NHS Borders, Headquarters, Education Centre, Borders General Hospital, Melrose TD6 9BD.

Recommendations:

The Board is asked to **approve** the inclusion of the declaration of interests for Mr Chris Myers in the Register of Interests.

Approval Pathways:

This report has been prepared for the Board.

Executive Summary:

1.1 In accordance with the Board's Standing Orders and with the Standards Commission for Scotland Guidance Note to Devolved Public Bodies in Scotland, members are required to declare annually any private interests which may be material and relevant to NHS business.

1.2 Attached are details received from members regarding any private interests which may be material and relevant to NHS business and constitute the Register of Interests.

Impact of item/issues on:

Strategic Context	Regulatory requirement.
Patient Safety/Clinical Impact	Not applicable
Staffing/Workforce	Not applicable
Finance/Resources	Not applicable
Risk Implications	Regulatory requirement.
Equality and Diversity	Not applicable
Consultation	Not applicable
Glossary	Not applicable

Borders NHS Board

Register of Interests of Board Members

This register has been drawn up in accordance with the Standards Commission for Scotland, Standards in Public Life: Model Code of Conduct for Members of Devolved Public Bodies.

Board Member: CHRIS MYERS ..... *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	n/a
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	n/a
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	n/a
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	n/a
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	n/a
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	n/a
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	- Seconded to the Scottish Borders Health and Social Care Partnership Integrated Joint Board. - Member of Scottish Borders Council Corporate Management Team - Member of 'Managers in Partnership'

Signed. Chris Myers ..... Date 24/11/2021

Borders NHS Board

Minutes of an Extra Ordinary meeting of the **Borders NHS Board** held on Wednesday 29 September 2021 at 4.15pm via MS Teams.

Present: Mrs K Hamilton, Chair
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Ms H Campbell, Non Executive
Mr J Ayling, Non Executive
Mrs A Wilson, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr L McCallum, Medical Director

In Attendance: Miss I Bishop, Board Secretary
Mr G Clinkscale, Director of Acute Services
Mr R McCulloch-Graham, Chief Officer, Health & Social Care
Mr A Carter, Director of Workforce
Dr A Cotton, Associate Medical Director
Mrs G Woolman, Director Audit Scotland
Mrs S Patterson, Deputy Director of Finance

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Fiona Sandford, Non Executive, Ms Sonya Lam, Non Executive, Mr John McLaren, Non Executive, Mrs June Smyth, Director of Planning & Performance, Dr Tim Patterson, Director of Public Health, Dr Janet Bennison, Associate Medical Director and Dr Tim Young GP, Associate Medical Director.

1.2 The Chair confirmed the meeting was quorate.

1.3 The Chair welcomed Mrs Gillian Woolman, Director Audit Scotland to the meeting.

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

2. Declarations of Interest

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

2.2 Mrs Gillian Woolman declared that she was also the appointed Auditor for Scottish Borders Council as well as the Scottish Borders Integration Joint Board.

The **BOARD** noted the verbal declaration by Mrs Gillian Woolman.

3. NHS Borders Annual Report & Accounts 2020-21

3.1 Mr Andrew Bone confirmed that he had circulated the Assurance Statement that had been signed off earlier in the year and omitted from the pack of papers in error. He confirmed that the assurance statement provided assurance to the Board from the Chair of the Audit Committee.

3.2 Mr Bone advised the Board that the certificate for the final Endowment Accounts had not yet been received. It would not prohibit the Board from approving the Board accounts however it did change the nature of the External Audit Report slightly. He confirmed that he had received email confirmation from the auditors that the intention was to award an unqualified certificate to NHS Borders.

3.3 Mr Bone then highlighted several other elements of the report and accounts including: drawing attention to the status of risk management arrangements; the endowment matter; and the nature of the report reflected the position reported at the end of March 2021.

3.4 Mr Bone also confirmed that as there had been several changes in Board membership in the financial period 2022-2021, assurance had been provided by the Executive Directors and scrutinised by the Non Executives in line with whatever they had seen since they had taken up their appointments.

3.5 Mrs Gillian Woolman presented the External Audit Annual Report 2020/21 and drew the attention of the Board to the key messages on page 3 of the report. She further highlighted several elements within the report including: post balance sheet events; the endowment funds accounts would change as a consequence of moving £500k; and that work was on-going with Mrs Susan Patterson to enable an unqualified certificate to be issued.

3.7 Mr James Ayling as Chair of the Audit Committee confirmed that the Audit Committee had been content to recommend the approval of the Annual Report and Accounts by the Board.

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

The **BOARD** noted the Annual Report for 2020/21 from Audit Scotland.

The **BOARD** adopted and approved for submission to the Scottish Government, the Annual Report and Accounts 2020/21 for the financial year ended 31st March 2021.

The **BOARD** authorised the Chief Executive to sign the Performance Report.

The **BOARD** authorised the Chief Executive to sign the Statement of Accountable Officer's responsibilities in respect of the Accounts.

The **BOARD** authorised the Chair and Director of Finance to sign the Statement of Health Board Members' responsibilities in respect of the Accounts.

The **BOARD** authorised the Chief Executive to sign the Governance Statement in respect of the Accounts.

The **BOARD** authorised the Chief Executive and Director of Finance to sign the Statement of Financial Position.

4. Patient's Private Funds Statement for 2020/21

4.1 Mr Andrew Bone presented an overview of the content of the statement and highlighted that: it had been reviewed by the Audit Committee; there were relatively modest total funds of around £50k in terms of receipts and a closing balance of £6k; and the audit had been received without any modifications.

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

The **BOARD** adopted and approved the Patient's Private Funds Statement for the financial year ended 31st March 2021.

The **BOARD** authorised the Director of Finance to sign the Patient's Private Funds Statement to certify its accuracy.

The **BOARD** authorised the Chief Executive to sign the Patient's Private Funds Statement to confirm its approval by the Board.

5. Any Other Business

There was none.

6. Date and Time of next meeting

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

The meeting concluded at 4.47pm.

Signature: ……..
Chair

EXTRA ORDINARY BORDERS NHS BOARD: 29 SEPTEMBER 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Declarations of Interest		
2	Appendix-2021-64 NHS Borders Annual Report & Accounts 2020/21	**Harriet Campbell:** I'm going to do that thing of just picking up on criticisms – so I want to start by saying that I appreciate the huge amount of work that has gone into this. Thanks all! P6 **of the pack**. Ralph's statement says "it feels as if we are now taking steps towards sustainably remobilising all of our services". I realise this was written some time ago but it feels like something of a hostage to fortune particularly with elective surgeries being cancelled again this week. I'm not asking for it to be changed but I wonder if we are setting ourselves up for some rather shouty criticism particularly given what is then shown in the report itself... P15 (not sure why I've never noticed this before). Why does Infection Control Risk sit with the Director of Finance? P18 surplus and deficit Generally (and specifically for the confirmation given on p31) what is James' and my position on approving the accounts etc given that we were not NEDs on the relevant date?	- - **Andrew Bone:** - **Andrew Bone:**

		I see that the Governance Statement (p32) is amended this year because of Covid-19. However the accountable officer's responsibilities and the Board Member's responsibilities seem fairly 'boiler plate'. Is that right (ie are they the same as in previous years?) If that's not right how are they different this year?	**Andrew Bone:**
		Pp32 and 33. Probably nothing but what is the significance of the different lettering on "(c) The Governance Statement" on p27 and "(d) The Governance Statement on p28" (and following?) Are they part of the same thing or not (ie is this a typo)? If not, what is the difference?	**Andrew Bone:**
		P33 says 'The Board's revised governance arrangements were reviewed monthly and have now returned to normal, except for meeting in public.' Is that right? We do meet in public, just not in person. Or were the public able to attend meetings other than full board meetings previously?	**Iris Bishop:** The statement is correct. The Board enables the public to observe the meetings via MS Teams so the meetings are in public. This will continue until such time as it is safe for the Board to meet in person and invite the public to attend the meetings in person.
		P38 what is the 'intranet ask the board facility'?	**Iris Bishop:** The Ask the Board forum was an opportunity to ask the Board questions about what was going on in the organisation and to discuss any issues or challenges. Questions were completely anonymous. If the question was: Offensive, Derogatory, Defamatory or contained inappropriate language the organisation reserved the right to edit as necessary, or refrain from posting the question in part, or in its entirety. All questions were received automatically as anonymous emails.

			Staff could include their name and contact details at the bottom of their question or comment if they wished the Board to respond directly to them as well as posting the question and response to the intranet. This facility has been removed.
		P41 how confident are we that our risk management process is now more fit for purpose?	**Tim Patterson:**
		P42 why aren't clinical risks more of a feature of our risk register? Is this something we should be looking into or concerned about?	**Tim Patterson:**
		P97 Under 'other health care expenditure' there has been a big leap in the year in the catchall 'other operating expenses'. What are these and why the doubling of cost?	**Andrew Bone:**
		P98 Again (and you'll note I don't like variation) I note on the operating income a big fall in patient charges for primary care. What are these and why the change?	**Andrew Bone:**
		P101 'Buildings' excludes 'dwellings'. Does NHSB own any dwellings? Is this Orchard Park which is held for sale and shown elsewhere? (minor point but equipment is spelled wrong twice on this page).	**Andrew Bone:**
		P107 I think the detail of the receivables - both individually impaired and past due - has not been properly completed (or at the very least the square brackets haven't been removed).	**Andrew Bone:**

		P114 Why are these capital commitments not provided for in the accounts (particularly if they have been contracted)? Apologies if this is in the SoFP. I can't see it there.	**Andrew Bone:**
3	Appendix-2021-65 External Audit Annual Report 2020/21	**Harriet Campbell:** P57 (and possibly elsewhere) the report refers to the 'Finance and Resources committee'. I presume this means Resources and Performance? P154 The first recommendation should have been completed by now. Has this been done? There's a typo at the bottom of this page too – I think it should be 2021/22	**Iris Bishop:** Yes it should consistently read "Resources & Performance Committee". **Gillian Woolman:**
4	Appendix-2021-66 Patient's Private Funds Statement for 2020/21	-	-

Borders NHS Board

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

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Mr T Taylor, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Ms H Campbell, Non Executive
Mr J McLaren, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr L McCallum, Medical Director
Dr T Patterson, Joint Director of Public Health

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

1. Apologies and Announcements

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

1.2 The Chair confirmed the meeting was quorate.

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

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

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

2. Declarations of Interest

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

2.2 The declarations of interest for Gareth Clinkscale were tabled.

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

3. Minutes of Previous Meeting

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

4. Matters Arising

The **BOARD** noted the action tracker.

5. Strategic Risk Register Report

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

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

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

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

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

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

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

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

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

The **BOARD** noted the report.

6. Regional Health Protection Service

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

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

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

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

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

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

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

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

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

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

7. Resources & Performance Committee Minutes: 06.05.21

The **BOARD** noted the minutes.

8. Audit Committee Minutes: 15.06.21, 20.07.21

The **BOARD** noted the minutes.

9. Endowment Committee Minutes: 07.06.21

The **BOARD** noted the minutes.

10. Financial Performance - August 2021

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

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

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

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

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

11. Clinical Governance Committee Minutes: 19.05.21, 21.07.21

The **BOARD** noted the minutes.

12. Quality & Clinical Governance Report

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

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

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

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

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

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

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

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

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

The **BOARD** noted the report.

13. Healthcare Associated Infection Prevention and Control Report

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

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

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

The **BOARD** noted the report.

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

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

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

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

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

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

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

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

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

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

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

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

15. Public Governance Committee Minutes: 23.02.21, 05.05.21

The **BOARD** noted the minutes.

16. Area Clinical Forum Minutes: 23.03.21

The **BOARD** noted the minutes.

17. NHS Borders Performance Scorecard

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

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

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

18. Borders NHS Board – Business Cycle 2022

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

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

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

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

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

19. Consultant Appointments

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

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

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

The **BOARD** noted the minutes.

21. Any Other Business

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

22. Date and Time of next meeting

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

The meeting concluded at 10.57am.

Signature: ……..
Chair

BORDERS NHS BOARD: 7 OCTOBER 2021

QUESTIONS AND ANSWERS

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

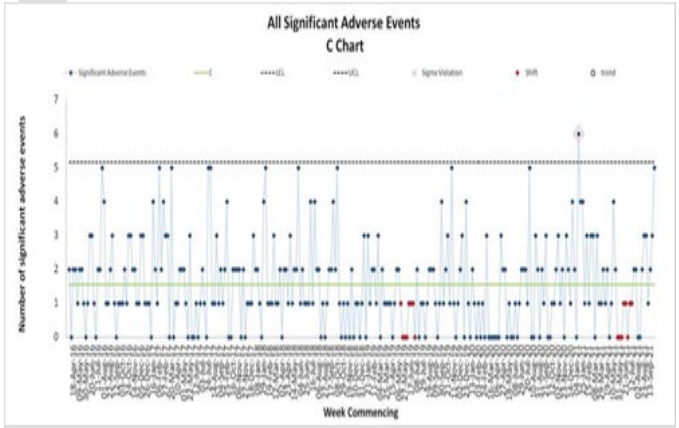
		More generally what concerns me is the relatively high number of risks for which the controls in place are considered to be inadequate. What, if anything, can and should be done about this – in a global sense rather than a risk-specific one?	• Likelihood: Possible (reasonable chance of occurring); Following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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Borders NHS Board Action Point Tracker

Meeting held on 2 September 2021 (Extra Ordinary)

Agenda Item: Coldingham Branch Surgery

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
3	5	The **BOARD** agreed that work would be taken forward in co-production with local communities, other stakeholders and sectors to explore ways for the Eyemouth Medical Practice to manage their appointment service to link to those patients who required public transport and for the provision of potential home delivery pharmacy services. The **BOARD** would monitor progress through it's Action Tracker.	**Chris Myers / Clare Oliver**	

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Tim Patterson Director of Public Health
Author:	Authors of report: Tim Patterson Authors of Strategy: Janice Robertson Strategic Planning & Policy Manager Shona Smith Communities & Partnership Manager

SCOTTISH BORDERS COUNCIL'S ANTI-POVERTY STRATEGY

Purpose of Report:

The purpose of this report is to ask the Board to note the Scottish Borders Council's Anti-Poverty Strategy

Recommendations:

The Board is asked to **note** the Scottish Borders Council's Anti-Poverty Strategy

Approval Pathways:

The Strategy has been endorsed by the Scottish Borders Community Planning Partnership Strategic Board. NHS Borders is a member of the Partnership Board.

Executive Summary:

1. This report proposes that NHS Borders Board notes the Scottish Borders Anti-Poverty Strategy and Action Plan as approved at Scottish Borders Council on 23 September 2021 and endorsed by the Scottish Borders Community Planning Partnership Strategic Board 18 November 2021.

2. The Anti-Poverty Strategy (Appendix 1) sets out the steps that Scottish Borders Council and Partners plan to take in tackling poverty in the Scottish Borders in relation to - economic poverty and income, fuel poverty, housing poverty, food poverty, impact on family and community health and wellbeing, and digital poverty.

Impact of item/issues on:

Strategic Context	The Scottish Borders face a number of unique challenges due to rurality – these include geography, ageing demographic, income deprivation, fuel deprivation, digital access, poor broadband, and food security. The challenges that we are facing within the Scottish Borders are accelerating as the longer-term impacts of Covid-19 are being felt within our communities. It must also be recognised that Scottish and UK also have a part to play to improve the lives of

	people in the Scottish Borders and reduce poverty through nationally set policies and strategies.
Patient Safety/Clinical Impact	Within all Scottish Community Planning Partnerships, more deprived areas have a lower life expectancy and a higher level of ill health than less deprived areas. This Strategy will help reduce these health inequalities.
Staffing/Workforce	By reducing health inequalities, this Strategy will help reduce pressure on our services/workforce as well as helping raise awareness of this issue amongst staff.
Finance/Resources	There is no direct impact on Board financial resources a result of this Strategy.
Risk Implications	This Strategy will help reduce Board strategic risks relating to health inequalities.
Equality and Diversity	By reducing health inequalities this Strategy will promote equality and diversity.
Consultation	The Strategy has been endorsed by the Community Planning Partnership Strategic Board. NHS Borders is a member of the Partnership.
Glossary	Provided in Strategy document as appropriate.

Situation

1. The Anti-Poverty Strategy (Appendix 1) sets out the steps that Scottish Borders Council and Partners plan to take in tackling poverty in the Scottish Borders in relation to - economic poverty and income, fuel poverty, housing poverty, food poverty, impact on family and community health and wellbeing, and digital poverty.

Background

2. In February 2021, the Scottish Borders Council approved the draft Scottish Borders Anti-Poverty Strategy, and agreed that the Anti-Poverty Working Group develop an approach to public consultation and create a final Strategy and Action Plan for approval and adoption.

3. The consultation was co-produced with third sector organisations and other partners to ensure that a combination of different types of engagement were undertaken. Partners engaged in the consultation and were able to speak directly to people experiencing poverty. This enabled the Council to identify further actions that could be taken to support our communities.

4. The Scottish Borders Anti-Poverty Strategy and Action Plan was subsequently agreed by the Scottish Borders Council in September 2021 and by the Scottish Borders Community Planning Partnership in November 2021.

Assessment

5. The Strategy sets out a clear vision and works with 6 themes and 11 outcomes and highlights areas of activity that the Scottish Borders Council and Partners aim to deliver to help reduce poverty in the Scottish Borders. The final version of the Strategy is attached at Appendix 1.

6. The Strategy recognises that there are already many plans and strategies in existence which contribute to reducing poverty in the Scottish Borders and these are outlined in the Strategy specifically to illustrate various Partners involved.

7. A Scottish Borders Council Anti-Poverty Strategy Members Reference Group will monitor the implementation of the Strategy and Action Plan to ensure that it benefits those most in need.

8. The Reference Group will comprise of 7 Elected Members of Council, appointed on a non-political basis. Although this is a Council Strategy, it is anticipated that the Reference Group will receive input from the Council's partners and other organisations and individuals, including those with lived experience of poverty, to help identify any gaps or areas for further focus.

9. Additional community engagement will be considered to further raise awareness and identify successes and opportunities to further aims of the Strategy. It is proposed that this includes Community Planning Partners' organisations to ensure a holistic approach.

10. The actions within the Strategy will be implemented and Council Officers will work in Partnership with colleagues across the Borders to deliver on the commitments contained in the Action Plan. An annual Progress Report will be presented to Council and to the Community Planning Partnership.

Scottish Borders Anti-Poverty Strategy 2021

CONTENTS

FOREWORD

Welcome to the first Anti-Poverty Strategy produced by Scottish Borders Council. There is a growing awareness of the issues of poverty across Scotland, and the Council is facing many challenges and constraints, compounded further by the impact of Covid-19.

The Scottish Borders face a number of unique challenges due to rurality - these include geography, ageing demographic, income deprivation, fuel deprivation, digital access, poor broadband, and food security.

We need to understand the causes and impacts of poverty and we are listening to residents, community planning partners and the third sector as we develop our Strategy further, therefore our Action Plan will contain specific actions to increase the life chances and experiences of all, alleviate financial pressures, and enable people to be part of their community.

The challenges that we are facing within the Scottish Borders are accelerating as the longer-term impacts of Covid-19 are being felt within our communities. We will therefore review this Strategy on a regular basis to ensure that it remains current and aligns to these challenges.

As well as providing support and opportunities, we also recognise the need to take a poverty informed approach to planning and delivery of services to begin to reduce the stigma of poverty, and to provide dignified and sustainable pathways out of poverty.

We believe that the combined knowledge, expertise and experience of Scottish Borders Council and our partners, as well as open and honest engagement with people experiencing poverty, will help us to tackle poverty and improve lives.

We recognise that a culture shift is required to reduce poverty and the stigma of poverty, and we are committed to playing our part to make that happen.

Thank you to everyone who has contributed to the development of the Strategy, in particular to people experiencing poverty who have given their time and shared their story, and we look forward to working towards reducing the impacts of poverty in the Scottish Borders.

Councillor Robin Tatler

Chair of the Anti-Poverty Working Group

INTRODUCTION

'The Scottish Government is committed to tackling poverty, but poverty has been rising and we are not on course to meet interim child poverty targets within three years. The relative child poverty target requires a fall of a quarter in the proportion of children in poverty compared to the latest data, which has increased compared to five years previously. The picture for other groups over the last five years is similarly disappointing, with no change in poverty for working-age adults and an increase for pensioners.'

'Work, social security and housing costs are vital to solving poverty in Scotland, as the coronavirus storm is sweeping many people into poverty and others deeper into poverty'

'Even before coronavirus, around a million people in Scotland were in poverty, living precarious and insecure lives.'

https://www.jrf.org.uk/report/poverty-scotland-2020

Setting out a clear vision and working with 6 themes and 7 outcomes, our Strategy highlights areas of activity that the Council and Partners aim to deliver to help reduce poverty in the Scottish Borders. We have identified key contributors to reducing poverty in the Scottish Borders already in existence and welcome these in support of this Strategy. It must also be recognised that Scottish and UK Governments have a part to play to improve the lives of people in the Scottish Borders and reduce poverty through nationally set policies and strategies. The Council will continue to lobby in support of these.

OUR VISION

We want a Scottish Borders where no-one lives in poverty. We want everyone to be able to achieve their full potential and feel healthy, happy, and valued. We want the Scottish Borders to be a place where everyone can play their part in understanding that tackling poverty is everyone's responsibility.

We believe that if we act locally, and in partnership, we can make a real difference.

We want this Scottish Borders Anti-poverty Strategy to be pro-active, evidenced by real experience and directed by need.

Working with the people of the Scottish Borders, we aim to find solutions to poverty challenges which support them in a way that works best for them.

POVERTY

A DEFINITION

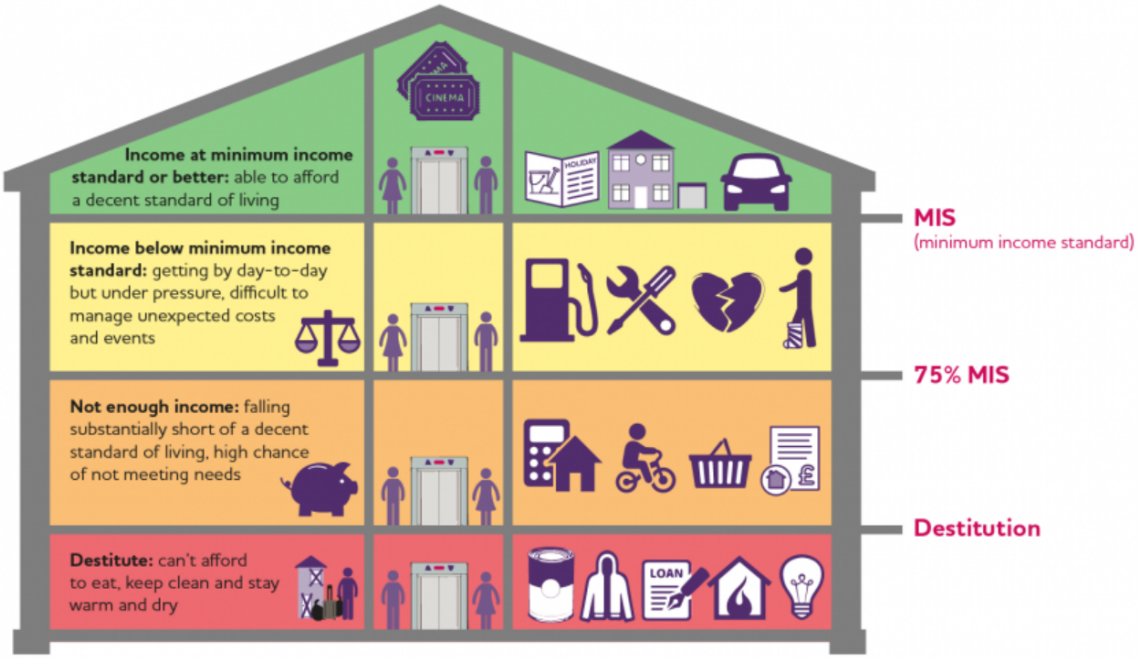
What is poverty?

According to the Joseph Rowntree Foundation (JRF), Poverty is when your resources are well below your minimum needs.

How does JRF define poverty in the UK?

Poverty affects millions of people in the UK. Poverty means not being able to heat your home, pay your rent, or buy the essentials for you or your children. It means waking up every day facing insecurity, uncertainty, and impossible decisions about money. It means facing marginalisation – and even discrimination – because of your financial circumstances. The constant stress it causes can lead to problems that deprive people of the chance to play a full part in society.

Levels of poverty JRF picture: - Focus on Minimum Income Standard (MIS)

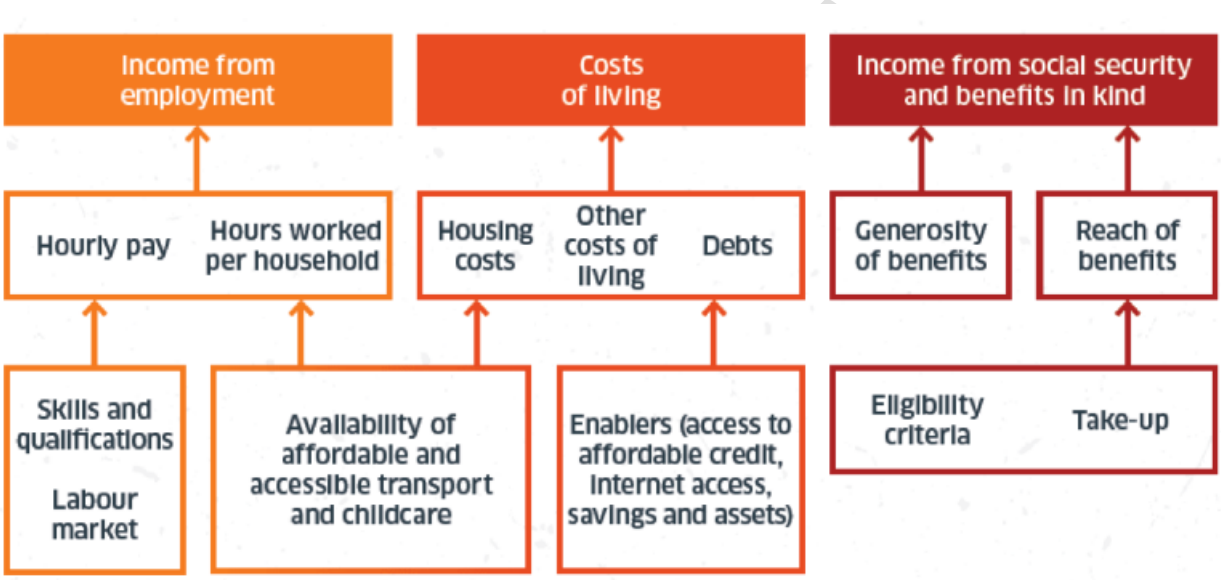


There are 3 levels of poverty

FACTORS

There are several factors that can result in people experiencing poverty.

As identified by the Scottish Government's "Every child, every chance: tackling child poverty delivery plan 2018-2022" direct drivers of poverty fall in to three main categories – income from employment, costs of living and income from social security. The relationship of these drivers to wider thematic areas is summarised below.



Other factors that may contribute or compound people experiencing poverty, and are taken into account in the Scottish Borders Anti-Poverty Strategy include:

- Fuel poverty
- Housing poverty
- Food poverty
- Health and wellbeing
- Connections to family, friends, and community
- Digital poverty

It is recognised that multi-generational poverty exists but reasons why poverty persists are less clear-cut, and reveal multi-dimensional causes, as highlighted in the report: "The persistence of poverty across generations" by the JRF.

CONTEXT

NATIONAL

Prior to the Covid-19 Pandemic, the Scottish Government published "Poverty & Income Inequality in Scotland: 2016-2019".[1] Key findings were:

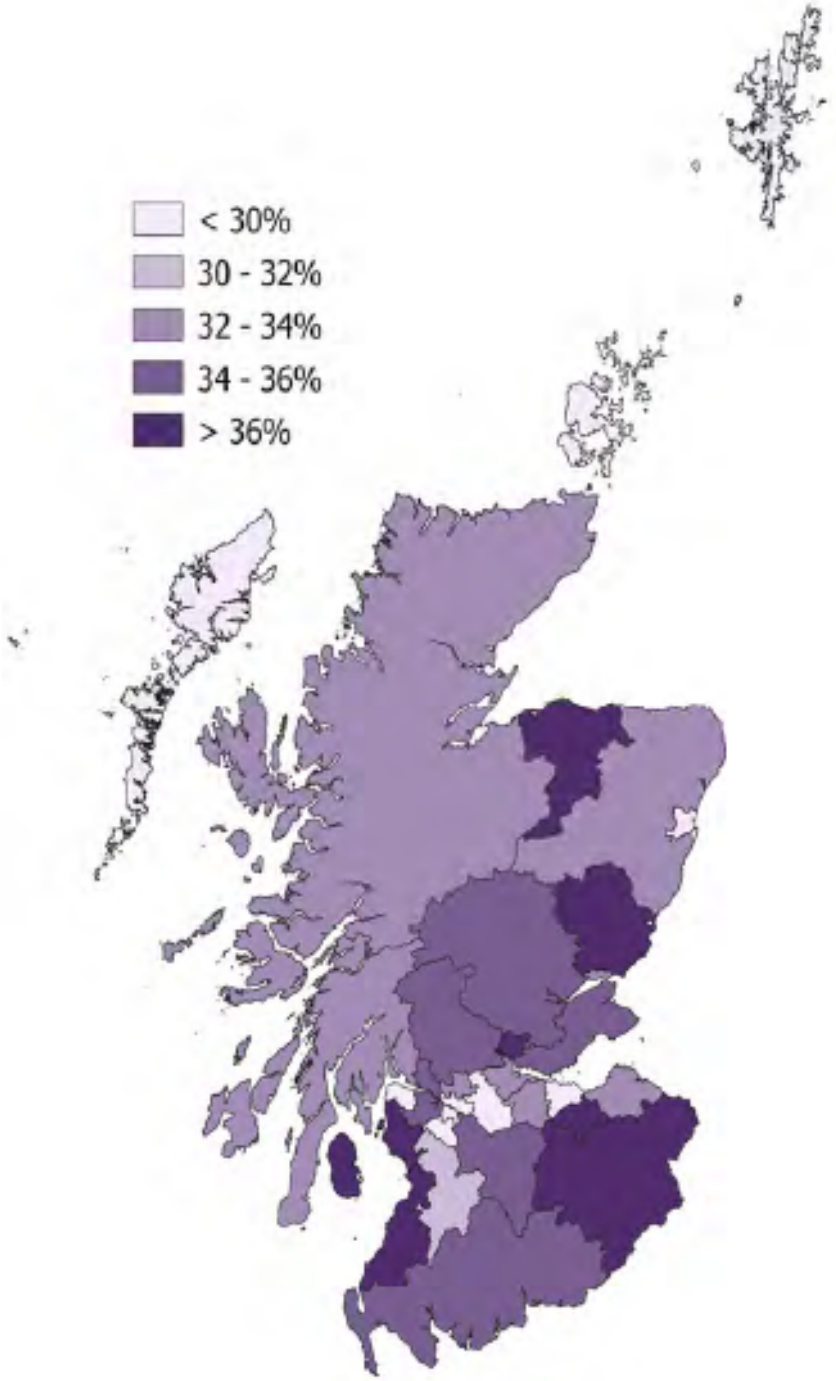
- It is estimated that **19%** of Scotland's **population** (1.02 million people each year) were living in relative poverty after housing costs in 2016-19. Before housing costs, 17% of the population (900,000 people) were living in poverty in 2016-19.
- It is estimated that **24%** of **children** (230,000 children each year) were living in relative poverty after housing costs in 2016-19. Before housing costs, it is estimated that 20% of children (200,000 children each year) were in relative poverty.
- In 2016-19, **60%** of working-age adults in relative poverty after housing costs as well as before housing costs were **living in working households**. This represents 380,000 working-age adults in poverty after housing costs, and 310,000 working-age adults before housing costs. **In-work poverty** for working-age adults has continuously increased since 2011-14.
- Relative poverty after housing costs for **pensioners** was **15%** in 2016-19 (150,000 pensioners each year). Before housing costs, 18% of pensioners (180,000 pensioners) were in relative poverty.

In October 2020, the Joseph Rowntree Foundation published a briefing "Poverty in Scotland 2020".[2] The report looks at what has happened to poverty in Scotland before and during the Coronavirus outbreak. Key findings of the report include:

- Even before coronavirus, around a million people in Scotland were in poverty, living precarious and insecure lives.
- By May 2020, there was a 65% increase in the number of households in receipt of Universal Credit (UC) compared to the start of the year.
- The coronavirus pandemic has had a detrimental effect on jobs and financial security, with workers on low wages or in poverty deeply affected.
- The proportion of workers in (Covid-19) at-risk industries vary across Scotland, with Scottish Borders being in the highest at-risk group of greater than 36%.

[1] https://www.gov.scot/publications/poverty-income-inequality-scotland-2016-19/
[2] https://www.jrf.org.uk/report/poverty-scotland-2020

Figure 4: The proportion of workers in at-risk industries varies across Scotland



Note: At-risk industries are defined as Accommodation and food, Retail and wholesale, Manufacturing, and Arts and entertainment.

Source: Business Register and Employment Survey (2018), Contains OS data, Crown copyright 2020.

LOCAL

There is poverty in the Scottish Borders. Evidence of this poverty is seen in "Scottish Borders Picture of Poverty" (Appendix A). Key findings include:

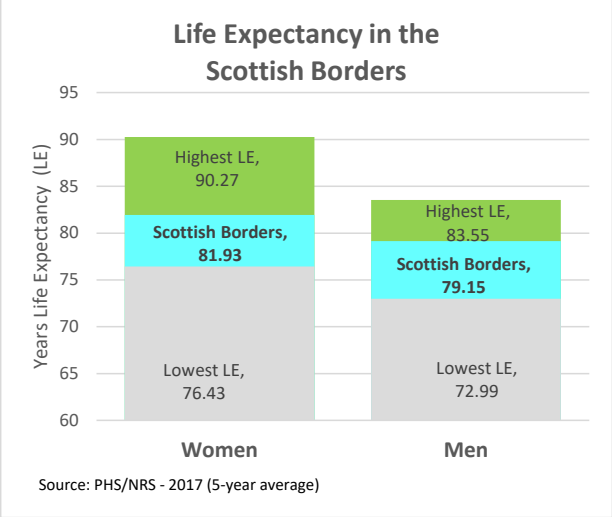
The **dependency ratio** is the relationship between the non-working age (0-15 years and 65+) population compared to those of working age.

A ratio of 70% (Scottish Borders for 2018) means that for every 1,000 people of working age there are 700 of non-working age.

Dependency ratio 2018 and 2043

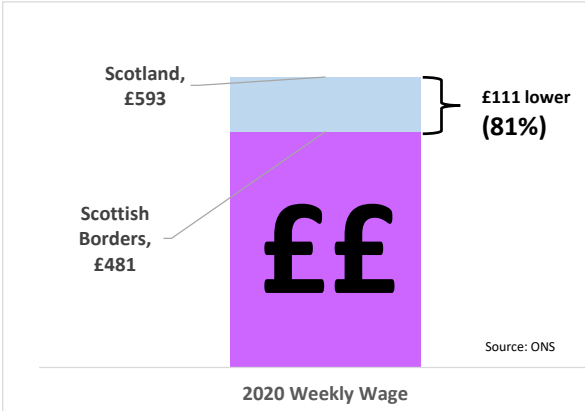
Dependency ratio for the **Scottish Borders**	
2018: **70%**	2043: **80%**
Dependency ratio for **Scotland**	
2018: **56%**	2043: **60%**

The dependency ratio for the Scottish Borders is higher than Scotland and is expected to increase.



Life expectancy for women in the Scottish Borders is **81.9** years, ranging from 76.4 to 90.3. For **men, life expectancy is 79.2 years**, ranging from 73.0 to 83.6. Within the Scottish Borders, like other areas, there is a clear relationship between an area's percentage of people that are income deprived and life expectancy; the higher the percentage income deprived the lower the life expectancy.

In 2020, the **median gross weekly pay** (workplace based) for full time workers in the Scottish Borders was £481, **£111 below** the £593 for Scotland or **81%**. (figure)

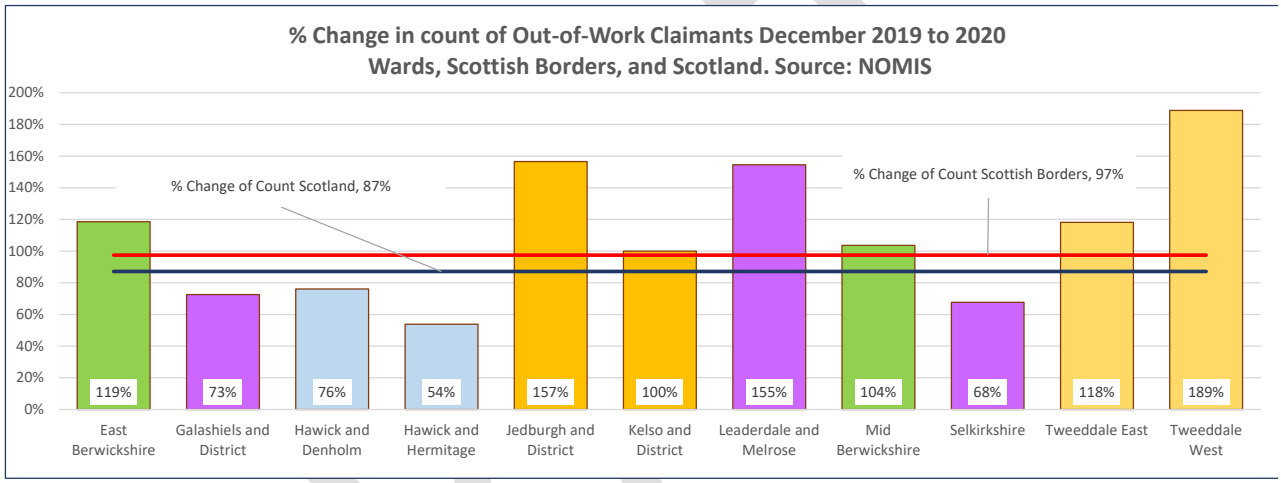


The median gross weekly pay (workplace based) for full time workers in the Scottish Borders has consistently been below the level for Scotland (83% between 2000 and 2020).

In 2020, the **median gross weekly pay** (residence based) for full time workers in the Scottish Borders was £522, **£73 below** the £595 for Scotland or **87%**.

Prior to the Covid-19 pandemic, **16.3%** of the **households** in the Scottish Borders were **workless**, slightly below the 17.7% for Scotland

Between December 2019 and December 2020, the number of people claiming **Out-of-Work benefits** aged 16 to 64 **increased** by **97%** (1,730) from 1,775 (2.6%) to 3,505 (5.2%) respectively.



Gross Value Added (GVA) for Scottish Borders is 73% of the GVA for Scotland.
GVA is the measure of the value of goods and services produced in an area, industry or sector of an economy.

Around **29%** of all households in the Scottish Borders are fuel poor, equivalent to approximately **16,000 households**. There seems to be a higher level of fuel poverty in the Scottish Borders compared to Scotland (25%), although it is not statistically different.

Households with higher levels of fuel poverty in the Scottish Borders are those that are Older (38%) and those in Social Housing (51%).

9.5% of the Scottish Borders population is income deprived, although there are 12 Intermediate Zones with more than **10%**.

12.6% children live in low-income families in the Scottish Borders, although there are 10 Intermediate Zones with more than **15%.**

8.7% of the people of working age are employment deprived, although there are 12 Intermediate Zones with more than **10%.**

According to DWP, in February 2020 there were **2,840** people claiming Pension Credit in the Scottish Borders. This equates to about 101 pension credit claimants per 1,000 people aged 65 and older. Within the Scottish Borders, the rate of pension credit ranges from a low of 54 per 1,000 to a high of 216 per 1,000. (It is thought that there is an under-claiming of Pension Credit in the Scottish Borders.)

2,840

People aged 60+ claiming Pension Credit

81.3% of households have home internet access in the Scottish Borders compared to 85% for Scotland.

13% of the Scottish Borders are unable to access decent broadband (USO) compared to 4% for Scotland, this varies across the Scottish Borders.

9% of adults in Scotland reported food insecurity (as defined by being worried during the past 12 months that they would run out of food due to lack of money or resources).

In January 2020 there were **17** Foodbanks / Fareshare Partners across the Scottish Borders. By July 2020 there were **40.**

All of these report increased demand.

The impact of the Coronavirus Pandemic so far in the Scottish Borders includes:

The number of **Universal Credit claimants** in the Scottish Borders **increased** by **80%** (3,700) from 4,600 in March 2020 to 8,300 in November 2020.

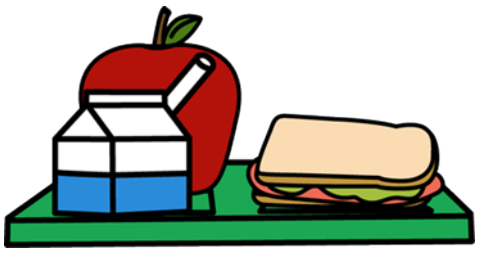
UC Universal Credit

80%
March to November 2020

3,300 jobs **furloughed** in the Scottish Borders (31 October 2020), accounting for 1.7% of Scotland's furloughed workforce.

The SDS's Partnership Action for Continuing Employment (PACE) aims to help minimise the impact for people and businesses facing redundancy. Between April and October 2020 **PACE** has engaged with **420** individuals and **15** employers.

PACE



There was a **20%** increase in free school meal awards from **1,659** in September 2019 to **2,075** in September 2020.

There has been a significant increase in the use of foodbanks, FareShare outlets and community kitchens.

In 2019-20 the Citizens Advice services in the Scottish Borders had **5,125** clients, gave advice 21,950 times, and gained over **£3.1** million for clients.

5,125 Clients

Client Gain £3.1 m

The Citizens Advice service in the Scottish Borders said to the Anti-Poverty Working Group:

> "Various measures have been put in place by the Government through the DWP to combat the impact of COVID-19 i.e., temporary increase in Universal Credit payments, payment break in repaying benefit overpayments and delay in decisions on disability benefit applications and renewals. However, these are all temporary measures and will impact greatly on income going forward.
>
> Similarly, furlough payments have saved job losses and redundancies, but the reduced income has caused financial difficulties and resulted in increased the use of credit for essential purchases.
>
> Payment holidays on mortgages, loans and credit cards will also lead to increases in monthly repayments in due course. All of which will cause financial hardship."

CHALLENGES AND OPPORTUNITIES

We must take account of challenges and opportunities identified so far as set out below. We will use these to work and consult with people to understand the issues involved and to improve service design and delivery to make a positive change for individuals, families, and communities.

Challenges – what we need to address

Demographics - dependency ratio and young adults moving out of the Scottish Borders - The dependency ratio for the Scottish Borders is higher than Scotland and is expected to increase.

Impact of Covid-19 –

- Increased use of Universal Credit
- 3,300 jobs furloughed
- Increase use of food banks and community kitchens
- Challenges to emotional wellbeing

Impact of Brexit -

- Friction in the transport of goods between the UK and EU
- Local businesses complying with new regulations and paperwork may result in delays and prove challenging
- UK's economy predicted to be smaller
- Compounded by Covid-19 pandemic (and restrictions)

Low wages/low skill -

The median gross weekly pay (workplace based) for full time workers in the Scottish Borders has consistently been below the level for Scotland (83% between 2000 and 2020).

Access to good broadband and mobile coverage – The rurality of the Scottish Borders is an issue, as is affordability for some

Fuel Poverty – The proportion of households who are defined as **'fuel poor'** in the Scottish Borders has consistently been higher than the Scottish Average.

Rurality of the Scottish Borders -

- Access to affordable and timely transport
- Equitable access to all services

Public Sector Budget Constraints –

The Council continues to face significant challenges as it aims to provide the best possible services within available resources available.

Opportunities – what is in place?		
South of Scotland Enterprise - sustainable economic and social development of the area, including improving the amenity and environment.	**Connecting Scotland** - over 700 devices issued that are supporting 300 individuals, 321 families, 63 care leavers and 25 vulnerable people including Digital Champions to support them.	
Borderlands Inclusive Growth Deal - £394.5M to narrow the productivity gap, increase the working age population and deliver inclusive growth.	**Health and Social Care Partnership –** delivering health and social care services across the Borders.	
Covid-19 Recovery – A Strategic Recovery Board is in place which advises the Council on appropriate recovery actions. The Council will make use of a Covid-19 Vulnerability Index to assist in decision making around recovery.	**Wellbeing Service** – delivering health and wellbeing advice and support across the Borders.	**Living Wage Group / Living Wage Area (Eildon)** SBC is an accredited Living Wage Employer and is encouraging more local employers to pay their staff the real Living Wage.
Strong and resilient communities - 59 Resilient Community Teams, 69 Community Councils and numerous third sector organisations and groups working together to support those in need within their communities.	**Regional Economic Partnership –** Strategy and Action Plan being developed. £2.7M invested in South of Scotland Destination Alliance.	
5 Community Assistance Hubs - SBC and CPP Partners providing person centred support and assistance to individuals across the Scottish Borders.	**Money Worries App** - being launched in February 2021 to provide further support to those in financial hardship	
City Deal - accelerating growth Investing funding in innovation, skills, and infrastructure, to accelerate economic growth while tackling	**Borders College** – 450 devices and data packages distributed to students. Young Person Guarantee – no-one left behind - ensuring those between 16 and 24 has the opportunity of work, education, or	

inequality and deprivation.	training.
Inspire Care - digital devices for Scottish Borders Care Home Residents	**Housing Associations supporting tenants** • Digital Access Programmes (supporting tenants to get online) • Debt advice • Signposting to other support services • Supporting tenancies
Inspire Learning - digital devices and online learning for Scottish Borders school children	**External funding** - over £2.5M dispersed to local third sector organisations in the Scottish Borders
Food Growing Strategy – currently in development	**SBC's Response to the Employability Challenge** Sets out Scottish Borders Council's approach to employability and training.

REAL LIFE EXPERIENCES

Gaining confidence and trust - SBHA

*"Last year I couldn't get myself out of the financial hole I was in…. I buried my head deep in the sand, ignoring letters, phone calls, whilst my rent arrears were piling up until my home was at risk of being taken off me. "SBHA's Welfare Benefits Officer talked me through it all and then helped me apply online. Universal Credit has changed my life…. before I thought my only option was to declare myself bankrupt. I work 20 hours a week and was completely surprised at what I'm entitled to. "Don't give up hope - there is help out there! "**Ms Y***

*"It's important, particularly for older people who might not be used to being online, to know that there's help like this available. And also, for people who have never claimed benefits before to know what's available. It's just great to know that there is help there. I feel better about things now" **Mr X***

SBHA Team Feedback

*"Having that local knowledge of my Tenants circumstances helped me to target support to those who I knew have health issues and would be worried about getting food and medicine. Having the support of the Hub and the resilience group was great." **SBHA Neighbourhood Housing Officer***

*"We are dealing with a lot of anxious people really worried about money." **SBHA Welfare Benefits Officer***

Quotes from Food Insecurity and Learning Loss Pilot Evaluation Report conducted for YouthLink Scotland

Forget the programme, the biggest key part here was the relationship that TD1 have got with families in the community... They have got a phenomenal relationship, they're well-known, and they go over and above for young people. So, there was trust there from the parents from the beginning. TD1 had full buy-in and the support, whether that be food, whether that be the activity packs, whether it be online sessions, there was trust there, and that was key.

Teacher, Scottish Borders

A multi-agency approach was definitely key, it meant that no young people were missed out.

Teacher, Scottish Borders

OUR 7 PRINCIPLES

Poverty in Scotland needs to be addressed. The Scottish Borders Council Anti-Poverty Strategy plans to improve the lives of individuals and families who are experiencing poverty and deprivation for whatever reason, including the recent impact of Covid-19. We will work together and involve all stakeholders in the process.

The following principles support our approach:

1. **Respect:** Treating everyone with dignity and valuing every contribution.
2. **Resilience:** Helping individuals and households to manage their own affairs and make informed choices and decisions about their lifestyle and prevent them falling into poverty; building resilience in people and communities.
3. **Person Focused:** Tailoring services and support to the different types and places of poverty and the different needs and characteristics of all our communities and identities, acknowledging that one solution does not suit all.
4. **Fairness:** Removing barriers that prevent some people from taking part in life, socially and economically. Promoting a society in which individuals and groups are treated fairly and receive a just share of the opportunities that our region has to offer.
5. **Sustainable:** Plan our actions for the long term, in an ongoing discussion with our residents. Designing and building services, infrastructure and organisations that are affordable and accessible.
6. **Shared:** Making sure there is a joint understanding of the issues around poverty in our region and working together in partnership.
7. **Communication:** Listening to and involving our residents, understanding their experiences, and using their advice.

THEMES AND OUTCOMES

Our themes are structured around the 'pockets, prospects, places' measurement framework adopted by the Scottish Government Child Poverty Strategy with our own additions of 'people,' 'partnerships,' and 'pathways.'

The actions contained in the Draft Action Plan in Appendix C are designed to meet the outcomes shown in the following table.

Theme	Outcome
Pockets	**Outcome 1:** Maximise financial resources of households on low incomes and reduce out-going costs. Low-income households can access services and be socially, digitally, and financially included.
Prospects	**Outcome 2:** Households on low incomes are sustaining employment and are re-skilling to enable them to seek alternative employment. **Outcome 3:** Reduce health inequalities and promote wellbeing.
Places	**Outcome 4:** Increase the number of people who live in warm, affordable homes.
People	**Outcome 5:** Increase opportunities and empower people to fully participate in their communities and bring about change.
Partnerships	**Outcome 6:** Improve partnership networks through use of technology and media channels and training opportunities to be more poverty aware and reduce poverty related stigma.
Pathways	**Outcome 7:** Develop and implement pathways to support people to move from dependence to independence.

KEY PLANS & STRATEGIES CONTRIBUTING TO REDUCING POVERTY IN THE SCOTTISH BORDERS

There are already many plans and strategies in existence which contribute to reducing poverty in the Scottish Borders and we have shown those that are considered key below. Other plans and strategies are in existence which have links to achieving the outcomes in the Anti-Poverty Strategy and they are detailed in Appendix B.

<table>
<tr>
<td>South of Scotland Enterprise – Operating Plan 2020/21
South of Scotland Enterprises vision:
“We want to drive inclusive growth, increase competitiveness, and tackle inequality within the region. We want to establish the South of Scotland as a centre of opportunity, innovation and growth.”</td>
<td>City Region Deal: Edinburgh & South East Scotland
City Region Deal is a mechanism for accelerating growth by pulling in significant government investment. By investing this funding in innovation, skills and infrastructure, performance will be significantly improved, and we will tackle inequality and deprivation.</td>
<td rowspan="2">Scotland’s Public Health Priorities
Live in vibrant, healthy and safe places and communities
Flourish in our early years
Have good mental health
Reduce the use of and harm from alcohol, tobacco and other drugs
Have a sustainable, inclusive economy with equality of outcomes for all
Eat well, have a healthy weight and are physically active</td>
</tr>
<tr>
<td>South of Scotland Regional Economic Strategy
Currently in development</td>
<td>Employability Challenge Response
Currently in development</td>
</tr>
<tr>
<td>Community Planning Partnership – Key Priorities 2020/21
An Action Plan developed by Scottish Border Community Planning Partnership in response to the ongoing pandemic.
Themed around the following:
Structure (Community Assistance Hubs), Digital, Employment & Economy, Education & Skills, Built Estate, Early Intervention & Prevention, Health & Wellbeing and Poverty.</td>
<td>Key Plans and Strategies to Reduce Poverty in the Scottish Borders
Scottish Borders Food Growing Strategy
Currently in development</td>
<td>Community Learning and Development
Community learning and development (CLD) aims to:
improve life chances for people of all ages, through learning, personal development and active citizenship
develop stronger, more resilient, supportive, influential and inclusive communities</td>
</tr>
<tr>
<td>Affordable Warmth & Home: Energy Efficiency Strategy 2019-2023
Affordable Warmth and Home Energy Efficiency Strategy vision
“More people live in energy efficient and affordably warm homes.”</td>
<td>Child Poverty Report Action Plan 2020/2021
Sets out planned activities to help alleviate Child Poverty in the Scottish Borders, and in particular, provides specific actions in relation to the impact of COVID-19.</td>
<td>Fit for 2024: Digital Borders
A key pillar of SBC’s Fit for 2024 is progressing the Digital Borders programme to help drive forward change and improve the quality of lives of residents.</td>
</tr>
</table>

DELIVERING THE STRATEGY

The Strategy will be delivered through an Action Plan. The Action Plan is still in development and a draft is shown at Appendix C.

We see the Action Plan as a live document and new actions are likely to be included as a result of the consultation exercise to be carried out, and the ongoing impact of the Covid-19 Pandemic.

The Action Plan is based on our key priorities and the actions are designed to achieve the outcomes set out for these as well as reflecting on the challenges and opportunities we have identified.

Key plans and strategies already contributing to reducing poverty have their own specific actions and these will be taken into account in our monitoring and evaluation methodology.

Many of the actions are already underway as part of service delivery carried out by SBC and Partners. Our Community Assistance Hubs, Resilient Community Teams, and our Third Sector Partners all make significant and valuable contributions towards the delivery of actions - many of them in partnership.

MONITORING AND EVALUATION

Monitoring and evaluating the Strategy will be carried out in several ways -

- Using the Covid-19 recovery matrix / index as a baseline.
- Updates will be provided by Partners as part of regular progress reporting of the Action Plan.
- Existing indicators in other plans will be reported where they relate to the Action Plan.
- Other measurement indicators will be developed as part of the Action Plan where they do not already exist.

In the longer term an assessment of the impact of the Strategy will be required. This will allow -

- A deeper understanding of poverty in the Scottish Borders
- Specific interventions and projects to be planned
- Recommendations to be made for future Strategy development

ANTI-POVERTY TASK FORCE

An Anti-Poverty Task Force will be established to develop an approach to ensuring delivery of the Action Plan. The Task Force will be made up of representatives from Scottish Borders Council, NHS Borders, and other key Partners. The Task Force will deal with operational issues and problem solving as well as reporting progress to Scottish Borders Council, the Community Planning Partnership Joint Programme Board, and the Community Planning Partnership Strategic Board.

SUMMARY

Scottish Borders Council and Partners are committed to making a difference to people's lives by reducing poverty in the Scottish Borders.

There are significant challenges ahead which must be addressed, and this Strategy will help us to do that.

We look forward to undertaking a consultation and engagement process and plan to reach as many people as possible, particularly those with lived experience of poverty. This will help us to create an Action Plan which is truly reflective of the work that needs to be done to plan and deliver services with a poverty informed approach in mind.

The longer term impact of Covid-19 is becoming clearer too, and we plan to address this by keeping the Action Plan live and aligned to current challenges and opportunities as a result.

We are determined to play our part by using our combined resources to achieve the best outcomes to tackle poverty, remove the stigma attached, and create opportunities for positive change.

APPENDICES

Appendix A – Scottish Borders Picture of Poverty 2021

Appendix B - Links to other key Strategies and Plans

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

RESOURCES & PERFORMANCE COMMITTEE MINUTES 02.09.2021

Purpose of Report:

The purpose of this report is to share the approved minutes of the Resources & Performance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

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.

Impact of item/issues on:

Strategic Context	As per the Resources and Performance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	R&PC – Resources & Performance Committee

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 2 September 2021 at 9.00am via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Ms S Lam, Non Executive
Mr T Taylor, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Mr J McLaren, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Mrs J Smyth, Director of Planning & Performance
Mrs N Berry, Director of Nursing, Midwifery & Operations
Dr T Patterson, Director of Public Health
Mr A Carter, Director of Workforce
Mr G Clinkscale, Director of Acute Services
Mrs Y Smith, Partnership Chair

In Attendance:
Miss I Bishop, Board Secretary
Mrs S Horan, Deputy Director of Nursing, Midwifery & AHPs
Dr A Cotton, Associate Medical Director
Dr Tim Young, Associate Medical Director
Mr C Myers, General Manager P&CS
Mrs S Paterson, Deputy Director of Finance
Mr P McMenamin, Deputy Director of Finance
Mrs C Oliver, Head of Communications

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Lucy O'Leary, Non Executive, Mrs Alison Wilson, Non Executive, Mr Andrew Bone, Director of Finance, Dr Lynn McCallum, Medical Director, Mr Rob McCulloch-Graham, Chief Officer Health & Social Care and Dr Janet Bennison, Associate Medical Director.

1.2 The Chair welcomed Mrs Susan Patterson, Deputy Director of Finance to the meeting who deputised for Mr Bone.

1.3 The Chair welcomed Dr Tim Young, Associate Medical Director of Primary & Community Services.

1.4 The Chair welcomed and congratulated Mr Gareth Clinkscale on his appointment as Director of Acute Services.

1.5 The Chair welcomed a range of other attendees who would be speaking to various items on the agenda.

1.6 The Chair confirmed the meeting was quorate.

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

2. Declarations of Interest

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

2.2 Ms Sonya Lam declared that her partner was a specialist advisor for the Scottish Government.

2.3 Mr Tris Taylor declared that he had a conflict of interest with regard to the Earlston Community Campus as he and his family were currently living in the catchment area for the medical practice.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declarations made by Ms Sonya Lam and Mr Tris Taylor.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 6 May 2021 were approved.

4. Matters Arising

4.1 **Q&A Question 5:** Ms Sonya Lam clarified that there was an offer for the Non Executives to work with Mrs June Smyth when producing the performance papers to make sure they had the information they required in terms of assurance.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

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

5. COVID-19 Remobilisation Plan 2021/22 (RMP3) – Update

5.1 Mrs June Smyth provided an overview of the underpinning action plan for RMP3 and associated updates. She confirmed the timelines for the submission of RMP4 and that the RMP3 updates would be included as part of RMP4.

5.2 Mr Tris Taylor commented that there was a balance to be struck to ensure in reality there was not too much of a gap between what was being demanded and what was being committed to. He noted the significant challenge of delivery according to demand and appreciated the honest conversation about not being able to deliver some services, such as

dentistry, to pre-pandemic levels whilst the pandemic remained. He enquired how much of a potential disconnect there was in understanding the full extent of the situation between the Scottish Government and politicians.

5.3 Mrs Smyth reminded the Committee that in terms of the RMP3 commitments, the plan was written with the services between January and March 2021 as the organisation was coming out of wave 2 of the pandemic. The planning assumptions that had been given at that time were that by the end of October everything would be back to normal. Waves 3 and 4 of the pandemic were not expected and the Scottish Government advised Health Boards that if they needed to slip things in RMP3, they should be clearly defined in RMP4.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update.

6. COVID-19 Remobilisation Plan 2021/22 (RMP3) - RMP4 (Midyear Update Against RMP3)

6.1 Mrs June Smyth apologised that the paper had been incorrectly titled. She commented that the organisation had been asked to plan for assumptions by the end of the March 2022 and therefore the commitments in RMP3 were being revisited to see if they were still feasible or achievable. It would be made clear in RMP4 what would be slipped or stood down.

6.2 Discussion focused on: encouraging clinical leaders and services to proactively embrace the use of digital appointments through "Near Me"; potential slippage of the timeline for the submission of RMP4; being more straightforward in the language used in the paper so that it was clear that some things would not be delivered; recruitment and retention issues; and potentially using an international ethical recruitment organisation.

6.3 Mr Ralph Roberts commented that RMP4 was an opportunity to reset expectations with the Scottish Government and set out what was required from them in order for the Board to deliver.

6.4 Mr John McLaren suggested the report be explicit about workforce risks and doubted that RMP4 would achieve more than RMP3 given the amount of pressure being seen across the system both locally and nationally.

6.5 Mrs Yvonne Smith commented that the messaging to staff was critical in ensuring they understood the reality of what was being expected and why.

6.6 Mrs Nicky Berry commented that staff were engaged in developing RMP4, they served the whole population of the Borders and were now living in a world that was unpredictable. She commented that staff were doing the best they could in a very unsettling environment and she agreed the communications to staff had to be right.

6.7 Mr Andy Carter commented that a national recovery plan and aligned national workforce strategy was due to be completed by December 2021 and the national HR Directors were in discussion with the Scottish Government about the pressures being felt by staff.

6.8 Mr Tris Taylor enquired about the percentage of risks related to occupational health and safety in regard to workplace injury or service incidents. Mr Carter commented that he

would take up the matter outwith the meeting and route it through the Staff Governance Committee.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the commissioning letter and guidance.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the timetable for the submission of the 1st Draft of RMP4.

The **RESOURCES AND PERFORMANCE COMMITTEE** delegated authority to the submission being signed off by the Chair and Chief Executive by 31st September 2021 on behalf of the Board, subject to subsequent formal Board approval in October 2021 (assuming that Boards were able to discuss those in the public domain, which was still to be confirmed by Scottish Government).

7. Finance Report for the period to the end of June 2021

7.1 Mrs Susan Patterson sought any questions on the report.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the board was reporting a £3.35m deficit for three months to end of June 2021.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in relation to Covid-19 expenditure and assumptions around funding in relation to same.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the issues highlighted within the report would be considered within the board's Quarter One Review.

8. Quarter One Review – Updated Financial Forecast 2021/22

8.1 Mrs Susan Patterson sought any questions on the report.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the board was forecasting an outturn position at 31st March 2022 of £8.49m over-spent, a movement from the previous (financial plan) forecast of £6.4m deficit.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the position reported in relation to COVID-19 expenditure and assumptions around funding in relation to same.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the drivers of movements in the financial forecast (against financial plan) and the actions identified within the forecast, including changes to recurring and non-recurring savings delivery.

9. Financial Turnaround 2021/22

9.1 Mrs June Smyth provided an overview of the content of the report and highlighted the progress that had been made and the revisiting of the governance of the programme in light of the internal revised decision making process being taken forward.

9.2 The Chair enquired about how the Non Executive cohort might become involved, such as having a Non Executive champion for the programme. Mrs Smyth commented that she would welcome any input and support from the Non Executive cohort in whatever format they preferred.

9.3 Mr Tris Taylor commented that he had been content with the Non Executive involvement in the Turnaround programme when it had been initially instigated by Bold, where a clear regular report that covered everything from an oversight perspective was shared with the cohort on a weekly basis.

9.4 Mr Ralph Roberts commented that it would be really important to make sure the Board were involved in and agreed the financial targets and in particular that they were realistic. He then suggested it was fair that Executives be held to account for delivery and explaining and justifying any variance. He further suggested the other aspect that Executives would be looking to the Board for, would be high level support around any decisions that came out of the service transformation as well as support with any difficult conversations with the Scottish Government.

9.5 Mr John McLaren supported the reintroduction of the regular report and sought a further conversation on the risks of progressing the programme given the previous conversation on RMP4. He suggested it was important to ensure the risks were explicit to enable the Board to fully understand what it was supporting.

9.6 The Chair reflected that the Bold process had been dynamic and she was unsure if the same speed could be achieved in the current climate. However, regular and frequent reports were what the Non Executive cohort were requesting in the early stages, with targeted responses to enable them to know when something had been achieved.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the contents of the report.

The **RESOURCES AND PERFORMANCE COMMITTEE** discussed how they wished to engage with the development of the future approach.

10. Developing NHS Borders Short, Medium and Long Term Strategy

10.1 Mrs June Smyth provided an overview of the content of the report. She highlighted the challenges in terms of the Integration Joint Board (IJB) and Scottish Government expectations of an updated strategic plan by the end of March 2022. She advised that detailed discussions with Scottish Borders Council (SBC) had yet to take place and enquired if the Board would be supportive of a more formal approach to the IJB and SBC before the end of the financial year instead of focussing internally on NHS Borders.

10.2 Mr Tris Taylor commented that he supported whole system planning and on reflection he suggested the drive to achieve it was at an organisational level, however the vision was missing. He suggested the proposal may have gone wider than was needed.

10.3 Cllr David Parker commented that he was relaxed in regard to a whole system approach and if the Board decided to do something purely for the Board that would be fine as well. However to undertake a whole system in partnership would make more sense given the potential for change with the likely introduction of a national care service in 4 years. He commented that he was relaxed to pursue both through the IJB or individually.

10.4 Mr Ralph Roberts commented it would make more sense to do in partnership given 50% of NHS services were delegated to the IJB. He was aware the IJB did not have enough capacity to produce a refreshed Strategic Commissioning Plan by March 2022. He suggested a full refresh would take some 18 months in the meantime a high level vision could be achieved in partnership.

10.5 Ms Sonya Lam commented that being able to enact the role of a Non Executive in terms of horizon scanning; having a combined vision across the whole system; being an anchor organisation; having a shared vision and values; and having clear strategic objectives were what was required. She suggested it would be aspirational to have something across the partnership, local authority and NHS Borders and enquired how that might be received by Scottish Government colleagues.

10.6 The Chair suggested it would be in line with the Scottish Government desire for integration to be meaningful and consistent with the principles in parts of the national care service consultation.

10.7 Mr Roberts suggested that over the course of the next 6 months a high level vision and objectives be agreed and a translation of those into what that meant for services would take longer. However, further work would need to be done in conjunction with communities and include workforce, finance and service strategies and ideally those would be developed in partnership with the IJB, Scottish Borders Council and other stakeholders.

10.8 The Chair commented that there must be strategies that interlinked from one to another to provide a wholly single health and social care system.

10.9 Ms Lam enquired about what could be done to enthuse people to a vision and retain a passion for what the future could look like.

10.10 Mr Roberts suggested in considering what a world class public health service might look like the key would be to get the high level vision established. He suggested it could be achieved by initially looking across the Clinical Strategy, IJB Strategic Plan and Strategic Principles and Objectives and adding some more ambition. The more challenging bit would be to turn that high level vision into a 3-5 year delivery strategy.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** discussed the proposed approach, next steps and timescales to develop an Organisational Strategy.

The **RESOURCES AND PERFORMANCE COMMITTEE** supported the approach of aligning timelines for developing NHS Borders longer term strategy and the IJB's Commissioning Plan taking on board not losing sight of our own organisation.

The **RESOURCES AND PERFORMANCE COMMITTEE** committed to reviewing and refreshing NHS Borders vision, values, organisational objectives and strategic principles between September 2021 – March 2022, and accepted that there could be some slippage with the timeline.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that an updated strategic needs assessment would be commissioned during the latter half of the financial year to help inform the development of the long term strategy.

11. Development of NHS Borders Trauma Rehabilitation Pathway

11.1 Mr Gareth Clinkscale provided an overview of the content of the report.

11.2 Mrs Sarah Horan enquired about the status of psychology support for major trauma in the Borders and the repatriation of patients back to Borders if they were to be sent directly to the NHS Lothian Major Trauma Centre. Mr Clinkscale advised that locally there were 2 trauma coodinators who would manage the journeys from the Major Trauma Centre to NHS Borders and from NHS Borders back to individuals homes. He further commented that a protocol had been agreed and was in place for out of hours cover 24/7. The protocol had been agreed as part of the regional standard operating procedure.

11.3 Mr Tris Taylor commented that there did not appear to be any clear evidence of public involvement and engagement. Mr Clinkscale commented that in terms of regional planning NHS Borders had been active members and he had been assured that public engagement and involvement had been undertaken on a regional level. He was aware that the third sector and public had been involved and engaged with through events carried out in partnership with the charities involved.

11.4 Mr Taylor commented that he would be keen to see the public and third sector engagement and involvement that was undertaken at the regional level. Mr Clinkscale committed to forwarding that information to Mr Taylor.

11.5 Ms Sonya Lam enquired about the current Scottish Borders demographic and if there was a piece of work to be taken forward in partnership with others on preventative measures such as road accidents. Mr Clinkscale advised that the preventative agenda was taken forward on a regional basis in conjunction with Police, Fire and NHS colleagues.

11.6 Mr James Ayling commented that he was a member of the Safer Communities Board and would welcome conversation with Mr Clinkscale on the preventative agenda outwith the meeting.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update around the establishment of the South East Trauma Network and approved the establishment of NHS Borders Trauma Rehabilitation Pathway.

12. Children and Young People's Centre

12.1 The Chair acknowledged the work that Mrs Stephanie Errington had undertaken in providing the update to the Board

12.2 Mrs June Smyth provided an overview of the content of the report and advised that it had been prompted by a discussion at the Board of Trustees held earlier in the year. The project had been paused a number of years previously and the Board were now being asked to stand it down as a separate programme of work. The intention was to include it in the wider discussions that would be taken forward on the whole Borders General Hospital campus.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the update provided and agreed that the proposal for a Children and Young People's Centre on the BGH campus should be considered in light of a refreshed Organisational Strategy which would be developed in the coming months as well as part of the medium term capital plans relating to the BGH campus.

13. Earlston Community Campus – including new Health Centre Premises

13.1 Mr Tris Taylor declared a conflict of interest with regard to the Earlston Community Campus item and withdrew from the discussion.

13.2 Mrs June Smyth provided an overview of the content of the report. She highlighted that it was a Scottish Borders Council capital development that provided an opportunity for the health centre to be relocated as part of the Earlston Community Campus.

13.3 Further discussion focused on: Planning permission to be sought by Scottish Borders Council in September; the medical practice seeking assurance; potential use as a model for other opportunities in the future; primary care premises assessment; an awareness of potential future housing builds and the knock on effect to smaller practices.

13.4 Mrs Susan Patterson commented that there was also the underlying question of whether the project would be affordable/best value for NHS Borders. She assured the Committee that there were models for finance and the impact of those could be presented in the context of the Boards financial plan.

13.5 Mrs Fiona Sandford enquired if the model really was the best value for NHS Borders and queried if it should be unpacked more before assurance was provided to the practice. She enquired if there were any alternatives and if something better could be done. Mrs Patterson advised that another more attractive solution was not available and the Scottish Government were keen to pursue a more campus type approach. She further commented that this approach was the best option for securing funding.

13.6 Ms Sonya Lam enquired if a review of GP and community services premises should be undertaken given the recent issues with Duns and Coldingham premises.

13.7 Mr Ralph Roberts commented that he had been involved in a similar model in Shetland and was fully supportive of the model as the right strategic thing to do. A wider primary care premises assessment had been undertaken and had highlighted that Earlston would require replacement and not just a refurbishment, however, that wider primary care premises

assessment had not been concluded. It also needed to be acknowledged that progressing with the partnership opportunity, could potentially lead to a reputational risk in progressing the project ahead of any other priorities and that would need to be managed.

13.8 Ms Lam suggested it was helpful to have that future services view and future proofing in terms of the way services were delivered and not just focusing on premises.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the assessment that the current Earlston Health Centre was no longer fit for purpose as outlined in the paper.

The **RESOURCES AND PERFORMANCE COMMITTEE** approved in principle the reprovision of the Earlston Health Centre to the proposed Earlston Community Campus, subject to confirmation of a suitable funding source.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that any capital / equipment costs for the reprovided Health Centre would be included in NHS Borders capital plan for 2023/24.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that the proposal would be in the public domain once planning permission was sought by the Council.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that a paper would be brought to a future Committee meeting once discussions had taken place with Scottish Government relating to the identification of a suitable funding source to formally approve the proposal.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that a paper would be presented to the November Committee meeting to outline the wider findings of the GP Premises Review.

14. Strategic Risk Report

14.1 Mrs Lettie Pringle provided an overview of the content of the report.

14.2 Ms Sonya Lam enquired how risk was reflected if not in the Committee. Dr Tim Patterson commented that a number of the items in the performance scorecard actually related to specific services and would be picked up under the operational risk register. Mrs Pringle confirmed that day to day risks were contained on the operational risk register.

14.3 Ms Lam challenged that operational risks that overlayed performance became strategic risks.

14.4 Mr John McLaren suggested the rating of high for the COVID vaccine delivery did not equate with the positive reports on delivery of the vaccinate or the number of staff sent home at short notice as they were not required. Dr Patterson commented that risks were allocated to risk owners who had the knowledge and expertise to be able to appropriately assess and rate their risks.

14.5 Mr Ralph Roberts was mindful of Ms Lam's challenge and suggested he take that comment away for consideration. He suggested the clinical strategy implementation risk was more medium term and he was happy to consider it as opposed to current performance.

14.6 Mrs Nicky Berry commented that the process for risks that were very high and high was that they were reviewed on a 6 and 12 month basis respectively.

14.7 Mr Tris Taylor suggested he was not sure that the risks allocated to the Public Governance Committee represented all of the risks that Committee might reasonably be expected to have an interest in scrutinising. Mr Roberts commented that that challenge was that many of the risks were multi-factorial and it could be argued that a number of Governance committees had an interest in them. It was something that would be kept under continual review

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** gained assurance that the strategic risks relating to finance and organisational performance activities were managed proportionately and appropriately, with the caveat that work would be taken forward outwith the meeting and recorded as an action on the action tracker.

The **RESOURCES AND PERFORMANCE COMMITTEE** gained assurance that the risks within the report represented all strategic financial and organisational performance risks facing NHS Borders currently.

15. Performance Scorecard

15.1 Mrs June Smyth commented that the report had been formulated against the background of services operating against the context of current operational pressures.

15.2 Mrs Harriet Campbell enquired why a choice was offered for delayed discharges. Mrs Smyth commented that she would pick up the matter with the Chief Officer Health & Social Care and email a full response outwith the meeting.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the July 2021 Performance Scorecard and the update on operational pressures being felt across health services in August 2021.

16. Primary Care Improvement Plan Update

16.1 Mr Chris Myers provided an overview of the content of the update.

16.2 Mr Paul McMenamin commented that primary care was a health care function delegated to the Integration Joint Board (IJB) and responsibility for the delivery of the Primary Care Improvement Plan (PCIP) sat with the IJB. Both the IJB and NHS Borders received an annual PCIP funding letter with an allocation of £3.26m ring fenced for PCIP. The Scottish Government had emphasised that any slippage was not to be used for savings or wider funding pressures. The PCIP Executive Committee had fully allocated the current funding across 7 workstreams, however he advised that there was a financial risk of insufficient funding to deliver all workstreams of the PCIP. He further commented that £276k non recurring remained undirected and he anticipated that it would be allocated later that day by the PCIP Executive Committee.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the report, the risks, and actions being undertaken to reduce the risks.

17. Resources & Performance Committee Business Plan 2022

17.1 Miss Iris Bishop provided an overview of the content of the paper.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the questions and answers provided.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Business Plan for 2022.

18. Any Other Business

18.1 There was none.

19. Date and Time of Next Meeting

19.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 4 November 2021 at 9.00am via MS Teams

The meeting concluded at 11.00am.

Signature: ……
Chair

RESOURCES & PERFORMANCE COMMITTEE: THURSDAY 2 SEPTEMBER 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Sonya Lam:** I declare that my partner is a specialist advisor for the Scottish Government.	**Iris Bishop:** Thank you Sonya I will record your declaration in the minutes.
2	Declarations of Interest	**Tris Taylor:** The paper about the Earlston Community Campus is something that materially impacts on me and my family.	**Iris Bishop:** Thank you Tris I will record this in the minutes.
		MINUTES OF PREVIOUS MEETINGS	
3	Minutes of Previous Meetings	**Harriet Campbell:** Did we ever get a response to Lucy's query (clever maths) at question 34? Would be interested to see this.	**June Smyth:** This was passed to the BI team who advised they were investigating but I've not yet had an update. A member of the planning team has taken an action to secure a response and we will issue as soon as this is received **Update:** A response was provided to Mrs Campbell and reports will be amended moving forward to make it clearer.
4	Minutes of Previous Meetings	**Karen Hamilton:** 11.2 Acronym list circulated as promised	**-**
		MATTERS ARISING	
5	Matters Arising	**Sonya Lam:** 9.5. Has there been any information from SG about performance data expectations and any contact with NEDs in NHS Borders regarding performance data for assurance?	**June Smyth:** Not for RMP3 but SG have included in RMP4 projection templates that broken down by quarter. They have indicated again that they may introduce a quarterly monitoring cycle but this is not yet in place / confirmed. We will look to build the indicators into our local monthly performance report once RMP4 has been submitted. I'm not aware of any contact with NEDs in NHS Borders regarding performance data for assurance.

6	Matters Arising	**Karen Hamilton:** None noted	**-**
7	Matters Arising	**Tris Taylor:** Q&A 35: What was the number of cases in which a discharge demand for nursing care should have been for residential care? Over what period did those cases occur and what percentage of discharges does this inflation of demand account for? Q&A 33, 39: Malcolm's question was specifically whether sustained improvement will only be possible once capacity in all three of those settings is increased. The answer supplied was that 'it will be a combination of factors.' This answer may be accurate but it is not precise. Factors cited are: - Policy - Strategy - Process - Compliance - Capacity It's my understanding that the suggestions from evaluation & Rob are that the Strategy (& by implication the policy) is broadly correct. Can we assume from this that the Policy is also correct? If so, that leaves Process, Compliance and Capacity, the last of which is divided into Residential Home Capacity, Nursing Home Capacity and Home Care Arrangements Capacity. We know from previous assurances that Capacity is a significant contributor. We also know from internal audit	**Rob McCulloch-Graham:** I have narrowed your question to the three at the end of your narrative; ***<u>What, if any, changes are wanted in Process?</u>*** ***<u>The relative status of Compliance today by comparison to baseline/pre-audit levels and the target level?</u>*** As was detailed within the internal audit review on the discharge programme and reported to both the Audit Committee and the R&P Committee, our major challenge has been compliance with policy and process. This remains a challenge for us. Whilst we have seen improvement across the various teams involved, this has been difficult to maintain. It requires constant vigilance from the Snr Officers within the Discharge Steering group. They have ensured the "moving on policy" is well communicate with staff teams and that it is shared with patients on admission. It would be fair to say the impact of this policy is variable, within its impact across the range of patients that present issues on discharge. Our estimate of need for discharge again is variable. We have seen improvement, but again

		that Compliance has been a significant contributor. Can specifics therefore be provided as to: - What, if any, changes are wanted in Process - The relative status of Compliance today by comparison to baseline/pre-audit levels and the target level - What change is required in each of the three categories of Capacity?	this requires on-going maintenance and review. There has been a degree of challenge across services on the expected levels of care required, especially between Nursing Care and Residential Care requirements. This is also linked to challenge within capacity, it is harder to secure nursing care places. The steering group have initiated further reviews of the list of delayed discharges, and have been able to appropriately amend requests for placements. Our processes have been identified by internal audit and Scottish Government as correct, our issue therefore remains to a degree compliance. ***What change is required in each of the three categories of Capacity?*** We have sustained the improvement in reduced delays from within Mental Health. These now remain between 2 and 4 delayed patients. Our Nursing Home capacity continues to be the main challenge, but has improved and we now have more capacity than six months ago. Where this capacity is at any given time however varies as and when vacancies occur. This is also true within residential care. In the main people wish to be placed within a

			care/nursing home close to where they currently reside. Our moving on policy states that patient need to identify three options and at least one should have a vacancy. As you will see from the previous reply the policy has been implemented but it is a challenge to ensure that it is complied with in every case. We have recently been placing patients exiting the hospital into temporary placements in other care homes, to await a further move to either a another residential place or home with a package of care. These actions, provide a temporary boost to patient flow, however these short placements are now providing further challenge as we have to re-negotiate a second move, whilst the hospital has further delays, more staff are required across more settings. We will keep this process under review as it may actually be causing further delays to the system. Residential and Nursing Homes have similar staffing issues to our Hospitals, in addition there are four homes which have been required to cease admissions due to instruction from the Inspectorate, or through in house demands in facing issues with staffing and the pandemic. We still have capacity in the system, however not all of that is in the areas required. With regards to providing packages of care, again internal and external staff teams are again facing the same issues as health staff, with high

			levels of staff absence. SBCares as a large provider have been able to cover for these instances to date, but are concerned with the expectation of further gaps in capacity coupled with growing demand in the lead up to winter. The independent care providers, now meet twice monthly as a collective, once with myself as CO. They have reached a mutual agreement between themselves that they can provide mutual support when an agency has a staffing crisis. This has operated across both home care and residential care.
8	Appendix-2021-16 COVID-19 Remobilisation Plan 2021/22 (RMP3)	**Harriet Campbell:** It is great that a lot of this is complete or ongoing, but- where issues should have been completed and instead we have 'in progress', 'TBC' or 'not yet complete' as an update, are there any likely timescales?. eg Eating Disorders pathway (p33 of pack – no numbers on document itself), PDS (p34/35), Emergency Access standard (p38) etc? If the answer is 'no, we don't know when this will happen' it would be good to know that. I'm not expecting anyone to go through these line by line in the meeting but a general overview would be helpful – maybe timescales are just always going to be unrealistic at the moment? I'm a bit confused by the note re respite care – I think the point is essentially that there just isn't the staff for any more people, whether permanent or temporary. Is that right? What is the difference between the perinatal mental health agenda on p37 and the perinatal mental health service on	**June Smyth:** At the time it was submitted RMP3 covered the financial year 2021/22 – therefore if there are no explicit timescales for the purpose of the action plan it was assumed that the deadline / completion date was end of March 2022. Although this paper provides an update on RMP3 actions, in preparing for RMP4 we are asking services to revisit the commitments they made in RMP3 to assess whether they are still feasible for this year (in light of the additional work commissioned for the next plan, and the system pressures / 4th wave of covid). As part of this process we will be more explicit with planned timescales. **Philip Grieve:** Yes that is right **Philip Grieve:** The agenda is the process of getting the indentified resource in regards to

		p32? There are a lot of acronyms in here i'm still not familiar with (sorry) – CHAT, PDS (something dementia service?), BAS, DES.	staffing - the service will be the end result **June Smyth:** Apologies these have been missed from the glossary - they stand for: • CHAT - Community and Home Assessment Team • PDS- Post Diagnostic Support • BAS- Borders Addiction Service • DES- Diabetic Eye Screening
9	Appendix-2021-16 COVID-19 Remobilisation Plan 2021/22 (RMP3)	**Sonya Lam:** • Perinatal CMHT: What does 'precarious although stabilising' translate to into terms of risk to service users and what assurance do we have that this will resolve by the beginning of 2022? • Respite options: how challenging is the recruitment of care home staff? How widespread is this across Borders care home services? Will or has this challenge impacted on other areas wider than respite? What mitigating actions are in place?	**Philip Grieve:** This means that due to the unprecedented pressures within the adult CMHT delays in recruitment to the perinatal midwife only some elements of resource for recruitment are in place, however the midwife post is advertised and the pathway has been established and in place for quite some time. All other resource for workforce is in place. Once the team is stabilised and staffing have returned to post (long term sick and vacancies) this pathway will be more robust **Rob McCulloch-Graham:** **Staffing issues in care.** Our Nursing Home capacity continues to be the main challenge, but it has improved and we now have more capacity than six months ago. Where this capacity is at any given time however varies as and when vacancies occur. This is also true within residential care. Residential and Nursing Homes have similar

			staffing issues to our Hospitals, in addition there are four homes which have been required to cease admissions due to instruction from the Inspectorate, or through in-house demands in facing issues with staffing and the pandemic. We still have capacity in the system, however not all of that is in the areas required. With regards to providing packages of care, again internal and external staff teams are again facing the same issues as health staff, with high levels of staff absence. SBCares as a large provider have been able to cover for these instances to date, but are concerned with the expectation of further gaps in capacity coupled with growing demand in the lead up to winter. Capacity and availability of care changes across the Borders, we are currently in difficulties in the Central Areas, including Selkirk and Galashiels. **Mitigation** We have been reducing the number of hours of care provided to individuals where possible, we have also worked with the independent sector to provide an alternative provision for medicine prompts. The output of these actions is to increase the capacity within home care services. The independent care providers, now meet twice monthly as a collective, once with myself as CO. They have reached a mutual agreement between themselves that they can provide

			mutual support when a particular agency has a staffing crisis. This has operated across both home care and residential care. We have recently been placing patients exiting the hospital into temporary placements in other care homes, to await a further move to either another residential place or home with a package of care. These actions, provide a temporary boost to patient flow, however these short placements are now providing further challenge as we have to re-negotiate a second move, whilst the hospital has grown further delays. More discharge staff are therefore required across more settings. We will keep this process under review as it may actually be causing further delays to the system. With regards to respite care, this has been particularly difficult within the pandemic as Social Centres and Day Centres for Learning Disabilities have necessarily been closed. We have redirected staff to work and support people in their own homes. Staff numbers again have added to this challenge. We worked closely with the Carers Centre and offered further funding and supported their contracting with additional third sector agencies to provide direct respite care to individuals that the centre had identified as in critical need.
		• Page 38: Improving the Emergency Access Target: I realise there are challenging operational issues at the moment, but with winter approaching is January 2022	**Gareth Clinkscale:** We have recently reviewed activity levels in the Emergency Department by hour/day of week which formed the basis of a

		too late to review the ED workforce/environment?	case for national Emergency Access Funding to increase medical capacity out of hours. The Emergency Department is currently operating with higher nurse staffing levels when compared to pre-pandemic. The leadership team are content that this will provide sufficient capacity as we head into the winter period. The Emergency Department and Unscheduled Care division leadership teams do not currently have the capacity to move this work forward while managing current pressures and ensuring the winter plan is delivered. My preference for this work is that it is done robustly and forecasts demand for the next 5 years. This will be a significant piece of work.
		• I realise recruitment and retention is an ongoing challenge and just within RMP3 there is mention of workforce issues in respite care (MH), midwifery in perinatal, dementia and outpatients. How are we progressing with addressing this? Do we know what support can be gained from the Centre for Sustainable Delivery as there is a workforce arm to the centre?	**Andy Carter:** Many of these recruitment issues are being felt nationally and are not specific to NHS Borders. We will work with anybody which can realistically help us to recruit to hard-to-fill positions. The Golden Jubilee centre (Clydebank) referred to has been established relatively recently and currently majors on advanced practitioner positions. We also continue to run recruitment for all Registered Nurse positions. Mental Health is currently particularly challenging to recruit to. We are reaching out to Universities to try and encourage newly qualified staff to take up employment with us. We are in early discussions to link in with other Scottish Health Boards and engage with Yeovil NHS Trust, specialists in international recruitment of healthcare staff. Our retiring staff are being encouraged to remain with us

			depending on their pension status, encouraged to remain substantive or join our Banks. Having shortlisted from 150, we are in the process of interviewing 70 candidates to take up Health Care Support Worker roles, in a bid to alleviate pressure on our Registered Nurses. Regarding retention, we are working with the Director of Nursing, Midwifery and AHPs to introduce a robust Exit Interview system linked to the national eESS (electronic employee support system) which will allow us to support the development of action plans based on the evidence we find.
10	Appendix-2021-16 COVID-19 Remobilisation Plan 2021/22 (RMP3)	**Karen Hamilton:** Noting the significant slippage here. Am I correct in assuming that these items will therefore be duplicated in RMP 4 with revised target dates or indeed actions? Have we advised John Burns of this slippage?	**June Smyth:** The delivery plan template as part of RMP4 submission will give an updated position against any actions we committed to as part of RMP3 so including any slippage / deferment to next year. RMP4 will be our chance to highlight our current position to John Burns. We have been encouraged by SG to use the opportunity of RMP4 to update them on any changes / slippages. Operationally SG receive a monthly submission of our planned V actual activity and the waiting times access team are in regular discussion with the acute team.
11	Appendix-2021-16 COVID-19 Remobilisation Plan 2021/22 (RMP3)	**Tris Taylor:** When will the Health Inequalities Impact Assessment be complete? Could a copy be provided? Action Plan>Acute Services>Older Persons' Assessment Area: is it realistic to assume that COVID-19 response measures will be relaxed sufficiently and permanently such	**June Smyth:** Capacity issues have meant we were unable to complete this for RMP3. We have timetabled this to take place (for RMP3 & RMP4 updates) towards the end of September, after which a copy can then be circulated. **Gareth Clinkscale:** This comment reflects the current position whereby both physical and workforce capacity that would be used to

		that the Older Persons' Assessment Area may be restarted and sustainably delivered?	develop the Older Person's Assessment Area is being used as part of the COVID-19 inpatient response. The model will be partly delivered while still maintaining COVID-19 response measures; we are increasing AHP input for this patient group, cohorting frail patients in the Medical Admissions Unit and have implemented a new frailty assessment on TRAK. We will be limited in the protected space and medical workforce we can release to the new OPAA model while providing the current level of COVID-19 capacity.
		Action Plan>Primary & Community Care Services>Allied Health Professional Services: 1) To what extent have the impacts on service users of a delay to June 2022 been quantified? Please share estimates. 2) How does the demography of those who will be disadvantaged correlate to that of Borderers currently disadvantaged in health inequalities terms? 3) Please describe the nature and scope of public/community/third sector involvement in a. the Service Specifications b. the work to structure community services.	**Paul Williams:** Due to annual leave this answer will follow after the meeting.
		Action Plan>Primary & Community Care Services>Community Dentistry: 1) Given the higher COVID-19 risks associated with dentistry, can pre-pandemic operating models ever deliver the same capacity again? 2) What position is being communicated to service users regards waiting times? To what extent is this a	**Chris Myers:** 1. This will be extremely challenging within the context of the ongoing Covid-19 pandemic and current Scottish Government advice from the Chief Dental Officer. 2. We have written out to all patients on the Public Dental Service's waiting list to

		coordinated position between Board and providers? Are we living our Board values to be open and transparent about the current and future positions?	communicate waits. Our Dental service are working closely with General Dental Service providers to ensure that we are as well coordinated as we can be between NHS and private dental providers.
		Action Plan>Primary & Community Care Services>Care Homes: excited to see how this work on the governance structures and partnership working develops.	-
		Action Plan>Public Health>Wider Public Health Activities>Development of enhanced strategic approach to health inequalities: please describe the nature and scope of involvement of service users, community representatives and third sector organisations to date and planned (or link me to a doc?)	**June Smyth:** The relevant document relating to this is the *Maximising the Impact of NHS Borders on Reducing Health Inequalities* which was presented to the Board in April this year. The paper referenced the proposed approach to involvement and engagement of service users and other stakeholders. Unfortunately to date we have not yet identified funding to resource the additional staff proposed for this programme. The resource proposal has been reviewed and reduced, and a funding source is being sought. Through reprioritisation of existing staff work has commenced but cannot begin in earnest until we have a team in place
		Action Plan>Primary & Community Care Services>Screening Programmes>accommodation/venue requirement: [this q is probably for the Director of Estates & Facilities] in light of the potential for medium/long-term demand for physical distancing associated with COVID-19, what are the limits on the Board's strategic and operational flexibility to vary sites of healthcare provision e.g. to include those not owned by the NHS?	**Chris Myers:** We have worked with partners such as SBC, Live Borders and the SPPA to support the provision of a number of services, vaccination clinics and staff

		Action Plan>Primary & Community Care Services>Screening Programmes>Consideration of potential impacts & unintended consequences…: I wasn't completely sure how to interpret the narrative: 1) Is it correct to say this is happening on a monthly basis but not to the desired extent due to the partial redeployment of 3 staff? 2) Could a summary of the outcomes of the reviews be provided?	**Tim Patterson:** Screening activity is reviewed regularly by staff. Early indication figures post covid pause that all programmes are resuming with high uptake. Initial pressure on diagnostic services, particularly Bowel Screening for colonoscopy, seems to be easing. Two specific inequalities work streams are still paused i.e. mental health and LD. Staffing remains a challenge since three senior screening staff are still on deployment to Testing and Testing and Protect due to recent surge in Covid cases and other staff being redeployed back to core services.
		Supporting Our Workforce>Staff Wellbeing Group: What systems are in place to assess the impact of the group on wellbeing? Does any such assessment analyse the demographics of participants against what we know of inequalities/health inequalities concerning our workforce to address the question of whether the take up/provision is equitable?	**Andy Carter:** iMatter (or its' derivatives like Everyone Matters) is the tool NHS Scotland use to measure engagement levels within teams. The iMatter questions and statements cover the range of Staff Governance commitments including that staff are provided with a safe environment, appropriately trained, well informed, involved in decisions and treated fairly & consistently. iMatter does ask for voluntary disclosure of personal make-up and provides very broad (not person specific) findings against different protected characteristics. This available at whole Health Board level. Along with Collecting Your Voices output last year, these tools provide a sense of well-being in the workforce or at least as close as we can get to these things at a corporate level. Work is ongoing at the moment to develop a 'Cultural Dashboard' which brings together a range of metrics to best sense-check how different parts

			of the organisation are coping/performing/ /feeling. There is no more important stakeholder/influencer in well-being terms than individual line managers who are closest to their teams and should always be able to gauge how their people are faring. It is also possible to study broad datasets (Occupational Health Annual Plan) of which staff groups/locales accesses Occupational Health & Safety services. **Andy Carter:** 1) The employment framework (pay, pension, policies, progression of careers) within NHS Scotland is an attractive one which compares favourably with other employers. We are a progressive employer; the terms & conditions of employment are fair and the Health Service, through its' worker-friendly Once For Scotland policies and Staff Governance Standard, is an exemplary employer. However, the significant and at present relentlessly growing demands on the Service are such that more staff are needed and the skilled supply line is not there in the numbers we currently require and will require over the next 5 years. All Health Boards continually have to sell ourselves in a very difficult and competitive marketplace. 2) That would be an unfortunate and incorrect inference. The organisation is both an Equal Opportunities and Disability Confident
		Supporting Our Workforce>Workforce Planning: Taken aback by the sentence: "with an ageing workforce and one with only 3% identifying as Black Asian or Minority Ethnic, it is vital that NHS Borders can sell itself as an exemplary and progressive employer which is a great place for health & care staff to learn and further their careers". If what is meant is that the org wants to be perceived as an employer that's equally attractive not only to an ageing, majority-white workforce, but also to earlier-stage, younger and Black, Asian & minority ethnic candidates, in order to mitigate strategic corporate risk through having a more diverse workforce: 1) What is the gap between selling the organisation as an exemplary and progressive employer and actually being one? If we are one, why the focus on selling ourselves? If we aren't one, what are the areas of work we are undertaking to change this and what outcomes and benefits are expected from each? 2) One might infer from the statement that an ageing, majority white workforce is somehow preventing the organisation from being an exemplary and	

		progressive employer; that would be an unfortunate inference without evidence that the org tends to favour older and white people in recruitment, which may be true – is it? If so, what corrective actions have been/are being taken, and to what extent is the org adequately exploiting the scope available to positively discriminate in favour of those with protected characteristics?	employer which uses the national Jobtrain recruitment system. Jobtrain presents recruiting managers with candidates (identified by only numbers) and withholds names and any personal sensitive data such as the Equality Act's defined protected characteristics. The name of the individual is only released once a candidate is already called to interview, after short-listing has taken place. More sensitive demographic data i.e. that which candidate's record on their application form Equal Opportunities section, continues to be withheld. Broadly speaking, if you take the race/ethnicity categories and identify the percentage of the total Scottish Borders population who identify as Asian/Scots Asian/Asian British, African, Caribbean, Black, Mixed/Multiple and exclude all White categories, that totals 1.3% (2011 Census). The percentage of the NHS Borders workforce who identify in the same categories totals 2.4%. NHS Borders employs a greater proportion of minority ethnic staff than the proportion found in the Health Board/Local Authority area it serves. NHS Borders welcomes applications from all parts of the society/communities it serves and in the current resourcing climate, would be very happy to generate more candidates, especially for its most hard-to-fill roles. NHS Borders, along with other NHS Scotland Health Boards, is exploring a working relationship with Yeovil NHS Trust; experts in international recruitment. In terms of

			positive discrimination, the Health Board engages in a number of employability schemes including Project Search (participants with learning disabilities), DWP's Kickstart scheme for 16-24 year olds, Borders Young Persons Guarantee, Modern Apprenticeships, Graduate Opportunities and we are currently awaiting further information from Scottish Government on the Job Creation Fund.
		Corporate/Support Services>Clinical and Professional Development: is there a missing timescale here? Is this about the redesign of a clinical & professional development service, or about service redesign in general? What has been the involvement of service users, the public and third sector organisations in any service redesign?	**Sarah Horan:** This service review was commenced as part of the Turnaround process per pandemic then halted. As Corporate Services are working through a wider review then any changes will be tested only with no actual change to the current operating model. Service users included were the Clinical Boards and Professional Leads. As no service redesign at present no public or 3rd sector involved at this time.
12	Appendix-2021-17 COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4	**Harriet Campbell:** Thank you for circulating this. Can you possibly make sure that you send the guidance round again when we see RMP4 (albeit for retrospective approval) as I'll have forgotten what it says by then? Is it 'normal' that we should be approving this retrospectively? I see it goes past lots of other sets of eyes in advance of being sent to SG, so I'm sure it is fine, but just want to check. More immediately how confident are we of sticking to this timetable? I see work has been happening on the plan	**June Smyth:** Noted thank you – we will make sure that the commissioning letter and guidance are re-circulated when RMP4 comes forward for consideration. It would be preferable for the Board or one of It's delegated committees to review and approve the plan before it is submitted, but SG timelines don't often align with Board planning cycles. Therefore for our Annual Operational Plans, and now our Remobilisation Plans these are often approved in this manner. This is not just an issue for NHS Borders, other Boards have

		over the Summer – are we on course?	similar challenges. The timeline was designed on receipt of the commissioning letter and based on our experience of developing previous plans. At the time of drafting the cover paper we were still on track. However given ongoing pressures it is proving difficult for service leads to prioritise this. As a result some of the earlier milestones might slip (e.g. we have just agreed to postpone the session with the ACF and APF to later in September). We aim to retain as far as possible the steps outlined from 20th September, but this will be subject to capacity of those involved in the development of the plan.
13	Appendix-2021-17 COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4	**Sonya Lam:** • Page 61/62. The Centre for Sustainable Delivery. Have we been approached or have we approached the CfSD? • Page 61: with the release of winter funds being dependent on SG approval of RMP4 at the end of November. This presumably presents a problem in the rapid recruitment of additional winter staff. Will the SG move to a position where winter funding is	**June Smyth:** Yes the CfSD have reached out to Boards. There have been several discussions with the acute team over the summer particularly around the heat map requirement and are actively being supported by them in terms of what is expected as part of the initial return and they are beginning to explore the support they may be able to provide the operational teams in terms of the areas identified in this return. Staff from CfSD recently met with some members of the executive team to sense check the discussions to date and a follow up meeting is being arranged. **Andrew Bone:** Boards have not been advised by SG of a move to recurringly allocate winter funding.

		mainstreamed as this must present an additional challenge with recruitment of staff on an annual basis?	
14	Appendix-2021-17 COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4	**James Ayling:** The Committee is being asked to "agree to the submission being signed off by the Chair and Chief Executive by 31st September 2021 on behalf of the Board, subject to subsequent formal Board approval in October 2021. Is that actually the case? Are we not being asked to delegate power to the Chair and Chief Executive to complete and submit in a final form as we will have passed the cut off date for submission by October? I see that the guidance states that for next year's plans, SG expect that the main narrative aspects of our operational plans will concentrate on setting out the strategic context and the outcomes that we are working towards over the **medium-term.** I then read in our Finance Report that The Scottish Government's **medium term** financial framework is currently under review (present version requires 3 year balanced position). Is this a potential mismatch?	**June Smyth:** Comments noted - We will bring forward the submission to the October Board and ask that they formally ratify the submission. The separate divisions of SG are trying to align all of the planning cycles but this may take time to fully achieve – until then as you say there may be a mismatch. Directors of Planning have highlighted this to SG colleagues, as have other Directors re their own planning cycles. **Andrew Bone:** Prior to the Covid Pandemic NHSS submitted Financial Plans covering a 3 year medium term planning timeframe. Discussions with SG Finance Director and the Board have agreed to submit a 3 year Financial Plan later on this calendar year as the Board needs to keep focused on its financial position in year and into future periods. It is assumed that with SG requesting a 3 year financial plan that an operational plan covering this same period will also be required from 1.4.22 onward.
15	Appendix-2021-17 COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4	**Karen Hamilton:** Noting the suggested template required for RMP4 will we capture actions/slippage from RMP3 satisfactorily?	**June Smyth:** The template will provide an update on key deliverables including slippage / deferment of activities. We will also provide an overarching narrative which will highlight the current system pressures.
16	Appendix-2021-17 COVID-19 Remobilisation Plan 2021/22 (RMP3) –	**Tris Taylor:** Pp18-19: pleased to see Scottish Government reference to the management of pain including chronic pain (53) and addressing inequalities (55). Is either a change from the	**June Smyth:** These were both highlighted specifically in the commissioning letter for RMP although we recognise the need to strengthen the response to this in RMP4.

	RMP4	requirements of RMP3? P23: where can I look for a summary of Board desired/actual to date outcomes around the extension of digital health and care?	I'm not sure I can signpost you to exactly what you are asking for - a new national Digital Health & Care strategy is to be published shortly. Work is underway to develop the plan and roadmap for the strategy and Digital & clinical Leads in Boards are contributing to that. This will help clarify the national context. Locally we have an in year plan with a significant pipeline of Digital projects which are being prioritised with the help of local managers and clinicians. As you know we are also working on a new Digital strategy for NHS Borders. This needs to be a response to feedback we are currently seeking from a broad range of stakeholders and aligned to our aspirations and strategic direction. It will also need to dovetail with our RMP and any refresh of our clinical strategy. Meantime the Digital team are working through the pipeline of projects, as prioritised, to support services to adopt the current technologies. If the board wishes we can give further detail to a future meeting or separately to interested board members, on the current plans for the next 6-12 months. This focus mainly on Office 365, Windows 10, Trak additional functionality GP Order Comms, embedding Near Me, upgrades to service specific systems, PCIP including vaccinations & CTAC.
17	Appendix-2021-18 Finance Report	**Harriet Campbell:** It was good news earlier this year that NHSB was de-escalated. Noting the deficit, and for information only (I'm not suggesting or implying anything) how bad would things	**Ralph Roberts:** A fair question but not one with a very clear answer. My assumption is this will depend on the scale of the recurrent deficit, the movement in the deficit and importantly the

		have to get to be re-escalated? This isn't a risk mentioned in the Q1 review, so maybe it is negligible.	confidence the SG team have in our ability to make progress; It is a reasonable point that until this the underlying deficit is finally addressed that further escalation remains a risk.
18	Appendix-2021-18 Finance Report	**Karen Hamilton:** General question: What impact on Finances will the current (and potentially ongoing) cancellation of electives have?	**Andrew Bone:** In terms of a use of resources it would expected that there would be a reduction in the use of supplies in theatres and surgical/orthopaedic wards. Staffing costs though, are predominately fixed, therefore these will continue to be incurred through the staff being redeployed to cover other areas. BET has continued to highlight to SG, through the Remobilisation Plan discussions, that should additional activity be required, above operational budget levels, to support the delivery of cancelled elective activity then additional resources would be needed to fund the associated costs.
19	Appendix-2021-19 Quarter One Review	**Harriet Campbell:** Thank you for adding best/worst/most likely outcomes Andrew! Silly point, but should it not be 'submitted' at 3.1 and not 'submission'? 3.6.14 Given what Lynn said in the last RPC meeting (at 6.4 of the minutes) about growth in prescribing due to ongoing chronic disease management, how realistic is it to expect non-recurring savings from prescription growth?	**Andrew Bone:** 3.1 – submission. Yes, you are correct. Hangover from earlier form of this sentence. 3.6.14 – the underlying trend is certainly towards growth in chronic disease management however we have not seen the level of overall growth in prescribing that was originally forecast. This is likely to be, at least in part, due to unmet need as a result of constraints on service capacity. We will continue to review the position during the course of 2021/22.

20	Appendix-2021-19 Quarter One Review	**James Ayling:** Thank you for additional section on sensitivity forecast. Part of the additional flexibility of £5m comes from a review of year end accruals against I&E of £1.6m. Is this amount broadly commensurate with previous years ?	**Andrew Bone:** The planned level for review of year end accruals is commensurate with previous years.
21	Appendix-2021-20 Financial Turnaround 2021/22	**Harriet Campbell:** 5.3 "at this point we think we will struggle to identify and deliver schemes to meet our financial targets". It sounds stupid, but what are the implications of this? What happens if we miss our targets? At what point does this start to impact on our ability to provide services to our population? P16, does removing a band 2 overnight post really save £92k per year? Seems an awful lot. What am I missing? P17 Next stupid question – why does public holiday working save money? Is it that we are using resources more efficiently? .Or am I reading this upside down and people won't be working on public holidays (and potentially getting overtime?)?	**Andrew Bone:** The immediate short term implication is that we will require brokerage (i.e. financial support) from Scottish government to deliver our plan in 2021/22. This requires agreement and creates a liability for future repayment, thereby presenting a further financial challenge for future years. The long term implications are of course that the board continues to spend more than it can afford to deliver its services. Any decision to restrict service delivery is likely to be subject to agreement of Scottish Government and there will be an expectation that the board has maximised opportunities for increased productivity and service redesign before progressing this approach. The removal of a single Band 2 post on a nightshift will actually equate to approximately 2.5 posts due to the total hours required to cover a night shift roster, including planned absence cover. The cost saving includes enhanced rates of pay for night shift workers. Public holidays – savings are achieved from reduction in public holiday rates (under Agenda For Change staff can earn double time for these

			shifts), as well as potential release of unnecessary staffing where this does not need to be reprovided (e.g. outpatient clinic reception posts which are already covered in normal working hours).
22	Appendix-2021-20 Financial Turnaround 2021/22	**James Ayling:** The paper proposes changing the governance arrangements for the turnaround programme to ensure that financial turnaround, savings and efficiencies are seen as part of our usual business rather than as an independent strand of work with separate governance arrangements. I therefore don't immediately follow the subsequent proposal that a new Quality and Sustainability Board be established which will amongst other things oversee the financial turnaround programme. Is this not contrary to the first proposal .Kindly clarify. The above proposal (presumably the new Q&S Board) is to be aligned to the proposed introduction of a Quality Management System (QMS). Is this to be the main purpose of the new Board as introducing TQM will, as has been discussed, be a big and potentially all consuming task. Financial turnaround will be a big ticket item for us going forward. Who in the organisation bears final operational responsibility for this? FD, CEO or ?	**June Smyth:** Apologies we haven't explained this very well. The previous Turnaround Programme included a mix of general efficiency/BAU/grip and control activities and service change/transformation themes. Under the proposed arrangements the former will be for business units to deliver (with reviews on progress at the quarterly quality and performance service reviews). The more transformational aspects will be overseen by the Quality & Sustainability Board. All of this is still being worked through and not yet finalised. number of activities. This is still all being worked through as part of the QMS system. The QMS system is being driven by the executive team and at present reports into the weekly BET meeting. The Q&SB will oversee programmes of work so in time it may oversee this as well. This is all still work in progress as we progress QMS and in particular the business processes pillar within that. Ultimately it is the Chief Executive as the Accountable Officer, although the approach taken by the executive team previously is that this was a shared and collective responsibility. We intend to take the same approach moving

			forward.
		Reducing HR costs by £8k. On the face of it seems counterproductive given recruitment problems?	Every department was/is required to look for efficiency savings and will argue that demand on their services and the criticality of their service provision should negate the need for this. We are considering a set format for services to undergo a service review as part of the financial sustainability discussions moving forward in order to inform any savings / investment discussions. Ultimately however hard choices will be required as we bring back the focus on financial sustainability as an organisation.
23	Appendix-2021-20 Financial Turnaround 2021/22	**Karen Hamilton:** 2.1.7 Is this timescale realistic/imposed?	**June Smyth:** The overall timescale is an SG requirement, and it is challenging given the continuing pressures in the system. The normal financial planning timescale as defined by SG is that a three year financial plan requires to be agreed by the Board and submitted to SG by the beginning of the new financial year. Draft plans are usually submitted early February to allow for review and discussion. The exact specifics of how the plan is developed within that timescale is left to each individual Board. As part of the financial planning process it had been anticipated that the successor to the Turnaround Programme would be in place to inform the Boards recovery plan. . Unfortunately due to the system pressures mentioned above this has had to slipped.
		3.2.9 Can you give a couple of examples of services deemed 'not currently viable'?	P18 of the paper (labelled appendix 3) outlines a number of schemes that are currently not viable. Most of these are no longer viable due to

			changes required in working practices in relation to COVID. These changes in practice continue to impact on service provision. It may be in future years these can be revisited but for planning purposes we have removed these from firm plans until we can reassess.
		3.3.7/3.3.8 Presumably we need to know likely impact on savings for these 76 proposals before progressing.	A high level assessment of each of the schemes will be required before we can progress further. This will allow us to concentrate resources on those schemes which can delivery most in an appropriate timescale. We will use the mandate / gateway process for this as we did previously.
		4.8 In principle I am in agreement with this but would need to be assured that this complements other groups and does not increase demand for staffing resources to service it. What is it adding and/or doing better?	The new decision making process / governance as outlined in the diagram has been directly informed from feedback from staff (through covid lessons learned, *Collecting Your Voices* feedback, discussions with Business Units and general feedback from the early QMS discussions). Its purpose is very much to streamline decision making, be more agile when required and less demanding. The introduction of this is removing the need for other meetings / groups. This is being led by the business processes pillar as part of QMS. It is still being refined and may be improved further as work progresses. Feedback to date has been very positive from the Business Units.
		Appendix 1 to Appendix 2021-20 No paragraph numbers.	Apologies – that appendix is the paper which was originally presented to the Board Executive Team which did not include paragraph numbers. It was shared as an appendix to provide the

		How are we to engage stakeholders and communicate this message to staff s that they get why an ideas has been shelved?	supporting detail to the cover paper. In the interests of time it wasn't reformatted for sharing with the Board. There was a feedback loop in place previously as part of the ideas pipeline and we will need to carefully consider how to bring this back on stream and communicate out to those who generated the ideas (if they identified themselves) as we begin to bring this work back on stream.
24	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**Harriet Campbell:** Are we supposed to be commenting on the Organisational Strategy at this stage? One thing leaps out at me: we don't seem to address the issue of where people go when they leave NHS care and I wonder whether we should say something like 'When hospital care is no longer required or appropriate, ensure the patient's discharge is as smooth and brief as is appropriate to be safe and effective and that their destination is clinically and personally appropriate for their needs.' That doesn't cover patients who go straight from primary care to social care though... Do we also want to include more about realistic medicine, particular in how we are going to implement all this?	**June Smyth:** No we're not asking you to comment on the organisational strategy at this stage – it was included in the papers for background information / as context. We'll note your comments though for future discussions.
25	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**Lucy O'Leary:** Thank you for this paper which provides me with reassurance that action is forthcoming to fill a major gap **Overall comment** – please can we be definite and consistent about what the strategic plan is going to be called? I note it is referred to as the Organisational/ Clinical Strategy here and the previous version is referred to in a number of ways which has caused me confusion	**June Smyth:** Noted thank you and yes we will clarify this as work commences. Our thinking is that for NHS Borders we would be developing an organisational strategy but this will require further discussion with partners if we take this forward collectively with the IJB/SBC. Board members are key stakeholders in influencing this as the work progresses.

		since I arrived. Very strong preference for the strategy we are discussing here to be called the Organisational Strategy (NOT "clinical") as it will cover much more than clinical issues – 1) ensuring that the underpinning drivers of change – estates, information, workforce etc – are seen as integral to the strategy and 2) taking a whole system view that incorporates health promotion/ ill health prevention/ social model of health/ whole system change as a starting point for our strategy with clinical issues flowing from that as a major but not exclusive area of focus **3.2 Needs assessment –** very welcome commitment to this. Note that it will be commissioned from an external provider. Would like to receive assurance as this develops about engagement and co-production with local stakeholders (is this within the Public Governance committee remit?)	We haven't yet agreed the scope of works relating to the strategic needs assessment but will feed your comment into the discussions which will shortly commence to commission this piece of work.
26	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**Sonya Lam:** • Welcome the paper and proposal to develop an integrated strategy with NHS Borders and SBC in the suggested timescale. Public consultation is key but would encourage a mechanism to engage service users during the process of development. • For my clarification, if the final launch of the integrated strategy is 2023, we are looking to refine/refresh what NHS Borders already has in terms of vision/values/objectives and strategic principles until the integrated strategy is developed and the same for the IJB. Would there be merit in having a shared vision, values and strategic principles between NHS B and the IJB, with associated objectives that the plans for NHS B	**June Smyth:** Noted thanks. Public involvement and engagement will be a key part of the strategy development work. The intention is to agree the overall approach / concept first of an integrated process and then detail out and agree how stakeholders will be involved and engaged. The proposal is that NHSB Board revisits the organisations currently agreed vision / values / objectives / strategic principles that are in place, over the remainder of this financial year. Concurrently the IJB will be developing an updated Strategic Plan. It may be possible to

		(RMP4) and the IJB strategic commissioning plan relate to.	develop these in partnership (NHSB/SBC/IJB) but we have yet to discuss and agree this formally with the IJB and SBC. The first step to this is securing feedback from NHSB Board Members. Once we have feedback from the discussion at the committee we can assess the next steps. One of the complicating factors in the discussion is that the IJB is due to have an updated, detailed Strategic Plan by the end of March, and which SG are expecting. We are suggesting that for the NHSB strategy we require a longer time frame to develop a detailed strategy (which includes involvement and engagement with stakeholders). At present we aren't fully aligned but there may be opportunities to do so, depending on feedback from initially R&PC and then subsequently IJB (and SBC in relation to those care services delegated to the IJB). Many of the objectives / commitments that will be contained within RMP4 are driven by SG through their specific asks of NHS Boards through to the end of March 2022.
27	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**James Ayling:** I note that for both the NHS Borders refreshed strategy and the IJB Strategic Commissioning Plan an updated needs assessment should be completed and that given capacity issues within the Public Health Team in Borders as a result of the pandemic, this will be required to be commissioned externally. I feel its unfortunate that this needs to go out of house as presumably we are best placed on the issues. Alternatively a third party view might be useful. Can you confirm that NHS Borders will be allowed to comment and	**June Smyth:** I note your comments, however given the pandemic it is just not possible for the Public Health department to undertake the needs assessment within the timescale proposed. There are other, national (NHS) bodies with expertise in this area who may be able to assist (and which support NHS Boards / IJBs with this type of work). The work will be commissioned by NHS Borders

		be involved in the final reports rather than being "imposed" on us. The 2017 report on Clinical Strategy asks in each section "What will success look like". I wonder in general how much of what is currently in place looks like was forecast? It potentially also begs the question of how far can we go in setting out objectives going forward given the pace of change in ideas /new developments /ongoing pandemic matters and of course new policy ideas eg Childrens Centre seemed v good at the time of approval but change in healthcare delivery renders it incompatible.	through the Director of Public Health and other executive team colleagues through the development of a detailed brief/scope. In line with other commissioned pieces of work it will be subject to regular review by the commissioner and there will be an opportunity for review of any draft reports before these are presented for consideration. Noted and agree therefore that as part of this work an assessment of "what has changed" and what the current policy and direction is currently looking like. The national Recovery plan has also been published and therefore alignment to the commitments within that will be crucial.
28	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**Karen Hamilton:** In principle an excellent idea. Will we include 'sub/underpinning strategies' to provide a comprehensive picture of where we are heading? 3.2 Do we have an indicative cost? Attach 3 Wow tight timescales! Are we realistic here bearing in mind new Chief Officer on the horizon?	**June Smyth:** That is our current thinking, yes. Indicative costs haven't yet been assessed – once we are clearer on the position of NHSB Board Members, IJB members etc. we can look to assess. Yes this is exceptionally tight, especially given the pressures within health and care systems at present. If the approach is agreed by NHS Borders the timescales will require further discussion with IJB/SBC. There may be options and opportunities to extend the timeline but that may require discussions with parties (including potentially SG) in terms of expectations. The timelines will also, of course, be dependent on service / planning capacity and depending on the status of the pandemic and as you say the appointment of a new Chief Officer.

29	Appendix-2021-21 Developing NHS Borders Short, Medium and Long Term Strategy	**Tris Taylor:** Observations: - Agree it is desirable to join strategy with partners. - Makes me think what we are after is a whole health economy strategy for the Borders. - So the missing pieces of the jigsaw are [at least] unpaid care, third sector and independent provision. - If these can be satisfactorily stewarded by partners especially (presumably) the Integration Joint Board, I would be excited about this approach. That is quite a big question though – thoughts? - Other than that – timescale suggests something will be needed in the interim to plug what is perceived as a major gap. - Options to accelerate – looks as if involvement could be designed in at an earlier stage/throughout, which might develop scope for acceleration.	**June Smyth:** Noted thank you. All of this is subject to further discussion with the IJB and SBC who may not be as supportive of this approach and who may have other expectations re timeline. I need to be clear that given other competing priorities / system capacity it is unlikely that we can escalate the timeline – if anything we may find we need to plan this over a longer time frame given some of the issues outlined in the response above.
30	Appendix-2021-22 Development of NHS Borders Trauma Rehabilitation Pathway	**Harriet Campbell:** This all sounds very sensible and positive, but my negative side wonders how it fits with the current huge pressures at the BGH. Are staff worried about the roll out on Monday? Where are we with recruiting all the staff that are set out in the report? Where did the spaces between the words go in the Guidelines from the BRSM? I am afraid I have only skimmed it as a result as it was hurting my brain... How are we doing with communicating this to the wider public? Has there been any feedback? The overview of communication actions seems to (perhaps) be a copy and paste from the NHS Lothian section (see top of page 265)	**Gareth Clinkscale:** I agree this is a very positive development. Staff are not worried about the rollout as the pathways with Edinburgh are in the majority operational. The Emergency Department works closely with the Royal Infirmary Edinburgh team and have been developing their local Trauma Unit response over the previous three year period. The Trauma Unit Coordinators have been in post for over 12 months now. The go-live will make little perceivable difference to teams within the BGH. The AHP rehabilitation posts will be advertised within the next two weeks. The document spacing issue (or lack of spacing

		and it's not clear what has yet been (or is to be) done.	issue) appears to have occurred when we have converted the paper to pdf. There is a national communication strategy on the implementation of the network. Our Communications team are awaiting a national communications steer and relevant local communication will follow.
31	Appendix-2021-22 Development of NHS Borders Trauma Rehabilitation Pathway	**Sonya Lam:** • Approve the establishment of the pathway • Minor correction to Caroline Lamb's title. Should read CEO NHS Scotland not NES. • 4.3.6: What are the certain job types that are challenging to recruit to? • For the £244,513.49, what is the return on investment in terms of outcomes for people who will use the services? What will be the success criteria/ ongoing measurement framework? • In terms of prevention, what does the data tell us about measures that can be put in place to prevent trauma in the Borders?	**Gareth Clinkscale:** Note correction to Caroline Lamb's title. 4.3.6 This comment refers to AHP posts that we have struggled to fill previously. Evidence from around the world shows that a coordinated and inclusive system of trauma care significantly reduces mortality by around 20 to 25% and improves outcomes for patients. The investment in rehabilitation will make a marked improvement in functional outcomes for patients. We are active member of the Scottish Trauma Audit Group (STAG) which provides benchmarked data on quality of care, overall experience and long term outcome of patients. This will be used to assess impact of the investment. More info at https://www.scottishtraumanetwork.com/our-work/data-audit/ Prevention has not been part of the scope of work of the local Trauma Unit development.
32	Appendix-2021-22 Development of NHS Borders	**Karen Hamilton:** 1.5 'Trauma Unit at BGH', does it have to be at BGH? Community Hospitals?	**Gareth Clinkscale:** 1.5 Patients admitted from the Emergency Department or repatriated from the Major Trauma Centre may still require

	Trauma Rehabilitation Pathway	4.3.7 Isn't 'summer' nearly over? 4.4.8 Do these costs include 'on costs', accommodation etc??	secondary care levels of care. They will also require input from numerous secondary care medical/surgical teams (Stroke, DME, Ortho and General Surgery) which equates to a low wte for each specialty. Delivering this across one or more Community Hospitals would increase the wte required to deliver service. 4.3.7 Summer is nearly over. This paper was written in the first ½ of July. 4.4.8 On costs and accommodation requirements were deemed minimal and as such would be absorbed by service.
33	Appendix-2021-22 Development of NHS Borders Trauma Rehabilitation Pathway	**Tris Taylor:** Is there any data about the demographics of those using trauma services over the last few years and how that maps onto health inequalities priorities in the Borders? Can a list of key stakeholders involved in the workshops and otherwise in this development be provided, with an indication of whether each represents staff, service users, carers, or others, at either national or local levels? I apologise that I have only so far skim-read this paper so please correct me if this is wrong, but it appears that section 8 of the paper erroneously refers to staff where the duty is to service users. If I am reading this paper correctly section 8 is telling me that a) there is a duty for public involvement in this redesign and b) that duty has not been executed. There is a Communications and Engagement Strategy but it appears unfinished (e.g. p38 'What are the key messages?') and to focus heavily on staff	**Gareth Clinkscale:** There is demographic data available on trauma cases for NHS Borders as collected via the Scottish Trauma Audit Group (STAG). There has not been work undertaken locally to map this onto health inequalities priorities in the Borders. I am happy to provide a list of key stakeholders who were involved in the pathway development. The Major Traumas Unit Project Manager has not been available in time to include in this Q&A return. Public engagement activities were delivered via the national and regional teams, where the parameters and expectations for local service development (including minimum rehabilitation requirements) were established. The new posts described within the paper largely reflect the

		communication, omitting much detail about engagement with end-users and groups representative of end-users. There is a reference on p49 to Borders public involvement via a Clinical Governance group but it is unclear to what extent this happened and what were the outcomes; and the action plan on p54 entirely excludes patients and carers from its table of External Audiences. Can you say a bit about how and whether the Board's public involvement duty has been discharged?	augmentation of local services and were developed over the previous 12 months. The pandemic has impacted on our ability to engage the public on this change during this period.
34	Appendix-2021-23 Children and Young People's Centre	**Harriet Campbell:** This all sounds very sensible, but given that donations of £1m were pledged by private individuals, is there a PR aspect to this that also needs to be considered? Have the major donors been approached and kept informed? If not, should they not be?	**June Smyth:** There may be a PR aspect to this, which will be considered by the Board of Trustees, should the Resources & Performance Committee agree with the recommendations outlined in the paper. If they do, then I will take a paper to the Board of Trustees explaining the position. (*For information, the donation was a 'donation in principle' and the donors were kept fully appraised of the situation. They are aware that the project has not progressed so this donation is no longer on the table. There are therefore no likely PR issues for the Board of Trustees).*
35	Appendix-2021-23 Children and Young People's Centre	**James Ayling:** I know its 6 years ago but wondered if we have kept those who either donated at the time or expressed major interest updated over the past few years.	**June Smyth:** Please see above response
36	Appendix-2021-23 Children and Young People's Centre	**Karen Hamilton:** Executive Summary – was this not an **outline** Business Case	**June Smyth:** The paper submitted to the Strategy & Performance Committee was titled as an Outline Business Case. This relates to the then planning guidance (relating to capital projects in particular) where the Board is required to develop an Outline Business Case (OBC) to secure agreement to proceed. Once agreement to the OBC has been granted the

			Board can then work up a more detailed case (Final Business Case or FBC). If approval is granted to the FBC the scheme can continue to completion. The original paper titled OBC included a timeline which referred to the need for an FBC.
37	Appendix-2021-24 Earlston Community Campus	**Harriet Campbell:** It's noticeable that one of the turnaround ideas was to own more and lease less property, in order to minimise recurring expenditure, yet this would have NHSB ceasing to use an owned property and entering into a long term lease. Not a question, as such (and I can see that there are many arguments in favour), but just pointing it out.	**Chris Myers:** There is a national drive to encourage public sector bodies to work more closely together on capital projects in order to secure economies of scale but also maximise the benefits to local communities with integrated facilities. **June Smyth:** Yes at that time that was the intention under the financial turnaround programme. However as Chris has outlined above there is a national drive for this and public sector bodies are strongly encouraged to pursue multi-agency proposals if possible when seeking to secure capital. In addition (and unrelated to this project) is the need for organisations to consider, in light of the pandemic, the space requirements in order for departments to operate safely. This in turn may lead to NHSB requiring more space (and therefore buildings) from which to operate, rather than reducing our estate footprint (some of which may require to be rented accommodation – at least in the interim). This is all yet to be fully assessed and worked through.
38	Appendix-2021-24 Earlston Community Campus	**James Ayling:** This certainly looks like an excellent partnership project which benefits all which needs to be pushed through even	**June Smyth:** I note your comments relating to financial information. The key driver for bringing the paper to the committee was the desire to

		though there is no funding in place at present. The approval sought is clearly subject to confirmation of a suitable funding source .There will be an ongoing lease charge and a capital charge for equipment .There is no note of these costs. I understand the wish to push on despite funding not being in place to take advantage of the current opportunity to progress this . I think it would be useful however for the current paper to show at least a rough estimate of the likely costs as given our current financial position we should be considering money as part of all approval processes irrespective of how valid the case for expenditure may be as is clearly the case here and before we give a commitment to a high profile project.	secure some level of formal commitment from the Board (via R&PC) to the concept of the proposal so as to assure the practice this was being seriously considered, before this enters the public domain. The practice became disengaged (for a number of reasons) with the previous discussions hence the ask for confirmation of a level of commitment. The council have a committed timeline relating to this project. High level discussions have taken place between NHSB Director of Finance and his counterpart in the council re funding mechanisms and next steps. Whilst this is the first proposal if its type within Borders there are other schemes elsewhere in Scotland where Health and Council (e.g. Education, Social Work and other services) are co-located within a newly developed campus. As outlined above the integrated approach to capital developments is being actively encouraged by SG.
		What happens if we do not have appropriate funding confirmed at the moment when we require to commit? Does the proposal just go on hold?	Should there be a funding gap then a number of options would be considered before having to put the proposal on hold. All of this will be worked up and brought back to the committee for formal approval, as outlined in the paper.
		The current premises are owned by NHS Borders. Might it be worthwhile considering any change of use application which may be required for it at the same time as the overall campus application ?	This will be considered in due course but not in time for SBC to submit the planning application for the new campus.
39	Appendix-2021-24 Earlston Community	**Karen Hamilton:** 2.2.1 Is there any 'community fund' monies from	**June Smyth:** At present there are no developer contributions to NHS Borders from developers /

	Campus	developers /house builders forthcoming?	house builders. SG Health are considering this at a national level and we are engaged in those discussions.
40	Appendix-2021-24 Earlston Community Campus	**Tris Taylor:** Living in the catchment area I have a conflict of interest in this paper.	**Iris Bishop:** Thank you Tris I will record this in the minutes.
41	Appendix-2021-25 Strategic Risk Report	**Sonya Lam:** • This report informs the Resources and Performance Committee of strategic risks relating to finance and organisational performance. In terms of organisational performance, I presume that 1593 relates to this. I can perhaps understand how this risk has reduced as it relates to the implementation of the clinical strategy but the register doesn't reflect the risk to the organisation around our current performance as outlines in Item 15. Perhaps this is reflected in risks that are reported to other committees.	**Tim Patterson/Lettie Pringle:** Risk 1593 highlights risks identified in achieving the strategic objectives of the clinical strategy. Risks have been identified and recorded to support the information within the performance reports. These sit at an operational level within the operational risk register.
42	Appendix-2021-25 Strategic Risk Report	**James Ayling:** I understand that an exercise was carried out earlier this year to identify areas of risk that would be transferable to NHS Borders which have been highlighted by other health boards within NHS Scotland. Did this exercise identify any of the 7 risks outlined in this report ? My main fear with risks is those which hit an organisation with no warning and an update on the current position on the risk action plan for failure of resilience would be helpful. Thank you.	**Tim Patterson/Lettie Pringle:** Five of the seven risks were identified as part of the gap analysis exercise by other boards, four of which were already included within NHS Borders Strategic risk register. The gap analysis exercise allowed a deep dive into these risks to ensure they were reflective of current risks facing NHS Borders and updated accordingly. The Internal Audit Report on Resilience was presented to the Audit Committee in September 2018. The main action taken following the 2018 Report is the introduction of a new online Business Continuity Planning and Management System which addresses most of the significant issues raised in the Internal Audit Action Plan. However training and exercise

			recommendations remain challenging due to the pandemic and other service pressures. It should also be noted that resilience team capacity issues are also of concern and are currently being reviewed.
43	Appendix-2021-25 Strategic Risk Report	**Karen Hamilton:** Increased level of risk on failure of Resilience noted and that it will fluctuate. Can we articulate mitigations here please?	**Tim Patterson/Lettie Pringle:** 90% of services have undertaken business impact assessments and business continuity plans are in place. The pandemic has however disrupted the planned programme of business continuity plan training and exercising. From June 2020, as instructed by Gold Command, all Business Continuity plans were reviewed in the light of experience and any lessons learned from wave 1 of the pandemic.
44	Appendix-2021-25 Strategic Risk Report	**Tris Taylor:** Confused as to why, being strategic, this isn't further up the agenda – have we only restructured the main Board agenda in this way? Chart 1, risk 'failure to meaningfully implement clinical strategy…' – am confused as to how this can have moved from High to Medium given that in the earlier paper on developing long term strategy there was a statement to the effect that the implementation of the Clinical Strategy had not been operationalised. P9, 'Failure of Resilience' – how is Resilience here defined – does it have a particular NHS definition? In general – the current position in which demand is outstripping supply to an unprecedented level appears to me to be a strategic risk that is not clearly represented in the seven cited; this is likely a medium- to long-term	**Iris Bishop:** Yes the R&PC agenda has not been restructured, but I will look at doing that for the next meeting. **Tim Patterson/Lettie Pringle:** Section 6a of the report states 'through successful implementation of actions and reviewing the consequence of the risk in line with the risk matrix this risk has been reduced.' This decision was taken after a comprehensive review of actions that had been taken. Resilience in NHS Borders is defined as dedicated by standard BSI 65000: the ability of an organisation to anticipate, prepare for, respond and adapt to incremental change and sudden disruptions in order to survive and prosper.

		change that may represent a paradigm shift in healthcare delivery and will not be resolved without strategic change. I'd also suggest, particularly in light of: - the impact on staff of enduring the last 18 months - the ambitious recruitment plans detailed in the NHS Recovery Plan - post-Brexit UKG limitations on immigration - the persistent lesser proportion of the Borders population that is of working age - the ongoing impact of long covid adding to the already c20% of people of working age who are disabled, that failure to diversify our workforce, positioning the org to execute on being an employer of choice for disabled people, will result in increasing constraints on capacity, with associated financial risk. Not sure this is reflected in the current register.	There are two strategic risks currently on the strategic risk register that are fed into the Staff Governance Committee relating to staffing. - *Impact on staff of enduring the last 18 months.* This is captured in a strategic risk which is fed into the Staff Governance Committee covering Staff Wellbeing risks. - *NHS Recovery Plan* This risk is covered under failure to remobilise successfully which feeds into the Board Executive Team - *Post Brexit UKG limitations on immigration* This is covered in the Brexit risk assessment under workforce - *The persistent lesser proportion of the Borders population that is of working age* With regards to the above, please see Q&A responses from Director of Workforce/Director of Planning & Performance. - *the ongoing impact of long covid adding to the already c20% of people of working age who are disabled* It is too early to assess the impact of long COVID on workforce going forward but this area will be kept under review

			- *Failure to diversify our workforce, positioning the org to execute on being an employer of choice for disabled people, will result in increasing constraints on capacity, with associated financial risk* With regards to failure to diversify our workforce, please see Q&A responses from Director of Workforce/Director of Planning & Performance.
45	Appendix-2021-26 Performance Scorecard	**Harriet Campbell:** Why does sickness absence not include Covid-19 related absence? Does that not render it meaningless? Is that just for the whole of Scotland information or for NHSB as well? (p329)	**Andy Carter:** As instructed by Scottish Government, Covid-related absence is recorded (and paid) as Special Leave rather than as Sickness Absence and separate codes have been establish to record the differing Covid absence reasons. These separate codes include staff isolating because they report Covid symptoms, staff isolating because a household member is suffering Covid symptoms, staff isolating because of Test & Protect contact, positive PCR test results, Long Covid etc. We report each separately and also the cumulative figure. All Boards report this way.
46	Appendix-2021-26 Performance Scorecard	**Lucy O'Leary:** Performance report **p15 – delayed discharges** Very interesting table of reasons for DD. Do the ALoS figures include the period of active treatment or only the days of delay? If the former, what is the average length of delay for each group (ie excluding the period from admission to clinically fit for discharge)?	**Rob McCulloch-Graham:** These LoS are only for the delayed days attributed to each DD not their total length of stay.
47	Appendix-2021-26 Performance Scorecard	**James Ayling:** Ophthalmology accounts for approx 25% of 12 week waiting time breaches . Where has this rapidly rising demand come from or was it to be anticipated? ?	**Gareth Clinkscale:** Ophthalmology has been one of the specialties that has seen a greater impact on delays through the pandemic. The 25% proportion of 12 week waits largely reflects a greater reduction in capacity when compared

			to some other specialties; capacity lost due to infrastructure, social distancing and other specialties with greater proportion's of patient work classified as 'urgent' receiving greater capacity.
		Earlier this year internal audit concluded that the controls in place with regards to sampling and checking of waiting times provided a No Assurance rating. Although this rating did not refer to the broader monitoring and reporting on waiting times within NHS Borders as we have here ....it would be good to know that the figures provided to us have been sampled and checked with the benefit of the revised procedures. Thank you. ..	**June Smyth:** Sampling has recommenced in August 2021 and this sees 5 cases a week reviewed, the access board will monitor this.
48	Appendix-2021-26 Performance Scorecard	**Karen Hamilton:** Makes for difficult reading , what support are we offering staff to manage this and what support are the Exec Team receiving to do like wise	**Andy Carter:** Contemporary research suggests that the line manager : employee relationship one is critical in terms of resilience levels and well-being at work. The Workforce Directorate (HR and Occupational Health & safety) work hard to equip managers with the necessary skill-set to perform well as people managers e.g. induction, on-line & in-person learning, coaching. Clearly, Covid-19 has generated previously unknown levels of workplace stress and strain and significantly affected the delivery of in-person training. Alongside the National Recovery Plan will be a National Workforce Plan. Included in that will be focus on the National Wellbeing Hub; a suite of national resources available to all Health & Care staff. NHSB already publicises this Hub and will continue to enhance its coaching capacity.
		P7 Alarming reset trajectories for 12 week waiting times.	**Gareth Clinkscale:** Ophthalmology has been

		Why is Ophthalmology so very high? P11 Noted comments re CAHMS	one of the specialties that has seen a greater impact on delays through the pandemic. The 25% proportion of 12 week waits largely reflects a greater reduction in capacity when compared to some other specialties; capacity lost due to infrastructure, social distancing and other specialties with greater proportion's of patient work classified as 'urgent' receiving greater capacity.
49	Appendix-2021-27 PCIP Update	**Harriet Campbell:** P332 'financial risk associated to insufficient recurrent funding for NHS Borders to either deliver all of the mandatory workstreams of the PCIP and / or an inability to deliver these workstreams as a direct result.' I'm not clear on what the difference is between not delivering the workstreams (because we don't have funding) and not being able to deliver the workstreams (as a result of not having funding). Can you possibly explain? Is one of these to do with the need to compensate GPs as set out on p340?	**Chris Myers:** Transitionary payments to GPs are yet to be negotiated at a national level by Scottish Government and the Scottish General Practitioners Committee (SGPC) The Scottish Government and SGPC will develop a set of principles for how transitionary services and payment arrangements will work in practice by the end of Summer 2021. Transitionary service arrangements are not the preferred outcome of the MoU parties (Scottish Government, BMA Scotland, NHS Board Chief Executives and HSCP Scotland), or something we see as a long-term alternative. All parties locally should remain focused on the redesign of services and delivery of the MoU commitments and transitionary arrangements should not be seen as a desired alternative, and we have been informed that in 2022-23 there will be a deadline to ensure that all services outlined under the Memorandum of Understanding 2 are delivered. We expect that the cost of these transitionary payments will broadly be equivalent to the costs of the programmes we are planning to deliver,

			albeit this will be confirmed when further information is available.
50	Appendix-2021-28 Business Plan 2022	-	-

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	*Andrew Bone, Director of Finance*
Author:	*Andrew Bone, Director of Finance* *Samantha Harkness, Senior Finance Manager*

FINANCIAL PERFORMANCE - OCTOBER 2021

Purpose of Report:

The purpose of this report is to provide board members with an update in respect of the board's financial performance (revenue) for the period to end of October 2021.

Recommendations:

The Board is asked to:

- **Note** that the board is reporting a £4.40m deficit for seven months to end of October 2021.
- **Note** the position reported in relation to Covid-19 expenditure and assumptions around funding in relation to same.
- **Note** the updated forecast outturn position (£7.78m deficit) following preparation of the Quarter Two (Q2) forecast.

Approval Pathways:

Financial monitoring reports are issued to budget holders during the third week of each month. The reports for the period to end October were issued during the week ending 19th November.

This report was presented to BET on Tuesday 30th November 2021.

Executive Summary:

SECTION 3 provides an overview of the board's financial performance for the seven months to end October 2021.

Table 1 – summarises income & expenditure for the year to date (£4.4m deficit)

SECTION 4 provides further commentary on the year to date performance, including key drivers for variance against plan (budget) within business units.

Table 2 – summarises performance on income recovery against budget at October 2021.
Table 3 – describes the operational performance by business unit over the same period.

SECTION 5 summarises the impact of COVID pandemic on the reported performance during the period.

Table 4 – summary Covid-19 expenditure for seven months to end October.

SECTION 6 provides update on the board's Quarter Two review and updated forecast outturn position (£7.78m overspent). This position reflects an improvement from Q1 forecast (£8.49m overspent).

SECTION 7 notes that the key risks arising from this paper will be fully considered through the board's financial plan.

Impact of item/issues on:	
Strategic Context	Impact on statutory financial targets.
Patient Safety/Clinical Impact	This report is for monitoring purposes and does not include any recommendations impacting on these dimensions.
Staffing/Workforce	
Finance/Resources	
Risk Implications	Risks are covered in the report.
Equality and Diversity	Compliant with Board policy requirements.
Consultation	Regular monitoring of financial performance is a requirement of the board's code of corporate governance and is not subject to consultation.
Glossary	• Acute Services includes General Surgery, Orthopaedics, Theatres And Critical Care, Obstetrics and Gynaecology, Paediatrics, Outpatients, Cancer Services, Diagnostics, BGH Pharmacy, Community Nursing, Planned Care • Set Aside includes General Medicine, Medicine for the Elderly, Accident and Emergency • IJB Directed Services includes Mental Health, Learning Disability, Allied Health Professionals, Family Health Services, External Providers, Social Care Fund, Integrated Care Fund • Corporate Directorates includes Executive Directorates, Estates and Facilities • External Healthcare providers includes Other NHS Scottish Boards, OATS, Private ECRs & Grants SGHSCD - Scottish Government Health and Social Care Department IJB - Integration Joint Board RRL - Revenue Resource Limit CRL - Capital Resource Limit AOP - Annual Operational Plan UNPACS - Unplanned Activity SLA - Service Level Agreement ECR - Extra Contractual Referrals OATS - Out of Area Treatments LMP - Local Mobilisation Plan RMP - Remobilisation Plan RRL - Revenue Resource Limit

FINANCE REPORT FOR THE PERIOD TO THE END OF OCTOBER 2021

1 Purpose of Report

1.1 The purpose of the report is to provide board members with an update in respect of the board's financial performance (revenue) for the period to end of October 2021.

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** that the board is reporting a £4.40m deficit for seven months to end of October 2021.

2.1.2 **Note** the position reported in relation to Covid-19 expenditure and assumptions around funding in relation to same.

2.1.3 **Note** the updated forecast outturn position (£7.78m deficit) following preparation of the Quarter Two (Q2) forecast.

3 Summary Financial Performance (Revenue)

3.1 The board's financial performance as at 31st October 2021 is a cumulative deficit of £4.40m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for seven months to end October 2021

	Opening Annual Budget[1] £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	246.40	293.93	140.46	140.25	(0.21)
Revenue Expenditure	246.40	293.93	155.29	159.48	(4.19)
Surplus/(Deficit)	**0.00**	**0.00**	**14.83[2]**	**19.23**	**(4.40)**

3.2 An updated forecast outturn position has been prepared based on the six month performance reported at end September. This forecast has identified a slight improvement in expected performance at end March with a year-end outturn position of £7.78m overspent (Q1 forecast, £8.5m). The updated forecast is discussed further in section 6, below.

[1] Opening budget reflects the board's recurring budget as at 1stApril and excludes ring-fenced allocations received in relation to Scottish Government portfolio budgets (non-recurring).
[2] Imbalance in year to date budget reflects phasing profile of planned income & expenditure.

4 Financial Performance –Budget Heading Analysis

4.1 Income

4.1.1 Table 2, below, presents analysis of the board's income position at end October 2021.

Table 2 – Income by Category, year to date October 2021/2022

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
SGHSCD Allocation	226.65	268.64	127.96	127.96	-
SGHSCD Anticipated Allocations	-	3.81	(0.44)	(0.44)	-
Family Health Services	10.24	11.56	7.30	7.30	-
External Healthcare Purchasers	4.24	4.39	2.62	2.39	(0.23)
Other Income	5.27	5.53	3.02	3.04	0.02
Total Income	**246.40**	**293.93**	**140.46**	**140.25**	**(0.21)**

4.1.2 This position remains largely unchanged from the trend demonstrated in previous reports. The shortfall in income recoveries from external healthcare purchasers reflects the decrease to elective activity patient flows between health boards during the course of 2020/21, which continues into 2021/22 and is expected to continue throughout the remainder of this financial year.

4.2 Operational performance by business unit

4.2.1 Table 3 describes the financial performance by business unit at October 2021.

Table 3 – Operational performance by business unit, October 2021

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	61.03	71.13	41.65	39.68	1.97
Acute Services - Savings Target	(2.13)	(2.12)	(1.23)	-	(1.23)
TOTAL Acute Services	**58.90**	**69.01**	**40.42**	**39.68**	**0.74**
Set Aside Budgets	25.30	27.86	16.23	16.73	(0.50)
Set Aside Savings	(1.09)	(1.09)	(0.64)	-	(0.64)
TOTAL Set Aside budgets	**24.21**	**26.77**	**15.59**	**16.73**	**(1.14)**
IJB Delegated Functions	105.76	134.41	75.28	74.92	0.36
IJB – Savings	(4.74)	(4.74)	(2.77)	-	(2.77)
TOTAL IJB Delegated	**101.02**	**129.67**	**72.51**	**74.92**	**(2.41)**
Corporate Directorates	32.81	25.50	7.51	7.17	0.34
Corporate Directorates Savings	(0.34)	(0.28)	(0.16)	-	(0.16)
TOTAL Corporate Services	**32.47**	**25.22**	**7.35**	**7.17**	**0.18**
External Healthcare Providers	28.55	30.96	18.28	18.26	0.02
External Healthcare Savings	(0.51)	(0.51)	(0.30)	-	(0.30)
TOTAL External Healthcare	**28.04**	**30.45**	**17.98**	**18.26**	**(0.28)**
Board Wide					
Depreciation	4.67	4.67	2.72	2.72	-
Planned expenditure yet to be allocated	(2.91)	10.57	0.14	-	0.14
Financial Recurring Deficit (Balance)	-	(12.35)	(7.20)	-	(7.20)
Financial Non-Recurring Deficit(Balance)	-	2.52	1.47	-	1.47
Board Flexibility	-	7.40	4.32	-	4.32
Total Expenditure	**246.40**	**293.93**	**155.29**	**159.48**	**(4.19)**

4.2.2 There are no new issues identified within the report. Expenditure trends remain subject to volatility in the operating environment with factors such as the level of COVID and non-COVID demand, workforce availability, remobilisation of services and Access performance all impacting on the deployment of resources across the wider health and care system. The commentary below reflects the key drivers reported within each business unit.

4.2.3 **Acute services** (non-delegated functions) are reporting a net under spend of £0.74m after non-delivery of savings. This includes a £1.97m under spend on core operational budgets. This reflects significant slippage on clinical supplies due to reduced levels of elective activity, as well as on-going vacancies against clinical workforce; vacancies are offset in part by on-going use of supplementary staffing, including agency, for both medical and registered nurse workforce.

4.2.4 **Set Aside.** Acute functions delegated to the IJB are reporting £1.14m overspend, of which £0.64m relates to non-delivery of savings. The balance is in relation to core service with increased expenditure on clinical workforce, including use of medical agency and additional nursing support to the Emergency department. Expenditure is above forecast trajectory due to continued pressure on unscheduled care flows and inpatient beds.

4.2.5 **IJB Delegated.** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an under spend on core budgets of £0.36m. A reduction in primary care services expenditure within public dental services is the main driver for the underspend reported in October. This reflects the reduction in throughput in dental services as a result of pandemic infection control measures. There are also underspends across AHP services linked to vacant posts.

4.2.6 **Corporate Directorates** are reporting an under-spend excluding savings. There are no significant changes within the current period. Cost pressures relating to staff residencies are offset by vacancies and some skill mix benefit within Corporate Nursing and Infection Control budgets.

4.2.7 **External Healthcare Providers.** In line with Q2 review there is an ongoing pressure on commissioning budgets from service agreements with other NHS boards (i.e. Lothian) and increases in health placements for complex Learning disabilities patients. These pressures are partially offset by reduced level of out of area emergency activity.

5 Covid-19 Expenditure

5.1 For the period to the end of October, funding of Covid-19 expenditure has been assumed and allocated to match reported spend within business units. Scottish Government have confirmed thatactual funding will continue to be released on a retrospective basis (as in 2020/21) following submission of quarterly Local Mobilisation Plan (LMP) tracker as part of the board's financial performance monitoring report to Scottish Government.

5.2 A second tranche of funding has been received in October and has been matched against existing financial plan commitments within the board's LMP.

5.3 Reported within the Core operational budgets as detailed in table 3 is Covid-19 expenditure and anticipated funding. Table 4 summarises this within each business unit.

Table 4 – summary Covid-19 expenditure for sevenmonths to end October 2021

	Revised Annual Budget[3] £m	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Covid-19 Expenditure				
Acute Services	0.44	0.39	0.39	-
Set Aside	0.13	0.13	0.13	-
IJB Directed Services	2.10	2.08	2.13	(0.05)
Corporate Directorates	4.47	2.33	2.31	0.02
Total Covid-19 Expenditure	**7.14**	**4.93**	**4.96**	**(0.03)**

5.4 During the last seven months funding has been allocated into operational budgets in line with plans which have been approved through RPG/OPG Gold command, ensuring that expenditure linked to Covid-19 is in line with the expected Local Mobilisation plans.

5.5 The approach taken to reporting of spend is in line with SG requirements and recognises that some elements of expenditure will be financed by the board, where existing resources have been redeployed to meet Covid-19 requirements. As anticipated within the board's plan this 'direct offset' is unlikely to be material given the expected remobilisation of services over the first six months of 2021/22.

6 Quarter Two Forecast

6.1 An updated forecast outturn position has been prepared based on the six month performance reported at end September. This forecast has identified a slight improvement in expected performance at end March with a year-end outturn position of £7.78m overspent (Q1 forecast, £8.5m).

6.2 The following table summarises the board's operational performance for the 6 months to end September and forecast position at end March.

[3] The revised annual budget for COVID represents funding currently assumed within service budgets and is will continue to be amended monthly in reflection of the resource commitments identified within LMP reports.

	Apr-Sept YTD £m	Q1 Forecast £m	Q2 Forecast £m
Operational Performance	(1.17)	(1.12)	(0.41)
Non-delivery of Savings targets	(2.18)	(7.37)	(7.37)
Outturn net of Covid-19	(3.35)	(8.49)	(7.78)

6.3 Non delivery of savings reflects shortfall on targets delegated to business units in the board's financial plan. The board continues to hold a significant recurring deficit in excess of this position which is managed through a combination of non-recurring savings and corporate flexibility.

6.4 COVID19 expenditure is forecast at £13.25m across NHS Board functions and the Scottish Borders Health & Social Care Partnership (including Scottish Borders Council). The board continues to assume that resources will be available to fully offset this expenditure at March 2022. A shortfall of £0.78m is forecast against local authority savings plans not otherwise reported in the NHS Board overall forecast.

6.5 The following table summarises the key movements against the board's financial plan:

	FP 21/22 £m	Q1 Forecast £m	Q2 Forecast £m	Movement from Q1 £m
Operational Performance	2.50	1.64	1.36	(0.28)
Cross Boundary Flows - Activity	0.50	0.00	0.00	-
Cross Boundary Flows - Price	0.00	(0.93)	(0.93)	-
IM&T Portfolio	0.00	(0.54)	0.00	0.54
Business Unit Savings (not delivered)	(6.31)	(7.37)	(7.37)	-
Unallocated Savings	(12.79)	(12.84)	(12.39)	0.45
NR Savings	4.70	6.55	6.55	-
Corporate Flexibility	5.00	5.00	*5.00*	-
Grand Total	(6.40)	(8.49)	(7.78)	0.71

6.6 The key drivers of the overall forecast remain as at Q1, with improved performance largely in relation to additional SG funds against areas of expenditure identified as cost pressures at Q1 (i.e. IM&T portfolio) and revision to unallocated savings held corporately following review of financial plan commitments.

6.7 Areas of operational variance include:

- Ongoing vacancies in core workforce, offset by use of agency staff to cover high risk areas including: Consultant gaps (acute medicine, mental health); registered nursing gaps within Borders general hospital.
- Slippage on core expenditure budgets against clinical supplies as a result of elective surgery activity (reduction).
- Increased cost of individual patient treatment and home care medicines.
- Increase to NHS Lothian SLA £0.93m above expected levels in financial plan.

6.8 The increase to NHS Lothian SLA has been reviewed by the operational sub-group of the regional directors of finance and cost increase is confirmed as consistent

with the current arrangements for East Coast Costing Model. Dialogue is ongoing around how these arrangements can be reviewed for future years to provide earlier indication of cost increases and to establish mechanisms for cost control where possible.

6.9 The savings position identified at Q1 review remains achievable in 2021/22 only as a result of non-recurring measures and corporate activities which require limited input from clinical and management colleagues. Efforts continue to identify additional actions that will not impact on patient safety or remobilisation of services however constraints on planning capacity are now a significant rate limiting factor on further progress in the immediate short term.

6.10 The planned remobilisation of the board's turnaround programme has been further delayed as a result of operational pressures described above. Deployment of PMO resources continues to be directed at recovery and remobilisation of core services. This position represents a significant risk to the board's long term financial sustainability (and financial planning for 2022/23 and beyond) and remains under active discussion with Scottish Government.

6.11 The recurring deficit identified in the board's financial plan was £18.8m, with actions identified to reduce this figure to £16.3m. Increased reliance on non-recurring actions in 2021/22 mean that this figure is expected to increase; a revised estimate will be provided through the development of the board's financial plan.

7 Key Risks

7.1 The delivery of the outturn position identified at Q2 review remains subject to a number of uncertainties, principally around the continued impact of COVID19 and operational challenges in the context of workforce availability and service performance. This position will be managed through ongoing dialogue with Scottish Government and the preparation of updates to forecast on a monthly basis. As reported previously, Scottish Government have introduced an enhanced reporting requirement upon savings delivery, reflecting the board's ongoing performance escalation.

7.2 The strategic register recognises the board's long term financial sustainability as extremely high risk and through the development of the financial plan further mitigating actions will be considered where possible.

7.3 An updated risk assessment is currently being prepared at a detailed level as part of the development of the board's financial plan.

Author(s)

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Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Andrew Bone, Director of Finance
Author:	Andrew Bone, Director of Finance

CLIMATE EMERGENCY & SUSTAINABILITY DEVELOPMENT

Purpose of Report:

The purpose of the report is to provide board members with an overview of the requirements for NHS Boards as laid out in the recently published 'A Policy for NHS Scotland on the Climate Emergency and Sustainable Development' (DL(2021)38).

Recommendations:

The Board is asked to:

- **Note** the issues described in the report.
- **Note** the requirements placed on NHS Borders arising from DL(2021)38.
- **Note** that an impact assessment and resource plan will be prepared in response to the policy.
- **Agree** that a development session for board members should be scheduled for early 2022.

Approval Pathways:

This report was presented to BET on Tuesday 30th November 2021.

Executive Summary:

SECTION 3 of the report describes the strategic context including previous policy commitments.

SECTION 4 of the report describes NHS Borders current status against previous policy commitments and national sustainability reporting (NSAT tool). The board currently performs poorly in this area. A key gap against policy is the lack of a current 'Sustainable Development Action Plan'.

SECTION 5 provides an overview of the 2021 policy. The full policy is attached as Appendix 1 to the report.

SECTION 6 identifies immediate next steps, including the following:

- Proposal to hold a board development session in early 2022
- Climate Change Risk Assessment added to Strategic Risk Register
- Impact assessment of policy and development of a resource plan

• Establishment of NHS Scotland and regional groups, and approach to NHS Borders participation. Appendix 1 – A Policy for NHS Scotland on the Climate Emergency and Sustainable Development Appendix 2 – Strategic Risk, Climate Emergency	
Impact of item/issues on:	
Strategic Context	Section 3 of the paper describes the strategic context in which it is prepared.
Patient Safety/Clinical Impact **Staffing/Workforce** **Finance/Resources**	**The paper is prepared for awareness only at this stage. An impact assessment will be undertaken as part of the 'next steps'.**
Risk Implications	The risks associated with the policy are described in Appendix 2.
Equality and Diversity	Equality & Diversity impact will be considered through the development of the board's *Climate Change Adaptation Plan* as required by the policy.
Consultation	This paper is prepared as briefing to board members only at this stage. The policy is in effect from November 2021 and the NHS Scotland strategy is published for consultation via Scottish Government website at the following link: https://www.gov.scot/publications/nhs-scotland-draft-climate-emergency-sustainability-strategy/
Glossary	COP26 – 'Conference of the Parties' (United Nations climate change conference) DL – Director Letter EMS – Environmental Management System HFS – Health Facilities Scotland GHG – Green House Gas NHSS – NHS Scotland NSAT – National Sustainability Assessment Tool SDAP – Sustainable Development Action Plan SDGs – Sustainable Development Goals SG – Scottish Government UN – United Nations

CLIMATE EMERGENCY & SUSTAINABLE DEVELOPMENT

1 Purpose of Report

1.1 The purpose of the report is to provide board members with an overview of the requirements for NHS Boards as laid out in the recently published 'A Policy for NHS Scotland on the Climate Emergency and Sustainable Development' (DL(2021)38).

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** the issues described in the report.

2.1.2 **Note** the requirements placed on NHS Borders arising from DL(2021)38.

2.1.3 **Note** that an impact assessment and resource plan will be prepared in response to the policy.

2.1.4 **Agree** that a development session for board members should be scheduled for early 2022.

3 Background

3.1 The Scottish Government declared a 'climate emergency' in April 2019.

3.2 Climate change has been identified as a global priority for over twenty five years, since the United Nations Framework Convention on Climate Change (1994). The Kyoto protocol (1997) set out the first international commitments to limit Greenhouse Gas (GHG) emissions and the Paris agreement of 2015 reiterated 'the need for an effective and progressive response to the urgent threat of climate change'. Following the recent COP26 the UN has again confirmed this position stating the '… alarm and utmost concern that human activities have caused around 1.1°C of global warming to date and that impacts are already being felt in every region'.

3.3 The UN set 17 global goals for sustainable development in 2015. The requirement for action on climate change is recognised within the context of these Sustainable Development Goals (SDGs). The SDGs cover a range of social and economic development objectives to be achieved by 2030. The Scottish Government has aligned its response to the climate emergency within this broader strategic context.

3.4 Responsibilities with regard to climate change were first established by law in Scotland through the Climate Change (Scotland) Act 2009 and were further amended through the Climate Change (Emission Reduction Targets) (Scotland) Act 2019.

3.5 The 2009 Act includes specific provisions which relate to all public bodies in Scotland, including NHS Boards. In summary, the duties of the Act (section 44) require that a public body must act to *mitigate*, to *adapt*, and to *act sustainably*:

"A public body must, in exercising its functions, act -

a) in the way best calculated to contribute to the delivery of the targets…
b) in the way best calculated to help deliver any [statutory adaptation] programme…
c) in a way that it considers is most sustainable".

Climate Change (Scotland) Act 2009, S.44/1

3.6 The 2019 Act accelerates the emission reduction targets set out in the 2009 Act, with a target to achieve net zero emissions by 2045 and the introduction of interim targets (75% reduction by 2030, 90% by 2040).

3.7 The most recent update to the Scottish Government's Climate change plan, published December 2020, presents these revised targets in the context of 'securing a green recovery' from COVID-19.

3.8 In addition to the general responsibilities outlined above, there are specific duties within the 2009 Act in relation to public sector governance, which include designation of executive and non-executive leadership roles, establishment of a sustainable development group, and the creation of a climate change adaptation plan.

3.9 In January 2012, the Scottish Government issued a sustainable development policy for NHS Scotland (CEL 2 2012), outlining the responsibilities of NHS Boards in relation to the 2009 Act. Accompanying this policy was a strategic framework developed by Health Facilities Scotland which established six domains within which plans should be developed: travel, procurement, facilities management, workforce, community engagement, and buildings.

3.10 In June 2019 following the Scottish Government's declaration of a Climate Emergency all NHS Scotland Chief Executives agreed the following six commitments:

- NHS Scotland will be a 'net-zero' greenhouse gas (GHG) emissions organisation by 2045 at the latest;
- All NHS Scotland new buildings and major refurbishments will be designed to have net-zero greenhouse gas emissions from April 2020;
- Each NHS Board should undertake a Climate Change Risk Assessment and produce a Climate Change Adaptation Plan to ensure resilience of service under changing climate conditions;
- NHS Scotland transport greenhouse gas emissions from its fleet will be net-zero by 2025 for small and medium vehicles and for all vehicles by 2030;
- The NHS supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environmental impacts;
- Each NHS Scotland Board should establish a Climate Change/Sustainability Governance group to oversee their transition to a net-zero emissions service.

3.11 The Scottish Government has recently published its draft *Climate Emergency and Sustainability Strategy 2022 to 2026 for NHS Scotland*. The strategy was launched during November 2021 during COP26 and is open for consultation until 10 February 2022.

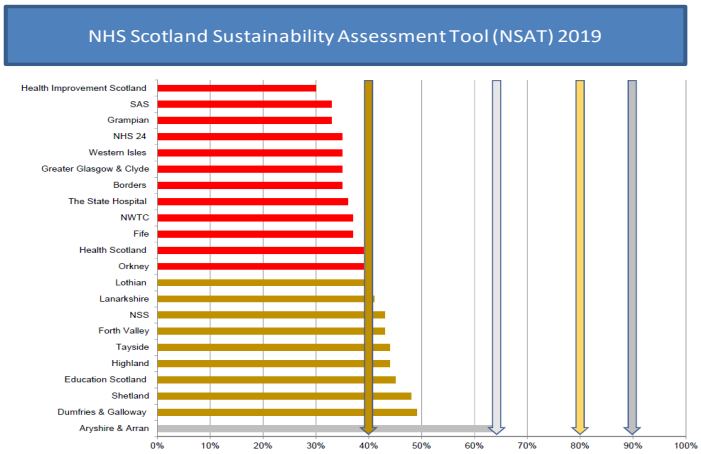
3.12 'A Policy for NHS Scotland on the Climate Emergency and Sustainable Development' was issued to Health Boards on 10th November 2021. This policy supersedes CEL 2 (2012) and takes immediate effect.

3.13 Both the strategy and the policy build on previous legislative and policy commitments and outline the need integrate policy aims into all planning, management decisions and operational practices across NHS Scotland. The policy is mandatory for all NHS Scotland bodies and its scope extends to all activities.

3.14 The full policy is attached as Appendix 1 to this paper and is summarised in section 5, below.

4 NHS Borders position

4.1 The Annual self-assessment tool (NSAT) is completed annually for submission to Scottish Government via Health Facilities Scotland. The most recently published benchmark (2019) shows all NHS Boards falling below 50%, with NHS Borders below the 'bronze' level.



4.2 The NSAT report assesses progress against the 2012 policy and 2019 commitments, including implementation of governance arrangements and preparation of a local Sustainable Development Action Plan (SDAP) report, as well as compliance with mandatory reporting and progress towards net zero.

4.3 The following table shows the most recent (2020) performance for NHS Borders. Points are assigned based on evidence aligned to action plans.

NHS Borders		Max score	Score awarded	% score awarded	Level
Governance & policy		120	28	23%	N/A
Our NHS	Transport	50	18	36%	N/A
	Greenspace	50	6	12%	N/A
	Capital projects	90	34	38%	N/A
	Nature & Biodiversity	30	0	0%	N/A
	Active travel	40	13	33%	N/A
Our people	Sustainable care	70	24	34%	N/A
	Ethics	15	7	47%	Bronze
	Welfare	35	21	60%	Bronze
	Communities	60	19	32%	N/A
	Awareness	30	4	13%	N/A
Our planet	Procurement	60	33	55%	Bronze
	GHG	40	8	20%	N/A
	Adaptation	55	24	44%	Bronze
	Waste	45	15	33%	N/A
	Environmental management	50	13	26%	N/A
Total		**840**	**267**	**32%**	**N/A**

4.4 As demonstrated above, NHS Borders is not currently meeting its obligations in regard to the 2012 policy and 2019 commitments. In many cases the score achieved is impacted by the lack of evidence for implementation of governance arrangements and the absence of a local action plan (SDAP).

4.5 A small NHS Borders working group was established in late 2020, chaired by the Director of Finance, with the aim of developing the board's action plan. The group includes representation from Estates & Facilities, Planning, and Risk management colleagues as well as a clinical stakeholder representative, however limited progress has been made due to lack of dedicated resources to support development of the plan.

5 Overview of the 2021 Policy

5.1 The policy outlines the background and drivers for change, its aims and objectives, updated requirements for governance and reporting, the approach to joint working with local authorities and other partner organisations, individual objectives within each domain including updated targets and milestones for delivery, and specific resources which health boards are expected to have in place to support delivery.

5.2 The following section provides an overview of the policy and its key sections:

Section	Reference	Key Points
Introduction	Page 2	"… policy is mandatory for all NHS Scotland bodies and its scope extends to all of their activities" "The aims of this policy must be fully integrated into all planning, management decisions and operational practices across NHS Scotland…"

Section	Reference	Key Points
Policy Aims	Page 3	Six aims described in the policy: – Contribute to achievement of UN SDGs – Net zero GHG emissions health service by 2040 or earlier – Ensure assets & activities are resilient to climate change impact – Culture of stewardship – environmentally sustainable healthcare – Contribute to circular economy, eliminating waste and pollution – Increase NHS contribution to biodiversity
Governance	Page 3, para 1-7	"Each NHS Scotland body must either establish a Climate Emergency and Sustainability Group or designate an existing committee as the lead group for climate emergency and sustainability. In either case, the group must be chaired by a member of its senior / executive management team and its membership must be of sufficient authority to ensure that the aims of this policy are fully integrated into all planning, management decisions and operational practices across the NHS Scotland body." - Chief Executive as accountable officer – Named Board member as strategic champion – Named Executive director to lead response – Reporting line to NHS Scotland Climate Emergency & Sustainability Board – Report progress via Health Board Annual Review
Integrated Approach and co-operation	Page 4, para 8-10	"… territorial Health Boards are required to use all reasonable efforts to work with the local authorities for their areas to achieve this policy's aims."
A Just Transition	Page 4, Para 11	Aligns the policy within UN SDGs, requiring Health Boards to: - "plan, invest and implement a transition to an environmentally and socially sustainable, climate resilient health service…" - "create opportunities… which help address inequality and poverty…" - "design and deliver… infrastructure, making all possible efforts to create decent, fair and high value work".
Net Zero	Pp4-5, para 12-18	– All NHS owned buildings heated by renewable sources by 2038 or earlier – Net zero emissions by 2040 or earlier for all activities under direct ownership or control – Net zero emissions by 2045 or earlier for activities not under direct ownership or control – Public Bodies Climate Change duties Report to be submitted annually (30 November)
Climate Change Adaptation	Page 5, para 19-23.	Climate Change Adaptation Plan "Each Scotland body must undertake a Climate Change Risk Assessment covering all operational areas and produce and implement a *Climate Change Adaptation Plan* to ensure resilience of service under changing climate conditions and these should be reviewed and updated at least every 5 years... Climate Change Risk Assessment "The key risks from the Climate Change Risk Assessment must be incorporated into each NHS Scotland body's corporate risk register".
Sustainable Care	Page 6, pp. 24-26	"Each NHS Scotland body must ensure their workforce consider the environmental impacts of treatments when making decisions about the care they provide".

Section	Reference	Key Points
Procurement	Page 6, para 27-29	"It is the responsibility of each NHS Scotland body to review the supply chain of the goods and services that it procures…"
Circular Economy	pp.6-7, para 30-32	"NHS Scotland bodies, with support from National Procurement, must identify and assess the life cycle of products and services and take action to reduce their environmental impact."
Water, Resource and Waste Management	p.7, para 33,34	Outlines reporting and monitoring requirements re. water and waste By 2025: - Reduce domestic waste by 15% or greater - Ensure no more than 5% landfill - Reduce food waste by 33% - Ensure 70% of domestic waste is recycled or composted NHS Boards to set internal targets for reduction and management of clinical waste
Biodiversity and Greenspace	pp.7-8, Para 37-43	"All NHS Scotland bodies must collaborate with local partners to improve the natural links between NHS greenspace and other local areas of greenspace". - Report every 3 years in line with duties in Nature Conservation (Scotland) Act 2004
Travel and transport	p.8, para 44-50	- Decarbonise owned and leased fleet by 2032 with staged targets for cars, light vehicles and large vehicles from 2025. - Develop a sustainable transport and travel policy.
Facilities	pp.8-9, para 51-55	- New buildings and major refurbishments to be designed to achieve net-zero. - Existing buildings to achieve GHG net zero emissions by 2040 or earlier without offsetting. - All NHS Scotland owned buildings to be heated from renewable sources by 2038.
Environmental Management Systems	p.9, para 56-57	- NHS Boards must implement ISO9001 and ISO 14001. - NHS Boards must have an effective Environmental Management System in place.
Resources	Pp9-10, para 58-63.	"A Climate Emergency and Sustainability Team which is sufficiently resourced in light of the scale and complexity of the challenge of decarbonisation, sustainability and climate resilience faced by that NHS Scotland body" Mandatory roles include: – Waste manager – Environmental management representative – Greenspace officer – Transport officer – Sustainable care medical planning team
Sustainability Assessment	p.10, para 64	- Report on achievement against SDGs using national Sustainability Assessment Tool (NSAT)
Awareness and Reporting	p.10, Para. 65-67	- Publish progress on board website annually (November) - Progress report will inform NHS Board Annual Review - NHS Boards to develop communication plan for staff, patients and local community

6 Implementation & Next Steps

6.1 This paper has been prepared in response to the policy published on 10th November and is presented to board members in order to build awareness of the issues described.

6.2 It is proposed that a development session is scheduled in early 2022 to consider how this agenda can be progressed moving forward.

6.3 A strategic risk assessment has recently been prepared and is attached as Appendix 2 to this report. Further work is being undertaken at a regional basis to develop comprehensive risk assessment against individual climate change impacts (e.g. floods).

6.4 An impact assessment and resource plan will now be developed to identify actions required to comply with the policy. It is clear that there will be additional investment required and at this stage no source of funding has been identified for this. An estimate of costs will be developed as part of the 2022/23 financial plan and discussed further through this route.

6.5 An NHS Scotland Climate Emergency and Sustainable Development Group is currently being established. This group is expected to be supported by representation from the three planning regions (East, West, North) and structures at a regional basis will be required to ensure coordination. Membership of a regional group is currently being developed. NHS Borders representative has not yet been confirmed; the Head of Estates & Facilities will attend the first meeting pending agreement.

Appendices

Appendix 1 – A policy for NHS Scotland on the Climate Emergency and Sustainable Development

Appendix 2 – Strategic Risk 4156: Effect of climate change has a detrimental effect on the delivery of NHS services in Scottish Borders region

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NHS Chairs
NHS Chief Executives
via email

10th November, 2021

Dear Colleagues

A POLICY FOR NHS SCOTLAND ON THE CLIMATE EMERGENCY AND SUSTAINABLE DEVELOPMENT - DL (2021) 38

I am writing to share with you the attached policy statement, a '**Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development'**.

This policy statement supersedes CEL 2 (2012) 'A Policy on Sustainable Development for NHSScotland 2012'.

Addressees should ensure that this letter is cascaded to all appropriate staff within their area of responsibility.

The attached document has been prepared in consultation with Health Boards and relevant Scottish Government and public sector stakeholders. It takes account of relevant wider Scottish Government policies and existing statutory duties on Health Boards.

The policy sets out aims and associated targets for NHS Scotland to work towards. The forthcoming NHS Scotland Climate Emergency and Sustainability Strategy will provide proposals for action to assist in meeting those aims and targets.

The Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development takes immediate effect.

Responding to the climate emergency is one of the Scottish Government's highest priorities and I look forward to working with you on this crucial matter.

Yours sincerely

Richard McCallum
Director of Health Finance and Governance

A Policy for NHS Scotland on the Global Climate Emergency and Sustainable Development

Introduction

Responding to the global climate emergency is one of the Scottish Government's highest priorities. Sustainable development, the concept that the needs of the present must be met "without compromising the ability of future generations to meet their own needs"[1] is integral to the Scottish Government's overall purpose. The Scottish Government's National Performance Framework shares the same aims as the United Nations' Sustainable Development Goals.

The purpose of this policy is to provide a framework for NHS Scotland to maximise its contribution to mitigating and limiting the effects of the global climate emergency and for the development of an environmentally and socially sustainable health service that is resilient to the locked-in impacts of climate change. **As such, the policy is mandatory for all NHS Scotland bodies and its scope extends to all of their activities.**

The aims of this policy must be fully integrated into all planning, management decisions and operational practices across NHS Scotland in order to respond fully to the global climate emergency and achieve an environmentally and socially sustainable health service.

Background

The planet is in the midst of a climate emergency as a result of human activity and urgent action is required to reduce greenhouse gas emissions, adapt to the changes caused by climate change and achieve an environmentally and socially sustainable society.

Climate change presents a serious risk to the health of people around the world and has been described by the Lancet Commission on Managing the Health Effects of Climate Change as "*the biggest global health threat of the 21 century"*[2].

At the same time, many of the actions to mitigate and adapt to climate change and improve environmental sustainability also have positive health benefits to such an extent that the Lancet Commission has described tackling climate change as "*the greatest global health opportunity of the 21st century*".[3] It is therefore incumbent on NHS Scotland to be an exemplar in responding to the climate emergency and achieving environmental sustainability.

Meeting the needs of the present requires action to address the inequalities in our society, inequalities which manifest themselves in significantly poorer health outcomes for the most deprived. Many of the health benefits of action to address the climate emergency and ecological crisis will have the greatest benefits for those with the worst health outcomes.

[1] Report of the World Commission on Environment and Development: Our Common Future (1987) ("the Brundtland Report") Para. 27.

[2] Reference

[3] The Lancet Commission on Managing the Health Effects of Climate Change (2015) – complete reference

Policy Aims

- Ensure that NHS Scotland bodies, as an integral part of their commitment to the health and wellbeing of the community, contribute to the achievement of the United Nation's Sustainable Development Goals.
- Ensure that NHS Scotland becomes a net-zero greenhouse gas emissions health service by 2040 or earlier where possible.
- Ensure that NHS Scotland's assets and activities are resilient to the impacts of a changing climate, particularly extreme weather events.
- Establish a culture of stewardship within NHS Scotland, where natural resources are safeguarded and responsibly used to provide environmentally sustainable healthcare.
- Establish NHS Scotland as part of the circular economy through designing out waste and pollution, keeping products and materials in use and contributing to the regeneration of natural systems.
- Increase NHS Scotland's contribution to tackling the ecological emergency and restoring biodiversity.

Governance

1. Each NHS Scotland body must implement a strong management structure as a means of ensuring the delivery of this policy's aims. Each NHS Scotland body must either establish a Climate Emergency and Sustainability Group or designate an existing committee as the lead group for climate emergency and sustainability. In either case, the group must be chaired by a member of its senior / executive management team and its membership must be of sufficient authority to ensure that the aims of this policy are fully integrated into all planning, management decisions and operational practices across the NHS Scotland body.

2. The Scottish Government Health and Social Care Directorates (SGHSC) have established an NHS Scotland Climate Emergency and Sustainability Board to provide leadership and governance to NHS Scotland's overall efforts in responding to the global climate emergency and achieving an environmentally and socially sustainable health service.

3. Each NHS Scotland body must appoint an executive lead for its climate emergency response and sustainability.

4. Each NHS Scotland body must appoint a member of its board to act as champion for its climate emergency response and sustainability at a strategic level to assist in articulating and promoting its sustainability priorities.

5. Each NHS Scotland body Chief Executive is accountable to the SGHSC for their organisation's implementation of this policy.

6. NHS Scotland bodies which encounter issues with or barriers to the implementation of this policy or its aims which cannot be resolved at NHS Scotland body level must escalate those issues to the NHS Scotland Climate Emergency and Sustainability Board.

7. As assessment of its progress against the aims of this policy will form part of each NHS Scotland body's annual ministerial review.

Integrated approach and co-operation

8. NHS Scotland bodies must take an integrated approach to the achievement of the aims of this policy. In developing plans or taking action, NHS Scotland bodies must consider the full range of this policies' aims.

9. NHS Scotland bodies must co-operate with each other with a view to achieving the aims of this policy.

10. The achievement of this policy's aims will require NHS Scotland bodies to work with their local communities and patients and with organisations outside of the NHS who have similar aims or who can assist NHS Scotland to achieve its aims. In particular, territorial Health Boards are required to use all reasonable efforts to work with the local authorities for their areas to achieve this policy's aims.

A Just Transition

11. In implementing this policy, NHS Scotland bodies must:

    a) plan, invest and implement a transition to an environmentally and socially sustainable, climate resilient, health service in a way which builds on Scotland's economic and workforce strengths and potential;

    b) create opportunities to develop resource efficient and sustainable approaches which help address inequality and poverty; and

    c) design and deliver low carbon and climate resilient investment and infrastructure, making all possible efforts to create decent, fair and high value work.

Net-zero

Scope 1 and 2 emissions

12. Having regard to national plans to decarbonise the UK's electricity supply by 2035, each NHS Scotland body must reduce the greenhouse gas emissions from its activities, the activities under its control and from the electricity, steam and heat purchased by it to net-zero by 2040 or earlier where possible. The UK's independent, statutory Climate Change Committee advises that most sectors will need to reduce emissions close to zero without offsetting.

13. All NHS owned buildings must be heated from renewable sources by 2038 or earlier where possible.

Scope 3 greenhouse gas emissions

14. NHS Scotland bodies must, as a minimum, reduce their associated greenhouse gas emissions from the following sources to net-zero by 2040 or earlier where possible:

    - energy transmission and distribution, having regard to national plans to decarbonise the UK's electricity supply by 2035
    - waste disposal
    - business travel, including grey fleet

- water consumption
- waste water treatment
- leased assets

15. Each NHS Scotland body must take sufficient action to influence a reduction in those greenhouse gas emissions which are linked to its activities but are from sources which it does not own or control (and are not included in paragraph 14) to maximise its contribution to reducing emissions to net-zero by 2045 or earlier where possible.

Interim targets

16. Where the 1990 baseline is known for an emissions source, the NHS Scotland body must reduce the emissions from that source by at least 75% by 2030.

17. Where the 1990 baseline is not known for an emissions source, the NHS Scotland body must set interim targets for reducing emissions from that source which are consistent with achieving the net-zero target for the emissions type.

Greenhouse gas emissions reporting

18. Each NHS Scotland body must assess their progress towards net-zero emissions via their annual Public Bodies' Climate Change Duties Report which is to be submitted to the Scottish Government by 30 November each year. NHS Scotland bodies should, as a minimum, report on their annual emissions associated with their:

    - building fossil-fuel energy use
    - owned and leased fleet fuel use
    - fluorinated gases and anaesthetic gases (where relevant)
    - purchased energy use (electricity, heat, steam)
    - energy transmission and distribution
    - waste
    - water consumption
    - waste water treatment
    - business travel, including the use of grey fleet
    - leased assets

Climate change adaptation

19. Each NHS Scotland body must undertake a Climate Change Risk Assessment covering all operational areas and produce and implement a Climate Change Adaptation Plan to ensure resilience of service under changing climate conditions and these should be reviewed and updated at least every 5 years.

20. In relation to existing facilities, these assessments and plans should cover a period at least 20 years into the future from the time of assessment.

21. In relation to planned facilities, these assessments and plans should cover a period at least 50 years into the future from the time of assessment.

22. The key risks from the Climate Change Risk Assessment must be incorporated into each NHS Scotland body's corporate risk register.

23. Progress on undertaking Risk Assessments and implementing Adaptation Plans, including in terms of how these are supporting national Scottish Climate Change Adaptation Programmes, is to be set out in each bodies' annual Public Bodies' Climate Change Duties Report.

Sustainable care

24. Each NHS Scotland body will foster and promote a culture of stewardship, where staff are mindful of the resources they use and share a vision of green and sustainable healthcare.

25. Each NHS Scotland body must ensure their workforce consider the environmental impacts of treatments when making decisions about the care they provide.

26. Each NHS Scotland body will ensure all employees are educated and trained on the principles of practising sustainably.

Procurement

27. Each NHS Scotland body must consider social and environmental sustainability when it is procuring goods and services. The procurement of goods and services by NHS Scotland bodies must further the aims of this policy.

28. NHS Scotland bodies are reminded of the sustainable procurement duty established by section 9 of the Procurement (Scotland) Act 2014, which can be viewed here: Procurement Reform (Scotland) Act 2014 (legislation.gov.uk). NHS Scotland bodies are required to follow the guidance and use the tools issued by the Scottish Government to assist in optimising the economic, social and environmental outcomes of their procurement activity.

29. It is the responsibility of each NHS Scotland body to review the supply chain of the goods and services that it procures to determine the extent of the associated greenhouse gas emissions and social and environmental impacts. Where an NHS Scotland body procures goods and services on behalf of another organisation, it is the responsibility of the procuring body to review the supply chain.

Circular economy

30. Each NHS Scotland body must contribute to the creation of a circular economy, working with National Procurement and with suppliers to design out waste and consider the entire life cycle of products and services, reducing the environmental impact, keeping products and materials in use and contributing to the regeneration of natural systems.

31. In particular, NHS Scotland bodies must:

    - promote the use of items and assets which have been designed for durability and upgradability;
    - prolong the use of items and assets through proper maintenance and promoting their reuse; and
    - promote the use of items and assets which can be recycled at the end of their useful life.

32. NHS Scotland bodies, with support from National Procurement, must identify and assess the life cycle of products and services and take action to reduce their environmental impact through the avoidance of pollution (including toxic chemicals, micro-plastics and pharmaceutical residues) and waste throughout their life cycle.

Water

33. Each NHS Scotland body must monitor its water usage and take action to reduce unnecessary water consumption.

Resource and Waste Management

34. Each NHS Scotland body must put in place a system for recording and reporting the volume and type of waste which it generates and the destination of that waste.

Targets

35. By 2025, each NHS Scotland body must:

    a) reduce its domestic waste arising by a minimum of 15%, and greater where possible, compared to a financial year 2012/13 baseline;
    b) ensure that no more than 5%, and less where possible, of all its domestic waste goes to landfill;
    c) reduce the food waste it produces by 33% against a financial year 2015/16 baseline; and
    d) ensure that 70% of all its domestic waste is recycled or composted.

36. Each NHS Scotland body must set appropriate targets for reducing the volume of healthcare waste it produces through measures including greater use of reusable items, improvements to waste segregation and increased recycling of recyclable materials.

Biodiversity and Greenspace

37. Under section 1 of the Nature Conservation (Scotland) Act 2004, it is the duty of each NHS Scotland body in exercising its functions to further the conservation of biodiversity so far as is consistent with the proper exercise of those functions. In addition to that duty, each NHS Scotland body must promote improvements to biodiversity in so far as is consistent with the proper exercise of its functions.

38. All NHS Scotland bodies must assess, and then take action to improve:

    a) the extent and quality of the greenspace they have;
    b) the contribution its estate makes to biodiversity; and
    c) the value of the ecosystem services its greenspaces provide.

39. Greenspace can have benefits for the health and wellbeing of staff, patients and communities. NHS Scotland bodies must manage their greenspace to increase its provision and improve access, quality and regular use by staff, patients and the local community.

40. Greenspace can have benefits in relation to climate change mitigation and adaptation through, for example, reducing flooding and absorbing heat. NHS Scotland bodies

must manage their greenspace to assist with climate change mitigation and adaptation.

41. All NHS Scotland bodies must collaborate with local partners to improve the natural links between NHS greenspace and other local areas of greenspace.

42. Where an NHS Scotland body proposes an action which would result in the loss in quantity or quality of greenspace to the NHS or its contribution to biodiversity, it must refer the proposal to the SGHSC.

43. It is the duty, under section 2A of the Nature Conservation (Scotland) Act 2004, of each NHS Scotland body to publish a report every three years on the actions taken by it in pursuance of its duty under section 1 of that Act during the period to which the report relates. These reports must be forwarded to SGHSC when they are published.

Travel and transport

44. All NHS Scotland bodies must take action to reduce the carbon emissions resulting from travel associated with their activities, including those associated with staff and patient travel. Those actions must include:

    - Actions to reduce the need for travel;
    - Actions to increase active travel;
    - Actions to increase the use of public or community transport to access services and sites;
    - Actions to reduce car use in support of the Scottish Government's aim to reduce the number of kilometres driven in Scotland by 20% by 2030 compared to a 2019 baseline; and
    - Actions to support the use of vehicles powered by renewable energy in preference to vehicles powered by fossil fuels.

45. The actions set out in the paragraph above must be taken in a way which supports access to services with a particular focus on addressing inequality of access.

46. Each NHS Scotland body must remove all petrol and diesel fuelled cars from their owned and leased fleets by 2025 or earlier where possible.

47. Each NHS Scotland body must phase out the need for it to purchase or lease any petrol or diesel light commercial vehicles by 2025 or earlier where possible.

48. Each NHS Scotland body must phase out the need for it to purchase or lease any petrol and diesel vehicles by 2030 or earlier where possible.

49. Each NHS Scotland body must decarbonise its owned and leased fleet by 2032 or earlier if possible.

50. Each NHS Scotland body will develop a sustainable transport and travel policy.

Facilities

51. All NHS Scotland bodies must take sufficient action to ensure that the buildings they own or occupy achieve net-zero greenhouse gas emissions by 2040 or earlier if possible. The UK's independent, statutory Climate Change Committee advises that

most sectors will need to reduce emissions close to zero without offsetting. Therefore, the public sector's owned estate needs to achieve as close as possible to absolute zero direct emissions.

52. All NHS Scotland new buildings and major refurbishments must be designed to have net-zero greenhouse emissions. Where a net-zero design is not currently practicable, the project must only be approved where a credible route map showing how net-zero emissions will be achieved before 2040 is produced.

53. In addition, all NHS Scotland owned buildings must be heated from renewable sources by 2038. All NHS Scotland new buildings must be designed to achieve that target. Where a renewable heat source is not currently practicable, the project must only be approved where a credible route map showing how renewable heating will be achieved before 2038 is produced.

54. All NHS Scotland buildings should be assessed for resilience to the locked in impacts of climate change over the expected lifespan of that building. Where resilience is not considered sufficient, an action plan must be set out to improve this.

55. Each NHS Scotland body's Property and Asset Management Strategy must support the achievement of this policy's aims and in particular the requirements to reduce carbon emissions, adapt to the changing climate and promote greenspace and biodiversity.

Environmental Management Systems

56. Each NHS Scotland body must implement the following management standards to further the aims of this policy: ISO 9001 and 14001 or equivalent. NHS Scotland bodies are not required to seek external confirmation or certification of its conformance with these standards.

57. Each NHS Scotland body must have an effective Environmental Management System in place which has been approved by the SGHSC.

Resourcing

58. Each NHS Scotland body must have a Climate Emergency and Sustainability Team which is sufficiently resourced in light of the scale and complexity of the challenge of decarbonisation, sustainability and climate resilience faced by that NHS Scotland body.

59. Each NHS Scotland body must appoint an Environmental Management Representative (EMR) with the responsibility, resources and authority to implement this policy in respect of environmental management.

60. Each NHS Scotland body must appoint a Waste Management Officer with the responsibility, resources and authority to implement this policy in respect of waste. The Waste Management Officer must have responsibility for all aspects of waste management within the organisation consistent with the Scottish Government's commitments towards zero-waste and a circular economy.

61. Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this policy in respect of greenspace and biodiversity.

62. Each NHS Scotland body must appoint an officer with the responsibility, resources and authority to implement this policy in respect of travel.

63. Each NHS Scotland body which provides clinical services must include a sustainable care medical planning team as part of its Climate Emergency and Sustainability Team.

Assessment of Sustainability

64. Each NHS Scotland body must assess its contribution to the achievement of the United Nation's Sustainable Development Goals on an annual basis using the National Sustainability Assessment Tool provided by NHS National Services Scotland.

Awareness and Reporting

65. Each NHS Scotland body must publish a report on its public website by November each year summarising its progress against the aims of this policy using a template approved by the SGHSC for that purpose. The progress report must be approved by the NHS Scotland body's Chief Executive and be provided to:

- The NHS Scotland body's staff
- The NHS Scotland body's board members; and
- SGHSC.

66. The annual progress report will form part of each NHS Scotland's body annual ministerial review.

67. Each NHS Scotland body must have a clear communications plan to ensure that staff, patients and the local community are aware of that NHS Scotland body's climate emergency and sustainability plans, policies and processes, and to support them to make sustainable choices. The communications plan must include measures to publicise the annual progress report.

Review

68. This policy and its implementation will be reviewed annually by the NHS Scotland Climate Emergency and Sustainability Board.

BET Strategic Risk Register BET Strategic Risk Register

Strategic Risk Register - Board Executive Team

Risk Description

ID	4156
Supporting Executive/Peer Support	
Risk Owner For further information and a list of risk owners please click the following link: **Risk Owners List**	Bone, Andrew - Director of Finance
Clinical Board	Strategic Risk Register *Board Executive Team Use Only*
Service	Strategic Risk Register *Board Executive Team Use Only*
Dept / Ward	Strategic Risk Register *Board Executive Team Use Only*
Title of Risk	Effect of climate change has a detrimental effect on the delivery of NHS services in Scottish Borders region
Description of risk	Climate Change risks arising from Climate Change Scotland Act 2009 (amended 2019)

Risk Assessment

Source of Risk (hazard/ problem/ concern)	Scottish Government legislation and policy – Climate Change Scotland Act 2009 amended by 2019 Scottish Government Climate Change Plan 2021
People Affected	Agency staff Bank staff Contractors Employees Healthcare partners Locums Organisation Patients Public Scottish Borders Council Trainees/ Students Visitors Volunteers Vulnerable groups
Risks Arising	Physical – risks associated with environmental change relating to the effects of, for example, increased temperatures and heat waves, enhanced rainfall and flooding, soil erosion, food production, freshwater availability, sea levels rising etc. We have seen some of these negative consequences already. Transition – relating to risks arising from policies and decisions that are needed and necessary to achieve net-zero by mid century. - Failure to meet the 6 Climate Change Chief Exec commitments: 1. NHS Scotland will be a 'net-zero' greenhouse gas emissions organisation by 2045 at the latest 2. All NHS Scotland new buildings and major refurbishments will be designed to have net-zero greenhouse emissions from April 2020 3. Each NHS Board should undertake a Climate Change Risk Assessment covering all operational areas and produce a Climate Change Adaptation Plan to ensure resilience of service under changing climate conditions 4. NHS Scotland transport GHG emissions from its owned fleet (small/ medium

	vehicles) will be net-zero by 2032 5. The NHS supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environmental impacts 6. Each NHS Scotland Board should establish a Climate Change/ Sustainability Governance group to oversee their transition to a net-zero emissions service Liability – risks relating to the future litigation to NHS Borders if we knowingly do not comply with the transition and willingly introduce environmental damage as a consequence.
Impact and Consequences of Risks Arising	Climate change objectives not met Litigation Major organisational loss Enforcement action Adverse publicity/ reputational damage Public relations damage Scottish Government scrutiny Unsustainable estate/ estate damage Impact on patient care/ access to services Financial loss

Existing Control Measures

Controls in place	Self Assessment on climate change (NSAT survey) EoS Risk assessments Sustainability Group to develop NHS Borders Sustainability Strategy Funding secured from SG for a review of estate to get to Zero greenhouse gas due by March 2022 the scope of this is building and engineering assets NHS Borders contracts all work out through built in frameworks to ensure appointment of contractors and tender processes capture net-zero greenhouse emissions to major refurbishments or new builds 15 electric vehicles in our fleet External funding to support engagement campaign for NHS Borders staff, once strategy published
Do the controls manage all risk to an acceptable level?	No
Gap Analysis	Climate Change Adaption Plan to ensure resilience of service under changing climate conditions, awaiting publication of national risk assessment Review fleet NHS Supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environments impacts Development of Sustainability Strategy Engagement with national consultant to produce Climate Change Adaptation Plan

Risk Grading

Current How serious is this risk on a scale of 1-5 using the **Risk Matrix**.	Consequence (current):	Extreme (5)
	Likelihood (current):	Likely (4 Strong possibility that this could occur)
	Rating (current):	20
	Risk level (current):	VHGH20

Risk Assessor Recommendation
These can include suggested further control measures, risk owners must consider these when recording actions in the Actions section.

Risk Assesor Recommendations Recommended actions suggested by Risk Assessor	NHS Borders should develop a Climate Change Action Plan in line with the policy aims directed by Scottish Government, and monitor delivery against this plan.

Risk Owner Management Details

Risk Status	Treat
Target How serious is this risk on a scale of 1-5 using the **Risk Matrix**.	Consequence (Target): Extreme (5) Likelihood (Target): Possible (3 May occur occassionally) Rating (Target): 15 Risk level (Target): HIGH15
Category of risk	Corporate Strategic Risk (Board Executive Team Use only)
Corporate Objective The Corporate Objectives 2020-2023 as set out by NHS Borders.	Promote excellence in organisational behaviour and always act with pride, humility and kindness. Provide high quality, person centred services that are safe, effective, sustainable a nd affordable. Reduce health inequalities and improve the health of our local population
Type of Risk	Adverse publicity/ reputation Business Continuity Financial/ Economical (including damage, loss, fraud) Inequalities Legal OH&S Environment and Equipment Patient Safety/ Clinical Risk/ Clinical Activity Political Project Risk Staffing and Competence

Key Dates

Date risk assessment completed (dd/MM/yyyy)	09/11/2021
Expected date of target level achieved or closed	31/12/2022
Review date (dd/MM/yyyy)	31/07/2022

Actions

Risk Reference	Responsibility ('To')	Assigned by ('From')	Module	Risk Action Plan	Due date	Completed Date	Priority
3395	Dave Bradon	BETRR	Risk Register	Review fleet for climate change adherence	31/03/2022		
3396	Shona Milne	BETRR	Risk Register	NHS Supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environments impacts	31/03/2022		
3397	Brian Douglas	BETRR	Risk Register	Engagement with national consultant to produce Climate Change Adaptation Plan	31/03/2022		
3444	Andrew Bone	Andrew Bone	Risk Register	Develop a resource plan aligned to NHS	31/03/2022		

				Borders Climate Emergency & Sustainability Action Plans			
3393	Andrew Bone	BETRR	Risk Register	Development of Sustainability Strategy	01/07/2022		
3394	Andrew Bone	BETRR	Risk Register	Development of Climate Change Action Plan	01/07/2022		

Approval Status of Risk

Date Risk Awaiting Final Approval Please enter the date this risk has been updated to awaiting final approval	19/11/2021
Governance Group	Performance and Resource Committee

Risk Owner/Approver Comments

Risk Owner/Approver Comments	

Feedback

Feedback to Risk Owners from Risk and Safety Team	
Audit Date	
Audit Comment	

Escalation/ Reporting
Please complete this section if you are escalating the risk

New risk owner This is most likely to be your line manager	
Date of escalation to Operational Manager	
Date of escalation to Service Manager	
Date of escalation to General Manager/ Head of Support Service	
Date of escalation to Director	
Date of escalation to Chief Executive	
Risk Reported	☐ Board Executive Team (BET) ☐ Clinical Board ☐ Clinical Executive ☐ Healthboard

☐ Other

☐ Risk Management Board

Contacts

	ID	Surname	Forenames	Name of Group (if applicable)	Category
▶	193697	Pringle	Lettie		Risk Assessor
▶	193698	Butterfield	Gemma		Staff member
▶	193699	Patterson	Lorna		Topic Specialist(s)
▶	193700	Bone	Andrew		Director

Documents

Created	Type	Description	ID
09/11/2021	Form	Progress - NHS Scotland Chief Exec Commitments	20339

Communication and feedback

Recipients

Message

Message history				
Date/Time	**Sender**	**Recipient**	**Body of Message**	**Attachments**
No messages				

Linked Records

No Linked Records.

Non-Compliance - Risk Appetite

What barriers have been encountered that prevent the risk being mitigated to an acceptable level?

Sumitted to Board Executive Team for further action

Paper(s) attached in the documents section of risk form ☐ If yes, please tick

Reasons for Rejection - History

No records to display.

Notifications

	Recipient E-mail	Date/Time			Job title

Recipient Name			Contact ID	Telephone Number	
Smyth, June	june.smyth@borders.scot.nhs.uk	09/11/2021 14:30:39	847		Director of Planning and Performance
Stephen, Jackie	jackie.stephen@borders.scot.nhs.uk	09/11/2021 14:30:39	23415		Head of IM&T
Patterson, Tim	tim.patterson@borders.scot.nhs.uk	09/11/2021 14:30:39	68639		Director Public Health
Macdonald, Nicola	nicola.macdonald@borders.scot.nhs.uk	09/11/2021 14:30:39	103397		Vaccination Clinical Service Manager
Smith, Kim	kim.smith2@borders.scot.nhs.uk	09/11/2021 14:30:39	103681		Lead Training & Professional Development
Roberts, Ralph	ralph.roberts@borders.scot.nhs.uk	09/11/2021 14:30:39	149785		Chief Executive
BET Strategic Risk Register, BET Strategic Risk Register	test@test.co.uk	09/11/2021 14:30:39	158140		BET Strategic Risk Register
Roberts, Ralph	ralph.roberts@borders.scot.nhs.uk	09/11/2021 14:30:39	166319		Chief Executive
Patterson, Tim	tim.patterson@borders.scot.nhs.uk	09/11/2021 14:30:39	166323		Director of Public Health
Smyth, June	june.smyth@borders.scot.nhs.uk	09/11/2021 14:30:39	166324		Director of Planning and Performance
McLaren, John	john.mclaren@borders.scot.nhs.uk	09/11/2021 14:30:39	166325		Partnership Director
Bone, Andrew	andrew.bone@borders.scot.nhs.uk	09/11/2021 14:30:39	166327		Director of Finance
Carter, Andy	andy.carter@borders.scot.nhs.uk	09/11/2021 14:30:39	166328		Director of Workforce
Clinkscale, Gareth	gareth.clinkscale@borders.scot.nhs.uk	09/11/2021 14:30:39	166330		Director of Acute Services
Horan, Sarah	sarah.horan@borders.scot.nhs.uk	09/11/2021 14:30:39	166335		Director of Nursing, Midwifery & AHPs
Myers, Chris	christopher.myers@borders.scot.nhs.uk	09/11/2021 14:30:39	166340		Chief Officer
mccallum, Lynn	lynn.mccallum@borders.scot.nhs.uk	09/11/2021 14:30:39	172312		Medical Director

Prebble, Laura	Laura.Prebble@borders.scot.nhs.uk	09/11/2021 14:30:39	182807		PA to Chief Officer
Brydon, Robin	robin.brydon@borders.scot.nhs.uk	09/11/2021 14:30:39	192884		Safety Advisor
Pringle, Lettie	lettie.pringle@borders.scot.nhs.uk	09/11/2021 14:30:39	193035		Risk Manager

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

CLINICAL GOVERNANCE COMMITTEE MINUTES 15.09.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Clinical Governance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

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.

Impact of item/issues on:

Strategic Context	As per the Clinical Governance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

Borders NHS Board
Clinical Governance Committee
APPROVED

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 15 September 2021** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non Executive Director (Chair)
Mrs A Wilson, Non Executive Director
Ms S Lam, Non Executive Director
Mrs H Campbell, Non Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Dr L McCallum, Medical Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr A Cotton, Associate Medical Director, Mental Health Services
Dr T Patterson, Joint Director of Public Health
Mrs L Jones, Head of Clinical Governance & Quality
Mrs N Berry, Director of Acute Services
Mrs S Horan, Director of Nursing Midwifery & Acute Services
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:
Dr T Young, Associate Medical Director, Primary & Community Services
Mr R Roberts, Chief Executive
Dr J Bennison, Associate Medical Director, Acute Services

The Chair welcomed:

Mr P Lunts, General Manager	(item 5.1)
Mrs J Dawson, Research Governance Manager	(item 5.4)
Mrs L Taylor, Nurse consultant & Lead Cancer Clinician	(item 6.6)
Mrs R Pulman, Nurse Consultant Public Protection	(item 7.2)

The Chair confirmed the meeting was quorate.

The Chair announced that today's meeting was Mrs Berry's last, the Committee extended their thanks to her and wished her well in her retirement. The Chair added that contribution to the meeting had kept us challenged and she will be missed.

2 Declarations of Interest

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

The CLINICAL GOVERNANCE COMMITTEE noted the following:

Ms Lam declared that her Partner is Specialist Advisor with the Scottish Government. Mrs Campbell noted that she was dealing with the Estate of person who committed suicide. No other declarations of interest noted.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 21 July were approved.

4 Matters Arising/Action Tracker

Matters Arising from the previous meeting were noted as follows:

Mrs Campbell had raised a concern regarding the follow up of items where the committee were not or only partly assured. Mrs Jones has had a conversation with Mrs Campbell to explain that there is work ongoing across the Board on how we record assurance so Mrs Campbell is assured that we are addressing her concern.

Action Tracker was updated as appropriate.

5 Patient Safety –

5.1 Clinical Prioritisation for Essential Services and Staff Allocation & Covid Summary Report

Mr Lunts provided an overview of the content of the report and slides and gave some background into the extreme pressures NHS Borders are facing at present and various scenarios for further pressure on services and the effect on patient care.

Dr McCallum supported Mr Lunts in his overview thanking him for his concise overview on what has been happening. She confirmed that the process has been very difficult particularly as the health and effect on the population has changed in the last 18 months and confirmed that there are risks involved with the process but there had been a collegiate approach to the process.

Discussion followed where several points were raised including concern regarding expectations of general public, Dr Herlihy commented that managing expectations is key as is how we communicate processes to the general public. Mrs Horan highlighted the pressure teams are feeling and how important it is to keep our staff safe, recognising staff may be working out with scope of practice. Dr McCallum acknowledged that working out with scope could lead to an increase in critical events and as a Board there needs to be recognised and some degree of being realistic about expectations.

Mrs Campbell thanked Mr Lunts for his report, commenting that there appeared to be a disconnection between what the public are seeing and what is happening in healthcare, reiterating the importance of communication to the public. Ms Lam also thanked Mr Lunts for very candid paper, she picked up on regulation issue and accountability and asked if this is common with other health boards, and what help are Scottish Government providing. Ms Lam enquired as to which areas are having staffing issues and what if

anything in particular is the main issue. Dr McCallum commented that issues have been raised directly with the NMC and through employee liaison meeting so that the GMC are cited on risk. Governance still needs to be in place regarding regulations. It is important that there is support for any individual who may find themselves in position where they are being investigated in terms of any critical events or fitness to practice. Other boards are in same situation, however due to the sizes and capacity of some of our services there is less resilience in comparison to some of the other boards. Communication to the Scottish Government on risk is being escalated through appropriate groups.

Mrs Berry commented that this scenario is the 'perfect storm' and a worst case scenario plan is imperative, this includes conveying plans to the general public.

The Chair commented that we should be supporting and including our GP colleagues in our communications.

There followed further discussion regarding risks and thresholds and the importance carrying out and documenting risk assessments. This included the suggestion of involving the CLO for advice, Mrs Pringle stated that CLO are not involved in risks and risks are managed through our risk management policy. Legal advice is given by CLO when a complaint or claim goes to litigation.

Chair commented that it was important that this decision had been collegiate and wanted to make sure that the Board can support them particularly with difficult decisions which ultimately may be needed. It was agreed that the power of listening is important. The Chair offered to take up this conversation with the Chief Executive and other non executives.

ACTION: Mrs Sandford will discuss what support then can give to the organisation with Mr Roberts.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that a process exists and that updates on outcomes will come to the committee at a future date.

5.2 Infection Control Report

Mr Whiting provided a brief overview of the content of the report. Staph Aureus Bacteremias (SAB) are on the increase, causes have been reviewed and there were no apparent recurring themes.

Discussion followed where several points were raised including note relating to previous report impact on IC control team. Chair enquired about learning from Covid incidence given that even though there is increased testing in Emergency Department (ED) there are still hospital acquired infections. Mr Whiting commented that the testing means there is more confidence in patient placement but patients who are testing negative in ED may be incubating and these patients are not identified on admission. Challenges are also faced regarding transmission due to the layout of the bays.

Mrs Campbell enquired about when the CAUTI group will meet, Mr Whiting confirmed that they had met in early September and timings of meetings will be looked at to ensure good attendance and representation. Work streams are progressing and review of catheter usage will take place focussing on the community initially.

Following a question from Mrs Lam regarding follow up of Covid testing there was a discussion regarding how tests sent to lab are followed up and what is the best way of doing this. Mr Whiting assured the Committee that the quadumverate have looked at the

best way to report Covid test results and the current process is the most appropriate.

There was also a discussion regarding Infection Control audit outcomes and monitoring trends, when numbers of infections are low this is challenging. The Infection Control team concentrate more on improvement and addressing any issues which have been highlighted.

Mrs Horan commented that the possibility of using 'testing teams' were being investigated. She assured the Committee that staff are reminded that it is important to keep the basics going particularly when under pressure

Dr McCallum confirmed there was a process the medical team have to follow up Covid tests, she will find out if Surgical teams also have a process in place.

ACTION: Dr McCallum will enquire if the surgical department has a process for follow up of Covid results following admission testing

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured processes are in place but not fully assured of outcomes.

5.3 Quarterly HSMR

Dr Herlihy provided a brief overview of the content of the report. She commented that figures remain within normal limits not withstanding nosocomial spread relating to deaths. Review of all Covid deaths and 20% of other deaths continue to be monitored.

A discussion followed regarding the Duty of Candour situation, Dr McCallum gave a brief overview of our position on Duty of Candour in particular relating to nosocomial deaths from Covid. The Committee acknowledged that this is a very complex situation and often difficult to apply Duty of Candour. Conversations are taking place at a national level and outcome is awaited.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured correct processes are being carried out.

5.4 Research Governance Annual Report

Mrs Dawson provided a brief overview of the content of the report. She commented that there had been an amazing contribution from clinicians during recovery trial, in particular pharmacy. Non Covid studies remain suspended but they are looking to re-open cancer trials. Mrs Wilson echoed Mrs Dawson's comments regarding the pharmacy contribution.

There was a discussion regarding the contribution research makes to the organisation in terms of benefit for patients, encouraging a better quality of clinician and financial benefit.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents

6 Effectiveness

6.1 Clinical Board update (Primary & Community Services)

Mrs Flower provided a brief overview of the content of the report. Care home report has been added to this Primary & Community Services report as previously requested. Two care homes have put a self imposed moratorium in place, one closed due to an active outbreak which will have impact on discharge delays and provision of care packages in

the community. Mutual aid in place to support care homes although this is difficult to action due to current situation in relation to outbreaks.

Mrs Flower reports that there had been an increase in reported incidences of violence and aggression which is impacting on the staff. There has also been a spike in inpatient deaths which has been reviewed which identified that the majority were expected deaths.

Ms Lam enquired about any control measures in place regarding minor injuries and the impact the delay in opening Care Treatment Assessment Centres is having on ED and what measures are in place in relation to dysphagia in adults with learning difficulties and children and young people. Mrs Flower responded that there is a triage system in place to signpost people to the correct service. They are working with communication team to inform the general public where the appropriate place of care is. Mr Williams responded that there were challenges within the Speech and Language service. There is now a new lead in place who is addressing these challenges and the governance of the service.

Mrs Campbell requested that there was more detail on how difficulties highlighted in the report were being dealt with and commented that she found some of the graphs difficult to read.

ACTION: Mrs Flower to highlight actions on reported difficulties in the report and look at making graphs easier to read.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that appropriate processes are in place but Committee is only partially assured as there are still areas of concern.

6.2 Clinical Board update (Mental Health Services)

Mrs Lerpiniere provided a brief overview of the content of the report. Issues in Huntlyburn have been particularly challenging. Challenges are being addressed.

Dr McCallum commended the Mental Health Team for managing this very difficult situation. Mental Welfare Commission has been consulted.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and understand difficulties reported. The Committee passed on their thanks to the Mental Health Services for the professional manner in which they have dealt with the situation.

6.3 Clinical Board update (Learning Disabilities Services)

Mr Lerpiniere provided a brief overview of the content of the report. There was no further discussion.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report

6.4 Clinical Board update (Acute Services)

Mrs Dickson provided a brief overview of the content of the report. Staffing remains a challenge work is continuing to address this. New starts are beginning to take up posts and there is further recruitment ongoing. There remains a high level of short term sickness. Collegiate working has been recognised and teams are to be commended for this.

The Chair commended the idea of preceptor posts. The Committee look forward to hearing more on home first and care at home services. Mr Williams gave a brief update on the ongoing recruitment for these services and reviews which will be forthcoming within the next couple of months.

Ms Lam enquired about the data on stroke and the challenges on meeting targets quite often due to availability of stroke beds and rehabilitation facilities. Discussion followed regarding these challenges. Mrs Campbell asked if having a new stroke Consultant will improve the service. It is expected that there will be a deeper dive into the stroke figures at a future meeting.

ACTION: deeper dive at future meeting on challenges regarding stroke patient pathways.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report

6.5 Pharmacy/Medicines Annual Update

Mrs Wilson provided a brief overview of the content of the report. Not included in the report was a plan to move to using the East region formulary possibly later on next year.

Mrs Campbell commented that she found the report difficult to complexity of technical information. Mrs Wilson agreed to adjust this and will update the committee at a future meeting. She also commented that the information on adverse drug events was not available for this report but the intention is to include these going forward.

Mrs Lam asked if it would be appropriate to have more frequent reporting from pharmacy. Mrs Wilson reports that they are looking at setting up a Medicines Governance Group which will report into the Committee at a more regular interval.

ACTION: Mrs Wilson will alter the content of the report to make it more readable. The report to also include more information on adverse events involving drugs in future.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and look forward to later updates.

6.6 Cancer Services Update

Mrs Taylor provided a brief overview of the content of the report and the back ground of the pathways and local and regional structures.

Mrs Taylor will send cancer pathway and escalation structure to Ms Laing for sharing with the Committee. Mrs Taylor invited any questions from the Committee and if there was anything in particular the committee wants including in reporting to let her know.

Plans are in place to catch up with backlog of colonoscopy referrals. There was discussion regarding supporting patients living with cancer following a question from Ms Lam regarding rehabilitation provision. There is funding from Macmillan and support is available via integrated services. Development posts are being put in place following a successful endowment fund bid.

ACTION: Mrs Taylor will send cancer patient pathway to Ms Laing who will share with Committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents

7 Assurance

7.1 Medical Appraisal and Revalidation Position 20/21

Dr Herlihy provided a brief overview of the content of the report. She reports that the appraisal process was suspended during Covid outbreak this had been restarted in October revalidations were put forward a year and appraisals we are responsible for which were due are now complete. Alerts for clinicians are being set up so they are aware which month the appraisal is due and when patient questionnaires need to be completed. Biggest issue is the number of appraisers available.

Ms Lam enquired about revalidation from other professional groups. A report will come to future meeting regarding nursing revalidation.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured on the processes and actions being addressed.

7.2 Public Protection Update

Mrs Pulman provided a brief overview of the content of the report. She reported similar challenges in delivering services during the pandemic. Key priorities have been connecting with staff and how key messages are delivered. Consultation and advice services have been promoted. Support for Child Protection Supervision has been available.

There was discussion regarding resilience in the team and how this had been addressed. Mrs Pulman commented that they are sharing knowledge and raising awareness on responsibilities for all staff with regard to public protection.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents.

9 Items for Noting

Infection Control Annual Report was noted by the Committee.

10 Any Other Business

There were no further items of competent business to record.

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 17 November 2021 at 10am via Teams Call.

The meeting concluded at 12:20

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Lynn McCallum, Medical Director
Author:	Laura Jones, Head of Quality and Clinical Governance

QUALITY & CLINICAL GOVERNANCE REPORT - NOVEMBER 2021

Purpose of Report:

The purpose of this report is to provide the NHS Borders Board with an exception report on activities and progress across areas of patient safety, clinical effectiveness and person centred care.

Recommendations:

The Board is asked to note this report.

Approval Pathways:

This report has been reviewed by the Board Executive Team.

Executive Summary:

This exception report covers keys aspects of clinical effectiveness, patient safety and person centred care in the context of the current pandemic response to COVID 19 within NHS Borders, including:

- Clinical pressures
- HSMR, crude mortality and COVID 19 deaths
- Care of the deteriorating patient
- Patient experience
- Research and innovation

The Board is asked to note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee.

Impact of item/issues on:	
Strategic Context	The 2020 Vision for Healthcare in Scotland and NHS Borders Corporate Objectives guide this report.
Patient Safety/Clinical Impact	Clinical prioritisation is underway to manage the NHS Borders response to the demands of the COVID 19 pandemic. This has required adjustment to core services and routine care.
Staffing/Workforce	Service and activities are being provided within agreed resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response.
Finance/Resources	Service and activities are being provided within agreed

	resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response.
Risk Implications	Each clinical board is monitoring clinical risk associated with the need to adjust services as part of the heightened pandemic response.
Equality and Diversity	Compliant.
Consultation	The content of this paper is reported to Clinical Board Clinical Governance Groups, the Pandemic Committee and Board Clinical Governance Committee.
Glossary	BGH – Borders General Hospital SCN – Senior Charge Nurse HSMR – Hospital Standardised Mortality Rate NEWS2 – National Early Warning Score 2 IV – Intravenous SPSO – Scottish Public Services Ombudsman HISES – Health Innovation South East Scotland

1. CLINICAL EFFECTIVENESS

1.1 Clinical Pressures

1.1.1 NHS Borders, along with other Boards in Scotland, are currently facing more extreme pressures on services than have been experienced in most people's working careers. Demand for services is intense and is exacerbated by significant staff challenges, due to absence and vacancies, and by the ongoing COVID 19 demand.

1.1.2 To deal with existing demand, it has already been necessary to reduce certain services, including elective operating and some mental health services, and to operate at staffing levels that are sub-optimal.

1.1.3 The Board Clinical Governance Committee met in November 2021 and discussed papers from all three clinical boards. Each clinical board raised themes around increasing numbers of delayed discharges and the strain this was placing on access to hospital beds across the system. A key concern within this was the number of complex patients delayed to accessing specialist beds locally or regionally or enhanced care placements in the community. Several measures are being taken to reduce the risk presented to patients and staff from these complex patients. However, current service constraints relating to staffing and the limited availability of additional staff to cover one to one nursing requests through bank and agency are causing concern across all clinical boards.

1.1.4 The Director of Nursing, Midwifery and Allied Health Professions and the Director of Workforce are reviewing what additional measures can be put in place to strengthen patient and staff safety including a complex case review process for patients and additional wellbeing support for staff. Operationally there is a need for a continued robust focus on whole system patient flow and the steps that can be taken to reduce delays as system pressures are likely to grow during the winter period.

1.1.5 These delays and ongoing staffing pressures are having a significant impact on the ability to admit patients to the acute hospital in a timely manner. Patients are therefore

waiting prolonged periods within the emergency department. This is requiring system and process change to clinical pathways to ensure patients receive timely clinical care whilst awaiting admission. Work is underway to look at escalation protocols for the emergency department to ensure additional support can be deployed on occasions where there are long delays in the department. This work will be critical for the winter period where demand is likely to be elevated.

1.1.6 Increased length of stay within the acute hospital is having a knock on effect to the ability to move patients into the correct beds in a timely manner. Standards such as access to the stroke unit within 24 hours of admission for a stroke patient have been challenging to achieve over the last 18 months.

1.1.6 The ongoing need for an additional COVID 19 ward and new addition of a delayed discharge ward within the Borders General Hospital (BGH) is placing a significant strain on staffing resources and the ability to remobilise elective surgery. Additional support provided by the military has helped to reduce this pressure a little in the short term and has enabled additional elective operating lists to be reinstated. Extra external capacity for Orthopaedics and Ophthalmology has been secured to reduce waits. Cancer surgery performance remains strong in line with national priorities.

1.1.7 Senior Charge Nurses (SCNs) continue to work on reduced supervisory hours with 80% of their time in most areas being clinical. The reduction in supervisory hours remains challenging for SCNs so additional administrative roles have been recruited to provide them with support. In addition, Clinical Nurse Managers are prioritising their workload to ensure an increased presence in clinical areas each day to provide leadership support. Additional healthcare support workers have been recruited and will take up post over the coming two months.

1.1.8 Allied health professions are prioritising care to align with current service pressures and have had to reduce the level of reablement support within the Home First Service in order to support gaps in social care. The inpatient teams are spreading their resource across a greater number of beds which is in turn impacting on the level of input available.

1.1.9 The Primary Dental Service remains under significant pressure with an increasing backlog of care due to current COVID 19 infection control practice mitigations and commitment to unscheduled care. The primary dental service continues to support urgent and emergency care in practices with staffing shortages relating to COVID 19.

1.1.10 On the 29 November 2021, the current national guidance on ‘red’, ‘amber’ and ‘green’ COVID 19 pathways will be replaced with winter ‘respiratory’ and ‘non-respiratory’ pathways which will apply across health and social care. The current COVID screening questions for patients and service users will be expanded to include other respiratory symptoms.

- The current ‘Amber’ pathway is similar to the ‘Non-respiratory’ pathway and would include elective activity.
- The current ‘Red’ pathway is similar to the ‘Respiratory’ pathway.

1.1.11 Despite some similarities with current pathways, implementation of the new pathways would have far reaching implications for delivery of our services. Full implementation may not be possible due to limitations of our premises and staffing challenges. Some aspects in the guidance continue to be discussed at a national level with

further information and clarity awaited. Meetings are being scheduled with each clinical board to support planning implementation of the respiratory pathways as far as this is achievable. The new guidance has also been discussed at the Care Home Oversight Operational Group.

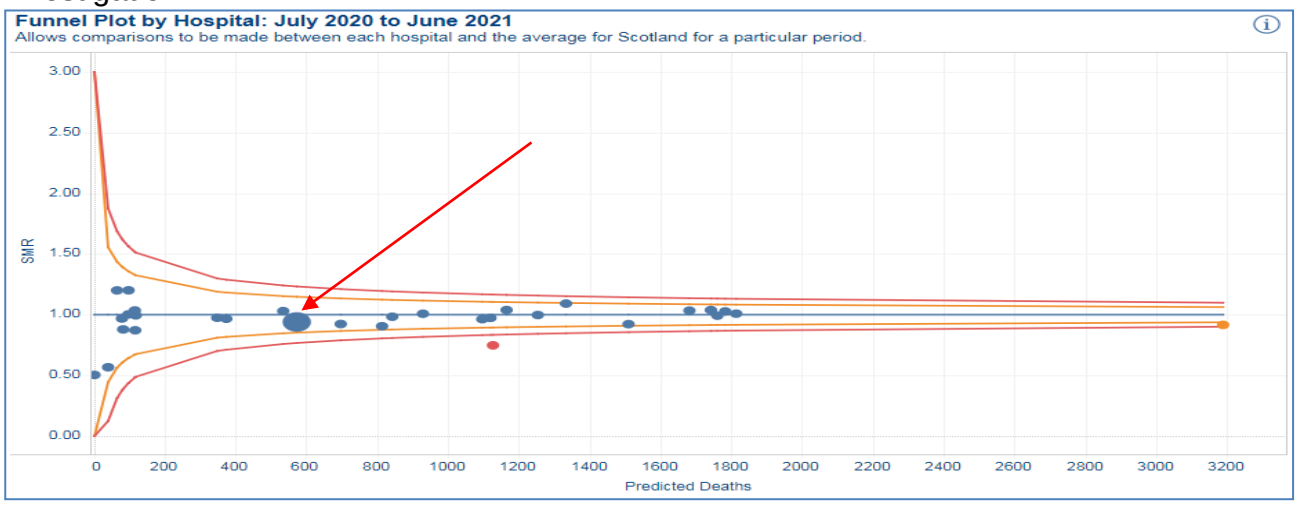
1.1.12 Whilst the Board Clinical Governance Committee continue to have close scrutiny of clinical pressures it was a recommendation from the November 2021 meeting that the public Board continue to receive a summary of the clinical pressures and the ongoing strain on staffing and resources.

2. PATIENT SAFETY

2.1 Hospital Standardised Mortality Rate (HSMR) and Crude Mortality

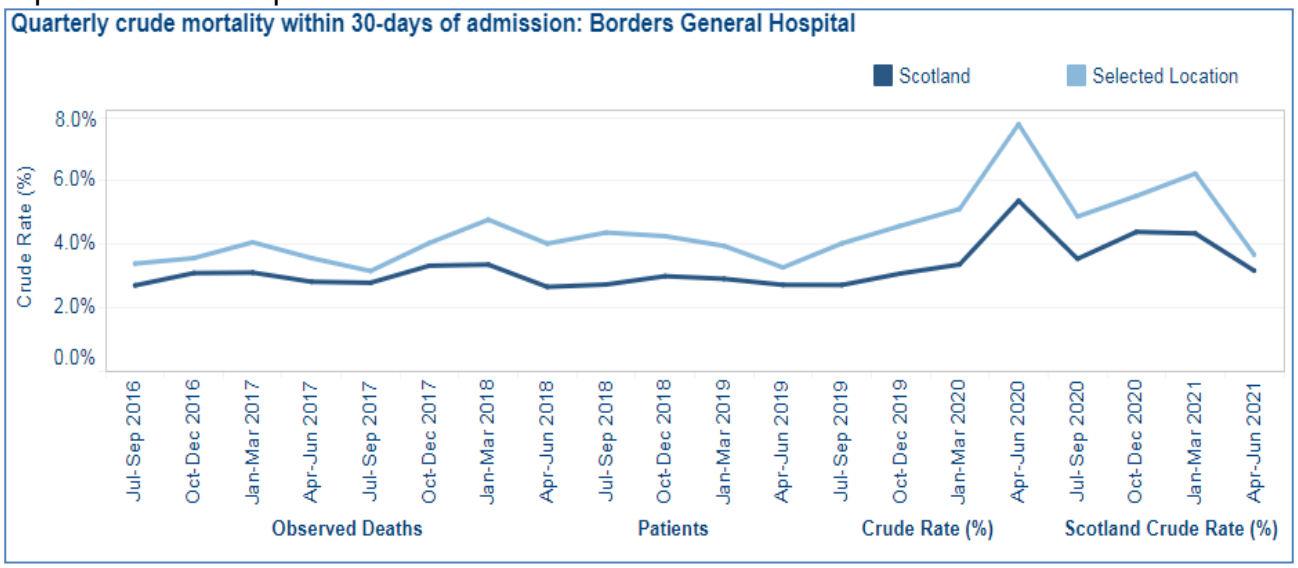
2.1.1 The NHS Borders HSMR for the tenth data release under the new methodology is **0.94.** This figure covers the period **July 2020 to June 2021** and is based on 539 observed deaths divided by 573 predicted deaths.

2.1.2 The funnel plot below shows **NHS Borders HSMR remains within normal limits** based on the single HSMR figure for this period therefore is not a trigger for further investigation:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.1.3 NHS Borders crude mortality rate for quarter April 2021 to June 2021 was **3.7%** and is presented in Graph 1 below:



*Contains deaths in the Margaret Kerr Palliative Care Unit

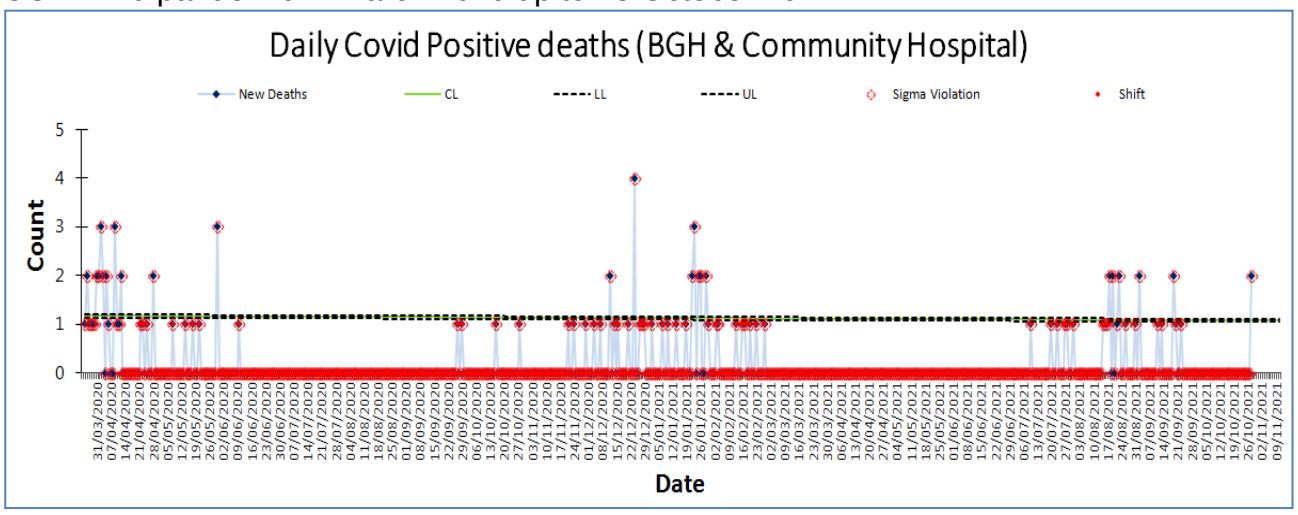
2.1.4 No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the BGH by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.1.5 COVID 19 deaths have contributed to an elevated crude mortality rate in wave 1 of the pandemic for the last quarter of 2019/20 and first quarter of 2020/21. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in these two quarters.

2.1.6 During the second wave of COVID 19 NHS Borders have experienced increased deaths from COVID 19 mirrored by an elevated crude mortality rate for the last two quarters of 2020/21.

2.2 COVID 19 Deaths

2.2.1 Graph 2 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 28 October 2021:



2.2.2 COVID 19 deaths between March 2020 and February 2021 occurring in a hospital within 30 days of admission have been reviewed for learning to inform the local delivery of care. In addition, the core mortality review programme has continued to review 20% of non-COVID 19 deaths in hospital within 30 days of admission. The collated summary of these reviews was presented to the Board Clinical Governance Committee in November 2021.

2.2.3 Advice has been sought through NHS Scotland Medical Directors and directly from the Scottish Government Chief Executive as to how the Duty of Candour should be applied in the context of COVID 19 nosocomial spread within inpatients. Guidance is awaited to inform local actions.

2.3 Care of the Deteriorating Patient

2.3.1 NHS Borders quality improvement lead for care of the deteriorating patient has, through the National Scottish Patient Safety Programme Expert reference group, been involved in co-designing the framework that underpins the collaborative aim to reduce harm and deliver better care and experiences for people in acute care. The main national aim continues to be on reducing cardiac arrests within the hospital setting. NHS Borders cardiac arrest rate is already fairly low (between 12-20 actual cardiac arrests annually).

Therefore NHS Borders focus is on early recognition and treatment of deterioration to reduce the incidence of Cardiac arrest.

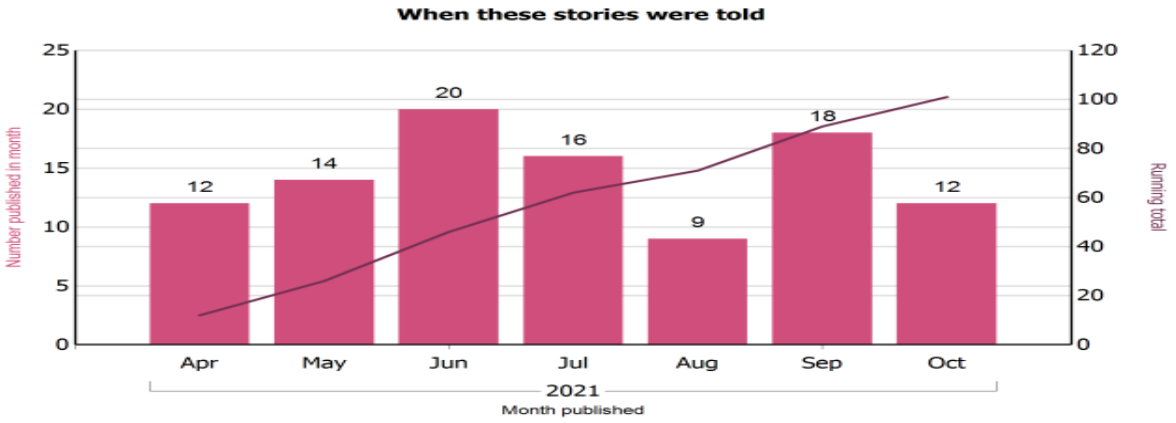
2.3.2 Both the National Early Warning Score 2 (NEWS2) and Intravenous (IV) fluids charts were rolled out within the BGH early spring 2020 due to the need for close observation and the monitoring of fluids particularly in COVID-19 patients, who can deteriorate rapidly due to the illness. Over the last few months steps have been taken to extend the use of NEWS2 to community settings with additional education and support. This is proven difficult to achieve due to continuing redeployment within the clinical areas, although planning is in place to continue the education and support of NEWS2 within the local Community and Care Home settings over the next three months.

2.3.3 An application for funding from the Centre for sustainable delivery was recently successful in gaining £17,000 towards providing further support towards the IV Fluid programme within NHS Borders. IV Fluid chart version 17 is currently being used throughout NHS Borders. A re-Audit of the accurate prescribing and completion of the charts is required prior to charts going to final print.

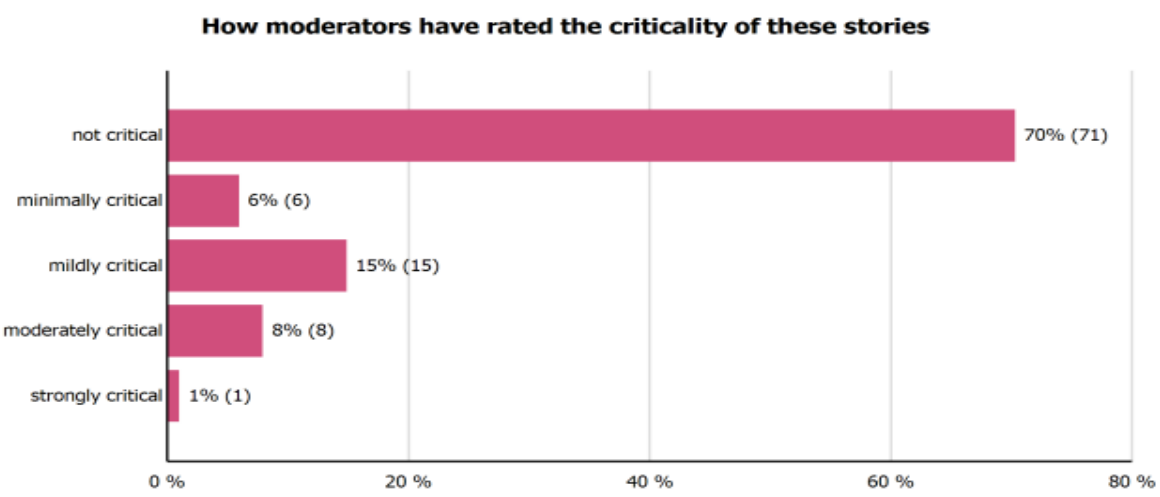
3. PATIENT EXPERIENCE

3.1 Care Opinion

3.1.1 For the period 1 April 2021 to 31 October 2021 101 new stories were posted about NHS Borders on Care Opinion. Graph 3 below shows the number of stories told in that period, as at 16 November 2021 these 101 stories had been viewed 14,643 times:



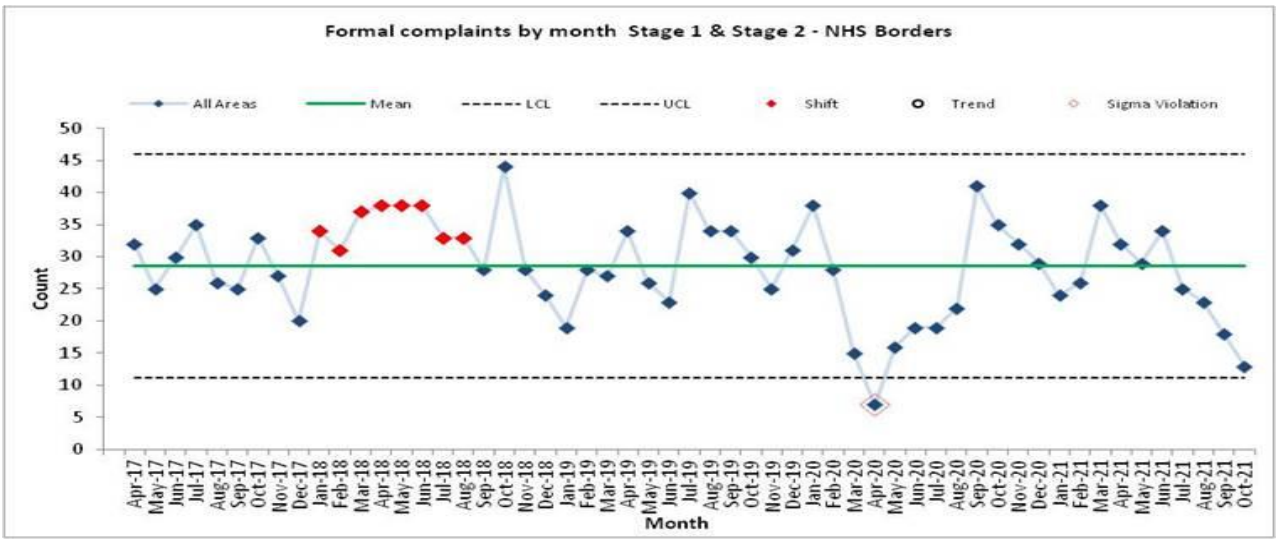
3.1.2 Graph 4 provides a description of the criticality of the 101 stories:



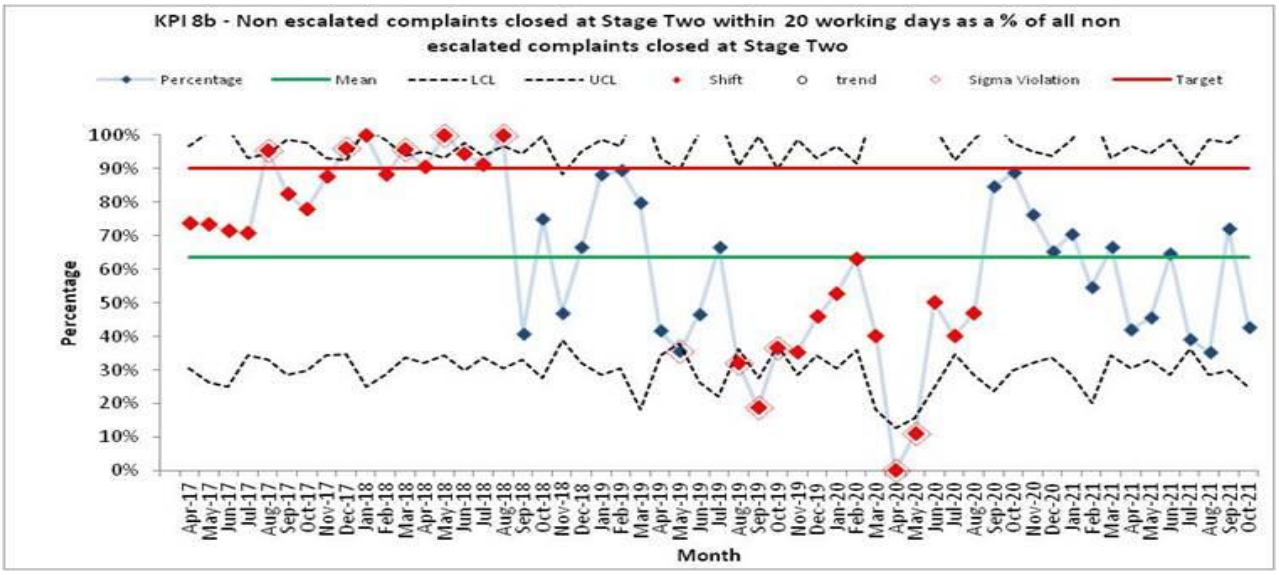
3.1.3 The word clouds below summarise what people felt was good and what could be improved in their posts about NHS Borders for this period:

3.2 Complaints

3.2.1 Graph 5 below gives the number of formal complaints received by month. The numbers of complaints being received are within normal limits, and show a reduction since June 2021:



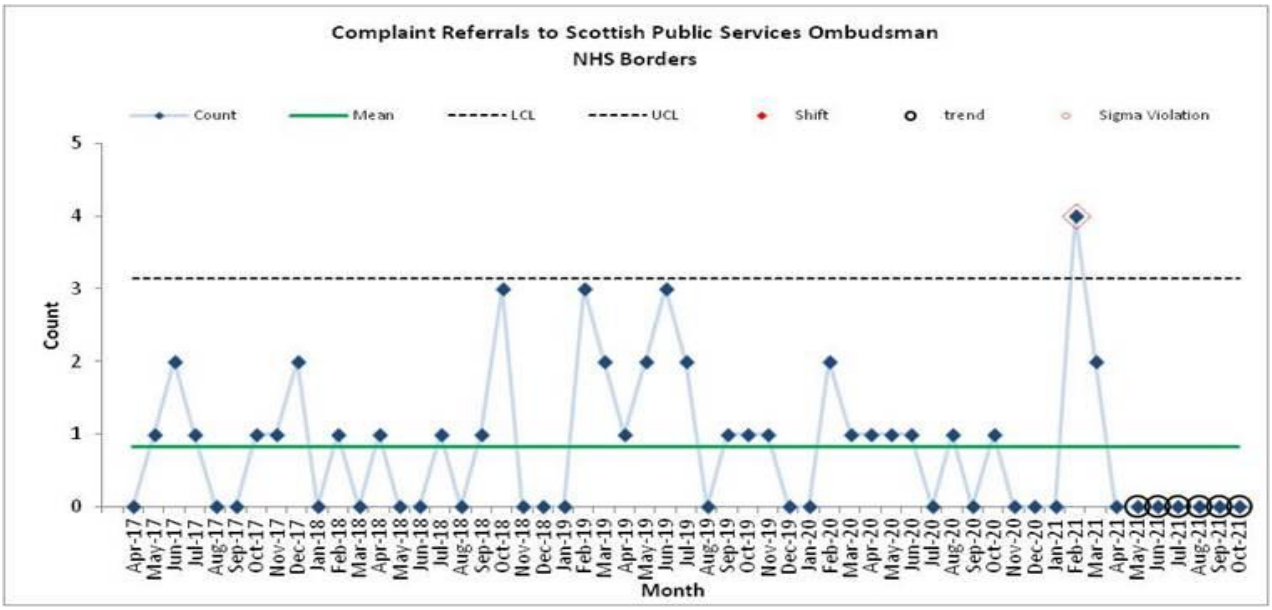
3.2.2 Graph 6 below shows the percentage of complaints responded to within 20 working days. As front line services continue to prioritise the remobilisation of services and on-going response to the COVID 19 pandemic clinical pressures have impacted on the ability of frontline clinical staff to respond to complaints investigations within normal timescales. This has impacted on the ability to consistently deliver responses within the 20 working day target. This is likely to continue over the autumn and winter period with the projected service demand profile:



3.3 Scottish Public services Ombudsman (SPSO)

3.3.1 The 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.

3.3.2 Graph 7 below shows complaint referrals to the SPSO to 31 October 2021. The graph shows a breach of the upper control limit in February 2021. Whilst the SPSO have not confirmed that they are investigating any new cases since March 2021, there have been 8 initial enquiries from the SPSO. Of these 8 cases, the SPSO have decided they will not investigate 5 cases and a decision is awaited on the remaining 3 cases:



4. Research and Innovation

4.1 NHS Borders continues to actively participate in priority COVID 19 studies, although there are significant ongoing challenges to clinical workload that make participation in the RECOVERY trial challenging. There is evidence that non-COVID clinical research activity is beginning to accelerate. NHS Borders has been approached to undertake three new clinical trials which are currently being assessed. In addition NHS Borders has been successfully awarded two new clinical trials in breast oncology which are expected to open late 2021/ early 2022.

4.2 NHS Borders continues to play an active role within Health Innovation South East Scotland (HISES) with partners NHS Lothian and NHS Fife. The structure of HISES is currently under review and a new Innovation Project Steering Group has been established to review innovation project proposals and assess suitability for regional support. The Chief Scientist Office is also undertaking a review of the Innovation Test Beds of which HISES is one, to assess whether the current structure and funding is appropriate. This review will include a self-assessment of regional activity. It is expected that there will be more direction given through the newly formed Scottish Health Innovation Partnership team to national priorities that the innovation test beds will be expected to support.

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Sarah Horan, Director of Nursing, Midwifery and AHPs
Author(s):	Natalie Mallin, HAI Surveillance Lead Sam Whiting, Infection Control Manager

HEALTHCARE ASSOCIATED INFECTION PREVENTION AND CONTROL REPORT September 2021

Purpose of Report:

The purpose of this paper is to update Board members on the current status of Healthcare Associated Infections (HAI) and infection control measures in NHS Borders.

Recommendations:

The Board is asked to **note** this report.

Approval Pathways:

The format of this report is in accordance with Scottish Government requirements for reporting HAI to NHS Boards. This report has not been submitted to any prior groups or committees but much of the content will be presented to the Clinical Governance Committee.

Executive Summary:

This report provides an overview for Borders NHS Board of infection prevention and control with particular reference to the incidence of Healthcare Associated Infections (HAI) against Scottish Government targets for infection control.

The report provides updates on:-

- NHS Borders infection surveillance against Scottish Government targets including *S.aureus* bacteraemia, *C.difficile* infections and *E.coli* bacteraemia
- Cleanliness monitoring, hand hygiene and the Infection Control compliance monitoring programme
- Infection Control work plan
- Incidents and outbreaks

Impact of item/issues on:

Strategic Context	This report is in line with the NHS Scotland HAI Action Plan.
Patient Safety/Clinical Impact	Infection prevention and control is central to patient safety
Staffing/Workforce	Infection Control staffing issues are detailed in this report.
Finance/Resources	This assessment has not identified any resource implications.
Risk Implications	All risks are highlighted within the paper.

Equality and Diversity	This is an update paper so a full impact assessment is not required.
Consultation	This is a regular bi-monthly update as required by SGHD. As with all Board papers, this update will be shared with the Area Clinical Forum for information.
Glossary	See Appendix A.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

1.1 Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland recently published the National Healthcare Associated Infection Annual Report for 2020. NHS Borders was not a statistical outlier for any of the Healthcare Associated Infections (HAI) included in the national surveillance programme for this time period. The full report is available to view via the link in Appendix B.

1.2 NHS Borders had a total of 22 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2021 and September 2021, 13 of which were healthcare associated infections.

1.2a The Scottish Government has 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 2021/22 (using 2018/19 as the baseline).

1.2b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 16 healthcare associated SAB cases per financial year. We are not currently on target to achieve this.

1.3 NHS Borders had a total of 7 *C. difficile* Infection (CDI) cases between April 2021 and September 2021; 4 of these cases were healthcare associated infections.

1.3a The Scottish Government has 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 2021/22 (using 2018/19 as the baseline).

1.3b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 9 healthcare associated CDI cases per financial year. We are currently on target to achieve this.

1.4 NHS Borders had a total of 58 *E. coli* Bacteraemia (ECB) cases between April and September 2021, 33 of which were healthcare associated.

1.4a The Scottish Government has set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2021/22 (using 2018/19 as the baseline) and with a total reduction of 50% by the end of 2023/24.

1.4b Based on total occupied bed days (TOBD) for the period April 2020 – March 2021, our target rate equates to no more than 25 healthcare associated ECB cases by 2021/22. We have not met this target. NHS Borders is not currently a statistical outlier from the rest of Scotland.

2.0 *Staphylococcus aureus* Bacteraemia (SAB)

See Appendix A for definition.

2.1 Between April and September 2021, there have been 22 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 1 case of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 1 shows a Statistical Process Control (SPC) chart showing the number of days between each 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.

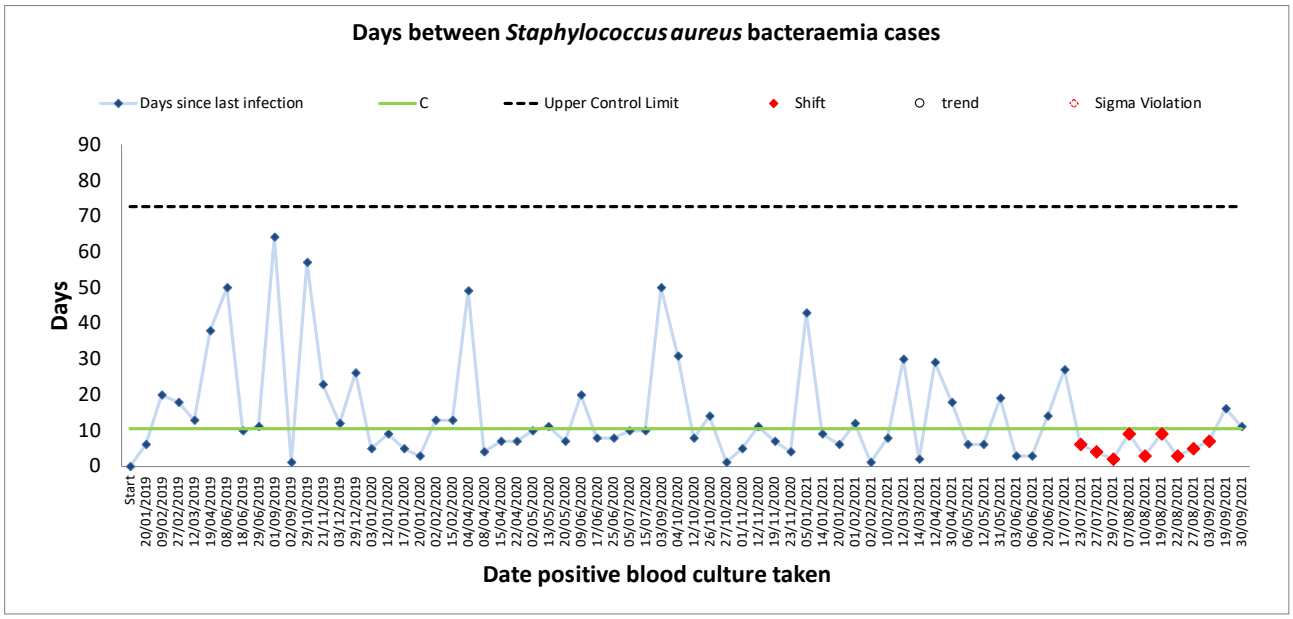


Figure1: NHS Borders days between SAB cases (January 2019–September 2021)

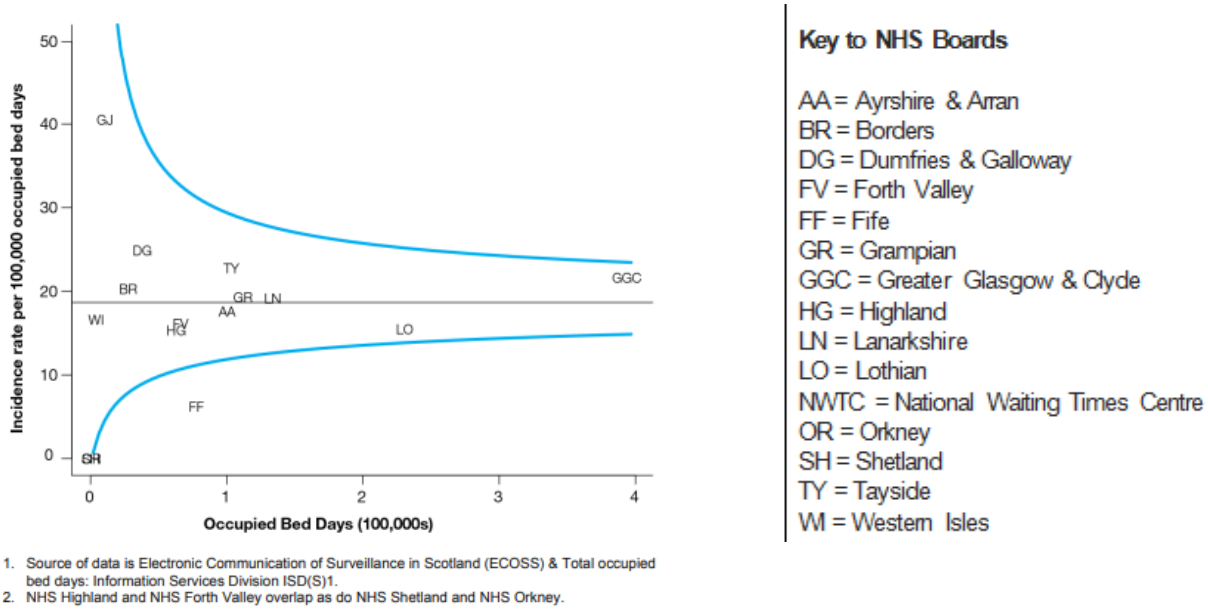
2.4 In interpreting Figure 1, it is important to remember that as this graph plots the number of days between infections, we are trying to achieve performance above the green average line.

2.5 The graph highlights that there has been a statistically significant shift in the number of days between SAB cases for the period July 2021 - August 2021. Review of the cases by Infection Prevention and Control (IPCT) has not highlighted a recurring theme or link with regards to SAB entry point and it is not thought that we currently have an outbreak. It is also worth noting that this graph includes community cases which had no healthcare intervention prior to the positive blood culture being taken.

2.6 During the reviews, the IPCT did identify poor documentation in relation to invasive devices which are a significant risk factor for bacteraemia. In response to this, we are currently exploring improvement opportunities with Clinical Nurse Managers.

2.7 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 2 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 2021 (Apr 2021 – Jun 2021).

2.8 During this period, NHS Borders (BR) had a rate of 20.3. The Scottish average rate was 18.7.

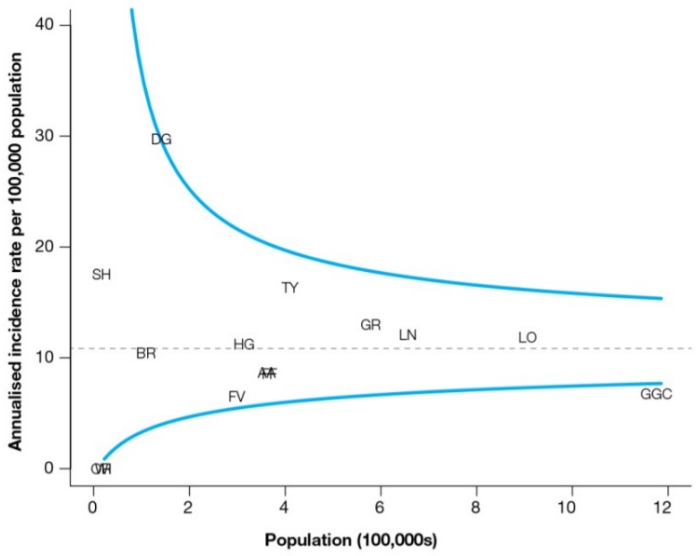


1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Highland and NHS Forth Valley overlap as do NHS Shetland and NHS Orkney.

Figure 2: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q22021

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. Figure 2 shows that NHS Borders was above the Scottish average rate but within the blue funnel which means that we are not a statistical outlier.

2.10 Figure 3 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q2 2021.During this period NHS Borders (BR) had a rate of 10.4 which was below the Scottish average rate of 10.9. Community acquired SAB 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) & NRS mid-year population estimates.
2. NHS Orkney and NHS Western Isles overlap as do NHS Ayrshire and Arran and NHS Fife.

Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2021

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 4 below shows a Statistical Process Control (SPC) chart showing the number of days between each 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. The graph shows that there have been no statistically significant events since the last Board update.

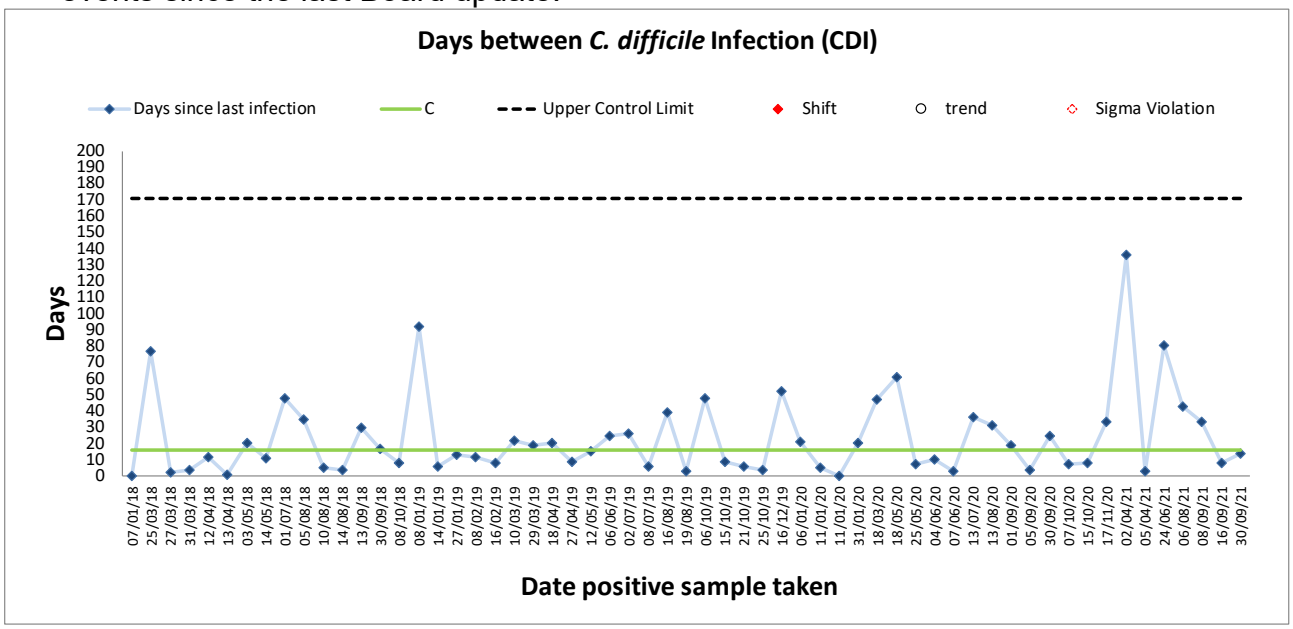
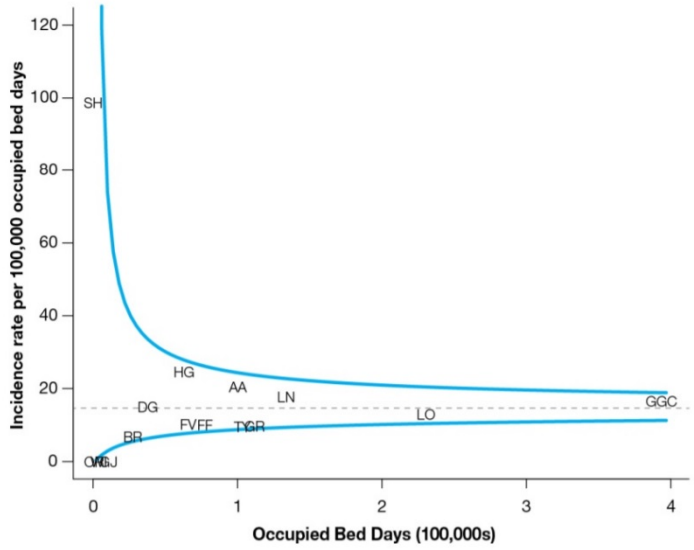


Figure 4: NHS Borders days between CDI cases (Jan 2018 – September 2021)

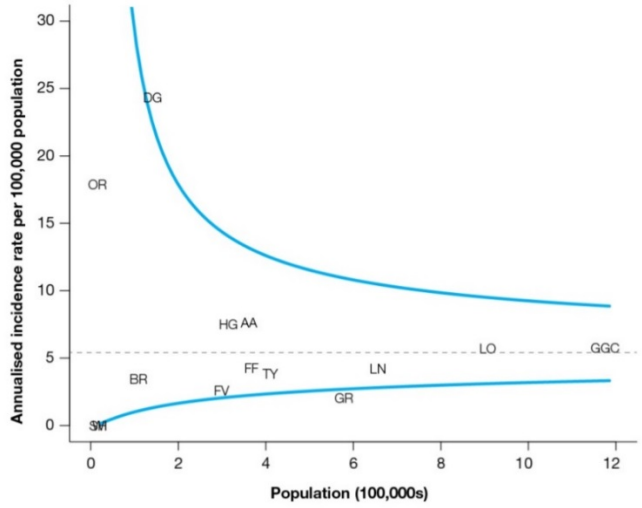
3.2 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q2 2021. The graph shows that NHS Borders (BR) had a rate of 6.8 which is below the Scottish average rate of 14.6.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Golden Jubilee, NHS Orkney and NHS Western Isles overlap as do NHS Grampian and NHS Tayside.

Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q2 2021

3.3 Figure 6 below shows a funnel plot of CDI incidence rates (per 100,000 population) in <u>community associated</u> infection cases for all NHS Boards in Scotland in Q2 2021. The graph shows that NHS Borders (BR) had a rate of 3.5 which is below the Scottish average rate of 5.4.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Shetland and NHS Western Isles overlap.

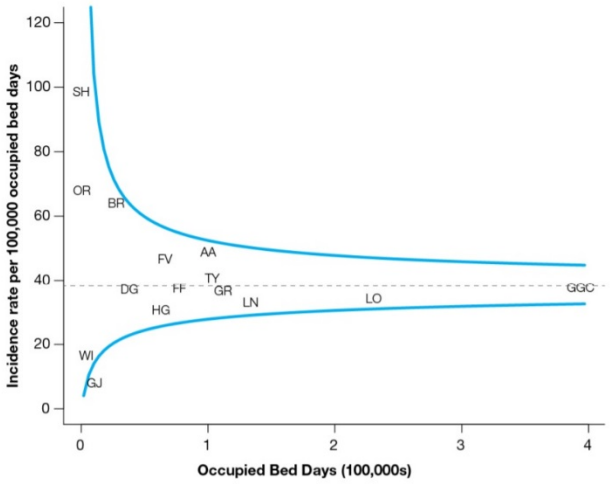
Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q2 2021

4.0 *Escherichia coli (E. coli)* Bacteraemia (ECB)

4.1 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI. The Prevention of CAUTI group continue to meet every 6 weeks to progress actions to reduce the associated risks. A key consideration of this group is to understand catheter use and management across NHS Borders as well as alternatives to catheterisation. The group is currently exploring options for capturing this information which can then be used to inform further improvement activity.

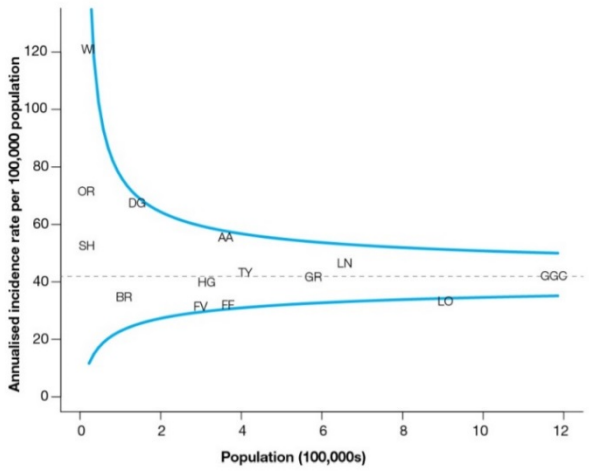
4.2ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 7 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2021. NHS Borders (BR) had a rate of 64.2 for healthcare associated infection cases which is above the Scottish average rate of 38.2; however, we are not a statistical outlier from the rest of Scotland.

4.3 Figure 8 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2021. NHS Borders (BR) had a rate of 34.8 for community associated infection cases which is below the Scottish average rate of 41.9. 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) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 7: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q2 2021



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.

Figure 8: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q2 2021

5.0 NHS Borders Surgical Site Infection (SSI) Surveillance

5.1 The Scottish Government updated the requirements for HAI surveillance on the 25th of March 2020. In light of the prioritisation of COVID-19 surveillance, all mandatory and voluntary surgical site infection surveillance has been paused from this date.

Mandatory surveillance of *E.coli* bacteraemia, *Staphylococcus aureus* bacteraemia and *C. difficile* Infections has continued but as light surveillance only.

6.0 Hand Hygiene

For supplementary information see Appendix A

6.1 The hand hygiene data tables contained within the NHS Borders Report Card (section 2, p.12) are generated from wards conducting self-audits.

6.2 NHS Borders' hand gel supplier (GoJo) periodically undertook hand hygiene audits and delivered ward-based training prior to the COVID-19 pandemic. A new nurse has recently been employed by the company and visited NHS Borders on the 31st August to recommence independent hand hygiene audits across an initial 5 areas. The outcome of these audits was overall compliance of 72%. Feedback was provided to the wards at the time of the audit. GoJo is due to return to NHS Borders on 16th November to re-audit some of the areas and provide on-site training to staff.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1The process of training Clinical Nurse Managers (CNMs) to complete spot checks out with their own area is ongoing. Uptake and training has been limited due to ICN capacity combined with staffing pressures across the acute site. To date, three CNMs have been trained.

7.2 IPCT capacity has recently increased with an infection control nurse returning to work from maternity leave. This has enabled the IPCT to resume some spot checking activity. In the last two months, spot checks have been undertaken in a total of 9 clinical areas across NHS Borders with an average compliance of 87%.

7.3 Full detailed Standard Infection Prevention and Control Precautions (SICPs) audits continue to be completed on a risk assessed basis by the Infection Prevention and Control Nurses.

8.0 Cleaning and the Healthcare Environment

For supplementary information see Appendix A.

8.1 The data presented within the NHS Borders Report Card (Section 2 p.12) is an average figure across the sites using the national cleaning and estates monitoring tool that was implemented in April 2012.

9.02021/22 Infection Control Workplan

9.1 The 2021/22 Infection Control Work Plan is an ambitious work plan given the ongoing impact of the COVID-19 pandemic. As at 03/11/2021 64% of actions due for completion have been completed with 13 actions outstanding. While these actions remain outstanding work towards them is progressing.

9.2 The Infection Prevention & Control Team (IPCT) report to each Infection Control Committee on progress against the 2021/22 work plan highlighting potential risks associated with any delay in implementation. IPCT prioritise activity associated with the highest risks such as outbreak management.

10.0 Outbreaks/ Incidents

COVID-19

10.1 In the period 1st September to the 5th October 2021, there were four COVID-19 related incidents for which a Problem Assessment Group and/or Incident Management Team was convened. Two of these incidents were single COVID-19 positive cases. The first incident occurred when a patient was admitted to a bay pending their COVID-19 admission screen result and later tested COVID-19 positive. The second incident occurred when a patient tested positive on their day 5 admission screen. In both cases, the patients were asymptomatic whilst in the bay and there was no evidence of onward transmission.

10.2 In September and October, there were two COVID-19 clusters which affected the following areas:

Wards affected	Total positive patients	Total positive staff	Total deaths
Medical Assessment Unit (MAU) and Hawick Community Hospital	3	2	X
Ward 9	7	0	X

10.3 It is worth noting that in Ward 9, the cluster was related to 3 separate bay closures during the same time period. It is not thought that these bay closures were related but the possibility can also not be excluded.

10.4 Learning from each incident is captured and acted upon in real time where appropriate. NHS Borders has implemented COVID-19 testing in ED which aids decisions on management and placement of patients and prioritisation of side rooms.

10.5 ARHAI Scotland produces data on COVID-19 cases by hospital onset status using national definitions (Appendix C). NHS Borders data for week ending 8th August 2021 to week ending 10th October 2021 is displayed in Figure 9 below.

Cumulative COVID-19 Cases by Hospital Onset Status
Summary

For NHS Borders, the total number of COVID-19 cases reported to National ARHAI Scotland, with specimen dates from week-ending 8 Aug 2021 to week-ending 10 Oct 2021, when including the community onset infections, was 3,601.

	% of total	n =
Community onset	98.6%	3,552
Non-Hospital onset	0.6%	23
Indeterminate Hospital onset	0.2%	8
Probable Hospital onset	0.2%	6
Definite Hospital onset	0.3%	12
Grand Total	100.0%	3,601

Figure 9: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

11.0 Infection Prevention and Control Team Capacity

11.1 Following successful interviews, a new trainee Infection Control Nurse has been appointed. A start date will be arranged when pre-employment checks have been completed.

11.2 The Infection Prevention and Control Team are currently undertaking a service review with the potential for future skill mix alterations.

12. New Winter Respiratory Guidance

12.1 On the 29th November 2021, the current national guidance on 'red', 'amber' and 'green' COVID-19 pathways will be replaced with winter 'respiratory' and 'non-respiratory' pathways which will apply across health and social care.

12.2 The current COVID screening questions for patients and service users will be expanded to include other respiratory symptoms.

- The current 'Amber' pathway is similar to the 'Non-respiratory' pathway and would include elective activity.
- The current 'Red' pathway is similar to the 'Respiratory' pathway.

12.3 Despite some similarities with current pathways, implementation of the new pathways would have far reaching implications for delivery of our services. Some aspects in the guidance continue to be discussed at a national level with further information and clarity awaited.

12.4 Meetings are being scheduled with each clinical board to support planning for implementation. The new guidance has also been discussed at the Care Home Oversight Operational Group.

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 hand hygiene and 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). More information on these organisms can be found on the NHS24 website:

Clostridioides difficile :**http://www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1**

Staphylococcus aureus :http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA:http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1

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 *C.diff* and SABs. More information on these can be found on the Scotland Performs website:

http://www.scotland.gov.uk/About/Performance/scotPerforms/partnerstories/NHSScotlandperformance

Understanding the Report Cards – Hand Hygiene Compliance
Hospitals carry out regular audits of how well their staff are complying with hand hygiene. Each hospital report card presents the combined percentage of hand hygiene compliance with both opportunity taken and technique used broken down by staff group.

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 infectionsand *Staphylococcus aureus (*including MRSA*)* bacteraemiacases 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

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
MRSA	0	0	0	0	0	0	0	1	0	0	0
MSSA	4	0	4	3	2	2	3	3	5	5	3
Total SABS	4	0	4	3	2	2	3	4	5	5	3

Clostridioides difficile infection monthly case numbers

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Ages 15-64	0	0	0	0	0	0	0	1	0	0	0
Ages 65 plus	1	0	0	0	0	2	0	0	0	1	3
Ages 15 plus	1	0	0	0	0	2	0	1	0	1	3

Hand Hygiene Monitoring Compliance (%)

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
AHP	100	98.1	100.0	98.0	98.8	98.8	97.8	96.4	97.8	98.2	94.2
Ancillary	100	91.9	94.9	96.7	99.3	92.6	100	98.8	95.2	97.5	92.2
Medical	100.0	100.0	92.3	95.0	97.0	92.4	96.3	96.2	94.3	98.8	96.2
Nurse	98.7	99.6	99.6	98.5	97.7	99.3	98.8	97.3	97.6	97.6	97.9
Board Total	**99.7**	**97.4**	**96.7**	**97.1**	**98.2**	**95.8**	**98.2**	**97.2**	**96.2**	**97.7**	**95.1**

*Self audit hygiene data reporting paused due to prioritisation of COVID-19 related work

Cleaning Compliance (%)

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Board Total	96.3	96.2	97.4	95.3	95.4	95.1	95.3	95.5	96.0	95.7	93.9

Estates Monitoring Compliance (%)

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Board Total	98.2	98.0	98.2	99.6	98.1	98.7	97.1	97.6	97.2	97.3	98.1

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	2	0	2	2	2	1	0	1	2	2	0
Total SABS	2	0	2	2	2	1	0	1	2	2	0

Clostridioides difficile infection monthly case numbers

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	1	0	0	0	0	2	0	0	0	0	0
Ages 15 plus	1	0	0	0	0	2	0	0	0	0	0

Cleaning Compliance (%)

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Board Total	96.3	95.4	96.5	96.0	96.7	97.3	93.6	95.3	96.1	95.5	95.6

Estates Monitoring Compliance (%)

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Board Total	99.1	98.1	99.1	98.8	99.1	98.5	93.1	95.5	95.0	95.7	95.5

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**

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	0	0	0	0	0	0	0	0	0	0
Total SABS	1	0	0	0	0	0	0	0	0	0	0

***Clostridioides difficile* infection monthly case numbers**

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
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**

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
MRSA	0	0	0	0	0	0	0	1	0	0	0
MSSA	1	0	2	1	0	1	3	2	3	3	3
Total SABS	1	0	2	1	0	1	3	3	3	3	3

***Clostridioides difficile* infection monthly case numbers**

	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021
Ages 15-64	0	0	0	0	0	0	0	1	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	1	3
Ages 15 plus	0	0	0	0	0	0	0	1	0	1	3

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 : http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346

MRSA:http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252

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:

http://www.hps.scot.nhs.uk/haiic/sshaip/publicationsdetail.aspx?id=30248

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:

http://www.hps.scot.nhs.uk/haiic/sshaip/ssdetail.aspx?id=277

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

Information on national hand hygiene monitoring can be found at:

http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be found at:

http://www.washyourhandsofthem.com/

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 the Healthcare Environment Inspectorate. More details can be found at:

http://www.nhshealthquality.org/nhsqis/6710.140.1366.html

APPENDIX B

ARHAI Scotland 2020 Annual Report

https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3212/documents/2_2021-09-21-arhai-hai-annual-report-2020.pdf

APPENDIX C

ARHAI Scotland COVID-19 Hospital Onset Definitions

Day of sampling post admission	Nosocomial categorisation
Before admission	Community onset COVID-19
Day 1 of admission/on **admission to NHS board**	Non-hospital onset COVID-19
Day 2 of admission	Non-hospital onset COVID-19
Day 3 of admission	Indeterminate hospital onset COVID-19
Day 4 of admission	Indeterminate hospital onset COVID-19
Day 5 of admission	Indeterminate hospital onset COVID-19
Day 6 of admission	Indeterminate hospital onset COVID-19
Day 7 of admission	Indeterminate hospital onset COVID-19
Day 8 of admission	Probable hospital onset COVID-19
Day 9 of admission	Probable hospital onset COVID-19
Day 10 of admission	Probable hospital onset COVID-19
Day 11 of admission	Probable hospital onset COVID-19
Day 12 of admission	Probable hospital onset COVID-19
Day 13 of admission	Probable hospital onset COVID-19
Day 14 of admission	Probable hospital onset COVID-19
Day 15 of admission and onwards to discharge	Definite hospital onset COVID-19
Post discharge	Community onset COVID-19

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

STAFF GOVERNANCE COMMITTEE MINUTES 14.06.2021

Purpose of Report:

The purpose of this report is to share the approved minutes of the Staff Governance Committee with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

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.

Impact of item/issues on:

Strategic Context	As per the Staff Governance Committee Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Compliant.
Consultation	Not Applicable.
Glossary	-

NHS Borders

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Monday, 14th June 2021, 2pm via Microsoft Teams

Present: Councillor D Parker, Non-Executive Director, Chair
Ms S Lam, Non-Executive Director
Ms H Campbell, Non-Executive Director

In attendance: Mr A Carter, Director of Workforce
Mr R Roberts, Chief Executive
Mrs E Cameron, HR Manager/OD Partner
Mrs Y Smith, Partnership Lead Staff-side, RCN
Mrs J Boyle, HR Manager
Mrs M Phillips, Minutes

1. Welcome, Introductions and Apologies

Councillor Parker welcomed everyone to the meeting.

Apologies were noted from Mrs A Paterson, Mrs V Hubner, Mr R Salmond, Mr J McLaren

2. Minutes of previous meeting held on 15th March were agreed as an accurate record of the meeting

Matters Arising

2.1 Gender and Part-time Working

Recent analysis has shown that almost 80% of the workforce is female, and that female workers are more likely to work part-time than their male counterparts. The Equality, Diversity & Inclusion in Employment Group will give this further consideration, specifically discussing how much of this is by choice (to accommodate caring responsibilities which might fall to females more than males) or whether only part-time working is offered in some job families.

2.2 Whistle-blowing

The new INWO standards came in from 1st April 2021. NHSB created an implementation plan to be in a position to receive its first whistle blowing complaints. To date, NHSB has not received any. NHSB is looking at the up-take of training around whistle blowing and looking at how whistleblowing sits within the IJB and independent contractors. Ms Lam commented that following Scottish Government advice she has not been involved with the SLWG which was set up around Whistleblowing but will be involved with an oversight group. Mr Carter advised that the ToR for the oversight group will be brought back to SGC once finalised.

2.3 Equality, Diversity & Inclusion in Employment Group

A revised ToR has been developed following feedback, including a statement that someone other than the Employee Director or Director of Workforce will Chair the group in the long-term, with any necessary support given and with the possibility of this being a developmental opportunity for someone from a minority group.

Ms Campbell asked for assurance that NHSB will try to improve its understanding of the level of disability inside the workforce and seek greater confidence in people disclosing this. Mr Taylor believed there was considerable under-reporting of disability inside the workforce and Mr Carter agreed to respond to this in coming weeks.

Ms Lam enquired if this group is monitoring culture and behaviour for the whole organisation or specific to this group, and what are the indicators of success. Mrs Cameron added that there has been work done nationally around culture and could look at building that into the organisation so that it is measurable and acceptable.

3. Workforce Metrics

Mr Carter reported on the workforce metrics submitted to the Committee. This covered the highlights of 2021 and shows how both Covid waves have impacted on the workforce.

Ms Lam asked about high staff turnover and questioned if the expiry of fixed-term contracts increases this and is there anything in the exit interviews to indicate the reasons for leaving. Mrs Cameron responded that there have been a lot of fixed-term contracts issued to bolster the workforce during Covid waves and these have subsequently come to an end. NHSB is looking at changing over to an electronic system for exit interviews rather than paper based which will allow data to be available.

The Committee noted the paper

4. Annual SG Monitoring Return

Mrs Cameron reported that the monitoring of Staff Governance had been stood down during Covid and has now been reinstated. Scottish Government has asked some very specific questions this time and we are working on this at the moment. The deadline to return to Scottish Government is September and will be signed off locally by Director of Workforce and Chief Executive and then through the Chair of this Committee.

The Committee noted the update

5. iMatter Update

Mrs Boyle advised the Committee that the iMatter survey will be live on 16th August 2021 and will run until 6th September 2021. The 60% response threshold has been removed this year and NHS Borders will receive a Board report for the first time in 4 years. Smaller teams of four or fewer people will still require 100% response rate in a bid to maintain confidentiality of individual opinion. An SMS text option is being introduced. NHSB is encouraging managers to move away from paper responses. Teams who respond online will receive their team report on 7th September 2021 whereas teams who complete paper responses will receive their team report on 20th September. Teams will now have 8 weeks to upload their action plans.

Mr Roberts asked if the organisation had the infrastructure to support the use of SMS text, in terms of collecting phone numbers. Mrs Boyle replied that line managers, when completing the team confirmation stage, will need to engage with their staff to get telephone numbers and HR are offering to support bigger teams if they need it. Staff can use personal or work phones, as well as personal email addresses.

Ms Lam asked how will NHSB know that action plans are being followed through and how is this measured. Mr Roberts responded that it would be good idea to link this into appraisals and incorporate this into the QMS staff engagement pillar. It is hoped that Board members will complete iMatter this year.

The Committee accepted this update.

6. Quality Management System – Staff Engagement Pillar

Mr Carter updated the Committee that there are number of pillars in QMS and one of them is Staff Engagement. This is led by Ms Horan, Mr McLaren and Mr Carter. Work is ongoing to ensure Staff Governance and iMatter are being focused on and future updates will be brought back to this meeting.

7. NHS Borders Interim Workforce Plan

Mr Carter updated the Committee that an Interim Workforce Plan has been submitted to Scottish Government and feedback is awaited. NHS Borders is hoping to engage the IJB to have a 3 year plan ready for April 2022.

Ms Lam asked if the plan will be aligned with the Clinical Strategy that is being worked on. Mr Roberts confirmed that NHSB is developing a new service strategy and the plan is to align these. Ms Lam asked what plans are in place to retain the ageing workforce. Mr Carter responded that the HR Directors are focusing on these issues throughout Scotland at the moment. The dashboard does show that there are high numbers of staff in the 50-54 year old group and succession planning will be very important.

The Committee approved this update.

8. Living Wage Accreditation

Mr Carter spoke on behalf of Mr McLaren who was not available for the meeting. NHSB is taking forward a joint initiative with Scottish Borders Council. NHSB is confident that it will meet the Real Living Wage Accreditation standard. Procurement has worked hard with Estates & Facilities, IM&T and Finance to examine the existing contracts that come under the remit of this accreditation and these employers will be contacted shortly. There will be communications released within the next couple of months to confirm that NHSB is supporting this accreditation.

The Committee acknowledged the work undertaken to date and supported pursuit of the accreditation.

9. East Region Recruitment

Mrs Cameron reported that in June 2018, all NHS Chief Executives agreed the recommendations from the Shared Services Recruitment Strategic Proposal to transform recruitment services across Scotland; to be delivered from three regional recruitment hubs. This work was progressed using robust project management techniques and has resulted in the establishment of an East Region Recruitment Service. The six Health Boards in the East Region are NHS Lothian, NHS Fife, NHS Borders, National Education for Scotland, Health Improvement Scotland and the Scottish Ambulance Service. The Board approved the decision to enter into this consortium in September 2020.

NHS Lothian has been identified as the Single Lead Employer and all recruitment staff who wished to remain part of the recruitment service have been transferred to NHS Lothian employment (TUPE) on 01 June 2021. In practice, there is no change to the recruitment service and it is business as usual. Organisational change will be taking place for these staff from July 2021 and NHSB is hoping to have a soft launch of the service in August 2021. From then on, the recruitment teams will be working closely together across the East Region with a fully functioning service in place by December 2021.

Ms Lam asked what the benefits and the risks are to having this in place. Mrs Cameron replied that Recruitment will start to perform to national agreed KPIs and this will provide robustness. Locally NHSB has a small recruitment team and have experienced high volumes of recruitment lately which means NHSB has had to triage recruitment to prioritise the filling of key vacancies. Using a shared service will allow the workload to be spread more evenly and allow for joint working. The risks are losing direct control over the recruitment team and relying on someone else to manage it. There will be a liaison person in place to manage the new relationship.

Ms Campbell asked if all staff took the option to TUPE over and Mrs Cameron replied that all but one employee did TUPE into the new structure.

.

The Committee accepted the update.

10. Training & Development Board

Mr Carter discussed the Training & Development Board. NHSB is establishing an overarching group to look at performance around training, with a particular focus on statutory and mandatory training. Meetings have been established with Co-Chairs - Director of Nursing Midwifery & AHPs, Employee Director and Director of Workforce and the ToR are being drafted. Updates will be brought to the Staff Governance Committee with some key training stats at a future meeting.

Ms Lam commented that this approach is very welcome, and staff do appreciate the investment in them in terms of their professional and personal development. A quality learning environment encourages students to want to stay and work here and it would be useful to able to measure this.

The Committee accepted the update.

11. Staff Charter - PACS

Mr Carter spoke to this item. PACS have launched this initiative in May 2021 to raise the profile of staff governance within the Community workforce. This does fit in with the Staff Pillar of the QMS as well as iMatter.

Ms Lam commented that she welcomes this and asked if other Quads will take this on and how will this align with the organisational vision? Mr Roberts added that we need to find the balance to allow parts of the organisation with devolved responsibility to tailor their response to any organisational vision. There will be consideration of taking this approach to the other clinical boards.

The Committee accepted the update.

12. Once for Scotland Policies

Mr Carter spoke to this item. The 'Once for Scotland' Workforce Policies Programme was paused at the end of March 2020, as efforts focused on the response to the coronavirus pandemic. The Home Working PIN Policy is being advanced though. The final consultation for this will take place during June/July 2021.

The Committee accepted the update.

13. Brexit

Mr Carter reported that from 2017 NHS Borders has concentrated on firstly identifying E.U. nationals in the workforce and then encouraging uptake of the settled status scheme by EU nationals resident before 31 December 2020. A workforce survey undertaken in the Autumn/Winter of 2017 led to 57 EU nationals responding and registering for email updates.

NHSB has sought to provide information and support to E.U. nationals and their line managers when they have chosen to come forward. With regular direct communication throughout the transitional period NHSB is confident that E.U. nationals in our workforce are aware of the deadline for EUSS applications.

Information from colleagues at Scottish Borders Council suggests that 200 EU nationals living in the Scottish Borders have still to apply for EUSS, hence the final push with NHSB communications last month.

Ms Campbell asked if there might be staff who find themselves in the position of being illegally employed from 1st July 2021 and are we confident there is no retrospective liability to the organisation? Mrs Cameron replied that NHSB has reached out to staff and has a robust register of staff involved. After 1st July 2021, NHSB should not be employing anyone illegally. Mr Carter added that this would be looked into and a response prepared for Ms Campbell.

The Committee accepted the update.

14. HR Related Activity

Mr Carter spoke to this item. As a requirement of NHSB internal audit process, ER case work is reported to the Staff Governance Committee and Area Partnership Forum on an annual basis.

The report highlighted Bullying & Harassment, Capability, Misconduct, Grievance, Workforce Policies and Whistleblowing stats and is a breakdown of who has been engaged in these processes.

The Committee accepted the report

15. Any Other Business

No other business

The Chair closed the meeting by thanking people for attending.

Date of next meeting:

Monday, 25th October 2021, 2.00pm, via Microsoft Teams

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Iris Bishop, Board Secretary
Author:	Iris Bishop, Board Secretary

AREA CLINICAL FORUM MINUTES 22.06.21

Purpose of Report:

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

Recommendations:

The Board is asked to **note** the minutes.

Approval Pathways:

This report has been prepared specifically for the Board.

Executive Summary:

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.

Impact of item/issues on:

Strategic Context	As per the Area Clinical Forum Terms of Reference. As per Freedom of Information requirements compliance.
Patient Safety/Clinical Impact	As may be identified within the minutes.
Staffing/Workforce	As may be identified within the minutes.
Finance/Resources	As may be identified within the minutes.
Risk Implications	As may be identified within the minutes.
Equality and Diversity	Not Applicable.
Consultation	Not Applicable.
Glossary	-

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 22nd June 2021 – 13:00 – 14:00
Via Microsoft Teams

Present: Alison Wilson (Chair; Area Pharmaceutical Committee) (AW)
Dr Kevin Buchan (GP/Area Medical Committee Chair/ACF Vice-Chair) (KB)
Nicky Hall (Area Ophthalmic Committee) (NH)
Paul Williams (Allied Health Professionals) (PW)
Kim Moffat, Minute Secretary (KM)

Apologies: Dr Caroline Cochrane (Psychology) (CC)
Ehsan Alanizi (Area Dental Advisory Committee) (EA)
Jackie Scott (Medical Scientists) (JS)
Peter Lerpiniere (Associate Director of Nursing for MH, LD & Older People) (PL)
John McLaren (Employee Director) (JMcL)

1 Covid Vaccinations Update

AW gave a brief overview of the latest Covid Vaccine position for NHS Borders, with thanks to Rob Cleat for providing this data. We are seeing a steady uptake of vaccines, drop in sessions starting this weekend and 18-29 year olds can go online and book an appointment for their vaccine.

2 APOLOGIES and ANNOUNCEMENTS

AW welcomed those present to the meeting and acknowledged the apologies listed above.

3 DRAFT MINUTE OF PREVIOUS MEETING 23.03.21

The Minute of the previous meeting, held on 23rd March 2021, was read and approved as an accurate record of the meeting with no changes.

AW touched on assurance standards, and that Iris Bishop will attend a future meeting to give the committee an update on this item.

ACTION: Update and remove draft; available to IB in committees drive for NHS Borders Board (KM)

4 MATTERS ARISING AND ACTION TRACKER

Action Tracker updates:-
AW and KM reviewed and updated the action tracker prior to this meeting. The committee is being asked for a formal work plan.

- Olive to come along to discuss new funding that is available for Realistic Medicine

ACTION: AW to meet with Ehsan Alanizi and Jackie Scott to discuss deputy attendance.

Safe staffing – more work done on nursing side. Applies to all clinical areas, get up date form Clare, suspended due to Covid. PL noted that Lynn Boyle leading on this safe staffing work, progressed in due course.

Public Protection – Rachael Pulman to come in October 2021.

5. Pharmaceutical Care Services Plan

AW gave a brief overview of this plan, which was circulated to ACF members before this meeting. ACF members were asked to review and approve or reject the plan, by email. As all responses were to approve the plan, the plan is herby ratified.

6 Whistleblowing

ACF should be sighted on whistleblowing as this is applicable to independent contractors, so should be able to raise concerns via confidential contacts, which are named as John McLaren and Andy Carter. Sonya Lamb is the Borders Non-Executive Director with specific responsibility for Whistleblowing, she can also be approached.

NH noted that Optometry have their own guidelines for whistleblowing and that she would share these with the committee.

ACTION: NH to email KM the Optometry guidelines so KM can issue to the ACF for information.

7 Clinical Prioritisation group

Hydrotherapy – issue being raised again, hydrotherapy unit being used to store surplus furniture currently.

PW has reviewed the history of Hydrotherapy within NHSB. If NHSB closed this service, then understanding was that an alternative location may be used. The hydrotherapy pool is part of AHP remobilisation plan, if not opened, then we would be the only health board in Scotland without one. This is currently with the Capital Planning group for costings, reviewing long and short term plans, then it will go to clinical prioritisation group. There is a valid clinical argument for the hydrotherapy pool, but there's nothing to say this has to be located at the BGH.

KB asked if the space for hydro pool is best, given the huge outpatient waiting lists. Outpatients ,ay possibly make better use of this space. PL commented that the backlog of patients does really affect the potential use of space.

PW advised that significant work would need to be done to change the space to be suitable for outpatients. Valid question to ask, clinical prioritisation will pick this up.

Clinical Prioritisation Group Feedback:

IM&T plan reviewed, lots of urgent items, is now being scored, to identify high priority items.

The CP group will then review Estates work, as there is a huge backlog and current demand for Estates.

8 CLINICAL GOVERNANCE COMMITTEE: FEEDBACK – AW

The CGC met a few weeks ago, usual topics (Infection Control), concern on Infection control (IC) Nursing, lack of ability to recruit, very important, looking at different ways to recruit to these posts. Not NHSB issue, it is being seen across Scotland.

Kirk Lakie gave an EAS update.

Care homes – there is a new agenda on this, positive feedback and good work going on in the care homes.

Dental access – there is a request for a deep dive around this, and inequalities that have been identified in this area due to Covid.

PL commented regarding IC nursing recruitment – the recruitment across all specialities is a huge area of concern. Nursing used to have 2 out turns a year, then it was 1, can we go back to 2? This is challenging for staff, looking at skill mix. Covid has possibly affected staff retirement/retention. This takes away experienced staff vs newly qualified staff with current, more modern knowledge.

AW advised there is a new pharmacist starting in the near future, unsure of date. Pharmacist education in training is changing also.

NH noted there is a backlog for Ophthalmology, (cateracts etc) with no trainees at present.

9 PUBLIC GOVERNANCE COMMITEE: FEEDBACK

No update as this meeting wasn't attended due to a diary clash.

10 NATIONAL ACF CHAIRS MEETING: FEEDBACK

Agenda sent, minutes also received, Interested to hear from other boards

11 NHS BOARD PAPERS: DISCUSSION

No concerns were raised in relation to board papers.

Remobilisation plan – we have attended various meetings on this, we are currently on Remobilisation plan 3, likely we will be required to do Remobilisation plan 4, possibly in September.

NHS borders have been de-escalated to level 2 for leadership, and level 3 for finances, this is really good news.

12 PROFESSIONAL ADVISORY COMMITTEES

12(a) Area Dental Advisory Committee (EA) - No update.
12 (b) Area Medical Committee/GP Sub Group (KB):
GP Sub – contract nature items, almost everything coming to fruition, VTP and CTACS, in good position to deliver a significant contract provision.
AMC – good, planned meeting to deliver change in the future. Use momentum to drive change in services, in a more open way for patients. A piece of work on long term conditions is ongoing.

12 (c) Area Ophthalmic Committee (NH) – No meeting, AGM planned for Teams.

A meeting was held with hospital (hospital ophthalmic team, Lynn McCallum, and others) to discuss work between AOC and Ophthalmology in BGH. Good meeting, no other follow up since.

12 (d) Area Pharmaceutical Committee (AW) – Pharmacy First was discussed as well as the changes in that, minor ailments service expanded to also include minor skin conditions. Pharmacy training for independent prescribers. New pharmacy application in Tweedbank being pursued. Application has been ongoing for a number of years, not progressed.

12 (e) Allied Health Professionals Advisory Committee (PW) – AHP service leads are in post, will assist with SHP structures. Topics discussed at AHP Professional Leads have included:

- Remobilisation – any professional issues that has arisen through remobilisation
- Advanced Practice – standardisation, governance and competency of Advanced Practice roles across AHP professions
- Practice Education – updates on clinical supervision, practice based learning backlog and future plans
- National updates – transforming roles agenda, national rehabilitation framework
- AHP structure – update on local AHP structure changes

12 (f) BANMAC (PL) – Last meeting was focused on development on nursing strategy, Nicky Berry and Sarah Horan had asked for this work. Reps have been asked to speak to their groups and feedback to BANMAC meeting.
Nursing vision; how do we see the workforce going forward, how to retain and sustain workforce,

12 (g) Medical Scientists (JS) – no update as a representative was present at this meeting.
12 (h) Psychology (CC) – no update as a representative was present at this meeting.

ACF noted the updates available.

ACTION: **All Advisory Committee representatives to send an update if unable to attend (KM-ALL)**

12 NHS BORDERS BOARD: FEEDBACK TO THE BOARD

- New pharmacy application in Tweedbank being pursued. Application has been ongoing for a nuber of years, not progressed.
- PL: Staff recruitment/retention/retirement recruitment challenges vs retiring colleagues (Covid concerns)
- Nursing strategy from BANMAC, Board to note
- PW: working closely to ensure moving in the same direction
- AMC progressing well and work ongoing

13 ANY OTHER BUSINESS

None.

DATE OF NEXT MEETING

The next Area Clinical Forum meeting is scheduled for **5th October 2021** at 13:00 via Microsoft Teams.

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Dr Tim Patterson Director of Public Health
Author:	Sara Mehdi and Dr Keith Allan Associate Director of Public Health

NHS BORDERS EQUALITY MAINSTREAMING REPORT 2021

Purpose of Report:

The purpose of this report is to advise the Board of progress made in Equality Mainstreaming and seek approval for publication.

Recommendations:

The Board is asked to Approve the report and its publication.

Approval Pathways:

This report has been reviewed by Health Inequality Steering Group.

Executive Summary:

i. Welcome to NHS Borders 2021 Equality and Diversity mainstreaming report.

ii. NHS Borders is an organisation which values diversity and equality. This report provides an overview as to the progress made to deliver this vision. Each NHS Board in Scotland has a duty to comply with the three aims of the Public Sector General Duty, the Equality Act 2010, and Specific Duties Scotland Regulations 2012, for NHS Borders this report serves as a valuable tool for the organisation in developing continuous improvement planning to embed mainstreaming now and into the future.

iii. The purpose of the Public Sector General Equality Duty is to ensure that all public bodies, including health boards, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. The current duty requires equality to be considered in relation to key health board functions including the development of internal and external policies, decision making processes, procurement, workforce support, service delivery and improving outcomes for patients/service users.

iv. The following list provides the specific duties which are intended to support public bodies, including health boards, in their delivery of the General Equality Duty:

1. Report progress on mainstreaming the public sector equality duty
2. Publish equality outcomes and report progress
3. Assess and review policies and practices (impact assessment)
4. Gather and use employee information

5. Publish statements on equal pay 6. Consider award criteria and conditions in relation to public procurement 7. Publish in a manner that is accessible v. This report includes routinely collected information as well as case studies to illustrate how NHS Borders is working towards mainstreaming as well as examining areas that require further improvement and development. vi. NHS Borders recognises the impacts Covid-19 has had on our patients, families, carers, staff and members of the wider Scottish Borders community and how this has increased equality challenges.	
Impact of item/issues on:	
Strategic Context	Statutory function to publish a Equality Mainstreaming Report to detail progress on mainstreaming the Public Sector General Duty • All Boards in Scotland are required to comply with the Public Sector General Duty, Equality Act (2010) and (Specific Duties) (Scotland) Regulations 2012. Implementation of these duties monitored by the Equality and Human Rights Commission in Scotland. • The purpose of the Duty is to ensure that all public bodies, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. • The duty requires equality to be considered in relation to key health board functions including the development of internal and external policies, decision making processes, procurement, workforce support, service delivery and improving outcomes for patients/service users.
Patient Safety/Clinical Impact	Mainstreaming helps ensure that we are a safe, effective and person centred organisation. The three aims of the 2010 Act's Public Sector General Equality Duty are as follows: • Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act. • Advance equality of opportunity between persons who share a relevant characteristic and persons who do not. • Foster good relations between people who share a protected characteristic and those who do not.
Staffing/Workforce	The purpose of the Duty is to ensure that all public

	bodies, mainstream equality into their day to day business by proactively advancing equality, encouraging good community relations and addressing discrimination. Mainstreaming should therefore have the effect of increasing inclusion within the workforce.
Finance/Resources	N/A
Risk Implications	No risk assessment undertaken as part of this report.
Equality and Diversity	See strategic context above.
Consultation	This report was compiled with the help of HR colleagues who supplied a large part of the data. Furthermore this report was reviewed within both the Equality, Diversity & Inclusion in Employment and the Health Inequalities Steering Groups.
Glossary	N/A

NHS BORDERS

EQUALITY MAINSTREAMING REPORT

2021

Executive Summary

i. Welcome to NHS Borders 2021 Equality and Diversity mainstreaming report.

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iv. The following list provides the specific duties which are intended to support public bodies, including health boards, in their delivery of the General Equality Duty:

8. Report progress on mainstreaming the public sector equality duty
9. Publish equality outcomes and report progress
10. Assess and review policies and practices (impact assessment)
11. Gather and use employee information
12. Publish statements on equal pay
13. Consider award criteria and conditions in relation to public procurement
14. Publish in a manner that is accessible

v. This report includes routinely collected information as well as case studies to illustrate how NHS Borders is working towards mainstreaming as well as examining areas that require further improvement and development.

vi. NHS Borders recognises the impacts Covid-19 has had on our patients, families, carers, staff and members of the wider Scottish Borders community and how this has increased equality challenges.

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1 INTRODUCTION

I. NHS Borders exists to serve all within the Scottish Borders, making efforts to prevent ill health, promote healthy living and treat those in need. The Health Board respects and responds to the multitude of different communities it serves and seeks to make people's engagement with Health & Care a positive and fair experience. The NHS Borders workforce is made up from people from both similar and different backgrounds and the Health Board strives to be inclusive and not treat any groups less favorably than others.

II. NHS Borders aims to value the different communities that make the organisation what it is, respect its diversity, promote equality as well as challenge prejudice and discrimination. Mainstreaming is the systematic integration of an equality perspective into our daily work and involves policy makers across a broad range of departments, as well as equality specialists and external partners.

III. Mainstreaming is a long-term method with the aim to ensure that the decisions made within NHS Borders are sensitive to the diverse requirements and experiences of patients, families, carers, staff and members of the wider Scottish Borders community. This report provides transparency and openness alongside evidence and information which plays a part in improving the decision making and improvement processes. Importantly, this report provides actions to be taken further in embedding Mainstreaming within NHS Borders.

IV. NHS Borders first Equality Mainstreaming Report 2013-17 set out its approach in working towards mainstreaming to reduce inequalities, including a set of Equality Outcomes which it aimed to achieve. Progress of these outcomes was monitored in updated report in 2015 through a self-evaluation and action plan approach:

http://www.nhsborders.scot.nhs.uk/media/286394/mainstreaming-report2015.pdf

V. Following the 2015 report, a further update on NHS Borders progress was provided in the Equality Mainstreaming Report 2017-2021:

http://www.nhsborders.scot.nhs.uk/media/488226/mainstreaming-2017-2021-version-1.pdf

VI. To better understand the demographic profile of the Scottish Borders population the following tables are presented; Table 1.1 provides a brief statistical overview of distribution of demographics of the Scottish Borders population; Table 1.2 details the languages used in the household amongst those aged Table 1.3 and over; and Table 3 covers declared ethnic groups in the Scottish Borders.

Table 1.1 - Demographic Overview of Scottish Borders Population	
Population of Scottish Borders (2019)	**115,510** (National Record of Scotland, 2019).
Age Structures	16% of the Scottish Borders population is under the age of 15. 58% of the Scottish Borders population is aged 15 – 64 years old and 25% of the Scottish Borders population is over the age of 65 (National Records of Scotland 2020).
Birth rate	**916 births** in the Scottish Borders (birth rate of **10.8 per 1,000** compared to 9.1 for Scotland) (National Records of Scotland, 2019).
Death rate	**1,299 deaths** in the Scottish Borders (death rate of **9.1 per 1,000** compared to 10.6 for Scotland) (National Records of Scotland, 2019).
Disability	**30%** of the Scottish Borders population have a long-term health condition (2011 census Scotland).
LGBT	**67%**of young people in the Scottish Borders said they knew someone who is **Lesbian, Gay, Bisexual or Transgender. 2.8% of Scottish Borders residents** (2.2% Scotland) identified **as LGB/ other** (SBC).
Child Poverty	**12.6%** of children in the Scottish Borders live in **low-income** families however there are **10 areas** with **more than 15%** of children living in poverty (Scottish Borders Anti-Poverty Strategy 2021).
Fuel Poverty	Around **29%** of all Scottish Borders Households are **fuel poor** (25% Scotland). This equates to roughly **16,000 households** (Scottish Borders Anti-Poverty Strategy 2021).
Religion in the Scottish Borders	**39.4%** Church of Scotland **6.3%** Roman Catholic **7.6%** Other Christian **0.2%** Muslim **0.7%** Other religion **37.8%** No religion **8%** Not stated (2011 census Scotland)

Table 1.2 - Scottish Borders Population Aged 3 and over Languages used at Home (2011 census Scotland)			
	Scottish Borders		Scotland
	Number	%	%
English only	105,456	95.42	92.62
Gaelic	40	0.04	0.49
Scots	1,219	1.10	1.09
British Sign Language	228	0.21	0.24
Polish	1.161	1.05	1.06
Other	2,410	2.18	4.50

Table 1.3 - Declared Ethnic Groups in Scottish Borders (2011 census Scotland)			
	Scottish Borders		Scotland
	Number	%	%
TOTAL	**113,870**	**100**	**100**
White	112,400	98.71	96.02
White - Scottish	89,741	78.81	83.95
White – Other British	18,624	16.36	7.88
White - Irish	767	0.67	1.02
White – Gypsy/Traveller	64	0.06	0.08
White - Polish	1,302	1.14	1.16
White - Other	1,902	1.67	1.93
Mixed or Multiple Ethnic Groups	316	0.28	0.37
Asian, Asian Scottish or Asian British	733	0.64	2.66
African	207	0.18	0.56
Caribbean or Black	91	0.08	0.12
Other ethnic groups	123	0.11	0.27

2 PROFILE DISTRIBUTION OF NHS BORDERS WORKFORCE COMPARED TO SCOTTISH WORKFORCE AND SCOTTISH BORDERS POPULATION

2.1 NHS Borders Workforce & Scottish Workforce (all Scotland workforce)

I. The age demographic of the NHS Borders workforce is in line with that of the Scottish workforce. A similar distribution of the majority of workers aged between 30 and 59 years is seen in both NHS Borders and Scottish workforces. Similarly to the Scottish workforce, the majority of NHS Borders workforce is white.

II. In 2020, the Scottish median hourly wage was £14.05 (excluding overtime for all employees) whilst the male and female median hourly wages of NHS Borders were £13.00 and £15.00, respectively. The median hourly wage for Scotland lies between the median hourly wage of NHS Borders' male and female employees.

2.2 NHS Borders Workforce & Scottish Borders Population

I. Our available Census data is 10 years old but seems to make a case to say that the NHS Borders workforce is broadly representative of the population it serves, with some notable exceptions such as the percentage of workers from a disclosed ethnic minority background being higher than what is recorded in the surrounding population and also Health & Care having a majority female workforce at around 80% of all workers. Discussions are underway locally and nationally about increasing interest in Health & Care roles from individuals who identify other than female.

3 LEGISLATIVE AND POLICY BACKGROUND

I. All health boards across NHS Scotland have a moral, ethical and legal duty to treat everyone fairly and without discrimination. In order to achieve this, NHS Scotland is required to meet the aims of the Equality Act (2010) as well as the Fairer Scotland Duty.

3.1 The Equality Act (2010) and Public Sector General Equality Duty

I. The Equality Act (2010) was implemented in order to protect those in the workplace and the wider society from discrimination. The Equality Act (2010) provides specific protection for people who fall under the nine "protected characteristics"- a set of defined characteristics for which people might face discrimination. These characteristics include, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

The three aims of the 2010 Act's Public Sector General Equality Duty are as follows:

1. Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited under this Act.

2. Advance equality of opportunity between persons who share a relevant characteristic and persons who do not.

3. Foster good relations between people who share a protected characteristic and those who do not.

II. The Public Sector General Equality Duty replaces the previous Race Equality Duty (2002), the Disability Equality Duty (2006) and the Gender Equality Duty (2007).

3.2 Fairer Scotland Duty

I. The Fairer Scotland Duty, Part 1 of the Equality Act (2010), came into effect in April 2018. It holds public bodies in Scotland legally responsible for taking into consideration ways in which inequalities caused by socioeconomic disadvantage can be reduced.

II. To meet the obligations of the Duty, public bodies must achieve the key requirements:

1. to actively consider how they could reduce inequalities of outcome in any major strategic decision they make; and

2. to publish a written assessment, showing how they've done this.

4 IMPORTANCE OF EQUALITY TO HEALTH

I. Equality is an extremely important aspect of healthcare and is vital to ensure that the needs of everyone are met. In healthcare, equality is about treating people alike according to their requirements in order to provide a common standard of care that does not discriminate. In addition to equality, it is important to maintain a holistic approach to healthcare. A holistic approach takes into account all aspects of a person's identity and how these aspects integrate with and affect each other. The combination of equality and a holistic approach helps to provide an intersectional, person-centered approach to care.

5 NHS BORDERS PROGRESS TO MAINSTREAM EQUALITY

I. NHS Borders is committed to ensuring that equality is mainstreamed into working practices and policies to achieve a more inclusive workplace and to ensure NHS Borders is a provider of equitable public services. This section of the report provides some key examples of action that NHS Borders has undertaken, including:

I.1. NHS Borders commitment to Equality and Diversity is highlighted on our website which recognises these as essential components of healthcare and provides useful links for members of the public.

I.2. NHS Borders' Equality and Diversity micro site on the Staff Intranet enables staff to access useful information, policies and processes including interpretation and translation guidelines and advice on carrying out Health Inequalities Impact Assessments (HIIAs) as well as useful materials and templates. The micro site contains links to national and local equality materials, including a local demographic profile and the national Equality Evidence Finder.

I.3. Equality and diversity e-learning is mandatory for all staff and despite the disruption caused by Covid-19 over the last 18 months, remains an important aspect of corporate induction and continuous professional development.

I.4. A domestic abuse awareness session is delivered to all staff at corporate induction which includes showing a DVD made by local women who have experienced domestic abuse.

I.5. Domestic abuse and other forms of Violence Against Women are covered in the Health Care Support Workers training programme.

I.6. Equality and diversity issues are integrated into other corporate training packages e.g. Managing Sickness Absence, Child Protection and First Line Manager training.

I.7. NHS Borders works in partnership with other agencies to protect children and adults from harm and also has staff based in the co-located Public Protection Unit alongside staff from Police Scotland and Scottish Borders Council. Tackling Hate Crime is a priority and the unit also co-ordinates child and adult protection. There is comprehensive guidance available online which includes information on trafficking, Female Genital Mutilation, Honour Based Violence, Child Prostitution and Children with Disabilities among others.

I.8. The Joint Health Improvement Team (JHIT) has been involved in the co-ordination of the Scottish Borders Violence Against Women Training Calendar which includes courses delivered by both partner agencies and NHS Borders staff depending on the subject matter and areas of expertise. The courses are as follows:

1. Domestic Abuse Basic Awareness
2. Why Doesn't She Just Leave
3. "My Family Hurts" What Borders Children Tell Us About Domestic Abuse
4. Raising Awareness of Rape & Sexual Abuse
5. Raising Awareness of Commercial Sexual Exploitation
6. Domestic Abuse & Substance Use

7. Older Women's Experiences of Domestic Abuse
8. Raising Awareness of Trafficking
9. The Forgotten Survivors
10. Raising Awareness of Safe Contact Issues
11. Stalking Workshop
12. Understanding Perpetrator Behaviour

1.9 Health Inequalities Impact Assessment (HIIA) examines the impact on the community when applying a proposed, new or revised policy or practice. HIIA goes beyond the public sector's legal duty of the Equality Act 2020 to assess impact (EQIA) by assessing the impact on:

2. Health inequalities
3. People with protected characteristics
4. Human rights
5. Socioeconomic circumstances

6 PROGRESS AGAINST EQUALITY OUTCOMES

Outcome 1 - We are seen as an inclusive and equal opportunities employer where all members of staff feel valued and respected and our workforce reflects our community.

6.1 Workforce Demographic

I. A general demographic breakdown of the NHS Borders workforce and average wage is shown in the following tables. The overall number of staff within the workforce has remained comparatively stable with very little variation from the year 2019 to 2020. During the pandemic response (March 2020-ongoing, at time of writing) the workforce has increased in size as additional resource has been required to cope with the added pressure in the system.

II. Table 6.1a shows the distribution of workforce by gender for the years 2019 and 2020. The majority of our workforce is female (81.89%). This proportion has remained approximately the same from 2019 to 2020.

Table 6.1a – Workforce by Gender				
Gender	**2019**		**2020**	
	Number of staff	**% of staff**	**Number of staff**	**% of staff**
Female	2,627	81.89%	2,621	81.78%
Male	581	18.11%	584	18.22%
Total	**3,208**	**100.00%**	**3,205**	**100.00%**

III. Table 6.1b shows that the age distribution profile of the workforce was comparable for both years. The majority of our workforce is aged over 35 years old and this did not change from 2019 to 2020. There is a reliance upon, and historical trend of females going into the caring professions/healthcare roles. Conversations are taking place and action plans are being devised to increase interest in caring professions/roles from males and of course, those who might identify as non-binary.

Table 6.1b – Workforce Age Profile				
Age Band	**2019**		**2020**	
	Number of Staff	**% of Staff**	**% of Staff**	**Number of Staff**
19 and under	22	0.69%	23	0.72%
20 - 34	667	20.79%	634	19.78%
35 - 49	1,114	34.73%	1,099	34.29%
50 - 64	1,358	42.33%	1,389	43.34%
65 and over	47	1.47%	60	1.87%
Total	**3208**	**100%**	**3205**	**100%**

IV. Table 6.1c shows the ethnic origin profile for both years, with the majority of the workforce identifying as White. In 2019, 73.94% of the workforce identified as white, with a 1% point increase observed in 2020 (74.95%). The next largest ethnic group is Asian (2019; 1.15%; 2020 1.28%). Almost a quarter of the workforce preferred not to provide their ethnicity. This, while a legal right, does restrict the interpretation of these data which are crucial to recognizing need to take positive action to increase minority ethnic representation within the workforce. Furthermore it suggests that more work may be needed to understand why this characteristic is not well reported and/or recorded.

Table 6.1c – Workforce Ethnic Origin Profile		
Ethnic Group	**Year**	
	2019	**2020**
African/Caribbean – all sub-groups	0.31%	0.25%
Asian – all sub-groups	1.15%	1.28%
White - Irish	1.03%	1.28%
White – Scottish	58.39%	59.00%
White – Other British	11.22%	11.33%
White - Other	3.30%	3.34%
Mixed/multiple ethnic groups	0.22%	0.19%
Other ethnic group	0.65%	0.66%
Prefer not to say	23.41%	22.31%
No information	0.31%	0.37%
Total	100%	100%

V. Table 6.1d shows that the proportion of the workforce with a medical condition remained remarkably similar between 2019 and 2020. It is reported that 18% of the working age population have a disability, as defined by the Equality Act 2010 (St Andrew University). On that basis, there appears to be under-reporting within the workforce. Management and staff-side colleagues are planning to engage the workforce in 2022 and invite employees to disclose whether they believe they have a disability, so that employee records may be updated.

Table 6.1d – Workforce Disability Profile		
Self-disclosed disability	**2019**	**2020**
Yes	0.94%	0.81%
No	97.69%	97.94%
Prefer not to say	1.15%	1.06%
No information	0.22%	0.19%
Total	100%	100%

VI. Table 6.1e shows very little variation in the distribution of sexual orientation of the workforce profile remains similar from 2019-2020. The majority of the NHSB workforce identifies as heterosexual. During 2022, the Health Board's Equality, Diversity & Inclusion in Employment Group will explore the 18% 'No information' figure and see if this figure may be converted into other categories.

Table 6.1e – Workforce Sexual Orientation Profile		
Orientation	**2019**	**2020**
Bisexual	0.44%	0.50%
Gay	0.37%	0.41%
Heterosexual	70.64%	71.89%
Lesbian	0.31%	0.28%
Other	0.16%	0.22%
Prefer not to say	8.23%	8.17%
No information	19.86%	18.53%
Total	100%	100%

VII. Table 6.1f shows that the largest proportion (33.73%) of our workforce has no religious affiliation and this remained the case from 2019 to 2020. Almost a quarter of the workforce preferred not to provide this information.

Table 6.1f - Workforce Religion Profile		
Religion	**2019**	**2020**
Buddhist	0.19%	0.16%
Christian – Other	7.14%	7.08%
Church of Scotland	22.23%	21.56%
Hindu	0.50%	0.47%
Muslim	0.25%	0.41%
Sikh	0.16%	0.09%
Roman Catholic	4.93%	4.99%
Other	2.65%	2.56%
No religion	31.70%	33.73%
Prefer not to say	26.62%	25.46%
No information	3.65%	3.49%
Total	100%	100%

6.2 NHS Borders Workforce Income

I. The following tables provide the distribution income by gender and staff group role, there is no difference seen between the average basic hourly rate and gender for AFC workforce grouping from 2019-2020. However, when considering medical and dental staff grouping, the average basic hourly rate for those identified as male is higher than female by £5 in 2019 with a reduction in the gap to £3 in 2020. Comparison of all staff average of basic hourly rate by gender remained the same for both years. An increase of £1 in the overall basic average rate per hour for all staff grouping was seen in 2020.

Table 6.2a - AFC Staff 2019/2020 - Average of Basic Hourly Rate (£) by Gender					
		2019	**Number of Staff**	**2020**	**Number of Staff**
Gender	Female	£14	2503	£15	2541
	Male	£14	482	£15	489
Grand Total		**£14**	**2985**	**£15**	**3030**

Table 6.2b - Medical & Dental Staff 2019/2020 - Average of Basic Hourly Rate (£) by Gender					
		2019	**Number of Staff**	**2020**	**Number of Staff**
Gender	Female	£38	122	£40	117
	Male	£43	94	£43	94
Grand Total		**£40**	**216**	**£41**	**211**

Table 6.2c - All Staff 2019/2020 - Average of Basic Hourly Rate (£) by Gender					
		2019	Number of Staff	2020	Number of Staff
Gender	Female	£16	2625	£16	2658
	Male	£19	576	£19	583
Grand Total		**£16**	**3201**	**£17**	**3241**

6.3 Policy

I. NHS Borders has a number of progressive Once for Scotland policies which support equality, diversity and inclusion in the workplace. These policies have anti-discrimination elements to them but it should be noted that a number of these policies are subject to national review at this time.

These policies include:

1. Adoption & Fostering Leave
2. Annual Leave
3. Appraisal, PDP & Review
4. Embracing Equality, Diversity & Human Rights Equal Opportunities
5. Facilities Agreement
6. Fixed-term Contracts
7. Flexible Working Requests
8. Grievance
9. Induction
10. Managing Employee Capability
11. Managing Employee Conduct
12. Maternity and Paternity Leave
13. Parental Leave
14. Recruitment and Selection
15. Redeployment
16. Retirement
17. Sickness Absence
18. Special Leave
19. Substance and Alcohol Misuse
20. Tackling Workplace Bullying and Harassment
21. Whistle Blowing

6.4 Disability Confident Employer

I. NHS Borders is a Disability Confident (formerly Two Ticks) employer, meaning that all job candidates who declare that they have a disability and who meet the minimum essential criteria for the role will be offered an interview.

II. When being invited to interview candidates are asked if they require any modification to the interview location/process to accommodate any need the individual may have. NHS Borders is regularly audited by Department for

Work & Pensions to make sure that it is fulfilling its Disability Confident accreditation/obligations.

6.5 Equality, Diversity and Inclusion (EDI) in Employment Group

I. NHS Borders is committed to providing equal opportunities and fair treatment for all. The Equality, Diversity and Inclusion in Employment Group have a number of important roles for maintaining this commitment in the field of employment, including:

I.1. Monitoring culture/behaviour and whether employees, students, volunteers and applicants believe the organisation treats people in a fair, consistent manner regardless of background

I.2. Building in a sense that NHS Borders is on a positive journey of constant improvement in the field of equality, diversity and inclusion

I.3. Having an action and outcome-focused outlook, investing in awareness/education, recognizing non-optimal performances and taking steps to change for the better

I.4. Encouraging harmony between different groups in the wider system

I.5. Collecting, collating and reporting on useful data to inform the equality agenda

I.6. Working to an annual work plan.

Good Practice Example - NHS Scotland Pride Pledge & Badge

II. ***NHS Borders has recently launched the NHS Scotland Pride Pledge and Badge initiative to show support for people with LGBTQ+ backgrounds. NHS Scotland designed the badge as a visual symbol which identifies its wearer as someone that people in the LGBTQ+ community (including those from a minority ethnic background) can feel comfortable approaching. The Pride Badge was created with the aim to promote a message of inclusion as well as acknowledge and raise awareness of the issues that members of the LGBTQ+ community can face when accessing healthcare.***

Outcome 2 - Our services meet the needs of and are accessible to all members of our community

6.6 Covid-19 Tracing Service

I. The Covid-19 Tracing Team was created in response to the Coronavirus pandemic. The service was developed in the span of one week in order to help the public meet the government safety requirements to protect against the rapidly spreading virus.

II. The team is multidisciplinary, made up of health protection nurses and contract tracing practitioners from all across NHS Borders. The contact tracing practitioners primarily consist of NHS Borders employees that are shielding and employees that have been redeployed due to their core work being non-essential.

III. The Covid-19 Tracing Service aims to ensure that all those in need of help during this time have access to it. This help can include:

III.1 Access to Coronavirus tests if required.

III.2 Access to financial assistance if required- the team liaises with Community Assistance Hubs to ensure that support can be found if needed.

III.3 Calling or sending SMS alerts to inform those that must self-isolate.

III.4 Providing hard copies of information that is otherwise shared online, by email or through SMS messaging. This is done as NHS Borders recognises that some groups may be excluded and unable to access a phone or computer.

III.5 Accessing translation services when English is not the first language in an outbreak setting.

III.6 Providing those in need of it with resources on mental health and wellbeing which include the signposting of relevant services.

III.7 Providing support for people isolating in an abusive environment- the team took part in training around domestic abuse in order to provide effective support. Additionally with SBC colleagues safe spaces to self-isolate were identified for those who needed them.

III.8 Liaising with Borders Addiction Service (BAS) to work out appropriate routes for support and to ensure that methadone prescriptions are delivered to people that are isolating whilst struggling with substance abuse.

Good Practice Example - Interpretation and Translation Service

IV. ***NHS Borders is committed to providing an excellent healthcare service which is accessible to all patients and members of the public. In order to achieve this, the Interpretation and Translation Service is used to try and overcome communication barriers which can be a major barrier to accessing healthcare.***

V. ***The Interpretation and Translation Service has been running within the Public Health directorate for approximately 11 years following the disbandment of the Equality & Diversity Team. A portion of the Equality & Diversity budget remains within Public Health and is used for paying for the Interpretation and Translation Service. This service provides interpreters and the translation of documents where there is a clinical need relating to a patient or to support staff.***

VI. ***A set of guidelines were drawn up to aid NHS Borders staff on the use of this service. The guiding principles of the Interpretation and Translation Service are detailed below:***
- ***Where there are communication difficulties, patients and staff have a right to communication support***
- ***The responsibility to ensure effective communication lies with healthcare staff. Staff must establish if a patient or service user requires an interpreter***
- ***they must not decide themselves whether a person's English is adequate.***
- ***Communication support should be provided using approved interpreters and translators***
- ***Interpreting and translation services should be provided to the patient free of charge***

Outcome 3 - Our staff treat all service users, clients and colleagues with dignity and respect.

6.7 Tackling Bullying and Harassment Policy

I. NHS Borders is committed to uphold a workplace that is free of bullying, harassment or intimidation of any nature. All employees have a responsibility and a right to treat and be treated by colleagues with dignity and respect irrespective of their gender, race or ethnicity, relationship or health status, pregnancy/maternity status, age, disability, sexual orientation, religion or belief system.

II. The policy is intended to support managers when dealing with bullying and harassment in the workplace by:

1. Raising awareness in staff that a policy/procedure exists and how it works

2. Encouraging management and staff to raise genuine concerns using the policy/procedure

3. Achieving a position whereby management and staff are confident in the policy/procedure and feel comfortable when using it

4. Improving the reporting and handling of such incidents

5. Facilitating open discussion on the efficacy of the policy/procedure

6. Providing, where appropriate, access to confidential counselling, advice and support for victims of bullying/harassment at work

7. Providing a programme for the communication of the policy, monitoring its effectiveness and training for those involved in applying the policy

8. Raising awareness that all staff, patients and visitors have a responsibility to ensure that their actions, attitudes or behaviours are not distressing or upsetting to others. Additionally, managers and supervisors have a specific responsibility to be vigilant about identifying and dealing with bullying/harassment at work, ensuring implementation of and adherence to this policy.

9. Providing access to responsive Occupational Health & Safety services.

6.8 Equal Opportunities Policy Statement

I. NHS Borders is committed to ensuring the elimination of all forms of discrimination on the basis of age, culture, disability, employment status, ethnic origin, faith, gender, gender reassignment, HIV status, marital status, nationality, offending record, political affiliation or trade union membership, race, religion, sexual orientation or social background.

II. It is important to recognise that 'equal opportunities' means ensuring that there is a 'level playing field' for all existing and potential employees by providing protection from unlawful discrimination. It does not mean treating everybody the same. The concept of 'equal opportunities' may therefore involve positive action. Examples of positive action may include:

1. Targeted staff training and development schemes
2. The use of specialist press for job advertising; and
3. Encouraging people of a particular race, gender or disability to apply for jobs wherever they are underrepresented in the current workforce
4. As part of implementing this policy, regular reviews of practices and procedures will be undertaken in partnership to ensure that:
5. They are consistent with the principles and aims of equal opportunities in employment
6. There is consistent and objective application across the whole employment field with individuals being selected, trained and promoted entirely on the basis of their abilities / potential and the requirements of the job
7. NHS Borders undertake Impact Assessments to ensure that equality and diversity measures have been considered and appropriate actions taken

6.9 Equality, Diversity and Human Rights Policy

I. This policy sets out NHS Borders's commitment to the principles, as defined below, of equality, diversity and human rights in employment and sets out the approach to be followed in order to ensure that such principles are consistently met.

II. The aims of this policy are as follows:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010 and less favourable treatment of other categories of worker as set out within other relevant legislation
2. Advance equality of opportunity between people who share a protected characteristic (i.e. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation) and those who do not
3. Foster good relations between people who share a protected characteristic and those who do not; and
4. Ensure that the organisation has due regard for the European Convention of Human Rights (ECHR) in the discharge of its function.

III. The following principles and values are key to the achievement of these aims:

1. Equality, diversity and human rights must be at the heart of NHS Borders and everything it does
2. Disadvantages suffered by people due to their protected characteristics will be removed or minimised in order to create an environment in which individual differences and the contributions of all staff are recognised and valued
3. Steps will be taken to meet the needs of people from protected groups where these are different from the needs of other people
4. Steps will be taken to reduce underrepresentation of people with particular protected characteristics and increase the diversity of our workforce, both at an organisational level and within different job roles
5. A zero tolerance approach will be taken to intimidation, bullying or harassment, recognising that all staff are entitled to a working environment that promotes dignity and respect for all
6. NHS Borders will act as an agent for change within local communities by positioning equality, diversity and human rights at the heart of local delivery plans
7. While this will be achieved in part by being championed at a senior level, it can only be fully achieved through all those working within NHS Borders recognising and adhering to their own personal responsibilities in this regard, and NHS Borders will therefore take steps to ensure that everyone in the organisation understands their rights and responsibilities under the policy
8. NHS Borders will ensure that arrangements are in place to support staff who have equality, diversity and human rights issues GB-HR – 2014-01-16 5

9. Equality and diversity monitoring will be undertaken on a regular basis, with resulting improvement actions being identified and achieved; and
10. This policy will be subject to ongoing monitoring to ensure that it is being fairly and consistently applied and that the stated principles and values are being met. The policy will be subject to regular review, in partnership, to ensure that it remains fit for purpose.

6.10 Maternity and Paternity Policy

I. NHS Borders is committed to ensuring consistent and equitable treatment for its employees in the matter of maternity leave and pay. This policy and protocol takes into account current employment legislation, associated codes of practice, Agenda for Change Regulations and progressive employment practice.

II. This policy and protocol is designed to answer the questions employees will have regarding maternity and paternity leave and pay and guides employees and managers through this complex and detailed subject. It includes detail of the criteria that have to be met to qualify for maternity and paternity leave and pay and the employees obligation to NHS Borders, for example the relevant timescales that have to be met and forms that have to be completed.

6.11 Parental Leave Policy

I. NHS Borders is committed to ensuring consistent and equitable treatment for its employees in the matter of parental leave. This policy takes into account current employment legislation, associated codes of practice, Agenda for Change Regulations and progressive employment practice.

II. This policy is designed to answer the questions employees will have regarding parental leave and pay and guides employees and managers through this complex and detailed subject. It includes detail of the criteria that have to be met to qualify for parental leave and pay and the employees obligation to NHS Borders, for example the relevant timescales that have to be met and the forms that have to be completed.

6.12 Flexible Working Policy

I. Flexible working opportunities benefit everyone: employers, employees and their families. NHS Borders knows that it makes good business sense to be open to flexible working requests from its employees; accommodating requests can help to retain skilled staff and reduce recruitment costs; to raise staff morale and decrease absenteeism; and, can help the organisation to react to changing service provisions. For employees, changes to working patterns can greatly improve the ability to balance home and work responsibilities

II. To be eligible to make a flexible working request in line with this policy, the employee must:

1. Not be an agency worker; and
2. Not have made another application to work flexibly during the previous 12 months. This does not prevent a manager agreeing with an employee that their request can be approved within that time period if the request was originally refused, but the work environment can now sustain the change requested.
3. Eligible employees are able to request:
4. A change to the hours they work e.g. voluntary reduced hours; job sharing
5. A change to the times when they are required to work e.g. flexi-time
6. A change to the place they are required to work

6.13 NHS Borders Behavioural Framework

I. The framework defines the behaviours that NHS Borders staff must demonstrate for our organisation to perform effectively. Everything that NHS Borders does relies on individuals and teams working interdependently, with our patients at the heart of everything we do. This framework is a statement of who NHS Borders is: what our patients can expect from us and what we expect from each other.

6.14 Values Based Recruitment (VBR)

I. NHS Borders uses a Values based approach to recruitment. VBR is an approach to help attract and select employees whose personal values and behaviours align with those of NHS Borders.

II. The values that are shared across Scotland's Health Service are:

1. Care and compassion
2. Dignity and respect
3. Openness, honesty and responsibility
4. Quality and teamwork.

III. NHS Borders recognises that staff who are valued and treated well improve patient care and overall performance and these values were developed as part of the 2020 Workforce Vision which aims to ensure that the health service has the workforce needed for the future.

IV. NHS Borders adopted those values when the Corporate Objectives were developed. Whilst it is recognised the values are core values of the majority of our staff, NHS Borders aims to ensure that these are embedded explicitly, and are a core element in how staff is recruited.

Good Practice Example- Covid-19 and Risk Assessment

v. ***NHS Borders was recently praised during a Healthcare Improvement Scotland inspection for instructing managers to risk assess minority ethnic staff for their greater susceptibility to adverse outcomes if they contracted COVID-19.***

Outcome 4 - We work in partnership with other agencies and stakeholders to ensure everyone has the opportunity to participate in public life and the democratic process

6.15 Co-production Charter (2019)

I. In 2019, the Co-production Charter was implemented between Borders Care Voice and the Scottish Borders Health and Social Care Partnership and produced by the Scottish Borders Mental Health and Wellbeing Forum. This document ensures that the national standards of engagement with all mental health services in the Scottish Borders are applied. This means that those with experience of mental ill health, their carers, as well as people who use the services are all involved with any commissioning, change or redesign processes from beginning to end, including evaluation and review. The involvement of these groups ensures that their voices are heard and that their knowledge and experiences are valued.

6.16 Borders Older People's Planning Partnership (2020)

I. In 2020, NHS Borders public involvement team worked alongside the Borders Older People's Planning Partnership in order to gain an understanding of how the lives of the older population were affected by the Coronavirus pandemic. An online survey and a telephone consultation took place to collect the feedback and lived experiences of older people in the Scottish Borders. The information gathered is to be used to support the region's ongoing recovery efforts, as well as transformation programmes being taken forward by the Scottish Borders Council, NHS Borders and the Health and Social Care Partnership. The Borders Older People's Planning Partnership is one of the Scottish Borders Health and Social Care Partnership's engagement and planning groups. The group consists of representatives from the Scottish Borders Council, NHS Borders, the third sector and local older people.

Good Practice Example - Money Worries App

II. *Good financial health has a positive impact on overall health and wellbeing. The Money Worries App was developed in order to mitigate the effects of ongoing welfare reform as well as the wider impact of COVID-19. The App is intended to aid people by providing access to quality assured information, as well as giving support to prevent escalating money worries. The Money Worries app is a digital directory with links to help with money, health, housing and work.*

III. *Co-developed by NHS Borders, Scottish Borders Council, Citizen's Advice Bureau, TD1 Youth Hub and Early Steps Parent's Group, the Money Worries App reflects the voices of much of the Scottish Borders' community.*

IV. *The App is a timely resource considering the changes projected for 2020 due to welfare reform which include:*

- *Universal Credit – Managed Migration of existing claimants*
- *Pension Credit into Universal Credit*
- *Abolition of Housing Benefits – housing costs within universal credit*
- *Full rollout of Scottish Devolved Benefits*
- *Scottish Child Payment*
- *Potential to increase access to unclaimed benefits*

V. *Against this economic backdrop, it is evident that the there is a need for continued support in the Scottish Borders to reduce poverty and inequality as well as improve health and wellbeing. Systems currently in place that convey the reality of poverty in the Scottish Borders include:*

- *The use of food banks*
- *Experiences with benefits systems*
- *Summer food programmes*
- *Income before and after housing costs*

VI. *The Money Worries App could support an early intervention and prevention approach by ensuring people can access the correct information and support at the right time. This could reduce further ill effects on the mental health of people who are experiencing uncertain economic circumstances.*

Outcome 5 - We work in partnership with other agencies and stakeholders to ensure that our communities are cohesive and there are fewer people living in poverty and the health inequality gap is reduced.

6.17 Early Years Pathway Pilot Project

I. An Early Years Pathway Pilot project has run in partnership with the Scottish Borders Council Financial Inclusion Team as part of a pathway initiative. The

project aims to improve access to benefits information, advice and support for early years families. Midwives and health visitors can refer new and expectant mothers to advisors form the project for assistance.

6.18 Community Food Growing Strategy – The Greenhouse Project

I. The Community Food Growing Strategy aims to support and facilitate all members of the community that wish to take part in growing produce. Scottish Borders Council has consulted with communities and groups already involved in Community Food Growing initiatives to help with the development of this strategy. The key objectives of the Food Growing Strategy are:

1. To provide a central resource for community growing information
2. To raise awareness around community growing in the Scottish Borders
3. To show you how to get growing: where, how and who can help you/your community group
4. To help you get your community growing project off the ground
5. To help identify potential allotment sites and growing spaces

II. The Greenhouse Project was developed for the Community Food Growing Strategy. The Joint Health Improvement Team works in partnership with Scottish Borders Council's Community Justice Team to grow a wide range of seasonal produce at a Greenhouse site in Galashiels. Produce is distributed back into the community through service settings and activities that support children and families.

III. The project has developed incrementally to offer new activities:

1. REHIS training & cooking classes with Community Justice Clients
2. Live cookery classes in early years settings
3. Recipe bags to support home cooking and healthier meals
4. Welfare boxes & food distribution during COVID
5. Distribution of plants to encourage home growing

Good Practice Example - Eat Well Age Well Delivery Group

IV. 1 in 10 older people are either at risk of or are suffering from malnutrition. The Eat Well Age Well (EWAW) group is a national delivery project and part of the Food Train charity. The group focuses on preventing, detecting and treating malnutrition in amongst older people living at home as well as promoting healthy ageing.

V. In addition to preventing malnutrition, it is important to anticipate those that are likely to become malnourished. The first steps to accomplish this are the screening and identification if malnutrition. The Malnutrition Universal Screening Tool (MUST) is the most commonly used tool in UK hospitals, care homes and/or communities. MUST requires the height and weight of the patient to be taken and includes weight change, recent intake and an at-risk score. Whilst these guidelines and standards have made progress, there are still many older people living at home in the community with malnutrition and at risk of malnutrition.

VI. Recently, new tools have been developed for the early identification of preventable malnutrition. Community-level solutions are necessary to identify at-risk individuals at an earlier stage. These new tools include the Patients Association Nutrition Checklist and the Paperweight Armband. The tools aim to:

- *Start conversations about eating, drinking, appetite and weight-loss*
- *Identify risk of malnutrition and offer guidance on next steps*
- *Raise awareness of potential risk of malnutrition*

Outcome 6 - We work in partnership with other agencies and stakeholders to ensure the difference in rates of employment between the general population and those from underrepresented groups is improved

6.19 JobTrain Recruitment System

I. The JobTrain recruitment system, which is used for employee recruitment by NHS Scotland, has built-in anti-discrimination measures. Shortlisting managers are not provided with applicant data such as names, addresses and demographic information in order to eliminate unconscious bias.

Good Practice Policy - Recruitment and Selection Policy

II. NHS Borders aims to recruit and select the most suitable person available for each authorised vacancy that arises, to help us to provide a high quality service.

III. Values Based Recruitment is an approach which attracts and selects students, trainees or employees on the basis that their individual values and behaviors align with the values of NHS Scotland. The purpose of Values Based Recruitment is to ensure that the future and current NHS Workforce is selected against these values so that we recruit the right workforce, not only with the

right skills and in the right numbers but with the right values to support effective team working in delivering excellent patient care and experience. Values Based Recruitment can be delivered in a number of ways: through pre-screening assessments, to values based interviewing techniques, role play, written responses to scenarios, and assessment centre approaches amongst others.

IV. *Jobtrain (above), the new online recruitment tool, provides a streamlined job application and candidate management process and will help to ensure a consistent approach to recruitment across the NHS in Scotland.*

V. *NHS Borders aims to encourage a diverse workforce representative of the local communities and may consider taking positive action to encourage applications from under-represented groups. It aims to provide a working environment where staff are valued and respected, and where discrimination, bullying and harassment are not tolerated. It is the responsibility of everyone involved in the recruitment process within NHS Borders to ensure no job applicant receives less favourable treatment than any other job applicant.*

Outcome 7 - We work in partnership with other agencies and stakeholders to ensure the difference in educational attainment between those who are from an equality group and those who are not is improved

Good Practice Example - Integrated Children and Young People's Plan

I. *As part of the Integrated Children and Young People's Plan, NHS Borders and the Scottish Borders Council are committed to reducing the poverty-related attainment gap. NHS Borders works alongside colleagues from Education Scotland, SEIC and the Scottish Government in order to support schools with the development of the Scottish Attainment Challenge. Progress and the key strengths in the first five years of the programme include:*

- *Schools working together to supplement Pupil Equity Fund plans across clusters*
- *Working with Community Learning and Development (CLD) and third-sector partners to help schools deliver successful programmes for the most disadvantaged children and young people, and their families*
- *Improvements in outcomes for care experienced children and young people, for example:*
- *An increase in attendance and a reduction in exclusion rates*
- *Increasing attainment in literacy for school leavers*
- *A higher proportion of Looked After young people in the Scottish Borders achieving qualifications in the Senior Phase than the national average*
- *An improving trend in the percentage of school leavers entering a sustainable positive destination*
- *Improvements in attainment for children and young people living within SIMD quintile 1 (Q1), for example:*
- *A higher attainment in literacy than the national average at third and fourth level*
- *An increased attainment in numeracy at level early level*

- ***An increase in overall attainment at SCQF levels 5 and 6 in the Senior Phase***

II. ***Progress in closing the poverty-related attainment gap, for example:***
- ***In literacy, at the first level the attainment gap has been reduced and at first, third and fourth level, the gap is below the national average***

Outcome 8 - We work in partnership with other agencies and stakeholders to ensure we have appropriate housing which meets the requirements of our diverse community

6.20 Affordable Warmth & Home Energy Efficiency Strategy (AWHEES)

I. Scottish Borders Council and NHS Borders are committed to creating an equal and fair environment, providing everyone with a chance to succed. A key step in achieving this is tackling fuel poverty which is why the Affordable Warmth & Home Energy Efficiency Strategy (AWHEES) was created. The aim of the Strategy is to provide affordable warmth and healthy homes for everyone living in the Borders.

II. An over arching priority for the AWHEES is that the co-benefits of the Strategy are maximised and any unintended impacts of installing energy efficiency measures are minimised. It should be ensured that appropriate means to mitigate any unintended effects are put in place. All actions and interventions within this Strategy are based around the particular needs of homeowners and not just the house and tenure type, as well as being outcome focused, rather than just target compliance based.

III. The Priorities that work towards fulfilling the AWHEES:
1. To work collectively with our partners to improve affordable warmth and energy efficiency in homes.
2. To explore wider measures to better manage energy and increase warmth in the home.
3. To ensure the AWHEES provides opportunities for all in the Scottish Borders.
4. A diverse range of partners, stakeholders and housing experts participated in developing the AWHEEs. The programme of engagement activity included the following:
5. Consultation across the Strategic Housing Services and wider services at SBC.
6. Engagement with the Borders Home Energy Forum focusing on the technical elements of the Actions, and the advice and support elements.
7. An online public consultation.
8. A series of semi-structured interviews, face-to-face or over the phone, with members of the Borders Home Energy Forum and their relative colleagues.
9. Engagement with community representatives, NHS Borders and Health and Social Care.
10. Engagement with the Energy Efficient Scotland Change Works in Peebles Working group and academics working on the monitoring and evaluation programme at the University of Edinburgh.

Good Practice Example - Strategic Group for Clinical and Care Oversight of Care Homes

IV. The Strategic Group for CCOCH is a multi-disciplinary team made up of professional key leaders across Scottish Borders Council and NHS Borders. The group was formed in response to the Coronavirus pandemic. It aims to ensure appropriate clinical and care professionals across the Health and Social Care Partnership (HSCP) take direct responsibility for the clinical support required for each care home in the Scottish Borders, as set out in the requirements given by the Cabinet Secretary for Health and Sport Committee.

V. Core membership of the group is proposed as follows:

- ***Director of Nursing, Midwifery & Acute Services (Chair)***
- ***Chief Operating Officer Adult Social Work and Social Care (Vice Chair)***
- ***Chief Officer Health & Social Care***
- ***Chief Social Work & Public Protection Officer***
- ***Medical Director***
- ***Joint Director of Public Health***

7 AREAS FOR DEVELOPMENT

I. The following are points we intend to focus on developing during the next years:

7.1 Proposed Programme: Addressing Health Inequalities

I. NHS Borders recognises that the most marginalized members our society have the poorest health outcomes, placing a significant demand on health services. Evidence shows that persistent health inequalities remain in both health outcomes and service experience in NHS Scotland. However, health inequalities are avoidable and can be mitigated on both an individual and structural level. Action taken by NHS Borders and its staff can directly and positively impact health inequalities.

1. The aim of this programme is to maximise the impact of NHS Borders in reducing health inequalities in the Borders. In order to achieve this:
2. Services should be designed and changed to minimize disadvantage and health inequality using a data driven approach
3. All staff should have an awareness of health inequalities and opportunities to reduce them
4. Organizational processes should be reviewed and changed to maximize their impact in reducing health inequalities
5. There should be a more equitable use of services
6. People experiencing health inequalities should be more able to influence services
7. The programme will have five workstreams:
8. Data: where we are now, what we have achieved, and how we

will measure and evaluate going forward
9. Engaging with communities and individuals
10. Service change
11. Role of NHS Borders as an 'anchor' organisation
12. Working with partners

8 IMPACT OF COVID-19

I. The emergence of pneumonia cases in December 2019 later became known to the world as the and a pandemic was declared by the World Health Organisation in March 2020.beginning of the spread of Covid-19. Cases of Covid-19 developed rapidly across the globe .

8.1 Inequalities as a result of COVID-19

I. The pandemic has had a number of consequences, resulting in several groups becoming particularly vulnerable. A few of these groups, as explained by Douglas et al., are listed below:

1. Older people - highest direct risk of severe Covid-19, more likely to live alone, less likely to use online communications, at risk of social isolation
2. Young people - affected by disrupted education at critical time; in longer term most at risk of poor employment and associated health outcomes in economic downturn
3. People of East Asian ethnicity - may be at increased risk of discrimination and harassment because the pandemic is associated with China
4. People with mental ill health - may be at greater risk from social isolation
5. People who use substances or are in recovery - risk of relapse or withdrawal
6. People with reduced communication abilities (eg, learning disabilities, limited literacy or English language ability) - may not receive key governmental communications
7. Homeless people - may be unable to self-isolate or affected by disrupted support services
8. People on low income - effects could be particularly severe as they are more likely to be in insecure work without financial reserves

8.2 NHS Borders Support for Vulnerable Groups

I. Many of NHS Borders' policies and groups mentioned in this report can be used to help ease the effects that the COVID-19 pandemic may have on the community and its vulnerable groups.

II. Support for older people:
1. Borders Older People's Planning Partnership (see Outcome 4)
2. Eat Well Age Well Group (see Outcome 5)

III. Support for young people:
1. Integrated Children and Young People's Plan (see Outcome 7)
2. Scottish Borders Council Child Poverty Indicator (CPI) Tool (see Outcome 7)

Support for people of East Asian ethnicity:

3. Tackling Bullying and Harassment Policy (see Outcome 3)
4. Equality, Diversity and Human Rights Policy (see Outcome 3)
5. Whistleblowing Standards (see Outcome 3)

Support for people with mental ill health:

6. Measures taken by Covid-19 Tracing team (see Outcome 2)

Support for people who use substances or are in recovery:

7. Measures taken by Covid-19 Tracing team (see Outcome 2)

Support for people with reduced communication abilities:

8. Interpretation and Translation Service (see Outcome 2)
9. Measures taken by Covid-19 Tracing team (see Outcome 2)

IV. Support for homeless people:

1. Housing First Service (see Outcome 8)

V. Support for people on low income:

1. Money Worries App (see Outcome 4)
2. Early Years Pathway Pilot Project (see Outcome 5)
3. Community Food Growing Strategy (see Outcome 5)
4. Affordable Warmth and Home Energy Efficiency Strategy (see Outcome 8).

9 Workforce Data

9.1 Introduction

I. This document provides detailed analysis of Workforce data required to report its performance against the nine protected characteristics, as well as pay gap information.

9.2 Context

I. Listed public authorities in Scotland are required by the public sector equality duty to publish information on their gender pay gap, and occupational segregation within their organisation. They are also required to report the steps that they are taking to proactively address the inequalities that are faced by their female workforce. "Close the Gap" has produced guidance for Scottish public authorities on the gender and employment aspects of the public sector equality and this report follows that advice.

II. The employee data has been obtained mostly from the HR Workforce system (the electronic Employee Support System, eESS) and the Finance system, cross-referencing data as necessary.

9.3 Workforce Analysis - The Nine Protected Characteristics

I. The data in each section is presented in the following order:

- Gender
- Disability

- Ethnicity
- Religion
- Gender reassignment
- Sexual orientation
- Age
- Marital/Civil partnership status

II. Data for pregnancy and maternity is not available at this time of publishing this report.

III. Table 9.3a shows that the workforce gender split remains statistically consistent with no large fluctuations in number of male and female employees between 2019 and 2020.

Table 9.3a - Total Number of Staff	
Year	Head Count
2019	3,208
2020	3,205

Table 9.3b - Workforce by Gender				
Gender	**2019**		**2020**	
	Number of staff	**% of staff**	**Number of staff**	**% of staff**
Female	2,627	81.89%	2,621	81.78%
Male	581	18.11%	584	18.22%
Total	**3,208**	**100.00%**	**3,205**	**100.00%**

IV. Table 9.3c shows the workforce shows a small decrease in employees with a disability between 2019 and 2020.

Table 9.3c – Workforce Disability Profile		
Medical condition in past 12 months	**2019**	**2020**
Yes	0.94%	0.81%
No	97.69%	97.94%
Prefer not to say	1.15%	1.06%
No information	0.22%	0.19%
Total	100%	100%

V. Table 9.3d shows workforce ethnicity ratios remain similar, with slight decreases in employees of African/Caribbean and mixed/multiple ethnic groups.

Table 9.3d – Workforce Ethnic Origin Profile		
Ethnic Group	**Year**	
	2019	**2020**
African/Caribbean – all sub-groups	0.31%	0.25%
Asian – all sub-groups	1.15%	1.28%
White - Irish	1.03%	1.28%
White – Scottish	58.39%	59.00%
White – Other British	11.22%	11.33%
White - Other	3.30%	3.34%
Mixed/multiple ethnic groups	0.22%	0.19%
Other ethnic group	0.65%	0.66%
Prefer not to say	23.41%	22.31%
No information	0.31%	0.37%

VI. Table 9.3e shows a slight increase in Muslim, Roman Catholic and no religious affiliation employees. Data trend remains similar between years. Almost a quarter of the workforce preferred not to provide this information.

Table 9.3e - Workforce Religion Profile		
Religion	**2019**	**2020**
Buddhist	0.19%	0.16%
Christian – Other	7.14%	7.08%
Church of Scotland	22.23%	21.56%
Hindu	0.50%	0.47%
Muslim	0.25%	0.41%
Sikh	0.16%	0.09%
Roman Catholic	4.93%	4.99%
Other	2.65%	2.56%
No religion	31.70%	33.73%
Prefer not to say	26.62%	25.46%
No information	3.65%	3.49%

VII. Table 9.3f shows that gender reassignment figures remain much the same although there was a slight increase in the percentage of people who chose to disclose gender reassignment status between 2019 and 2020.

Table 9.3f – Workforce Gender Reassignment Profile		
Gender Assignment	**2019**	**2020**
No	96.60%	96.88%
Yes	0.09%	0.12%
Prefer not to say	1.40%	1.28%
No information	1.90%	1.71%

VIII. Table 9.3g shows that Sexual orientation figures remain much the same although there has a slight increase in the percent of the workforce who chose to disclose their sexual orientation between 2019 and 2020.

Table 9.3g – Workforce Sexual Orientation Profile		
Orientation	**2019**	**2020**
Bisexual	0.44%	0.50%
Gay	0.37%	0.41%
Heterosexual	70.64%	71.89%
Lesbian	0.31%	0.28%
Other	0.16%	0.22%
Prefer not to say	8.23%	8.17%
No information	19.86%	18.53%

IX. Table 9.3h shows the number of employees aged 50 and over has increased from 2019 to 2020 whilst the number of employees aged between 20 and 49 years old has decreased.

Table 9.3h – Workforce Age Profile				
Age Band	**2019**		**2020**	
	Number of Staff	**% of Staff**	**% of Staff**	**Number of Staff**
19 and under	22	0.69%	23	0.72%
20 - 34	667	20.79%	634	19.78%
35 - 49	1,114	34.73%	1,099	34.29%
50 - 64	1,358	42.33%	1,389	43.34%
65 and over	47	1.47%	60	1.87%
Total	**3208**	**100%**	**3205**	**100%**

X. Table 9.3i shows marital status stayed relatively similar from 2019 to 2020 however more people chose to disclose their marital status in this time period.

Table 9.3i – Workforce Marital Status Profile		
Marital Status	2019	2020
Civil partnership	0.09%	0.09%
Divorced	5.11%	4.46%
Married	59.66%	61.84%
Single	32.08%	31.29%
Widowed	0.81%	0.75%
No information	2.15%	1.56%

9.4 Disability Pay Gap

Disability Pay Gap	**1.90%**

The figures for 2019 are as follows:

Table 9.4a – Average of Basic Hourly Rate 2019		
Disability	**Average of basic hourly rate**	**Count of Staff**
Yes	16	29
No	16	3131
Prefer not to say	19	36
No information	36	5
Grand Total	**16**	**3201**

Table 9.4b Distribution of medical conditions in last 12 months and Pay Quarter							
Hourly Pay Quartile	**Count of Medical Conditions In 12 Months**					**Quartile percentage**	
	Yes	**No**	**Prefer not to say**	**No information**	**Grand Total**	**Yes**	**No**
Lower	13	782	5		800	1.6	98.4
Middle	7	785	8		800	0.9	99.1
Upper Middle	2	790	8		800	0.3	99.7
Upper	7	774	15	5	801	0.9	99.1

Median pay	£/hr
Middle Medical Condition	11
Middle No Medical Condition	14
Median Medical Condition Pay gap	**17.8%**

The figures for 2020 are as follows:

Table 9.4b Distribution of medical conditions in last 12 months and Pay Quarter							
Hourly Pay Quartile	**Count of Medical Conditions In 12 Months**					**Quartile percentage**	
	Yes	**No**	**Prefer not to say**	**No information**	**Grand Total**	**Yes**	**No**
Lower	13	790	7		810	1.6	98.4
Lower Middle	5	798	7		810	0.6	99.4
Upper Middle	2	801	7		810	0.2	99.8
Upper	5	789	12	5	811	0.6	99.4
Grand Total	**25**	**3178**	**33**	**5**	**3241**	**0.8**	**99.2**

Table 9.4c – Average of Basic Hourly Rate 2020		
Disability	**Average of basic hourly rate**	**Count of Staff**
Yes	16	25
No	17	3178
Prefer not to say	20	33
No information	42	5
Grand Total	**16.78**	**3241**

Disability Pay Gap ('No' baseline)	**4.0%**

Median pay (no info excluded)	£/hr
Middle Medical Condition	11
Middle No Medical Condition	14
Median Medical Condition gap	**26.2%**

9.5 Gender Pay Gap

I. Notes:

I.1. The overall figure is skewed in favour of males because of the larger ratio of male employees in the higher paid medical scales. This is a known issue and the national policy is to encourage more females into medical training. As highlighted in previous reports it will take many years to filter through the higher paid posts due to the length of time it takes to train, then reach a senior level as well as the fact that we no longer report on Doctors in the Training Grades (DiT). However, we can say that the Pay Gap is reducing. This is evidenced by previous overall pay gap of approx. 20%.

I.2. Note that Doctors in the training grades (DiTs) are not included in the mainstreaming report as their employment from 1 August 2018; transferred to NHS Lothian and NHS Education for Scotland as part of a national initiative to establish a single employer throughout training. Doctors in the training grades rotate from East of Scotland Hospitals to work, be trained and locally managed in NHS Borders Hospitals whilst on placement.

I.3. We have utilised basic hourly pay rather than aggregate pay therefore the figures reflect basic guaranteed earnings rather than overall earnings which are variable. Most out of hours AFC staff are female therefore their average aggregate pay will be boosted by unsocial shift allowances. No comment can be made overall as shift pay for higher paid medical staff (and males are more prevalent in this profession) as their average aggregate pay will also be boosted by unsocial shift allowances.

I.4. Hourly pay rates are rounded to nearest Pound however; the calculation of the Gender Pay Gap is based on the original basic pay figure which explains the presence of a Pay Gap even though the Average of Basic Hourly Rate is noted as the same for male and female employees in the report.

I.5. There was no entitlement to bonuses during this time period; therefore no requirement to include bonus pay in these calculations.

As at 31st March 2019

Table 9.5a - AFC Staff Gender Pay Gap 2019		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	14	2503
Male	14	482
Grand Total	14	**2985**
Gender Pay Gap	**-3.0%**	

Table 9.5b - Medical & Dental Staff Pay Gap 2019		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	38	122
Male	43	94
Grand Total	40	**216**
Gender Pay Gap	**11.4%**	

Table 9.5c – All Staff Pay Gap 2019		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	16	2625
Male	19	576
Grand Total	16	**3201**
Gender Pay Gap	**17%**	

Table 9.5d Distribution of Staff Pay by Gender and Quartile 2019					
Hourly Pay Quartile	**Count of Gender**			**Quartile Percentage**	
	Female	**Male**	**Grand Total**	**%Female**	**%Male**
Lower	613	187	800	76.6	23.4
Lower middle	691	109	800	86.4	13.6
Upper middle	704	96	800	88.0	12.0
Upper	617	184	801	77.0	23.0
Grand Total	**2625**	**576**	**3201**	**82.0**	**18.0**

Median pay	**£/hr**
Middle female	14
Middle male	13
Median Gender Pay gap	**-12.6%**

As at March 31st 2020

Table 9.5e - AFC Staff Gender Pay Gap 2020		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	15	2541
Male	15	489
Grand Total	15	**3030**
Gender Pay Gap	**-4.2%**	

Table 9.5f - Medical & Dental Staff Pay Gap 2020		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	40	117
Male	43	94
Grand Total	41	**211**
Gender Pay Gap	**7.4%**	

Table 9.5g – All Staff Pay Gap 2020		
Gender	**Average of basic hourly rate (£)**	**Count**
Female	16	2658
Male	19	583
Grand Total	17	**3241**
Gender Pay Gap	**15%**	

Median pay	**£/hr**
Middle female	15
Middle male	13
Median Gender Pay gap	**-15.7%**

Table 9.5h Distribution of Staff Pay by Gender and Quartile 2020					
Hourly Pay Quartile	**Count of Gender**			**Quartile Percentage**	
	Female	**Male**	**Grand Total**	**%Female**	**%Male**
Lower	611	199	810	75.4	24.6
Lower middle	707	103	810	87.3	12.7
Upper middle	693	117	810	85.6	14.4
Upper	647	164	811	79.8	20.2
Grand Total	**2658**	**583**	**3241**	**82.0**	**18.0**

10 Data Sources

2019 Scottish borders population

https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/scottish-borders-council-profile.html#:~:text=This%20is%20the%2012th%20highest,Scotland's%20population%20rose%20by%207.6%25.&text=In%202019%2C%20there%20were%20more,%25)%20living%20in%20Scottish%20Borders.

Age structures

https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/scottish-borders-council-profile.html#:~:text=This%20is%20the%2012th%20highest,Scotland's%20population%20rose%20by%207.6%25.&text=In%202019%2C%20there%20were%20more,%25)%20living%20in%20Scottish%20Borders.

Birth/death rate

https://www.nrscotland.gov.uk/files/statistics/council-area-data-sheets/scottish-borders-council-profile.html#:~:text=This%20is%20the%2012th%20highest,Scotland's%20population%20rose%20by%207.6%25.&text=In%202019%2C%20there%20were%20more,%25)%20living%20in%20Scottish%20Borders.

Life expectancy

https://www.scotborders.gov.uk/downloads/file/7859/scottish_borders_insights_heathy_life_expectancy_2017-19

Average weekly earnings

https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/placeofresidencebylocalauthorityashetable8

Disability

https://www.scotlandscensus.gov.uk/search-the-census#/

LGBT

https://www.scotborders.gov.uk/download/downloads/id/2972/equality_mainstreaming_report_and_equality_outcomes_2017_%E2%80%93_2021.pdf (SBC People Dept.)

Child poverty

https://www.scotborders.gov.uk/download/downloads/id/7818/scottish_borders_anti-poverty_strategy_2021.pdf

Fuel poverty

https://www.scotborders.gov.uk/download/downloads/id/7818/scottish_borders_anti-poverty_strategy_2021.pdf

Religion

https://www.scotlandscensus.gov.uk/search-the-census#/

Languages

https://www.scotlandscensus.gov.uk/search-the-census#/

Declared ethnic groups

https://www.scotlandscensus.gov.uk/search-the-census#/

Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	June Smyth, Director of Planning & Performance
Author:	Gemma Butterfield, Planning and Performance Officer

NHS BORDERS PERFORMANCE SCORECARD – OCTOBER 2021

Purpose of Report:

The purpose of this report is to update the Board on NHS Borders latest performance against the measures set out in the 2021/22 Remobilisation Plan (RMP3) alongside some key targets and standards that were included in previous Annual Operational Plans Local Delivery Plans (LDP).

As part of the remobilisation process following COVID-19 Scottish Government required all boards to develop and submit a remobilisation plan (RMP3) for 2021/22. As part of this plan trajectories were submitted which replaced some, but not all measures, previously contained within the Annual Operational Plan (AOP) 2020/21. The performance data presented in the attached scorecard therefore relates to:

- Trajectories contained within RMP3.
- Targets contained within previous AOPs where performance against these is still being recorded
- Performance against standards contained within previous LDPs where performance against these is still being recorded

Typically, the performance scorecard format and the measures contained within it are finalised and 'locked down' for the commencement of the financial year. However, for 2021/22 Scottish Government has yet to confirm monitoring arrangements relating to remobilisation plans, other than the routine monitoring relating to waiting times. There may therefore be a requirement to add to the performance scorecard should additional monitoring requirements be introduced by Scottish Government. In addition, as we continue to remobilise services there may be other measures or activity we would want to propose to monitor at Board level. If this is the case they will be highlighted to the Board before being included in future reports.

Recommendations:

The Board is asked to **note** the October 2021 Performance Scorecard.

Approval Pathways:

This report has been prepared with input from the Service Leads, who have signed off their relevant sections. The cover paper has been reviewed and approved by the Director of Planning & Performance.

Executive Summary:

1.1 As highlighted previously, the monthly Performance Scorecard has been re-formatted and updated to enable members to monitor performance against the RMP3 trajectories, previous AOP and LDP measures. Reporting will continue to develop as we progress through the remainder of the year and have had the opportunity to revisit the format of the scorecard, which we plan to include key demand and activity information.

1.2 Narrative on actions being taken to achieve targets and standards are now based on exception reporting on this smaller set and is noted in this cover paper. RMP3 trajectories, LDP Standards and key local performance indicators will be measured twice yearly in the Managing Our Performance (MOP) Report which is presented to the Board. A more detailed comparison of our performance against other Boards in Scotland will be provided in the MOP.

1.3 Areas of positive performance as at 31st October 2021 are detailed below:

- 1504 patient breaches against **12 Week Waiting Time for an Inpatient** Appointment trajectory of 2705 in October 2021 (page 8)
- 36 patient breaches against the **12 Week Treatment Time Guarantee** trajectory of 374 in October 2021 (page 9)
- 435 patient breaches against the **Diagnostics Waiting Times** trajectory of 558 in August 2021 (page 10)
- 100% performance achieved **Drug and Alcohol 3 Week Referral to Treatment** in October (page 12)

1.4 The following performance measures are reported outwith of standard/ trajectory in October 2021. As reporting develops we will revert to reporting on an exception basis and narrative will be provided for measures outwith for 3 consecutive months.

1.5 18 Week Referral to Treatment (RTT)

1.5.1 The national referral to treatment standard requires NHS Borders to see and treat, or discharge 90% of patients referred into secondary for assessment or treatment within 18 week. Historically this is a standard we have been able to meet on a month to month basis.

1.5.2 The increase in both Outpatient and TTG waiting times since March 2020, particularly for routine outpatient assessment or routine surgery, has put pressure on our RTT performance and our ability to meet this standard. As a consequence we have not reported meeting this standard since June 2020.

1.5.3 Addressing the performance deficit we currently have will be determined by our ability to recover pre-COVID-19 activity levels in our outpatient clinics, and addressing longer routine waits in a number of high volume outpatient services. This is where the overwhelming majority of “clock stops” from an RTT standard occur.

1.5.4 NHS Borders is continuing to work to replace physical outpatient capacity lost on the Borders General Hospital site to the redesign of emergency and urgent care

services. We are also continuing to work with SG colleagues in planning to address backlogs across outpatient services through the provision of additional ad hoc capacity where this is possible. This includes the selective use of locums, external and independent sector providers.

1.6 CAMHS 18 Weeks Referral to Treatment

1.6.1 Significant work has progressed within the service to address access to timely assessment. In the short term the Board will continue to show poor performance as the service is targeting their longest patients waiting and this doesn't prevent continual referrals being made to the service. However the service does still continue to clinically prioritise patients.

1.6.2 Due to increased funding made available from Scottish Government the service has progressed to enhance and increase its overall workforce specifically in the short term to address the backlog and waiting times. With the second phase of Recovery and Renewal funding now available we are in the process of reviewing our recruitment plans. We continue to carry significant staffing vacancies within our psychology service despite concerted efforts to recruit. However it is anticipated there will be a significant improvement in timely access to our service once recruitment is complete.

1.7 Accident & Emergency 4 Hour Standard

1.7.1 Our A&E department continued to face significant pressures in October with return to pre COVID-19 attendee numbers including significant long waits for inpatient beds which impacted on flow.

1.7.2 As part of The Re-designing Urgent Care project we are reviewing how we can implement sign posting and re-direct patients locally to assist with the position. Our communications team continues to support with media releases.

1.8 Delayed Discharge

1.8.1 In September 2021 there continued to be delayed discharges for patients waiting for both residential care and packages of care, which contributed to us not achieving the previously set trajectory.

1.8.2 We have increased focused actions aimed at delivering the recommendations of the recent Delayed Discharge Audit. Work continues to embed processes whilst working as a whole system and this is monitored weekly through the Health & Social Care Partnership Delayed Discharge Performance Meeting.

1.9 Sickness Absence

1.9.1 NHS Borders absence rate (sickness and COVID-19) for October 2021 was 7.4%, of which 1.3% was COVID-19 related and 6.1% non-COVID-19 related. In comparison to the month of September we have seen a decrease in all absence of 0.9%, with COVID-19 related absence decreasing from 1.6% to 1.3%.

1.9.2 HR continue to send detailed monthly reports to line managers and continue to support the management of absence through running attendance clinics for

managers and policy training events. The Work and Wellbeing Service also continue to support staff and managers.

1.10 Planned V Actual Activity Update

1.10.1 As RMP3 and subsequently RMP4 replace the previously agreed AOP, all boards now have to return planned activity versus actual activity reports to Scottish Government on a monthly basis for some key areas; for October 2021 NHS Borders reported:

Activity	Planned	Actual	Variance
Key Diagnostics	2449	1489	-960
New Outpatient Activity	1970	1417	-553
TTG Activity	374	100	-274

1.11 RMP4 Targets and Trajectories

1.11.1 Once the Board has received confirmation that the targets and performance trajectories contained in RMP4 have been accepted by Scottish Government then these will be included in future Performance Scorecards.

Impact of item/issues on:	
Strategic Context	Regular and timely performance reporting is an expectation of the Scottish Government.
Patient Safety/Clinical Impact	The RMP3 trajectories, Annual Operational Plan measures and Local Delivery Plan standards are key monitoring tools of Scottish Government in ensuring Patient Safety, Quality and Effectiveness are being carried out in NHS Health Boards.
Staffing/Workforce	Directors are asked to support the implementation and monitoring of measures within their service areas.
Finance/Resources	Directors are asked to support financial management and monitoring of finance and resource within their service areas.
Risk Implications	There are a number of 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.
Equality and Diversity	Health Inequalities Impact Assessments have been completed for earlier remobilisation plans and there is one currently in production for RMP3 which the first draft is being shared with the RMP4 ratification item at December Board Meeting.
Consultation	Performance against measures within this report have been reviewed by each service area.

Glossary	AOP – Annual Operational Plan LDP – Local Delivery Plan RMP3- Remobilisation Plan for 2021/22 RMP4 – updated Remobilisation Plan for 2021/22

NHS Borders

PERFORMANCE SCORECARD

As at 31st October 2021

October 2021

Information & BI Services

Month

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Contents

INTRODUCTION

PERFORMANCE MEASURES

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 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

So that the direction of travel towards the achievement of the standard/trajectory can be easily seen, the following indicators shown below are used:

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	-
Standard/Trajectory has been achieved this month	✓
Standard/Trajectory has not been achieved this month	X

Annual Operational Plan

Every year the Scottish Government Health Department (SGHD) asks each Health Board to report to them on their performance and delivery plans for the next financial year. This report was called the Local Delivery Plan (LDP) and formed an agreement on what Health Boards will achieve in the next year with SGHD. From 2018/19 Boards are no longer required to produce an LDP which have been replaced by Annual Operational Plans (AOP) that have AOP measures associated with them. Boards are also still required to monitor LDP standards which NHS Borders will do through the six month Managing Our Performance Report. As a result of the COVID-19 Pandemic the 2021/22 AOP has been replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, therefore this report contains a mix of RMP3 trajectory performance, previous AOP and LDP measures.

Please note:

Some anomalies may occur in data due to time lags in data availability and national reporting schedules.

Key Metrics- Against AOP Standards and RMP3 Trajectories where applicable

September Reported Performance - Area Achieving Standard/Trajectory

Drugs and Alcohol clients waiting < 3 weeks from referral to treatment

Aug 2021		Sep 2021	Target	
100.0%	↔	100.0%	≥ 90%	✓

Diagnostics - 8 key tests waiting > 6 weeks target as at month end

Sep 2021		Oct 2021	Trajectory	
440	↑	435	558	✓

Inpatient/Daycase patients waiting > 84 days TTG target as at month end

Sep 2021		Oct 2021	Trajectory	
22	↓	36	374	✓

New Inpatients waiting > 12 weeks target as at month end

Sep 2021		Oct 2021	Trajectory	
1426	↓	1504	2705	✓

September Reported Performance - Area Outwith Standard/Trajectory but within Tolerance

Cancer Waiting Times 62-day target

Aug 2021		Sep 2021	Target	
96.7%	↓	86.2%	≥ 95%	X

Cancer Waiting Times 31-day target

Aug 2021		Sep 2021	Target	
100.0%	↓	89.3%	≥ 95%	X

Psychological Therapy Referral to Treatment within 18 weeks

Aug 2021		Sep 2021	Target	
90.1%	↓	89.0%	≥ 90%	X

New Outpatients waiting > 12 weeks target as at month end

Sep 2021		Oct 2021	Trajectory	
4801	↓	5819	5949	X

September Reported Performance - Area Significantly Outwith Standard/Trajectory

Delayed Discharges as at census date (last Thursday of the month) delayed over 72 hours [1]

Sep 2021		Oct 2021	Trajectory	
45	↑	42	10	X

CAMHS patients treated within 18 weeks from referral to treatment

Aug 2021		Sep 2021	Target	
42.4%	↑	70.6%	≥ 90%	X

A&E patients discharged or transferred within 4 hour target

Sep 2021		Oct 2021	Target	
77.2%	↓	75.9%	≥ 95%	X

Maintain Sickness Absence Rates below 4%

Sep 2021		Oct 2021	Target	
6.7%	↑	6.1%	4.0%	X

% of patients seen within 18 weeks Combined Performance

Sep 2021		Oct 2021	Target	
81.8%	↓	76.7%	≥ 90%	X

[1] This trajectory will alter next month to follow the new all DDs trajectory submitted to SG as part of RMP4.

Performance Measures

Cancer Waiting Times

62 Day Cancer - 95% of all cases with a Suspicion of Cancer to be seen within 62 days

Standard
95.0%

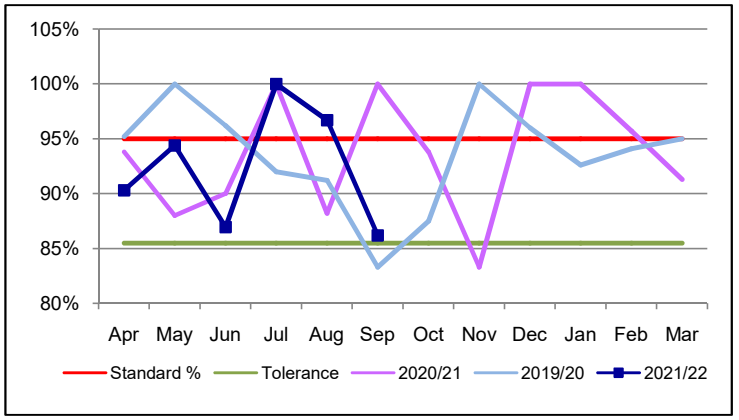
Tolerance
86.0%

Latest NHS Scotland Performance
84.1% (Apr - Jun 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	90.3%	94.4%	87.0%	100.0%	96.7%	86.2%						
2020/21	93.8%	88.0%	90.0%	100.0%	88.2%	100.0%	93.8%	83.3%	100.0%	100.0%	95.7%	91.3%
2019/20	95.2%	100.0%	96.2%	92.0%	91.2%	83.3%	87.5%	100.0%	96.0%	92.6%	94.1%	95.0%

Please Note: There is a 1 month lag time for data. August data unavailable at this time.

Actual Performance (higher % = better performance)



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31 Day Cancer - 95% of all patients requiring Treatment for Cancer to be seen within 31 days

Standard
95.0%

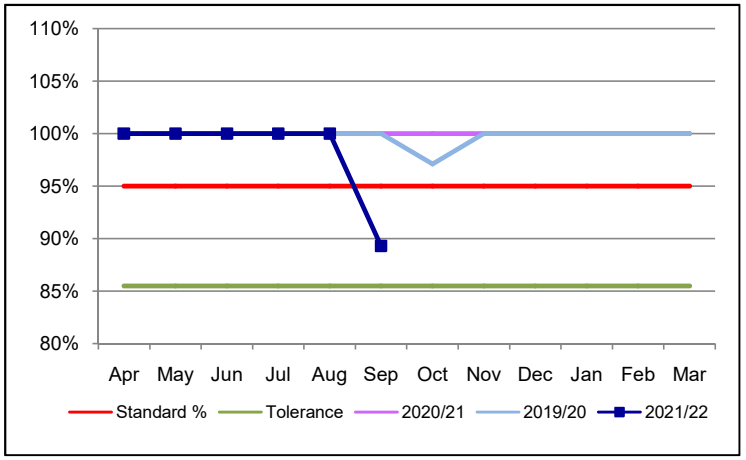
Tolerance
86.0%

Latest NHS Scotland Performance
98.1% (Apr-Jun 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	100.0%	100.0%	100.0%	100.0%	100.0%	89.3%						
2020/21	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2019/20	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.1%	100.0%	100.0%	100.0%	100.0%	100.0%

Please Note: There is a 1 month lag time for data. August data unavailable at this time.

Actual Performance (higher % = better performance)



Stage of Treatment - 12 Weeks Waiting Times

Standard - 12 weeks for first outpatient appointment

Trajectory
5949

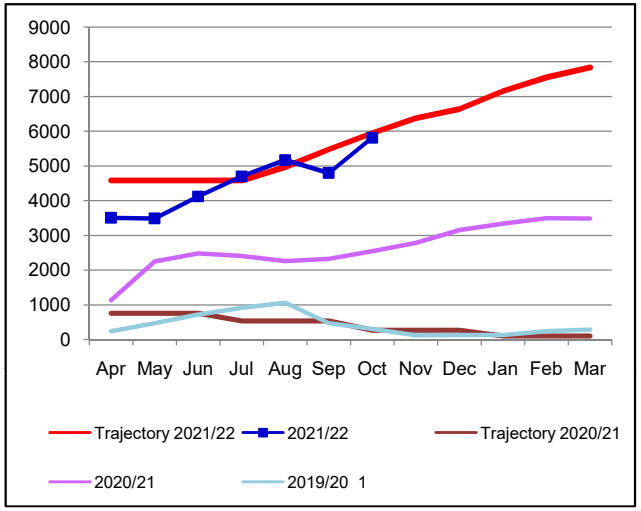
Tolerance
6538

Latest NHS Scotland Performance	**NHS Borders Performance (as a comparative)**
53.0% (June 2021)	49.7% (June 2021)

	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trajectory 2021/22	4580	4580	4580	4580	4964	5481	5949	6373	6644	7159	7553	7843
2021/22	3507	3489	4123	4702	5172	4801	5819					
Trajectory 2020/21	755	755	755	535	535	535	270	270	270	100	100	100
2020/21	1132	2253	2482	2406	2263	2324	2542	2783	3158	3344	3498	3489
2019/20 [1]	236	467	719	911	1055	467	301	120	128	127	240	287

[1] Please note performance is measured against Trajectory not standard as per 2019/20 AOP

Actual Performance (lower = better performance)



12 week breaches by specialty

	Apr-20	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**
Cardiology	12	53	37	43	51	66	94	108	134	151	163	162	175	162	250	273	261	147	252
Dermatology	327	460	523	524	500	526	526	550	616	562	550	534	402	534	505	597	695	707	864
Diabetes/Endocrinology	10	26	39	43	43	43	41	34	42	50	51	56	66	56	84	101	104	105	101
ENT	41	149	180	182	184	202	225	262	296	350	354	378	414	378	548	530	446	387	420
Gastroenterology	15	15	20	23	22	24	23	25	37	50	71	76	91	76	106	109	140	125	138
General Medicine	14	6	11	14	5	2	1	0	0	1	2	1	0	1	0	1	0	5	0
General Surgery	28	105	161	187	218	302	383	433	461	481	564	628	682	628	677	712	743	733	762
Gynaecology	52	131	168	148	122	80	75	93	99	101	103	90	81	90	71	98	123	165	219
Neurology	74	145	167	163	144	146	149	159	164	145	130	83	67	83	103	136	171	177	184
Ophthalmology	109	284	375	379	376	376	467	545	695	807	873	907	925	907	1120	1275	1433	1200	1634
Oral Surgery	141	284	335	342	299	273	272	274	251	217	148	44	25	44	19	10	8	5	12
Orthodontics	7	20	22	22	22	22	26	28	29	33	40	39	41	39	27	35	36	41	55
Other	78	134	137	123	100	98	83	66	67	73	91	97	103	97	99	96	103	86	78
Pain Management	7	26	27	23	18	5	1	0	0	0	0	0	0	0	0	0	0	0	1
Respiratory Medicine	14	8	10	9	8	24	54	74	101	114	120	130	141	130	163	181	200	160	236
Rheumatology	0	3	18	21	11	7	2	3	5	10	7	10	5	10	12	28	24	21	26
Trauma & Orthopaedics	183	328	124	32	17	5	1	3	9	17	17	9	6	9	10	141	262	323	351
Urology	20	76	128	128	123	123	119	126	152	182	214	245	283	245	329	379	423	414	486
All Specialties	**1132**	**2253**	**2482**	**2406**	**2263**	**2324**	**2542**	**2783**	**3158**	**3344**	**3498**	**3489**	**3507**	**3489**	**4123**	**4702**	**5172**	**4801**	**5819**

Stage of Treatment - 12 Weeks Waiting Times Continued

Standard: 12 Weeks Waiting Time for Inpatients

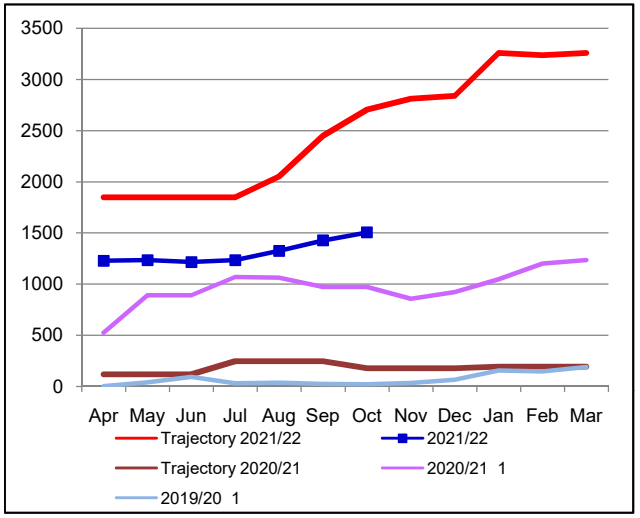
Trajectory
2450

Tolerance
2693

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory 2021/22	1849	1849	1849	1849	2052	2450	2705	2814	2841	3259	3237	3260
2021/22	1227	1234	1215	1233	1325	1426	1504					
Trajectory 2020/21	116	116	116	245	245	245	176	176	176	190	190	190
2020/21 [1]	525	890	891	1070	1064	973	973	857	924	1048	1201	1236
2019/20 [1]	1	39	92	29	35	24	20	32	65	155	146	191

[1] Please note performance is measured against trajectory not standard as per 2019/20 AOP

Actual Performance (lower = better performance)



12 week breaches by specialty

	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
ENT	24	43	43	61	62	52	36	30	25	34	39	34	32	33	37	40	39	41	48
General Surgery	90	146	147	167	161	130	120	116	122	144	163	173	160	160	154	158	195	214	231
Gynaecology	42	73	73	79	82	71	71	63	67	81	100	108	115	109	110	107	115	135	149
Ophthalmology	103	190	190	238	243	236	229	219	212	222	249	239	238	233	218	221	236	246	249
Oral Surgery	14	31	31	41	39	36	35	37	39	49	57	58	65	72	76	82	90	92	101
Trauma & Orthopaedics	223	356	356	413	402	386	342	323	389	439	503	527	526	548	547	562	590	635	656
Urology	29	51	51	71	75	62	61	69	70	79	90	97	91	79	73	63	60	63	70
All Specialties	**525**	**191**	**525**	**1070**	**1064**	**973**	**894**	**857**	**924**	**1048**	**1201**	**1236**	**1227**	**1234**	**1215**	**1233**	**1325**	**1426**	**1504**

12 Weeks Treatment Time Guarantee

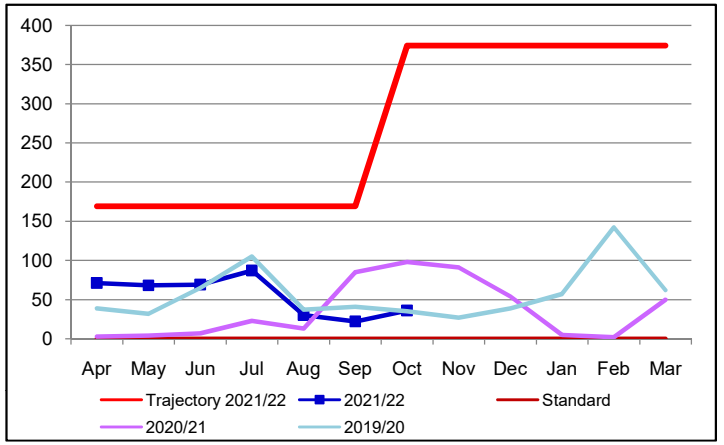
12 weeks TTG - 12 Weeks Treatment Time Guarantee (TTG 100%)	Trajectory
	169

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
64.2% (June 2021)	48.2% (June 2021)

Tolerance: 186

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory 2021/22	169	169	169	169	169	169	374	374	374	374	374	374
2021/22	71	68	69	87	30	22	36					
2020/21	3	4	7	23	13	85	98	91	54	5	2	50
2019/20	39	32	65	105	37	41	35	27	39	57	142	62

Actual Performance (lower = better performance)



18 Weeks Referral to Treatment (RTT)

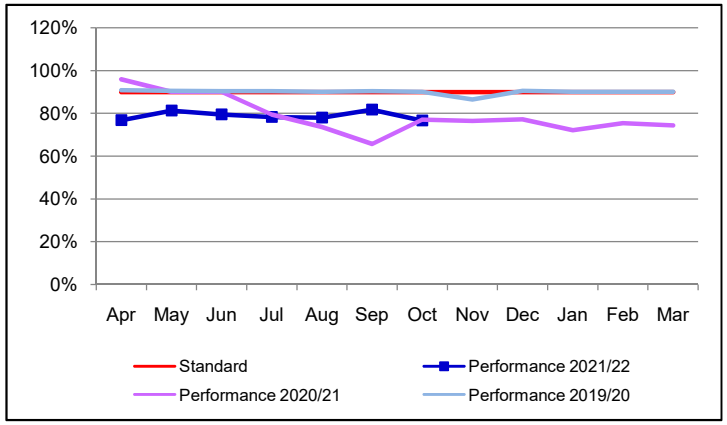
Standard: Combined Pathway Performance	Standard
	90.0%

Latest NHS Scotland Performance
74.8% (June 2021)

Tolerance: 81.0%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
2021/22	76.8%	81.3%	79.5%	78.3%	78.0%	81.8%	76.7%					
2020/21	95.9%	90.1%	90.1%	79.4%	73.6%	65.7%	77.0%	76.4%	77.2%	72.1%	75.4%	74.4%
2019/20	90.8%	90.5%	90.4%	90.4%	90.0%	90.4%	90.0%	86.5%	90.5%	90.1%	90.0%	90.0%

Actual Performance (higher % = better performance)



Please Note: data has a 1 month lag time to ensure it is in line with national reporting

Diagnostic Waiting Times

Waiting Target for Diagnostics - zero patients to wait over 6 weeks

Trajectory

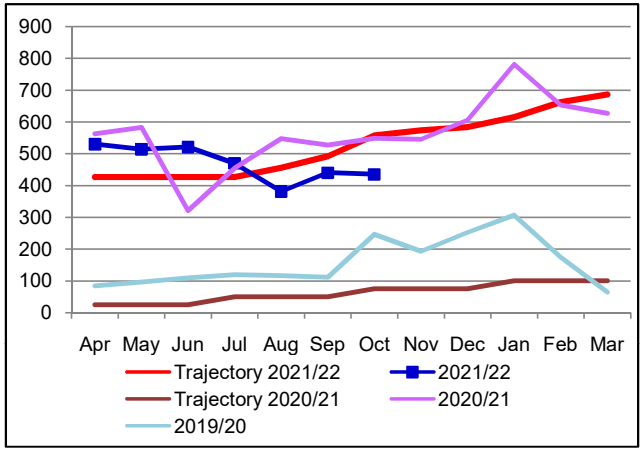
492

Tolerance

541

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory 2021/22	427	427	427	427	456	492	558	574	584	615	662	686
2021/22	530	514	521	470	381	440	435					
Trajectory 2020/21	25	25	25	50	50	50	75	75	75	100	100	100
2020/21	563	583	321	455	547	527	548	545	606	781	653	627
2019/20	84	96	109	119	116	111	247	193	253	307	175	64



The national standard is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests.
The breakdown for each of the 8 key diagnostics tests is below:

6 weeks	**Apr-20**	**May-20**	**Jun-20**	**Jul-20**	**Aug-20**	**Sep-20**	**Oct-20**	**Nov-20**	**Dec-20**	**Jan-21**	**Feb-21**	**Mar-21**	**Apr-21**	**May-21**	**Jun-21**	**Jul-21**	**Aug-21**	**Sep-21**	**Oct-21**
Endoscopy	14	20	10	17	21	29	53	63	75	95	101	109	118	123	132	152	155	168	173
Colonoscopy	76	47	36	31	38	38	34	12	4	28	26	41	50	43	39	43	26	31	34
Cystoscopy	4	17	19	24	37	30	31	40	36	38	30	14	17	27	23	20	5	3	7
MRI	101	92	116	130	127	99	106	112	124	191	113	96	77	127	143	90	27	17	18
CT	88	145	132	157	199	176	139	117	132	197	221	260	168	138	151	137	107	130	92
Ultra Sound (non-obstetric)	280	245	108	82	101	138	173	195	233	232	162	107	100	56	31	28	54	88	108
Barium	0	17	19	14	24	17	12	6	2	0	0	0	0	0	2	0	7	3	3
Total	**563**	**583**	**440**	**455**	**547**	**527**	**548**	**545**	**606**	**781**	**653**	**627**	**530**	**514**	**521**	**470**	**381**	**440**	**435**

CAMHS Waiting Times

18 weeks CAMHS - 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

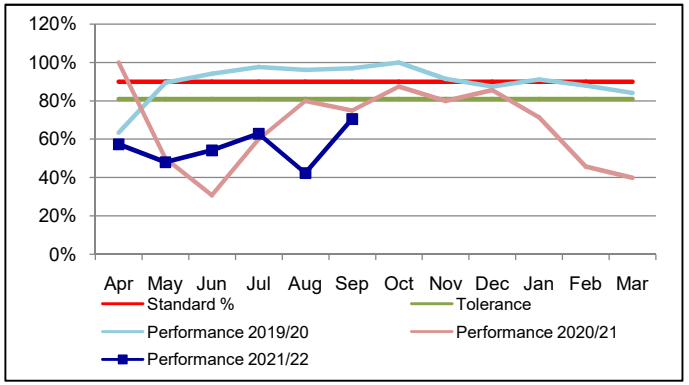
Standard
90.0%

Tolerance
81.0%

Latest NHS Scotland Performance
72.6% (Apr - Jun 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2021/22	57.5%	48.1%	54.3%	63.0%	42.4%	70.6%						
Performance 2020/21	100.0%	50.0%	30.8%	60.0%	80.0%	75.0%	87.5%	80.0%	85.7%	71.4%	45.8%	40.0%
Performance 2019/20	63.5%	89.4%	94.1%	97.6%	96.2%	97.0%	100.0%	91.4%	87.5%	91.2%	88.0%	84.2%

Actual Performance (higher % = better performance)



Psychological Therapies Waiting Times

Standard: 18 weeks referral to treatment for Psychological Therapies

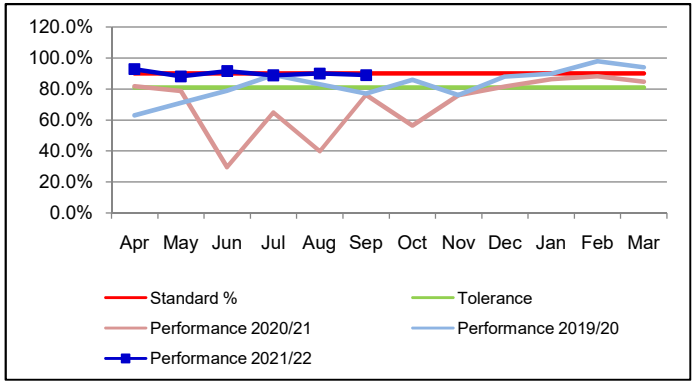
Standard
90.0%

Tolerance
81.0%

Latest NHS Scotland Performance
82.7% (Apr - Jun 2021)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
Performance 2021/22	92.9%	88.2%	91.7%	88.9%	90.1%	89.0%						
Total Patients Currently Waiting >18 Weeks:	215	170	166	164	160	171						
Performance 2020/21	82.0%	78.8%	29.6%	64.9%	40.0%	76.3% [5]	56.5% [6]	76.1%	81.7%	86.5%	88.3%	84.7%
Total Patients Currently Waiting >18 Weeks:	185	225	250	271	218	180	162	157	169	156	181	201
Performance 2019/20	63.0% [2]	71.0% [3]	79.0% [4]	89.0% [4]	83.0%	77.0%	86.0%	76.0%	88.0%	90.0%	98.0%	94.0%
Total Patients Currently Waiting >18 Weeks:	162 [2]	172 [3]	159	125	125	137	158	125	135	138	140	164

Actual Performance (higher % = better performance)



[2] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay

[3] Psychological Therapy data does not include CAMHS or LD due to EMIS reporting delay, but does include the Doing Well Service and DBT Team for the first time

[4] Psychological Therapy data for LD and CAMHS is NOT included (due to EMIS reporting delay and staff absence respectively). Data for Dialectical Behaviour Therapy (DBT) Team now included, as well as anxiety management patients starting treatment with the Doing Well Service

[5] Data now includes all PT Services

[6] Renew, Primary Care PT Service started in October 2020.

Drug & Alcohol Treatment

Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery

Standard
90.0%

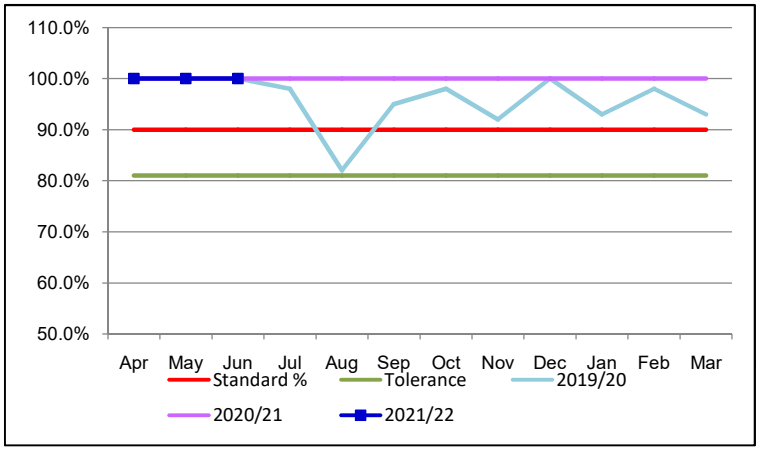
Latest NHS Scotland Performance
95.6% (Jan - Mar 2021)

Tolerance
81.0%

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%
2021/22	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%						
2020/21	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
2019/20	100.0%	100.0%	100.0%	98.0%	82.0%	95.0%	98.0%	92.0%	100.0%	93.0%	98.0%	93.0%

Note: Updates provided Quarterly

Actual Performance (higher % = better performance)



Accident & Emergency 4 Hour Standard

4 hour A&E - 4 hours from arrival to admission, discharge or transfer for A&E treatment (95%)

Standard

95.0%

Latest NHS Scotland Performance

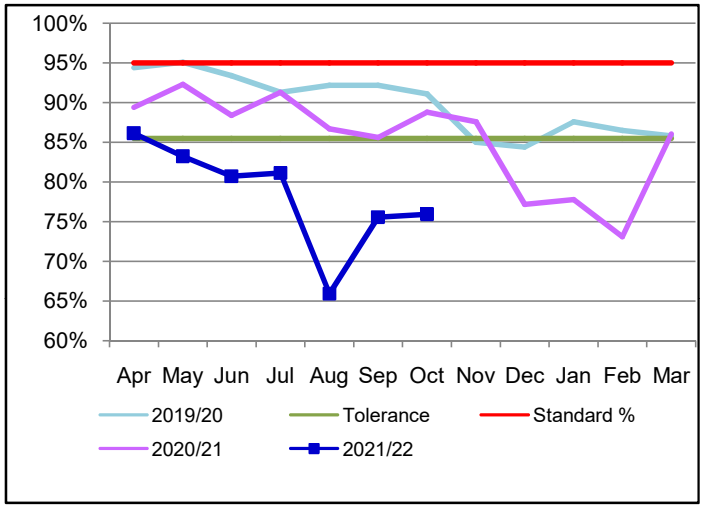
76.1% (September 2021)

Tolerance

85.5%

Actual Performance (higher % = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%
2021/22	86.1%	83.2%	80.7%	81.1%	65.9%	75.6%	75.9%					
2020/21	89.4%	92.3%	88.4%	91.3%	86.7%	85.6%	88.8%	87.6%	77.2%	77.8%	73.1%	86.1%
2019/20	94.4%	95.1%	93.4%	91.3%	92.2%	92.2%	91.1%	85.0%	84.4%	87.6%	86.5%	85.8%



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.

Emergency Access	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Flow 1	96.8%	98.2%	99.3%	99.7%	98.2%	98.1%	98.0%	99.0%	97.1%	97.4%	97.6%	99.5%	97.8%	98.3%	97.6%	96.8%	96.0%	98.9%	97.7%
Flow 2	84.3%	89.4%	84.5%	84.8%	79.0%	77.3%	80.3%	80.9%	73.6%	75.8%	72.5%	81.1%	79.7%	78.3%	73.9%	77.0%	66.2%	72.5%	75.7%
Flow 3	86.7%	89.1%	80.2%	85.5%	70.5%	69.6%	81.8%	78.5%	57.7%	59.6%	50.0%	80.2%	81.2%	71.9%	67.6%	61.4%	29.4%	47.9%	49.5%
Flow 4	84.2%	81.3%	74.2%	86.1%	80.8%	78.7%	83.0%	81.8%	75.8%	74.2%	64.7%	77.7%	78.5%	75.6%	65.5%	74.0%	53.8%	53.6%	54.4%
Total	**89.4%**	**92.3%**	**88.4%**	**91.3%**	**86.7%**	**85.6%**	**88.8%**	**87.6%**	**77.2%**	**77.8%**	**73.1%**	**86.1%**	**86.1%**	**83.2%**	**80.7%**	**81.1%**	**65.9%**	**75.6%**	**75.9%**

Note: December 2020 ED Significant Facility 32 MIU opened. EAS calculated on unplanned attendances only.

Delayed Discharges

Standard: Delayed Discharges - delays over 72 hours

Standard

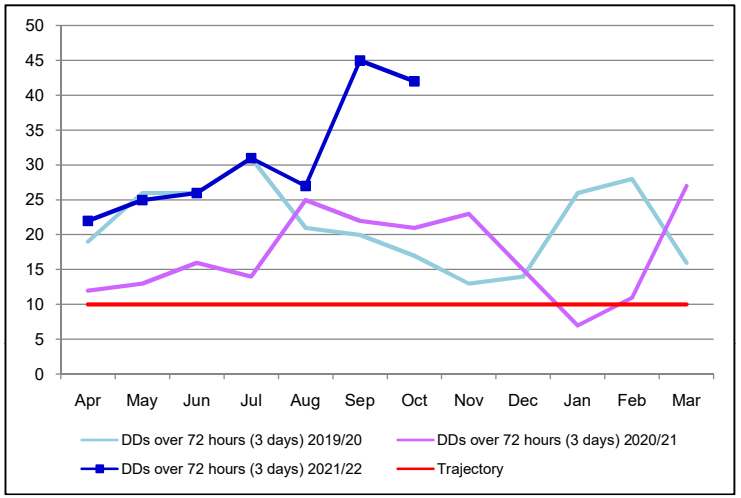
0

Tolerance

1

Actual Performance (lower = better performance)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard	0	0	0	0	0	0	0	0	0	0	0	0
Trajectory	10	10	10	10	10	10	10	10	10	10	10	10
DDs over 2 weeks 2021/22	15	15	15	21	24	27	31					
DDs over 72 hours (3 days) 2021/22	22	25	26	31	27	45	42					
Occupied Bed Days (standard delays)	852	885	947	1077	1086	1426	1580					
DDs over 2 weeks 2020/21	5	10	8	10	14	17	10	16	8	3	8	18
DDs over 72 hours (3 days) 2020/21	12	13	16	14	25	22	21	23	15	7	11	27
Occupied Bed Days (standard delays)	418	579	641	674	793	824	681	871	688	478	528	903
DDs over 2 weeks 2019/20	10	13	18	21	16	16	10	7	2	19	21	13
DDs over 72 hours (3 days) 2019/20	19	26	26	31	21	20	17	13	14	26	28	16
Occupied Bed Days (standard delays)	727	859	922	891	960 [1]	968	686	688	659	971	1027	859



[1] Data is provisional at time of reporting

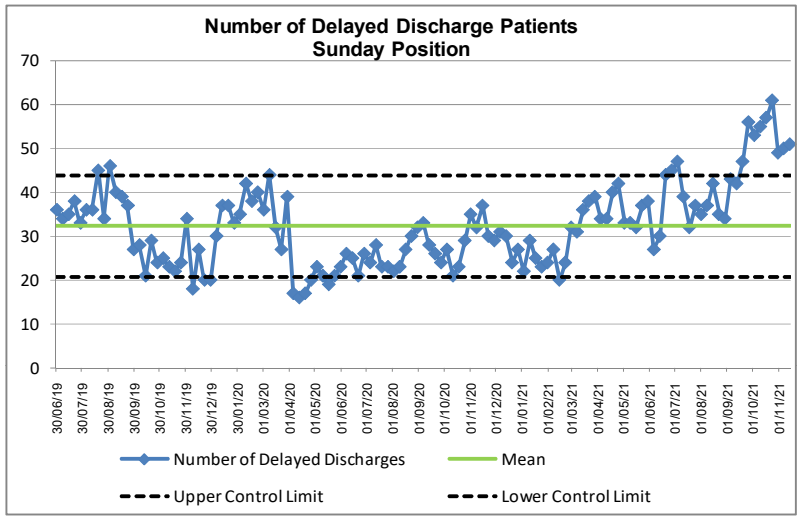
Please Note: The census date changed nationally in July 2016 from 15th of every month to the last Thursday of every month

For reference, national census data is used for monthly occupied bed days (standard delays only).

The trajectory noted here was the one previously agreed for patients over 72 hours. Please see the next page for the total delays trajectory agreed with SG this month. That will be used going forward.

Delayed Discharges - Continued

Standard: Delayed Discharges - delays over 72 hours



Delayed Discharges at Census Point

	As at 29/04/21	As at 27/05/21	As at 24/06/21	As at 29/07/21	As at 26/08/21
Standard Cases	29	36	39	27	32
Complex Cases	2	2	3	3	0
Total	**31**	**38**	**42**	**30**	**32**

Delayed Discharges Discharged in October 2021

Reason for Delay	Cases	Average LoS
1. Assessment	4	12.8
2. Waiting Residential Home	8	53.4
3. Waiting Nursing Home	13	47.5
4. Waiting Care Arrangments to go Home	25	28.3
6. Complex	1	4.0
Total	**51**	**35.5**

Sickness Absence

Standard: Maintain Sickness Absence Rates below 4%

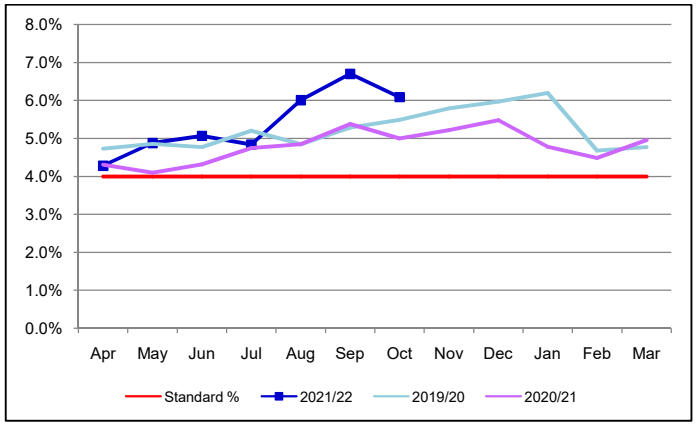
Standard
4.0%

Tolerance
4.4%

Latest NHS Scotland Performance
4.67% (2020/21) [1]

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Standard %	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%
2021/22	4.3%	4.9%	5.1%	4.8%	6.0%	6.7%	6.1%					
2020/21	4.3%	4.1%	4.3%	4.8%	4.9%	5.4%	5.0%	5.2%	5.5%	4.8%	4.5%	5.0%
2019/20	4.7%	4.9%	4.8%	5.2%	4.9%	5.3%	5.5%	5.8%	6.0%	6.2%	4.7%	4.8%

Actual Performance (lower % = better performance)

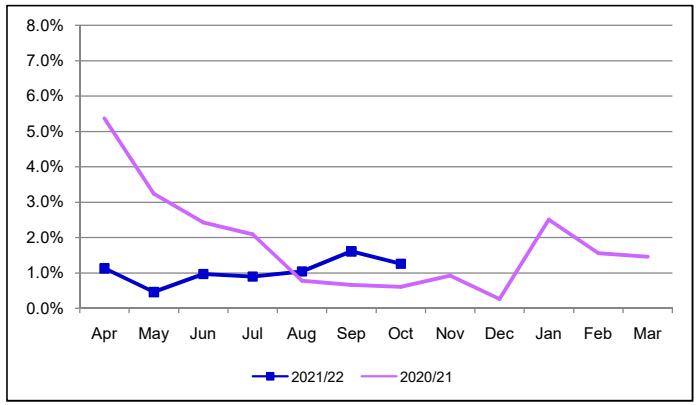


[1] Sickness absence data does not include any COVID-19 related absences.

For information: Covid Absence Rates

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	1.1%	0.5%	1.0%	0.9%	1.0%	1.6%	1.3%					
2020/21	5.4%	3.2%	2.4%	2.1%	0.8%	0.7%	0.6%	0.9%	0.3%	2.5%	1.6%	1.5%

Actual Performance (lower % = better performance)



Alcohol Brief Interventions (ABI)

Standard: Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings

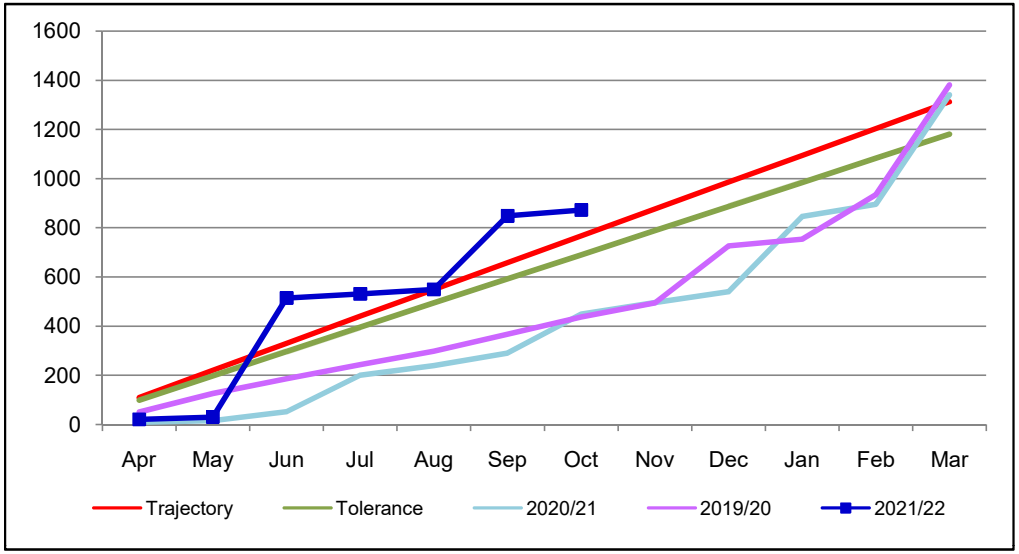
Standard	Tolerance
1312	within 10%

Actual Performance (higher = better performance)

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
123.8% (2019/20)	105.3% (2019/20)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory	110	220	330	440	549	658	767	876	985	1094	1203	1312
2021/22	21	30	514	531	549	848	872					
2020/21	9	15	52	200	239	290	449	496	540	846	896	1341
2019/20	51	126	186	244	298	367	437	495	727	754	934	1381

Please Note: Standard is1312 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.



Smoking Quits

Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% most deprived SIMD areas

Standard	Tolerance
173	within 10%

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

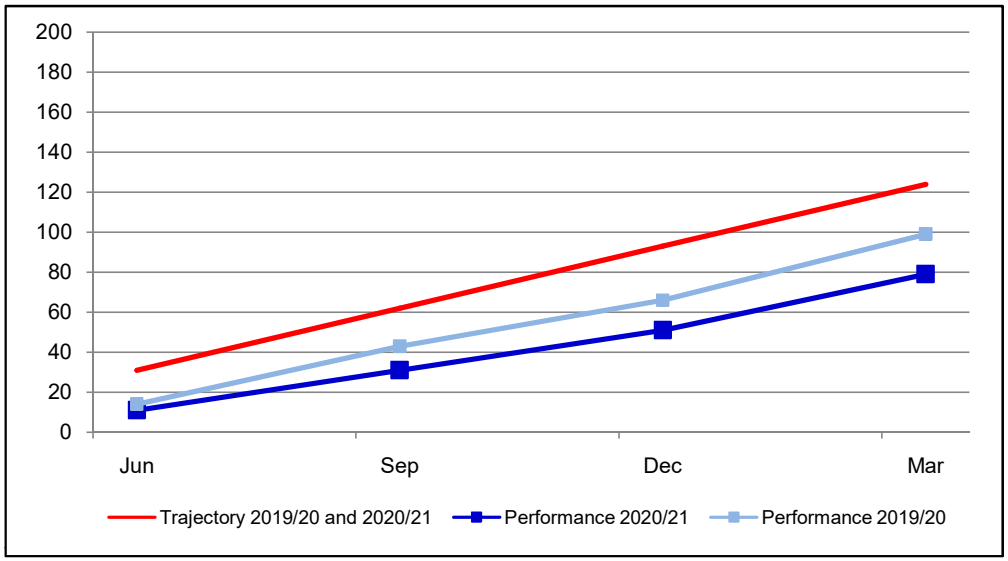
Actual Performance (higher = better performance)

	Jun	Sep	Dec	Mar
Trajectory 2020/21	31	62	93	124
Performance 2020/21	11	31	51	79
Trajectory 2019/20	31	62	93	124
Performance 2019/20	14	43	66	99
Trajectory 2018/19	33[1]	66	99	132
Performance 2018/19	34	60[2]	78	103

[1] Quarter 1 of 2018/19 target has been reduced from 43 quits to 33 quits

[2] Provisional figure provided by the service

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.



Borders NHS Board

Meeting Date: 2 December 2021

Approved by:	Dr Tim Patterson, Joint Director of Public Health
Author:	Fiona Doig, Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership

JOINT HEALTH IMPROVEMENT TEAM ANNUAL REPORT 2020-2021

Purpose of Report:

The purpose of this report is to brief the Board on the contents of the Joint Health Improvement Team (JHIT) 2020-2021 Annual Report (Appendix 1)

Recommendations:

The Board is asked to **note** the report.

Approval Pathways:

This report has been in conjunction with the JHIT Management Team before being approved by the Public Health Governance Committee.

Executive Summary:

The JHIT Annual report presents a snapshop of the work undertaken by the Joint Health Improvement Team during 2019-20.
This includes:

- Support to the COVID-19 response
- An overview of participation in interventions and training/capacity building activities
- Highlighted activities linked to each of the Public Health priorities for Scotland.

JHIT is part of NHS Borders Public Health Department and the staff team includes members from both NHS Borders and Scottish Borders Council (SBC).

Support to the COVID-19 response (p5-6)
Members of JHIT management team led the work to co-ordinate shielding list for NHS Borders and set up the Community Infection Control Advisory Service (CICAS). Member of the wider team were deployed across a range of responses including BGH ward, testing, contact tracing and PPE training.

An overview of participation in interventions and training/capacity building activities (p8-9)
Page 8 highlighted the range of activities and the reach achieved across the team while page 9 outlines the range of training offered. Training was adapted to be delivered online and new short courses in mental health improvement and suicide prevention were developed in response to identified need. In 2020-21 there were 515 individual training

attendances compared to 498 in 2019-20.

Highlighted activities linked to each of the Public Health priorities (PHP) for Scotland (p10-.

- Priority 1: A Scotland where we live in vibrant, healthy and safe places and communities (p10)

Work highlighted in this PHP is the Greenhouse Project. The partnership between JHIT and SBC's Community Justice Team supports the distribution of seasonal produce from greenhouses to service settings and activities supporting children and families. Community Justice clients receive supportive training while families have access to fresh healthy foods supplemented by cooking classes and recipes.
The Older People's Survey engaged 487 older people in Borders in sharing experience of COVID-19 and identified areas for development. This work is being taken forward by the Borders Older People's Planning Partnership. JHIT Health Improvement Lead for Communities is a member of this group.

- Priority 2: A Scotland where we flourish in our early years (p12-14)

Work highlighted in this PHP includes an innovative programme of behaviour change learning in early years settings (p14). This was funded by the East Region Diabetes Prevention Partnership and developed with support from SBC and NHS Education for Scotland. 111 participants completed Health Beginnings MAP training to support the child healthy weight programme. The training included specific learning related to health weight, physical activity and oral health.

- Priority 3: A Scotland where we have good mental well being (p15-17)

Work highlighted in this PHP showcases the successful partnership with Breathing Space, and as well as communication and awareness building, Breathing Space benches were launched in Huntlyburn Space to Grow Project and the Springfield development in Duns p15).

Building on the success of the existing Six Ways to Be Well a new version of the young people's self help guide was co-produced with young people and partners; Young Scot; YouthBorders and Community Learning and Development (p16).

- Priority 4: A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs (p18)

The Wellbeing Service operated throughout COVID-19. A new Psychological First Aid programme was developed from April 2020 in response to changing needs during the pandemic.

- Priority 5: A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all (p19-20)

Work highlighted in this PHP describes the role of the Financial Inclusion group and the increased benefits achieved through targeted early years work including the new Money Worries App which was developed in partnership with SBC, Citizen's Advice Bureau and TD1 youth project. The app provides access to quality assured information linked to money, health, housing and work.

- Priority 6: A Scotland where we eat well, have a healthy weight and are physically active (p21)

Work highlighted in this PHP includes the development of a Whole System Approach to

support healthy weight in Eyemouth. The first on-line community engagement workshop took place in March 2020 and identified existing barriers and opportunities to being healthy in Eyemouth (p21).

JHIT co-funds the SBC Walk It programme which offers local 'health' walks led by trained volunteers across Borders. Activity was reduced due to COVID-19 restrictions, however, 107 walks took place within the year including dementia friendly walks (p23)

Next steps:
Continuing work programmes include:

- Implementing delivery of Fit 4 Fun Families programme
- Building on existing financial inclusion work including increasing the reach and use of the Money Worries App
- Pursing phase 2 of the Whole System Approach in Eyemouth
- The partnership with Breathing Space

Impact of item/issues on:	
Strategic Context	The work of JHIT aligns to the national Public Health priorities for Scotland which have been adopted by NHS Borders. Reducing inequalities and promoting health and wellbeing link to CPP and HSCP priorities. Ongoing work will support Scottish Borders Council's Anti-Poverty Strategy.
Patient Safety/Clinical Impact	Investment in prevention and early intervention will reduce future demand on health services.
Staffing/Workforce	Full staffing to core JHIT team following deployment to COVID-19 response has been in place since October.
Finance/Resources	JHIT operates within its existing budget.
Risk Implications	Remobilisation of partnership working following COVID-19 and the depletion of staffing resources is ongoing.
Equality and Diversity	Actions undertaken by JHIT are in line with reducing inequalities.
Consultation	A small in-house team of JHIT staff and Head of Health Improvement developed this report based on recommendations on format and content from the wider team. The final draft of the report was shared at a JHIT Team Meeting before onward dissemination.
Glossary	CPP – Community Planning Partnership JHIT – Joint Health Improvement Team HSCP – Health and Social Care Partnership PHP – Public Health Priorities SBC – Scottish Borders Council

Joint Health Improvement Team

Annual Report 2020-2021

Contents

Introduction

Our Joint Health Improvement Team (JHIT) Annual Report for 2020-2021 provides a snapshot of key pieces of work during the last 12 months. Our overall aim is to reduce inequalities in health by promoting good health throughout the life stages; building capacity and capability within our communities and workforce and creating healthier future for all.

We have aligned our report to Scotland's Public Health Priorities and to provide an update on the key work areas highlighted in last year's report. The new management structure within JHIT has been confirmed since January 2021 and we have also had a significant change following Barbara Jessop's, Health Improvement Specialist Maternal and Infant Nutrition decision to retire at the end of March following a long and successful time in the team.

While some programmes of work continued during the COVID-19 pandemic, all areas of delivery were adapted in response to COVID-19 guidelines and social distancing required. As well as adapting practice in relation to our core work all members of the team have contributed to the COVID-19 response through leading new programmes and services; supporting delivery and providing evidence based advice.

I am very proud of the way that the team have responded positively to adapt to changes not only in what we do but how we do it. JHIT colleagues have delivered one-to-one interventions; developed and delivered group work and training and also hosted a community engagement event on virtual platforms while working from home. We have built stronger links with existing and new partners and had to find ways of keeping in touch and supporting each other.

JHIT staff have demonstrated their skills, flexibility and passion to make a difference for people in Borders and I hope that this report brings the flavour of the successes achieved by JHIT despite a year of significant challenge.

Fiona Doig
Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership

Joint Health Improvement Team (JHIT)

JHIT is part of NHS Borders Public Health Department and the staff team includes members from both NHS Borders and Scottish Borders Council.

Our team is led by the Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership.

We have three lead roles who support their dedicated teams in the following areas:

Public Health Lead for Children and Young People/Child Health Commissioner

- Maternal and Infant Nutrition
- Child Healthy Weight
- Children and Young People's Emotional Health and Wellbeing
- Healthy Relationships

Health Improvement Lead for Adults and Health and Social Care

- Wellbeing Service
- Adult Mental Health and Wellbeing
- Health Promoting Health Service

Health Improvement Lead for Communities and Vulnerable Groups

- Healthy Living Network
- Older People
- Training and Development
- Community Justice
- Poverty and Inequalities

This work is delivered with the support of our Administration Team and Data and Performance Officer.

JHIT COVID-19 Response

The way JHIT delivered its work changed significantly during the year, however, we also made a significant contribution to the direct COVID-19 response from March 2020 and, while some staff returned to the team over the course of the year, we did not have our full staff complement return until April 2021. JHIT staff led the development of three new areas of work:

Shielding

Shielding co-ordination was led by the Head of Health Improvement and supported by Public Health and wider colleagues including staff from Scottish Borders Council. This involved ensuring timely addition of new people to the shielding list; ensuring referring colleagues were aware of criteria and processes and liaising with Scottish Borders Council. In addition, to ensure people who were shielding understood what this involved and were able to access support, over 2100 calls were made to individuals during April - May 2020. The shielding list is still maintained by Public Health staff.

Community Infection Control Advisory Service (CICAS)

The CICAS team was set up by the Public Health Lead for Children and Young People/Child Health Commissioner as a direct response to the need for national and local guidance. CICAS provided support for care homes and other residential community providers around infection control procedures, risk assessments, access and use of PPE. Working jointly with the Infection Control Team CICAS was staffed by nursing colleagues from the wider organisation and supported by Public Health/JHIT Personal Assistant. From 1st October 2020 CICAS was brought under direct responsibility of our Infection Control colleagues.

Test & Protect

JHIT staff also played leadership roles in what eventually became the Test and Protect services. From March onwards Health Improvement Specialists and Practitioners supported the health protection advice and management and early set-up of the Testing Team. Two members of staff took on Team Lead positions within the Contact Tracing Team and ensured the implementation of new systems and support to a staff team from all areas of the organisation many of whom were deployed due to not being able to work in their usual roles.

JHIT COVID-19 Response

PPE Training

Two members of staff who are experienced trainers were deployed in March to act as trainers for PPE in the Borders General Hospital and subsequently in community settings.

Acute Support

We had a number of staff volunteer to work in the acute hospital and one member of staff was deployed early on to work on one of our acute wards.

Further Admin Support

All members of our administrative team took on co-ordination and administrative roles for Problem Assessment Groups and Incident Management Teams for Health Protection.

In addition to those specific roles outlined many of the team were involved in making shielding phone calls, contact tracing and other 'ad hoc' requests to support the work of the wider Public Health Team and organisation.

The skills, experience and enthusiasm of JHIT staff played a huge contribution in all sorts of ways and it has been good to welcome people back.

JHIT staff have also contributed to the new workstreams within NHS Borders:

NHS Borders Staff Wellbeing Group

Early in the pandemic NHS Borders convened a Staff Wellbeing Group which helped facilitate early responses to the impact on staff, for example, provision of formal and informal psychological support for staff. JHIT staff have been active members of the group since its inception.

NHS Borders Health Inequalities Work

NHS Borders has established a Health Inequalities Steering Group and is in the process of developing a programme approach to maximise the impact of the organisation on mitigating health inequalities.

This work has gathered focus in response to the evidence the disproportionate impact of the pandemic on people experiencing health inequalities.

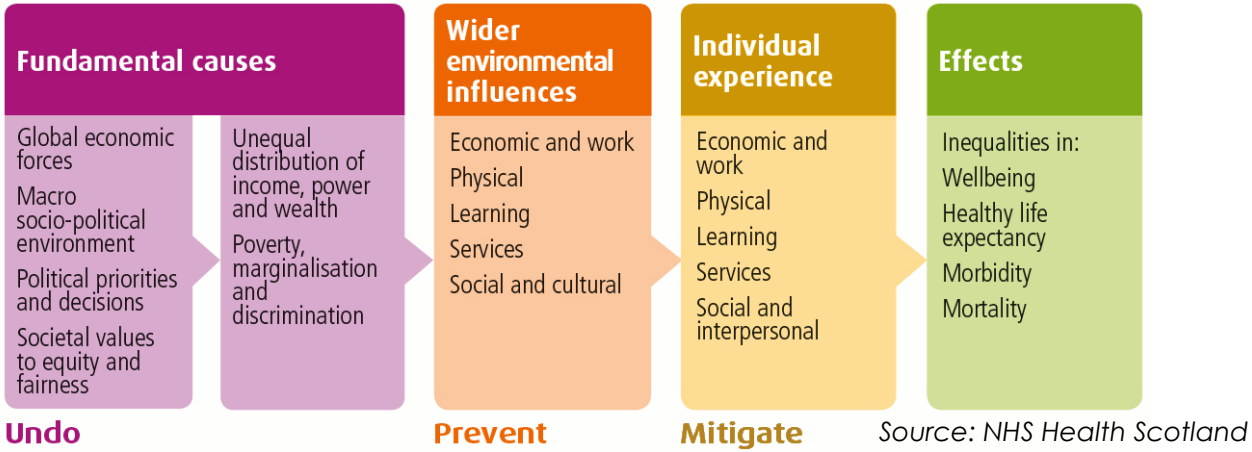
Public Health Priorities for Scotland

Public Health Priorities

The Scottish Government has agreed a clear set of related and inter-dependent priorities for Scotland which are:

1. A Scotland where we live in vibrant, healthy and safe places and communities
2. A Scotland where we flourish in our early years
3. A Scotland where we have good mental wellbeing
4. A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
5. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
6. A Scotland where we eat well, have a healthy weight and are physically active

The agreed priorities reflect public health challenges to focus on over the next decade to improve the public's health.



Source: NHS Health Scotland

Economic, environmental and social factors all influence the health of individuals and communities. Poverty, early life experience, neighbourhood environments and social contexts are at the heart of health inequality. Actions need to be taken over time across all these areas as well as by addressing individual experiences.

Public Health Scotland

Public Health Scotland (PHS) is Scotland's national organisation for Public Health and brings together the three domains of Public Health: Health Protection, Health Improvement and Healthcare Public Health.

In 2020 PHS published its Strategic Plan and have adopted the following as its focus:

- COVID-19 recovery
- Mental wellbeing
- Community and place
- Poverty and children

These areas are likely to continue to shape the work of JHIT going forward.

Activities Overview

Mental Health Improvement / Suicide Prevention

- **241** people took part in digital mental health improvement and suicide prevention training
- **40** people took part in memorial event for people who have died by suicide
- Young people's wellbeing guide uploaded to **12,500** school pupil's ipads
- **170** responses to our men's mental health survey
- **2** Breathing Space benches installed in the Borders

Breastfeeding in the Borders Support (BiBS)

- Volunteers **32**
- BiBS requests at discharge **339**
- Near Me Referrals **20**

BiBS Breastfeeding in the Borders support

JHIT Training

- Participants **515**
- Courses **56**

Quit Your Way* (Apr - Dec 20)

QUIT YOUR WAY with our support

- Quit attempts **328**
- Total quits at three months post quit date **98**

(*as this is a three month target people who quit in March will not be followed up until June 2021)

Healthy Start Vitamins

- Women's **1658**
- Children's **398**

New Vitamin D

- Children's **360**

Wellbeing Service

- New referrals **1950**
- Average **163** per month
- Consultations **11,340**

Wellbeing Service Live Well Feel Better

Walk It

- Walks **107**
- Participants **994**
- Walk Leaders trained **62**

walkit walk your way to health & happiness

Training and Capacity Building

Learning and Skills for Health

Building community capacity is a core health improvement function. Our 'Learning and Skills for Health' training programme is for everyone; staff, partners and the wider community. Learning and Skills for Health has a specific focus on wellness and what we can all do to help build a culture of health.

Health improvement training equips participants with the knowledge and skills to raise and discuss a health and wellbeing issue with confidence, so that they can support people to make small changes which cumulatively can make a big difference. Participants come from a variety of organisations including local authority, NHS, third sector, volunteers, private individuals.

During 2020-21 we moved to online delivery for training which allowed us to reach more people than in our previous year. In 2020-21 there were 515 individual attendances for training compared to 498 in 2019-20.

Our Offer

Our training and capacity building offer reflects the Public Health Priorities although many, while aligned across one area will also influence wider priorities. We have presented courses offered to partners below.

1) A Scottish Borders where we live in vibrant, healthy safe places and communities	• Facilitation skills to help with research into older people's experience of COVID-19
2) A Scottish Borders where we flourish in our early years	• Child healthy weight toolkit • Sleep training • Solihull
3) A Scottish Borders where we have good mental wellbeing	• Be suicide alert • Give yourself breathing space with NHS24 • Looking after your mental health • Mental health improvement / suicide prevention informed level • Mental health improvement / suicide prevention informed level plus • Preparing for a challenging winter • Supporting young people
6) A Scottish Borders where we eat well, have a healthy weight and are physically active	• REHIS - elementary food and health

Priority 1 A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Greenhouse Project

The JHIT works in partnership with Scottish Borders Council's Community Justice Team to grow a wide range of seasonal produce at a greenhouse site in Galashiels.

Produce is distributed back into the community through service settings and activities that support children and families.

The project has developed incrementally to offer new activities

- REHIS training & cooking classes with community justice clients
- Live cookery classes in early years settings
- Recipe bags to support home cooking and healthier meals
- Welfare boxes and food distribution during COVID-19
- Distribution of plants to encourage home growing

Produce distributed included

Spring onions, onions, leeks, rocket, mint, coriander, sage, rosemary, fennel, oregano, spinach, parsley, basil, cucumbers, sweet peppers, carrots, beetroot, radish, pea pods, jalapeno chilli, rhubarb, courgettes, thyme, cayenne chilli, broad beans, tomatoes, potatoes.

Galashiels Early Years Centre

The Early Years Centre used the produce to top up 300 food parcels for children and families.

Families reported

- Eating more varied and healthier diets
- Tasting new foods
- Cooking more home made meals

New partnerships have developed in the last year with

- Children 1st
- Action for Children
- LINKS Eyemouth

Feedback from all services suggests the produce helped

- Families to cook healthier meals and grow their own produce
- Services to maintain connections with families

"Thank you so much for the fresh veg last week, I managed to make a pan of soup and a tomato sauce for pasta. We are currently in rent arrears and struggling to get through the week, your food top ups make a huge difference." (Parent)

"Overall I am extremely glad and grateful for the opportunity to work with the Unpaid Work Team and the NHS Health Improvement Team, I hope the partnership will continue." (Early Years Centre Manager)

Priority 1 A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Older People's Survey

The Borders Older Peoples Planning Partnership (BOPPP), one of the Health & Social Care Partnership's engagement and planning groups, wanted to engage with older people to gain a better understanding of how they experienced COVID-19 . The purpose of the engagement was to review services during the pandemic and inform our planning for the future.

Health Improvement staff contributed to

- Project planning
- Training design, co-ordination and delivery
- Implementation of project
- Analysis of findings

Staff support

We invited staff to support engagement with older people throughout November and December 2020 and we provided induction training on MS Teams.

The training aimed to:

- Provide the background to the engagement with older people
- Define the approach we are taking and clarify what we will do with the information you gather
- Introduce you to the technical aspects of the questionnaire process and citizen's space
- Share some good guidance for a conversational style approach
- Advise you of the next steps following on from your input

We wanted to hear from older people themselves how they experienced the lockdown by asking them

- What worked well?
- What challenges they experienced?
- How can we improve the support provided to ensure older people stay safe and well?

Final reports are in development, initial analysis suggests that overall older people felt well supported by services.

Key areas for development include

- Mental health and wellbeing
- Social support

Scottish Borders Health and Social Care PARTNERSHIP

Independent Responses
332

Semi Structured Conversations
155

Total Survey Responses
487

Priority 2 A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Programme for Government Funding

In 2020/2021 we received 'Programme for Government' funding to increase breastfeeding rates and reduce breastfeeding drop off rates at 6 - 8 weeks following birth.

The funding covers three areas of work

- Raising awareness of breastfeeding in Eyemouth: a whole community approach (2019-Feb 2021)
- Breastfeeding in the Borders Peer Support (BiBS) Programme
- Work towards Baby Friendly Accreditation, supporting the Infant Feeding Advisor with education, audit, evaluation of audit findings, and implementation of recommendations with the aim to achieve sustainability in 2020

Work taken forward with this funding includes

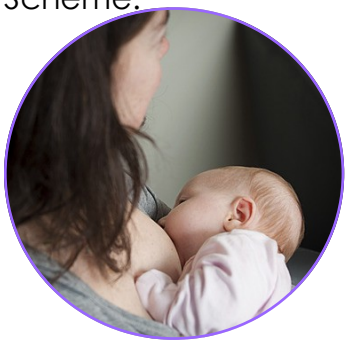
- Increased Public Acceptability of Breastfeeding Eyemouth Project
- BiBS Programme
- UNICF Breastfeeding Friendly Initiative (BFI)

Increased Public Acceptability of Breastfeeding Eyemouth Project 2019-Febuary 2021

The national Breastfeeding Friendly Scotland Scheme was launched in 2019. 21 businesses signed up within the in the local area which will encourage breastfeeding families to feel confident and supported whilst feeding in public.

The Early Learning and Childcare settings in Eyemouth are currently piloting the Breastfeeding Friendly Scotland Early Learning Scheme.

Pre and post questionnaire from the project has highlighted an improvement in attitudes towards breastfeeding across the town.



Breastfeeding in the Borders Support (BiBS) Group

Virtual group

- Launched in November, running every Monday
- Between November 2020 and end of March 2021 20 people have signed up, 5 of whom signed up during pregnancy
- Total attendance in this time period at group is 38

"The group was so much help to me, not only with breastfeeding support but also with general mum advice"

"I feel uplifted when I come off the call, it really sets me up for the week"

"I am so glad you set up this group, I wouldn't have felt confident joining a group face-to-face"

Priority 2 A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

UNICF Breastfeeding Friendly Initiative (BFI)

On the 8th December 2020 NHS Borders achieved UNICEF - Sustainability Gold Award for Maternity Services. We are the third board across Scotland to achieve this prestigious award, and the initial UNICEF feedback reflected on the submission of an 'outstanding 'portfolio.

Virtual Weaning Video Clips

In response to COVID-19, the Community Food Workers were unable to deliver face to face weaning information sessions for families who are reaching this key transition milestone. To adapt to a new 'virtual' way of life they created a series of weaning information video clips to share through social media, via the NHS Borders Bumps, Babies & Beyond Facebook page.

Bitesize video clips with top tips for getting started with weaning, first foods to try, simple homemade recipes and general tips and advice have been developed and uploaded, for a universal audience. The video clips are intended to guide parents through the weaning process and cope with any challenges that might arise. This approach will ensure the right support at the right time is accessible to parents in the comfort of their own homes.

The seventeen weaning video clips were released on Tuesday 16th June 2020 and shared by a number of partners including NHS Borders Facebook page and the Early Years Centres' Facebook pages.

Once all our video clips had been released, we asked for some feedback. In our feedback survey we asked if there is anything else they would like to see.

"Short, simple messages and informative descriptions to choose which to view. Also a good variety of topics"

"Perhaps extending the series to cover moving forward from first tastes and early weaning to build up to meals, lumpier foods etc."

Video Clips Reached
16,138 people

Views
825

Reactions, Comments, Shares
194

Priority 2 A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Virtual Weaning Plus Video Clips

Following on from the weaning video clips, and taking into consideration the feedback we received, we then went on to compile a new set of video clips for moving onto the next stage of weaning, with information taken from our weaning plus information sessions. The eight new weaning video clips were released on 10th September 2020.

Video Clips Reached
4,215 people

Views
276

Reactions, Comments, Shares
114

Virtual Weaning Question and Answer Sessions

Although the video clips filled a gap in the service, as COVID-19 continued to prevent face to face sessions from taking place, we were concerned that there was still limited opportunity for families to ask questions and receive person centred advice.

We launched a monthly virtual weaning Q&A, tips and advice session on Thursday 17th December 2020 through the digital platform MS Teams. This has continued on into the New Year taking place on the last Wednesday of every month. These sessions allow families to get answers to any questions or queries in regards to weaning their babies, whilst allowing them the opportunity to meet other families. Since beginning these sessions, 11 families have attended the sessions.

"Very useful resource (especially for first time mums) and well presented. Thank you for taking the time to run the online session"

Healthy Beginnings: MAP of Behaviour Change Learning Programme

The Healthy Beginnings: MAP of Behaviour Change Learning Programme has been developed as an early intervention and prevention approach to child healthy weight for early years practitioners. This will provide practitioners working in early years services with the opportunity to enhance existing and learn new behaviour change skills and techniques. The training programme has been led by NHS Borders with support from Scottish Borders Council and developed by NHS Education for Scotland (NES).

111 Participants
16 Workshops
Partners Attending
Health Visiting, School Nursing, Oral Health, Early Learning & Child Care, Early Years Centres, Early Years Modern Apprentices and 3rd Sector

Priority 3 A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

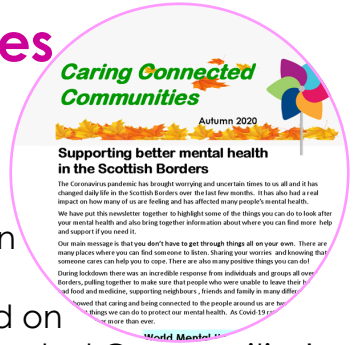
Promoting Good Mental Health and Wellbeing During COVID-19

COVID-19 specific resources for improving and protecting mental health and for preventing suicide were produced and were posted online, shared via social media, circulated to the community assistance hubs and sent to partner organisations.

We collated a 'resilient communities toolkit'. This provided sources of help and support available for mental health and wellbeing during the first lockdown. We circulated this signposting information pack to community assistance hubs, community groups, Community Learning and Development, the Shielding Team and third sector partners.

We also co-ordinate weekly wellbeing information and messages for health and social care staff working on the frontline.

Caring and Connected Communities Campaign



We developed a plan for an Autumn communications campaign focused on 'Caring and Connected Communities' and involved partners in creating content for two newsletters that went out with media releases in October and December 2020.

Posts made via Small Changes Big Difference Facebook page
124 posts

Most popular post reached
6,300 people

Instagram was also launched to try to reach a younger audience via social media.

You Matter We Care – Breathing Space Partnership

During 2020 we had a partnership with national NHS 24 service 'Breathing Space', Scotland's emotional support helpline. This involved increased advertising of the helpline via radio adverts, washroom panels and digital advertising and two awareness sessions. Breathing Space benches were launched on World Kindness Day and Breathing Space Day 2021 – one at Huntlyburn Space to Grow garden launched on World Kindness Day in November 2020 and one in Duns, launched by Berwickshire Housing Association at their new Springfield development on Breathing Space Day in February 2021.

Priority 3 A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

After a Suicide Working Group

We continue to seek input from people who are bereaved by suicide in the Borders to shape our work. This year 40 people took part in the "Light Up Their Life" lantern making project as a way for people to remember those who have died by suicide. Working with Alchemy Film and Arts, the group are also making a video as part of the Scottish Mental Health Arts Festival in May 2021.

Increased Availability of Digital Training and Capacity Building

The pandemic meant that face to face training could not be delivered and as it became clear that we would have to cancel more Applied Suicide Intervention Skills Training and Scottish Mental Health First Aid Training, we refocused our approach to deliver other training online to help meet the demand.

"I found the training really informative. It was delivered in a very welcoming, inclusive way and I have enjoyed taking part."

"I have already discussed training sessions with colleagues, and will encourage colleagues to consider doing the training themselves."

"I am now more aware of how to pick up on the signs that someone may be having suicidal thoughts and feel better prepared on how to help that person going forward."

Young People's Mental Health and Wellbeing

We co-produced a new version of the young people's self-help guide for mental health via online focus groups with young people and partners; Young Scot, Youth Borders and Community Learning and Development.

We launched the new guide via a new six week campaign #BordersWellbeing, based on the Six Ways to Be Well, alongside a new health and wellbeing Young Scot microsite and uploaded it to 12,500 school pupils' iPads.

Priority 3 A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

See Me Toolkit: Tackling Mental Health Stigma and Discrimination in Schools

The See Me toolkit is for anyone who is interested in learning more about the impact that stigma and discrimination has on people who struggle with their mental health, and wants to do something to make things better.

Module 1 of the toolkit

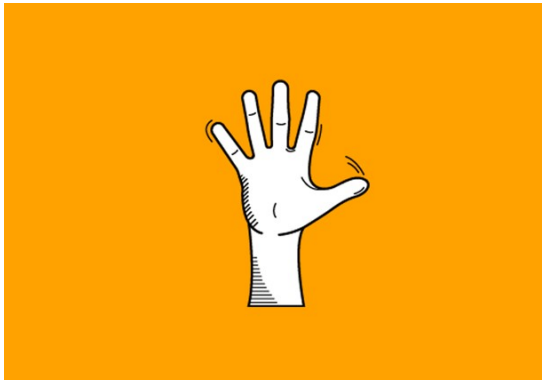
Is an interactive online learning which took place over 3 sessions with S6 pupils.

Learning Outcomes

After working through this module students will have:

- An increased understanding of mental health stigma and discrimination
- A greater awareness of the impact of mental health stigma and discrimination
- An increased knowledge of the ways we can reduce mental health stigma and discrimination across various settings
- Information on where you can access resources to continue your development

See Me
End mental health discrimination



In 2020 S6 pupils registered
132

Total attendance of staff and pupils over 3 sessions
286

Priority 4 A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

The Wellbeing Service

Wellbeing Service
Live Well Feel Better

Provides evidence based, early interventions supporting lifestyle change to increase physical activity, reduce weight and eat healthily, quit smoking and support emotional wellbeing. The service is currently delivered via telephone and video call and in GP surgeries. During COVID-19 all consultations have been offered by telephone or video call.

The Wellbeing Service is embedded into primary care and operates across the Borders. Although referrals dropped during the first three months of the pandemic from April to June 2020, they picked up during the second half of the year. The service offered an enhanced range of services to support mental health and wellbeing, with the addition of Psychological First Aid from April 2020. During 2020, emotional health and wellbeing referrals rose as a proportion of all referrals.

Consultations
January - December 2020
11,340

New Referrals
January - December 2020
1,950

Referrals Split
Emotional Wellbeing 63%
Smoking 20%
Lifestyle 17%

Oh Lila

All Early Years Centres and nurseries including private and voluntary are ensuring at least 2 staff members from each establishment are trained in the use of a resource called Oh Lila. Oh Lila is a child friendly resource suitable for use with children aged 3 to 6 years and aims to build resilience and protective factors in young children, helping them to develop social skills and encouraging them to communicate.

This programme provides people working with young children the expertise and confidence to better identify vulnerable children supporting them to intervene at an earlier stage. Despite a pause in the delivery of Oh Lila Training, 120 participants have received training with a further 2 courses planned for 2021 to provide a session for the remaining staff.

Priority 5 A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

Child Poverty

A Child Poverty Strategic Group was established within Scottish Borders in 2019. Members have developed and an agreed action plan and activity report submitted to Scottish Government. JHIT lead the Financial Inclusion Group which is a sub-group of the above and has developed work including:

- Pilot in Galashiels Health Centre where an Early Years money advisor was present during the midwifery clinic - this work has been paused due to COVID-19
- Heath Visitors are now routinely asking about money worries at every contact and refer on to the SBC Financial Support and Inclusion Team where required

This work is supported by the Money Worries Leaflet (2019) which is used by Health Visitors and Midwives.

Referrals to Financial Support Team
April 2020 – March 2021
430

The majority of these were direct referrals from Health Visitors. The Financial Support and Inclusion Team increased benefits.

Pregnant women and families with young children increased benefits
£1.3 million

Best Start Grant

We continue to support the Best Start grant scheme.

In total from March 2020 - March 2021 1,925 Best Start and Best Foods Grants applications were made, 73% were authorised in Scottish Borders this is above the average for Scotland.

March 2020 - March 2021
Total claim for Scottish Borders families
£458,545

Universal Credit

The Government increase in Universal Credit of £20 per week and the new Scottish Government benefits and grants were a very welcome boost to young families during that period. With introduction of the new Scottish payments and grants families were surprised to find that they had additional entitlement and benefits.

For the cases referred gains reached
£50,000
over 5 month period to March 2021

Priority 5 A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

Money Worries App

Good financial health has a positive impact on our overall health and wellbeing. To mitigate the impact of ongoing welfare reform and the wider impact of COVID-19 we developed a Money Worries App. The app is intended to help people access quality assured information and support to prevent money worries escalating. The app is a digital directory with quality assured national and local information and links to help with:

- Money
- Health
- Housing
- Work

Key Outcomes

- The app was developed in response to consultation
- The app has been co-produced by NHS Borders, Scottish Borders Council, Citizen's Advice Bureau and TD1 Youth Hub, Early Steps Parents Group
- The app reflects the voice of parents living in the Scottish Borders
- 55 people signed up as a volunteer to test the app during the testing phase
- The app was successfully launched on 16th March 2021

Next Steps for the Project Team

- Generate a series of video clips to increase awareness from a housing, health and work perspective
- Reconnect with partners to confirm launch and build further engagement through conversations

Media Release & Social Media Asset	Reach	Engagement	Shares
NHS Borders Social Media	10,478	123	28
Scottish Borders Council Social Media	6,353	29	10
CAB Video Clip	4,763	388	14

Download on the App Store

GET IT ON Google Play

Priority 6 A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Child Healthy Weight (CHW) Minimum Standards, Pathway, Training and Programme for Families

With the release of the Scottish Government Child Healthy Weight (CHW) Minimum Standards; a new child healthy weight pathway is being established in the Scottish Borders. This is to facilitate children and young people (aged 27th months – 18 years) and their families to get the support they need, to promote healthy eating and stay active.

In order to implement the CHW standards a toolkit was developed in partnership with NHS Borders/NHS Fife CHW Leads. The CHW toolkit provides information and resources for health professionals to successfully implement the standards. It provides a one stop shop of current guidelines and advice regarding both nutrition and physical activity.

Toolkit training was then developed by NHS Borders and has been provided to all our Health Visitors and School Nurses.

The training covered a variety of topics including childhood obesity, introduction into raising the issue, stigma, new pathway and programme, nutrition and physical fitness/activity.

Overall the training was well received and ensured key workers working with and measuring children's weight in Borders are following a consistent approach, well informed and know where to refer children/families that may require support.

"Thanks so much for this training. It was informative and I found it useful to have things presented in a way that had examples of how to use the tools available" – School Nurse

"The training was a useful update on the issues surrounding childhood obesity"

Fit4Fun Families

Scottish Borders Fit4Fun Families

A new CHW service for children, young people and families is in development.

Once referred/self referred into Fit4Fun Families the CHW Service Team will triage individuals and families into the appropriate programme and level of support.

JHIT will lead on the Tier 2 Fit4Fun Families programme which will be delivered by an experienced team in either a group or 1:1 setting depending on individual requirements.

Fit4Fun will support children/young people and their families to make positive lifestyle changes, it is family focused and offers practical tips for healthy eating and getting more active. We will work with families to identify specific goals they want to achieve, tailoring sessions to give the right support.

Priority 6 A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Whole Systems Approach (WSA) Eyemouth

The Scottish Borders is one of five areas in Scotland to have secured funding to deliver a WSA to community planning in Eyemouth. There are three main phases:

- Collectively form an understanding of the issue, context and wider system
- Create a plan for action collaboratively with a wide set of stakeholders; actions should be aligned and jointly prioritised
- Learn and refine as you go by involving stakeholders and embedding monitoring and evaluation

The first of two digital workshops was held on 31st March 2021 to give Eyemouth residents and other stakeholders the opportunity to get involved using this approach and help develop a community led plan for the area. Based on local priorities, the overall aim was to look at ways of supporting local residents to become healthier and fitter, with a particular focus on children, young people and health inequalities generally. This workshop helped us to develop a shared understanding of

- What already exists and works well to influence healthy weight among the local population in Eyemouth
- Key priorities and what matters to people in Eyemouth, so that we can develop a community led action plan

A wide range of local participants joined us and we took advantage of digital tools to capture the discussions and outcomes, produced four causal maps and developed our vision statement.

Next Steps

Production of a draft action plan based on the priorities identified and meet with local stakeholders to:

- Agree actions and identify leads to deliver on these
- Invite stakeholders to chair future meetings to embed our community led approach
- Develop our communications plan so that we take advantage of the full range of channels and share what's taking place locally
- Work with stakeholders to develop a proposal for phase 2 grant funding

Links Lockdown

This programme of work in Eyemouth responded to COVID-19 continuing to provide nutritional support to children and families through the distribution of meal bags.

This work made a contribution to community planning priorities; tackling food and fuel poverty and promoting and increasing digital access.

Further funding has been received to continue the development of this project.

Participation Data

Recipes bags designed 10
Meal bags delivered 375
Families 74 Children 161
Volunteers 5

Digital Engagement

Posts 10 Comments 1851
Reactions 4492
New members 75
Number of active members 185

Priority 6 A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Good Mood, Good Health, Good Food

Health Improvement developed the Good Mood, Good Health, Good Food resource during the COVID-19 pandemic, in response to a request from Youth Borders.

Youth workers had adapted their food security work to provide home deliveries and virtual cooking sessions with children, young people and families. Staff were looking for support to enhance this offering including:

- Nutritional information
- Recipes
- Cooking on a budget
- Staying well

A virtual training session was offered to Youth Borders using MS Teams. The session was co-facilitated by Health Improvement and Youth Borders trainers, engaging 4 staff members from Community Learning & Development, TD1 Youth Hub and Youth Borders.

The training aimed to

- Explore the resource
- Build staff capacity to deliver health and cookery sessions in a socially distanced environment

The training session included

- An Eatwell Guide question and answer session
- Portion size and energy
- Sugar activity guessing game
- Links to the Hi 5 Youth Award

Session feedback

"Good knowledge from this resource to look at what a baseline would be to get someone started on healthy cooking and eating"

"Money vs. skills vs. realistic help to make lifestyle changes, show and share ideas to young people"

Paths to Health - Walk It

The aim of the Paths to Health Walk it Project is to support and develop walks in all locations in the Scottish Borders. Walk-It forms part of the national initiative to improve Scotland's health. The project is co-funded by NHS Borders and Scottish Borders Council.

Walk-It aims to

- Encourage exercise as part of a healthy lifestyle
- Promote walking as a way of getting fit & managing stress
- Create a safe, social and inclusive walk
- Build links with partners and networks
- Recruit, train & support volunteers
- Have fun!

2020-21 Data
107 led walks
994 attendances
62 Walk leaders trained
8 Dementia friendly walks

https://www.scotborders.gov.uk/downloads/download/1392/walk_it_annual_report

Looking Forward / Next Steps

From April 2021 we have welcomed back our staff from their deployed roles to the COVID-19 response. As well as welcoming back our returners we are looking forward to some new members of the team following the management restructure and recruitment to vacant posts.

We look forward to further developing existing work relating to the Public Health Priorities which we expect may be realigned in response to COVID-19 recovery.

Continuing work programmes include:

- Implementing delivery of Fit 4 Fun Families programme
- Building on existing financial inclusion work including increasing the reach and use of the Money Worries App
- Pursing 'phase 2' of the Whole System Approach in Eyemouth
- Wellbeing Service
- Reviewing our training offer based on this year's experience

Over this year we expect to have an increased focus on mental health and wellbeing through the work led by team members including and in supporting the Children and Young People's Leadership Group commissioning of local services.

We are also leading work in NHS Borders on embedding the United Nations Charter on the Rights of the Child and have commissioned work relating to experiences of mental health in both men and people of colour.

We are looking forward to continued contributions to NHS Borders Staff Wellbeing Group; Health Inequalities Programme and Scottish Borders Council's Anti-Poverty Strategy.

Need to contact us

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