Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 3 February 2022** 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-2022-1
9.02	**3**	**MINUTES OF PREVIOUS MEETING** 02.12.21	Chair	Attached
9.03	**4**	**MATTERS ARISING** Action Tracker	Chair	Attached
9.05	**5**	**STRATEGY**		
9.05	5.1	Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	Director of Planning & Performance	Appendix-2022-2
9.10	**6**	**FINANCE AND RISK ASSURANCE**		
9.10	6.1	Audit Committee minutes: 13.09.21, 15.11.21	Board Secretary	Appendix-2022-3
9.11	6.2	Finance Report	Director of Finance	Appendix-2022-4
9.21	6.3	Capital Plan 2021/22 - Update	Director of Finance	Appendix-2022-5
9.31	**7**	**QUALITY AND SAFETY ASSURANCE**		
9.31	7.1	Clinical Governance Committee minutes: 17.11.21	Board Secretary	Appendix-2022-6
9.32	7.2	Quality & Clinical Governance Report	Medical Director	Appendix-2022-7
9.45	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2022-8
10.00	7.4	Care of Older People in Hospitals Update	Director of Nursing, Midwifery & AHPs	Appendix-2022-9
10.10	**8**	**ENGAGEMENT**		
10.10	8.1	Staff Governance Committee Minutes: 14.06.21, 25.10.21	Board Secretary	Appendix-2022-10
10.11	8.2	Area Clinical Forum Minutes: 05.10.21	Board Secretary	Appendix-2022-11

10.12	**9**	**PERFORMANCE ASSURANCE**		
10.12	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2022-12
10.30	**10**	**GOVERNANCE**		
10.30	10.1	Board Committee Memberships	Chair	Appendix-2022-13
10.31	10.2	Scheme of Integration Refresh	Chief Officer Health & Social Care	Appendix-2022-14
10.36	10.3	Alcohol & Drugs Partnership Annual Report 2020-2021	Director of Public Health	Appendix-2022-15
10.58	10.4	Scottish Borders Health & Social Care Integration Joint Board minutes: 22.09.21, 20.10.21 EO	Board Secretary	Appendix-2022-16
10.59	**11**	**ANY OTHER BUSINESS**		
11.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 7 April 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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to include the Declaration of Interests for Mrs Lucy O'Leary to the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

2.2.1 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.

2.3 Assessment

2.3.1 The Register of Interests is made up of details received from members regarding any private interests which may be material and relevant to NHS business and constitute the Register of Interests.

2.3.2 The Register is 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.

2.3.3 Quality/ Patient Care

Not applicable.

2.3.4 Workforce

Not applicable.

2.3.5 Financial

Not applicable.

2.3.6 Risk Assessment/Management

Regulatory requirement.

2.3.7 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.8 Other impacts

Regulatory requirement.

2.3.9 Communication, involvement, engagement and consultation

Not applicable.

2.3.10 Route to the Meeting

This has been previously considered by the Board Executive Team, 25 January 2022.

2.4 Recommendation

The Board is asked to **approve** the inclusion of the revised Declarations of Interest for Lucy O'Leary in the Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Declaration of Interests, Lucy O'Leary.

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: …LUCY O'LEARY…. *(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	none
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.	none
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.	none
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	none
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.	none
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	none
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.	none

Signed……Lucy O'Leary (via email)…….. Date ……21/12/21……...

Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 2 December 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 Ayling, Non Executive
Cllr D Parker, Non Executive
Mr J McLaren, Non Executive
Mrs A Wilson, 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, Director of Public Health

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of Workforce
Mr G Clinkscale, Director of Acute Services
Mr C Myers, Chief Officer Health & Social Care
Mrs L Jones, Head of Clinical Governance & Quality
Mr S Whiting, Infection Control & Laboratory Service Manager
Mr K Allan, Associate Director of Public Health
Mrs F Doig, Head of Health Improvement & Strategic Lead ADP
Ms S Laurie, Communications Officer
Ms L Brown, Communications Officer
Mr J Hislop, Borders Telegraph
Dr P Levack
Ms L Adams

1. Apologies and Announcements

1.1 Apologies had been received from Dr Tim Young, Associate Medical Director P&CS, Dr Janet Bennison, Associate Medical Director Acute and Dr Amanda Cotton, Associate Medical Director MH&LD.

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

1.3 The Chair welcomed members of the public to the meeting.

1.4 The Chair confirmed the meeting was quorate.

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 on the agenda along with any further questions. The Q&A would not be revisited during the discussion.

2. Register of Interests

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

The **BOARD** approved the inclusion of the declaration of interests for Mr Chris Myers in the Register of Interests.

3. Minutes of Previous Meeting

3.1 The minutes of the extraordinary meeting of the Borders NHS Board held on 29 September 2021 were approved.

3.2 The minutes of the previous meeting of the Borders NHS Board held on 7 October 2021 were approved.

4. Matters Arising

4.1 **Minute 6.8: Regional Health Protection Service:** Dr Tim Patterson suggested an agreed model would likely be available later in the year and an update be provided in March. The Chair asked that a progress report be provided to the March Resources & Performance Committee meeting.

4.2 Mr Tris Taylor asked that public engagement be addressed in the progress report. Dr Patterson assured the Board that feedback on the Boards' public engagement discussion had been fed back to the Programme Board and it would be for that Programme Board to decide it if wished to take matters further. Mr Ralph Roberts commented that the Programme Board had been asked to take forward an assessment against major service change criteria which would influence the type of engagement to be taken forward.

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

The **BOARD** noted the action tracker.

5. Scottish Borders Council's Anti-Poverty Strategy

5.1 Dr Tim Patterson provided an overview of the background to and content of the strategy.

5.2 The Chair sought clarification that although the document was marked as draft it was in fact the final document. Dr Patterson confirmed that it was the final document. He commented that all of the political parties had endorsed the strategy and as a health organisation NHS Borders would be involved in supporting implementation through the reference group and monitoring through the Community Planning Partnership.

DRAFT

5.3 Mrs Lucy O'Leary commented that she was slightly concerned that the document referred to an action plan that was not attached and she was keen to view it in terms of actions on health inequality.

5.4 Mr Tris Taylor queried if the anti poverty strategy was important enough to bring to the Board why it had been designated as for noting and not for recommending action. He also queried why it had not been brought through the governance committee charged with health inequalities. He suggested if the Board were not accountable for delivering it then why had it been put before the Board, if the Board were partially accountable then where was the action for the Board to perform and monitor. Whilst a political statement was welcomed it did not translate to accountability.

5.5 Mr John McLaren suggested fair working practices should be considered and looked at and sought evidence of that in future reports given a significant number of staff were undertaking multiple part time jobs and he suggested the next piece of work to be engaged with be handled through the Fair Living Wage Sub Group which NHS Borders was a member of.

5.6 Dr Patterson reminded the Board that the document was a Scottish Borders Council (SBC) Elected Member Working Group document and all he could do was collate the views of the Board and feed them back to the relevant Council Officers.

5.7 Mr Ralph Roberts commented in regard to issues on governance, that there was a realisation that working in partnership was complicated. His main point was that it was an SBC strategy and he urged the Board to welcome it as it was about SBC playing into issues that would have an impact on the health of the population and he suggested the Board accept it in that spirit. He also suggested the Board should welcome the update in terms of where SBC had got to with the work as it would ultimately lead to improvements in a reduction in poverty which would have an impact on health.

5.8 Cllr David Parker commented that it was the right direction of travel in terms of anti-poverty and there was an action plan to support the strategy, which he would ensure was circulated to colleagues outwith the meeting.

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

The **BOARD** noted the Scottish Borders Council's Anti-Poverty Strategy

6. Resources & Performance Committee Minutes 02.09.21

The **BOARD** noted the minutes.

7. Financial Performance

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted the £4.4m deficit, COVID-19 expenditure and the forecast reduction of £8.5m outturn at the end of March 2022 to a £7.78m forecast deficit. In terms of the Quarter 2 forecast, he assured the Board that it had been prepared at the end of

month 6 and month 7 was in line with it and the main driver of the deficit was the non delivery of savings and slippage on some core expenditure budgets.

7.2 In terms of COVID-19 expenditure, Mr Bone reported that the Scottish Government had released some additional funding received in October to bring the Board up to date in terms of expenditure and they had confirmed the Board would be fully funded for all projected costs for the financial year 2021/22.

7.3 In regard to savings, Mr Bone advised that they remained a key issue and NHS Directors of Finance had been discussing the issue with the Scottish Government, who had confirmed a full offset to savings non delivery for 2021/22, subject to validation around the process. He expected to achieve a breakeven forecast once the matter had been addressed.

7.4 He further advised that the remobilisation of the turnaround programme had not happened due to significant operational pressures and the inability to redirect resource back to savings delivery. He assured the Board he was in on-going dialogue with the Scottish Government in that respect.

7.5 Mr James Ayling commented that he welcomed Mr Bone highlighting the issue of savings and enquired if more resource needed to be directed to processes and procedures to achieve cost effective savings. Mr Bone commented that more resource needed to be devoted to developing savings plans whilst also having a level of focus on processes and procedures and he was in discussion with the Scottish Government around the potential for additional resources.

7.6 Mrs June Smyth commented that resource availability would continue to be a challenge in developing plans, especially given the need to engage with services who continued to be constrained by service pressures.

7.7 Ms Sonya Lam enquired about the balance between savings and improving quality and how many quality improvement advisers there were. Mr Bone commented that there was an optimism amongst the Executive Team that if quality improvement was driven the right way, then savings would be released. It was recognised that it would take time to achieve and there would be a balance between schemes which were perceived as low impact to services but which provided financial benefit and those that allowed transformation and aligned quality with a productive and efficient service.

7.8 Dr Lynn McCallum commented that it was important to have clinical leadership to find the solutions and not to enforce a financial turnaround programme on pressurised clinical teams. She suggested engaging with clinicians to have them lead the process and find the solutions would be best, given it was clear in most medical literature that organisations with good clinical leadership were the most financially viable organisations and that should be the way forward for NHS Borders.

7.9 Mrs Sarah Horan echoed Dr McCallum's comments and advised that the organisation had some patient safety fellows who were not working in quality improvement roles at present given the current pressures on the system. She suggested the organisation look at what it had in order to drive efficiencies and there would need to be investment in clinical leadership to enable people to develop

the entire skill set they would need to find solutions and drive up quality and release savings.

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

The **BOARD** noted that the Board was reporting a £4.40m deficit for seven months to end of October 2021.

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

The **BOARD** noted the updated forecast outturn position (£7.78m deficit) following preparation of the Quarter Two (Q2) forecast.

8. Climate Emergency & Sustainability Development

8.1 Mr Andrew Bone provided an overview of the report and drew the attention of the Board to section 3 and the strategic context.

8.2 Mrs Lucy O'Leary enquired in relation to capital developments being taken forward. Mr Bone advised that there were no major building works in the immediate pipeline, however he was keen to bring some forward in the near future, subject to national level tests.

8.3 Mr James Ayling suggested that to undertake an assessment of realistic care and then add an assessment on the environmentally friendly way to deliver that care would be a real challenge. Mr Bone commented that there was active work being taken forward on a national level to look at how clinical practice might change to be more sustainable and provide better treatment in a more sustainable way.

8.4 Mrs Alison Wilson highlighted that one of the most widely used anti-inflammatory drugs had a negative impact on the environment. She commented that national procurement colleagues were at an early stage in looking at the environmental impact of all the things they commissioned.

8.5 Dr Lynn McCallum commented that whilst environmental impact would not be chosen over efficacy, it would be taken into account and local clinicians were keen to engage on environmental issues in the NHS.

8.6 Mrs Harriet Campbell reiterated that the policy and the report were focused on net zero and enquired what could really be done on a day to day level. She further suggested it be recorded as a separate strategic risk as further climate change events would potentially become more regular and impact on NHS services.

8.7 Mrs Sonya Lam suggested a Board Development session be used to explore the subject further and that it might be incorporated into strategic development. In terms of clinical leadership and service improvement, she welcomed the ethos of thinking about that in the broader sense as an improvement perspective instead of a clinical one.

8.8 Mr Tris Taylor welcomed the quality of the report in breaking down the responsibility and duties of the Board and setting them out so clearly. He suggested the subject might be taken up under risk management.

8.9 The Chair welcomed the idea of a Board Development session dedicated to climate change and incorporating it into strategic development.

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

The **BOARD** noted the issues described in the report.

The **BOARD** noted the requirements placed on NHS Borders arising from DL(2021)38.

The **BOARD** noted that an impact assessment and resource plan would be prepared in response to the policy.

The **BOARD** agreed that a development session for board members should be scheduled for early 2022.

9. Clinical Governance Committee Minutes 15.09.21

The **BOARD** noted the minutes.

10. Quality & Clinical Governance Report

10.1 Mrs Laura Jones drew the attention of the Board to the theme across all Clinical Boards of on-going clinical pressures faced by services as a consequence of the pandemic and the mitigation of associated risks. She highlighted the HSMR data remained within normal limits with an expected decline in crude mortality ahead of wave 3. In terms of patient experience there had not been an increase in formal complaints which was being experienced in some other health boards. Whilst there was an increase in waiting times that had not yet equated to complaints and staff continued to proactively engage with people with long waiting times.

10.2 In terms of Question 16 in the Board Q&A regarding the qualification of a deteriorating patient, Mrs Jones advised that deteriorating patients were identified through the National Early Warning Score (NEWS) which looked at the basic observations of a patient which were carried out every 4 hours, and that score was totalled by nursing staff and if it exceeded 2 they raised awareness to the Critical Care Outreach Team. Every patient had a different baseline which was taken into account in identifying a patient who maybe unwell enough to become unwell quickly. She commented that the NEWS system was operated well in the Borders General Hospital (BGH) as a baseline process and patient safety feature.

10.3 The Chair commented that she was encouraged that the organisation was not seeing the issues being experienced in other Health Boards in regard to patient experience. Mrs Jones commented that other Health Boards were seeing a significant increase in complaints regarding waiting times and she was hopeful that the proactive engagement of staff with patients to keep them informed at various points on their waiting times journey had allayed potential complaints. She further commented that the team were also undertaking early resolution and the unblocking of issues to avert other issues becoming formal complaints.

10.4 Mrs Fiona Sandford reported that the Clinical Governance Committee had discussed clinical pressures at great length at its recent meeting and she underlined point 1.1.10 in the report in regard to the introduction of respiratory and non respiratory pathways and the impact that may have going forward. She further commented that as tragic as each death was, it appeared that NHS Borders was the only Board to have undertaken a full inquiry into every COVID death over the course of the pandemic.

10.5 Mr Gareth Clinkscale and Dr Lynn McCallum both welcomed the proactive approach that had been given to waiting list patients.

10.6 Ms Sonya Lam enquired if investment was being made through the whole flow of patients. Mrs June Smyth confirmed that Mental Health services and Allied Health Professionals (AHPs) were also maintaining contact with individuals to give a consistency across the whole organisation and not just within the acute setting.

10.7 Mr Chris Myers commented that some additional non recurring funding had been received from the Scottish Government which was being used to increase capacity and address the challenge of recruitment to social care, AHPs and OTs. He advised that the NHS Scotland Health & Social Care Workforce plan was shortly due for release and one of the pieces of work to be taken forward from that would be an integrated workforce plan.

10.8 Mrs Sarah Horan commented that work remained on-going to place resource to have the best effect on patients. In the acute setting an Interim Care ward had been established which carried a risk due to staffing mix and in the medium to long term international recruitment was commencing.

10.9 Ms Lam suggested an early warning could be given to regulators that international recruitment had commenced for clinical staff to minimise any potential delays in the process.

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

The **BOARD** noted the report.

11. Healthcare Associated Infection – Prevention & Control Report

11.1 Mr Sam Whiting drew the attention of the Board to Section 2.1 on page 4 of the report and the reference to 22 cases of Meticillin-sensitive Staphylococcus aureus (MSSA) and clarified that there were actually 21 cases and 1 case of Meticillin-resistant Staphylococcus aureus (MRSA). He further commented that there were currently no bed closures related to COVID across NHS Borders.

11.2 Mrs Harriet Campbell enquired about the impact and concerns of putting in place the respiratory and non respiratory pathways. Mr Whiting explained that on admission or arrival at reception, screening questions should be used to determine which pathway was appropriate for the patient. He advised that there were physical limitations with our premises across the estate as well as staffing challenges which limited our ability to implement separate waiting areas or cohort staff according to the pathway. The Infection Control Team were working with Clinical Boards on the

safest way to implement the pathways for staff, patients and visitors. He assured the Board that some other Health Boards had the same challenges in terms of physical limitations of premises and were taking the same approach to implementation and risk mitigations.

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

The **BOARD** noted this report.

12. Staff Governance Committee Minutes 14.06.21

The minute was withdrawn.

13. Area Clinical Forum Minutes 22.06.21

The **BOARD** noted the minutes.

14. NHS Borders Equality Mainstreaming Report 2021

14.1 Mr Keith Allan provided an overview of the content of the report.

14.2 The Chair sought a point of clarification in that the Board were asked to approve the report for publication, however there could be amendments the Board wished to see made prior to publication. Mr Allan advised that whilst there was a timeline pressure for publication, he would be content to make any amendments as a result of discussion at the Board. He reminded the Board that the report was constrained by what it had to report against.

14.3 Ms Sonya Lam enquired about the route for scrutiny of the report before it was presented to the Board. Mr Allan advised that the report had been written at a late stage due to staffing pressures as a consequence of the pandemic and had been shared with the Health Inequalities Steering Group and the Staff Equalities Group.

14.4 Ms Lam enquired about the outcome of presenting it to the staff equalities group and noted that it was very action and activity orientated. She enquired what success would look like and suggested any improvements be included in the report so that the Board could be clear on what had been achieved. Mr Allan commented that the next iteration would include improvements and trends as legally the organisation had to review what it was measuring against.

14.5 Mrs Harriet Campbell commented that she was keen to learn more about the outcomes and suggested that could be done at a workshop. Anecdotally she suggested that a greater number of younger people in education were likely to identify as gender fluid/neutral/non-binary and would therefore know someone who did. Mr Allan advised that the data was based on NHS Borders HR questionnaires and it was possible that different age groups would answer that question differently.

14.6 Mrs Lucy O'Leary asked that the means and medians be clarified before the report was published.

14.7 Mr Tris Taylor suggested the report should have been submitted to the Public Governance Committee prior to the Board. He commented that it was a

performance report but did not describe the targets or baselines. Mr Allan commented that the format would be reviewed for the next iteration and he would make sure the staff equality agenda did not overshadow the population equality agenda.

14.8 Mr Taylor further suggested that the report appeared to be outcome focused without being impact focused. It lacked targets, trends or demand knowledge. He questioned if the disability statistics were really relevant in relation to the narrative and was mindful that the organisation had a duty, to the staff who declared themselves as disabled, to positively impact on disabled people of working age in the Borders and he did not want that action to be delayed.

14.9 Mrs O'Leary noted that in terms of disability it was sought from new employees on their application form and they could choose whether or not to declare a disability and for some long standing employees their status could change over the time of their employment but it was not a requirement of them to update their status with the organisation.

14.10 Mr Allan commented that he would be happy to caveat the tables in terms of small numbers.

14.11 Mr Andy Carter suggested a workshop would be helpful in reviewing the information and formulating a meaningful action plan. The point Mr Taylor had raised in regard to small numbers was valid and the organisation needed to be careful about what it did with those. He advised that the organisation was a disability confident employer, it was involved in Project Search and brought people into the organisation every year who had learning disabilities and deployed them across a range of services. In terms of Lesbian, Gay, Bisexual, Transgender plus (LGBT+) a positive campaign had been held with many staff signing up to the pride pledge.

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

The **BOARD** approved the report and its publication with minor amendments suggested.

The **BOARD** agreed to undertake a workshop and to add the action to the Action Tracker.

15. NHS Borders Performance Scorecard

15.1 Mrs June Smyth provided an overview of the content of the report and advised that in moving forward on Remobilisation Plan 4 (RMP4) new targets and trajectories would be put into the report. The current report was based on RMP3.

15.2 Mr James Ayling enquired about the slippage on cancer waiting times as there were no figures included for October. Mrs Smyth commented that in terms of areas outwith trajectory the format used would flag for those areas off track for 3 months in a row. She advised that there was a delay in the cancer data available for October and the report.

15.3 Mr Gareth Clinkscale advised that the cancer target had been deteriorating in relation to colorectal cancer due to staffing issues and the availability of ICU post operation. The patients impacted through internal capacity issues had been

resolved and discussions had taken place with the Golden Jubilee to undertake operations for other cancer patients.

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

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

16. Joint Health Improvement Team Annual Report 2020-2021

16.1 Mrs Fiona Doig provided an overview of the content of the report and drew the attention of the Board to the Board Questions on Breastfeeding, Vitamin D and Child Healthy Weight.

16.2 Mr Tris Taylor welcomed the layout of the report and the content. In terms of performance reporting and the need for context, trends and background data he suggested the Board might introduce contextual data in the round as a key principle of its reporting.

16.3 Mr Andrew Bone suggested it was a fair comment and suggested the Executive Team would consider how that might be achieved in a reasonable timeline.

16.4 Mrs Lucy O'Leary welcomed the report on activity and enquired what impact it had on outcomes and if that was something that should be a standard question on all papers even if the purpose of the paper was something different.

16.5 The Chair commented that it was a valid point and agreed to consider how the impact on outcomes could be referenced in all future Board papers.

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

The **BOARD** noted the report.

17. Any Other Business

17.1 **Remobilisation Plan (RMP4) Feedback Letter:** This item was withdrawn as the letter had not been received.

17.2 **Risk Management:** This item was withdrawn.

18. Date and Time of next meeting

18.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 3 February 2022 at 9.00am via MS Teams.

The meeting concluded at 10.57am.

Signature: ……..
Chair

DRAFT

BORDERS NHS BOARD: 2 DECEMBER 2021

QUESTIONS AND ANSWERS

Fiona Sandford: Very clear papers, and I look forward to the discussion.

No	Item	Question/Observation	Answers
1	Appendix-2021-85 Register of Interest	-	-
2	Minutes of Extra Ordinary Meeting	-	-
3	Minutes of Previous Meeting	**Karen Hamilton:** 5.7 was this progressed with BET 14.4 Flow chart??	**Ralph Roberts:** Followed up by individual BET members; also reviewed as part of BET agenda item on 30/11 with report from Risk team on KPIs associated with Strategic risk register including Review time, whether risk within Risk appetite and status of action plans. **Paul Williams:** A flow chart outlining the governance and accountability of Falls is being developed by the Falls strategic group and will be made available to the Board once complete.
4	Matters Arising/ Action Tracker		
5	Appendix-2021-86 Scottish Borders Council's Anti-Poverty Strategy	**Karen Hamilton:** Noted Cover paper Assessment 8 : Community Planning Partnership role in this. Input from partners etc – what is the route for this for Health.	**Tim Patterson:** A Scottish Borders Council Anti-Poverty Strategy Members Reference Group will monitor the implementation of the Strategy and Action Plan to ensure that it benefitsthose most in need. 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

DRAFT

			receive input from the Council's partners and other organisations including NHS Borders. As the model develops, any requests for membership of the Reference Group will come through the Community Planning Partnership.
6	Appendix-2021-86 Scottish Borders Council's Anti-Poverty Strategy	**Harriet Campbell:** a) If this has already been approved (although I note it is still marked 'draft' by SBC and endorsed by the Community Planning Partnership, then what is the actual point of it being brought to this meeting? Surely if we need to note/comment/contribute, we should do so before it is adopted? b) Where is the strategy in it? All it seems to do is 'recognises that there are already many plans and strategies in existence which contribute to reducing poverty in the Scottish Borders and then list these 'specifically to illustrate various Partners involved' . Is there no actual unified strategy? I'm certainly struggling to see how this could be implemented. c) For what it's worth I am very disappointed not to see significantly more in here about education. If we aren't educating our young people properly their chances in future life are significantly impacted. Why doesn't it mention the Integrated Children and Young People's plan discussed in the equality report (p230)?	**Tim Patterson:** a. NHS Borders Board is asked to note the Strategy which has been produced by the SBC. A response to the Strategy consultation was previously produced by Fiona Doig and agreed by BET. b. An important aim of the Strategy is to recognise that there is a significant amount of work happening already in the Borders to reduce poverty and that the elected members are fully behind this work. c. The SBC will still welcome any further comments about the Strategy that NHS colleagues wish to make and I can feed these back to the relevant officer.
7	Appendix-2021-87 Resources & Performance Committee minutes	**Karen Hamilton:** Noted	-
8	Appendix-2021-87 Resources & Performance Committee	**Harriet Campbell:** Did we get an answer on my question about why patient choice is offered at discharge. This ties in	**Iris Bishop:** My apologies Harriet I thought this had been answered in the R&PC Q&A for the 4 November meeting. I have separately

DRAFT

	minutes	with Tris's queries (and Rob's response) in the Q&A about the policy on discharge. I suppose effectively I'm asking if we still think this is the right policy in the current circumstances?	issued to you an email and supporting document covering the Moving On Policy.
9	Appendix-2021-87 Resources & Performance Committee minutes	**Harriet Campbell:** P87 Could we have an answer to the questions raised here please?	**Iris Bishop:** The R&PC Q&A for 02.09.21 has been updated with the missing answer and issued to the Committee.
10	Appendix-2021-88 Finance Report	**Karen Hamilton:** Noted 4.2 Comment: essentially savings have been achieved through non delivery of services – correct? 5.5 Can you clarify second sentence of this para please.	**Andrew Bone:** Non-recurring savings are largely as a result of fortuitous benefits outwith core services and through a review of commitments against commissioning budgets. A small element of these savings may result in recurring releases following further review. There is £1.3m of recurring savings identified in the Q2 forecast – these savings have not yet been released and continue to be reviewed. Areas for recurring savings include prescribing, procurement and a small element of service change. **Para 5.5.** The sentence reads: **"**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". **This paragraph is no longer relevant.** No direct offset has been reported during the first six months and this position is expected to remain for duration of 2021/22. One area of indirect offset is identified, being the repurposing of existing hospital bed capacity to COVID19 ward. In this circumstance, only

DRAFT

			additional costs above base budgets are recovered from additional SG funds.
11	Appendix-2021-88 Finance Report	**Fiona Sandford:** My only point I'd like to see developed is in the Finance paper and relates to the NHS Lothian SLA. This fairly significant cost variance seems to have come out of the blue – please can we hear more about plans to ensure that we get more warning.	**Andrew Bone:** This has been highlighted since Q1 review however it has been raised as a concern by all regional partners that there is a need for early warning of emerging cost pressures through regional health board SLAs. Steps are being implemented to ensure that a forward look is prepared as part of the financial planning process for future plans. This will be implemented for 2022/23 financial plan.
12	Appendix-2021-89 Climate Emergency	**Karen Hamilton:** Noted Agree with comment: Section 6 mentions Board Dev session in early 2022? Demand for Dev Session access is high – can we make sure we priorities these sessions in discussion with CEO and BET.	**Iris Bishop:** I have a plan for the Board Development sessions for next year and will ensure BET are fully sighted on it.
13	Appendix-2021-89 Climate Emergency	**Harriet Campbell:** P125. I would like to flag up (and I think should be in the report and definitely for the development session) the fact that there is a growing campaign to have climate change declared a public health emergency of immediate concern by WHO. See this BMJ article but I could point you to others https://doi.org/10.1136/bmj.m797). NHS Scotland policy touches on this but doesn't go into any detail or make it a focus. The report to the Board focuses on reaching net zero which makes it all feel a bit distant from the 'day job' of running a health board. This will have real material impact on health – we are already seeing weather events that have a direct impact on our population's health and these are only going to get more serious. So I think there are	**Andrew Bone:** Thanks Harriet, I recognise this and was not my intention to minimise this issue. At this stage I am seeking to build awareness starting from the perspective of the policy, but I do recognise that the Climate Emergency will have wider implications for how services are designed and delivered which are potentially transformational to clinical services. We are fortunate to have a small group of very engaged clinicians who are focussed on this issue and keen to see it reflected in our action plans. I see this as an area that we would give greater weight to in the proposed development session early in the new year.

DRAFT

		two things here. First the business of trying to minimise our impact (which is what this report is aimed at) and second preparing ourselves for the direct health impact of the change we are already seeing. I think we need to give serious consideration to including this second as a separate risk in its own right.	I will reflect on how we can capture this aspect through our risk register following this week's board meeting.
14	Appendix-2021-90 Clinical Governance Committee minutes	**Karen Hamilton:** Noted	**-**
15	Appendix-2021-91 Quality & Clinical Governance Report	**Karen Hamilton:** Noted	-
16	Appendix-2021-91 Quality & Clinical Governance Report	**Harriet Campbell:** P165 What/who qualifies as a deteriorating patient and why is cardiac arrest a focus for this? It seems to me that the usual meaning of 'deteriorating' would/could include a multitude of situations including (perhaps especially) those with progressive incurable conditions (such as Parkinsons) or terminal diagnoses, end of life and palliative care.	**Laura Jones:** Deteriorating patients were identified through the National Early Warning Score (NEWS) which looked at the basic observations of a patient which were carried out every 4 hours, and that score was totalled by nursing staff and if it exceeded 2 they raised awareness to the Critical Care Outreach Team. Every patient had a different baseline which was taken into account in identifying a patient who maybe unwell enough to become unwell quickly.
17	Appendix-2021-92 Healthcare Associated Infection – Prevention & Control Report	**Karen Hamilton:** Noted	-
18	Appendix-2021-92 Healthcare Associated Infection – Prevention & Control Report	**Harriet Campbell:** P177 has the GoJo visit (referred to in the report as scheduled for 16 November but actually then cancelled) been rescheduled and is there any feedback from this?	**Sam Whiting:** The visit is now planned for January 2022 (due to staff sickness at GoJo) – we are currently liaising with GoJo to establish a firm date for this.
19	Appendix-2021-93	**Karen Hamilton:**	-

DRAFT

	Staff Governance Committee Minutes	Noted	
20	Appendix-2021-94 Area Clinical Forum Minutes	**Karen Hamilton:** Noted	-
21	Appendix-2021-94 Area Clinical Forum Minutes	**Harriet Campbell:** P196. Is there an update on the hydrotherapy pool please? This doesn't seem to make much progress.	**Paul Williams:** Remobilisation of Hydrotherapy has remained challenging for several reasons: - Infection control. Until Oct 2021 National guidance on management of infection control risks had not been provided. This is now in place and local guidance can now be developed. - Estates. A significant amount of estates work is required in order to make the facility fit for purpose as the area was converted in storage during 'wave 1' of the pandemic. The capital planning group has approved this work, but capacity issues within the estates team mean that spring/ summer 2022 is a realistic timeframe. - Workforce. Physiotherapy workforce has been stretched to provide therapy across additional inpatient beds and community services meaning that the staff required to delivery hydrotherapy have not been in place. This also remains a challenge in other Health Boards. The clinical impact of the loss of hydrotherapy has not been underestimated and has been added to the organisation's risk register. The remobilisation of this service remains part of

DRAFT

<table>
<tr><td></td><td></td><td></td><td>AHP service's plans amongst the many other competing priorities.</td></tr>
<tr><td>22</td><td>Appendix-2021-95
NHS Borders Equality Mainstreaming Report 2021</td><td>Karen Hamilton:
Approved for Publication
Table 1.1 – fascinating stats on LGBT in relation to known person as opposed to those self declaring?
Table 6.1b and others – no real shift in data over 1 year comparison. Are the trends more positive over a longer periods?</td><td>Keith Allan: While the data in this current publication were somewhat limited by the disruption caused by covid (e.g. census was paused) we can see changes in our locally held data. Using "Workforce age profile" as an example (table 6.1b in the current report):

<table>
<tr><th colspan="3">Table 6.1b – Workforce Age Profile</th></tr>
<tr><th rowspan="2">Age Band</th><th>2019</th><th>2020</th></tr>
<tr><th>% of Staff</th><th>% of Staff</th></tr>
<tr><td>19 and under</td><td>0.69%</td><td>0.72%</td></tr>
<tr><td>20 - 34</td><td>20.79%</td><td>19.78%</td></tr>
<tr><td>35 - 49</td><td>34.73%</td><td>34.29%</td></tr>
<tr><td>50 - 64</td><td>42.33%</td><td>43.34%</td></tr>
<tr><td>65 and over</td><td>1.47%</td><td>1.87%</td></tr>
<tr><td>Total</td><td>100%</td><td>100%</td></tr>
</table>

We can compare to the data in the previous mainstreaming report which gives:

<table>
<tr><td></td><td>% of Staff</td></tr>
<tr><td>Age</td><td>2014</td></tr>
<tr><td>16-29</td><td>9.99%</td></tr>
<tr><td>30-44</td><td>30.99%</td></tr>
<tr><td>45-59</td><td>52.81%</td></tr>
</table>
</td></tr>
</table>

DRAFT

			<table><tr><td>Over 60</td><td>6.21%</td></tr></table> Looking at the Workforce by Gender data (in current report) we see that in 2020 of our staff 81.78% were female, whilst in 2016 this figure was 82.87% and in 2014 the figures was 82.32% (data on these latter points from previous mainstreaming report).
23	Appendix-2021-95 NHS Borders Equality Mainstreaming Report 2021	**Harriet Campbell:** P206. Point of detail but the page numbers in the table of contents have gone awry (and look frankly terrifying!)	**Keith Allan:** Apologies for this, it appears to be a problem with versions of word and embedding docs (as flagged earlier). It will be correct for publication. **Andy Carter:** Lots of important questions. I shall address the Workforce elements and will start with an overview and then get a little more detailed. Perhaps a short workshop in 2022 might be worth doing or an off-line conversation? This whole arena represents *work in progress* within the NHS Borders HR Department. I intend to make progress in this arena going forwards, increasing capacity and expertise, however the pressure generated from COVID19 has limited the amount of time which has been available for this type of detailed data gathering and interpretation. What limited workforce analyst time there is has been directed towards recruitment, making sure NHSB employees are paid on time & correctly and keeping national systems operating effectively.

DRAFT

			NHS Borders is a listed public authority. It has a General Equality Duty to eliminate unlawful discrimination, advance equality of opportunity and foster good relations between people. It is also bound by the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 and those duties include the duty to gather and use employee information, the duty to publish gender pay gap information and the duty to publish statements on equal pay. NHS Borders delivers on aspects of these duties but will need to do more to satisfy the full extent of the statutory requirements. NHS Borders has an Equal Opportunities Policy and Equal Pay Statement; updating both are on the work-plan for the Equality, Diversity & Inclusion in Employment Group.
		P217 Is it possible to have wage figures by ethnicity/disability/other protected characteristics? Also broad position within the organisation by ethnicity/gender/disability etc. Having written this I see that some of these are given much later in the document (p238). It would have been helpful to have them at this stage. How is a pay gap calculated? Is it that on average members of the workforce are paid 1.9% less than others? (and why, when men and women on AFC are paid the same hourly rate is there a -3% pay gap?). Similarly what is an 'average of basic hourly rate'? Although I am unclear on how the figures are	P217 – *wage figures by other protected characteristics .. and position within organisation* – I shall schedule time for this work in 2021/2 Q4 and 2022/3 Q1. Not currently available. Low levels of disclosure in some areas (e.g. disability) may distort figures. Low level disclosure is an acknowledged issue in own right. Pay gap advice in legislation is simply *'percentage difference among its employees between men's average hourly pay (excluding overtime) and women's average hourly pay (excluding overtime).'* Scottish Government report that in 2020, the gender pay gap for full-time employees working in Scotland was 3.0%. Pay gaps open up over

DRAFT

		calculated it seems clear that there is a distinct pay gap in particular for those with a medical condition. Why is this?	historical time-frames and take many years to close. The greater prevalence of part-time working in the female workforce can exacerbate the gap e.g. differences in working pattern/earnings and obstacles to career progression/development. In NHSB we see that average female pay is greater than average male pay. More women are in higher paid jobs (Band 6 upwards).
		P214. The desired outcome is '… all members of staff feel valued and respected and our workforce reflects our community'. It appears, comparing the figures that the workforce broadly represents the community on ethnicity, and we have an explanation of the predominantly female workforce, but what about other protected characteristics? 30% of the Borders workforce has a disability but the workforce is (self-declared), less than 1%. I have previously raised the issue of those with a disability who choose not to declare it, but it seems there is more than can be done here. I'm also not seeing any evidence of 'feeling valued' as an outcome. What attempts have we made to measure this? Does imatter allow for data to be extracted on gender/ethnicity etc? Similarly with outcome 2, while this all sounds extremely positive, it seems to cover some fairly narrow issues. It would also be helpful to have some metrics to confirm that what has been done is actually having the intended outcome. And on outcome 3, it's noticeable that the word clouds at p166 show communication as the biggest	P214 – *disability (self-disclosed) …* we are considering options for 2022 to improve disability disclosure levels. We may have a disproportionately low number of people with disabilities in the workforce but I think disability is under-represented for different reasons e.g. technically (satisfied legal definition) a disability but individual opts not to describe themselves as having a disability, worry that it may impact on their work, don't believe that it's their employer's business. *iMatter* …. NHS Borders does not currently have a split of the iMatter results by protected characteristics. This was previously available under the former Staff Survey. It is likely to be made available at NHS Scotland level, which is of some use. *Feeling value …..* at team level, you can derive data on how engaged your team are.

DRAFT

		area for improvement. This suggests (although of course doesn't prove) that there may be occasions where the way in which individuals are treated falls short of the desired outcome. Again, with this as with other outcomes it would be helpful, where metrics are appropriate, to have some to evidence the outcomes. P227 What uptake of the money worries app has there been? What feedback has there been from users?. P230 "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" What if any positive action has been taken and what results have followed? P232 Is the proposed programme in place? If not when will it start and what reporting on outcomes will there be and to whom?	**Keith Allan:** Money Worries App: There were 141 downloads of the app in Q1. We are awaiting Q2 figures. Additionally a recent consultation was undertaken to which 48 people responded. No barriers to the download of the app were seen and its ease of use, accessibility and quality of information were all praised. 28 respondents gave the app a score of 4.32/5 and 46/48 said they would promote it (zero people said they would not). **Andy Carter:** *Positive action ….* NHS Borders advertised its Director of NM&AHPs vacancy within the Royal College of Nursing's Black, Asian and Minority Ethnic network which operates inside NHS England and Wales (not in Scotland) and includes several thousand members. NHS Borders is a Disability Confident employer (national accreditation). NHS Borders engages in multiple employability initiatives such as Kickstart (16-24, some way from employment market), Project Search (candidates with learning issues), Young Persons Guarantee and Job Creation Fund. Multiple placements, multiple conversions into substantive employment.

DRAFT

		P237 the figures for the age profile of the workforce don't square with what I think I remember from the Staff Governance Committee. I note these are for 2019 and 2020. Am I right in thinking that the age profile has reduced slightly this year?	*Age profile ….* Average age across whole workforce has come down in 2021; retirement of older workers, recruitment of younger workers, shift is very small but makes workforce slightly 'younger'.
24	Appendix-2021-96 NHS Borders Performance Scorecard	**Karen Hamilton:** Noted	-
25	Appendix-2021-96 NHS Borders Performance Scorecard	**Harriet Campbell:** P249 Planned v Actual activity. What is the 'planned' activity? Is this per RMP3/RMP4/something else? Eg When 2449 key diagnostic tests 'planned'? Surely this is an ever-changing number? It is disappointing to see cancer waiting times slip quite noticeably when they (particularly 31 day treatment) have been so exemplary over the last while. Is there an identifiable reason for this? What can be done to bring them back up? A big improvement in CAMHS 18 week times over the last month. Not there yet but is it over optimistic to see this as a sign that things are improving?. Opthalmology 12 week breaches continue to increase. This was discussed at the last meeting. What if any further measures/support can be put in place?	**June Smyth:** The planned activity are a set of projections made when submitting RMP3 and then have been updated as part of RMP4 when our trajectories have been updated. SG guidance when commissioning RMP4 stated the previous monthly activity and planned activity figures should not be revised when the template is submitted to them monthly. The deterioration in cancer performance was a consequence of two specific issues. - An increase in colorectal patients waiting for surgery related to dealing with the backlog in the bowel screening programme nationally. - Surgical capacity constraints over the summer. Both related to unscheduled activity pressures and surgeon availability. Performance for October will show an improvement and this has continued into November.

DRAFT

			In addition we are working with NGJH to develop an alternative colorectal pathway should we encounter similar capacity issue in the future given risks. I have noted but haven't got underneath the Gynae issues. Danny, are you able to shed any light on this. Pauline anything to add. Pauline, not we have palns for Respiratory capacity but don't know the detail in terms of the increase. Do you have a feel for what might be driving the increase?
		A big increase in gynaecology waiting times in the last few months too. Why is this? Is there an equality issue here?	Access to clinic space to see routine outpatients has been limited due to COVID-19 restrictions and the changes this has brought to space to see outpatients coupled with an increase in urgent referrals. Work in currently underway with a dedicated PMO Project Manager to identify way of maximising capacity to see patients, it is anticipated this will conclude March 22. Work is underway to provide additional waiting times initiative clinics at evening and weekends to support the service reduce waiting times. We do not believe this to be an equality issue.
		Similarly a big increase in waiting times for respiratory medicine (although I note that this follows a sharp decrease in September.) Is there a particular issue/cause here?	In October the service had an issue in relation to consultant availability which meant reduced activity, this coupled with rising demand had an impact on waiting times. The acute management team are actively working with the service to implement solutions to reduce

DRAFT

			waiting times.
26	Appendix-2021-97 Joint Health Improvement Team Annual Report 2020-2021	**Karen Hamilton:** Noted	**-**
27	Appendix-2021-97 Joint Health Improvement Team Annual Report 2020-2021	**Harriet Campbell:** P269 Very clear cover paper highlighting what has been done towards each priority. Thank you! P279 Might be useful to have some of these figures as percentages - eg 339 BIBS requests – what percentage is that of new mothers? 360 New Vitamin D for children – how many would ideally receive it? P292 To what extent, if at all, does the Child Healthy Weight initiative interact with Mental Health on eating disorder related issues or are these treated entirely separately?	**Fiona Doig:** Thank you for this feedback. Bibs referral is offered to all women who are breastfeeding at point of discharge. We have a high uptake of referrals, mostly from hospital but also at a smaller number from health visitors, community midwives and GPs (78% in recent quarter). However, in the same quarter 45% of women were breastfeeding at this point therefore referrals to Bibs represents 35% of all births. All infants up to one year are eligible for the new Vitamin D and ideally uptake would be close to 100%. There were 799 births in Borders in 2020. CHW pathways are being developed with reference to, and alongside, continuing developments in established mental health pathways (CAMHS and Paediatric Psychology). A live advert is currently in place for a bespoke part-time Clinical Psychology

DRAFT

			post to further the CHW work. Further post and process developments will interface with other specialities as appropriate. To support the pathway all members of the CHW team are trained in behaviour change and also have received trauma informed training.
28	Appendix-2021-98 Remobilisation Plan RMP4 Feedback Letter	-	-

DRAFT

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**	**Update:** From an NHS Borders public involvement perspective this piece of work is closed. There remains activity amongst the Coldingham Community through the renamed East Berwickshire Wellness Group, focused on the development of a 'wellness model" by potentially creating the use of community assets (ie. Village Halls), to provide clinics within the villages. Anecdotally to date there have been no patient complaints received by the Practice about access to face to face appointments due to transport limitations, or any issues with pharmacy provision.

Meeting held on 2 December 2021

Agenda Item: Matters Arising

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
4	4.1	**Minute 6.8: Regional Health Protection Service:** Dr Tim Patterson	**Tim Patterson**	**In Progress:** Item scheduled for Resources & Performance Committee meeting to be held

		suggested an agreed model would likely be available later in the year and an update be provided in March. The Chair asked that a progress report be provided to the March Resources & Performance Committee meeting.		on 3 March 2022.

Agenda Item: Climate Emergency & Sustainability Development

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
5	8	The **BOARD** agreed that a development session for board members should be scheduled for early 2022.	**Andrew Bone**	**In Progress:** Board Development session on 30 June 2022 identified.

Agenda Item: NHS Borders Equality Mainstreaming Report 2021

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
6	14	The **BOARD** agreed to undertake a workshop and to add the action to the Action Tracker.	**Keith Allan** **Andy Carter**	**In Progress:** Board Development session on 6 October 2022 identified.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)**
Responsible Executive/Non-Executive:	**June Smyth - Director of Planning & Performance**
Report Author:	**Gemma Butterfield - Planning & Performance Officer**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plans / COVID-19 Remobilisation Plans

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

On 7th December 2021 NHS Borders received formal feedback from Scottish Government in relation to the refreshed COVID-19 Remobilisation Plan for 2021/22 - RMP4. The feedback letter is attached at Appendix 1, which outlined that Scottish Government were content with our plan and were content for us to take the plan (if not already approved) to be taken through our governance processes and to publish the plan.

2.2 Background

NHS Borders submitted RMP4 to Scottish Government on 30th September 2021. As previously agreed the plan was signed off by the Chair and Chief Executive prior to

submission and was subsequently formally approved by the Resources and Performance Committee at their meeting on 4th November 2021 and then ratified by the Board at their meeting on 2nd December 2021 (in private session).

2.3 Assessment

In their feedback letter Scottish Government have noted that due to the ongoing nature of the current Omicron response the plan will evolve and that they are keen to work with NHS Borders over the coming months to understand the implications and provide support such as the ongoing support being received from the Centre for Sustainable Delivery (CfSD).

They have also detailed the need for Boards to submit progress updates to them against our key deliverables, with the first of these updates due for submission by the end of January 2022. On 17th January 2022 Scottish Government wrote to all Boards commissioning this update, see Appendix 2, with an extended deadline date of 9th February 2022. The Planning & Performance Team are working with key stakeholders to complete NHS Border return. This will be signed off by the Board Executive Team and brought to the March 2022 Resource & Performance Committee for noting.

As RMP4 has already been through our governance process it has now been made available on our public website and Scottish Government have been made aware of this. The link to the document is www.nhsborders.scot.nhs.uk/corporate-information/about-the-board/remobilisation/

2.3.1 Quality/ Patient Care

This will be assessed as part of the detailed recovery plan discussions currently underway.

2.3.2 Workforce

This will be assessed as part of the detailed recovery plan discussions currently underway.

2.3.3 Financial

Work is underway to continue to understand the financial impact of recovery, but this is not yet complete. RMP3 and the Mid-Year update RMP4 is supported by an underpinning financial plan, which the Board received in a private session in April 2021.

2.3.4 Risk Assessment/Management

This will be continually assessed by the business units as we move through recover and the remobilisation of our services.

2.3.5 Equality and Diversity, including health inequalities

A Health Inequalities Impact Assessment for RMP4 remains ongoing a copy of which has previously been shared with the Board.

2.3.6 Other impacts

Non-Applicable

2.3.7 Communication, involvement, engagement and consultation

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

- See below

2.3.8 Route to the Meeting

The draft RMP4 plan was developed in conjunction with service leads, reviewed by the Board Executive Team and then approved by the Chair and Chief Executive for submission. The submitted version has been shared for review and comment with the Area Partnership Forum, Area Clinical Forum, Recovery Planning Group, members of the IJB and members of NHS Borders Board for an opportunity to review and comment. This cover paper was reviewed and approved by the Director of Planning & Performance.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1- Scottish Government Feedback Letter
- Appendix No 2- Scottish Government Update Commissioning Letter

NHSScotland Chief Operating Officer

Scottish Government
Riaghaltas na h-Alba
gov.scot

T: 0131-244 2480
E: John.burns@gov.scot

7 December 2021

By email

Dear Ralph,

RMP4 – Updated Remobilisation Plan for 2021/22

Thank you for submitting the latest iteration of your Remobilisation Plan. As we head into the second winter of the Covid-19 pandemic, I would like to take this opportunity to thank you and your teams for your dedication and hard work in delivering healthcare for our communities, in the face of considerable challenges.

I would also like to acknowledge the work that has gone into the development of this latest Plan, and in particular the input and support in developing and using the new format we trialled for RMP4. I would be grateful if you could pass on my thanks to all involved. I am very conscious of the extremely difficult, and rapidly changing, context in which your Plan was developed. I recognise that these plans will evolve over time in response to changing circumstances, and we are keen to continue to work with you in the coming months to understand the implications and to provide support. Accordingly, and in a very practical way, the support from CfSD, will assist to shape and refine your Plan, and through the associated Delivery Board, I envisage significant progress will be made on the road to recovery.

Indeed, the process of planning for delivery becomes more, not less, important during a time of high pressure, uncertainty and changeability. The planning process, and the ongoing development of the Plan, therefore provides not only a foundation for us to agree what we aim to deliver over this next period, but also a basis for discussion about the risks which could impact on our ability to deliver, and how we can work together to mitigate these. The new format used this time round has also allowed us to build a more comprehensive picture of both aspiration and risk across all Health Boards, and will hopefully support collaboration between Boards in developing their plans.

The updated plans will continue to inform the regular engagement which already takes place between SG Policy Teams and relevant service leads within your teams, providing a direct feedback route to pick up any ongoing queries regarding your proposals. In addition, the ongoing supportive work with CfSD will also provide a mechanism for developing and progressing actions in a dynamic way.

Finance

Following our Quarter One review, we wrote to confirm to NHS Boards on 26 October that funding will be provided for full Covid-19 and remobilisation costs on a non-repayable basis. This includes anticipated underachievement of savings in year, with an expectation however that Boards continue to take appropriate measures to reduce this funding requirement. This letter also set out expected actions for the remainder of the year and in advance of the 2022-23 financial year.

We have received your Quarter Two financial return and are working through the detail included. Where further clarification is required we will follow up with your Director of Finance.

Costs in relation to remobilisation should continue to be reported through quarterly finance returns. You must ensure that any recurring impact from these actions is clearly reported, as this is a key focus of our review in advance of the draft Scottish Budget on 9 December.

Winter Planning

Helen Maitland, my National Director for Unscheduled Care, wrote to you previously on 2 November confirming the Winter funding available to your Board, and confirming that this should be targeted to deliver the key priorities noted in the Remobilisation Plan guidance, and as reflected in the Winter related elements of your Plan. I recognise how challenging the forthcoming Winter is likely to be for the entire health and care service and Helen's team stand ready to support you wherever possible to meet those challenges.

Planned Care

We will also be in touch subsequent to this letter to confirm your remaining allocation of Waiting Times Funding for this financial year.

Next Steps

Bearing the above comments in mind, and recognising that your plans will continue to evolve with the support of CfSD, I am content that you now take your updated Remobilisation Plan for the second half of 2021/22 through your own governance processes and would then ask that you make it available on your website.

In order to monitor progress on the delivery of your updated RMP4 going forward, we are putting in place arrangements to request progress updates against the key deliverables that you have identified in your Delivery Planning Template. Updates should be submitted at the end of January 2022, covering Quarter Three, and the end of April 2022, for Quarter Four. These updates should include any changes to your plans for the following quarters. Details on the specific requirements for these updates will be issued in due course, and the engagement of CfSD will support this exercise

Three Year Operational Recovery Plans 2022-25

As you know, we are proposing to move to a slightly longer-term period of three years, for future Operational Plans. This will enable a more strategic approach to planning and support programmes of service transformation, aligned with the NHS Recovery Plan and the Care and Wellbeing Portfolio.

These three-year plans will take the form of a Recovery Plan for the period of 2022-25 for your Board. They will encompass a relatively high level narrative setting out your key priorities for recovery and transformation within this period, and how these contribute to our national priorities, underpinned by a spreadsheet-based Annual Delivery Plan (ADP).

This latter element, which will build on the format and content of the delivery planning template used for RMP4, will continue to form the basis for ongoing engagement as well as regular quarterly progress reports to Scottish Government, recognising the continuing fluidity in our operating context and supporting responsive changes to plans in-year.

In recognition of the pressures that you are currently working under, and the high level of uncertainty and volatility that remains in the system, these three year plans will be scheduled for **submission at the end of July 2022**. We intend that that this will allow sufficient time for you to take stock of your position as we move out of Winter, to consider your priorities, engage meaningfully with your staff, partners, communities and stakeholders on their desired outcomes, and to develop greater integration between your service, finance and workforce plans. In order to ensure that there is no gap in oversight during this period, it is important that you ensure that your Delivery Plans are kept updated as set out above.

We are also moving back to three year financial planning, and whilst we anticipate requiring some detail of plans in advance of the start of the financial year, we will use the Quarter One review in 2022-23 as an opportunity for Boards to refresh their financial plans to align with the three-year operational plans. Further detail will provided on this process in due course.

In the meantime, we have established a Short Life Working Group with a small group of Planning Leads from across the NHS Territorial and National Boards and SG officials. This team will be working closely together to produce guidance for the 2022-25 Recovery Plans and will remain in close contact with the wider Planning Collaborative Group.

Thank you again to you and your teams for all the hard work they have put in to developing this plan, and I look forward to working in partnership with you as we develop our vision for delivery in the NHS over the next three years.

Yours sincerely

JOHN G BURNS
NHSScotland Chief Operating Officer

NHSScotland Deputy Chief Operating Officer –
Planning and Sponsorship

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: NHSAnnualOperatingPlans@gov.scot

17 January 2022

By email

Priority Communication No.: OCENHS/2022/009

RMP4 Quarter 3 Progress Update

Dear Colleagues,

I would firstly like to wish you all a very happy, and belated, New Year. As I come into role this week, I am very much aware of the immense pressure that you are all currently facing and appreciate the extraordinary efforts by you and your teams to meet these challenges.

As indicated in your RMP4 feedback letters, I am writing to request that you submit the Quarter 3 Progress Update against your 2021/22 Remobilisation Plan (RMP4). This update will be especially useful as RMP4s were developed and submitted prior to the Omicron wave of the pandemic and therefore we expect that your position as at the end of December is likely to be significantly different from the position you had anticipated when your Plan was submitted. We are also all too aware that the increasing impacts of the Omicron wave means that your position, at mid-January, will not be what it was at end December – and we will give that full weight in our consideration of the Progress Updates.

Bearing all of this in mind, and wishing to minimise the work we are asking you to do, this update is limited to the Delivery Plan element of RMP4, using the **Delivery Plan Template**. We are **not** requesting updates to the narrative element of your RMP4, to the data templates submitted in September or any other documents submitted with RMP4.

The Progress Update should be a brief update of progress, or otherwise, against the deliverables identified in the RMP4 Delivery Plan, with a focus on highlighting changes since the Plan was submitted at end of September. Further details are available in the attached guidance document. A blank Delivery Plan template is also attached with this letter, highlighting the sections requiring an update. The Operational Planning team have created Excel versions of all plans that were submitted in MS Word and so please get in touch with them, if it would be helpful for the team to share them with you separately.

In light of the current pressures, the timeline for submission of the Quarter 3 Progress Update is requested by **Wednesday 9 February 2022.** In moving the

submission date back from the original plan of 31 January, I would ask that there is no further slippage to this date.

Please submit your updates to nhsannualoperatingplans@gov.scot. National Boards will also wish to copy the updates to their Sponsor Teams. In the meantime, if you require any support or have any questions please get in touch with Yvonne Summers Head of Operational Planning, or any of her team, who will be happy to help (yvonne.summers@gov.scot).

Finally, I would like to thank the members of the Planning Collaborative for their input and feedback, and in particular the Directors of Planning Working Group that has been formed to support the development of guidance around future operational plans. It is important that we continue to work and collaborate closely together as we continue the development of shared expectations and procedures for operational planning. We will continue to work to make further adjustments and improvements, especially as we look to develop guidance related to medium term plans. It is hoped that this guidance will be issued by the end of March 2022.

Yours sincerely,

Paula Speirs
NHS Scotland Deputy Chief Operating Officer – Planning and Sponsorship

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Audit Committee Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

The minutes are presented to the Board as per the Audit Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Audit Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Audit Committee 15 November 2021
- Audit Committee 13 December 2021

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit Committee minutes 13.09.21
- Appendix No 2, Audit Committee minutes 15.11.21

Minutes of a Meeting of **Borders NHS Board Audit Committee** held on Monday, 13th September 2021 @ 2 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director
Ms S Lam, Non Executive Director
Mr T Taylor, Non Executive Director (Left at 3.10 p.m.)

In Attendance: Mr A Bone, Director of Finance
Ms S Brook, Audit Manager, Grant Thornton
Mrs J Brown, Director, Audit, Grant Thornton
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs K Hamilton, Chair NHS Borders (Left at 2.55 p.m.)
Mr A Haseeb, Senior Audit Manager, Audit Scotland
Mrs S Paterson, Deputy Director of Finance, Head of Finance
Dr T Patterson, Director of Public Health
Mrs L Pringle, Risk Manager (Items10.1 & 10.2)
Mr R Roberts, Chief Executive
Mr G Samson, Audit Senior, Audit Scotland
Mrs J Smyth, Director of Planning & Performance (Item 6.2)
Mrs G Woolman, Director, Audit Scotland (Left at 2.20 p.m.)

1. **Introduction, Apologies and Welcome**

James Ayling noted this was his first meeting as Chair and welcomed those present to the meeting. Apologies were received from Fiona Sandford, Non Executive Director.

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meetings: - 15th June and 20th July 2021**

Gillian Woolman noted that the minutes of 20th July 2021 reflected the order of the agenda rather than the actual running order which took place on the day and highlighted that the minutes did not flow accordingly. It was agreed to leave the order as per the agenda as it was highlighted within item 1 of the minutes that the agenda would be considered in a revised order.

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Trackers
Andrew Bone referred to the second action regarding the delay in implementing the high risk recommendation within the Pharmacy Controls Internal Audit report and

advised that he had discussed this with the Director of Pharmacy and there would be a further delay in implementing this. It was noted that this was detailed within the audit follow up report.

The Committee noted the action trackers.

5. **Governance & Assurance**

5.1 *Audit Follow Up Report*

Sue Brook spoke to this item, drawing attention to sections of the report which highlighted outstanding actions against previous audits, including the risk status of these actions and those items overdue for completion. Sue Brook noted that the timescales for a number of incomplete actions had been revised following review by executive leads. June Smyth referred to the Waiting Times audit and the sample checking of waiting times and confirmed that the Access Board are now meeting on a regular basis and will receive a summary report on the unavailability codes which will highlight trends and alert the Access Board to any changes in the use or application of these codes over time. Tris Taylor referred to the deadlines being rolled forward and assumed this was due to the pandemic, however if this was due to capacity issues he enquired if this was a conscious decision made by management. Andrew Bone explained that this situation has emerged as a pattern over recent reports and it does appear as though there is an increased level of slippage against previous performance. He further noted that this has not been a conscious decision but is the result of individual lead director review of actions within their own portfolio. Andrew suggested that the Board Executive Team review the slippage on timelines and assess if this is becoming an issue and proposed providing an update to the December meeting to address this if found to be more than a short term issue. This was agreed. Sonya Lam commented that it was not clear what risks could materialise if there was a delay and whether the organisation could afford to let these slip. Andrew proposed that if Committee members had any specific issues they email him direct and he would follow up within the next four weeks.

The Committee noted the report.

6. **Internal Audit**

6.1 *Internal Audit Plan Update Report*

Jo Brown spoke to this item which provided an update on progress with the Internal Audit Plan for 2021/22. Jo highlighted that the Health & Safety Reporting audit had been moved to January as this worked better for the service and she assured it would still be delivered within the financial year. Jo also reminded of discussion at the June meeting to broaden the Sickness Absence audit to include wider workforce issues and proposed that recruitment, due to this having moved to a new Health Board Consortium arrangement,be no longer included as an area for review during 2021/22 and instead a review focusing solely on staff retention be undertaken. The effectiveness of the new recruitment arrangements with the regional service could be considered within the three year Strategic Internal Audit Plan. Jo advised that the audit around the Endowment controls had been omitted from the update but confirmed this could be accommodated within the contingency and they would be working up a scope for this audit. James Ayling asked if timings permitted that the findings

from this audit be presented to the December meeting. Tris Taylor asked if it would be more appropriate for the Endowment Fund Board of Trustees to approve this audit being undertaken. Andrew Bone confirmed that the Audit Committee can act in an advisory manner and that he proposed the Board of Trustees formally ask the Audit Committee to take this forward at its next meeting on 27th September 2021. It was noted that the Chair of the Board of Trustees was content with this proposal.

Sonya Lam referred to the Statutory/Mandatory Training audit and enquired what control measures were in place for mandatory training. Jo understood these to be what was deemed to be mandatory training by the government. Sonya highlighted the risk around staff capacity at the present time to undertake this training. Jo confirmed that she had raised the decline of uptake with the Director of Workforce and would ensure that this point is picked up as part of the review which was currently being undertaken.

The Committee noted the update.

6.2 *Internal Audit Report – Governance During Covid-19 and Remobilisation and Recovery*

Sue Brook spoke to this item which noted that the audit had concluded that there was partial assurance with improvement required and that one medium finding, three low findings and one advisory finding had been reported.Sue went on to take the Committee through the findings as well as the areas of good practice which had been found to be in place. June Smyth referred to the medium finding regarding the remobilisation plan follow up and monitoring of actions and confirmed that an update report had been presented to the Resources and Performance Committee on the 2nd September 2021 where it stated that all RMP3 commitments would be revisited for RMP4 before going forward to Borders NHS Board. June also referred to the low risk finding which stated that the most recent iteration of the RMP3 did not include how pain management services would be considered alongside remobilisation of all other services and assured that specific reference to this would be made within RMP4. Tris Taylor asked if the lessons learnt around governance arrangements would come forward to the Board. June advised that it had been proposed to apply these broadly, not just in relation to the governance arrangements, and would be engaging with services. This would ultimately come forward to a Committee but which one had yet to be determined.

The Committee noted the report.

7. <u>External Audit</u>

7.1 *2020/21 Annual Audit Report (Including ISA 260 Requirement)*

This item was taken as the first substantive item on the agenda

Gillian Woolman spoke to this item and reminded members that she had taken the Committee through the report in detail at the previous meeting on 20th July 2021. Gillian highlighted the changes to the report which now referenced the issue identified within the Endowment Fund accounts and confirmed that the amendments to balances in the Endowment Fund accounts did not have any impact on the balances consolidated in the NHS Board accounts and that the Board accounts could therefore be presented for approval in advance of the

final Endowment Fund accounts being presented to the Trustees thereof for approval. Gillian referred to exhibit 2 detailing the significant findings from the audit of the financial statements noting (a) costs incurred for PPE and testing kits had been included in the final accounts for NHS Borders (this information was received after the draft version of the accounts were issued to Board members for review and were now included in the final pack being recommended for approval today) and (b) the IJB outturn results and ring fenced reserves of the IJB for the current and previous year (2019/20), as comparator, were now consolidated in the NHS Borders' primary financial statements and further detailed in the supporting notes to the accounts.

Gillian advised that subject to any issues arising during the final review process she expected to issue an unmodified audit opinion. It was noted that the Annual Audit Report and Annual Accounts would go forward to the Borders NHS Board on 29th September 2021 for formal approval with submission to the Scottish Government on the 30th.Gillian explained that although the independent auditor's opinion for the Endowment Fund Annual Accounts was expected to be signed prior to the 29th, if this this was not received the independent auditor's report would still be signed but that the annual audit report would be amended. Andrew Bone confirmed that this is currently on track and although the Endowment Fund Annual Accounts will not have been formally approved by the Trustees by this date, in terms of the audit, it was expected that this would be concluded within the timeline.

The Committee noted the report and thanked Audit Scotland for their work in conducting the audit and assistance in regard to the Endowment Accounts issue.

8. **Annual Accounts 2020/21**

8.1 *Final Annual Report and Accounts 2020/21*

Susan Paterson spoke to this item and updated that a further three amendments had been agreed with the External Audit team. Susan went on to take the Committee through the amendments which included inclusion of the figure for PPE issued to the IJB, the date updated to 30th September for the accounts being approved for issue by the Board and the outturn financial position for the IJB surplus being incorporated within the Board's accounts. Susan advised that wording within the Annual Report regarding the audit for the Endowment Accounts would be amended to provide appropriate disclosure. It was noted that the accounts were being presented today to agree that they go forward to the Borders NHS Board meeting on the 29th September 2021 for formal approval. Asif Haseeb highlighted that Docusign would be used as per last year's accounts and suggested that the date be left blank for completion as part of that process. This was agreed.

The Committee noted the most recent adjustments for the Annual Report and Accounts 2020/21.

The Committee approved that theAnnual Report and Accounts for 2020/21 go forward for formal approval by the Board at its meeting on 29th September 2021.

9. **Fraud & Payment Verification**

9.1 *NFI Update*
Susan Paterson spoke to this item and reported that 1,116 matches had been received in January 2021 and progress on these would continue to be reported to the Committee. It was noted that 93% of matches have been investigated with no fraud being identified to date.

The Committee noted the update.

10. **Risk Management**

10.1 *Update on Very High Risks*
Lettie Pringle spoke to this item. Lettie highlighted that the key points to note were that training has been paused pending a decision by management around staffing resource within the Risk Management team. This also impacted on training of the Risk Champions within the Clinical Boards as part of the Risk Champion Network being implemented. Lettie advised that the Risk Management KPIs had been updated for 2021/22 and would be supported by the introduction of Clinical Board Risk Champions with a view to improving compliance across the organisation. It was also noted that the Risk Management Board now reports into the Operational Planning Group with risk management strategies and policies being approved via the Quality and Sustainability Board.

Sonya Lam referred to the development of a Risk Champion Network and enquired how the organisation would know how effective this is, bearing in mind the issues being experienced with staff capacity. Tim Patterson explained that when the Risk Management Board started to meet again as part of the remobilisation phase it had worked with members to identify areas of concern which needed to be addressed and additional support to Clinical Boards to identify and assess risk had been raised as an issue. The model agreed was to have a Risk Champion for each Clinical Board as this would change the culture and ultimately will improve the quality of care. Risk Champions had been identified and were developing a risk management plan for their respective Clinical Boards. The Risk Management Board would know if this was a success by the monitoring of these and the KPIs. Lettie added that there was more than one champion for each Clinical Board area to spread out any capacity issues. Tris Taylor referred to the comparison of agreed risks for the organisation as at 8th March and 10th August 2021 as he noted a rise in the total number of risks and asked if this would settle over time. Lettie explained that the total number has increased during this timeframe due to the Covid Risk Register being amalgamated with the Operational Risk Register.

The Committee noted the update.

10.2 *Annual Risk Management Report 2020/21*
Lettie Pringle spoke to this item and reported that the Risk Management objectives and KPIs were not fully achieved during 2020/21. This was primarily due to risk owners having competing priorities. An action plan has however been put in place to address the issues and although timescales may be longer than expected it was hoped to complete this by the end of the financial year.

James Ayling asked for an update on the timescales for agreeing KPIs and when these would come forward to the Audit Committee for review. Lettie advised that these had been agreed at the Risk Management Board in June and had been included within the quarter 1 review presented to the Operational Planning Group. Lettie agreed to provide an update on the action plan at the December meeting. James asked what the main priorities were over the next 2 – 3 months for the Risk Management team. Tim Patterson advised that if the capacity issues are addressed then focus will be on training, however if not there will be limited resource to support the risk agenda. Ralph Roberts added that there is a framework in place and if working well the organisation would get the assurance from this, however noted that there are capacity issues within the system. Ralph noted that the KPIs, although not as robust as the framework, will provide the organisation with an indication of where it is at. Andrew Bone highlighted the need to consider what level of information would be required to provide the necessary assurance and how best to resource this.

The Committee noted the Risk Management Annual Report.

11. **Integration Joint Board**

James Ayling referred to the Audit Committee Terms of Reference as he did not feel that the Committee was receiving sufficient information, by way of the IJB Audit Committee agenda and minutes, to provide it with the necessary assurance. Andrew Bone advised that it was the intention to review the Audit Committee Terms of Reference and workplan to ensure all elements are appropriate for the Committee and suggested that this be included as part of that review. This was agreed.

The Committee noted the link to the IJB Audit Committee agenda and minutes.

12. **Items for Noting**

12.1 *Information Governance Committee Minutes: 16th June 2021 (Draft)*

The Committee noted the draft minutes of the Information Governance Committee on 16th June 2021.

13. **Any Other Competent Business**

13.1 *Tender Waiver for MRI Replacement Infrastructure Works at Borders General Hospital*

The Committee noted the tender waiver approval for the MRI replacement infrastructure works at the Borders General Hospital.

13.2 *Tender Process for Network Capacity Uplift*
James Ayling felt that it would have been helpful to have received allrelevant information and clarity around delegated authority as it was unclear within the report received. Andrew advised that this had been reviewed by the Board Executive Team and approved by himself and the Chief Executive who had the necessary authority. Going forward a standard proforma would be used to ensure all the relevant questions were answered.

The Committee noted the tender process had been followed for the network capacity uplift and the subsequent appointment of Borderlink.

14. **Chair's Reflections**

James Ayling considered that there had been good discussion at the meeting and if anyone felt that something could have been done better or in a different way he was happy to receive any feedback.

15. **Date of Next Meeting**

Monday, 13th December 2021 @ 2 p.m., MS Teams.

An extraordinary meeting to be arranged to review the Endowment Annual Accounts and the findings from the Internal Audit on Endowments in due course.

BE
24.09.21

Minutes of a Meeting of **Borders NHS Board Audit Committee Members** held on Monday, 15th November 2021 @ 2 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director
Ms S Lam, Non Executive Director
Mr T Taylor, Non Executive Director
Mrs F Sandford, Non Executive Director

In Attendance: Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mr A Haseeb, Senior Audit Manager, Audit Scotland
Mrs G Woolman, Director, Audit Scotland

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those to the meeting. No apologies had been received. James noted that as permitted under the Committee's terms of reference invitations had only been extended to Committee members and the external auditors.

2. **Declaration of Interest/Quorum**

There were no declarations of interest and the meeting was quorate.

3. **General Discussion with External Auditors (Audit Scotland)**

James Ayling explained that the purpose of the meeting today was primarily to give an opportunity, particularly for the new members of the Committee, to have a general discussion with Audit Scotland, the Board's External Auditors.

Gillian Woolman thanked members for this opportunity and advised that it is good practice to meet with the Non Executive Audit Committee Members on an annual basis as a minimum. Gillian advised that their appointment as External Auditor was for a period of six years and that they were currently in year five. Gillian explained that Audit Scotland adhere to the Code of Audit Practice which sets the framework for public audit in Scotland. It was noted that this outlines the responsibilities of external auditors appointed by the Auditor General for Scotland. Gillian agreed to supply a copy of the current Code of Audit Practice to the Committee for information. Gillian went over the principles of public audit and highlighted the importance of independence due to the appointment process, i.e. the Auditor General appoints the auditor and not NHS Borders. Gillian explained that Audit Scotland keep up to date with audit practices and approaches and assured that they look ahead for audit risks when undertaking audits. It was noted that the audits carried out include the following wider dimensions: financial management, financial sustainability, governance and transparency and performance/best value. Their main interaction is with the Audit Committee. Gillian advised that reports are prepared in order to give the Audit Committee confidence in having enough information to allow them to fulfil their role. It was noted that the Accountable Officer is responsible for having arrangements in

place to ensure best value, which includes partnership working, leadership and governance.

James Ayling enquired if it was intentional that Audit Scotland was also the External Auditors for the Integrated Joint Board (IJB). Gillian confirmed that Audit Scotland was the appointed Auditor for both NHS Borders and Scottish Borders Council and accordingly Audit Scotland assumed the role for the IJB as they were dependent on the financial systems of both organisations. It was noted that this was the consistent approach across Scotland. Fiona Sandford referred to financial management and value for money and asked what members should look for to ensure optimal output. Gillian explained that these are drawn out within the annual report and provided specific examples. Tris Taylor felt a more direct approach to highlight these was required. Gillian agreed to draw out more relevant information for the Audit Committee's attention going forward. Sonya Lam felt that more assurance was required around performance as she did not feel making a comparison against other Boards was sufficient. Gillian advised that the organisation has both national and local performance targets and that Audit Scotland undertake relative performance reporting through the NHS Overview report. Gillian added that her colleagues who undertake performance audits are hoping to look further into health inequalities in future. James asked for assurance that should there be any areas of concern these would be raised with him. Gillian confirmed that if there were any issues these would be raised in a timely fashion.

The Committee thanked Audit Scotland for attending and providing an overview of their work.

4. **Strategic Risk Review**

James Ayling referred to the paper (prepared by Lettie Pringle) which proposed an enhanced strategic risk governance structure relating to consideration of strategic risks. James noted the history behind this proposed enhancement which stemmed from a concern raised at the last Board meeting that a strategic risk may be of relevance to more than one committee and that governance committees should review all strategic risks and not just those allocated to an individual committee. Tim Patterson had subsequently met with James as this appeared to be contrary to an earlier Audit Chair view. The committee noted that the paper highlighted that the respective Executive Leads have the responsibility of bringing relevant risks to the attention of their relevant Governance Committee and proposed that any assurance issues Committees have in regards to aspects of a risk not within their assurance remit should be raised with the Risk Manager to include within the report to be submitted to the relevant Committee who provide assurance for the strategic risk. James reported that the proposals contained in this paper, which had been approved by BET, had been discussed as a potential way forward and sought members views thereon. In general it was felt that the approach suggested could be an improvement. James stressed however that the role of the Audit Committee was not to formulate risk procedures but instead to assess their effectiveness once adopted. After general discussion on the paper and other issues relating to risk including its key role in the organisation and the importance of recognition of strategic risks it was noted that this paper would require relevant approval.

5. **Induction for Members**

James Ayling advised that he had asked the Director of Finance for a formal induction pack for Audit Committee members and the draft pack was presented today for comment. Tris Taylor noted that he was content with the pack issued. Both Fiona Sandford and Sonya Lam noted concerns around transparency. Fiona agreed with the approach and welcomed this but felt some form of induction around the culture within NHS Borders would also be of benefit to Non Executive Directors. . Sonya also noted that performance was not included within the pack despite this being an overarching organisational risk.

James noted that the appendix detailing the induction papers helpfully rated them in terms of their importance and relevance and suggested that members deal with those issues in the first instance. He also noted that he personally found it helpful to go back over minutes and papers from earlier years.

After discussion the Committee approved the induction pack for use by its members.

6. **Date of Next Meeting**

Monday, 13th December 2021 @ 2 p.m., MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Finance Report – November 2021**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Head of Management Accounting**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

2.1.1 The paper provides the board with an update on financial performance within NHS Borders.

2.2 Background

2.2.1 NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This requires that individual boards report to SG on their financial performance through a monthly Financial Performance Report (FPR), which includes comparison of year to date performance against plan and a forecast of the expected outturn performance at 31st March. Formal quarterly reviews are undertaken at the end of each quarterly cycle (June, September, and December).

2.2.2 As per the Board's Code of Corporate Governance, it is a matter reserved for the board to determine the frequency with which (financial) performance is reported.

2.2.3 The director of finance is required to: "Prepare and submit for audit, timeous financial statements, which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question".

2.2.4 Extant practice is that financial performance is reported monthly, with review of performance delegated to the Resources & Performance Committee (R&PC) and reports published for awareness to the board in the periods where no R&PC is scheduled.

2.2.5 The R&PC committee is specifically remitted to "review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements".

2.2.6 The Medium Term Financial Framework sets out the requirement to deliver this statutory breakeven over a three year planning cycle.

2.2.7 These arrangements have been temporarily paused during the period of Emergency Powers following the onset of the COVID 19 pandemic. Interim arrangements require NHS Boards to submit a single year financial plan aligned the board's Remobilisation Plan (RMP).

2.2.8 It has been confirmed that additional resources will be made available in 2021/22 to Health Boards to support delivery of a breakeven position, subject to assessment of financial performance. This includes support to non-delivery of savings where this has been impacted by activities to support COVID 19 response and RMP.

2.2.9 SG have confirmed their intention to return to a three year financial planning cycle by summer 2022/23.

2.3 Assessment

2.3.1 Quality/ Patient Care

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.2 Workforce

Any issues related to this topic are provided as background to the financial performance report and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.3 Financial

The report is intended to provide briefing on year to date and anticipated financial performance within the current financial year. No decisions are required in relation to the report and any implications for the use of resources will be covered through separate paper.

2.3.4 Risk Assessment/Management

The paper includes discussion on financial risks where these relate to *in year* financial performance against plan. This risk is significantly mitigated in 2021/22 as a result of the Scottish Government's interim financial framework through which it is expected that the board will receive additional non-recurring revenue allocation to offset non-delivery of savings. This funding, once confirmed, is expected to support delivery of a breakeven financial performance in 2021/22.

Financial risk for 2022/23 and beyond is considered through the board's Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

This paper supports the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes, by ensuring that the board regularly reviews expenditure against plan and by so doing is able to consider whether performance indicates any variation from plan which may impact on these areas.

An impact assessment has not been completed because this is a routine performance report which monitors expenditure against plan. The financial plan for 2021/22 is aligned to the board's Remobilisation Plan for which a separate Impact Assessment has been completed.

2.3.6 Other impacts

There are no other relevant impacts identified in relation to the matters discussed in this paper.

2.3.7 Communication, involvement, engagement and consultation

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

State how his has been carried out and note any meetings that have taken place.

- Financial performance reports are published to individual budget managers within three weeks of the end of each monthly reporting period.
- The Board Executive Team (BET) received this report on 1st February 2022.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Not relevant.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Finance Report (Revenue) for the period to end November 2021

FINANCE REPORT FOR THE PERIOD TO THE END OF NOVEMBER 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 November 2021.

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** that the board is reporting a £4.73m deficit for eight months to end of November 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 November reported position is in line with the revised year end forecast outturn (£7.78m deficit).

3 Summary Financial Performance (Revenue)

3.1 The board's financial performance as at 30th November 2021 is a cumulative deficit of £4.73m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for eight months to end November 2021

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	246.40	294.74	160.59	160.40	(0.19)
Revenue Expenditure	246.40	294.74	180.58	185.12	(4.54)
Surplus/(Deficit)	**0.00**	**0.00**	**19.99**	**24.72**	**(4.73)**

3.2 This reported position is in line with the improved expected performance expected at the end of March which is £7.78m deficit, as communicated in the M07 Finance Report.

4 Financial Performance –Budget Heading Analysis

4.1.1 Income

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

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

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
SGHSCD Allocation	226.65	272.67	146.23	146.23	-
SGHSCD Anticipated Allocations	-	0.40	(0.44)	(0.44)	-
Family Health Services	10.24	11.72	8.31	8.31	-
External Healthcare Purchasers	4.24	4.39	2.98	2.75	(0.23)
Other Income	5.27	5.56	3.51	3.55	0.04
Total Income	**246.40**	**294.74**	**160.59**	**160.40**	**(0.19)**

4.1.3 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 November 2021.

Table 3 – Operational performance by business unit, November 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	71.62	47.99	45.57	2.42
Acute Services - Savings Target	(2.13)	(2.12)	(1.41)	-	(1.41)
TOTAL Acute Services	**58.90**	**69.51**	**46.58**	**45.57**	**1.01**
Set Aside Budgets	25.30	27.91	18.73	19.27	(0.54)
Set Aside Savings	(1.09)	(1.09)	(0.73)	-	(0.73)
TOTAL Set Aside budgets	**24.21**	**26.82**	**18.00**	**19.27**	**(1.27)**
IJB Delegated Functions	105.76	134.46	85.94	85.60	0.34
IJB – Savings	(4.74)	(4.74)	(3.16)	-	(3.16)
TOTAL IJB Delegated	**101.02**	**129.72**	**82.78**	**85.60**	**(2.82)**
Corporate Directorates	32.81	26.26	10.99	10.62	0.37
Corporate Directorates Savings	(0.34)	(0.27)	(0.18)	-	(0.18)
TOTAL Corporate Services	**32.47**	**25.99**	**10.81**	**10.62**	**0.19**
External Healthcare Providers	28.55	31.19	21.06	20.95	0.11
External Healthcare Savings	(0.51)	(0.46)	(0.31)	-	(0.31)
TOTAL External Healthcare	**28.04**	**30.73**	**20.75**	**20.95**	**(0.20)**
Board Wide					
Depreciation	4.67	4.67	3.11	3.11	-
Planned expenditure yet to be allocated	(2.91)	9.73	0.17	-	0.17
Financial Recurring Deficit (Balance)	-	(12.35)	(8.23)	-	(8.23)
Financial Non-Recurring Deficit(Balance)	-	2.52	1.68	-	1.68
Board Flexibility	-	7.40	4.93	-	4.93
Total Expenditure	**246.40**	**294.74**	**180.58**	**185.12**	**(4.54)**

4.2.2 **Acute services** (non-delegated functions) are reporting a net under spend of £1.01m after non-delivery of savings. This includes a £2.42m 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.

4.2.3 **Set Aside.** Acute functions delegated to the IJB are reporting £1.27m overspend, of which £0.73m 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.

4.2.4 **IJB Delegated.** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an under spend on core budgets of £0.34m. A reduction in primary care services expenditure within public dental services continues to be the main driver for the underspend reported in November. This reflects the reduction in throughput in dental services as a result of pandemic infection control measures. There are also underspends across Community Nursing and AHP services linked to vacant posts.

4.2.5 **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. Savings mandates of £0.10m were actioned against Corporate Directorate budgets during November.

4.2.6 **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. Savings mandates of £0.05m were actioned during November against commissioning budgets.

5 Covid-19 Expenditure

5.1 For the period to the end of November, funding of Covid-19 expenditure has been assumed and allocated to match reported spend within business units. Scottish Government have confirmed that actual 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 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 eight months to end November 2021

	Revised Annual Budget[1] £m	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Covid-19 Expenditure				
Acute Services	0.45	0.41	0.45	(0.04)
Set Aside	0.14	0.14	0.13	0.01
IJB Directed Services	2.43	2.40	2.49	(0.08)
Corporate Directorates	4.64	2.72	2.70	0.02
Total Covid-19 Expenditure	**7.43**	**5.67**	**5.76**	**(0.09)**

5.3 During the last eight 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.

5.4 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 Key Risks

6.1 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 on-going dialogue with Scottish Government and the preparation of updates to forecast on a monthly basis. As reported previously, Scottish Government has introduced an enhanced reporting requirement upon savings delivery, reflecting the board's on-going performance escalation.

[1] 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.

6.2 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.

6.3 An updated risk assessment is currently being prepared at a detailed level as part of the development of the boards finance plan.

Author(s)

Samantha Harkness Senior Finance Manager Sam.harkness@borders.scot.nhs.uk	

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Capital Plan 2021/22 - Update**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Susan Paterson, Deputy Director of Finance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

Updates are provided to the Resource & Performance Committee on progress against the board's capital plan on a quarterly basis. As a result of operational pressures the committee's meeting in January was cancelled. This update covers the period to 31st December 2022 and is presented to the board as a result of timing i.e. that the next Resources & Performance Committee will not meet until March 2022, at which point the situation described in the paper will no longer be current.

The report describes the total capital resources available to the board in 2021/22 and expenditure for the year to date (to end December). At that point resources of £8.9m have been identified against which £3.6m had been spent, leaving a balance of £5.3m remaining. This position includes a number of allocations agreed following Mid Year Review which are additional to the plan. These allocations are discussed further below.

Slippage on capital projects is managed by considering the phasing of portfolio budgets across the five year plan, with expenditure brought forward where possible to offset any slippage in the current plan. For 2021/22 this has involved acceleration of equipment replacement to offset slippage on (largely) building projects. Despite this it remains likely that there will be a balance of funds not spent at the end of March.

2.2 Background

Capital expenditure against plan is reported on a quarterly basis to the Resources & Performance Committee. Expenditure plans are amended each quarter to reflect additional allocations negotiated with Scottish Government and expected phasing of projects.

Phasing of expenditure can be across multiple years and the plan is managed on a dynamic basis through rephasing of priorities to balance resources and expenditure on an ongoing basis. This means that some projects are brought forward where slippage is identified in year; other projects may be considered for deferral should there be insufficient resources to meet their planned spend (this has not been required in 2021/22).

Additional resources may be allocated in year as a result of national and regional programmes; this may include agreement to a 'Once for Scotland' procurement (this would typically cover high cost medical technologies or business systems where there is a shared need across Health Boards).

2.3 Assessment

Expenditure to Date as at end December 2021

The Capital Plan for 2021/22 has been updated to reflect additional allocations agreed following Mid Year Review. Total funding of £8.86m, including receipts, is confirmed, against which £3.57m has been incurred to date.

Expenditure plans comprise a number of individual projects together with rolling programmes of investment to medical equipment, estates and backlog maintenance and IM&T. The plan includes resources (and commitments) carried forward from 2020/21 as well as additional allocations agreed during the current year.

Table 1 below details the planned projects and expenditure incurred for the 9 month period to date.

Table 1 – summary 2021/22 Capital expenditure incurred to 31st December 2021

	2021/22 Capital Plan £m	Q2 YTD (Apr-Sep) £m	Q3 YTD (Apr-Dec) £m
MRI	0.65	0.18	0.53
CT scanner	0.70	-	-
Endoscopy Equipment	1.80	-	-
Forensic Medical Examination Suite	0.99	0.02	0.03
Pharmacy – Dispensing Robot	0.30	-	-
Primary Care premises	0.09	-	0.09
Borders Health Campus	0.15	-	-
Patient Flow	0.20	-	-
Rolling Programmes			
Estates and Backlog Maintenance	1.29	0.38	1.17
Medical Equipment	0.34	0.08	0.14
IM&T including Digital Portfolio Projects	1.80	0.15	1.35
Project Management Support	0.24	0.09	0.13
Feasibility and scoping works	0.13	0.01	0.13
Uncommitted	0.18	-	-
Total CRL	**8.86**	**0.91**	**3.57**

Total resources available to the plan have increased by £3.75m in Quarter three. This is a result of additional capital slippage being made available to national networks to support investment in nationally prioritised equipment replacement and renewal. Slippage arises at a national level due to significant disruption to major infrastructure projects (e.g. Elective Treatment Centres) during the pandemic.

Table 2 provides a summary of the increased resources allocated by Scottish Government during Quarter three.

Table 2 – Movements in CRL from 30th September to 31st December 2021

	2021/22 Capital Plan £m
Total Capital Budget as at 31st September 2021	**5.11**
Additional Allocations – Quarter 3	
National Equipping Board – Endoscopy	1.80
Scottish Cancer Network – Mobile equipment	0.04
National Facilities Board – Laundry Equipment	0.11
Digital Portfolio – Year 3	1.50
Additional Forensic Med Exam Suite	0.30
	3.75
Total Capital Resource Limit (CRL)	**8.86**

There are two allocations which drive the majority of this increase. These are discussed in detail below.

Endoscopy Equipment
The national equipping board considers major equipment life cycle replacement on a 'Once for Scotland' basis. For NHS Borders both the MRI and CT replacement projects have previously been funded through this route. At MYR a request was submitted for acceleration of the planned replacement of the board's diagnostic Endoscopy equipment which is approaching the end of its useful life. A second tranche of additional funds financed by capital slippage was released in December 2021 and NHS Borders was successful in securing funding for this expenditure. Procurement is being undertaken on an NHS Scotland basis for this equipment and orders have been placed through this route with expected delivery by end March 2022.

Digital Portfolio
A financial pressure was identified at Q1 review in relation to the Digital Portfolio arising from changes to UK treasury rules around non-cash DEL allocations. This pressure was reflected in the Q1 review as an increase to the board's overall revenue gap in 2021/22. Following further negotiations at Mid Year Review (MYR) agreement was reached with SG finance directorate to make available additional capital resources (£1.5m) to offset this shortfall. In order to support this, agreement was also provided to support a capital/revenue virement. This update was reflected in the board's updated revenue forecast at MYR (Q2).

Updating the Forecast for 31st March
The overall portfolio continues to be subject to increased volatility at an NHS Scotland and local level. Slippage has been recorded from a number of areas in the plan as a result of a factors including service and capital planning/estates capacity, supply chain delay and contractor availability. The Board's Capital Investment Group (BCIG) is regularly updated on the impact of these factors on the completion timeline for each project.

Work is currently underway to confirm forecast expenditure to end March. It is however already clear that there will be projects which will remain either undelivered or in progress at end March.

Wherever possible, slippage against existing projects will be managed either through year end management (i.e. deferral of funding by agreement with Scottish Government) or through rephasing of commitments identified against the 2022/23 plan (largely in relation to equipment replacement and IM&T commitments).

A further update on this position will be provided to the Resources & Performance Committee in March 2022.

2.3.1 Quality/ Patient Care

Capital investment in infrastructure and medical technologies is essential to delivering facilities which are fit for purpose and support quality and patient care. Slippage on the programme will result in short term delay to improvements which are expected from individual projects and will therefore have an adverse impact on the timing of expected benefits. Conversely, the acceleration of equipment replacement programmes through increased investment in 2021/22 will have a positive impact on the quality of care as equipment is modernised and there is a reduced level of disruption from equipment failure.

2.3.2 Workforce

The impact on workforce from capital investment is two-fold: firstly in relation to the benefits for staff (and patients) from improvements to the working environment; secondly, as a result of the increased workload to key staff groups (capital planning, estates, IM&T) arising from the planned investments.

This report does not highlight any specific impact arising from the changes to the plan. Resources to deliver the plan remain a risk as reported previously.

2.3.3 Financial

The financial impact of the plan is described above.

2.3.4 Risk Assessment/Management

The main risks identified in the plan are in relation to:

- Year end slippage. Actions to mitigate this risk continue to be explored with Scottish Government colleagues and through BCIG.
- Resources to deliver the plan. This issue is mainly in relation to longer term capital planning and it is expected that this can be managed within the plan for 2021/22.

A specific risk exists in relation to delivery of the FME suite project. This project is expected to be delivered by 31st March 2022 in order to meet Scottish Government timescales however the contractor's schedule of works suggest that this timeline will not be met. This position remains under review with slippage likely to be a few weeks. Actions to address are currently being explored.

2.3.5 Equality and Diversity, including health inequalities

No impact assessment has been prepared in relation to this report. The report is a regular update on expenditure on capital plans; individual assessments are undertaken where required against specific projects.

2.3.6 Other impacts

There are no other relevant impacts described in the paper.

2.3.7 Communication, involvement, engagement and consultation

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

State how his has been carried out and note any meetings that have taken place.

- Borders Capital Investment Group (BCIG), 31st January 2022

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- BCIG, 31st January 2022 (per above)

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

No appendices

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Lynn McCallum, Medical Director**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Clinical Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Clinical Governance Committee 19 January 2022

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 15.11.21

Borders NHS Board
Clinical Governance Committee
APPROVED

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 17 November 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)
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr T Young, Associate Medical Director, Primary & Community Services
Dr T Patterson, Joint Director of Public Health
Mrs L Jones, Head of Clinical Governance & Quality
Mr G Clinkscale, Director of Acute Services
Mrs S Horan, Director of Nursing, Midwifery and Allied Health Professions
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mr S Whiting, Infection Control Manager
Dr K Allan, Associate Director of Public Health
Mrs K Smith, Head of Clinical & Professional Development

1 Apologies and Announcements

No apologies were noted.

The Chair welcomed:

Dr K Allan, Associate Director of Public Health – Deputising for Mrs L Pringle (item 5.4)

Mrs K Smith, Head of Clinical & Professional Development (item 8.1)

No paper was presented for item 8.2 therefore the Blood Transfusion annual report was deferred to next meeting in January 2022.

The Chair confirmed the meeting was quorate.

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**:**

Previous declarations by Ms Lam and Mrs Campbell were still relevant.

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 15 September 2021 was approved.

4 Matters Arising/Action Tracker

Matters Arising from the previous meeting were noted and action tracker updated as appropriate.

5 Patient Safety

5.1 Infection Control

Mr Whiting provided a brief overview of the content of the report. There are still concerns regarding the fabric of building in particular ventilation which may have a direct impact on patient safety. He suggested that to provide assurance to the Committee a report from the Head of Estates and Facilities on this matter would be prudent.

Plan for representative from the company who provide hand gel has been delayed due to staff from the company not being available. Mr Whiting will update us when this visit has taken place.

Mr Whiting gave an overview on the challenges relating to the new draft respiratory guidance and pathways due to be introduced at the end of November. The National Guidance suggests that the mixing in bays of cohorted of patients should be avoided but due to the capacity and size of the hospital the guidance may be difficult to implement. Dr McCallum agreed with Mr Whiting regarding the concerns on the delivery of the new guidance due to the logistical issues relating to the age and layout of our buildings. Staffing concerns were also an issue due to the small size of the respiratory team both medical and nursing. This also has implications for GP surgeries. Discussion followed regarding the implementation and the fallout if pathways not followed. Mr Whiting noted that this conversation is being had at a National level. All risks and mitigations will be noted on the risk register. Mrs Sandford asked that this report discussed at the Board due to the high level of risks involved. Mr Roberts agreed that this discussion should be had at the Board and supported the inclusion on the Risk Register.

Further discussion took place regarding Estates Strategy both medium and long term and if there was opportunity to flag to the Scottish Government in order for us to further mitigate risks in particular in the short term. The Committee recognised that this would also have an impact on the elective/non respiratory pathways. This will be raised as part Centre for Sustained Delivery (CFSD) and planned care work which is ongoing.

Mr Whiting will explore support from estates to attend next meeting for update.

Mrs Campbell and Mrs Sandford commented that it is important we don't lose sight of our SAB and CAUTI numbers. Despite reinstatement of CAUTI group infections do not appear to be decreasing. Discussion took place regarding targets for reducing use of and number of days catheters are used. The Committee agreed it would be useful to see what the National picture is in particular related to frailty patients during the pandemic.

ACTION: Mr Whiting will explore support from estates at future meeting

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and although not assured by the content of the report but is assured that the issues identified are being addressed.

5.2 Quarterly HSMR

Mrs Jones provided a brief overview of the content of the report. She reported that HSMR remains within normal limits, also noting that there has been a reduction in our crude mortality rate.

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

5.3 Mortality Review Annual Report

Dr Herlihy provided a brief overview of the content and background of the report since introduction of new review process. Discussion took place following overview, issues highlighted were predominantly regarding documentation and the difficulty to define hospital acquired Covid. It was noted that there appeared to be fewer deaths during pandemic but this was most likely linked to the reduction in admissions to hospital in waves one and two of the pandemic. Dr Herlihy commented that it was reassuring that our figures were no higher than the National average.

Dr McCallum acknowledged the amount of work involved in this report and thank Dr Herlihy and colleagues for their efforts.

Mrs Wilson highlighted safety issues regarding electronic systems and record keeping and concern of how far behind NHS Borders are in digital documentation. This issue has been discussed in other forums. Mrs Horan asked Mrs Wilson as Chair of Area Clinical Forum could raise this issue in this group for support.

Mrs Sandford enquired about the progress of Duty of Candour in relation to Covid. There is expected to be guidance relating to this issue. There are discussions to be had in relation to timing as some of these deaths were at the start of the pandemic and there should be sensitivity relating to whether or not duty of candour discussions would be counterproductive for the relatives at this late stage.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that there is the right data and that the corrections are being carried out.

5.4 Strategic Risk Management Report

Dr Allan provided a brief overview of the content of the report. Discussion followed regarding the status of strategic risks. Risks associated with recruitment and retention of staff has been redirected to the Staff Governance Committee. Mrs

Sandford raised a concern that this move had not been highlighted to the Clinical Governance Committee and these risks remain a clinical risk so Committee should still receive an oversight of these risks.

Dr Allan explained that each committee had oversight of the risks they were responsible for but also the whole register was available for a whole system overview. The Committee asked Dr Allan if he would feed back their concerns regarding the recruitment and retention of staff. Discussion followed regarding the evolving nature of the strategic risk register and the alignment of responsibilities to each Board Committee. Dr Allan commented that this is still a work in progress.

Discussion followed regarding risks and process and assurance when risks outcomes are inadequate. There was further discussion regarding workforce and which disciplines the risk covered. Dr Allan confirmed the risk pertained to all workforce and not just medical staff.

ACTION: Dr Allan to relay comments regarding risks register responsibilities to the Risk Manager.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the processes but not the outcomes.

6 Person Centred

6.1 Patient experience

Mrs Jones provided a brief overview of the content of the report. Mrs Jones gave an update on the ongoing work regarding tightening up response times, this has improved but there is still work to be done on tightening up the response times. Some of the lag is partly due to frontline staff pressures. She reports that Public Governance Committee has started to take a closer look at patient experience which adds a further degree of scrutiny for assurance.

Ms Lam enquired about nature of report and if this was one that was shared out with the organisation. Mrs Jones commented that this particular report was most likely not in a format that could be shared externally but communication on patient experience performance was something that was shared out with general communication plans via mediums like social media channels. Mrs Jones assured Ms Lam that patient experience measures were considered by each board alongside all the other measures which direct quality improvement work on a monthly basis.

Mrs Campbell asked if any improvements that had been made were clearer in the report. Mrs Jones agreed that she would include comparisons in future report. Mrs Sandford enquired about data regarding GP complaints in particular waiting times and access. Discussion followed regarding complaint reporting within GP practices and the difficulties of obtaining this information as GPs are independent contractors and have their own patient experience processes.

ACTIONS: Mrs Jones will tighten up reporting.
Dr McCallum will discuss with GPs regarding sharing of complaint outcomes.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured on its content

7 Effectiveness

7.1 Clinical Board update (Mental Health Services)

Mr Lerpiniere provided a brief overview of the content of the report and asked Committee to support paper; he reported that this has been a particularly difficult period of time. He thanked Clinical Governance Team for their support during recent adverse event reviews but reports that they recognise they are behind with reviews at present and they are working on that.

The Committee recognises the challenges being faced at present by Mental Health Services which in some cases can be caused by one extremely challenging patient. Mr Lerpiniere highlighted that challenging patients are often ones that cover all boards and not just Mental Health and he thanked colleagues across the organisation for their support.

Dr McCallum enquired as to how any debriefs and learning can be fed back to Clinical Governance Committee.

Mrs Campbell asked if there was a way of the Non Executives supporting debriefs. Mr Lerpiniere welcomes this support where appropriate. This suggestion should be discussed with the Board Chair.

ACTION: Dr McCallum and Mrs Jones will explore how to share learning from debriefs

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the content noting that challenges are being addressed.

7.2 Clinical Board update (Learning Disabilities Services)

Mr Lerpiniere provided a brief overview of the content of the report. He gave an updated on out of area placements, staff sickness issues and recruitment.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that processes are in place to support any challenges presented.

7.3 Clinical Board update (Acute Services)

Mrs Dickson and Mr Clinkscale provided a brief overview of the content of the report. Pressures continue across the Acute Services with performance against national targets remaining a concern. Workforce is still a challenge, support from the Military has been extended for a further four weeks. Recruitment and sickness absence also remain a concern.

Discussion followed regarding other pressures within the service including significant waiting periods, ambulance waits and stroke services. It is hoped that additional stroke Consultant and increase in senior Emergency Department Capacity will help. Orthopaedics outpatient department will remain as a surge area for the Emergency Department over the winter period.

Dr McCallum asked for assurance that the recently cancelled Clinical Governance meetings will be reinstated as it is important that this focus remains. There is also concern about capacity of clinical staff to take part in Significant Adverse Events Reviews, some suggestions have been put forward and it is hope that these will help. Mr Clinkscale commented that discussions are taking place regarding freeing

up capacity to cover significant event reviews and how we can now increase elective outpatient and surgical activity. The Committee noted that remobilisation of surgical activity is of greatest concern.

The Committee asked what support they would receive from Centre for Sustainable Delivery. Mr Clinkscale gave a brief update on what shape this support might take. Dr McCallum commented that this report would be welcomed. Further discussion took place regarding trajectories for remobilisation and how the access team can work with Centre for Sustainable Delivery and in particular meeting four hour target. Mr Roberts commented that it is important to also get reassurance that we are doing as much as we physically can at present and work towards addressing challenges is progressing.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured processes are in place but await further updates for full assurance on outcomes.

7.4 Clinical Board update (Primary & Community Services)

Mrs Flower provided a brief overview of the content of the report. Concerns remain regarding risks relating to lack of medical cover in Community Hospitals although this is currently being addressed. Other challenges are not dissimilar to the other boards.

Mrs Flower noted that the previous moratoriums on Care Homes have been lifted. Care Home resilience still causing concern but significant collaborative working continues to assist with this issue. Care Home support visits have been restarted.

Ms Lam enquired about GP not being able to support ANP training has physicians associate been explored as an alternative. Mrs Flower reports that this has been explored.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that processes are in place.

8 Assurance

8.1 Nursing Appraisal and Revalidation Position 20/21

Mrs Smith provided a brief overview of the content of the report. She cited difficulties in particular with student placement during pandemic.

Mrs Campbell enquired about funding for Advanced Nurse Practitioners. The target from the Scottish Government to fund Advance Nurse Practitioners has been achieved there funding has stopped. Mrs Smith comments that Advanced Practice Steering Group is looking at different ways to fund these posts and clinical nurse specialists going forward.

Discussion took place regarding student experience and how we work collaboratively with university to provide the best experience. There are several opportunities for students to feedback on their experiences.

Funding for Non medical prescribing will need to be provided by each board. Mrs Horan is looking at how the education fund can be used equitably across the organisation.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured on

the content of the report

9 Items for Noting

Items presented for noting were acknowledged by the Committee.

10 Any Other Business

Mrs Horan commented that Mrs Smith is retiring in December, the Committee thanked her for her support and wished her well. Mrs Horan thanked her personally for all her invaluable support. She also noted that the Mrs Smith's post has been successfully recruited to.

Meeting dates for 2022/23 were noted for information.

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 19 January 2022 at 10am via Teams Call.

The meeting concluded at 12:20

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Quality and Clinical Governance Report – January 2022**
Responsible Executive/Non-Executive:	**Lynn McCallum, Medical Director**
Report Author:	**Laura Jones, Head of Quality and Clinical Governance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to:

- Clinical governance

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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:

1. Clinical pressures
2. COVID 19 deaths
3. Patient experience

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

2.2 Background

Clinical Pressures
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 staffing challenges, due to absence and vacancies, and by the ongoing COVID 19 demand.

In order to meet the current demands on health services a clinical prioritisation process has continued across clinical boards. Through this process several services providing routine or non-urgent care have been stepped back to release workforce capacity to support urgent and emergency care. This has been a challenging piece of work given the pressures this will present to long term service provision and the complexity of moving staff to new environments but has been strongly supported by colleagues from across services with a focus on maintaining patient safety in areas of most urgent need. The response from staff across health and social care has been exceptional. Staff wellbeing remains an area of concern as NHS Borders continues to operate under this heightened level of demand and workforce pressure.

The Board Clinical Governance Committee met in January 2022 and discussed papers from all three clinical boards. Each clinical board raised themes around:

- increased staff absence due to COVID 19
- increasing numbers of delayed discharges and the strain this was placing on access to hospital beds across the system
- access to specialist beds for a number of complex patients awaiting Borders Specialist Dementia Unit (BSDU) or specialist placements in care homes
- access to specialist beds regionally/nationally for complex mental health and learning disability patients
- reductions in available care and nursing home beds as a result of availability of workforce, COVID 19 outbreaks or temporary closures

Whilst the Board Clinical Governance Committee continue to have close scrutiny of clinical pressures it was a recommendation from the January 2022 meeting that the public Board continue to receive a summary of the clinical pressures and the ongoing strain on staffing and resources.

2.3 Assessment

CLINICAL EFFECTIVENESS

Mental Health
Mental health inpatient wards have continued to function, broadly, as normal throughout the pandemic. While there has been no identified COVID 19 ward, each ward has a standard operating procedure for the management of suspected or confirmed cases of COVID-19 and all inpatients have individual rooms. The wards have noted periods of escalated acuity and situational crises, these have been particularly noticeable following periods of lockdown, and this has led to continuous pressure for most of the year. Additional staffing was recruited for a 12 month period to allow greater flexibility.

Huntlyburn is the only General Adult Psychiatry ward, and is also used as a "place of safety" (as designated under Mental Health legislation) in clinical circumstances where

it is required. As can happen, throughout 2021 the ward has had people admitted to "a place of safety", irrespective of the fact that these patients did not fit the criteria of the ward. To maintain safety at times when the service was under the greatest pressure Huntlyburn needed additional staffing due the frequency of incidents and staff were redeployed from the community teams for a short period with unquestionable consequences for the community teams. Throughout this time "Improved Observational Practice" was applied as a model.

In Mental Health there is a focus on ensuring flow within the unit given the small bed base and the fact that there are no surge beds for acute mental health patients within NHS Borders. Occupancy levels are monitored daily to ensure timely discharges. Contingency arrangements come into place when the unit reaches 16 inpatients as maximum capacity is 19. The contingency plans include, consultant review of all patients, use of crisis team to support at home and consideration of suitable transfers to the rehabilitation unit if safe to do so. Transfer between units is, as would be expected, closely monitored due to infection control and all testing and isolation protocol are followed.

In the last year the options to manage delayed discharges from the BSDU have been severely curtailed. During 2020 the throughput and turnover had notably improved, but this has not been sustained. The factors leading to this are complex and not all within the control of the service. The access to beds in residential and nursing homes is at a premium and access to specialist provision required for patient with advanced dementia is even more of a rarity. The unit maintains scrutiny and reporting but pressure is such that patients who would ideally be assessed in BSDU are, at times, being admitted to the acute hospital, and BSDU, a unit resourced for 12 patients has recently opened a 13th bed. This has been placed on the risk register as "high risk and there is active consideration of alternative options as part of a longer-term plan.

In adult psychiatry crisis management has returned to normal business in-hours and out of hours however following the COVID19 first wave there has a threefold increase in contacts and referrals.

The Mental Health Crisis Team/Liaison Team continues to work closely with Acute services, the Borders Emergency Care Service and the Distressed Brief Intervention service to manage unscheduled Mental Health presentations at the BGH.

Acute Services

Acute services continue to experience significant staffing challenges at the same time as increased need for both unscheduled and COVID 19 inpatient beds. There has been a significant increase in staff absence as a result of COVID 19. This comes on top of what was already a higher than average sickness level within ward areas and a reduced registered nurse establishment resulting from vacancies and an inability to recruit.

Skill mix has been adjusted to provide wards with additional support in the short term. Risk assessments have been carried out in conjunction with Clinical Nurse Managers (CNMs) and Senior Charge Nurses (SCNs) for each of the affected areas. The Human Resources (HR) department will be supporting the management of sickness absence within several ward areas for a period of three months, recognising that SCN’s are primarily working clinically. They will work closely with the ward SCN’s and look to tailor the support as much as possible to specific areas.

Staffs from non-ward areas and from across clinical boards and corporate services have been redeployed to help support the opening of additional COVID beds in COVID 2 and COVID 3; and to support pressures being experienced through heightened sickness absence across all services.

Routine elective surgery has been suspended in early January to help support the staffing challenges with cancer surgery continuing through wards 7 and 9.

There continues to be a high number of patients requiring 1:1 supervision which further increases the need for additional Healthcare Support Workers (HCSWs) through the nurse bank system. The fill rate for shifts recently has sat at around 39% through the regional nurse bank making it difficult to cover all shifts and mitigate the risks associated with this patient group.

On-going recruitment continues looking at all options including the employment of six international Registered Nurses with the aim of postholders being in place by 31 March 2022.

There continues to be a high level of delayed discharges within acute beds as a result of the pressures across health and social care services. This in addition to the need for additional COVID 19 beds is having a significant impact on patients waiting for admission to hospital. These waits are being experiencing by patients:

- within the emergency department whilst awaiting admission for unscheduled care
- within the hospital whilst waiting on access to specialist beds such as the stroke unit
- awaiting admission for elective surgery

A new pathways coordination team has been established in the BGH which will coordinate discharges to all intermediate care, community hospitals and care settings through the borders.

There have also been additional beds provisioned in Upper Deanfield in Hawick which are able to be utilised for patients on an interim basis while they await their package of care. All transitional care beds within Garden View are being utilised and are full with a waiting list. The BGH continues to discharge appropriate patients to the four community hospitals.

Primary and Community Services

Primary and Community Services are experiencing the same pressures relating to staff absence and have like other clinical boards followed the clinical prioritisation approach to ensure services are covered based on most urgent need.

All four community hospitals have a significant number of delayed patients. This is due to waits for packages of care and placements. All patients are being reviewed under the delayed discharge group.

There has been a noted rise in the number of acutely confused patients with dementia and/or previous brain injury in community hospitals which has resulted in a noticeable increase of adverse events related to violence and aggression. The staff continue to

manage this with support from other specialist services whilst patients await beds in BDSU or specialist beds within care homes.

The oversight of Care Homes remains in place with a daily review of the data dashboard identifying if there are any concerns around Infection Prevention and Control (IPC), Personal Protective Equipment (PPE), staffing levels and potential outbreaks. This report is shared with the strategic group on a daily basis. The Care inspectorate and infection control continue to carry out visits to care homes to ensure infection control practice is being maintained and addressed where required.

The number of care homes beds within the Borders has declined in the last three months as a result of moratoriums, lack of staff and care home temporary closure to admissions due to outbreaks. In addition, there has been an impact on the number of available nursing beds as a result of the care homes being unable to recruit registered nurses into their organisation. One care home with nursing beds has now submitted notice that they will be moving from 'nursing' to residential care only.

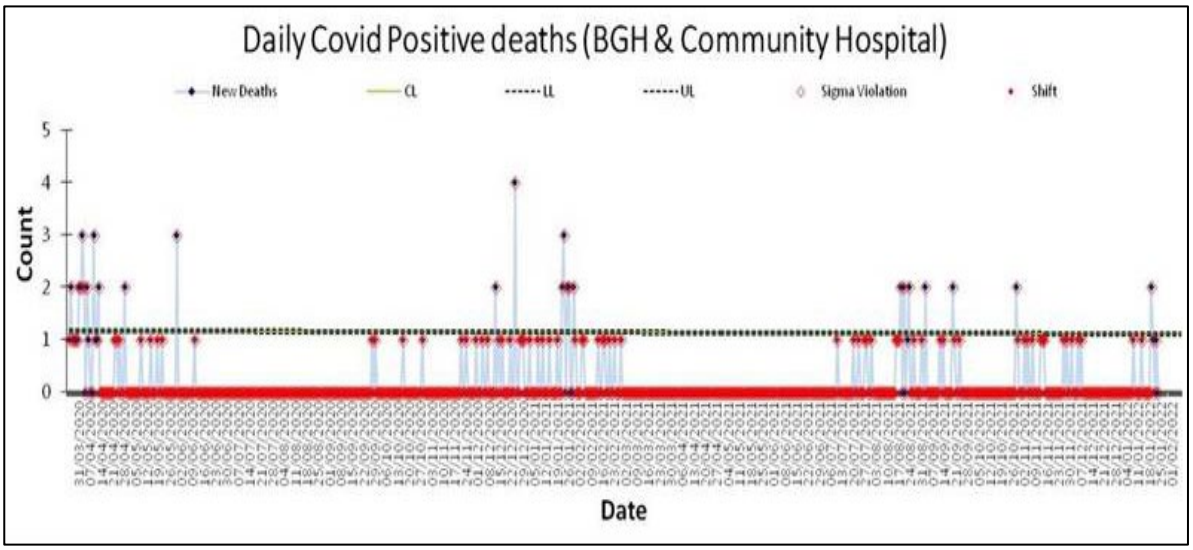
The prioritisation of services during this period of heightened demand and workforce pressure is introducing delays for routine and non-urgent care in particular outpatient pathways for Allied Health Professionals and Dental Services.

The Public Dental Service (PDS) remains under significant pressure due to heightened staff sickness. Priority resources have been diverted to support telephone triage and patient support.

PATIENT SAFETY

COVID 19 Deaths

Graph 1 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 23 January 2022:



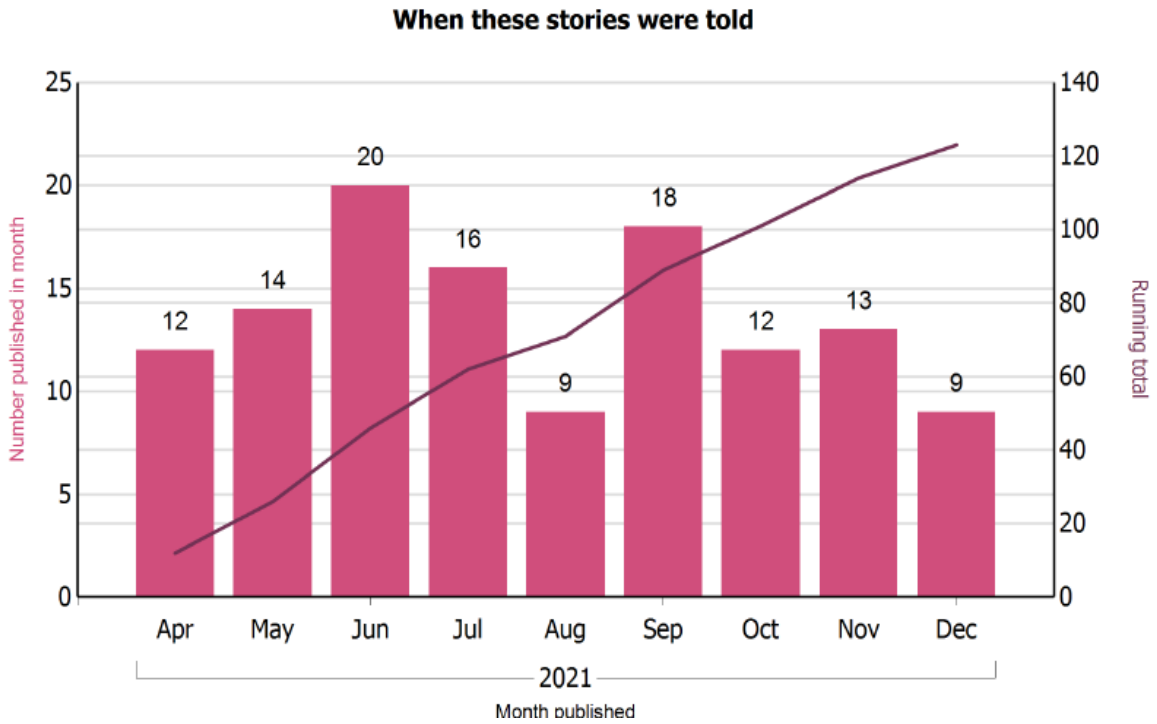
COVID 19 deaths between March 2020 and June 2021 occurring in a hospital within 30 days of admission have been reviewed for learning to inform the local delivery of care. In addition, the core mortality review programme has continued to review 20% of non-COVID 19 deaths in hospital within 30 days of admission. The collated summary of reviews for 2020/21 was presented to the Board Clinical Governance Committee in November 2021.

The mortality review team continue to review all COVID 19 deaths and are currently working on the review of deaths between July 2021 and January 2022. After this wave a decision will be taken as to best approach for the review of COVID 19 deaths moving forward with a recommendation for consideration by the Board Clinical Governance Committee.

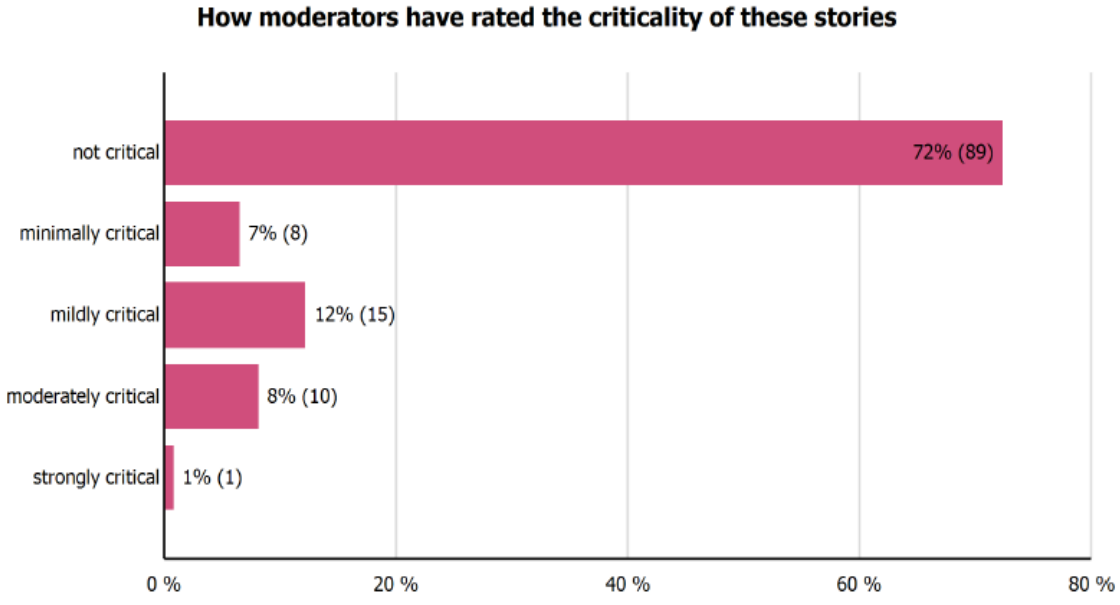
PATIENT EXPERIENCE

Care Opinion

For the period 1 April 2021 to 31 December 2021 123 new stories were posted about NHS Borders on Care Opinion. Graph 2 below shows the number of stories told in that period, as at 21 January 2022 these 123 stories had been viewed 19,268 times:



Graph 3 provides a description of the criticality of the 123 stories:



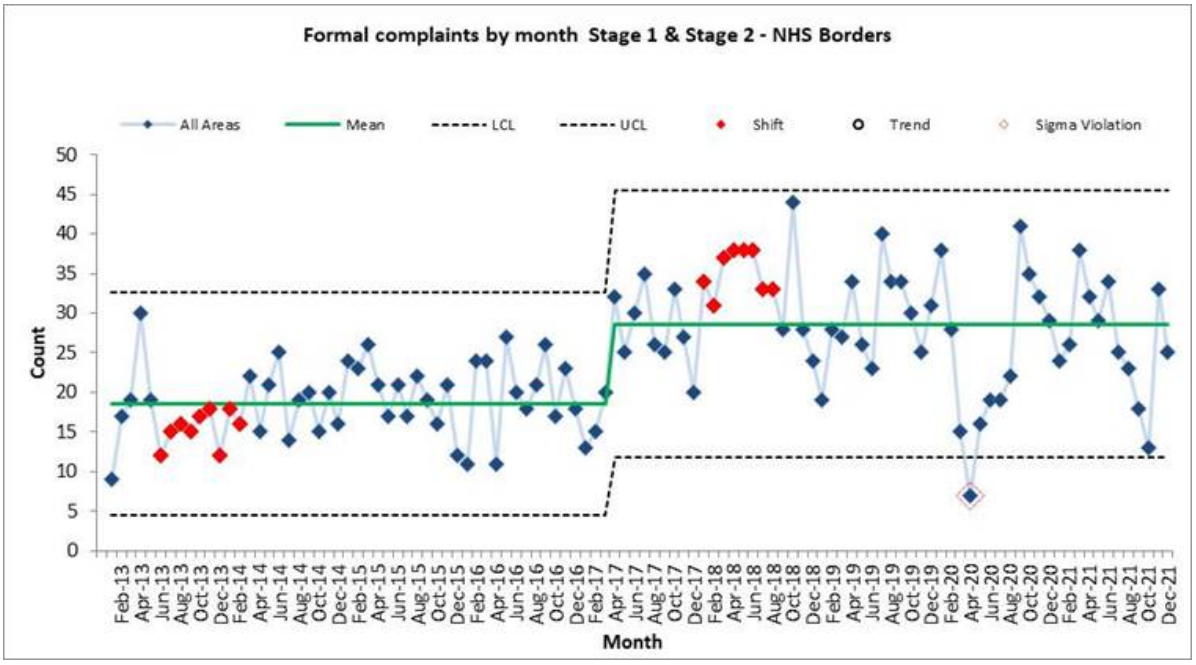
The word clouds below summarise what people felt was good and what could be improved in their posts about NHS Borders for this period:

What was good?

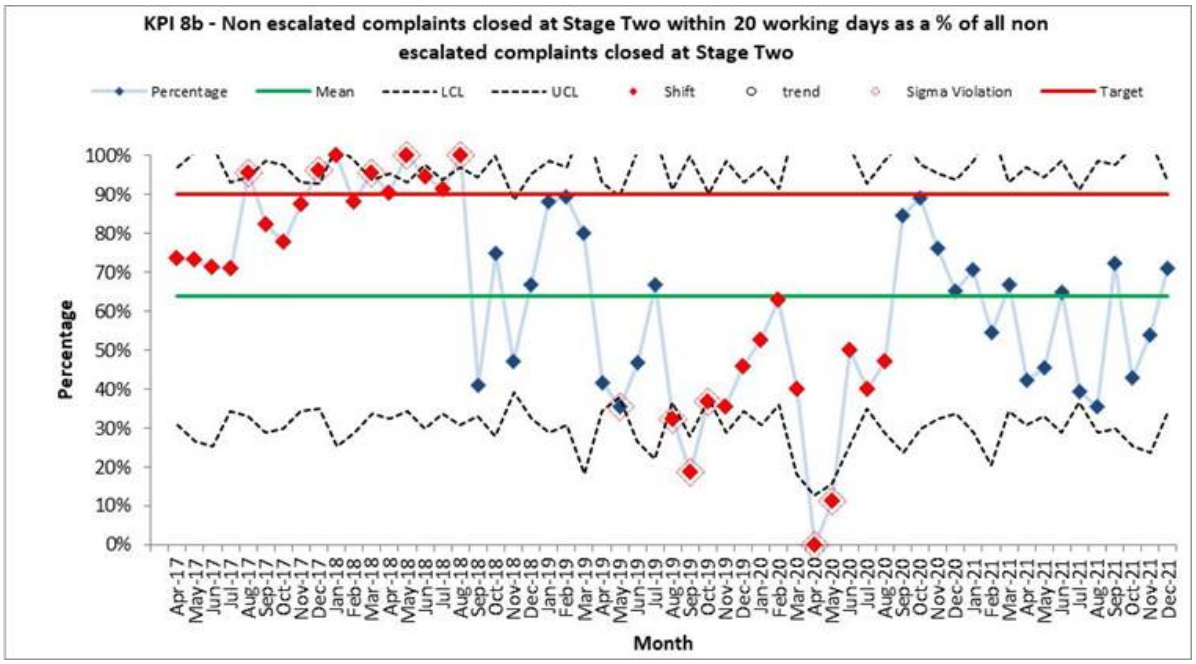
What could be improved?

Complaints

Graph 4 below gives the number of formal complaints received by month. The number of complaints being received remains within normal limits:



Graph 5 below shows the percentage of complaints responded to within 20 working days. As front line services continue to prioritise the 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 winter period:

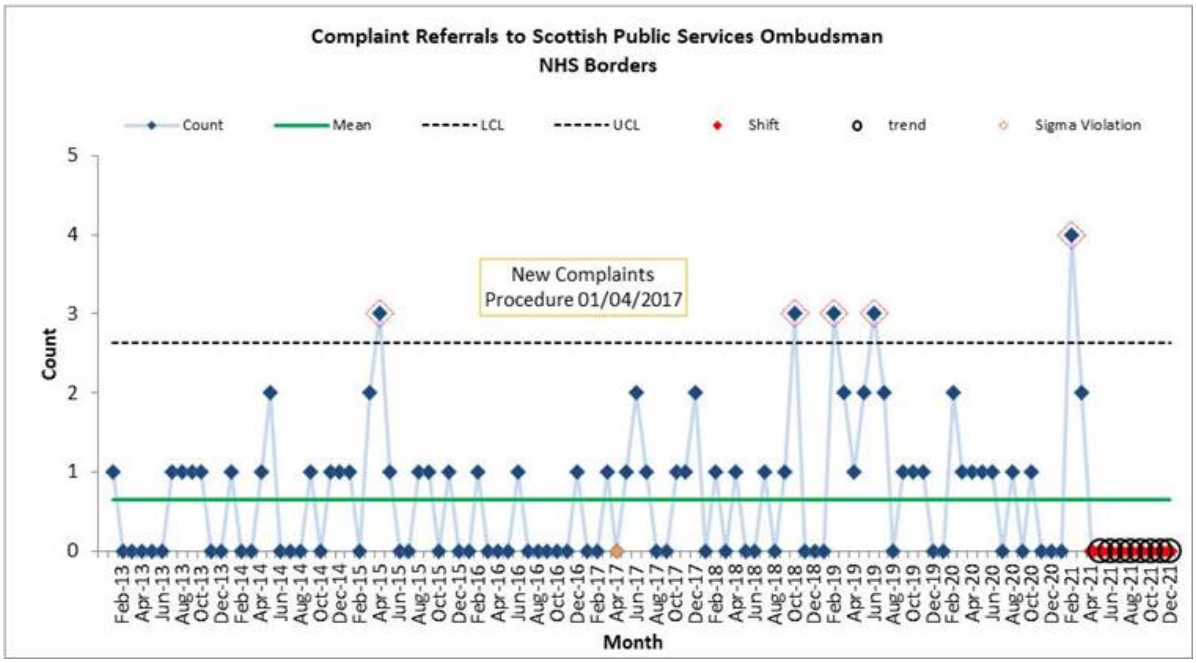


Scottish Public services Ombudsman (SPSO)

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.

Graph 6 below shows complaint referrals to the SPSO to 31 December 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 9 initial enquiries from the SPSO. Of these 9 cases, the SPSO have decided they will not investigate 5 cases and a decision is awaited on the remaining 4 cases:



2.3.1 Quality/ Patient Care

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 non-urgent and routine care. This prioritisation has necessitated the step down of services resulting in increased patient waits and a backlog of demand.

2.3.2 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. Staff have been required to support the ongoing extreme service demand many moving to support services out with their own team or clinical board. There has been an outstanding response from staff in this respect but many staff are exhausted and wellbeing remains an area of constant focus and concern whilst we continue to operate at this level of response.

2.3.3 Financial

Service and activities are being provided within agreed resources and staffing parameters with additional COVID 19 resources being deployed to support the pandemic response. As outlined in the report the requirement to step down services to prioritise urgent and emergency care has introduced waiting times within a range of services which will require a recovery plan during remobilisation.

2.3.4 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the need to adjust services as part of the heightened pandemic response.

2.3.5 Equality and Diversity, including health inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report. A wide range of patient groups will be affected by the delays in service provision outlined in the paper which will require individual consideration within each service during this period and remobilisation.

2.3.6 Other impacts

No additional points to note.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

The contents of this report have previously been considered by The content of this paper is reported to Clinical Board Clinical Governance Groups, the Pandemic Committee and Board Clinical Governance Committee within a selection of papers received throughout the months of December 2021 and January 2022.

2.4 Recommendation

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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Infection Prevention and Control Report – December 2021**
Responsible Executive/Non-Executive:	**Sarah Horan, Executive Director of Nursing, Midwifery and Allied Health Professionals**
Report Author:	**Natalie Mallin, HAI Surveillance Lead** **Sam Whiting, Infection Control Manager**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Government policy/directive

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

- Safe

2 Report summary

2.1 Situation

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

2.2 Background

The format of this report is in accordance with Scottish Government requirements for reporting HAI to NHS Boards.

2.3 Assessment

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

1.1 NHS Borders had a total of 27 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2021 and November 2021, 16 of which were healthcare associated infections.

1.1a 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).

1.1b 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 on target to achieve this.

1.2 NHS Borders had a total of 10 *C. difficile* Infection (CDI) cases between April 2021 and November 2021; 6 of these cases 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 CDI rate per 100,000 total occupied bed days (TOBDs) by 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 9 healthcare associated CDI cases per financial year. We are currently on target to achieve this.

1.3 NHS Borders had a total of 76 *E. coli* Bacteraemia (ECB) cases between April and November 2021, 40 of which were healthcare associated.

1.3a 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.

1.3b 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 November 2021, there have been 26 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.

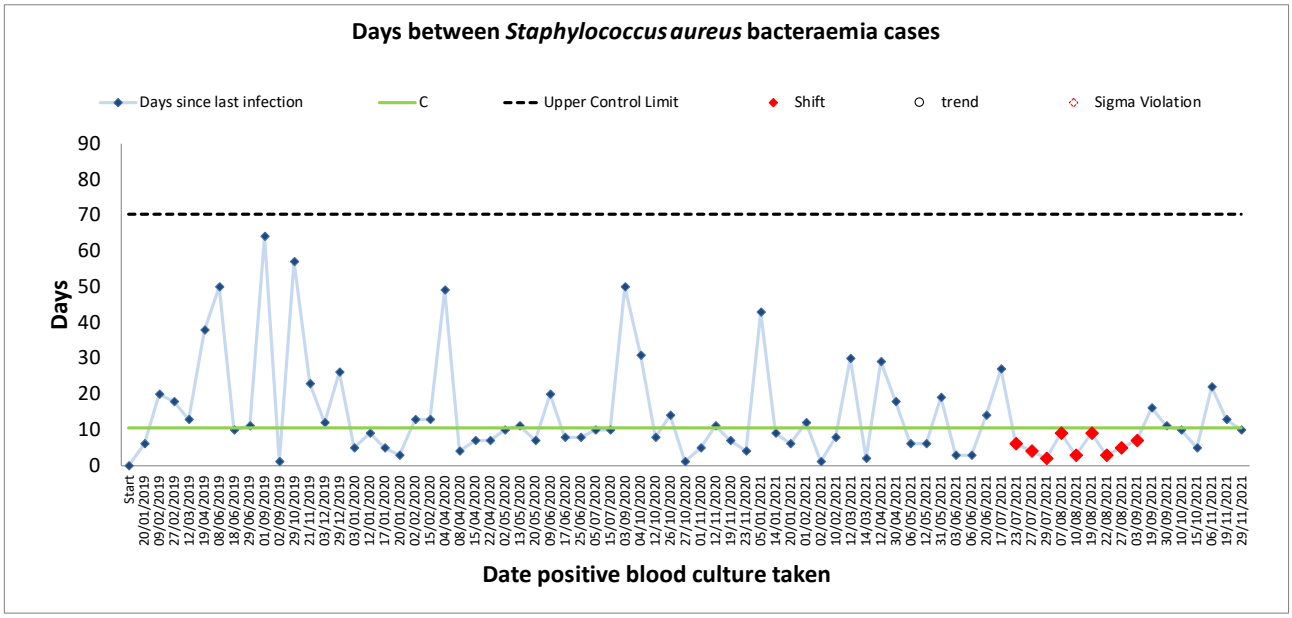


Figure1: NHS Borders days between SAB cases (January 2019–November 2021)

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.

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 2 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.

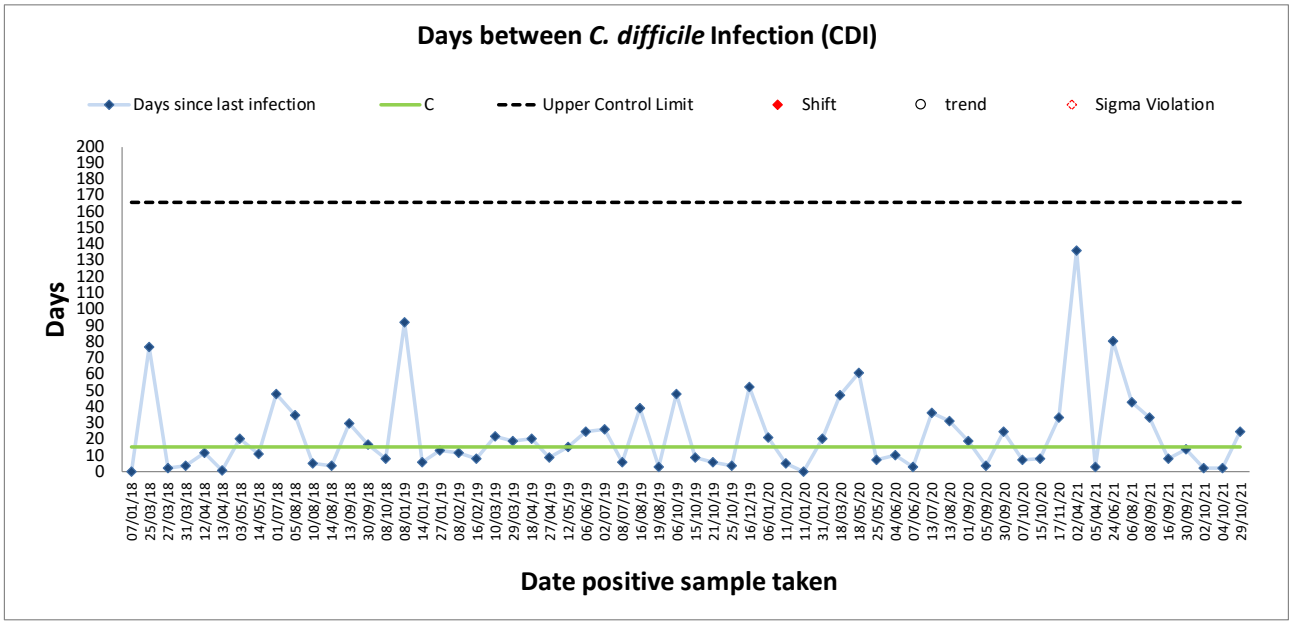


Figure 2: NHS Borders days between CDI cases (Jan 2018 – November 2021)

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) as shown in Figure 3 below. Whilst the Prevention of CAUTI group is scheduled to meet every 6 weeks to progress actions to reduce the associated risks, wider system pressures including the recent increase in COVID-19 cases has impacted on progress of this Group.

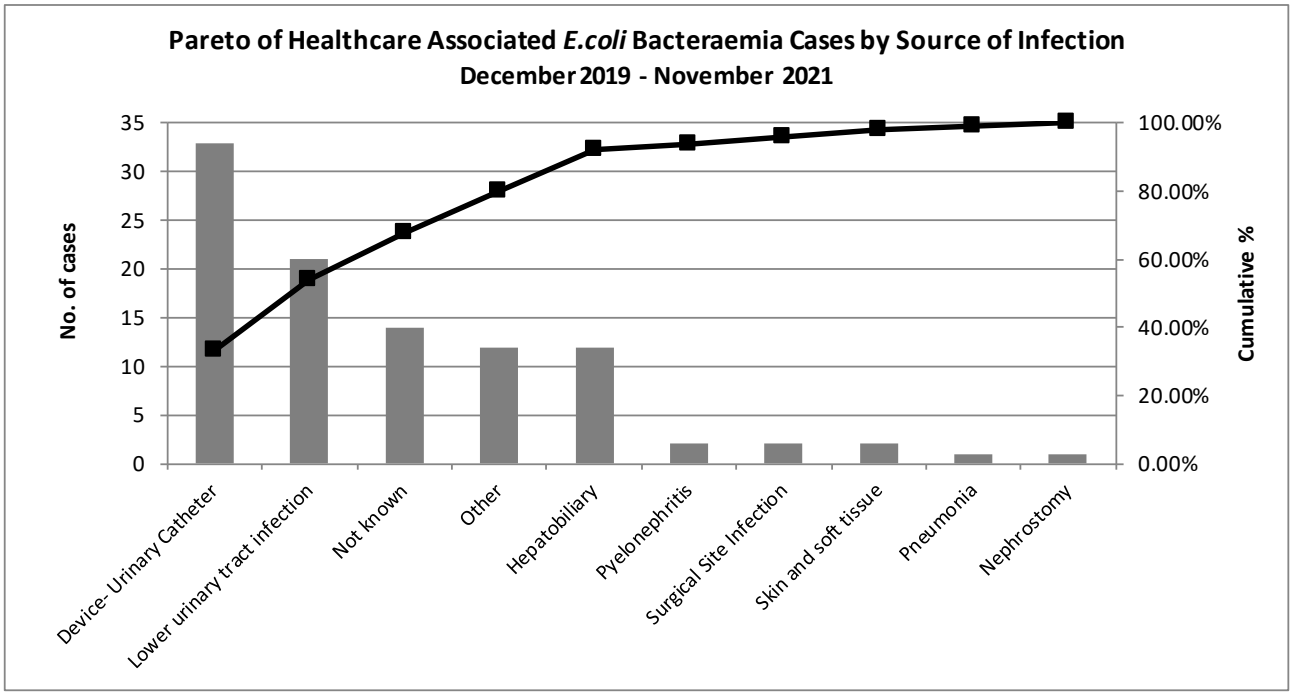


Figure 3: Pareto chart of healthcare associated ECB cases by source of infection

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 representative has been employed by GoJo and visited NHS Borders on the 31st August to recommence independent hand hygiene audits across an initial 5 areas. The representative is scheduled to return to BGH late January 2022.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 IPCT capacity increased in September 2021 with an infection control nurse returning to work from maternity leave. This has enabled the IPCT to resume some spot checking activity. In November, spot checks were undertaken in a total of 12 clinical areas across NHS Borders with an average compliance of 82%. In December, the average compliance across 12 clinical areas was 89%. Nine of the areas checked in December were different locations from the areas checked in November.

7.2 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.

9.0 2021/22 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 05/01/2022, 60% of actions due for completion have been completed with 16 actions outstanding. While these actions remain outstanding work towards some of 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 Between 18th October 2021 and 21st December 2021, there were 4 COVID-19 related incidents for which a Problem Assessment Group and / or Incident Management Team was convened. One of the incidents was a single COVID-19 case in a non-COVID-19 area with no further positive cases identified. A summary of COVID-19 clusters for this period is shown in Figure 4 below. Learning from each incident is captured and acted upon in real time where appropriate.

Wards affected	Total positive patients	Total positive staff	Total deaths
Ward 7	12	1	X
Borders Specialist Dementia Unit	6	2	X
Ward 4	4	0	X

Figure 4: Summary of COVID-19 clusters

10.2 ARHAI Scotland produces data on COVID-19 cases by hospital onset status using national definitions (Appendix B). NHS Borders data for week ending 17th October 2021 to week ending 19th December 2021 is displayed in Figure 5 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 17 Oct 2021 to week-ending 19 Dec 2021, when including the community onset infections, was 4,057.

	% of total	n =
Community onset	99.0%	4,018
Non-Hospital onset	0.4%	17
Indeterminate Hospital onset	0.1%	3
Probable Hospital onset	0.2%	8
Definite Hospital onset	0.3%	11
Grand Total	100.0%	4,057

Figure 5: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

10.3 NHS Borders has been working with ARHAI Scotland to undertake further analysis of the recent COVID-19 clusters and single case incidents. This analysis includes Whole Genome Sequencing (WGS) of COVID-19 positive cases from August 2021 to identify potential epidemiological links and routes of transmission of COVID-19 within the healthcare environment. The review has now concluded and feedback has confirmed nosocomial transmission and links between some of the clusters that took place during August 2021.

10.4 NHS Borders has recently been invited by ARHAI Scotland to be part of the development of a new reporting system that has the potential to identify clusters in real-time in an accessible format. Previously, the receipt of cluster investigation reports had a time delay of a number of weeks which meant that we were only able to reflect on incidents retrospectively. It is hoped that once the new reporting system has been developed, clusters could be identified more rapidly supporting improved outbreak management decision making.

11.0 Infection Prevention and Control Team Capacity

11.1 Following successful interviews, a new trainee Infection Control Nurse has been appointed and commenced on 3rd of January 2022.

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 15th December 2021, NHS Borders implemented the national winter 'respiratory' and 'non-respiratory' pathways which replaced the previous national 'red', 'amber' and 'green' COVID-19 pathways.

- The current 'Amber' pathway is similar to the 'Non-respiratory' pathway and includes elective activity.
- The current 'Red' pathway is similar to the 'Respiratory' pathway.

12.2 The current COVID screening questions for patients and service users have been expanded to include other respiratory symptoms.

12.3 The new guidance included some changes in relation to PPE with eye protection and aprons only required on the respiratory pathway when delivering direct care. Following recommendation from the PPE Committee, Gold Command approved the continuation of existing PPE guidance to avoid confusion for staff. This requires staff to wear eye protection and aprons within 2 metres of a patient on the respiratory pathway.

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:

Clostridioidesdifficile :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

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
MRSA	0	0	0	0	0	1	0	0	0	0	0
MSSA	4	3	2	2	3	3	5	5	3	2	3
Total SABS	4	3	2	2	3	4	5	5	3	2	3

Clostridioides difficile infection monthly case numbers

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Ages 15-64	0	0	0	0	0	1	0	0	0	1	0
Ages 65 plus	0	0	0	2	0	0	0	1	3	2	0
Ages 15 plus	0	0	0	2	0	1	0	1	3	3	0

Hand Hygiene Monitoring Compliance (%)

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
AHP	100.0	98.0	98.8	98.8	97.8	96.4	97.8	98.2	94.2	91.5	99.3
Ancillary	94.9	96.7	99.3	92.6	100	98.8	95.2	97.5	92.2	97.8	90.0
Medical	92.3	95.0	97.0	92.4	96.3	96.2	94.3	98.8	96.2	97.7	94.4
Nurse	99.6	98.5	97.7	99.3	98.8	97.3	97.6	97.6	97.9	98.0	97.0
Board Total	**96.7**	**97.1**	**98.2**	**95.8**	**98.2**	**97.2**	**96.2**	**97.7**	**95.1**	**96.2**	**95.2**

*Self audit hygiene data reporting paused due to prioritisation of COVID-19 related work

Cleaning Compliance (%)

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Board Total	97.4	95.3	95.4	95.1	95.3	95.5	96.0	95.7	93.9	95.8	96.8

Estates Monitoring Compliance (%)

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Board Total	98.2	99.6	98.1	98.7	97.1	97.6	97.2	97.3	98.1	98.7	98.7

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	2	2	2	1	0	1	2	2	0	0	0
Total SABS	2	2	2	1	0	1	2	2	0	0	0

Clostridioides difficile infection monthly case numbers

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	2	0	0	0	0	0	1	0
Ages 15 plus	0	0	0	2	0	0	0	0	0	1	0

Cleaning Compliance (%)

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Board Total	96.5	96.0	96.7	97.3	93.6	95.3	96.1	95.5	95.6	96.6	95.3

Estates Monitoring Compliance (%)

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Board Total	99.1	98.8	99.1	98.5	93.1	95.5	95.0	95.7	95.5	97.4	97.7

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

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0

Clostridioides difficile infection monthly case numbers

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 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

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
MRSA	0	0	0	0	0	1	0	0	0	0	0
MSSA	2	1	0	1	3	2	3	3	3	2	3
Total SABS	2	1	0	1	3	3	3	3	3	2	3

Clostridioides difficile infection monthly case numbers

	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021
Ages 15-64	0	0	0	0	0	1	0	0	0	1	0
Ages 65 plus	0	0	0	0	0	0	0	1	3	1	0
Ages 15 plus	0	0	0	0	0	1	0	1	3	2	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

This is an update paper so a full impact assessment is not required.

2.3.6 Other impacts

None identified

2.3.7 Communication, involvement, engagement and 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.

2.3.8 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the Clinical Governance Committee.

2.4 Recommendation

Board members are asked to:-

Discussion – Examine and consider the implications of the content of this paper.

3 List of appendices

The following appendices are included with this report:

- Appendix A, Definitions and Supplementary Information
- Appendix B, ARHAI Scotland COVID-19 Hospital Onset Definitions

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 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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Care of Older People in Hospitals Update**
Responsible Executive/Non-Executive:	**Sarah Horan/Peter Lerpiniere**
Report Author:	**Peter Lerpiniere Associate Director of Nursing for Mental Health, Learning Disability and Older People.**

1 Purpose

This is presented to the Board for:

- Discussion

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to brief the Board on activity relating to the Care of Older People in Hospital standards and to assure the board that activity to maintain and improve practice against the standards has continued prior to the pandemic and during the current exceptional circumstance.

2.2 Background

NHS Borders is committed to the delivery of safe, quality, affordable services which demand focus on maintaining a high quality of clinical care, the Healthcare Improvement Scotland Care of Older People in Hospital Standards (2015) are, in many areas, the

clinical and care standards to which we are held.

2.3 Assessment

The Covid-19 pandemic has remained a dominant influence on both community and hospital care throughout 2021. Inevitably this has impacted on service delivery. However NHS Borders can take justifiable pride in not only the way staff have responded to the rising and falling demands of the global pandemic but also in continuing to strive for a high standard in all areas of practice.

2.3.1 Quality/ Patient Care

Throughout the paper, attached as (Appendix 1) there are areas where the challenges within the current climate and the determination to make progress can be seen as Evidence of that aspiration in the last year can be seen in:
· The efforts made to overcome the inherent barrier that a high standard of PPE puts in the way of person-centred communication. This involves time spent with people giving comfort and reassurance.
· The person-centred assessment and SMART goals developed following AHP assessment to promote rehabilitation.
· The introduction of the Discharge Pathway and co-ordination team to promote effective and efficient discharge planning across the system. The majority of our in-patient beds are occupied by older people, this paper outlines areas of practice and areas in-development relating to the Care of Older People in Hospital Standards 2015 and seeks to assure the board that work in relation to the Older People's Pathway continues to ensure standards are maintained and quality is improved

2.3.2 Workforce

The workforce, when benchmarked against these standards in the current climate, can feel under pressure as staffing levels have been stretched to breaking point during the most demanding points of the pandemic.

2.3.3 Financial

The financial impact is addressed within the individual planning for pieces of work referred to within the paper.

2.3.4 Risk Assessment/Management

Individual projects evaluate risk thresholds in relation to their own sphere of influence and mitigate/manage accordingly.

2.3.5 Equality and Diversity, including health inequalities

The Care of Older People in Hospital standards reflect the delivery of an equitable application of care standards irrespective of protected characteristics.
Ensuring that the age of a person is not the determining factor in their care in our hospitals is their defining aspiration.

2.3.6 Other impacts

Other impacts are reflected throughout the paper.

2.3.7 Communication, involvement, engagement and consultation

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

State how his has been carried out and note any meetings that have taken place.

The COPH Group has had a public member throughout its incarnation. Unfortunately the public member retired during the 2021, and as the group has been stood down during the pandemic the member has yet to be replaced.

2.3.8 Route to the Meeting

This report has been prepared with the support of a range of clinicians and managers to reflect the work of across innumerable areas of clinical practice and all boards.
In the current climate this has predominantly been done virtually and via email.

The report has been approved via the Director of Nursing.

2.4 Recommendation

Discussion – Examine and consider the implications of a matter

3 List of appendices

The following appendices are included with this report:

- Appendix No 1: Care of Older People in Hospital Standards Board update

Care of Older People in Hospital Standards Board update

November 2021

Peter Lerpiniere

Associate Director of Nursing for

Mental Health, Learning Disability and Older People

Standard 1: Involving older people: "What and who matters to me"		
Older people in hospital have the opportunity and are enabled to discuss their needs and preferences, including the people they wish to be involved in their care.		
Criteria	Areas of Strength	Areas in Development
1.1: Throughout their journey, older people in hospital have the opportunity: a) to say what and who matters to them. b) are supported to ensure this is achieved, and c) have this regularly reviewed. 1.2: Older people in hospital are assessed to ensure their communication and sensory needs are met. 1.3: The patient's representative is involved where the patient has difficulties in communicating what and who matters to them. 1.4: Information about what and who matters to the patient is used in all care and treatment plans, provides the basis for shared decision-making, and: a) informs the setting and reviewing of personal goals and outcomes b) is regularly reviewed by the multidisciplinary team, and c) informs handovers, care transitions and discharge planning.	• The Adult Unitary Patient Record (AUPR), is now on version 21, most recent update is from June 2021  2021_06_16 Adult Multidisciplinary Asse Within the AUPR work continues to promote using care planning across all disciplines as standard. This follows a modifed Activities of Daily Living model (Roper, Logan & Tierney) • Throughout the first wave of Covid 19 the AUPR had to be slimmed down to allow for potentially faster admission and response. We have moved back to the previous documentation taking the learning from that experience into further iterations. • Patient Passports for people with learning disability routinely accompany every patient with a learning disability on every admission. • AUPR includes communication deficits and aids in assessment and incorporates carers views. This is identified at the admitting ward, and is re-assessed on arrival(or as soon as possible after) to Department of Medicine for the Elderly (DME) ward to ensure that the initial assessment was correct. • Fundamentals of Care Audit Tool is used to monitor: ○ how patients are being spoken to ○ how they are supported ○ how they feel ○ Are they included in decisions about their care. Any actions required are entered into an action plan to be completed. • Ward Quality audits continue to be carried out by Clinical Governance team – recognizing the challenges to all currently – with the number of records tailored to each unit. Audits include completion and monitoring of "What Matters To You?" • Getting To Know Me is completed for all people diagnosed with dementia through MHOAS as part of Post Diagnostic Support. • Getting To Know Me offered to family members to	• The AUPR is an iterative document. It will continue to require updating to reflect the changing care environment – as was evidenced during Covid19. does not currently record who the patient has consented to have involved in discussions about their care. • Getting To Know Me although completed as part of post diagnostic support and intended to be brought with patient when admitted to hospital does not come with the patient often enough when they come into hospital from home. • OPLS have access to EMIS to gain GTKM developed during PDS to support person centred care during admission and should be used to support care planning. • Family engagement remains variable and has been limited due to reduced visiting during pandemic although remains under regular review • Harm reduction "rounds" – weekly meetings with ADoN to monitor completion.

	complete with patients in hospital where cognitively impaired. • Under normal circumstances our hospitals have open and accessible visiting arrangements But we are currently following guidance on visiting during Covid19 as directed by Scottish Government. • Part of that process is for the patient to identify their designated visitor and we work with that person to support care during that person's stay in hospital. • Rehabilitation plans are patient centered and for safe and effective care - "What Matters to Me". • In Community Hospitals, following on from MDT, the patient and/or carer is informed of the meeting outcomes and engaged in discussion of rehabilitation goals, care plan and discharge plans. • NHS Borders has a translation services webpage. http://intranet/microsites/index.asp?siteid=92&uid=39 • NHS Borders has a webpage devoted to leaflets available in different languages and a link to wider services through NHS Scotland. http://intranet/microsites/index.asp?siteid=92&uid=41 • Information about what and who matters to the patient is discussed at length each week at the MDT. • Staff are being encouraged to implement the ReSPECT forms for patients to support discussions about the type of care people want.	

Standard 2: Maintaining patient dignity and privacy		
Older people in hospital will be treated with dignity and privacy, particularly during communication, physical examination and activities of daily living.		
Criteria	Areas of Strength	Areas in Development

2.1 A patient's preferences around dignity and privacy during sensitive conversations and activities of their daily living are sought, documented, actioned and shared with the multidisciplinary team, as required.
 	
2.2 Staff are competent in providing and supporting effective communication, and demonstrate a dignified person-centred approach.
	• As cited in Standard 1 the service Fundamentals of Care Audit Tool monitors:
	  ○ What Matters to me audits.
	  ○ Is this supported by observation of practice?
	  ○ Is this supported by what is heard?
	• NHS Borders Complaints Handling Procedure reflects NHS Borders' commitment to welcoming all forms of feedback, including complaints. http://intranet/resource.asp?uid=31213
	• NHS Borders welcomes feedback through Care Opinion.
	• Where required people with dementia/learning disability coming in to hospital for planned admission (e.g. Surgery/Day Case surgery) adaptations are made as required for person-centred approach.
	• NHS Borders has in-place a Chaperone Policy. http://intranet/resource.asp?uid=32124
	• Wards are considerate in prioritizing single rooms for end of life care.
	• The communication workstream in Back To Basics – Forward to Excellence programme continues to focus on the importance of making people feel welcome.
		• There is one toilet and/or shower in the bay, so patient's personal care activities are regularly carried out at their bedside.
		• Wards private sitting areas are limited which does not always support dignity and privacy during sensitive conversations however ward 14 are trialling access to small quiet room where more sensitive conversations can take place or simply a very quiet area where people can be afforded a little peace.
		• The Community Hospitals have no "relatives rooms, but, efforts are made to ensure privacy at such times which may include difficult conversation taking place in the office.
		• Personal Protective Communication (PPE) often acts as a barrier to person-centred communication as experienced by the patient. Staff work tirelessly and consciously to overcome that physical barrier using their emotional intelligence. (This is hard to quantify and measure but is good practice being undertaken across the board).

Standard 3: Decision-making, consent and capacity		
Older people in hospital are involved in decisions about their care and treatment.		
Criteria	Areas of Strength	Areas in Development
3.1 Patients will not be excluded from services, treatment or care on the basis of age. 3.2 Patients will not be excluded from services, treatment or care on the grounds of cognitive impairment. 3.3 Patients (and/or representatives) are involved in all discussions and decision-making relating to their care and treatment, and healthcare records clearly document: a) who the patient has consented to being involved in discussions and decision-making b) who has been involved in the decision-making process c) what information has been provided to the patient (and/or representative) d) the treatment options and alternatives available to the patient, and e) the patient's decision. 3.4 The patient's capacity for decision-making relating to their care and treatment, is assessed, regularly reviewed and documented, where clinically indicated. 3.5 For patients assessed as not having capacity to make decisions, the principles of the Adults with Incapacity (Scotland) Act 2000 are applied as follows: a) patients are supported to express their opinion and make a decision as much as they are able to	• The AUPR and ReSPECT support decision making and capacity. • Latest AUPR makes more explicit who the patient has consented to being involved in discussions and decision-making including identification of Power of Attorney – this will be a change in practice which requires continuous monitoring with new iterations of the AUPR. • Referral for Extra Contractual Referral is in no way age defined. • Ready access to Consultants in Geriatric Medicine ensure patients are not excluded from services, treatment or care on the basis of age or cognitive impairment. • S47 forms are regularly reviewed and updated or discontinued appropriately. • Patients (and/or representatives) involvement in discussions and decision-making relating to care and treatment is currently recorded in the narrative of patients daily records. • Patients assessed as not having capacity to make decisions are supported to express their opinion and make a decision as much as they are able to. • Proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders. • Where patient does not have capacity to make informed decisions about their care in line with AWI, it is routine practice to engage with significant others to discuss the patient's wishes in relation to their care and record in patients notes. • Getting to Know Me:	• Specialist Nurse in Liaison Psychiatry incorporating best practice into junior doctor induction session. • Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will continue to support capacity assessment and equality of access to services for people with mental health problems. • Specialist Nurse in Liaison Psychiatry incorporating best practice into junior doctor induction session. • AWIA training has been delivered to junior doctors and ANP's as part of their induction and will be delivered upon request. • AWIA training being delivered to community hospital mental health staff. • AUPR is under new development, with AWIA assessment being made more prominent. • Second Opinion Capacity assessments are more frequently being requested, despite the RMP clearly carrying these out. Work is needed to find out why these requests are being made. • Consultant in Liaison Psychiatry proactively supporting patient decision making. • Recording of discussions with relatives is inconsistent and discussion of Power of Attorney is not robustly pursued in all areas. • Consideration for testing AWI documentation and guidance in one booklet as implemented in NHS Fife although has not commenced • MWC "Authority to discharge" report action plan under implementation and ongoing review to reflect MWC guidance in inpatient areas

b) proxy decision-makers (for example, welfare attorneys) are consulted regarding the patient's proposed care and treatment, and c) the healthcare records document capacity assessment and contain copies of a Certificate of Incapacity and Power of Attorney orders.	○ On diagnosis of dementia (as part of post-diagnostic support) the patients/carers/family are encouraged to complete Getting to Know Me and advised to bring this for all hospital visits. ○ Staff request this on admission and if the patient does not have one, they will provide the document for the patient/family/carer to complete. ○ Information from the document is used to personalise care planning and provide specific information regarding the person's wishes. • Commitment 7: in line with National recommendations NHS Borders has combined the section 47 Adults with Incapacity (Scotland) Act 2000 documentation to include a treatment plan aiding compliance in completing both. • Where guidance required on compliance with Principles of Adults With Incapacity Act wards can consult with Older Adult Psychiatric Liaison service or Consultant Nurse in Dementia.	• Patient's capacity for decision-making relating to their care and treatment is assessed, regularly reviewed and documented – "not always".(AWIA)

Standard 4: Initial assessment on admission to hospital		
Older people have an initial assessment on admission to hospital, which identifies: • their current health needs and any predisposing conditions which may heighten the risk of healthcare-associated harm • and where care and treatment can most appropriately be provided.		
Criteria	Areas of Strength	Areas in Development
4.1 The initial assessment identifies opportunities to deliver care in community settings where clinically appropriate. Care plans are developed to allow care to be transitioned to community-based teams with specialist knowledge and skills. 4.2 A multidisciplinary care plan is developed and reviewed with the patient (and/or representatives), and includes: a) results of initial and subsequent assessments, for example, comprehensive geriatric assessment, hip fracture pathways, initiation of pathways for the deteriorating patient. b) results of medicines review, including ability to self-manage medication c) planned frequency and dates for care plan reviews, and actions to be taken as part of the review. 4.3 Staff can access additional patient information, such as advanced care plans, anticipatory care plans or the key information summary, where this is available. 4.4 Assessments will be repeated during an acute episode of care when there has been a change in the health status of the patient.	• NHS Borders has ED Fractured Neck Of Femur pathway. • NHS Borders has a Fractured neck of Femur pathway. • Most recent iteration of AUPR includes a comprehensive range of nursing assessment tools to ensure accurate assessment – including the HIS frailty screening tool which highlights patient who will benefit from Comprehensive Geriatric Assessment. • We aim to achieve 100% medicine reconciliation for all patients in line with Scottish Patient Safety Programme work. This process is audited across the hospital (medical and surgical). The admission data is collected by the pharmacy team and reports to the monthly medicines reconciliation group. • There has been expansion of NHS Borders RAD Team (Rapid Assess and Discharge) work from the ”front door” of hospital, i.e. in A&E and Medical Assessment Unit. The AHP led team aims are:- ○ “Turnaround “ at front door ○ Prevent inappropriate admissions to downstream wards ○ Facilitate early discharge from assessment unit ○ Early identification of appropriate pathways and/or rehabilitation needs ○ Frailty pathway supported by joint working with OPLS to ensure robust plans are in place for “at risk “ groups • The RAD team have recruited 2 x HCSW	• The Home First (formerly Hospital 2 Home) team have increased the range of options on initial assessment with regards to admission avoidance and rehabilitation. • The development of the Community Hospital and Care Home Assessment Team within Mental Health increases the options of assessment and management of people with dementia specifically in community hospitals. In 2018 Murray House, Kelso has opened and provides 18 specialist dementia care home placements. 7 of these beds are funded by the IJB for 5 years. • The liaison psychiatric service is being reviewed as part of mental health transformation agenda and will examine capacity to participate in assessment on admission within workstream. This work is in hiatus due to Covid-19 but remains in scope. • The Older Person’s Assessment Area (OPAA) was “up and running” for 2 months prior to Covid19. The model worked with this cohort of patients, focusing on enabling patients. We anticipate that we will return to this model in due course when resource permits.. • The older adult pathway has identified 4 work streams which includes those discharged home to formal care. • The previously used Person Centred Care Tool is being revised to become supervision focused. • Frailty screening tool to be completed in ED completed on TRAKCARE denoting patient as “frail”.

	undertake initial assessments, to continue rehabilitation plans as identified by AHP's and to prevent deconditioning. ***For further details on the work of RAD see Standard 12 – Rehabilitation*. • OPLS Nurse / "front door Geriatrician" carry out early assessments in MAU to ensure prompt decisions for older patients. There is now a twice daily MAU board round where appropriate patients are identified for discharge, transfer to DME ward or community based rehabilitation. The morning board round is followed by the frailty huddle to ensure a robust MDT plan for each patient. • At initial assessment and review by Multi-disciplinary team, including geriatrician, will consider if care can be delivered in a community based setting or at home. • Rehab plans/nursing transfer letter/discharge script all go community team delivering care. • Patients in MAU are reviewed by geriatrician daily and MDT discussion at the frailty huddle (Mon –Fri) • Medicine reconciliation carried out on admission. • Access to pharmacy technician who will assess patients ability to manage medication and advise accordingly • All junior Drs can access ECS and eKIS. • Older People's Liaison Service nurses (OPLS)can access mental health notes necessary via EMIS • Patients in DME wards are reviewed 3x week on ward round by geriatrician with a weekly MDT and daily in MAU.	

Standard 5: Comprehensive geriatric assessment

Older people presenting with frailty syndromes have prompt access to a comprehensive geriatric assessment and management by a specialist team.		
Criteria	Areas of Strength	Areas in Development
5.1 A comprehensive geriatric assessment is initiated within 24 hours of admission to hospital by suitably skilled staff for patients presenting with frailty syndromes. Where a CGA is not clinically appropriate, this will be documented in the patient's healthcare record. 5.2 Patients with frailty syndromes reach a specialist geriatric bed within 24 hours of admission. 5.3 Patients with frailty syndromes who require other specialist input (for example, orthopaedics, oncology, palliative care or general surgery), reach the appropriate bed within 24 hours of admission. 5.4 Staff can provide evidence that they have the appropriate experience, specialist knowledge and skills in undertaking comprehensive geriatric assessment. 5.5 Organisations can demonstrate timely access to comprehensive geriatric assessment, specialist beds and teams that are monitored, reviewed and remedial action is taken as appropriate.	• Elderly patients in hospital requiring rehabilitation are identified through Ward MDTs as to which setting for best outcome, i.e. Community Hospitals, transitional care/home, H2H. • *Home First details embedded in Standard 12: Rehabilitation.* Patients admitted to MAU will be reviewed by a geriatrician or member of the MDT within 1 day of admission (Mon - Fri) initiating assessment based on CGA principles. Patients identified for transfer will be in DME beds within 24hrs. These are audited – although audit has been limited during C19. • AHPs working Sundays initiate their component of Comprehensive Geriatric Assessment. • Ortho geriatrics - Ward 9 have geriatrician input daily to initiate Comprehensive Geriatric Assessment. • Patients, where appropriate, admitted directly to ward 9 from ED. • Executive team have daily update on number of patients awaiting a bed in DME and how long they have been waiting. • Alerts are placed on Trak-care to alert staff if patients are known to palliative care team. • Comprehensive geriatric assessment: Staff (Older People Liaison Services, RAD, and Geriatric Consultants) are able to provide evidence that they have appropriate experience, specialist knowledge and skills in undertaking these assessments. • Staff have regular appraisals and opportunities for continuous professional development. • eLearning modules are available in Dementia – at Informed & Skilled Practitioner level, Stress and Distress, Adults with Incapacity, Adult support and protection. • OPLS standing item on DME Unit meeting, any issues can be escalated if necessary and appropriate actions taken.	• Continuous review of assessment practice to improve waiting times to DME & community hospitals. • Ongoing programme of work with involvement and engagement from health and social care colleagues to transform the Older Person's pathway. • Delivering the national and local approach is to care for people as close to home as possible and avoid hospital admissions which requires a shift in the balance of care for medicine of the elderly. • For winter 2020/21 the development of the Borders Urgent Care Centre which plans to centralise GP Acute Assessment referrals with GP capacity and a Minor Injuries service at the BGH. This should ensure more older patients are cared for in a scheduled service outside the busy Emergency Department environment. • The creation of an Older Person's Assessment Area in the Medical Admissions Unit at the start of the year – stalled after only two months at the start of the pandemic. This approach will be restarted as partof winter plan 

	• All AHP staff have training needs identified at yearly appraisals and if requiring a specific rehabilitation skill, this will be identified and addressed with an action plan. • Skill mix team supports training through robust supervision and mentoring. • There are in-house learning opportunities, both uni-professional and multi- professional, CPD and Learnpro, and/or attendance at external courses. • Health care support workers are encouraged to complete relevant NVQ. and competencies training. • Home First team now embedded as an important part of Older Persons Pathway. • The establishment of daily BGH Integrated Huddles to review all complex discharges. These huddles bring together Senior Nurses, Social Work, AHPs and Operational Management to provide rapid multi-disciplinary problem solving to ensure timely transfer of care for predominantly older patients. This group has been a key factor in reducing the number of delayed discharges on the BGH site.	

Standard 6: Pharmaceutical care		
Pharmaceutical care contributes to the safe provision of care for older people in hospital.		
Criteria	Areas of Strength	Areas in Development
6.1 There is effective communication with the patient (and/or representatives) about the multidisciplinary care plan, which includes any medication changes, and the long term medication plan when transferring to and from all settings. 6.2 Medicines reconciliation (Med Rec) is undertaken within 24 hours of admission and at discharge.6.3 The multidisciplinary team assesses the patient's (and/or representatives) ability to manage their medicines safely, including **before** discharge. 6.4 At the point of discharge, the patient (and/or representatives) will receive the correct medicines and information to support taking them appropriately. 6.5 The multidisciplinary team will ensure support and monitoring of medicines for patients who require this after discharge. 6.6 National polypharmacy guidelines are implemented. 6.7 A proactive clinical pharmacy service is available and supports medicines reconciliation, review and compliance assessment.	• Patients (and/or representatives) are updated re: ongoing care plan / medication changes by different members of the MDT throughout their hospital stay. On transfer between care settings this information is provided via the Immediate Discharge Letter (IDL). The pharmacy team or nursing staff will confirm medication changes with the patient (and/or representatives) prior to discharge / transfer. Pre-covid 19 data on this would have been captured via the patient feedback questionnaires. • Medicine Reconciliation (Med Rec) is completed by the MDT on admission and discharge – primarily by junior doctors, ANPs and pharmacists. Med Rec is also completed in the GP practices after discharge by the primary care pharmacy team. • Within the BGH medicines management reviews are carried out proactively prior to discharge. These assessments are recorded using a standardized assessment tool which is kept in the patient's notes. All patients reviewed by the pharmacy team are initially screened for the need of a full medicines management review. Examples of patients not needing a review are those already on the highest level of support at home, NH residents, palliative patients or those who are strongly supported by their family. Patients are also referred to the pharmacy team for review by the MDT (including the social work team or through the Intregrated Huddle). Within the last 12 months in the BGH 166 patients received a full medicines management assessment with appropriate changes made to ensure that they had sufficient support with their medicines at home. • Where required medicine management reviews are also carried out at Waverley, Garden View and in patients' own homes. • The pharmacy team worked with social work in developing questions for use on STRATA and MOSAIC to provide a standardized approach in assessing patient needs for	Medication changes are documented on the IDL which is given to all patients on discharge. The MDT continues to communicate with patients (and/or representatives) about medication changes and continue to improve on the documentation of these discussions. During Covid-19 the pharmacy team were minimizing contact with vulnerable patients therefore have been relying on nursing or medical staff to have these conversations with patients. Med Rec is no longer audited for the Scottish Patient Safety programme, but the pharmacy team continue to support Med Rec education sessions with the junior medical staff. Training continues for the ward based pharmacy technicians to complete medicine management assessments to support the proactive review of patients across all wards in the BGH. The MDT will continue to communicate with patients (and/or representatives) about medication changes and monitoring needs but we will improve on the documentation of these discussions / arrangements Polypharmacy reviews for patients on surgical wards are not carried out routinely. Surgical patients are referred back to the GP / primary care pharmacy teams for a review of medication where a polypharmacy review would be appropriate.

managing their medicines safely by “trusted assessors” in community.

- Below is the standardised assessment tool used and also a breakdown of the Medicine Managment reviews completed in the community.


Medicines Management Assessm


Primary Care Assessments 2020-2(

- The IDL and medication are issued to all patients at discharge. The clinical pharmacy team review as many of these discharges as possible - where this has been done this will be recorded on the TRAK IDL

- Medical and nursing staff discuss ongoing monitoring needs with the patient / carers / GP / DNs as required. These discussions are documented in the patient’s notes and recorded on the IDL. This will also be confirmed again with the patient prior to discharge, particularly for any new medicines.

- National guidelines such as the Polypharmacy guidance, Prescription for Excellence and Palliative Care guidelines are being implemented across NHS Borders. Medical teams receive Polypharmacy training at numerous points throughout the year – offered both for those specifically within DME and to the wider medical cohort (specifically to the FY2s, GP trainees and NMPs over the past year).

- For community hospitals, GPs will be implementing these guidelines

In previous reports we proposed that we would begin auditing the anticholinergic burden for patients.

- An audit was completed in DME reviewing patients’ individual anticholinergic burden (ACB) and assessing our practice of reducing this burden through our polypharmacy reviews. This is important as medicines with anticholinergic properties are associated with increased confusion, dizziness and falls. They have also been shown to increase patient mortality. The audit showed we decreased

	the ACB in 37% of our patients, with a 48% reduction in the number of patients prescribed a medicine with a significant ACB score (scores of 2 or 3). Scores of 3 or more are associated with increased cognitive impairment and mortality. • *Regrettably this work has been put on hold during Covid-19 but there are plans to re-implement this from January 2022.*	

Standard 7: Assessment and prevention of decline in cognition

Older people in hospital have their cognitive status assessed and documented.		
Criteria	Areas of Strength	Areas in Development

7.1 A cognitive assessment is undertaken at initial assessment, or where clinically indicated, and documented in the patient's healthcare record.
 	
7.2 As part of the cognitive assessment, acute changes to usual cognitive status are identified and confirmed by the patient and/or representative.
 	
7.3 Any previous diagnosis of dementia, delirium or depression are confirmed and inform care and treatment.
 	
7.4 Wards caring for patients with cognitive impairment or delirium:
a) have appropriate lighting and noise levels for the time of day
b) provide information that aids communication, for example large signage
c) actively encourage the patient's representatives to visit, and be involved with the patient's care if they usually do so, and
d) promote healthy sleep and encourage a normal sleep pattern.
	• 4AT is embedded in AUPR documentation and carried out on all patients over the age of 65 on MAU.
	• Collateral information is obtained at the earliest opportunity to establish sudden changes in patients cognition.
	• Previous diagnosis of dementia, delirium, or depression are confirmed via Emis, Liaison Psychiatry or MH Older Adult Service and inform care and treatment during admission.
	• Delirium training is also routinely offered in the Borders General Hospital and Community Hospitals by the Older Adult Liaison Psychiatry team.
	• There are information posters and leaflets widely available on wards which explain delirium and these are made available to patients and their families.
	• Environmental audits have been carried out on DME, and all community hospitals
	• Signage throughout the hospital has been adapted to reflect best practice in dementia recommendations.
	•
	• Community Hospital and Care Home Assessment Team is improving access and support for cognitive assessment in Community Hospitals.
	  • Approachability and accessibility of this service has improved cognitive care planning to the benefit of the patients.
	  • BRAT (Borders Risk Assessment Tool) embedded into CH practice
	  • Assessment for level of observation routinely undertaken.
	  • Use of activity coordinators to promote purpose and wellbeing.
	  • Give them their own room.
	  • Flexible approach to visiting.
	• Patient positioning in the ward takes into
		• 4AT is not consistently carried out despite being promoted by nursing staff and senior medical team. Consideration should be given for nursing staff to complete and review 4AT. (This is practice in Community Hosp's)
		• Where person is moved to another ward, follow-up 4AT may be delayed or missed.
		• Orientation boards are needed in all ward areas.
		• Cognitive decline is factored into decisions made around rehabilitation and informs referral to H2H.
		• Development of Community Hospital and Care Home Assessment Team will improve access and support for cognitive assessment in Community Hospitals.
		• Review of Psychiatric Liaison service will include assessment of cognition in older people.
		• Awareness and education of Think Frailty and Think Delirium toolkits is offered to clinical staff at Hospital to home and the Community Hospital. Consideration for nursing staff to complete and review 4AT.
		• Environmental Audit of MAU is ongoing by our Dementia Nurse Consultant
		• A greater number of patients are awaiting care home and home care resources, delaying their discharge. This is leading to faster cognitive decline whilst they wait in an inappropriate environment. Work is required to promote early discharge for those who are confused in hospital due to delirium or dementia.
		• People with confusion are often admitted without hearing aids, making assessment difficult and risking misdiagnosis of severity of confusion. Work is needed to fund "hearing Amplifiers" for all ward areas which can be given to patients and returned upon discharge.
		• Hospital has supported "Johns Campaign" and

	account environmental factors which may impact on cognition/sleep/etc… • Environmental factors which may provide subconscious or easy orientation for people with cognitive deficits are being supported in Kelso and is to be rolled-out to other Community Hospitals.	have open visiting and overnight stay areas, actively encouraging relatives to be collaborative partners in care delivery and assessment of future needs. ***(This has been severely curtailed by the restrictions and challenges of the pandemic)***

Standard 8: Delirium		
Older people in hospital experiencing an episode of delirium are assessed, treated and managed appropriately.		
Criteria	Areas of Strength	Areas in Development
8.1 Patients with a diagnosis of delirium have common causes of delirium considered and documented, and their management and progress reviewed by the multidisciplinary team. 8.2 If, during comprehensive geriatric assessment, a new cognitive abnormality or a sudden change in cognition is identified, the patient will be assessed for delirium. 8.3 Monitoring for delirium will continue until the patient is either cognitively settled, delirium is confirmed, or an alternative diagnosis is confirmed. 8.4 Capacity to consent to treatment is assessed and documented for patients for whom delirium is ongoing after initial treatment. 8.5 Staff, and the patient's representative, are made aware when a patient has been diagnosed with delirium.	• There is increased awareness of delirium as a syndrome and delirium diagnosis is routinely recorded in the patient's notes. • Clinicians routinely and habitually initiate basic screening measures for physical causes. • New AUPR includes 4AT as initial cognitive indicator as part of assessment on admission. • Where dementia is known or suspected, staff follow Protocol for management of people with cognitive impairment or dementia presenting to the Borders General Hospital. • Some staff across the hospital have undertaken delirium training modules on Learnpro. • Liaison Psychiatry Nurse Specialist has undertaken bespoke delirium training sessions with Medical, Nursing and AHP staff. • There is now a stock of delirium Awareness leaflets for patients and families and Delirium toolkits for staff. These have been circulated to all ward areas and there is evidence that patients and families have found these beneficial • There are leaflet stations across the hospital containing a range of Alzheimer Scotland leaflets, AWI/Power of Attorney leaflets. There are also 'Think Delirium' posters in all in-patient units and Scottish Delirium Association Pathway poster on appropriate clinical areas. • Where Cognitive impairment impacts on recovery/re-enablement or where presentation is a cause for concern direct referral by telephone/email to Mental health older people liaison service is available. • NHS Borders liaison nurse specialist and Consultant Psychologist operate delirium call back clinic. • A pathway has been developed for clinicians	• Delirium screening is not embedded throughout none all areas of the BGH. • It would be useful to audit the numbers of people who have received this information and to obtain feedback, through satisfaction surveys, in order to measure any and what tangible benefit these have had. • Whilst this pathway has been in place for several years, there is a lack of evidence that patients have been referred to the community mental health team and many patients who have been delirious are not being referred onward for further assessment. • The ward environments through most of the BGH are not delirium/dementia friendly. Lighting, noise and orientation points all pose problems for people with delirium. • Other ward areas, where people with delirium receive care have not yet had any environmental audit. • Assessment of capacity performance has slipped and improvement work is needed to understand the reasons for this. • There remains a lack of understanding as to the nature of legal capacity and to the ethos of presumed capacity. • Awareness and education of Think Frailty and Think Delirium toolkits is offered to clinical staff at Hospital to home and the Community Hospital. Consideration for nursing staff to complete and review 4AT. • Work is needed on locally produced Delirium Leaflets for staff and patients as these cannot always be sourced. This is now in development. • • Cognitive screening of all adults over the age of 65 using the 4AT is part of initial

	to refer patients who have been delirious to either the Liaison teams Delirium call back clinic or onwards to the Older Adults community mental health team. • Environmental audits for people with cognitive impairment have been undertaken in DME ward 14 and are in progress on DME ward 12. • Signage across the BGH campus has been changed to support people with cognitive and visual impairments in some areas that have been refurbished (ward 12 (covid 2), ward 4 and radiology) • In cases where cognitive impairment does not resolve, there is a pathway for staff to refer to the Liaison Psychiatry Nurse Specialist for Older Adults. • S47 and treatment plans are frequently now completed for people who are diagnosed with delirium and are kept under regular review. Some staff across the hospital have undertaken delirium training modules on Learnpro. •	assessment on admission to hospital. This is customarily completed for direct admissions to CH's and our ambition is to retro-actively into BGH. • Time bundle AUPR but not completed often enough. The importance of this to be reiterated to acute hospital and Community Hospital staff.

Standard 9: Dementia		
Older people in hospital with a confirmed or suspected diagnosis of dementia receive high quality care.		
Criteria	Areas of Strength	Areas in Development
9.1 Patients with a diagnosis of dementia have this documented together with their baseline level of cognition and function, and current care and support provision on admission to hospital. 9.2 Patients with dementia receive high quality care in hospital which reflects current best practice such as the *Standards of Care for Dementia in Scotland* and *the 10 Care Actions.* 9.3 When a new diagnosis of dementia is suspected and depending on symptoms and severity, patients are referred: a) to the specialist older people mental health liaison team during admission, and b) for post-discharge follow-up by either a community mental health team for older people or a primary care team.	• MWC for Scotland undertook themed visit to community hospitals. Dementia Nurse Consultant has developed action plan which was signed off by chief officer for health and social care. Please refer to current version of action plan which is reviewed every 3 months. Last reviewed September 2021 with 4 actions outstanding. *Recommendation 12 is unachievable and has been escalated to the MWC.*  MWC action plan Final V10 2021 - with • People with a diagnosis of dementia on admission have this recorded in their notes as part of past medical history and current problems. • New AUPR includes 4AT as initial cognitive indicator as part of assessment on admission. • 6CIT now introduced and also used for assessment • Current support and level of ability is recorded in admission documentation. • Nursing staff can access Mental Health background and care plans through EMIS if required, usually through the OPLS nurse • Baseline cognitive assessment using 4AT is undertaken on admission. • Further assessment of cognitive function is made where clinically appropriate: ○ To inform capacity assessment ○ To support care planning ○ To support discharge planning ○ This should then be recorded in the patient's notes. • Few people are given a diagnosis of dementia during admission to hospital but in the cases where this happens this is recorded on discharge letter. • Individualised patient care plans have been	• "What Matters To Me" (WMTM) and Getting To Know Me (G2KM) whilst in evidence, do not always inform care on a daily basis - these are more firmly embedded into the new Adult Unitary Patient Record to better inform care planning. • There is a need for more face-to-face learning opportunities and a dementia microsite for staff is under development. • There has been little uptake in the attendance of stress and distress training by hospital staff across both the BGH and the Community Hospitals since October 2018 all new staff achieve as part of the corporate induction. (via Learnpro) • There are 12 dementia champions (DC) across BGH and community hospitals. ○ *Cohort 11 commenced September 2021 with 8 enrolled from BGH and CH.* ○ *Cohort 4 of DSIL (Dementia Specialist Improvement Leader) programme has 2 enrolled with 2 from cohort 3 in BSDU.* ○ Competing demand on Dementia Champions has led to limited success in their role and that some have changed roles and do not have capacity to continue as a DC • June 2019 Scottish Government/Alzheimer Scotland published priorities and action plan for Dementia Nurse Consultants in Scotland and a local action plan is being developed atA review was delayed during pandemic although a further action plan is in progress and will support the agreed Memorandum of Understanding (MOU) (23/11/21) of the Dementia Consultant role and will be reported to SEND, CNOD and to local Clinical Governance Committee twice a year. The MOU has clear national aims and one local

	developed and PDSA improvement methodology cycles employed to measure the efficacy – these form the basis of the care plans now embedded in new AUPR.although compliance is erratic currently • Getting To Know Me [GTKM] documentation is sought from all people with an identified or suspected dementia to inform person centered- care • The use of "What Matters to Me" [WMTM] is widespread across the hospital to inform individualised care needs and preferences – with mixed efficacy. • There is wide spread training across the hospital on dementia care, mapped against the Promoting Excellence framework, with E-Learning available at Informed, Skilled and Enhanced practice levels. • Nursing and AHPs are the highest recipients of dementia care training. • The BGH has a standard to assess the cognition of all adults over the age of 65 on admission. • Tools are in place to undertake such an assessment • There is a commitment to re-assess cognition further into the person's admission where there is a notable change in cognition or functioning. • Staff can access electronic databases to ascertain whether or not the person is known to a community mental health team or worker and that worker can be contacted directly to support the person. • The Herbert Protocol was implemented in conduction with Police Scotland  Herbert Protocol.pptx	aim identified.  Nurse Consultant report_FINAL.pdf • Community Hospital & Care Home Assessment Team is now working with community hospitals to support people with dementia. • Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will continue to support capacity assessment and equality of access to services for people with mental health problems. • Strategy 4 was due for consultation April 2020 although due to covid-19, and through virtual consultation a dementia covid 19 recovery plan was implemented in conjunction with the 3rd strategy for 18 months  dementia-covid-19-national-action-plan-cc Care coordination model presented to OPP and DSIG for consideration as an integrated approach  care-coodination-workshop-flash-report.pc • Given the staffing pressures currently BGH have reached out for MH nurses via "unorthodox resources " (Guild) with a noticeable impact on patient care and behaviour.

Standard 10: Depression		
Older people in hospital with a confirmed or suspected diagnosis of depression receive care and have appropriate management and interventions put in place to minimise decline and contribute to quicker recovery.		
Criteria	Areas of Strength	Areas in Development
10.1 Patients with a confirmed or preliminary diagnosis of depression on admission, including those with a primary diagnosis of dementia, have this documented. 10.2 If assessment indicates possible depression, this is documented and a care plan agreed. 10.3 Patients in hospital with a diagnosis of depression (confirmed or suspected) are referred to: a) specialist older people mental health liaison team (if input is required during admission) b) community mental health team for older people or c) a primary care team on discharge, or condition-specific specialists.	• Patients with a known diagnosis of depression on admission have this recorded as both part of their medical history and current problem/presentation. • Where considered appropriate, if Mental Health services are involved with a patient they are alerted and interventions during admission discussed and recorded in patient record. • Patients who are presenting with low mood or suspicion of depression are referred to the Liaison Psychiatry team including: ○ Consultant Psychiatrist. ○ Specialist Nurse in Liaison Psychiatry in Borders General Hospital. • The Community Hospital and Care Home Assessment Team who support people with depression in community hospitals. • Ward staff are aware of their roles and responsibilities in relation to the local referral processes to specialist or community teams. • Depression is noted in the discharge letter to promote follow-up or onward referral where appropriate.	• Training and promotion of appropriate assessment tools (e.g. HADS, PHQ-9, Cornell, GDS) by wards before referring to psychiatry may lead to fewer inappropriate referrals. • This may explain why there often referrals to psychiatry for understandable low mood, where no symptoms of depression are evident • There is remain a high number of referrals where greater ward interaction could be the solution but Psychiatry seems an 'easy alternative'. • Consideration of why it remains highly uncommon for consent to be sought, prior to a referral to psychiatry and how to change that practice. • Medical, Nursing and AHP staff training in the clinical symptoms and approaches to depression in the general hospital and of the risks of anti-depressant prescribing has been undertaken by the Liaison team. • Liaison Psychiatry team have developed a screening and management tool for those with low mood / depression in the BGH and a pathway for referring to Liaison psychiatry. • There is a need for Medical, Nursing and AHP staff training in the clinical symptoms and approaches to depression in the general hospital and of the risks of anti-depressant prescribing. • There are limited resources and services for older people including no access to psychological therapies in inpatient settings.. • Limited knowledge of low mood and suicidality among nursing staff has been identified as an area of weakness. The Suicide Prevention Action Plan supports

		Workforce development plans including suicidality training. • Psychiatric liaison service is a workstream in the Mental Health transformation agenda and will continue to support capacity assessment and equality of access to services for people with mental health problems.

Standard 11: Falls prevention management		
Older people in hospital are assessed for their risk of falls within 24 hours of admission, and have appropriate measures put in place to reduce that risk.		
Criteria	Areas of Strength	Areas in Development
11.1 A falls risk assessment is initiated within 24 hours of admission. 11.2 Patients with identified falls risk factors have a care plan for meeting those needs or mitigating those risks whi ch: a) is developed with the patient (and/or representative) b) is shared in an appropriate format, and c) includes a medicines review. 11.3 A clear falls prevention plan is documented and shared with the multidisciplinary team on discharge or transition between care settings. 11.4 Staff can deliver safe and effective falls pre vention and management. 11.5 Clear process and protocols are in place for the organisation to review, record, share in formation and monitor all falls in hospital.	• Falls strategy group- wide stakeholders across all professions, partners, fire and rescue, SAS, care home managers and SBC- working on strategy for NHSB – focussing on inpatient falls management and community falls prevention. • Back to Basics governance group continues to provide a focus for reduction in falls with harm. • The “Essential care after a fall” guideline has been updated. • Clinical Improvement Facilitator conducting falls analysis where areas may have disproportionate number of falls. • Assessment of patients for risk of falls, and completion and review of the person centred falls bundle. • The person centred falls bundled has been updated using a QI approach and has seen a significant increase in compliance within the pilot site of MAU. • With approval from MH clinical governance committee, following QI project, introduction of adapted falls bundle linked with care plan in Melburn Lodge (Borders Specialist Dementia Unit) & Lindean, recognising the different needs of this patient group. • Audit of equipment across acute site ensuring access and availability for appropriate patients. • Use of enhanced care observation by nursing is important but only in certain groups of patients and not all falls risk this is tailored to patients who are identified as unable to maintain their own safety • Essential care after a fall guideline (available online. • http://intranet/resource.asp?uid=21178	• Falls microsite is currently under construction and will provide information and guidance for staff. • New falls bundle to be rolled out across inpatient wards following successful pilot in MAU • Using care plans to promote the realistic medicine approach to risk assessment and planned management. • Shared risk with patient/carer/family to reduce restrictions placed on patient (E.G. Reducing close observations.) • Although Medicine Reconciliation does not include the list of medications which contribute to falls. all areas have a laminated sheet of low, medium and high risk meds. • Work continues to standardize leaflets across pathway eg Up and About • Patient placement in wards which includes understanding of where all falls are happening and why- e g using datix information and measles mapping of wards. • Previous response to planning has been reactive – falls work now using a QI methodology approach. Testing with support from QI skilled and trained staff on request from SCN/CNM. • All falls from acute site and community hospitals are identified at the hospital wide safety huddle Monday to Friday 8.30am. • Ward level staff knowing their data- working with the SCN/CNM to understand their data and how this can be accessed and displayed. Using the Care Assurance Information Resource as part of the Excellence in Care work to review data over time with the view to using this at divisional clinical governance and quality meetings. This will influence early triggers for improvement as well as assurance.

	• Review of falls timely through datix process- and Falls Review Tool (available online • http://intranet/resource.asp?uid=35941 . • Use of technology when appropriate for certain groups of patients • eg Bed sensors used to alert staff when vulnerable people stand, while being mindful that patients distress can increase with the noise of bed/chair sensors where patients want to get away from the noise and therefore at more risk of falls. • At time of writing there is a 2 week trial of technology options across the BGH. • Utilisation of the falls pathway to consider (see attached doc, to ensure we are covering all aspects as one size does not fit all but requires a Person centred approach eg assessment of continence, delirium, medication, etc).	○ Development of new SCN score cards underway. • SCN owning PSST and applying the principles consistently, testing of revised version in acute setting in 2 wards using QI methodology. This work is ongoing and the CNM/SCN taking this forward. We are aiming for electronic version once full testing complete. • There are a number of environmental issues- red ergonomics of toilets, bathroom, lighting, colours support environmental assessment aligning with assessment as there are synergies.

Standard 12: Rehabilitation		
Older people in hospital have access to rehabilitation services that are timely, accessible and person-centred.		
Criteria	Areas of Strength	Areas in Development
12.1 A multidisciplinary rehabilitation plan is developed with the patient (and/or representative), and includes: • goals and outcomes that are specific, measurable, achievable, realistic and timed (SMART) • details of support for the patient (and/or representative) to maintain their skills and function in hospital while they wait for discharge, and • regular reviews and updates of agreed goals and outcomes. 12.2 The patient receives a rehabilitation plan, which is delivered in a timely manner and in an appropriate setting for the patient. 12.3 Rehabilitation is carried out by a multidisciplinary team who are trained and skilled in delivering rehabilitation, enablement and developing personal goals and personal outcomes. 12.4 The organisation can provide evidence of how rehabilitation services are delivered including: rapid provision of equipment for example, equipment or adaptations to the patient's home (including care homes), and • availability of alternative facilities to a hospital ward (including their home or homely setting) for the older person to	• Nursing, Medical and Allied health professionals are integral to the rehabilitation provision within BGH and of the 4 Community Hospitals. • All Older adults in an inpatient setting are encouraged to remain physically active promoting independence and reablement • Specialist Occupational Therapy and Physiotherapy, Speech and Language Therapy or Dietetics assessment and treatment will be provided on identification of needs by the ward MDT • Following an AHP assessment, all patients have a treatment plan with SMART goals and outcomes. Person centred and person driven goals should be clearly outlined in the PUR.Goals and outcomes are routinely reviewed by therapists and discussed at ward huddles and MDTs as appropriate to influence discharge planning and care plans • 12.2 / 12.4 MDT assessment and planning should ensure that patients are discharged to Assess in their own homes where possible and ongoing rehabilitation should happen in the most appropriate inpatient setting when not safe to be at home. • 12.3 Promoting physical activity, reablement and rehabilitation are the responsibility of all staff, being led and guided by relevant AHPs. • 12.4. Close working relationships with Scottish Borders Council Equipment Store provide equipment for discharge as required.	• Environmental limitations within the BGH provides a barrier to rehabilitation. Lack of space on individual wards for adequate rehabilitation requires the necessity to move patients to the AHP Hub gym area for therapy sessions. This has an impact of rehab staff capacity and potential for peer/ wider team engagement in rehabilitation. • National Equipment shortages will likely provide a significant challenge in 2021/22. Local processes being developed to mitigate these risks. • Mixed functions of community hospitals provide a limit to rehabilitation capacity. Stroke rehab guidelines unable to by met in community hospitals due to lack of specialist workforce across AHP professions. • Locality based AHP structure in development across the Scottish Borders to bolster team resilience and to ensure that focus on prevention admission of Older Adults to hospital is prioritized alongside promoting home based rehabilitation • Regional Major Trauma funding will support the flow of Older Adults moving from hospital based services into the community by providing robust rehabilitation pathways and outcome measures. • Ongoing development of Home First intermediate Care service to focus on Discharge to Assess and admission prevention.

receive their rehabilitation, where it is clinically appropriate and safe to do so.		

Standard 13: Pre-discharge planning		
Effective discharge planning is a continual process and starts as soon after admission as possible, or before admission for planned admissions. Communication, including transfer of information between healthcare and social care professionals, is essential to a seamless process of transition.		
Criteria	Areas of Strength	Areas in Development
A multidisciplinary discharge plan is developed with the patient, including those with cognitive impairment (and/or representatives), and includes: a) details of specialist assessments (for example, a comprehensive geriatric assessment) and outcomes b) details of future care plans and/or referrals to specialist, community or primary care, and c) consent obtained from those with power of attorney or legal guardians where a patient does not have capacity. 13.2 The patient's representative is involved in discharge planning with the patient's consent and can access carer advice and support if required. 13.3 For new episodes of cognitive impairment or depression identified during admission, the diagnosis and any residual symptoms are clearly documented on the discharge letter and communicated to the patient (and/or representative), the primary care team, and any condition specific specialist teams for appropriate follow-up. 13.4 The immediate discharge letter is sent to the GP within five working days of the patient's discharge. 13.5 Primary care and other health and social care community teams are informed of discharge plan.	• Integrated MDT Huddle takes place twice daily in MAU identifying options for supporting patients to move to next part of their care journey. • The opportunity to refer to Home First supports a wider range of options in planning discharge and facilitates potential early discharge. • Medical wards operate a multi-disciplinary approach to discharge planning. • Where an adult consents to a social work assessment (or legal proxy if the adult no longer retains sufficient capacity to consent to assessment) the assessment undertaken by the hospital social worker reflects the professional views of members of the multi-disciplinary team as well as the thoughts and experiences of the adult and their carer. • The assessment produces outcomes and indicates which outcomes are critical to the safest discharge plan. • The discharge letter reflects the multi-discipline teams decisions and services that are in place and those that will be required to achieve the agreed outcomes. • The social work assessment considers current and future/potential risks to the adult and their carer in implementing the discharge plan. • In addition, the assessment highlights how these risks can be mitigated and decisions made by the adult and their carer regarding how risks will be managed. • All risk assessments are audited by the social work team manager before discharge from hospital proceeds and any gaps in planning identified for remedial action. • Social Workers do not commence an assessment without written consent from the adult or their legal proxy and this document is stored within the local authority's electronic recording systems.	Day of Care Audit highlighted that: • Medical wards do take a multi-disciplinary approach to discharge planning • Each of the community hospitals are developing consistent approach to multi-disciplinary team discharge planning. ○ Documentation on the roles and responsibilities of MDT being re-drafted aiming to develop a more standardized but nonetheless locality sensitive approach to discharge planning can be agreed and implemented. ○ General Managers for Primary and Community Care and for Patient Pathways are engaging with key partners to redraft and refine this documentation. ○ MDTs will then be supported by the General Managers to implement agreed procedures and practices. • Where possible the management of risks includes anticipatory care planning and is considered in ReSPECT documentation. • Social worker puts a detailed case note onto Mosaic and/or copy documentation as this is either requested by the adult or their legal proxy and would be guided by the adult and/or their legal proxy about what details are put into the assessment i.e. need to know basis • DME wards hold once weekly large scale MDT meeting and twice daily Dynamic Daily Discharge in order to improve communication and promote more cohesive care. These are often supported by Clinical Nurse Manager where appropriate. • Where absence of capacity to make decisions inhibits the ability to plan discharge

	• Social work compliance with this requirement is frequently audited.
	• Where
	  ○ there are no legal powers in place
	  ○ the adult no longer retains capacity
	  ○ a section 47 certificate is in place
	the views of the consultant are requested whether or not a social work assessment can commence - where all professionals and the carer are in agreement and it can be considered to be a part of the care plan for the adult while in hospital.
	This decision is recorded on the Unitary Patient Record.
	• Carers are fully involved in the assessment process and their input is seen as crucial to the assessment by social workers where the adult has given consent for this involvement.
	• New episodes of cognitive impairment are included in discharge letter to prompt further investigation.
	• Cases of delirium identified where concerns remain on discharge can be referred to the delirium follow-up clinic run by Older Persons Psychiatric Liaison Nurse and Head of Psychology for Older Adults.
	• In the few cases where dementia is diagnosed while in hospital.
	  ○ Discharge letter informs GP.
	  ○ Referral to MHOAS for Post-diagnostic support.
	  ○ Patients are added to the primary care dementia register.
	• The Ward informs District Nurses of discharge plan which is documented in the UPR.
	• Social work informs locality social work teams and the care provider, which is evidenced through MOSAIC.
	• All adults referred to social work services are offered an assessment of needs as well as signposting to other relevant agencies and service providers.
	• The quality of social work services offered to adults in hospital is audited by the local authority and shared with the IJB and NHS through the Joint Older Adults Strategy Group for the purpose of developing strategy and driving
		we work with social work partners to enact legislation (EG. Guardianship, Section 13ZA of the Social Work Act.). Work ongoing to streamline this process.
		  ○ During the first wave of the Covid-19 pandemic Scottish Government prepared emergency legislation to facilitate the rapid discharge of people unable to consent due to a lack of capacity. The was never enacted as services worked intensively together to do this effectively – including in the Borders.
		• In May of 2021 the MWC published guidance report on “Authority to Discharge.” NHS Borders Action Plan is underway and supported by the Consultant Nurse in Dementia.
		• Implementation of Discharge and Pathway Coordination Team in December 21 as a single point of access for Discharge Pathway.
		  ○ Appropriately and rapidly signpost patients and make use of community services
		  ○ Promote early intervention to identify patients discharge pathway
		  ○ Co-ordinate and support staff to discharge patients without delay
		  ○ Reduce length of stay in acute settings
		  ○ Improve flow and utilise the use of beds and services in the Scottish Borders
		  ○ Reduce admissions to hospital

	continual improvements.	

Standard 14: Care transitions		
Older people in hospital are supported during periods of transition or delays between care environments through co-ordinated, person-centred and multi-agency planning.		
Criteria	Areas of Strength	Areas in Development
14.1 There is a co-ordinated person-centred approach to care transitions for older people in hospital, which includes the patient's representative where appropriate. 14.2 Effectiveness is monitored in terms of patient (and/or representative) experience as well as service impact. 14.3 The patient will have access to a health or social care member of staff who is responsible for co-ordinating their transition back to the community in collaboration with all relevant agencies. 14.4 The care and support needs of patients who are delayed from hospital discharge are reviewed weekly.	• Integrated MDT Huddle takes place twice daily in MAU identifying options for supporting patients to move to next part of their care journey. • These site daily 0830am and 1345 huddles coordinate hospital-wide transitions of care. • This includes representation from the whole hospital nursing leadership, medical leadership, AHPs, Pharmacy, Site & Capacity, Social Care and support services. • Social Workers commence an assessment once consent from the adult or their legal proxy is obtained, this document is stored within the local authority's electronic recording systems. • Social work compli • ance with this requirement is frequently audited. Where there are no legal powers in place and the adult no longer retains capacity and a section 47 certificate is in place, the views of the consultant are requested with regards to whether or not a social work assessment can commence (where all professionals and the carer are in agreement and it can be considered to be a part of the care plan for the adult while in hospital). This decision is recorded on the Adult Unitary Patient Record. • Carers are fully involved in the assessment process and their input is seen as crucial to the assessment by social workers where the adult has given consent for this involvement. • As part of Back2Basics communication workstream a review of Datix incidents of transitions in care.	• We are working to create more virtual systems to plan transfers into the community. • Home First offering wider range of options for care transitions. • Opening of additional dementia specialist beds in Murray House in Kelso offers options for different care settings. Patient's referred to Murray House are assessed by their staff in hospital to facilitate smoother transition. • Integrated Specialist Dementia Panel being developed to review those on waiting list for commissoined SD beds at Murray House. Currently 7 although proposal for 12 being pursued . • Development of Community Hospital and Care Home Assessment Team from Mental Health will facilitate transitions in care for people with dementia. • Borders Dementia strategic Implemention group relaunched and now chaired by Brian Paris. •

Standard 15: Patient pathway and flow		
Older people in hospital are cared for in the right place at the right time.		
Criteria	Areas of Strength	Areas in Development
15.1 Boarding of any patient is minimised. 15.2 Arrangements are in place to improve flow for older people to ensure that the right patient is cared for in the right way, in the right place at the right time. 15.3 Systems and processes are in place to minimise the potential patient safety risks and poorer outcomes associated with patients not being cared for in the right place. 15.4 Organisations demonstrate adherence to transfer policies to ensure that hospital moves add value for patient care and are due to clinical need and not service pressures. 15.5 Patients with cognitive impairment are not moved to another bed, room or ward unless clinically necessary for their treatment or to manage clinical risks. 15.6 If, after multidisciplinary team agreement, the patient is moved, the reason for the move is clearly documented and shared with the patient (and/or their representative).	Boarding poses particular risks during Covid-19 and is therefore under even greater scrutiny than usual. The following bullet points reflect "normal times". • Current practice recognises boarding as unavoidable at times, but will always strive to keep patients within clinically appropriate areas, discharge is preferable to boarding if clinically appropriate. • There is a Standard Operating Procedure, 'Boarding patients out with Speciality in the Borders General Hospital' which states , '*Older frail patients should be moved in hospital as little as possible, and never out-of-hours for non-clinical reasons. Patients with cognitive impairment, delirium, dementia or a learning disability should not be boarded out with speciality unless this is clinically necessary.*' • There is a risk assessment for boarding on the back of the 'Patient Transfer Sheet' to encourage safe boarding practices. • OPLS Nurse / "front door Geriatrician" carry out early assessments in MAU to ensure prompt decisions for older patients. • Geriatrician led ward rounds operate in Orthopaedics, again to ensure early identification of patients suitable for transfer to DME and the right care for older patients out-with DME. • Patients identified for DME who remain in MAU for whatever reason have ongoing Older Person's Liaison Service support and Geriatrician input. • Patients in MAU identified for DME are not moved to other wards unless it is unavoidable. The decision to transfer a patient from MAU to DME is documented to ensure clarity in value of move.	• In the last 2 years months there has been a number of changes across the system which have impacted positively on our patient pathways both within the acute and community setting. • A programme continues to improve flow through the BGH and build resilience including: • Twice Daily Dynamic Discharge programme to strengthen ward processes that deliver flow • Site & Capacity team to manage flow • Continued development of ambulatory care pathways. • Strengthening of flow management processes within the hospital • Despite these continuous positive steps the challenges posed by the pandemic continue to demand new solutions with each wave.

Standard 16: Skills mix and staffing levels		
Older people in hospital are cared for by knowledgeable and skilled staff, with care provided at a safe staffing level.		
Criteria	Areas of Strength	Areas in Development

16.1 Training in the knowledge and skills to care for older people in hospital is available to all staff, including support staff.
16.2 Staff demonstrate the knowledge, skills and competencies necessary within their role for the delivery of safe and effective care for older people, including awareness of carer involvement.
16.3 Staff who care for people with cognitive impairment or dementia are trained in line with the *Promoting Excellence* framework.
16.4 Staff training is available for the identification and management of depression in older people.
16.5 There are clear processes in place to demonstrate safe staffing levels with the appropriate skills mix.
16.6 For nursing staff, workforce planning tools are implemented.
16.7 There are clear processes in place for staff to escalate any concerns about staffing levels and there are associated plans to mitigate safety risk.
16.8 There are processes in place for the monitoring of multidisciplinary staffing levels and skills mix.
16.9 Professional accountability for senior clinical decision-making is clear and is complemented by clinical leadership, supervision and support for staff.
	• Fundamental skills Registered Nurse & HCSW programmes were introduced in February 2018 to incorporate, Life Support, Infection Control, Anticoagulation, Deteriorating patient, Food, Fluid & Nutrition, Tissue Viability and Falls – this programme is currently being redesigned to an online educational model. The aim is to support renewed staff and patient safety requirements following the impact of the Covid-19 public health pandemic.
	• Fundamental of Care Assurance tool has been implemented to provide leadership and support to the SCN and their Teams to improve care principles in the clinical setting. Mock Inspections by senior nurses identifies Staff and patient perspectives on the clinical environment are captured and nursing notes reviewed. The nurse in Charge is given immediate feedback and action is taken on any areas of concern immediately this is currently suspended following the impact of Covid-19.
	• Training across the hospital estate on dementia care, mapped against the Promoting Excellence framework, with E-Learning available at Informed, Skilled and Enhanced practice levels.
	• Within the Dementia Skilled module awareness raising on dementia, delirium and depression.
	• Link nurses for key areas of practice.
	  ○ Falls
	  ○ Tissue Viability
	  ○ Food Fluid and Nutrition.
	  ○ Dementia Champions.
	• Continuing the commitment to QI training across NHS Borders with staff trained to use a QI approach through a number of national programmes .
	• Rostering Guidance is available to staff and day-to-day dependency is assessed to ensure safe staffing levels are in place. SCN's have requested and been given the
		• SCNs join senior leaders in mock inspections utilising the Fundamental of Care Assurance tool.
		• NHS Borders were implementing a programme of transformational practice development to develop a culture of person-centred practice for SCN's – this has been suspended due to Covid-19.
		• Since March 2020, following the impact of Covid-19 all scheduled classroom clinical skills, resuscitation and practice education was discontinued to accommodate the pandemic response.
		• Reinstatement requires measures to support the safety of staff avoid any potential threat of the virus. Release of current venues to accommodate face to face teaching was explored however the 2m distancing negated any effective implementation.
		• Challenges in the current environment present the opportunity to move to an online model. While education programmes are being ebuilt, this also needs to be balanced with access to socially distanced PC's and a quiet place to study. Disadvantaged staff groups may have unreliable access, competition for access to technology and underdeveloped skills for online learning.
		• Promoting Excellence framework was refreshed in 2021 and all materials accessible via TURAS. A short life working group has been established to scope current training compliance to identify gaps and present to the mental health training group

	authority to manage their own rosters. NHS Borders complies with HIS healthcare staffing programme, clear processes are in place to run workload tools, this programme suspended in March 2020 due Covid-19. Plan to restart in late October. Preparation remains under way for introduction of Safe-staffing legislation. • Staffing level concerns are escalated through Clinical Nurse Managers and placed on Safety Briefs for discussion at morning and afternoon meetings and consequent patient flow huddles providing real time assessment of staffing levels aligned to workload supporting redistribution of staff to mitigate any safety risks. • Leadership from DoN down emphasises organizational role in supporting staff where staffing ratios are under pressure - particularly during pandemic • Workload tools highlight evidence of staffing levels against activity for wider stakeholders to explore whether current levels meet service need. Workload tool escalation process ensures the ADoN reviews all recommendations. • Professional accountability for senior clinical decision making is developed through management supervision and the appraisal process.	 promoting-excellenc e-2021-framework-he for approval.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Staff Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Andy Carter, Director of Workforce**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

The minutes are presented to the Board as per the Staff Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Staff Governance Committee Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Staff Governance Committee 25 October 2021
- Staff Governance Committee 14 December 2021

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Staff Governance Committee minutes 14.06.21
- Appendix No 2, Staff Governance Committee minutes 25.10.21

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.

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

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Monday, 25th October 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 Mrs E Cameron, HR Manager/OD Partner Mr J McLaren, Employee Director Mrs J Boyle, HR Manager Mrs K Lawrie, Partnership Lead Mrs L Pringle, Risk Manager

1. Welcome, Introductions and Apologies

Councillor Parker welcomed everyone to the meeting.

Apologies were noted from A Wilson, A Paterson, R Roberts, R Salmond, V Hubner, A Paterson.

2. Minutes of previous meeting held on 14 June 2021 were agreed as an accurate record of the meeting.

Matters Arising

2.1 Whistle-blowing

On 01 April 2021 a new approach to whistleblowing was adopted by NHS Scotland.

Sonya Lam is NHS Borders Whistleblowing Champion. Sonya is supported by Andy Carter and John McLaren who perform confidential contact roles.

NHS Borders created a new guide for staff which was placed on the intranet and there has been associated publicity (Staffshare/All Line Manager e-mails). NHS Borders sees whistleblowing as an important part of the overall dashboard around culture and having indicators that give us an indication of how it feels to work for NHSB at any particular moment in time.

There has been a single whistleblowing case to date. This will be reported to SPSO/INWO.

More work is required to generate a reporting line into the Health Board from the IJB and Independent Contractors on whistleblowing activity. Andy Carter will take this up with Chris Myers when he takes up appointment as Chief Officer.

Sonya Lam added that NHS Borders will produce an annual whistleblowing report in 2022 and agreed that the independent contractor issue is something being experienced across Scotland.

There was further discussion about what constitutes whistleblowing, what can be handled as business as usual and the distinction between personal grievances and matters in the public interest.

2.2 Workforce Metrics

The workforce metrics presentation was talked to.

Sonya Lam asked about progress with electronic exit interviews since its' mention at the last meeting. Edwina Cameron responded that NHS Borders does now have the ability to carry out electronic exit interviews and is also offering people the opportunity to have a face to face discussion with an independent person, not associated with their place of work.

Karen Lawrie added that exit interviews are really important and we need to understand why people leave.

2.3 East Region Recruitment

Sonya Lam enquired if we have had any feedback with regards to the Regional Recruitment Service. Edwina Cameron confirmed that all Borders staff have now been TUPE transferred to NHS Lothian. NHS Borders had hoped to start the handover to the regional service in October 2021 but due to the pressure of recruitment activity across the East region, the decision has been made to slow the process. NHS Borders is not anticipating passing management to the Regional Service until Easter 2022. The Service as a whole does not want to de-stabilise recruitment at a time when NHS Boards need to recruit people quickly. The staff involved have been fully involved and informed about proceedings.

2.4 Equality, Diversity & Inclusion in Employment Group

Harriet Campbell enquired about disability monitoring. Andy Carter stated that he had met with Tris Taylor around equality generally and had also discussed this. He added that he believed NHS Borders does have a degree of under reporting of disability in the workforce and wants to work with Occupational Health colleagues to see if NHS Borders can find a way for people to disclose their disability status and for that to be kept behind a firewall to protect the data.

Harriet Campbell added that we need to be clear as to what we are asking staff, why we are asking them and to ensure they understand why we are asking them in regards to disclosing disability information. Andy Carter confirmed that when asking if someone has a disability, NHS Borders gives them the statutory definition from the Equality Act about having a long term condition usually lasting more than 12 months that adversely affects one's ability to carry out normal day to day activities. People self disclose whether they feel they are in that category or not. Andy Carter agreed that more could be done to make the case for the employer asking for this data and explaining what is done with it.

Mr McLaren asked if sickness absence information around adjustments at work might help here? Andy Carter responded that there might a link but not every adjustment will track back to a disability.

2.5 BREXIT

Harriet Campbell asked about staff who might be working illegally for NHS Borders but who might not realise that. Andy Carter stated that he had had assurances from Bob Salmond that through appropriate engagement with co-workers, all relevant staff had achieved Settled or Pre-settled status.

3. Annual SG Monitoring Return

Edwina Cameron reported that NHS Borders completes a monitoring framework and supplies this to Scottish Government. The framework used is 10 years old.

Sonya Lam asked if the Staff Governance Committee takes its' assurance from this process of submitting a report and waiting for the feedback from Scottish Government. Edwina Cameron said that this is how things are done at present.

Harriet Campbell enquired if the Committee is looking to be assured that NHS Borders has appropriately responded to the Government's monitoring framework or is the Committee looking to be appropriately assured that the Staff Governance Standard is being embraced within NHS Borders? Andy Carter explained that at present it is more the former, with Scottish Government critiquing the NHS Borders return and once that feedback is received, NHS Borders considers adapting what it does to fulfil the Staff Governance Standard/revisit its action plan. Andy Carter is happy to shift the emphasis more towards providing evidence that management teams are fulfilling their statutory commitment around Staff Governance.

The Committee noted this update

4. Workforce Metrics

Edwina Cameron delivered a presentation on behalf of Bob Salmond. Workforce Dashboard Aug 2020 – Aug 2021.

Harriet Campbell asked if there was data on the causes for the mental health and musculoskeletal absences? Andy Carter advised that there could be a link between levels of COVID activity and spikes in absence attributed to mental health issues and musculoskeletal problems. There has also been a degree of short-staffing in some areas too, putting added pressure on the workforce.

Sonya Lam asked Andy Carter if NHS Borders operates an Occupational Health Physiotherapy service. Andy Carter confirmed that NHS Borders does have a Staff Physiotherapist who has been performing in-person consultations since around April 2021.

John McLaren said that many staff are exhausted from the ongoing emergency response to COVID.

Andy Carter described some of the interventions to help staff at this difficult time including the National Wellbeing Hub, the Workforce Specialist Service, the military Aid for Civil Agencies and the increase in referrals/counselling going on inside Occupational Health.

The Committee approved this update

5. Workforce Risks

Lettie Pringle discussed her report on how the health board discharges its risk management responsibilities through its governance committees. The SGC has a responsibility for providing assurance to the board on risks associated with workforce. The committee has to consider risks that may require further scrutiny and seek assurance from risks owners regarding the management of these risks.

John McLaren suggested that the SGC cannot accept the risk or be assured of the risk around staff wellbeing; stating this is a significant issue and even accounting for all preventative activity in this arena, staff still feel under pressure and staff are still taking sick leave. Sonya Lam questioned whether NHS Borders has enough staff capacity.

Lettie Pringle confirmed that the report is slightly out of date, not picking up on the appointment of a new Medical Director in Autumn 2020.

The Committee approved this update with the caveat around the concerns that John McLaren raised

6. iMatter Update

Jennifer Boyle talked to this paper.

The overall response rate in 2021 was 52%, 1% lower than our iMatter response rate in 2019.

NHS Borders Employee Engagement Index (EEI) score was 74, down by 2 points from 2019.

NHS Borders is now in an action planning stage and encouraging teams to engage with the action planning process.

Harriet Campbell asked how the EEI is calculated and what is the SGC's role in engaging with iMatter. Jennifer Boyle confirmed that the calculation of the EEI score is relatively complex and shared the following explanation: 'The Employee Engagement Index (EEI) is calculated based on the number of responses for each point on the scale (Strongly Agree to Strongly Disagree) multiplied by its number value (6 to 1). These scores are added together and divided by the overall number of responses to give the score to show level of engagement'[1]. Jennifer Boyle sought the SGC's ongoing commitment to embrace iMatter and encourage all managers to do the same. John McLaren added that the SGC are key players in ensuring that the Health Board take this responsibility seriously.

David Parker asked Andy Carter to craft a Staff Share on the back of discussions today, encouraging engagement with the action planning process. Andy Carter was very happy to work with Councillor Parker on this.

[1] Sentence inserted into Minutes as agreed at December SGC meeting.

The Committee approved this update.

7. Living Wage Accreditation

John McLaren updated the Committee that NHS Borders is now formally accredited as a Living Wage employer and everything is in place for us to ensure that there is follow-up and review in the future. NHS Borders will be on two websites identified as Public Sector employers who are Living Wage employers, including Poverty Alliance Scotland. NHS Borders is working with SBC and other local businesses on a project called the "Eildon Project" to try and encourage more businesses within the Central Borders to join us in terms of becoming a Living Wage employer.

The Committee approved this update.

8. Any Other Business

No other business

The Chair closed the meeting by thanking people for attending.

Date of next meeting:

14th December 2021, 2.30pm, via Microsoft Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**Alison Wilson, Non Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Area Clinical Forum with the Board.

2.2 Background

The minutes are presented to the Board as per the Area Clinical Forum Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board as per the Area Clinical Forum Terms of Reference and also in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Area Clinical Forum 30 November 2021

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Area Clinical Forum minutes 05.10.21

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 5th October 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)
Suzie Flower Ass Nurse director, Chief Nurse H&SC, BANMAC Chair
John McLaren (Employee Director) (JMcL)

1 APOLOGIES and ANNOUNCEMENTS

AW welcomed those present to the meeting and acknowledged the apologies listed above.
AW also gave a warm welcome to Callum Cowan, our newest management trainee and thanked Peter Lerpiniere for his tenure at ACF as BANMAC chair. We look forward to welcoming Suzie Flower as new BANMAC chair, to the ACF at our next meeting.

2 Unscheduled Care Winter Plan – Gareth Clinkscale

Gareth Clinkscale provided a short presentation to the committee, giving an overview of this year's Winter plan:

- current health challenges, falling staff numbers from demographic changes
- Rising demand and acuity
- Resurgence of infectious diseases; Covid activity is expected to peak alongside Flu, Norovirus. However with the general public being more careful and practicing hand hygiene, this will hopefully help to lessen the spread.

The main priorities of the 21/22 winter plan are to create maximum use of community capacity, multi role and grade recruitment strategy (means greater variety of roles and grades – even funding council HR posts to recruit to home care etc). Robust delivery management and contingency plans; we have a paediatric plan due to Respiratory syncytial virus (RSV) as we are seeing these levels increasing. The winter plan also is focuses on protecting electives; there are around 1900 patients waiting for elective surgery.

We are adopting processes that worked well in previous years and investing in advanced AHP capacity. There are some elements that are different this year, for example:

- Enhancing community capacity – we recruit to more home first posts,
- Paediatric plan for increased capacity on w15
- Trial to increase consultancy cover out of hours care, for the next 6 months,
- Older persons assessment area in MAU
- Exploring protected elective capacity – work in progress

- Community care review team
- RSV modelling
- Increasing minor injuries capacity in localities community treatment assessment centres (CTAC)

The committee were advised that in relation to RSV, NHS Borders numbers were relatively low, compared to Lothian and Tayside. It was noted that electives are currently cancelled until the end of next week. Work is ongoing to ensure electives are protected, and a paper going to clinical prioritisation group to ensure a baseline staffing for electives. The planning is that the electives will restart w/c 18th October.

The committee learned that the winter planning board discussed the management of long term conditions, respiratory, frailty and cardiology; clinical reps are to be identified to see what else can be done to support this. The frailty work is underway but not as well-known as the others and will be pulled together to ensure no double doing. There will be an update at next week's winter board meeting on this.

GC advised that management and teams are having to re-evaluate some plans, likely to see greater demand for Covid than expected, registered nurses are being utilised in the best way possible.

3 DRAFT MINUTE OF PREVIOUS MEETING 22.06.21

The Minute of the previous meeting, held on 22nd June 2021, was read and approved as an accurate record of the meeting with no changes.

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:-

ACTION: AW to meet with Ehsan Alanizi and Jackie Scott to discuss deputy attendance.

Safe staffing – no response from HR as yet for this, Kim to follow up.

5. East region Formulary (ERF)

This has been to other committees; we have taken decision to move to ERF as the existing platform is no longer fit for purpose. A single formulary for Scotland was proposed, but too difficult. Lothian got funding to look at an ERF. We have close link with Lothian around specialist services and we are aligned in similar ways of working. The move to new formulary platform in 2022, Lothian's systems are up and running and looking good. Fife and NHSB are producing ongoing work on a PDF format.

There is a national dental formulary also, asking for relevant specialists to be involved as and when required.

6 RMP4

ACF members were invited to the latest iteration and discussion. RMP4 was submitted on 30th Sept, updates to follow in due course.

CLINICAL GOVERNANCE COMMITTEE: FEEDBACK – AW

Clinical Prioritisation (CP) was a focus of this meeting, and as it turned out, we didn't need to enact the plan, which is good. CP meetings are held on a Monday in order to maintain sight of current situation, especially now as we are going into winter.

HSMR data were all within normal levels.

107 Covid deaths, these are reviewed as part of Mortality review.

Digital strategy – paper to OPG on Monday, taking that forward as a board and we welcome this work.

9 PUBLIC GOVERNANCE COMMITEE: FEEDBACK

No update as this meeting wasn't attended due to a diary clash.

10 NATIONAL ACF CHAIRS MEETING: FEEDBACK

AW unable to attend the last meeting but Caroline Lamb, Director General for Health & Social Care was in attendance. Next ACF national meeting is in November 2021.

11 NHS BOARD PAPERS: DISCUSSION

No discussion required.

12 PROFESSIONAL ADVISORY COMMITTEES

12(a) Area Dental Advisory Committee (RZ) -

Topics discussed at the Dental Advisory committee were:

- Access issues, due to advanced infection Control procedures and fallow times, SG have made grants available for ventilation and equipment to assist with AGPs
- Recruitment – not only the dentists, but all dental care professionals.
- Hospital dental services – last ADC meeting last week saw the same position as of June 2021 that there is one consultant on long term leave, there is limited access to theatres, some staff leaving or retiring.

The Public Dental Service is overwhelmed with unscheduled care and long waiting lists, especially for Paediatric patients. Child smile has restarted so this is positive news.

Management of significant events – all contractors have been informed - there's a gap in the governance of this; there seem to be no pathway for reporting significant events however it is believed that this will be coming soon.

AW noted this update and also commented that the current situation that dental colleagues are seeing was mentioned at the recent Clinical Governance committee.

GP and AHP colleagues would also welcome clarification of guidance in 'closing the loop' on clinical incidents and avoidance of double doing between the Health board and external contractors.

12 (b) Area Medical Committee/GP Sub Group (KB):
GP Sub – pivoting towards CIG (clinical interface group)
What is PC/GP remit? Seeing unfunded shift of work that is going to Primary care, there is a meeting this Thursday to settle the issues.

AMC
The group is functioning well. Chronic disease management conversations with clinicians ongoing on how to link / improve flow for patient between primary and secondary care. Meeting due in October.

12 (c) Area Ophthalmic Committee (NH) –
There was a catch up meeting at end of August, talking about first port of call, monitoring conditions coming through
Jeff setting meeting with hospital staff to discuss what is primary care and what is secondary care
Work ongoing to standardise practices
No AGM meeting has been arranged as yet.
When there are no staff in the Eye Centre, a referral pathway needs to be developed rather than sending patients to the Emergency Department.

12 (d) Area Pharmaceutical Committee (AW) –

Palliative Care service was launched in September, available from 6 pharmacies across Border localities. There is no pharmacy in Galashiels on the books as yet, due to pharmacist availability. They stock additional supplies for palliative care patients.
We are progressing with Tweedbank pharmacy application; this is now out for consultation. We will then collate responses and create a report, which will go to pharmacy practices committee.
Pharmacies are signing up to the Vaccine transformation programme.
There is lots of work going ahead with Pharmacy first; a number of pharmacists are being trained as independent contractors, and we are looking for more to train up.

12 (e) Allied Health Professionals Advisory Committee (PW) –
There are a lot of things happening at the moment:

- There are pressures across the 3 clinical boards – we strive to balance, react and support as best we can.
- The service has not been as stretched, seeing some difficulty recruiting to AHP posts which we have not experienced before.
- Ongoing work occurring to the AHP career framework
- Service specification work going on, governance and performance (access times, clinical outcomes etc.)
- Staff and teams supporting staff wellbeing / development despite challenges

AW commented that it is unusual that AHP roles have not been filled, as it was usually due to lack of fixed posts. Now there are fixed posts, it seems that these are challenging to recruit to. PW

advised that the AHP service are looking to develop general skills across professions, to make the service more resilient.

12 (f) BANMAC (SF)

The last meeting of BANMAC was in September, however it was poorly attended which resulted in a lack of feedback. A joint strategy of nursing, midwifery and AHPs was discussed, along with a Terms of reference refresh.

Cross boundary working is also being worked on. How can district nursing work across different services. Need to ensure we have the correct representation at BANMAC.

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

- Dental services are finding it problematic to recruit to posts, with long waiting lists, especially in paediatrics. Management of significant events; there is currently no reporting mechanism for this,
- A referral process for Nicky and kevin re: referral process
- A Referral pathway needs to be developed for primary care to secondary care, rather than sending patients to the Emergency Department.

13 ANY OTHER BUSINESS

No other business was raised.

DATE OF NEXT MEETING

The next Area Clinical Forum meeting is scheduled for **30th November 2021** at 13:00 via Microsoft Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**NHS Borders Performance Scorecard**
Responsible Executive/Non-Executive:	**June Smyth Director of Planning & Performance**
Report Author:	**Gemma Butterfield Planning & Performance Officer**

1 Purpose

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 (RMP4) alongside key targets and standards that were included in previous Annual Operational Plans Local Delivery Plans (LDP).

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Safe
- Effective

2 Report summary

2.1 Situation

Following Scottish Government Sign off of RMP4 NHS Borders Performance Scorecard has been updated to reflect agree performance measures whilst retaining performance against previous AOP/ LDP Measures.

2.2 Background

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, followed by a mid-year update (RMP4). 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.

2.3 Assessment

This is the first meeting that the updated performance scorecard has been presented to Board Members. It is anticipated that the format will continue to develop as the Business Intelligence Team continue to work and agree a final format going forward and in align with Active Governance.

The Quarterly RMP4 trajectories will be added to the scorecard next month, which will be presented to the Resource & Performance Committee at their March 2022 meeting, when the December position is reporting to ensure the full quarter is reported.

The operational teams continue to align their resource to the current pressures being faced due to the OMICRON COVID-19 response, and the impact this is having services. Therefore, Planning & Performance have compiled this reported without their input using information available. We anticipate that this will only be the case for this paper, and we will return to more detailed narrative for the next iteration of performance reporting.

There are four areas of performance that are reported outwith of agreed performance standard for November 2021:

<u>18 Weeks Referral to Treatment (RTT)</u>

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.

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. Work is actively underway to increase physical space available to carry out outpatient activity, with project management support being given by the PMO.

<u>CAMHS 18 Week referral to Treatment Time</u>

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.

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.

A&E 4 Hour Emergency Access Standard

Our A&E department continued to face significant pressures in November with return to pre COVID-19 attendee numbers including significant long waits for inpatient beds which impacted on flow.

Sickness Absence

NHS Borders absence rate (sickness and COVID-19) for November 2021 was 7.4%, of which 1.1% was COVID-19 related and 6.3% non-COVID-19 related. In comparison to the month of October 2021 we have seen a decrease in COVID-19 related absence decreasing from 1.3% to 1.1%.

2.3.1 Quality/ Patient Care

The RMP4 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.

2.3.2 Workforce

Directors are asked to support the implementation and monitoring of measures within their service areas.

2.3.3 Financial

Directors are asked to support financial management and monitoring of finance and resource within their service areas.

2.3.4 Risk Assessment/Management

There are several measures that are not being achieved, and have not been achieved recently. For these measures service leads continue to take corrective action or outline risks and issues to get them back on trajectory. Continuous monitoring of performance is a key element in identifying risks affecting Health Service delivery to the people of the Borders.

2.3.5 Equality and Diversity, including health inequalities

Health Inequalities Impact Assessments have been completed for earlier remobilisation plans and there is one currently in production for RMP3 which was shared with the RMP4 ratification item at December 2021 Board Meeting.

2.3.6 Other impacts

None Highlighted

2.3.7 Communication, involvement, engagement and consultation

Performance against measures within this report has been reviewed by each service area.

2.3.8 Route to the Meeting

The Performance Scorecard has been developed by the Business Intelligence Team with any associated narrative being collated by the Planning & Performance Team in conjunction with the relevant service area.

2.4 Recommendation

- **Note- November 2021 Performance**

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

NHS Borders

PERFORMANCE SCORECARD

As at 30th November 2021

January 2022

Information & BI Services

Month

1
2
3
4
5
6
7
8
9
10
11
12

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

As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Pan has been replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, therefore this report contains RMP4 trajectory performance, but also continues to demonstrate previous AOP and LDP measures. Please note RMP4 Template 1projections have been set quarterly rather than monthly as per Scottish Government Guidance.

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 RMP4 Trajectories where applicable

November 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 [1]

Oct 2021		Nov 2021	Trajectory	
435	↑	432	984	✓

Inpatient/Daycase patients waiting > 84 days TTG target as at month end

Oct 2021		Nov 2021	Trajectory	
36	↓	85	374	✓

New Inpatients waiting > 12 weeks target as at month end [1]

Oct 2021		Nov-21	Trajectory	
1504	↓	1582	2131	✓

Cancer Waiting Times 31-day target

Sep 2021		Oct 2021	Target	
1	↑	1	≥ 95%	✓

New Outpatients waiting > 12 weeks target as at month end [1]

Oct 2021		Nov 2021	Trajectory	
5819	↑	5927	7181	✓

November Reported Performance - Area Outwith Standard/Trajectory but within Tolerance

Cancer Waiting Times 62-day target

Sep 2021		Oct 2021	Target	
86.2%	↑	93.1%	≥ 95%	X

Psychological Therapy Referral to Treatment within 18 weeks

Sep 2021		Oct 2021	Target	
89.0%	↓	82.1%	≥ 90%	X

All Delayed Discharges as at census date (last Thursday of the month) [1]

Oct 2021		Nov 2021	Trajectory	
61	↑	51	43	X

November Reported Performance - Area Significantly Outwith Standard/Trajectory

% of patients seen within 18 weeks Combined Performance

Oct 2021		Nov 2021	Target	
76.7%	↓	74.6%	≥ 90%	X

CAMHS patients treated within 18 weeks from referral to treatment

Sep 2021		Oct 2021	Target	
70.6%	↑	75.0%	≥ 90%	X

A&E patients discharged or transferred within 4 hour target

Oct 2021		Nov 2021	Target	
75.9%	↓	69.6%	≥ 95%	X

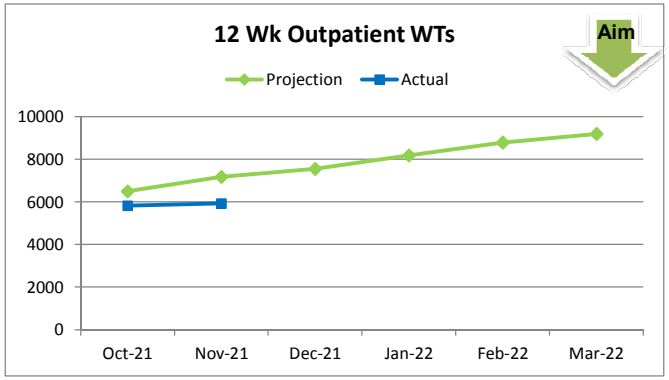
Maintain Sickness Absence Rates below 4%

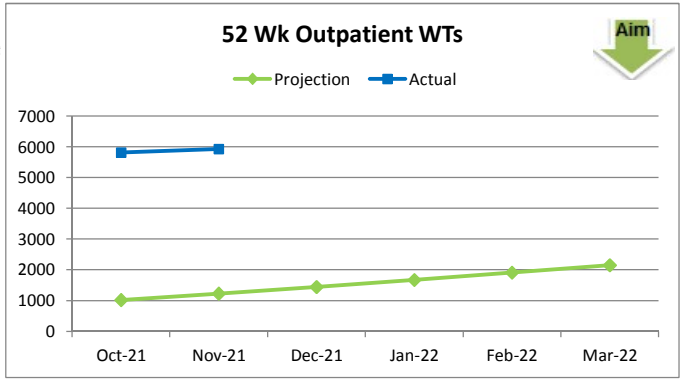
Oct 2021		Nov 2021	Target	
6.1%	↓	6.3%	4.0%	X

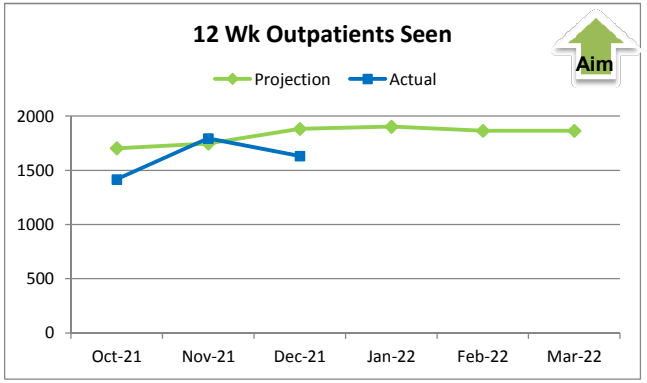
[1] These are RMP4 trajectories

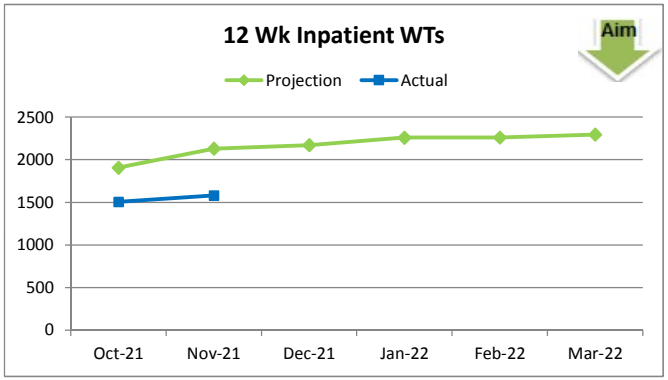
Please Note: Next month RMP4 Template 1 trajectories will be included at Q3 2021/22 quarter end

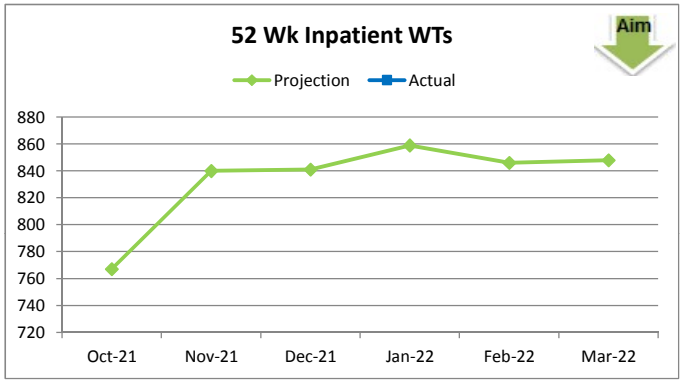
Remobilisation Plan 4

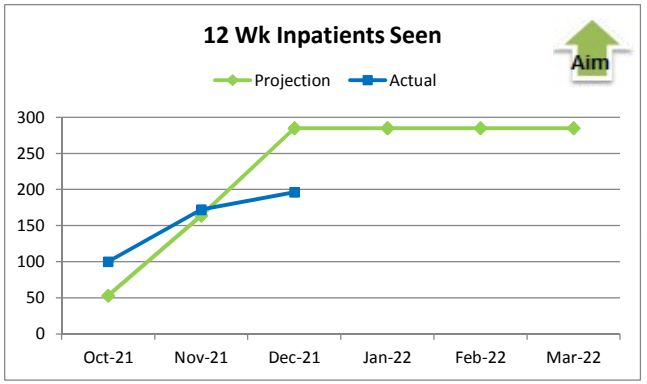


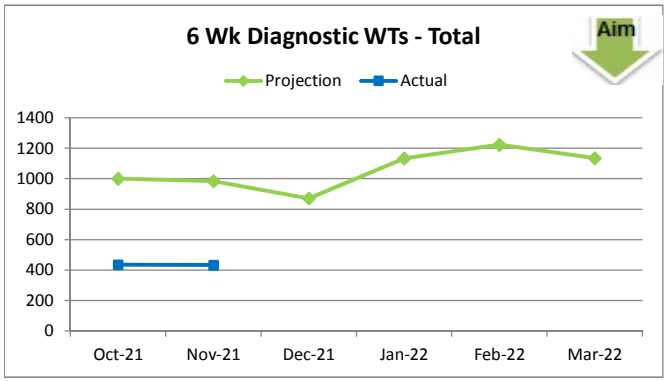


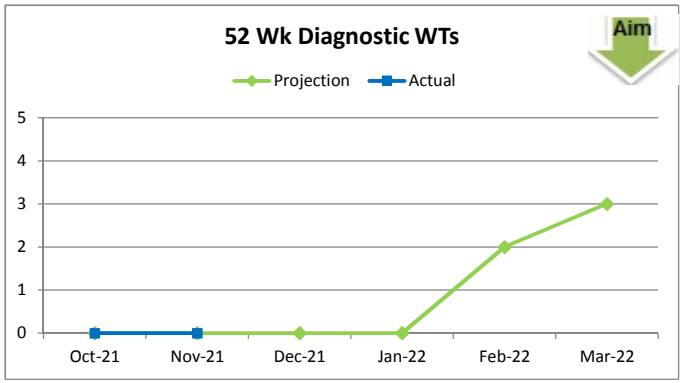


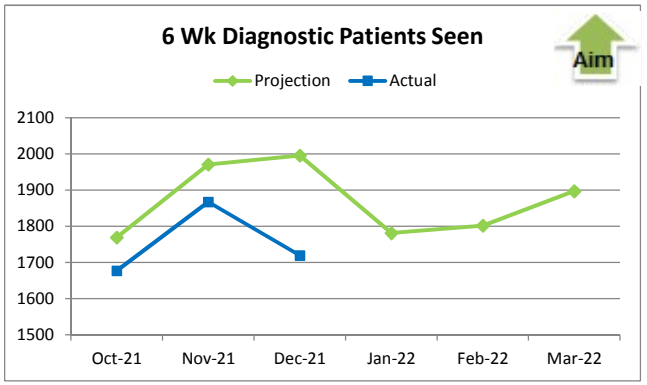






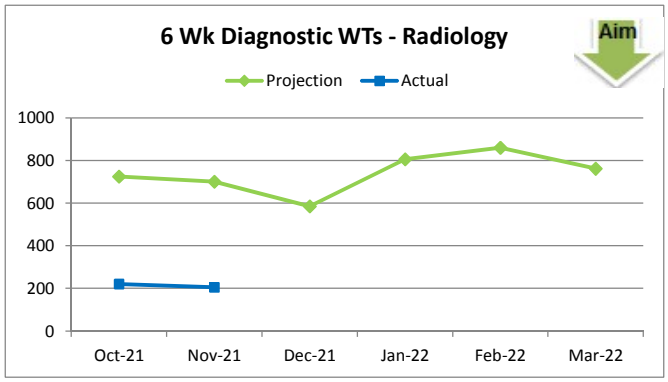


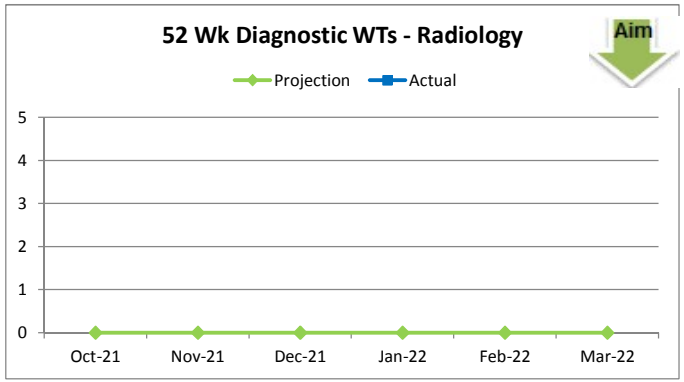


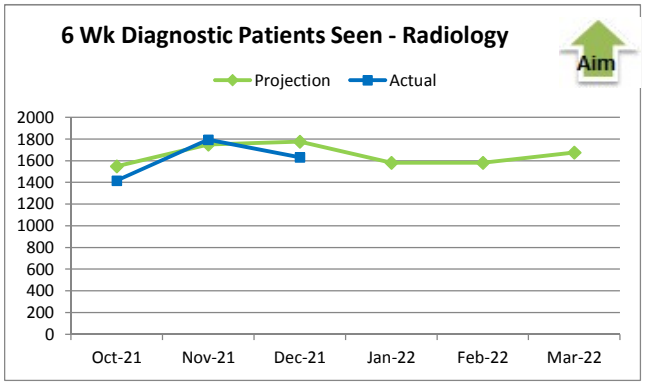


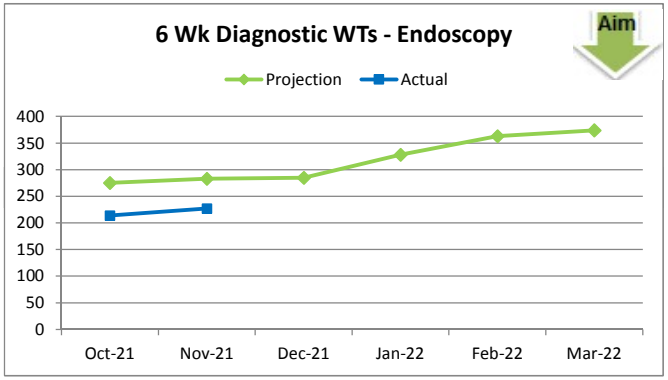
Remobilisation Plan 4

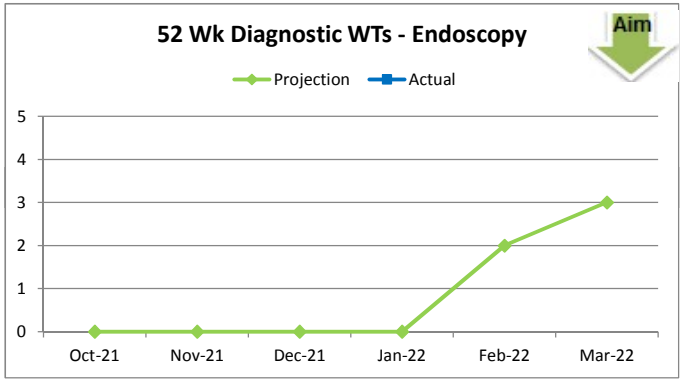
Diagnostics Detail

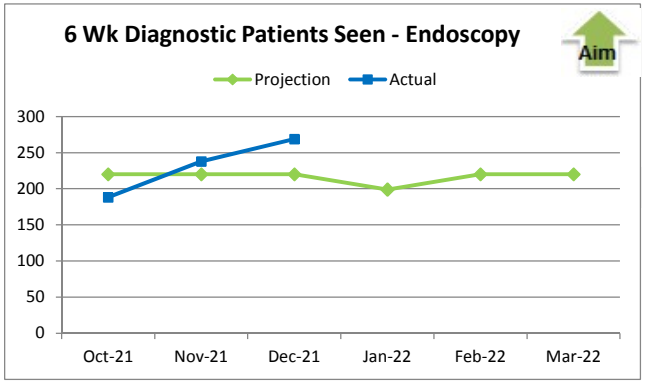




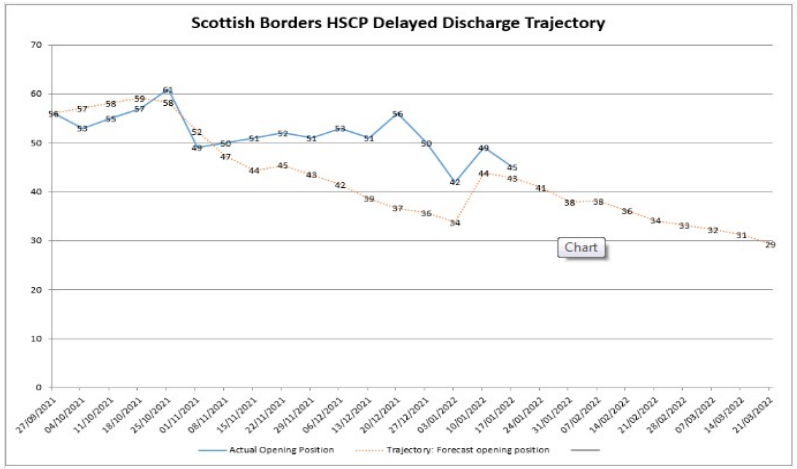






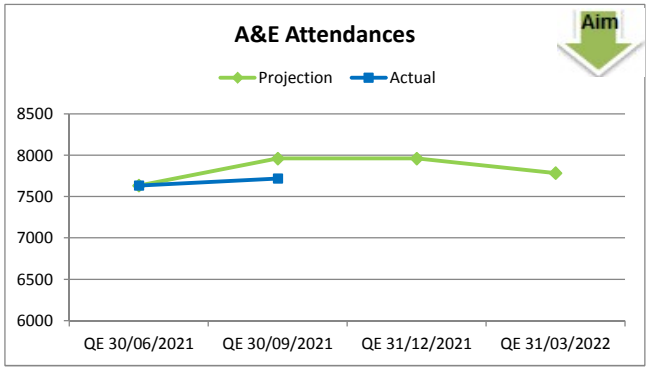


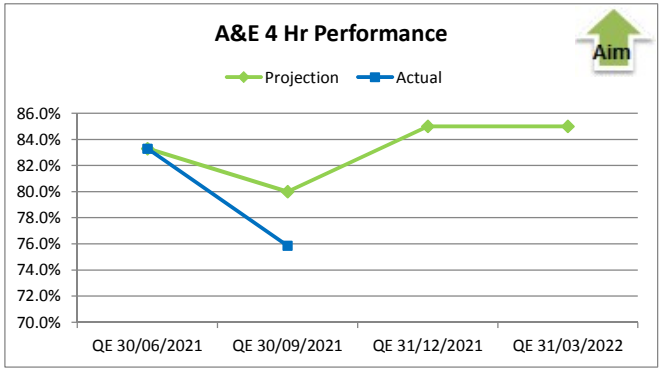
Delayed Discharges Trajectory

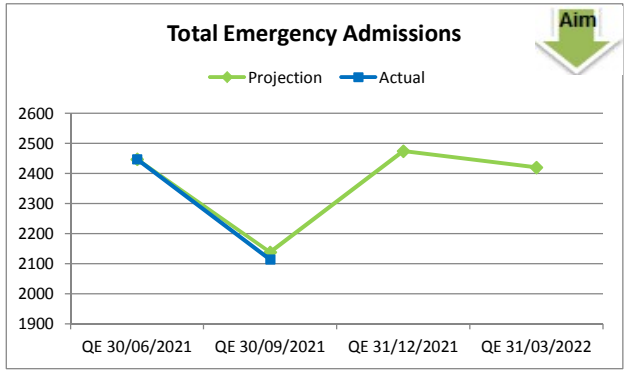


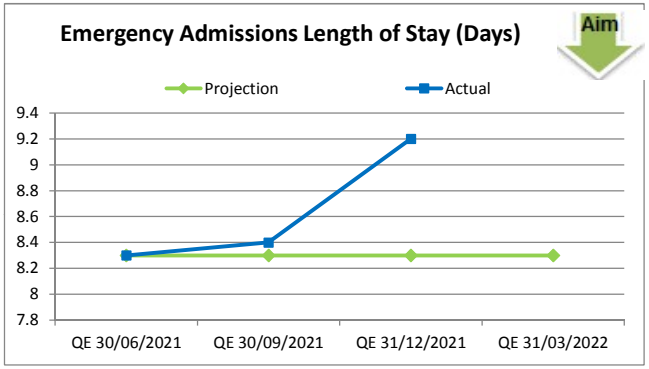
Remobilisation Plan 4

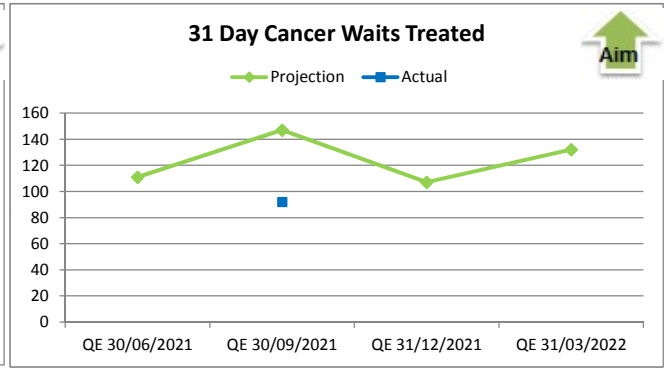
Quarterly Achievement - Template 1

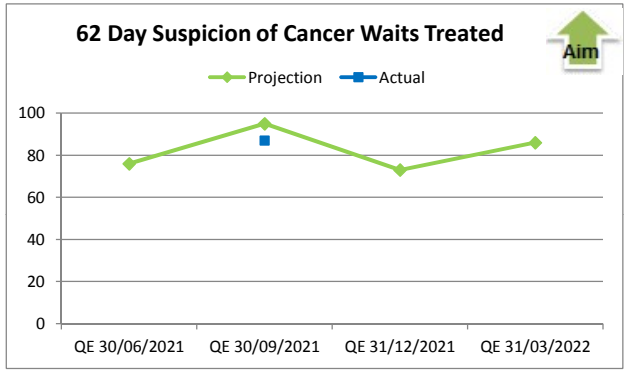


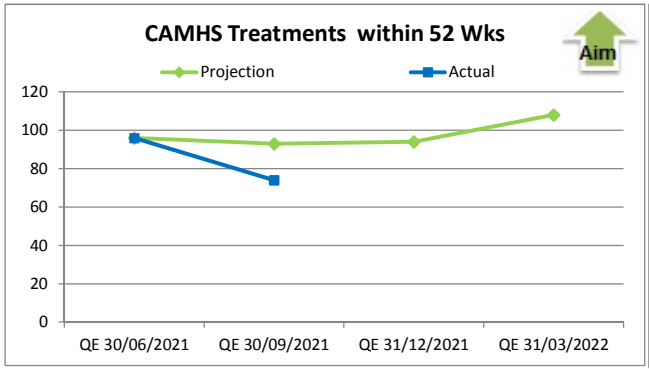


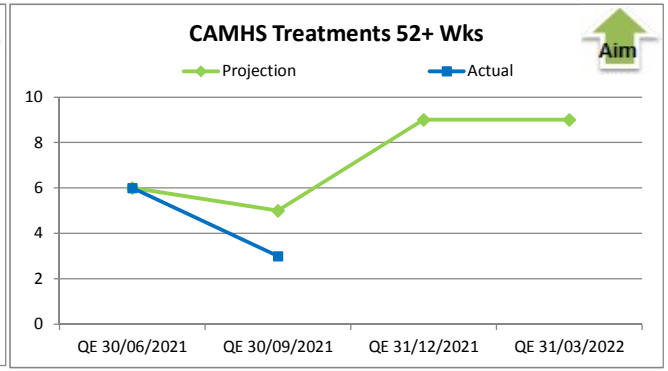


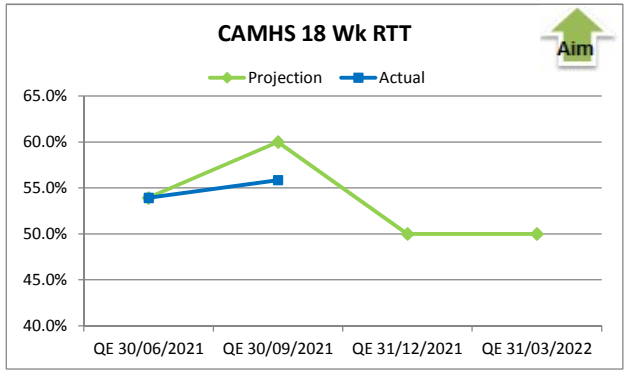






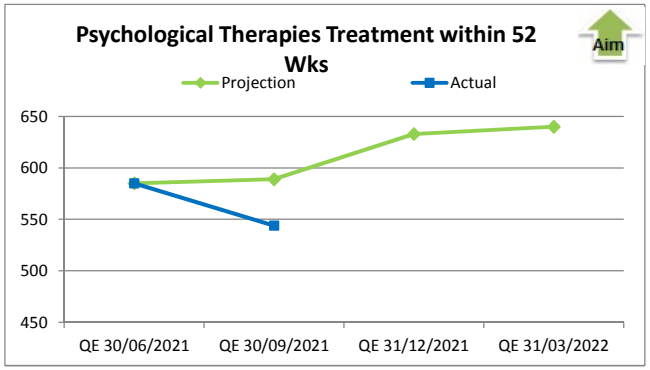


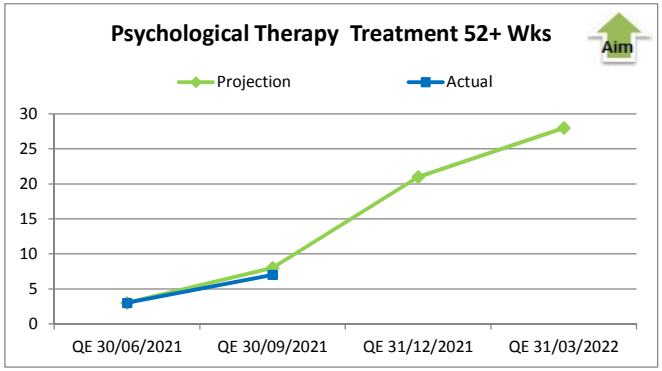


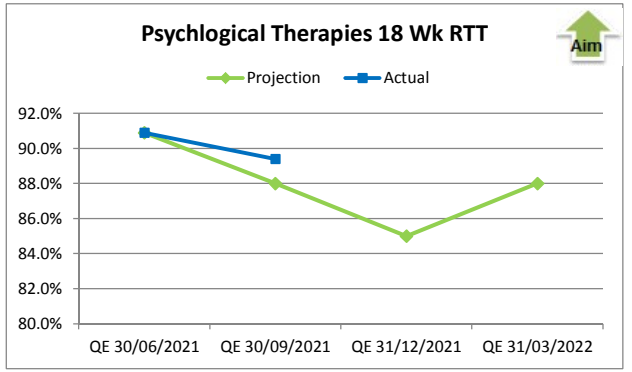


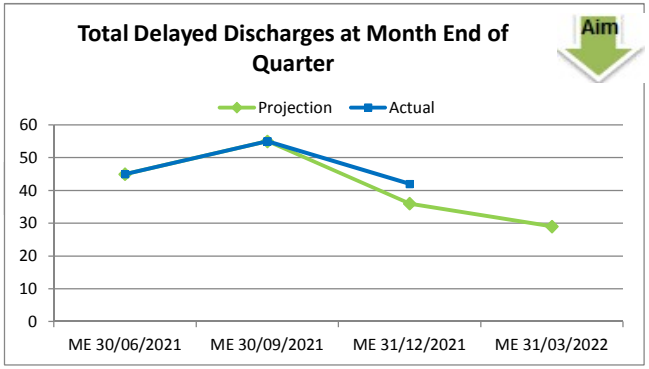
Remobilisation Plan 4

Quarterly Achievement - Template 1









Annual Operating Plan 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%

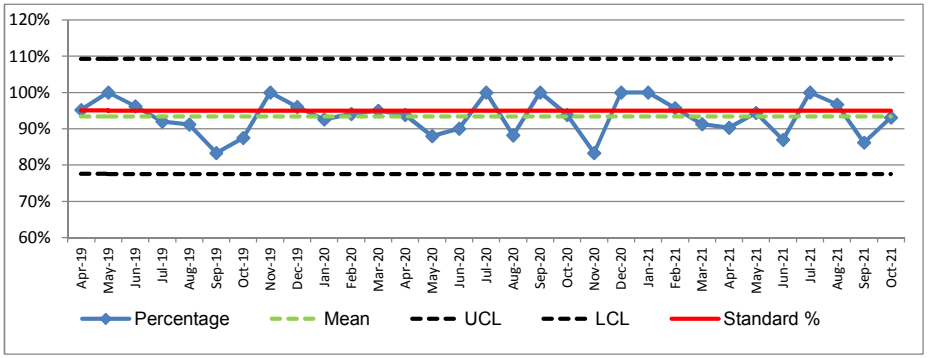
Tolerance
86.0%

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%	93.1%					
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)



---

31 Day Cancer - 95% of all patients requiring Treatment for Cancer to be seen within 31 days

Standard
95.0%

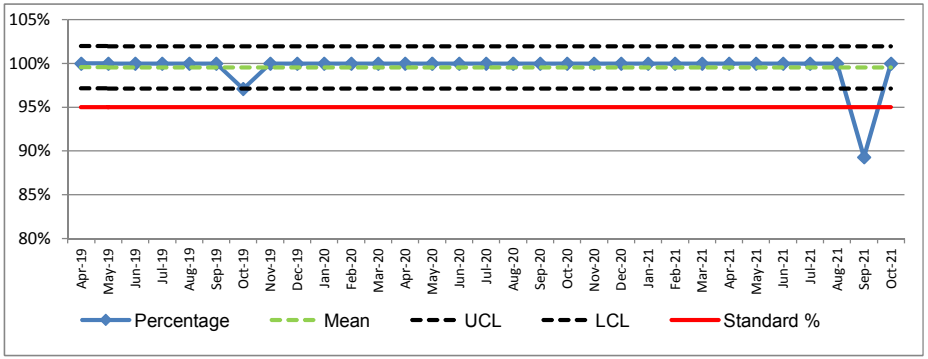
Tolerance
86.0%

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%	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%	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

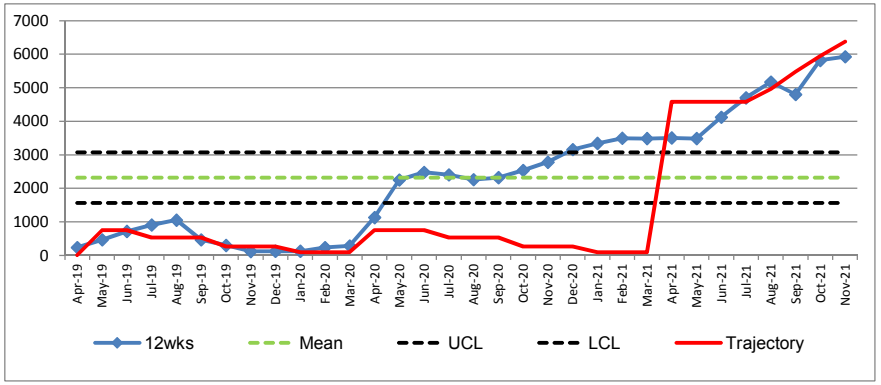
Standard - 12 weeks for first outpatient appointment

Trajectory
6373

Tolerance
7004

Latest NHS Scotland Performance	**NHS Borders Performance (as a comparative)**
53.0% (June 2021)	49.7% (June 2021)

Actual Performance (lower = better performance)



	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	5927				
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

12 week breaches by specialty

	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	Nov-21
Cardiology	53	37	43	51	66	94	108	134	151	163	162	175	162	250	273	261	147	252	265
Dermatology	460	523	524	500	526	526	550	616	562	550	534	402	534	505	597	695	707	864	941
Diabetes/Endocrinology	26	39	43	43	43	41	34	42	50	51	56	66	56	84	101	104	105	101	52
ENT	149	180	182	184	202	225	262	296	350	354	378	414	378	548	530	446	387	420	409
Gastroenterology	15	20	23	22	24	23	25	37	50	71	76	91	76	106	109	140	125	138	130
General Medicine	6	11	14	5	2	1	0	0	1	2	1	0	1	0	1	0	5	0	2
General Surgery	105	161	187	218	302	383	433	461	481	564	628	682	628	677	712	743	733	762	736
Gynaecology	131	168	148	122	80	75	93	99	101	103	90	81	90	71	98	123	165	219	228
Neurology	145	167	163	144	146	149	159	164	145	130	83	67	83	103	136	171	177	184	205
Ophthalmology	284	375	379	376	376	467	545	695	807	873	907	925	907	1120	1275	1433	1200	1634	1710
Oral Surgery	284	335	342	299	273	272	274	251	217	148	44	25	44	19	10	8	5	12	11
Orthodontics	20	22	22	22	22	26	28	29	33	40	39	41	39	27	35	36	41	55	55
Other	134	137	123	100	98	83	66	67	73	91	97	103	97	99	96	103	86	78	65
Pain Management	26	27	23	18	5	1	0	0	0	0	0	0	0	0	0	0	0	1	1
Respiratory Medicine	8	10	9	8	24	54	74	101	114	120	130	141	130	163	181	200	160	236	250
Rheumatology	3	18	21	11	7	2	3	5	10	7	10	5	10	12	28	24	21	26	19
Trauma & Orthopaedics	328	124	32	17	5	1	3	9	17	17	9	6	9	10	141	262	323	351	350
Urology	76	128	128	123	123	119	126	152	182	214	245	283	245	329	379	423	414	486	498
All Specialties	**2253**	**2482**	**2406**	**2263**	**2324**	**2542**	**2783**	**3158**	**3344**	**3498**	**3489**	**3507**	**3489**	**4123**	**4702**	**5172**	**4801**	**5819**	**5927**

Stage of Treatment - 12 Weeks Waiting Times Continued

Standard: 12 Weeks Waiting Time for Inpatients

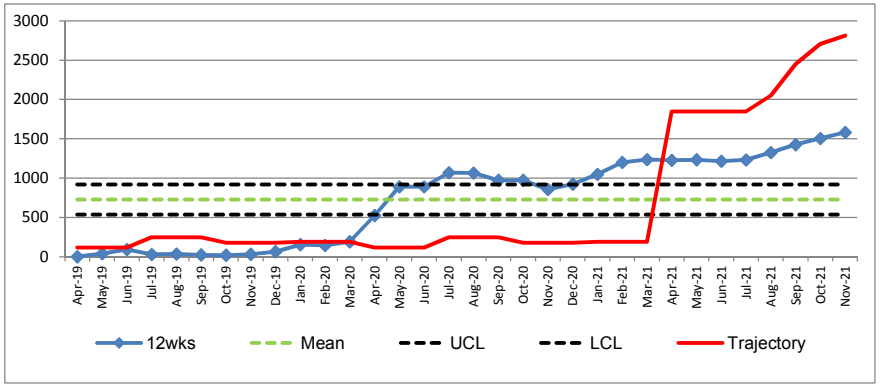
Trajectory
2814

Tolerance
3093

	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	1582				
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

	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	Nov-21
ENT	43	43	61	62	52	36	30	25	34	39	34	32	33	37	40	39	41	48	46
General Surgery	146	147	167	161	130	120	116	122	144	163	173	160	160	154	158	195	214	231	240
Gynaecology	73	73	79	82	71	71	63	67	81	100	108	115	109	110	107	115	135	149	164
Ophthalmology	190	190	238	243	236	229	219	212	222	249	239	238	233	218	221	236	246	249	253
Oral Surgery	31	31	41	39	36	35	37	39	49	57	58	65	72	76	82	90	92	101	109
Trauma & Orthopaedics	356	356	413	402	386	342	323	389	439	503	527	526	548	547	562	590	635	656	686
Urology	51	51	71	75	62	61	69	70	79	90	97	91	79	73	63	60	63	70	84
All Specialties	**191**	**525**	**1070**	**1064**	**973**	**894**	**857**	**924**	**1048**	**1201**	**1236**	**1227**	**1234**	**1215**	**1233**	**1325**	**1426**	**1504**	**1582**

12 Weeks Treatment Time Guarantee

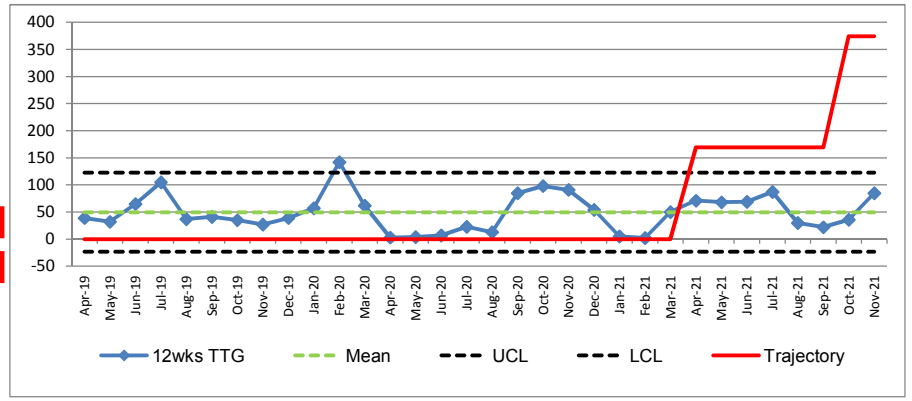
12 weeks TTG - 12 Weeks Treatment Time Guarantee (TTG 100%)	Trajectory
	374

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
64.2% (June 2021)	48.2% (June 2021)

Tolerance: 411

	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	85				
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)

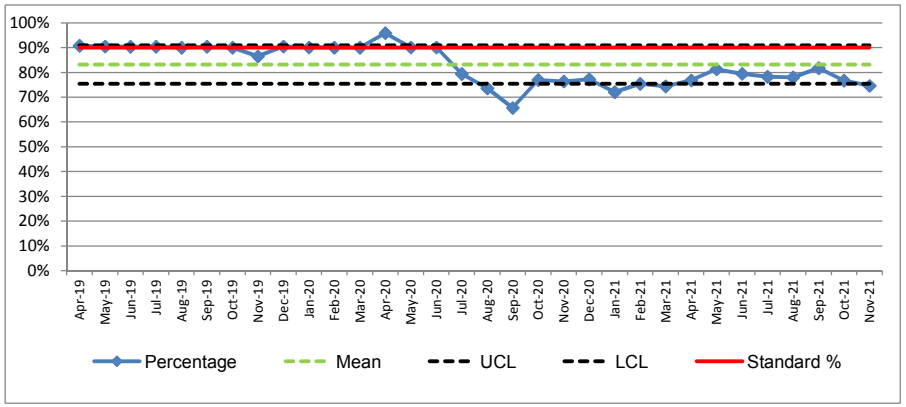
Standard: Combined Pathway Performance	Standard
	90.0%

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%	74.6%				
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

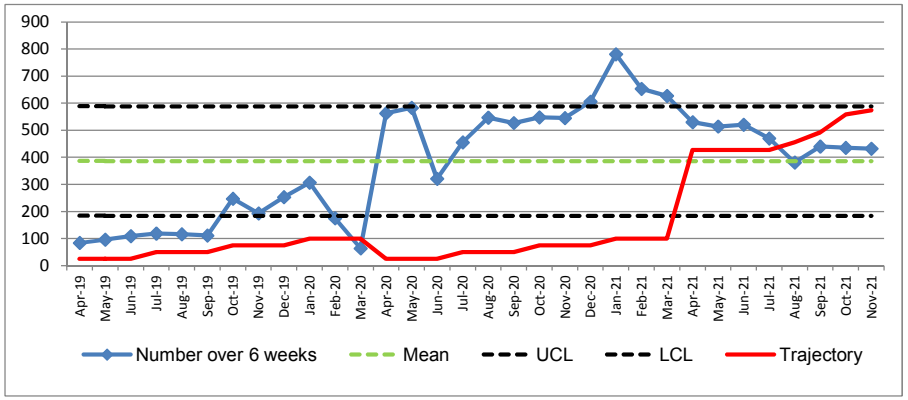
Diagnostic Waiting Times

Waiting Target for Diagnostics - zero patients to wait over 6 weeks	**Trajectory** 574

Tolerance 631

	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	432				
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
Trajectory 2019/20	25	25	25	50	50	50	75	75	75	100	100	100
2019/20	84	96	109	119	116	111	247	193	253	307	175	64

Actual Performance (lower = better performance)



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	**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**	**Nov-21**
Endoscopy	20	10	17	21	29	53	63	75	95	101	109	118	123	132	152	155	168	173	180
Colonoscopy	47	36	31	38	38	34	12	4	28	26	41	50	43	39	43	26	31	34	37
Cystoscopy	17	19	24	37	30	31	40	36	38	30	14	17	27	23	20	5	3	7	10
MRI	92	116	130	127	99	106	112	124	191	113	96	77	127	143	90	27	17	18	27
CT	145	132	157	199	176	139	117	132	197	221	260	168	138	151	137	107	130	92	91
Ultra Sound (non-obstetric)	245	108	82	101	138	173	195	233	232	162	107	100	56	31	28	54	88	108	80
Barium	17	19	14	24	17	12	6	2	0	0	0	0	0	2	0	7	3	3	7
Total	**583**	**440**	**455**	**547**	**527**	**548**	**545**	**606**	**781**	**653**	**627**	**530**	**514**	**521**	**470**	**381**	**440**	**435**	**432**

CAMHS Waiting Times

18 weeks CAMHS - 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)

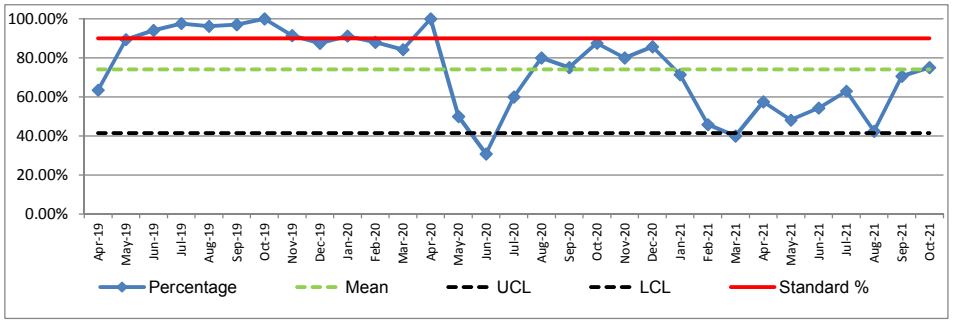
Standard
90.0%

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%	75.0%					
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

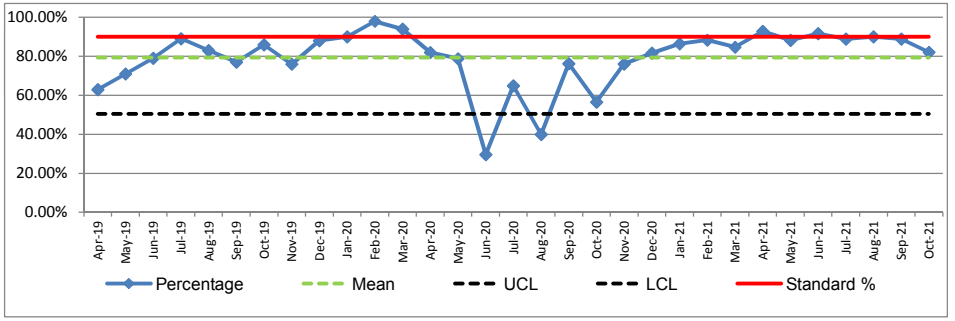
Standard
90.0%

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%	82.1%					
Total Patients Currently Waiting >18 Weeks:	215	170	166	164	160	171	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%

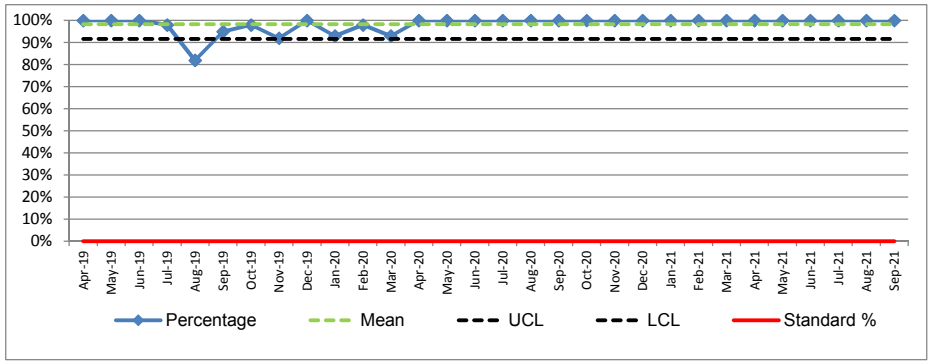
Tolerance
81.0%

Latest NHS Scotland Performance
95.6% (Jan - Mar 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%
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%

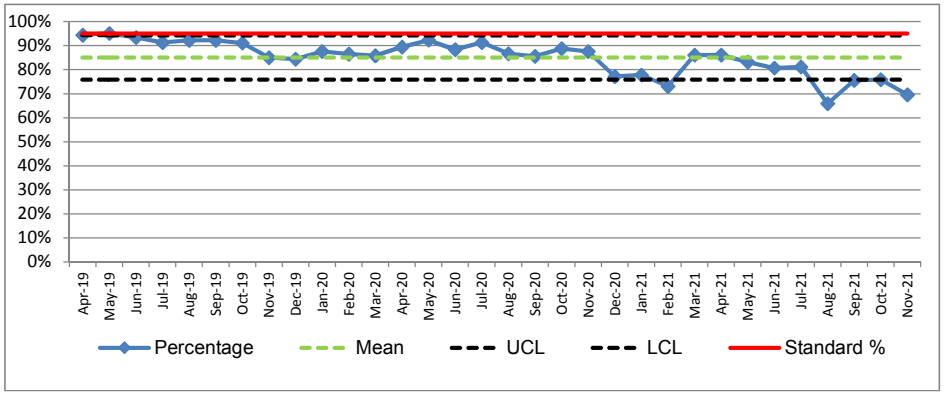
Latest NHS Scotland Performance

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%	69.6%				
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	**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**	**Nov-21**
Flow 1	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%	96.8%
Flow 2	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%	70.1%
Flow 3	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%	40.0%
Flow 4	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%	48.1%
Total	**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%**	**69.6%**

Note: December 2020 ED Significant Facility 32 MIU opened. EAS calculated on unplanned attendances only.

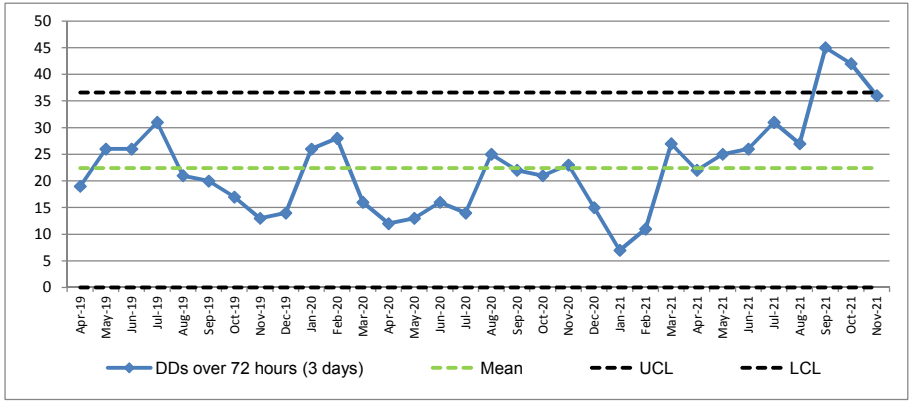
Delayed Discharges

Standard: Delayed Discharges - delays over 72 hours	**Standard** 0	**Tolerance** 1

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DDs over 2 weeks 2021/22	15	15	15	21	24	27	31	26				
DDs over 72 hours (3 days) 2021/22	22	25	26	31	27	45	42	36				
Occupied Bed Days (standard delays)	852	885	947	1077	1086	1426	1580	1342				
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

Actual Performance (lower = better performance)



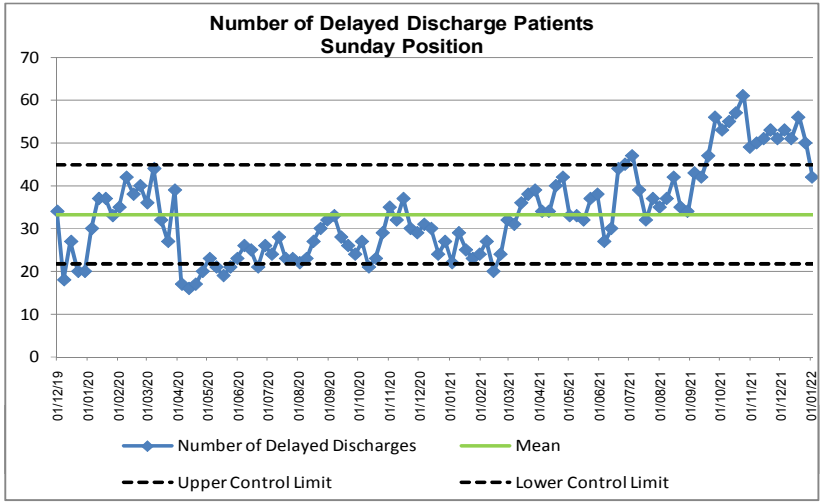
Please Note: The census date changed nationally in July 2016 from 15th of every month to the last Thursday of every month

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 November 2021

Reason for Delay	Cases	Average LoS
1. Assessment	6	9.8
2. Waiting Residential Home	7	24.3
3. Waiting Nursing Home	4	19.5
4. Waiting Care Arrangments to go Home	34	24.3
5. Patient and family related reasons	5	7.2
6. Complex	1	41.0
Total	**57**	**21.2**

Sickness Absence

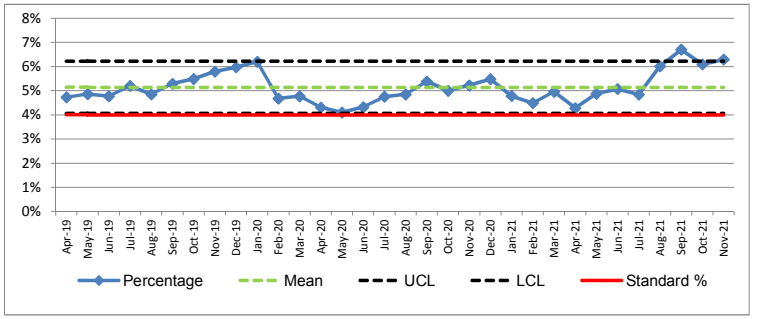
Standard: Maintain Sickness Absence Rates below 4%	**Standard** 4.0%

Latest NHS Scotland Performance
4.67% (2020/21) [1]

Tolerance 4.4%

	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%	6.3%				
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)

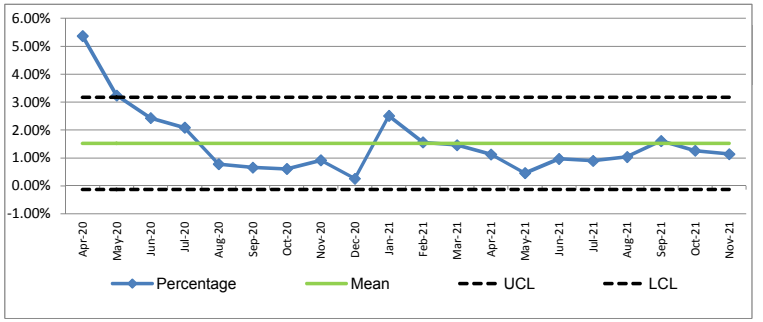


[1] Sickness absence data does not include any COVID-19 related absences.

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%	1.1%				
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

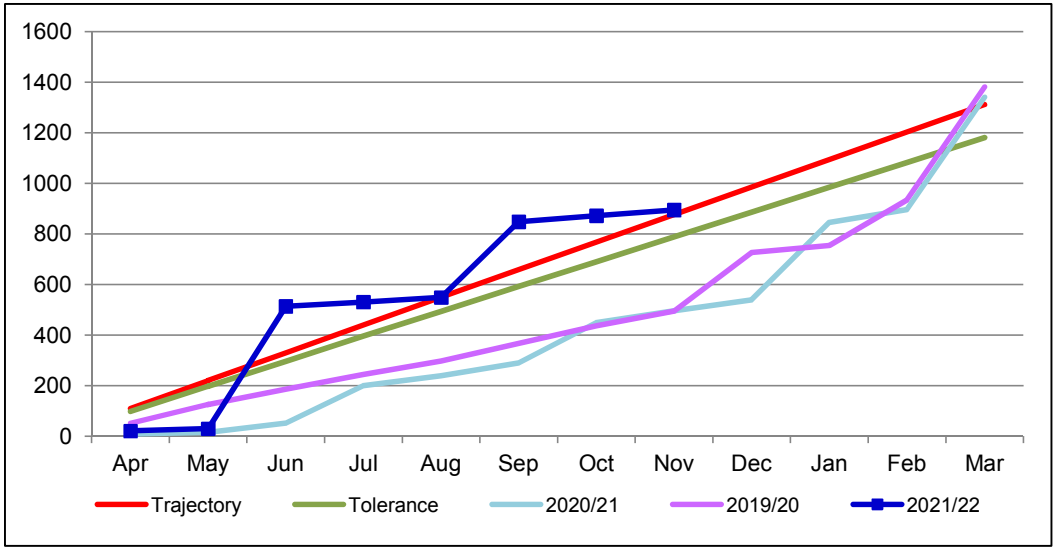
Standard	Tolerance
1312	within 10%

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	895				
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)

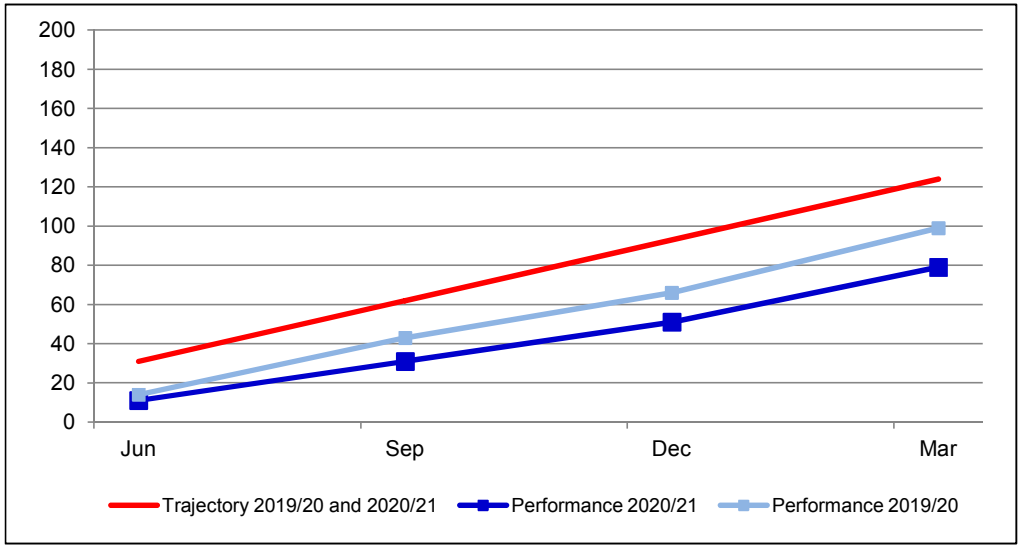
Actual Performance (higher = better performance)

	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.



NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Board Committee Memberships**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Person Centred

2 Report summary

2.1 Situation

Following the retiral of Mr Malcolm Dickson as a Non Executive of Borders NHS Board a vacancy for a Non Executive member of the Integration Joint Board arose.

The Chair nominated Mrs Harriet Campbell to join the Integration Joint Board.

2.2 Background

In line with the Code of Corporate Governance the Board must approve the Non Executive member membership, including the appointment of Chairs and Vice Chairs as appropriate, of its Committees.

2.3 Assessment

This report provides an update to the changes in Board memberships since those agreed by the Board on 24 June 2021.

- Mrs Harriet Campbell has joined the Integration Joint Board.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Committees are created as required by statute, guidance, regulation and Ministerial direction and to ensure efficient and effective governance of the Boards' business.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content of the report.

- Board Executive Team, 25 January 2021

2.4 Recommendation

The Board is asked to formally **approve** the membership and attendance of Non Executive members on its Board and other Committees as recommended by the Chair with immediate effect.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, NHS Borders Non Executives Committee Chart.

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2022 – 01.01.2022

Name/Cttee	Tris Taylor	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Alison Wilson (ACF)	Lucy O'Leary	Cllr David Parker (LA)	Sonya Lam (Whistle-blowing)	Harriet Campbell	James Ayling	Exec Lead & Secretariat
Borders NHS Board (All NEDs)	X	X	VC	C	X	X	X	X	X	X	CEO BS
GOVERNANCE											
Resources & Performance Committee (All NEDs)	X	X	X	C	X	X	X	X	X	X	CEO BS
Audit Committee (4 NEDs)	X		X					X		X	DoF DoF PA
Clinical Governance Committee (4 NEDs)			C		X			X	X		MD CG&Q PA
Staff Governance Committee (4 NEDs)		X					C	X	X		DoW HR Admin
Public Governance Committee (3 NEDs)	C					X	X				DoP&P DoP&P PA
Remuneration Committee (5 NEDs)		X	X	C					X	X	DoW BS
Area Clinical Forum (Chair ACF)					C						ACF Chair CEO PA
PARTNERSHIP											
Area Partnership Forum (Chair APF)		C									ED ED PA
Community Planning Partnership Strategic Board (Chair & Vice Chair)			X	X							SBC
Police, Fire & Rescue & Safer Communities Board (1 NED)										X	SBC
OTHERS											
Endowment Fund Board of Trustees (All NEDs)	X	X	X	C	X	X	X	X	X	X	DoF DoF PA
Expert Advisory Group to Endowment Cttee (4 NEDs)		C		X	X					X	DoP&P DoP&P PA
Area Drugs & Therapeutics Cttee (ACF Chair)					C						DoP DoP PA
Car Park Appeals Panel (1 NED)		C									GSM GSM
Whistleblowing Champion								X			Scottish Government

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2022 – 01.01.2022

Name/Cttee	Tris Taylor	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Alison Wilson (ACF)	Lucy O'Leary	Cllr David Parker (LA)	Sonya Lam (Whistle-blowing)	Harriet Campbell	James Ayling	Exec Lead & Secretariat
OCCASIONAL/AS AND WHEN NECESSARY											
Discretionary Points Committee (Annual)			**C**								**DoW MSM**
Pharmacy Practices Committee				**X Interim**							**MD DoP PA**
Dental Appeals Panel (1 Vacancy) (Final escalation stage only)											**MD MD PA**
ECR Panels (1 Vacancy) (Final escalation stage only)											**MD DPH PA**
TOTAL	**5**	**8**	**8**	**7**	**7**	**4**	**5**	**7**	**6**	**7**	

Vacancies highlighted in green.
Changes highlighted in pink.

KEY

C	Chair	MSM	Medical Staffing Manager
VC	Vice Chair	GSM	General Services Manager
X	Member	DoP	Director of Pharmacy
CEO	Chief Executive	SBC	Scottish Borders Council
DoF	Director of Finance	ED	Employee Director
DoNMAS	Director of Nursing, Midwifery & Acute Services	PA	Personal Assistant
DPH	Director of Public Health	CO H&SCI	Chief Officer Health & Social Care Integration
MD	Medical Director	DoW	Director of Workforce
BS	Board Secretary		

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2022 – 01.01.2022

SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD AND ASSOCIATED COMMITTEES

Name/Cttee	Tris Taylor	John McLaren (APF)	Fiona Sandford	Karen Hamilton	Alison Wilson (ACF)	Lucy O'Leary	Cllr David Parker (LA) (IJB Vice Chair 2017-20)	Sonya Lam (Whistle-blowing)	Harriet Campbell	James Ayling	Exec Lead & Secretariat
Scottish Borders Health & Social Care Integration Joint Board (H&SC IJB) (5 NEDs Required)	**XV**	**XV**		**XV**	**A**	**XV** (Vice Chair from July 21)	**(XV) Chair from April**		**XV**		**IJB CO BS**
H&SC IJB Audit Committee (2 NEDs Required)				**C -XV**		**XV**					**IJB CO BS**
H&SC IJB Strategic Planning Group **(Vice Chair of IJB, Chairs the SPG)**						**XV** (Chair from July 21)					**IJB CO PA**
TOTAL	**1**	**1**	**0**	**2**	**1**	**3**	**1**	**0**	**1**	**0**	

Changes highlighted in pink.

KEY

C	Chair
VC	Vice Chair
XV	Member (Voting)
XNV	Member (Non Voting)
BS	Board Secretary
IJB CO	Integration Joint Board Chief Officer
IJB CFO	Integration Joint Board Chief Financial Officer
SBC	Scottish Borders Council
A	Attendee

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Scheme of Integration Refresh**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

In line with the Public Bodies (Joint Working) (Scotland) Act 2014 and given the current pandemic pressures placed on both health and social care services as well as awaiting the final recommendations from the National Care Service consultation, a **light touch review** of the Scottish Borders Scheme of Integration is being taken forward on behalf of NHS Borders and Scottish Borders Council.

2.2 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 introduced a statutory duty for NHS Boards and Local Authorities to integrate the planning and delivery of health and social care services. It required the creation of Integration Authorities. The aim was to ensure that:

- Health and social care services should be firmly integrated around the needs of individuals, their carers and other family members.
- Health and social care services should be characterised by strong and consistent clinical and care professional leadership.
- The providers of services should be held to account jointly and effectively for improved delivery.
- Services should be underpinned by flexible, sustainable financial mechanisms that give priority to the needs of the people they serve, rather than the organisations through which they are delivered.

Integration aims to improve people's lives by ensuring better care and support are available for people who live with long-term conditions and disabilities, many of whom are older people. It also aims to ensure that services are provided in a seamless and co-ordinated way.

The Scottish Borders Scheme of Integration is a legally binding agreement between the NHS Borders and Scottish Borders Council

The Scheme of Integration:-

- Must include the delegation of a minimum set of services prescribed in legislation
- Must cover a range of matters identified in regulations
  - Engagement of stakeholders
  - Clinical and care governance arrangements
  - Workforce and organisational development
  - Data sharing
  - Financial management
  - Dispute resolution
  - Local arrangements for the Integration Joint Board
  - Local arrangements for operational delivery
  - Liability arrangements
  - Complaints handling
- Be reviewed, revised and publicly consulted upon every 5 years

2.3 Assessment

The Scheme of Integration defines the scope of the Integration Joint Board / Health and Social Care Partnership, along with the supporting arrangements to ensure the integrated planning and delivery of certain Health, Social Care and Adult Social Work Services.

The light touch review consultation can be accessed via Scottish Borders Council's consultation and Survey Hub by following the link below:

https://scotborders.citizenspace.com/social-work-integration/scheme-of-integration-2022-consultation/

The closing date for feedback is the 28th February.

Comments and feedback will also be used to inform any further revisions by the partner organisations to the Scheme of Integration, which will be taken forward over the next 12 month period.

The final version of the refreshed Scheme of Integration will be presented to the Resources & Performance Committee on 3 March 2022 and Scottish Borders Council on 31 March 2022 for approval.

The formally approved scheme will then be submitted to Scottish Ministers for Ministerial approval.

2.3.1 Quality/ Patient Care

The Scheme of Integration covers a range of matters identified in regulations including clinical and care governance arrangements

2.3.2 Workforce

The Scheme of Integration covers a range of matters identified in regulations including workforce and organisational development

2.3.3 Financial

The Scheme of Integration covers a range of matters identified in regulations including financial management

2.3.4 Risk Assessment/Management

The Scheme of Integration covers a range of matters identified in regulations including being reviewed, revised and publicly consulted upon every 5 years

2.3.5 Equality and Diversity, including health inequalities

An HIIA will be being carried out on the Scheme of Integration.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

A range of stakeholders have been contacted to advise them of the launch of the light touch review consultation and that it can be accessed via Scottish Borders Council's consultation and Survey Hub.

Stakeholder groups include:-

- Independent Care Sector Providers Strategic Advisory Group
- Public Involvement Group
- Unpaid Carers
- Borders Carers Centre
- Borders Care Voice
- Area Clinical Forum
- IJB Strategic Planning Group
- Integration Joint Board
- Board Executive Team NHS Borders
- Corporate Management Team Scottish Borders Council

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development.

- Board Executive Team, 25 January 2022

2.4 Recommendation

The Board is asked to **note** the progress being made with the light touch review of the Scheme of Integration.

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Revised Scheme of Integration
- Appendix No 2, Table of amendments

Health and Social Care Integration Scheme for the Scottish Borders

CONTENTS

Preface

The Public Bodies (Joint Working)(Scotland) Act 2014 requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. They can also choose to integrate planning and delivery of other services – additional adult health and social care services beyond the minimum prescribed, and children's health and social care services:

The Act requires that the Local Authority and the Health Board jointly prepare, consult and then agree an Integration Scheme for the Local Authority Area, prior to them submitting it to Scottish Ministers for final approval. The Act states that the purpose of an integration scheme is to set out:

- which integration model is to apply; and
- the functions that are to be delegated in accordance with that model.

The Act also requires that the Health Board and the Local Authority undertake a joint consultation as part of the preparation of their integration scheme. This Integration Scheme describes how the new Act will be applied within the Scottish Borders.

Individuals and communities in the Scottish Borders have benefited from the integration of designated Health and Social Care services already. This Integration Scheme has been informed by considerable local experience of developing and delivering integration in practice; and also benefitted from a considerable amount of on-going dialogue and positive interaction with a range of stakeholders over recent years. The Health Board and the Local Authority are committed to continuing that constructive engagement.

The legislation supporting Health and Social Care Integration, through the Integration Joint Board, offers the opportunity for Councillors, Health Board Non-Executive Directors, the Third Sector and Independent Sector to work together to plan for a future health and care service able to meet the demands of the future. The Integration Joint Board will plan and commission services to ensure we meet our national and local outcomes all based on providing a more person centred approach with a focus on supporting individuals, families and communities.

In line with the legislation, the Integration Joint Board will not only plan but also oversee the delivery of the integrated services for which it has responsibility. In line with its Strategic Commissioning Plan, the Integration Joint Board will require that the Local Authority and Health Board provide services to match what is required and it will oversee performance and targets to ensure that delivery is in line with the outcomes.

Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 (the Act) requires Health Boards and Local Authorities to integrate planning for, and delivery of, certain adult health and social care services. They can also choose to integrate planning and delivery of other services – additional adult health and social care services beyond the minimum prescribed by Ministers, and children's health and social care services.

The Act requires them to prepare jointly an Integration Scheme setting out how this joint working is to be achieved. There is a choice of ways in which they may do this: the Health Board and Local Authority can either delegate .between each other, or can both delegate to a third body called the Integration Joint Board. Delegation between the Health Board and Local Authority is commonly referred to as a "lead agency" arrangement. Delegation to an Integration Joint Board is commonly referred to as a "body corporate" arrangement.

This document uses the model Integration Scheme where the "body corporate" arrangement is used and sets out the detail as to how the Health Board and Local Authority will integrate services. Section 7 of the Act requires the Health Board and Local Authority to submit jointly an Integration scheme for approval by Scottish Ministers.

Once the scheme has been approved by the Scottish Ministers, the Integration Joint Board (which has distinct legal personality) will be established by Order of the Scottish Ministers.

The Act requires that an Integration Scheme, once approved, must be re-submitted and follow the consultation process set out in the regulations if it is to be amended. Changes to documents referred to within the Integration Scheme (eg Workforce Plan) do not require the Integration Scheme to go through this process – only changes to the Integration Scheme itself.

As a separate legal entity the Integration Joint Board has full autonomy and capacity to act on its own behalf and can, accordingly, make decisions about the exercise of its functions and responsibilities as it sees fit. However, the legislation that underpins the Integration Joint Board requires that its voting members are appointed by the Health Board and the Local Authority, and consists of Councillors and NHS Non-Executive Directors. Whilst serving on the Integration Joint Board its members will carry out their functions under the Act on behalf of the Integration Joint Board itself, and not as delegates of their respective Heath Board or Local Authority.

The Integration Joint Board is responsible for the strategic planning of the functions delegated to it and for ensuring oversight of the delivery of its functions set out within the Integration Scheme in Section 4. This scheme covers the health and wellbeing of all adults including older people and universal children's health services in accordance with Section 29 of the Act. Further, the Act gives the Health Board and the Local Authority, acting jointly, the ability to require that the Integration Joint Board replaces their Strategic Commissioning Plan in certain circumstances. In these ways, the Health Board and the Local Authority together have significant influence over the Integration Joint Board, and they are jointly accountable for its actions.

Vision, Aims and Outcomes of the Integration Scheme

Scottish Borders Council and Borders Health Board will build on a history of partnership working. By maximising the opportunities presented through legislation we aim to achieve the highest outcomes for the people of the Scottish Borders. By creating our new integrated arrangements across health and social care we will enhance, strengthen and develop the formerly separate services for the provision of adult health and social care. By integrating service delivery and fulfilling the expectations of our Strategic Commissioning Plan we seek to enhance and promote the health and wellbeing of the people of the Scottish Borders.

Working with the Third and Independent Sector, we will provide a unified approach across the public sector with a common sense of purpose. We will engage with service users, carers, staff and members of the public to empower individuals and communities to be a driving force for how the services will be shaped and developed. In turn, we will deliver the best possible services that will be safe, of the highest quality, person centred, efficient and fair.

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. The Integration Joint Board will set out within its Strategic Commissioning Plan how it will deliver the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under Section 5(1) of the Act namely:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

INTEGRATION SCHEME

The parties:

Scottish Borders Council, established under the Local Government (Scotland) Act 1994 and having its principal offices at Newtown St Boswells, Melrose, Roxburghshire, TD6 OSA ("the Council");

and

Borders Health Board, established under section 2(1) of the National Health Service (Scotland) Act 1978 (operating as "NHS Borders") and having its principal offices at Borders General Hospital, Melrose, Roxburghshire, TD6 9BS ("NHS Borders") (together referred to as "the Parties")

1. Definitions and Interpretation

1.1 In this Integration Scheme, the following terms shall have the following meanings:-

- "The Act" means the Public Bodies (Joint Working) (Scotland) Act 2014;
- "Integration Joint Board" means the Integration Joint Board to be established by Order under section 9 of the Act;
- "Outcomes" means the National Health and Wellbeing Outcomes prescribed by the Scottish Ministers in Regulations under section 5(1) of the Act
- "The Integration Scheme Regulations" means the Public Bodies (Joint Working) (Integration Scheme) (Scotland) Regulations 2014
- "Integration Joint Board Order" means the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014
- "Scheme" means this Integration Scheme;
- "Strategic Commissioning Plan" means the plan which the Integration Joint Board is required to prepare and implement in relation to the delegated provision of health and social care services to adults and universal children's health services in accordance with section 29 of the Act.
- "Universal children's health services" refers to the functions exercisable in relation to the health care services set out in paragraphs 11-15 of Appendix 2, Part 2, Section 3, which are delegated in relation to persons of any age.
- "Payment" means the term used in legislation to describe the integrated budget contribution to the Integration Joint Board. This payment does not require a cash transaction to be made. The term is also used to describe the non cash transaction the Integration Joint Board makes to the Health Board and Local Authority for carrying out the directed functions.

1.2 In implementation of their obligations under the Act, the Parties hereby agree as follows:

- In accordance with section 1(2) of the Act, the Parties have agreed that the integration model set out in sections 1(4)(a) of the Act will be put in place for Scottish Borders, namely the delegation of functions by the Parties to a body corporate that is to be established by Order under section 9 of the Act. This Scheme comes into effect on the date the Parliamentary Order to establish the Integration Joint Board comes into force.

2. Local Governance Arrangements

2.1 Part of the remit of the Integration Joint Board is to prepare and implement a Strategic Commissioning Plan in relation to the provision of such health and social care services to people in their area in accordance with the requirements of the Act.

2.2 The regulations of the Integration Joint Board's procedure, business and meetings form the Standing Orders which may be considered at the first meeting of the Integration Joint Board.

2.3 Borders Health Board, Scottish Borders Council and the Integration Joint Board are all responsible for the achievement of the outcomes. (Appendix 1). The Integration Joint Board has oversight of the functions delegated to it and of the performance of the services related to those functions. The Chief Officer is responsible for reporting to the Integration Joint Board on performance of those services in the context of a performance framework agreed by the Integration Joint Board via the Chief Officer.

2.4 The Chief Officer will prepare an annual report on performance on delivery of the Strategic Commissioning Plan to the Integration Joint Board and share it with Borders Health Board and Scottish Borders Council.

2.5 The Integration Joint Board will have a distinct legal personality and the autonomy to manage itself. There is no role for Scottish Borders Council or Borders Health Board to, acting separately, sanction or veto decisions of the Integration Joint Board. In the event of a dispute arising between Borders Health Board and Scottish Borders Council the dispute resolution mechanism will be followed as set out at Section 14.

2.6 The Integration Joint Board may create such Committees that it requires to assist it with the planning and oversight of delivery of services which are within its scope. This is provided for in legislation. The Integration Joint Board may establish an Audit Committee, to seek and secure assurance over effective governance.

2.7 As agreed by Borders Health Board and Scottish Borders Council, the Integration Joint Board shall comprise five NHS Non-Executive Directors appointed by Borders Health Board, and five Elected Councillors appointed by Scottish Borders Council. The Integration Joint Board will include non-voting members as prescribed by Regulation 3 of the Public Bodies (Joint Working) (Proceedings, Membership and General Powers of Integration Joint Boards) (Scotland) Order 2014.

2.8 The term of office of voting Members of the Integration Joint Board shall last as follows:

(a) for Local Government Councillors, three years, thereafter Scottish Borders Council will identify its replacement Councillor(s) on the Integration Joint Board,

(b) for Borders Health Board nominees, three years, thereafter Borders Health Board will identify its replacement Non Executive(s) on the Integration Joint Board.

2.9 At the first meeting of the Integration Joint Board it elected a Chairperson and Vice Chairperson from the voting membership of the Integration Joint Board.

2.10 The Chair and Vice–Chair posts rotate on a three year basis between Borders Health Board and Scottish Borders Council, with the Chair being from one body and the Vice-Chair from the other.

2.11 All appointments, including the appointment of the Chair and Vice Chair, will be reviewed every 3 years. Members can be reappointed.

3. Delegation of Functions

3.1 The functions that are to be delegated by Borders Health Board to the Integration Joint Board are set out in Part 1 of Appendix 2. The services to which these functions relate , which are currently provided by Borders Health Board and which are to be integrated, are set out in Part 2 of Appendix 2.

3.2 Each function listed in column A of Part 1 of Appendix 2 is delegated subject to the exceptions in column B and only to the extent that:

(a) There are a number of functions delegated at Section 3 of Part 2 of Appendix 2 which are delegated in relation to persons of any age (universal children's health services)); and

(b) the function is exercisable in relation to care or treatment provided by health professionals for the purpose of health care services listed in Section 1 of Part 2 of Appendix 2; or

(c) The function is exercisable in relation the health and care services listed in Section 2 of Part 1 of Appendix 2.

3.3 The functions that are to be delegated by Scottish Borders Council to the Integration Joint Board are set out in Part 1 of Appendix 3. The services to which these functions relate, which are currently provided by Scottish Borders Council and which are to be integrated, are set out in Part 2 of Appendix 3.

3.4 Each function listed in column A of Part 1 of Appendix 3 is delegated subject to the exceptions in column B and only to the extent that it is exercisable in relation to persons of at least 18 years of age.

4. Local Operational Delivery Arrangements

4.1 The Integration Joint Board is responsible for the strategic planning and oversight of the delivery of the services related to the functions delegated to it. This will be

carried out by the development of a Strategic Commissioning Plan as per section 29 of the Act. This plan will set out the arrangements for carrying out the integration functions and how these will contribute to achieving the nine National Health and Well-Being outcomes. As per Section 26 of the Act, the Integration Joint Board will give direction to Borders Health Board and Scottish Borders Council to carry out each function delegated to it. Assurance to the Integration Joint Board over the performance of services delivered by Borders Health Board and Scottish Borders Council will be provided by regular and frequent monitoring to the Integration Joint Board by the Chief Officer.

4.2 The Integration Joint Board will have provided to it, the necessary resources to undertake the functions delegated by Borders Health Board and Scottish Borders Council.

4.3 Borders Health Board and Scottish Borders Council Executives responsible for the delivery and management of any services within the scope of the Integration Joint Board, will report on performance on a regular basis to the Integration Joint Board through the Chief Officer.

4.4 The Integration Joint Board will:-

a. Appoint its Chief Officer.

b. Appoint its Chief Financial Officer.

c. Convene a Strategic Planning Group specifically to enable the preparation of Strategic Commissioning Plans in accordance with section 32 of the Act; inform significant decisions outside the Strategic Commissioning Plan in accordance with section 36 of the Act; and review the effectiveness of the Strategic Commissioning Plan in accordance with section 37 of the Act, in line with the obligations to meet the engagement and consultation standards.

d. Prepare, approve and implement a Strategic Commissioning Plan for all of its delegated functions, in accordance with the Act; supported by an integrated workforce and organisational development plan.

e. Establish arrangements for locality planning in support of key outcomes for the agreed localities in the context of the Strategic Commissioning Plan.

f. Approve the Strategic Commissioning Plan as presented by the Chief Officer, before the integration start date in accordance with the Act.

g. Approve the allocation of resources to deliver the Strategic Commissioning Plan within the specific revenue budget as delegated by each Party (in accordance with the standing financial instructions/orders of both Parties), and where necessary to make recommendations to either or both Parties.

h. Prepare and publish an annual financial statement that sets out the amount that the Integration Joint Board intends to spend in implementation of the Strategic Commissioning Plan in accordance with the Act.

i. Share an Annual Report with Borders Health Board and Scottish Borders Council.

j. Have oversight of the performance of all the services referred to in 3.1, 3.2, 3.3 and 3.4 above, through the Chief Officer.

4.5 The Integration Joint Board may consider the following:

a. Maintaining and routinely reviewing an integrated risk management strategy, including (where necessary) to make recommendations to either or both Parties.

b. Establishing a standing Audit Committee to focus on financial audit and governance matters, including (where necessary) making recommendations to either or both Parties.

c. Establishing a Joint Staff Forum to focus on applying the principles of staff governance across services in partnership with trade unions, and where necessary to make recommendations to either or both Parties without impacting or undermining the consultation and bargaining mechanisms for staff employed by Borders Health Board and Scottish Borders Council.

4.6 **Targets and Performance Management**

4.6.1 Borders Health Board and Scottish Borders Council will establish a Performance Management Framework which meets the obligations set out in legislation and will take account of targets, measures and objectives which are in force at any given time for integrated and non integrated functions. The Integration Joint Board will receive frequent and regular monitoring reports on the agreed performance framework in pursuit of the delivery of the Strategic Commissioning Plan, including all delegated and set-aside budgets.

4.6.2 Both parties will develop for the Integration Joint Board a Performance Management Framework with a list of all relevant targets, measures and arrangements which relate to the integration functions and for which responsibility is to transfer, in full or in part, to the Integration Joint Board. Scottish Borders Council and Borders Health Board have existing performance management processes and the Integration Performance Management Framework will align with those processes to avoid duplication and streamline reporting and will as far as possible, draw on existing data sets and reporting mechanisms.

4.6.3 In meeting the delivery requirements of the national health and wellbeing outcomes, consideration will need to be given to any additional resource requirements for collecting and reporting information that is not currently collected, both in operational and support terms.

4.6.4 The Integration Joint Board will receive regular reports for the delegated functions from Borders Health Board and Scottish Borders Council on the delivery of integrated services and issue directions in response to those reports to ensure improved performance.

4.6.5 The Chief Officer will provide regular Strategic Commissioning Plan Performance Reports to the Integration Joint Board for members to scrutinise performance and impact against planned outcomes and commissioning priorities. This will culminate in the production of an annual performance report to the Integration Joint Board. The Strategic Commissioning Plan Performance Report will also provide necessary information on the activity and resources that relate to the planned and actual use of services, including the consumption patterns of health and social care resources by locality. The information will provide the opportunity for the Integration Joint Board resources to be used flexibly, to provide services co-designed with local communities, for their benefit.

4.6.6 The national and local performance measures and targets as they relate to the delegated functions outlined in 3.1, 3.2, 3.3 and 3.4 will be delegated in relation to the oversight of operational delivery arrangements and in relation to the strategic planning outcomes and performance reporting. These performance measures and targets may be fully or partially delegated by both Parties to the Integration Joint Board. Responsibility for financial planning and management of integrated budgets is the responsibility of the Integration Joint Board which is accountable for the delivery of the Strategic Commissioning Plan and associated financial objectives.

4.7 Corporate Services Support

4.7.1 With regard to corporate services support, Scottish Borders Council and Borders Health Board have:-

- identified the corporate resources used to deliver the delegated functions;
- agreed the corporate support services required to fully discharge Integration Joint Board duties under the Act.

4.7.2 These support services include, but are not limited to:-

- Finance (including capital planning)
- HR
- ICT
- Administrative Support
- Committee Services
- Internal Audit
- Performance Management
- Risk
- Insurance

4.7.3 Arrangements are in place for the provision of appropriate Corporate support and this is kept under on-going assessment and review.

4.7.4 In regard to support for strategic planning there will be set out local arrangements for the preparation of the strategic commissioning plan with support from Borders Health Board and Scottish Borders Council, taking into account the relevant activity and financial data covering the services, facilities and resources that relate to the Strategic Commissioning Plan. Local arrangements will be reviewed formally on an annual basis taking account of any changes to the Strategic Commissioning Plan.

5. Clinical and Care Governance

5.1 Assurance to the Integration Joint Board and subsequently, Scottish Borders Council and Borders Health Board in respect of the key areas of governance will be achieved through explicit and effective lines of accountability. This accountability begins in the care setting within an agreed clinical and care governance framework established on the basis of existing key principles embedded in the governance and scrutiny arrangements for Borders Health Board and Scottish Borders Council.

5.2 The Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing, Midwifery & AHPs and Director of Public Health) share accountability for clinical governance of NHS services as a responsibility/function delegated from the Chief Executive of Borders Health Board.

5.3 These Directors continue to hold accountability for the actions of the Borders Health Board clinical staff who deliver care through health and social care integrated services. They attend the Borders Health Board Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by Borders Health Board and which in turn will provide assurance to the Integration Joint Board that it has undertaken its duties in this respect.

5.4 As part of the integration arrangements the Chief Social Work Officer will provide oversight and advice to the Integration Joint Board on the quality of social work services delivered by social work staff through health and social care integrated services. The Chief Social Work Officer will continue to provide professional leadership for social work and be accountable for statutory decisions relating to Social Work. The Chief Social Work Officer is then held to account by Scottish Borders Council for such decisions and ensures that links are made across all Social Work services. The Chief Social Work Officer also advises Scottish Borders Council on the delivery of social work services through an annual report which will be made available to the Integration Joint Board for assurance purposes. Scottish Borders Council will in turn provide assurance to the Integration Joint Board via the Chief Social Work Officer.

5.5 Clinical governance groups operating for services within the Integrated Joint Board will consider a wide range of reports within their annual work programmes relating to clinical and care governance. These groups provide formal assurance through the NHS Borders Board Clinical Governance Committee. Beyond the annual report from the Board Clinical Governance Committee to the Integrated Joint Board specific assurance can be requested on Clinical and Care Governance matters relating to the delegated functions as and when required.

5.6 As part of the regular monitoring process the Integration Joint Board may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Public Protection Committee (which encompasses adult and child protection activity and assurance across the partnership), Area Drug and Therapeutics Committee and Area Clinical Forum (ACF) or specific professional advisory groups under the ACF structure.

5.7 The appropriate appointed Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing, Midwifery & AHPs and Director of Public Health) will support the Chief Officer and the Integration Joint Board in the manner they support Borders Health Board for the range of their responsibilities.

5.8 The Chief Social Work Officer will support the Chief Officer and the Integration Joint Board in the same manner they support Scottish Borders Council. Appropriate arrangements are in place for the Chief Social Work Officer to discharge their responsibility to health and social care staff who have a professional or corporate accountability to the Chief Social Work Officer.

6. Chief Officer

6.1 The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act.

6.2 The Chief Officer will be accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services as set out in Appendices 2 and 3.

6.3 Where the Chief Officer does not have operational management responsibility for services included in integrated functions, the parties will ensure that appropriate communication and liaison is in place between the Chief Officer and the person/s with that operational management responsibility.

6.4 The Chief Officer will be a member of the Parties relevant senior management teams and be accountable to and managed by the Chief Executive's of both Parties.

6.5 The Chief Officer is seconded to the Integration Joint Board from the employing body.

6.6 Where there is to be a prolonged period where the Chief Officer is absent or otherwise unable to carry out their responsibilities, the Scottish Borders Council's Chief Executive and Borders Health Board's Chief Executive will jointly propose an appropriate interim arrangement for approval by the Integration Joint Board's Chair and Vice-Chair at the request of the Integration Joint Board.

7. Workforce

7.1 Borders Health Board and Scottish Borders Council will jointly develop and put in place for their employees delivering integrated services, a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan).

7.2 Core HR services will continue to be provided by the appropriate corporate HR functions in Scottish Borders Council and Borders Health Board.

7.3 The corporate HR functions in Scottish Borders Council and Borders Health Board will provide the necessary resources to ensure the development and implementation of the joint organisational development plan and the outline workforce plan and will, where appropriate, consult with stakeholders.

7.4 Both the joint organisational development plan and the outline workforce plan will be refreshed periodically by the parties and the Integration Joint Board.

7.5 Borders Health Board and Scottish Borders Council professional/clinical supervisions arrangements for professional and clinical staff will continue until superseded by any jointly agreed arrangements.

8. Finance

8.1 The Integration Joint Board will seek assurance from Borders Health Board and Scottish Borders Council over the sufficiency of resources to carry out its delegated duties and adjust its performance accordingly, following which it will approve the initial amount delegated to it. This will continue in future years following negotiation with the other parties.

8.2 The arrangements in relation to the determination of the amounts paid, or set aside, and their variation, to the Integration Joint Board by Borders Health Board and Scottish Borders Council are set out below at sections 8.3, 8.4.8.5 and 8.6:-

8.3 Payment in the first year to the Integration Joint Board for delegated functions

8.3.1 The baseline payment was established by reviewing past performance and existing plans for Borders Health Board and Scottish Borders Council for the functions to be delegated, adjusted for material items.

8.3.2 Delegated baseline budgets were subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they were realistic. There was an opportunity in the second year of operation to adjust baseline budgets to correct any inaccuracies.

8.4 Payment in subsequent years to the Integration Joint Board for delegated functions

8.4.1 In subsequent years the Chief Officer and the Integration Joint Board Chief Financial Officer will develop a case for the Integrated Budget based on the Strategic Commissioning Plan. The financial plan will be presented to Borders Health Board and Scottish Borders Council for consideration as part of the annual budget setting process. The case should be evidenced, with full transparency demonstrating the following assumptions:-

- Performance against outcomes
- Activity changes
- Cost inflation
- Price changes and the introduction of new drugs/technology
- Agreed service changes
- Legal requirements
- Transfers to/from the amounts made available by Borders Health Board for hospital services
- Adjustments to address equity of resource allocation

8.4.2 Borders Health Board and Scottish Borders Council should consider the following when reviewing the Strategic Commissioning Plan:

- The Local Government Financial Settlement
- The uplift applied to NHS Board funding from Scottish Government
- Efficiencies to be achieved

8.4.3 Whilst the Integration Joint Board will plan, agree and deliver the Strategic Commissioning Plan and related Financial Plan, this will follow a process of joint discussion and planning with the other parties.

8.5 Method for determining the amount set aside for hospital services

8.5.1 This should be determined by the hospital capacity that is expected to be used by the population of the Integration Joint Board area.

8.5.2 The capacity should be given a financial value using the data from the latest Integrated Resources Framework (IRF).

8.5.3 It will be the responsibility of the Council Section 95 Officer and the NHS Board Accountable Officer to comply with the agreed reporting timetable and to make available to the Integration Joint Board Chief Financial Officer the relevant financial information required for timely financial reporting to the Integration Joint Board. This will include such details as may be required to inform financial planning of revenue expenditure. The Integration Joint Board's Chief Financial Officer will manage the respective financial plan so as to deliver the agreed outcomes within the Joint Strategic Commissioning Plan viewed as a whole. Monitoring arrangements will include the impact of activity on set aside budgets.

8.6 In-year variations

8.6.1 Neither Borders Health Board nor Scottish Borders Council may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change. Where appropriate supplementary resources are identified or received by Borders Health Board or Scottish Borders Council e.g. as a result of RSG redetermination, these will be passed on to the Integration Joint Board through increasing the level of budgets delegated to it.

8.6.2 The Chief Officer of the Integration Joint Board will deliver the agreed outcomes within the total agreed delegated resources. Where there is a forecast outturn overspend against an element of the operational budget the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget with the relevant finance officer of the constituent authority. The recovery plan will need to be approved by the Integration Joint Board.

8.6.3 Should the recovery plan be unsuccessful the Integration Joint Board may request that the payment from Borders Health Board and Scottish Borders Council be adjusted, to take account of any revised assumptions. It will be the responsibility of the authority who originally delegated the budget to make the additional payment to cover the shortfall.

8.6.4 In the case of joint services any additional payment will be agreed pro rata in line with the original budget level.

8.6.5 The Integration Joint Board should make repayment in future years following the same methodology as the additional payment. If the shortfall is related to a recurring issue the Integration Joint Board should include the issue in the Strategic Commissioning Plan and financial plan for the following year.

8.6.6 Additional adjustments may be required, for example, when errors in the methodology used to determine the delegated budget are found. In these circumstances the payment for this element should be recalculated using the revised methodology.

8.6.7 Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve. If an underspend arises from a material error in the assumptions made to determine the initial budget, the methodology of the payment may need to be recalculated using the revised assumptions.

8.6.8 Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to.

- The Integration Joint Board will have financial accountability for the funding received as payments from Borders Health Board and Scottish Borders Council. This financial accountability will not apply to notional funding for Set Aside Budgets included within the Strategic Commissioning Plan.

- The Integration Joint Board will follow best practice guidelines for audit;

  - The Integration Joint Board and their Chief Financial Officer will receive financial management support from Borders Health Board and Scottish Borders Council who will:

  - Record all financial information in respect of the Integration Joint Board in an integrated database, and use this information as the basis for preparing regular, comprehensive reports to the Integration Joint Board.

  - Support the Chief Financial Officer of the Integration Joint Board to allow them to carry out their functions in preparation of the annual accounts, financial statement prepared under section 39 of the Act, the financial elements of the Strategic Commissioning Plan and other reports that may be required.

  - Ensure monthly financial monitoring reports relating to the performance of the Integration Joint Board against the delegated budget will be submitted to the Chief Officer within 15 working days of the month end for reporting to the Integration Joint Board.

- Ensure regular reports will be prepared on the financial performance against the Strategic Commissioning Plan.

- Provide a schedule of payments to the Integration Joint Board following approval of the Strategic Commissioning Plan and its related financial plan. It is intended that this will be a one-off payment made during April/May of each financial year. This payment may be subject to in-year adjustments.

- In advance of each financial year a timetable of financial reporting will be submitted to the Integration Joint Board for approval.

8.7 **Capital Assets:**

8.7.1 The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure. In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure.

8.7.2 The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements.

8.8 **Year-end balances:**

8.8.1 In line with guidance, a process for jointly agreeing, reporting and carrying forward any unused balances at the end of the financial year will operate.

9. Participation and Engagement

9.1 Section 6(2)(a) of the Public Bodies (Joint Working) (Scotland) Act 2014 requires Local Authorities and Health Boards to prepare an Integration Scheme. Before submitting the Integration Scheme to Scottish Ministers for approval, the Local Authority and Health Boards have consulted with:-

- Staff of the Local Authority likely to be affected by the Integration Scheme;
- Staff of the Health Board likely to be affected by the Integration Scheme;
- Health professionals;
- Users of health care;
- Carers of users of health care;
- Commercial providers of health care;
- Non-commercial providers of health care;
- Social care professionals;
- Users of social care;
- Carers of users of social care;
- Commercial providers of social care;
- Non-commercial providers of social care;
- Non-commercial providers of social housing; and

- Third sector bodies carrying out activities related to health or social care.

9.2 Feedback from all of the above has been used to inform the refresh of the Scheme of Integration.

9.3 There are national standards for community engagement and participation which underpin how Scottish Borders Council and Borders Health Board operate.

9.4 Timely and effective communications and engagement is a key component in the development, review and renewal of the Strategic Commissioning Plan. A communications and engagement strategy and action plan should be developed, in conjunction with the Strategic Planning Group to support this work.

10. Information-Sharing

10.1 The PAN Lothian and Borders General Information Sharing Protocol update was agreed by the Pan Lothian and Borders Data Sharing Partnership December 2014.

10.2 Scottish Borders Council, the Borders Health Board and the Integration Joint Board agree to be bound by the Information Sharing Protocol

10.3 This protocol describes the key principles the parties must adhere to for information to be shared lawfully, securely and confidentially. Other signatories will be added as appropriate.

10.4 Procedures for sharing information between Scottish Borders Council, Borders Health Board, and, where applicable, the Integration Joint Board will be drafted as Information Sharing Agreements and procedure documents, as required. This will be undertaken by a sub group (the Borders Data Sharing Partnership) on behalf of the PAN Lothian and Borders Data Sharing Partnership, and will detail the more granular purposes, requirements, procedures and agreements for the Integration Joint Board and their delegated function.

10.5 The national protocol on information sharing – Scottish Accord for the Sharing of Personal Information (SASPI) – will be adopted in due course.

10.6 **Information-Sharing and Confidentiality** All staff are bound by the data confidentiality policies of their employing organisations and the requirements of the Information Sharing Protocol that is in place.

10.7 **Information Sharing and data handling** With respect to person identifiable material, data and information will be held in both electronic and paper format and only be accessed by authorised personnel in order to provide the service user with the appropriate service within the partnership. It may be necessary to share information with external agencies and in that case consent will be sought from the service user if no statutory requirement to share information exists. In order to comply with the Data Protection Act 1998 all parties will always ensure that any personal data that is processed will be handled fairly, lawfully and with justification.

10.8 Scottish Borders Council and Borders Health Board will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The Integration Joint Board may require to be

Data Controller for personal data where it is not held by either Scottish Borders Council or Borders Health Board.

10.9 Roles and responsibilities for Third party organisations will be detailed in contracts with respective commissioning bodies, and access to shared records agreed in advance.

10.10 Procedures will be based on a single point of governance model through the Data Sharing Partnership. This allows data and resources to be shared, with governance standards, and their implementation, the separate responsibility of each partner. Shared datasets governance will be agreed by all contributing partners prior to access.

10.11 Following consultation, Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of Borders Health Board and Scottish Borders Council and the Integration Joint Board.

10.12 Once established, Agreements and Procedures will be reviewed every two years by the Borders Data Sharing Partnership, or more frequently if required.

10.13 **The Public Records (Scotland) Act:** Both parties are scheduled Public Authorities under the Public Records (Scotland) Act and have a duty to create and have approved a records management plan. The Integration Joint Board also has a records management plan in compliance with the requirements of the Act. Reference to information management procedures of the integrated service will be recorded in both parties plans, including information sharing and other record keeping arrangements and duties that pertain to services contracted out to third party service providers or external agencies will also be included.

10.14 **Record keeping:** The parties will work towards common records and templates that are readily available for staff to use, in particular:

- Data sharing agreement template
- Consent forms for data sharing
- A data sharing log (this will be a public document)
- Data sharing agreement Review form

10.15 Responsibility for the maintenance and distribution of joint service templates, logs and Borders Health Board and Scottish Borders Council records sits with the Chief Officer. File plans and records retention schedules for records created solely by the Integrated Services will be devised and approved by the Integration Joint Board.

10.16 Responsibility for records created, retained and disposed by each organisation remains with that organisation. Each party will maintain their existing records according to their own policies and disposal schedule.

10.17 **Security:** The success of information sharing relies on a common understanding of security. The information sharing protocol refers to the expected standard but each party must maintain its own guidance to ensure it meets that standard and that controls to manage the following elements are included:-

- Safe storage of documents transported between work and site. Access to electronic and physical records. Use of laptops, memory sticks and other portable data devices when working off site (including at home);

- Confidential destruction;

- Security marking on electronic communications when applicable

10.18 **Access to information - Freedom of Information (FOI):** Both Borders Health Board and Scottish Borders Council will receive Freedom of Information requests and will manage these requests through their own existing processes. Both parties process involves a central FOI Co-ordinator for each organisation, a 10 day timescale for departments to respond to the FOI Co-ordinator and Service Director sign off prior to the response being returned to the requestor. The Co-ordinators of both organisations will work closely together and communicate regularly in relation to FOI.

10.19 Where an FOI relates to a joint service, the receiving organisation will forward the FOI to the relevant Service Manager who will provide the requested information on behalf of both organisations. The receiving organisation will undertake the progress monitoring, responsibility for redacting, quality checking and responding to the applicant. A list of services that are in scope for Integration will be shared between the two organisations. All FoI's that relate to integrated services will be signed off by the Chief Officer.

10.20 Should one organisation receive a request that also relates to the other, this request will be managed by the receiving organisation by partnership working of both organisations' FoI Co-ordinators.

10.21 Both organisations will use the same performance measures and report regularly to the Integration Joint Board and to the Office of the Scottish Information Commissioner (OSIC).

10.22 FOI requestors will be logged. Requests for review will be administered by the organisation who dealt with the request and will include review panel members from both organisations.

10.23 **Subject Access Requests:** The differing charging regimes in each organisation for Subject Access and Access to Medical Records requests prevents a joint approach being adopted for gathering of personal information. Therefore, each party will manage its requests following that organisation's procedures.

10.24 If a subject access request refers to the integrated service it may be necessary to send out two responses. The requestor should be informed at the outset that this will happen. There will be no change to the process for managing access to deceased persons records.

10.25 **Privacy and confidentiality:** Most of the information the integrated services will handle will be personal and confidential in nature. All staff with access to shared information will

1. receive regular training in handling personal data compliantly;

2. have access to systems and records removed as soon as they leave the post that allows them to share information;

3. be subject to appropriate level of vetting by HR. This particularly applies to existing staff that may not have been subject to checks in their current role but require it in their integrated services post.

10.26 **Information Governance:** The Information Governance reporting arrangements for each party are as follows:

1. Borders Health Board: The Information Governance Committee reports to the Borders Health Board's Audit Committee.

2. Scottish Borders Council: The Information Governance Group reports to the Corporate Management Team.

11. Complaints

11.1 The Parties agree that complaints in relation to the delegated functions as set out in Part 2 Appendix 2, and Part 2 Appendix 3, will be received, managed and responded to by the appropriate lead organisation and agree to the following arrangements in respect of this:-

- Complaints in relation to integrated services or Scottish Borders Council services can be made to Scottish Borders Council, Headquarters.

- Complaints in relation to integrated services or Borders Health Board services can be made to NHS Borders, Borders General Hospital.

- Each organisation will have a clearly defined description of what constitutes a complaint contained within their organisations complaints handling documentation.

- A framework has been developed that clearly shows the lead organisation for each integrated service and the contact details for those who will be responsible for progressing any complaints received. The lead organisation will take responsibility for the triage of the complaint, and liaise with the other organisation to develop a joint response where required.

- Where the complaint is multi-faceted and has a multi-agency dimension to it, the Chief Officer will designate one of the existing processes to take the lead for investigating and coordinating a response. The Chief Officer will have an overview of complaints related to integrated services and will provide a commitment to joint working, wherever necessary, between the parties when dealing with complaints about integrated services.

- If a complaint remains unresolved through the defined complaints-handling procedure, complainants will be informed of their right to go either to the Scottish Public Services Ombudsman for services provided by Borders Health Board, or to the Social Work Complaints Review Committee following which, if

their complaint remains unresolved, they have the right to go to the Scottish Public Services Ombudsman for services provided by Scottish Borders Council.

- There will be three established processes for a complaint to follow depending on the lead organisation.

    1. Statutory Social Work.
    2. NHS.
    3. Independent Contractors – All Independent Contractors involved with the Integration Joint Board, will be required to have a Complaints Procedure in place. Where complaints are received that relate to a service provided by an Independent Contractor, the lead organisation will refer the complainant to the Independent Contractor for resolution of their complaint. This may be done by either provision of contact details or by the lead organisation passing the complaint on, depending on the approach preferred by the complainant.

- The current process for gathering service user/patient/carer feedback within Borders Health Board and Scottish Borders Council, how it has been used for improvement, and how it is reported will continue.

12. Claims Handling, Liability & Indemnity

12.1 Borders Health Board will continue to follow their CNORIS programme for their services and Scottish Borders Council will continue with their current insurance processes. This will be applied to all integrated services.

12.2 Where there is a shared liability negotiations will take place as to the proportionality of each parties liability on a claim by claim basis.

13. Risk Management

13.1 The risk management strategy will include: risk monitoring, risk management framework and the strategic risk register.

13.2 As part of the risk management strategy the Chief Officer will be responsible for drawing to the attention of the Integration Joint Board any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

13.3 Business Continuity plans will be in place and tested on a regular basis for the integrated services.

14. Dispute resolution mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of Borders Health Board and Scottish Borders Council, will meet to resolve the issue;

(b) If unresolved, the Borders Health Board, and Scottish Borders Council will each prepare a written note of their position on the issue and exchange it with the others;

(c) In the event that the issue remains unresolved, the Chief Executives (or their representatives) of Borders Health Board and Scottish Borders Council will proceed to mediation with a view to resolving the issue.

(d) A professional independent mediator will be appointed. The mediation process will commence within 28 calendar days of the agreement to proceed.

(e) The Mediator shall have the same powers to require any Partner to produce any documents or information to him/her and the other Partner as an arbiter and each Partner shall in any event supply to him such information which it has and is material to the matter to be resolved and which it could be required to produce on discovery; and

(f) The fees of the Mediator shall be borne by the Parties in such proportion as shall be determined by the Mediator having regard (amongst other things) to the conduct of the parties.

14.2 Where the issue remains unresolved after following the processes outlined above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached.

14.3 The Chief Executives shall write to Scottish Ministers detailing the unresolved issue, the process followed and findings of the mediator and seek resolution from Scottish Ministers.

APPENDIX OF DOCUMENTS – HEALTH AND SOCIAL CARE SCHEME OF INTEGRATION

Appendix No	Document
1 HSC Integration Scheme 151215 diagr	Integration Joint Board Governance Arrangements The Integration Joint Board has established its own Audit Committee.
2 APPENDIX 2 Functions Delegated I	Functions delegated by the Health Board to the Integration Joint Board
3 APPENDIX 3 Functions Delegated I	Functions delegated by the Local Authority to the Integration Joint Board
4 Appendix 4 Carers Act.docx	Functions delegated by the Health Board and Local Authority to the Integration Joint Board in respect of the Carers Act.

Scottish Borders
Health and Social Care
PARTNERSHIP

Scheme of Integration 2022 tracked changes overview

Section		Original version	Revised version
Local Governance Arrangements	2.9	At the first meeting of the Integration Joint Board it will elect a Chairperson and Vice Chairperson from the voting membership of the Integration Joint Board. The Chair and Vice–Chair posts shall rotate annually between Borders Health Board and Scottish Borders Council, with the Chair being from one body and the Vice-Chair from the other. The first Chair of the Integration Joint Board will be from Scottish Borders Council.	At the first meeting of the Integration Joint Board it elected a Chairperson and Vice Chairperson from the voting membership of the Integration Joint Board.
Local Governance Arrangements	2.10	The initial appointment of the Chair and Vice Chair will be for a period of 12 months.	The Chair and Vice–Chair posts rotate on a three year basis between Borders Health Board and Scottish Borders Council, with the Chair being from one body and the Vice-Chair from the other.
Local Governance Arrangements	2.11	The terms of office for the Chair and Vice Chair shall rotate on a three year basis.	Removed.
Targets and Performance Management	4.6.7	The performance management framework will be in place by the end of March 2016.	Removed.
Corporate Services Support	4.7.1	With regard to corporate services support, Scottish Borders Council and Borders Health Board will by the end of March 2016, have:	With regard to corporate services support, Scottish Borders Council and Borders Health Board have: • identified the corporate resources used to deliver

Section		Original version	Revised version
		• identified the corporate resources used to deliver the delegated functions; • agreed the corporate support services required to fully discharge Integration Joint Board duties under the Act.	the delegated functions; • agreed the corporate support services required to fully discharge Integration Joint Board duties under the Act.
Corporate Services Support	4.7.2	These support services will include, but not be limited to:- • Finance (including capital planning) • HR • ICT • Administrative Support • Committee Services • Internal Audit • Performance Management • Risk • Insurance	These support services include, but are not limited to:- • Finance (including capital planning) • HR • ICT • Administrative Support • Committee Services • Internal Audit • Performance Management • Risk • Insurance
Corporate Services Support	4.7.3	By end of March 2016, agreements specifying the associated support services will be in place. These agreements will be kept under review during the initial year and, thereafter, will be reviewed formally (and agreed by all parties) annually.	Arrangements are in place for the provision of appropriate Corporate support and this is kept under on-going assessment and review.
Corporate Services Support	4.7.4	In regard to support for strategic planning there will be set out local arrangements for the preparation of the strategic commissioning plan with support from Borders Health Board and Scottish Borders Council, taking into account the relevant activity and financial data covering the services, facilities and resources that relate to the Strategic Commissioning Plan. Local arrangements will be	In regard to support for strategic planning there will be set out local arrangements for the preparation of the strategic commissioning plan with support from Borders Health Board and Scottish Borders Council, taking into account the relevant activity and financial data covering the services, facilities and resources that relate to the Strategic Commissioning Plan. Local arrangements will be

Section		Original version	Revised version
		reviewed formally on an annual basis taking account of any changes to the Strategic Commissioning Plan.	reviewed formally on an annual basis taking account of any changes to the Strategic Commissioning Plan.
Clinical and Care Governance	5.2	The Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing and Director of Public Health) share accountability for clinical governance of NHS services as a responsibility/function delegated from the Chief Executive of Borders Health Board.	The Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing, Midwifery & AHPs and Director of Public Health) share accountability for clinical governance of NHS services as a responsibility/function delegated from the Chief Executive of Borders Health Board.
Clinical and Care Governance	5.3	These Directors continue to hold accountability for the actions of the Borders Health Board clinical staff who deliver care through health and social care integrated services. They attend the Borders Health Board Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by Borders Health Board and which in turn will provide assurance to the Integration Joint Board.	These Directors continue to hold accountability for the actions of the Borders Health Board clinical staff who deliver care through health and social care integrated services. They attend the Borders Health Board Clinical Governance Committee which oversees the clinical governance arrangements of all services delivered by health care staff employed by Borders Health Board and which in turn will provide assurance to the Integration Joint Board that it has undertaken its duties in this respect.
Clinical and Care Governance	5.5	The Integration Joint Board, and where required the Strategic Planning Group and Localities, will receive Clinical and Care Governance reports from the parties on matters relating to the delegated functions.	Clinical governance groups operating for services within the Integrated Joint Board will consider a wide range of reports within their annual work programmes relating to clinical and care governance. These groups provide formal assurance through the NHS Borders Board Clinical Governance Committee. Beyond the annual report from the Board Clinical Governance Committee to the Integrated Joint Board specific assurance can be requested on Clinical and Care Governance matters relating to the delegated functions as and when required.

Section		Original version	Revised version
Clinical and Care Governance	5.6	As part of the regular monitoring process the Integration Joint Board may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Adult Protection Committee, Child Protection Committee (for universal childrens health services), Area Clinical Forum and Area Drug and Therapeutics Committee.	As part of the regular monitoring process the Integration Joint Board may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Public Protection Committee (which encompasses adult and child protection activity and assurance across the partnership), Area Drug and Therapeutics Committee and Area Clinical Forum (ACF) or specific professional advisory groups under the ACF structure.
Clinical and Care Governance	5.7	The appropriate appointed Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing and Director of Public Health) will support the Chief Officer and the Integration Joint Board in the manner they support Borders Health Board for the range of their responsibilities.	The appropriate appointed Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing, Midwifery & AHPs and Director of Public Health) will support the Chief Officer and the Integration Joint Board in the manner they support Borders Health Board for the range of their responsibilities.
Workforce	7.1	Borders Health Board and Scottish Borders Council will jointly develop and put in place for their employees delivering integrated services, by the end of March 2016, a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan).	Borders Health Board and Scottish Borders Council will jointly develop and put in place for their employees delivering integrated services, a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan).
Participation and Engagement	9.2	Staff and practitioner events were held from October 2014 to January 2015. Engagement events took place in February 2015 in all 5 localities in Scottish Borders. The consultation over the Scheme of Integration was launched on	Removed.

Section		Original version	Revised version
		22 December 2014 (closing on 13 March 2015 – 12 week statutory consultation period) with a press release and emails to all identified stakeholders. The Draft Scheme of Integration was posted on both the Scottish Borders Council and Borders Health Board websites along with details of how people could respond or provide their comments and feedback. This included electronic forms and an email address as well as telephone and postal address.	
Participation and Engagement	9.3	Feedback from all of the above has been used to inform the final Scheme of Integration.	Feedback from all of the above has been used to inform the refresh of the Scheme of Integration.
Participation and Engagement	9.4	There are national standards for community engagement and participation which underpin how Scottish Borders Council and Borders Health Board operate. A framework has been developed to take into account these requirements, specifically Scottish Government Planning Advice note 2010 and CEL 4(2010) 'Informing, engaging and consulting people in developing health and community care services'.	There are national standards for community engagement and participation which underpin how Scottish Borders Council and Borders Health Board operate.
Participation and Engagement	9.5	Communication and Engagement is vital to the success of integrated services and the reputation of all partners involved. The Parties will support the Integration Joint Board to develop a Communications and Engagement Plan that incorporates the continuing role of the Strategic Planning Group in the development, review and renewal of the Strategic Commissioning Plan. To do this, the Parties will provide appropriate resources and support to develop both a	Timely and effective communications and engagement is a key component in the development, review and renewal of the Strategic Commissioning Plan. A communications and engagement strategy and action plan should be developed, in conjunction with the Strategic Planning Group to support this work.

Section		Original version	Revised version
		Communications Strategy and supporting action plan. The Strategy will ensure that Communications and Engagement/co-production is effectively linked to the role of the Strategic Planning Group. The Strategy and first iteration of the Communication and Engagement Plan will be in place by April 2016.	
Information Sharing	10.14	**The Public Records (Scotland) Act:** Both parties are scheduled Public Authorities under the Public Records (Scotland) Act and have a duty to create and have approved a records management plan. The Integration Joint Board will become a body under the duties of the Act and will comply with the requirements of the Act. Reference to information management procedures of the integrated service will be recorded in both plans, including information sharing and other record keeping arrangements and duties that pertain to services contracted out to third party service providers or external agencies will also be included.	**The Public Records (Scotland) Act:** Both parties are scheduled Public Authorities under the Public Records (Scotland) Act and have a duty to create and have approved a records management plan. The Integration Joint Board also has a records management plan in compliance with the requirements of the Act. Reference to information management procedures of the integrated service will be recorded in both parties plans, including information sharing and other record keeping arrangements and duties that pertain to services contracted out to third party service providers or external agencies will also be included.
Information Sharing	10.20	Where an FOI relates to a joint service, the receiving organisation will forward the FOI to the relevant Service Manager who will provide the requested information on behalf of both organisations. The receiving organisation will undertake the progress monitoring, responsibility for redacting, quality checking and responding to the applicant. A list of services that are in scope for Integration and their Managers will be developed and shared between the two organisations. All FoI's that relate to integrated services will be signed off by the Chief Officer.	Where an FOI relates to a joint service, the receiving organisation will forward the FOI to the relevant Service Manager who will provide the requested information on behalf of both organisations. The receiving organisation will undertake the progress monitoring, responsibility for redacting, quality checking and responding to the applicant. A list of services that are in scope for Integration will be shared between the two organisations. All FoI's that relate to integrated services will be signed off by the Chief Officer.

Section		Original version	Revised version
Risk Management	13.1	The Corporate Risk functions in Borders Health Board and Scottish Borders Council will support the Chief Officer to develop a risk management strategy by the end of March 2016. In the context of the risk management strategy the initial list of risks to be reported will be outlined in the first formal meeting of the Integration Joint Board from 1 April 2016.	Removed.
Risk Management	13.2	The risk management strategy will include: risk monitoring and risk management framework; the integrated management risk register; and the strategic risk register.	The risk management strategy will include: risk monitoring, risk management framework and the strategic risk register.
Appendix of Documents	1	Integration Joint Board Governance Arrangements The Integration Joint Board may establish its own Audit Committee. The chairs of all 3 Audit Committees would, in such circumstances, (Borders Health Board, Scottish Borders Council and the Integration Joint Board) be expected to work in an integrated way.	Integration Joint Board Governance Arrangements The Integration Joint Board has established its own Audit Committee.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Alcohol & Drugs Partnership Annual Report 2020-2021**
Responsible Executive/Non-Executive:	**Dr Tim Patterson, Joint Director of Public Health**
Report Author:	**Fiona Doig, Head of Health Improvement/Strategic Lead Alcohol & Drugs Partnership**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The ADP is required to submit an Annual Review to Scottish Government using a prescribed template (see Appendix 1). Recognising the limitations of the template the ADP has also developed a narrative 'highlight' report which provides a more detailed update on some key developments and activities during 2020-21 (see Appendix 2). The reports do not represent all work carried out across the partnership.

The highlight' report includes an update on progress against Ministerial Priorities; drug and alcohol services responses during COVID-19 pandemic and progress in relation to areas for improvement identified in the ADP Strategic Plan 2021-2023.

This is being brought to the Board for their awareness.

2.2 Background

Borders ADP is a partnership of agencies and services involved with drugs and alcohol. It provides strategic direction to reduce the impact of problematic alcohol and drug use. It is chaired by the Joint Director of Public Health and the Vice Chair is Scottish Borders Council's Director – Social Work and Practice. Membership includes officers from NHS Borders, Scottish Borders Council, Police Scotland and Third Sector.

The highlight' Annual Report shows positive progress in many of the reporting areas and extracts are presented below. There are some areas where the ADP will seek work to improve in future work. There is a two year Delivery Plan in place which is monitored by the ADP Board

2.3 Assessment

The highlight' Annual Report shows positive progress in many of the reporting areas and extracts are presented below. There are some areas where the ADP will seek to improve in future work. There is a two year Delivery Plan in place which is monitored by the ADP Board.

2.31 Highlighted areas in narrative Annual Report

- Drop-in clinics were postponed due to COVID-19 but all drug and alcohol services remained open throughout 2020-21 and adapted service provision to ensure all current and new clients were still able to access support (p29).

- During 2020-21, 512 individuals started treatment with 99% starting within three weeks of referral against target of 90% (p30).

- Online recovery/fellowship meetings continued throughout 2020-21 with WAWY Mutual Aid Partnerships meeting online and expanded (p30).

- In 2020-21 there were 49 first supplies of Take Home Naloxone provided across Borders. In Borders we have reached 86% of our estimated population of opiates/benzodiazepines drug users with a first time kit compared with 57% nationally by end March 2021 (p31).

- Good progress is being made in Borders in relation to Medication Assisted Treatment (MAT) standards[1] 1-5. Borders Addiction Service (BAS) has been awarded national funding to participate in a MAT Sub-Group test of change. The numbers of people starting same day prescribing increased. Patient choice expanded to include additional formulations of an existing medication (buprenorphine) Espranor and Buvidal (p31). Espranor is a sub-lingual formulation and Buvidal is an extended release injection.

- Despite schools being closed due to restrictions, CHIMES (Children Affected by Parental Substance Use/Family Service) was able to support children impacted by

[1] https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/

a family member's alcohol and/or drug use, young carers and parents with concerns around their drug/alcohol use. During 2020-21 CHIMES staff members applied for and distributed over £65,000 to families to enable practical support e.g. fuel, energy, food and broadband costs as well as activities, technology and equipment (p32).

- During 2020-21 Borders ADP Support Team coordinated 12 online training courses with 130 participants attending (p33).

- A total of 1341 alcohol brief interventions were delivered across Primary Care, Antenatal and wider settings. This was against a target of 1312 (102%) (p33).

2.32 Areas for improvement identified in the ADP Strategic Plan 2021-2023

2.321 Involvement of people with lived experience
The 2020-2023 ADP Strategy Refresh highlighted the need to improve the involvement of people with lived experience. Pre COVID-19 positive meetings were held with people with lived experience and family members. This panel has continued to meet online and consider how to develop lived experience involvement in ADP planning. This group is chaired by the Recovery Engagement Officer within We Are With You (WAWY) and supported by officers from Serendipity Recovery Café, Scottish Recovery Consortium and ADP Support Team (p34).

2.322 Independent Advocacy
The ADP contributes a small amount of funding (£5,000) towards the contract for independent advocacy in Borders. No further development has progressed in 2020-21 and the ADP is currently exploring additional capacity within the system (p34).

2.323 Pathways for people experiencing both mental health and substance use concerns ('co-morbidity')
Development of formal pathways was not progressed during COVID-19, however, work is ongoing within Mental Health to progress this work (p35).

2.4 Preventing drug related deaths

Prevention of drug related deaths remains a priority for all ADP partners. The 2019 Annual Report was produced and presented at the Critical Services Oversight Group (CSOG).

In May 21, a pilot to test a Non Fatal Overdose Pathway was established to ensure people experiencing non fatal overdose are identified and offered appropriate outreach and aftercare including referral into drug treatment service (p31).

2.5 Quality/ Patient Care

As described above, despite the challenges that COVID-19 brought, the highlight report describes the successful partnership working across agencies and how services ensured people continued to receive support as well as meeting demands of Scottish Government and newly expanded Drugs Policy Team.

2.6 Workforce

This is an annual report therefore no impact on staffing.
Recruitment is underway to support the additional areas of work noted below.

2.7 Financial

2.71 Financial position 2020-21

The financial position for 2020-21 is presented in the Annual Review (p24). Members will be aware of the significant additional funding provided to ADPs as part of the £50 million investment by Scottish Government to support a National Mission to reduce drugs harm and deaths. This funding is in place for 5 years from 2021-2026.

2.72 Additional funding 2021-22

Borders ADP received its funding notifications in June and August 2021. At its meeting on 21.10.21 the ADP confirmed how it will allocate the funding. A total of £510,280 has been awarded to Borders. Due to the timing of the award letters and decision making processes, at time of writing contractual negotiations with providers are still being progressed.

Funding is awarded across seven different priority areas as presented in Table 1 below.

1. June letter - Additional allocations 2021-2026	
National Mission	106,308
Residential Rehabilitation	106,308
Whole family approach	74,416
Total announced June	£287,032
2. August letter – Additional allocations 2021-2026	
Buvidal	85,047
Outreach	63,785
Near-fatal overdose pathways	63,785
Lived and living experience panels/forums	10,631
Total announced August	£223,248

Table 1: Additional Borders allocation of National Mission £50 million.

A Scottish Government FAQ's document has been circulated to the ADP Board which confirms we should consider the existing Programme for Government funding as recurring.

The ADP agreed allocation of these additional funds based on:

- existing evidence (MAT standard implementation assessment; residential rehabilitation survey, discussions to develop ADP Strategy 2020)
- feedback from services and people with lived and living experience
- funding requirements from Scottish Government.

Final agreements re funding dispersal were agreed at the ADP in October 2021 as follows:

National Mission Funding

National Mission Funding £106,287	**Award**
3% uplift on We Are With You (WAWY) contracts	£13,161
Additional WAWY capacity (1 WTE)	£35,000
Additional Borders Addiction Service (BAS) capacity	£57,126

Residential Rehabilitation Funding

Residential Rehab £106,287	
Additional places (70% of funding)	74,401
Peer navigator (WAWY 0.6 WTE)	18,625
Additional capacity BAS (equivalent Support Worker 0.5 WTE)	13,400
Total*	**£106,426**

*there is a minimal over commitment in this budget line

Whole Family Approach

Whole Family Approach £74,416	
3% uplift on CHIMES contract	£7646
Additional CHIMES capacity (1 WTE)	£35,000
Additional WAWY Capacity (0.8 WTE)	£31,500
Total	**£74,146**

Buvidal

Buvidal is a long acting formulation of buprenorphine which is administered by monthly injection. This funding will be allocated to support implementation of Buvidal supply.

Outreach and non-fatal overdoses

These funding streams have been bundled together to reflect current arrangements and existing successful working practices.

Outreach and Non-fatal overdoses (£127,570)	
WAWY (1.0 WTE)	35,000
BAS	65,000
Pharmacy	12,500
Peer navigator (0.4WTE)	12,417
Logistics	2,000
Total	£126,917

Lived and living experience

We currently commission a role within WAWY to support this area of work. Scottish Drugs Forum has been awarded a national contract to co-ordinate and support panels. We await further information relating to the requirements for this funding prior to agreeing allocation.

2.73 Contracts and procurement

The ADP Support Team has been supported by SBC Contracts and Procurement to ensure appropriate routes to commissioning. The current plans are in place:

- WAWY – vary the existing contract with new funding requirements and extend to March 2023. A PIN notice has been issued in Winter 2021 to explore the market and inform a Commissioning Strategy.
- Action for Children CHIMES – this service is jointly funded by the Children and Young People's Leadership Group (CYPLG) funding. The CYPLG has extended all services until end March 2023 to enable a commissioning review. A variation will be issued to confirm new funding requirements.

- BAS – an SLA is in place until March 2024, however, this will be review and updated to reflect additional requirements. It is aimed to have this in place for April 2022.

2.74 Governance
Services participate in a quarterly contract monitoring meeting. Quarterly performance and finance reports are reviewed by the ADP. Scottish Government now requires quarterly reporting of finances and residential rehabilitation requirements.

2.8 Risk Assessment/Management
Development of lived experience - engagement with people who have alcohol and drug problems can be challenging and many social and economic influences outside the control of the ADP will impact on the success of the initiatives. If agencies fail to prioritise this area of work outcomes may not be achieved.

2.9 Equality and Diversity, including health inequalities

A Health Inequalities Impact Assessment was completed for the ADP Strategy.

2.10 Other impacts

n/a

2.11 Communication, involvement, engagement and consultation
The ADP has carried out its duties to involve and engage external stakeholders where appropriate:

The Annual Report was produced by the ADP Support Team in consultation with commissioned alcohol and drugs services and a representative from Borders Recovery Community.

2.12 Route to the Meeting
This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- ADP Board, 27 September 2021
- Joint Executive Team, 2 November 2021
- Borders Integrated Joint Board, 15 December 2021

3 Recommendation

This report is for NHS Board awareness – For members information only.

4 List of appendices

The following appendices are included with this report:

- Appendix 1, Alcohol & Drugs Partnership Annual Review 2020/21
- Appendix 2, ADP Highlight Annual Report 2020/21

Appendix 1, Alcohol & Drugs Partnership Annual Review 2020/21

ALCOHOL AND DRUG PARTNERSHIPANNUAL REVIEW 2020/21 (Scottish Borders)

I. Delivery progress
II. Financial framework

This form is designed to capture your **progress during the financial year 2020/2021** against the Rights, Respect and Recovery strategyincluding the Drug Deaths Task Force emergency response paper and the Alcohol Framework 2018We recognise that each ADP is on a journey of improvement and it is likely that further progress has been made since 2020/21. Please note that we have opted for a tick box approach for this annual review but want to emphasise that the options provided are for ease of completion and it is not expected that every ADP will have all options in place. We have also included open text questions where you can share details of progress in more detail. Please ensure all sections are fully completed.**You should include any additional information in each section that you feel relevant to any services affected by COVID-19.**

The data provided in this form will allow us to provide updates and assurance to Scottish Ministers around ADP delivery. The data will also be shared with Public Health Scotland (PHS) evaluation team to inform monitoring and evaluation of drugs policy.

We do not intend to publish the completed forms on our website but encourage ADPs to publish their own submissions as a part of their annual reports, in line with good governance and transparency. All data will be shared with PHS to inform drugs policy monitoring and evaluation, and excerpts and/or summary data from the submission may be used in published reports. It should also be noted that, the data provided will be available on request under freedom of information regulations.

In submitting this completed Annual Reviewyouare confirming that this partnership response has been signed off by your ADP, theADP Chair and Integrated Authority Chief Officer.

The Scottish Government copy should be sent by **Wednesday 14thOctober 2021** to:drugsmissiondeliveryteam@gov.scot

NAME OF ADP: **Borders ADP**

Key contact:
Name: **Fiona Doig**
Job title: **Head of Health Improvement/Strategic Lead - ADP**
Contact email: **Fiona.doig@borders.scot.nhs.uk**

I. DELIVERY PROGRESS REPORT

1. Representation

1.1 Was there representation form the following local strategic partnerships on the ADP?

Community Justice Partnership	Y
Children's Partnership	Y
Integration Authority	Y

1.2 What organisations are represented on the ADP and who was the chair during 2020/21?

Chair*:* Dr Tim Patterson, Joint Director of Public Health, NHS Borders and Scottish Borders Council

Representation

The public sector:

Police Scotland		Y
Public Health Scotland	N	
Alcohol and drug services		Y
NHS Board strategic planning	Y	
Integration Authority		Y
Scottish Prison Service (where there is a prison within the geographical area)		N/A
Children's services		Y
Children and families social work		Y
Housing		Y
Employability		N
Community justice		Y
Mental health services	Y	
Elected members		Y
Other	Local Authority Commissioning and Procurement NHS Finance Manager Joint Health Improvement Team	

The third sector: we commission SDF to provide independent third sector representation

Commissioned alcohol and drug services	Y
Third sector representative organisation	Y
Other third sector organisations	N
People with lived/ living experience	N
Other community representatives	N
Other	N

1.3 Are the following details about the ADP publically available (e.g. on a website)?

Membership	N
Papers and minutes of meetings	N
Annual reports/reviews	Y
Strategic plan	Y

1.4 How many times did the ADP executive/ oversight group meet during 2020/21?
The ADP Board met 5 times during 2020/21.

1.5 Please give details of the staff employed within the ADP Support Team

Job Title	Whole Time Equivalent
1. Head of Health Improvement/ Strategic Lead ADP	0.5 WTE
2. Coordinator	1 WTE
3. Project Officer	0.8 WTE (increased from 0.4 May 2021)
4. Data & Performance Officer	0.25 WTE

Total WTE 2.55 (Permanent)

2. Education and Prevention

2.1 In what format was information provided to the general public on local treatment and support services available within the ADP?
Please tick those that apply (please note that this question is in reference to the ADP and not individual services)

Leaflets/ take home information	Y
Posters	N
Website/ social media http://www.nhsborders.scot.nhs.uk/badp	Y
Accessible formats (e.g. in different languages) Available on demand.	Y
Other Please provide details…….	☐

2.2 Please provide details of any specific communications campaigns or activities carried out during 19/20 *(E.g. Count 14 / specific communication with people who alcohol / drugs and/or at risk)*(max 300 words).
Due to COVID-19 there were no specific communications or activities relating to Count 14. However regular communication was shared on ADP website for members of the public around support that available from drug and alcohol services as well as new facilities e.g. click and collect IEP provision. Weekly service updates were provided to Scottish Drugs Forum and Scottish Borders Council during Spring-Autumn 2020.

2.3 Please provide details on education and prevention measures/ services/ projects provided during the year 19/20 specifically around drugs and alcohol (max 300 words).

Alcohol Focus Scotland was commissioned by Borders Alcohol & Drugs Partnership to deliver the Oh Lila programme to nurseries and agencies within the local authority area, following a successful pilot session delivered in September 2019.

During February 2020, four training sessions were held for early years establishments face to face, with a further 3 sessions due to take place in May 2020. Due to COVID-19 restrictions and lockdown this training was postponed. The remainder of training was picked up in Winter/Spring 2020/21 in a virtual training environment using MS Teams.
Drop in sessions via MS Teams were also offered to staff to support those who had been trained prior to lock downs and unable to practice using the materials.
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.

During 2020/21 Borders ADP Support Team coordinated 12 online training courses with 130 participants in attendance (76 Statutory sector, 30 Voluntary sector, 24 other such as housing association and foster carers).
Courses delivered included Emerging Trends, Introduction to Foetal Alcohol Syndrome, Benzodiazepines and Managing Emotion

2.4 Please provide details of where these measures / services / projects were delivered

Formal setting such as schools Y
Youth Groups ☐
Community Learning and Development Y
Other – please provide details multiagency training, drug and alcohol services Y

2.5 Please detail how much was spend on Education / Prevention activities in the different settings above

Formal setting such as schools
Youth Groups
Community Learning and Development
Other – as above £5298

2.6 Was the ADP represented at the Alcohol Licensing Forum?

Yes Y
No ☐

Please provide details (max 300 words)
The ADP Co-ordinator represents Public Health on the Local Licensing Forum.

The LLF met jointly with the Licensing Board in December 2020 and noted the report provided by the Board. The Licensing (Scotland) Act 2005 required the Board to hold hearings in public, however, the lockdown meant that this was not possible. With both businesses and licensing authorities under unprecedented disruption as a result of the Covid-19 outbreak, the Scottish Government moved swiftly and passed the Coronavirus (Scotland) Act 2020 which allowed the Board some flexibility with regard to the timescales and deadlines stipulated in the 2005 Act. In addition, the 2020 Act contained provisions which gave the Board a new discretion to dispense with the requirement to hold meetings in public and to instead provide alternative means for persons to be heard by telephone, video conferencing or by written communication including by electronic means. As a consequence, the Board was able to recommence meetings by Microsoft Teams Video Conferencing and held its first meeting by this medium on 31 July 2020. This has subsequently enabled the Board to meet on a monthly basis as it normally did prior to the Covid-19 outbreak.

2.7 Do Public Health review and advise the Board on license applications?
All ☐
Most ☐
Some Y
None ☐

Please provide details (max 300 words)
Borders ADP Support Team review all new licence and variations on behalf of Public Health.
Occasional licences which have a child/family element and that are brought to the attention of ADP Support Team by Licensing Standards Officer

3. RRR Treatment and Recovery - Eight point plan

People access treatment and support – particularly those at most risk (where appropriate please refer to the Drug Deaths Taskforce publication Evidence-Based Strategies for Preventing Drug-Related Deaths in Scotland: priority 2, 3 and 4 when answering questions 3.1, 3.2, 3.3 and 3.4)

3.1During 2020/21 was there an Immediate Response Pathway for Non-fatal Overdose in place?

Yes	☐
No	☐
In development	Y

Please give details of developments (max 300 words)
Protocol between SAS, NHS Borders Addictions Service (BAS) and Emergency Dept was put in place in 2019 but was not fully implemented. In February 2021 agreement was reached for ADP Support Team to progress a pilot with information sharing with SAS, Police and NHS for all individuals experiencing a non-fatal overdose. This pilot was implemented in May 2021 with evaluation to take place in September 2021. Information is shared on a daily basis via SAS with BAS and any additional referrals received from Police to BAS. The Assertive Engagement Team (ES Team) will then make contact with individuals within 48hours of referral with appropriate harm reduction advice and support into service where appropriate.

3.2 Please provide details on the process for rapid re-engagement in alcohol and/or drug services following a period of absence, particularly for those at risk and during COVID-19. Are services fully open at normal levels / blended services on offer?(max 300 words).

In addition to the NFO pathway, the ES Team accept referrals from the core team in both BAS and We Are With You for people who have missed appointments, pharmacy pick-ups or have not engaged since original referral. Referrals will also be made by the Substance Liaison Service in the acute hospital. The ES Team will make additional attempts to engage with individuals via phone or face-to-face visits.

Drop-in clinics were postponed due to COVID-19 but all drug and alcohol services remained open in the Borders and were able to see new and current clients via telephone, online or where clinically appropriate face to face for those at high risk. Appropriate COVID-19 safety measures were in place. Where clients were asked to self-isolate or shield, staff were able to deliver medication as required including naloxone and injecting equipment provision. No staff in drug and alcohol services were transferred to work in other areas in response to COVID-19 in 2020-21.

All services are now open although, in line with COVID-19 restrictions, some activities remained online during the year e.g. recovery groups in WAWY. Drop-in clinics and First Steps harm reduction groups were suspended until post April 2021.

3.3 What treatment or screening options were in place to address drug harms? *(mark all that apply)*

Same day prescribing of OST	Y	
Methadone		Y
Buprenorphine and naloxone combined (Suboxone)	Y	
Buprenorphine sublingual		Y
Buprenorphine depot		Y
Diamorphine		N
Naloxone		Y
BBV Screening (although lab suspended work for part of the year)		Y
Access to crisis support		Y *
Access to detox from opiates/benzos - rehab		Y

Other non-opioid based treatment options	☐Please provide details…….

* We do not have an addiction specific crisis service but have duty system that frequently supports people in crisis. Referrals are made to crisis services outside addictions, such as Distress Brief Interventions or the Crisis Team in Mental Health.

3.4 What measures were introduced to improve access to alcohol and/or drug treatment and support services during the year, particularly for those at risk 20/21 (max 300 words).
Services exceeded the Local Delivery Plan Standard with 99% (492/496) of referrals starting treatment within three weeks during 2020/21.

Borders Addiction Service (BAS) continued to provide same day prescribing where safe with 80% starting on same day and the remaining 20% commencing within 7 days in Quarter 4 2020/21.

At the start of lock down all clients on an OST prescription were reviewed and moved to reduced supervision. The service has now reviewed those and completed further risk assessments moving those at most risk back to daily supervision of their medication.

For people instructed to self isolate, medication was being delivered where required.

IEP/Naloxone:
All Community Pharmacies providing IEP had returned to normal working hours from 11.5.20. WAWY launched a click and collect service and was also open from 11 – 3pm daily for collection of IEP and Naloxone. Home deliveries were also made for IEP and naloxone to those who could not access equipment, where safe to do so.

Expansion of naloxone provision:
Following the letter from Scottish Government about the letter of comfort from Lord Advocate to expand naloxone provision into non drug services, this was implemented in Community Rehabilitation Team, Homelessness Service, CHIMES and Justice Services. All Community Pharmacies also received an invitation to sign up to a Service Level Agreement to supply take home naloxone and emergency naloxone supply.

CHIMES (CAPSM service)
This service continued to support children, young people and parents offering home visits, door- step visits and socially distanced walks. Families were supported to access emergency funds for supporting families in crisis and in need of immediate support for food, clothing, gas/ electricity and fuel for vehicles.

3.5 What treatment or screening options were in place to address <u>alcohol</u> harms? *(mark all that apply)*

Fibroscanning	N	
Alcohol related cognitive screening (e.g. for ARBD)	Y	
Community alcohol detox		Y
Inpatient alcohol detox		Y
Alcohol hospital liaison	Y	
Access to alcohol medication (Antabuse, Acamprase etc.)		Y
Arrangements for the delivery of alcohol brief interventions in all priority settings		Y – although due to COVID-19 restrictions, ABI ceased in A&E.
Arrangements of the delivery of ABIs in non-priority settings	Y	
Other – Please provide details	☐	

People engage in effective high quality treatment and recovery services

3.6 Were Quality Assurance arrangements in place for the following services?(examples could include review performance against targets/success indicators, clinical governance reviews, case file audits, review against delivery of the quality principles):

	Adult Services	*Children and Family Services*
Third sector	Y	Y
Public sector	Y	N/A
Other	N/A	N/A

3.7 Please give details on how services were Quality Assured including any external validation e.g. though care inspectorate or other organisations?(max 300 words)

- Third Sector Adult: ADP quarterly monitoring meetings are in place based on Service Specification.
Service registered with Care Inspectorate – last inspection was in June 2018.

- Third Sector Children and families: ADP quarterly monitoring meetings are in place based on Service Specification. Internal safeguarding audits on case-files are carried out quarterly by senior managers. This service is jointly commissioned with the local Children's Planning Partnership and performance is reviewed by the Commissioning Sub-Group which includes meeting with young people using the service.
- Public Sector Adult: ADP quarterly monitoring meetings are in place based on Service Specification.
- Local and senior managers from all commissioned services attend quarterly Quality Principles meeting.

Thank you for completing the recent Scottish Government ADP Pathways Survey, which gathered data for 2019/20. The following questions look to gather the same data for 2020/21.

3.8 Were there pathways for people to access residential rehabilitation in your areain 2020/21?

Yes Y

No ☐

Please give details below (including referral and assessment process, and a breakdown between alcohol and drugs referrals) (max 300 words)

BAS accept self referrals and referrals from colleagues such as GP's and Social Workers. Medical assessment is undertaken by the Addictions Psychiatrist in BAS. Assessment is undertaken by a BAS Support Worker.

3.9 How many people started a residential rehab placement during 2020/21? (if possible, please provide a gender breakdown)

3 in Total for 2020/21 (2 males, 1 female)

People with lived and living experience will be involved in service design, development and delivery

3.10 Please indicate which of the following approaches services used to involve lived / living experience / family members *(mark all that apply).*

For people with lived experience:

Feedback/ complaints process	Y	
Questionnaires/ surveys		N
Focus groups / panels	N	
Lived/living experience group/ forum	Y	
Board Representation within services	N	
Board Representation at ADP	N	
Other		Naloxone Peer Champions now members of Harm Reduction group. Staff Recruitment

Please provide additional information (optional)
Click or tap here to enter text.

For family members:

Feedback/ complaints process	Y	
Questionnaires/ surveys		N
Focus groups / panels	N	
Lived/living experience group/ forum	Y	
Board Representation within services	N	
Board Representation at ADP	N	
Other		☐Please provide details…….

Please provide additional information (optional)
Click or tap here to enter text.

3.11 Had the involvement of people with lived/ living experience, including that of family members, changed over the course of the 2020/21 financial year?

Improved	Y
Stayed the same	☐
Scaled back	☐
No longer in place	☐

Please give details of any changes (max 300 words)
A new lived experience panel for individuals and family members has continued to meet and consider how to develop lived experience involvement in ADP Planning. This group is chaired by Recovery Engagement Officer within WAWY and supported by officers from Serendipity Recovery Café, Scottish Recovery Consortium and ADP Support Team. The group met on 5 occasions during 2020/21 with Terms of Reference and methods of communication agreed. Input from Scottish Recovery Consortium on A Human Rights Approach were provided. An update from the panel is a standing item the ADP Board Meeting Agendas and we are working with the group to further develop our processes.

3.12 Did services offer specific volunteering and employment opportunities for people with lived/ living experience in the delivery of alcohol and drug services?

Yes Y
No ☐

Please give details below (max 300 words)
Scottish Drugs Forum are working alongside We Are With You Borders to implement a Peer Naloxone Supply to people at risk of, or likely to witness an overdose. This is a Drug Death Task Force funded project and an immediate response to the increasing drug related deaths in Scotland. Recruitment took place in March 2021. WAWY has volunteering roles for people with lived experience.

People access interventions to reduce drug related harm

3.13 Which of these settings offered the following to the public during 2020/21?*(mark all that apply)*

Setting:	*Supply Naloxone*	*Hep C Testing*	*IEP Provision*	*Wound care*
Drug services Council	N/A	N/A	N/A	N/A
Drug Services NHS	Y	Y	Y	Y
Drug services 3rd Sector	Y	Y	Y	Y
Homelessness services	Y	N	N	N
Peer-led initiatives	Y	N/A	N/A	N/A
Community pharmacies	Y	N	Y	N
GPs	N	Y	N	Y
A&E Departments	Y	N	N	Y
Women's support services	Y	N	N	N
Family support services	N	N	N	N
Mental health services	Y	N	N	N
Justice services	Y	N	N	N
Mobile / outreach services	Y	Y	Y	Y
Other … *(please detail)* Click or tap here to enter text.	☐	☐	☐	☐

A person-centred approach is developed

3.14To what extent were Recovery Oriented Systems of Care (ROSC) embedded across services within the ADP area? ROSC is centred around recognising the needs of an individual's unique path to recovery. This places the focus on autonomy, choice and responsibility when considering treatment.

Fully embedded ☐
Partially embedded X
Not embedded ☐

Please provide details(max 300 words)

Commissioned services in Borders take a proactive approach to delivering ROSC and have continued to ensure harm reduction support, assertive engagement, family support and recovery is available during COVID-19.

Representation of lived experience continues to be explored with our lived experience group exploring ways to ensure lived experience is involved in development of ADP Strategy and Delivery plan.

Access to Buvidal has increased. Of the people receiving opiate substitute prescriptions:
- 63% receive Methadone
- 22% receive Oral Buprenorphine
- 15% receive Buvidal

Good relationships are in place via the Children and Young People's Leadership Group, Community Justice Board and individual services supported by ADP members.

ADP provide a small amount of funding (£5,000) towards the contract for independent advocacy in Borders. Development of advocacy has been outstanding for two years and had been compounded by COVID-19 as well as:
- Pausing of review of existing adult independent advocacy contract
- Children and Young People's Leadership Group unable to progress a decision relating to children's advocacy.

Until the independent advocacy contract is reviewed, ADP have agreed to support workforce development within the current service provider and enhance their capacity.

3.15Are there protocols in place between alcohol and drug services and mental health services to provide joined up support for people who experience these concurrent problems (dual diagnosis)?
Yes ☐
No x

Please provide details(max 300 words)

There are no formal protocols in place however the Borders Addiction Service is housed within NHS Borders Mental Health directorate so there is ready opportunity for liaison. This liaison is enhanced by the fact that the Consultant in Addictions Psychiatry in BAS is also a member of the Community Mental Health Team. Likewise the BAS Service Manager also has responsibility for the Mental Health Rehabilitation Service.
BAS hosts a small Addictions Psychology Therapies Team. Third sector alcohol and drugs services are able to directly refer into this team.
Development of more formal pathways was not progressed during COVID-19.

Is staff training provided (dual diagnosis)?
Yes X
No ☐

Please provide details (max 300 words)
Dual Diagnosis was delivered as part of the training directory for 2020-21

Have mental health services requested Naloxone following updated guidelines from the Lord Advocate?
Yes x
No ☐

Please provide details (max 300 words)
Mental Health Inpatient Ward and Community Mental Health Teams as well as Rehab Team are now all able to supply naloxone.

The recovery community achieves its potential

3.16 Were there active recovery communities in your area during the year 2020/21?

Yes Y
No ☐

3.17 Did the ADP undertake any activities to support the development, growth or expansion of a recovery community in your area?

Yes Y
No ☐

3.18 Please provide a short description of the recovery communities in your area during the year 2020/21 and how they have been supported (max 300 words)

MAP Groups – Mutual Aid Partnership Groups met online and expanded to include impact of lockdown on recovery, drug and alcohol related discussion and wider recovery activities for example quizzes and relaxation sessions. These groups take place three times per week.

Serendipity was required to close all groups but support was made available via phone or email.

Information on SRC online directory of online recovery and support activities was made available on ADP website and shared with staff

A trauma-informed approach is developed

3.19 During 2020/21 have services adopted a trauma-informed approach?

All services Y
The majority of services
Some services ☐
No services ☐

Please provide a summary of progress (max 300 words)
An audit of Knowledge and Training was carried out across drug and alcohol services with trauma informed training, coaching and motivational interviewing training being identified as a gap for some new staff. Training needs were built into Training directory for 2021-22.

Services currently offer psychologically-informed care at Tier 1 via Motivational Interviewing and at Tier 2 via Core CBT Skills for Relapse Prevention and Recovery Management which is well-embedded across the services.

Trauma informed training has been provided 'in house' but on limited occasions.

MAT DDTF funding:
Funding was also secured to support MAT Standard 6 from the MAT DDTF funding to ensure psycho social intervention at Tier 2 level across our services with Addiction Psychology Treatment Team (APTT) providing training and coaching across all three services. This will increase capacity within the team as well as recruit 2 further posts. Agreement has been reached that this funding will commence from September 2021 for one year. It is hoped that this will also ensure that people can access Tier 2 level intervention from BAS, WAWY or CHIMES at a much earlier stage to avoid requirement for tier 3 / 4 level intervention.

An intelligence-led approach future-proofs delivery

3.30 Which groups or structures were in place to inform surveillance and monitoring of alcohol and drugharms or deaths? *(mark all that apply)*

Alcohol harms group	N
Alcohol death audits (work being supported by AFS)	N
Drug death review group	Y
Drug trend monitoring group	Y
Other	☐Please provide details…….

3.21 Please provide a summary of arrangements which were in place to carry out reviews on alcohol related deaths and how lessons learned are built into practice. If none, please detail why (max 300 words)
There are no formal arrangements to undertake alcohol related deaths specifically. However, any death in service (e.g. NHS or third sector) is subject to a review and lessons learned applied to that service. ADP invited AFS to discuss the published Alcohol Deaths Audit Guidance. It was not possible to progress this work in 2020-21.

3.22Please provide a summary of arrangements which were in place to carry out reviews on drug related deathsand how lessons learned are built into practice (max 300 words)

Borders Drug Death Review Group (DDRG) is in place to ensure liaison between agencies in efforts to introduce interventions aimed at reducing drug-related deaths at local level.

The DDRG is a small closed group chaired by the Chief Social Work Officer that meets on a regular basis to share and analyse relevant information on all drug related deaths including those people not in treatment services.

The aim of the group is to reduce Drug Related Deaths (DRDs) by exploring the circumstances of a death once confirmed by pathology as a DRD in the Scottish Borders; to identify learning from the reviews and promote best practice; contribute to the National Drug-related Deaths Database (NDRDD) and; implement national and local drug strategies to reduce problem drug use.

Any implications for policy or practice are then taken back through members to their organisations for progression facilitated by an Outcomes Reporting template for each review. Where an individual has been a patient of NHS Borders at time of death or within 12 months of death the Outcomes Reporting template is sent to the Healthcare Governance Lead of the appropriate Clinical Board.

Separate Management Reviews are also carried out by Borders Addictions Service where a client is in service at time of death with actions identified where appropriate. Membership of the DDRG group includes NHS, Police, Scottish Borders Council, Drug Services and ADP Support Team. An annual report is provided to Critical Services Oversight Group (Chief Officers from Police, NHS and Local Authority) to allow scrutiny of the process.

4. Getting it Right for Children, Young People and Families

4.1 Did you have specific treatment and support services for children and young people (under the age of 25) with alcohol and/or drugs problems?

Yes	☐
No	X

Please give details (E.g. type of support offered and target age groups)

Children and young people, depending on their presentation and needs, are supported through the Wellbeing for Resilience service (11-18). WAWY and BAS accept referrals from aged 16.

4.2 Did you have specific treatment and support services for children and young people (under the age of 25) affected by alcohol and/or drug problems of a parent / carer or other adult?

Yes X
No ☐

Please give details (E.g. type of support offered and target age groups)

Chimes service offers support to children and young people (up to 18 years) impacted by another's alcohol and/or drug use. An initial home visit is undertaken as part of the assessment process. Children will work with a key worker for 1:1 support, however, the nature of the work often involves additional family members and work can therefore take place in small familial groups where appropriate.
As well as emotional support for resilience, children can also access group work including first aid and life-skills.

The service will work with parents (or the substance using family member) to help understanding and mitigation of the impacts on the child including emotional and behavioural development. This can also include some work to support wider treatment goals e.g. relapse preventions.
The service also works with kinship carers to provide support and understanding

4.3 Does the ADP feed into/ contribute toward the integrated children's service plan?

Yes X
No ☐

Please provide details on how priorities are reflected in children's service planning e.g. collaborating with the children's partnership or the child protection committee?(max 300 words)

The ADP Strategic Lead is a member of the local Children and Young People's Leadership Group and Chair of the Commissioning Sub-group.
The current Children and Young People's Integrated Services Plan for 2020-21 had five key priorities and these are relevant to children and young people impacted by their own or others' substance use:
1. Keeping children and young people safe
2. Promoting the health and well-being of all children and young people and reducing health inequalities
3. Improving the well-being and life chances for our most vulnerable children and young people
4. Raising attainment and achievement for all learners
5. Increasing participation and engagement.

4.4 Did services for children and young people, with alcohol and/or drugs problems, change in the 2020/21financial year?

Improved ☐
Stayed the same X
Scaled back ☐
No longer in place ☐

Please provide additional information (max 300 words)

The Wellbeing for Resilience has been in place for three years and continues to provide support to children and young people.

4.5 Did services for children and young people, affected by alcohol and/or drug problems of a parent / carer or other adult, change in the 2020/21 financial year?

Improved ☐
Stayed the same X
Scaled back ☐
No longer in place ☐

Please provide additional information (max 300 words)

Chimes (Action For Children) provides a service to CAPSM children (up to age 18), parents, expectant mothers and (usually kinship) carers as well as raising awareness of the impact of alcohol and drug use on children and develop understanding of resilience and the protective factors that may help the children and the family with practitioners.

4.6 Did the ADP have specific support services for adult family members?
Yes ☐
No X

Please provide details (max 300 words)

WAWY provides one to one and group support for impacted adult family members based on the Craft programme. Chimes also provides support for family members where there is a child impacted, this includes kinship carers.

4.7 Did services for adult family members change in the 2020/21 financial year?

Improved ☐
Stayed the same X
Scaled back ☐
No longer in place ☐

Please provide additional information (max 300 words)

Due to COVID-19 restrictions some support was delivered via telephone and online during 2020-21.

4.8Did the ADP area provide any of the following adult services to support family-inclusive practice? *(mark all that apply)*

Services:	*Family member in treatment*	*Family member not in treatment*
Advice	x	x
Mutual aid	x	x
Mentoring	☐	☐
Social Activities	☐	☐
Personal Development	☐	☐
Advocacy	☐	☐
Support for victims of gender based violence	☐	☐
Other *(Please detail below)*	☐	☐

Please provide additional information (max 300 words)
The Domestic Abuse Advocacy Service in Borders is provided by Scottish Borders Council.

5. A Public Health Approach to Justice

5.1If you have a prison in your area, were arrangements in place and executed to ensure prisoners who are identified as at risk left prison with naloxone?

Yes ☐
No ☐
No prison in ADP area X

Please provide details on how effective the arrangements were in making this happen (max 300 words)
Click or tap here to enter text.

5.2 Has the ADP worked with community justice partners in the following ways?*(mark all that apply)*

Information sharing X
Providing advice/ guidance X
Coordinating activities ☐
Joint funding of activities ☐
Upon release, is access available to non-fatal overdose pathways? ☐
Other ☐Please provide details

Please provide details (max 300 words)

The Justice Social Work Service supports the delivery of ABI. The service delivers ABI as part of the Induction process for individuals subject to unpaid work, in addition to screening when undertaking Criminal Justice Court Report interviews.

The Justice Social Work Service commissions a Drug Treatment and Testing Order service, delivered in partnership with BAS. Use of DTTO by the Court is relatively low and is currently under review.

The service's Group Manager sits on and contributes to the Drug Death Review Group.

The Reconnect Women's programme were able to start up with small groups after COVID-19 restrictions in August 2020. The CBT based work undertaken can be accessed on either a voluntary or court mandated bases. Drug and Alcohol support services have over the year, played a part in the sharing of keep safe and other support information to women as part of the programme delivery. Reconnect also have access and can supply Take Home Naloxone as part of the extension to non drug services.

While the use of Diversion by the Procurator Fiscal Service is relatively low, opportunities to refer individuals to drug and alcohol support services are in place. This is a useful opportunity to engage and deliver Early Effective Intervention across Youth and Adult Justice, with an aim to address problematic substance use that is impacting negatively on decision making and behaviours avoiding remittance to the Court.

5.3 Has the ADP contributed toward community justice strategic plans (E.g. diversion from justice) in the following ways?*(mark all that apply)*

Information sharing	X
Providing advice/ guidance	X
Coordinating activates	☐
Joint funding of activities	☐
Other	☐Please provide details

Please provide details (max 300 words)
ADP Support Team is represented on the Community Justice Board. The Community Justice Manager is a member of the ADP. Information sharing includes supporting the production of the Justice Board's strategic assessment and associated plan.

5.4 What pathways, protocols and arrangements were in place for individuals with alcohol and drug treatment needs at the following points in the criminal justice pathway?Please also include any support for families. (max 600 words)

a) Upon arrest
An Arrest Referral scheme is in place in Lothian and Borders area. ABI's are performed in the one Custody Suite in Borders although during 2020-21, Hawick Custody Suite was closed for some time.

b) Upon release from prison
Pathways are in place between Justice Social Work Services and BAS and other third sector services including WAWY. The arrangements seek to ensure signposting and referrals are made timeously for those being released from custody following a short term custodial sentence. BAS are in a position to enable ready access to prescriptions including same day prescribing where appropriate.

Development work is ongoing and seeks to strengthen the links between, drug and alcohol services, Justice Social Work and Scottish Prisons, with an aim to increase the take up of services by those returning to the community.

Statutory Throughcare and Community Court disposals are well supported by alcohol and drug services, including BAS and A/WAWY. Referral pathways are well established. Engagement with services is often a court or parole mandated requirement for those presenting with drug and alcohol issues. Support services regularly feed into the statutory review process and inform case management plans.

6. Equalities

Please give details of any specific services or interventions which were undertaken during 2020/21 to support the following equalities groups:
6.1 Older people *(please note that C&YP is asked separately in section 4 above)* No specific intervention
6.2 People with physical disabilities No specific intervention
6.3 People with sensory impairments No specific intervention
6.4 People with learning difficulties / cognitive impairments. No specific intervention
6.5 LGBTQ+ communities No specific intervention
6.6 Minority ethnic communities No specific intervention
6.7 Religious communities No specific intervention
6.8 Women and girls(including pregnancy and maternity) ABI's are delivered by midwives in antenatal settings and by health visitors. CHIMES can provide support to pregnant women. A Foetal Alcohol Syndrome training session was delivered as part of the ADP Workforce Development Training Directory An input was delivered to the Violence Against Woman Partnership Delivery Group on drug deaths and women.

II. FINANCIAL FRAMEWORK 2020/21

Your report should identify all sources of income (excluding Programme for Government funding) that the ADP has received, alongside the funding that you have spent to deliver the priorities set out in your local plan. It would be helpful to distinguish appropriately between your own core income and contributions from other ADP Partners. It is helpful to see the expenditure on alcohol and drug prevention, treatment & recovery support services as well as dealing with the consequences of problem alcohol and drug use in your locality. You should also highlight any underspend and proposals on future use of any such monies.

A) Total Income from all sources

Funding Source (If a breakdown is not possible please show as a total)	£
Scottish Government funding via NHS Board baseline allocation to Integration Authority	£1,049,582
2020/21 Programme for Government Funding	£657,583
Additional funding from Integration Authority	0
Funding from Local Authority	£209,047
Funding from NHS Board	£841,471
Total funding from other sources not detailed above	£25,000
Carry forwards	£121,709
Other	0
Total	£2,904,392

B) Total Expenditure from sources

	£
Prevention including educational inputs, licensing objectives, Alcohol Brief Interventions)	£25,920
Community based treatment and recovery services for adults	£1,918,039
Inpatient detox services	0
Residential rehabilitation services	£5,892
Recovery community initiatives	£258
Advocacy Services	£5,000
Services for families affected by alcohol and drug use	0
Alcohol and drug services specifically for children and young people	£252,973
Community treatment and support services specifically for people in the justice system	£66,465
Other	£196,643
Total	£2,471,190

[1]It is not possible to disaggregate the spend on inpatient detox from overall mental health spend.

[2] Our children and families service works with adult family members e.g. kinship carers, WAWY provides 1:1 and facilitated group support to family members. It is not possible to disaggregate this from the wider overall contract.

7.1 Are all investments against the following streams agreed in partnership through ADPs with approval from IJBs? *(please refer to your funding letter dated 29th May 2020)*

- Scottish Government funding via NHS Board baseline allocation to Integration Authority
- 2020/21 Programme for Government Funding

Yes Y
No ☐

Please provide details (max 300 words)
Click or tap here to enter text.

7.2 Are all investments in alcohol and drug services (as summarised in Table A) invested in partnership through ADPs with approval from IJBs/ Children's Partnership / Community Justice Partnerships as required?

Yes Y
No ☐

Please provide details (max 300 words)
Click or tap here to enter text.

Appendix 2, ADP Highlight Annual Report 2020/21

ADP

Highlight Annual Report
2020-21

Contents – Please note page numbers not aligned due to embedding of document

1. Introduction

The Alcohol & Drugs Partnership (ADP) is required to produce an annual report for Scottish Government based on a template provided. This narrative report is intended to provide an update on some key developments and activities during 2020-21. This report does not include the full extent of all work carried out.

The role of the ADP is to deliver Scotland's national alcohol and drug strategy, Rights, Respect and Recovery and provide strategic direction to reduce the level of drug and alcohol problems amongst children, young people and adults in the Borders based on local need.

Despite all the challenges that COVID-19 brought, this report highlights the successful partnership working across agencies and demonstrates how, even in times of crisis, they came together to ensure those most at need continued to receive the support they required as well as meeting the demands of the Scottish Government and new Drugs Policy Team.

During 2020-21, Scottish Parliament agreed a motion declaring Scotland's drug deaths a public health emergency and announced additional national funding to be provided to support action to prevent drug deaths.

Funding

There were four different funding streams for ADP in 2020-21.

Funding	Amount
1. Core Funding	£1,049,582
2. Programme for Government Funding	£358,278
3. Drugs Death Task Force funding (allocated Nov 2020)	£26,688
4. Additional Drug Death Prevention Funding (allocated Feb 2021)	£47,773

Appendix one provides a summary of spend in 2020-21.

Ministerial Priorities

ADPs are required to deliver work to address the following Ministerial Priorities which reflect Rights, Respect and Recovery and the Alcohol Framework.

- A recovery orientated approach which reduces harms and prevents deaths
- A whole family approach
- A public health approach to justice

- Prevention, education and early intervention
- A reduction in the affordability, availability and attractiveness of alcohol

ADPs are expected to set their own actions, improvement goals, measures and tests of changes alongside national deliverable to drive quality improvement at a local level.

The priorities are reflected in our local Strategic Plan 2020-23.

ADP Support Team

In 2020-21, the ADP Support Team included the following staff: 1.0 WTE Head of Health Improvement/Strategic Lead ADP, 1.0 WTE ADP Coordinator, 0.5 WTE Data and Performance Officer (shared post with Health Improvement) and 0.4 WTE hours Personal Assistant.

Appendix Two provides a summary of representation by the ADP Support Team on wider partnership groups.

2. Drug & Alcohol Services COVID-19 Response

There are three ADP commissioned drug and alcohol services in the Scottish Borders: Borders Addiction Service; We Are With You and CHIMES. These services provide a range of harm reduction, treatment and psychological interventions, as well as wider support including employment, housing and family members support. For more information on local services click here.

Adult Drug & Alcohol Services

Drop-in clinics were postponed due to COVID-19 but all drug and alcohol services remained open throughout 2020-21 and adapted service provision to ensure all current and new clients were still able to access support. At the start of lock down all clients receiving Opiate Substitute Therapy (OST) (e.g. methadone) had the frequency of the supervision of their medication by pharmacies reviewed and reduced to support pressures within pharmacies. Supervision frequency was reviewed on an ongoing basis to minimise risk.

Services used a combination of telephone, online and face to face for those at high risk with appropriate safety measures in place. Where clients were asked to self isolate or shield, staff

were able to deliver medication as required including naloxone and Injecting Equipment. Services were also able to offered face to face 'therapeutic' meetings e.g. walks, meeting in socially distanced public spaces which has been helpful for particularly isolated people when restrictions allowed. During 2020-21, 512 individuals started treatment with 99% starting within three weeks of referral against target of 90%

Recovery Groups

Online recovery/fellowship meetings continued throughout 2020-21 with WAWY Mutual Aid Partnerships meeting online and expanded to include impact of lockdown on recovery, drug and alcohol related discussion and wider recovery activities for example quizzes and relaxation sessions.

Serendipity maintained contact with people over the phone. Online fellowship meetings were being provided by UK Smart Recovery, UK Narcotics Anonymous and UK Alcoholics Anonymous.

Staff Deployment

The number of hours for the Consultant in Addictions Psychiatry were increased. Members of the ADP Support Team were required to support wider Public Health Team including shielding and contact tracing as well as maintaining the work of the ADP.

3. Ministerial Priorities

The following is a summary of action against each ministerial priority:

3.1 A recovery orientated approach which reduces harms and prevents deaths

- Following the letter from Scottish Government about the letter of comfort from Lord Advocate to expand naloxone provision into non drug services naloxone is also available from:
    - Mental Health Rehab
    - Justice Social Work
    - Local children affected by parental substance use service
    - Homeless Service

- All Community Pharmacies also received an invitation to sign up to a Service Level Agreement to supply take home naloxone and emergency naloxone supply.

- In 2020-21 there were 49 first supplies of Take Home Naloxone provided across Borders. A target had been set to supply 28 first supplies of THN in the year. Borders has reached **86% of our estimated population of opiates/benzodiazepines drug users** with a first time kit compared with 57% nationally by end March 2021.

- Scottish Drugs Forum is working alongside We Are With You Borders to implement a Peer Naloxone Supply to people at risk of, or likely to witness an overdose. This is a Drug Death Task Force funded project and an immediate response to the increasing drug related deaths in Scotland. Recruitment took place in March 2021.

- Establishment of an additional Injecting Equipment Provider.

- Development of a Non Fatal Overdose Pathway to ensure people experiencing non fatal overdose are identified and offered appropriate outreach and aftercare including referral into drug treatment service if not already engaged. Commenced May 2021.

- Development of non-fatal overdose leaflet (by Crew) to increase knowledge and awareness of signs of overdose and what to do in an emergency circulated widely.

- Skills building training in benzodiazepines for alcohol and drugs services staff.
- Funding was secured to ensure psychosocial intervention at Tier 2 level across our services with Addiction Psychology Treatment Team (APTT) providing training and coaching across all three services.

- Borders ADP leads a multi-agency Drug Death Review Group chaired by our Chief Social Work Officer/Vice Chair ADP. The 2019 Annual Report was produced and presented at the Critical Services Oversight Group (CSOG).

- Good progress is being made in Borders in relation to Medication Assisted Treatment (MAT) standards[2] 1-5 and BAS is participating in the MAT Sub-Group test of change. The numbers of people starting same day prescribing increased. Patient choice expanded to include Espranor and Buvidal.

[2] https://www.gov.scot/publications/medication-assisted-treatment-mat-standards-scotland-access-choice-support/

- Our local Drug Trend Monitoring Group continued to meet to share intelligence regarding emerging trends of drugs/alcohol use and related harm. The mailing list is used to disseminate briefings/alerts to members.

- New national Drug & Alcohol Information System (DAISy) implemented in Borders on 1st April 2021.

3.2 A whole family approach

- Despite schools being closed due to restrictions, CHIMES (Children Affected by Parental Substance Use/Family Service) was able to support children impacted by a family member's alcohol and/or drug use, young carers and parents with concerns around their drug/alcohol use. Staff moved to working from home and providing support to current caseload; parents, concerned others and children via telephone, text, email and video calls via Skype and Microsoft Teams. Door step visits were offered to families where CHIMES needed to see children to ensure safety and wellbeing.

- During 2020-21 CHIMES staff members applied for and distributed over £65,000 to families to enable practical support e.g. fuel, energy, food and broadband costs as well as activities, technology and equipment.

- WAWY and CHIMES provided one to one and group support for adult family affected by someone else's alcohol or drug use based on CRAFT (Community Reinforcement and Family training programme).

- Four training sessions were provided to early years establishments on Oh Lila Training. 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.

- The ADP Strategic Lead is a member of the local Children and Young People's Leadership Group and Chair of the Commissioning Sub-group

3.3 A public health approach to justice

- The Justice Social Work Service supports the delivery of ABI. The service delivers ABI as part of the Induction process for individuals subject to unpaid work, in addition to screening when undertaking Criminal Justice Court Report interviews.

- The Justice Social Work Service commissions a Drug Treatment and Testing Order service, delivered in partnership with BAS. Use of DTTO by the Court is relatively low and is currently under review.

- The service's Group Manager sits on and contributes to the Drug Death Review Group.

- The Reconnect Women's programme was able to start up with small groups after COVID-19 restrictions lifted in August 2020. The CBT based work undertaken can be accessed on either a voluntary or court mandated bases. Drug and Alcohol support services have over the year, played a part in the sharing of keep safe and other support information to women as part of the programme delivery. Reconnect also have access and can supply Take Home Naloxone as part of the extension to non drug services.

- While the use of Diversion by the Procurator Fiscal Service is relatively low, opportunities to refer individuals to drug and alcohol support services are in place. This is a useful opportunity to engage and deliver Early Effective Intervention across Youth and Adult Justice, with an aim to address problematic substance use that is impacting negatively on decision making and behaviours avoiding remittance to the Court.

3.4 Prevention, education and early intervention

- During 2020-21 Borders ADP Support Team coordinated 12 online training courses with 130 participants in attendance (76 Statutory sector, 30 Voluntary sector, 24 other such as housing association and foster carers). Courses delivered included Emerging Trends, Introduction to Foetal Alcohol Syndrome, Benzodiazapines and Managing Emotion.

- Due to COVID-19 there were no specific communications or activities relating to Count 14. However regular communication was shared on ADP website for members of the public around support that is available from drug and alcohol services as well as new facilities e.g. click and collect injecting equipment provision. Weekly service updates were provided to Scottish Drugs Forum and Scottish Borders Council during Spring-Autumn 2020.

- Scottish Borders Council Education Department were supported in development of their Policy and Procedures for Managing Substance Use in Schools and Educational Settings

Alcohol Brief Interventions

- A total of 1341 alcohol brief interventions were delivered across Primary Care, Antenatal and wider settings. This was against a target of 1312 (102%).

3.5 A reduction in the affordability, availability and attractiveness of alcohol

- Borders ADP Support Team review all new licence and variations on behalf of Public Health.
- Occasional licences which have a child/family element and that are brought to the attention of ADP Support Team by Licensing Standards Officer

4. Progress in relation to ADP Strategic Plan 2021-2023

The ADP Strategic Plan identified the following areas for improvement:

- Lived experience involvement
- Independent Advocacy
- Pathways for people experiencing both mental health and substance use (dual diagnosis)

Below is a short update on progress:

Lived Experience involvement in development of ADP Strategy and Delivery plan.

A new lived experience panel for individuals and family members has continued to meet and consider how to develop lived experience involvement in ADP Planning. This group is chaired by Recovery Engagement Officer within WAWY and supported by officers from Serendipity Recovery Café, Scottish Recovery Consortium and ADP Support Team. The group met on 5 occasions during 2020-21 with Terms of Reference and methods of communication agreed. Input from Scottish Recovery Consortium on A Human Rights Approach were provided. An update from the panel is a standing item on the ADP Board Meeting Agendas and we are working with the group to further develop our processes.

Independent Advocacy

ADP provide a small amount of funding (£5,000) towards the contract for independent advocacy in Borders. Development of advocacy has been outstanding for two years and had been compounded by COVID-19 as well as:

- Pausing of review of existing adult independent advocacy contract
- Children and Young People's Leadership Group unable to progress a decision relating to children's advocacy.

Until the independent advocacy contract is reviewed, ADP has agreed to support workforce development within the current service provider and enhance their capacity.

Pathways for people experiencing both mental health and substance use (dual diagnosis)

There are no formal protocols in place however the Borders Addiction Service is housed within NHS Borders Mental Health directorate so there is ready opportunity for liaison. This liaison is enhanced by the fact that the Consultant in Addictions Psychiatry in BAS is also a member of the Community Mental Health Team. Likewise the BAS Service Manager also has responsibility for the Mental Health Rehabilitation Service. BAS hosts a small Addictions Psychology Therapies Team. Third sector alcohol and drugs services are able to directly refer into this team. Development of more formal pathways was not progressed during COVID-19.

Appendix One: Finance Summary

A) Total Income from all sources

Funding Source (If a breakdown is not possible please show as a total)	£
Scottish Government funding via NHS Board baseline allocation to Integration Authority	£1,049,582
2020/21 Programme for Government Funding	£657,583
Additional funding from Integration Authority	0
Funding from Local Authority	£209,047
Funding from NHS Board	£841,471
Total funding from other sources not detailed above	£25,000
Carry forwards	£121,709
Other	0
Total	£2,904,392

B) Total Expenditure from sources

	£
Prevention including educational inputs, licensing objectives, Alcohol Brief Interventions)	£25,920
Community based treatment and recovery services for adults	£1,918,039
Inpatient detox services	0
Residential rehabilitation services	£5,892
Recovery community initiatives	£258
Advocacy Services	£5,000
Services for families affected by alcohol and drug use	0
Alcohol and drug services specifically for children and young people	£252,973
Community treatment and support services specifically for people in the justice system	£66,465
Other	£196,643
Total	£2,471,190

[1]It is not possible to disaggregate the spend on inpatient detox from overall mental health spend.

[2] Our children and families service works with adult family members e.g. kinship carers, WAWY provides 1:1 and facilitated group support to family members. It is not possible to disaggregate this from the wider overall contract.

Appendix Two: ADP Support Team Representation on other committees

National

- Alcohol Focus Scotland Board (Director)
- DAISy Implementation Group
- Drug Death Coordinators Meeting
- National Drug Death Task Force Meetings and Multiple and Complex Needs Sub-group
- Public Health Alcohol SIG (Vice Chair)
- Scottish Government and Alcohol and Drugs Partnership Quarterly Meetings

Local

- Adult Protection Delivery Group
- Child Protection Delivery Group
- Children and Young People's Leadership Group
- Justice Board
- Mental Health and Wellbeing Board
- Violence Against Women Partnership Executive and Delivery Group

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**3 February 2022**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This has been previously considered by the following group as part of its development. The group has supported the content.

- Integration Joint Board 20 October 2021
- Integration Joint Board 15 December 2021

2.4 Recommendation

The Board is asked to **note** the minutes which are presented for its:

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 22.09.21
- Appendix No 2, Integration Joint Board minutes 20.10.21

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 22 September 2021** at **10am** via Microsoft Teams

Present:

(v) Cllr S Haslam
(v) Cllr E Thornton-Nicol
(v) Cllr T Weatherston
(v) Cllr J Linehan
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mr T Taylor, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
Dr K Buchan GP
Mr D Bell, Staff Officer SBC
Mr R McCulloch-Graham, Chief Officer
Mr N Istephan, Chief Executive, Eildon Housing
Ms G Russell, Partnership Chair NHS
Mrs L Gallacher, Borders Carers
Mrs J Smith, Borders Care Voice
Mr S Easingwood, Chief Social Work and Public Protection Officer
Mrs S Horan, Director of Nursing, Midwifery & AHPs

In Attendance:

Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mrs N Meadows, Chief Executive SBC
Mr A Bone, Director of Finance NHS
Ms J Holland, Chief Operating Officer SBCares
Mrs J Stacey, Chief Internal Auditor SBC
Mr P McMenamin, Deputy Director of Finance/Business Partner IJB NHS
Ms S Bell, Communications Manager SBC
Ms C Oliver, Communications Manager NHS
Mr G McMurdo, Programme Manager, SBC
Mr C Myers, General Manager Primary & Community Services NHS
Dr K Allan, Associate Director of Public Health
Mr S Burt, General Manager MH&LD
Mr P Lunts, General Manager Transformation NHS
Mr G Mark, Care Inspectorate
Ms H Jacks, Planning & Performance Officer NHS

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr David Parker, Dr Lynn McCallum, Medical Director, Mr David Robertson, Chief Financial Officer, and Dr Tim Patterson, Director of Public Health and Ms Linda Jackson, LGBT+.

1.2 The Chair welcomed guest speakers to the meeting including Mr Geoff Mark, Mr Simon Burt, Mr Graeme McMurdo and Mr Phil Lunts.

1.3 The Chair confirmed that the meeting was quorate.

1.4 It was noted that the meeting was not being live streamed.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the meeting of the Health & Social Care Integration Joint Board held on 26 May 2021 were approved.

3.2 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 28 July 2021 were approved.

4. MATTERS ARISING

4.1 Cllr Shona Haslam requested that the data and evaluation of discharge to assess as mentioned in the minutes of 26 May 2021 be formally recorded as an action on the action tracker and the data and evaluation be submitted to the IJB.

4.2 **Action 3:** The Annual Performance Report (APR) was presented to the meeting which clarified the closure of Action 3.

4.3 **Action 2020-2:** Mr Rob McCulloch-Graham confirmed that the "Renew" service was being evaluated and regular reports were received by the PCIP Executive. He confirmed that a full evaluation would be shared with the IJB at a later date (2022).

4.4 **Action 2020-3:** Mr McCulloch-Graham confirmed that a timeline for the Scheme of Integration refresh was a substantive item on the meeting agenda.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. STRATEGIC RISK REGISTER UPDATE

5.1 Mr Rob McCulloch-Graham provided an overview of the content of the report.

5.2 In relation to the workforce issues, Mrs Karen Hamilton enquired if there were streamlined strategies in terms of recruitment by Scottish Borders Council (SBC) to be speed up the process and be more competitive with other organisations. Mrs Netta Meadows confirmed that the shortlisting process of applications had been speeded up in order to ensure applicants were not lost due to a delay in responding to them.

5.3 Mrs Jen Holland reminded the Board that all providers were chasing the same staff from the same local population pool. She suggested there was a need for a short term

strategy and longer term work on creating a career pathway for health and social care staff and those coming into that sector.

5.4 Mrs Sarah Horan commented that she and Mrs Holland were committed to creating a career pathway for health and social care staff along with Borders College.

5.5 Mrs Jenny Smith commented that third sector providers also felt the same recruitment pressures.

5.6 Mrs Lynn Gallacher reminded the Board that when health and social care were struggling with recruitment issues, inevitably it was the unpaid carers cohort that ended up picking up the pieces and she asked that they be factored into the whole area of workforce risk.

5.7 Mr Tris Taylor commented that the first risk on the list was culture change, which was marked as a major risk but unlikely to occur. He enquired how that risk of the delivery of culture change was being measured and monitored and by what point the IJB could expect changes to be made. He further enquired if there was a planned trajectory for it.

5.8 Mr McCulloch-Graham commented that when the culture was not working well there was a division in the partnership and then risk becomes apparent. That was why it was identified as a risk and required to be managed. He did not think it could be quantified however, he gave the example of if the partnership were falling short it would need to say so and try and remedy it.

5.9 Mr Nile Istephan enquired how informed officers were about why recruitment and retention was so challenging suggesting it could be related to stress, values, work patterns, pay, etc. He commented that as an independent provider his organisation had the same recruitment challenges and suggested a sharing of the understanding of those challenges should inform the actions required going forwards.

5.10 The Chair enquired to what extent recruitment challenges were COVID-19 related. Mrs Horan commented that the pandemic had appeared to make people move open to changing jobs. She advised that she and Mrs Holland would include other providers in the collective approach to health and social care recruitment and retention.

5.11 Mrs Holland commented that the SBC data collected from exit interviews clearly showed much of the low paid workforce moving away from social care into retail and hospitality roles which were perceived as less stressful for the same pay.

5.12 Cllr Elaine Thornton-Nicol suggested all the partnership organisations get together and produce a joint recruitment strategy to be clear on what was required by who.

5.13 Mr McCulloch-Graham commented that recruitment had remained an issue for all parties and the pandemic had heightened the challenges. He emphasised that a short, medium and long term solution was required.

5.14 The Chair commented that in regard to culture change it was important that it be an element of any redeveloped strategy.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the IJB Strategic Risk Register to ensure it covered the key risks of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the actions in progress to manage the risks.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update would be provided in December 2021.

6. OUTLINE BUSINESS CASE – COMPLEX CARE UNIT FOR ADULTS WITH A LEARNING DISABILITY

6.1 Mr Nile Istephan declared an interest in the item as a provider of LD services with Eildon.

6.2 Mr Simon Burt provided background to the item and an overview of the current status of the proposal.

6.3 The Chair enquired about the amount of work and engagement that had been undertaken. Mr Rob McCulloch-Graham commented that social workers had been working closely with the families of those who would be returning to the Scottish Borders as well as those who would remain in their current residencies. For some clients it would be beneficial to them to come back to the Scottish Borders and for some others with complex needs the move would be too great an issue for them. He advised that the partner relationship with Cornerstone was very positive.

6.4 Mr Istephan commented that discussions had been on-going for some time and he welcomed the intended reduction of out of area placements. He enquired if the placements were long term arrangements or if there was an expectation of throughput through the facility. He further enquired if the timeframe of 24 months to get the service up and running was realistic.

6.5 Cllr Shona Haslam commented that in terms of the proposals around a National Care Service (NCS) being established and given capacity issues for both SBC and NHS Borders, she enquired if the proposal should be added to the risk register. She further commented that she was concerned about investing in a service where the money might not be recouped or the contributing bodies may have no influence over the service provision.

6.6 Mr McCulloch-Graham commented that in terms of timescales the project had been spoken about for 4 years and he did not think that 24 months was unrealistic, indeed it had been Cornerstone that had identified 24 months as an appropriate timescale. He reminded the Board that the project was to the benefit of the people of the Scottish Borders. In terms of the NCS, he suggested that it would be at least 4 years before any NCS was put in place, which was too long a wait for many individuals who would benefit from the facility.

6.7 Cllr Tom Weatherston commented that he fully supported the proposals which were good for service users and their families. He further commented that what was missing from

the report was that SBC picked up the bills for fuel and hotels for family members to visit their loved ones in facilities outwith the Scottish Borders.

6.8 Mr Ralph Roberts commented that he was supportive of the proposals and wished to understand better the recommendation "To support the inclusion of the charity "Cornerstone" in the ongoign work at this stage." Mr McCulloch-Graham commented that the recommendation referred to Cornerstone being the preferred partner.

6.9 Mrs Sarah Horan whilst supportive of the proposals enquired if the facility would be residential given the demographics of the identified service users. She also commented that there was no mention of respite beds, given the pressure being felt by unpaid carers and their families and repeated Mr Istephan's question in regard to throughput.

6.10 Mr Tris Taylor commented that the IJB existed to make directions to SBC and NHS Borders and he enquired if the recommendations should be amended to reflect that.

6.11 Mrs Netta Meadows commented that she did not agree with Mr McCulloch-Graham's comments that a delay in the project due to the NCS would amount to years. She commented that the proposal was required to go through the SBC decision making process, and should have been through that route before being submitted to the IJB, especially as it would be SBC that undertook the capital loans. She suggested the recommendation be amended to be clear that the IJB were giving a strategic steer to SBC to take the appropriate next steps.

6.12 Mrs Lynn Gallacher agreed with the need for the facility and sought further information on respite beds and the care village initiative and how the proposed facility would fit into the care village scenario. Mr McCulloch-Graham agreed that there was a need for respite beds and the project would not provide respite care, it would provide residential packages of care to the people of the Scottish Borders. There would be linkages to the care village, however the facility would be a standalone facility on the Tweedbank site.

6.13 Mr McCulloch-Graham suggested the recommendation be amended to "The IJB is asked to agree that Cornerstone is identified as the preferred partner".

6.14 Mr Burt clarified that the facility would provide long term homes for the service user group who required a specific physical environment as well as an expert staffing group. It would be challenging to provide any respite element within the facility. He commented that capital provision for the project would be provided by Cornerstone. The facility would be purpose built on land provided by SBC and the partnership would have the preferred option on beds. If there were beds that were surplus then Cornerstone would offer them to other organisations. Mr Burt advised that he had evidenced that locally there was enough demand to fill the facility.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the need for additional local capacity within the provision for Adults with Complex Needs.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that Cornerstone was identified as the preferred partner.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the strategic direction of the proposals.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed SBC to undertake contracting arrangements with Cornerstone at the appropriate time.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed NHS Borders to work with Cornerstone to support the clients in the facility at the appropriate time.

7. SCOTTISH BORDERS CARE HOME MODELLING

7.1 Mr Phil Lunts provided a presentation to the IJB on care home modelling and highlighted several elements including: demographic changes; data sources; and care home capacity.

7.2 Mrs Karen Hamilton enquired if the criteria was the same when making comparative data across Boards. Mr Lunts commented that the comparison of data for intermediate care beds and transitional care beds was lacking as they were often coded differently.

7.3 Mrs Jen Holland welcomed the presentation and sought further information on care home beds, nursing beds, the definition of community hospital beds across Scotland. She further enquired what the provision of extra care housing looked like across Scotland and how the provision of step up facilities impacted on care home beds. Mr Lunts commented that the distinction between nursing, residential and community hospital beds was important and the length of stay in nursing homes was moving closer to the length of stay in community hospitals. In terms of extra care housing the data used was from 2018/19 and suggested the Scottish Borders extra care housing provision was not as high as some other places across Scotland.

7.4 Dr Keith Allan commented that there appeared to be a smaller tranche of older people moving directly form their own home to care homes than the Scottish average and he enquired if that was to do with the fragility of people when they made that move. Mr Lunts commented that Scottish Borders had higher rates of admission from hospital to care homes than the national average, he was unsure if that meant people were being inappropriately put into care homes from hospital, or if they were at home for too long before being admitted to hospital and then transitioned to a care home, instead of being transitioned directly to a care home from their own home.

7.5 Mr Nile Istephan commented that the analysis pointed towards the need to remodel the delivery of care going forward to enable people to remain independent in their own homes than being placed in residential care facilities, given the longer older people retained their independence the better the outcomes for them. He commented that he was keen to get involved and engage in discussions on areas and ideas to move services upstream and tackle the preventative agenda.

7.6 Mr Lunts referred to the Indigo report commissioned by SBC in 2017 which had concluded that services needed to be commissioned to sustain people in their own homes and advised that, that conclusion continued to be supported by the data.

7.7 Mr Ralph Roberts sought clarity on: what the work was that would need to be taken forward from the findings of the report; where decisions would be made; what decisions would need to be made; in looking at service models and understanding within that what was being said about care homes and care in the community; what did it mean for the community hospital model; and the work should be done collectively to create the best possible solutions for the people of the Borders.

Mr Ralph Roberts left the meeting.

7.8 Cllr Elaine Thornton-Nicol welcomed the opportunity to have conversations about enabling people to remain independent within their own homes, to expand the provision of extra care housing and housing with care.

7.9 Mr Tris Taylor suggested the presentation had provided the quality of information required to allow the IJB to consider and make decisions. There was enough data available including that from 2017, to enable the IJB to make appropriate directions. He suggested a set of recommendations and directions be brought back to the IJB for consideration.

7.10 Mrs Netta Meadows welcomed the information and sought further data on community services and carers to enable a whole system model to be realised along with the inclusion of horizon scanning.

7.11 Mrs Meadows enquired about the next steps which she suggested would be through the commissioning strategy being respectful of the work being undertaken by SBC and NHS Borders.

7.12 Mr David Bell reminded the Board that there were already lessons learnt from the Shadow IJB discussions on the same subject and he suggested those lessons could be brought to the fore to include in any further planning discussions.

7.13 Mr McCulloch-Graham suggested the next stage would be a revision to the commissioning plan to look at the capacity available and enable more intermediate and step up care. He advised that there would need to be a development fund put in place to provide investment and pump priming through the disinvestment in hospital beds and reinvestment in reducing demand on residential care. There would be a need to look at the drivers to enable change to happen.

7.14 The Chair thanked Mr Lunts for an informative presentation and commented that it contained the data and information that all reports to the IJB should aspire to.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the report and recommendations.

8. APPOINTMENT OF EXTERNAL MEMBER OF IJB AUDIT COMMITTEE

8.1 Mrs Karen Hamilton provided a brief overview of the content of the report and highlighted that it had been valuable to have an external member on the Committee and Mr Jim Wilson had agreed to continue his membership of the Committee.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the extension of the appointment of Mr Jim Wilson as External Member of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee to 31 October 2024.

Mr John McLaren left the meeting.

9. ANNUAL PERFORMANCE REPORT 2020/21

9.1 Mr Rob McCulloch-Graham provided background to the requirements and purpose of the report.

9.2 Mr Graeme McMurdo provided an overview of the content of the report and highlighted several elements including: legislative requirements and certain areas of content that have to be included; flexibility to add additional content; spotlight sections; balance between performance, readability and legislative requirements.

9.3 Cllr Shona Haslam commented that she had read the report in some detail and was still unclear as to how the partnership had performed, by how much admissions had been reduced and how much patient flow through the hospital had been increased.

9.4 Mr McMurdo explained that for those trends data since 2016 had been referred to and was probably contained in the appendices instead of being more upfront in the report.

9.5 Cllr Haslam commented that the reports were not clear on the impact or differences that had been made since the previous report and advised that she was unable to support it in its current form.

9.6 Mr Tris Taylor enquired if the carers section was now co-produced, and he suggested there had been no advancement in the report compared to the previous version and he endorsed Cllr Haslam's view.

9.7 Mr McCulloch-Graham drew the attention of the Board to page 9 of the report and the factors against which the partnership was required to report against. He emphasised that it was not an evaluation report as it was a performance report and followed Scottish Government guidance and was required by the Scottish Government on an annual basis. He suggested a separate evaluation report could be commissioned by the IJB. In terms of emergency hospital admissions he advised it had been a negative trend over the last 4 years and Scottish Borders were better than Scotland and better than the local target, and that example provided the IJB with a clear picture of what the partnership performance was and was written in a way the public could understand. In terms of attendance at A&E, Scottish Borders were the worst in Scotland but better than the local target. Mr McCulloch-Graham advised the Board that the report met all of the parameters required by the Scottish Government and if members were dissatisfied an additional report should be commissioned.

9.8 Cllr Shona Haslam proposed the report not be recommended for approval. Mr Tris Taylor seconded the proposal.

9.9 Voting members voted on the proposal: 4 members voted to approve the report; 1 member abstained; 2 members voted against the report. The majority vote carried the decision.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the APR for publication.

Mr Tris Taylor left the meeting.

The meeting was no longer quorate.

10. SCHEME OF INTEGRATION UPDATE AND TIMETABLE

10.1 Mr Rob McCulloch-Graham provided a brief overview of the content of the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the timeline for the review of the Scottish Borders HSCP Integration Scheme.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the intention to progress the review of the Integration Scheme through the Strategic Planning Group.

11. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 30 JUNE 2021

11.1 Mr Andrew Bone provided an overview of the content of the report.

11.2 Mrs Netta Meadows commented that whilst the report showed a breakeven position there was significant pressure in the LD service and significant funds had been moved into that service from SBC in order to bring it back to a zero position.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast adverse variance of (£5.951m) for the Partnership for the year to 31 March 2022 based on available information

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that whilst the forecast position includes costs relating to mobilising and remobilising in respect of Covid-19, it also assumes that all such costs will again be funded by the Scottish Government in 2021/22.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the position includes additional funding vired to the Health and Social Care Partnership during the first quarter by Scottish Borders Council to meet reported pressures across social care functions from managed forecast efficiency savings within other non-delegated local authority services and funding brought forward in respect of Covid-19 expenditure.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any expenditure in excess of the delegated budgets in 2021/22 will require to be funded by additional contributions from the partners in line with the approved scheme of integration

12. ANY OTHER BUSINESS

12.1 The Chair advised that although there would be an IJB Development session held on 20 October it would be shorted to allow for an Extra Ordinary IJB Audit Committee to be held at 10am to agree the Annual Accounts for approval by the IJB, and an Extra Ordinary IJB held at 10.30am to formally approve the Annual Accounts.

12.2 The IJB Development session would be held from 10.45am until 12noon.

12.3 Mr Rob McCulloch-Graham advised that an event on the National Care Service (NCS) consultation would be run on 7 October facilitated by the Alliance and the IJB Development session on 20 October would also focus on the NCS.

13. DATE AND TIME OF NEXT MEETING

13.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 December 2021, from 10am to 12noon, via Microsoft Teams.

Scottish Borders
Health and Social Care
PARTNERSHIP

Minutes of an Extra Ordinary meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 20 October 2021** at **10.30am** via Microsoft Teams

Present:
(v) Cllr D Parker (Chair)
(v) Cllr S Haslam
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
Mr D Bell, Staff Officer SBC
Mr R McCulloch-Graham, Chief Officer
Ms V MacPherson, Partnership Chair NHS
Mrs L Gallacher, Borders Carers
Mrs J Smith, Borders Care Voice
Mr S Easingwood, Chief Social Work and Public Protection Officer
Mrs S Horan, Director of Nursing, Midwifery & AHPs

In Attendance:
Miss I Bishop, Board Secretary
Mr R Roberts, Chief Executive NHS
Mr D Robertson, Chief Financial Officer SBC
Mrs J Stacey, Chief Internal Auditor SBC
Mr P McMenamin, Deputy Director of Finance/Business Partner IJB NHS
Mr G McMurdo, Programme Manager, SBC
Dr T Patterson, Director of Public Health
Ms J Amaral, BAVS
Mr G Samson, Audit Scotland
Mrs Gillian Woolman, Audit Scotland
Mr Asif Haseeb, Audit Scotland

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Tom Weatherston, Cllr Jenny Linehan, Mr John McLaren, Non Executive NHS, Dr Lynn McCallum, Medical Director, Mr Andrew Bone, Director of Finance NHS, Mrs Netta Meadows, Chief Executive SBC, Ms Linda Jackson, LGBT+, Mr Nile Istephan, Chief Executive Eildon Housing, and Dr Kevin Buchan GP.

1.2 The Chair welcomed Mrs Gillian Woolman, Mr Asif Haseeb and Mr Graeme Samson from Audit Scotland to the meeting.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none declared.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the meeting of the Health & Social Care Integration Joint Board held on 22 September 2021 were approved.

4. MATTERS ARISING

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. 2020/21 ANNUAL AUDIT REPORT

5.1 Mrs Gillian Woolman provided an overview of the content of the report and drew the attention of the Board to the specific elements set out in the covering letter.

5.2 The Chair recorded the thanks of the Board to Mrs Woolman and her team for providing the report during the on-going pandemic and all of the challenges that entailed.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** accepted the Audit Scotland Report and Management Letter.

6. SCOTTISH BORDERS INTEGRATION JOINT BOARD ANNUAL ACCOUNTS 2020/21 (AUDITED)

6.1 Mr David Robertson advised that he was acting as the Chief Financial Officer for the IJB on a temporary basis. He provided an in-depth analysis of the content of the Annual Accounts and drew the attention of the Board to each individual section and he specifically highlighted the carry forward and reserves positions, as well as the Audit Scotland recommendation that an appointment be made to the Chief Financial Officer post as soon as possible.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the 2020/21 Annual Accounts (audited).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the report and the 2020/21 Annual Accounts.

7. ANY OTHER BUSINESS

No further business had been notified.

8. DATE AND TIME OF NEXT MEETING

8.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 15 December 2021, from 10am to 12noon, via Microsoft Teams.

8.2 The Chair recorded his thanks to everyone for attending the Extra Ordinary meeting.

The meeting concluded at 11am.