Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 7 April 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**	Chair	Appendix-2022-17
9.02	**3**	**MINUTES OF PREVIOUS MEETING** 03.02.22	Chair	*Attached*
9.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
9.05	**5**	**STRATEGY**		
9.05	5.1	Pharmaceutical Care Services Plan (2022 update)	Director of Pharmacy	Appendix-2022-18
9.15	5.2	National Workforce Strategy	Director of Workforce	Verbal
9.30	**6**	**FINANCE AND RISK ASSURANCE**		
9.30	6.1	Strategic Risk Report	Director of Public Health	Appendix-2022-19
9.37	6.2	Audit Committee minutes: 13.12.21	Board Secretary	Appendix-2022-20
9.38	6.3	Endowment Fund Board of Trustees minutes: 27.09.21, 16.21.21, 31.01.22	Board Secretary	Appendix-2022-21
9.39	6.4	Resources & Performance Committee minutes: 04.11.21	Board Secretary	Appendix-2022-22
9.40	6.5	Finance Report	Director of Finance	Appendix-2022-23
9.45	6.6	Financial Plan 2022-23	Director of Finance	Appendix-2022-24
9.59	**7**	**QUALITY AND SAFETY ASSURANCE**		
9.59	7.1	Clinical Governance Committee minutes: 19.01.22	Board Secretary	Appendix-2022-25
10.00	7.2	Quality & Clinical Governance Report	Medical Director	Appendix-2022-26
10.15	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2022-27

10.30	**8**	**ENGAGEMENT**		
10.30	8.1	Public Governance Committee minutes 24.09.21, 10.11.21	Board Secretary	Appendix-2022-28
10.31	8.2	Staff Governance Committee Minutes 14.12.21	Board Secretary	Appendix-2022-29
10.32	8.3	Medical Education Report	Director of Medical Education	Appendix-2022-30
10.45	**9**	**PERFORMANCE ASSURANCE**		
10.45	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2022-31
10.54	**10**	**GOVERNANCE**		
10.54	10.1	Redress Scheme for survivors of historical abuse in residential care in Scotland – Acknowledgement of the harms of the past	Chief Executive	Appendix-2022-32
10.55	10.2	Scheme of Integration Refresh	Board Secretary	Appendix-2022-33
10.56	10.3	Integration Joint Board membership	Chair	Appendix-2022-34
10.57	10.4	Consultant Appointments	Director of Workforce	Appendix-2022-35
10.58	10.5	Scottish Borders Health & Social Care Integration Joint Board minutes: 15.12.21	Board Secretary	Appendix-2022-36
10.59	**11**	**ANY OTHER BUSINESS**		
11.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 30 June 2022 at 9.00am via MS Teams	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 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 formally constitute 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

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.

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.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Regulatory requirement.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to **approve** the Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Register of Interests.

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: …KAREN HAMILTON…….. *(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.	• Maintained registration with SSSC • Trustee of Manor Village Hall Endowment Trust • Secretary/Treasurer of above • Secretary for Manor SWRI

Signed- ………………….. Date ……31.03.22…………..

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: HARRIET CAMPBELL *(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	Employee of Douglas Home & Co Ltd, 47-49 The Square, Kelso TD5 7HW (part time solicitor). Owner and manager of holiday let, Little Hermitage, Kelso.
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.	
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.	
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	
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.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	
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.	Chair, Kelso High School Parent Council. Member Borders-wide group of High School Parent Council Chairs.

Signed……*Harriet Campbell*………………………….. Date …28 March 2022……..

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: SONYA LAM *(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	• Self employed in coaching practice with KnowYouMore • NHS Lothian Allied Health Professions (AHP) Bank Worker
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.	• Member of the Chartered Society of Physiotherapists and Chair of the Professional Awards Panel

Signed Sonya Lam Date: 28 March 2022

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: …DAVID PARKER……….. *(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	Scottish Borders Councillor Non Executive Member of the Scottish Local Government Pension Scheme Non Executive Member of the Scottish Teachers Pension Scheme
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.	Non Executive Director of NHS Borders
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.	Nil
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	Nil
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.	Nil
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	Nil
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.	Nil

Signed…… David Parker Date 31 March 2022

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 ……31/03/22…………..

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: JAMES AYLING (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	NIL
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.	NIL
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.	NIL
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	NIL
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.	NIL
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	NIL
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.	NIL.

Signed .... Date 30 March 2022

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: FIONA SANDFORD………*(please insert your full name in capital letters)*

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

Signed… Fiona Sandford ………………………………….. Date…1.iv.2022……………...

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: Alison Wilson……………. *(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.	Pharmacy awards judge and attendee at presentation evening
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.	Member of Unite

Signed…… [signature] ………………….. Date ……04/04/22…………..

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: RALPH ROBERTS *(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	
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.	
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.	
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	
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.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	
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.	Member, Managers in Partnership Wife employed by NHS Borders and NHS Education for Scotland in Practice Education and the Board's COVID response

Signed Date 29.03.2022

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: ANDREW STEPHEN BONE

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	Nil
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.	Nil
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.	Nil
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	Nil
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.	Nil
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	Nil
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.	Nominated 'B' director (public sector representative) on Hub South East Scotland Ltd; Vice-chair, Scottish Branch, Healthcare Financial Manager's Association (HFMA)

Signed ………… [signature] …………………………….. Date …… 30th March 2022 …...

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: **SARAH HORAN**

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	NIL
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.	NIL
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.	NIL
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	NIL
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.	NIL
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	NIL
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.	NIL

Signed   Date 28 March 2022

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: **JUNE SMYTH**

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.	**Member of *Managers in Partnership* Trades Union**

Signed [signature] Date **25th March 2022**

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: ANDREW N. CARTER *(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	
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.	
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.	
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	
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.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	
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.	MEMBER OF SCOTTISH PUBLIC PENSION AGENCY (SPPA) SCHEME ADVISORY BOARD (SAB)

Signed *A.N. Carter* Date 31/03/2022

Borders NHS Board

Register of Interests of Board Members

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

Board Member: CHRIS MYERS

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

Signed Christopher Myers Date 01/04/2022

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: GARETH CLINKSCALE

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	Nothing to Declare
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.	Nothing to Declare
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.	Nothing to Declare
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	Nothing to Declare
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.	Nothing to Declare
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	Nothing to Declare
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.	Nothing to Declare

Signed [signature] Date 01.04.22

Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 3 February 2022 at 9.00am via MS Teams.

Present: Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
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

In Attendance: Miss I Bishop, Board Secretary
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
Ms S Laurie, Communications Officer
Ms L Brown, Communications Officer
Mr P Lerpiniere, Associate Director of Nursing, MH & LD
Mrs F Doig, Head of Health Improvement
Ms S Elliot, Alcohol & Drugs Partnership Co-ordinator
Mr P Kelly, JPI Media Publishing Limited
Mr P Seeley

1. Apologies and Announcements

1.1 Apologies had been received from Mr Tris Taylor, Non Executive, Dr Tim Patterson, Director of Public Health, Mrs June Smyth, Director of Planning & Performance, 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 Mr Keith Allan, Associate Director of Public Health to the meeting who deputised for Dr Patterson.

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

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

1.5 The Chair confirmed the meeting was quorate.

1.6 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.

1.7 The Board welcomed the new format of the papers presented to the meeting and gave thanks to the Executives for pulling together the answers for the Q&A.

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 revised declaration of interests for Mrs Lucy O'Leary in the Register of Interests.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Borders NHS Board held on 2 December 2021 were approved.

4. Matters Arising

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

The **BOARD** noted the action tracker.

5. Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)

5.1 Mr Ralph Roberts provided a brief overview of the content of the paper and advised that an update against RMP4 would be provided to the Scottish Government over the following weeks.

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

The **BOARD** noted the report.

6. Audit Committee minutes: 13.09.21, 15.11.21

The **BOARD** noted the minutes.

7. Finance Report

7.1 Mr Andrew Bone provided an overview of the content of the report and advised that it was presented to the Board for awareness. He highlighted the £4.73m deficit at the end of November 2021 and the position on COVID expenditure. The forecast at the end of March 2022 was a £7.78m deficit which was in line with the forecast for the Quarter 2 review. He clarified that he had received confirmation from the

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Scottish Government that support would be provided to offset the deficit culminating in a break even position at the end of the financial year.

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

The **BOARD** noted the report.

8. Capital Plan 2021/22 - Update

8.1 Mr Andrew Bone provided an overview of the report and advised that the capital position was heavily influenced by the construction industry and its ability to undertake projects in the current environment of the pandemic. The level of resource was just under £9m and £3.6m had been spent to date. Mr Bone highlighted that the CT scanner replacement would be delivered and installed the following year. In regard to endoscopy equipment which had been a high risk issue for NHS Borders, the programme for its replacement had been accelerated as part of the national procurement process across NHS Scotland. He further advised that building projects would incur slippage and some contingency measures were being explored to manage the potential level of slippage at the end of the year.

8.2 Mr Bone also referred to capital allocations received in year and the digital portfolio. He confirmed that all funding being received was as a result of slippage on national capital programmes.

8.3 The Chair enquired about progress with the Forensic Medical Examination Suite (FMES). Mr Bone advised that the unit had been commissioned and work was on-going as there had been some disruption to the schedule leading to the completion date of the end of March being unlikely to be met.

8.4 Mrs Lucy O'Leary sought clarification that the CT scanner would be installed by the summer of 2022. Mr Bone confirmed it would be the summer of 2022.

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

The **BOARD** noted the report.

9. Clinical Governance Committee minutes: 17.11.21

The **BOARD** noted the minutes.

10. Quality & Clinical Governance Report

10.1 Mrs Laura Jones provided an overview of the content of the report. She highlighted several key elements including: the clinical prioritisation work that was taking place; access to specialist beds across the whole system including care homes for dementia placements; and provision of one to one care for patients.

10.2 Mrs Lucy O'Leary enquired in regard to the dementia overflow issue, where the planning was taking place for the capacity requirements for inpatient dementia beds.

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10.3 Dr Lynn McCallum commented that a significant plan had been produced and would play into the Integratoin Joint Board (IJB) Strategic Plan for commissioning. The Borders Special Dementia Unit (BSDU) provided special care for a complex cohort of patients who were not all dementia patients and she emphasised that a longer term plan was required.

10.4 Mr Chris Myers assured the Board that there was an implementation strategy group that was looking at all dementia pathways in care and in hospitals. The plan continued to be developed and there had been challenges in the provision of dementia downstream capacity in residential and nursing care home settings. An independent sector nursing home that had provided dementia care no longer wished to offer that service and work was on-going to look at mitigating any loss of capacity for dementia placements in private nursing settings for the present and longer term.

10.5 Ms Sonya Lam enquired about the take up rate for NHS Borders in terms of the staff bank and recognised there would be a review in 2022. She further enquired if the issue of staffing and sickness absence could be accelerated.

10.6 Mr Andy Carter commented that he and Mrs Sarah Horan would be meeting with NHS Lothian Staff Bank to explore those issues. There had been some improvement in the fill rate and he was keen to ensure the arrangement was beneficial to NHS Borders.

10.7 Mrs Horan commented that there was a contextual aspect in terms of getting the service that was being asked for given the vast majority of bank staff in the Borders were already on substantive contracts in NHS Borders. She advised there were quarterly performance meetings and the arrangement would be reviewed after the first year to ensure value for money was being achieved for the service commissioned from NHS Lothian.

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

The **BOARD** noted the report and detailed oversight on each area delivered through the Board Clinical Governance Committee.

11. Healthcare Associated Infection – Prevention & Control Report

11.1 Mr Sam Whiting drew the attention of the Board to section 6.2 of the report and advised that hand hygiene audits had taken place the previous day with good improvements noted with 8 audits undertaken with an average score of 88% and within that areas of 100%. He further advised that in relation to section 11.1 and infection control staffing, the new infection control nurse who had been recruited had changed posts within NHS Borders and a new advert had been released for the vacancy.

11.2 Mrs Fiona Sandford commented that there appeared to be a difficulty in recruiting and retaining staff within infection control and she enquired what could be done to make the job more attractive and keep people in post for longer. Mrs Sarah Horan advised that there was a national working group looking at infection control teams and a movement away from nursing and towards infection control practitioners.

11.3 Mr Whiting advised that the intention was to recruit an infection control nurse in the first instance and if that was unsuccessful a role change to an infection control practitioner would be pursued, however that would change the wider infection control team roles.

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

The **BOARD** noted the report and discussed, examined and considered the implications of the content of the report.

12. Care of Older People in Hospitals Update

12.1 Mr Peter Lerpiniere provided an overview of the content of the report, he advised that the standards remained the same but the situation was fluid and year on year focus was placed on the areas of pressure. The report focused on the hospital part of the pathway and did not refer to care home beds and the social care pathway. In terms of age profile Healthcare Improvement Scotland had confirmed that the pathway was about the individual and age was not a barrier.

12.2 Ms Sonya Lam enquired how well the standards were met. Mr Lerpiniere commented that all the processes were in place and benchmarking and audits took place in order to provide assurance.

12.3 Mrs Laura Jones confirmed that the audit programme undertook an audit of 20 patients per month in every adult area, although that had been reduced to 10 during the past few months as a consequence of the pandemic. She advised that the granular data was available and reporting was provided to the Clinical Governance Committee to provide assurance to the Board.

12.4 Dr Lynn McCallum commented that she was reflective of the fact that when considering where older people should be, hospital was often not the right place, and strategically as an organisation there should be more of a focus on delivering high quality care and parameters for when older people were admitted to hospital. She commented that a new clinician would be commencing with NHS Borders in April who was an expert in hospital and home pathways. She further commented that the frailty unit was focused on individuals admitted for health care and was able to discharge people back to their homes with the necessary support to care for them at home and emphasised that the whole system pathway including hospital components needed to be considered.

12.5 Mrs Lucy O'Leary commented that there was so much reliance on the child poverty action plan that she was concerned that it played down the impact of poverty on those who were not children or did not have children, but would become older people. It was not addressed within the action plan but would impact on the creation of a whole system approach to health and the determinants of health.

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

The **BOARD** noted the update and discussed, examined and considered the implications of the content of the report.

13. Staff Governance Committee Minutes: 14.06.21, 25.10.21

13.1 In regard to the minutes of 25.10.21 and the discussion on Equality, Diversity & Inclusion in Employment Group, it was agreed to direct the questions that related to workforce to the Staff Governance Committee to consider and for the Public Governance Committee to pick up the questions related to engagement.

The **BOARD** noted the minutes.

14. Area Clinical Forum Minutes: 05.10.21

14.1 Ms Sonya Lam enquired if the collective expertise of the Area Clinical Forum was optimised. Mrs Alison Wilson commented that it was a statutory committee, however in Borders as in other Health Boards its role and purpose was diminishing and it was difficult to gain clinical support when clinicians were hard pressed to be released to attend meetings. She assured the Board that there were other groups and forums within NHS Borders where clinicians were present and their views were taken into account such as the Operational Planning Group.

14.2 Mrs Sarah Horan commented that a re-energising of some of the underpinning Advisory Groups such as the Allied Health Professionals (AHPs) and Borders Area Nursing and Midwifery Advisory Committee (BANMAC) might assist.

The **BOARD** noted the minutes.

15. NHS Borders Performance Scorecard

15.1 Mr Ralph Roberts provided a brief outline of the content of the report and highlighted that performance had been sustained over the past year on a number of targets. Significant challenges remained in terms of the elective programme and the child and adolescent mental health service (CAMHS).

15.2 Dr Lynn McCallum commented that in reality the ripple effect of a 2 year pandemic would be felt for years to come, especially in regard to the exhaustion of staff, and level of non COVID related harm that had impacted health care.

15.3 Mrs Sarah Horan commented that staff wellbeing, training, education and development would be key in retaining staff and being the organisation where people wanted to work and develop professionally.

15.4 Further discussion focused on: the quality management system; compassionate leadership approach; workloads; nursing ratios; moral injury; delivery of high quality patient care; engagement; Scottish Government awareness of compassionate leadership in the NHS; the pressures faced by all Health Boards; and sustainability of services in the future.

15.5 Mr Andy Carter provided an update on the Scottish Government investment into overseas recruitment infrastructure, an online national wellbeing hub and workforce specialist services.

15.6 Mr Gareth Clinkscale provided an update on the Centre for Sustainable Delivery (CfSD) work that had been taking place over the past few months and had enabled

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additional programme and project management capacity to be provided for unscheduled care improvement work to be taken forward.

The **BOARD** is asked to **note** the Q&A.

The **BOARD** is asked to **note** the Performance Scorecard for November 2021.

16. Board Committee Memberships

16.1 The Chair provided and overview of the content of the paper.

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

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

17. Scheme of Integration Refresh

17.1 Mr Chris Myers provided an overview of the content of the paper and the requirement for a light touch review of the Scheme of the Integration. He advised that the review was open until 28.02.22 on citizen space. All feedback would be welcomed whether from individuals, organisations or groups.

17.2 Mrs Sonya Lam enquired about the inclusion of whistleblowing within the Scheme. Mr Myers commented that the operational delivery of services remained with the partner bodies and the whistleblowing processes within those bodies would remain in place.

17.3 Mrs Harriet Campbell enquired about the joint organisational development plan timeframe. Mr Myers commented that there was an expectation that all partnerships would have an integrated workforce plan based on the national workforce plan framework and that was being taken forward. In regard to the joint organisational development plan he would pursue that outwith the meeting.

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

The **BOARD** noted the progress being made with the light touch review of the Scheme of Integration.

18. Alcohol & Drugs Partnership Annual Report 2020-2021

18.1 Mrs Fiona Doig provided a brief overview of the content of the report.

18.2 Mrs Alison Wilson commented on the fantastic work that had been and continued to be progressed. She commented that the lack of funding of supervision therapy put pressure on the pharmacy budget and had been continually raised over the previous 5 years.

18.3 Mr James Ayling enquired about the use of naloxone and its distribution, available data on its impact in reducing deaths and foetal alcohol syndrome being mentioned 3 times when it was more prevalent than other things.

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18.4 Mrs Doig commented that the dispensing of naloxone was dependent on the GP practice and the service had been expanded into pharmacies, so that when a prescription for methadone was fulfilled an emergency kit could be collected at the same time. In assessing the impact of naloxone deaths the evidence was taken from looking at those released from prison who were at risk when returning to their normal social environment and was difficult to predict.

18.5 Mrs Doig commented that in regard to foetal alcohol syndrome, the emphasis in the immediate past had been on drug death prevention with a focus on treatment services for those with drug problems. There had not been the same emphasis on a more preventative approach to alcohol issues. However the ADP was committed to raising awareness on alcohol issues with those who were in family units where alcohol was prevalent and those who may become pregnant.

18.6 Mrs Alison Wilson commented that in regard to naloxone the purpose of the naloxone service was to increase access and it had been a good decision as the COVID pandemic had impacted GPs who were triaging and had limited accessibility.

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

The **BOARD** noted the report.

19. Scottish Borders Health & Social Care Integration Joint Board minutes: 22.09.21, 20.10.21 EO

The **BOARD** noted the minutes.

20. Any Other Business

20.1 There had been no notification of any further business to be discussed.

21. Date and Time of next meeting

21.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 7 April 2022 at 9.00am via MS Teams

The meeting concluded at 10.46am.

Signature: …………………………………..
Chair

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BORDERS NHS BOARD: 3 FEBRUARY 2022

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answers
1	Appendix-2022-1 Register of Interest	**Karen Hamilton:** Approved – no comment	-
2	Minutes of Previous Meeting	**Karen Hamilton:** Noted – no comment	-
3	Matters Arising/ Action Tracker	**Karen Hamilton:** Noted – no comment	-
4	Matters Arising/ Action Tracker	**Tris Taylor:** 4.2 It's my recollection that I asked for details of what public engagement had been undertaken – should I infer that no public engagement has been undertaken about this? 5.8 Was the action plan circulated? So sorry if I have missed it – please let me know when if so. 14 Equalities Mainstreaming Report – at a recent Audit Committee of 13/12/21 it came to light that this 2021 report appears to omit reference to external	**Ralph Roberts: Minute 4.2:** No public engagement has been undertaken on this at the present time. This is because this proposal is about the internal structure of teams to provide a service and there is no proposal to change the nature of the service provided to the public on which to engage. However in light of the issue raised the Programme Board has been asked to check this against the Major service change criteria which would inform if any Public engagement was appropriate. This will be addressed within the agreed future Board update. **Iris Bishop:** My apologies the Action Plan was forwarded to me on 09.12.21 and I appear to have failed to send it on to Board members. I have now circulated it by email on 02.02.22. **Iris Bishop: Action Tracker - Action 6:** The Chair is reviewing and revising the current schedule of subjects proposed for Board

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		audit recommendations relating to the 2019 report. In light of this and the lack of specificity on local inequalities strategy and deliverables, can it be satisfactory that the Board Development session identified will not happen until October? Does this demonstrate the urgency required in the context that a) pandemic conditions are known to widen inequalities, and b) there is not yet any assurance that we have acted on our own outstanding recommendations from the 2019 report according to the external auditors? This does not sit well with deferring Board level consideration for nine months. 16.3 Could we have an action on the tracker for this?	Development sessions for 2022. **Iris Bishop: Minute 16.3:** If the Board as a collective agree to include it on the Action Tracker I can include it.
5	Appendix-2022-2 Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	**Harriet Campbell:** 2.3 How is progress on delivering the update due by 9 Feb? I imagine that post-omicron there may be some fairly significant changes. Can we have an update on these at this stage?	**June Smyth:** The planning team are currently working through the update- this is being signed off by BET on 04/02/22 prior to submission, the update will be brought forward to the March Performance & Resource Committee Meeting for noting
6	Appendix-2022-2 Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	**Karen Hamilton:** Noted – no comment	-
7	Appendix-2022-2 Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	**James Ayling:** Please confirm details of the level of resource/expertise which we have received from CfSD. The 7 Dec email states that "The new format used	**Gareth Clinkscale:** CfSD have provided a range of experts from across surgery, outpatients, unscheduled care and senior human resources who are providing a range of time to our operational and director teams. This input ranges from an hours a fortnight up

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		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." Has the SG shared details of this more comprehensive view of aspiration and risk with us? What **further** forms of collaboration between Boards might this email be anticipating?	to half a day a week They have also supported us to secure programme and project management capacity for national services Scotland (2.9WTE) At the point of writing this response nothing confirmed by SG, this may form part of Annual Review, further detail may be shared when they commission the 2022/23 plan NHS Borders already collaborates with other boards in several ways such as through the East Region and through mutual aid, there may be further opportunities through plans being structured in the same format. There has been some discussion with SG around regional collaboration around recovering waiting times.
8	Appendix-2022-2 Scottish Government Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	**Sonya Lam:** Page 34 (2.3): What support are we receiving from the CfSD in terms of refining our plan? Page 34: What will our key messages re: changes to RMP4 be to SG in the update report due 9 February? Page 36: What does collaboration between Boards in developing plans look like? What are the opportunities?	**Gareth Clinkscale:** CfSD are actively reviewing and inputting into unscheduled care, surgery, outpatients, and workforce plans which sit under RMP4 **See answer above** **See answer above**
9	Appendix-2022-2 Scottish Government	**Tris Taylor:** 2.3.7 I'm assuming this question is about external	**June Smyth:** External stakeholders have had an opportunity to review in the following:

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	Feedback Letter- NHS Borders Remobilisation Plan 2021/22 (RMP4)	stakeholders – please can we have a specific answer as it's not immediately obvious from 2.3.8.	• Area Partnership • IJB
10	Appendix-2022-3 Audit Committee minutes: 13.09.21, 15.11.21	**Harriet Campbell:** P52 Very interested in this discussion on risk review. Lettie's paper will 'require relevant approval'. Whose approval is this and what has happened since?	**Andrew Bone:** Following the meeting I discussed with Tim Paterson, as executive lead for Risk Management. We agreed that the proposals are for changes to the management framework in place for risk management and therefore the decision should reside with the Board Executive Team. BET had already approved the report prior to its presentation to Audit Committee however given the uncertainty over ownership we agreed to revisit this position at BET to confirm. This has not yet happened due to disruption to normal business meetings over last 6-8 weeks however we will pick up with BET in advance of next Audit Committee and I will ensure the outcome is advised to the committee for noting.
11	Appendix-2022-3 Audit Committee minutes: 13.09.21, 15.11.21	**Karen Hamilton:** Noted – no comment	-
12	Appendix-2022-4 Finance Report	**Karen Hamilton:** Noted – no comment	-
13	Appendix-2022-4 Finance Report	**Tris Taylor:** 2.3.7 I'm assuming this question is about external stakeholders – please can this be revised.	**Andrew Bone:** Apologies, you are correct. The new format has caught us out. I will amend for future reports and acknowledge this point in the meeting. The report should have stated the following: *This is an internal performance report and as*

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			such no consultation with external stakeholders has been undertaken.
14	Appendix-2022-5 Capital Plan 2021/22 - Update	**Fiona Sandford:** Would be interested to hear more on the financial arrangements for the Digital Portfolio (P4) @ Clinical Governance it was recognised our ability to implement digital improvements was slower than larger Boards and that this was hampering our recruitment and retention of staff.	**Andrew Bone:** A planned update on the Digital Portfolio was deferred following cancellation of the Resources & Performance Committee in January. It is anticipated that this update will be presented to the next meeting of the committee in March. This will include assessment of the resource implications of current digital programme.
15	Appendix-2022-5 Capital Plan 2021/22 - Update	**Karen Hamilton:** Noted – no comment	-
16	Appendix-2022-5 Capital Plan 2021/22 - Update	**Sonya Lam:** Page 66: What level of confidence do we have that SG will agree to deferral of funding if required?	**Andrew Bone:** Flexibility on capital budgets is managed on a national level. The level of slippage in 2021/22 is unprecedented and SG have advised that they cannot at this stage make commitment to deferral of all resources. We have an open dialogue with SG around the level of likely slippage and we are advised to continue to plan on the basis that this will be manageable, but to ensure we make every effort to manage locally where possible. We have identified further actions that may be possible locally to manage slippage but this required additional work before we can confirm whether viable. My overall assessment would be that I would expect to see reinstatement of resource where we have a clear commitment to existing projects, but if there are resources that were agreed as additional to plan in 2021/22 and we are unable to deliver in that period, then these

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			may default to SG and we would have to revisit our requests in 2022/23.
17	Appendix-2022-5 Capital Plan 2021/22 - Update	**Tris Taylor:** 2.3.7 I'm assuming this question is about external stakeholders – please can this be revised.	**Andrew Bone:** re. Q13 above, same response pertains. The report should state: *This is an internal performance report and as such no consultation with external stakeholders has been undertaken.* Apologies for confusion and will amend future reports to reflect the correct position.
18	Appendix-2022-6 Clinical Governance Committee minutes: 17.11.21	**Fiona Sandford:** P3:I understand we still don't have guidance on Duty of Candor in relation to Covid. This is becoming increasingly urgent; and I wonder if we as a Board should take a position P5: The challenges on MH services caused by one challenging patient – the Board may want to recognise the problems that arise from this	**Laura Jones:** Yes, we would agree with this and are working on a position statement for inclusion in the Duty of Candour annual report which would be considered by the Clinical Governance Committee at their March 2022 meeting. For Board to note.
19	Appendix-2022-6 Clinical Governance Committee minutes: 17.11.21	**Karen Hamilton:** Noted – no comment	-
20	Appendix-2022-6 Clinical Governance Committee minutes: 17.11.21	**James Ayling:** The Chair of this Committee noted that the Risks associated with recruitment and retention of staff had been redirected to the Staff Governance Committee and a concern was raised that this move had not been highlighted to the Clinical Governance Committee and these risks remain a clinical risk so	**Laura Jones:** It has been agreed that CGC will also continue to be given reports on this area as an area of mutual interest given direct link to ability to deliver clinical services. Staff Governance will take lead role.

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		the Clinical Governance Committee should still receive an oversight of these risks. I would ask that this is not lost sight of and some consideration is given to prior communication and agreement of such events. We do have a new procedure being trialled and this should be fed back into it.	
21	Appendix-2022-7 Quality & Clinical Governance Report	**Lucy O'Leary:** P80 (3/10 of report). In 2021, for how much of the time did Huntlyburn require extra staffing to deal with the "place of safety" issue referred to in the report? BSDU – in 2021, how many times were patients admitted to BGH/ other hospitals as a result of lack of capacity in BDSU and what is that as a % of the number of admissions to BDSU itself?	**Laura Jones:** A detailed audit is currently underway. Early analysis suggests there have been approximately 46 patient's outwith criteria (general adult psychiatry) for Huntlyburn ward over the last year. The outputs of the audit will give a clear view of the mix and acuity of patients and can be presented on conclusion back through the Board Clinical Governance Committee. At any one time the liaison psychiatry service manage a case load of around 30 patients in the acute hospital who have a diagnosis of dementia. In the last year there have been people continuously waiting for admission to BSDU, this would not necessarily be the norm but BSDU has delayed discharges due to a lack of specialist provision in the care home sector for placements for this group of patients. Specialist care home beds for this group of patients exist in 1 main location in the Borders with 27 beds; however there has been little or no movement from BSDU into these beds for over 18 months. Knowe South is also a provider but has not been unable to accept

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		Are out of area admissions considered/ made in these circumstances and if so how many of these were there in the same period?	patients with dementia for some time. Out of area placements are only considered for exceptional cases.
22	Appendix-2022-7 Quality & Clinical Governance Report	**Fiona Sandford:** As above: P4 #3 the number of patients requiring 1:1 supervision.	**Laura Jones:** For Board to note.
23	Appendix-2022-7 Quality & Clinical Governance Report	**Karen Hamilton:** Noted – no comment	-
24	Appendix-2022-7 Quality & Clinical Governance Report	**James Ayling:** I see "Improved Observational Practice" was applied as a model at Huntlyburn. What does this comprise please? 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. The paper refers to alternative options being considered…briefly what are these? Briefly what was the change to the complaints procedure in April 17 following which there was an increase. Apologies If I have missed this from an earlier meeting ?	**Laura Jones:** Improved Observational Practice is now the norm in settings such as Huntlyburn. It is a model of observation originally conceptualised and trialled using quality improvement methodology supported by NHS Education Scotland. It focuses on an Enhanced Engagement approach where targeted interventions respond to identified areas of vulnerability at specific times or in specific circumstances. As per answer to Q21 above. The model complaints handling process was introduced in 2017. This moved away from having 2 streams for complaints handling of formal and informal to stage 1 and 2. It also moved the next line of complaints escalation to the SPSO if complainants were not satisfied

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			with their response. Prior to this Boards would reopen complaints sometimes several times if complainants were not satisfied but it is now recommended that the Ombudsman as a third party consider these cases if the complainant wants to access this route.
25	Appendix-2022-7 Quality & Clinical Governance Report	**Sonya Lam:** Page 80. What is the 'Improved Observational Practice' model and was this model deployed for these exceptional circumstances? Acknowledge this has been a challenging period through the pandemic. In terms of flow, what impact has the pandemic had on the prevention agenda i.e. supporting people before they reach a crisis point?	**Laura Jones:** As detailed in Q24 answer above. Mental Health and Learning Disability services have worked to maintain care provision for urgent and emergency presentations and for those where input is required to prevent acute deterioration. To a variable extent, depending on staffing and other pressures, that has meant routine activity at times has either been reduced, delayed or paused. There is a risk in those circumstances that the opportunity for earlier intervention, to prevent further deterioration, is lost. Staff have worked hard to maintain services focussed according to clinical need. It is worth noting that prevention of mental illness and disorder (where that is possible), and reduction of risk of deterioration of presentations in those with mental disorder, is also the job of the partner agencies and local communities. The pandemic has affected the capability of these structures to support good mental health generally which, in addition to specific areas where we have seen increased presentations (such as with eating disorder or in young people), means the effects of the

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			pandemic in terms of demand to Mental Health services will be felt for some time. The prevention agenda will require highly effective collaboration between Public Health, Health and Social Care Partnerships, third sector agencies and communities. For acute services the need to meet the urgent and emergency demand over this period has required the deployment of staff from a wide range of other acute services, other clinical boards and corporate services. This has included staff from specialist nursing teams whose remit would usually involve more regular contact with outpatients routinely to head off crises and to be first point of contact when things start to go wrong. Whilst these services have not be stopped completely they have been reduced requiring prioritisation of clinical need and urgency.
		Page 81: Although early days with the regional approach, is this model problematic for NHS Borders if fill rates are 39%. What are the fill rates in NHS Lothian?	A fill rate of 39% is problematic as it then leaves shifts uncovered. The fill rates vary from week to week with a national average of approximately 50% over the course of the pandemic as requests have been extraordinary. Lothian have seen higher fill rates and this is being explored to ensure that we are getting value from having a regionalised service. A full review of the regional working will be scheduled in 2022 to allow time after the pandemic for “new normal” working to become established.
26	Appendix-2022-7	**Tris Taylor:**	**Laura Jones:**

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	Quality & Clinical Governance Report	2.3.7 I'm assuming this question is about external stakeholders – please can this be revised.	Question asked of all papers for consideration in paper template.
27	Appendix-2022-8 Healthcare Associated Infection – Prevention & Control Report	**Harriet Campbell:** What is the effect of/ penalty for not hitting our infection control targets? P92 has the hand hygiene visit actually now happened?	**Sam Whiting:** Infection Control targets are included in a range of measures that have historically been considered by the Scottish Government as part of the Board annual review process. It is likely that at some stage, the Scottish Government will seek further information on our approach and improvement activity in support of the targets. The hand hygiene visit is scheduled for 02/02/22.
28	Appendix-2022-8 Healthcare Associated Infection – Prevention & Control Report	**Karen Hamilton:** 6.2 Hand hygiene – GoJo monitoring. Is this done by recording how much gel is used month on month? If not could it? Be good to see the Audit at some point? 2.3 - 1.1 and 1.2 – have we achieved the target of 10% reduction and 25% reduction under 1.3	**Sam Whiting:** The GoJo rep physically visits wards and undertakes the compliance audits for us. Hand gel usage was reviewed a few years ago – both at a local level and national level as a potential proxy for hand hygiene compliance. In reality there were too many confounders to draw too much conclusion from the data and the information was too crude to inform improvement activity. 1.1 Target not met 1.2 On track to achieve this target 1.3 Target not met
29	Appendix-2022-9 Care of Older People in Hospitals Update	**Harriet Campbell:** What defines an 'older person' in this context?. Is it a hard age definition (eg over 65 per p120) or it is more	**Peter Lerpiniere:** If I may quote from the standards document. "*Older people are the focus of these standards.*

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		nuanced and individual?	*However, the project group sought not to provide a definitive age cut-off point; treatment and care will be determined by a range of considerations, including functionality. It was not felt appropriate to state that these standards applied to all people aged over 65 or 75 years of age.*" More importantly I think we would aspire to meet these standards for all patients irrespective of age.
		Are we/can we be sure that NHSB is applying these standards to everyone to whom they should be applicable?	This is, again, not a straightforward question. We strive to apply the standards to all patients. We have a proactive audit programme, and monitor performance – but the question is not always a simple "Yes/No". The COPH standards themselves state: "*NHS boards will be asked to demonstrate processes for access to assessment, treatment and care, for example, comprehensive geriatric assessment and falls prevention, although in recognition of health inequalities across Scotland, this may vary by NHS board. As a consequence, the standards should be reviewed pragmatically by service providers: not every criterion will apply to all older people in hospital."*
		Several items/actions in the standards are (understandably) on hold (egpp 115 and 119) as a result of the pandemic. Is there a timescale for restarting these?	I cannot put a hard and fast timescale on this – we are still slaves to the recovery to some extent. The priorities of how we stand services back-up will be set by, in this case, predominantly the acute board. However – these standards are not just considered good

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		What provision is made for older people (possibly confused) who may not speak any/much English?	practice they also promote efficient, effective clinical practice. There are Interpretation and Translation Guidelines – updated April 21. Telephone/digital media are used as first line. In the case of someone with confusion we may seek a face to face appointment.
30	Appendix-2022-9 Care of Older People in Hospitals Update	**Lucy O'Leary:** This is a really comprehensive report – thank you. What are the high impact changes that we should be prioritising and focusing effort on in the immediate future (ie what should we be doing in the next 3-6 months to make the biggest improvement to older people's experience?	**Peter Lerpiniere:** Thanks Lucy – I regret that if you ask me this question last year, this year, next year the answer will be the same. Frailty, Falls, Food Fluid & Nutrition, Tissue Viability, Good communication, Deteriorating patients and – for those who have seen me here before – delirium and dementia. These are our staples. We will never eradicate falls (for example) unless we keep people in bed – then we'll be dealing with pressure area breakdown… Coming out of the pandemic, in my view, we need to double-down on getting these things right.
31	Appendix-2022-9 Care of Older People in Hospitals Update	**Fiona Sandford:** This is extremely thorough and interesting; recognise so many of the 'areas in development' that affect the whole health care system. Should progress with these be reported to CG or other committee? Also interested to know what plans are in place to	**Peter Lerpiniere:** Sarah and I have discussed how to frame this a little differently so the board see this in context with other pieces of work, not isolation. This work is about patient safety, about good communication and about adverse events – I am happy to present to CG or other group. 4AT is of particular interest to me as a former

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		ensure 4AT is consistently carried out Ditto hearing aid issues and other areas in development Also, unless I've missed it, we are not explicit about the shortage of nursing home/ care home beds and the impact this has on all of this.	Dementia Specialist. It is done by nurses in some of the Community Hospitals and by doctors (sometimes) in BGH. It is part of an audit I have just asked colleagues to support me with around communication – it is not consistently applied. Hearing Aids is a different issue – people are sometimes admitted with them forgotten, in an emergency – amplifiers would help. The baffling thing for me is when people come in without them in case they lose them. Surely the one place you want to be certain of hearing is in a hospital… It doesn't fall within the compass of this report – but it is absolutely vital to effective delivery of care!
32	Appendix-2022-9 Care of Older People in Hospitals Update	**Karen Hamilton:** 2.3.7 Is the group likely to be reconvened soon? How are areas for improvement managed and monitored?	**Peter Lerpiniere:** As said earlier I have asked Sarah to consider how we ensure this particular report less in isolation – but I expect the group to reconvene shortly. There are audits on a number of pieces of work collated through B2B and/or SCN dashboards. Individual pieces of work are evaluated in the manner appropriate when they are started. It may be through QI methodology for example.
33	Appendix-2022-9 Care of Older People in Hospitals Update	**James Ayling:** Thank you for such a comprehensive report setting out the standards and procedures etc in place and in	**Peter Lerpiniere:** You rightly observe this is a vast agenda, but much of it is our absolute mainstream work. Individual workstreams are

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		particular noting areas for development . It's a big subject and in a non pandemic time one could consider an entire meeting discussing this. Within the above report there is a vast number of complex requirements legislative and otherwise. How do we make sure that those dealing with patients are on top of these requirements and then kept up to date on new practice etc.? Do we have in house training capability or do we require third parties? At what age is a person deemed to fall within the "older people " category? I see a delirium 4AT test is routinely carried out for 65+.	led by appropriate clinicians and staff updated with changes in practice (Falls, Tissue Viability for example). More legislative issues can be led by specialists in an area. The Mental Welfare Commission have recently published guidance on "Authority to Discharge" and guidance around learning on the legal issues will be led either by our Dementia Nurse Consultant or Mental Health Officer Social Work colleagues. Where there is a substantive change we will bring in an external expert to train and cascade. I have answered above – we are asked to be "individualistic" about this. I think, to be honest, calling them the Care of Older People Standards is misleading.
34	Appendix-2022-9 Care of Older People in Hospitals Update	**Sonya Lam:** I am assured that there is activity against each of the standards and sub-standards outlined. It may be how the standards are articulated (and the considerable number of them) but I am challenged to understand how well we meet the standards. What evidence do we have that demonstrates the extent to which we meet them?	**Peter Lerpiniere:** It is a fair question and there are continuous audits which evaluate some of our practice to consider whether we meet aspects of the standards, but as you note the standards themselves do not set a numerical benchmark. What HIS are looking for (and to be clear – we do not do this for inspection purposes.) is that our processes are robust and they create a climate in which good care is delivered. That we expect to do the right thing. I have recently asked colleagues to collate an audit on whether we are collecting "Who Matters To Me" rather than "What…" because the standards expect we should not only aspire to involve relatives effectively, but that we should be able to demonstrate their

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			participation in decision making. This happens repeatedly for aspects – but we cannot audit everything.
		How does this evidence provide assurance that we maintain and improve practice against the standards?	Currently it does for some areas – but not for others. Our work on falls has been continuous for several years. The pharmacy staff are continually striving to improve medicine reconciliation for example, and multiple other audits.
		Are the areas for development targeted at areas where we don't meet the standards?	The "Areas for development" are those identified by subject experts where they believe work has been undertaken but needs completed or refined, or where work has been identified as necessary in their field. I know that more work has been incomplete this year due to pandemic.
35	Appendix-2022-9 Care of Older People in Hospitals Update	**Tris Taylor:** 2.3.7 Please could this answer be specific about involvement during the period reported on.	**Peter Lerpiniere:** A member of the Public Partnership has sat on the COPH group since its inception. He was an absolute star – a genuine critical friend. Regrettably he retired this year and will be replaced when the COPH group are up and running in the New Year.
36	Appendix-2022-10 Staff Governance Committee Minutes: 14.06.21, 25.10.21	**Karen Hamilton:** Noted – no comment	-
37	Appendix-2022-10 Staff Governance Committee Minutes: 14.06.21, 25.10.21	**Tris Taylor:** What has been the outcome of the work on disability, and has progress been made on answering the questions put via email on 02/06/21 about the apparent inequity shown in the reported proportion of disabled staff and disabled staffing of WTE posts at	**Andy Carter:** The questions will be referred back to the Staff Governance Committee and for the engagement questions the Public Governance Committee for consideration.

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		NHS Borders compared with ONS estimates of the total percentage of the workforce which is disabled? For reference, the questions posed were: 1) Taking into account the rights of disabled people [to work and employment], can action be taken to qualify the risk this current position poses to a) our organisation and b) our population? 2) Can statistics be supplied regarding the equivalent proportion of workforce in our primary & community delivery partners? 3) To what extent have Health Inequality Impact Assessments conducted in the last 2 years considered the impact of NHS Borders activity on disabled people, in particular the potential for change to create positive impact? To what extent has the Board considered strategically its potential as an anchor organisation in this population to mitigate negative impact on employment opportunities for disabled people, and create positive impact? 4) How many disabled people and disability organisations has the Board engaged with in the past 2 years? What proportion of our engagement and co-production activity is with disabled people and disability organisations? Is this equitable?	
38	Appendix-2022-11 Area Clinical Forum Minutes: 05.10.21	**Karen Hamilton:** Noted – no comment	-
39	Appendix-2022-12 NHS Borders Performance Scorecard	**Harriet Campbell:** P160. CAMHS waiting times will reduce when there are more staff. This seems to be a fairly natural	**Simon Burt:** The initial allocation of funding from Scottish Government was only committed non recurrently. Outcomes from recruitment

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		conclusion, but it's unclear if more staff have actually been recruited. Without them the waiting time is unlikely to reduce. P160 "Planning & Performance have compiled this reported without their input using information available" is this reflected in the fact that there is a lack of consistency in the periods covered by the graphs on pp 162 et seq and the fact that some charts don't have 'actual' lines? If that isn't the reason, what is?	initiatives were therefore poor. Scottish Government have now confirmed that Recovery and Renewal funding is recurring. We have now revised our recruitment plans which have been approved by the MH Quad and all posts are in the process of being recruited to. It will take time to recruit as all Health Boards are recruiting to similar pots of additional funding. Our current projection to reduce the waiting list from 250 to between 50 and 100 is for March 2023. This may slip if posts take longer to fill. Thank you for the feedback, I will ensure the BI Team review, some of the charts demonstrate performance against a quarterly trajectory meaning that the performance for Q3 will be presented in December Performance Scorecard
40	Appendix-2022-12 NHS Borders Performance Scorecard	**Fiona Sandford:** Really like the format for RMP4 target performance, and can see some promising data there, particularly good to see that we seem to be getting close to target on delayed discharges. Easy to see where we are falling short of target. CAMHS disappointing	**June Smyth:** Thank you for the positive feedback I will ensure this is fed back to the team.
41	Appendix-2022-12 NHS Borders Performance Scorecard	**Karen Hamilton:** A&E 4 hour waiting times performance shows little sign of improvement. Our performance against other Boards is also poor. I appreciate flow is an issue relating to delayed discharge and this is not a problem that sits alone. Have we considered more fundamental/structural solutions? Be happy to discuss this further at the meeting.	**Gareth Clinkscale:** Karen is right to recognise that there are other factors beyond Delayed Discharge that are playing into levels of performance against the four-hour standard. Continued provision of COVID-19 inpatient capacity and vacancy/sickness levels have limited our ability to increase non-covid bed capacity to pre-pandemic levels. The

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		Delayed discharges still give cause for concern sadly but we are aware of the reasons – hopes for future improvement?	Emergency Department continues to hold GP assessment activity which is placing further pressure on the front door of the hospital. Some of the gains made pre-pandemic in consistent delivery of patient flow, both through and out of the hospital, have been diluted during the previous two years as a consequence of us operating on emergency footing for an extended period of time. There are other structural and intangible challenges at play here too; challenges which have been exacerbated by the pandemic. We are in the process of designing a programme that will engage our workforce in the improvement and redesign required to improve
42	Appendix-2022-12 NHS Borders Performance Scorecard	**Tris Taylor:** 2.3.7 I'm assuming this question is about external stakeholders – please can this be revised.	**June Smyth:** The Performance Scorecard is not developed with any external stakeholders so this will be revised in future reports
43	Appendix-2022-13 Board Committee Memberships	**Karen Hamilton:** Approved no comment – welcome to Harriet on IJB	-
44	Appendix-2022-13 Board Committee Memberships	**Tris Taylor:** 2.3.7 Is it worth considering whether to log changes to the public representative membership of the Public Governance Committee in these reports? If the intent is to report on Non Executive involvement it is not necessary, but if it is to act as a record of Committee membership then it might be helpful.	**Iris Bishop:** This paper is purely about Non Executive memberships of Committees and Groups and would not be appropriate to log changes in the various Committees own memberships.
45	Appendix-2022-14 Scheme of Integration Refresh	**Harriet Campbell:** Thank you for the chart showing changes. Very helpful indeed. Can you confirm that these are the only changes from the previously published and agreed scheme? Queries below refer to page numbers in that chart.	**Iris Bishop:** Yes these are the only changes from the last approved version.

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		P219 4.7.4 The original and new versions are exactly the same. Is a change planned and if so what is it?	**Iris Bishop:** Apologies you are correct this section has not changed and should not have been included in the chart of amendments. It already does what is says.
		P 221 7.1 Are these new documents? If so who is to prepare and approve them and by when? If not, is it correct to say 'will jointly develop'?	**Iris Bishop:** These are not new documents they were to have been in formulated by March 2016, however they were delayed. The interim workforce plan has been formulated and submitted to Scottish Government. **Iris Bishop:** I am unsure on the status of the Joint Organisational Development Plan.
		P222'A communications and engagement strategy and action plan should be developed, in conjunction with the Strategic Planning Group to support this work'. Again is this new work? If so it doesn't necessarily feel very 'light touch' Who is to take responsibility for this and by when?	**Clare Oliver:** Although there has been on-going communications support to the Partnership the development of a new Communications (and Engagement?) Strategy is a significant piece of work and conversations are currently underway between the Chief Officer, Director of Planning and Heads of Communications in NHS Borders and SBC to look at this.
		P223 (and possibly elsewhere) . The previous scheme pre-dated GDPR (in force May 2018). Does the updated scheme incorporate any new requirements following that legislation?	**Iris Bishop:** NHS Borders and Scottish Borders Council remain as the Data Controllers for their respective records and abide by GDPR. The IJB has a joint Partnership Information Governance Group that meets on a quarterly basis to ensure it is where necessary abiding by the correct legislative requirements for

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		And indeed any other legislation that is now in force and wasn't then?	sharing data and information. The Scheme was updated in 2018 as a consequence of the Carers' Act and required delegated functions.
46	Appendix-2022-14 Scheme of Integration Refresh	**Karen Hamilton:** Paper presented for awareness, is there an expectation that/opportunity for Board Members to offer views separately from the Board Meeting. Accept that this is a light touch review – when will a fuller more in depth review come to the Board?	**Iris Bishop:** Board members can access the public consultation via the link in the paper and feed in comments directly. Any comments gathered as part of the review will be considered and fed into a fuller review, if required, over the course of the next 12 months. The intention would be to provide the Board with the outcome of any fuller review in 2023.
47	Appendix-2022-14 Scheme of Integration Refresh	**James Ayling:** Looking at dates in 2.3 of paper it is unfortunate that the 5 year review will not be able to take into account the results of the consultation being completed at end Feb 22. The exercise will presumably need to be repeated. Presumably this is a knock on from having other pandemic priorities. Workforce 7.1 .There is no new time limit for introduction of plan.	**Iris Bishop:** Due to the pandemic we were given the ability by the Scottish Government to take a light touch review approach to the 5 year consultation. When the comments from the light touch review are gathered in we will review them and then have the ability to undertake a fuller consultation over the next 12 months. **Iris Bishop:** The interim workforce plan has been formulated and submitted to Scottish Government, negating a need for a timeline in the scheme itself.
48	Appendix-2022-14 Scheme of Integration Refresh	**Tris Taylor:** 2.3.7 Assuming this question is about external stakeholders, please can this be revised.	**Iris Bishop:** I would be keen to discuss this comment outwith the meeting so that I can understand the issue better as we have targeted various stakeholder groups (as per section 2.3.7 and the consultation is open to

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		Appendix: please can these documents be provided in full, instead of as icons inoperable in a PDF.	the general public. **Iris Bishop:** I had not included them as full documents given they did not form part of the proposed light touch changes to the Scheme of Integration. However, I have now emailed them to the Board members separately on 02.02.22.
49	Appendix-2022-15 Alcohol & Drugs Partnership Annual Report 2020-2021	**Harriet Campbell:** P233 Should ADP membership/papers be publicly available? If so, why aren't they?	**Fiona Doig:** We submitted the same response in our report to Scottish Government for 2019-20 and have not received feedback that this is an expectation, however, we have asked the question directly following the Board question. We have not done this to date due to the sensitive (including often commercially sensitive) nature of ADP business. I have included on the ADP Board Agenda for Monday 8th Feb to discuss and happy to feedback.
50	Appendix-2022-15 Alcohol & Drugs Partnership Annual Report 2020-2021	**Fiona Sandford:** Very interesting report with some promising indicators	-
51	Appendix-2022-15 Alcohol & Drugs Partnership Annual Report 2020-2021	**Karen Hamilton:** Given the Pandemic challenges there is evidence of some excellent work in the Review. Areas for improvement are acknowledged. Given Scotland's overall performance on reducing drug related deaths and their continued focus on improvement , I am wondering how we perform in this area compared to other Boards?	**Fiona Doig:** National Records Scotland (NRS) reports on rate of drug deaths in terms of the general population. On that measure Borders appears to perform better than other Boards, however, that could be attributed purely to our lower prevalence rate. A potentially more accurate measure may be the rate by the population at risk. The table below compared our performance to other

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broadly comparable boards. The challenge with this calculation is that, based on estimated prevalence data our estimated number of people at risk is 510 therefore small variations in the number of people lost to drug deaths will impact on our percentage rate.

Area	Number of Drug Deaths (NRS) 2020	Drug Deaths as % of population at risk
Borders	18	3.5%
Angus	14	1.8%
Argyll & Bute	16	2.8%
East Lothian	14	1.5%
Highland	33	2.3%
Midlothian	21	2.8%
Moray	10	3.7%
Stirling	31	3.5%
Scotland	1339	2.3%

The Board will be aware that national data is subject to a considerable reporting lag due to the time taken to confirm toxicology results. Data is reported for calendar years and 2021 data is expected to be published in September 2022.

In terms of actions to reduce drugs deaths we are confident that the work of our assertive engagement team and the non-fatal overdose pathway are in line with expectations and that we are ahead of some Boards in that respect.

Borders Addiction Service has been used as an example of good practice for implementing Medication Assisted Treatment (MAT)

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			standards including access to same day prescribing of opioid substitution therapy (e.g. methadone, buprenorphine) and patient access to long-acting buprenorphine. In the most recent data available we had 76% of our estimated target population in drug treatment. There is no comparable data available for other boards, however, Scottish Government is planning to introduce a treatment target and we expect the local reach of service to be higher than the Scottish average.
52	Appendix-2022-15 Alcohol & Drugs Partnership Annual Report 2020-2021	**Tris Taylor:** **Cover paper:** What is the Annual Operational Plan referenced in the cover paper? Please could a copy be supplied? Who is accountable for the performance described in this report? How does this report fit within the overall picture of assurance information relating to this work?	**Fiona Doig:** We have been advised that Scottish Government (SG) colleagues will issue a template for an operational plan. To date this has not been issued, however, we have developed a local Plan and I have attached this here. This is updated and reported to the ADP. ADP Delivery Plan 2021-22 (year 2)_Revi Commissioned alcohol and drugs services (NHS Borders Addiction Service (BAS); We Are With You; Action for Children) are responsible to the ADP for their performance as is the ADP Support Team. The ADP is accountable to the IJB. SG views the Annual Review as a Quality

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			Assurance document. To date we have had no feedback from SG on the two most recent reports submitted.
		To what extent is the Board accountable for the delivery of these services?	BAS has an SLA with the ADP. The Board is responsible for ABI and Waiting Times LDP targets.
		To what body does the ADP Board report?	We report to IJB and SG.
		Within local public health arrangements and with the Director of Public Health being a joint appointment across Council and Health Board, how is governance split? Is there a satisfactory single point of accountability organisationally for this work?	I'm not sure it's appropriate for me to confirm the governance split for the post and/or make assumptions regarding if current arrangements are satisfactory. It would be helpful if I could ask that DPH responds to the two highlighted points and supports a further discussion with colleagues. I'm hoping that's an acceptable offer to pick up when Tim returns from leave.
		Why is there only baseline/target context given where performance exceeds target? Did performance exceed target in all respects?	There are currently only two national targets: ABI and Waiting Times. We set a local target for Naloxone. We are anticipating a national target for uptake of drug treatment.
		2.8 Is it really the case that involvement of people with lived experience is the only or main perceived risk under management? This risk as presented appears to exclude as potential contributors those who no longer have issues with drugs or alcohol, and family members of people who have or had alcohol or drug problems – is the assessment of this risk fair?	The term 'lived experience' is used to include people who are currently experiencing alcohol and/or drug problems; people in recovery and impacted family members. I can see the wording in the paper is not in line with this convention.

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		Are there no risks relating to harm that actual or potential service users may come to if services fail to address need – particularly in light of the widening in inequalities experienced under pandemic conditions? **Report** 1.2 & 3.10 Why does the partnership not have lived experience at Board level either within services or at the ADP itself? When will this be rectified? 3.12 Is it accurate to answer 'yes' here – are there examples of employment opportunities as well as volunteering? If not, why are there no employment opportunities for people with lived experience? How many people in total are employed, and what number of whole-time equivalent posts exist, in services?	The risks outlined in the paper are in relation to the report submitted rather than any wider operational and delivery risks across the ADP workplan. I have noted it would be helpful to provide a wider assessment for future updates. ADP Board: we have been working with people over the last 14 months to engage and develop this work alongside Serendipity Recovery Community Network (local Borders community) and Scottish Recovery Consortium. To date individuals do not feel ready to attend and contribute to the Board meetings, however, the staff member leading this work is invited to attend the meeting and feedback to the Lived Experience Forum. Feedback from the Forum is a standing agenda item on the Board. It is not possible to confirm when individuals will feel prepared to attend. Scottish Drugs Forum have received national funding to support local areas with implementing Living Experience Panels and our first meeting with the team takes place next week. There are staff and volunteers with lived experience working in services and involved in recruitment processes. Current posts: Addiction Worker Trainee post (paid) Peer Naloxone Champions 4 paid (1

			volunteering for personal reasons) Currently being recruited using additional funding: 3 support worker posts and one employability worker in WAWY all to have lived experience There are paid staff roles in all services filled by people with lived experience although not directly employed as such. In BAS the majority of posts are for qualified clinical staff. Total of all staff employed in all roles in service at time of reporting is WTE = 43.6
		3.14 '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' – what does this mean? Are people exploring how to be involved in the development, or are they involved in the development? As well as the development, are they involved in the delivery? What changes have been made in development based on the involvement of people with lived experience?	We have an established group (Lived Experienced Forum) which has been meeting on a regular basis to discuss how people can influence the planning and delivery of ADP work. This could happen in a number of different ways e.g. through sharing views in the Forum where ADP Support Team are present, attending ADP Board. As per above we have an interim arrangement for formal representation. Currently people from the Forum and the recovery group are participating in work to improve our pathways for accessing residential rehabilitation. Feedback from the Forum members influenced national messaging about access to alcohol

DRAFT

			following COVID-19 restrictions
		3.19 trauma-informed approach – thank you for this positive information.	-
		6 What patterns (if any) of protected characteristics are observed in Borderer users/potential users of these services?	A new national database (DAISy) was implemented in April 2021 and while it does collect data on age, sex, ethnicity, pregnancy and disability we are unable to access this data as currently DAISy is only able to report on basic waiting times data. There is no collection of other protected characteristics. Local information reflects national data, and in previous years our drug clients are more likely to be male than female (60:40), alcohol clients show a less defined male: female breakdown but still have more men in service. Most people are white (Scottish). 30% of alcohol clients are over 50 compared to 23% of drug clients. People accessing services are more likely than the general population to self-report disability. There is published evidence that people identifying as LGBTQ+ have higher levels of alcohol and drug use as a whole. One of the recommendations arising from the review of the SG/COSLA Partnership Delivery Framework is to standardise and improve needs assessments at local level. Public Health Scotland will be supporting this work.

DRAFT

<table>
<tr><td></td><td></td><td>Highlight report

Some text appears to duplicate responses in the main report. If it is necessary to review this report, please identify the passages that convey new information.</td><td>An annotated version of the report is attached. We have highlighted sections that are not in the cover paper as noted below.

<table><tr><th>Section</th><th>Page</th></tr><tr><td>2</td><td>5</td></tr><tr><td>3.1</td><td>5-6</td></tr><tr><td>3.2, 3.3,</td><td>7</td></tr><tr><td>3.4, 3.5</td><td>8</td></tr></table>
Narrative Annual Report 2020-21 Highlig</td></tr>
<tr><td>53</td><td>Appendix-2022-16 Scottish Borders Health & Social Care Integration Joint Board minutes: 22.09.21, 20.10.21 EO</td><td>-</td><td>-</td></tr>
</table>

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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:	**7 April 2022**
Title:	**Pharmaceutical Care Services Plan (2022 update)**
Responsible Executive/Non-Executive:	**Alison Wilson, Director of Pharmacy**
Report Author:	**Alison Wilson, Director of Pharmacy**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Borders Board approved the three year Pharmaceutical Care Services Plan in 2021 and requested that the Action Plans and any other updates be submitted to the Board annually. Paper tabled is the 2022 update.

2.2 Background

The purpose of the NHS Borders Pharmaceutical Care services Plan 2021-24 is to evaluate the current service provision, identify any gaps and support the decision making process on any future application for a new community pharmacy in the Scottish Borders. A secondary function of the plan is to inform and engage members of the public, health professions and planners in the planning of pharmaceutical services available in Scottish Borders.

2.3 Assessment

Updated the Action Plans – year on year to reflect actions that have been completed and any new/moved actions. Any other changes have been highlighted at the start of the Plan and in green.

2.3.1 Quality/ Patient Care

N/A

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

Supports NHS Borders Equality & Diversity through ensuring equitable access to Pharmaceutical care.

2.3.6 Other impacts

N/A

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.

- See below in Route to Meeting – reviewed by GP Sub Group; Public Partnership as well as internal committees of NHS Borders.

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.

Area Pharmaceutical Committee	27th April 2021
GP Sub-committee of Area Medical Committee	24th May 2021
Covid Recovery Planning Group	7th June 2021

Public Partnership Forum	17th June 2021
Area Clinical Forum	22nd June 2021 (virtual approval 14th June 2021)
NHS Borders Board	24th June 2021

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

NHSB Pharmaceutical Care Services Plan 2021-2024 (2022 Update).pdf

NHS Borders Pharmaceutical Care Services Plan
April 2021 – March 2024

Version: 2.0

Issue Date: April 2022

Status: 2022 UPDATE to FINAL

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Document Details

Name	Job Title / Role	Signature	Date
Authored By: **Alison Wilson**	Director of Pharmacy		30/04/2021
Approved By: **Dr Lynne McCallum**	Medical Director		26/05/2021
Approved By: **NHS Borders Board**	NHS Borders Board	At meeting	24/06/2021

Document Pathway

Document Pathway – Groups:-	Approved on:
Area Pharmaceutical Committee	27th April 2021
GP Sub-committee of Area Medical Committee	24th May 2021
Covid Recovery Planning Group	7th June 2021
Public Partnership Forum	17th June 2021
Area Clinical Forum	22nd June 2021 (virtual approval 14th June 2021)
NHS Borders Board	24th June 2021
File Location:-	borders\Pharmacy\Community Pharmacy\Pharmaceutical Care Services Plan\NHS Borders Pharmaceutical Care Services Plan\2021-22

Document Change Log

Version	Author/Contributor	Issue Date	Change
1.0	Alison Wilson; Dawn MacBrayne; Kate Warner	November 2020	Review content; update format, data sources and content.
1.1	Dawn MacBrayne; Adrian Mackenzie	December 2020	Updates to Community Pharmacy information/services
1.2	Keith Maclure	December 2020	Updates to GP based Pharmacy information/services
1.3	Lynne Amos; Adrian Mackenzie	December 2020	Care Home Services; CP/Vaccination Services
1.4	Cathryn Park/Kirsten Thomson	April 2021	Updates to Hospital Pharmacy Services
1.5	Alison Wilson	April 2021	Key Challenges / Conclusion / review all
1.6	Sonya Lam / Alison Wilson	June 2021	Suggestions from Board member including to align with SB H&SC Strategic Plan and NHS Borders organisational purpose
2.0	Pharmacy Senior Management Team	January-February 2022	Updates to Action Plans 2021-2024
2.0	Include Pharmacy Application Process at appendix 8	February 2022	
2.0	Minor updates and some suggestions from NHS Borders Board	February 2022	Coldingham closed; additional funding for WTE increase for care home pharmacy tech not received

Executive Summary

Introduction

NHS Borders provides health services to a population of approximately 115,500[1]. The local demographic profiles show that generally the population of the Scottish Borders is older than Scotland as a whole and is more rural[2].

From the evidence gathered and outlined in this plan, it is apparent that the current service provision is adequate for the populations' immediate needs and no major gaps have been identified.

NHS Borders Pharmaceutical Care Services Plan combines the six commitments from The Scottish Government's 2017 vision and action plan "Achieving Excellence in Pharmaceutical Care" with our own local healthcare requirements, objectives and action plans over the coming years. The Plan takes into account the NHS Borders Organisational Objectives 2020-2023 and Scottish Borders Health & Social Care Partnership Strategic Plan 2018-2021. Please follow links to Appendices for more information.

Each chapter in the plan refers to the visions below, addressing the current and future plans for NHS Borders. The Conclusion & Action Plans outline how the commitments will be addressed across 2021-2024.

1. **Improved and Increased Use of Community Pharmacy Services**
    - *Minor Ailment Service* (now called NHS Pharmacy First Scotland)
    - *Chronic Medication Service* (now called Medicines Care and Review Service)
    - *Independent Prescribing & Advanced Clinical Skills* (now called Pharmacy First Plus)
    - Public Health Service
2. **Pharmacy Teams Integrated into GP Practices**
    - GP Practice based Pharmacy
3. **Transformed Hospital Pharmacy Services**
    - Transformation requirements
    - Discharge Process
    - Quality improvement & performance measures
    - Modern Outpatient Programme
4. **Pharmaceutical Care that supports Safer Use of Medicines**
    - Data Measurement & Monitoring
    - Medicines Reconcilliation
    - Pharmacy Role Awareness
    - Quality Improvement in Community Pharmacy
5. **Improved Pharmaceutical Care at Home or in a Care Home**
    - Improvement Approaches
6. **Enhanced Access to Pharmaceutical Care in Remote and Rural Communities**
    - Recruitment and Retention
    - Availability of technology to support R&R

[1] Population estimate from National Records of Scotland, updated April 2020
[2] Scottish Borders Strategic Assessment 2020

Community Pharmacy – GP Practice-Based Pharmacy – Hospital Pharmacy

Figure 1 Integrated Pharmaceutical Care

Together all of these services play an important part by:

- Improving healthcare access for the public.
- Delivering safer use of medicines for patients.
- The right professional with the appropriate skill set delivering patient centred care.
- Making best use of a digitally enabled infrastructure.
- Improving medicine supply processes and enhancing delivery of pharmaceutical care.

Key Challenges

Previous Challenges Addressed

Each year, the Pharmaceutical Care Services Plan outlined challenges facing the Board. From the 2020/21 Plan, **the challenges have been addressed as follows**:-

Development of clinical services within communities.	COVID-19 and social distancing created many challenges. Pharmacy teams within community pharmacy and practices adapted their roles through use of Near Me for consultations; creating a hub model; remote logins to practices and using PPE. New services, such as NHS Pharmacy First Scotland, were introduced and the roll out of pharmacotherapy continued.
Developing and progressing the closer partnership working between GP practice and community pharmacies.	Although this slowed during the first lockdown, progress was made as outlined above.
Delivery of patient safety programme.	Medicines reconciliation measures are no longer required to be reported on nationally; awaiting update from the Scottish Patient Safety Programme. At BGH there has been a local focus on missed doses of medicines but impact of COVID-19 has limited progress.
Delivery of services to care homes.	Support was provided to care homes locally from the Lead Pharmacist and Care Homes Technician. Key areas of focus were end of life care and repurposing medicines to deal with urgent need in acutely unwell residents.
Demand for support with medicines.	Limited progress was made in this area due to the extreme pressure faced by community pharmacists during lockdown. Many community pharmacies had to change patient-facing opening times to enable them to source medicines and plan the day ahead.
Supporting community pharmacists through the independent prescribing course and utilisation of those skills when attained.	8 pharmacists are qualified as independent prescribers. Pads have been ordered for all 8 pharmacists under the Common Clinical Conditions code (now called NHS Pharmacy First Scotland). Data shows that 3 Pharmacists have been using these skills regularly up to March 2021 with others ready to start April 2021.

Future Challenges facing NHS Borders

Staff Recruitment, Retention and Training & Skills Gaps

- Recruitment and retention of staff to a rural health board and succession planning:-
  - Potential loss of aseptic services may make BGH pharmacy a less attractive place to work for junior pharmacists wanting to undertake core hospital training.
  - The need to shift the perception of pharmacy services from an operational to a clinical service with appropriate resource to embed this.
- Workforce and the increased demand for qualified pharmacists and pharmacy technicians largely created by the Primary Care Improvement Plan and the Pharmacotherapy service.
- Impact of an aging population on staff of working age to deliver care.
- Adequate resources to meet the education and training requirements of all staff.
- Changes to education and training of pharmacists and pharmacy technicians will require an investment in suitably trained staff.
- Emerging roles using the skills of pharmacist independent prescribers and ensuring gaps left behind are filled by suitably skilled and knowledgeable pharmacy technicians

Impact on Services

- Meeting the needs of service users whilst redesigning the acute pharmacy service.
- Potential impact of loss of aseptic services and impact on pharmacy services and Borders Macmillan Centre.
- Impact of an aging population and increasing demand from pharmaceutical services.

Pace of Digital Transformation

- Digitisation and automation to help increase the reach of pharmacy services in a rural area and improve sustainability.
- Digital transformation keeping pace with other acute pharmacy departments across Scotland.

Background

The Scottish Borders

The Scottish Borders has one Health and Social Care Partnership: Scottish Borders Council and NHS Borders, formed on 1st April 2016. The Scottish Borders Strategic Assessment 2020outlines the rural nature of the Scottish Borders. Almost half of the population live outside the main towns with no health and social care services close by.

Plans include more local care and support so that people can live more independently in their own homes and communities; more local services; making services easier to get to; more local support to help people stay well; sustainable transport links and more suitable places for people to live.

There are 5 main areas – known as Localities:-

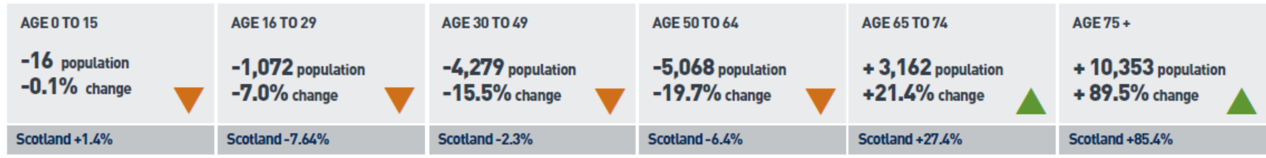
Berwickshire
Cheviot
Eildon
Teviot &Liddesdale
Tweedale

Locality populations outlined at APPENDIX-01

Figure 2 - Scottish Borders Localities Map

Population

The overall population of Scotland is expected to increase between 2014 and 2039 but the overall population of Scottish Borders is not expected to change significantly in the same period[3]. However, the constitution of the population by banded age group is expected to change significantly, with a drop in the proportions of children and working-age people and an increase in the proportion of pension-age people. These changes are expected to be more marked in Scottish Borders than in Scotland as a whole.



AGE 0 TO 15	AGE 16 TO 29	AGE 30 TO 49	AGE 50 TO 64	AGE 65 TO 74	AGE 75 +
-16 population -0.1% change	-1,072 population -7.0% change	-4,279 population -15.5% change	-5,068 population -19.7% change	+ 3,162 population +21.4% change	+ 10,353 population + 89.5% change
Scotland +1.4%	Scotland -7.64%	Scotland -2.3%	Scotland -6.4%	Scotland +27.4%	Scotland +85.4%

[3] Source: National Records of Scotland

Rural & Remote

The Scottish Borders covers around 1,827 square miles and is the 4th most rural area in Scotland with 30% of the population living in settlements of below 500 people[4]. The location of Community Pharmacies and the services provided by them is an important consideration in such a rural area.

Figure 3 Transport Links

In previous years, transport has played a key role in the access to all services in a rural location with 16% reporting issues with transport as a barrier to health. Post COVID-19, and with improvements in technology, fewer patients may travel to hospital as a centralised location. Issues for rural and remote patients must be addressed with different solutions.

This highlights the importance of access to pharmaceutical care through our Community Pharmacies and Dispensing Practices; as well as Prescribing Support services in GP practices.

Health

A key source for understanding health, care and wellbeing is the Scottish Public Health Observatory (ScotPHO profile) website[5].

- Male life expectancy in the Scottish Borders (78.6 years) is higher than Scotland's (77.1 years), although it can range from 73.5 years to 84.6 years.
- Female life expectancy in the Scottish Borders (82.6 years is higher than Scotland (81.1 years), however it ranges from 78.8 years to 83.5 years.
- The proportion of adults that self-assess their general health as "Good or Very Good" had decreased in the Scottish Borders over the last few years.
- More people in the Scottish Borders report a limiting, long-term health condition (29%) compared to Scotland (24.6%).
- Scottish Borders consistently has a lower rate of all-cause mortality in 15-44 year olds compared to Scotland.

Patient numbers with long term conditions can also be an indicator of ill health and the requirements of the local patient population. Charts detailing this can be found at APPENDIX-07.

[4] Source: Local Police Plan 2020-23 The Scottish Borders; Police Scotland
[5] https://scotland.shinyapps.io/ScotPHO_profiles_tool/

Deprivation

The Scottish Index of Multiple Deprivation (SIMD) looks at the extent to which an area is 'deprived' across seven domains: income, employment, education, health, access to services, crime and housing. Data zones in rural areas tend to cover a large land area and reflect a more mixed picture of people experiencing different levels of deprivation.

The SIMD2020 shows that 6% (9) of the 143 data zones in the Scottish Borders are part of the 20% most deprived of all of Scotland. A further 17% (24) of the data zones in the Scottish Borders are amongst the 2140 most deprived in Scotland.

The distribution of the 143 data zones in the Scottish Borders can be seen in the map[6] below.

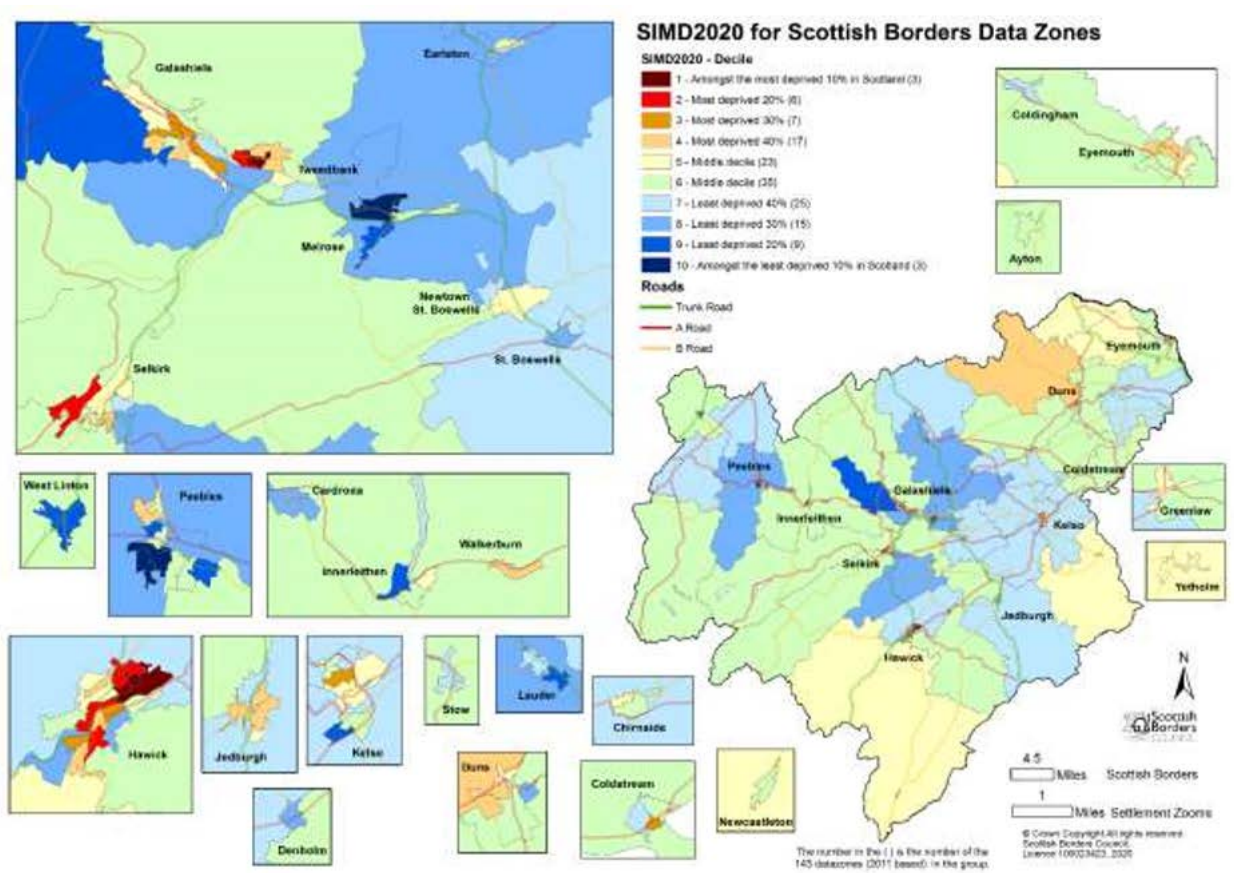


Figure 4 Index of Multiple Deprivation map Scottish Borders

In areas of deprivation, continuity of pharmacy services and pharmaceutical care is important to reduce adverse effects of taking multiple medications and hospital visits. In addition pharmacies provide an important public health role through smoking cessation, substance misuse, Sexual health services and provision of advice.

[6] https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/

Introduction to the Pharmaceutical Care Services Plan

Introduction

In a modern NHS, Community Pharmacists provide an accessible and convenient contact point for patients, offering high levels of expertise on the best use of medicines and drug technologies, vital to ensure quality patient care and best use of resources.

The community pharmacy contract underpins the approach to modernising community pharmacy services - both in the way that services are delivered by community pharmacists and how they are planned and secured by NHS Boards. There is a statutory duty on NHS Boards to provide or secure the provision of pharmaceutical services they consider necessary to meet local needs and publish plans for where and what pharmaceutical care services are to be provided in their area.

Figure 5 Community Pharmacy

This plan focuses on Community Pharmacy, ensuring that provision is based on locally identified needs and that patients have access to a full range of patient-centred and holistic services. It also details the relationship between Community Pharmacy, Hospital and GP Based Pharmacy to support the population of the Scottish Borders.

Aim of the Plan

The aim of the Pharmaceutical Care Services Plan is to identify the current and anticipated needs of the Borders population with reference to pharmaceutical care services and is subject to extensive consultation with professional and public partners. The plan should be embedded within the planning processes of NHS Borders in order that the necessary resources for implementation can be identified in subsequent health plans.

The Plan also reviews the enablers for pharmaceutical transformation[7], outlined below, and how these will be addressed by NHS Borders:-

- **Enhanced clinical capability and capacity – through pharmacy workforce**
- **Digital information and technologies through improved service delivery**
- **Sustainable services that meet population needs**

[7] Scottish Government Achieving Excellence in Pharmaceutical Care – Enabling Pharmaceutical Transformation

Current Pharmaceutical Service Provision

Current Service Provision - Community Pharmacy

Pharmaceutical care services are currently provided in the Scottish Borders by 29 Community Pharmacies and 2 Dispensing Practices.

Community pharmacies are independent contractors who provide a service to NHS Scotland in accordance with national regulation and locally negotiated contracts. All Community Pharmacies have submitted business contingency plans. Availability of a current plan is a requirement for any pharmacy participating in a local enhanced service.

In addition to the community pharmacy network, 2 GP practices (shown as '1' on map) hold dispensing doctor contracts (Stow and Newcastleton). These practices are contracted to dispense medicines for some or all of their patients. Dispensing doctors play an essential role in the dispensing and supply of medicines to patients in rural communities. *UPDATED 2021 – Coldingham closed.*

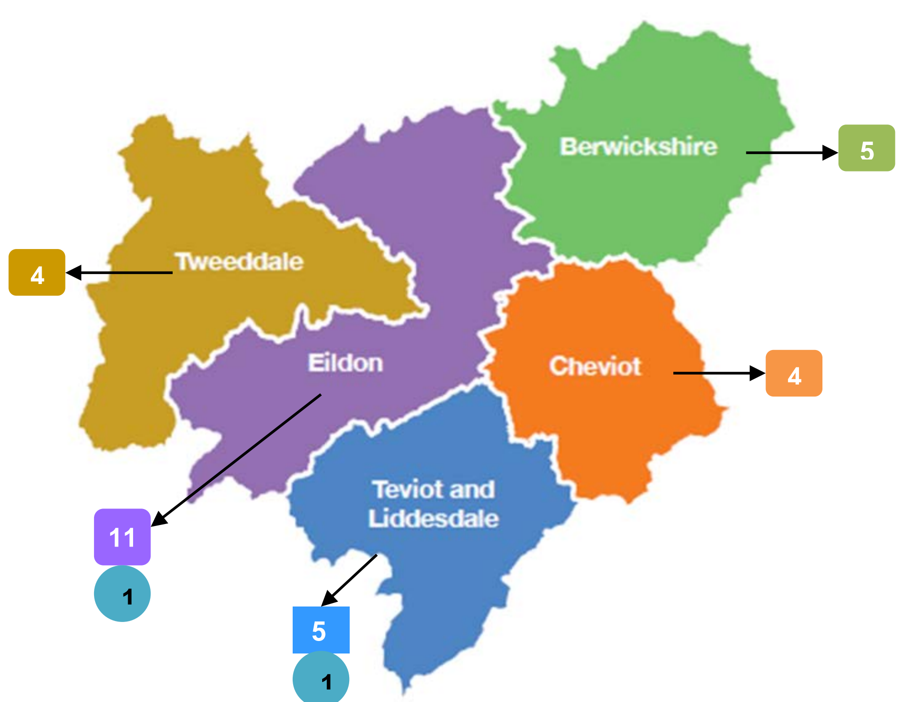


Figure 6 Community Pharmacy map Scottish Borders

The most recent Community Pharmacy Survey undertaken in July 2019 reported the following details for NHS Borders:

Health Board	Role	Headcount	Full Time Equivalent
Borders	Pharmacist	37	31.21
Borders	Pharmacy technician	38	30.10
Borders	Support staff	108	74.67

These figures demonstrate that 22.95% of the workforce is pharmacists in NHS Borders pharmacies compared to a Scotland average of 19.5%.

Compared to the previous survey in 2016, pharmacists appear to have seen a reduction in FTE since 2016. There has been a displacement of Pharmacists from Community Pharmacy to Primary Care[8] with the community roles being filled by less experienced pharmacists. The report also details the vacancy rate for pharmacists and locum pharmacists. For NHS Borders pharmacists it was 3.10% (range within Scotland was 1.71% - 13.85%) and for locum pharmacists 28.78% (0%-73.26%). These figures suggest that NHS Borders is in a much better position compared to other Scottish Health Boards.

Access to Pharmaceutical Care Services

The population of the Scottish Borders access pharmaceutical care services in line with the Hours of Service Scheme. Most GP practices are closed by 6pm, Monday to Friday. The hours of Service Scheme means that all community pharmacies are open for most of this period. The flexibility within the scheme means that pharmacies may be able to open earlier and remain open for longer at their own discretion.

Response to COVID-19 Pandemic

During the first lockdown in 2020, community pharmacy saw an increase in workload as many patients received earlier prescriptions or 2 months at a time. Access to GP surgeries was restricted and patients turned to the community pharmacist for advice and support. In order to support pharmacies manage the increased demand, the NHS Borders, along with other Health Boards, permitted pharmacies the option of temporarily amending their patient facing hours to allow them to prioritise their workload and undertake essential cleaning of areas to reduce virus spread. Not all pharmacies felt the need to reducing their patient facing hours and many pharmacies worked longer hours in the mornings and evenings to maintain services. There was some delay in pharmacies obtaining the right PPE in the early part of the COVID-19 outbreak which caused challenges with ensuring staff were adequately protected. Once the 1st lockdown was eased patient-facing opening hours reverted to normal and pharmacies were able to maintain this during the 2nd lockdown in 2021.

Community Pharmacy Service Availability

Each contracted Pharmacy in the Scottish Borders must open for five and a half days a week and opening hours should reflect the local GP Practice times. There are variations to these hours depending upon individual circumstances and applications for slightly shorter or longer hours have been made at various times to suit the local situation.

Saturday and Sunday opening provides Community Pharmacy cover across the localities. Many Pharmacies open during public holidays and this is publicised through NHS24 and NHS Borders communications. A rota is in place for Christmas and New Year holidays, for which a fee is paid, to ensure emergency cover is maintained. Weekend opening times for each locality at APPENDIX-02

[8] Community Pharmacy Workforce Survey 2019 - https://test1.nes.digital/pharmacy-report-2019.html

Accessible and Confidential Services

As a provider of health services, Pharmacies must adhere to The Equality Act 2010 which states that a person must not be treated in a discriminatory way because of a "protected characteristic" by service providers (including providers of goods, services and facilities) when that person requires their service. Pharmacies must take reasonable steps to provide auxiliary aids or services, which will enable their service to be accessible to all.

In order to provide many of the additional services available to patients, community pharmacies must have a suitable environment that offers the patient the privacy expected of such services. A consultation room or private area enables patients to have personal discussions with some privacy and other services, such as emergency contraception, can be provided in a confidential manner. Hand washing facilities is also required for some services.

A number of pharmacies are constrained by their premises. Some may make arrangements to see patients at the GP practice. Guidance on premises requirements is available to pharmacies and aids the planning of any future pharmacy premises or refurbishment.

Confidential and accessible facilities in Community Pharmacies at APPENDIX-03

Community Pharmacy Application Process

Updated February 2022

The Community Pharmacy Application process is included in this plan at APPENDIX-08.

Current Service Provision - GP Practice-Based Pharmacy

Integrating pharmacists with advanced clinical skills and pharmacy technicians was a key commitment within "Achieving Excellence in Pharmaceutical Care" and has been accelerated with the inclusion of Pharmacotherapy with the new General Medical Services contract of 2018. Recruitment and work has been underway since 2018 to achieve this aim and core services available are listed here. The plan sets out goals and aims for this service.

Current GP Cluster service cover diagram at APPENDIX-04

Core Pharmacotherapy Services

- Acute/Repeat prescribing requests
- Discharge letters
- Medicines Reconciliation
- Medicines safety reviews/recalls
- Monitoring high risk medicines
- Non clinical medication review
- Monitoring clinics
- Medication compliance reviews (patient's own home)
- Medication management advice and reviews (care homes)
- Formulary adherence
- Prescribing indicators and audits

Current Prescribing Support / Pharmacotherapy Team

The original Prescribing Support Team comprised 3 WTE Pharmacists and 2.4 WTE Technicians. PCIF and PCIP funding have added to the team and the planned Team will be 13 WTE Pharmacists and 13 WTE Technicians.

Currently NHS Borders has 10 WTE Pharmacists and 12 WTE Technicians (4.5 pre-registration).

NHS Borders Pharmacotherapy Team has Lead Pharmacists/Technicians in specialist areas:-

- Respiratory
- Diabetes
- Pain
- Stoma
- Controlled Drugs
- Scriptswitch
- Medicines Care & Review (Serial Prescribing)

NHS Borders has representation on the Scottish Practice Pharmacy & Prescribing Advisors Association and National Pharmacy Technician Group Scotland.

Current Service Provision - Hospital Pharmacy

Delivering Secondary Care Pharmaceutical Services

Pharmaceutical needs of patients are met in a variety of ways within a secondary care setting, including:-

- Medicines management & safe supply of medicines
- Guideline development & governance
- Patient facing roles
- Working within the MDT
- Aseptic services
- Outpatient / day case

Current BGH Pharmacy Services

There are 11 WTE Clinical Pharmacists, 17.3 WTE Pharmacy Technicians and 12.4 WTE Assistant Technical Officers (ATO) working in Borders General Hospital Pharmacy[9]; employing the following core departmental requirements:-

- Pharmacists and pharmacy technicians have joint professional responsibility for operational and clinical services within BGH for the procurement and safe supply of medicines.
- Effective teams with defined roles and shared objectives.
- Pharmacy technician and Pharmacist leads, for all relevant areas, with the ability to work autonomously to influence patient care delivery.
- Collaborative working between clinical and operational services.

Pharmacists and Technicians provide front line care; ensuring that medicines are prescribed with evidence based care and the most appropriate and cost effective interventions are provided. Achieving high quality, patient centred services that are safe, effective, sustainable and cost effective. Clinical pharmacy technicians work with patients and/or their carers to help them manage their medicines and work with Community Pharmacy, social care and primary care colleagues to support an integrated approach to the discharge process – across the interfaces of care.

The aim to create a technology enabled Pharmacy department was included in last year's plan and has started with the rollout of electronic ward cabinets in Wards 4, 5, 6 and Emergency Department. The next phase of the rollout was approved to include Wards 7, 9, 12, 14, Borders Stroke Unit/Margaret Kerr Unit, Intensive Care Unit, Theatres, Pharmacy Controlled Drugs and all four Community Hospitals. The introduction of the cabinets has demonstrated increased governance of medicine transactions; greater availability of patient level dispensing data for stock medicines; savings in Pharmacy and Nursing staff time; reduction in stock spend and better management of stock levels. The 2021-24 Pharmaceutical Care Services Plan aims to build on this and other successes to develop a digitally enabled workforce to release time for patient facing care.

[9] Staff numbers as at April 2021; WTE=Whole Time Equivalent

Pharmaceutical Care Services Plan2021-24 – NHS Borders

NHS Borders Pharmaceutical Care Services Plan aims to address the 6 commitments of the Scottish Governments' Achieving Excellence in Pharmaceutical Care[10]. Each commitment is addressed in this section – with Action Plans for each commitment at Action Plans 2021-24.

1. Improved and Increased Use of Community Pharmacy Services

The structure of the UK healthcare model places community pharmacy at the front line of healthcare delivery and are a key part of the NHS Scotland strategy around Reshaping Urgent Care. This is made possible by an expanding range of services coupled with a delivery model that is designed to maximise accessibility through appointment, free access and extended hours of opening.

Throughout the COVID-19 pandemic, community pharmacies continued to provide a key role in supply of medicines and supporting the population with health related queries when many other services had reduced to very limited face to face access. Pharmacy closures during this period were very rare and are a testament to the high standards of infection control measures implemented by pharmacy teams and the cooperation of the public during this time.

Major changes to services are listed below:

NHS Pharmacy First Scotland (NHS PFS)

The Scottish Government is committed to increasing access to community pharmacy services by developing and implementing redesigned minor ailment and common conditions services available to all. The focus is on the community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long term conditions.

Introduced in July 2020, NHS PFS replaced *the Minor Ailment Service* and is a **consultation service** provided by the community pharmacy team. The consultation can result in 3 outcomes:

TREATMENT **REFERRAL**

Advice will always be given. Treatment may be provided if appropriate. The medicine will be supplied free of charge from a nationally agreed Approved List or the patient may prefer to buy a product over the counter (for example, where the patient wants a specific branded medicine).

This is a National Service and all Community Pharmacies in NHS Borders provide this service.NSS Pharmacy Activity data is being monitored to evaluate how this service is being provided at

[10] https://www.gov.scot/publications/achieving-excellence-pharmaceutical-care-strategy-scotland/

[APPENDIX-05](#)and [APPENDIX-06](#)commentary on the evaluation is in the Data Measurement and Monitoring section.

Medicines Care and Review Service/Serial Prescribing & Dispensing

The Medicines Care and Review service (MCR), *previously named Chronic Medication Service*; aims to further develop the contribution of community pharmacists in the management of patients with long-term conditions. MCR supports patients to manage the medications they take for their condition. The pharmacist is responsible for: a review of the patient's medicines; production of a care plan within the pharmacy and; where appropriate, provision of a prescription to treat a stable long-term condition that lasts 24 or 48 weeks. This system allows for care of the patient with long-term conditions to pass to the community pharmacy. The data below shows that MCR dispensed items has increased from 1065 in week 45 2019 to 1515 in week 45 2020, an increase in MCR items dispensed of 42%.

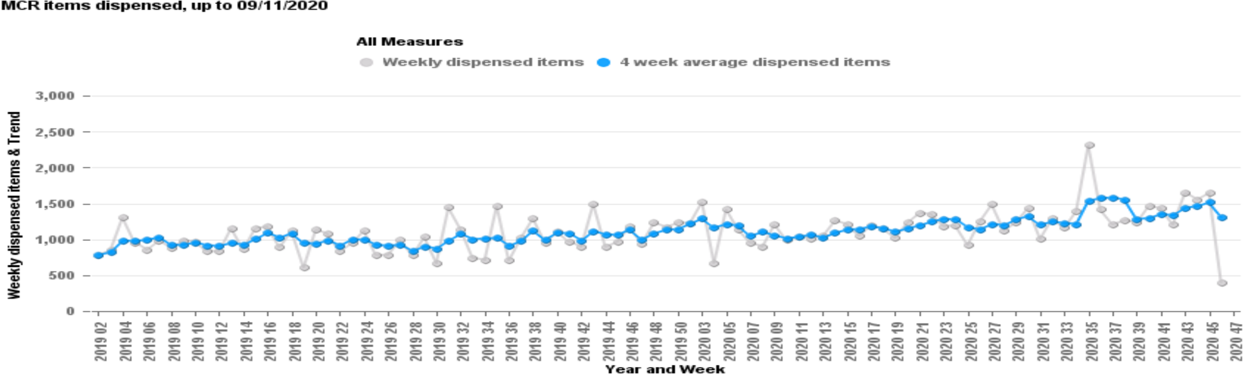


Figure 7 Medicines Care & Review Service to Nov 2020

Independent Prescribing & Advanced Clinical Skills (Pharmacy First Plus)

There are currently 8 independent prescriber community pharmacists (and 5 in training) that provide community pharmacy services in NHS Borders, covering 5 of the 29 pharmacies (14%). Recent changes through the introduction of Pharmacy First Plus, [PCA(P)(2020)16 - Independent Prescribing Service (NHS Pharmacy First Plus)](#), have provided a structure through which these independent prescribers can provide advanced skills and services within a community pharmacy. NHS Borders is working with these pharmacists to support and facilitate the provision of Pharmacy First Plus.

Public Health Service

Community pharmacists are highly accessible primary care practitioners and provide a unique opportunity to improve signposting and access to information and services. This includes the most vulnerable in our communities such as people with mental health problems, homeless people and substance misusers, all of whom might have difficulty in accessing mainstream healthcare. Public Health Services delivered through community pharmacy include: smoking cessation services; sexual health services; gluten free food services; unscheduled care services (CPUS); vaccination services.

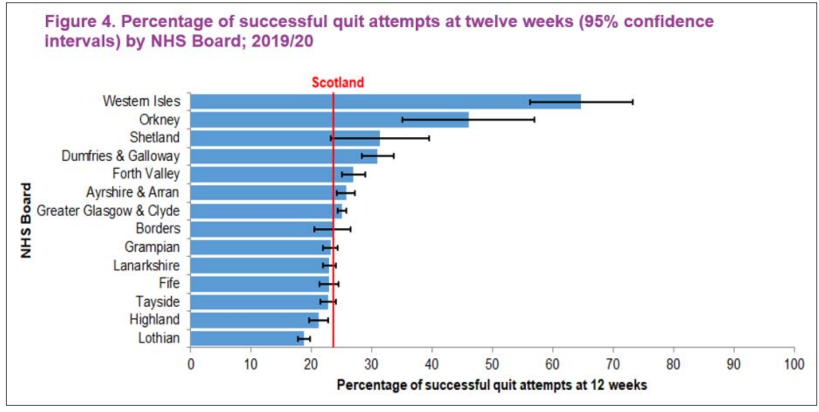


Figure 8 Smoking Cessation Service 2019/20

Looking at smoking cessation services, this table demonstrates that data for NHS Borders is comparable to the Scottish average when measuring successful quit attempts at 12 weeks.

The data has identified that the types of services accessed to support smoking cessation makes a difference, with those accessing specialist services twice as likely to be still not smoking after 12 weeks compared with those who use pharmacy based services (39.5% and 18.6% respectively). This represents a challenge going forward for pharmacy services to review delivery of the service to improve rates. Further details can be found at: https://beta.isdscotland.org/find-publications-and-data/lifestyle-and-behaviours/smoking/nhs-smoking-cessation-service-statistics-scotland/

Community Pharmacy Urgent Supply (CPUS)

Unscheduled care can be described as: "NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It follows that such demand can occur at any time and that services to meet this demand must be available 24 hours a day."

In the past the largest group of patients requiring unscheduled care tended to use one of the following routes: an urgent appointment with their GP; advice from NHS 24; referral to the Out of Hours service via NHS 24.Service developments, implemented within community pharmacy, have led to pharmacies becoming an important access route for people requiring unscheduled care particularly over weekends and public holidays.

The graph below shows the data of items dispensed by NHS Border pharmacies. The peak in supply during weeks 13 to 19 in 2020 demonstrate the significant part community pharmacies played in providing NHS services during the COVID-19 lockdown of March-April 2020.

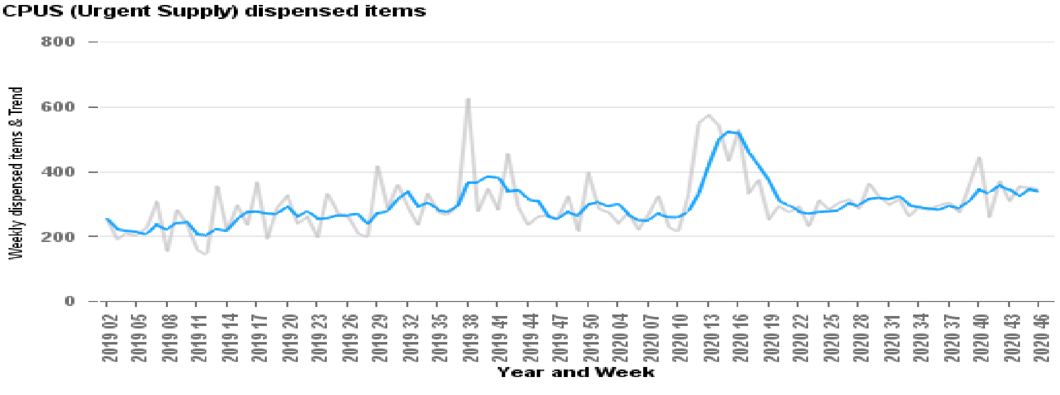


Figure 9 CPUS 2019/20

Universal Claim Form activitydetail can be found at APPENDIX-06with commentary in the Data Measurement and Monitoring section.

Vaccination Services

The 2018 General Medical Services (GMS) contract has specified that all vaccination programmes will be moved out of general practice by the end of 2021, with each Health and Social Care partnership responsible for the transformation of services. The COVID-19 outbreak in 2020 has impacted on the timescale of this however it still remains on course to happen.

As part of the response to COVID-19, NHS Borders in line with most other Scottish Health Boards commissioned community pharmacies to undertake an NHS Flu vaccination service building on the private flu service that many contractors had operated for a number of years. This supported NHS Borders in the first transition to delivering flu vaccination services out with GP practices.

The delivery of the flu vaccination programme and the success of private vaccination services through community pharmacy demonstrate the demand from the general public for these services and willingness for pharmacy contractors to meet the demand. As the Vaccination transformation Programme is taken forward it is hoped that community pharmacies will become a cornerstone in the delivery of vaccines in the future.

One of the obstacles in the way of a community pharmacy service that will need resolving is that currently pharmacies can only provide vaccinations as a private service in our pharmacies, due to the 1978 NHS (Scotland) Act which refers to 'medical practitioners' and those under their supervision as the only groups that the NHS can contract with for vaccination provision. During the COVID-19 period pandemic legislation allowed pharmacies to undertake vaccination services. However as we transition back towards normality this will need to be resolved.

In the 2020-21 Flu season 15 out of the 29 pharmacies in NHS Borders participated in the service and administered almost 1000 vaccines to Frontline Social Care Staff, Pharmacy Staff, Optician's staff and a mop-up of the Over 65s and Under-65s at risk. The service was well received by patients and staff who found pharmacy vaccination to be a convenient way to get vaccinated.

There is also a large amount of interest in how community pharmacy can support the widespread vaccination of initial doses and booster doses of COVID-19 vaccine as Scotland and the rest of the world works to control the COVID-19 virus. Plans are being discussed at an NHS Scotland level to look at how this can be taken forward nationally.

2. Pharmacy Teams Integrated into GP Practices

GP Practice Based Pharmacy

The Pharmacotherapy Team based in GP Practices is working towards achieving the desired outcomes of the General Medical Services (GMS) Contract – Pharmacotherapy level 1.

CORE AND ADDITIONAL PHARMACOTHERAPY SERVICES		
	Pharmacists	Pharmacy Technicians
Level one (core)	• Authorising/actioning[15] all acute prescribing requests • Authorising/actioning all repeat prescribing requests • Authorising/actioning hospital Immediate Discharge Letters • Medicines reconciliation • Medicine safety reviews/recalls • Monitoring high risk medicines • Non-clinical medication review Acute and repeat prescribing requests includes/ authorising/actioning: • hospital outpatient requests • non-medicine prescriptions • installment requests • serial prescriptions • Pharmaceutical queries • Medicine shortages • Review of use of 'specials' and 'off-licence' requests	• Monitoring clinics • Medication compliance reviews (patient's own home) • Medication management advice and reviews (care homes) • Formulary adherence • Prescribing indicators and audits

Figure 10 Pharmacotherapy Services Level 1

The practice-led pharmacy service ensures that the team work to the top of their licence and incorporates the principles of Realistic Medicine. One aim is to have appropriate tasks done by well-supported, experienced Technicians. Pharmacy Assistants (x6) will also contribute to the roles in the Pharmacotherapy Team. Nationally the aim for the Pharmacotherapy Team is to have 1:5000 list size – patient facing. Currently NHS Borders is around 1:6,500.

The following table gives an indication of the type of work which would be expected at each level. It is not a complete list and it is important to note with all staff there will be an initial learning/development phase, where team members develop competency and capability in their tasks. This is particularly relevant to students, but still applies to Pharmacist Independent Prescribers being asked to prescribe either a drug new to them or in a new clinical situation. Training & development should become increasingly self-directed through the Agenda for Change banding system.

Staff Member	Work expected at this level/band
Student Technician (Pharmacotherapy Assistant)	• Routine tasks; following standard operating procedures; will coordinate the collection of information, input and provide basic data, update clinical records as appropriate and collate information in support of quality medication reviews. • Be a point of contact for the pharmacy team, on areas such as supply problems, issues with prescriptions. The role will be to triage the information to the most appropriate member of staff. • Specific tasks allocated by line manager to support senior Pharmacotherapy staff. • Discuss use of medicines over the phone with patients. • Competencies to allow completion of Pharmacy Technician college course. • Ad hoc tasks as agreed with line manage/mentor and having received appropriate

	training.
Technician 4	• Work through Vocational program from NES. • All Level 1 Pharmacotherapy tasks after demonstrating confidence & competency (evidenced and signed off by line manager). • Protocol-led project work to support cost-effective, realistic medicine, e.g. dose optimisation, drug switches (including Scriptswitch), Formulary compliance. • Supporting practices to do Non-clinical Medicine Reviews. • Tasks allocated by line manager to support senior Pharmacotherapy staff, e.g. Scriptswitch, processing prescribing reports. • Drug searches to support Quality Improvement projects, prescribing indicators and audit. • Medicine Reconciliation work to support patient Primary-Secondary Care interface, including Care home work, processing Treatment Summary Reports/ supporting MCR etc. • Medicine shortages support work – liaison with Community/Industry where appropriate.
Technician 5	As per 4, plus: • All Level 1 Pharmacotherapy & Level 2 & 3 Technician tasks. • Care home review and Care at Home projects • Identifying and prioritising Technician work, development of Technician-led projects (e.g. Care home reviews). • Supporting work for the Gluten-Free Food Service and Scriptswitch. • Specials (unlicensed medicine) authorisations and follow up. • Line manager to Band 4's. • Prescribing Reporting management. • National User Group representation for assorted IT systems and policy.
Pharmacist 6	• On final rotation from BGH clinical team • Clinical support to Technicians for core PST work. • Medicines Reconciliation, if required, to support Technicians & other Team Pharmacists. • Community Hospital discharge liason with Care at Home project. • Medicine reviews and efficiency projects to support General Practice • Following NES Vocational Training . • Level 1-2 Pharmacotherapy– only completing activities where competency and confidence is established.
Pharmacist 7	As B6, plus: • Interim Care bed & Community Hospital pre-discharge reviews (MDTs?). • Polypharmacy 7-step review/MUR Reviews to support 8A's. • Helping 8A Specialist with project reviews and staff training.
Pharmacist 8A	As B7, plus: • Identifying individual practices variation. • Devising, negotiating and managing projects to improve practice performance. • Level 1-2 Pharmacotherapy– only completing activities where competency and confidence is established. • Leading on the main National Strategies: Respiratory, Diabetes & Pain, as well as more recent publications such as the Stoma recommendations, with subsequent input to the local MCN/Formulary sub-groups. • Line management of pharmacists.
Independent Prescriber Pharmacist	• Level 1-3 Pharmacotherapy– only completing activities where competency and confidence is established. • Following the national GP Practice Pharmacist competency framework guidance (currently under development).
Pharmacist 8B	As per 8A plus: • Team lead and line manager. • Strategic reviews & planning. • Representing Medicines Management at Board meetings. • Negotiating and planning Enhanced Services. • Representing NHS Borders at National Pharmacotherapy Oversight Groups • Financial forecasting and analysis.

3. Transformed Hospital Pharmacy Services

For our hospital pharmacy service to be most effective, the level of our work needs to be manageable in order to deliver safe and effective pharmaceutical care. Part of the plan for hospital services includes defining and publicising the role of pharmacy services to the organisation, ensuring that work is efficient, minimising reactive workloads where care of patients is planned, and developing performance indicators.

Transformation requirements

- Development of technology enabled care (e.g. electronic prescribing, robotics) to enable pharmacy staff to be available on the ward, assisting people to achieve the best outcome from their medicines.
- To support advanced practice of pharmacists and pharmacy technicians through investment of education and training for all staff.
- Integration to multi-disciplinary teams to support safe prescribing and administration of medicines at ward levels.
- Support all pharmacists to become independent prescribers with full integration to clinical multi-disciplinary teams.
- Ensure the pharmaceutical care needs of complex patients are targetted using triage processes for pharmacists and pharmacy technicians (e.g. polypharmacy, multiple comorbidities, organ failure, frail and vulnerable).
- Review benefits of a 7 day pharmacy clinical service aligned to local organisational developments.
- Support local delivery of realistic medicine within BGH.

Discharge Process

The BGH pharmacy team will ensure the supply of medicines at discharge is efficient and safe. As the role of the primary care pharmacy teams develop, there is an identified need to minimise duplication of workload around the medicines reconciliation process for the hospital pharmacy team. This will be reviewed as follows:

- Digitally enabled, improved communication between secondary care, primary care and community pharmacy
- Medicines management support, assessment and sign posting
- Development of clinical pharmacy technician patient centred roles to facilitate safe supply of medicines at discharge
- Develop a range of discharge processes that meet the needs of individual patients (e.g. pre-packs for independent patients) in line with contractual changes within community pharmacy services
- Review the role of the clinical pharmacist in the discharge process to minimise duplication of medicines reconciliation between primary and secondary care

The Prescribing Support Team in NHS Borders process hospital discharge letters and medicine reconcilliation as well as supporting practice staff to complete Non-Clinical Medicine Reviews. This

frees up GP time whilst maintaining accuracy and patient safety in admission and discharge process. It forms part fo the Pharmacotherapy service detailed in commitment 2.

Quality improvement & performance measures

- Identify areas for improvement and develop subsequent audit plans through medicines governance groups
- Revamped medicines safety programme wider than medicines reconciliation.
- Engagement with non-pharmacy key stakeholders to embed and improve medicines governance across BGH with identified outcome measures
- Ensure all pharmacy staff have a role in quality improvement with understanding of the methodology
- Support development of research skills and advanced practice of pharmacy staff in partnership with academia

Modern Outpatient Programme

With the driver for patients to receive more complex drug therapies at home there will be opportunity for pharmacists to work at an advanced level to facilitate this by engagement with clinical specialities. This will facilitate more cohesive multidisciplinary team working to create opportunities for advanced practice in line with local organisational developments.

4. Pharmaceutical Care that supports Safer Use of Medicines

Data Measurement & Monitoring

Community Pharmacies use a Universal Claim Framework (UCF) that allows pharmacies to claim payment for pharmacy-led services such as: NHS PFS, unscheduled care, public health services and gluten-free food service (GFFS).APPENDIX-06 demonstrates how NHS Borders compares to all other Scottish Health Boards for these services. At present it is difficult to interpret this data due to Health Board variables but it will be useful to look at trends in the data in the future

An example of how this data has been used to monitor pharmacy activity and provide feedback to prescribers/dispensers is described below. The graph below shows choice of treatment in smoking cessation services demonstrating that only 16.1% of all items were for the first-line choice varenicline (compared to a Scottish average of 17.8%).

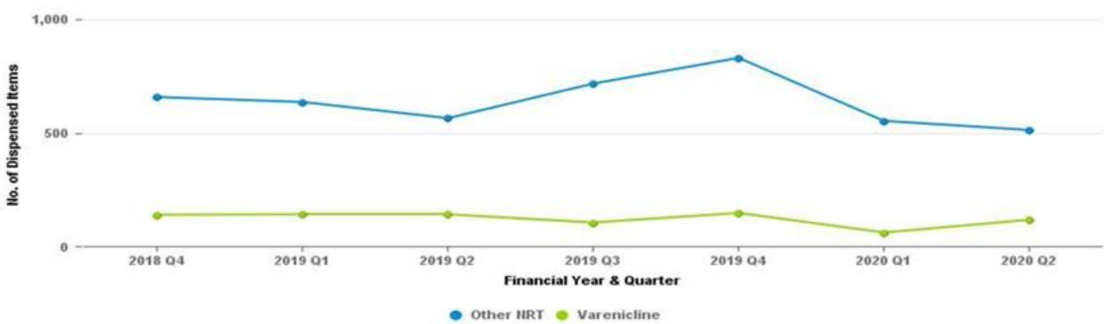


Figure 11 Example of pharmacy activity and monitoring

This information was fedback to community pharmacies with guidance promoting a change in clinical behaviour. NHS Borders will develop a feedback system that facilitates changes in line with clinical recommendations.

Did you know?

- Varenicline is first choice in the Borders Joint Formulary.
- Data shows that smokers are more likely to successfully quit using varenicline plus behavioural support (see chart).
- A study published in the Lancet reported that varenicline was not associated with a significant increase in neuropsychiatric events compared to placebo[1].

1. Lancet 2016; 387:2507-20

Figure 12 Educational message sent with data feedback

Data monitoring systems have been established to allow, for example:

- Adherence to the GFFS formulary by the lead dietitian
- Monitoring of smoking cessation data by Smoking Cessation Services
- Adherence to the National Approved List for NHS PFS

Medicines Reconcilliation

There is an identified need to minimise duplication of workload around the medicines reconcilliation process for the hospital pharmacy team and the planned review is outlined under the Discharge Process.

Pharmacy Role Awareness

One positive that be taken from the COVID-19 pandemic of 2020 is the increased awareness of the services that community pharmacy can provide. The general public are now much more aware of the breadth of service provison.

A recent study undertaken by Community Pharmacy Scotland outlines the "soft skills" that are important and make community pharmacy services valued:

- 80.5% of people accessing community pharmacy rated complete satisfaction of their overall experience
- 57% access community pharmacy because of the existing relationship with the pharmacy team
- 41% of people would go to their GP if community pharmacy was unavailable.

The research also found that 93% of people want their GP and pharmacist to work closer together. Initiatives such as the NHS PFS has helped to integrate services and NHS Borders has work with GP practices and Optometrists to explain the service and how referral between professions work.

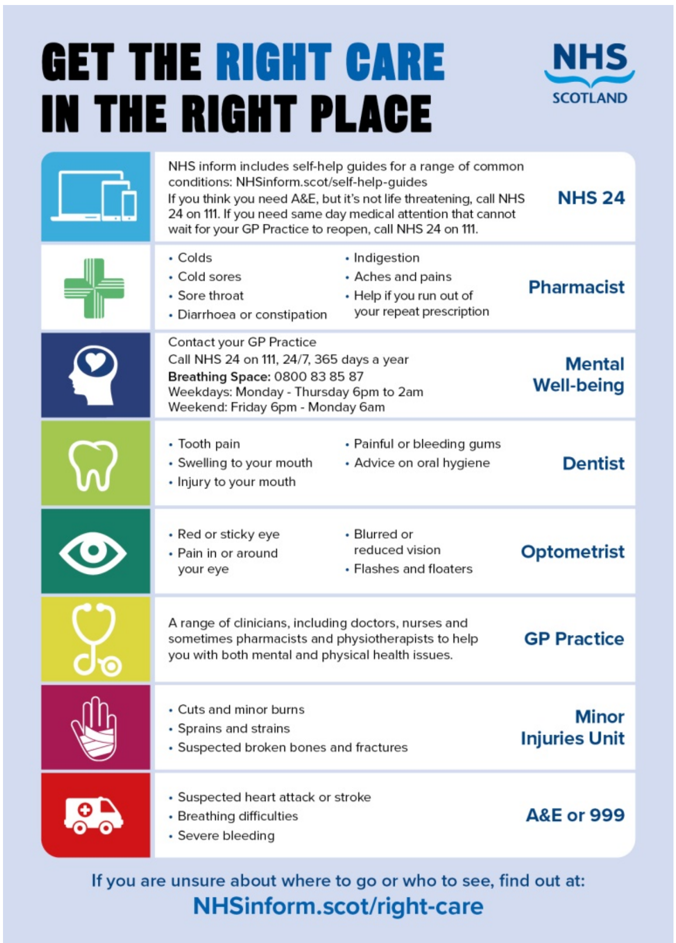


Figure 13 NHS Services communications - urgent care

This "at a glance" guide to NHS services is part of a communications toolkit designed to raise awareness about a new approach to accessing urgent care. As you can see, Pharmacy has a prominent position in this new approach.

Quality Improvement in Community Pharmacy

The COVID-19 pandemic has re-enforced the need for preparation and continuity planning. All Community Pharmacies were provided with a Business Continuity Plan template to help them plan for potential significant disruption to the delivery of the health care services. A Memorandum of Understanding (MOU) was also drawn up to allow agreement between Community Pharmacies and NHS Borders on temporary reassignment of registered pharmacists/technicians to assist with business continuity.

As higlighted above in the Data Measurement and Monitoring section, analysis of community pharmacy activity will continue to be used to improve service delivery.

The Community Pharmacy Funding Settlementfor 2020-2023[11]contains a Quality Improvement element. Funding for 2020 is provided to support implementation and training for NHS PHS and participation in a NES workforce survey. These quality improvement activities will help to inform service development.Pharmacy's professional body, the Royal Pharmaceutical Society is calling for "all pharmacists to have access to protected learning time (PLT) to support and enable their professional development". NHS Borders supports the wellbeing agenda and will work to support the development of PLT processes.

[11]https://www.cps.scot/media/3134/pca-p-2020-2-community-pharmacy-funding-settlement-2020-21-2022-23.pdf

5. Improved Pharmacuetical Care at Home or in a Care Home

Improvement Approaches

The provision of services to care homes was audited during 2018-19 and throughout 2019/20 and 2020/21 the following priorities have continued to be monitored:-

- Delivery of high quality pharmaceutical care
- Recording of outcomes
- Reducing medicines waste

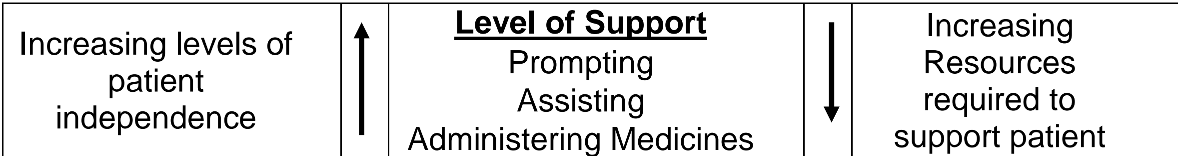
The Integrated Care Fund Project worked with Health & Social Care to review the Medicines Administration Charts (MAR) – a service to support home carer administration of medicines – and to improve joint working within the multi-disciplinary team to ensure patients are supported safely to be as independent as possible. This work continues now with the Pharmacotherapy Team.

Project Introduction

Our frailest patients outside of the hospital environment are looked after either in their own homes or in Care Homes, yet this is the only location where patients do not receive regular face to face pharmaceutical care input tailored to them as individuals. Many of these patients are at risk of adverse effects due to their frailty and multi morbidity.

The pressure in Social Care services is also felt by Pharmacy as the increasing elderly population, on multiple medications, results in more patients who require support to take their medicines and support re-ablement, promote independence and self care. Many patients receive social care visits to support them with their medicines, with no reviews of the medicines which may lead to a reduction in the number and/or need for visits or the length of visits due to the number of medicines.

The table below shows the effect of different levels of input on patient independence and resources.



Increasing levels of patient independence	↑	**Level of Support** Prompting Assisting Administering Medicines	↓	Increasing Resources required to support patient

It has become apparent that many carers and social care workers have issues around medicines management and that advice from a member of pharmacy staff who understands the issues related to care providers is necessary to reduce risk to patients and staff administering medicines.

Medicines Management Project

In 2018 to 2020, Pharmacy led a medicines management project, which explored how to further support patients who require assistance with taking their medication. This project was funded by the Integrated Care Fund (ICF) and aimed to demonstrate the benefits of providing pharmaceutical advice into social care decision making for patients who need support to take their medication.

The project supported Social Care & Health Care Management to ensure that appropriate medicines management assessments were undertaken for all patients who were being supported or likely to be supported with medication tasks by a social care provider. The project team also provided medicines management advice to care providers along with medication training to support workers in care at home and care homes.

Supporting Independence remains a focus as an outcome of an assessment and with appropriate methods of dispensing and the use of appropriate tools to support independence; this reduces the need for support from a care provider.

The project focused on care at home and also included enablement within the transitional care facility at Waverley Care Home and discharge to assess unit at Garden View. The aim of the project was to also identify the resources needed to develop the support beyond the project areas.Evidence in the project supports benefits to patients following a joint Health & Social Care approach to the assessment of patient's needs in relation to medicines management, focusing on independence and self care.

At the point of assessment the benefits of a medicines review will contribute to reducing harm to patients from their medicines and may result in patients being prescribed fewer medicines, improve patient safety and reduce errors. This could support independence, support family in assisting with medication and could result in a reduction of medication tasks where other support is required.

Recommendations from the project

- Funding should be identified to continue pharmacy technician support to liaise with Scottish Borders Council Contracts Manager and Care at Home Providers to provide support, individual patient assessments and advice.
- Consideration should be given to providing refresher training to all care at home providers which focuses on outcome of screenings/assessments, definitions of prompt, assist and administer and levels of need. This will ensure consistency of approach with medicines management across Scottish Borders.
- Any future work to implement this must include 1 WTE pharmacist to ensure that a review of medication, in line with best pharmaceutical care takes place. This review will also contribute to ensuring that the objectives outlined as part of the project are delivered.
- Support should be provided to all localities within Scottish Borders Council which would require an additional pharmacy technician resource (1 WTE) giving a total of 2 WTE of pharmacy technician time. It is recommended that due to logistics and cover across the area that this will involve a head count of more than 2 individuals.

As yet, no funding has been approved by the ICF, however 1 WTE Pharmacy Technician, specifically designated to care homes and care at home, was recruited in 2019, as part of the pharmacotherapy team.

The work carried out by this pharmacy technician is restricted due to capacity, but includes providing advice and support on medicines management to:

- social care assessors
- care providers
- community pharmacy
- pharmacotherapy team

This advice includes resolving issues to ensure the correct support worker medication tasks are in place which enable independence, where appropriate, and ensure medicines are taken as prescribed.

The pharmacy technician liaises with pharmacotherapy colleagues to ensure medicines reviews are carried out in the care at home patients they had involvement with and co-ordinates regular medicines reviews in care homes. The work carried out by the pharmacy technician at the moment is limited to providing advice and carrying out medicines assessments for complex cases only. If funding was to become available for further technicians to be recruited, this would enable more support to be provided to social care and health, including:

- Carrying out medicines assessment visits on all service users identified as requiring support with medicines. The purpose of the visit is to:
  - Visit the person in their own home to provide advice on why they take each of their medicines and when/how they should take them.
  - Discuss the medicines currently in their home and removing any that are no longer prescribed.
  - Determine the person's ability to manage their medicines independently and provide advice on appropriate aids.
  - Establish the correct level of medication support that may be required from social care to enable the person to take their medicines correctly.
  - Review a person's medication to ensure the minimum doses are required which in turn may reduce carer visits.
  - Feedback the outcome of the assessment to social care to enable the person's support plan to be updated accurately.

The overall aim of the assessment visit is to ensure the person takes their medicines correctly and decrease the chance of them becoming ill or being admitted to hospital due to medicines mismanagement.

Providing advice on medicines management training and protocols to social care & health. This could enable continuity over all service providers.

6. Enhanced Access to Pharmaceutical Care in Remote and Rural Communities

Due to the rural nature of the Scottish Borders, in previous Pharmaceutical Care Services Plans, transport has been a key part of access to services. With COVID-19, expectations of access have changed with communities relying more on their local services (often Community Pharmacy) and increasing use of technology to overcome distance. During the pandemic Community Pharmacies and volunteers provided an extended delivery service, at not inconsiderable cost, which some patients still rely on.

As a short-term COVID-19 response, an NHS Scotland Funded delivery service was comissioned nationally from January to March 2021. Delivery services in the long-term are not a funded NHS service nor a contractural obligation and could be withdrawn at any time.

Consideration is given in the Plan to the travel time to a Pharmacy with 20 minutes average journey time deemed reasonable with the size and nature of the Scottish Borders. Access coverage in this map - using 20 minute isochrones. A single green circle = 1 Pharmacy; others indicated by numbers.

Figure 14 Access to community pharmacies map

Out of hours / unscheduled care / Pharmacy First services provided by Community Pharmacies, particularly on Saturdays, enables access to more local services for rural and remote communities.

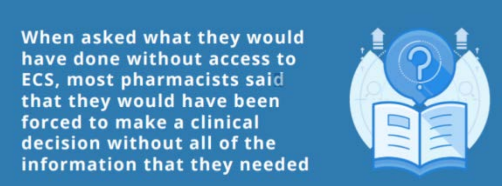
Recruitment and Retention

Scottish Government in circular PCA(P) 2020 (16)1[12] indicated the intention to establish a National Community Pharmacy Early Career Framework[13]. This framework would bring together the National Post-Registration Foundation Training programme for newly qualified pharmacists currently provided by NES and the Independent Prescriber course, creating a simple pathway to maximise the pharmacists' expertise in medicines and, with the introduction of the new NHS Scotland Pharmacy First Plus service, the opportunity for pharmacists to further enhance patients' care.

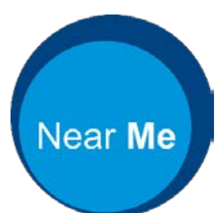
Community Pharmacy Scotland (CPS) and the Scottish Government (SG) have agreed to provide funding to support the establishment of the National Community Pharmacy Early Career Framework. This funding will be made available in the form of a monthly grant to contractors who provide the support, detailed in the agreement, to each of their employed pharmacists undertaking the National Post-Registration Foundation Training Programme.

Availability of technology to support Rural &Remote

The Emergency Care Summary (ECS) was made available to Community Pharmacies during the COVID-19 lockdown of March 2020. This national system allows pharmacies to deliver enhanced and efficient patient care by enabling them to access patient records no matter which Board they live in or Community Pharmacy they present at. A survey undertaken by Community Pharmacy Scotland demonstrated the benefits of access to ECS with the following findings:



Use of the ECS is monitored by NHS Borders and, at present, use is low. NHS Borders will continue to monitor to ensure all community pharmacies maintain their ability and skills required to access the information and will promote use through educational programmes.

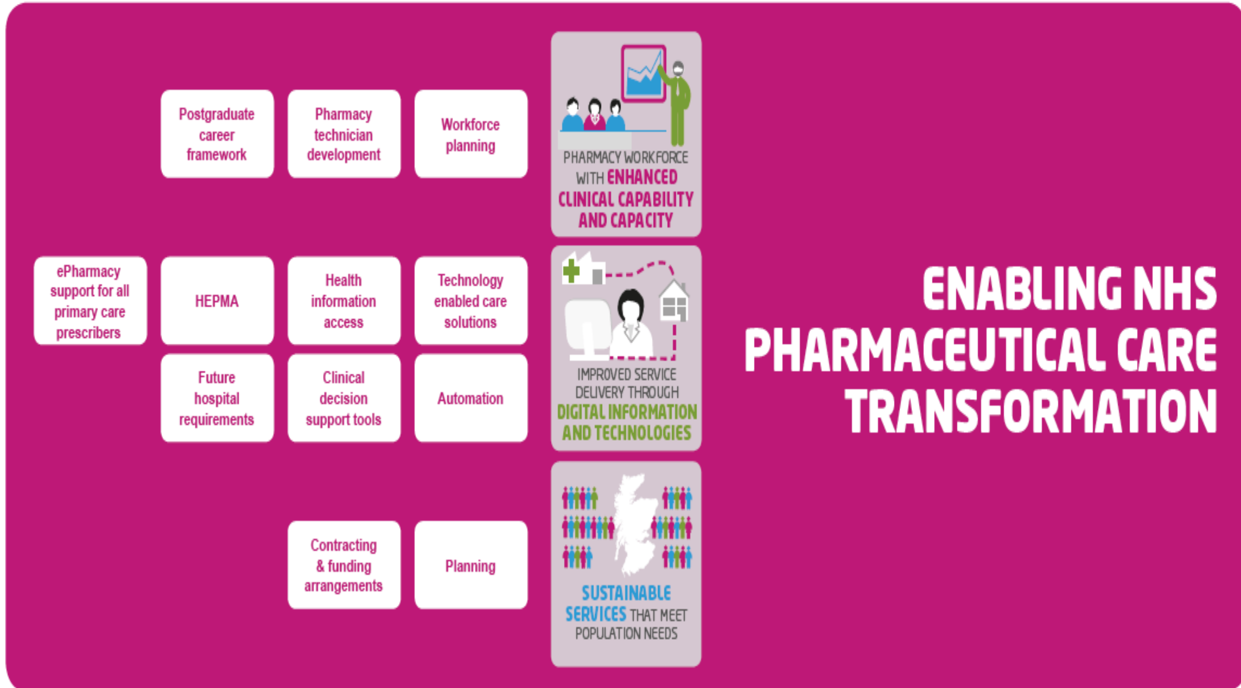


NearMe is NHS Scotland's video consulting service. It is valuable technology that allows access to care for patients who find it difficult to attend health care premises and, in times of the COVID-19 pandemic, can be used to reduce exposure to the virus for both clinicians and patients.

NearMe technology was made available to all NHS Borders Community Pharmacies in July 2020. Fifteen (50%) of community pharmacies have so far signed up to use the technology. NHS Borders have offered training sessions to promote its use, provide support and continue to monitor access.

[12] https://www.cps.scot/media/3696/circular-pca-p-2020-16-national-career-pathway-and-introduction-of-a-common-clinical-conditions-independent-prescribing-servi.pdf
[13] https://www.cps.scot/news-insight/news/early-career-framework-for-community-pharmacists-in-scotland/

Enabling NHS Pharmaceutical Care Transformation



Enabling NHS Pharmaceutical Care Transformation provides three final commitments in the vision for Achieving Excellence – outlining the changes to the planning and delivery requirements for sustainable NHS pharmaceutical care. This will be achieved by NHS Borders Health & Social Care Partnership taking a proactive approach to planning and delivery and creating an integrated role for pharmacy across all healthcare settings.

The following three enablers have been identified by Scottish Government to ensure that pharmacy teams have the resilience to be able to respond and adapt to the changing needs and pressures.

1. Pharmacy Workforce - with enhanced clinical capability and capacity
2. Improved Service Delivery – through digital information and technologies
3. Sustainable Services – that meet population needs

Areas and actions can be found at:-

2021-24 PLAN for Enabling NHS Pharmaceutical Care Transformation.

Conclusion

NHS Borders Pharmaceutical Care Services Plan 2021-24 addresses the six commitments from "Achieving Excellence in Pharmaceutical Care" and combines those with the NHS Borders Clinical Strategy/Health & Social Care Plan – Statement of Intent.

From the evidence gathered and outlined within this plan, it is apparent that the current service provision is adequate for the populations' immediate needs. No major gaps have been identified.

Changes to the pharmacy contract, and its associated care services, has provided the platform for community pharmacy services to continue to develop significantly. Community Pharmacies have, made a fundamental contribution to the health of the population in the Scottish Borders, particularly throughout the COVID-19 pandemic.

The future of community pharmacy services in the Scottish Borders will be shaped by the projected increase and ageing of the population; the on-going work required around the pandemic; and changes to the GMS contract. There will be additional opportunities and challenges for pharmacy to support vaccination, pharmacotherapy and multi-disciplinary work.

Evidence highlights some potential risks to community pharmacy in the short to medium term, such as recruitment and retention of staff. These challenges must be addressed as part of the on-going service development – with a focus on equal opportunities and meeting the changing needs of the population.

Action Plans 2021 - 2024

Action Plans for all six commitments are outlined on the following pages. There is a colour code for the following three years and when Actions are expected by – **2021/22**; **2022/23**; **2023/24**. ***The Pharmaceutical Care Services Plan Actions will be reviewed and updated annually.***

Date	Review Details
January 2022	All Action plans to Senior Management Team for update
March 2022	All Action plans updated and reviewed

Action Plans 2021-2024

The following tables outline the Action Plans for each of the 6 commitments over the coming three years and finishes with the plan for Enabling NHS Pharmaceutical Care Transformation.

1. PLAN for Improve and Increase Use of Community Pharmacy Services

2021/22 - 2022/23 - 2023/24		Update April 2022
NHS Pharmacy First Scotland (NHS PFS)	1. Use Universal Claim Form data data to monitor NHS Pharmacy First Scotland service provision. 2. Monitor National Approved List compliance. 3. Develop and share educational messages to community pharmacy teams.	1. On-going; UCF activity data is provided and monitored monthly. It is made available to all community pharmacies through NHS Borders community pharmacy webpage and presented at the Area Pharmaceutical Committee and Community Pharmacy Borders committee meetings. New data analysis is currently being developed to monitor trends in each individual community pharmacy. 2. COMPLETE – there is no payment for non compliance. 3. COMPLETE - Worked with Midwifes to produce guidance on management of dyspepsia, thrush and constipation in pregnant women to support them being treated through Pharmacy First. On-going; continue to work in other clinical areas to support/build confidence in specific patient groups and the wider population.
Medicines Care and Review Service (M:CR) (including serial dispensing)	1. Monitor use and identify areas of low uptake. 2. Support engagement between GP practices and Community Pharmacies. 3. Audit use of PCR in community pharmacy.	1. On-going. 2. COMPLETE - Work with Pharmacotherapy Team to promote use of MCR. Good engagement from GP practices and community pharmacies to increase use. Champion Pharmacist role engagement increased. 3. Monitoring the use of PCR to record elements of GFF service and following up where data is not input/updated.
Independent	1. Provide support through provision of service	1. COMPLETE - Approval to Practice documentation has been

Prescribers (Pharmacy First Plus)	specification. 2. Establish clear peer review process. 3. Facilitate and encourage training of pharmacists. 4. Audit provision of service. 5. Establish provision of service in each locality. 6. Establish provision of service in 50% of community pharmacies.	developed to meet the governance needs of NHS Borders. 2. COMPLETE - All PIPs and trainees are invited to attend a two monthly peer review process facilitated by NHS Borders. This has been well attended. Pharmacists share best practice and discuss elements of the service. 3. On-going; supporting pharmacies to identify training required and facilitate accordingly; including providing and attending Teach and Treat Hubs. 4. COMPLETE - Prescribing data is provided monthly and reviewed within the peer review session. 5. On-going – 5 pharmacies providing – Lauder, Earlston, Duns, Selkirk and Greenlaw – 3 out of 4 localities covered (West pharmacist is undertaling IP training). 6. 5 out of 29 pharmacies so far = 17%; 2022 x 3 IP pharmacists adds 3 locations = 27%
Public Health	1. Monitor according to national targets for smoking cessation 2. Support engagement between Well Being Service and Community Pharmacies. 3. Monitor formulary compliance for smoking cessation,Emergency Hormonal Contraception and Gluten Free Food Service. 4. Produce regular compliance report for dissemination to Community Pharmacies. 5. Ensure Pharmacy entries are kept up to date on NHS Inform 6. Support the roll out of the extensions to the sexual health service to include supply of contraception and training on supporting people affected by sexual assault. 7. Support the development of vaccination services via community pharmacies as part of the	1. On-going. 2. COMPLETE - Review of activity has resulted in plans for the Well Being Service to provide additional pharmacy support for 2022-23. Includes marketing, advertising, introduction of referral forms and short educational online training sessions. 3. On-going; smoking cessation and emergency hormonal contraception monitored through UCF activity data. Data on patients using the GFF is fedback to community pharmacies to facilitate the annual health check. 4. COMPLETE - This relates to formulary choice for smoking cessation but as the first choice is no longer available the report is not necessary at this time. 5. On-going; Pharmacies inform NHSB and NHS Inform of any changes to details. 6. COMPLETE – contraception rolled out; training on sexual health being produced by NES 7. On-going; 1 pharmacy delivering travel health services;

	response to COVID and the roll-out of the Vaccination Transformation Programme.	encouraging more to deliver in 2022. 9 pharmacies delivered flu vaccination services for 2021/22- providing 2,400 vaccinations to end December 2021; other pharmacies do not have the space/staff resources to deliver.
Community Pharmacy Engagement	1. Continue to engage Community Pharmacy in cost efficiency. 2. Work with Community Pharmacies and Practices to implement a test of change to reduce waste medicines. 3. Review how performance data can be supplied to pharmacies improving performance and reducing variance.	1. No progress due to Covid. 2. No progress due to Covid. 3. No progress due to Covid. 1-3 Include in 2022/23 and progress as soon as possible.

2. PLAN for Pharmacy Teams Integrated into GP Practices

2021/22 - 2022/23 - 2023/24		Update 2022
Medicines Management	1. Discharge Letters / ECS improvement work. 2. Getting to the root of medicine issues and solving them 3. IDL Processing. 4. Data collection of monthly activity.	1. On-going; interface QI work continues with Medical Assessment Unit and other stakeholders. Pharmacy Support Staff Obselete Medicines protocol improving accuracy of repeat lists. 2. On-going. 3. Level 1 GPCP contract work occuring across all practices. 4. Monthly activity being manually collated, and linked into national work to streamline data collection through Scottish Therapeutic Utility software.
Serial Prescribing	1. Reducing actioning and signing burden within Practices. 2. Allowing Community Pharmacy to better schedule/spread workload. 3. Encourage steady growth in all practices (a focused project would result in increased seasonal burden at Rx expiry & review time). 4. Patients being sytemically and ad hoc by	1. Reducing signing burden by continued increase in serial prescribing in Borders from around 10,000 items/month in 2019 to nearly 20,000 items/month in 2021. This work continues as several practices take part in the HIS Acutes Project (Acutes→Repeats→Serial). 2. Included in above. 3. On-going; included in above. 4. Protocols and training under development to allow extra

	Pharmacy team 5. Weekly progress statistics issued to Practices.	support from non-clinical staff to underpin and drive serial prescribing. 5. COMPLETE – This is monthly rather than weekly and further work is happening nationally to improve quality of data.
Improvement Work	1. Specific projects for step-wise improvement of previous GP systems.	1. On-going; Unified Prescribing Policy and HIS Acutes Project involvement will continue this year.
Releasing GP Capacity	1. Discharge letter / ECS improvement. 2. Supporting new GMS contract.	1. On-going. 2. On-going.
Medication & Polypharmacy Review	1. A systematic review program will target the highest need medicines management problems. 2. Time and expectation management within practice to allow time to do consistently and effectively.	1. On-going; an experienced member of GPCP team will be leading a Polypharmacy/Realistic Medicine program starting February 2022. 2. On-going with work above.
Specialist Clinics	1. Chronic Pain. 2. Heart Failure. 3. Respiratory. 4. Mental Health. 5. Polypharmacy/Realistic Medicine. 6. Others depending on local needs and capacity.	1. Linking in with Pain Team and with NHS Fife work from February 2022. 2. No update at his time. 3. Joint working COPD review project underway. National Strategy parked in NHSB at moment but we will be re-visiting environmental projects (aerosol devices) later in 2022/23. 4. Linking in with Mental Health team to develop and improve local strategy including drug monitoring. 5. An experienced member of GPCP team will be leading a Polypharmacy/Realistic Medicine program starting February 2022. 6. National Strategies will be re-starting/refreshed as we come out of Covid pandemic. Starting in February 2022 we wil be benchmarking the National Therapeutic Indicators to establish local KPI.

3. PLAN for Transformed Hospital Pharmacy Services

2021/22 - 2022/23 - 2023/24	Update 2022

Transformation requirements	1. Technology enabled care in 2021 – next phase of ward cabinet rollout to Ward 7, 9, 12, 14, Borders Stroke Unit/Margaret Kerr Unit, Intensive Care Unit, Theatres, Pharmacy Controlled Drugs and 4 x community hospitals. 2. Pharmacy Automated Dispensing System (robotics) January-March 2021. 3. HEPMA – Hospital Electronic Prescribing & Medicines Administration to remove paper based processes from prescribing and medicines administration; improve patient safety and quality of care. Part of national rollout timings. 4. Support advanced practice of pharmacist and pharmacy tehcnicians though investment of education and training for all staff. 5. Support pharmacists to become independent prescribers. 6. Pharmacists integration to clinical multi-disciplinary teams to support safe prescribing and administration of medicines at ward level. 7. Triage processes for pharmacists and pharmacy tehcnicians – complex patients. 8. Review benefits of 7 day pharmacy clinical service. 9. Support local delivery of realistic medicine.	1. COMPLETE - Electronic cabinets have been purchased and installation planned for wards. I community hospital installation January 2022; others planned. 2. Business case approved; awaiting other departments to be able to move forward. Installation will result in pharmacy staff released to patient facing roles, better stock control and reduced drug errors. 3. On-going; scoping and engagement work continues in conjunction with IM&T colleagues and other national teams involved in roll-out. Outcomes to be measured – drug errors (prescribing and administration; timeliness and missed doses) and improved medicine communication between secondary and primary care. 4. On-going – Royal Pharmaceutical Society (RPS) is still to publish the advanced practice framework end of March 2022 and the first intake would be in Summer 2022. 5. On-going; 4 and 5 plan to increase number of pharmacist prescribers and involvement in QI projects and research. We currently have 4 pharmacist independent prescribers and 2 in training. Developing education and training for technicians has benefits for patient facing roles and support for wards; increase number of checking pharmacy technicians and technicians within clinical services. 6. On-going. 7. On-going. 8. Benefits under review – volume of dispensing at weekends; number of discharge prescriptions processed and impact on on-call service; also digital transformation success. 9. Prescribing guidance being developed as appropriate along with regional formulary work; polypharmacy reviews where appropriate.
Discharge	1. Digitally enabled, improved communication	1. On-going.

Process	between secondary and primary care and community pharmacy. 2. Assessment and sign-posting of medicines management support. 3. Development of clinical pharmacy technical roles. 4. Development of discharge processes to meet individual patient requirements. 5. Review clinical pharmacist role in the discharge process.	2. On-going; using number of referrals received from on-pharmacy colleagues as measure.
Quality Improvement & Performance Measures	1. Defining and communicating the role of Pharmacy services to the wider hospital. 2. Developing performance indicators to ensure workload is efficient and as proactive as possible. 3. Improving medicines governance across BGH with identified outcome measures. 4. Development of research skills and advanced practice – in partnership with academia.	1 – 4 On-going due to pandemic and sickness absence in team.
Modern Outpatient Programme	1. Development of pharmacists working at an advanced level to facilitate complex drug therapies at home with clinical specialities. 2. Facilitate more cohesvie MDT working – advanced practice.	1 – 2 On-going due to pandemic and sickness absence in team.

4. PLAN for Pharmaceutical Care that supports Safer Use of Medicines

2021/22 - 2022/23 - 2023/24		Update 2022
Data Measurement & Monitoring	1. Using data monitoring to measure adherence to Gluten Free Food Service; smoking cessation and NHS Pharmacy First services.	1. COMPLETE - Senior Prescribing Support Pharmacist undertakes monitoring on a regular basisin conjunction with the teams.
Medicines Reconcilliation	1. Connected to Discharge process in Hospital Pharmacy Services.	1. COMPLETE - IM&T are taking this forward - to send discharge letters, where patient consent is obtained, to community

		pharmacies. This is being followed up by Pharmacy Project Manager.
Pharmacy Role Awareness	1. Promote NHS Pharmacy First Scotland service. 2. Raise awareness on new approach to accessing urgent care. 3. Continue to promote closer working GP and pharmacist.	1. COMPLETE - Work undertaken as part of Covid pandemic response and reshaping urgent care workstream. Promoting through Communications team. 2. COMPLETE - See above 1. 3. On-going; regular interface work with Practice based teams including pharmacotherapy team to promote joint working.
Quality Improvement in Community Pharmacy	1. Improve service delivery through analysis of community pharmacy activity and services provided.	1. COMPLETE - Senior Prescribing Support Pharmacist is leading and this overlaps with data monitoring above.

5. PLAN for Improved Pharmaceutical Care at Home or in a Care Home

2021/22 - 2022/23 - 2023/24		Update 2022
Improvement Approaches	1. Increase standard of delivery of care in patients' own homes. 2. Work with Pharmacotherapy Team to review patients' medication support needs & ensure medication reviews. 3. Provide education & advice to Health & Social Care staff on medicines management. 4. Support Health & Social Care staff with complex medicines management assessments. 5. Improve the pharmaceutical care of residents in care homes 6. Review the current service provided by Community Pharmacy and introduce more clinical support to link in with work of Pharmacotherapy Team. 7. Pharmacy led, structured medication review as	All on-going – 5,6,7 have been moved to action in 2022/23 due to Covid making this unable to complete in 2021/22. NHS Borders Board asked if an increase to the WTE of Care Home Pharmacy Technician post. Repsonse to this is No and in the short term care homes and care at home is funded by Winter planning. A business case has been submitted to winter planning group for pharmacy resource to cover care homes and care at home.

	part of MDT. 8. Pharmacy specialist advice and educaiton on use of medicines/policies/procedures. 9. Medicines waste.	

6. PLAN for Enhanced Access to Pharmaceutical Care in Remote and Rural Communities

2021/22 - 2022/23 - 2023/24		Update 2022
Recruitment and Retention	1. Support Pharmacists to complete the Independent Prescribing qualification and other training available.	1. We have a total of five community pharmacists currently undertaking their IP training. Continue to promote.
Availability of technology to support Rural & Remote	1. Reviewing the use of Telehealth and Telecare to improve the ability to deliver pharmaceutical care to patients despite the geographical challenges and improve efficiency of pharmacy services. 2. Accessibility of medical records on an read/write basis. 3. Monitor support of Emergency Care Summary by Community Pharmacies, feedback data and promote use. 4. Provide educational sessions to promote the use of Near Me by Community Pharmacies. 5. Share best practice use by other health care professionals to demonstrate benefit, for example, completion of annual gluten-free health check using Near Me.	1. On-going; working with all pharmacies to ensure access to Near Me, uptake is low but is available to all pharmacies. Regular update/discussion - Area Pharmaceutical Committee meetings. Continue to support. 2. On-going work which has the support of Medical Director. 3. COMPLETE - Support provided to all Pharmacists and Technicians although use is low. Continue to provide support. 4. COMPLETE - Education sessions have been made available. 5. COMPLETE and on-going- Led by Senior Prescribing Support Pharmacist - Peer Group team to share experiences and GFF service briefing imminent.

2021-24 PLAN for Enabling NHS Pharmaceutical Care Transformation

2021/22 - 2022/23 - 2023/24		Update 2022
Postgraduate career	1. Implement Scottish Government recommendations for Independent Prescribers.	1. Work progressing in line with National Oversight Groups supported by our Education and Training lead Pharmacist/

framework	Check SG target for IPs and set proportional target for NHSB. 2. Provide administration support to enable service provision of Pharmacy First Plus. 3. Establish peer review processes to support high level services 4. Support introduction of Protected Learning Time in Community Pharmacies.	2. COMPLETE 3. COMPLETE 4. On-going
Pharmacy technician development	1. Career framework. 2. Developing advanced skills and roles.	1–2 Career opportunities in Surgery, Mental Health introduced and further work will be taken forward when new lead practice technician starts April 2022.
Workforce planning	1. Be responsive to SG policy recommendations and CPS advice following publication of workforce planning data in 2021.	1. On-going
ePharmacy support for all primary care prescribers	1. Review weekly report on pharmacy-led electronic data, feedback to relevant teams and provide associated educational messages. 2. Review data in line with national and local guidelines. 3. Ensure that responsibility is given to NHSB pharmacist who is able to recommend policy development. 4. Develop method of communicating data to CPs.	1-4 COMPLETE
HEPMA	1. Working with other Boards and within NHS Borders to implement HEPMA.	1. On-going; work continues on this project within NHS Borders.
Health Information Access	1. Support and promote safe sharing of information between NHS Borders and GP practices.	1. On-going
Technology enabled care solutions	1. Ensure CPs retain access to ECS. 2. Support use of ECS. 3. Ensure CPs retain access to Near Me. 4. Support use of Near Me.	1-6 Access available; continuing to promote use and benefits within Community Pharmacy.

	5. Provide specific training to pilot use of Near Me such as consultations within smoking cessation service and annual check for the gluten-free food service. 6. Facilitate use of Near Me in service provision to Care Homes.	
Automation	1. Be aware of and monitor impact of off-site dispensing. 2. Request and review feedback from users of off-site dispensing. 3. Pharmacy Automated Dispensing System (Robotics) in BGH.	1-2 COMPLETE 3. Waiting for Finance and Estates to progress.
Clinical decision support tools	1. Provide training on use of shared decision making tools. 2. Access to resources and training.	1-2 On-going
Contracting and funding arrangements	1. Ensure responsibility is assigned to NHSB pharmacist to review and determine impact of SG PCAs.	1. On-going
Planning	1. Monitor resilience of CPs - collation of business continuity plans 2. Lessons learned – Covid-19 responses. 3. Be prepared for future emergencies – NHSB responsible pharmacist. 4. Ensure clear policies and procedures for communication pathways.	1. COMPLETE 2. On-going 3. COMPLETE 4. COMPLETE

APPENDIX-01 SCOTTISH BORDERS BY LOCALITY – POPULATION >500

The table below shows the towns within each locality with a population >500.

<table>
<tr><th>Locality</th><th>Town</th><th>Population</th><th>Locality</th><th>Town</th><th>Population</th></tr>
<tr><td rowspan="7">Berwickshire</td><td>Eyemouth</td><td>3,540</td><td rowspan="7">Eildon</td><td>Galashiels</td><td>12,670</td></tr>
<tr><td>Duns</td><td>2,722</td><td>Selkirk</td><td>5,586</td></tr>
<tr><td>Coldstream</td><td>1,867</td><td>Melrose</td><td>2,457</td></tr>
<tr><td>Chirnside</td><td>1,426</td><td>Tweedbank</td><td>2,073</td></tr>
<tr><td>Greenlaw</td><td>629</td><td>Lauder</td><td>1,773</td></tr>
<tr><td>Ayton</td><td>573</td><td>Earlston</td><td>1,766</td></tr>
<tr><td>Coldingham</td><td>549</td><td>Newtown St Boswells</td><td>1,347</td></tr>
<tr><td rowspan="4">Cheviot</td><td>Kelso</td><td>6,821</td><td rowspan="7">Tweeddale</td><td>Peebles</td><td>8,583</td></tr>
<tr><td>Jedburgh</td><td>3,961</td><td>Innerleithen</td><td>3,064</td></tr>
<tr><td>St Boswells</td><td>1,466</td><td>West Linton</td><td>1,561</td></tr>
<tr><td>Yetholm</td><td>618</td><td>Cardrona</td><td>919</td></tr>
<tr><td rowspan="3">Teviot &Liddesdale</td><td>Hawick</td><td>14,003</td><td>Walkerburn</td><td>711</td></tr>
<tr><td>Newcastleton</td><td>757</td><td colspan="2"></td></tr>
<tr><td>Denholm</td><td>625</td><td>Total pop +500 towns</td><td>82,067</td></tr>
</table>

Figure 15 Population >500 Scottish Borders by Locality

APPENDIX-02 COMMUNITY PHARMACY WEEKEND OPENING TIMES

Locality	Town	Community Pharmacies & Dispensing Practices	Saturday Opening	Sunday Opening
Berwickshire	Chirnside	GLM Romanes Pharmacy	-	-
	Coldingham	Dispensing Practice	*08:45-12:30*	-
	Coldstream	GLM Romanes Pharmacy	*08:45-12:30*	-
	Duns	GLM Romanes Pharmacy	09:00-17:00	-
	Eyemouth	GLM Romanes Pharmacy	*09:00-15:00*	-
	Greenlaw	GLM Romanes Pharmacy	-	-
Cheviot	Kelso	Boots Pharmacy Lloyds Pharmacy	08:30-17:00 09:00-17:00	- -
	Jedburgh	Boots Pharmacy Jedburgh Pharmacy	09:00-16:00 *09:00-13:00*	- -
Eildon	Earlston	M Farren Pharmacy	*09:00-13:00*	-
	Galashiels	Boots Pharmacy Borders Pharmacy Lloyds Pharmacy M Farren Pharmacy Tesco Pharmacy	08:30-18:00 09:00-17:00 09:00-17:00 09:00-13:00 08:00-20:00	10:00-18:00 - - - 09:00-18:00
	Lauder	Lauder Pharmacy	*09:00-13:00*	-
	Melrose	Boots Pharmacy	09:00-17:00	-
	Newtown St Boswells	Eildon Pharmacy	*09:00-12:00*	-
	Selkirk	Lindsay & Gilmour *(closed 1-2pm)* Right Medicine Pharmacy	09:00-17:00 *09:00-13:00*	- -
	Stow	Dispensing Practice	-	-
Teviot &Liddesdale	Hawick	Boots Pharmacy Borders Pharmacy Hawick Health Centre & Pharmacy Lindsay & Gilmour Pharmacy TN Crosby Pharmacy	09:00-17:00 09:00-17:00 - 09:00-17:00 *09:00-12:00*	- 10:00-17:00 - - -
	Newcastleton	Dispensing Practice	-	-
Tweeddale	Innerleithen	M Farren Pharmacy	*09:00-12:30*	-
	Peebles	Boots Pharmacy Lloyds Pharmacy	09:00-17:30 09:00-17:00	- -
	West Linton	West Linton Pharmacy	*09:00-13:00*	-

Figure 16 Community Pharmacy Weekend Opening Times

APPENDIX-03 COMMUNITY PHARMACY - ACCESSIBLE AND CONFIDENTIAL SERVICES

Locality	Town	Community Pharmacies & Dispensing Practices	Privacy - Is a separate enclosed room available?	Sound proof & private	Located close to, or part of, main counter	And/or area screened from main retail area	Wheelchair access	Large enough for 2 people plus Pharmacist	Worktop /desk	Hand washing facilities
Berwickshire	Chirnside	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Coldstream	GLM Romanes Pharmacy	✓	✓	✓	✓	-	✓	✓	✓
	Duns	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Eyemouth	GLM Romanes Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Greenlaw	GLM Romanes Pharmacy	-	-	-	-	-	-	-	-
Cheviot	Kelso	Boots Pharmacy	-	-	✓	✓	✓	✓	✓	-
		Lloyds Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Jedburgh	Boots Pharmacy	-	✓	✓	✓	✓	✓	✓	✓
		Jedburgh Pharmacy	-	✓	✓	✓	✓	✓	✓	-
Eildon	Earlston	M Farren Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Galashiels	Boots Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
		Borders Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
		Lloyds Pharmacy	✓	✓	✓	✓	✓	✓	✓	-
		M Farren Pharmacy	-	✓	-	✓	✓	✓	✓	✓
		Tesco Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	Lauder	Lauder Pharmacy	-	✓	-	✓	✓	✓	✓	✓
	Melrose	Boots Pharmacy	-	✓	✓	✓	✓	✓	✓	✓
	Newtown St Boswells	Eildon Pharmacy	-	✓	-	✓	-	✓	✓	✓
	Selkirk	Lindsay & Gilmour Pharmacy	-	✓	✓	✓	✓	✓	✓	✓
		Right Medicine Pharmacy	-	✓	-	✓	✓	✓	✓	✓
Teviot & Liddesdale	Hawick	Boots Pharmacy	✓	✓	✓	✓	✓	✓	✓	-
		Borders Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
		Hawick Health Centre & Pharmacy	-	✓	✓	✓	✓	✓	✓	-
		Lindsay & Gilmour Pharmacy	-	✓	✓	✓	✓	✓	✓	✓
		TN Crosby Pharmacy	-	✓	✓	✓	✓	✓	✓	-
Tweeddale	Innerleithen	M Farren Pharmacy	-	-	✓	✓	✓	✓	✓	-
	Peebles	Boots Pharmacy	-	-	-	-	-	-	-	-
		Lloyds Pharmacy	✓	✓	✓	✓	✓	✓	✓	✓
	West Linton	West Linton Pharmacy	-	-	-	✓	-	-	✓	-

Figure 17 Community Pharmacy Accessible and Confidential Services

APPENDIX-04 GP CLUSTER – PHARMACY SERVICE COVER

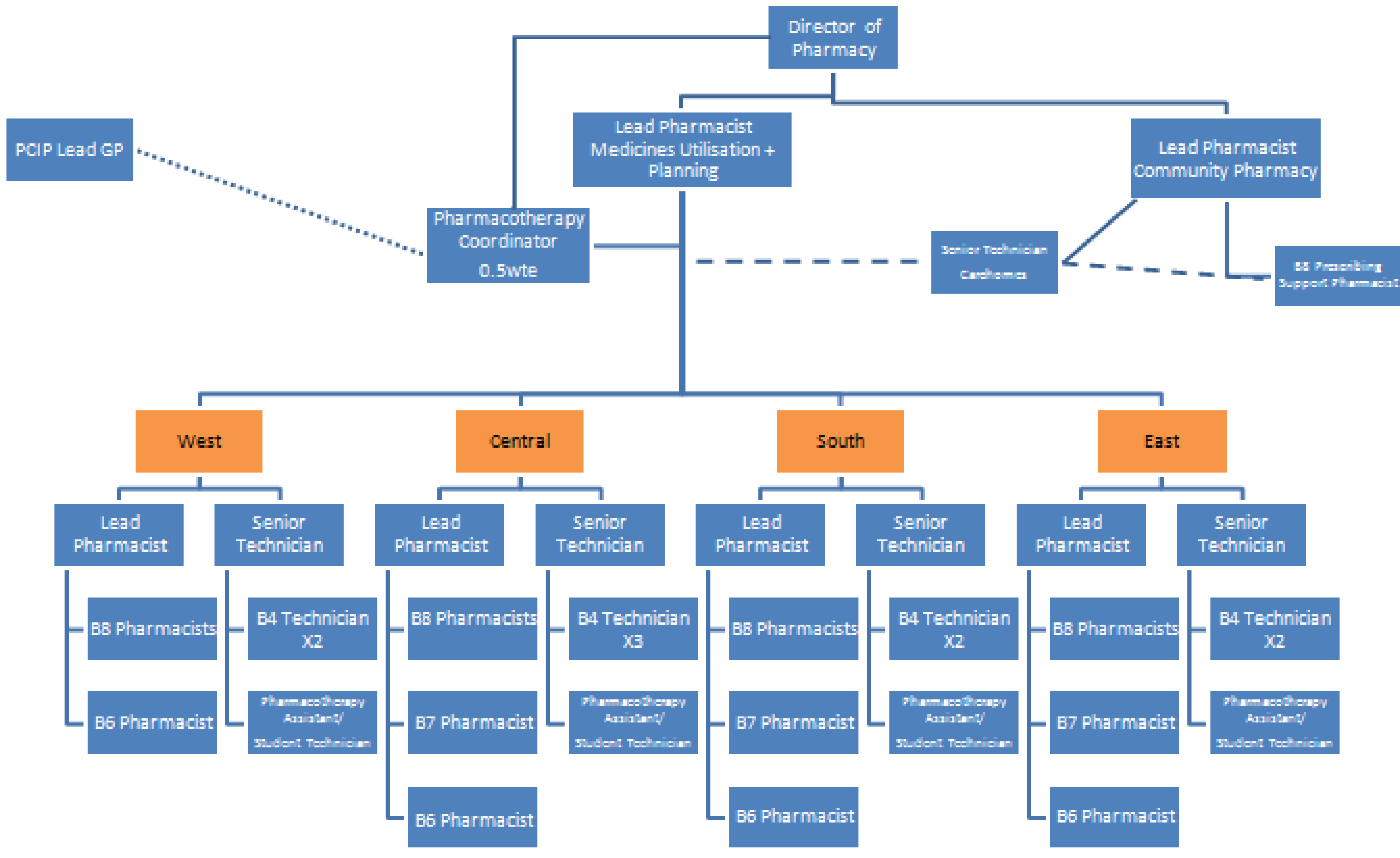


Figure 18 GP Cluster Pharmacy Service Cover

APPENDIX-05 MONITORING OF NHS PHARMACY FIRST SCOTLAND

NHS Pharmacy FirstScotland service – UTI consultation, referral, advice

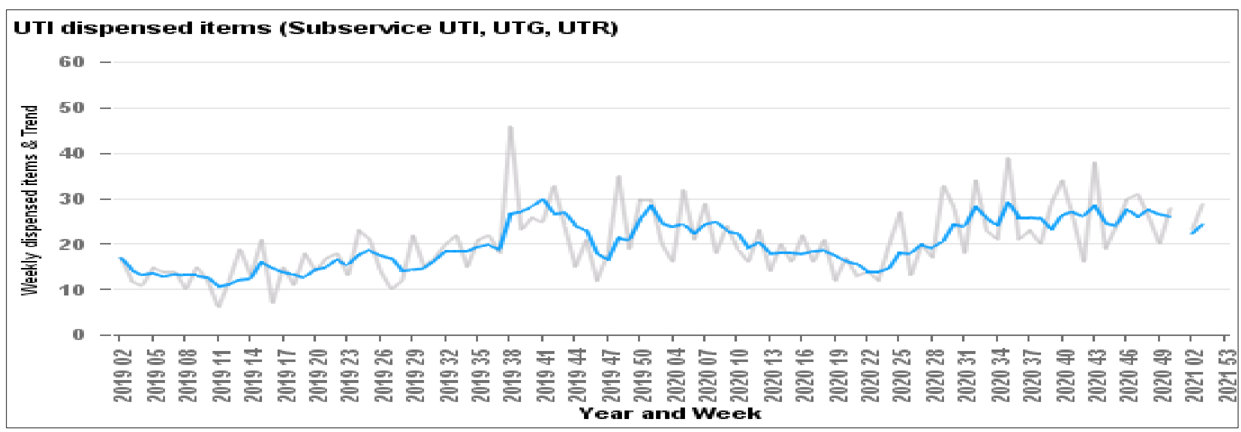


Figure 19 NHS Pharmacy First - Consultation and item dispensed

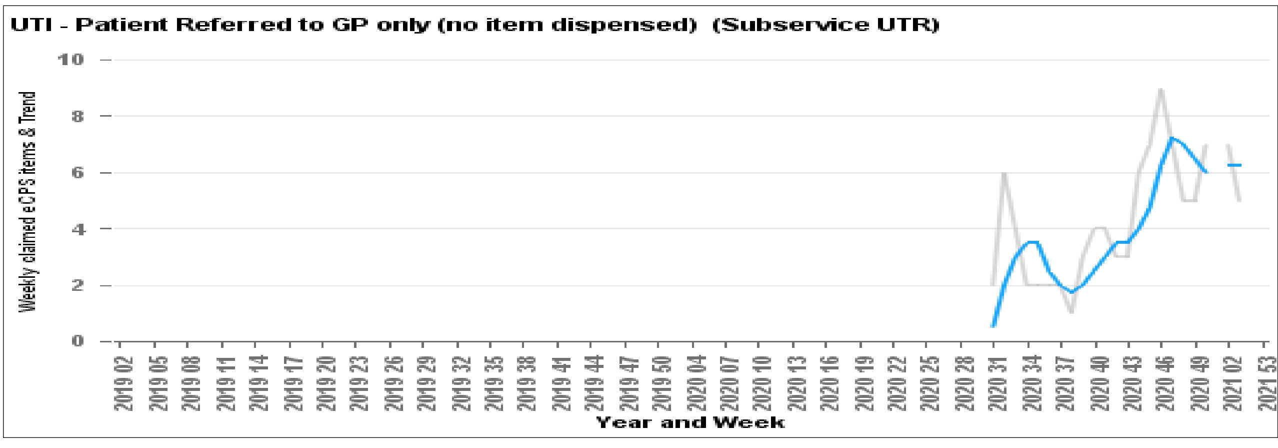


Figure 20 NHS Pharmacy First - Consultation and referral to GP practice

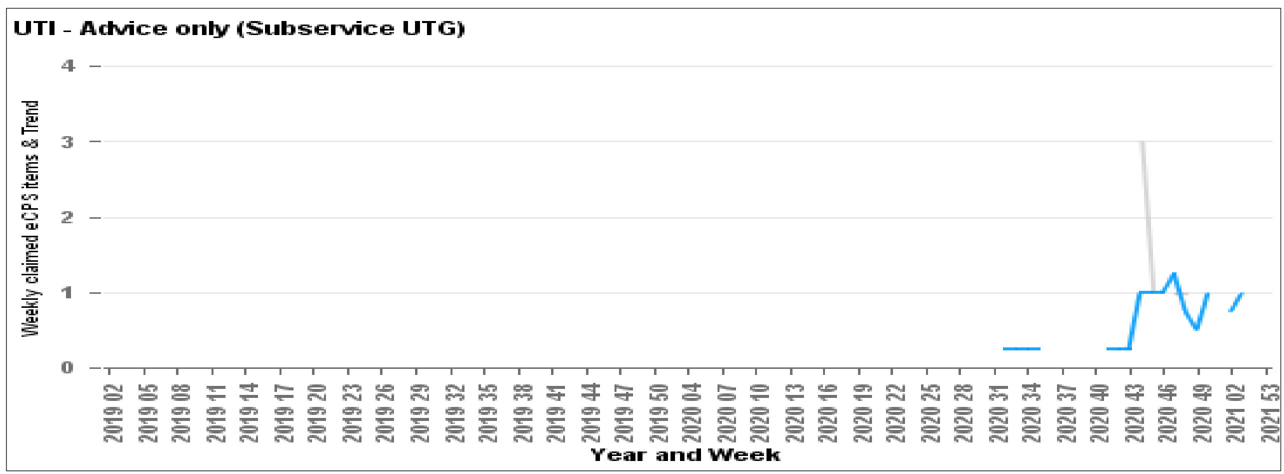
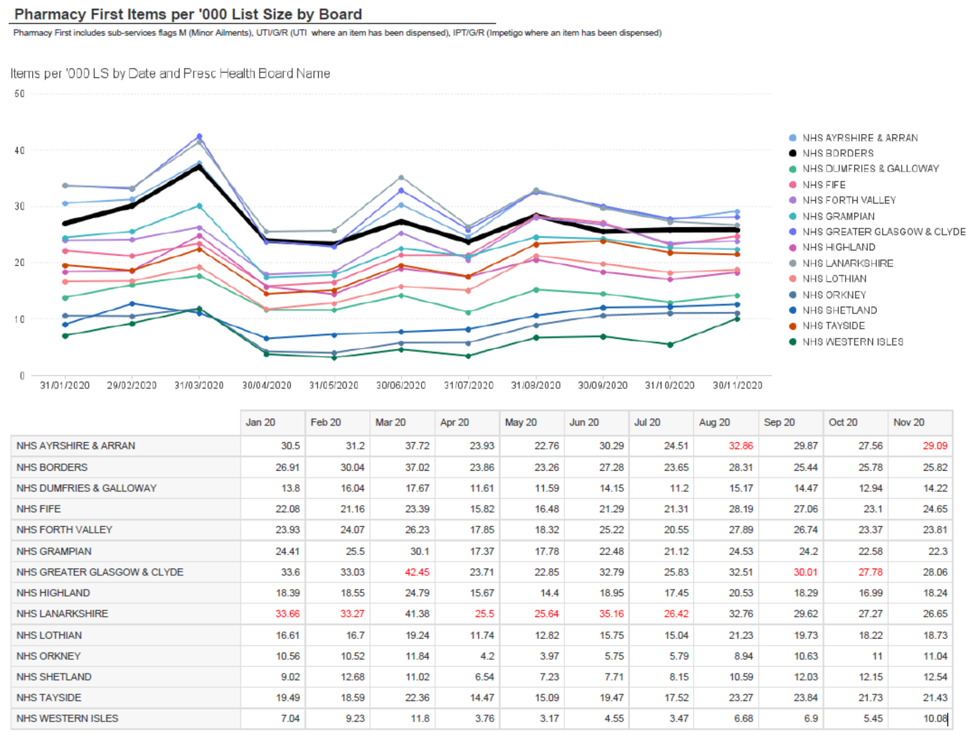


Figure 21 NHS Pharmacy First - Consultation and advice given

Note: data for referrals and advice given was only made available from week 31

APPENDIX-06 MONITORINGOF UNIVERSAL CLAIM FORM ACTIVITY

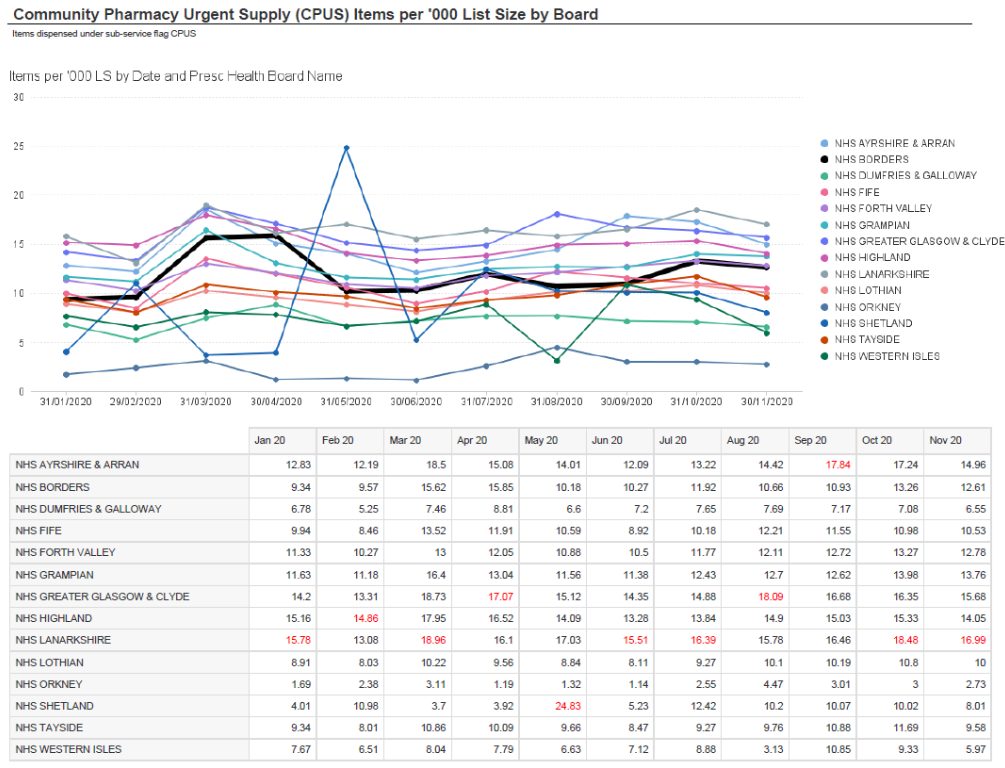
NHS Pharmacy First Activity data(all items)



	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
NHS AYRSHIRE & ARRAN	30.5	31.2	37.72	23.93	22.76	30.29	24.51	32.86	29.87	27.56	29.09
NHS BORDERS	26.91	30.04	37.02	23.86	23.26	27.28	23.65	28.31	25.44	25.78	25.82
NHS DUMFRIES & GALLOWAY	13.8	16.04	17.67	11.61	11.59	14.15	11.2	15.17	14.47	12.94	14.22
NHS FIFE	22.08	21.16	23.39	15.82	16.48	21.29	21.31	28.19	27.06	23.1	24.65
NHS FORTH VALLEY	23.93	24.07	26.23	17.85	18.32	25.22	20.55	27.89	26.74	23.37	23.81
NHS GRAMPIAN	24.41	25.5	30.1	17.37	17.78	22.48	21.12	24.53	24.2	22.58	22.3
NHS GREATER GLASGOW & CLYDE	33.6	33.03	42.45	23.71	22.85	32.79	25.83	32.51	30.01	27.78	28.06
NHS HIGHLAND	18.39	18.55	24.79	15.67	14.4	18.95	17.45	20.53	18.29	16.99	18.24
NHS LANARKSHIRE	33.66	33.27	41.38	25.5	25.64	35.16	26.42	32.76	29.62	27.27	26.65
NHS LOTHIAN	16.61	16.7	19.24	11.74	12.82	15.75	15.04	21.23	19.73	18.22	18.73
NHS ORKNEY	10.56	10.52	11.84	4.2	3.97	5.75	5.79	8.94	10.63	11	11.04
NHS SHETLAND	9.02	12.68	11.02	6.54	7.23	7.71	8.15	10.59	12.03	12.15	12.54
NHS TAYSIDE	19.49	18.59	22.36	14.47	15.09	19.47	17.52	23.27	23.84	21.73	21.43
NHS WESTERN ISLES	7.04	9.23	11.8	3.76	3.17	4.55	3.47	6.68	6.9	5.45	10.08

Figure 22 NHS Pharmacy First Activity Data (all items)

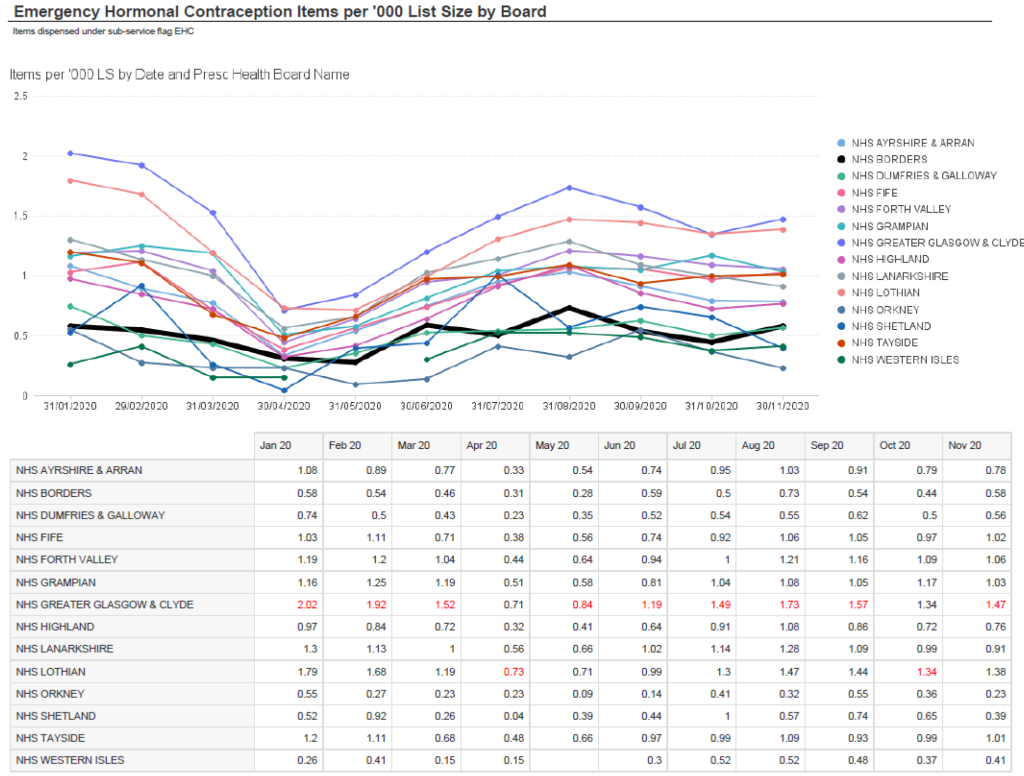
Community Pharmacy Urgent Supply



	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
NHS AYRSHIRE & ARRAN	12.83	12.19	18.5	15.08	14.01	12.09	13.22	14.42	17.84	17.24	14.96
NHS BORDERS	9.34	9.57	15.62	15.85	10.18	10.27	11.92	10.66	10.93	13.26	12.61
NHS DUMFRIES & GALLOWAY	6.78	5.25	7.46	8.81	6.6	7.2	7.65	7.69	7.17	7.08	6.55
NHS FIFE	9.94	8.46	13.52	11.91	10.59	8.92	10.18	12.21	11.55	10.98	10.53
NHS FORTH VALLEY	11.33	10.27	13	12.05	10.88	10.5	11.77	12.11	12.72	13.27	12.78
NHS GRAMPIAN	11.63	11.18	16.4	13.04	11.56	11.38	12.43	12.7	12.62	13.98	13.76
NHS GREATER GLASGOW & CLYDE	14.2	13.31	18.73	17.07	15.12	14.35	14.88	18.09	16.68	16.35	15.68
NHS HIGHLAND	15.16	14.86	17.95	16.52	14.09	13.28	13.84	14.9	15.03	15.33	14.05
NHS LANARKSHIRE	15.78	13.08	18.96	16.1	17.03	15.51	16.39	15.78	16.46	18.48	16.99
NHS LOTHIAN	8.91	8.03	10.22	9.56	8.84	8.11	9.27	10.1	10.19	10.8	10
NHS ORKNEY	1.69	2.38	3.11	1.19	1.32	1.14	2.55	4.47	3.01	3	2.73
NHS SHETLAND	4.01	10.98	3.7	3.92	24.83	5.23	12.42	10.2	10.07	10.02	8.01
NHS TAYSIDE	9.34	8.01	10.86	10.09	9.66	8.47	9.27	9.76	10.88	11.69	9.58
NHS WESTERN ISLES	7.67	6.51	8.04	7.79	6.63	7.12	8.88	3.13	10.85	9.33	5.97

Figure 23 Community Pharmacy Urgent Supply

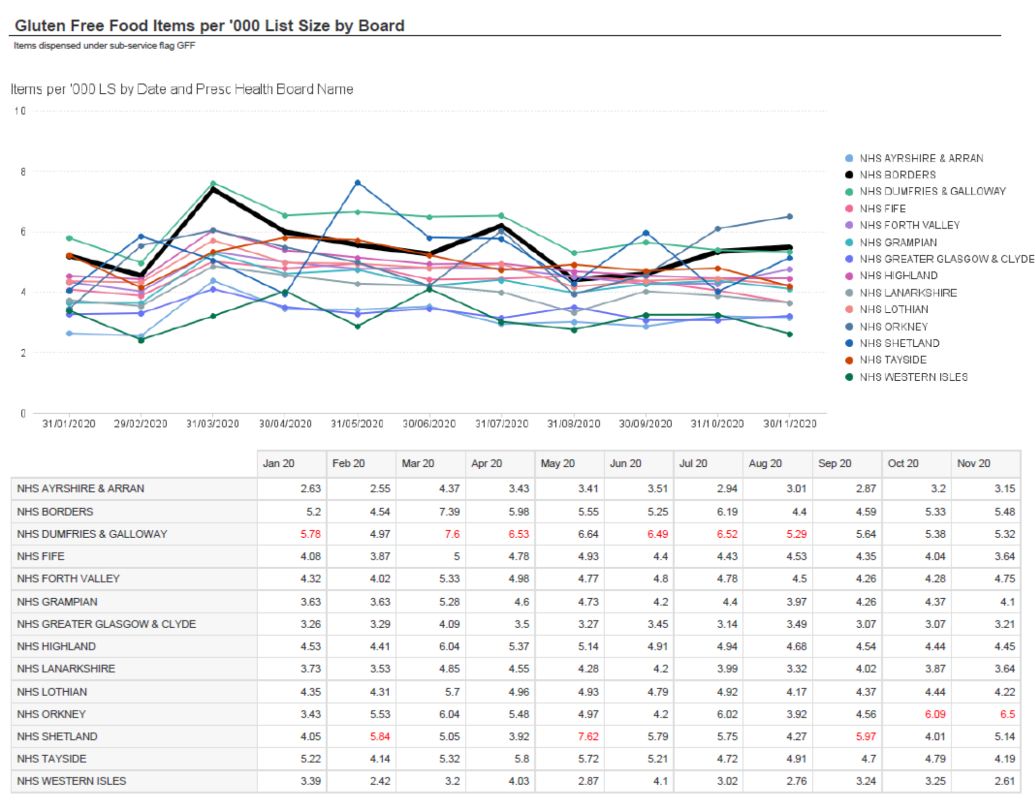
Emergency Hormonal Contraception



	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
NHS AYRSHIRE & ARRAN	1.08	0.89	0.77	0.33	0.54	0.74	0.95	1.03	0.91	0.79	0.78
NHS BORDERS	0.58	0.54	0.46	0.31	0.28	0.59	0.5	0.73	0.54	0.44	0.58
NHS DUMFRIES & GALLOWAY	0.74	0.5	0.43	0.23	0.35	0.52	0.54	0.55	0.62	0.5	0.56
NHS FIFE	1.03	1.11	0.71	0.38	0.56	0.74	0.92	1.06	1.05	0.97	1.02
NHS FORTH VALLEY	1.19	1.2	1.04	0.44	0.64	0.94	1	1.21	1.16	1.09	1.06
NHS GRAMPIAN	1.16	1.25	1.19	0.51	0.58	0.81	1.04	1.08	1.05	1.17	1.03
NHS GREATER GLASGOW & CLYDE	2.02	1.92	1.52	0.71	0.84	1.19	1.49	1.73	1.57	1.34	1.47
NHS HIGHLAND	0.97	0.84	0.72	0.32	0.41	0.64	0.91	1.08	0.86	0.72	0.76
NHS LANARKSHIRE	1.3	1.13	1	0.56	0.66	1.02	1.14	1.28	1.09	0.99	0.91
NHS LOTHIAN	1.79	1.68	1.19	0.73	0.71	0.99	1.3	1.47	1.44	1.34	1.38
NHS ORKNEY	0.55	0.27	0.23	0.23	0.09	0.14	0.41	0.32	0.55	0.36	0.23
NHS SHETLAND	0.52	0.92	0.26	0.04	0.39	0.44	1	0.57	0.74	0.65	0.39
NHS TAYSIDE	1.2	1.11	0.68	0.48	0.66	0.97	0.99	1.09	0.93	0.99	1.01
NHS WESTERN ISLES	0.26	0.41	0.15	0.15		0.3	0.52	0.52	0.48	0.37	0.41

Figure 24Emergency Hormonal Contraception items

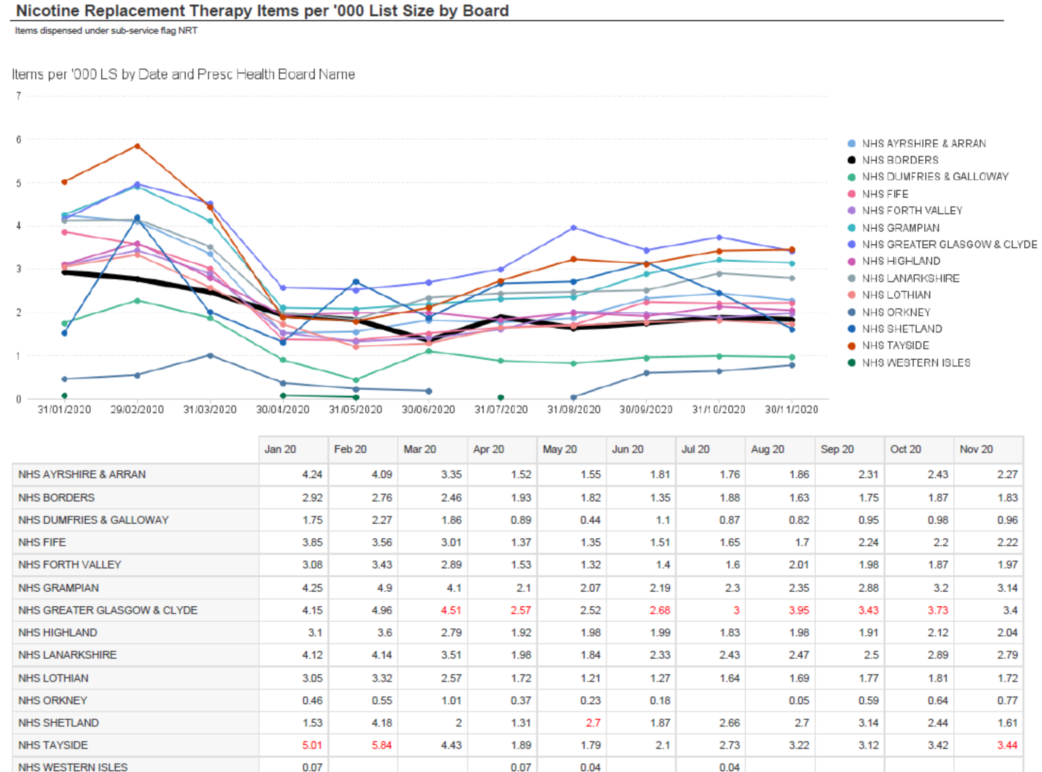
Gluten Free Food Service



	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
NHS AYRSHIRE & ARRAN	2.63	2.55	4.37	3.43	3.41	3.51	2.94	3.01	2.87	3.2	3.15
NHS BORDERS	5.2	4.54	7.39	5.98	5.55	5.25	6.19	4.4	4.59	5.33	5.48
NHS DUMFRIES & GALLOWAY	5.78	4.97	7.6	6.53	6.64	6.49	6.52	5.29	5.64	5.38	5.32
NHS FIFE	4.08	3.87	5	4.78	4.93	4.4	4.43	4.53	4.35	4.04	3.64
NHS FORTH VALLEY	4.32	4.02	5.33	4.98	4.77	4.8	4.78	4.5	4.26	4.28	4.75
NHS GRAMPIAN	3.63	3.63	5.28	4.6	4.73	4.2	4.4	3.97	4.26	4.37	4.1
NHS GREATER GLASGOW & CLYDE	3.26	3.29	4.09	3.5	3.27	3.45	3.14	3.49	3.07	3.07	3.21
NHS HIGHLAND	4.53	4.41	6.04	5.37	5.14	4.91	4.94	4.68	4.54	4.44	4.45
NHS LANARKSHIRE	3.73	3.53	4.85	4.55	4.28	4.2	3.99	3.32	4.02	3.87	3.64
NHS LOTHIAN	4.35	4.31	5.7	4.96	4.93	4.79	4.92	4.17	4.37	4.44	4.22
NHS ORKNEY	3.43	5.53	6.04	5.48	4.97	4.2	6.02	3.92	4.56	6.09	6.5
NHS SHETLAND	4.05	5.84	5.05	3.92	7.62	5.79	5.75	4.27	5.97	4.01	5.14
NHS TAYSIDE	5.22	4.14	5.32	5.8	5.72	5.21	4.72	4.91	4.7	4.79	4.19
NHS WESTERN ISLES	3.39	2.42	3.2	4.03	2.87	4.1	3.02	2.76	3.24	3.25	2.61

Figure 25 Gluten Free Food Service

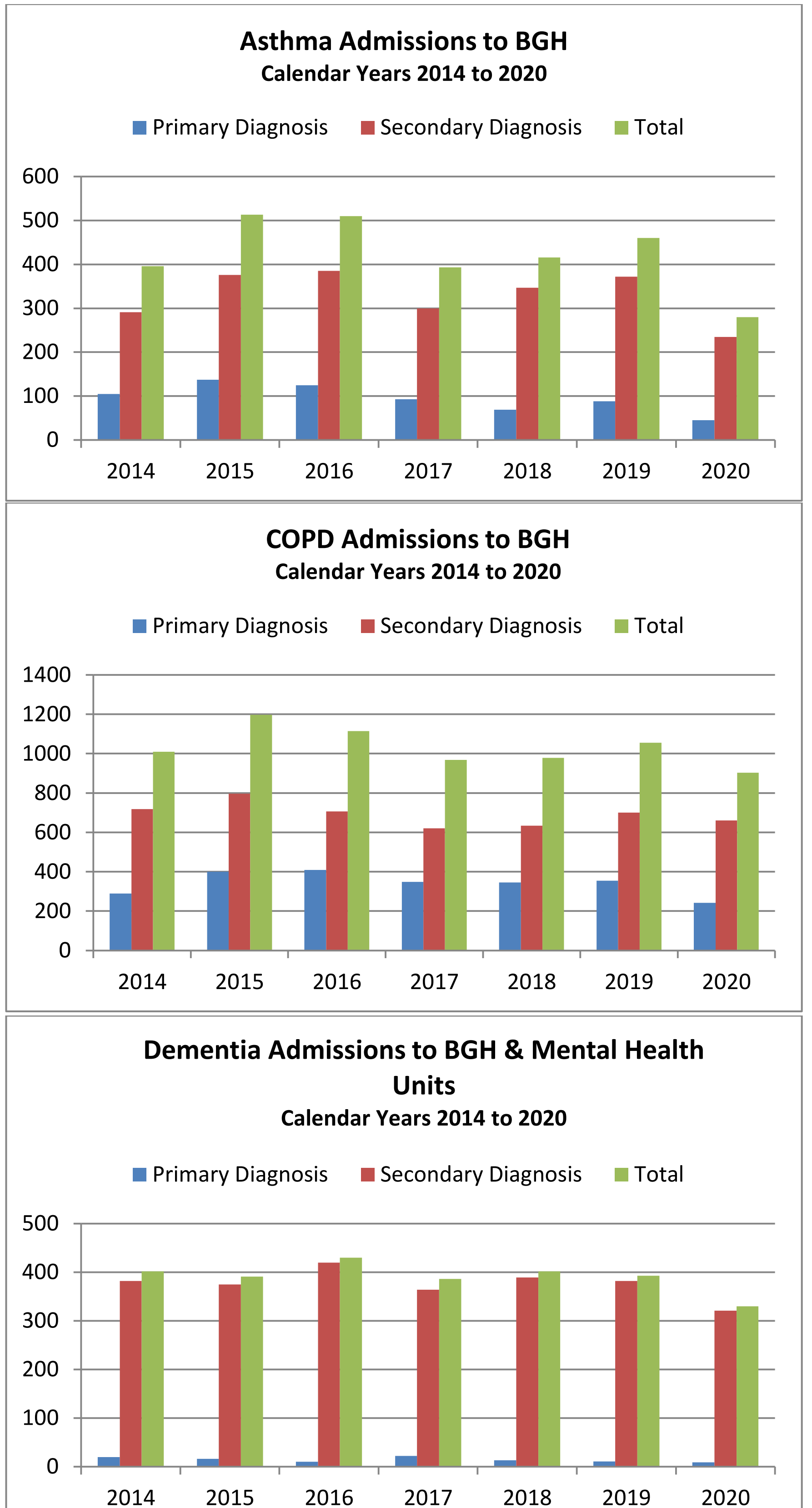
Smoking Cessation Service



	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20
NHS AYRSHIRE & ARRAN	4.24	4.09	3.35	1.52	1.55	1.81	1.76	1.86	2.31	2.43	2.27
NHS BORDERS	2.92	2.76	2.46	1.93	1.82	1.35	1.88	1.63	1.75	1.87	1.83
NHS DUMFRIES & GALLOWAY	1.75	2.27	1.86	0.89	0.44	1.1	0.87	0.82	0.95	0.98	0.96
NHS FIFE	3.85	3.56	3.01	1.37	1.35	1.51	1.65	1.7	2.24	2.2	2.22
NHS FORTH VALLEY	3.08	3.43	2.89	1.53	1.32	1.4	1.6	2.01	1.98	1.87	1.97
NHS GRAMPIAN	4.25	4.9	4.1	2.1	2.07	2.19	2.3	2.35	2.88	3.2	3.14
NHS GREATER GLASGOW & CLYDE	4.15	4.96	4.51	2.57	2.52	2.68	3	3.95	3.43	3.73	3.4
NHS HIGHLAND	3.1	3.6	2.79	1.92	1.98	1.99	1.83	1.98	1.91	2.12	2.04
NHS LANARKSHIRE	4.12	4.14	3.51	1.98	1.84	2.33	2.43	2.47	2.5	2.89	2.79
NHS LOTHIAN	3.05	3.32	2.57	1.72	1.21	1.27	1.64	1.69	1.77	1.81	1.72
NHS ORKNEY	0.46	0.55	1.01	0.37	0.23	0.18		0.05	0.59	0.64	0.77
NHS SHETLAND	1.53	4.18	2	1.31	2.7	1.87	2.66	2.7	3.14	2.44	1.61
NHS TAYSIDE	5.01	5.84	4.43	1.89	1.79	2.1	2.73	3.22	3.12	3.42	3.44
NHS WESTERN ISLES	0.07			0.07	0.04		0.04				

Figure 26 Smoking Cessation Service

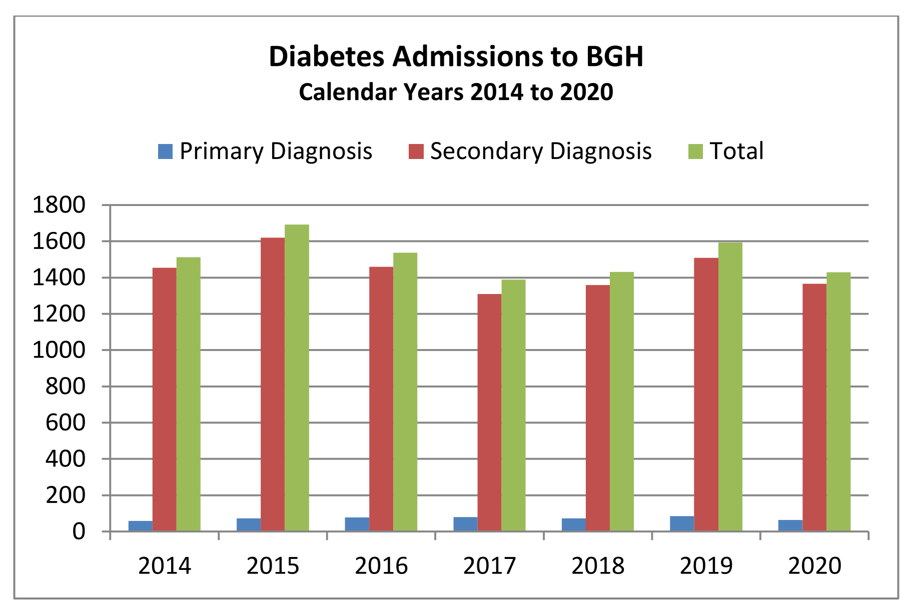
APPENDIX-07 PATIENT NUMBERS – LONG TERM CONDITIONS

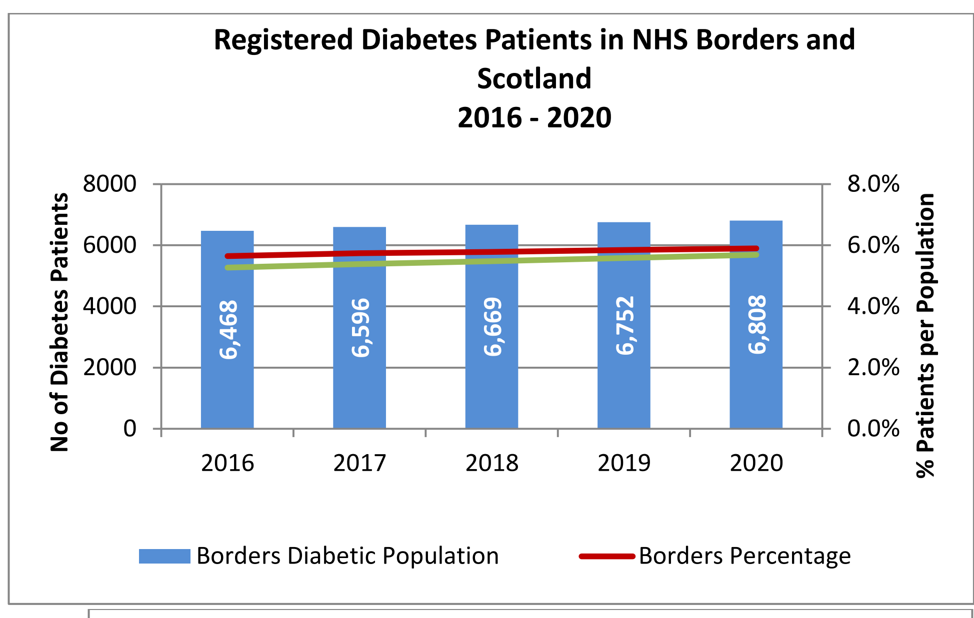


Spreadsheet/data available

2021-04-21 Long Term Conditions Char

2021_04_20_Diabetes NHSB.xlsx





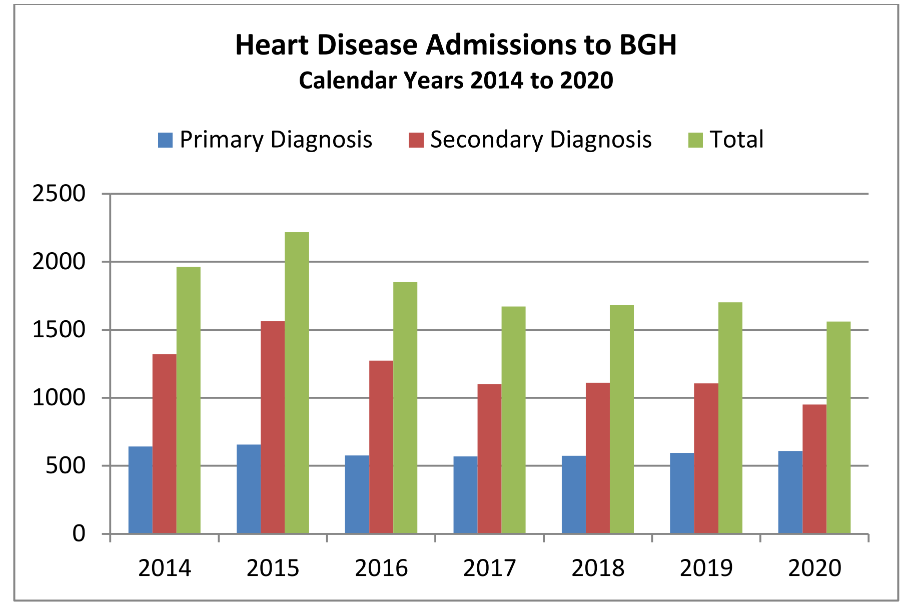


Figure 27 NHSB Long Term Conditions – Asthma, COPD, Dementia, Diabetes, Heart Disease

APPENDIX-08 COMMUNITY PHARMACY APPLICATION PROCESS

Pharmacy Application Process, NHS Borders Primary & Community Contracts Manager

Register of Interest

- Potential applicant to email **Primary.Care@borders.scot.nhs.uk**
- Noting the geographic area in which the are intersted in opening a new pharmacy
- Primary Care Team will confirm note of interest and inform potential applicant of place in order of applications/register of interests.

Pre-Application Meeting

- Meeting held between potential applicant, Pharmacy Lead and Primary Care Team.
- Discussion covering neighbourhood, proposed premises, opening hours and services to be provided.

Joint Public Consultation

- Public consultation to invite views on potential service provision, gaps in existing services and to measure level of support for potential application
- Open for 90 working days.
- Responses collated into a Consultation Analysis Report (CAR).

Formal Application

- Receipt of formal application from the applicant, within 90 days of consultation completion.
- If following the CAR the applicant does not wish to proceed with the formal application, the process ends here.

Consultation with Pharmacy Contractors

- 30 day consultation with existing pharmacy contractors in the local area, inviting comment on the application.

Pharmacy Practices Committee

- Formal application, CAR and output of consultation with existing pharmacy contractors is considered by the Pharmacy Practices Committee (PPC).
- PPC will apply the statutory test (Regulation 5(10)).
- Application will be granted if the PPC are satisfied that the application meets the statutory test.

Decision

- Application will be granted if the PPC are satisfied that the application meetings the statutory test.
- The Applicant and those making representation will be nofied of the decision and the right to appeal.

APPENDIX-09 NHS BORDERS ORGANISATIONAL PURPOSE, OBJECTIVE, PRIORITIES AND VALUES 2020-2023

Available at http://www.nhsborders.scot.nhs.uk/media/786877/Organisational-Objectives-2020_2023-APPROVED-14072020.pdf

The NHS Borders Pharmaceutical Care Services Plan addressed the following areas:-

- Reduce health inequalities and improve the health of our local population.
- Provide high quality, person centred services that are safe, effective, sustainable and affordable.
- Promote excellence in organisational behaviour and always act with pride, humility and kindness.

To implement objectives, NHS Borders plan to:	Location in PCSP objective addressed:
Increase investment in Primary and Community health and care services to deliver care as close to home as possible.	PLAN for Improved and Increased Use of Community Pharmacy Services – page 37 PLAN for Improved Pharmaceutical Care at Home or in a Care Home – page 39 PLAN for Enhanced Access to Pharmaceutical Care in Remote and Rural Communities – page 40
Work closely with the Integration Joint Board, Scottish Borders Council, the third sector and other partners to deliver the best possible health and social care for the people of the Borders.	PLAN for Improved and Increased Use of Community Pharmacy Services – page 37 PLAN for Improved Pharmaceutical Care at Home or in a Care Home – page 39
Be agile and innovative in our thinking, decision making and actions.	Addressed in PLAN for Enabling NHS Pharmaceutical Care Transformation – page 40
Provide community alternatives to hospital care so that we can safely reduce the number of people who need to be admitted to hospital.	PLAN for Improved and Increased Use of Community Pharmacy Services – page 37 PLAN for Pharmacy Teams Integrated into GP Practices – page 38 PLAN for Improved Pharmaceutical Care at Home or in a Care Home – page 39
Provide local acute care on the BGH campus except when the service cannot be safely and sustainably provided by NHS Borders.	PLAN for Transformed Hospital Pharmacy Services – page 38
Provide services from a reduced number of NHS sites and beds and use a proportion of the resources released to support our investment in health and social care community services.	PLAN for Improved and Increased Use of Community Pharmacy Services – page 37 PLAN for Enhanced Access to Pharmaceutical Care in Remote and Rural Communities – page 40
Increase our use of digital technology to benefit people and support changes in our services.	Addressed in PLAN for Enabling NHS Pharmaceutical Care Transformation – page 40
Reshape our support services to maximise the level of resources invested in front line care.	PLAN for Improved and Increased Use of Community Pharmacy Services – page 37 PLAN for Pharmacy Teams Integrated into GP Practices – page 38
Prescribe medicines in line with evidence based care and ensure the most appropriate and cost effective interventions are provided.	Throughout the plan, aim of Community Pharmacy, Pharmacy Services in GP Practices and Hospital based Pharmacy.
Focus on prevention and early intervention to improve the physical and mental health and wellbeing of the people in the Borders and reduce health inequalities.	Throughout the plan, aim of Community Pharmacy, Pharmacy Services in GP Practices and Hospital based Pharmacy.
Focus on the renewal of the health and wellbeing of our communities following the impact of Covid-19.	Response to Covid-19 pandemic, page 16, is on-going.
Change the skill mix of our workforce by transforming roles to meet current and future needs and provide care by the most appropriately trained person.	PLAN for Transformed Hospital Pharmacy Services – page 38 Addressed in PLAN for Enabling NHS Pharmaceutical Care Transformation – page 40

APPENDIX-10 SCOTTISH BORDERS HEALTH & SOCIAL CARE PARTNERSHIP STRATEGIC PLAN 2018-2021

Available at
https://www.scotborders.gov.uk/downloads/file/5131/integration_strategic_plan_2018-21

The Integration Strategic Plan identifies three strategic objectives:-

- Improve the health of the population and reduce the number of hospital admissions
- Improve the flow of patients into, through and out of hospital.
- Improve the capacity within the community for people who have been in receipt of health and social care services to better manage their own conditions and support those who care for them.

The seven partnership principles which feed into and inform the local objectives have also been acknowledged in the Pharmaceutical Care Services Plan:-

1. Prevention and early intervention
2. Accessible services
3. Care close to home
4. Delivery of services with an integrated care model
5. Greater choice and control
6. Optimise efficiency and effectiveness
7. Reduce health inequalities.

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APPENDIX-12 ACKNOWLEDGEMENTS AND BIBLIOGRAPHY

This plan has been developed by the Director of Pharmacy, Lead Pharmacists, and Area Pharmaceutical Committee. The following documents are acknowledged as providing essential information in the completion of this plan:

1. Population estimate from National Records of Scotland, updated April 2020
2. Scottish Borders Strategic Assessment 2020
3. Source: National Records of Scotland
4. Source: Local Police Plan 2020-23 The Scottish Borders; Police Scotland
5. https://scotland.shinyapps.io/ScotPHO_profiles_tool/
6. https://www.gov.scot/collections/scottish-index-of-multiple-deprivation-2020/
7. Scottish Government Achieving Excellence in Pharmaceutical Care – Enabling Pharmaceutical Transformation
8. Community Pharmacy Workforce Survey 2019 - https://test1.nes.digital/pharmacy-report-2019.html
9. Staff numbers as at April 2021; WTE=Whole Time Equivalent – from Pharmacy Dept.
10. https://www.gov.scot/publications/achieving-excellence-pharmaceutical-care-strategy-scotland/
11. https://www.cps.scot/media/3134/pca-p-2020-2-community-pharmacy-funding-settlement-2020-21-2022-23.pdf
12. https://www.cps.scot/media/3696/circular-pca-p-2020-16-national-career-pathway-and-introduction-of-a-common-clinical-conditions-independent-prescribing-servi.pdf
13. https://www.cps.scot/news-insight/news/early-career-framework-for-community-pharmacists-in-scotland/
14. SCI Diabetes data (for both Borders and Scotland)
15. BGH Admissions with Long Term Conditions: Discharge Calendar Years 2014 to 2020; Source: SMR1 SMR4

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Strategic Risk Report**
Responsible Executive/Non-Executive:	**Tim Patterson, Director of Public Health**
Report Author:	**Lettie Pringle, Risk Manager**

1 Purpose

This is presented to the Committee for:

- Awareness

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Effective

2 Report summary

2.1 Situation

The paper provides the bi-annual update of the strategic risk register for NHS Borders.

The Health Board are asked to note this report.

2.2 Background

Understanding strategic risk forms a component part of ensuring that corporate values and objectives are obtained. The strategic risk register is fed into the Health Board on a bi-annual basis to inform members of the current strategic risks NHS Borders is facing.

2.3 Assessment

The strategic risk register has been reviewed and updated by risk owners. This has identified that three risks have now been removed from the strategic risk register.

However, there has also been an increase in very high risks; 3 new risks have been identified and one risk has escalated from a medium risk to very high risk relating to staff wellbeing.
69% of strategic risks are graded as very high or high risk to the organisation.
Within this report key performance indicators have been included, identifying areas of improvement in compliance required.
An exercise into assurance was undertaken with the Board Executive Team to identify committees who would be required to give additional assurance to risks as a supporting committee. A number of issues were highlighted at the Audit Committee on 21st March and as such this process remains in development until these issues are addressed.

2.3.1 Quality/ Patient Care

This report covers performance against key indicators. Any implications of individual risks will be addressed by a separate paper as required.

2.3.2 Workforce

This report covers performance against key indicators. Any implications of individual risks will be addressed by a separate paper as required.

2.3.3 Financial

This report covers performance against key indicators. Any implications of individual risks will be addressed by a separate paper as required.

2.3.4 Risk Assessment/Management

This report covers performance against key indicators. Any implications of individual risks will be addressed by a separate paper as required.

2.3.5 Equality and Diversity, including health inequalities

This report covers performance against key indicators. Any implications of individual risks will be addressed by a separate paper as required

An impact assessment has not been completed because it is not required for this report.

2.3.6 Other impacts

No other relevant impacts identified.

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.

- Meetings with risk owners throughout 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.

- Board Executive Team, 1 March 2022
- Audit Committee, 21 March 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Strategic Risk Report
- Appendix No 2, Strategic Risk Register

Strategic Risk Report

Understanding strategic risk forms a component part of ensuring that corporate values and objectives are attained.

Strategic risk is defined as: ***"risk concerned with where the organisation wants to go, how it plans to get there, and how it can ensure survival"***

(British Standards Institute Risk Management BS 31100:2011).

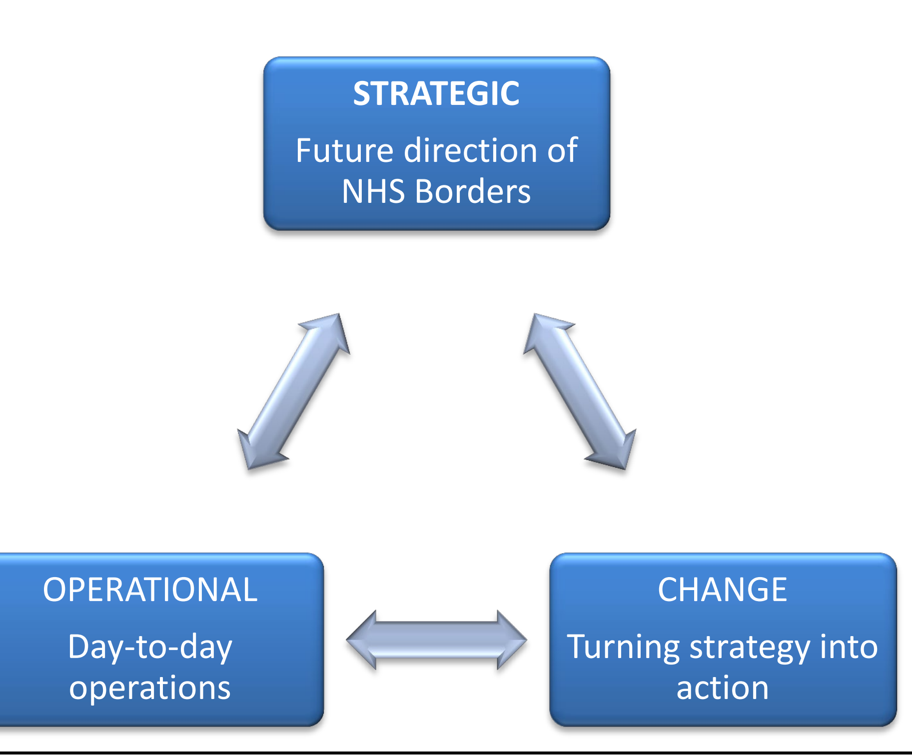

Chart 1: Strategic and operational risk framework

The strategic risk identification closely reflects the corporate direction of the organisation through implementing Board strategies and risks to attaining the Corporate Objectives. BET have a watching brief to identify and manage further risks as strategic issues arise, therefore BET should not be an assurance group for strategic risks as it would create a conflict of interest.

The strategic risk register is now held within the electronic risk management system. This allows the risk owners to update risks in real time.

As part of the governance structure for strategic risks, specific risks are fed into a lead governance committee, as identified by each risk owner. The lead governance committee will provide assurance to the Health Board.

Audit Committee	Full strategic risk register/ risk management process
Clinical Governance Committee	Risks associated with patients/ clinical activity/ clinical aspects
Public Governance Committee	Risks associated with communication/ engagement
Resource and Performance Committee	Risks associated with finance/ organisational performance
Staff Governance Committee	Risks associated with workforce

No	Risk	Previous Risk Level (Sept 2021)	Current Risk Level (Feb 2022)	Lead Governance Group	Comments
24	Staff Wellbeing during and post COVID-19 pandemic (ID3915)	Medium	Very High	Staff Governance Committee	Although many controls are in place this does not mitigate the risks coming from reduced capacity and staffing within teams.
1	Non-achievement of financial targets (RRL and CRL), (ID1589)	Very High	Very High	Performance and Resource Committee	Risk controls maintained. This risk will be replaced with an updated risk assessment imminently; risk 3588 currently in development.
5	Failure of Resilience. (ID1592)	Very High	Very High	Performance and Resource Committee	It is expected the likelihood of this risk will fluctuate, reflecting current operational risks arising relating to day-to-day activities.
25 NEW	The effect of climate change has a detrimental effect on the delivery of NHS services in Scottish Borders region (ID4156)		Very High	Performance and Resource Committee	Risk controls maintained. The development of an NHS Borders Sustainability Strategy and Climate Change action plan is due to be implemented by July 2022.
26 NEW	Impact of inability to sustain independent contractors services across all part of the Borders population (ID3910)		Very High	Performance and Resource Committee	The IJB are expected to issue a Direction to NHS Borders and the Scottish Borders Council on 2 March 2022 relating to the requirement to develop an integrated workforce plan, including support for immediate sustainability issues within HSCP provided and partner provider services.
16	Number of people in Hospital receiving care in an inappropriate setting impacting on clinical outcomes (ID398)	Very High	Very High	Clinical Governance Committee	Ongoing issue as a consequence of delayed discharges. NHSB/SBC are working together to resolve.
27 NEW	Organisational compliance with health and safety regulations and legislation (ID3032)		Very High	Staff Governance Committee	A robust action plan is in place to reduce this risk in the longer term. Controls monitored and maintained.
17	Potential to comply with infection control standards and precautions relating to fabric and layout of buildings (ID583)	Very High	Very High	Clinical Governance Committee	Constraints and limitations of inpatient facilities impact on reduction of this risk in the short term, although controls are in place and maintained. Working towards the longer term requirement for development of Premises Strategy in accordance with Clinical Strategy objectives.
18	Reducing the harm from inequalities (ID3129)	Very High	Very High	Public Governance Committee	Risk reviewed to incorporate employment inequalities as well as health inequalities.

	Risk	Previous Risk Level (Sept 2021)	Current Risk Level (Feb 2022)	Lead Governance Group	Comments
2	Destabilisation of clinical services within NHS Borders due to inability to recruit and retain medical workforce. (ID1591)	High	High	Clinical Governance Committee	Work ongoing to ensure recruitment more attractive to future applicants and reduce risk of vacancies.
28 NEW	Digital infrastructure and security controls being inadequate to support local needs (ID3405)		High	Performance and Resource Committee	Controls monitored and maintained. Action plan due dates delayed due to Omicron surge, new target dates entered for completion of actions.
29 NEW	Cyber Security (ID1178)		High	Performance and Resource Committee	Controls monitored and maintained. Action plan due dates delayed due to Omicron surge, new target dates entered for completion of actions.
9	Failure to plan effectively for a significant outbreak for communicable disease e.g. epidemic, pandemic (ID1596)	High	High	Clinical Governance Committee	Risk is currently being tolerated and all current controls in place are monitored to ensure they are still appropriate and effective and risk reviewed regularly.
3	Less effective service delivery as a result of ineffective partnership working with key organisational partners (ID1585)		High	Performance and Resource Committee	Risk controls maintained.
30 NEW	Failure to achieve appropriate access to emergency and elective services (ID3912)		High	Clinical Governance Committee	Risk reviewed and controls maintained. Further work being undertaken to reduce front door pressures through unscheduled care review. Work with partner organisations to increase patient flow.
6	National and regional agenda for training delivery not fully implemented. (ID 1594)	High	High	Staff Governance Committee	Internal Audit of Stat/Mand training undertaken and a resultant action plan created which should support reduction of risk level.
19	Risk to COVID-19 vaccination programme delivery (ID3127)	High	High	Performance and Resource Committee	Risk updated to reflect the current position of the vaccination programme. This risk will be re-assessed following the release of the Scottish Government's strategy regarding vaccinations.
32 NEW	Failure to effectively involve patients, public and third sector partners in decision making (ID3918)		High	Public Governance Committee	
31 NEW	Sustaining safe staffing levels and providing clinical specialist services resulting from ability to recruit professional groups (ID3911)		High	Clinical Governance Committee	Controls monitored and maintained. Action plan updated to highlight additional measures to be put in place to reduce the risk level.
21	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up (ID3766)	Medium	Medium	Staff Governance Committee	A Governance group has been established to monitor activity relating to whistleblowing in NHS Borders.
22	Failure to implement remobilisation successfully (ID2958)	Medium	Medium	Clinical Governance Committee	Controls monitored and maintained. Further actions added to action plan to support reduction in risk level.

	Risk	Previous Risk Level (Sept 2021)	Current Risk Level (Feb 2022)	Lead Governance Group	Comments
8	Failure to meaningfully implement clinical strategy. (ID1593)	Medium	Medium	Performance and Resource Committee	Controls monitored and maintained. Further actions added to action plan to support reduction in risk level.
10	Financial decision-making in partner organisations' budgets impacts on NHS Borders. (ID1586)	Medium	Medium	Performance and Resource Committee	This risk will be amalgamated into risk 3588, currently in development.
23	Board breaches of Code of Corporate Governance (ID2686)	Medium	Medium	Performance and Resource Committee	Risk controls maintained.
4	Sustainability of organisational leadership. (ID1597)	High	Medium	Staff Governance Committee	This risk has been updated to a tolerated risk. Controls reviewed and maintained. A robust action plan is in place to ensure any changes in circumstances do not allow the risk level to escalate uncontrollably.
12	Unacceptable Clinical Performance. (ID1588)	High	Medium	Clinical Governance Committee	Risk controls maintained.

Risks Removed from Strategic Risk Register

	Risk	Risk Level Achieved	Reason for Removal
14	Coronavirus and COVID-19 (ID1682)	Very High	This risk has evolved since entry onto the strategic risk register in 2020. The strategic risks associated with this are now identified in other strategic risks
20	Executive Nurse Director role during COVID-19 (ID1760)	Medium	Role now embedded into systems and processes
7	Impact of Brexit on Health Board (ID1595)	Medium	This is no longer a strategic risk. Day to day risks relating to this will be identified within the operational risk register

Risk 14 was entered onto the strategic risk register at the beginning of the pandemic in 2020 and highlighted the risks around the uncertainty of the disease and impacts this had on NHS Borders delivery of services. This has now evolved and more understanding around the impacts COVID-19 has on NHS Borders are captured in other strategic risks such as vaccination programme risk, remobilisation risk and outbreaks of communicable diseases risk. Risks relating to day-to-day operations are captured on the operational risk register.

Risk 20 was initially put on the strategic risk register following an expansion of the role into care home oversight and the associate risks with this as a new service. This role is now embedded into processes and procedures; as such this risk has now been de-escalated onto the operational risk register. The creation of the Care Home Oversight Team, which is funded on a recurrent basis, is now in place and any risks relating to the day-to-day activities can be raised through the operational risk processes. The governance of this workstream is reported into the Clinical Governance Committee.

Risk 7 has now run its course strategically and processes embedded into operations. Any risks relating to Brexit will be raised through the operational risk register.

Risk Movement

The below risk profile highlights the increase in risks on the strategic risk register and increase in very high risks facing NHS Borders. 69% of strategic risks are graded as very high or high risks to NHS Borders. Since September 2021 there has been an increase in very high risks; 3 new risks and one risk relating to staff wellbeing escalated from medium to very high risk. Two high risks have been managed down to medium risks and another high risk has reduced its likelihood of occurrence, but remains a high risk.

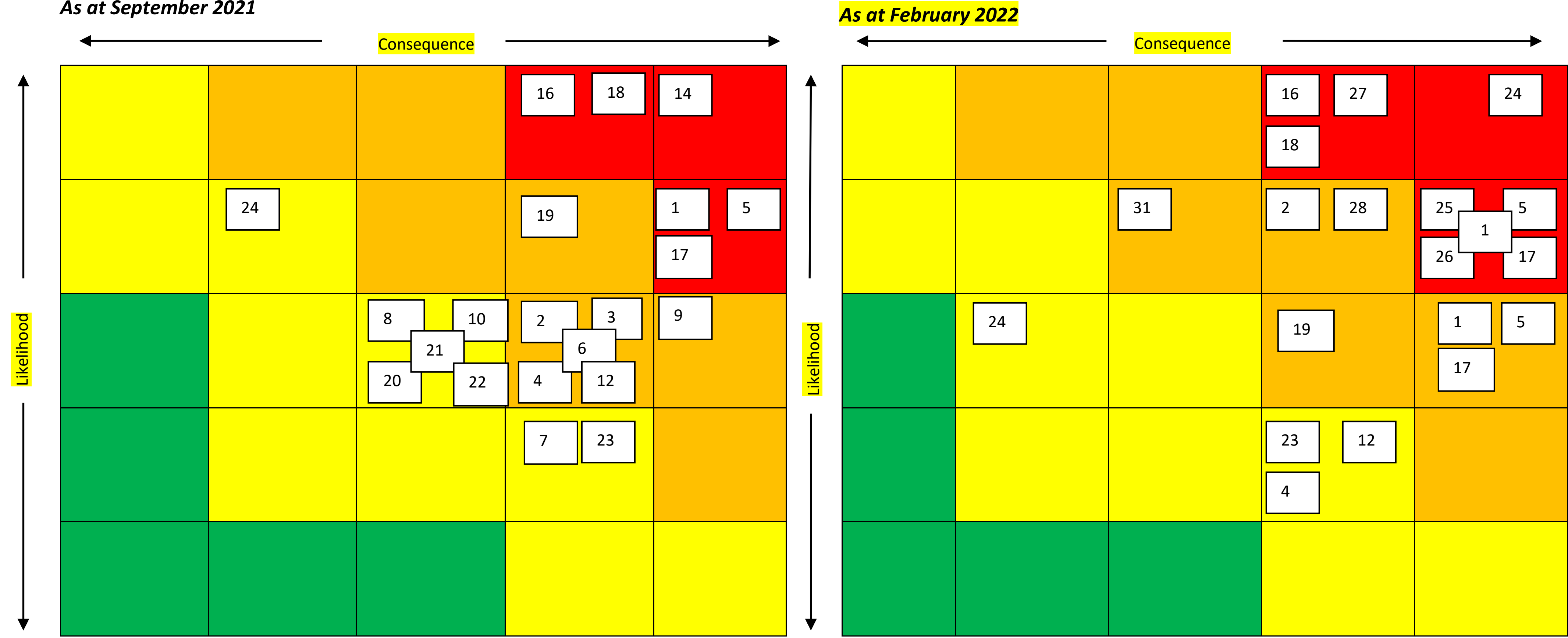

Chart 2: Strategic risk movement

Key Performance Indicators

Performance Tool			
R	Under Performing	Current performance is significantly outwith the trajectory set	Under the target by 11% or greater
A	Slightly Below Trajectory	Current performance is moderately out with the trajectory set	Under the target by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory set	Matches or exceeds the target

			Compliance Level						
Target Descriptor			Target	As at 25.11.2021	As at 28.01.2022	As at 08.03.2022	Performance compared to previous report	Status	Comments
Within review date by risk level	Current Risk Level	Review timescales (no more than)	90%						
	Very High	Every 6 months		66%	80%	89%	↑	A	Number of Risks Outwith Review Date 1 of 9
	High	Every year		90%	89%	100%	↑	G	Number of Risks Outwith Review Date 0 of 9
	Medium	Every 2 years		71%	100%	100%	↔	G	Number of Risks Outwith Review Date 0 of 8
	Low	Every 2 years		100%	100%	100%	↔	G	Number of Risks Outwith Review Date 0 of 0
Timescales for risk approval	Risks in development not approved within policy timescale	Risks in development should be finally approved within 104 days	80%	0%	0%	0%	↔	R	Number of Risks in development over 104 days: 1 of 1; currently 1 risk sitting at 363 days in development. Please note this is a risk that will replace 2 risks currently on the strategic risk register as identified in risk chart p2-p4 (Risk No. 1 and Risk No. 10).
Risk outwith risk appetite taken through appropriate risk appetite process			100%	0%	0%	0%	↔	R	No risks taken through the risk appetite process; potential for 21 very high and high risks to be outwith risk appetite
Action plans in place			100%	92%	93%	100%	↑	G	All risks have an action plans in place for risks on the risk register
Number of staff completing risk management eLearning			80%	80%	80%	90%	↑	G	eLearning: Adverse Event Reporter eLearning No of staff undertaken: 9 of 10

Scrutiny and Assurance

For each strategic risk a governance committee is identified by the risk owner as the lead committee to provide scrutiny and assurance to the health board.

An exercise was undertaken by the Board Executive Team to highlight were each risk would be required to be presented at a supporting assurance committee. The paper was discussed at the Audit Committee on 21st March. A number of issues were highlighted in relation to the proposed approach to assurance of individual risks including: discussion regarding the role of BET within the assurance process; and consideration of the alignment of individual risks to specific committees and whether these were appropriately assigned. It was recognised that there remains a concern regarding the practicality of how committees will seek assurance on strategic risks not aligned directly with their own portfolio. No changes were agreed at the committee however it was recommended that the process remain 'in development' and that these and other issues are addressed during implementation.

Between September 2021 and February 2022, risks were presented to the Clinical Governance Committee, Public Governance Committee and Staff Governance Committee. Audit Committee, at this time, had no specific risks to provide assurance for, instead gaining assurance that the risk management process and systems in place are appropriate.

	Risks managed appropriately and proportionately		Systems are in place to record these risks		
	Assurance Given	Assurance Not Given	Assurance Given	Assurance Not Given	Comments
Audit Committee					November 2021 - Report presented to the Audit Committee highlighting the process in place for information sharing process for strategic risk assurance**.** This was approved by the Audit Committee. *Next report Due April 2022*
Clinical Governance Committee					November 2021 - Assured by processes but not the outcomes. Concern raised over specific risk relating to workforce, which the SGC are lead governance group, as this risk will impact on clinical activity. *Next report Due May 2022*
Public Governance Committee					September 2021 - Decision on assurance deferred on whether risks were managed appropriately and proportionately. As it stands cannot give full assurance that this group is seeing all risks that may impact on Public Governance. Assured systems in place to record risks. *Next report Due May 2022*
Performance and Resource Committee					August 2021 - Assurance given for both risks being managed appropriately and proportionately and that there are systems in place to record these risks. *Next report Due May 2022*
Staff Governance Committee					October 2021 – Assurance could not be given around the staff wellbeing risk. Whilst it was acknowledged there are controls in place, these are not reducing the risk to the organisation. Assurance was given on the systems and processes being appropriately used and followed. *Next report Due March 2022*

Chart 3: Scrutiny and assurance

Recommendation

The Health Board is asked to NOTE the report.

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
3915	Strategic Risk Register *Board Executive Team Use Only*	McLaren, John	Andy Carter	Staff Governance Committee	Staff Wellbeing during and post COVID-19 pandemic	COVID-19 threatens all operations as a result of its potential impact on duty of care and staff wellbeing.	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable.	10/05/2021	V High (25)	Medium (9)	Treat	NHS Borders policies and procedures NHS Borders training Occupational Health support to all staff Ensure daily situational updates sent to all staff via COVID19 update Creation of wobble rooms, enabling staff to find some quiet time during their working day Free access to Wellbeing Apps Covid microsite and FAQs regularly updated Training for staff being deployed from other areas Refreshment trolleys located throughout organisation Practical advice available on microsite including information around childcare, accommodation, financial, transport etc COVID-19 risk assessments and controls in place COVID-19 age calculator to access vulnerability and supporting individual risk assessments Permitted to recruit final year nursing students as HCSWs on 15 hour contracts (6 x 15 hour contracts) WFH risk assessment tool and supporting guidance documentation Funding through Charities together to support staff wellbeing initiatives Staff Wellbeing Group established Direct engagement between organisation and trade unions Open discussions around risks Occupational Health & Safety Forum Local Partnership Forums HSE Readiness SLWG Risk Management Board WFH SLWG Joint working with SBC to improve delayed discharges	No	Significant concerns from staff and management regarding patient flow Reduced capacity within inpatient units impacting on staff wellbeing Reduced staffing	30/11/2021	Ongoing development of initiatives through the staff wellbeing group communication and posters to be issued informing staff of all support available

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
4156	Strategic Risk Register *Board Executive Team Use Only*	Bone, Andrew		Performance and Resource Committee	Effect of climate change has a detrimental effect on the delivery of NHS services in Scottish Borders region	Climate Change risks arising from Climate Change Scotland Act 2009 (amended 2019)	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	09/11/2021	V High (20)	High (15)	Treat	Self Assessment on climate change (NSAT survey) EoS Risk assessments Sustainability Group to develop NHS Borders Sustainability Strategy Funding secured from SG for a review of estate to get to Zero greenhouse gas due by March 2022 the scope of this is building and engineering assets NHS Borders contracts all work out through built in frameworks to ensure appointment of contractors and tender processes capture net-zero greenhouse emissions to major refurbishments or new builds 15 electric vehicles in our fleet External funding to support engagement campaign for NHS Borders staff, once strategy published	No	Climate Change Adaption Plan to ensure resilience of service under changing climate conditions, awaiting publication of national risk assessment Review fleet NHS Supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environments impacts Development of Sustainability Strategy Engagement with national consultant to produce Climate Change Adaptation Plan	31/07/2022	Development of Sustainability Strategy Development of Climate Change Action Plan Review fleet for climate change adherence NHS Supply chain will be reviewed to determine the extent of associated greenhouse gas emissions and environments impacts Engagement with national consultant to produce Climate Change Adaptation Plan Develop a resource plan aligned to NHS Borders Climate Emergency & Sustainability Action Plans
1592	Strategic Risk Register *Board Executive Team Use Only*	Patterson, Tim		Performance and Resource Committee	Failure of Resilience	Failure to have adequate and tested resilience in place for NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	V High (20)	Medium (5)	Treat	1.Training and exercising business continuity plans overseen by Resilience Committee 2.Monitoring that adequate plans exist & are relevant 3.Continue to implement actions coming out of internal audit, including exercise plan, e-learning for selected groups, and awareness raising 4.Process for updating resilience plans agreed 5.IT implemented new technology stack including improved recovery and restore solutions to minimise impact and likelihood of failure. 6.Agreed location for a second resilient facility and procurement underway to build 7. Electronic business continuity system implemented to increase and support joint working between departments to highlight key dependencies	No	Internal audit on business continuity highlighted a number of gaps including keeping business continuity plans up to date. The implementation of the business continuity electronic system should assist in addressing this issue. Related to this is the release of staff to complete the business continuity plans. Whilst an agreed location for a second resilient facility is underway, this still remains a risk to the organisation until the project is completed	30/10/2022	Transfer secondary equipment to the resilient facility when available Action plan in progress following internal audit recommendations Draft Resilience Policy

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
1589	Strategic Risk Register *Board Executive Team Use Only*	Bone, Andrew	Ralph Roberts	Audit Committee	Non-achievement of financial targets (RRL and CRL)	Non-achievement of financial targets (RRL and CRL) and Non achievement of financial targets (RRL and CRL) during Covid19 pandemic	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	21/10/2019	V High (20)	High (10)	Treat	1.Additional support and expertise in financial turnaround 2.Improved communication and staff engagement to agree how financial sustainability is achieved 3.Put in place a structure to deliver financial turnaround including work streams with executive leaderships and accountability supported by a well resourced PMO 4.Put in place processes and decision making which is clear and supports financial turnaround 5.Annual Operational Plan 6.Ongoing review and update of the financial plan. 7.Maintain strong links with SG – quarterly meetings 8.Seek support similar to the boards in special measures. 9.Medium and longer term planning 10.Horizon scanning and networking. 11.Organisational and public awareness of the financial environment and challenge. 12.Ensuring we have financial grip and control. 13.Ensure management information and reporting is timely, accurate, understood and acted upon. 14.Monitoring of financial position and delivery of efficiency. 15.Robust project management. 16.Focus on quality 17.Senior Clinical input into decision making 14.Work closely with East Region 15.Review/benchmark of all services (Discovery) and identify variation 16.Develop Integrated working with health and social care partners facilitated through the Executive Management Team (SBC and NHS) 17.Increase Focus of the organisation/board onto the financial agenda 18.Creation of a new Board Sub Committee – The Finance & Resources Committee . 19.Increase in the resources to support the financial agenda – set up of a Project Management Office 20.Improve financial awareness in the organisation	No	Update. As at Q1 review 2021/22 the board is projecting a financial deficit of £8.49m. This position assumes additional resources will be provided to fully fund ongoing costs of COVID 19 response. The financial gap of £8.49m is £2.09m increase on gap described in the board's financial plan for 2021/22 (£6.4m). This position has been shared with Scottish Government and it is expected that there will be further dialogue around additional support required to manage the position in 2021/22. As at 12/08/21 no date is confirmed for these discussions.	31/03/2022	Finance benchmarking with peer HBs through national/regional networks to ensure Local Mobilisation Costs are robustly assessed (ongoing from May20) Review of Capital planning assumptions with SG colleagues via National Infrastructure Board (NHSB/NIB meeting mid-July20). Review of Financial Plan at Q1 Review (July20) to include specific focus on both Covid-19 and "recovery/renew" workstream. Interim financial governance arrangements implemented to ensure grip & control in relation to Covid-19 related expenditure. Regular reporting of spend against Covid-19 Local Mobilisation Plan (LMP) to Scottish Government colleagues in agreed template. Covid-19 specific financial reporting to BET and NHSB Board as part of routine finance reports (monthly). Increased frequency of national finance networks to ensure consistency in approach with peer systems, including weekly Corporate Finance Networks and Director of Finance meetings chaired by Scottish Government Health Department Interim Finance Lead. Directors of Finance/Strategic Change review of Turnaround Programme to assess impact of delays in current programme and opportunities for reprioritisation of future plans arising from LMP/renew workstreams. Direct dialogue with SG finance colleagues to ensure that financial planning assumptions are in line with those made nationally. Regular (monthly) update to financial forecasts for Covid related expenditure. Review Grip & Control Action Plan biannually Production and implementation of a financial recovery plan for the next 3 financial years which returns the organisation to financial sustainability Creation of a NHS Borders financial strategy which details the road map on how this will be delivered Increase dialogue with the public and communities to address the financial challenge Ensure clinicians are at the centre of financial turnaround Develop an integrated financial plan across IJB, SBC and NHS Ensure financial accountability is accepted at every level of the organisation Develop Engagement Plan for Financial Savings programme(s) Wider clinical input to develop and implement plans and strategies Transformational changes to all services required Review demand, protocols and thresholds Realising realistic medicine Increased focus on quality and clinical variation Link with national and regional efficiency work streams and shared services programme

Appendix 2 – Strategic Risk Register

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
398	Strategic Risk Register *Board Executive Team Use Only*	Roberts, Ralph	Chris Myers	Clinical Governance Committee	Number of people in Hospital receiving care in an inappropriate setting impacting on clinical outcomes	Patients receiving care in inappropriate settings because of extended hospital stays and delays in discharge, resulting in lower quality of care and poorer outcomes.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	25/01/2022	V High (20)	Medium (9)	Treat	Admission and discharge processes agreed DD target in place; DD monitoring / reporting DD Audit taken place with relevant action plan Daily discussion on whole system planning through Integrated Huddle Integrated service planning through Strategic leadership team and Winter planning board;	No	Information evidences continued levels of DD, particularly in Community Hospitals, Complex MH patients and in the BGH	30/06/2022	Increase short term capacity for Care Home beds and POC Develop plans for long term Care Home capacity and Commissioning strategy Progress SIP and ensure implementation provides clear plan to address DD on an ongoing basis Ensure IJB 22/23 Budget supports reduction of DD Embed effective implementation of agreed Discharge processes with delegated services embed agreed DD processes effectively within Acute services Progress DD Action plan (following DD Audit)
3032	Strategic Risk Register *Board Executive Team Use Only*	Carter, Andy		Staff Governance Committee	Organisational compliance with health and safety regulations and legislation	Health and Safety at Work etc Act 1974 - This Act places a legal duty on employers to ensure, so far as reasonably practicable, the health, safety, and welfare of employees, and to ensure that employees and others are kept safe. Non compliance with legislative requirements would result in increased risk of ill health, unnecessary injury to staff, patients and visitors, in some circumstances death could occur. NHS Borders reputation would be damaged, leading to negative public perception and potentially undermine patients willingness to receive care from our services and impact staff recruit. NHS Borders and Directors/Senior Managers open to criticism, prosecution and financial impact of safety failings.	Provide high quality, person centred services that are safe, effective, sustainable and affordable.	17/11/2020	V High (20)	High (12)	Treat	NHS Borders policies and guidance Provide Leadership advice & systems for adverse event management Electronic risk management system Provide competent RIDDOR reporting systems, supporting reviews/SAER when required Highlighting issues to the Heath Board Centralised RIDDOR reporting Officers OHS Forum Hierarchy in place for escalation of health and safety issues Stat/mand training LearnPro dashboard to monitor compliance with training Risk Register Safe Systems of Work for some areas Generic risk assessments Limited number of competent topic specialists	No	- Lack of strategies: OH&S, risk management, premises and equipment. - Change management processes does not factor in OH&S implications. - No defined health and Safety structure. - Policy gaps, additional polices required, existing policies require to be reviewed and updated. - Single points of failure within service, limited ability to respond to additional demands on service. - Venue restrictions for statutory practical training, lack of uptake in existing training provision preventing skills development and progression. - COSHH policy not fully implemented. - Lack of robust and systematic audit and monitoring program. - Limited quality monitoring systems to ensure adequacy of risk assessments, control measures, improvement/action plans, local OH&S policies, adverse event reviews and Standard Operating Procedures. - Inconsistency of controls across the organisation. - Poor compliance with existing policies. - Plan, do, check, act model of continuous improvement not embedded into culture	01/08/2022	Develop 5/10 year Occupational Health & Safety Strategy Develop premises and equipment strategy to support health and safety Integrate occupational health and safety as a consideration in governance structure for change management Review health and safety structure and service delivery model Review health and safety policy arrangements Benchmark of health & safety training to establish core Review COSHH policy Plan 2022 audit programme to ensure monitoring Review H&S SAER system Investigate embedding total quality management systems for health and safety Identified members of BET/senior management to complete Nebosh excellence in h&S leadership

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583	Strategic Risk Register *Board Executive Team Use Only*	Bone, Andrew	Sarah Horan	Clinical Governance Committee	Potential to comply with infection control standards and precautions relating to fabric and layout of buildings.	Risk to NHS Borders of patients catching a healthcare associated infection associated with limited single room provision and specification of multi-bedded bays. Current fabric/specification of inpatient buildings does not provide the appropriate standard for preventing HAI. Constraints and limitations of inpatient facilities do not enable patients to maintain 2 metres social distancing from each other (detailed in attached SBAR). This increases risk of cross transmission of pathogens requiring droplet or airborne precautions.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	05/10/2020	V High (20)	Medium (5)	Treat	-Infection Control policies (including isolation guidance) -Infection control training for staff -Robust infection surveillance to identify possible increased infection incidence i.e. clusters and outbreaks including sophisticated IPC software systems to enhance reporting including contact tracing. Identification of cross transmission would lead to outbreak response to control and reduce risk of further spread. -SGHD requirement to increase single rooms when undertaking major refurbishment -Liaison between bed management team and infection control team -Pre-admission MRSA screening -HAI admission screening/assessment and transfer documentation -PPE (to protect staff, visitors and patients) -Whenever a broken sink is replaced or an area subject to significant refurbishment, hand wash basins are replaced with models that comply with current national guidance. -24/7 access to IPC advice including dynamic situational risk assessment. -Robust communication systems both within and across the wider organisation i.e. IPCT daily safety brief, hospital safety brief and daily outbreak meetings when needed. -Co-location of IPCT and laboratories facilitates 'real-time' reporting of laboratory results. -IPC spot-check and audit activity of clinical areas to check on staff practice and cleanliness (there have been extended periods through the COVID pandemic where this has not been maintained due to volume of queries and clinical workload). -High visibility of IPC team members in clinical areas (there have been extended periods through the COVID pandemic where this has not been maintained due to volume of queries and clinical workload). -Highly accessible supply of personal alcohol-based hand rub. -Routine and terminal clean protocols -Staff wear face masks while working in clinical areas -Patients supported and encouraged to wear masks in multi-bedded bays when not in bed or on their chair. -All inpatients are screened for COVID-19 to support clinical decision making on appropriate patient placement. This reduces the risk of patients with COVID-19 being placed in multi-bedded bays with patients who have a negative screen result. POCT tests now in use in ED and endoscopy. Confirmed COVID-19 patients are either isolated in single rooms or cohorted with other confirmed positive patients. -Inpatients in multi-bedded bays are asked to wear a mask if they can tolerate it when they are not in their bed or on their chair. -Increased cleaning frequency in patient areas. -Repeat patient screening for COVID-19 as	No	Borders General Hospital has wards with 6-bedded bays which are very cramped with inadequate storage for equipment. To provide a context - we put 6 patients into an area 56m2. compared with the current national standard of 64m2 for 4 beds. Certain pathogens such as Norovirus are so transmissible - especially in the context of gastrointestinal symptoms and 6 patients sharing 1 toilet that when one patient succumbs, it is normal for other patients to be affected. An episode of projectile vomiting can travel great distances (>3 m forward spread and 2.6 m lateral spread). (J Infect Prev. 2014 Sep; 15(5): 176–180.) Current guidance relating to the COVID-19 pandemic highlights the importance of physical distancing which cannot be achieved in our current multi-bedded bays. Ultimately, the only way to mitigate this risk is to increase spacing between patients either by reducing the number of patients in multi-bedded rooms or re-provision of inpatient services in more spacious accommodation. Consideration has been given to introducing screens between beds but this would introduce greater risks. (reduced airflow, increased temperature, moving and handling risks, access to patient, observation of patients, increased cleaning requirements) Air changes per hour to be assessed in Ward 12 bedrooms.	30/06/2022	Confirm future role and purpose of Ward 5 to inform refurbishment requirements Develop plan for re-developing/new build BGH in accordance with Clinical Strategy "The Borders General Hospital will be a modern fit for purpose facility which will be the key to NHS Borders delivering 21st Century health and social care".

determined by SGHD.
-Staff wear PPE with many having received recent training on safe donning and doffing of PPE. Staff have ongoing access to this training.
-Staff supported and encouraged to undertake regular LFD testing.
-Tristel Fuse cleaning agent is being used for the high risk patient pathway.
-Where possible encourage natural ventilation of areas by opening windows/doors (windows restricted to <100mm)
-Engineering control measures, mechanical ventilation – operating times extended.PPM schedules in place.
-Ventilation rates – programme in place to measure air changes/hour by a contractor.
- At times where there is excess inpatient capacity and there are empty beds in multi-bedded bays, prioritisation should be to place patients in the four corners of the room first and fill the middle two beds last.
- Checks on compliance with admission and repeat COVID-19 screening.
- Agreement for criteria to reduce number of patients in multi bedded bay
Staff and managers instructed to undertake individual COVID age risk assessments - particularly when considering working in high risk pathway areas.
Structured assessment of location for high risk pathway patients (MAU Annex and Ward 12) conducted by IPCT, Occ Health, Estates & Facilities, Safety Advisor, BGH Management. When COVID inpatients low in number, MAU Annex is used, as numbers increase, Ward 12 is converted into COVID inpatient ward. MAU Annex benefits from all single rooms, large rooms with tighter fitting bedroom doors, en-suite with clinical hand wash sinks. Ward 12 has air vents in the multi-bedded rooms.

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
3129	Strategic Risk Register *Board Executive Team Use Only*	Patterson, Tim		Public Governance Committee	Reducing the harm from inequalities	Risk related to failure to address inequalities resulting in poorer health outcomes for certain groups or parts of the population, including health and social care workers.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Promote excellence in organisational behaviour and always act with pride, humility and kindness.	02/12/2020	V High (20)	High (12)	Treat	Whilst this is a societal issue, the healthboard can put in actions to mitigate. NHS Borders agreed a health in all policies approach Joint Health Improvement Team delivers on national/local priorities and offers training to understand their role in reducing inequalities Screening programme Effective partnership with different sectors to help reduce health inequalities Advocating to reduce health inequalities Equality and Diversity in Employment Group, overseeing implementation of equalities act Best practice (PIN) Policy framework in recruitment, pay terms and conditions and employment Equalities mainstreaming report Monitoring of workforce statistics iMatter staff experience tool Partnership and employee relations and access to support (contact officers and occupational health)	No	Quality services with allocation of resources proportionate to need Mitigation of inequalities through employment and procurement processes Inequalities within society is outwith NHS Borders full control Pay imbalance centered around gender Workforce reporting Evidence of impact of policy framework	01/04/2022	Development and implementation of workforce strategy, integrated workforce plan and equalities mainstreaming report Whole system approach involving NHS looking at service provision, training and service allocation NHS Borders working towards Living Wage employer status Child Poverty action plans Money worries app developed through Healthy Living Network Working with children and young people leadership group Working with SBC to support health impact assessment for Fairer Scotland Duties Act (2018) ADP – Drug related death action plan Implement and embed Anti Poverty Strategy
3405	Strategic Risk Register *Board Executive Team Use Only*	Smyth, June		Performance and Resource Committee	Digital infrastructure and security controls being inadequate to support local needs	Local Digital & Information infrastructure and security standards being inadequate to support local needs	Provide high quality, person centred services that are safe, effective, sustainable and affordable.	12/02/2021	High (16)	Medium (6)	Treat	Capital refresh annual plan Operational routine maintenance and patching & SOPs Digital portfolio investment programme IG policies and support team Digital portfolio governance Board and process BI workplan & standards	No	Lack of Digital strategy and forward agreed view for investment inadequate cyber governance process and controls sustainable IT infrastructure support model and regular training for staff inadequate BI data warehousing and data visualization infrastructure and process Long term funded staffing model across all digital teams	31/03/2022	New Digital Strategy developed & agreed by NHS Board Develop new target Operating Model for digital teams Ensure appropraite governance & plans in place to meet cyber & IG legislation Ensure IT infrastrcture refresh plan in place for 3-5 years Secure sustainable funding model for Digital
3910	Strategic Risk Register *Board Executive Team Use Only*	Myers, Chris	Lynn McCallum	Performance and Resource Committee	Impact of inability to sustain Primary Care independent contractors services across all part of the Borders population	Impact of inability to sustain Primary Care independent contractors services across all part of the Borders population impacting on other services	Provide high quality, person centred services that are safe, effective, sustainable and affordable.	07/05/2021	High (16)	Medium (9)	Treat	Close liaison with primary carer providers (community pharmacies, GPs, general dental services). Increase in the engagement between Primary and Community Services Clinical Board and Community Optometry. Business Continuity Plans reviewed by the NHS Borders P&CS and Pharmacy teams Ongoing work in relation to the Primary Care Improvement Plan which supports General Practice sustainability	No	Significant concerns relating to the sustainability of General Practice in particular within the Scottish Borders - associated to the termination of contract of the former Duns Medical Group, closure of the Coldingham Branch Surgery, merger discussions between Elwyn and Braeside practices, and challenges relating to the provision of out of hours General Practice (BECS). The IJB are expected to issue a Direction to NHS Borders and the Scottish Borders Council on 2 March 2022 relating to the requirement to develop an integrated workforce plan, including support for immediate sustainability issues within HSCP provided and partner provider services.	30/09/2022	Development and implementation of HSCP Integrated Workforce Plan

Appendix 2 – Strategic Risk Register

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
1178	Strategic Risk Register *Board Executive Team Use Only*	Smyth, June		Performance and Resource Committee	Cyber Security	There is a risk that Cyber security measures in place are not adequate to sufficiently protect against future / emerging threats. A Cyber Maturity review by internal audit will flag areas of concern	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	25/09/2017	High (15)	Medium (8)	Treat	Firewall perimeter security Patching of Microsoft Operating systems within 4 weeks of release Anti-virus client and server updated as new patterns available	No	Gap will be fully identified as part of Cyber Maturity review by Internal Audit in addition to ; No dedicated staff with Cyber security skills Insufficient staff to manage patching No patching of non Microsoft products Insufficient governance and reporting No regular testing performed	31/03/2022	Lead development of an action plan followign maturity review by PWC share teh action plan with resilince committee, strategy group * Board if required. Ensure that patchign regime up to date and reported on to IG Committee Develop case for teh right resources & Capacity in teh IT team (Secuirty expert skills) Implement the Cyber Action plan Undertake Cyber essentials accreditation Review outcome of NIS audit and develp plan to fill gaps
1596	Strategic Risk Register *Board Executive Team Use Only*	Patterson, Tim		Clinical Governance Committee	Failure to plan effectively for a significant outbreak for commuicable disease e.g. epidemic, pandemic	Commuicable disease planning not prioritised due to operational priorities and other strategic priorities.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	22/10/2019	High (15)	High (15)	Tolerate	Operational plans Business continuity plans for health services Vaccination program for staff and vulnerable patient groups, where a vaccine is available Response arrangements will be based on strengthening and supplementing normal delivery mechanisms as far as is practicable Plans on an integrated multi-agency basis with risk sharing and cross-cover between all organisations Work across the organisation seeking to mobilise the capacity and skills of all healthcare staff (including students and those who are retired), contractors and volunteers Treatment and admission criteria should remain clinically based and hospital admission criteria should be applied in a transparent, consistent and equitable way that utilises the capacity available for the seriously ill and most likely to benefit	No	Lack of staffing and estate to implement plans	01/09/2022	Ensure plans are up-to-date Excersize plans to ensure they are effective Monitor controls in place to ensure risk is not escalating
1585	Strategic Risk Register *Board Executive Team Use Only*	Roberts, Ralph	Chris Myers	Performance and Resource Committee	Effectiveness of partnership working	Less effective service delivery as a result of ineffective partnership working with key organisational partners	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	30/11/2021	High (12)	Medium (6)	Treat	Established IJB Joint Chief Officer accountable to NHS Borders Chief Exec and Scottish Borders Council Chief Exec. Joint team meetings at an operational level The creation of the joint Executive Management Team - which is working well Sharing of information facilitated through the IJB e.g. audit committee Established Community Planning Partnership Use of the Social Care Fund and Transformation Fund to pump prime projects that will deliver integrated working Governance arrangements in place IJB governance in place, Executive Management Team between NHSB, SBC and the IJB. Strategic plan agreed, regular meetings with staff groups and members of the public through locality working groups. Chief Officer attends the Staff joint Forum. HSCP Staff Comms being considered. Strategic Commissioning Policy will be considered by the IJB on 15 December 21. Review of scheme of integration being undertaken	No	Whilst controls have been put in place to reduce this risk to an acceptable level, they will take time to be fully effective Needs greater joint working between NHSB and SBC supported through IJB. The IJB requires further resource to support more communication amongst staff teams and across the population. Joint financial planning has started however requires time to bed in. Joint performance reporting in place to report to IJB , this should also report to NHSB Board and Council.	31/03/2022	Review effectiveness of Partnership working and develop longer term opportunities for further improvement Further communications across staff and population, newsletter, locality working groups, roadshows, IJB governance and joint working arrangements agreed. Review Operational leadership arrangements for HSCP in light of DNAHP post change and IRASC Agreement of strategic implementation plan, governance and capacity Development of locality plans Develop locality management model and integrate locality teams Create joint financial framework Review effectiveness of Partnership working in light of COVID response and develop opportunities to further improve, building on COVID success Progress action plan from integration self assessment

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3912	Strategic Risk Register *Board Executive Team Use Only*	Clinkscale, Gareth	Chris Myers	Clinical Governance Committee	Failure to achieve appropriate access to emergency and elective services	Failure to achieve appropriate access to emergency and elective services	Provide high quality, person centred services that are safe, effective, sustainable and affordable.	28/10/2021	High (12)	Medium (8)	Treat	Regularly reviewed by Hospital Management on the state of ED and whether this is also affecting elective activity. Option of opening Ward 17 to allow wards to take patients from ED. Issue will be staffing and funding if we require more agency to do this. ED working with Ambulance Service to review the number of ambulances on their way into ED and for ED to escalate if required.	Yes		28/10/2022	Winter board planning to deliver enhanced capacity across health and social care Winter bed plan being developed Refresh strategic plans
1594	Strategic Risk Register *Board Executive Team Use Only*	Carter, Andy	Sarah Horan	Staff Governance Committee	National and regional agenda for training delivery not fully implemented	Incomplete delivery of statutory/ mandatory and professional skills training	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	22/10/2019	High (12)	Medium (8)	Treat	NHS Borders Statutory and Mandatory training policy Identification of Executive Directors as Statutory/Mandatory Risk owners and Project Manager Implementation of the Central Booking system to ensure dynamic and robust monitoring and reporting of Statutory and mandatory training compliance Managers and Employees consulted about Statutory and Mandatory training issues through SMWG, APF and reports to NHS Borders Audit Committee, Clinical Executive Operational Group and Staff Governance Committee. Cycle of reporting to HEI's and NES. Internal audit action plan Employers Liability Insurance. Topic specialists keep up to date with current risks and good practice control measures. Quarterly performance reviews LearnPro tools in place to monitor compliance LearnPro process for manager accountability	Yes		01/08/2022	Annual review of Statutory and Mandatory training policy. Accurate identification of statutory and mandatory training requirements Senior managers to ensure staff are released for Statutory and Mandatory training as identified Regular review of SLA's with third parties Ensure annual compliance position is reported to the governance committees Support to managers to ensure implementation of effective PDPs Inclusion in dashboard report to staff governance committee

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3127	Strategic Risk Register *Board Executive Team Use Only*	Roberts, Ralph	Chris Myers	Performance and Resource Committee	Risk to Covid-19 Vaccination programme delivery	There is a risk that the Covid-19 Vaccination Programmes is not delivered to fully satisfy national requirements	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	02/12/2020	High (12)	High (12)	Tolerate	Training updated to take into account changes to green book. Local training pack developed to highlight local processes and procedures for staff and public Use experienced vaccinators leading the clinics Operational group in place to monitor risks that arise Strategic oversight by Gold Command Programme Board oversight Pharmacy processes in place to ensure labelling correct Adverse Event recording system in place to record events specifically relating to COVID19 vaccination programme Clinical Prioritisation Working with HR to manage any staffing issues that arise Severe weather planning ongoing to reduce risks that may impact on delivery of this programme Secure storage identified Public and staff information leaflet Staff support available to all staff (Work and Wellbeing team etc) Security policy in place SBC assurance that back up generators in place Business continuity plan in place Process in place should an allergic reaction occur in rural location Vaccination Staffing Bank implemented Security risk assessment for COVID vaccinations undertaken Additional fridge/ freezer capacity in pharmacy Defib, O2 and adrenaline available at all vaccination clinics and SAS bus O2 and adrenaline available on road trips	No	Jan 2022 - need to develop long term plan for future of vaccination programme once updated strategy on Covid vaccine programme available Awaiting confirmed staffing budget Venue/utilities budget not in place, Scottish Government financial planning still to be carried out before monies allocated to boards	31/03/2022	Create Business Continuity Plan Develop processes for rural areas if allergic reaction occurs Monitor budget for COVID-19 vaccination programme Continuity in place for freezer in case of break down Confirmation and approval of vaccinators Develop Long term workforce & capacity plan for Vaccine Programme

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3911	Strategic Risk Register *Board Executive Team Use Only*	Horan, Sarah	Andy Carter	Clinical Governance Committee	Sustaining safe staffing levels and providing clinical specialist services resulting from ability to recruit professional groups	Sustaining safe staffing levels in accordance with Workload tools and triangulation of safe staffing. Potential to not be able to provide adequate levels of patient care as a result of inability to recruit to both Registered Nurses and Health Care Support Workers.	Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	07/05/2021	High (12)	Medium (9)	Treat	Rigorous control of rostering to ensure staff have adequate time off work. All elective work undertaken on a needs clinical prioritisation basis. Use of supplementary staff (bank and agency when available) to maintain core numbers on shifts whenever possible Alteration of skill mix in wards to meet patient care needs. Use of staff wellbeing services and Occupational Health/HR to manage sickness absence. Up skilling of non registered staff to undertake more advanced roles. Open recruitment to all nursing staff rolling advert. Deployment of non clinical facing staff to support clinical Deployment of Dementia Nurse consultant to lead/advise of care and interventions for patients who require enhanced observations of care (EOC) Recruitment of a Lead Nurse for EOC patients within acute services to support design of stress/distress activity with BGH ward areas. International recruitment of RGNs under way with 7 wte starting March 2022	No	Despite the above ,patients requiring enhanced observations can remain at risk as require enhanced observation or above staffing. Social care unable to provide POC or alternate place of care at pace to meet current demands. National shortage of Registered Nurses makes adequate recruitment to match attrition challenging. On going work on up skilling HCSWs on an annual basis requites funding recurrently.	25/02/2022	International recruitment of RGNs - professional lead identifed to support HR lead post to be advertised 5 nurses currently expcted to arrive April 2022 Over recruitment of HCSWs to enable getting ahead of current attrition rates via retirement Using Princes Trust to maximise employability of individuals as HCSWs via on the job training and support Ongoing developemtn programme of HCSWs to Band 4 level of knowledge and subsequent employment as such, Working with Borders College Identifcation and support for HCSWs to train as RGNS via Open University with a job guarantee at the end of training Trajectory of age likely retirements by Clinical Board and ward area to map out highkest risk areas to target workforce developments Secure funding to maintain preceptor posts on a recurrent basis with an immediate need for extension past June 2022 Supportive Visits by family to contribute to immedaite care needs of relative within SOP Clinical Prioritasation Process to maintain essential services and release satff for delpyment follwoing safe reduction of some aspects of serive delivery Essential visiting inplemented to reduce further risk of Omicron infction into clinical areas
3918	Strategic Risk Register *Board Executive Team Use Only*	Smyth, June		Public Governance Committee	Failure to effectively involve patients, public and third sector partners in decision making	Failure to effectively involve patients, public and third sector partners in decision making could lead to harmed relationships, reputational damage and in extreme cases government intervention which would impact on timescales for service changes and developments.	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	10/05/2021	High (12)	Medium (8)	Treat	Public Governance Committee in place. Public involvement and participation group. National guidance and statute. Local strategy and process (currently being updated). Commissioning relationship with some key third sector partners locally.	No	Address in an action plan the gap analysis and through the Public Engagement Pillar linked to the new decision making framework There is a need to refine and update local strategy and process to reflect latest guidance. There is a need to increase awareness on the requirements to engage and the process to be followed by service leads. Don't have a set of quality standards to guide, measure and evaluate public engagement. Need to embed service attendance and contribution to PGC Need to review membership of PGC	31/03/2022	Develop updated action plan based on QMS pillar work

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
3766	Strategic Risk Register *Board Executive Team Use Only*	Carter, Andy	John McLaren	Staff Governance Committee	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up	Failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up and raise concerns and ideas for improvement	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	14/04/2021	Medium (9)	Medium (6)	Treat	Hard copy posters displayed throughout NHS Borders at acute, community, MH and LD sites. Working Group supporting the implementation of whistleblowing legislation, policy and processes which will develop into the oversight group Once for Scotland policy supported by local guidance and processes Whistleblowing legislation Whistleblowing intranet pages OH support offered to whistleblowers Strong links with CG&Q/Risk colleagues to capture potential whistleblowing incidents recorded in adverse events Updated Decision making framework developed and to be implemented Borders Quality Approach devised and Implementation plan being developed (long term approach);	Yes		01/04/2022	Infrastructure planning to be undertaken Whistleblowing development session with the health board Promote whistleblowing legislation, policy and processes to support understanding and thus support the attainment of an open and transparent culture Quarterly report to Staff Governance Committee Annual whistleblowing report to health board Development of whistleblowing confidential contacts network Development of process in linking data of adverse events with the local whistleblowing processes Development of process to measure the culture around whistleblowing Delivery of awareness sessions throughout NHS Borders Implement updated Decision making framework (as part of Borders Quality approach) Develop Implementation plan for Borders Quality approach

2958	Strategic Risk Register *Board Executive Team Use Only*	Smyth, June		Clinical Governance Committee	Failure to implement remobilisation successfully	COVID-19 remobilisation plans were put in place in May 2020 to support NHS Borders in moving from reduced services to a business as usual approach, allowing for contingencies to be put in place as the virus fluctuates and to reduce the pressure on the board using a whole system approach. These plans were updated during 2021/22 via RMP3 and then RMP4. Failure to implement this successfully will have ramifications throughout NHS Borders.	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	15/07/2021	Medium (9)	Medium (6)	Treat	Pandemic Committee/Gold Command established Plans for escalation of COVID-19 response in event of a second wave of the pandemic include step down of elective remobilisation plans in order to release bed capacity Plans for escalation of COVID-19 response in event of a third wave of the pandemic including bed escalation plan and potential step down of elective activity to release staff/bed capacity Planning for winter may require remobilisation plans to be amended depending on the availability of resources such as staffing e.g. reduction of elective activity Discussions with Lothian to revisit our Service Level Agreement levels may lead to other changes in activity levels all patients considered urgent continued to be treated, including those with urgent cancer referrals / diagnoses Business cases have been developed for each of the mandatory services (required by Scottish Government) which have been robustly scrutinised in order to determine the levels of staffing required for these to continue to operate over an anticipated 12 months. The assumption has been made that all deployed staff will continue to be available to these services until at least the end of March 2021, to enable external staff to be recruited The flexibility to scale up and scale down services is important and we are maintaining a dynamic equilibrium between staffing-up new services (such as the new functions established / required in response to COVID-19)and the need to either bringing established services back on-stream or increasing the levels of services offered The internal remobilisation working group considers all resource requests brought forward by services assessed as critical in order for them to either continue to operate as a COVID-19 response function, remobilise services to a greater level than which they are currently operating, respond to winter pressures or to deliver the extended 'flu vaccine programme for 2020 The Clinical Oversight group continue to advise on clinical prioritisation of the remobilisation plan at an organisational level, including the allocation of resources and timing and order of recommencement of services. Clinical prioritisation of individual patients continues to take place at service level – based on royal college or other internal guidelines - supported by local Clinical Prioritisation Groups to review the allocation of resources on an individual patient-specific basis. A group has been established to assess patients for surgical procedures using the Scottish Government Guidelines for Prioritisation of Cancer Surgery Escalation triggers provide an early warning of the potential need to implement additional capacity or other measures and a weekly update is shared with Gold Command Predictive modelling is in place to plan for a potential further peak (or peaks) of COVID-19 demand. This work is informed by national guidance and early warning from Public Health Scotland and UK-wide	Yes		31/03/2022	Review remit of Recovery Group Monitor controls in place to ensure risk level is not escalating Assess appropriateness of clinical services over time A health promoting health service is a national initiative whose concept is that 'every healthcare contact is a health improvement opportunity'. All staff promote this message. Review remobilisation progress of RMP3 commitments and refresh for RMP4 Revisit with Business Units current commitments in RMP4 to assess what will not deliver in 2021/22 and requires to be deferred or stood down Review AMS preparing for winter checklist and assess priorities for action alongisde key RMP4 deliverables for remainder of 2021/22 Undertake a prioritisation session of PMO, Planning and Estates Projects capacity to support and prioritise remobilisation efforts

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
												information, but is also advised and guided by local intelligence and knowledge, particularly from our local Public Health teams, testing and tracing services and the local authority. Robust plans continue to exist to rapidly increase inpatient capacity should COVID-19 activity increase to a level that impacts on NHS Borders healthcare services External recruitment exercises Use of temporary isolation structures in ITU/ critical care Staff wellbeing support; psychological support for staff members, collecting your voices, staff risk assessments, supporting working from home The local remobilisation group is ensuring health inequalities impact assessments are being undertaken and an equalities focus will continue to be important in ensuring equity National and local updated policies and guidance Financial plans in place Quarterly financial forecasts submitted to Scottish Government Business continuity plans in place and accessible electronically Structures in place for Clinical Boards to escalate issues Operational Planning Group now in place, replacing Recovery Planning Group but continues to oversee COVID-19 related issues and proposals, making recommendations to BET/Gold Command. New SG assurance template in place which will assist in the assessment of service capacity and situation (yellow/amber/red/black)- to be reviewed alongside modelling reports to provide update on actual position and modelled future position Plans being developed should the Board be required to respond to increased RVIs in paediatrics Regional support and pathway in place for RVIs in paediatrics				

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
1593	Strategic Risk Register *Board Executive Team Use Only*	Smyth, June	Lynn McCallum	Performance and Resource Committee	Failure to meaningfully implement clinical strategy to meet the needs of the population	Ensure the Clinical Strategy is implemented successfully across NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	Medium (9)	Medium (6)	Treat	Fiscal Financial control Public engagement process. Public Health strategy and monitoring of population health Staff engagement processes underpinned by principles of partnership working. Scheme of Integration, strategic plan, and commissioning implementation plan. Proactive contact with political and media stakeholders. Board Executives & Non Executives to attend the SBC area forum network. Regular engagement with staff around key strategic issues. The establishment of NHS Borders Financial Turnaround Programme has resulted in a number of programmes of work being established across all business units. Each area of work has been cross referenced with the key principles of the clinical strategy to ensure their alignment and to ensure that any changes are consistent with the direction of travel of the organisation. agreed Purpose, Aim, Values and Objectives in place (signed off by Board in June 2020) providing a framework within which NHSB operates within the context of the clinical strategy.	Yes		31/03/2022	Developed robust community services to support people in their own homes Service reviews undertaken in line with set process as per Business Process Pillar Explore future DGH model Proactively engage with SEAT Acute Services programme Proactive partner in Borders CPP Development of Public Involvement Strategy Explore impact and opportunity of Community Empowerment Act Complete Road to Digital including network refresh, VDI, Trak and applications upgrade Create Target Operating Model to fit the new technologies. Ensure staff have adequate training in new technologies. As part of TOM develop service delivery model and workforce plan Utilise national e-Health networks to gain synergies and improvements locally Review whether the 2017 Clinical Strategy remains fit for purpose and reflects NHSB overall direction of travel Revisit the Purpose, Aims, Values and Objectives for NHSB with NHSB Board to refine/agree for 2022 onwards Design service review process via Business Process Pillar discussions Initiate conversation with IJB Chief Officer and SBC CE re development of a core set of purpose/aims/values/objectives Revisit actions following Board discussion on 22 November 2021
1586	Strategic Risk Register *Board Executive Team Use Only*	Bone, Andrew		Audit Committee	Financial decision-making in partner organisations' budgets impacts on NHS Borders	Financial decision-making in partner organisations' budgets impacts on NHS Borders	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	21/10/2019	Medium (9)	Medium (6)	Tolerate	1.Work as part of the NHS Scotland Corporate Finance Network to jointly highlight the impact of the reduction 2.Scheme of integration agreed and actioned 3.Issue of directions 4.Integrated working with Chief Officer and Chief Finance Officer 5.Regular meetings between CFO and NHS DoF/members of NHS Finance team provided an opportunity to share information. 6.The development of health and social care integration & integrated budget. Development sessions for board members 7.Operational integrated working 8.Service redesign opportunities 9.Integrated Reporting 10.Regular meetings between NHS Borders and SBC Finance departments 11.Share information on financial outlook and financial plan to promote better understanding of financial challenges and impact of decisions 12.Agreement of information sharing protocol 13.Alignment of budget timetables 14.Alignment of financial planning 15.Coordination of internal audit plans 16.Quarterly meetings with SG finance 17.Longer term financial planning 18.Clarity of system and process 19.Use of the transformation budget and social care fund 20.Set up of the Executive Management Teams which meets regularly, develop understanding, communication and relationships and focus on key issues	Yes		31/03/2022	Joint financial planning (SBC,NHSB, IJB) Improved understanding of their budgets and sources of funding which impact on their services - financial awareness work stream Integrated working/ services Service redesign Clarity on how the increased funding to the IJB is supporting service redesign and reducing pressure in the NHS Confirm resources for Integrated management structures and ensure this is reflected in financial governance arrangements. IJB financial plan which underpins the IJB strategic plan Review of set aside budgets in line with the letter from NHS Scotland DoF

ID	Service	Risk Owner	Supporting Executive/Peer Support	Governance Group	Title of Risk	Description	Corporate Objective	Opened	Risk level (current)	Risk level (Target)	Risk Status	Controls in place	Adequacy of controls	Gap Analysis	Review date	Risk Action Plan
2686	Strategic Risk Register *Board Executive Team Use Only*	Bone, Andrew		Audit Committee	Board breaches of Code of Corporate Governance	The risk that NHS Borders does not comply with the code of corporate governance	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population	29/10/2020	Medium (8)	Medium (8)	Tolerate	Code of corporate governance Governance committees Internal Audit on governance Regular checks of declarations of interest Regular checks on gifts and hospitality 2 yearly counter fraud awareness session with Board Appointed counter fraud champion Annual governance statement	Yes		31/03/2022	Roadshows - code of corporate governance Monitor controls in place to ensure risk is not escalating
1597	Strategic Risk Register *Board Executive Team Use Only*	Roberts, Ralph		Staff Governance Committee	Sustainability of organisational leadership	Disruption to organisational leadership arising from changes to the Senior leadership team	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Reduce health inequalities and improve the health of our local population, Safe patient care	22/10/2019	Medium (8)	Medium (8)	Tolerate	Project Rise for the development of senior managers' leadership skills had been in place; Strategic Implementation plan PMO- processes giving structure to decision making. Vacancy management system. Limited training programme available for management skills/decision making. Appraisal/PDP undertaken- objective setting. National /Organisational strategies available. Workforce Planning for NHS Borders and Health & Social Care Partnership Ongoing succession plan plan for Executive Team: new DoF, DoW, MD, DN & DAS now in post; CO in place BET team development programme in place Induction programme for new Directors in place Borders Quality approach now developing alongside new Decision making arrangements	Yes	Staff training and support given to managers Whilst controls have been put in place to reduce this risk to an acceptable level, they will take time to be fully effective Potential gap in Operational leadership - plans being developed; some risk associated with Recruitment	30/09/2022	Progress implementation of Borders Quality Approach including Leadership development plans Review Operational leadership arrangements for HSCP in light of DNAHP post change and IRASC Complete appointment of new MD Complete Induction for new Executive Colleagues Recruitment for gaps in BET to progress as quickly as practical Work with Director of Workforce to develop ongoing training plans

1588	Strategic Risk Register *Board Executive Team Use Only*	McCallum, Lynn	Sarah Horan	Clinical Governance Committee	Unacceptable Clinical Performance	Unacceptable performance by: -Doctors and dentists, pharmacy -Nursing, midwifery and AHPs -Independent contractors	Promote excellence in organisational behaviour and always act with pride, humility and kindness., Provide high quality, person centred services that are safe, effective, sustainable and affordable., Safe patient care	21/10/2019	Medium (8)	Medium (8)	Tolerate	1.Training & Induction 2.Policy for introduction of new procedures and treatments (ADTC, Clinical Gov Committee), GMC/NMC professional standards and so on. 3.HCPC - health and care professionals council. 4.Strong focus on local SPSP and strict adherence to procedures enforced. 5.HSMR and other clinical outcomes measures are monitored closely e.g. quality dashboards, weekly safety dashboard, mortality reviews, mortality and morbidity review, quality, safety and HAI core audits, patient feedback, clinical audits 6.Appraisal & revalidation for all Doctors, Registered Nurses and Midwives 7.Clinical Governance framework 8.Healthcare governance systems 9.Significant Adverse Event Review process with Adverse Event Management Policy. Duty of candour process. 10.Value Based Recruitment standard recruitment process for all staff across NHS Borders. 11. Patient feedback investigations and SPSO case review. 12. Yearly group supervision in midwifery. 13.Annual Fitness to Practice process for GPhC. 14.GPhC community pharmacy inspection process.	Yes		30/06/2022	Investigations process to be developed for claims Learning from complaints/adverse events Developing clinical leadership to support good practice Fostering and supporting flexible medical recruitment Introduction of revised Nursing revalidation process Develop systems that provide assurance about the quality of care delivered Implement leadership programmes: SCN programme with NES/QMU, Programme for Person Centered Care with QMU, Back to Basics Monitor controls to ensure they are still effective and risk is not escalating

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 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 21 March 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, Audit Committee minutes 13.12.21

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

Present: Mr J Ayling, Non Executive Director (Chair)
Mrs F Sanderson, Non Executive Director
Ms S Lam, Non Executive Director
Mr T Taylor, Non Executive Director

In Attendance: Mr A Bone, Director of Finance
Ms S Brook, Audit Manager, Grant Thornton
Mrs J Brown, Director, Audit, Grant Thornton
Mr G Clinkscale, Director of Acute Services
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mrs K Hamilton, Chair, NHS Borders
Mrs L Pringle, Risk Manager (Items 9.1 – 9.3)
Mr R Roberts, Chief Executive
Mr G Samson, Audit Senior, Audit Scotland
Mrs S Thomson, Information Governance & Cyber Assurance Manager (Items 5.2 and 11.1)

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those present to the meeting. Apologies were received from Mrs G Woolman, Director, Audit Scotland, Mr A Haseeb, Senior Audit Manager, Audit Scotland and Mrs S Paterson, Deputy Director of Finance (Head of Finance).

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meetings-13th September 2021 and 15th November 2021**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The Committee noted the action tracker.

5. **Governance & Assurance**

5.1 *Audit Follow Up Report*
Sue Brook spoke to this item. Sue reported that the status of 31 recommendations had been reviewed, noting that 13 had been completed, 12 were not yet due for closure, four have a revised timescale from management

and two were overdue with no updates or revised timescales having been received. Sue advised that there had been good engagement with management and steady progress in implementing actions.

Sonya Lam referred to the 2019/20 Duty of Candour audit which noted the recommendation that "lead reviewers training will take place with a Duty of Candour component" had a revised implementation date of 31st March 2022. Sonya asked if the organisation was at risk by not having this in place prior to this date as a substantial amount of time had passed since the original deadline. Ralph Roberts agreed to pick this up with Laura Jones and provide the Committee with an update.

The Committee noted the report and approved the revised dates within the four audits highlighted.

5.2 *Information Governance – Mid Year Report*

Susie Thomson spoke to this item. Susie explained that the Information Governance Committee oversees a programme of work designed to improve compliance on information governance issues and went over the broad headings which fall under the Committee's remit. Susie went on to give an update on the Information Governance Work Plan which included an update on staff recruitment. Susie referred to privacy breach detection (FairWarning) and advised that there had been an increase in self look-ups, however this in the main was due to new staff who had not received the normal training due to the pandemic. Instances had been dealt with through the HR policies in place and reassuringly numbers had reduced in the last quarter. It was noted that the number of FOIs received had increased when compared to the same timescale for the previous year. The response rate remained at 100%. In regard to cyber security Susie advised that a module was being developed for Learnpro which would raise staff awareness. Susie highlighted that the completion rate for the Code of Conduct training remained the same as the previous year (71%) and that she hoped to see an increase in this going forward. James Ayling referred to the Information Governance minutes later on the agenda (item 11.1) and reference within to requests from managers to access health records of staff. James sought clarification around whether this issue was in response to actual breach of data governance arrangements. Susie confirmed that it was not and that the request was not granted and would not progress further.

The Committee noted the report.

5.3 *Internal Audit Recommendations – Update on Slippage of Timescales*

Andrew Bone spoke to this item. Andrew reminded members of discussion at the previous meeting around the number of recommendations with extended timescales. It was noted that the process in place prior to the pandemic was to invite managers to attend the Audit Committee to provide an update should the timescale have slipped by more than 3 months. Andrew asked the Committee to consider whether this process should now be reintroduced and the timing of same. Tris Taylor noted that he would like to see this reintroduced with immediate effect and in addition he would like to receive a control chart which included data on closures/extension dates. Andrew agreed to discuss the introduction of a control chart with Internal Audit. Ralph Roberts advised of a letter just received from Scottish Government in response to the recent Omicron

variant which stated that all non critical activity should be stood down and focus should only be on emergency care. Ralph understood the importance of putting this process back in place but questioned the timescale for doing this in light of the letter received. Fiona Sandford also fully supported reintroducing the process but not at the present time due to current circumstances. Sonya Lam stressed the need not to lose sight of any of the high risk actions by delaying the reintroduction of the monitoring process. James Ayling supported the reintroduction of the three month update process but also felt that there was a clear instruction from Scottish Government, compliance with which would be a significant contributor to deadlines not being met, as staff would be required to undertake clinical duties to support the Covid response. James summarised that the consensus view of the Committee was to reintroduce the process and suggested that he discuss timescales for reintroduction with Andrew Bone early in the new year within the context of the then prevailing pandemic situation and with a view to the process potentially being reintroduced on a phased basis from the next meeting in March.

The Committee noted the update and agreed the reintroduction of enhanced monitoring against non delivery of actions in line with the process in place prior to the pandemic. The timing of this to be agreed.

5.4 *NSS Service Audits Update*

Andrew Bone spoke to this item and explained that National Service Scotland (NSS) provide a number of services to NHS Scotland on a Once for Scotland basis which includes payments of contractors within the primary care sector as well as provision of a number of single instance business IM&T systems. It was noted that NSS commission a service auditor (KPMG) to review the control systems in place and to provide reports for sharing with service users. Andrew explained that for the previous two years a qualified opinion had been received for Practitioner Services due the lack of evidence to provide assurance that payment processes were operating in line with approved procedures. It was noted that disclosure of this position was made within NHS Borders' annual accounts. Andrew advised that a comprehensive action plan has been issued by the Director of Finance at NSS and that NHS Scotland Directors of Finance receive regular updates on progress against this plan. Sonya Lam enquired if there were any other third party arrangements that get audited in this way. Andrew explained that these arrangements differ from the typical service agreements between Health Boards, where NHS Borders purchases activity provided by another hospital, because in the case of the NSS arrangement we are effectively sub-contracting our own payment processes. Andrew advised that the only payment processes undertaken on a Once for Scotland basis are those provided by NSS. James Ayling asked if NHS Borders had a contractual relationship with these auditors. Andrew confirmed that they did not and that the contractual relationship is with NSS.

The Committee noted the report.

6. **<u>Internal Audit</u>**

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 advised that since the last meeting two

audits had been undertaken, namely Mandatory and Statutory Training which was currently out for management comments and Endowment Fund Controls which had been issued to management. It was noted that the plan was on track and there was sufficient resource to deliver this.

The Committee noted the update.

7. **External Audit**

7.1 *External Audit Annual Audit Report 2020/21 – Update on Recommendations*
Andrew Bone spoke to this report which provided an update on the recommendations from External Audit's Annual Audit Report for 2020/21 as well as some recommendations carried forward from 2019/20. Andrew took the Committee through these and advised that he planned to provide the Committee with updates on a regular basis. Tris Taylor referred to the recommendation relating to "equality considerations" as he noted concern that the response was inadequate and did not give assurance that actions within the recommendation have been undertaken. Tris agreed to provide Andrew with some background information to allow him to pick up with Tim Paterson as the responsible Director to provide an update. Graeme Samson advised that he had no concerns around this but would take into account the issues raised as all recommendations would be revisited as part of the 2021/22 audit.

The Committee noted the update.

7.2 *Audit Scotland Report: Tracking the Impact of Covid19 on Scotland's Public Finances*
Andrew Bone spoke to this item which was one of a series of audit reports from Audit Scotland. Although not specific to Health, Andrew felt that there were items of interest for the Committee within the report. Andrew confirmed that the points made within the report remained valid following the budget announcement the previous week. James Ayling asked about spend due to Covid19 as he was under the impression that this would be reimbursed. Andrew advised that to date all identified spend, where additional, has been funded by resource allocation from Scottish Government, but that there are some areas of expenditure where it is not possible to identify accurate expenditure, for example generic supplies and consumables, where usage cannot be tracked to a specific clinical condition. Andrew advised that there has not been any material increase in this expenditure which would indicate an issue.

The Committee noted the report.

7.3 *Audit Scotland Reports - Process*
Andrew Bone spoke to this item and explained how Audit Scotland reports are distributed across the organisation. Andrew highlighted that the aim of the paper is to provide the committee with a proposed mechanism to ensure that all relevant reports are being directed to appropriate committees for consideration. Andrew proposed that the Committee receive a report in the format received today going forward. This was agreed.

The Committee approved the amendment to the existing process.

8. **Fraud & Payment Verification**

8.1 *Countering Fraud Operational Group Update*
Andrew Bone spoke to this item which provided an update from the last meeting of the Countering Fraud Operational Group held on 8th November 2021. Andrew advised that Countering Fraud Services (CFS) had provided a presentation on the Fraud Action Plan where it was noted that a national risk assessment exercise will be undertaken by CFS on behalf of Boards. They will also work with Boards on items of relevance which will inform each Board's individual action plan. Andrew also highlighted that CFS will now issue a Fraud Standards Statement at the end of each financial year which will be included as part of the annual assurance suite of reporting.

The Committee noted the update.

8.2 *NFI Update*
Andrew Bone spoke to this item and reported that out of a total of 1,116 matches issued to NHS Borders, all barring 21 have now been fully investigated. Those not yet resolved relate to payroll testing where information is awaited from partner organisations in order to complete the match. Andrew referred to the actions in place arising from the review of potential duplicate payments to suppliers. It was noted that although there had been no duplicate payments made there were 16 matches identified to have duplicate supplier's references and that operational processes are in place to ensure that any duplicate supplier accounts are closed when identified.

The Committee noted the update.

9. **Risk Management**

9.1 *Strategic Risk Register*
Lettie Pringle spoke to this item and advised that the strategic risk register had been presented to Borders NHS Board in September 2021. Lettie acknowledged that this should have come to the Audit Committee prior to the Board and advised it will do so going forward. It was noted that overall the Board were content with the procedures in place, however a discussion had taken place around the governance structure which was an item later on today's agenda. Tris Taylor referred to the scrutiny and assurance section and noted that a report was due to go to the Staff Governance Committee in October 2021 and asked for an update on this. Lettie agreed to look into this and provide an update on the assurance statement.

The Committee noted the update.

9.2 *Risk Management Annual Report – Action Plan Update*
Lettie Pringle spoke to this item which provided a progress update on the Risk Management Annual Report action plan. It was noted that 15 actions were complete, 10 were in progress and two not yet started. James Ayling referred to action 27, inclusion of security into the risk management framework as per statutory requirements. It was noted that this had yet to be started due to capacity issues and James asked for this to be progressed as a matter of

priority as it is a statutory requirement and an update should be provided at the next meeting. James also asked for update on the vacancies within the Risk Team. Lettie advised that there had been a restructure and a new post for a Risk Co-ordinator has been agreed for one year supported by a Risk Facilitator. A further temporary post until the end of March 2022 for a Risk Administrator had also been agreed to support in the system support for Display Screen Equipment Assessments and adverse event administration tasks. This would bring the Risk Team's staffing to 4 WTE covering all Clinical Boards and Support Services within NHS Borders.

Tris Taylor referred to action 13, to schedule a Board development session on strategic risk, as it stated that the deadline may need to be extended to allow time to prepare a useful and informative session and asked who had requested this extension. Lettie advised that this followed advice from herself and the Clinical Governance Committee as information on the risk appetite has now been requested to be included as part of this session.

The Committee noted the progress made on the Risk Management Annual Report action plan.

9.3 *Strategic Risk Governance Structure*

Lettie Pringle spoke to this item. Lettie advised that at the Borders NHS Board meeting on 7th October 2021 queries were raised around an element of the governance structure for NHS Borders' strategic risks. Further discussions had taken place since then with the Chair of the Audit Committee and separately with the Board Executive Team. Lettie explained that the amendment referred to in the paper was intended to enhance the existing process by strengthening the information sharing arrangements for strategic risk assurance. Lettie advised that the alignment of strategic risks to a single Governance Committee is intended to provide clarity of where the lead role for assurance on each risk resides. It was noted that it would be the responsibility of the Lead Executive for each committee to ensure they scan the full strategic risk register and bring forward any relevant aspects to the appropriate Governance Committee. Tris Taylor noted reference to the existing process being approved by the Audit Committee in April 2020, however there was no meeting in April but there was one in March where dissemination of the policy, with caveats, had been approved. Tris went over the comments made on the policy at that meeting as he did not feel that the paper received today describing the improved process addressed all of the issues raised. Ralph Roberts acknowledged the issues originally raised in March 2020 in relation to how oversight on strategic risk was to be assigned to committees and in particular where there were aspects of an individual risk which might be relevant to a number of committees. Ralph outlined his understanding of the revised process: that a single committee would be designated as the 'owner' of the risk for purposes of assurance, but that all committees should give consideration to any other risks within the strategic risk register which they regard as within scope of their own remit and raise any assurance issues with the Risk Manager so that these issues can then be reported to the relevant committee to inform that committee in conducting its business. Sonya Lam stressed that it would be important for the Chairs of the Governance Committees to understand what they are accountable for and suggested that this should be a standing item on agendas. James Ayling proposed that the process outlined be given an opportunity to see if it

could work effectively and suggested a period of 12 months. This was agreed. James added that the Audit Committee would assess how effective the process was after the 12 month period. James further noted that the committee was not responsible for formulating the operational procedure but would seek assurance and highlight any areas where weaknesses are identified.

The Committee agreed the changes outlined in the information sharing process for strategic risk assurance.

10. **Integration Joint Board**

James Ayling reminded members of comments made at the last meeting regarding the adequacy of current information provided to the committee in seeking assurance on the work of the IJB. He advised that he had discussed this further with the Director of Finance and had looked at the Code of Corporate Governance to try and ascertain what the Committee required sight of to be given the correct level of assurance in relation to its own role. It was noted that a meeting with IJB reps would be arranged as well as checking what processes are in place within other NHS Boards to address their own assurance requirements in this area. James highlighted that the appointment of a consistent external audit partner, Audit Scotland, across all partners including SBC and the IJB, gave some measure of comfort.

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

11. **Items for Noting**

11.1 *Information Governance Committee Minutes: 29th September 2021 (Draft)*
Sonya Lam referred to the use of What'sApp as she was aware that this is a very popular tool used by doctors in other organisations and if this was not seen as a recognised form of communication within NHS Borders then what would be seen as such. Susie Thomson advised that a risk assessment has been undertaken and the findings will be presented to the Information Governance Committee for discussion as well as looking at what other tools are available as there are functions within the O365 suite.

The Committee noted the draft minutes of the Information Governance Committee meeting held on 29th September 2021.

12. **Any Other Competent Business**

James Ayling noted that the Audit Committee receives assurance from the other Governance Committees but not from the Board Executive Team (BET) or Gold Command. James questioned if the Committee should be looking for some assurance from BET and Gold Command in the context of governance during the pandemic. Ralph Roberts advised that Gold Command is an operational group and in terms of outcomes these should be reported through other governance routes. Tris Taylor stressed the need to maintain an appropriate level of governance during emergencies. Fiona Sandford added that in extraordinary times the organisation must not lose sight of good governance. Andrew Bone agreed to review the Terms of Reference for BET and Gold Command to clarify how reporting aligns with the requirements of the Code of Corporate Governance and assurance framework.

13. **Date of Next Meeting**

Monday, 21st March 2022 @ 2 p.m., MS Teams.

Memorandum

Audit Committee, 13th September 2021
Under Item 6.1 there was discussion on the role of the Audit Committee in relation to an Internal Audit commissioned by the Endowment Board of Trustees. The minute of the meeting records:

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

This action was subsequently amended following clarification at the Endowment Fund Board of Trustees meeting on 27th September 2021 where it was agreed that the Internal Audit report would be considered by the Board of Trustees itself and that the Health Board's Audit Committee would not be required to undertake this review.

BE
23.12.21

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Endowment Fund Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Endowment Fund Board of Trustees with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 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.

- Endowment Fund Board of Trustees 24 March 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, Endowment Fund Board of Trustees minutes 27.09.21
- Appendix No 2, Endowment Fund Board of Trustees minutes 16.12.21
- Appendix No 3, Endowment Fund Board of Trustees minutes 31.01.22

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 27th September 2021 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee (Left at 3.45 p.m.)
Mrs K Hamilton, Trustee (Chair)
Mrs S Horan, Trustee
Dr L McCallum, Trustee
Mr J McLaren, Trustee
Mrs L O'Leary, Trustee
Mr R Roberts, Trustee
Mr T Taylor, Trustee
Mrs A Wilson, Trustee

In Attendance:
Ms C Barlow, Fundraising Manager
Mrs B Everitt, PA to Director of Finance (Minutes)
Mrs S Paterson, Deputy Director of Finance (Head of Finance)
Mr G Reid, Investment Advisor
Mrs J Smyth, Director of Planning & Performance

1. Introduction, Apologies and Welcome

Karen Hamilton welcomed those present to the meeting. Apologies had been received from Mrs F Sandford, Trustee, Ms S Lam, Trustee and Cllr D Parker, Trustee.

2. Declaration of Interests

James Ayling referred to the Valuation Report at item 6.1, namely the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

3. Minutes of Previous Meeting – 7th June 2021

The minutes were approved as an accurate record.

4. Matters Arising

Action Tracker
The action tracker was noted.

Accounting for Investment Income and Gains
Andrew Bone spoke to this item which provided an update on progress towards resolution of the issues raised in regard to the accounting for investment income and gains. Andrew highlighted the summary table which provided an up-to-date status on each action, including timescales. In terms of the Endowment Fund Annual Accounts it was noted that work is ongoing with the intention of this being concluded in the next week. Andrew drew Trustees' attention to the action on Trustee indemnity and advised that there was a paper going to Borders NHS Board meeting on 7th October 2021 which would hopefully address the issues around this.
Andrew was confident that the resolution outlined in the appendix to the paper would be accepted by the External Auditors for the Endowment Fund accounts and that he

had discussed with the appointed legal advisors, Turcan Connell, who have advised that this approach is reasonable and in line with advice previously issued.

Andrew advised that a third recommendation had been omitted from the paper on whether or not Trustees wished to lift the suspension on unrestricted funds and proposed that this is considered by Trustees in addition to the recommendations in the paper. Andrew referred to the Endowment summary restatement at appendix 2 which noted a balance of just over £700k and proposed that Trustees consider whether to lift this suspension in light of the actions in place to mitigate the financial risk. Tris Taylor suggested that Trustees wait for the outcome of the paper going to Borders NHS Board around Trustees' indemnity before making this decision. James Ayling added that he felt the solution being proposed to resolve the issues should be ratified before lifting the suspension. Harriet Campbell noted that the approach being applied was conservative and that there was potential that the review of restricted funds would result in increased flexibility moving forward. On this basis she would be happy to lift the suspension following implementation of the proposed recommendations and approval of the final accounts. James stated that once the Endowment Fund accounts were approved he too would also be content to lift the suspension.

James also referred to the recommendation at 4.1, namely deferring approval of the final Endowment accounts pending conclusion of the audit to be undertaken by Internal Audit as he would like to see this extended to include the results of the review on the restricted funds. James felt that it would be reasonable for Trustees to have all this information within the next six weeks. Andrew advised that both the Endowments audit and the review of the restricted funds were separate items on the agenda and would be discussed later in the meeting, however he anticipated that the review of restricted funds may take longer than six weeks although he would hope that all of the actions agreed would be concluded before the end of the calendar year.

Colleen Barlow provided Trustees with an update on applications made for Endowment funding and those currently on hold. Tris enquired if it would be possible, rather than lift the suspension, to allow projects currently on hold to proceed as long as there is no over commitment. Andrew agreed to liaise with the relevant parties and come back to Trustees with any immediate requests for funding.

The Board of Trustees noted progress against the actions.

The Board of Trustees agreed that approval of the final accounts should be deferred pending conclusion of the Internal Audit review on Endowments.

The Board of Trustees agreed that the suspension remain in place pending further discussion and that any requests for funding which require immediate resolution be considered by exception.

Children & Young People's Centre – Update

June Smyth spoke to this item and reminded Trustees that they had asked for a formal response from Borders NHS Board on releasing the £500k currently held in the General Endowment Fund (Fund 400) for the Children & Young People's Centre. June confirmed that a paper had been presented to the Resources & Performance Committee on 2nd September 2021 where they had agreed with the proposed approach that this will no longer come forward as a stand-alone project and would be considered as part of longer term pieces of work.

James Ayling referred to the £1m underwrite which he assumed was linked to the Children's Centre and asked for the purpose of the annual accounts if this would be treated as a post balance sheet event. Andrew Bone clarified that the £1m underwrite related to adjustment at March 2020 to offset unrealised losses against the investment fund and that the balance held against the children's centre was reduced to £500,000 at that time. Andrew advised that, on the basis that Trustees approved the release of the ring-fenced funds back to the general fund, then the treatment of this as a post balance sheet event would be discussed with auditors and disclosed if required.

James noted that there was some spend associated to this project within the accounts and assumed that lessons learnt would be taken on board. Susan Swan agreed that this would be considered in final adjustments and lessons learnt would be discussed via the governance review.

The Board of Trustees noted the current position outlined within the paper.

The Board of Trustees agreed to the release of the ring-fenced funds unless there were any technical reasons of being unable to do this. *[Memorandum – it has been confirmed following the meeting that this is not the case].*

The Board of Trustees noted that a revised proposal may come forward in due course to include request for investment to support transformation of services for Children and Young People.

5. Governance Review

5.1 *Internal Audit (Endowments)*

Andrew Bone spoke to this item which proposed that Trustees commission an internal audit of the Endowment Fund's system of internal controls to be undertaken by Grant Thornton, the Board's Internal Auditors.

Concern was shown around the potential conflict of interest by using the Health Board's Internal Auditors. It was recognised that this issue reflects ongoing discussions around the independence of NHS charities from the Health Board, and the role of Non Executive members of the Board as Trustees. It was acknowledged that this could not be resolved satisfactorily during the meeting. James Ayling suggested that the conflict of interest was primarily an issue for Grant Thornton and that this should be addressed through the contract for this work, which should be between the Board of Trustees and Grant Thornton. It was noted that the proposal to use the contingency days within the Board's own internal contract erodes the independence of this work and that the contractual arrangements for the work should protect the independence of Trustees.

An updated draft specification was awaited for the audit and it was being proposed that approval of the final specification be remitted to the Director of Finance and James Ayling, as a Trustee representative to the Director of Finance, and that the contract be approved by the Chair of the Board of Trustees following agreement of this specification.

It was further proposed that the findings from the audit be reviewed by an extraordinary meeting of the Board's Audit Committee. Karen Hamilton enquired if the Endowment Advisory Group might be a more suitable group to review the findings. James felt that an extraordinary meeting of the Board of Trustees would be more appropriate and in regard to the conflict of interest suggested asking Grant Thornton if they feel they have any conflict of interest by undertaking this audit. Tris Taylor asked if it would be possible to ask an independent auditor to undertake this. James reminded that Grant Thornton are using contingency days to do this and if another auditor was sourced their services would have to be paid for. Andrew added that we would also have to go through a procurement process to engage another auditor which would add further delay. Andrew Bone agreed to discuss with Grant Thornton to clarify if there was any conflict of interest.

The Board of Trustees agreed to commission Grant Thornton to undertake an audit of the Endowment fund accounting processes and systems of control, subject to confirmation that Grant Thornton were satisfied that this did not present a conflict of interest for themselves.

The Board of Trustees agreed the scope of the audit be remitted to the Director of Finance with a nominated representative of the Board of Trustees (James Ayling).

The Board of Trustees agreed that the audit and any recommendations should be considered in detail by an extraordinary meeting of the Endowment Fund Board of Trustees (to be scheduled following confirmation of timescales for completion of the audit).

5.2 *Review of Restricted Funds*

Andrew Bone spoke to this item and advised that during discussion with Turcan Connell around the initial piece of work he had taken the opportunity to request a quote for a further piece of work to undertake a review of the unrestricted funds. A quote of £1.5k plus VAT had been received, with an indication that this may vary following confirmation of the final specification. Karen Hamilton suggested setting a threshold within which the Board of Trustees approve variation without any further approval. John McLaren noted his support for this piece of work to be progressed as it has been outstanding for some time. Trustees agreed that a threshold for referral back to the Board of Trustees be set should costs increase by more than £500. Andrew Bone clarified that this would be £500 excl VAT (a total value of £2,000 plus VAT).

The Board of Trustees approved the engagement of Turcan Connell to undertake the review of fund restrictions as outlined in the paper.

The Board of Trustees remitted agreement of any further specification, including timescales, to the Director of Finance. If the cost increased by more than £500 excl. VAT above the original quote then it would come back to Trustees for virtual approval.

5.3 *Update on Governance Review*

Susan Paterson reported that the national review is now expected to report before the end of 2021 (calendar year) and that since the recommendations from the review may have a significant impact on the governance processes in place it was

proposed to pause the governance review pending receipt of the recommendations which would be reviewed by the working group in the first instance. It was indicated that the governance review would still be expected to conclude before the end of financial year 2021/22.

The Board of Trustees noted the update.

6. Funds Management

6.1 *Investment Advisor Report*

Graham Reid spoke to this item and reported that the portfolio continues to make good progress with a total return of 17.43% noted over the past year. Graham highlighted the remarkable recovery the portfolio has made since the initial stock market decline in February/March 2020 and advised that for the time being Covid is not a major risk for the financial markets. Harriet Campbell referred to the income cash statement within the report and enquired about the regular outgoings. Graham advised that these are the dividend interest payments paid to NHS Borders Board Endowment Fund. James Ayling referred to the recent issues within the Chinese property market and asked if this would have any impact on the portfolio. Graham advised that this is a Chinese real estate issue rather than a global issue so did not anticipate any impact on western markets.

The Board of Trustees noted the report.

7. Fundraising

7.1 *Fundraising Plan 2021/22 - Update*

Colleen Barlow spoke to this item. Colleen explained that the plan contained three objectives, namely concluding reorganisation of the restricted funds and make any agreed applications to the Scottish Charity Regulator by 31st March 2022. It was noted that meetings with Fund Managers are currently being scheduled to look at recent expenditure and to ensure funds are fit for the service in place. For the second objective the Fundraising Team would have ongoing involvement in the development and implementation of the Endowment Strategy and continue to support and inform staff whilst this is being developed as well as encourage the spending of restricted funds in the first instance. For the final objective this involved the day to day running of the Fundraising office where it was noted that for the first quarter incoming donations totalled £212,580 with 34% being stewarded by Fundraising. This included a significant legacy gift of £129,618 to Palliative Care.

Harriet Campbell referred to the Legacy Giving page on the website which promoted gifting to restricted funds as she felt strongly that any gifts should be used where there is the greatest need and donors should be encouraged to gift with no restrictions, with exception of any specific fundraising drives or projects. Colleen advised that she would be reviewing this page and would be happy to discuss the terminology with any of the Trustees via email if they wished.

The Board of Trustees noted the update.

7.2 *NHS Charities Together – Grant Updates*

Colleen Barlow spoke to this item. Colleen reminded Trustees of the stage one and two grants previously received from NHS Charities Together. Colleen provided an update on the stage two grant noting a one year partnership between NHS Borders and various partners had been put in place to support carer's respite and reduce inappropriate hospital admissions. Colleen went on to explain that the stage three grant application had been developed by the Staff Wellbeing Group and focussed on providing rest areas for staff across the BGH and community sites as well as increasing physical activity outdoors for all staff, including those working from home, to facilitate social interaction, inclusion and collaborative engagement. A decision on the application was expected by the end of the month. This would be circulated to Trustees for information when received.

The Board of Trustees noted the update.

8. **Capital Projects Update**

8.1 *Capital Projects Update*

June Smyth spoke to this item which provided an update on the Macmillan Centre, Changing Facility and Mammography projects. It was noted that due to the pandemic there had been no significant movement with any of the projects. In regard to the Changing Facility project June highlighted that a freestanding modular unit had previously been agreed as the best option and explained that a suitable site had been identified but would be unavailable until the staff testing tent in this area has been removed. It was noted that there will be engagement with the public members involved to gain their views on the site identified.

June explained that in regard to the other projects some elements would be picked up but in terms of the availability of clinicians to engage she did not expect to see much progress over the next 3 – 6 months, particularly as we head into winter.

The Board of Trustees noted the update.

9. **Any Other Business**

None.

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

Monday, 31st January 2022 @ 2 p.m.

Extraordinary meeting to be arranged to approve the Endowment Fund Annual Accounts and to discuss the findings of the Endowments Internal Audit.

BE
08.10.21

Minutes of an Extraordinary Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Thursday, 16th December 2021 @ 10 a.m. via Microsoft Teams.

Present: Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee
Mrs K Hamilton, Trustee (Chair)
Ms S Lam, Trustee
Mrs L O'Leary, Trustee
Mr J McLaren, Trustee
Mr R Roberts, Trustee
Mrs F Sandford, Trustee
Mrs A Wilson, Trustee

In Attendance: Ms C Barlow, Fundraising Manager
Mrs B Everitt, PA to Director of Finance (Minutes)
Mrs S Paterson, Deputy Director of Finance (Head of Finance)

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting. Apologies had been received from Cllr D Parker, Trustee, Dr L McCallum, Trustee, Mrs S Horan, Trustee, Mr T Taylor, Trustee and Mrs J Smyth Director of Planning & Performance.

2. **Declaration of Interests**

There were no declarations of interest.

3. **Endowment Financial Controls**

3.1 *Internal Audit Report on Endowment Financial Control Environment*
Andrew Bone spoke to this item. Andrew reminded Trustees that three key pieces of work had been previously agreed in addition to the work on the annual accounts in regard to the investment income issue. Andrew went over these, namely to commission Grant Thornton, the Board's Internal Auditor, to undertake a review on the Endowment financial controls, commission Turcan Connell, with support from Susan Paterson and Colleen Barlow, to take forward the restricted funds review and a letter to be issued to confirm Trustees' indemnity. It was noted that the review of restricted funds being undertaken by Turcan Connell would not be a barrier for Trustees approving the annual accounts presented at today's meeting. It was expected that this piece of work would be concluded early 2022 and would inform the Endowment Governance Review. Andrew also updated on Trustees' indemnity: NHS Borders Board have agreed that a letter be issued to all Trustees confirming their status around this, and confirmed that advice had been sought from the Central Legal Office. A specific contract for an indemnity policy was being scoped out and it was anticipated that this would be in place the following week. It was also noted that a meeting of the Endowment Governance Group would be scheduled early 2022 to refresh to governance review and to consider the findings from the national review and an update would be provided at the January meeting.

Andrew went on to take Trustees through the Internal Audit report which he clarified was owned by the Board of Trustees and not NHS Borders Board. It was noted that the audit was commissioned to look at the controls in place in relation to

Endowment funds, including how legal requirements are addressed, and entailed looking at the systems and processes in place for the record keeping of Endowment funds as well as observing the understanding of legal obligations. Andrew highlighted that the overall rating was partial assurance with some improvement required. Andrew referred to the summary section of the report and confirmed that there was no issues highlighted which Trustees were not already aware of and that it gave reasonable assurance around the systems of internal control in place. In regard to the recommendations, there were two issues raised: one low risk finding that the Endowment Fund Financial Operating Procedures and Governance Framework, along with the reporting, required to be updated following the accounting issue identified; and one advisory finding that Trustees, and the supporting management team, would benefit from charity specific training and networking/seeking advice from other NHS Boards/NHS Charities. It was noted that neither of these recommendations would be an obstacle for Trustees approving the annual accounts at today's meeting. Andrew assured that training for the Finance team involved in Endowment accounting was a priority for early 2022 and that Trustee development would be considered through the governance review and in consideration of the national review findings.

James Ayling noted that this was a positive report and there seemed to be a good level of expertise within the Finance Team. James referred to the summary of findings and the similar names listed for cost codes ('BER' and 'BEU') as he felt it may be worth looking at these classifications to avoid errors being made by using the wrong code. Karen Hamilton asked for clarity on who would take forward the recommendations and factor these into the action plan, recognising that there was a risk that these might slip as a result of current NHS operational pressures. Andrew confirmed that he would pick these up with others as appropriate and proposed consolidating the actions, along with other local and national actions, into one action plan and providing an update at the January meeting. This was agreed.

Harriet Campbell noted her concern around the coding on what is restricted and not restricted and the need for clarity to make the charity more workable, particularly from Fundraising's point of view. Andrew highlighted that the report stated that income had been accounted for in the correct way so there were no identified errors in terms of process. Susan Paterson added that she had agreed with Turcan Connell the level of information they would require in regard to the review of restricted funds and that feedback is awaited on the information shared to date. An update report would be presented to the January meeting. Harriet also stressed the need for clarity around cash donations received.

The Board of Trustees noted the report.

4. **Endowment Fund Annual Report & Accounts 2020/21**

4.1 *Draft 2020/21 Report from Trustees and Annual Accounts*

Susan Paterson spoke to this item and advised that she was asking Trustees to approve the Endowment Annual Report and Accounts at today's meeting to allow submission to OSCR by the 31st December 2021 deadline. Susan reminded Trustees that they had previously had sight of the Annual Report and Accounts and that the version presented today took into account the adjustment and restatement following the investment issue identified. Susan took the Trustees through the report and noted points raised by Trustees, including those highlighted in advance by James Ayling where Susan had prepared response

including suggested amendments to the final report. The amendments prepared in response to James Ayling's written questions are attached as an annex to the minutes.

Harriet Campbell enquired if Trustees would have to reconsider the financial governance risk given the issues identified. Andrew confirmed that this would need to be revisited and would be included as part of the governance review with recommendations coming forward to Trustees in due course for approval.

Susan agreed to make the necessary changes as discussed and asked Trustees if they were content to approve the annual accounts subject to these amendments. Trustees noted that they were content to approve on this basis.

Susan referred to the letter of representation which Karen Hamilton would be asked to sign as Chair of the Board of Trustees. This would be returned to Geoghegans, External Auditor for Endowments and a copy filed with OSCR. James Ayling referred to the "Subsequent Events" section where it noted that "all events subsequent to the date of the financial statements which require adjustment or disclosure have been properly accounted for and disclosed". Susan confirmed that this was a further point added as part of the work undertaken by Geoghegans to state they had received all information transacted by the charity since 31st March and that this further review had not resulted in any further amendments being identified as applicable. Sonya Lam noted that there was reference to restricted funds with deficits and asked how these are controlled and monitored. Susan explained that these are reviewed on a monthly basis and if there are any deficits these are picked up with the Fund Manager. It was noted that these are primarily due to a timing issue, where commitment has been made in advance of receipt of income or transfer of funds already confirmed.

The Board of Trustees approved the Endowment Fund Annual Report & Accounts for 2020/21.

4.2 *External Audit Memorandum*

Susan Swan spoke to this item and advised that this had originally been received in June but had been amended due to the restatement work. The report received today detailed the work completed and recommendations made along with management responses to these. It was noted that a progress update report on any outstanding issues would be presented to the January meeting. James Ayling noted a discrepancy on funds with a deficit balance listed on pages 4 and 7. Andrew Bone advised that this was due to minor amendment to the initial methodology agreed with the auditors and that because the value was not considered material following discussion with Turcan Connell, no change was required to the memorandum but that the methodology had been corrected going forward.

The Board of Trustees noted the External Audit Memorandum.

5. **Any Other Business**

External Auditor for Endowments
Andrew Bone advised that the current contract with Geoghegans was now concluded and a tendering process would be undertaken. An update on this would be brought back to Trustees in due course.

James Ayling noted his thanks to Andrew, Susan and the Finance Team for all their input over the last few months. Karen Hamilton echoed these comments and noted her appreciation over what had been a difficult period.

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

Monday, 31st January 2022 @ 2 p.m.

BE
22.12.21

Questions from James Ayling & Responses on item 4.1 (Draft 2020/21 Report from Trustees and Annual Accounts)

P7
Fundraising Function…. As has been noted within this report the Fundraising Team have worked flexibly throughout 2020/21 to enable focus to be given to the many supporting activities to the Health Board during the challenging months of 2020 into 2021. A reduced annual charge levied for 2020/21 reflects the commitment given by the Team to the Board's Communications function during the initial phase of the pandemic in early 2020. A total of £47,748 in year (2019/20: £67,028) costs of fundraising have been reported in the SOFA (Page 23). The restricted fund "Fundraising Costs" reported a deficit balance of £143,824 (Note 11, page 37). This fund will be considered by the Trustees during 2021/22 as a result of the decision to release the funds previously designated to the project.

Do we not need to be clearer on the project here and state it is the Children's Centre ….I don't see it defined earlier.

Response: The deficit balance was accrued through pump prime costs of the time spent by the fundraising team on the Children's Centre project. Additional wording proposed:
"The restricted fund "Fundraising Costs" reported a deficit balance of £143,824 (Note 11, page 37) which was incurred as the cost of the time spent by the fundraising team on the fundraising feasibility study and to support the development of the business case for the BGH Children's Centre Project. This fund will be considered by the Trustees during 2021/22 as a result of the decision to release the funds previously designated to the project".

P13
Reserves Policy - Unrestricted Funds… Funds which are not for a specific purpose are held as unrestricted. The Board of Trustees report a balance of unrestricted funds of £732,453 at 31st March 2021 (restated to £389,236 as at 31st March 2020). The increase in Unrestricted Funds is a combination of the transfer of funds from "designated unrestricted" following a decision by the Trustees to release the funds previously held for the Children's Centre project and also to a prior year restatement of balances following the apportionment of investment portfolio gain/loss to Restricted funds over the period 2010/11 to 2019/20.

Do we not need to say for clarity that the decision to release the children's funds was post year end ??…ties in with later post balance sheet wording.

Response: Wording below to be added to this paragraph directing reader to the Accounting Policies on page 26 which provides details of the Post Balance Sheet Event.

"The decision to release the funds previously held for the Children's Centre project has been reported as a Post Balance Sheet Event, full details are provided on page 26, the Accounting Policies section, of this report".

P13
Reserves Policy – Restricted Funds…given that we specifically refer to the **increase** in unrestricted funds (as set out in above point) and show the figures and change …why do we not show here the **decrease** in restricted funds?

Response: Restricted Funds are analysed in a greater level of detail in Note 11 page 38 for current year and separately for prior year Note 11 page 39.

Additional wording to be added to paragraph on p.13 as follows:
"An analysis of the balances held as at 31st March 2021 for Restricted Funds is provided in Note 11 page 38 (Balances for the prior year, 2019/20, are detailed on page 39)".

P13
Designated Fund – Unrestricted Fund …. The level of funding held in the Designated Fund – Children and Young Person's Centre Project is maintained at a value of £0.5m, which is reported within these accounts.

Whilst this may be the case at year end it gets a bit confusing since 3 paras above it we have referred to the subsequent decision to release the funds and is wrong at the date of signing…does it need changing or an explicit statement that this was the case at year end to avoid confusion…is it not inconsistent with the wording in p 13 re reserves policy noted in point 2 above. Maybe I am getting confused with restatement of figures and timing.

Response: Acknowledged. Additional wording to paragraph on Designated Fund - Unrestricted to note the following:

"The level of funding held in the Designated Fund – Children and Young Person's Centre Project as at 31st March 2021 was reported at a value of £0.5m. A Post Balance Sheet Event has been actioned following a decision by the Trustees during September 2021 to release the designated funding and the £0.5m balance has been returned to, and is reported for these accounts as part of, the General (Unrestricted) Fund".

P26
Post Balance Sheet Event
At the Trustee meeting on 27th September 2021, before the date of signing of the accounts, the Trustees agreed to return the monies held as designated against the proposed Children's Centre Project, £500,000, to the General (Unrestricted) Fund. This decision followed the presentation of a report by NHS Borders **[to the Trustees]** which detailed that the intended Children's Centre Project was no longer being progressed as a standalone project. **[With this information the Trustees decided to release the funds which had been designated against this project]**. The designated funds have been reported within the balance of General (Unrestricted) funds in the 2020/21 Annual Report and Accounts.

This wording is not accurate. NHS Borders did not say the project was not being progressed. The Trustees decided. In addition the report did not detail that the Centre was no longer being progressed. The paper noted various matters relating to the project and in light thereof … proposed that the Board of Trustees revisit their current commitment of £500,000 from unrestricted funds as a contribution to the overall costs of the project.

Response: Wording amended [see underlined sections within above text].

P39

I don't understand why we have this page showing Analysis of Specific Charitable Funds as at 31 March 20……the preceding page is for the period to 31 March 21 ..is this a requirement or an unintended lift from last year?

Response: The Charity Financial Reporting Standard FRS 102 to which we comply requires us to provide prior year balances where those are available to enable the reader of the accounts to see the level to which individual balances have been utilised (or not) throughout the year.

Presentation on 2 pages is result of formatting. We will review format and content of this report for the 2021/22 accounts and ensure Trustees are consulted on any proposed changes.

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 31st January 2022 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee (Left meeting at 3.20 p.m.)
Mrs K Hamilton, Trustee (Chair)
Mrs S Horan, Trustee (Left meeting at 3.30 p.m.)
Ms S Lam, Trustee
Dr L McCallum, Trustee (Left meeting at 3.30 p.m.)
Mr J McLaren, Trustee
Mrs L O'Leary, Trustee
Mrs F Sandford, Trustee
Mr T Taylor, Trustee (Left meeting at 3.15 p.m.)
Mrs A Wilson, Trustee (Left meeting at 3.30 p.m.)

In Attendance:
Ms C Barlow, Fundraising Manager
Mrs B Everitt, PA to Director of Finance (Minutes)
Mrs S Paterson, Deputy Director of Finance (Head of Finance)
Mr G Reid, Investment Advisor

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting. Apologies had been received from Mr R Roberts, Trustee, Cllr D Parker, Trustee and Mrs J Smyth, Director of Planning & Performance.

2. **Declaration of Interests**

James Ayling referred to the Valuation Report at item 6.1, namely the holdings in "First Sentier Invr Stewart Invrs Asia Pac Ldrs" and declared an interest as this investment was managed by a company of which he was previously a Director and that he receives a pension from its ultimate parent company.

3. **Minutes of Previous Meetings – 27th September and 16th December 2021**

James referred to paragraph 3 of item 5.1 of the minutes of 27th September 2021 and advised that he was a Trustee representative rather than a Trustee advisor as recorded.

The minutes were approved as an accurate record with the proviso that this change be made.

4. **Matters Arising**

Action Trackers
The action trackers were noted.

Process for the Appointment of the External Auditor for the Endowment Fund
Susan Paterson spoke to this. Susan proposed putting in place a short life working group which would include a minimum of 3 Trustees, one of which would be Karen Hamilton as Chair of the Board of Trustees, to take forward the procurement process for appointing an External Audit service for the Endowment Fund for a three year

period (1st April 2021 – 31st March 2024). It was noted that the process would have to be completed in time for the auditors being on site for the annual audit by mid April. Lucy O'Leary and Sonya Lam put themselves forward to be a member of this group and Alison Wilson agreed to attend if her diary permitted.

The Board of Trustees agreed to a short life working group (SLWG) being formed to progress the procurement of External Audit services for the Endowment Fund for a 3 year period from 1st April 2021 to 31st March 2024.

The Board of Trustees requested that the SLWG present a tender report and recommendation to the full Board of Trustees on a preferred auditor for the Endowment Fund.

5. **Funds Management**

5.1 *Investment Advisor Report*

Graham Reid spoke to this item and reported that the portfolio value at 19th January 2022 was just over £5m. Graham advised that the portfolio was down by £75,000 as a consequence of market volatility. It was noted that the threat of inflation resurging had affected some of the investments, particularly within the equity growth sector, and expectations for growth on a global scale may need to be lowered compared to rates experienced in previous years when there were far more benign inflationary conditions. Graham also highlighted the impact on gas/fuel increases and the situation with Russia which all have an impact on the market.

James Ayling referred to the covering report and in particular the section detailing the return summary for the period 2016 to 2021. James noted that the table only included the ARC benchmark and not the actual benchmark which the portfolio is benchmarked against. James suggested that this, and the Consumer Price Index, be included in future reports. Graham agreed to amend the reporting methodology and incorporate these going forward. Fiona Sandford enquired if the split of growth versus value within the equity exposure in the portfolio was the correct balance. Graham felt that it was and explained that in order to see long term performance, growth companies have been pursued and in the longer term the portfolio should benefit from taking this risk and accepting the premium paid for companies that deliver real growth. It was noted that within the portfolio there is still a significant presence in traditional value stocks – the extractive industries, oil's, miners, UK financials, food and drink etc, and 25% of the total equity exposure was UK focussed. As this emphasis on growth had been successful for a number of years and the strategy was to remain with growth, Graham did not anticipate any major strategic changes being made. Harriet Campbell noted that the portfolio had underperformed slightly against the portfolio benchmark over the previous year. Graham went on to provide examples over a 1, 3 and 5 year period and noted that there were periods when the portfolio had significantly outperformed the benchmark, but conceded that, net of fees, in 2021 the portfolio had lagged the benchmark by around 1.25%. James suggested that for transparency the table be revised to show the total return net of fees. Graham agreed to include this in future reports. Harriet also enquired if there was an Environmental, Social and Governance Strategy. Graham advised that there was not a specific strategy for NHS Borders but assured that Investec's approach is to be very much more environmentally aware when looking at investments. Susan

Paterson agreed to circulate the Investment Policy which details the parameters which Graham works to for Trustees' information.

James noted that in comparing the historical ARC data for the last few years, the portfolio had not performed as well at the beginning of the pandemic in 2020, taking that year in isolation, as it had been doing several years prior and indeed, in 2021 as a whole. James asked if there was a reason for this. Graham agreed to provide an update on this and circulate around Trustees for information.

The Board of Trustees noted the report.

5.2 *Review of Investment Portfolio Benchmark*
Susan Paterson spoke to this item. Susan advised that this is reviewed on an annual basis and recommended continuing with the combined benchmark and review again in January 2023 to ensure it is the most appropriate at that time. Karen Hamilton proposed that this be approved unless anyone had any issues with this recommendation. James Ayling asked who reviewed this and made the recommendation. Susan confirmed that she makes the recommendation upon receiving advice from the Investment Advisor who has the expertise in this area.

The Board of Trustees noted that a review had taken place and approved the recommendation to continue to report on a combined benchmarking approach using the primary benchmark of the Investec bespoke Strategic Asset Allocation (SAA), inflation data and ARC benchmarks for the period 1st April 2022 to 31st March 2023.

6. Financial Report

6.1 *Primary Statements and Fund Balances*
Susan Paterson spoke to this item and reported that as at 31st December 2022 the balance sheet showed a cumulative total of £5.74m. Susan referred to the Statement of Financial Activities appendix which provided details of the income and expenditure. It was noted that income totalled £495k which did not include the total funds stewarded by Fundraising which was expected to be in excess of £200k. In regard to the donations and legacies income received, Susan advised that the following item on the agenda would provide the full details of these.

Susan referred to the work on the restricted funds review which was being supported by Turcan Connell and advised that as part of this work the categorisation of funds had been expanded. Susan went on to take Trustees through these. Susan reminded Trustees of the agreement to remove the designation of funds held for the Children's Centre project and as a result of this a decision to address charges made against this fund would require to be made. A paper would be presented to the next Board of Trustees in regard to this.

Harriet Campbell enquired why the statements were to the 31st March 2022. Susan advised that a standard annual reporting template is used and acknowledged that this header was misleading, however the narrative noted that it was for the period to 31st December 2021. Susan agreed to amend the template to reflect the period being reported. Harriet also asked why, in relation to donors, Fundraising costs were split 50/50. Susan explained that this was a historic agreement from when the Fundraising Team had been put in place but this could be looked at again if Trustees felt this was appropriate. Harriet referred to the

investment income on the Statement of Financial Activities appendix as she noted that this was only against unrestricted funds. Susan confirmed that the procedure to allocate investment income and investment portfolio gains and losses across Restricted and Unrestricted Funds on an annual basis is being presented for approval at the meeting today as part of the revised Financial Operating Procedure for the Charity. The recommendation which has been included in the updated procedure details that an annual allocation would be actioned based on the average annual balance on each Restricted Fund. Susan agreed to add narrative to future reports to provide clarity. Susan went on to advise that a paper would be presented to the next meeting which would make recommendation on the rationale for the annual allocation of investment income, gains and losses to be actioned one year in arrears.

The Board of Trustees noted the report.

6.2 *Register of Legacies and Donations*

Susan Paterson spoke to this item which provided an update on the legacies, grants and donations received between 1st April and 31st December 2021. Harriet Campbell requested additional information on the reconciliation of the income figures reported in this report against the total incoming resources as reported by the Charity on the Statement of Financial Activities in the Primary Statements report. Susan explained that income received as donations, where the value is less than £5k on an individual basis, are not reported on the Legacies report. Susan explained that the Legacies, Grants and Donations report detailed income totalling £280,457, with the figure of £401,027 being detailed on the Primary Statements report. Susan agreed to provide the requested reconciliation to Trustees and circulate for information.

The Board of Trustees noted the report.

7. **Governance Framework**

7.1 *Endowment Governance Action Plan - Update*

Andrew Bone spoke to this item. Andrew advised that it was his intention to provide a more detailed update to the next meeting on 24th March 2022. Andrew reminded that the work commenced by the Endowment Governance Working Group last July 2021 had been paused until the outcome of the national review had been received. Andrew stressed the need to ensure all actions from the various routes are captured and built into a work programme which will be undertaken over the next 12 – 18 months.

The Board of Trustees noted the update.

7.2 *Financial Operating Procedures – Investment Gains & Losses*

Susan Paterson spoke to this item. Susan explained that narrative had been added to the Financial Operating Procedure as per the recommendation made within the Internal Audit report which Trustees had received on 16th December 2021.

The Board of Trustees noted the additional content included in the Endowment Fund Financial Operating Procedure which detailed the accounting treatment for investment income, investment management fees and investment portfolio gains and losses.

The Board of Trustees approved the Endowment Fund Financial Operating Procedure for immediate use.

7.3 *Restricted Funds Review - Update*
Susan Paterson spoke to this item. Susan advised that the majority of funds will have been reviewed by the 31st March 2022, however there would be a small percentage which would not have been as there was not the resource to complete this within the timescale. It was noted that the findings from the review, along with the application to OSCR, would be brought to a future meeting for approval. Lucy O'Leary asked for more detail on the Palliative Care Fund, particularly relating to the type of services which are and can be supported by the Fund. Susan agreed to provide this outwith the meeting.

The Board of Trustees noted the update and progress made.

7.4 *Charity Development – Funding Opportunity*
(*Colleen Barlow left the meeting for this item)*
Andrew Bone spoke to this item and advised that NHS Charities Together had provided an opportunity to apply for a grant of £35,000. It was noted that £5,000 of this grant must be spent on membership fees for a period of two years leaving a balance of £30,000 for charity support. The paper outlined the proposal to create a Charity Development Manager post. Andrew advised that it was proposed to extend the existing fixed term postholder covering maternity leave for the Fundraising Manager. John McLaren noted his concern that this approach may not be in line with employment policies and that in normal circumstances he would expect to see a post advertised to give others the opportunity to apply. John further clarified that this was not a reflection on the individual in post. John asked that assurance be sought from the Director of Workforce that this was an acceptable way forward. Alison Wilson agreed with these comments around equal opportunity and also enquired around the outputs from this investment. Fiona Sandford felt that there were weaknesses around strategy and spending and if this could be built into this role then it would be a good use of money. Sonya Lam also felt that learning from initiatives invested in would also be extremely beneficial. Andrew felt that the scope of the role could accommodate all of the points raised and that he would take up these points with colleagues in developing the specification. Andrew advised that he had previously discussed with the Director of Workforce around extending the fixed term post and would pick up the comments raised with him. Andrew asked Trustees if they were content to support in principle subject to clarification of the appropriate recruitment approach by the Director of Workforce. This was agreed in principle.

The Board of Trustees approved in principle the appointment of a Charity Development Manager which would be funded from the NHS Charities Together development grant.

8. **Capital Spend**

8.1 *Capital Projects Update*
Andrew Bone provided an update on the capital projects and the following was noted:

- Changing Facility – not moved forward and is still under discussion.

- Macmillan Centre – there is a potential short term solution and options are being looked at. Longer term options are also being scoped with an option appraisal process being undertaken in the next 2 – 3 months. Susan Paterson highlighted the need to keep donors updated on progress.
- Mammography Unit – equipment has been purchased but the refresh of the mammography space is still on hold as a result of the constraints upon works within the BGH building.
- Outdoor spaces – benches have been acquired for outdoor spaces and the Head of Estates is awaiting advice from Nature Scotland on the development of the outdoor spaces work so it was hoped to progress this in the near future.

The Board of Trustees noted the update.

9. **Fundraising**

9.1 *Fundraising Update*

Colleen Barlow spoke to this item. Colleen advised that Fundraising is working with Capital Planning around the Macmillan Centre and a communication to donors is now due to provide an update as the project recommences. It was noted that there had been two successful applications for endowment funding detailed within the report which Fundraising had facilitated. Colleen advised that the new Fundraising Officer has now taken up post. It was noted that in the second and third quarters of 2021/22, Fundraising had stewarded 81% of the donations received.

The Board of Trustees noted the update.

9.2 *Covid19 Endowment Fund Activity*

Colleen Barlow spoke to this item. Colleen highlighted that individual donations have slowed down and that the fund included the grants received from Charities Together to use against the Covid response. These included those for stage 2 (Community Partnerships) and stage 3 (Staff Recovery and Wellbeing). It was noted that since the pause to spending from this fund had been approved by Trustees in April 2021, to allow the remaining funds to be ring fenced to support lasting memories projects, one such project had been approved, namely the production of commemorative pin badges for all staff who have worked throughout the pandemic.

The Board of Trustees noted the update.

9.3 *Endowment Funding Requests - Update*

Colleen Barlow spoke to this item. Colleen explained that the applications within the report were out-dated and there would be a requirement to check for any updates, however the purpose of it was to give Trustees an overview on the overall amount being requested. It was noted that most of these applications were carried over from the last Endowment Advisory Group meeting held in 2020 and have been on hold since. It was noted that attempts had been made to secure funding from applicable restricted funds.

Karen Hamilton noted concern around funds being on hold for such a long period of time and asked Trustees for their views on lifting restrictions. Andrew

Bone confirmed his view that it would be acceptable to lift the pause on the unrestricted funds following the amendments made to redistribute investment income and gains in line with advice received. If Trustees found the applications acceptable Andrew suggested a meeting of the Endowment Advisory Group be arranged to review these and make recommendations. John McLaren felt that there could be reputational damage to the charity if no progress is made in the near future. Karen felt that the Endowment Strategy would be crucial as part of this work and hoped that this would be progressed as a priority by the Endowment Governance Working Group.

The Board of Trustees noted the update and approved lifting the restrictions on the unrestricted funds.

It was agreed that a meeting of the Endowment Advisory Group be arranged to review applications and make recommendation for approval.

10. **Any Other Business**

None.

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

Thursday, 24th March 2022 @ 9 a.m.
Monday, 16th May 2022 @ 2 p.m.

BE
10.02.22

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Resources & Performance 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 Resources and Performance Committee with the Board.

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 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.

- Resources & Performance Committee 3 March 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, Resources & Performance Committee minutes 04.11.21

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 4 November 2021 at 9.00am via MS Teams.

Present: Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Ms S Lam, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Mrs L O'Leary, Non Executive
Mr J McLaren, Non Executive
Mrs A Wilson, Non Executive
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Mr A Bone, Director of Finance
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of Workforce
Mr G Clinkscale, Director of Acute Services
Ms V MacPherson, Partnership Chair

In Attendance: Miss I Bishop, Board Secretary
Dr K Allan, Associate Director of Public Health
Dr A Cotton, Associate Medical Director
Mrs C Oliver, Head of Communications

1. Apologies and Announcements

1.1 Apologies had been received from Cllr David Parker, Non Executive, Mr Tris Taylor, Non Executive, Mrs Sarah Horan, Director of Nursing, Dr Tim Young, Associate Medical Director, Dr Janet Bennison, Associate Medical Director and Dr Tim Patterson, Director of Public Health.

1.2 The Chair congratulated Mr Chris Myers, on his appointment as Chief Officer Health & Social Care and looked forward to his regular attendance at the meetings going forward.

1.3 The Chair confirmed the meeting was quorate.

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

2. Declarations of Interest

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

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

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the verbal and written declaration made by Ms Sonya Lam.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 2 September 2021 were approved.

4. Matters Arising

4.1 **Action 8:** Ms Sonya Lam commented that the risk was an operational risk but also a strategic risk and she enquired at what point it moved onto the strategic risk register and how it would be addressed and monitored. Mr James Ayling suggested he and Ms Lam discuss the matter at their next catch up on the 15th November. The Chair suggested the item be left on the action tracker.

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

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

5. COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update

5.1 Mrs June Smyth provided an overview of the content of the report. She advised that the version that had been submitted to the Scottish Government had not included the delayed discharge trajectory as it had not been available at that time, however it was included in the report before the Committee. Feedback from the Scottish Government on the Remobilisation Plan was awaited and was likely to be light touch feedback in recognition of the continued pressures on health services.

5.2 Mrs Fiona Sandford commented that in relation to point 7.4, to fund posts on a short term basis in the current climate was a waste of money and she suggested the Board think about anything that could be done to achieve long term funding of posts and more realistic recruitment. Mrs Smyth assured the Board that the level of risk in terms of recruitment and services was being monitored. However short term funding did not enhance targeted recruitment in a competitive market and it was not possible to sustain and deliver services on short term funding.

5.3 Mr John McLaren commented that the difficulties in recruitment were not limited to the mental health service, they were endemic across the organisation.

5.4 Mr Ralph Roberts commented that he and other Board Chief Executives continued to make representations to the Scottish Government for recurrent funding.

5.5 Mrs Harriet Campbell enquired about the increase in ICU capacity across NHS Scotland had Mr Gareth Clinkscale confirmed that NHS Borders had a baseline of 5 level 3 ITU beds and could increase that number if there was a mixture of levels. The increase in ITU provision referred to by the Scottish Government was a core uplift across NHS Scotland and equated to 1 bed for NHS Borders.

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

The **RESOURCES & PERFORMANCE COMMITTEE** formally approved RMP4, on behalf of NHS Borders Board.

6. Financial Performance

6.1 Mr Andrew Bone provided an overview of the content of the report and highlighted: the financial position was £3.26m overspent; capital expenditure of £900k against a budget of £5m; COVID-19 expenditure assumptions; and an update from the Scottish Government outlining the items to be taken forward on the back of the Quarter 1 review.

6.2 In regard to Capital, Mr Bone advised that the purchase of the CT scanner would happen in the current financial year however installation would be in the next financial year. In regard to the Forensic Medical Examination Suite, a tender process had been launched and a good level of applications had been received. The dispensing robot funding had been agreed however the project had not been progressed as further work was required to implement it.

6.3 Mr Bone confirmed that in general other areas of slippage were the estates backlog maintenance programmes, with both supply chain issues and difficulties in accessing areas to undertake the works, as well as the Estates Department capacity. He emphasised that he had no major concerns about slippage on capital, given relationships with the Scottish Government on capital were good.

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

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the board was reporting a £3.26m deficit for six months to end of September 2021.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the board was reporting capital expenditure of £0.91m for the period to date against the annual plan of c£5.11m.

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

The **RESOURCES & PERFORMANCE COMMITTEE** noted the update on in year financial monitoring and planning assumptions advised by Scottish Government.

7. Financial Planning Process and Timescales 2022/23

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements including savings plans and the current status of the financial planning framework nationally. He reminded the Committee that NHS Borders had operated in line with the Scottish Government medium term financial framework which required Health Boards to plan for break-even over a three year planning cycle and that prior to the pandemic the organisation had not been in balance and that continued to be the current situation. The SG framework had been suspended at the beginning of the pandemic but would be reintroduced as a 3 year financial plan in 2022/23. Mr Bone advised that he was working on the assumption that the Scottish Government would require the plan to be submitted to them by the end of March 2022.

7.2 Further discussion included: recurring investment in staffing against non recurring funds; understanding the relationship between non recurring resources and recurring costs; mental health recruitment issues; Scottish Government categories of funding; and balancing NHS Borders risk against the level of risk Scottish Government expected NHS Borders to take.

7.3 Ms Sonya Lam enquired given the pressures and challenges on recruitment, funding and service sustainability, at what point NHS Borders would declare the situation was unsustainable without further input from the Scottish Government.

7.4 Mr Ralph Roberts commented that in general terms there were continual conversations some 2-3 times per week between all Health Boards and the Scottish Government on the sustainability of services. Discussions were also taking place on a regional basis and within the organisation at all levels. The Centre for Sustainable Delivery had been invited into NHS Borders to undertake some diagnostic work on the planned care plans for the Remobilisation Plan which would provide confirmation of what could be achieved with or without additional capacity and support from the Scottish Government.

7.5 Mr Gareth Clinkscale gave an update on the access team input that was currently being received from the Scottish Government.

7.6 Mr Bone further mentioned the reintroduction of the Scottish Government Performance Escalation Framework of which NHS Borders remained at Level 3 for Financial sustainability.

7.7 Mrs Alison Wilson commented that from a clinical perspective, some of the issues with attracting new staff and providing efficient services were related to a lack of development of automation and electronic systems due to potential under investment in IM&T over previous years.

7.8 Mrs Fiona Sandford commented that she would be keen to hear more about digital solutions and IM&T resource.

7.9 Dr Lynn McCallum reinforced Mrs Wilson's point from a clinical perspective and recognised that IM&T were working hard, however the resource they had was exceptionally limited and any clinical innovation always required a digital solution. The larger Health Boards appeared to have larger teams and more capacity to deliver solutions that clinicians were seeking and it did impact on clinical recruitment.

7.10 Mrs Lucy O'Leary empathised that there must be a constant high level of stress for the Executive Team and Finance Teams given they were being tasked with delivering a position that was unlikely to be deliverable.

7.11 Ms Lam commented that whilst the focus appeared to be on remobilisation there were concerns on flow and she enquired if the access team input was inclusive of work on flow. Mr Clinkscale confirmed that the access team were looking at wider system issues such as reductions in capacity, workforce impacts and unscheduled care pressures. The session held the previous day had focused on the partnership need to deliver more capacity and recognised that it was a closely interlinked system.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the assumptions related to the Scottish Government financial planning framework for 2022/23.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the expected timescales for publication of the board's 'Mid Year Review' financial forecast to 31st March 2022.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the draft timetable for production of the board's financial plan for 2022/23.

The **RESOURCES AND PERFORMANCE COMMITTEE** endorsed the process outlined for production of the board's financial plan.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the risks identified in the paper that further work to assess the risks attendant on the financial plan would be undertaken in line with financial planning timescales.

8. Aseptic Pharmacy Dispensing Service Provision

8.1 Mrs Alison Wilson provided an overview of the content of the paper and highlighted that there had been a commitment as part of the national shared services programme to look at aseptic services across Scotland. The resources available to run aseptic services were limited given the specialist role required and Board Chief Executives had recommended that services were consolidated from 23 services across NHS Scotland to 11. The national recommendation had been that the NHS Borders service would close and be provided by the NHS Lothian service.

8.2 Mr John McLaren had been keen to retain the aseptic service in NHS Borders however he recognised the difficulties in recruiting to the specialist post required and that the unit would require a new area to ensure it was fit for purpose. He was also concerned that the NHS Lothian service may not be as flexible as the NHS Borders service had been, especially during the pandemic.

8.3 Mrs Wilson commented that the initial preferred option had been to retain the aseptic service locally, however with the financial and risk appraisals having been carried out and the inability to recruit to an accountable pharmacist, that option had moved away from being the preferred option. In terms of flexibility, potentially that could be an issue, however the majority of the work was planned. Similar issues had been raised at NHS Ayrshire & Arran and those had been resolved through proper scheduling. In terms of wastage, stock levels would be kept to a minimum and NHS Lothian would be able to make some products by exception for NHS Borders.

8.4 Mr Ralph Roberts commented that it was a difficult decision and a finely balanced judgement and the final view of the Board Executive Team had been that a local aseptic service could not be staffed and that would be an on-going issue. The Team could not endorse putting a service in place based on a single point of failure on an on-going basis, as well as the need to find additional space and move other facilities to accommodate it. He suggested the Committee accept Option 3 as the preferred direction of travel as there was further work to be taken forward with NHS Lothian and to mitigate risks.

8.5 Mrs June Smyth commented that the service would not be at a level any lower than that provided to other patients across the region. NHS Borders had been fortunate to have a personalised and flexible service that was not the same across the rest of Scotland, but it could not be retained due to an inability to staff it and that situation was unlikely to change in the future.

8.6 Dr Lynn McCallum commented that the issue with recruitment was likely to be seen increasingly across small services. Clinical engagement and leadership would be key in achieving financial turnaround and empowering clinical teams to address staffing or merging very small services.

8.7 Mrs Harriet Campbell was reassured that the Committee were not being asked to make a definitive decision. She was concerned about the drain of resources from NHS Borders which was leading to a loss of services and tied into the previous discussion on the provision of digital resources to make NHS Borders more attractive as a place to work. She enquired if the provision of a new aseptic unit would attract the specialist pharmacist required. It would be a shame to step down services to only provide what other Boards provided when the current service had been so flexible and accommodating.

8.8 Mrs Fiona Sandford commented that in the short term the NHS Lothian option should be pursued, unless NHS Borders could be made more attractive to recruit permanent staff by having the best possible digital systems and innovations. In the short term the NHS Lothian option was the only choice.

8.9 Mr James Ayling suggesting looking at the decision in the context of NHS Borders services being sustainable and struggling to achieve what was required.

8.10 Mr McLaren was uncomfortable in endorsing Option 3 until he had been assured in regards to the content of the contract with NHS Lothian to provide the aseptic service. He commented that the fragility of providing services to the local population would be further eroded if smaller services were merged with NHS Lothian as the main provider.

8.11 Mr Roberts emphasised the need to ensure the right scale of services were provided in the Borders to sustain the Borders General Hospital. In terms of patient experience of the service it would be very minor given the service was a support service to clinical services. In terms of cancer services they would be delivered locally across the region.

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

The **RESOURCES & PERFORMANCE COMMITTEE** noted the work to date relating to the provision of an aseptic pharmacy dispensing service within Borders and approved the adoption of Option 3 with the caveat of the paragraph below and asked that a further report be submitted to the Committee. This would mean that once implemented, NHS Lothian would provide the aseptic service and the aseptic suite at the Borders General Hospital would close.

This is subject to further discussion with NHS Lothian, led by the Director of Acute Services to ensure we are satisfied that the level of service offered is at the same level of service provided in the East Region and that NHS Lothian cancer service is sighted on the proposal. It is also our intention to undertake a proportionate level of public involvement before the changes are implemented. We aim to conclude these discussions by the end of the financial year and will report back to the Committee the final outcome.

9. Primary Care Premises Review

9.1 Mrs June Smyth provided an overview of the content of the report and highlighted: future proofing facilities; investment priorities for the future; the process followed for the review; engagement with the GP Executive, Primary Care Improvement Plan (PCIP), Practice Managers and Primary and Community services; and the next steps in developing a more detailed action plan.

9.2 The Chair enquired how the GP Practices within Community Hospitals were differentiated within the review. Mrs Smyth commented that the review took place within the walls and boundaries of the GP Practice and did not include the community hospital elements of the buildings. However a further technical assessment would be taken forward to look at community hospitals and whether they were fit for purpose.

Mr James Ayling left the meeting.

9.3 Ms Sonya Lam enquired if future proofing would be taken forward beyond the context of the PCIP. Mrs Smyth commented that future proofing had taken place in recognition of the PCIP. However, it also recognised the need for additional space for future developments and services, through the creation of generic space with a multiple purpose approach, against

the backdrop of demographics, the Scottish Borders Council Housing plan, small GP Practices sustainability and potentially moving towards a community hub approach.

9.4 Mr Andrew Bone spoke of future proofing in the context of capital planning and the Scottish Government model of programme based infrastructure planning.

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Primary Care Services & Premises Review report which outlined the wider findings of the full premises review.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the extensive consultation with the GP Executive would follow in the coming months to create an action plan based on the report findings.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that an engagement plan would be developed to sit alongside the action plan.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the next steps as highlighted in the report.

10. Performance Scorecard

10.1 Mrs June Smyth provided an overview of the content of the report.

10.2 Mr Gareth Clinkscale highlighted the performance in regard to cancer services and that there was a potential risk to the current 62 day target being maintained in terms of colorectal cancer and those patients who required post operation ICU care. He was also keen to bring a fuller set of information to the Committee related to remobilisation capacity issues. In terms of length of stay he advised the Committee that pre pandemic the organisation had been in a strong position in terms of acute non elective length of stay however that position was likely to have reduced since the pandemic.

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

The **RESOURCES & PERFORMANCE COMMITTEE** noted the September 2021 Performance Scorecard.

11. Terms of Reference Review

11.1 Miss Iris Bishop reminded the Committee that an update to the Terms of Reference had taken place in April 2021. With the recent change in Directors 2 further minor changes to membership titles were proposed.

11.2 Mr Ralph Roberts asked that the differentiation of roles for the Chief Officer as the Chief Officer of the IJB and the Director of Primary and Community services be made clearer.

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

The **RESOURCES & PERFORMANCE COMMITTEE** reviewed the Terms of Reference and with the inclusion of a clear differentiation of roles for the Chief Officer, recommended them to the Board for formal approval as part of the next refresh of the Code of Corporate Governance.

12. Self Assessment

12.1 Miss Iris Bishop introduced the self assessment and asked that individuals complete them and return them to her by 3 December 2021. A review of the returns would take place and a report to cover any actions or development needs would then be brought to the next meeting of the Committee for consideration.

12.2 Miss Bishop advised that she would circulate the self assessment in word format after the meeting.

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

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to individually undertake a self assessment for the period 2020/21 and to submit returns to the Board Secretary by Friday 3 December 2021.

13. Any Other Business

13.1 There was none.

14. Date and Time of Next Meeting

14.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 20 January 2022 at 9.00am via MS Teams

The meeting concluded at 10.53am.

Signature: ……………………………
Chair

RESOURCES & PERFORMANCE COMMITTEE: 4 NOVEMBER 2021

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	**Sonya Lam:** I declare my partner works as a specialist advisor for the Scottish Government.	**Iris Bishop:** Thank you Sonya I will record your declaration in the minutes.
		MINUTES OF PREVIOUS MEETINGS	
2	Minutes of Previous Meetings	**Harriet Campbell:** At 15.2 I asked about delayed discharges and choice and June said she would come back to me. Could we have an update please. More generally - and I'm sure this will come up in the dashboard too - with major concerns around patient flow can I ask two unpalatable questions: 1. In early 2020 hospitals very effectively and quickly cleared their decks to make way for a feared influx of covid patients. We all know that had some terrible results in terms of infections in care homes but is there nonetheless something that can be taken from this - in extremis places were found for people to go. Why is this no longer possible? and 2. Really brutally why is it not possible just to say: we need the bed for someone sicker than you. I know social services/your family will find it tough but you have to go home now. Horrid questions but maybe they have to be asked.	**Chris Myers:** Our local 'Guidance on planning and managing discharge from hospital' provides further information on the choices process. This is attached at Appendix 1 to this Q&A. In early 2020, whilst a number of patients did rapidly transfer out of acute settings to locations including their homes and residential care. At the time there was sufficient capacity in these settings to do this. During the first lockdown, people had more capacity to care for their relatives due to a reduction in work commitments and travel, and so relatives were more able to take on additional care responsibilities in these extraordinary circumstances. In residential care, there was also more available capacity for transfers. At this stage this capacity is significantly reduced. There are 3 major factors that broadly affect this: 1. Increased demand for care, 2. Increased dependency/need of those requiring care, 3. reduced workforce / carer availability in the context of self-isolation, fatigue and burnout.

			In relation to the second question, the HSCP has a duty of care and public protection to individuals requiring care, and many people waiting for care in hospital settings have high levels of need which require significant levels of input. As a result, there is increased risk to these individuals of discharging them without care, and of associated hospital readmission. In instances where people are readmitted after discharge (e.g. having falls at home), then their level of medical need, function and social need/ dependence reduces further.
		MATTERS ARISING	
3	Matters Arising Action Tracker	-	-
4	COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update Appendix-2021-29	**Lucy O'Leary:** P 59 (covering letter) – reference to the Whole Systems Modelling Tool. Where can I find information on this tool (methodology and design, rather than the outputs for Borders in this instance)? P 115, s 3.5 – Borders Urgent Care Centre How much (absolute numbers and % would be helpful) of the demand that could be handled initially by this route (ie people with non-life-threatening conditions) is still bypassing it and going direct to A&E? And what proportion of A&E demand does this represent? P 149 ff – trajectories. I assume that these tables variously represent scenarios 1 and 2 referred to in the text, but I can't see where this is marked accordingly. Would it be helpful to add a header/ footer indicating which table refers to which scenario to avoid confusion and ensure that SG	**June Smyth:** I have asked the Business Intelligence to provide the latest guidance on the tool and I will circulate it as soon as I have received. **June Smyth**: Data still currently being analysed and an update will be included as part of the deep dive into the reshaping urgent care project, which is referred to in a later Q&A. **June Smyth**: Noted thank you we will action for any future iteration

		and we don't end up comparing apples to oranges at some stage?	
5	COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update Appendix-2021-29	**Fiona Sandford:** 1.7 Delayed Discharge performance projections: do we have a timescale when this will be available? 7.4: '18-25 requirements and Clinical Director Role' … need to attract recurrent funding… Q: why are they not funded recurrently and what can we do to push this along?	**Chris Myers:** We now have projections available- which are enclosed within the attached presentation **Paul McMenamin**: A key challenge in longer-term planning and delivery within the Mental Health clinical board is driven by the nature of how the Scottish Government funds NHS Borders to deliver services. One of the key drivers of this is the high policy profile that mental health services have at a national level and the Scottish Government's use of specific funding allocations (as opposed to baseline allocation) as instruments to publicly implement and deliver policy. For the current financial year, 17% of the total spend that NHS Borders plans to make across the Mental Health clinical board (over £3.7m) is predicated on non-recurring funding, which is neither insubstantial, nor does it enable robust, strategic long-term planning. 2021/22 is perhaps an acute example of this, a year when there has been a number of significant commitments by the Scottish Government towards a range of priorities including Child and Adolescent Mental Health Services, Psychological Therapies and Psychology and other strategic workstreams, compounded by 2021 having been a Scottish Parliamentary election year and inherent

		8.3.1 totally support this	uncertainty therein. Whilst this financial support is welcome, its (currently) short-term nature does have a number of implications such as the ability to plan over the medium to long-term, recruitment challenges and potential financial risk to the Board going forward should recurring commitments be required to be made. The degrees of assurance provided by the Scottish Government to date over likely, if any, future funding allocations vary. A number of the allocations relate strictly to only 2021/22 whilst others, without providing assurance over future years, do talk about consideration of the need to plan over the medium-term. As a health board that remains in escalation as a result of its historic financial plan challenges, the need for prudence and risk aversion remains of paramount importance however and as frustrating or challenging as the position is, is understandable. Discussions remain ongoing both nationally and directly at a local level with the Scottish Government, with both the Scottish Government Mental Health and Health Finance directorates to achieve clear assurance over ongoing funding commitments in order to alleviate these challenges above and to enable more strategic and sustainable planning in order to deliver the outcomes targeted going forward.

		Appendix 1: Delivery plan: PCIP 'Community Treatment and Care Service' pilot: Can we hear more about this at some stage please? Remobilisation of Community Dentistry 100% NHS GDS working above baseline activity of 20% - Q is this adequate? CAMHS: Psychological Services – why do we have lack of data, and concerns about accuracy?	**June Smyth:** Noted thank you – we will ask this to be part of any future PCIP update to the Board. **Cathy Wilson:** The SG baseline remains the same at 20%. We have one practice with an action plan to improve (they have gone from 11% to 14%). They have very specific issues in that they are mainly private with some NHS children. They are however working with us (PDS) to improve. The average activity level for GD in NHSB is sitting at approx. 55% (three month rolling average). **Caroline Cochrane**: Issues were identified in 2019 in terms of what was being included as a CAMHS PT referral. Discussions took place with the CAMHS Psychology lead, but unfortunately staff sickness and then our CAMHS lead leaving the service in September 2020, meant this issue was not resolved. We recruited a new lead in April 2021 and have been working closely with him on this issue. However, the CAMHS psychology team has been operating on a very reduced staffing basis in 2020 and 2021 and as a result, only the most urgent referrals have been attended to. The psychology model during this period has been one focusing more on consultation and supervision of other CAMHS mdt team members rather than the wider role it would have played had we been at full capacity. As a result, we believe that the current referrals

		Non Elective Hospital Spell Activity Chart: do we have to longest Mean Hospital LOS in Scotland? Is this a concern?	to psychology/PT in CAMHS are significantly lower than they would normally be. **June Smyth:** This is currently being looked at and the answer will follow.
6	COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update Appendix-2021-29	**Harriet Campbell:** Can you possibly explain how SGs uplift of ICU capacity from 173 to 202 beds fits with the actual permanent increase of 1 level three bed or sure capacity of an extra 20? As we head into November is performance matching the plan? 7.4 "Overall the funding allocated to NHS Borders using the NRAC formulae is insufficient to achieve the objectives set out in the Recovery and Renewal letter from Scottish Government" Says it all….and presumably doesn't only	**Gareth Clinkscale**: The 1 permanent uplift we have been asked to deliver is NHS Borders proportion of the National Uplift Scottish Government have advised effected Board needs to be in place. On top of this to further support COVID-19 surges we have been asked to maintain the ability to uplift capacity to 20 patients. Whilst there is the physical capacity to create this number of beds, due to workforce pressures, remobilisation of other services across the organisation and updated national guidance around safe ICU staffing ratios we no longer have sufficient staffing to reach this level. Exceeding 12 level 3 beds would require nurse: patient ratios below 1:2 and would impact on emergency, urgent and cancer care. **June Smyth:** October performance data is not yet available but the position will be closely monitored through clinical boards / access board / board reports once the RMP4 indicators are built into the performance scorecard. **Andrew Bone:** The Scottish Government have indicated that they will be reviewing the NRAC formula during the course of the next parliament. There is no set timetable for this review. There

		apply to mental health. Have we had any response on this? What can be done to push?	is ongoing dialogue with Scottish Government colleagues with regard to Recovery & Renewal plans and resources available to support this agenda. It is also worth noting that members of the executive team are due to meet with the Minister for Mental Health (Kevin Stewart MSP) in November and it is expected that Mental Health Recovery & Renewal will be covered at this meeting.
		Appendix 1 p78. Target of 100% AHP outpatient activity by October. Was this achieved? If not, how nearly was it achieved? If it was achieved, huge congratulations to those who made it happen. Is there learning in here that could inform other service areas?	**Paul Williams:** Unfortunately, in line with many other NHS Borders services 100% remobilisation has not been achieved and projections have been modified for RMP4. Across the 20+ AHP outpatient services remobilisation rates have varied between 40-80%. Reasons for this variability include ongoing covid restrictions, workforce recruitment and absence challenges, and ongoing prioritisation of inpatient services due to whole system pressures.
		P90 medium term covid capacity is red but also marked as " complete". Seems contradictory?	**June Smyth**: Apologies if this was not clear the complete is in relation to the Interim COVID-19 Bed Plan aspect of the work.
		Should know this but what is the discharge lounge? Guessing it is a day room to clear space early in the day. Is under utilisation therefore the result of actually not being able to discharge people?	**Gareth Clinkscale:** The Discharge Lounge is a seating area in the hospital that patients can be transferred to on their day of discharge to wait for transport. Under utilisation reflects ward leadership in terms of use of the lounge, there being a greater number of opportunities to

			transport patients sooner than pre-pandemic (and so less opportunity to wait) and an increase in patients not deemed suitable for the lounge from an Infection Control perspective (for example COVID-19 positive patients).
		Appendix 3. Have we at any time since March 2020 been able to achieve 90% of 2019/20 outpatient activity? (I should probably know that but I don't, sorry). If not realistically is it actually likely to happen over this winter - it needs several key things to happen, over some of which we have no control - and if not surely this is not really a "best case" scenario at all? Even 65 % seems optimistic given winter pressures. I suppose I am really asking "what scenario is actually likely?" Do we need an absolute worse case scenario? The numbers are pretty scary as it is.	**Gareth Clinkscale:** The highest level of Outpatient activity delivered post-pandemic is 80% pre-pandemic levels. 90% is assessed as realistic however delivery timelines have slipped due to operational pressures. Recruitment is however complete and 2/3 capital projects are moving from planning to implementation phase.
		P173. What are the blue question marks for?	**June Smyth:** I believe the blue question marks should have been deleted from the final version, we will ensure this is amended.
7	COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update Appendix-2021-29	**Sonya Lam:** 1. Page 56: 1.7 – have we had any informal feedback from SG?	**Gareth Clinkscale**: There has been no formal feedback received on RMP4. We have asked for support from the Centre for Sustainable Delivery with remobilisation in recognition of the significant challenge with Surgery remobilisation.
		2. Page 59: Have we used or do we intend to use the Whole System Modelling Tool?	**Phil Lunts**: The Whole System Modelling Tool provides a range of different functionality, with much of it still in development. NHS Borders has been an early adopter in testing this functionality. We have used the Acute Unscheduled Predictor as a weekly forecast of

			changing bed demand over the next 12 weeks. We also used the Winter Modelling functionality to provide baseline predicted winter bed demand that directed our Winter Planning. We are involved in testing of social care demand and elective demand modelling elements currently.
		3. Page 65: Acknowledge the considerable effort made with the vaccination programme. What is the level of confidence that it will deliver	**Nicola MacDonald**: Delivery of the vaccinations commenced in early December 2020. The Programme has offered first doses to all known individuals aged 12 and over and second doses to all those eligible. Mop up for Covid vaccination dose 1 and dose 2 will be on going to those that come forward. Tranche 2 Covid Third dose, Flu vaccination and Covid Boosters commenced in September 2021. Those severely immunosuppressed have been offered a third dose and a booster dose is being scheduled in line with national delivery by at risk and age cohort category's All those aged 70 and over have been appointed. We are currently Awaiting Scheduling to letter all those in the 60-69 age cohort and 16 – 59 At Risk, with underlying health conditions, A national online portal will be available mid-November for those 50-59 years of age and adult household contacts of immunosuppressed individuals. Health & social care workers have been using a national staff booking portal and

			we continue to see uptake at clinics from this. We have planned clinics up to 21st December, however, work is ongoing to identify dates and venues to add additional clinics where possible.
		4. Page 67. 2.3 – Test & protect. Recognising the challenges with staffing, do we meet the service specifications/KPIs	**Keith Allan**: Nationally set targets for staffing of the NHSB Tracing Team are that we have 12 WTE staff rostered on per day. Due to leave and sick leave we are currently averaging 8 WTE tracers plus 1 WTE Team Lead per day. This difference is made up by inclusion of national NCTC Tracing staff put at our disposal. Therefore we do meet the required WTE per day. In terms of KPI, this is monitored nationally (as well as through local management) with feedback delivered to Boards. We follow national SOPs and guidance within the Tracing team and so meet these KPI.
		5. Page 68: 3.4 – In the context of Public Health Scotland's modelling of anticipated demand over winter, what numbers anticipate to be prevented from admission and will this be sufficient to make an impact on inpatient flow? Are there contingency plans if prevention doesn't impact on the numbers of people requiring hospital intervention?	**Philip Lunts**: As noted above, we modelled scenarios for winter demand for beds and used this to identify actions to help manage demand. We are updating this to reflect both changing models of current demand (including Covid scenarios) and the expected ability of services to deliver on the proposed changes. This will allow us to determine whether additional measures need to be put in place. This will an ongoing and dynamic process
		6. Page 69: 5.1 – what are the specific care programmes?	**June Smyth**: There are 4 areas individual programmes of work sit under: • Support for Scottish Government Commissioned Unscheduled Care

			Programmes • Cancer Performance and Early Diagnosis Programmes • Scottish Access Collaborative and Modernising Patient Pathways Programmes • Other planned care programmes
		7. Page 69: 6.3 – what is the purpose of the CfSD heat map?	**June Smyth**: The purpose of the heat map is to provide a strategic overview of programmes to help identify areas of synergy, duplication and opportunity. In addition, it provides a clear description of where the greatest opportunities lie from programmes and indeed where efforts should be focused. In addition, this also provides the opportunity to layer onto the map potential future opportunities as they are identified.
		8. Page 70: 7.3 - Is an alternative solution required to develop a sustainable service particularly if the issue is being the smallest mainland Board	**June Smyth**: Your question is noted and is one we would need to consider further in due course
		9. Page 70: 7.6 - With the suggested critical pause, what are the risks to people who use these services?	**June Smyth**: The Transformation Programme has paused in terms of redesigning the way we deliver services. patients continue in the interim to be able to access / receive support through the current service provision.
		10. Page 71: 8.2 – Is the Healthcare Chaplaincy Service facilitating any Values Based Reflective Practice sessions for teams?	**Sarah Horan:** The Hospital Chaplain offers listening sessions but these are not in the format enquired about

		11. In terms of the Winter Planning template, amber indicates that systems and processes are in development and will be in place for end of October. Are the amber plans now green or is there risk of them being red? Are there areas of concern/risk?	**Gareth Clinkscale:** Not all elements of the Scottish Government Winter Planning Checklist will deliver to green status. For example, where service capacity does not exist and would not be cost-effective or deliverable in time for winter then this will remain amber. The Winter Planning Board, which meets fortnightly, is focussed on the delivery of the 16 winter projects that form the focus of the 2021/22 winter plan. 6 of these projects are currently assessed as green, 9 amber and 1 red.
8	COVID-19 Remobilisation Plan 2021/22 (RMP3) – RMP4 Mid Year Update Appendix-2021-29	**James Ayling:** Do we have the Our Hospital Delayed Discharge performance projections yet? After 6 months on the Board I can see the impact these have on overall performance. Section 7 on Mental Health and Wellbeing packs a real punch. I note that an interim plan re CAMHS and Psychological Services was submitted on 2nd July 2021 and followed up with a more detailed paper. A further document was sent to the Directorate for Mental Health on 13th August 2021. Have we received a response? 8.2.2 We now have a dedicated Staff Psychologist. Very pleased at this development **Delivery plan progress report .winter preparedness.** Paper notes medical cover for weekends to support discharge-- Increase number of weekend discharges through provisions of an additional 0.4 WTE registrar.	**Chris Myers:** We now have out projections available which are enclosed in the attached presentation **June Smyth**: There is ongoing dialogue between NHS Borders and the Directorate for Mental Health regarding our plans and funding allocations. **June Smyth:** Noted thank you. **Gareth Clinkscale**: This support has been put in place during each of the three previous winter periods and is usually delivered through additional hours/locum capacity. We have

		Paper then says---Awaiting Vacancy Approval from Finance. Confident to fill role through agency. Can internal approval not be expedited for this important role ? **Winter preparedness** Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate. Service is a Monday to Friday service, no scope at present to provide a 7 day service due to workforce constraints. What will happen at the weekends to those needing assistance?	sought to recruit this year however have additional hours/locum as a contingency plan. **Gareth Clinkscale**: There is no at home Respiratory community service at weekends. Patients with Acute requirements for care will be admitted and cared for under the General Physician 'on take' in the BGH over the weekend. This is a typical model in a small DGH setting.
9	Financial Performance Appendix-2021-30	**Fiona Sandford:** SG letter re Q1 position and funding Under-achievement of savings P2 #4. Do we know how SG will judge 'appropriate review and control at Board level'	**Andrew Bone:** We do not yet have clarity on how this would be reviewed. I expect to meet with SG colleagues within next 2 weeks and would expect to have greater clarity following that meeting.
10	Financial Performance Appendix-2021-30	**Sonya Lam:** Thank you for a clear paper. Noted. Page 184, 5.4 & Page 187 (letter from SG): I understand we will have to provide further mitigating actions to decrease the deficit gap in the Q2 report. Is the reinstatement of the financial turnaround programme dependent on bringing back staff who have been re-purposed or is it the case that staff in the business units do not have the capacity to work on this. Is the financial turnaround programme approached from a quality service perspective, with follow-on financial gain?	**Andrew Bone:** At Q1 review we identified limited scope for any further savings in the current year, and continue to carry a risk on delivery of the plans that do remain in place. I do not believe we will be able to identify any further mitigation without increasing service risk. Without PMO resource and service input we will carry a very high risk around the development and delivery of savings plans. We do not currently have any resource directed towards identification of savings opportunities. We will need to address this moving forward in

			order to develop savings plans, but at this stage it is likely this would be for 2022/23 rather than in year delivery. Our intention is that we would look to align financial sustainability with the wider Quality approach in order to achieve goal congruence between resource and service plans. We will need to discuss how this approach fits with our continued performance escalation status in relation to financial performance, both with SG and internally.
11	Financial Performance Appendix-2021-30	**James Ayling:** Can you confirm that there is no risk of capital allocations being scaled back in future by SG due to a back log of allocated yet not commenced capital projects? I see info re low capital spend on the new Forensic Examination suite .I recall that it was anticipated that a contract would be let by October . Can you confirm current position. I need to update Police and Fire Communities Board at meeting this Friday. Thank you. Letter fromRichard McCallum dated 26th October . Any view on what constitutes appropriate review at a Board level given the letter itself refers to: *likely resource constraints we will face going into 2022-23* and *uncertainty on the overall funding envelope for 2022-23 ?* Given that Mr McCallum's letter is not a pro forma letter to	**Andrew Bone:** Capital Allocations We are currently working up plans for how we can rebalance our programme to maximise spend in current year by bringing forward future priorities and we are working closely with SG colleagues on this. There is a risk on resource however SG have recognised that this issue is shared across the wider NHS infrastructure planning landscape and are developing a national coordination approach to support boards with multi-year infrastructure planning. I think our main risk is centred around capacity to deliver projects in next 12 months but the financing risk is probably manageable given other flexibility within the programme. FME The tender has progressed and submissions are under review. I expect an update later this week and will ensure we provide the latest position in

		all Boards does this reflect a concern that our Board is not currently reviewing matters/savings appropriately? Our paper on Financial Planning process indicates that progress towards development of forward plans is limited as a result of PMO and service/management capacity and as such, the ongoing suspension of the financial turnaround programme from March 2020 remains in place. PMO work is obviously seen by the SG as critical. Do we have plans/priorities re PMO function? Is monthly monitoring a precursor of further escalation? Important to prevent that particularly from a negative public and workforce perception.	advance of your meeting. At this stage I am not expecting significant slippage on timescales however we will reevaluate upon appointment of contractor. R McCallum letter See comments above re. 'appropriate review at a Board level'. I expect to have more information on this following discussion with SG colleagues in next couple of weeks. Richard has advised that this letter reflects his intention to reintroduce the performance management arrangements required for HBs who are escalated under the Performance Escalation Framework. NHS Borders was one of several HBs who were subject to this scrutiny pre-pandemic. It would not be unreasonable to infer that there may be some level of concern given the continued suspension of our turnaround programme which was flagged at Q1 with expected timescales for remobilisation by October (now slipped). I would suggest we pick up the issue of PMO resource as a question at the meeting. The prioritisation of PMO resources is under active discussion via BET. There are significant demands on this resource outwith financial sustainability planning. Monthly monitoring is not automatically a precursor for further escalation. This is standard performance measure which we would expect

			given our ongoing escalation. There is however a risk that we will not provide sufficient assurance in relation to our current organisational focus on financial sustainability. We need to be clear about where this actually sits on our current priorities – we have deprioritised throughout the pandemic and have not yet managed to bring back online. Our financial turnaround programme does remain suspended given service pressures and this is a significant risk.
12	Financial Planning Process and Timescales 2022/23 Appendix-2021-31	**Sonya Lam:** Noted	-
13	Financial Planning Process and Timescales 2022/23 Appendix-2021-31	**James Ayling:** UK Chancellor spend last week on devolved matters results in c**£4.6billion** extra for SG . Hopefully this will be reflected in increased NHS spend at some stage.	**Andrew Bone:** The Scottish budget will be presented to parliament on 9th December. This will include confirmation of additional resources available to NHS Scotland.
14	Aseptic Pharmacy Dispensing Service Provision Appendix-2021-32	**Lucy O'Leary:** Suggest that future non-financial option appraisals should include risk as a domain. It seems less than ideal to have gone through the NFOA, arrived at a preferred option on the basis of potential benefits only, and then have that outcome challenged by a parallel process looking at risks.	**Alison Wilson:** I would like to look at the whole process and the lesson learnt from it. There were things that could have been done differently.
15	Aseptic Pharmacy Dispensing Service Provision Appendix-2021-32	**Fiona Sandford:** Exec summary Recommendations #2 'proportionate level of public involvement' : would be good to know a bit more about this.	**June Smyth:** Proportionate public involvement – this reflects the fact that on the surface it could be suggested that patients won't even be aware of the fact that the service provided has moved from NHSB to NHSL as this is a 'supportive' function and service. In addition, this change was nationally directed. However, in light of the

			fact that there may be some slight changes to the model provided it would be appropriate to have a level of public involvement as we explore this change further with NHSL and as we potentially move to implement. This will be lesser than the level of public involvement we would plan for in a major service redesign, however, hence the reference to proportionate.
		P9 #2 number of patients affected: I am correct as reading this as 15% of 175, ie 26 people, and that during the test a delay caused by toxicity assessment happened on 18 occasions, so some delay is normal? OR is it that moving to Lothian would significantly exacerbate existing delays? Under Risks: quality patient centred care: Patients will need to travel to Lothian / come in at weekends: all patients? 15%?	**Alison Wilson:** Yes delays do happen occasionally. We anticipate that the Lothian model could increase delays if there was a change in patient circumstances e.g. if a repeat blood test was required or sometimes patients come in earlier and we are asked to bring forward making the product on the day. This won't be able to happen through Lothian as products need to be ordered the day before.
		Big picture question: is this move a predictor of more and more services being moved to Lothian?	Unlikely from a pharmacy point of view.
16	Aseptic Pharmacy Dispensing Service Provision Appendix-2021-32	**Harriet Campbell:** If you had to give me one **primary** reason for recommending option 3 what would it be?	**Alison Wilson:** Makes better use of limited resources and for me this would be Aseptic Accountable Pharmacist.
		The time critical and travel requirements of option 3 concern me. What resilience would we have if there was, eg, another "Beast from the East" and Soutra were shut for several days?	This will need to be worked through. During "Beast from the East" we engaged with the police to help escort our wholesaler's vans down the A7/A68 so we could do the same again.
		What control will NHSB have over standards at Lothian in the future if this is put in place? ie if standards start to slip there is there a risk that we will be in a position of not being able to do anything about it?	Standards are highly regulated and we would want to see the annual audit reports to ensure they were being maintained. We have contingency arrangements in place if a unit has

		What public consultation is planned and how/when will this be carried out?	to close suddenly. **June Smyth:** The Public Involvement Team were asked at a late stage to supply a public member to the aseptic review however there were no takers. The team will arrange a discussion with the Director of Pharmacy and service representatives in order to facilitate and support the design of an engagement and involvement exercise in line with the response to Q15.
17	Aseptic Pharmacy Dispensing Service Provision Appendix-2021-32	**Sonya Lam:** Thank you for providing a comprehensive and thorough options appraisal process.	-
18	Aseptic Pharmacy Dispensing Service Provision Appendix-2021-32	**James Ayling:** Clearly a well considered and thoughtful paper pulling together a lot of work. I agree with the recommendation on option 3 . Mitigation of specialist staffing/recruitment issues Higher weighting for patient safety Considerably earlier delivery. Will presumably free up space for eg pharmacy if required. Option 2 might take 3-5 years and the estimate states that should the project be delayed beyond 2022 (almost inevitable) the following additional allowances should be added to the total construction cost for inflation Year: 3.9% 2 Years: 8.1% 3 Year : 12.4% . I don't believe (but correct me if I am wrong) that these very likely	**Alison Wilson:** Pharmacy space is at a premium. Additional cold store space will be required for the prefilled products. No these are estimates and haven't been taken into account.

		potential increases have been taken into account in the cost comparison which would increase the cost of option 2. The reports into the Sick Kids Hospital and the recent March 2021 report into the Queen Elizabeth University Hospital clearly indicate the challenges and issues arising from ventilation/infection control in new premises. It would seem prudent to manage these risks by transferring them to Lothian .	
19	Primary Care Premises Review Appendix-2021-33	**Fiona Sandford:** Noted	-
20	Primary Care Premises Review Appendix-2021-33	**Harriet Campbell:** To what extent is usage noted affected by the pandemic? With fewer patients receiving face to face care are we at risk of making decisions based on usage figures that don't/won't reflect "normal" usage?	**June Smyth:** Latest information gathered reflected new models of care including balance of face to face and virtual. Opportunity to change type of space required rather than overall volume to support new delivery models. E.g., use of "pods" for virtual consult rather than consult room.
21	Primary Care Premises Review Appendix-2021-33	**Sonya Lam:** Page 223, table 1. What is meant by Code of Conduct or is this code of practice? Page 224. Additional actions: should this include requirements for energy/carbon reduction?	**June Smyth:** Yes sorry should be Code of Practice; we will update. Any major investment will be required to be delivered carbon neutral. The information from Faithful & Gould has identified where investment required to address current standards.
22	Performance Scorecard Appendix-2021-34	**Fiona Sandford:** 1.3: Again, glad to see 100% Treatment for Cancer 1.5.2: CAMHS: look forward to seeing improvement once recruitment complete, good to see two candidates starting in October	**June Smyth:** Noted thank you **June Smyth:** Noted thank you

		1.6.2: I'd be interested to have a deep dive into the Re-designing Urgent Care Project sometime	**June Smyth:** Work is currently underway to assess the project and review key metrics after which we can facilitate a deep dive.
		1.7: disappointing delayed discharges increase	**Chris Myers**: Having reviewed 140 weeks of retrospectively data, we know that since June we have seen an increase from the average in the number of referrals for care (demand) from 11.4 to 19.4 per week. The number of discharges /removals (activity) from the delayed discharge list has increased from the average of 11.3 to 18.3. Unfortunately, with the increase in demand, the gap between demand and activity has increased, and the number of people delayed has also gone up. We have therefore built our forecasts to the end of March based on the demand and activity from most recent statistically significant period and factored in mitigating actions. As a result, we expect that delays have peaked last week, will reduce to 36 on the 27 December, and will reduce to 29 on the 28 March.
		1.8: Sickness absence rate worrying	**Ailsa Paterson**: It is acknowledged that we are seeing a rise in absence rates which are being closely monitored. There has been an increase in absence rates across the NHS in Scotland and we continue to experience a level of absence below the national rate. We are in the process of developing a Staff Wellbeing Plan which will describe interventions to help the workforce get through the remainder of the emergency response phase and set out plans in the medium-longer term. RMP4 details the

			additional interventions that have been established to support staff which includes the Work and Wellbeing team increasing capacity and the introduction of a staff psychologist. The Staff Wellbeing Group has agreed projects to support the mental health of staff and are currently progressing the Spaces Project, which sets out to identify and establish fit-for-purpose spaces for staff to use during their rest breaks. Feedback from Collecting Your Voices and iMatter will shape future initiatives also.
23	Performance Scorecard Appendix-2021-34	**Harriet Campbell:** How is the trajectory for delayed discharges worked out? Is static at 10 which seems to bear little relationship to reality.	**June Smyth:** This trajectory is the previous trajectory set as part of RMP2 and will be updated to reflect the trajectory submitted to Scottish Government as part of our RMP4 submission once we have received formal feedback from them. See answer above for more detail around delayed discharges.
24	Terms of Reference Review Appendix-2021-35	**Lucy O'Leary:** I understand why we would want to include the DofAcuteS in the group membership, but does this represent parity of representation/ engagement between acute services and other sectors for which the Board also has commissioning/ performance management responsibility?	**Iris Bishop:** The membership of the Committee is made up of all Board Executive Team members as well as a partnership representative in order to ensure there is parity across the whole of NHS Borders services.
25	Self Assessment Appendix-2021-36	**Harriet Campbell:** Practical question: is this us being asked to do this now? Or are we just being put on notice that it will be required before December?	**Iris Bishop:** You are being asked to take it away and do it over the next few weeks and ideally send it back to me by 3 December 2021 please.
26	Self Assessment Appendix-2021-36	**James Ayling:** I presume that the results are managed and collated anonymously ?	**Iris Bishop:** Yes

APPENDIX 1

Guidance on Planning & Managing Discharge from Hospital

MAIN RESPONSIBILITY	:	Chief Executives and Medical Directors of Health Boards Chief Social Work Officers Heads of Service Team Leaders – Social Work Group Managers – Social Work Hospital / General Management Clinical Nurse Managers Local Authority and NHS staff involved in patient discharge
LEGISLATION	:	Social Work (Scotland) Act 1968 Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 Social Care (Self-directed Support) (Scotland) Act 2013 Adults with Incapacity (Scotland) Act 2000 Mental Health (Care and Treatment) (Scotland) Act 2003 Human Rights and Equalities Legislation The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014
POLICIES	:	CEL 32(2013) Guidance on Choosing a Care Home on Discharge from hospital Guidance for Local Authorities and NHS Boards on the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993

1. INTRODUCTION

Scottish Borders Council and NHS Borders have a responsibility to ensure adequate processes are in place for a safe and timely discharge which enables patients to return to a community setting as soon as they are medically well enough to do so, where their individual outcomes can be identified more accurately. To achieve this, assessment should, whenever possible, take place outwith the hospital environment, in order that patients can maximise their potential.

The purpose of this guidance is to provide clear and consistent advice on the facilitation of discharge within the timescales set by the Scottish Government. This will comply with the National Health and Wellbeing Outcomes (see Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014). The guidance will set out the overarching principles of good discharge planning.

2. GUIDING PRINCIPLES

People who are delayed for more than 48 hours after their date of clinical readiness are less likely to return to live independently in a community setting.

Wherever possible, assessment decisions should not be made within an acute hospital setting. Preferably people will either be discharged home or transferred out of the acute hospital to an NHS or SBC Intermediate Care facility to allow the individual time to recover, rehabilitate and then be assessed. When the patient is medically ready to leave hospital but further assessment is required to address their social care needs, or their assessed/preferred discharge destination is not immediately available, then interim arrangements will be made for them to move to a suitable step down facility while assessment is ongoing, or to await service provision.

In the circumstances where a person is being considered for discharge from hospital to a care home this decision must be taken following a full assessment of the individual's potential for recovery, rehabilitation and reablement.

In order of preference, the assessment will take place:

1. in the person's own home
2. in an Intermediate Care facility (Community Hospital or SBC)
3. in exceptional circumstances as a matter of last resort in the acute hospital setting

Moving into a care home is a major decision for a person and should be treated as such. To ensure people feel supported throughout the process, preparation and planning needs to commence as early as possible should be coordinated and agreed across the multidisciplinary team and take account of the person's wishes regarding involving family and/or carers to support them.

3. CAPACITY

The issue of the patient's capacity to make informed decisions about future care should be assessed as early as possible and reviewed as appropriate in the patient's journey to avoid unnecessary delays in the patient's discharge. If it is assessed by the Doctorin charge of the patients care, within the MDT that the patient does not have capacity to make decisions regarding their future care needs, then consideration should be given immediately to the appropriateness of convening an Adults with Incapacity Decision Making Meeting where multidisciplinary discussion will determine the most appropriate and least restrictive course of action to facilitate discharge. (Discharging Patients Who May Lack Capacity Guidance Appendix 1).

4. DISCHARGE PLANNING

Discharge planning should begin on admission, or soon after, in partnership with the patient, family, carer and/or proxy as outlined in the Scottish Borders Discharge Protocol (Appendix 2).

As part of ongoing care and discharge planning, each individual identified as requiring health and or social care services will have ongoing multi-disciplinary assessment. As part of this assessment process, a Estimated Date of Discharge (EDD) should be discussed and agreed by the MDT and the patient and their family, carer and/or proxy.

The EDD is the date that all teams jointly aim to have the person clinically fit and ready for discharge; allowing hospital discharge teams up to 2 working days to secure services. Staff from both Health and Social Care will attend MDT meetings where EDD discussions will take place and will ensure good communication of this decision making processes to other relevant staff.

If the patient's health needs change, the EDD should be adjusted accordingly, again following full discussion with the MDT and the patient, family, carer and/or proxy. (see EDD Guidance Appendix 3).

The setting of an EDD will be required both when moving from hospital to an intermediate resource, and when moving on from a intermediate resource.

5. INTERIM ARRANGEMENTS

If it becomes clear during the assessment process that the services required are unlikely to be available on the EDD, then interim arrangements must be in place to ensure discharge can take place on the agreed date.

5.1 Housing

If rehousing is required, then an appropriate application should be completed as early in the discharge planning process as possible.

However, many patients can return to their existing properties in the short term, even when they require rehousing. If adequate short term arrangements can be made with the support of appropriate equipment (eg raised toilet seat or commode) and social care input, then discharge should proceed. This ensures equity for those citizens of the Scottish Borders who await rehousing in their existing properties and who may be experiencing similar difficulties

For those patients who cannot be accommodated safely in their existing properties, then SBC bed based intermediate care should be considered (see Appendix 5 for criterias). Should this be unavailable or unsuitable, then alternative interim arrangements should be considered.

Advice and guidance regarding housing services are available on the Scottish Borders Council website:
https://www.scotborders.gov.uk/info/20011/housing_and_homeless/490/council_housing_and_housing_associations

Scottish Borders Homelessness strategy and additional information is available at Appendix 4.

5.2 Domiciliary Care Support

Where this support cannot be met by Home First, a referral will be made to Social Work to request a Package of Care. The agreed Support Plan will be sourced by the Matching Unit.

The EDD should be clearly marked on the referral. Care managers/social workers should then notify the Integrated Huddle/MDT Meetings to ensure the patient is being discussed.
Should the care be unavailable on the specified date, this should be clearly communicated to the MDT and the patient, family, carer, and/or proxy immediately and discussion should then take place about how to progress the discharge.

5.3 Care Home Admission

Admission to a care home from a hospital setting should only take place after the patients needs and/or their representatives have been considered taking account of rehabilitation/ recovery. Before this decision is finalised, step down to assess options should be considered to ensure the patient has an opportunity to optimise their rehabilitation/recovery with appropriate supports in place but outwith a clinical setting. The assessment should be fully discussed with the patient, family, carer and/or proxy and all relevant information should be provided to them.

The patient, family, carer and/or proxy should be provided with information on care homes which can meet the individual's needs, and be advised to consider the range of settings and that they must identify their three preferred care homes to the social worker/care manager within 7 days, with at least one of the care homes having an immediate vacancy.

For Care Homes in the Scottish Borders, the digital referral system, STRATA is used to identify vacancies. Should the care homes not have a vacancy available, the patient, family, carer and/or proxy must identify a suitable interim care home which the patient will be expected to move to on the identified EDD or when funding is available. The social worker/care manager, with the support of the MDT, must advise the patient, family, carer and/or proxy of this and should issue the standard letter in Appendix 9. The social worker/care manager must make the patient, family, carer and/or proxy aware during this initial discussion of the Choice process (see CEL 32 (2013) in Appendix 6).

The need to proceed with discharge, even if the preferred home is not available, must be clearly stated by the social work team as once an assessed need is identified, the local authority have a

duty to meet those assessed needs. The social worker/care manager, with support from the MDT, should explain to the patient, family, carer and/or proxy why an interim move is considered to be in the best interests of the patient, and they should be reassured that they will remain on a waiting list for their preferred home, and will be offered the opportunity to transfer there when a place becomes available, if that is their wish.

The social worker/care manager should then complete the relevant Mosaic workflows to seek approval for funding and should include the EDD. STRATA should be completed to formalise the referral to the Scottish Borders care homes. If the care home is out of area or a specialised facility, social work will follow internal processes for the referral.

As soon as the patient, family, carer and/or proxy identifies their preferred or interim care home, and funding is approved, the social worker/care manager should contact the care home manager to discuss the patient's referral, ensure that they can meet their needs, and to confirm potential admission date to the care home. If the care home is unable to offer a placement for any reason, then another suitable care home with a vacancy must be identified.

If the patient, family, carer and/or proxy has not advised of their choice of care home within 7 days of the initial discussion, and/or there is reasonable reason to assume they are unlikely to do so, the social worker/care manager must advise the Team Leader who, in partnership with the NHS instigate the Integrated Discharge Case Conference to support the Choice Process and send the family/POA/Patient the letter in Appendix 7.

6 CHOICE PROCESS

The procedures outlined below should be followed if, at any stage, the patient, family, carer and/or proxy are unwilling to engage with the above process.

6.1 When the patient or proxy disagrees

If the patient, family, carer and/or proxy disagrees with the discharge planning arrangements, the Social Worker/Care Manager will continue to make the practical arrangements for the patient to move to a suitable care home and should advise their Team Manager in order that the Choice Process will be facilitated via an Integrated Discharge Case Conference. While the Integrated Discharge Case Conference is being arranged, the Social Worker/Care Manager should, with the support of the MDT, continue to work with the patient, family or carer to move towards a resolution.

Should it be necessary to convene an Integrated Discharge Case Conference, a formal letter will be sent as soon as possible in the name of NHS Borders to the patient, family or carer, inviting them to attend at a specified time. The Moving On policy process would be led by NHS Borders and Social Work would work alongside this to explain and support the process whilst looking to identify relevant care arrangements.

The Integrated Discharge Case Conference will be led by Hospital Management, Senior Charge Nurse or appropriate Clinical Nurse Manager, and should be supported by Social Work. The Social Worker/Care Manager and a member of the clinical team should also be in attendance to give information and to support the patient.

Whilst it is always preferable to work with patients, families, carers and proxies to achieve a shared resolution, the ongoing discharge arrangements to an appropriate interim care home will be made clear at the Integrated Discharge Case Conference. The patient and their family/carer will be advised that any interim arrangement made will be temporary and that they can continue to seek their preferred choice of care home but that people do not have the right to choose to remain in hospital when there are no medical reasons for them to be there, and remaining in hospital care is not an option during this process.

A further letter will be sent by the NHS Lead to the patient or their proxy following the Integrated Discharge Case Conference to outline the discussion held, and any decisions made.

Patients, family or proxies have the right to challenge the clinical decision that the patient is ready for discharge. However, this right does not extend to insisting that the patient remains in hospital, purely on grounds of choice. Should the patient or proxy disagree with the decision regarding clinical fitness for discharge, the Senior Charge Nurse should support them to carry out an Appeal Against Medical Discharge. This must be done in writing within 3 working days of the meeting and decision being made.

A proxy is in no stronger a position than the adult, had they retained capacity. As such, they cannot make a decision requiring that the adult remains in hospital once they are fit for discharge.

If a proxy continues to object to the patient being discharged they should be encouraged to approach the Sheriff to make a decision under Section 3 of the 2000 Act regarding their power to insist the adult is not moved.

7. ESCALATION TO ASSOCIATE MEDICAL DIRECTOR

If no resolution is possible following escalation through the consultant in charge of the patients care and the Integrated Discharge Case Conference, then the situation should be escalated to the Medical Director. Responsibility for this will lie with the NHS Lead as identified above. In making further decisions, the Medical Director will use the checklist (Appendix 8) and will issue the letter (Appendix 9).

Where the patient, family or proxy continue to unreasonably refuse to engage with the choice and/or discharge process a Health Board can choose, as a last resort, to seek enforcement of the discharge through the courts with support from both organisations legal departments. The NHS legal team would lead the enforcement. The SBC legal position would be focused on the person's rights dependent on their individual circumstances ie incapacity.

8. SUMMARY

Discharge planning must place the patient at the centre of all decision making and should focus on achieving the best outcomes for each individual. All decisions must be achieved through a multidisciplinary process which recognises the risks associated with prolonged stays in hospital past the point of medical fitness, and which seeks to facilitate timely discharge to home, or the most appropriate interim resource to continue the assessment and rehabilitation process.

9. Lead Officers for the Procedure:

a) Name: Chris Myers
b) Designation: General Manager, Primary and Community Services

a) Name: Brian Paris
b) Designation: Chief Officer, Adult Social Work and Care

10. Procedure Approved by: Nicky Berry, Director of Operations

Appendices

Appendix 1 – Discharging Patients who may lack capacity

Appendix 1
Discharge Manageme

Appendix 2 – Discharge Management Admission & Discharge

Appendix 2
Discharge Manageme

Appendix 3 – EDD Flowchart

Appendix 3
Discharge Manageme

Appendix 4 – Homeless Strategy

Homelessness_Strategy___April_2009.pdf

Housing_difficulties_english.pdf

Appendix 5 – SBC Intermediate Care Criteria

Appendix 5
Intermediate Care Cri

Appendix 6 – CEL 32, Choosing a Care Home

Appendix 6
Discharge Manageme

Appendix 7 – Your Next Place of Care – 3 Choices

Appendix 7 Youre next place of care 3 c

Appendix 8 – CEL 32 Checklist

Appendix 8
Discharge Manageme

Appendix 9 – Moving on Letters and Meeting information

You are Ready to Leave Hospital .docx

TEMPLATE Integrated Discharge

TEMPLATE Integrated Discharge

TEMPLATE Integrated Discharge

TEMPLATE Integrated Discharge

NHS Borders

Meeting: Borders NHS Board

Meeting date: 7 April 2022

Title: Finance Report – February 2022

Responsible Executive/Non-Executive: Andrew Bone, Director of Finance

Report Author: Samantha Harkness, Senior Finance Manager

1 Purpose

This is presented to the Committee 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

This is a routine performance report outlining the financial performance of NHS Borders. It is presented to the board in line with the board's financial reporting policy.

2.2 Background

NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This framework lays out the requirements for submission of Financial Performance Reports (FPR) to SG which include comparison of year to date performance against plan with full review of outturn forecast undertaken on a quarterly basis.

NHS Borders has determined that regular finance reports should be prepared in line with the SG framework (i.e. monthly).

The board has remitted the Resources & Performance committee to "review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements".

The board continues to receive regular finance reports for reporting periods where there is no scheduled committee meeting.

2.3 Assessment

2.3.1 Quality/ Patient Care

Any issues related to this topic are provided as background to the financial performance report. It is expected that any relevant issues will be raised through separate report via the appropriate reporting line.

2.3.2 Workforce

Any issues related to this topic are provided as background to the financial performance report. It is expected that any relevant issues will be raised through separate report via the appropriate 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. Long term financial risk is considered through the board's Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because the report is presented for awareness and does not include recommendation for future actions.

2.3.6 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

Not Relevant. This report is presented for monitoring purposes only.

2.3.8 Route to the Meeting

This report has been considered by the following groups as part of its development.

- Senior Finance Team, 22nd March 2022
- Board Executive Team, 5th April 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Finance Report for the period to end February 2022

FINANCE REPORT FOR THE PERIOD TO THE END OF FEBRUARY 2022

1 Purpose of Report

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

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** that the board is reporting a breakeven position for eleven months to end of February 2022.

2.1.2 **Note** that this position is achieved following confirmation of additional funding of £7.8m by Scottish government to offset non-delivery of savings.

2.1.3 **Note** the position reported in relation to Covid-19 expenditure and the update on funding allocations in relation to same.

3 Summary Financial Performance (Revenue)

3.1 The board's financial performance as at 28th February 2022 is a breakeven position. This position is summarised in Table 1, below.

Table 1 – Financial Performance for eleven months to end February 2022

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	246.40	300.63	221.25	221.04	(0.21)
Revenue Expenditure	246.40	300.63	263.99	263.78	0.21
Surplus/(Deficit)	**0.00**	**0.00**	**42.74**	**42.74**	**0.00**

3.2 Underlying financial performance remains in line with Q3 forecast, i.e. £7.8m deficit. The forecast has been amended to breakeven following agreement of additional support to offset non-delivery of savings during 2021/22.

3.3 The additional funding to offset non-delivery of savings is included within a total package of support made available to address the impact of the COVID19 pandemic. This funding is non-repayable and recognises that the board's ability to deliver savings has been materially impacted by the pandemic. As previously reported, this position is reflective of operating conditions across NHS Scotland.

4 Financial Performance –Budget Heading Analysis

4.1.1 Income

4.1.2 Table 2 presents analysis of the board's income position at end February 2022.

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

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
SGHSCD Allocation	226.65	301.02	201.07	201.07	-
SGHSCD Anticipated Allocations	-	(17.78)	(0.44)	(0.44)	-
Family Health Services	10.24	12.45	11.60	11.60	-
External Healthcare Purchasers	4.24	4.39	4.04	3.69	(0.35)
Other Income	5.27	5.82	4.98	5.12	0.14
Total Income	**246.40**	**305.90**	**221.25**	**221.04**	**(0.21)**

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 reduction in elective activity during the pandemic and the impact that this has had upon cross boundary patient flows.

4.2 Operational performance by business unit

4.2.1 Table 3 describes the financial performance by business unit at February 2022.

Table 3 – Operational performance by business unit, February 2022

	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	73.62	67.18	63.60	3.58
Acute Services - Savings Target	(2.13)	(2.11)	(1.93)	-	(1.93)
TOTAL Acute Services	**58.90**	**71.51**	**65.25**	**63.60**	**1.65**
Set Aside Budgets	25.30	28.45	26.09	25.74	0.35
Set Aside Savings	(1.09)	(1.05)	(0.96)	-	(0.96)
TOTAL Set Aside budgets	**24.21**	**27.40**	**25.13**	**25.74**	**(0.61)**
IJB Delegated Functions	105.76	141.31	121.07	120.60	0.47
IJB – Savings	(4.74)	(4.74)	(4.35)	-	(4.35)
TOTAL IJB Delegated	**101.02**	**136.57**	**116.72**	**120.60**	**(3.88)**
Corporate Directorates	32.81	27.02	21.00	20.78	0.22
Corporate Directorates Savings	(0.34)	(0.27)	(0.25)	-	(0.25)
TOTAL Corporate Services	**32.47**	**26.75**	**20.75**	**20.78**	**(0.03)**
External Healthcare Providers	28.55	31.52	29.01	28.78	0.23
External Healthcare Savings	(0.51)	(0.45)	(0.42)	-	(0.42)
TOTAL External Healthcare	**28.04**	**31.07**	**28.59**	**28.78**	**(0.19)**
Board Wide					
Depreciation	4.67	4.67	4.28	4.28	-
Planned expenditure yet to be allocated	(2.91)	5.09	0.23	-	0.23
Financial Recurring Deficit (Balance)	-	(12.35)	(11.32)	-	(11.32)
Financial Non-Recurring Deficit(Balance)	-	2.52	2.31	-	2.31
Board Flexibility	-	7.40	6.78	-	6.78
SG Additional Support*	-	5.27	5.27	-	5.27
Total Expenditure	**246.40**	**305.90**	**263.99**	**263.78**	**0.21**

**year to date impact of additional non-recurring support to non-delivery of savings.*

Acute services (non-delegated functions) are reporting a net under spend of £1.65m after non-delivery of savings. This includes a £3.58m under spend on core operational budgets. The increase in the core underspend reflects the on-going trend related to 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. The position reported in previous periods is restated following confirmation of funding to offset the additional costs of COVID inpatient beds due to the pandemic.

4.2.2 **Set Aside.** Acute functions delegated to the IJB are reporting £0.61m overspend, of which £0.96m relates to non-delivery of savings. The underlying performance before savings non-delivery is £0.35m underspent. This position is improved from previously reported as a result of additional COVID funding confirmed against staffing costs within A&E, and a reduction in drugs costs for non-hospital prescribing. There continues to be significant operational pressure on unscheduled care flow and inpatient beds however this is not manifesting in additional expenditure due to recruitment challenges and corresponding vacancies within the core position.

4.2.3 **IJB Delegated.** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an under spend on core budgets of £0.47m. A reduction in primary care services expenditure within public dental services continues to be the main driver for the underspend. This reflects the reduction in throughput in dental services as a result of pandemic infection control measures. There are also underspends across AHP services linked to vacant posts.

4.2.4 **Corporate Directorates** are reporting an under-spend of £0.22m excluding savings. There are no significant changes within the current period. Cost pressures relating to staff residencies are offset by vacancies and some skill mix benefit within Corporate Nursing and Infection Control budgets.

4.2.5 **External Healthcare Providers.** Excluding non-delivery of savings there has been a slight improvement to the position previously reported. This improvement follows confirmation of marginal rate adjustment to the NHS Lothian service agreement for cross boundary patient flows.

5 Covid-19 Expenditure

5.1 COVID19 expenditure continues to be reported within the board's business unit core performance by separate heading as detailed in Table 3. Table 4 provides summary of this expenditure as at end February.

Table 4 – summary Covid-19 expenditure for eleven months to end February 2022

	Revised Annual Budget £m	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Covid-19 Expenditure				
Acute Services	1.06	1.05	1.05	-
Set Aside	0.17	0.17	0.19	(0.02)
IJB Directed Services	3.53	3.52	3.53	(0.01)
Corporate Directorates	5.11	3.80	3.85	(0.05)
Total Covid-19 Expenditure	**9.87**	**8.54**	**8.62**	**(0.08)**

5.2 During the last eleven 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. The variance of £0.08m relates to costs incurred where further validation is required before funding is released.

5.3 Scottish Government has now issued final settlement of COVID19 funding for 2021/22. This settlement fully funds the health board for all relevant costs identified in the quarter three forecast, together with additional support to offset non-delivery of savings referenced above.

5.4 Balance of funding not yet allocated is held in reserve and it is expected that any surplus funds will be ring-fenced and utilised against relevant costs in 2022/23.

6 Key Risks

6.1 There are no new risks identified within the position.

6.2 Following confirmation of COVID19 funding in February there is now a high likelihood that the board will deliver a breakeven position at end March 2022.

6.3 The strategic risk register recognises the board's long term financial sustainability continues to present as very high risk and that additional actions are required to address this. The development of financial recovery plans for 2022/23 and beyond will be considered through the financial planning process.

6.4 An updated risk assessment is currently being prepared as part of the board's financial plan.

Author(s)

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Financial Plan 2022-23**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance** **Susan Paterson, Deputy Director of Finance**

1 Purpose

This is presented to the Board for:

- Decision

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

Approval of the financial plan, including agreement of opening revenue and capital budgets, is a matter reserved for the board.

The financial plan has been developed in line with the requirements of the Scottish Government's interim financial planning framework which requires NHS Boards to prepare a one year revenue plan for 2022-23.

It is expected that boards will be required to prepare a three year revenue plan update by summer 2022 following the Scottish Government spending review.

2.2 Background

NHS Borders remains at stage three on the Scottish Government's Performance Assessment Framework in relation to its financial performance. During the past two years progress to address the board's financial deficit has been limited and cost

pressures have increased. The challenge facing the board remains significant and breakeven in 2021/22 will only be achieved through the provision of additional Scottish Government financial support. The board continues to work closely with SG finance colleagues as it develops its financial improvement programme for 2022/23 and beyond.

The 2022/23 plan is prepared in the context of a high level of uncertainty in relation to the operating conditions which will impact on the board's financial performance in the next twelve months.

This includes external factors relating to the population health and the pandemic, such as the emergence of new variants, as well as the indirect impact of wider economic forces, e.g. general inflation, fuel prices, and other impacts of global factors such as the war in Ukraine and EU Exit.

It also includes factors more directly affecting demand and capacity within health and care, such as increasing numbers of long waits for assessment and treatment, emerging health inequalities, availability and wellbeing of workforce, constraints on physical space and service throughput as a result of infection control measures.

In this context, the one year financial plan is presented as an interim update to the board's Remobilisation plans and seeks to balance the requirement to manage the immediate pressures of the pandemic and the process of remobilisation during the early part of 2022/23, together with setting initial direction towards the board's long term strategy for financial sustainability, which remains in development and for which further update will be available following preparation of the three year financial plan in summer 2022.

2.3 Assessment

One year Revenue Plan 2022-23

The Resources & Performance Committee discussed the draft financial plan at its meeting on 3rd March 2022; this included review of planning assumptions and risks, including scenario modelling which considered the impact of these factors on potential in year financial performance.

Table 1 provides a summary of the proposed one year financial plan for 2022/23.

Table 1 – Financial Plan (revenue) 2022/23

	Recurring £m	Non-Recurring £m	Total £m
Net Expenditure (Core Revenue Resource Outturn)	**287.2**	**22.4**	**309.6**
Baseline Allocation (Including NRAC parity uplift)	234.8		234.8
Anticipated Allocations: Rec/ Non-Rec/ Earmarked	32.7	18.4	51.1
Core Revenue Resource Limit (RRL)	**267.5**	**18.4**	**285.9**
Financial Gap before Savings	**(19.7)**	**(4.0)**	**(23.7)**
Savings Target (as approved by Board)	4.0	1.0	5.0
Non-Recurrent Measures	0.0	6.5	6.5
Forecast Variance against Core RRL	**(15.7)**	**3.5**	**(12.2)**

The final one-year revenue plan describes a recurring deficit of £15.7m, net of savings delivery. The in-year deficit is projected at £12.2m.

The position described reflects a worsening in year performance against 2021/22 (projected £7.8m gap at quarter three review). Breakeven in 2021/22 will be achieved only through additional support made available by Scottish Government to offset the non-delivery of savings, and through the resources available to fully fund Covid19 related expenditure.

The plan assumes that the costs of actions to mitigate the impact of the pandemic will continue to be fully funded. This position remains under review given the UK government spring budget statement of 23rd March. An indicative forecast of £11.7m, including Social Care, has been prepared for 2022/23 however this forecast is likely to reduce following recent announcements in relation to testing and test and protect. An updated forecast will be prepared on an on-going basis in response to latest position.

The Scottish Borders IJB carries a significant reserve in relation to COVID resources not utilised in 2021/22 and this will be utilised against planned expenditure before any additional investment is required.

The recurring deficit at March 2023 is projected at £15.7m, remaining in line with the opening deficit brought forward. This position relies on delivery of £4.0m recurring actions during 2022/23.

Overall savings are forecast at £5m (£4m recurring) with a further £6.5m to be identified through corporate flexibility and other non-recurring measures not impacting on clinical care. The board's financial improvement programme has not yet been fully remobilised and plans for delivery of the £5m savings required to achieve the position identified in the plan remain at outline stage. Significant focus in the early part of 2022/23 will be required to rapidly scope and implement detailed plans for delivery to meet this objective.

The projected £12.2m deficit in 2022/23 presents a significant risk to the board's financial sustainability. In current economic circumstances the board will need to demonstrate it has taken all possible steps to ameliorate this position before seeking additional support from Scottish Government.

Any financial support is likely to be on the basis of brokerage and require repayment in future years. The board continues to carry a repayment commitment of £8.3m in relation to its pre-pandemic financial position.

The level of risk attendant on the plan remains significant, both in relation to uncertainty in planning assumptions and the challenge of delivering actions to mitigate the net deficit after investment.

Appendix 1 provides further detail of the plan.

Provision of resources to the IJB

The following table summarises the budget allocation proposed by NHS Borders for the functions delegated to the IJB for 2022/23. This was presented to the IJB at its meeting on 2nd March and will be formally confirmed following approval of the board's financial plan.

The table shows the additional recurring and non-recurring funding available to the IJB, as outlined in the board's financial plan.

Table 2 – IJB Delegated Resources 2022/23

	IJB Delegated £m	Set Aside £m	TOTAL £m
Recurring Baseline Recurring	120.3	26.9	147.2
Savings Targets *Net Baseline*	(4.7)	(1.0)	(5.7)
Additional Recurring Resources	*115.6*	*25.9*	*141.5*
Additional Non-Recurring Resources	3.7	1.4	5.1
	0.0	0.8	0.8
Total Resources	**119.3**	**28.1**	**147.4**
Uplift	**3.2%**	**8.4%**	**4.2%**

The level of delegated resources is set based on those elements of the NHS Borders financial plan which relate to functions delegated to the IJB and is in line with the principle of the "equity" model, i.e. that the IJB shall be funded in line with the approach taken within the board's own financial plan. This includes commitment to fund statutory commitments, cost pressures and service developments impacting on delegated functions in 2022/23.

Included within the budget is uplift to the Social Care Fund, the Transformation Fund and Resource Transfer in line with the board's uplift (i.e. 2%).

Pay pressures have been calculated on the basis of SG pay policy guidelines for 2022/23 although it should be noted that pay negotiations are not expected to conclude until summer 2022. It is anticipated that any increase above public sector pay policy will be financed through additional allocation.

Non pay inflation is estimated at 2% in line with SG advice, Funding will be held in reserve pending confirmation of actual impact. The board will consider any additional impact arising from general inflationary pressures through its quarterly review process.

Prescribing growth is assumed in line with local horizon scanning, with further work underway to determine the actual impact on primary care and hospital prescribing in 2022/23.

The budget includes investment in recurring and non-recurring cost pressures highlighted through work with Business Units.

Delivery of a breakeven position for the IJB will require identification of actions to meet the IJBs savings target of £5.7m. This target is carried forward from previous financial years and no increase has been applied to 2022/23 budgets pending a review of the health board's overall savings requirements as part of the development of its medium term (three year) financial plan.

The scheme of integration requires any expenditure in excess of delegated budgets is funded by additional contributions from the partners (i.e. NHS Borders and Scottish Borders Council). Underpinning the IJB budget offer is the assumption that the IJB will make every effort to achieve savings in line with the expectations outlined within the board's financial plan and that any support provided to offset the IJBs position will

be non-recurring and subject to the same conditions applied to the health board's own financial performance.

Appendix 2 provides breakdown of the 2022/23 IJB budget for health functions by area of expenditure.

Draft Five year capital plan 2022/23

The board's five year capital plan remains in development and will be subject to agreement of additional resources through national infrastructure programmes and in relation to submission of major business cases to Scottish government during the period of the plan.

A draft plan has been prepared which identifies current commitments against the board's anticipated capital resources for 2022/23 and beyond. Table 3, below, summarises these current commitments.

Table 3 – Draft Capital Plan commitments 2022/23 – 2026/27

Project Title	2022/23	2023/24	2024/25	2025/26	2026/27
	£m	£m	£m	£m	£m
Available Resources					
Formula Capital	2.48	2.48	2.48	2.48	2.48
National Infrastructure Programme*	0.80	-	-	-	-
Total Resources	**3.28**	**2.48**	**2.48**	**2.48**	**2.48**
Expenditure Commitments					
Rolling Programmes					
IM&T	0.20	0.25	0.25	0.25	0.25
Estates & Backlog maintenance	*1.50*	1.40	1.40	1.40	1.40
Medical equipment	0.14	0.25	0.25	0.25	0.25
Radiology/Imaging equipment	tbc	-	-	-	-
Innovation Fund	0.00	0.20	0.20	0.20	0.20
Capital Planning support					
Project Management	0.24	0.28	0.28	0.28	0.28
Feasibility/Consultancy support	0.00	0.10	0.10	0.10	0.10
Prior year projects					
Forensic Medical Examiner Suite	0.40				
Endoscopy Decontamination	0.80				
Planned Expenditure	**3.28**	**2.48**	**2.48**	**2.48**	**2.48**

The Board's 2022/23 Capital Formula allocation of £2.48m, an increase of 5% from previous years, was confirmed in the Scottish Parliamentary budget which was approved on 10th February 2022. This resource finances the board's rolling programmes and capital planning infrastructure. Rolling programmes are targeted at ongoing infrastructure maintenance and equipment replacement, and include resources to address statutory compliance and estates backlog maintenance.

There is limited flexibility within this resource to address any new projects which are expected to be financed through development of individual business cases for agreement through Scottish government capital investment group and under the programmes set out by the national infrastructure board.

Funding through the national equipping programme has not yet been confirmed. The plan assumes £0.8m in relation to replacement of Endoscopy decontamination

equipment. This equipment has been identified as the board's highest risk in relation to equipment replacement. Replacement of the CT Scanner was approved in 2021/22 and funded through the national equipping programme; the implementation of the replacement is scheduled for summer 2022 and it is expected that there will be a requirement to finance the necessary works from within the board's overall capital resource. The plan will be revised following confirmation of project costs and agreement of any additional resources with Scottish Government.

Work is ongoing to refresh the board's Property and Asset Management Strategy. It is expected that over the next five years the board will seek to implement the recommendations of its recent Primary Care Premises review, including commissioning of new health centres, and begin a programme of major refresh to the Borders General Hospital, as well as conducting a wider accommodation review encompassing its community and mental health estate, and corporate accommodation.

The experience of the pandemic has highlighted the need to urgently progress with infrastructure renewal across the NHS Borders estate, with physical constraints particularly apparent following implementation of infection control measures at BGH and the consequential displacement of services from existing footprint due to lack of available space. Whilst remobilisation of services will include restoration of some elements of normal operations it is anticipated that the increase to demand, including backlog for treatment, will result in further pressure on what is a constrained hospital environment. In these circumstances, essential life cycle maintenance becomes increasingly challenging without impacting directly on clinical services.

The investment required to deliver this emerging property and asset management strategy is likely to be significant. The programmes described above will require development of individual business cases for agreement of Scottish government and will need to be supported by the establishment of project teams which will manage the design and construction programme aligned to the business cases.

The Scottish government has laid out plans to increase the level of capital investment in NHS Scotland over a 10 year timeline, including a specific commitment towards the refresh of the BGH. Over the next few months the board will engage with the national infrastructure board to explore how this work can begin to progress.

Not included above, but subject to active discussion with SG colleagues, is further capital investment to support the board's digital transformation programme and legacy projects related to the 'Road to Digital' strategy. Investment is likely to be directed via the newly established national Health and Social Care digital strategy programme board.

2.3.1 Quality/ Patient Care

The plan outlines the financial resources and planned expenditure in 2022/23 and indicative capital investment requirements over a five year period. These resources are aligned to the board's short and medium term actions to move out of the pandemic and begin remobilisation of services.

The constraints on overall resource, and challenges of unmet demand, will be addressed through the development of individual plans aligned to Scottish government strategy for recovery and renewal.

2.3.2 Workforce

The plan includes specific investment for cost pressures and other workforce risks, with decisions made on a limited basis to support investment in medical staffing to mitigate immediate pressures. These investments include:

- Investment in additional clinical development fellows on a one year fixed term basis to address immediate risks in relation to medical training grade rotas and out of hours hospital cover.

- Appointment of 2WTE additional consultant physicians to support medical workforce sustainability within Acute and Older people's medicine at BGH. These appointments are made on a proleptic basis (against future retirals) pending a wider medical workforce review to be undertaken during 2022/23.

The plan also includes limited investment in workforce in a number of other areas, however there remains a high risk that the plans required to address post-pandemic demand will increase the challenge around workforce recruitment and retention which is already manifest in the level of ongoing vacancies across clinical staff groups (e.g. registered nursing).

Workforce sustainability will be considered further through the development of the board's workforce plans and long term financial plan during summer 2022.

2.3.3 Financial

The 2022/23 revenue plan is presented in detail in Appendix 1, and budget resources to the IJB described in Appendix 2. Issues related to the plan are described in section 2.3 above.

The net deficit presented in the plan remains subject to further review with update to the Resources and Performance committee in May 2022 in relation to the development of financial recovery plans. Further updates will be provided following the Quarter one review and development of the medium term (three year) financial plan.

This position will continue to be discussed with Scottish government colleagues in light of the board's status on the performance escalation framework and its requirement to provide assurance in relation to financial recovery action plans and longer term strategy for financial sustainability.

Movements from the draft financial plan

As noted, the draft financial plan was discussed by the Resources & Performance committee as its meeting on 3rd March 2022. The position presented to the committee recognised an improved position from earlier draft plans shared with Scottish Government during February and was broadly in line with the final plan presented above.

A small number of adjustments have been made to the plan following this discussion and are outlined below.

CNORIS. The draft plan estimated the impact of NHS Borders' share of the updated clinical negligence provision for NHS Scotland at 2.15%, in line with population weighted (NRAC) share. Further advice from Scottish Government has confirmed the board's share should be estimated at 1.4% of the national adjustment (£20m), i.e. £0.28m. This is a reduction of £0.15m from previous estimate.

Drugs & Prescribing. The draft financial plan described a £2.2m pressure on prescribing costs. Following confirmation that new medicines fund will increase significantly from 2021/22 levels the prescribing forecast has been amended to reflect a revised pressure of £1.4m. This position includes further update to prescribing growth assumptions in FHS prescribing. The overall movement in forecast is £0.833m.

Energy price increase. The draft plan included an initial estimate of price variation in energy costs at £0.5m. Following update from national procurement colleagues which advised a 35% increase above previously modelled gas prices this position has now been estimated at £1.0m, an increase of £0.5m.

Medical Workforce sustainability. As outlined under 'workforce' (section 2.3.2 above). The plan has been amended to increase the board's contingency reserve to £2.6m (an increase of £0.6m) in light of the risks described. The actual impact in 2022/23 will be established at Quarter One review, with likely slippage on some elements of the plan due to recruitment challenges.

All other elements of the overall plan remain as discussed by the Resource and performance committee in March.

2.3.4 Risk Assessment/Management

The plan includes a significant level of uncertainty arising from both indirect (e.g. economic) and direct (e.g. demand, pandemic) factors. A financial risk register has been prepared which looks at the sensitivity of key variables and considers the likely impact of these issues. The plan includes provision of £2.6m contingency for financial risk and it is likely that this will be utilised in full against workforce and inflationary pressures during 2022/23.

There is no provision for additional investment in increased demand except where this is separately financed by Scottish Government. The Scottish government budget approved in February 2022 does include additional investment in areas of specific priority outlined in the Programme for Government and the board continues to work with SG colleagues to refine plans for delivery of additional capacity in relation to these areas.

Financial sustainability remains on the board's strategic risk register as high risk and a full update to this risk, including mitigating actions, will be implemented following approval of the financial plan.

2.3.5 Equality and Diversity, including health inequalities

The plan outlines how the health board will utilise its overall resources in support of its short and medium term priorities, including core service delivery. Resources are aligned to the board's previously stated service priorities and agreed plans and the adjustments within the plan reflect unavoidable cost pressures and business cases approved at national, regional or local level and which have been subject to individual assessment in relation to their impact on equality and diversity, and health inequalities.

The financial plan is limited in scope to short term measures to be undertaken in 2022/23 to manage unavoidable financial pressures, and to investment in previously agreed business cases and priorities. The plan does include a specific commitment to £2m investment in supporting the broader aims of transformation across health services, with detailed plans to be developed in alignment with financial improvement programmes and separate strategic priorities including the IJBs strategic implementation plan.

An impact assessment has not been completed because it is expected that assessments are prepared against individual action plans on a case by case basis.

2.3.6 Other impacts

There are no other impacts identified.

2.3.7 Communication, involvement, engagement and consultation

No engagement undertaken. Engagement will be undertaken where relevant in relation to individual changes identified within the plan and through the relevant strategic programme, e.g. IJB strategy.

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.

- Resources & Performance Committee – 4th November 2021
- Board Members development session – 3rd February 2022
- Scottish Borders IJB – 2nd March 2022*
- Board Executive Team – 22nd February 2022
- Resources & Performance Committee – 3rd March 2022
- Board Executive Team – 22nd March 2022*
- NHS Borders Capital Investment Group – 28th March 2022
- Board Executive Team – 29th March 2022*

**discussion of individual items relevant to the plan*

2.4 Recommendation

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

In relation to the one year revenue plan the board is requested to:-

- **Approve** the financial plan for 2022/23
- **Approve** the delegated resource to Scottish Borders IJB for 2022/23
- **Approve** the delegation of budgets to health board retained functions for 2022/23 in line with the plan

In relation to the capital plan the board is requested to:-

- **Endorse** the direction of travel in relation to the development of the five year capital plan
- **Approve** the delegation of budgets in relation to rolling programmes

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Financial Plan (Revenue) 2022/23
- Appendix 2, IJB Delegated budgets 2022/23

Appendix 1 – NHS Borders Financial Plan (Revenue) 2022/23

AVAILABLE RESOURCES

Description	R £000s	NR £000s	Total £000s
Base RRL			
General Uplift	(4,528)	0	(4,528)
NRAC	(2,700)	0	(2,700)
NIC H&SC Levy	(1,305)	0	(1,305)
	(8,533)	**0**	**(8,533)**

ANTICIPATED EXPENDITURE

Description	R £000s	NR £000s	Total £000s
Opening Deficit	15,836	0	15,836
Pay Terms & Conditions	4,941	0	4,941
Drugs & Prescribing	1,410	0	1,410
Non Pay Inflation & Growth	1,305	0	1,305
Board Provisions	280	0	280
Property Costs inc. Capital Charges	1,258	0	1,258
Winter Plan (NHSB)	0	800	800
National Programmes (NHS Scotland)	460	233	693
Regional Programmes (East Region/SEAT)	0	0	0
Cost Pressures - Prior year commitments	990	1,000	1,990
Cost Pressures - Acute	25	0	25
Cost Pressures - P&CS	229	40	269
Cost Pressures - MH & LD	12	0	12
Cost Pressures - Commissioning	984	0	984
Cost Pressures - Corporate	330	0	330
Innovation (including digital transformation)	0	1,587	1,587
Board Provisions & Reserves	0	4,600	4,600
Other	186	(250)	(64)
	28,246	**8,010**	**36,256**
Financial Plan Gap before Actions	**19,713**	**8,010**	**27,723**

ACTIONS TO ADDRESS GAP

Savings Delivery			
Prescribing	1,000		1,000
Business Units/Corporate	1,000		1,000
Procurement & Commissioning	1,000		1,000
Transformation	1,000		1,000
Corporate (non-recurring)		1,000	1,000
	4,000	**1,000**	**5,000**
Operational Performance			
Pays (Vacancies)		1,200	1,200
Supplies (Elective Surgery)		800	800
	0	**2,000**	**2,000**
Corporate Flexibility			
Review of FP & Reserves (In year phasing)		2,500	2,500
Contingency Reserve		1,000	1,000
IJB Reserves		2,000	2,000
Balance Sheet & C/Fwd		2,500	2,500
SG Allocations Slippage		500	500
	0	**8,500**	**8,500**
Total Actions identified	**4,000**	**11,500**	**15,500**
NET FINANCIAL PLAN GAP	**15,713**	**(3,490)**	**12,223**

Appendix 2 – IJB Delegated Budgets 2022/23

IJB FINANCIAL PLAN

Scottish Borders Health and Social Care PARTNERSHIP

Summary	2022/23		
	HSCP NHS £'000	Hospital Set Aside £'000	Total Budget £'000
Joint Learning Disability Service	**3,599**	**0**	**3,599**
Joint Mental Health Service	**18,910**	**0**	**18,910**
Joint Alcohol & Drugs Service	**423**	**0**	**423**
Older People Services	**0**	**0**	**0**
SB Cares	**0**	**0**	**0**
Physical Disability Service	**0**	**0**	**0**
Prescribing	**23,132**	**0**	**23,132**
Generic Services			
Independent Contractors	31,708	0	31,708
Primary Care Improvement	1,053	0	1,053
Community Hospitals	6,254	0	6,254
Allied Health Professionals	7,507	0	7,507
District Nursing	4,102	0	4,102
NHS directed funds (social care)	12,960	0	12,960
Generic Other	14,375	0	14,375
	77,958	**0**	**77,958**
Large Hospital Functions			
Accident & Emergency		3,366	3,366
Medicine & Long-Term Conditions		18,012	18,012
Medicine of the Elderly		6,932	6,932
Winter Planning		800	800
		29,110	**29,110**
Targeted Savings	**(4,739)**	**(1,046)**	**(5,785)**
Total	**119,284**	**28,063**	**147,348**

NHS Borders

Meeting: Borders NHS Board

Meeting date: 7 April 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 16 March 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 19.01.22

Borders NHS Board
Clinical Governance Committee

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 19 January 2022** 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)
Mrs L Jones, Head of Clinical Governance & Quality
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, Director of Public Health
Mr G Clinkscale, Director of Acute Services
Mrs S Horan, Director of Nursing Midwifery & Allied Health Professionals
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
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager
Ms J Lees, Health Improvement Specialist (Suicide Prevention)

1 Apologies and Announcements

The Chair invited Dr McCallum to give an update on the pressures across NHS Borders to give context to reporting for this meeting. Dr McCallum and Mr Clinkscale gave a brief update on what the main pressures were stating that the patient to staff ratio had been the worst that most have seen throughout their professional lives. Clinical prioritisation group had been reconvened and has been seen to be a very positive step to assist clinicians in their decision making process allowing for oversight over the whole organisation allowing areas which were causing most concern to be appropriately supported.

They both highlighted that both clinical and non clinical staff across the organisation had responded exceptionally well supporting areas they might not normally work in and that despite the pressures there were many positives to build on moving forward. Mr Clinkscale highlighted that there had been a knock on effect on waiting times which will be felt for quite some time.

Dr Young commented that there it was encouraging moving forward that there had been a noticeably more collegiate approach across the organisation in response to

this particular wave of the pandemic.
Apologies were received from:

Mr R Roberts, Chief Executive
Dr J Bennison, Associate Medical Director, Acute Services

The Chair welcomed Ms J Lees, Health Improvement Specialist (Suicide Prevention) (item 8.1) and announced Dr J O'Donnell, Clinical Director for laboratory services would be joining the meeting for (item 8.2)

The Chair confirmed the meeting was quorate.

The Chair announced that there would be a slight alternation to the running order of the meeting.

2 Declarations of Interest

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

The **CLINICAL GOVERNANCE COMMITTEE** noted that the previous declarations by Ms Lam and Mrs Campbell were still relevant.

No other declarations of interest noted.

3 Minute of Previous Meeting

Grammatical correction made to page eight of acute services update.

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 17 November 2021 was approved

4 Matters Arising/Action Tracker

Matters Arising from the previous meeting were noted on the action tracker which was updated accordingly.

Following discussion about external review of palliative care pathway Dr McCallum noted that our Palliative Lead – Dr Howell will be leaving us to take up a post as Clinical Director for Children's Hospices Across Scotland (CHAS). The Committee wished her well and noted her huge contribution here in NHS Borders, she will be sorely missed

5 Patient Safety

5.1 Infection Control Report

Mr Whiting provided a brief overview of the content of the report and discussion followed where several points were raised.

He updated the data slightly as it was slightly out of date since paper had been written. Since November there had been a further SAB case and therefore NHS Borders had not met Scottish Government target for SAB infections. Of the healthcare associated cases the largest number of infections related to catheter

associated urinary tract infections which was similarly t he case with the E.COLI infections. Therefore tackling CAUTI would be of great benefit to reducing infection rates.

Mr Whiting commented that the impact and pressures on team due to prioritising Covid management meant other team activities have not been progressing as normal. Management of Covid has a huge impact on patient flow and groups like CAUTI group which is very important, have not been able to progress. Details of priorities are included in the paper.

Ms Lam enquired about an apparent rise in SAB cases between July and September and if there was anything particular causing this. Mr Whiting reports that all cases are reviewed and cross referenced for themes but there does not seem to be any obvious cause or themes relating to this increase.

Ms Lam also enquired if there was any new learning from the five Covid outbreak cases which were investigated. Mr Whiting noted that he had not included the learning from these cases and will include any learning in future reports. He gave a short update on the cases and the different tests conducted on admission to hospital, stating that in particular they have confirmed the importance of five day screening to help stop Covid spread.

Mrs Campbell asked if late day five testing was a regular occurrence, and should we be considering Duty Candour particularly when the late testing leads to the death of a patient. Mr Whiting confirmed that this is a recurring theme and there has been a significant amount of work taking place to make the testing process much more reliable. Mr Clinkscale that several measures were tried to ensure that the day five screening is taking place on time and being reported appropriately to the senior management team, it is expected that this will give further assurance that the testing is taking place on time. He did assure the Committee that admission testing was taking place consistently and at a very high level. Dr McCallum confirmed that all Covid deaths are reviewed and should day five testing be highlighted as an issue the Duty of Candour would be applied.

Mrs Campbell asked it there was a decision not to do SSI surveillance and if so why was this the case and if there had been any clinical impact since this surveillance had been stopped. Mr Whiting confirmed that SSI surveillance had indeed stopped as there is not the capacity in the team to do this, it is likely to have some clinical impact as the surveillance is what prompts any actions and interventions and review.

Dr McCallum commented that additional guidance has been given to staff in relation to FFP3 and measures staff can take to protect themselves further.

Mrs Jones noted that the Ethical Advice & Support Group had been re-established and Dr James had submitted papers regarding how the Infection Control Team had adapted their approach during this latest outbreak of Covid. These papers were scrutinised and discussed at the Ethical Advice & Support Group who supported the teams approach.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report but is only partially assured by the contents. The Committee are expecting actions from audits and measurable improvement through the CAUTI Committee in order to be fully assured.

ACTION: Ms Laing will share papers discussed at Ethical Advice & Support

Group with the Non Executives for information.

8.1 Suicide Annual Report - paper taken out of sequence

Dr Lees provided a brief overview of the content of the report. The Committee was asked to note that the data is for 2020 which is the most recent available. There is a higher percentage of deaths in men which is a consistent trend. There incidence of death by suicide is 3.5 percent higher in the more deprived areas which is consistent with the rest of Scotland. The numbers of deaths by suicide in the Borders area were slightly higher than in previous year but the 5 year average remains consistent. The Borders appears to have a higher rate of suicide in women but there does not appear to be any apparent reason for this although it is being reviewed.

A discussion followed where several points were raised including action plan on addressing suicide including suicide prevention training which has been successfully moved onto a digital platform and has been very well received. The gold standard training is face to face but it has not been possible to deliver this as yet. NHS Borders will take part in new multiagency review process as part of a pilot and the Suicide strategy will be released in September this year.

Mr Lerpiniere commented that it is hoped that the multiagency suicide review group will glean information from the multiple support groups to help understand the risks and factors that lead to suicide in order to prevent them happening.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by work on going in suicide prevention.

7 Effectiveness – papers taken out of sequence

7.2 Clinical Board update (Mental Health Services)

Mr Lerpiniere provided a brief overview of the content of the report in particular the concerns for CAHMS and the also limitations relating to areas to discharge for DME patients following acute admissions.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured that issues highlighted are being addressed but acknowledge the work staff are doing. Same as LD

7.3 Clinical Board update (Learning Disabilities Services)

Mr Lerpiniere provided a brief overview of the content of the report.

A discussion followed where several points were raised including the challenges which still remain with out of area placements which come at extensive cost to NHS Borders. Out of area placements continue to be followed but this remains difficult due to distances and limitations on staff. Nursing homes are limiting the number of challenging patients they will place and this has a knock on effect on the whole system.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured that issues highlighted are being addressed but acknowledge the work staff are doing.

7.1 Clinical Board update (Primary & Community Services)

Mrs Flower provided a brief overview of the content of the report.

A discussion followed where several points were raised including an issue with no clear governance around non medical prescribing. This will be a focus moving forward Mrs Flower assures the committee that there is a fix for these concerns and will keep the committee informed on progress. Mrs Flower commented that the community facilities are facing the same issues as highlighted in mental health, and over the whole system in relation to delayed discharges and appropriate placement of patients when moving on. There have been challenges relating to lack of leadership posts in the Community Hospitals, staff have come forward to cover and support these challenges. Working closely with Care Home Oversight Group and Public Health which has helped to provide oversight of any outbreak or other issues within care homes.

Mrs Campbell enquired what can be done if care homes withdraw nursing support, Dr McCallum commented that they are working with the IJB and the wider Health and Social Care Partnership to look how care is commissioned. This will ensure we can continue to work collaboratively to provide nursing support in the care homes.

Conversation took place regarding the reasons for increase adverse events reported particularly in Cheviot and Kelso areas and what these events were relating to and if there was an overlap with staffing issues. Mrs Flower commented that although increases are being seen, we have also seen better reporting. It was not felt that the events were related to challenges with workforce but rather the higher complexity in patients.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured that issues highlighted are being addressed but acknowledge the work staff are doing.

7.4 Clinical Board update (Acute Services)

Mrs Dickson provided a brief overview of the content of the report.

A discussion followed where several points were raised including significant staffing challenges in the last few weeks. Mrs Dickson gave comment on rapid rise of cases and staff sickness/isolation. Support was given from other areas to help reduce gaps. Site and capacity team have been asked to support the out of hours periods. CNMs have been supporting wards and ward teams have been finding this helpful. Mrs Dickson commented that the support at mealtimes has been invaluable.

A dedicated phone line which was set up for staff to report sickness absence is now seeing a decline in reported absence. Significant impact having additional Covid beds open has been recognised but these are slowly being stepped down.

Mrs Jones asked the committee to note that the CNMS provided cover during the times of severe shortage and committee is asked to acknowledge the commitment of teams to reduce the level of risk to the patients. Staff often coming in and staying on at personal cost to them, we must not underestimate the impact that this has had on staff. Specialty nurse redeployment has impact on their own workload on return to their positions as there is no back fill provided,

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents due to the complexity of the demand on staffing and services but acknowledges again the resilience of staff and support of leadership at this time.

5 Patient Safety – papers taken out of sequence

5.2 Adverse Event Overview

Mrs Jones provided a brief overview of the content of the report. Discussions followed where several points were raised including the spike in significant adverse events in the main due to a single rather complex patient, she commented that the non executives had previously been sighted on this point. The events are to be reviewed but due to the complexity and various agencies involved this may take some time once they have the most appropriate reviewer, report will come back at a later date.

The Organisation relies on clinical staff to review events and due to unprecedented demands on staff it has not been possible to adhere to timescales. This has been reported through the board and nationally.

Mrs Jones noted that we are still pushing for position from Scottish Government on Duty of Candour report and whether nosocomial spread of Covid-19 should be included.

Further discussion took place relating to learning & improvement from adverse events. Mrs Jones commented that that we had a very proactive patient safety and quality improvement team who encourage each team to monitor and learn from any actions highlighted.

The CLINICAL GOVERNANCE COMMITTEE noted the report and is partially assured by the contents, due to significant pressures on staff at present and not being able to follow up on reviews within timescale.

5.3 Patient Safety Annual Report

Mrs Jones provided a brief overview of the content of the report. A discussion followed where several points were raised including the increase in falls seen during second Covid wave, this had been seen nationally but no apparent reasons have been identified. There is work ongoing nationally to unpick this phenomenon.

Discussion also took place regarding the numbering of priorities in Excellence in Care and in particular health screening, Mrs Jones commented that the priorities are nationally dictated but to be assured that these relate more to data collection element of the programme to fit in with national reporting.

Following a question from Ms Lam, Mrs Jones updated the committee on the grading process and how this is managed by the patient safety team including the development of grading tolls for pressure damage, she acknowledged that this had been challenging due to current staffing issues and some of the events had not been graded in as timely a manner as before the pandemic.

Further discussion also took place regarding enhanced monitoring and

documentation group and what the group would be prioritising. Mrs Jones, Dr McCallum and Ms Lam agreed to continue the conversation out with the meeting regarding both of these issues.

Discussion followed regarding digital capacity, including clinical prioritisation on IM&T workplan to consolidate systems and maximise capabilities. Mrs Wilson commented that the risk around IM&T solutions should be escalated as the Board is falling behind in terms of IM&T meaning that difficulties in recruiting to the Board may become and even bigger issue.

ACTION: Discussion regarding documentation and digital solutions.

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

6 Person Centred

6.1 Claims Update

Mrs Jones provided a brief overview of the content of the report. Due to the sensitivity of the report it is difficult to discuss fully however Mrs Jones notes that the learning from claims is taken through the patient safety programme.

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

8 Assurance

8.2 Blood Transfusion Annual Report

Dr O'Donnell was not present for his report. The questions raised were partially answered by Mrs Jones but any further questions will be sent directly to Dr O'Donnell.

Questions posed

1. What does fragile position mean? What are the risks?
2. What does support from clinical governance mean?

ACTION: Above questions will be directed to Dr O'Donnell for response

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

9 Items for Noting

9.1 2022/23 Draft Workplan was noted

9.2 Minutes of Other Committees we presented for noting

10 Any Other Business

New corporate Reporting Templates were presented. The Committee will be sent these when calling for papers going forward. Committee asked to delete old

reporting templates.

Guidance for writing reports is available and will be sent with the call for papers. Ms Lam also asked if there could be guidance on content of reporting could be developed in particular on how to present graphs to make it easier for non executives to decipher.

September and November meetings clash with IJB Ms Laing will check with Mrs Bishop and arranged alternative dates as required.

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 16 March 2022 at 10am via Teams Call.

The meeting concluded at 12:15

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Quality and Clinical Governance Report – March 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

2.1.1 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. Hospital standardised mortality and COVID 19 deaths
3. Patient experience

2.1.2 The Board is asked to:

- note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee

- note the concern raised by the Committee in relation to the service and patient impact as a result of the on-going pressures around staffing and patient flow as a result of increased length of stay and delayed discharges
- seek an update from the BET of the steps being taken to mitigate, as far as possible, this impact

2.2 Background

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

2.3 Assessment

2.3.1 CLINICAL EFFECTIVENESS

2.3.2 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 for periods of time to release workforce capacity to support urgent and emergency care. This has been a challenging piece of work given the pressures this has presented 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.

2.3.3 The Board Clinical Governance Committee (CGC) met in March 2022 and discussed papers from all three clinical boards. Each clinical board continued to raise themes around:

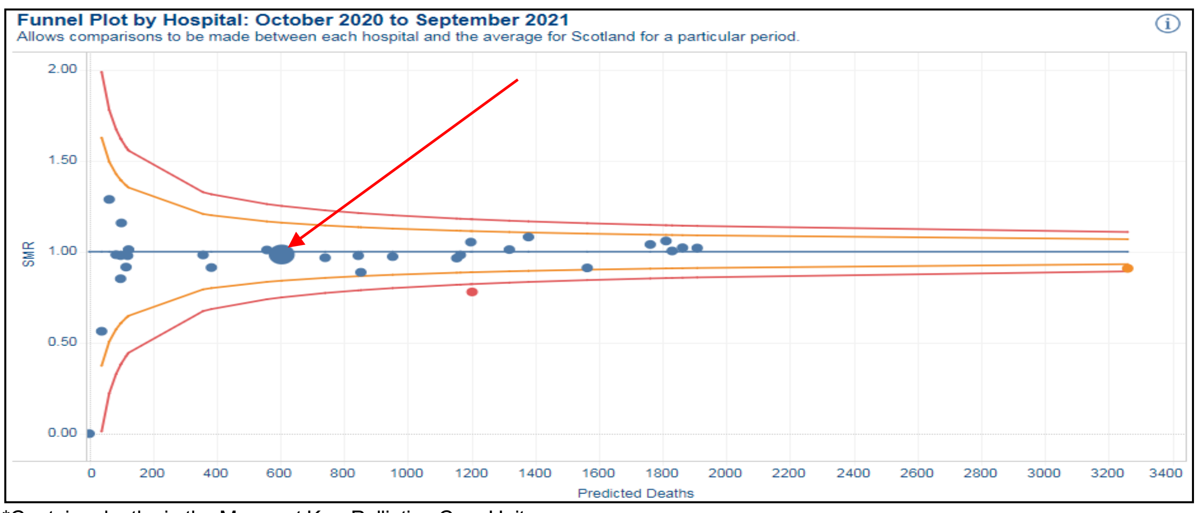
- heightened staff absence compounded by the level of COVID 19 spreading across the Scottish Borders community
- delays in patient flow including increasing length of stay and numbers of delayed discharges and the strain this was placing on access to inpatient beds and emergency and elective access times. These delays were extending across all 3 clinical boards. In mental health this has led to admission outwith criteria to Huntlyburn ward; in primary and community services to delays in admission from home to community hospitals and in acute services to lengthy delays in admission for unscheduled care and an inability to fully remobilise elective surgery
- increased waits for outpatient specialist services and surgery resulting from staff absence and a lack of available staffed beds for full remobilisation of elective surgery
- the ongoing impact of COVID 19 resulting in temporary closures of beds across community hospitals and care homes further contributing to maintaining timely patient flow across the health and social care system

2.3.4 Whilst the Board CGC continues to have close scrutiny of clinical pressures there have been two areas where assurance has not be able to be provided at the last 3 CGC meetings relating to the impact of staffing levels and the combined pressure of increased length of stay and delayed discharges on unscheduled access and elective

care. The CGC recognised the complexity of the themes being raised by clinical boards and the need for a whole system response across health and social care. In addition, the CGC noted the significant effort from staff across services and from clinical management teams to mitigate risks as far as possible within their own control. However, acknowledging the significant impact these two areas are having on whole system flow and patient safety and the need for a system wide response to mitigate risk and deliver a sustainable plan for the future the CGC recommended that staffing and length of stay coupled with delayed discharges be considered more fully by the board to assess what further measures can be taken to support service delivery.

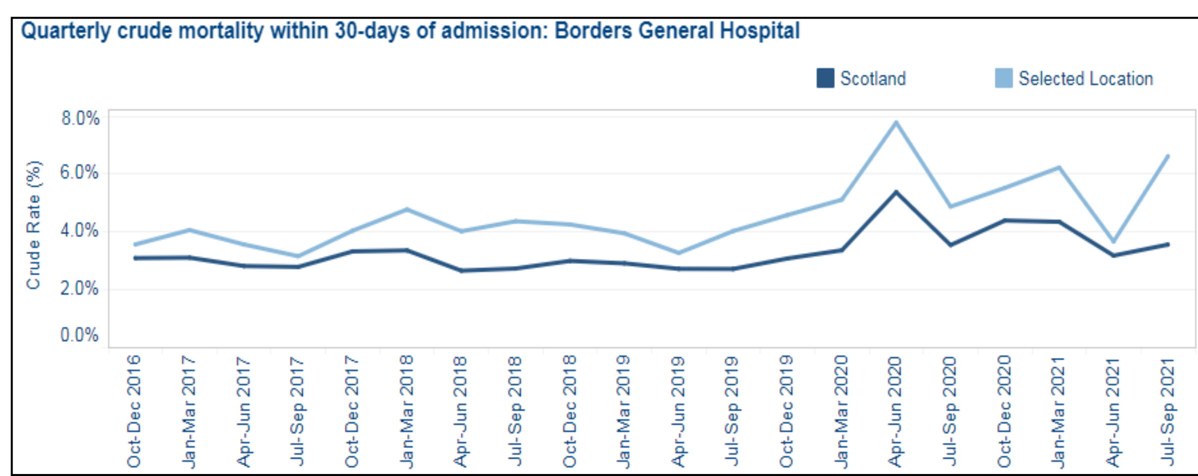
2.3.5 PATIENT SAFETY

2.3.6 NHS Borders Hospital Standardised Mortality Rate (HSMR) for the 11th data release under the new methodology is 0.98. This figure covers the period October 2020 to September 2021 and is based on 595 observed deaths divided by 604 predicted deaths. The funnel plot below shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period therefore is not a trigger for further investigation:



*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.7 NHS Borders crude mortality rate for quarter July 2021 to September 2021 was **6.6%** and is presented in Graph 1 below:



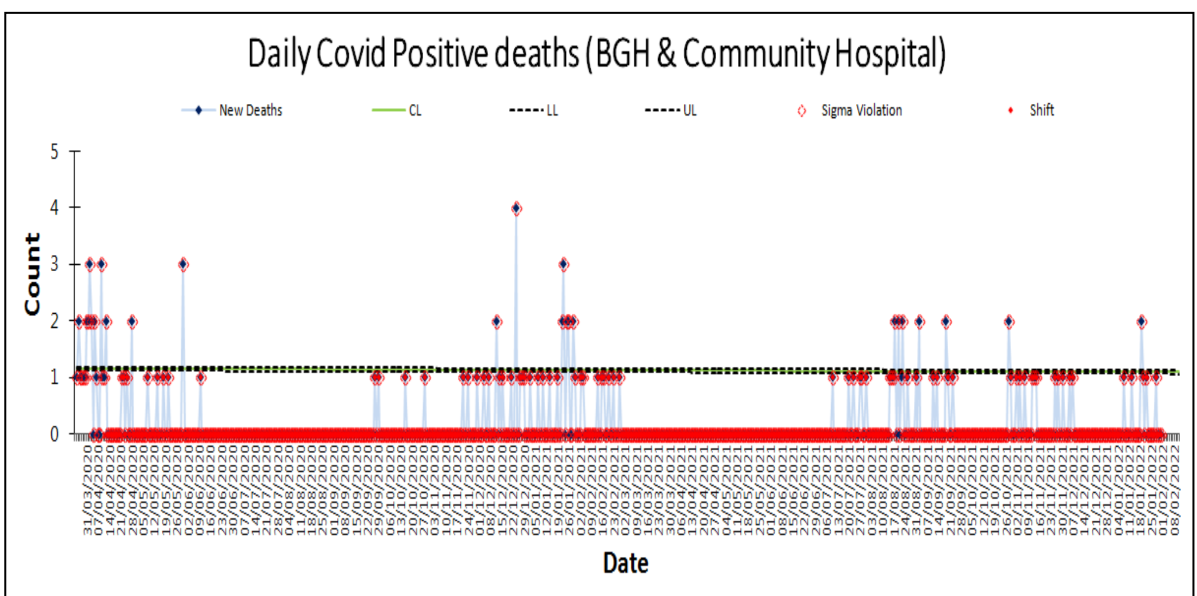
*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.8 No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the Borders General

Hospital (BGH) by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.3.9 Deaths occurring in waves 1, 2 and 3 of the COVID 19 pandemic have contributed to the elevated crude mortality rates in quarter 4 of 2019/20; quarters 1, 3 and 4 of 2020/21 and quarter 2 of 2021/22. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in quarter 4 of 2019/20 and quarter 1 of 2020/21.

2.3.10 Graph 2 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 31 January 2022:

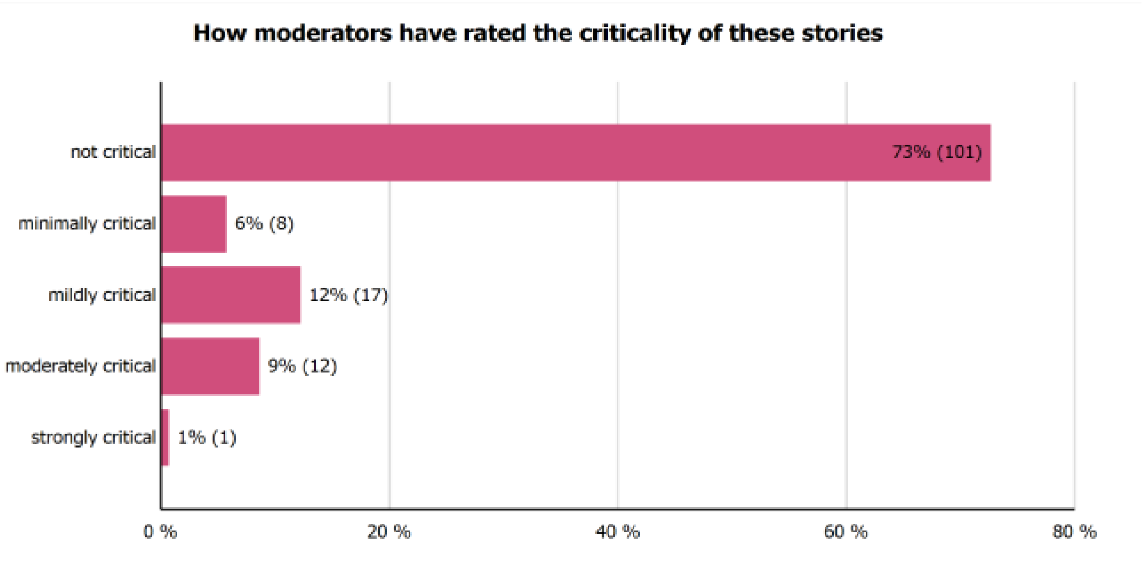


2.3.11 83% of COVID 19 deaths occurring between March 2020 and February 2022 in a hospital within 30 days of admission have been reviewed for learning to inform the local delivery of care. The remaining twenty-five cases will be reviewed over the coming two months. In addition, the core mortality review programme has continued to review 20% of non-COVID 19 deaths in hospital within 30 days of admission. From April 2022 onwards COVID 19 deaths will be reviewed under the same sampling approach as all other deaths.

2.3.12 PATIENT EXPERIENCE

2.3.13 For the period 1 April 2021 to 28 February 2022 139 new stories were posted about NHS Borders on Care Opinion. Graph 3 below shows the number of stories told in that period, as at 25 March 2022 these 139 stories had been viewed 23,864 times:

2.3.14 Graph 3 provides a description of the criticality of the 139 stories:

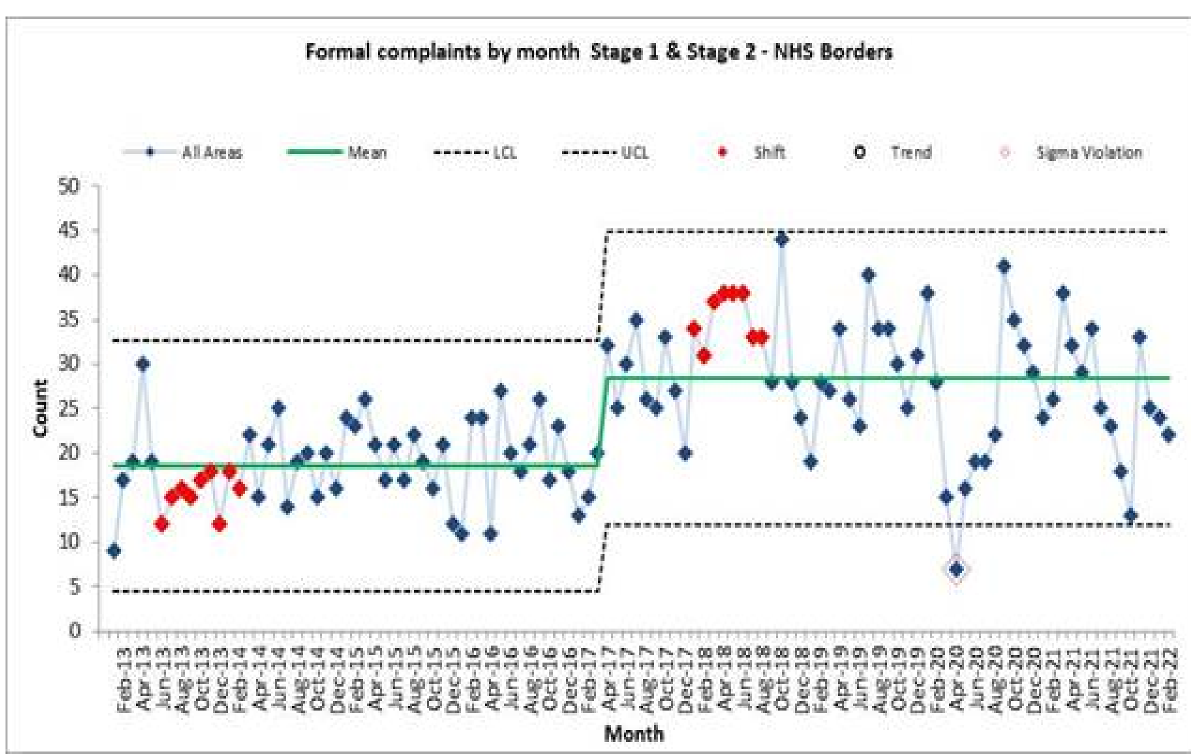


2.3.15 The word clouds below summarise what people felt was good and what could be improved in their posts about NHS Borders for this period:

What was good?

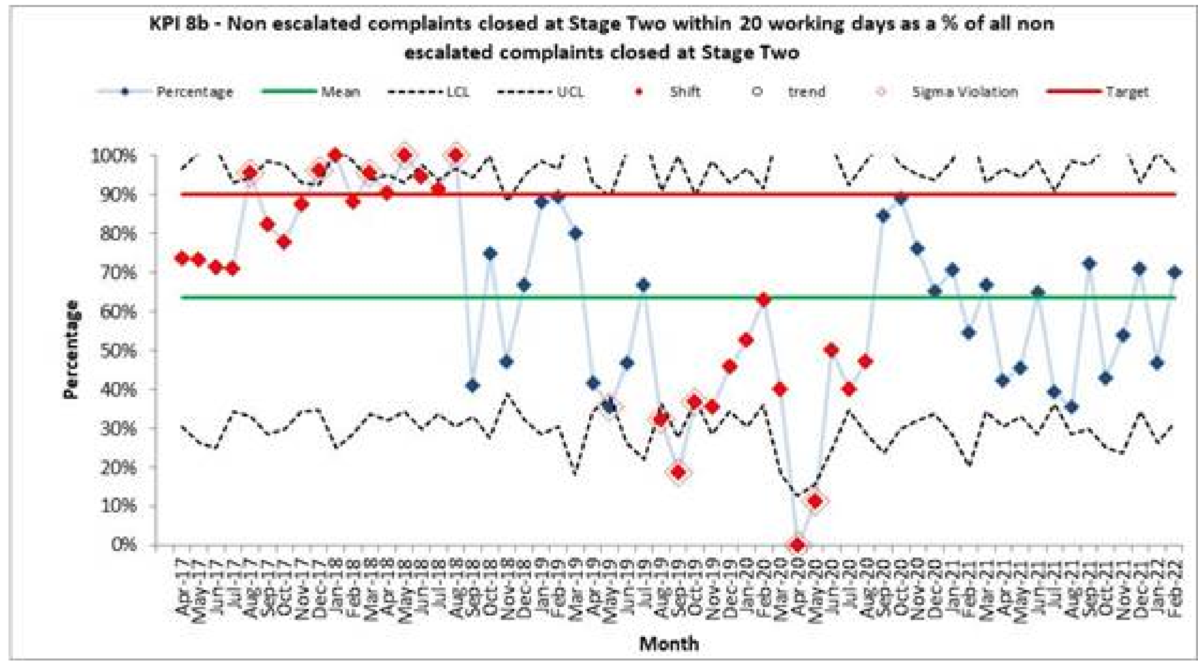
What could be improved?

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



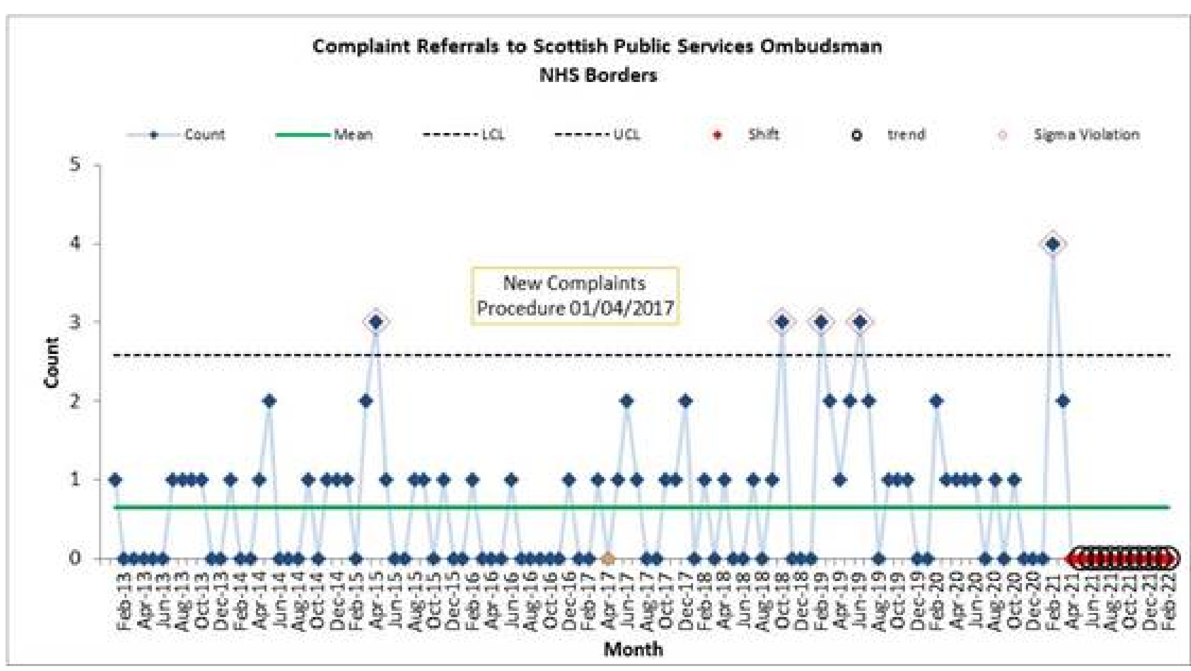
2.3.17 Graph 5 below shows the percentage of complaints responded to within 20 working days. As front line services continue to prioritise the on-going response to the COVID 19 pandemic clinical pressures have impacted on the ability of frontline clinical staff to respond to complaints investigations 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/spring period:



2.3.18 The Scottish Public services Ombudsman (SPSO) are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the involvement of the SPSO is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling.

2.3.19 Graph 7 below shows complaint referrals to the SPSO to 28 February 2022. Whilst the SPSO have not confirmed that they are investigating any new cases since March 2021, there have been 12 initial enquiries from the SPSO. Of these 12 cases, the SPSO have decided they will not investigate 6 cases and a decision is awaited on the remaining 6 cases:



2.3.20 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.

2.3.21 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.

2.3.22 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.

2.3.23 Risk Assessment/Management

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

2.3.24 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.

2.3.25 Other impacts

No additional points to note.

2.3.26 Communication, involvement, engagement and consultation

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

2.3.27 Route to the Meeting

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 February 2022 and March 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
- note the concern raised by the Committee in relation to the service and patient impact as a result of the on-going pressures around staffing and patient flow as a result of increased length of stay and delayed discharges
- seek an update from the BET of the steps being taken to mitigate, as far as possible, this impact

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Healthcare Associated Infection – Prevention & Control Report - January 2022**
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 30 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2021 and January 2022, 17 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 have not achieved this target.

1.2 NHS Borders had a total of 10 *C. difficile* Infection (CDI) cases between April 2021 and January 2022; 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 91 *E. coli* Bacteraemia (ECB) cases between April 2021 and January 2022, 46 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 January 2022, there have been28cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 2 cases 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. The graph shows that there have been no statistically significant events since the last Board update.

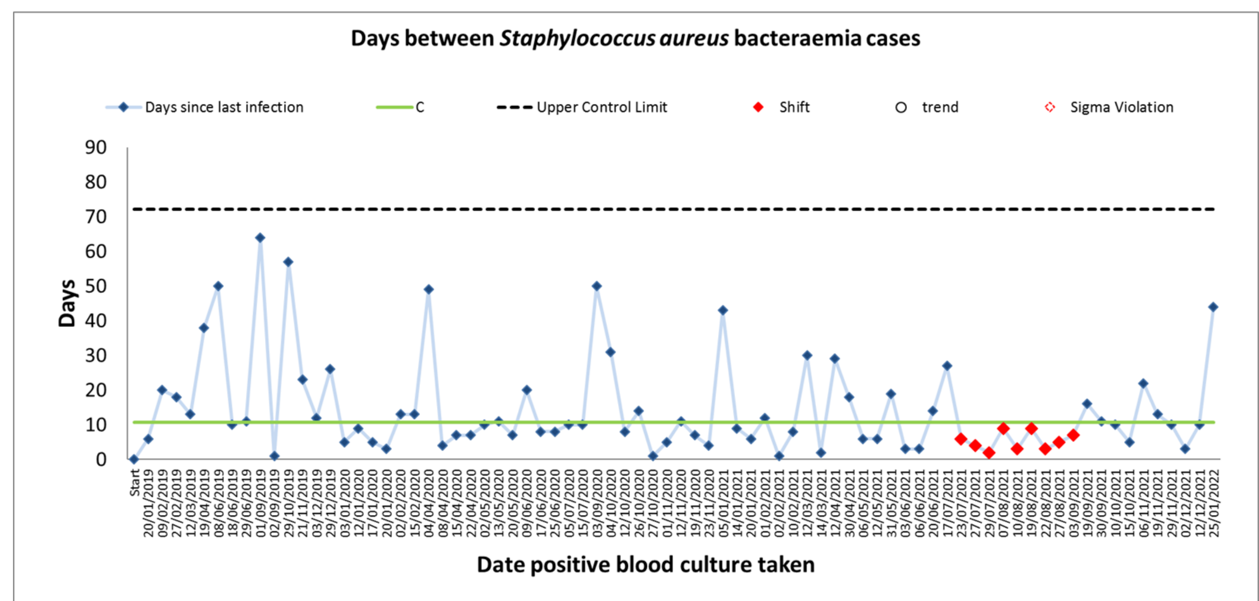
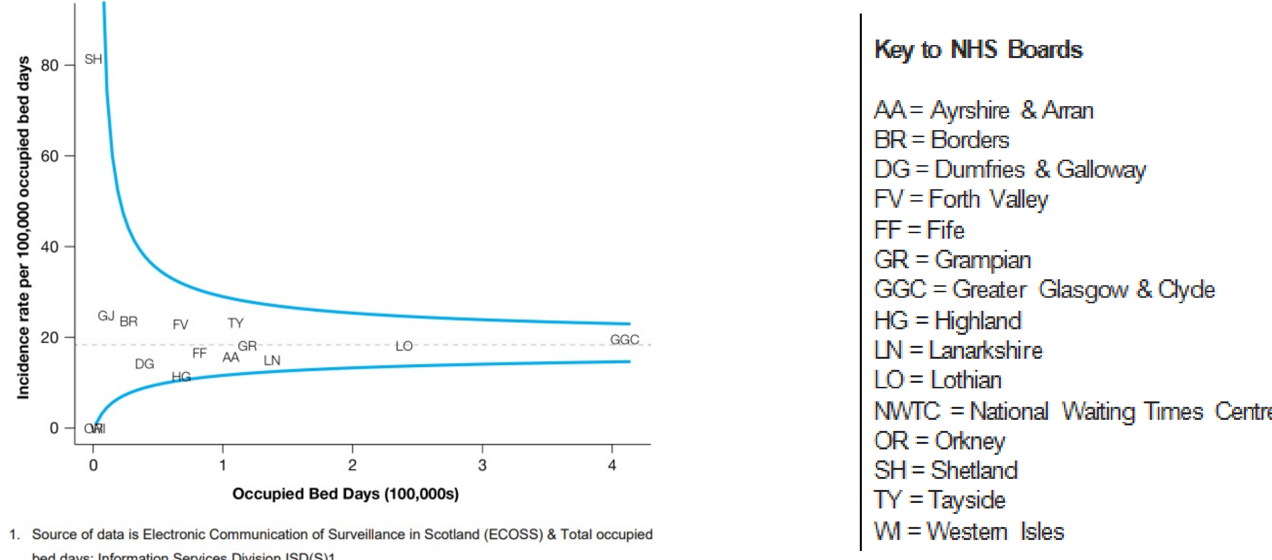


Figure1: NHS Borders ‘days between’ SAB cases (January 2019– January 2022)

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

2.5 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 2 below shows the most recently published data as a funnel plot of <u>healthcare associated</u> SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 3 2021 (Jul 2021 – Sep 2021). During this period, NHS Borders (BR) had a rate of 23.6 which was above the Scottish average rate of 18.3.

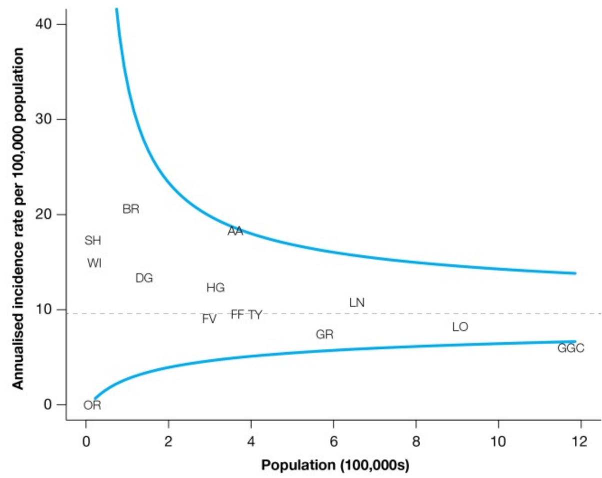


1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Orkney and NHS Western Isles overlap.

Figure 2: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q3 2021

2.6 A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days. Figure 2 shows that NHS Borders was within the blue funnel which means that we are not a statistical outlier despite our rate being above the Scottish average.

2.7 Figure 3 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q3 2021.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.

Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2021

2.8 During this period NHS Borders (BR) had a rate of 20.7 which was above the Scottish average rate of 9.6 but we are not a statistical outlier from the rest of Scotland. It is worth noting that community acquired SAB cases had no healthcare intervention prior to the positive blood culture being taken.

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 4 below shows a Statistical Process Control (SPC) chart showing the number of days between each CDI case. As with SAB cases, the reason for displaying the data in this type of chart is due to CDI cases being rare events with low numbers each month. The graph shows that there have been no statistically significant events since the last Board update.

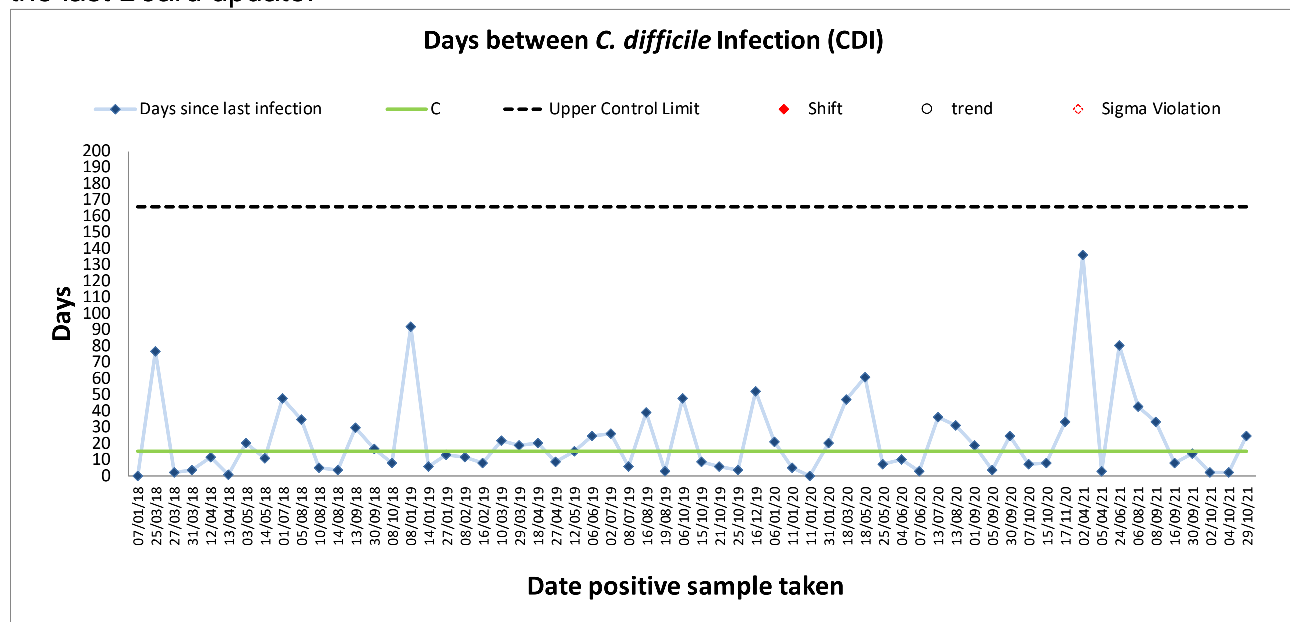
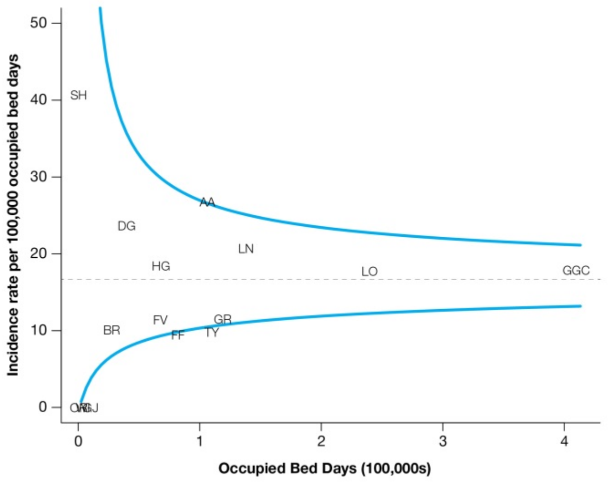


Figure 4: NHS Borders days between CDI cases (January 2018 – January 2022)

3.2 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) of <u>healthcare associated</u> infection cases for all NHS Boards in Scotland in Q3 2021.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Golden Jubilee, NHS Orkney and NHS Western Isles overlap.

Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q3 2021

3.3 The graph shows that NHS Borders (BR) had a rate of 10.1 which was below the Scottish average rate of 16.7.

3.4 Figure 6 below shows a funnel plot of CDI incidence rates (per 100,000 population) of community associated infection cases for all NHS Boards in Scotland in Q3 2021.

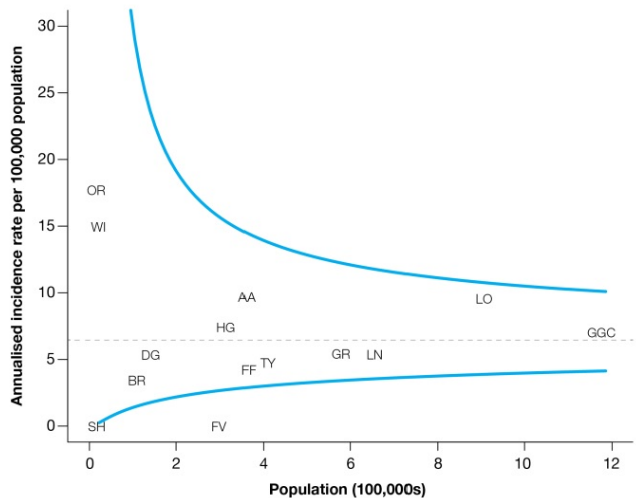


Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2021

3.5 The graph shows that NHS Borders (BR) had a rate of 3.4 which was below the Scottish average rate of 6.5.

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 7 below. An update on quality improvement work relating to CAUTI is provided under item 12 of this paper.

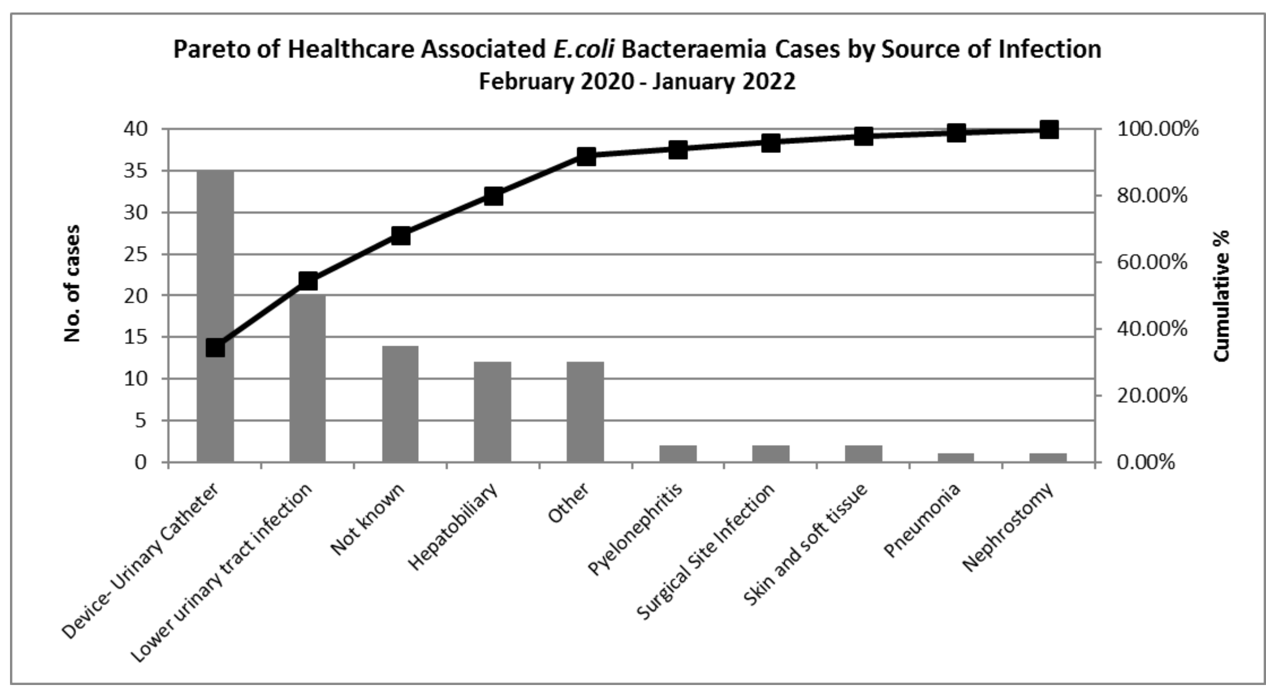
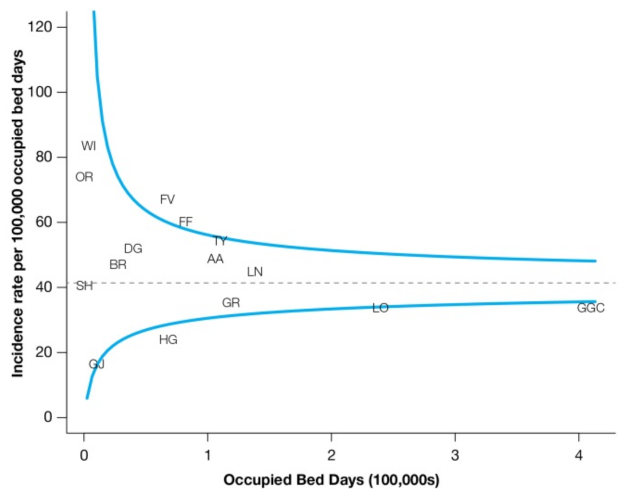


Figure 7: Pareto chart of healthcare associated ECB cases by source of infection

4.2 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 8 below shows a funnel plot of <u>healthcare associated</u> ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2021. NHS Borders (BR) had a rate of 47.2 for healthcare associated infection cases which was above the Scottish average rate of 41.4; however, we were not a statistical outlier from the rest of Scotland.

4.3 Figure 9 below shows a funnel plot of <u>community associated</u> ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 2021. NHS Borders (BR) had a rate of 62.0 for community associated infection cases which was above the Scottish average rate of 41.1; however, we were not a statistical outlier from the rest of Scotland. It is worth noting that community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.



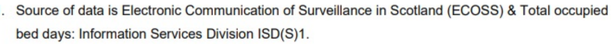
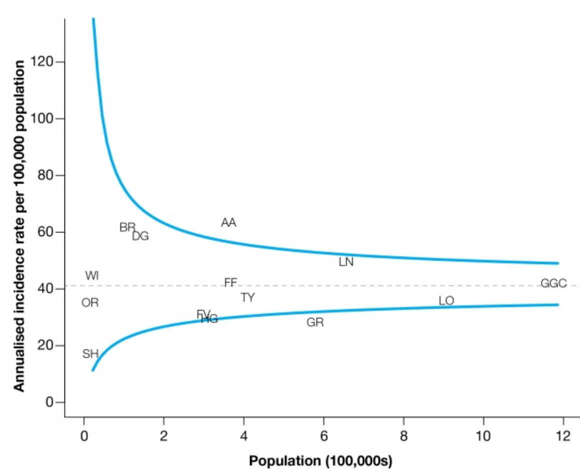


Figure 8: Funnel plot of <u>healthcare associated</u> ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2021



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.

Figure 9: Funnel plot of <u>community associated</u> ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 2021

5.0 NHS Borders Surgical Site Infection (SSI) Surveillance

5.1 The Scottish Government updated the requirements for HAI surveillance on the 25th of March 2020. In light of the prioritisation of COVID-19 surveillance, all mandatory and voluntary surgical site infection surveillance has been paused from this date. Mandatory surveillance of *E.coli* bacteraemia, *Staphylococcus aureus* bacteraemia and *C. difficile* Infections has continued but as light surveillance only.

6.0 Hand Hygiene

For supplementary information see Appendix A

6.1 The hand hygiene data tables contained within the NHS Borders Report Card (section 2, p.12) are generated from wards conducting self-audits.

6.2 NHS Borders' representative from the hand hygiene product supplier Gojo visited Borders General Hospital in February 2022 and conducted hand hygiene audits across 8 areas with an overall outcome of 88% compliance. This is an improvement from the last visit in August 2021 where 5 areas were audited with an overall outcome of 72%. Each area was given feedback following their audit with a breakdown of staff compliance across the 5 moments for hand hygiene.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1At the Infection Control Committee meeting in December 2021, a new hybrid approach to spot checking was described with plans for follow-up spot checks of poorly scoring areas (achieving a 'Red' status) to be re-visited within 2 weeks jointly by an IPCN and CNM.

7.2 As a further development, the IPCNs propose to trial modified timescales for follow-up visits to optimise spot checking activity and ensure capacity is available to respond and provide support to areas of significant concern.

7.3 The outcome of each spot check is a Red, Amber or Green status ('RAG') determined by the overall score. An area achieving a Green score (i.e. 90% or above) will be revisited within 3 months instead of 2 months. Areas achieving an Amber score (80% - 89%) will be revisited within 6 weeks instead of 4 weeks. This releases capacity to focus on areas with a Red score (i.e. below 80%).

7.4 A Red score will continue to prompt a meeting with the IPCT, SCN, CNM and Facilities Manager to identify and agree on improvement activity. A joint follow-up spot check visit by IPCN and CNM will be conducted within 2 weeks. This proposal was approved by the Infection Control Committee on 2nd March 2022 and the trial will commence with immediate effect.

7.5 In January and February 2022, management of COVID-19 was prioritised due to the significant increase in community prevalence and subsequent hospital incidents being managed by IPCT. In January, spot checks were undertaken in a total of 6 clinical areas across NHS Borders with an average compliance of 85%. In February, a further 12 spot checks were undertaken with an average compliance of 93%.

7.6 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.NHS Borders cleaning compliance continues to be slightly above the national average.

8.2 The Facilities Manager has implemented the following actions to improve the accuracy of monitoring and reporting through this national system:

- The supervisors' line managers now spend time with the Infection Prevention and Control Team to develop their knowledge and understanding of infection control issues and concerns.
- The supervisors' line managers continue to peer check facilities monitoring to provide education and reinforce correct standards
- Supervisors with consistently high Facilities monitoring scores are observed completing monitoring on a more frequent basis
- New supervisors receive Facilities monitoring training from their line manager not another supervisor
- Audits and spot checks will be cross-referenced with the most recent monitoring results and the previous feedback provided
- Closer working between Infection Control and Facilities Management to develop understanding and to address concerns promptly
- The supervisors rotate which areas they monitor each month to avoid any supervisor routinely monitoring their own area of responsibility

9.02021/22Infection 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 02/03/2022, 67% of actions due for completion have been completed with 14 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 23rd December 2021 and 22nd February 2022, there were 18 COVID-19 related incidents for which a Problem Assessment Group and/or Incident Management Team was convened. Eight of the incidents were 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 10 below. Learning from each incident is captured and acted upon in real time where appropriate.

Areas affected	Total positive patients	Total positive staff	Total deaths
Lindean (Ward)	3	4	X
Ward 4 (Ward)	21	4	X
DME 14 (Ward)	29	12	X
Ward 9 (Bay 2)	1	1	X
MAU (Bay 2 & 3)	4	0	X
Ward 7 (Bay 1)	6	3	X

Ward 9 (Bay 1 & 2)	7	0	X
Ward 5 (Bay 6)	4	0	X
Ward 4 (Bay 4) &BSU (Bay 2)	3	0	X
Ward 7 (Bay 2)	1	1	X

Figure 10: 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 28th November2021 to week ending 30th January 2022 is displayed in Figure 11 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 28 Nov 2021 to week-ending 30 Jan 2022, when including the community onset infections, was 8,400.

	% of total	n =
Community onset	99.2%	8,329
Non-Hospital onset	0.0%	4
Indeterminate Hospital onset	0.1%	10
Probable Hospital onset	0.2%	18
Definite Hospital onset	0.5%	39
Grand Total	100.0%	8,400

Figure 11: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

11.0 Infection Prevention and Control Team Capacity

11.1 Following the departure of a trainee Infection Control Nurse, the post has been re-advertised. Interviews are scheduled for 25th March 2022.

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11.2 The Infection Prevention and Control Team are currently undertaking a service review with the potential for future skill mix alterations.

12.0 Quality Improvement Update

12.1 Due to prioritisation of work related to COVID-19, consistent progress of infection control related quality improvement activity has been impacted. As part of the Infection Prevention & Control workload recovery, a review of current processes as well as re-allocation of essential workload has been progressed to allow quality improvement work to be re-instated from 01/02/2022.The following quality improvement projects have been identified as priorities:

Invasive device – urinary catheters	The first meeting of the Prevention of CAUTI Group with the new chair was held 22/02/2022. The terms of reference will be reviewed following this new appointment. A driver diagram has been drafted for the group to review and change ideas to be considered. Urinary catheters remain the primary cause of healthcare associated *Staphylococcus aureus* Bacteraemia (SAB) and *Escherichia coli* (E. coli) Bacteraemia cases.
Invasive device – PVC documentation	Improvement work has commenced with collection of baseline data. A short survey for medical and nursing staff is planned to obtain an overview of staff awareness and use of current documentation to allow consideration of education required.
Hand hygiene	Following independent hand hygiene audits carried out in February 2022, targeted improvement work is planned relating to access and availability of alcohol based hand rub (ABHR) to support staff to perform hand hygiene at the appropriate opportunities.
Infection Control screening documentation	The infection screening section of NHS Borders Multidisciplinary Assessment and Documentation paperwork has been updated to include respiratory screening as per national guidance. Work is ongoing to align these updates within separate assessment documentation.

12.2 Links have been established to align this quality improvement work with patient safety, Excellence in Care and Back to Basics programmes.

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§ionID=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§ionID=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

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
MRSA	0	0	0	1	0	0	0	0	0	1	0
MSSA	2	2	3	3	5	5	3	2	3	1	1
Total SABS	2	2	3	4	5	5	3	2	3	2	1

Clostridioides difficile infection monthly case numbers

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Ages 15-64	0	0	0	1	0	0	0	1	0	0	0
Ages 65 plus	0	2	0	0	0	1	3	2	0	0	0
Ages 15 plus	0	2	0	1	0	1	3	3	0	0	0

Hand Hygiene Monitoring Compliance (%)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
AHP	98.8	98.8	97.8	96.4	97.8	98.2	94.2	91.5	99.3	97.1	100
Ancillary	99.3	92.6	100	98.8	95.2	97.5	92.2	97.8	90.0	94.8	98.7
Medical	97.0	92.4	96.3	96.2	94.3	98.8	96.2	97.7	94.4	97.4	99.3
Nurse	97.7	99.3	98.8	97.3	97.6	97.6	97.9	98.0	97.0	98.1	99.6
Board Total	**98.2**	**95.8**	**98.2**	**97.2**	**96.2**	**97.7**	**95.1**	**96.2**	**95.2**	**96.8**	**99.4**

Cleaning Compliance (%)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Board Total	95.4	95.1	95.3	95.5	96.0	95.7	93.9	95.8	96.8	96.1	96.3

Estates Monitoring Compliance (%)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
BoardTotal	98.1	98.7	97.1	97.6	97.2	97.3	98.1	98.7	98.7	98.7	98.9

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
MRSA	0	0	0	0	0	0	0	0	0	1	0
MSSA	2	1	0	1	2	2	0	0	0	0	0
Total SABS	2	1	0	1	2	2	0	0	0	1	0

Clostridioides difficile infection monthly case numbers

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	2	0	0	0	0	0	1	0	0	0
Ages 15 plus	0	2	0	0	0	0	0	1	0	0	0

Cleaning Compliance (%)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Board Total	96.7	97.3	93.6	95.3	96.1	95.5	95.6	96.6	95.3	97.1	96.3

Estates Monitoring Compliance (%)

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Board Total	99.1	98.5	93.1	95.5	95.0	95.7	95.5	97.4	97.7	98.1	97.9

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

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
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

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
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

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
MRSA	0	0	0	1	0	0	0	0	0	0	0
MSSA	0	1	3	2	3	3	3	2	3	1	1
Total SABS	0	1	3	3	3	3	3	2	3	1	1

Clostridioides difficile infection monthly case numbers

	Mar 2021	Apr 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022
Ages 15-64	0	0	0	1	0	0	0	1	0	0	0
Ages 65 plus	0	0	0	0	0	1	3	1	0	0	0
Ages 15 plus	0	0	0	1	0	1	3	2	0	0	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 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

Clostridioidesdifficile 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:	**7 April 2022**
Title:	**Public Governance Committee Minutes**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
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 Public Governance Committee with the Board.

2.2 Background

The minutes are presented to the Board as per the Public 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 Public 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.

- Public Governance Committee 11 February 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, Public Governance Committee minutes 24.09.21
- Appendix No 2, Public Governance Committee minutes 10.11.21

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Friday 24th September 2021 9.30-11.30am
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive Director
Cllr David Parker, Non Executive Director
Margaret Simpson, Chair Scottish Borders Enterprise Chamber
Chris Lau, Volunteer Centre

In Attendance:
June Smyth, Director of Planning & Performance
Clare Oliver, Head of Communications and Engagement
Philip Grieve, Service Manager, Mental Health
Sharon Bleakley, NHS Healthcare Improvement Scotland Community Engagement
Shelagh Martin, NHS Healthcare Improvement Scotland Community Engagement
Graeme McMurdo, Programme Manager, SBC
Carol Graham, Public Involvement Officer
Laura Jones, Head of Clinical Governance & Quality
Chris Myers, General Manager, P&CS
Cathy Wilson, Clinical Service Manager, P&CS
Lettie Pringle, Risk Manager, Risk & Safety
Alison Wilson, Director of Pharmacy
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting.

2. Apologies & Announcements

Apologies had been received from: Lynn McCallum, Medical Director, Nicky Hall, ACF Representative, Kirk Lakie, Deputy Hospital Manager, Iris Bishop, Board Secretary

The Chair thanked the Committee for their attendance and welcomed Chris Lau from the Volunteer Centre for his first meeting

The Chair advised that the meeting was quorate. The meeting was recorded for the purpose of minutes.

3. Minutes of Previous Meeting:

The minutes of the meeting held on 5th May were noted as an accurate record

4. Matters Arising and Action Tracker

The Public Governance Committee noted the action tracker.

Matters arising:

Action 45 - Adult changing facility update. June Smyth advised that the members of the working group agreed to purchase a modular unit. An update on the progress will go to Board of Trustees. The site identified is presently occupied by the testing tent, which is a requirement, so we are unable to progress any further at the moment. The testing tent has agreement to be in place until end of March 2022 and could be required for longer. We will keep the committee updated of progress. Cllr D Parker asked if the placement of the modular unit was suitable for staff in that location and J Smyth confirmed that this is the best place due to the facilities that are already in place and reserve parking will be available. The option of taking away further parking spaces was not acceptable. M Simpson will send feedback from Ability Borders scenario discussion regarding the location onto J Smyth. J Smyth will take any feedback to the PMO manager and added although this is preferred site other options would be considered.

Action 51 – Summary of Actions from pertinent complaints of care opinion feedback. L Jones updated the committee that the suggestion is for the Clinical Boards, who attend the committee, to include any complaints since previous meeting in their reports. Clinical Governance will assist drawing out actions for the Clinical Boards. In addition, any themes or aggregate actions could be included in the section within annual report.

Action 52 – Public Health Update. J Smyth advised due to capacity issues within the service, she has been unable to engage Public Health in attending this meeting but a report should be provided for each meeting until this is resolved.

Action 53 – Strategic Planning Group Carers Workstream. C Oliver updated that the group meet regularly and this action should be closed.

5. Business Agenda Items:

5.1 Chairs Update

T Taylor has been asked to join the NHS Scotland Improving Population Health Forum. The membership of the forum includes chairs of equivalent committees from Health Boards across Scotland. As we do not have a Public Health Committee the Public Governance Committee was felt to be nearest equivalent. The forum feeds into the NHS Board Chairs Improving Population Health Group. This relates to paper on population health that was published by Scottish Government. The ToR will be shared when available.

5.2 Public Involvement & Engagement Update

C Oliver highlighted updates that have taken place since the paper was submitted. There was another meeting with public members in August with good feedback being received about the structure and the agenda items being discussed.

A 'what if' meeting was held with 5 public members and used 3 real life scenarios which focused on access to GP, elective procedures and emergency department. We were looking to understand what the perceptions of the public members were of the challenges we are facing and some potential solutions to those. We allowed 15 minutes on each scenario and the feedback we received was very good. This was a different approach for us and useful to help with the type of information that we send out to the public and their expectations are high, but the reality is quite different listening to reports from the clinical boards. The input from the public members is invaluable and helpful.

M Simpson commented that the work being carried out by Clare and Carol Graham is first class and the changes being made are beneficial. Following this meeting the scenarios were discussed with Ability Borders and found it mirrored the feedback. The Third sector needs to be involved to support along with the public members
S Martin added it is good to hear about the scenario meeting and the feedback received. Could this be added onto the agenda for the upcoming joint meeting with NHS Healthcare Improvement Scotland Community Engagement

Due to the pressures within services, we were unable to have further meetings in September as planned for the Hear from You project. These will take place as soon as we can.

The Older Peoples Pathway is being revised regarding the communications and engagement involvement and a project initiation document is being prepared.

The Public Engagement pillar has a workshop planned in October and would like to bring the presentation from this to the next Public Governance Meeting.

T Taylor asked for update about recruiting additional members for public involvement. C Oliver responded that the representation that is already in place is being underpinned by the networks that we can tap into, which gives more diverse group of people. There is ongoing work in this area and will feed into the Health Inequalities work being commissioned by the Board.

M Simpson commented that they are reaching out widely to the groups that they do not normally reach and have been working on Voices training which allows people to feel more comfortable in the sessions to speak up and we are receiving good feedback and suggestions. We are reaching out widely, but they don't particularly want to attend formal meetings. We do get views and opinions but not all through committee style meetings.

T Taylor asked what the timelines is for Health Inequalities. J Smyth responded that a paper was signed off by the Board in April. This was proposal for tackling Health Inequalities required, there is additional work going on in the background. The Director of Finance and J Smyth are looking at additional sources of finance that are needed to deliver. Discussions have been taking pace with the BET team and the Operational Planning Group about this programme work and the further pieces of work it links into. There would be a significant amount of funding required to take this forward. There is some activity happening although it has slipped from what was originally intended.

T Taylor noted that paragraph 1.3 in the paper submitted, it mentions Borders Care Voice and Borders Carer centre as IJB Third Sector voting members and this is not the case.

The Committee noted the report and agreed to a presentation about the Public Involvement Pillar at the next meeting.

6.1 Clinical Board Updates:

Acute: The committee noted apologies from Kirk Lakie.
A report from the Cancer experience group was circulated. This group has just recently started meeting again and any updates will come to future meetings

The Committee noted the update

Mental Health: P Grieve attended the meeting to give an update. The MH Rehabilitation service is engaged in an exercise in relocating supported accommodation for people with severe mental health issues. Individual patient feedback and views was sought in relation to the potential new accommodation being proposed. We worked closely with BIAS and they

supported gathering the feedback which gave a degree of objectivity and allowed a safe space for honest and open feedback which was feedback to the service.
Currently reviewing Gala Resources Centre which is a day service provider jointly between health and social work. There was a stakeholder event with people with lived experience and other stakeholders and we tailored a smaller group with 2 service users to gain their feedback in a safe space.
We now have full staff complement of peer support workers, that are people with lived experience who are currently employed by NHS Borders within Adult Community Health Teams. With another newly appointed waiting to start within the Rehab Service. They are actively involved in any recruitment events or interviews panels within the services.
Continue to have strong relationship with Borders Care Voice through Co-Production Charter. We are also strengthening links with sector organisations such as PND Borders and Health in Mind, which is commissioned by MH which covers befriending and peer support. We are trying to link in a more strengthened peer support worker network with Veterans First Point, Health in Mind to have a peer support forum. The peer support workers organised an introductory engagement day which was attended by Scottish Recovery Network and Mental Welfare Commission and within CAMHS we had first stakeholder event in July.
We are currently preparing survey focus group themes with Public Engagement and Clinical Governance for MH Transformation.

C Lau asked what the waiting list like at the moment and P Grieve replied that in Children's services they are struggling to meet the18 week referral to treatment target. We will still struggle to meet that in the imminent future, and this is due to high acuity in clinical demand within the service. There is also an increase in urgent and unplanned referrals to the service which withdraws resources away from the routine and planned work. There are no young people's inpatient beds available across Scotland and they are admitted into adult ward. The CAMHS service has paused taking any new patients to allow the bottle neck for the next four weeks. The team are working very hard to try and see people in a timely fashion.

M Simpson commented that through Social Enterprise Chamber they have funded two projects, one called STAND to help combat grooming of young people, and the other was to provide a counselling service for people up to age of 30. To date this has funded 100 hours of counselling for those people. Could this be linked into the network. M Simpson will send information to P Grieve.

T Taylor asked are we matching our population needs appropriately and equitable. P Grieve replied that there have been recent clinical prioritisation meetings within MH which highlighted that the service is in bigger crisis than the acute service in BGH, however, we are getting support that we need to deliver our services. There have been difficult choices about what we need to focus on, and the Board are fully aware and receive regular updates. We are aware that all the clinical services are under extreme pressure at the moment.

Tris Taylor thanked Philip Grieve for his update.

The Committee noted the update

P&CS: C Myers
Cathy Wilson reported to the committee regarding the closure of the Coldingham branch surgery.
Full public consultation was undertaken in July/August and 132 responses were received. The key themes were identified and included transport issues, GP appointments, ageing/increasing population, parking limitations and concerns over busy pharmacy in Eyemouth.

A Health Inequality Impact Assessment was completed, and recommendations went to BET on 2nd September. The Board approved recommendations for closure and the branch surgery will close on 1st October.
We are continuing to liaise with Eyemouth Medical Practice and will be made aware of any patients who are particularly affected by this closure. Also working with Promoting Health Improvement Team and Public Health to look at if there are any further impacts on health and equalities. C Oliver commented that a member of the community has created community action group and taking a community led approach to the needs of the community who can work alongside the promoting health improvement team.

C Lau asked if the 132 responses were relatively low considering there are over 500 patient users per month. C Oliver replied that Healthcare Improvement Scotland worked with us and they felt 132 was a good response. We had written to all registered patients of the GP practice, approx 6500, and informed them of the proposed change.

T Taylor asked if there is enough resources and capacity within the PH Health Improvement group to create capacity and provide support in small communities. J Smyth commented that some of the smaller community hubs have approached NHS when grants are available. Where we can, we will link in but If it is not currently in our service plans for strategic direction we will not be able to spend a lot of time supporting but will have conversations with community groups. Looking to build up more infrastructure through locality hubs and are in discussions with SBC as to how health can support and engage.

C Myers updated for P&CS: Due to scope of service provided with approx. 90% of healthcare activity being delivered through Primary services and independent contractors, our involvement with public engagement is crucial to any work we are doing around service redesign. We have been taking significant levels of public engagement and thank the small team for their support.

There is other work ongoing not noted in the report as it sits across the H&SC partnership although focused on work P&CS are doing such as Older Peoples Pathways Agenda, the development of intermediate care services, acute services for older people in hospital and discharge process. Following on from IJB there is a Pathways Zero Locality Subgroup which is looking at how do we work more integrated and effectively with communities to anticipate and prevent ill health and members of the voluntary sector and public have been involved.

There has been work with public members in both covid vaccination programme and the developing transformation vaccination programme. Our growth of the programme is tailored through the feedback and views from public and their experiences.

The public dental service wrote to 12000 patients on their lists to inform them that waiting times has increased to two years and if they had emergencies how to get in touch with the service and this is being monitored. Significant work is going on to try and reduce these waiting times within the service.

There will be P&CS representative on the Borders Community Planning Partnership meetings, and they will be working across the aforementioned agendas and tying in with the Public Involvement Team. Further work is being carried out with the Primary Care Improvement Plan which is taking services to the community rather than taking away from them and the process involves health inequalities impact assessment and public involvement.

Tris Taylor thanked Cathy and Chris for their updates and commented it is good to see such integrated approach to involvement and engagement in the clinical boards.

The Committee noted the presentation and updates

6.2 Health Improvement Scotland Community Engagement: S Bleakley attended the meeting and updated that due to internal restructures she is now the Engagement Programmes manager for the South and East region. This covers Dumfries & Galloway, Borders, Lothian and Forth Valley.

There are some updates to the paper that was circulated with the agenda. A report from Gathering Views exercise on redesign of urgent care services has now been published and is available on HIS website, the link will be circulated to the committee.

Quality Framework for Community Engagement has now gone live and is available on the website and will circulate the link, if there any comments or questions on the draft materials there is an email address for submitting these. We are also looking for Boards and Partnerships to road test the process and all CEOs and COOs have been written to. J Smyth asked if a copy of the letter could be shared with her.

T Taylor commented that the Planning with People document looks very useful. C Oliver responded that they have been working alongside and meet with colleagues from HIS and from Public Engagement perspective we welcome the work and changes that are being made. S Bleakley added that her service change colleagues have informal workshop around planning for people guidance and is available if anyone would like to use it.

T Taylor noted that there is a section in the Planning with People document about need to evidence the impact of engagement. This is something we have talked about before and perhaps we could we start asking clinical boards to start providing information regarding the impacts. C Oliver added that through the Public Engagement workstream and working with partners we could start looking at how this could be progressed. Making sure it is meaningful evaluation and metrics and not just box ticking, we will start to work towards this.

The Committee noted the update

6.3 Pharmaceutical Care Services Plan: Alison Wilson, Director of Pharmacy, shared with the Committee that this paper has already been to the Board and was asked to bring it here. As part of control of entry for Community pharmacies for application of new community pharmacy contract we are obliged to have pharmaceutical care services plan and update on annually basis, although it was noted that most other Boards are updating every 3 years. This has been refreshed to keep in line with national services. If an application came in we would consult with the community neighbourhood although are limited to how much we can do.
Asking the committee for thoughts and comments how this can be more meaningful for them.
T Taylor asked how this committee could look for assurance that pharmaceutical services are being delivered and the public are kept fully informed and engaged. J Smyth commented that while it is not a legal requirement from Scottish Government, it is important for us to develop local priorities once we can get back onto more level footing. Looking at future and living with Covid we do need to engage communities to look what the future might look like. We can assure the committee that anything that is service change then the public will be cited on that and processes we follow are appropriate.

The Committee noted the update

6.4 Strategic Risk Report: L Pringle, Risk Manager, Health & Safety, informed the committee that in 2020 the risk management governance framework for strategic risk was improved and the appropriate strategic risks would feed into the governance groups, with the Audit Committee having an oversight of the full strategic risk register. This committee will have

oversight of the strategic risks relating to communication and engagement on a bi-annual basis. This is the first paper to this committee and there is one risk relating to inequalities. Following Audit Committee discussion, additional works being undertaken by the Board Exec team to ensure the risk captures health inequalities and employment inequalities. This risk is supported by three operational risks covering each aspect of the inequalities agenda. Within the report there is further risk in development relating to the Board effectively engaging with patients, public and third sector partners. The risk register structure has an approval process before the risk goes onto the risk register. Once the risk has been through the process it will be added to the next report.
The committee are asked to gain assurance that the strategic risk in the report is being managed appropriately and are assured that processes and systems are in place to record these risks.
T Taylor asked about what other risks are on the register that this committee should be considering. J Smyth replied that the question would be better directed to the Resource and Performance Committee at Board level and any other risks allocated can be brought to this committee for consideration. Regarding the question about risk to general population there is paper currently being worked on and this could be included and brought back in the future report. Tris also asked about what improvement is being delivered with the Health Inequalities work that is in progress. June replied that they are managing as effectively as they can to reduce the risk within the resources that have been allocated. As part of the assessment this has not been able to reduce the risk and it does raise the question about trying to secure resources internally. We can take this away and look at it.

The Committee did not yet feel able to take assurance that strategic risk relating to the Committee's remit was appropriately managed and controlled but was assured that work is ongoing toward that target.

The Committee noted the update

7. <u>Any Other Business:</u>

Nothing to report

8. <u>Future Meeting Dates 2021</u>

Wednesday 10th November 9.30-11.30

All via MS Teams

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Wednesday 10th November 2021 9.30-11.30am
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive Director
Cllr David Parker, Non Executive Director
Chris Lau, Volunteer Centre

In Attendance:
June Smyth, Director of Planning & Performance
Clare Oliver, Head of Communications and Engagement
Kirk Lakie, Deputy Hospital Manager
Philip Grieve, Service Manager, Mental Health
Sharon Bleakley, NHS Healthcare Improvement Scotland Community Engagement
Carol Graham, Public Involvement Officer
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting.

2. Apologies & Announcements

Apologies had been received from: Nicky Hall, ACF Representative, Lynn Gallacher, Margaret Simpson, Chris Myers, Shelagh Martin

Apologies also received from Lynn McCallum, Medical Director. T Taylor asked if Lynn is still required to be in attendance for this meeting. J Smyth to speak to Lynn to check if she can be stood down.

The Chair thanked the Committee for their attendance

The Chair advised that the meeting was not quorate. It was agreed that no decisions would be made today. The meeting was recorded for the purpose of minutes.

3. Minutes of Previous Meeting:

The minutes of the meeting held on 24th September

T Taylor asked if all members of the group be recorded as members and not listed in attendance.

T Taylor made changes to the Chair's report and amended the summary on item 6.4. The changes were noted.

As this meeting is not quorate the Committee agreed to send these minutes to all members of the group to ask for virtual approval.

4. Matters Arising and Action Tracker

The Public Governance Committee noted the action tracker.

Matters arising:

Health Inequalities – Last meeting mentioned slippage on proposed times, J Smyth updated that discussions are taking place how we will be able to progress this and what we wanted to do in terms of enhanced programme but without additional resources at moment. This will be discussed at Board meeting in December and an update can come to PGC.

Coldingham Branch Surgery Closure – Updates to come back to PGC. C Oliver responded that the Board have asked that we stay close to this situation, although this is being actively progressed within the Community and they are keeping us close through Jenny Sutton. Clare to bring an update back to next meeting.

T Taylor suggested that future updates re this and Health Inequalities could be included in the updates from Clinical Boards going forward unless the Board specifically ask the Committee to take them forward.

Evidencing Impact of Engagement – Will include impact evaluation metrics in strategy or approach to come back to future PGC

Action Tracker:

Adult Changing Facility – No further update. Photos were shared with working group as per Margaret Simpson request and offer of further discussion when location has been finalised. This is kept open on the Action tracker to be able to keep sight of it.

Clinical Boards Summary to include information about complaints or care opinion feedback. The request has gone to the Business Units to provide this, although this will be picked up through the Public Involvement Pillar. This action can be closed.

5. Business Agenda Items:

5.1 Chairs Update

At the last PGC meeting there was item on Strategic Risks from Lettie Pringle. T Taylor commented that the committee could not currently be assured that there are adequate systems for managing and controlling public involvement risk. We were confined in our view to just a single risk, which had been one of a number of strategic risks the Board face. We were not given sight of the full number, only the ones allocated to this committee.

Following a Board discussion, a paper is going to the next Audit Committee about allocation of various risks to the various committees and looking to strengthen the process and have more of a role around broader risks, not just the ones allocated to specific committees. A good reason for having a broader view of what other committees are looking at is that there are some control measures that are put against other strategic ricks that we do not see that do involve public engagement. We should have an understanding of how that's being delivered as that would satisfy us that the systems and processes that are in place are adequate.

5.2 Public Involvement Pillar Presentation

J Smyth shared a presentation. The Board is in process of rolling out the Quality Management System across the organisation and the Public Involvement Pillar is fundamental part of this.

A workshop was held recently where some of the Public Governance Committee were invited along with members of the network that Clare and Carol have been developing. We shared some of the challenges the organisation is facing and we continue to face as result of pandemic. Such as staff who have worked in high pressure environment for last 20 months, the significant clinical backlog that has built up and will continue as we are unable to deliver services with same capacity as we did pre-covid. Also, we need to learn to live with the changes as we come out of the pandemic. Pre-covid we were in financial turnaround and are not financially sustainable as an organisation given the current growing deficit, so we need to develop a long term sustainability plan as we start to come out of the pandemic.

At the first coalition workshop we shared our thinking to date and as part of ethos of the public involvement pillar, is to work together as a team to co-produce exactly what we are aiming to do and how we can work together to achieve that. We will work with the coalition to design this and not tell them how we want to deliver it.

The pandemic has allowed us to develop much closer working relationships across Health & Social Care including the third Sector. Community resilience were able to support with assistance hubs and support to individuals. NHS Borders is looking at how to bring about some culture change within the organisation to allow us to become a compassionate organisation. Any new approach is being driven by contributions from third sector, patients and service user involvement in our recovery and normalisation of services.

We commissioned Professor Michael West, who leads very much in this kind of area of compassionate leadership and has published several books on the subject. He attended a Leadership Seminar we had with the Exec Team and Senior Leaders and Managers across the organisation. The session was recorded and available if committee members would like to learn more about his approach and what we are trying to deliver with it.

We will involve and engage our users and carers and that will be the standard we will set for the services so there is a framework which services can operate as they look to involve members of the public and others in the redesign of services. Also involved in general and in discussions around services and the way we deliver them.

We are planning the second workshop and will be working towards key outputs and key actions that relate to what we are trying to deliver.

C Lau commented that he did attend the workshop, it was good exercise to engage the third sector and individuals. Will be good to see how we can make the changes and develop a strategy and plan to deliver services.

Cllr Parker commented the presentation was very clear and added this is interesting approach and could be applied to many organisations. June replied that they are in conversations with colleagues in SBC trying to work more collaboratively. A Project Board has been set up in SBC regarding the Place programme, and Clare Oliver will be attending this.

T Taylor enquired about the coalition members and C Oliver replied that they include representation across our business units including Public Health. There is membership from Borders Care Voice, Carers Centre and the Alliance. A list of the membership can be shared with the Committee for information. J Smyth added that they didn't go into the workshop with a plan in mind as want this to be an opportunity to build up together and it is different way from working previously. The conversation provided good examples about what would make a difference, previously these conversations are held at more high level. The Quality Management System is not something we will get to end of in 6 months, it is about the way we will be doing business and how we can design services and involve users in discussions.

An update from the second workshop will be brought to next meeting

The Committee noted the presentation

5.3 Public Involvement and Engagement Update

C Oliver updated the Committee that the Hear From You community engagement initiatives have been paused at the moment, but we are committed to this initiative and it will be picked up again. We are linking into the membership to see if there are people we might want to approach to support on specific and individual pieces of work.

The Older Peoples Pathway – there have been a number of changes to the structure and focus on the work streams. Clare is currently working with the Programme Manager for 'Pathway Zero', one of the four workstreams within the OPP to advise on the public involvement approach. It is SBC who are leading on the work and another demonstration of working across organisations and utilising the resources for the most benefit.

The Public Involvement Pillar, as discussed earlier is exciting piece of work and some of the members from this committee are involved. There has been good feedback from NHS colleagues, service users and third sector.

C Lau commented that it is good work with the Hear from You initiative but asked if they will be engaging with young people who are dealing with mental health and other issues. Clare replied that while public involvement is not engaging directly with this group, although the mental health teams do as part of their day-to-day business. As the public involvement pillar progresses and as we create the framework, that part will be then how services feedback to us. We do have links into relevant groups but they are not included in reports at the moment as we are not directly involved with them but this something to take into consideration when we progress with the pillar. There is the opportunity to work across the partnership and with colleagues at SBC who have people to specifically work and engage with young people.

T Taylor commented that it would be useful organisationally to engage meaningfully with people with many or all protected characteristics so we have really helpful challenges.

6.1 Clinical Board Updates:

Acute: K Lakie attended the meeting to give an update. Kirk reported that the Public Governance Committee was discussed within our Senior Management Group who gave some examples from their services where public engagement or feedback is being used currently or shaping the way that we are redesigning services. Our primary focus within Acute is winter and remobilisation recovery but there are areas that involve public engagement.

We developed a Cancer strategy, which is in response to the National Cancer policy document. We have a good history in cancer services of engaging with patients and carers and their lived experience with the services that we provide and how we can improve to make it better for them. This has been updated post Covid. It was taken recently to the Public Engagement Group for feedback to ensure we were taking it through a process they were comfortable with and were focused correctly in terms of work planning to take forward over next 3 year programme of work.

The National Advisory Council service has approached us to think about how we use care opinion locally to capture patient experience. At the moment we do not actively promote this so we are going to do some work using cancer services using the care opinion for feedback. We will include it on any documentation we send out to patients and carers to inform them that it is there for feedback to services and how we can incorporate this into the Governance framework that we can develop for other service areas.

We can use this approach with other elective services. Some of the challenges we are facing is recovering capacity that we lost during Covid and as part of the remobilisation process and also current waiting times. We will update the Public Engagement Group regularly and seek feedback from there.

We are working on reshaping urgent care programme. Although this has an operational feel they do engage with partners across primary and community services and social care. This is looking at how we can develop capacity for urgent care beyond the acute hospital setting and how we can work to build capacity outside the Acute sector. For patients who are in distress or require access to urgent support the group involves 2 members of Public Involvement Group, and they give important feedback. Work is ongoing developing a flow navigation centre approach to supporting people outside of Acute hospital setting.

As an example of using feedback to make changes we have altered the pathway in Maternity services to allow skin to skin initial contact with mother and baby when the mother is requiring urgent intervention from medical team post-delivery. Also the trauma teams have reviewed the unplanned trauma pathway. Previously patients were asked to fast at home waiting for an opportunity to go to theatre. We are managing the patient experience better now and working on a planned pathway to ensure better experience getting patients through the pathway and their treatment.

We are engaged with the Quality Management Systems approach to how we work and using the concept of patient reported outcome measures into the feedback mechanisms that we get in real time from patients actively involved or experiencing the services we are able to provide and how to incorporate that into the governance processes that are in place at the moment and how we use that information for planning, developing and changing services moving forward.

C Lau asked if charities and groups supporting cancer patients were engaged. Kirk responded that they do engage with Macmillan services and have considered including them in the monthly governance meetings and patient experience groups. We will look at how we can be more engaging with people who want to be involved in the cancer services and in particular the voluntary sector more.

T Taylor reflected that bringing a blend of people into public engagement allows assurance that we are trying to effectively discharge our duties, trying different approaches and being honest with people. Tris thanked Kirk for his update

The Committee noted the update

Mental Health: P Grieve attended the meeting to give an update. Within the Mental Health Older Adult Community Team we aim to have a service user, person with lived experience and carer at 3 monthly service meetings. At the moment we do not have carer and we are trying to get representation for the meeting.

Within the Community Rehabilitation Team we had a person with lived experience involved with the recruitment to a mental health nurse to the team.

Adult Community Mental Health Team (CMHT). There are on-going connections with Health in Mind – third sector commissioned service in relation to the creation and implantation of a Staying Well Action Plan (SWAP) document, peer reviewed including people with lived experience, peer support workers employed within Health in Mind and peer support workers employed by NHS Borders. Recent meeting with Nurture the Borders peer support workers to determine and link the service to the newly created perinatal mental health service. Commenced people with lived experience interviews as part of Mental health transformation relating to the CMHT and Borders Crisis Team. Working closely with Borders Care Voice on carer and family's engagement. This document when signed off can be shared and will be able to be adapted for any health care setting.

CAMHS – Stakeholder Reference Group continues to meet regularly. We have commenced a consultation questionnaire to do a one month snapshot for children and young people and families around the current environment within CAMHS.

In relation to the transition care plan and agenda within CAMHS, we have had youth involved previously within the service. One of the challenges was identifying key groups of youths to be involved with the engagement and would welcome and links or contacts from members of this group. Chris Lau added that there is the Youth Borders organisation and will forward list to Philip.

Services users and people with lived experience and carer involvement is permeated through the Transformation programme in Mental Health. This is currently paused due to unprecedented demand on services and will be reviewed this week to recommence the programme and will keep the Committee updated. Public engagement is a standing agenda across all our service meetings to enhance and keep as a sense check and help capture the work that is going on across all mental health services.

Tris Taylor thanked Philip Grieve for his update.

The Committee noted the update

P&CS: It was noted that C Myers has moved onto new role as Chief Officer for IJB and C Wilson is now the Interim Clinical Manager for P&CS. Cathy is unavailable today but will be attending future meetings.

Public Health: Will send a written report to meetings for update to the committee. They will attend in person if there are particular programmes of work to update on, such as health inequalities, but due to capacity issues within the department they are unable to commit to sending someone to attend every meeting at the moment.

T Taylor commented that he does have a couple of questions relating to the report sent in and would welcome a short conversation with Fiona Doig at the next meeting if she would be able to attend. J Smyth to speak to Fiona to arrange this.

The Committee noted the update

6.2 Health Improvement Scotland Community Engagement:

S Bleakley informed the committee of updates that were not included in the submitted paper. NHS Health Improvement Scotland Community Engagement (HISCE) support the volunteer managers in NHS Scotland national programme. The team do not manage volunteers, but support the volunteer managers in the Boards around the country. Volunteering has been disrupted by Covid, from being told to step down to working on risk assessments and remobilisation of volunteers. It has been great to see this coming back on stream.

The team operate a Citizen's Panel which runs 3 or 4 times a year, where questions on a variety of subjects are posed, the most recent being the redesign of urgent care dentistry, elective care and Patient Safety Commissioner. The results are being analysed and will be available on our website along with previous panel results.

We are running a series of webinars on engaging with people from the seldom heard harder to reach groups that we know are out there. If anyone is interested the details are on our website.

` Part of the engagement program manager role is to build strategic relationships with Board colleagues and a meeting has been set up with June and Claire to have a further conversation around the quality framework and NHS Borders and how the two can come together.

T Taylor enquired to what extent should this committee be assessing how the work Health Improvement Scotland Community Engagement is specifically impacting NHS Borders, and do they have obligations or are they there to provide support and guidance. Sharon replied that HISCE are there to offer support and guidance in all aspects of community engagement, and can be critical friend if needed and want to support you to be doing the best with your community engagement.

S Bleakley to bring update to future meeting on the role that Healthcare Scotland Community Engagement can provide with support for major service change.

The Committee noted the update

7. Any Other Business:

Nothing to report

8. Future Meeting Dates 2022

9th February 9.30-11.30am
11th May 9.30-11.30am
11th August 9.30-11.30am
10th November 9.30-11.30am

All via MS Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 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 23 March 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, Staff Governance Committee minutes 14.12.21

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Tuesday, 14th December 2021, 14:30-16:30
via Microsoft Teams

Present: Councillor David Parker, Non-Executive Director (Chair)
Ms Sonya Lam, Non-Executive Director
Ms Harriet Campbell, Non-Executive Director
Mr John McLaren, Employee Director
Mrs Karen Hamilton, Chair
Mrs Alison Wilson, Non-Executive Director
Ms Gail Russell, Partnership Staffside Support

In attendance: Mr Andy Carter, Director of Workforce
Mrs Ailsa Paterson, Associate Director of Workforce
Mrs Vikki Hubner, Head of Work & Well Being
Mr Bob Salmond, Associate Director of Workforce

Minutes: Mrs Josie Gray (not in attendance, taken from a recording of the meeting)

1. Welcome, Introductions and Apologies

Councillor Parker welcomed everyone to the meeting.

Apologies were noted from Mrs Vikki MacPherson, Mrs Yvonne Smith, Mrs Karen Lawrie, Ms Edwina Cameron & Mr Ralph Roberts.

2. To agree Minutes of Previous Meeting

The minutes of the previous meeting, held on 25 October 2021, were agreed without amendment.

2.1 Matters Arising

Minutes from the meeting, held 14 June 2021, were discussed following an action from 02 December 2021 Board Meeting. This related to a sentence under item 2.3 'Equality, Diversity & Inclusion in Employment Group' which referenced Mr T Taylor. As Mr Taylor was not present at the meeting and the previous paragraph captures the essence of what was said it was agreed to remove this sentence from the June SGC Minutes.

Item 6 'iMatter Update' of the minutes from the meeting held 25 October 2021, made reference to calculation of the Employee Engagement Index (EEI) and it was agreed to amend the minutes by transcribing this calculation into the minutes as content from the meeting.

Councillor Parker went on to explain that from a local governance perspective that chat (in Microsoft Teams) should not be used as a function for discussion during the meeting. Karen Hamilton agreed to take this back to Ralph Roberts and Iris Bishop from a procedure point of view. John McLaren reiterated that we need to be clear from this discussion if this relates to the organisations behaviour or just at Board level, noting some operational meetings are complex and would be a lot longer (duration) if the chat function was not used. Karen

Hamilton suggested a further conversation in BET to decide when chat is a useful function and when appropriate / inappropriate to use.

Minutes from 25 October 2021 meeting discuss Workforce Risks and Sonya Lam highlighted that the strategic items on the Risk Register associated with the SGC are not mentioned and queried whether this should be added as a standing item on the agenda going forward. The SGC agreed this proposal.

The SGC was asked to note these updates.

3. Staff Governance Workforce Dashboard & cover paper

Bob Salmond shared his presentation with the SGC, noting Quarterly updates are provided to highlight trends within the workforce. Focus is around the main workforce metrics of absence, recruitment (specifically speed of recruitment) and internal promotions.

Sickness absence (overall) rate peaked last month (September 2021) to 6.70%, the second highest in last 12 months. Sickness absence including Covid absence also peaked last month to 8.31%, noting Covid absence reached a peak in April 2020, second peak January 2021 and is appearing to reach a third peak in Autumn 2021. Acute sector departments have high levels of absence and work is ongoing to address this with the support from Work & Wellbeing and Partnership. A Senior Charge Nurse (SCN) from BGH, seconded to HR, is also providing intense support to SCNs with the management of sickness absence and hopeful this intervention will improve absence management. Hours lost by absence highlighted mental health issues were the predominant reason with muscular-skeletal next in line.

Looking at recruitment activity, statistics have shown prior to the pandemic (November 2019) compared to November 2021 that there has been a 283% increase in recruitment volume (number of posts advertised each month) and tribute was given to the recruitment team for taking this forward, noting winter posts, Test & Trace and Vaccination Programme posts have been recruited to in a very short space of time. Local target to seek to recruit within 8 weeks was achieved for 86%. Data also looked at the time taken to recruit new staff, noting a national metric target of 116 days of first approval of vacancy, recorded on national recruitment system (Job Train). Performance against this Key Performance Indicator (KPI), over the last 5 months, has been within this target, with the exception of October & June 2021. Some factors, beyond the control of the recruitment team, were noted as bringing about some delay, such as managers capacity to shortlist and making requests to recruit.

Staffside had previously asked around internal promotions and data was shared; highlighting that approximately 1 in 10 NHSB employees were promoted to a higher band in the last 2 years, with 339 employees promoted to a higher band between November 2019 and October 2021. 69 employees were also promoted to a fixed term secondment or acting arrangement.

Sonya Lam agreed recruitment activity has been a big success and congratulated the efforts of teams involved. Sonya went on to question whether we are seeing a difference around absence reasons, in particular muscular-skeletal and the working environments these arise from, and queried whether Occupational Health (OH) should be targeting staff groups. Vikki Hubner stated Occupational Health Physiotherapy has seen a recent increase in referrals and that data indicates these referrals are predominantly from middle age women in acute areas with a variation of back / neck / shoulder issues, noting this is being looked at to ascertain if in-line with national trends. Vikki went on to state that stress issues previously raised are now tipping into medical issues and burn-out, therefore, longer more intense appointments are now required for staff, putting more pressure on the whole system. PMAV / Moving & Handling training is looked at across the piece as well as on a case by case basis to provide information the organisation can utilise.

Sonya raised the question if we should be using control charts against our absence data. Bob pointed out data from clinical areas was recorded within the new 'Tableau' system and data reports are constantly under review.

Sonya credited achievements against target for vacancies but queried if any delays between a vacancy request and approval were rising, noting previous issues around this. Bob made comment around vacancy control issues, noting pre-pandemic had a strict process which reflected our financial position with business case submission required before approval. During the pandemic this process has become more agile and more autonomy given to clinical boards. Therefore, the speed of approval to advertising has not seen delays.

Sonya asked if any equality data around internal promotions was available to highlight any equality issues. Bob confirmed equal opportunities information backs up internal promotion and diversity monitoring is a part of all recruitment. It was suggested to bring this back under Matters Arising at the next SGC.

John McLaren praised the recruitment team for their efforts, noting considerable departmental changes within HR and additional pressures due to the pandemic. John asked the SGC to note this.

With regards to internal promotions John wanted to ensure from an equality perspective whether these promotions were shared across all bands, noting the promotion of lower bands was less visible. John went on to ask for clarification around race equality within these promotions and asked Bob if we had any data around this. Bob confirmed the need to discuss with colleagues a system of parameters around bands of promotion and to also look at issues of equality. It was noted that this report is being presented to the Area Partnership Forum (APF) and Friday and agreed to return to this at the next SGC under Matters Arising.

Harriet Campbell reinforced the critical need to discuss the matter of equality (bandings, race, sexuality, age etc) at the next meeting. Harriet observed, around muscular-skeletal issues, that these are most likely prevalent over the population as a whole, noting national increase in mental health issues, and presumed we have more control over addressing these, stating an interest to learn why staff are getting injured. Harriet also queried how the SGC links in with the APF.

Vikki confirmed Occupational Health would like to look at each referral with a view to ascertain whether appropriate training is in place and that procedures are being followed, whilst also acknowledging that an increase in patient care needs (more deconditioned patients being admitted) may be partly responsible, to decide if the issues being seen can be prevented.

John explained that the APF is the working arm of the SGC, noting that everything SGC are responsible for is also the responsibility of the APF to ensure it is happening operationally. John made comment that the reporting up to the SGC still needs to be addressed (with more regular updates being fed in) and it was agreed that John, Andy Carter & Ralph Roberts would look at this, along with the Local Partnership Forums (LPFs) feeding into the APF and the Occupational Health & Safety Forum in to the SGC. Andy Carter made further comment that the APF is the chief negotiating body between management, trade unions and the organisation as the main industrial relations vehicle where we agree what we can agree locally.

With regards to race and ethnicity, Andy acknowledged occupational segregation within NHS Boards and mobility through the ranks is a critical indicator and is keen to look further at data. Andy commented that muscular-skeletal data around manual handling, age of workforce etc are good patterns to look for but mentioned since the advent of covid there has been a decrease in physical activity in the general population and wondered if there were any linkages here within the workforce (i.e. not attending their normal pilates classes).

Sonya stated that this data is key, noting some national targets were captured within the data but suggested some more KPIs to use locally to ensure we are going in the right direction.

Andy reiterated the need to work together on the most important KPIs to further analyse local data and it was agreed for Andy and Bob to take this forward.

The SGC were asked to note this update.

4. Whistleblowing Update

Andy Carter highlighted key issues around Whisleblowing, referencing a recent issue around the Integrated Joint Board (IJB) scheme of integration (to be discussed further later in meeting).

Background: The Independent National Whistleblowing Officer (INWO) is part of the Scottish Public Service Ombudsman (SPSO) from which principles and standards are being worked to across NHS Scotland. Raising Whistleblowing concerns (a guide for NHSB) was launched in April 2021, followed by a Whisleblowing Short Life Working Group and focus is now on establishing a Whistleblowing Governance Group going forward. In the last quarter (September 2021) a single case with issues relating to whistleblowing was raised, for which the investigation took 2 months. Andy stated learning has since come out of this case and noted that on a human level, for the Whisleblower & person who was the subject of whistleblowing concerns, both felt enormous strain from the process, despite HR & OH support. NHSB needs more confidential contacts than the 2 existing (John McLaren & Andy Carter) and advertising for these has been deferred until January 2022. Andy also made note that we need to 'up' the publicity level for whisleblowing as an ongoing programme, acknowledging it as important to a healthy NHSB culture, to ensure concerns are listened to and appropriately actioned. John agreed strongly with Andy's summary.

Sonya noted the timing of the release of these new standards and gave credit to both Andy & John for progressing. Sonya stated one of the challenges across other health boards is that the standards cover people who are not only employees but also people who provide services to the NHS (contractors, volunteers etc) and mentioned using the revision of IJB scheme of integration to embed these standards and encouraged the members of the SGC to link in with IJB colleagues around this.

Sonya went on to state that the NHSB Whistleblowing Annual Report is intended to be presented to the Board in February and that in terms of governance this should also come through the SGC.

Harriet queried if from the one experience of whistleblowing so far, what our learning experiences are and what we should take from this to ensure we can make the process easier? Andy commented that this first case was a difficult one and it became evident that there were parts of the INWO web pages that did not fit neatly into providing support to the people involved. NHSB are linking in with INWO to report this. A post whisleblowing investigation will look at issues around confidentiality, settlement agreements etc and further learning will be taken from this. It was noted there are only 36 managers within NESS who have had whistleblowing training, hence the need to expand upon the number of people trained in whistleblowing and Confidential Contacts locally. Sonya went on to state that some of the issue not measured is how concerns are managed as business as usual, stating if we have a culture where it is safe for people to feel comfortable and speak up, the hope would be that they can raise this through business as usual, noting the numbers of whistleblowing

cases is not necessarily the correct way to measure this but rather to have a safe culture for speaking up. Sonya went on to comment that work is taking place around creating a cultural scorecard to provide us with an indication of speaking up. As a small board the question of maintaining externality and objectivity is also a challenge which we may have to work with other boards over agreement. Andy confirmed a number of incidents have come very close to triggering whistleblowing within the last 6 months and they were certainly discussed at great length as business as usual; very significant issues taken very seriously by management. One area of focus is health and social care within the IJB world and issues whether we have NHS and social work staff working shoulder to shoulder with clients and patients and what the process of whistleblowing is for each statutory agency, noting in theory whistleblowing is there for employees, students etc to escalate concerns not taken seriously. Therefore, what is the process to let each party know about the concerns? Ralph suggested the need for some sort of protocol with SBC around this. It was agreed to have further discussion around this out with SGC with the IJB looking at how to get agreement from other organisations or IJBs to ensure we adhere to the standards, noting that for people in health and social care the same standards do not apply. Councillor Parker agreed that a discussion between SBC and NHSB should take place to include the IJB standards going forward. Andy and Sonya agreed to link in with Chris Myers around instigating this discussion.

5. National Workforce Strategy

The National Workforce Strategy has not yet been issued but is expected this week, Andy will circulate to the SGC once received. Key points included will be Public Health messages, stance against violence towards health staff, completion of statutory & mandatory training and resource gaps in service provision. The aim will be for NHSB to use this as an infrastructure to create our own localised People Strategy. Councillor Parker was keen to see this and agreed a future discussion around this.

6. HR Optimisation

Andy gave an update on what was taking place within the HR department. Andy has been in post for 18 months and has inherited a structure. Lots of conversations have taken place within the HR department and a number of things were coming through. The Business Partner Model never gained traction, slightly confused reporting line and never quite made connection into the Acute Quad that we hoped it might, possibly lack of understanding around Business Partner role. Greater opportunity for communication flow across members in HR team and coming up with better ways to improve this. HR now have their own local 5 behavioural objectives, how to engage with each other and customers. The offering of the HR intranet is being taken to next level for a 'go-to' place for HR materials. Quads have provided good feedback about specialsit teams within HR which are operating well. Previously HR had a system with 2 halves of dept (Employee Relations, HR Policy Activity / Corporate HR functions around recruitment and workforce planning. Some changes are materialising already, noting Ailsa Paterson & Bob Salmond have key strategic leadership roles with Quads; Ailsa working with Gareth Clinkscale & Acute Team, Andrew Bone & Finance and Estates; Bob working with IJB, Primary & Community Services (P&CS), Mental Health and corporate directorates. This change provides a significant HR presence right at the most senior level within Quads, is within normal HR resources and no additional funds. Andy explained he is looking at rationalising HR job titles, reducing to two thirds of titles in use; Andy's title to potentially to change to HR Director instead of Workforce (similar for Ailsa and Bob as Associate Directors) in line with the national group of HR Directors. It was agreed for the HR organisational chart to be circulated with proposals alongside the old organisational chart, noting Andy is keen to have SGC colleagues as a sounding board, critical friends within clinical / non clinical areas to feedback how HR is meeting needs. The

first half of 2022 will be used to embed these changes and Andy will be paying close attention to HR staff and customers to ensure changes are making a difference and delivering for managers.

Harriet stated the HR changes were very well thought out and raised a question around the benefits and outcomes, how this is going to be better and how we are going to measure this to evaluate the success? Andy stated the primary thing is to reach in to the Quads, starting now and embedding Ailsa & Bob to give strategic HR management is very valuable, providing critical feedback from Quad leads. Ailsa & Bob are to direct traffic with recruitment moving to the East Region Model in Easter 2022. HR Managers and Advisers will also be assigned to Quads, allowing Quad leads to strategically know who their precise HR colleagues are. It was agreed for further updates on this to be brought back to the SGC.

7. Any Other Competent Business

Harriet requested the SGC papers to be issued in one pack, referring to issues with multiple attachments. Josie Gray is asked to take this action forward. In summary it was also agreed for the SGC to develop KPIs and add a standing item to future agendas on Workforce Strategic Risk.

8. Date of next meeting

It was previously agreed for the next meeting to be scheduled for mid-March 2022. However, noting comments made by Sonya that it is important for the SGC to see the Annual Whistleblowing Report prior to the next Board, it was agreed to schedule the next meeting for end of January / early February. Councillor Parker proposed Wednesday 2nd February a possible option. Josie Gray is asked to schedule the next meeting along with a 2022/23 timetable of SGC and circulate.

The Chair closed the meeting by thanking people for attending.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**Wednesday 16 March 2022**
Title:	**Medical Education Report: April 2021-January 2022**
Responsible Executive/Non-Executive:	**Dr Lynn McCallum, Medical Director**
Report Author:	**Dr Olive Herlihy, Director of Medical Education**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The aim of this report is to provide an update on the progress, developments and areas of concern within medical education covering the period from 1st April 2021 to March 2022. Medical education is responsible for teaching, training and well being of undergraduates (medical students) and postgraduate (trainees) based at the BGH. Additionally Medical Education is also responsible for ensuring all trainers have access to training to maintain recognition of trainer (ROT) status to enable then to continue to provide supervision to both UG and PG trainees. Updates in all these areas are covered in this report.

2.2 Background

As a Local Education Provider, NHS Borders must abide by GMC Standards for medical education. The persistence of red flags in GMC surveys will lead to a Deanery quality visit with recommendations. Failure to comply with recommendations may lead to removal of trainee posts. 2020 Survey was postponed due to COVID but for 2021 is back on track. If we continue to address the issues with improvements then flags should reduce.

More transparency is being asked for ACT spending the failure to provide these details could potentially lead to a reduction in funding and failure to support students locally could lead to reduction/withdrawal in student numbers.
It is important to recognise that students and trainees are the potential consultants of the future and important for NHS Borders succession planning.

2.3 Assessment

Undergraduate Training

- The continued upgrade and maintenance of accommodation for students (and trainees) working with Eildon Housing, Finance and Estates for positive impact on wellbeing.
- Medical Education to work with Finance and medical departments to identify ACT monies used to support Undergraduate teaching which is embedded in services, for the purposes of reporting in the annual accountability report.

Postgraduate Training

- To support Medical Education with the implementation of TRICKLE wellbeing App to engage trainees to drive positive change for the training experience and the benefit of patients.
- Support medical education to work with acute general medicine and NES to create a sustainable resilience and appropriately filled rota for acute medical takes to enable a reduction in work load
- Support Medical Education in development of networks for advancing equity in medicine locally.

Trainers

- To prioritise clinical supervision of Undergraduate and Postgraduate trainees in job plans for all consultants in clinical practice
- To support Director of Medical Education in facilitating the Recognition and Approval of Trainers process and role in subsequent revalidation

Undergraduate Education

Teaching and Training: The departments of Medicine, Paediatrics and Obstetrics and Gynaecology were highlighted for Recognition of Excellence by the Undergraduate Quality Review Panel for 2021 and letters of good practice were sent to each of the departments. Feedback from other departments including Psychiatry, anaesthetics was also positive.

Wellbeing: While teaching experiences on the whole were positive the main issues raised in feedback relate to Wi-Fi in the residencies and access to computers. With respect to the Wi-Fi we successfully bid for ACT slippage to install Wi-Fi into the student houses in the residencies by Border link. It has now been installed in the student houses but has been delayed due to COVID illness in the installation company. To resolve access to computers we had successfully bid for ACT slippage in 2020 to purchase secure ipad lockers with ipads for students in senior medicine and surgery and these have just been connected to the network (February 2022) and are awaiting testing.

The improvement to accommodation has been well received and we continue to get positive feedback. We had one outbreak of COVID earlier in the year requiring isolation in the residencies with support from the Medical Education team which was gratefully received. As a consequence of this event housing allocation has been revised by year to ensure all UG in the same year are housed together.

Medical ACT Funding: NHS Borders submitted our ACT accountability report on the 31st July 2021 to NES confirming our allocation for 2020 and a supportive narrative around the use of ACT funds and outlining new initiatives for the period. Specifically in this report NES ask for use of measurement of teaching data and financial allocations. Medical Education has been working with our trainers to identify all teaching within the departments by timetabling and we are working with finance to determine time allocation of staff to teaching to associate this with costs. For 2021_22 we had an increased allocation of circa £52,000. Bids successfully proposed for these monies included additional simulation kit, employment of a modern apprentice to support medical education administration team, the upgrade of the Wi-Fi in the residencies, upgrade of the bathroom facilities in the residencies, purchase of soft furnishing and linen for the residencies and monies for repairs and maintenance of the bikes previously purchased for students in 2020.

In 2020 ACT funding was received for the purchase of bicycles and a secure storage shed for use by medical students when on placement in NHS Borders. Unfortunately due to work demand and limited capacity in the Estates department this work remains incomplete as we wait for the ground to be prepared for placement of the secure shed which will be erected by the company from whom it was purchased by 31 March 2022.

The upgrade of the bathroom facilities will require support from Eildon housing which has been slow to establish. Additionally, as the lease is due to expire in 2028 NES are reluctant to support funding for improvements if the lease is not going to be renewed. Therefore clarity is needed regarding the future of the lease of these houses currently used in part for students placed in NHS Borders during clinical attachments.

Additional ACT Funds: We received notification in early November of additional funding being made available by the SG for additional undergraduate students entering programmes in 2021/22. NHS Borders allocation of this was circa £19,000. We have put in a bid for these monies to purchase study pods for the library to replace the open desk plan currently in place. This has been successful and we await arrival of the pods.

Physicians' Associates (PAs) NHS Borders completed the first clinical attachments for 3 PAs in July 2021. All were successful in passing their exams and one has been

employed locally. A further 3 students have started in 2022. Feedback from the PAs about their experience locally was very positive. A presentation was made to the medical unit. Learning guides were completed to be used by future students which have prompted the university to provide more generic guidance for trainers and trainees in peripheral placements.

Post Graduate Education

Teaching and Training: This year's DME report was split into two parts. The first part required an account of local governance structures and the 2nd part on feedback from the NTS (National training survey) and STS (Scottish Training Survey) surveys. Part 1 was looking at the governance of quality of both UG and PG medical education. This includes how the board is made aware of educational developments and concerns; how we evaluate induction; address areas of concern or red flags; use of Datix and the feedback process to trainees in particular; links between senior managers and trainees to enable feedback on training and support for trainers to maintain trainer status.

As in 2020 the Quality report only required feedback on specialities performing at the top and bottom 2% of these surveys. Both geriatric medicine and obstetrics and gynaecology departments were in the top 2% and thankfully we did not have any department in the bottom 2%. There have been many positives in training and education for trainees in 2021_22:

- Much of our teaching remained face to face with positive feedback from trainees.
- Teaching is also available on Microsoft Teams to enable those who could not attend in person to join.
- Simulated teaching has increased in many departments. The Surgical team set up a weekly skills club led by a clinical development fellow with consultant input. Foundation simulation (SIM) continued and scenarios were updated to reflect current guidance and incorporation of COVID scenarios with positive feedback from all sessions. The Paediatric team ran monthly SIM sessions for trainees. The Anaesthetic department set up skills training for central line insertion for all medical trainees and interested others. The Stroke team ran several simulated thrombolytic sessions throughout the year to train all those potentially involved in the administration of thrombolytic agents. The Foundation doctors set up evening training for students living in accommodation locally and this received positive feedback.
- A Quality Improvement (QI) symposium was held in July for presentations of QI projects undertaken by trainees and prizes were awarded. This was a very successful event with great feedback and we plan to run it again later this year.
- NES has provided good practice letters to obstetrics/ gynaecology, Paediatrics and surgery for positive feedback regarding the training experience in these specialities.

Following a Quality Review Panel (QRP) by NES on the GMC and NTS surveys, General Medicine (GIM) received an inquiry regarding Red flags with respect to Work load / Rota and teaching experience for ST/CT trainees (Appendix 1). This is an ongoing issue highlighted in the cumulative feedback over the last five years. This year was a result of a number of factors including

- o trainee shielding
- o trainees on restricted duties
- o Resignation of a Locum appointment for service after 6 months
- o Sickness absence due to COVID including isolation
- o employment of locums cancelling at short notice

One of the issues with the senior medical rota is the allocation of trainees from NES to NHS Borders to support this rota which falls short of the numbers required to run it safely (minimum of 10 required) necessitating additional staff. Short term rota gaps as a consequence of the above and difficulty getting locum cover impacts on the remaining trainees available for the rota increasing their workload. The SE of Scotland DMEs has met with NES in an attempt to address this problem.

NES also requested DME feedback regarding a free text comment from an ST in Psychiatry regarding the rota and 24 hour cover period. This had been raised in a previous QRP for the GP trainees. Discussions had been had with the Psychiatry consultants and trainees regarding the rota which moved to a 12 hour shift period since august 2022 and we await an update in the coming year (appendix 2).

Wellbeing: The doctor in training iMatter Pulse survey was undertaken in September. A total of 5 questions were asked relating to health and well being of trainees. Of 95 surveys sent there were 41 respondents i.e. 43%. Overall the trainees experience working with NHS Borders was positive 6.9/10.

The key areas that remain a concern in many departments are rotas (Medicine, Psychiatry, Orthopaedics, Surgery), handovers and workload based on feedback from focus feedback groups and from the NTS as above. Some of these rota issues were resolved with improved staffing for the August intake and rota reviews specifically with task delegation to others. In medicine, 6 Clinical Development Fellows were appointed (normally 4) with the aim of providing a buffer for the senior rota. It remains to be seen how effective these changes have been but current feedback/comments in the TRICKLE App suggest the issue is ongoing and currently impacted by sickness absence predominantly.

TRICKLE: Is an award-winning people engagement and wellbeing app which has been piloted by trainees since November 2021. It surfaces trending ideas, suggestions and hot topics within our organisation enabling engagement on team priorities, tackle and track relevant issues and drive positive change, together. Trickle has given the trainees a platform to raise their voice - and be heard. In the short period it has been live many issues have been raised and addressed including rota concerns, handover and IT issues. Trickle has enabled Med Ed to deal with concerns in real time and engage the trainees in solutions. Currently we are looking for funding for the license for this App for 2022 and onwards. We are seeking support from endowments on the premise that staff wellbeing significantly improves productivity, care quality, patient safety, patient satisfaction, financial performance and the sustainability of our health services (Caring for Doctors, Caring for Patients). Nursing staff participated in our initial pilot and senior nursing and hospital management are keen to introduce this App to the wider nursing community. TRICKLE is being used in the Scottish Government and in NHS Scotland (by NES, NHS Tayside, NHS Lothian and pilots are running in other Boards). The cost per trainee is 20p per day but increasing the number of participants using the App reduces the cost.

Funding to support Medical Education and training: Additional funding has been provided at the request of NES to support study leave and in particular to enable trainees to gain competences that have not been possible during the pandemic. Applications were invited from placement Boards in NHS Scotland for non-recurring funding to support the education and training of doctors in training programmes in NHS Scotland. NHS Borders bid for iPads and a secure locker to enable increased access to Teams based education locally including Mortality and Morbidity and weekly Grand Rounds in addition to recording equipment for induction and teaching to enable improved audio quality of the recording for those unable to attend on the day. The bid was unfortunately rejected on the grounds that NES policy is to not fund IT equipment such as iPads or laptops as it is an employer responsibility to provide staff with any equipment they require to undertake their duties. We have appealed on the basis that these iPads were strictly for educational purposes and to widen access to educational events remotely but we have not had any further feedback.

Advancing Equity in Medicine: NES have set up an Advancing Equity in Medical Education Group to promote equity and reduce differential attainment of all under-represented groups. Andrew Duncan, ADME has taken the lead locally aiming to link with Lothian as the placement board for trainees who have networks in place currently including networks for BAME, LGBTQ, Disability (and Youth) and leads for international medical graduates (IMG) network.

Trainers

All consultants within individual departments are required to supervise trainees which most departments manage without difficulty. However, within General Medicine due to unfilled posts, consultants who do not have ROT status and Less Than Full Time consultants within Medicine there is a short fall of trainers to support trainees necessitating those who are present to supervise more than the previously agreed 2 trainees. NES guidance advises that no consultant should have more than 4 trainees simultaneously. The trainer is given 0.25 PA per week per trainee but unfortunately many consultants that are supervising don't have time allocated in their job plan currently as job planning has yet to be completed within the unit.

In terms of ongoing recognition of training supervising consultants are expected to provide evidence over a 5 year cycle against the 7 GMC Domains. Those that were due to expire by the end of July 2021 had their recognition extended by 12 months. Currently ACT funding supports the Clinical Educator Programme for ongoing training and recognition. However this has been proving difficult to access and the training available does not always meet the trainer's requirements. Ongoing discussions are been held between the DME and the University to see how this can be revised for the benefit of trainers. In the mean time, the DME in Lothian on behalf of the SE Boards (Borders, Fife, Lothian) successfully bid for monies to support on line training for trainers from an independent company MIAD to provide on line training for 150 new faculty and 350 current faculty which will start at the beginning of the financial year to allow individuals time to book in advance.
Provide analysis of the situation and considerations. Assess the current position, identifying any organisational risks, stakeholder considerations and evidence base to help inform decision making.

2.3.1 Quality/ Patient Care

Improving the experience of trainees in NHS Borders and looking after their well being impacts positively on patient care and safety. Importantly these are the doctors of the future and a positive experience will support recruitment and retention for the future.

2.3.2 Workforce

Creating an open honest, supportive culture will help recruit and retain an important NHS workforce

2.3.3 Financial

All Boards have to meet the requirements of a Performance Management Framework to receive Medical ACT funding, including an annual accountability report which covers:

1. Actual Medical ACT expenditure for the previous financial year
2. Up-to-date baseline budgets for Medical ACT showing the allocation to each specialty/department
3. Measurement of Teaching compliance

It is important that this funding is used for the provision of medical education as above

2.3.4 Risk Assessment/Management

Ensuring a structured, inclusive positive experience for medical students and trainees supports a future work force.

Providing transparency on ACT fund spending is integral to continued funding. Improving the educational and clinical experience of trainees impacts positively on patient care and service delivery and is the corner stone for future recruitment within NHS Borders.

Clinical supervision should be a priority in SPA time in job plans as without adequate supervision we will impact on trainee allocation by NES. Currently all services are trainee dependent for delivery.

2.3.5 Equality and Diversity, including health inequalities

Health Inequalities Assessment not required for this report.

2.3.6 Other impacts

Ensuring a positive training experience for all trainees is an important for future recruitment at all levels.

2.3.7 Communication, involvement, engagement and consultation

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

The DME attends the Scottish DME bimonthly meetings. This group has shared representation in national committees so that all relevant information can be communicated at these meetings:

These groups include

- Foundation Programme Management Group (FPMG) – DME NHS Borders representative
- National Association of Clinical Tutors (NACT UK)
- Quality Review Panel for specialties
- Scottish Association of Medical Directors
- SAS Doctors Development Group
- Realistic Medicine – DME NHS Borders representative
- ROT working group
- Scottish Shape of Training transition and implementation group
- Doctors and Dentists in Training (DDiT)
- Advancing Equity in Medicine

2.3.8 Route to the Meeting

- Shared national issues in relation to training which impact locally are discussed at national meetings and resolutions agreed as appropriate. Local DME reports are not shared nationally.
- Clinical Governance Committee.

2.4 Recommendation

Medical Education asks the Board to acknowledge the progress in Medical Education facilities and experience and to support the team in continuing to improve the quality of training for all training and non-training grade doctors working at the BGH.

Appendix 1

Scotland Deanery

DME Enquiry

Name	Dr Olive Herlihy
Role	DME, NHS Borders
Programme	Medicine (Group 1 dual specialties)

ENQUIRY	
Reference	

Following discussion at the Medicine Quality Review Panel on 12th November 2021 it was agreed that further information was required in regard to the following:

Site: Borders General Hospital
Unit/department: General Internal Medicine
Trainee group: Specialty Trainees
Issue/concern: Red flags for Teaching and Workload (Could you please provide some detail around what you think may be the reasons behind the red flags).

STS TREND 2017-2021

Programme/Level group	Indicator	2017	2018	2019	2020	2021	5-year longitudinal Trend
ST	Clinical Supervision	grey	white	grey	grey	white	white
	Educational Environment	grey	white	grey	grey	white	white
	Handover	grey	white	grey	grey	white	white
	Induction	grey	white	grey	grey	white	white
	Teaching	grey	white	grey	grey	red	white
	Team Culture	grey	white	grey	grey	white	white
	Workload	grey	white	grey	grey	red	amber
	Number of responses	3	5	2	1	8	

I would be grateful if you could look into this matter in your role as Director of Medicine Education and send your response to *medicine.qualitymanagement@nes.scot.nhs.uk* by 28th February 2022. If you need further clarification of any points mentioned above, or if you'd like to discuss this enquiry, don't hesitate to get in touch.

Quality Improvement Manager: Alex McCulloch & Kelly More
Specialty Group: Medicine
Email: Medicine.Qualitymanagement@nes.scot.nhs.uk

Scotland Deanery

Response

Teaching: National teaching is incorporated into the rotas so the trainees are able to attend. Local teaching has been either in a clinic or ward setting over recent years and formal bed side teaching for those studying MRCP. However the consultant body have recognised the need for time tabled teaching for ST/IMT and this has been set up since December 2021 (time table attached). It has been well attended and well received.

Work load:
For the ST rota there is a min of 10 persons required to manage the work load. In 2021 we had 7 trainees allocated to medicine. To complete the min of 10 we appointed a LAS and 2 clinical development fellows (CDFs) and to give some resilience the CT2 also participated on the rota giving a total of 11. However one trainee was shielding during COVID and had restricted duties on return. Another was working at 0.7WTE and attached to the BGH for 7 month period and one of CT2's had restricted duties for the period of attachment to the BGH. The LAS who had been appointed for the year left after 6 months to a permanent post. These gaps were required to be filled by locums who covered the on call duties but it was difficult to get locums on a more permanent basis and on occasions where locums were employed to cover they did not always arrive as planned. The situation became more problematic in the summer months during the second wave of COVID due to sickness absence and COVID isolation.

Additionally, annual leave and study leave was granted as were urgent requests which impacted on the staff available to cover during these periods, albeit that locums had been requested.

The necessity to move doctors to cover rota gaps resulted in reduced staff on wards resulting in lack of continuity and increased workload for trainees on the wards in general, thus reflecting the feedback in the survey.

A comment from a trainee in our focus feedback group at the end of the year sums up the feeling regarding the rota which is reflected in our red flags:

'In general, the rota seems very tight in terms of numbers of staff. When compared to working elsewhere, I do think the BGH is allocated less trainees/patient but planning in advance for this would make for an overall less stressful experience'.

Based on these experiences from 2021 we have employed more non-training doctors in CDFs to cover the wards duties at middle grade level and provided rota support at senior level, if possible, based on training.

With respect to the Senior trainee rota we have tried to recruit additional staff to support this rota but struggled to recruit at this level. Currently the rota has the minimum 10 required, but with COVID isolation and sickness absence, the short term gaps and the challenge to recruit locum staff cover continues.

The rota requires more resilience and additional trainees to support service requirements would improve the overall experience of the trainees.

Appendix 2

Name	Olive Herlihy
Role	DME
Programme	Core Psychiatry

ENQUIRY	
Reference	*Mental Health 2021*

Following discussion at the Mental Health Quality Review Panel on 12 November 2021 it was agreed that further information was required in regard to the following:

Site: Borders General Hospital
Unit/department: Core Psychiatry
Trainee group: Core
Issue/concern: Core Psychiatry – STS freetext comment about living conditions

LEVEL	Programme	number of trainees in unit surveyed	Negative Comments
CT1	Core Psychiatry Training South East	1	I will be avoiding BGH in future purely due to the 24 hours out of hours cover. We regularly work from 9.30 until after midnight, with no guarantee of being able to go to bed after. I feel is it bad for us and for patients.

I would be grateful if you could look into this comment in your role as DME and provide me with a response by 28 February 2022. If you need further clarification of any points mentioned above, or if you'd like to discuss this enquiry, don't hesitate to get in touch:

Quality Improvement Manager: Natalie Bain
Specialty Group: Mental Health
Email: Natalie.bain@nhs.scot

Response
This was raised at the GP QRP in March 2021 and a response was sent to the deanery in May 2021 as requested with respect to a similar free text comment (emails trail and rotas attached). The shift pattern was changed as agreed with the trainees and details outlined below. If you require anything further please let me know Olive Herlihy DME NHS Borders **Updated response from HR Jan 2022** The 24-hours out of hours cover rota was replaced in August 2022, the move to a 12-hour shift pattern was effective from that date. This was fully discussed with junior doctor representatives and consultants in advance including an agreement with the trainees in post at the time that we would not change the rota format until the full August change over, given the personal commitments etc made on off duty days / weekends off. HR met with a junior representative on 22 December 2021 about the forthcoming February 2022 rota and agreed a modification to the rota cycle so that weekends were no longer split. The representative commented on the feedback she had received/suggestions from her colleagues. This change may alleviate concerns about the weekend frequency (now 1 in 4.5 previously 3 in 8). The representative raised no concerns about the rota. In July 2021 there were 7 doctors participating in out of hours; there are now 12 due to career grade support which has also alleviated the frequency of out of hours. The monitoring of the old 24-hour rota in January 2021 was compliant with hours and rest – although the trainees did report issues about workload intensity on weekends which the CD of Psychiatry followed up individually. The monitoring in June 2021 received insufficient returns. The monitoring of the new 12-hour rota in November 2021 only had 3 returns from trainees so insufficient to declare an outcome but every recorded shift was compliant with rest, natural breaks and hours. A further monitoring period would have been scheduled this month but the SG has paused monitoring between 17/12/21 – 02/02/22 due to Omicron, which means the rota would be declared compliant on the basis of available evidence and in consultation with all parties we will seek a representative period for the next round of monitoring in April – May – June 2022.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 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 (AOPs) and Local Delivery Plans (LDP).

This is presented to the Board for:

- Awareness
- Discussion

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 time the revised Performance Scorecard has been presented to the Board therefore this paper is to inform the Board of February Performance and is also seeking support for the updated format moving forward, a presentation will be provided to the Board Members at the development session where the format and approach can be discussed in more detail.

The scorecard has been formatted to allow for Board members to easily see performance against RMP4 and previous AOP/ LDP targets by area. As we continue to develop the scorecard an area for narrative will be included in each section containing targeted questions designed to give Board members context and assurance:

- What is the data telling us?
- Why is this the case?
- What is being done?
- What learning has been applied?

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. At the Access Board meeting on 23rd March 2022 Planning & Performance presented the draft updated format to members and confirmed that narrative would need to be reinstated via service leads from April 2022.

There are four areas of performance that are reported outwith of agreed performance standards for February 2022, excluding Quarterly measures which will be reported in March's Performance Scorecard:

18 Week Combined Performance

The pressures faced within the acute hospital have limited our ability to meet this AOP standard on a monthly basis. Waiting times are currently measured against the RMP4 agreed trajectories for both 12 week and 52 week Outpatient and Inpatient Waits.

CAMHS 18 Week Referral to Treatment Time

We continue to carry significant staffing vacancies within our psychology service despite concerted efforts to recruit. It is anticipated however that 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. 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 February with return to pre COVID-19 attendee numbers including significant long waits for inpatient beds which impacted on flow. Work continued with our colleagues in Health and Social Care to reduce the number of delayed discharges however they have also faced significant pressures which has continued to impact our ability to discharge from hospital.

Sickness Absence

NHS Borders absence rate (sickness and COVID-19) for February 2022 was 7.14%, of which 2.32% was COVID-19 related and 4.82% non-COVID-19 related. In comparison to the month of January 2022 we have seen a decrease in COVID-19 related absence of 1.18% and a decrease in sickness absence of 0.58%.

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.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

A Health Inequalities Impact Assessment has been completed as part of RMP3/4.

2.3.6 Other impacts

None Highlighted

2.3.7 Communication, involvement, engagement and consultation

This is an internal performance report and as such no consultation with external stakeholders has been undertaken.

2.3.8 Route to the Meeting

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

2.4 Recommendation

- **Note-** February 2022 Performance

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 28th February 2022

February 2022

Information & BI Services

Month

1

2

3

4

5

6

7

8

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11

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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

January Reported Performance - Area Achieving Standard/Trajectory

Drugs and Alcohol clients waiting < 3 weeks from referral to treatment

Nov 2021	Dec 2021	Target
98.0%	97.0%	≥ 90%

Diagnostics - 8 key tests waiting > 6 weeks target as at month end [1]

Jan 2022	Feb 2022	Trajectory
436	474	662

Cancer Waiting Times 31-day target

Dec 21	Jan 22	Target
100.0%	100.0%	≥ 95%

Cancer Waiting Times 62-day target

Dec 2021	Jan 22	Target
96.0%	95.5%	≥ 95%

A&E Attendances [1]

Q2	Q3	Trajectory
7718	6834	7960

Total Emergency Admissions [1]

Q2	Q3	Trajectory
2114	1986	2474

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

Psychological Therapy Referral to Treatment within 18 weeks

Dec 2021	Jan 2022	Target
85.7%	85.0%	≥ 90%

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

Jan 2022	Feb 2022	Trajectory
43	56	38

January Reported Performance - Area Significantly Outwith Standard/Trajectory

% of patients seen within 18 weeks Combined Performance

Jan 2022	Feb 2022	Target
72.1%	65.2%	≥ 90%

CAMHS patients treated within 18 weeks from referral to treatment

Dec 2021	Jan 2022	Target
65.0%	67.9%	≥ 90%

A&E patients discharged or transferred within 4 hour target

Jan 2022	Feb 2022	Target
69.5%	66.0%	≥ 95%

Maintain Sickness Absence Rates below 4%

Jan 2022	Feb 2022	Target
5.4%	4.8%	4.0%

Emergency Admissions Length of Stay [1]

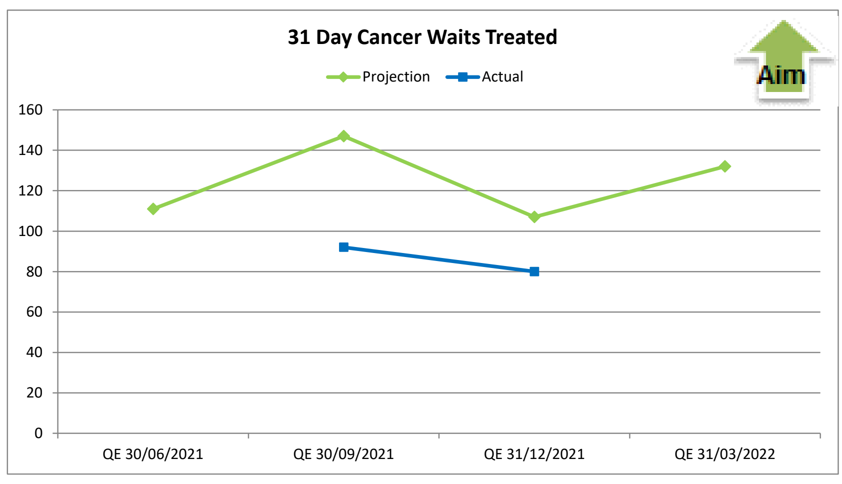
Q2	Q3	Trajectory
8.4	9.2	8.3

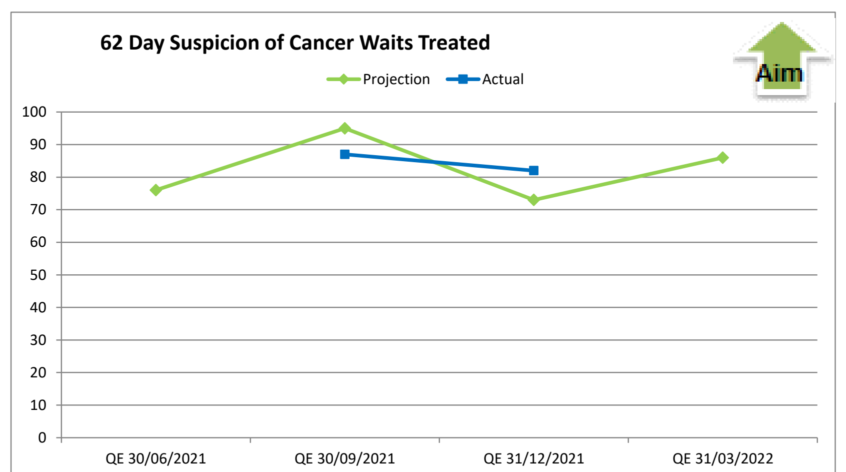
[1] These are RMP4 trajectories

Performance Measures

Cancer Waiting Times

Remobilisation Plan 4
Quarterly Achievement





Cancer Waiting Times

62 Day Cancer - 95% of all cases with a Suspicion of Cancer to be seen within 62 days

Standard
95.0%

Latest NHS Scotland Performance
83.1% (Jul - Sep 2021)

Tolerance
86.0%

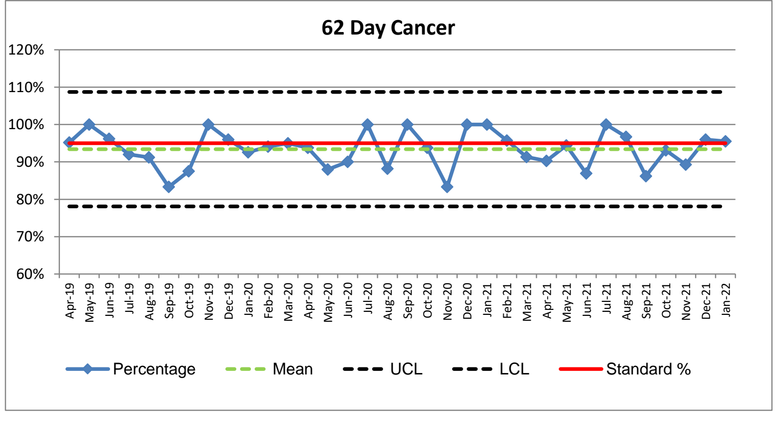
31 Day Cancer - 95% of all patients requiring Treatment for Cancer to be seen within 31 days

Standard
95.0%

Latest NHS Scotland Performance
96.7% (Jul - Sep 2021)

Tolerance
86.0%

Actual Performance (higher % = better performance)



Actual Performance (higher % = better performance)

31 Day Cancer

105%
100%
95%
90%
85%
80%

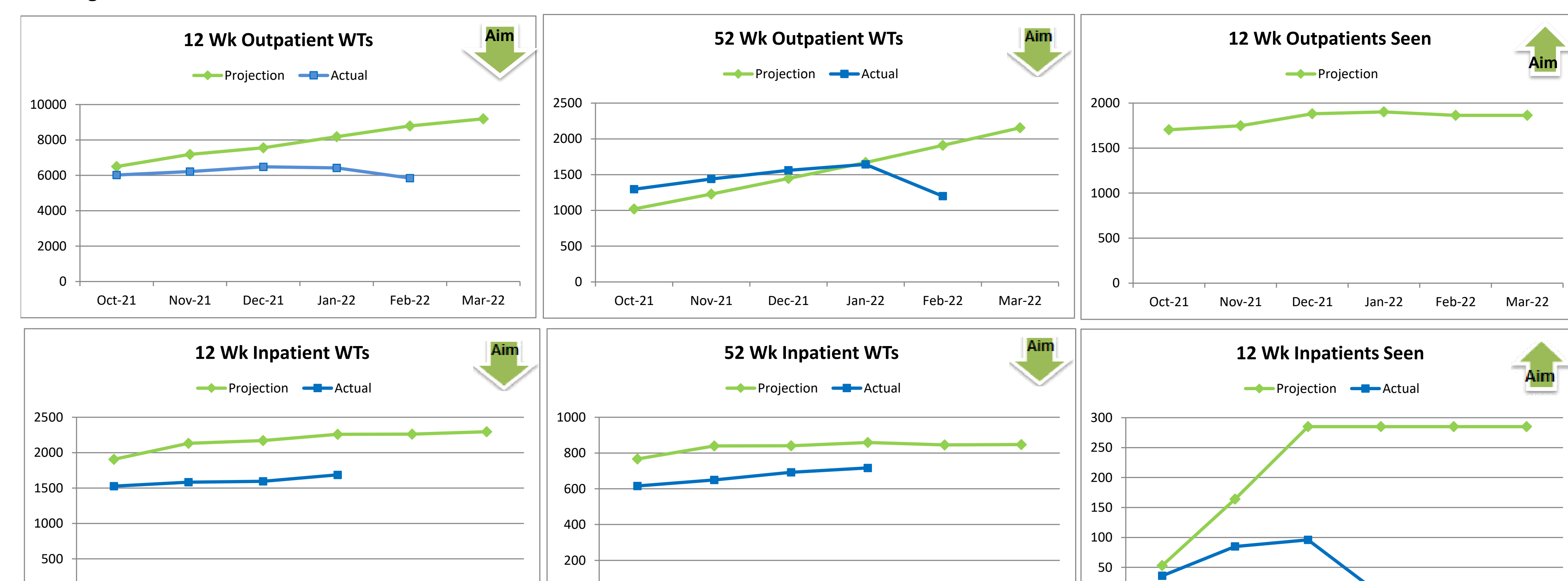
Apr-19 … Jan-22

Percentage Mean UCL LCL Standard %

Please Note: There is a 1 month lag time for data. August data unavailable at this time.

Remobilisation Plan 4

Waiting Times



Stage of Treatment - 12 Weeks Waiting Times

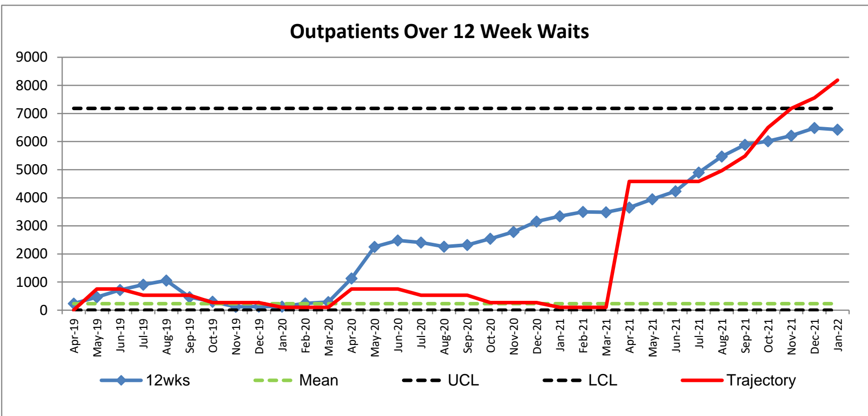
Standard - 12 weeks for first outpatient appointment

Trajectory
8186

Tolerance
8996

Latest NHS Scotland Performance	**NHS Borders Performance (as a comparative)**
48.05% (Sep 2021)	39.30% (Sep 2021)

Actual Performance (lower = better performance)



12 week breaches by specialty

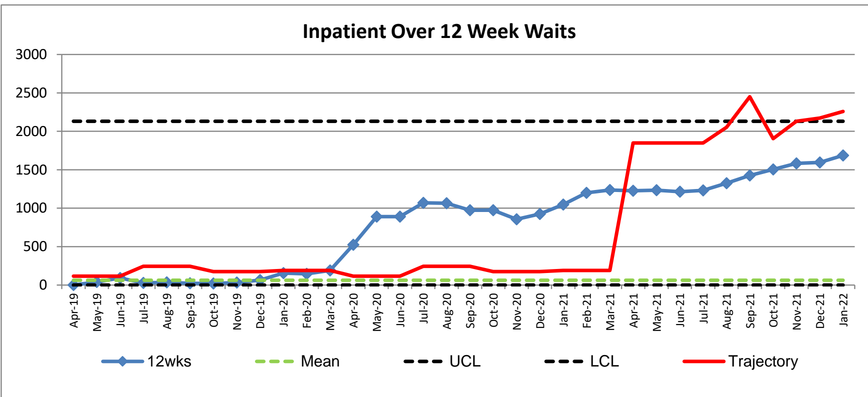
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cardiology	182	211	249	275	258	253	253	262	262	271		
Dermatology	405	461	517	604	726	841	874	976	1063	1079		
Diabetes/Endocrinology	66	72	85	102	112	114	102	48	66	75		
ENT	419	498	557	568	481	454	453	432	422	391		
Gastroenterology	94	108	110	114	144	147	139	137	155	179		
General Medicine	0	0	0	1	0	5	1	2	1	2		
General Surgery	749	740	663	791	842	892	858	835	840	635		
Gynaecology	80	75	75	100	135	175	220	239	240	217		
Neurology	70	76	107	137	178	188	184	213	232	254		
Ophthalmology	940	1029	1146	1288	1479	1590	1649	1748	1835	1901		
Oral Surgery	28	29	19	13	14	11	13	11	12	28		
Orthodontics	41	46	30	35	36	51	55	57	51	49		
Other	115	110	109	113	124	105	88	80	85	113		
Pain Management	0	0	0	1	1	2	1	2	3	1		
Respiratory Medicine	154	163	180	201	224	237	255	271	286	303		
Rheumatology	6	14	15	28	29	25	26	23	23	19		
Trauma & Orthopaedics	12	10	22	142	252	321	351	360	402	384		
Urology	291	309	345	384	438	476	493	514	506	522		
All Specialties	**3652**	**3951**	**4229**	**4897**	**5473**	**5887**	**6015**	**6210**	**6484**	**6423**	**0**	**0**

Stage of Treatment - 12 Weeks Waiting Times Continued

Standard: 12 Weeks Waiting Time for Inpatients

Trajectory
2259

Tolerance
2483



12 week breaches by specialty

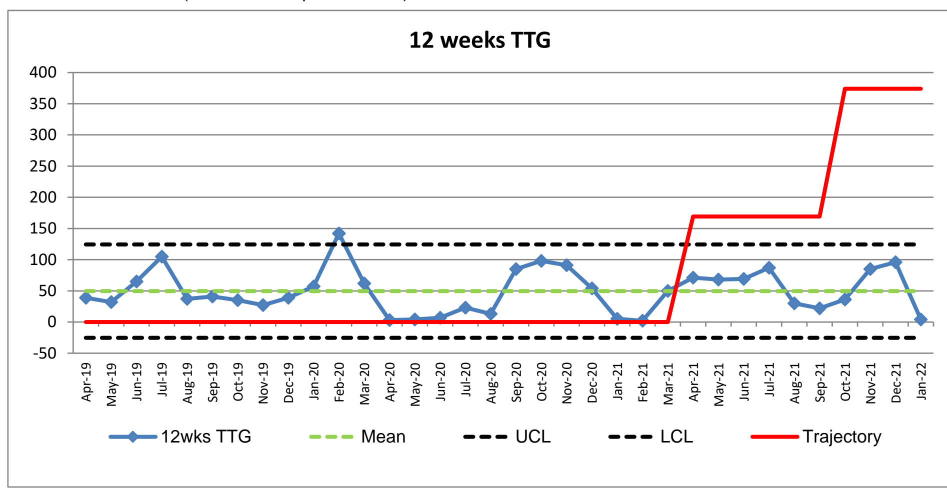
	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
ENT	32	33	37	40	39	41	48	46	40	57		
General Surgery	168	170	163	167	198	216	233	240	255	278		
Gynaecology	115	113	116	112	117	136	150	164	153	158		
Ophthalmology	242	238	226	230	238	248	252	253	246	261		
Oral Surgery	65	72	78	83	90	92	101	109	110	114		
Trauma & Orthopaedics	544	570	574	593	609	646	671	686	703	726		
Urology	92	86	78	73	64	67	72	84	89	93		
All Specialties	**1227**	**1234**	**1215**	**1233**	**1325**	**1426**	**1504**	**1582**	**1596**	**1687**		

12 Weeks Treatment Time Guarantee

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

Latest NHS Scotland Performance	NHS Borders Performance	Tolerance
70.2% (Sep 2021)	59.1% (Sep 2021)	411

Actual Performance (lower = better performance)



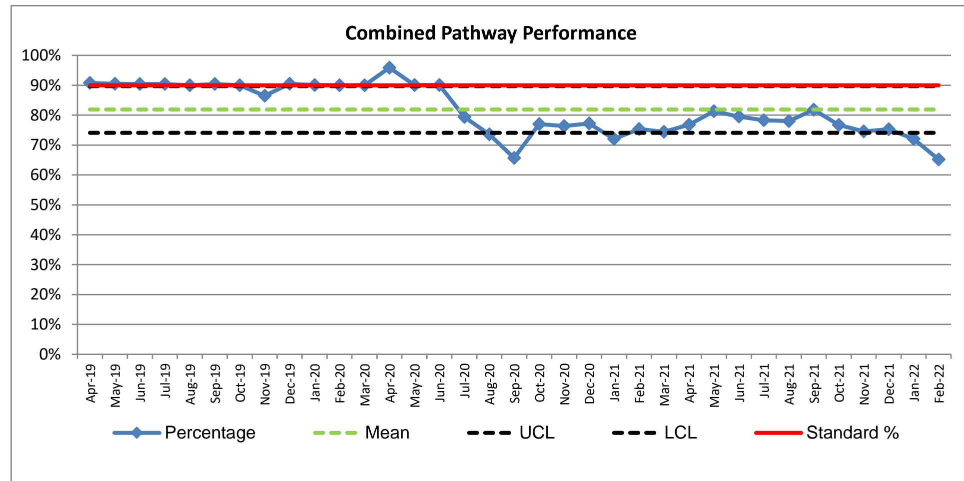
[1] Data unavailable at time of reporting.

18 Weeks Referral to Treatment (RTT)

Standard: Combined Pathway Performance	Standard: 90.0%

Latest NHS Scotland Performance	Tolerance
74.9% (Sep2021)	81.0%

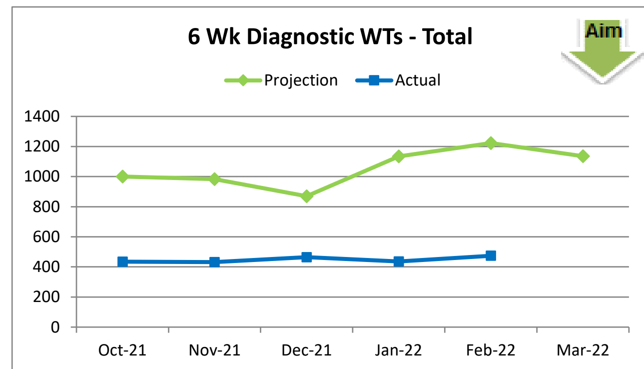
Actual Performance (higher % = better performance)

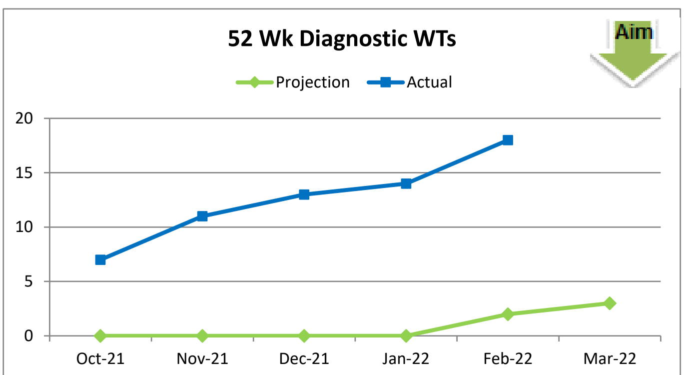


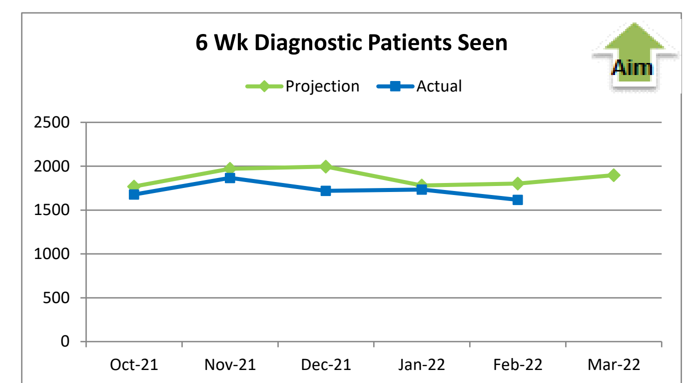
Please Note: data has a 1 month lag time to ensure it is in line with national reporting

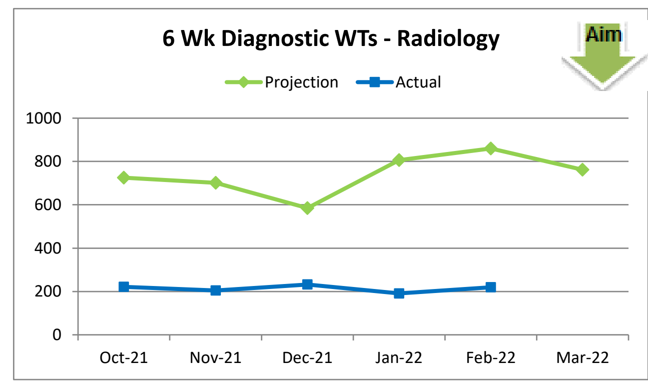
Remobilisation Plan 4

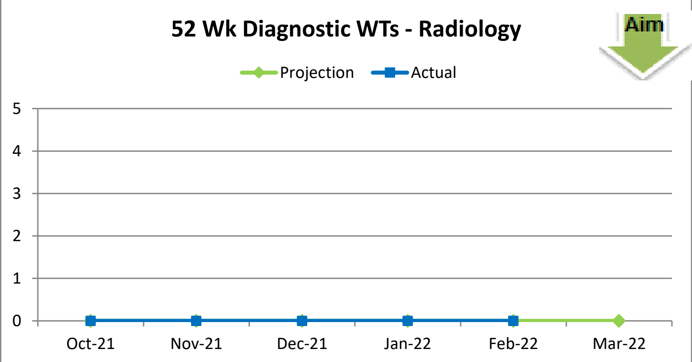
Diagnostics Detail

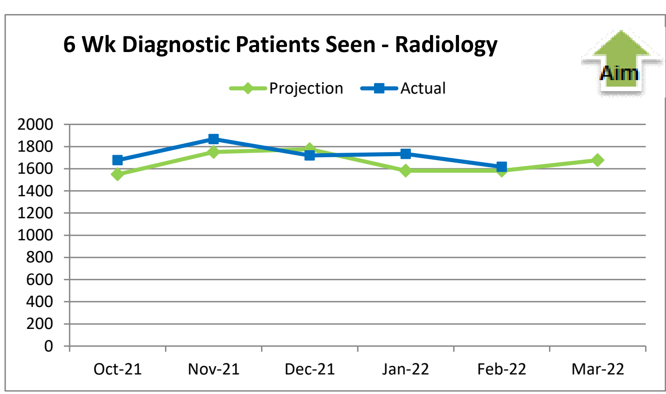


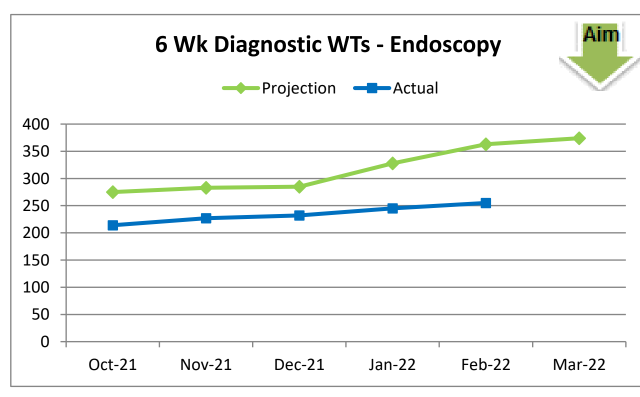


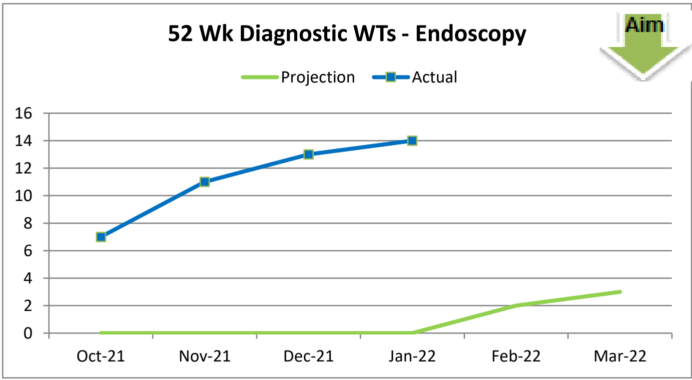


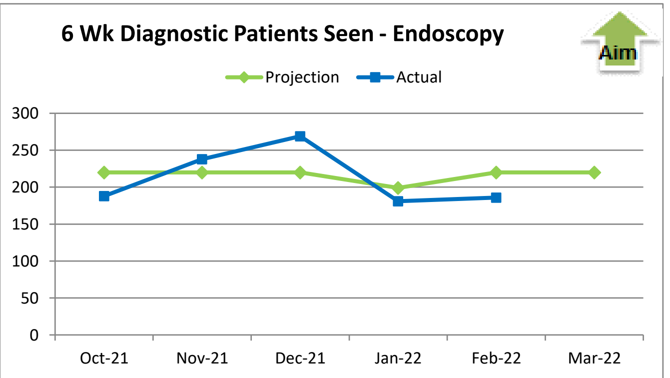








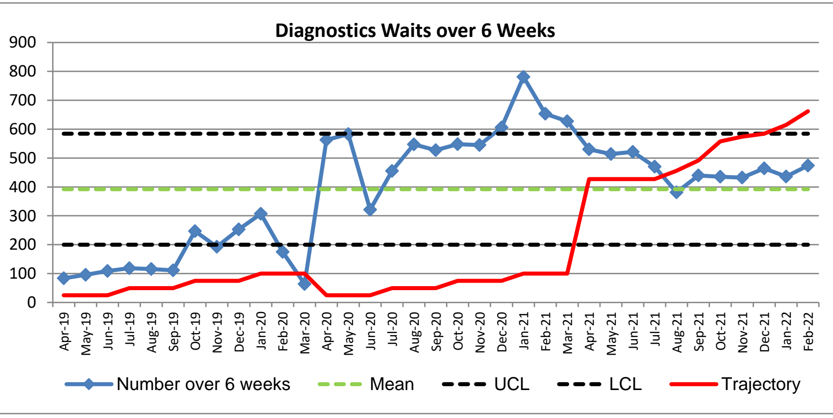




Diagnostic Waiting Times

Waiting Target for Diagnostics - zero patients to wait over 6 weeks	Trajectory 574
	Tolerance 631

Actual Performance (lower = better performance)

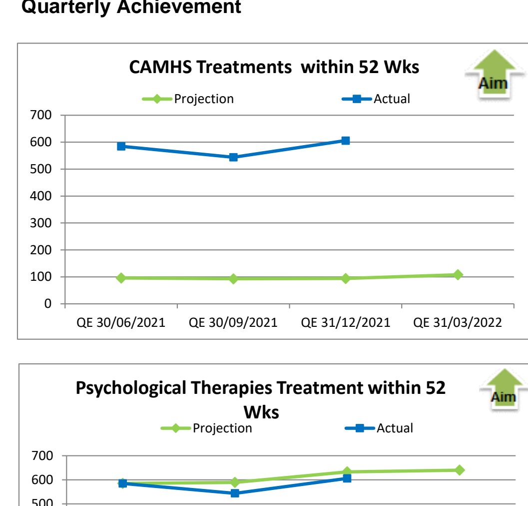


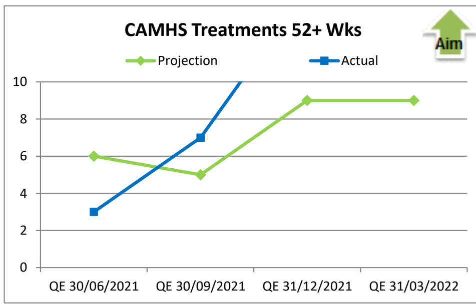
The national standard is that no patient waits more than 6 weeks for one of a number of identified key diagnostic tests. The breakdown for each of the 8 key diagnostics tests is below:

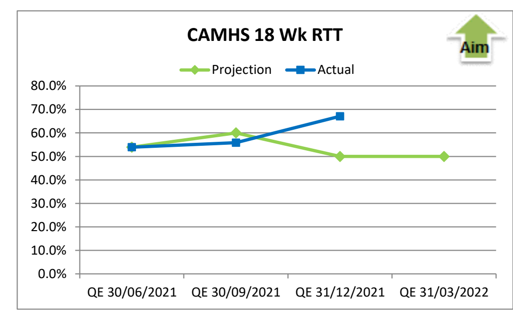
6 weeks	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Endoscopy	118	123	132	152	155	168	173	180	190	197	198	
Colonoscopy	50	43	39	43	26	31	34	37	39	45	43	
Cystoscopy	17	27	23	20	5	3	7	10	3	3	14	
MRI	77	127	143	90	27	17	18	27	49	29	51	
CT	168	138	151	137	107	130	92	91	103	58	51	
Ultra Sound (non-obstetric)	100	56	31	28	54	88	108	80	75	103	117	
Barium	0	0	2	0	7	3	3	7	5	1	0	
Total	**530**	**514**	**521**	**470**	**381**	**440**	**435**	**432**	**464**	**436**	**474**	

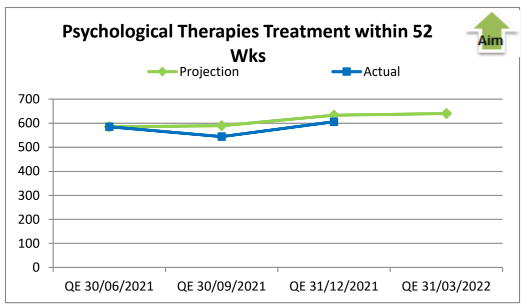
Remobilisation Plan 4 - Mental Health Waiting Times

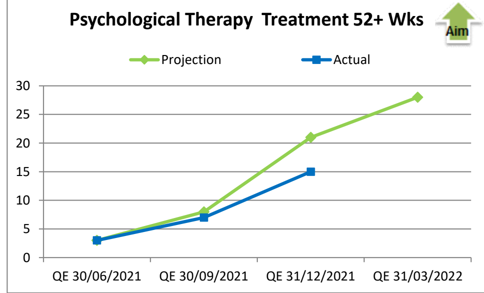
Quarterly Achievement

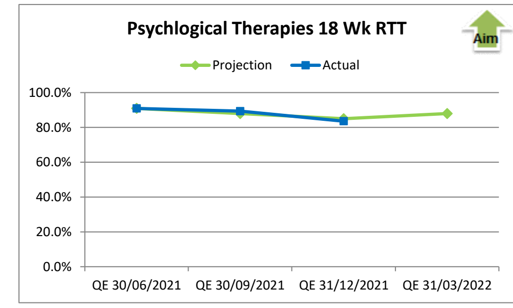










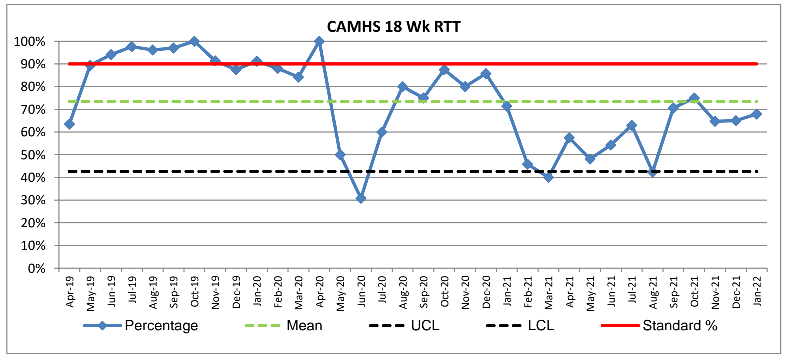


CAMHS Waiting Times

	Standard
18 weeks CAMHS - 18 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (90%)	90.0%

Latest NHS Scotland Performance	Tolerance
78.6% (Jul - Sep 2021)	81.0%

Actual Performance (higher % = better performance)

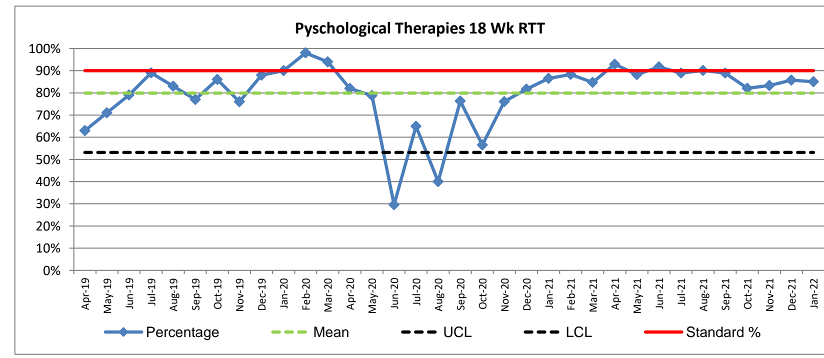


Psychological Therapies Waiting Times

	Standard
Standard: 18 weeks referral to treatment for Psychological Therapies	90.0%

Latest NHS Scotland Performance	Tolerance
87.2% (Jul - Sep 2021)	81.0%

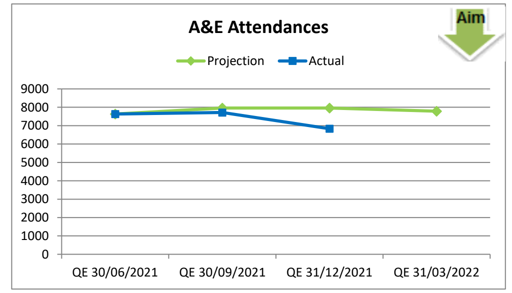
Actual Performance (higher % = better performance)

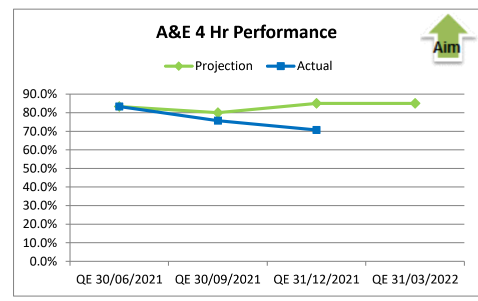


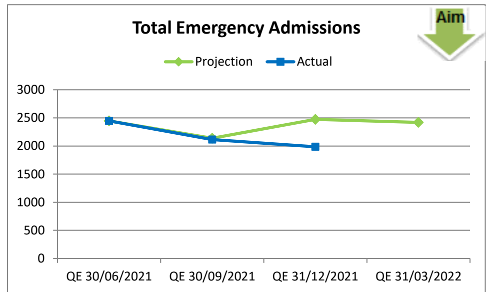
Please Note:
From Sep 2019 data includes all PT Services
Renew, the Primary Care PT Service started in October 2020.

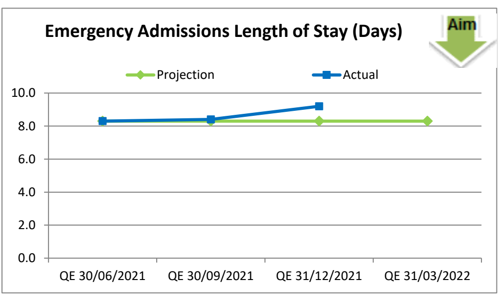
Remobilisation Plan 4

Quarterly Achievement









Accident & Emergency 4 Hour Standard

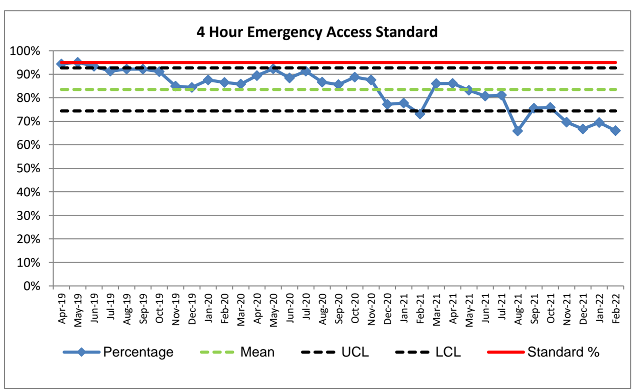
4 hour A&E - 4 hours from arrival to admission, discharge or transfer for A&E treatment (95%)

Standard
95.0%

Latest NHS Scotland Performance
75.7% (December 2021)

Tolerance
85.5%

Actual Performance (higher % = better performance)



Emergency Access	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Flow 1	97.8%	98.3%	97.6%	96.8%	96.0%	98.9%	97.7%	96.8%	97.3%	97.0%	95.6%	
Flow 2	79.7%	78.3%	73.9%	77.0%	66.2%	72.5%	75.7%	70.1%	70.2%	70.3%	66.7%	
Flow 3	81.2%	71.9%	67.6%	61.4%	29.4%	47.9%	49.5%	40.0%	28.6%	38.3%	25.1%	
Flow 4	78.5%	75.6%	65.5%	74.0%	53.8%	53.6%	54.4%	48.1%	49.5%	52.7%	49.7%	
Total	**86.1%**	**83.2%**	**80.7%**	**81.1%**	**65.9%**	**75.6%**	**75.9%**	**69.6%**	**66.7%**	**69.5%**	**66.0%**	

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

A&E Unplanned Attendances

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	2284	2478	2547	2667	2274	2383	2354	2217	2264	2142	2203	
2020/21	1511	1928	2176	2450	2538	2496	2179	2135	1857	1824	1702	2031
2019/20	2792	2834	2834	2918	2917	2761	2714	2673	2739	2668	2316	1901

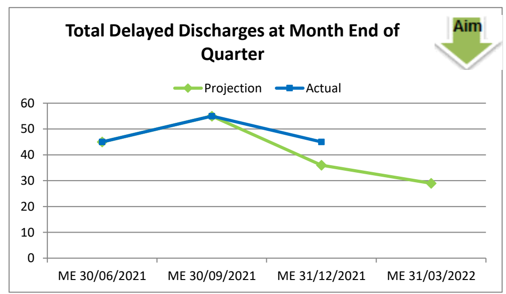
Note: ED Significant Facility 32 opened December 2020 & from this point ED unplanned attendances only included.

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.

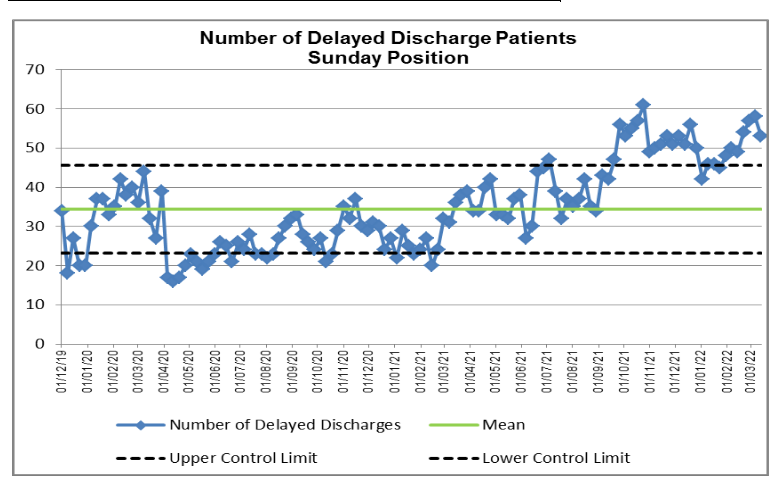
Remobilisation Plan 4 - Delayed Discharges

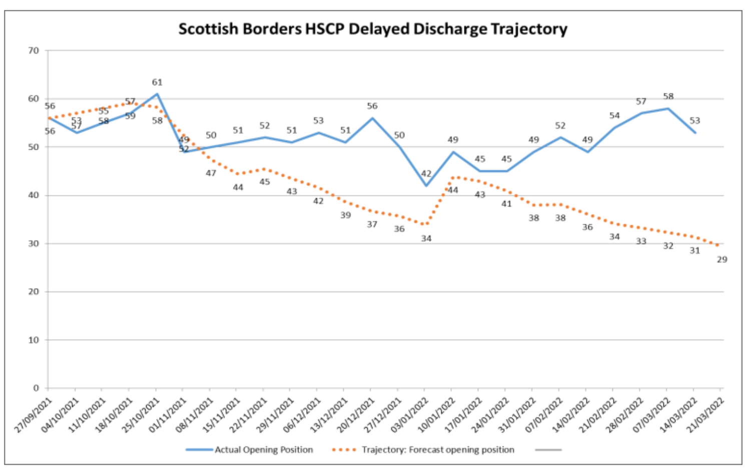
Quarterly Achievement



Delayed Discharges

Target: Delayed Discharges - all Delays





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	As at 30/09/21	As at 28/10/21	As at 25/11/21	As at 30/12/21	As at 27/01/22	As at 24/02/22
Standard Cases	29	36	39	27	32	54	51	43	39	34	43
Complex Cases	2	2	3	3	0	1	4	4	6	9	13
Total	**31**	**38**	**42**	**30**	**32**	**55**	**55**	**47**	**45**	**43**	**56**

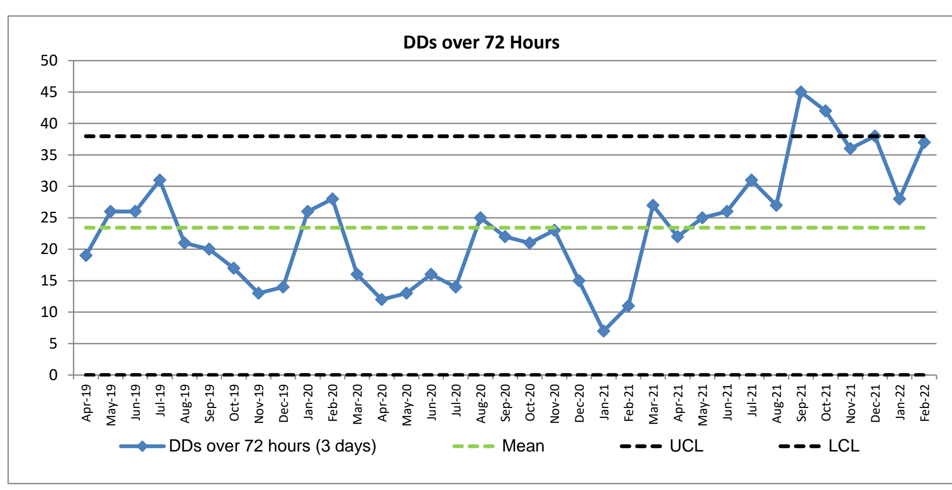
Delayed Discharges Discharged in February 2022

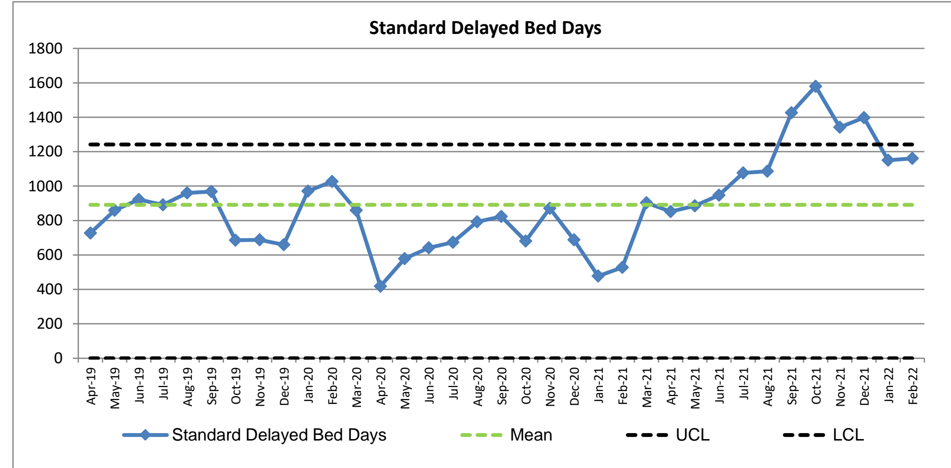
Reason for Delay	Cases	Average LoS
1. Assessment	5	14.2
2. Waiting Residential Home	8	39.3
3. Waiting Nursing Home	12	40.0
4. Waiting Care Arrangments to go Home	16	9.9
5. Patient and family related reasons	0	0.0
6. Complex	3	21.0
Total	**44**	**24.7**

Delayed Discharges - Continued

Standard: Delayed Discharges - delays over 72 hours	**Standard** 0	**For Information:** Delayed Discharges - standard delayed bed days
	Tolerance 1	

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).

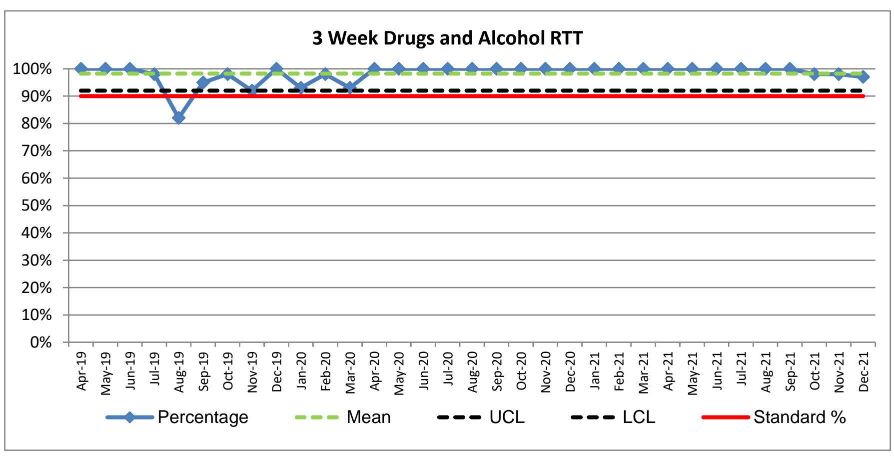
The trajectory noted here was the one previously agreed for patients over 72 hours. Please see the next page for the total delays trajectory agreed with SG this month. That will be used going forward.

Drug & Alcohol Treatment

Standard: Clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery	Standard
	90.0%

Latest NHS Scotland Performance	Tolerance
95.6% (Jan - Mar 2021)	81.0%

Actual Performance (higher % = better performance)



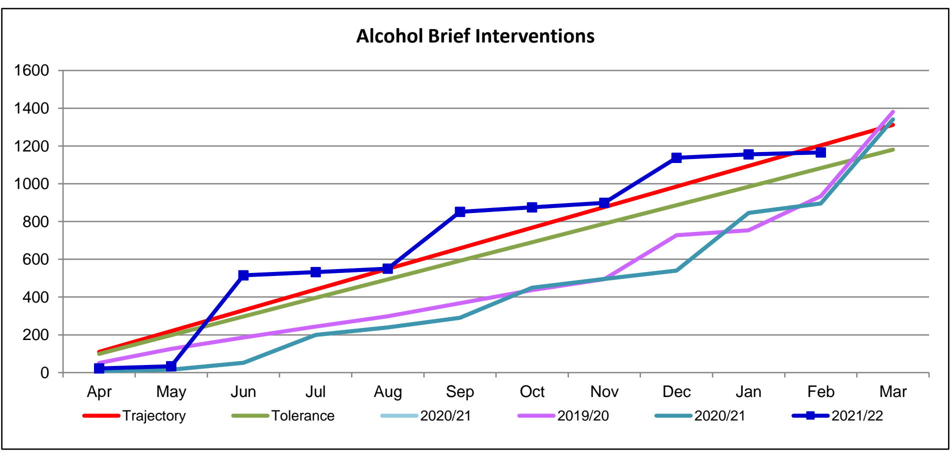
Note: Updates provided Quarterly

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
	1312

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)	Tolerance
123.8% (2019/20)	105.3% (2019/20)	within 10%

Actual Performance (higher = better performance)



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.

Sickness Absence

Standard: Maintain Sickness Absence Rates below 4%

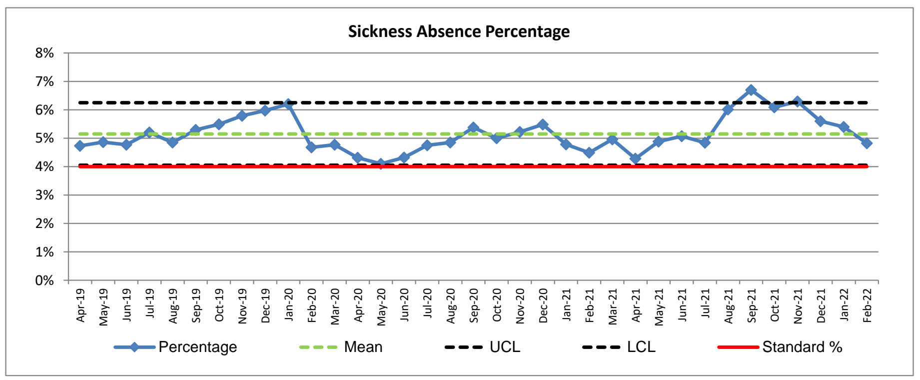
Standard
4.0%

For information: Covid Absence Rates

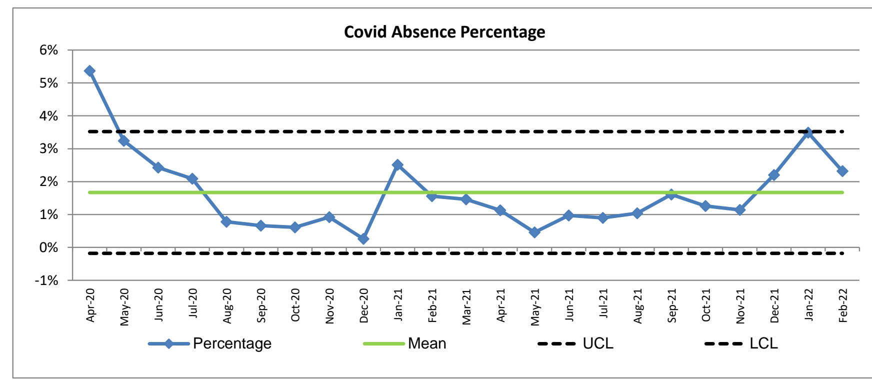
Latest NHS Scotland Performance
4.67% (2020/21) [1]

Tolerance
4.4%

Actual Performance (lower % = better performance)



Actual Performance (lower % = better performance)



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

Smoking Quits

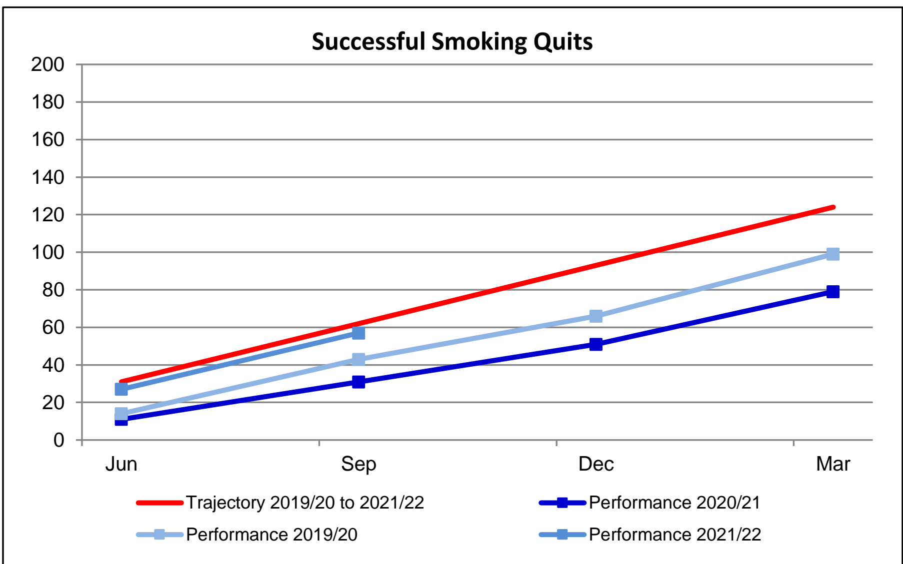
Standard
124

Standard: Sustain and embed successful smoking quits, at 12 weeks post quit, in the 40% most deprived SIMD areas

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

Tolerance
within 10%

Actual Performance (higher = better performance)



[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:	**7 April 2022**
Title:	**Redress Scheme for survivors of historical abuse in residential care in Scotland – Acknowledgement of the harms of the past**
Responsible Executive/Non-Executive:	**Ralph Roberts, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Emerging issue

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

All 22 NHS Scotland Boards have formally confirmed their participation in the Redress scheme for survivors of historical child abuse in residential care settings in Scotland, under the provisions of the 2021 Act.

2.2 Background

The Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021 creates a Redress scheme for survivors of child abuse in relevant care settings (as defined within the Act to include a residential care facility including a hospital). The scheme seeks to acknowledge and provide tangible recognition of harm and its impact on survivors. It includes financial and non-financial redress for those who

wish to submit applications. Financial contributions to the scheme were sought from those organisations that were responsible for the care of children at the time of the abuse. Although the scheme relates to residential care settings before the 2004 Act which established the current structure of NHS Scotland health boards, all boards agreed to contribute.

2.3 Assessment

In establishing the Scheme, it was recognised that financial redress was only one aspect of acknowledging past harm within care settings for vulnerable children in Scotland. In addition to financial contributions, to be publicly listed as a contributor to the Scheme, each NHS Scotland Health Board must publicly acknowledge the wrongfulness of historical child abuse, and the harm that abuse caused to survivors.

Contributors to the scheme will also be required to report to Ministers annually. As specified in the Act, this redress report must include information about any support the organisation provided for individuals who were abused as children; for example, advice and assistance on accessing historical records.

2.3.1 Quality/ Patient Care

As per the Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021

2.3.2 Workforce

As per the Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021

2.3.3 Financial

As per the Redress Scheme.

2.3.4 Risk Assessment/Management

As per the Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

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 groups as part of its development.

- Board Private meeting: 3 February 2022

2.4 Recommendation

The Board is asked to note the report.

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Letter from Chair, Board Chief Executives to Deputy First Minister: 14.03.22
- Appendix No 2, Letter from Deputy First Minister to Chair, Board Chief Executives: 30.03.22

NHS Board Chief Executives
Executive Support Team
Gyle Square
1 South Gyle Crescent
EDINBURGH
EH12 9EB
nss.nhsscotlandexecsupport
@nhs.scot

Deputy First Minister
Scottish Government
St. Andrews House
Regent Road
Edinburgh
EH1 3DG

Date 146March 2022

Enquiries to Ralph Roberts
Direct Line
Email Ralph.Roberts@borders.scot.nhs.uk

Dear Deputy First Minister,

Redress Scheme for survivors of historical abuse in residential care in Scotland – Acknowledgement of the harms of the past

I write on behalf of NHS Scotland Boards to formally confirm that all 22 Boards have committed to participating in the redress scheme for survivors of historical child abuse in residential care in Scotland via the Redress Payments Determined approach.

We understand that in order to be publicly listed as a scheme contributor, and therefore be included in the waiver provisions, organisations must both contribute a fair and meaningful financial contribution and provide the acknowledgement required by section 14 of the Act.

We acknowledge the wrongfulness of historical child abuse, and the harm this caused to survivors. We offer our full and sincere apologies to anyone who suffered harm and abuse while in the care of NHS Scotland.

We, as Scotland's NHS Boards, recognise that this scheme seeks to acknowledge and provide tangible recognition of past harm, and its impact on survivors. Participation in the redress scheme is a practical part of our national apology to children who suffered harm while in NHS care.

Further, we recognise that financial redress is only one aspect of acknowledging past harm within care settings for vulnerable children in Scotland.

I hereby confirm in writing that all 22 NHS Scotland Health Boards (detailed below) agree to contribute. Boards will pay for their share of all cases allocated to them, which names an institution ran by them as a relevant care setting.

All 22 of Scotland's NHS Boards are fully committed to supporting the Redress Scheme. By contributing to the Scheme, we are setting out the commitment from NHS Scotland to support survivors and take steps to provide some redress for past trauma.

We therefore commit to living our values of care and compassion by pledging to be open, transparent and caring in how we engage with anyone who was in the care of NHS Scotland and who makes an application for a redress payment.

Yours sincerely

Ralph Roberts
Chief Executive, NHS Borders
Chair, NHS Scotland Board Chief Executives

All 22 NHS Scotland Health Boards have agreed to participate in the redress scheme:

NHS 24
NHS Ayrshire and Arran
NHS Borders
NHS Dumfries and Galloway
NHS Fife
NHS Forth Valley
NHS Golden Jubilee
NHS Grampian
NHS Greater Glasgow and Clyde
NHS Healthcare Improvement Scotland
NHS Highland
NHS Lanarkshire
NHS Lothian
NHS National Education Scotland
NHS National Services Scotland
NHS Orkney
NHS Shetland
NHS Tayside
NHS Western Isles
Public Health Scotland
Scottish Ambulance Service
The State Hospital

An Leas-phrìomh Mhinistear agus Ath-shlànachadh Cobhid
Deputy First Minister and Cabinet Secretary for Covid Recovery
John Swinney MSP

T: 0300 244 4000
E: dfmcscr@gov.scot

Ralph Roberts
Chief Executive, NHS Borders
Chair, NHS Scotland Board Chief Executives

30 March 2022

Dear Ralph

Thank you for your letter of 16 March, in respect of the Redress Scheme for survivors of historical abuse in residential care in Scotland – Acknowledgment of the harms of the past.

I am writing to confirm my acceptance, of your proposal to join the scheme on the Redress payments determined model, with an initial payment of £100,000, and a commitment to contribute up to two thirds, or £10,000 (whichever is greater), to every Redress payment which is considered to be relevant to NHS Scotland Boards. I accept this as a fair and meaningful contribution under Section 14 of The Redress for Survivors (Historical Child Abuse in Care) (Scotland) Act 2021, and welcome the participation of all twenty two of Scotland's NHS Boards in Scotland's Redress Scheme.

Many of Scotland's most vulnerable children in care in the past were failed. Facing up to our collective legacy requires us to address those failures together. While we know that no redress scheme can ever make up for the suffering which survivors of childhood abuse endured, it is essential that we now make our very best efforts to respond to those who were harmed, and this redress scheme is a vital element of that response.

While the financial element of redress is important, our redress scheme looks beyond that form of recognition and requires all of us to reflect on what went wrong in the past, and to consider what we can all do today to make sure our children in care are looked after as well as possible.

Please extend my thanks to all NHS Boards for their commitment to participate in Scotland's Redress Scheme. My officials will be in touch shortly to ensure all the necessary steps are taken to include NHS Boards on the Contributor list.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.gov.scot

Yours Sincerely,

JOHN SWINNEY

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Scheme of Integration Refresh**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary** **Hayley Jacks, NHSB Planning & Performance Officer**

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 NHS Scotland quality ambition(s):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This report proposes an updated Scheme of Integration in line with NHS Borders obligations under the Public Bodies (Joint Working) (Scotland) Act 2014.

The Scottish Borders Scheme of Integration is a legally binding agreement between the NHS Borders and Scottish Borders Council. The Scheme of Integration defines the scope of the Integration Joint Board, and Health and Social Care Partnership, along with the supporting arrangements to ensure the integrated planning and delivery of certain Social Care, Social Work and Health Services.

In line with the practice for all Local Authorities and Health Boards, the Scottish Borders Council and NHS Borders are legally required to review, revise and publicly consult on the Scheme of Integration every 5 years.

Given the current pandemic pressures placed on both social care and health services, and the future national implications of the National Care Service, Health Boards and Local Authorities have been advised by the Scottish Government that a light touch review of their local Scheme of Integration is appropriate. As a result, this approach has been adopted by NHS Borders and the Scottish Borders Council.

In undertaking a light touch review, no major changes to the existing Scheme of Integration were identified. Changes within the scheme relate to updating the content to reflect the current context in each area, as opposed to the context in 2018, in order to ensure that it continues to comply with relevant legislation and policies.

The national development of the National Care Service and the associated Community Health and Social Care Boards is currently 'a known unknown.' As a result, at this time no changes were required to be made to the Scheme of Integration as a result of this. Once there is further clarity on the scope and the local implications, an update to the Council will be provided.

A range of stakeholders were contacted to advise them of the launch of the light touch review consultation and how to access it via Scottish Borders Council's Citizen Space.

We received 30 responses from this consultation, with feedback summarised within the report. All feedback will be acted upon.

Changes to the Scheme of Integration are noted in Appendix 3 (Section 4.7.4 was included in the consultation in error as it did not have any amendments made to it) and the revised Scheme of Integration is included within Appendix 4.

2.2 Background

The Public Bodies (Joint Working) (Scotland) Act 2014 requires each Health Board and corresponding Local Authority to have an Integration Scheme in place. The 'Scheme' sets out the integration model, the delegated functions, the financial arrangements and budget for the functions. The legislation also requires the Local Authority and Health Board to review the Integration Scheme.

The Scottish Borders Scheme was approved in 2015 and amendments were made in 2017/18 to reflect the implementation of the Carers (Scotland) Act 2016.

Recent Government guidance states that whilst there is no need for Health & Social Care Partnerships to produce a successor Scheme, Health Boards and Local Authorities should ensure that they jointly carry out a review of the existing Scheme and that the review be acknowledged jointly and formally. The guidance stated that even if changes are considered to be minor or 'technical', including changes to tense and tone that these changes must still be consulted on, prior to submission of the revised Scheme to Scottish Ministers for approval (Appendix 1).

The Scottish Borders Integration Scheme has been reviewed. The 'light-touch' review identified no major changes to the existing Scheme of Integration. The changes made

relate to updating the existing content to better reflect the current context. The remainder of this paper details the work that has been undertaken and the changes made.

2.3 Assessment

At its September 2021 meeting, the Health & Social Care Integration Joint Board approved the timeline for the review of the Scottish Borders Integration Scheme and agreed that this work be taken forward through the Strategic Planning Group. Scottish ministers expect that the review is completed and returned by 31 March 2022.

The 2014 Act details the consultation requirement for reviewing the Integration Scheme. The views of consultees should be sought on whether changes to the Scheme are necessary or desirable as well as on any proposed changes. Similarly the recent Government guidance stressed the importance of stakeholders being given the opportunity to provide feedback on any issues they wish to raise and not just the proposed changes.

An online consultation on the Scheme was undertaken over a six-week period between 18th January - 28th February 2022 (using Scottish Borders Council's consultation and Survey Hub Citizen Space).

The consultation responses were collated and a summary report of the responses is included under Appendix 2. A summary of the changes made to the Scheme are shown in Appendix 3.

In response to the proposed updates made to the Scottish Borders Scheme of Integration, these were generally welcomed and accepted by those who responded. One area of change relating to the Targets and Performance section received some confliction and comments made would infer that the wording of the refresh to that section were inadequate. All comments and feedback in relation to the review will be addressed and acted upon accordingly.

Respondents were also invited to comment on the performance of the Scottish Borders Health & Social Care Partnership as noted in Appendix 2. Feedback received regarding operational services, ranging from GP practices to Care and Dental Services, have been collated and will be fed back to the services concerned. Communications to respondents regarding feedback received will be made via the appropriate channels and to individuals where contact details were made available as part of the consultation participation.

The full updated Scottish Borders Integration Scheme is appended in Appendix 4.

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

There are no costs attached to any of the recommendations contained in this report.

2.3.4 Risk Assessment/Management

The 2014 Act requires Health Boards and Local Authorities to carry out a review of Integration Schemes. Failure to do so would breach the legislation. 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 impact assessment has not been completed because an assessment is being undertaken to understand whether there is a need for a HIIA to be completed for this piece of work. Should it be deemed necessary, it will be being carried out on the Scheme of Integration in conjunction with key stakeholders and brought back to the Board for noting when complete.

2.3.6 Other impacts

The development of a National Care Service is currently 'a known unknown,' and once we have further clarity on the scope and local implications of that, an update to the Council and Health Board will be provided.

2.3.7 Communication, involvement, engagement and consultation

A range of stakeholders were contacted to advise them of the launch of the light touch review consultation and how to access it 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
- Senior Leadership Team Scottish Borders Council

In addition, there has been parallel consultation undertaken with the Scottish Borders Council Strategic Leadership Team in line with the joint responsibility placed on NHS Borders in jointly preparing an integration scheme with Scottish Borders Council under the Public Bodies (Joint Working) (Scotland) Act 2014.

2.3.8 Route to the Meeting

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

- Non Executives: 16 March 2022

2.4 Recommendation

This report was approved by the Board via email by 31 March 2022.

This report was approved by Scottish Borders Council on 31 March 2022.

Borders NHS Board is asked for **formally record its agreement** as reached via email by 31 March 2022 as per below:

Borders NHS Board is asked to **note** the process undertaken and the findings.

Borders NHS Board is asked to **approve** the enclosed reviewed and updated Scottish Borders Scheme of Integration.

Borders NHS Board is asked to **agree** that the updated Scheme of Integration be submitted to Scottish Ministers for approval.

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Note to IJB Chief Officers from Scottish Government
- Appendix No 2, Scheme of Integration refresh consultation results
- Appendix No 3, Table of amendments
- Appendix No 4, Revised Scheme of Integration

Mental Wellbeing and Social Care Directorate
Governance, Evidence & Finance Division

Donna Bell
Director, Mental Wellbeing and Social Care Directorate
E: donna.bell@gov.scot

IJB Chief Officers
Health Board Chief Executives
Local Authority Chief Executives

19 August 2021

Dear IJB Chief Officers,
Health Board Chief Executives,
Local Authority Chief Executives,

Review and revision of Integration Schemes

We recently wrote to IJB Chief Officers, asking for updates on Integration Scheme reviews and the creation of revised Schemes.

I would like to thank Chief Officers and their colleagues for taking the time to respond to this request and for all the work that has gone into the various reviews that have recently and are currently taking place. I would also like to thank the areas who have already prepared and submitted a revised Integration Scheme for approval. I am particularly grateful given the signicant pressures you all face as we continue to respond and recover from COVID-19.

In light of some of the responses received, I wanted to write to provide an update on the Scottish Government's expectations for the Integration Scheme review and revision process and to ensure understanding across all three partners: IJBs, Health Boards and Local Authorities.

We will be making contact with individual areas directly to have more focussed discussions and to answer specific questions that were raised, but we feel it would be useful to cover the following points with all areas and partners. I would also encourage you to always seek advice from your own legal teams to ensure that your Integration Scheme review and revision processes adhere to the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

1. Requirements to review and revise an Integration Scheme

It has been made clear in previous advice to IJB Chief Officers in March 2020 and March 2021 (attached separately) that whilst the 2014 Act does not require Health Boards and Local Authorities to prepare a revised Integration Scheme it does require them to carry out a review and then prepare a revised Scheme if desirable or necessary. This was why we

advised that reviews could be carried out to fulfil the legislative requirements of the 2014 Act with any consequent work being carried out at a later date. This advice was to reflect the tremendous pressures that health and social care services have been under as we have responded to COVID-19, which made it extremely difficult to prioritise this work.

Whilst we still face pressures as we continue to respond and recover from the pandemic, **it is now essential that this further work identified in these reviews is started, or continued, at pace**, whether that means carrying out a further, more comprehensive review and/or preparing a revised Integration Scheme. Whilst amendments to Integration Schemes were made in 2017/18 to reflect the implementation of the Carers (Scotland) Act 2016, many of the Schemes in place have not been comprehensively reviewed with a full consultation since they were first approved in 2015. Reviews need to take place to ensure that Integration Schemes reflect any changes that have occurred since they were last approved and to ensure that stakeholders are involved in determining the arrangements of integrated health and social care services for their areas.

Unless you have recently submitted a revised Integration Scheme for approval or a comprehensive review with a consultation has been carried out since 2015 (and so a review is not due within the next year), **I would ask that each area provide us with a timeline for when they plan to carry out their Integration Scheme reviews, consultations and revisions.** This will allow us to keep track of local plans and progress and will ensure we can provide the necessary support where required. Timelines can be provided to the Scottish Government via Jack.Walker@gov.scot and Jenny.Nolan@gov.scot. I appreciate that some initial work may need to be undertaken before these timelines can be produced, but I would ask that you make every effort to provide them by the end of September 2021.

2. Requirements to consult

The 2014 Act sets out the requirements for carrying out consultations when reviewing and revising Integration Schemes. The views of consultees must always be sought on whether changes to the Integration Scheme are necessary or desirable as well as on any proposed changes, even if changes are not initially deemed necessary. These views must be taken into account along with any other issues consultees wish to raise. Your own legal advisors will no doubt be able to provide you with more detailed advice on these requirements.

It is essential that stakeholders are always given the opportunity to provide feedback on *any* issues they wish to raise with regards to the Integration Scheme and not just the proposed changes. This is to ensure that integrated services can be planned and led locally in a way which is engaged with the community, as per the integration planning and delivery principles. This also ensures that the review and revision of an Integration Scheme is not solely led by the small number of people involved in the IJB, Health Board and Local Authority but rather by the population that will be affected by the Schemes.

The prescribed stakeholders who must be consulted are set out in The Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014, with detailed guidance on community engagement and participation for NHS Boards, IJBs and Local Authorities being found in Planning with People.

3. Defining a revised Integration Scheme

If, following a review and consultation, *any* changes to the Integration Scheme are needed or desirable then a revised Integration Scheme must be formally prepared, consulted on and submitted to Scottish Ministers for approval. This includes changes considered to be ‘minor’

or ‘technical’, including changes to tense and tone. Once a revised Scheme has been prepared and consulted on, it can be submitted to Scottish Ministers for approval via Jack.Walker@gov.scot and Jenny.Nolan@gov.scot. Before submitting the revised Scheme for approval, I would encourage you to always seek advice from your own legal teams on the content of the Scheme to ensure it fulfils the requirements of the 2014 Act.

If no changes are identified within your Integration Scheme then confirmation of the completed review, including relevant consultation, should be forwarded to the Scottish Government for our records via the contacts listed above.

4. Implications of the National Care Service (NCS) and wider reform of social care

Understandably questions have been raised regarding the need to review and revise Integration Schemes given the consultation that has now been published on the establishment of a NCS and potential reform of social care and integrated services. At this stage, we envisage the arrangements for the NCS being in place by the end of this Parliamentary term; equivalent to a full lifetime for an Integration Scheme. It is essential therefore that work begins, or continues, at pace to review and revise Integration Schemes as quickly as practicable. As above, this is not just to adhere to legislative requirements, but also to ensure that where needed, Integration Schemes are updated to reflect the inevitable changes that have occurred since they were last approved and to reflect the changes to the population’s needs and preferences.

I hope these points are helpful and offer further clarity on the process that the legislation sets out. As noted above, we will be making contact with individual areas in the near future but, should you have any questions in the meantime, please do get in touch.

With Kind Regards,

Donna Bell

Donna Bell

Scheme of Integration 2022 Consultation

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

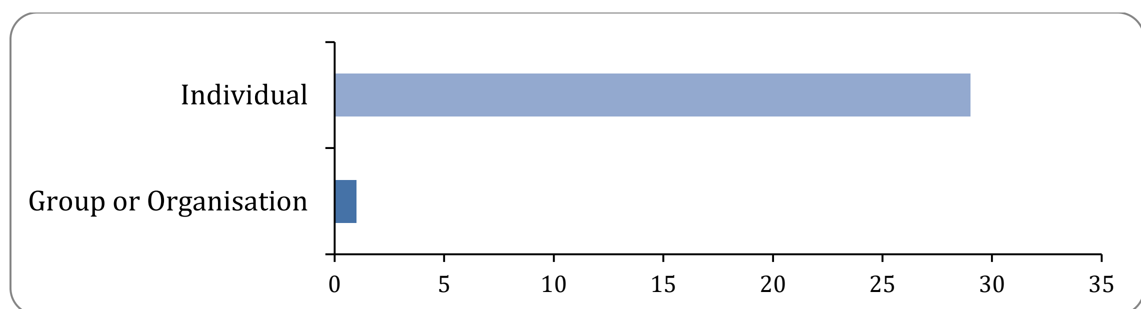
This report was created on Tuesday 01 March 2022 at 11:47

The activity ran from 18/01/2022 to 28/02/2022

Responses to this survey: **30**

How are you responding to this Scheme of Integration consultation?

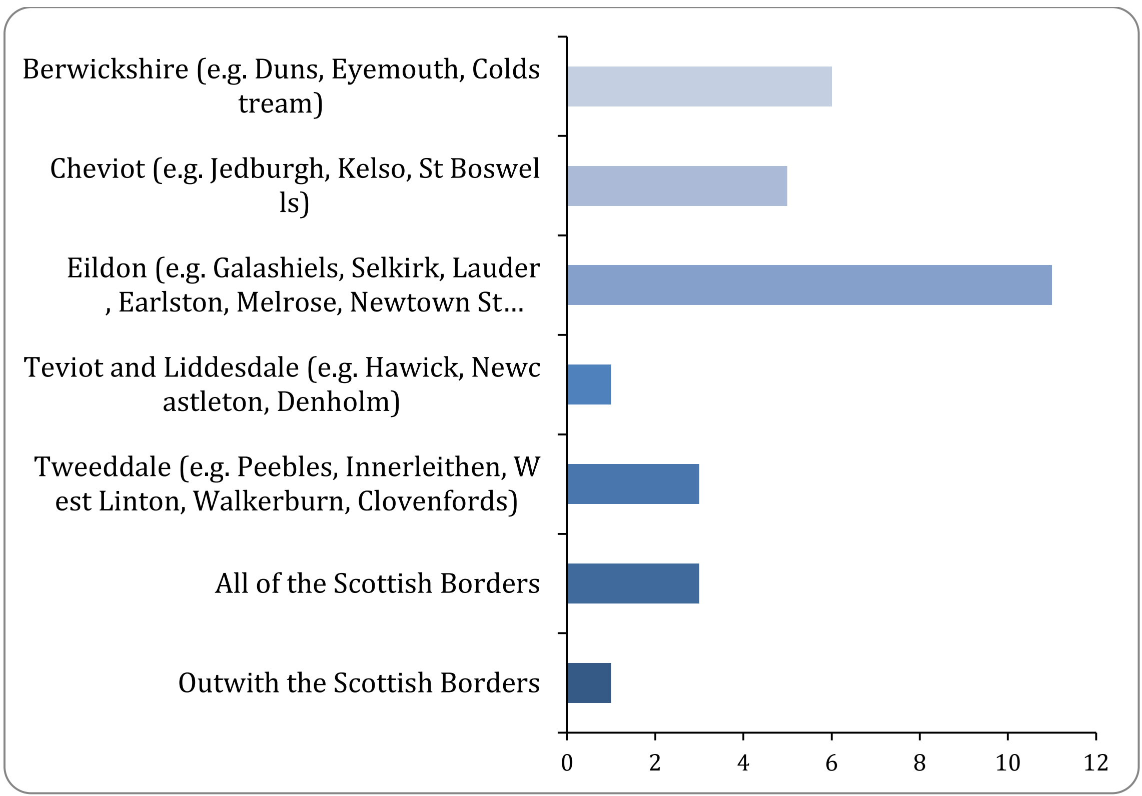
There were 30 responses to this part of the question.



Option	Total	Percent
Individual	29	96.67%
Group or Organisation	1	3.33%
Not Answered	0	0.00%

Which locality in the Scottish Borders are you based?

There were 30 responses to this part of the question.



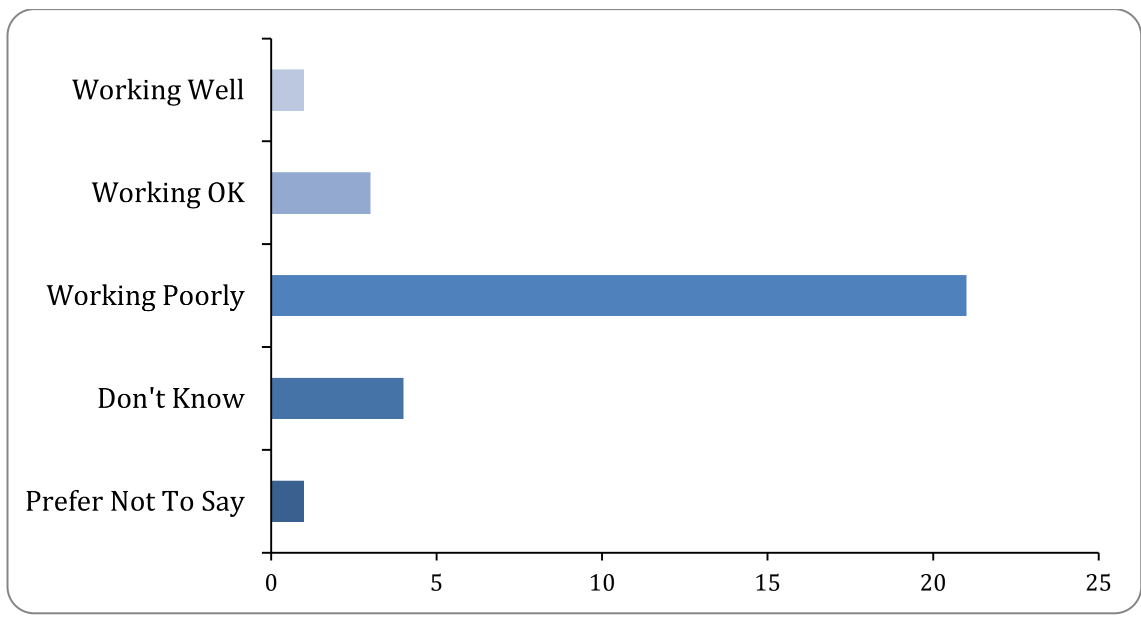
Option	Total	Percent
Berwickshire (e.g. Duns, Eyemouth, Coldstream)	6	20.00%
Cheviot (e.g. Jedburgh, Kelso, St Boswells)	5	16.67%
Eildon (e.g. Galashiels, Selkirk, Lauder, Earlston, Melrose, Newtown St Boswells)	11	36.67%
Teviot and Liddesdale (e.g. Hawick, Newcastleton, Denholm)	1	3.33%
Tweeddale (e.g. Peebles, Innerleithen, West Linton, Walkerburn, Clovenfords)	3	10.00%
More than one locality (please specify below)	0	0.00%
All of the Scottish Borders	3	10.00%
Outwith the Scottish Borders	1	3.33%
Prefer Not to Say	0	0.00%
Not Answered	0	0.00%

If more than 1 locality, please detail.

There were 2 responses to this part of the question.

What do you think of Scottish Borders Health and Social Care?

There were 30 responses to this part of the question.



Option	Total	Percent
Working Well	1	3.33%
Working OK	3	10.00%
Working Poorly	21	70.00%
Don't Know	4	13.33%
Prefer Not To Say	1	3.33%
Not Answered	0	0.00%

Do you have any comments about your experience of Scottish Borders Health and Social Care?

There were 15 responses to this part of the question.

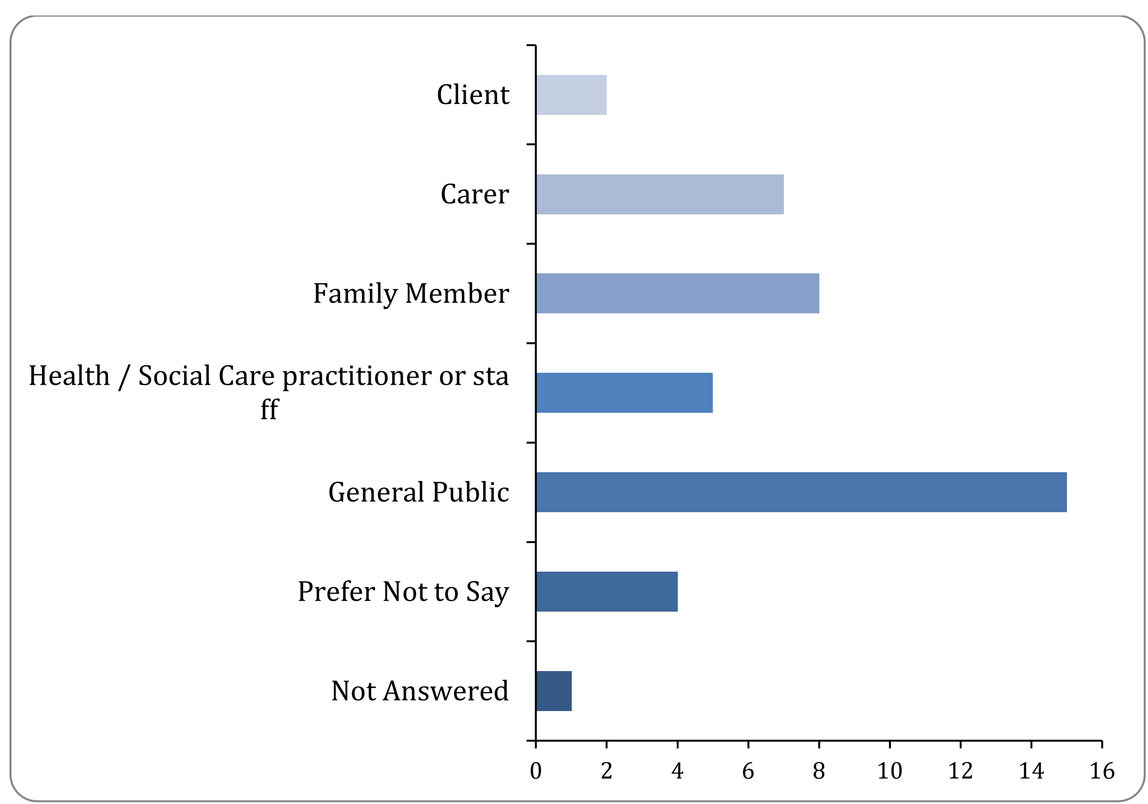
1	At a local level, dealing with local social work, it has been good - social workers understand the issues & needs of their clients. This level of support extends no further than the 'grass roots' though. In my experience, all levels above 'grass roots' have exhibited total unwillingness to listen and change, determinedly and doggedly pressing on with their own agenda, unwilling to accept that their strategy might be wrong, despite input from carers and carers representative groups. Personally & collectively (as part of a support group), I have been stonewalled, misled and patronised over a period of almost 3 years now. There are officers making decisions who it would seem have very little understanding of reality or the predicament of carers and those they care for. Recent changes in personnel at the IJB offer a chink of light but it is early days and in the meantime a significant amount of damage has been inflicted on carers and cared for by bloody minded officials. Change, accountability and a genuine willingness to listen (as opposed to

	box ticking and lip service) is desperately needed.
2	Continually asking for meetings to try and alleviate the issues with staffing so we can work geographically this has still not happened
3	Day care services for disabled young adults is very limited. As is respite for same. Residential care homes in the Borders are few and far between.
4	During the period of the pandemic the services available have not been as positive as in the past and it is hoped the service level will return as soon as possible but it would seem there re other hurdles to overcome in particular recruitment.
5	Haven't found a National health dentist since we moved her last July! Still using one in Corbridge!
6	it is slow to respond to matters, is 9-5 based and out of hours service lacks depth and range of knowledge needed to respond to emergency support requests
7	Lack of liaison between relevant departments and unawareness of procedures and liminations, and tendency to rely on apologies rather than evidence of real determination to find satisfactory solutions.
8	NHS is under pressure due to lack of social care availability
9	Significant systemic capacity issues in the delivery of social work support for children and families - leading at times to unsafe and unsupported situations for children, YP and parents - difficultly recruiting and retaining social work staff. Cuts to education budget impacting on vulnerable and marginalised children and families. CAMHS completely overwhelmed by demand for a service - with the tariff for support and waiting list times becoming ever higher. School nurses working at above capacity - leading to reduced ability to support and respond to children/YP and families. Mental Health supports for people experiencing chronic difficulties and distress and/or addiction issues programme based and/or time limited interventions - issues being early discharge, relapse and 'behaviour based' programmes - rather than addressing some of the underlying cases of distress - such as poverty unresolved trauma. Gaps in services - particularly in relation to autistic children, YP and adults who are in distress, suicidal/risk of harm. Gaps in services for YP at risk of harming others - particularly in relation to sexual or GBV. Cuts in funding to community based Domestic Abuse services. Lack of clarity in relation to professional practice in supporting children and YP experiencing gender dysphoria.
10	Since covid 19 struck the services have dipped, lots of third sector services have been withdrawn instead of supported, so many people with poor physical and mental health have been let down badly.
11	There has been too much out sourcing of services resulting in difficulties and shortages. There are too few residential care and nursing homes in the borders offering quality care and there are no adequate day services with support for those with high levels needs which further isolates them from society and adds extra

	pressure onto their family. There is no alternatives to receiving direct payments for young adults with high level Autism and similar, resulting again in isolation for them and their families and lack of care options.
12	Very difficult to speak to a medical professional when calling the GP practice. Especially when during work hours, very limited with only able to make appointments if calling at 8:30am. Told to call only at 8:30am even if non emergency and wishing to schedule appointment in upcoming weeks. Since Coldingham doctors surgery closure, I feel that the pressures on Eyemouth practice are greater and the demand is higher. Services within Eyemouth need improved for the elderly who need to travel there for appointments and for the growing population within the area.
13	Very poor and extremely basic care. 1. No appointments available after 4.30pm. We need increase hours as for those who work is very difficult to find an appointment. 2. Very basic care! Paracetamol is the magic pill that sorts any kind of health problem 3. GP they think they can treat anything with pain killers and they are not willing at all to send the patient to further specialist investigations-save money comes first than save the patient. 4. An annual full check-up must be have anybody. I moved here 10 year ago and I never had a full check-up and when I asked the answer was: Why? 🙄 Well, it's easier to prevent that to treat!
14	Very short staffed. The staff they have are over worked and stressed due to the lack of support
15	What do they do, some people seem to get everything while others don't.

As an individual, what describes you? (Tick all that apply)

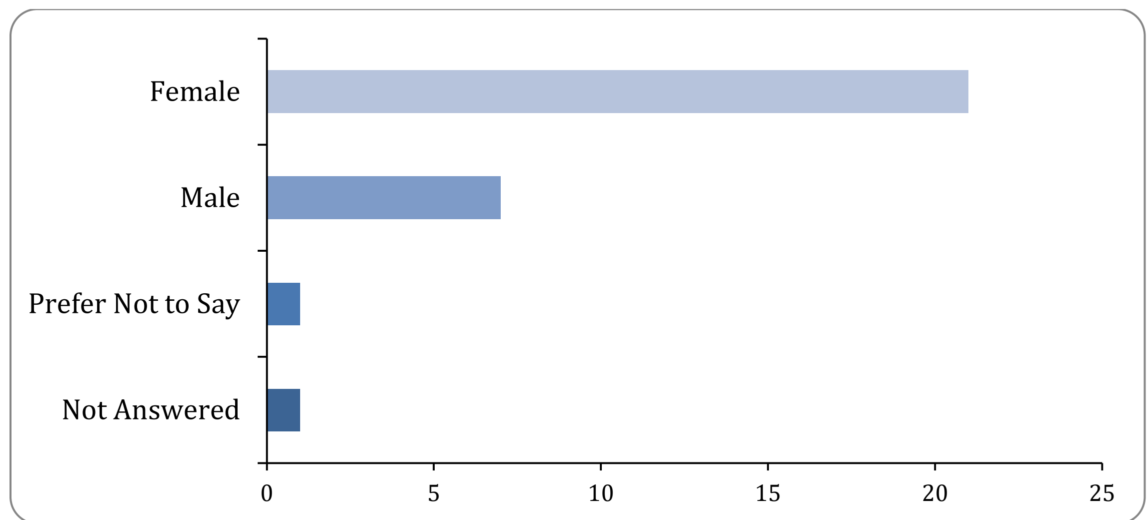
There were 29 responses to this part of the question.



Option	Total	Percent
Client	2	6.67%
Carer	7	23.33%
Family Member	8	26.67%
Health / Social Care practitioner or staff	5	16.67%
General Public	15	50.00%
Prefer Not to Say	4	13.33%
Not Answered	1	3.33%

How do you identify yourself?

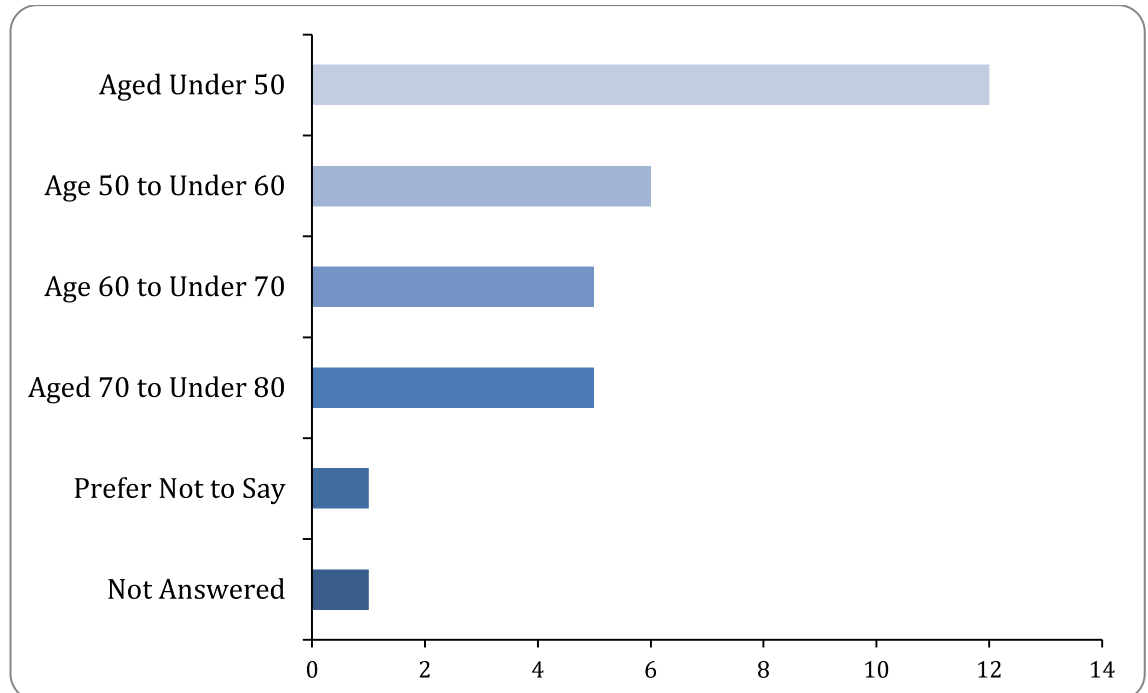
There were 29 responses to this part of the question.



Option	Total	Percent
Female	21	70.00%
Male	7	23.33%
Use Other Term	0	0.00%
Prefer Not to Say	1	3.33%
Not Answered	1	3.33%

How old are you?

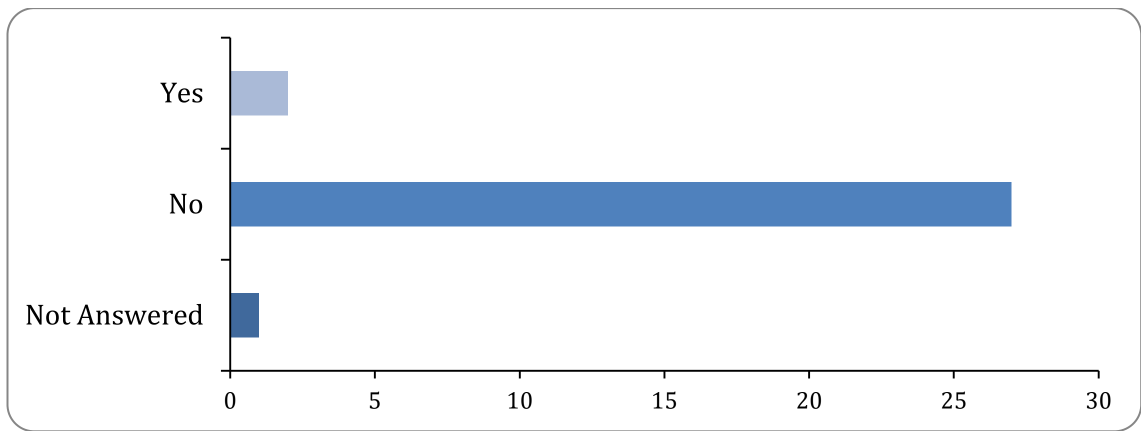
There were 29 responses to this part of the question.



Option	Total	Percent
Aged Under 50	12	40.00%
Age 50 to Under 60	6	20.00%
Age 60 to Under 70	5	16.67%
Aged 70 to Under 80	5	16.67%
Aged 80 or Older	0	0.00%
Prefer Not to Say	1	3.33%
Not Answered	1	3.33%

Do you consider yourself to have a disability?

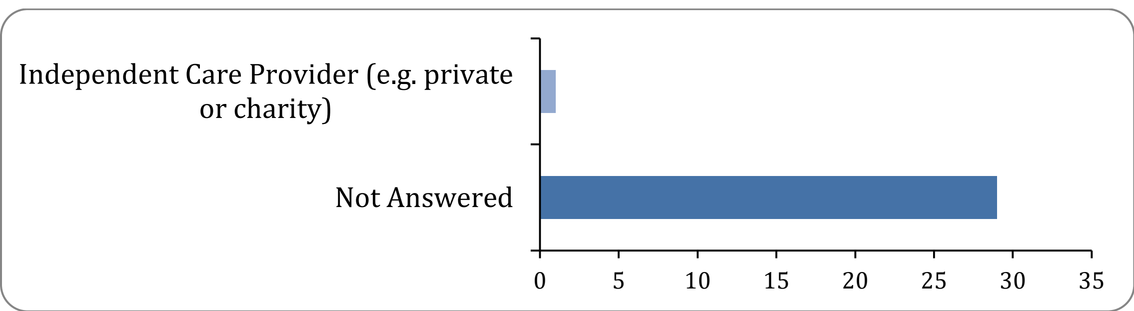
There were 29 responses to this part of the question.



Option	Total	Percent
Yes	2	6.67%
No	27	90.00%
Prefer Not to Say	0	0.00%
Not Answered	1	3.33%

What type of group or organisation are you?

There was 1 response to this part of the question.



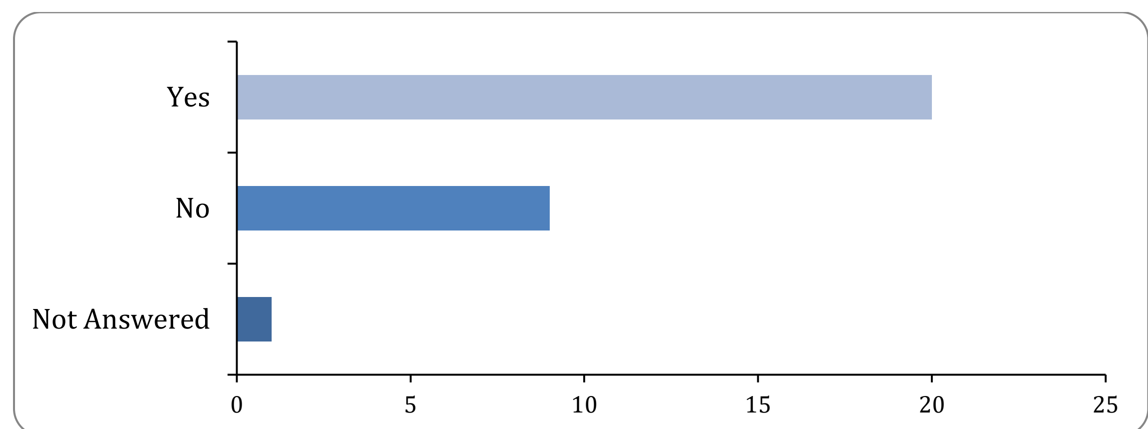
Option	Total	Percent
Client Group	0	0.00%
Public Sector Care Provider	0	0.00%
Independent Care Provider (e.g. private or charity)	1	3.33%
Community Group	0	0.00%
Other Group or Organisation	0	0.00%
Not Answered	29	96.67%

What is your organisation name?

There was 1 response to this part of the question.

Do the changes to Section 2 - Local Governance Arrangements make sense?

There were 29 responses to this part of the question.



Option	Total	Percent
Yes	20	66.67%
No	9	30.00%
Not Answered	1	3.33%

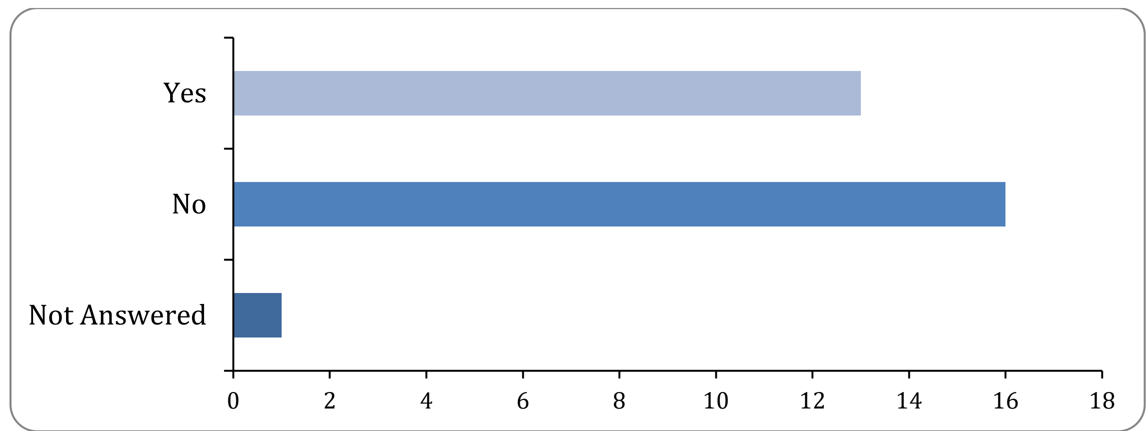
Do you have any comments about the Local Governance Arrangements?

There were 6 responses to this part of the question.

1	Continuity and a longer period of service are essential for accountability.
2	allows more time to embed changes
3	See little change of substance
4	It's the same people who sit on these boards nothing ever changes or improves.
5	?
6	All policy is weighted in favour of how SBC wishes to apply it to individuals

Do the changes in Section 4.6 Targets and Performance make sense?

There were 29 responses to this part of the question.



Option	Total	Percent
Yes	13	43.33%
No	16	53.33%
Not Answered	1	3.33%

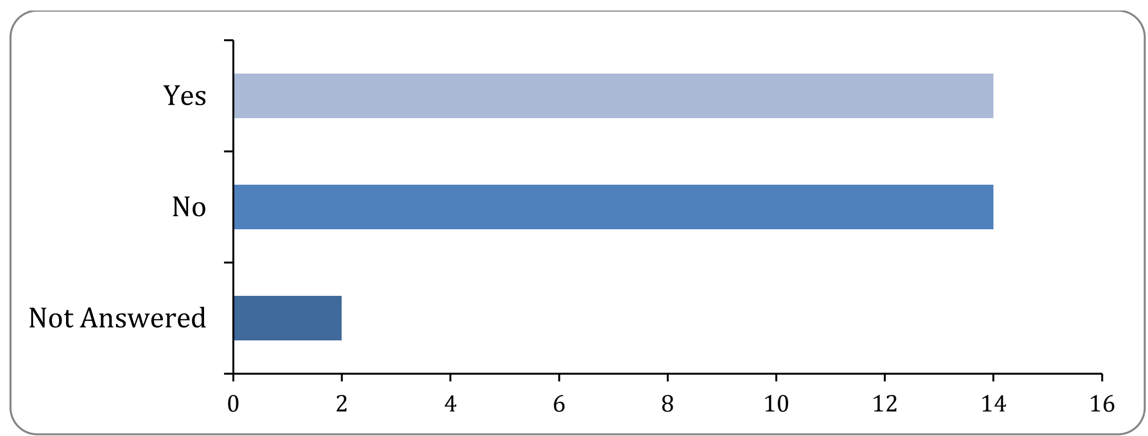
Do you have any comments about the Targets and Performance section?

There were 6 responses to this part of the question.

1	All it says is 'removed'
2	It sounds ideal but will it be put into practice
3	See no change
4	there is no time scale indicated for when it will be in place.
5	Tick boxes which do not give realistic results
6	Why was the performance management removed?

Do the changes to Section 4.7 - Corporate Support Services make sense?

There were 28 responses to this part of the question.



Option	Total	Percent
Yes	14	46.67%
No	14	46.67%
Not Answered	2	6.67%

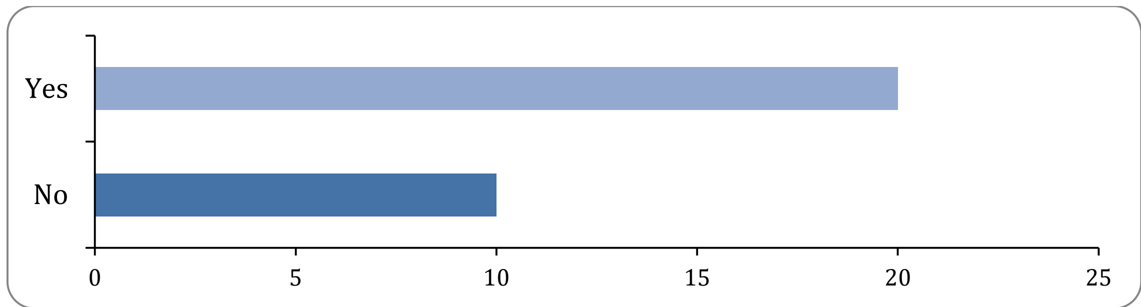
Any comments about the Corporate Support Services section?

There were 6 responses to this part of the question.

1	4.7.4 is the same?
2	Again, dependant on how SBC wish to portray input
3	Have no idea what this means or the outcome which will be achieved
4	See little change
5	Should Procurement be included in 4.7.2?
6	Whilst appreciating the formation of the Integrated Board is a Scottish Government Requirement to "force" the integration then the cost would seem rather high.

Do the changes to Section 5 – Clinical and Care Governance make sense?

There were 30 responses to this part of the question.



Option	Total	Percent
Yes	20	66.67%
No	10	33.33%
Not Answered	0	0.00%

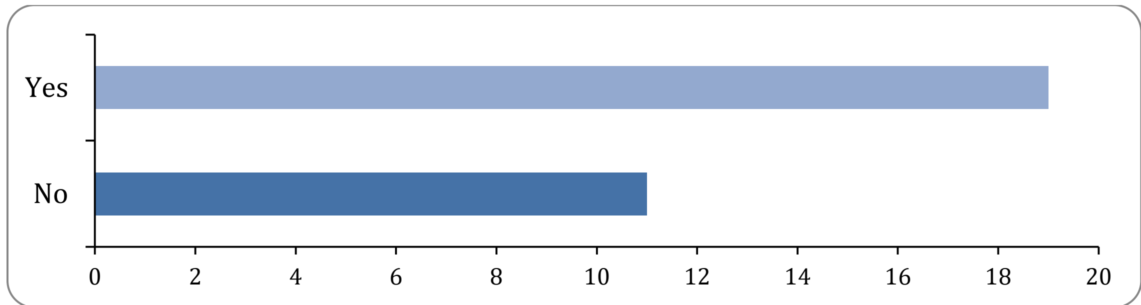
Do you have any comments about the Clinical and Care Governance section?

There were 6 responses to this part of the question.

1	Changes in paper do not result in changes in practice
2	Little material change
3	There needs to be greater clarity on accountability. What does it mean and how will accountability be ensured? Where is the accountability commitment with regard to Social Care?
4	There seems to be a significant and costly amount of report writing keeping all sides informed - it is to be hoped that the reports are read, meaningful and add to the improvement in the service.
5	Why.
6	Working together to improve outcomes will hopefully benefit the ones who most need it

Do the changes to Section 7 – Workforce make sense?

There were 30 responses to this part of the question.



Option	Total	Percent
Yes	19	63.33%
No	11	36.67%
Not Answered	0	0.00%

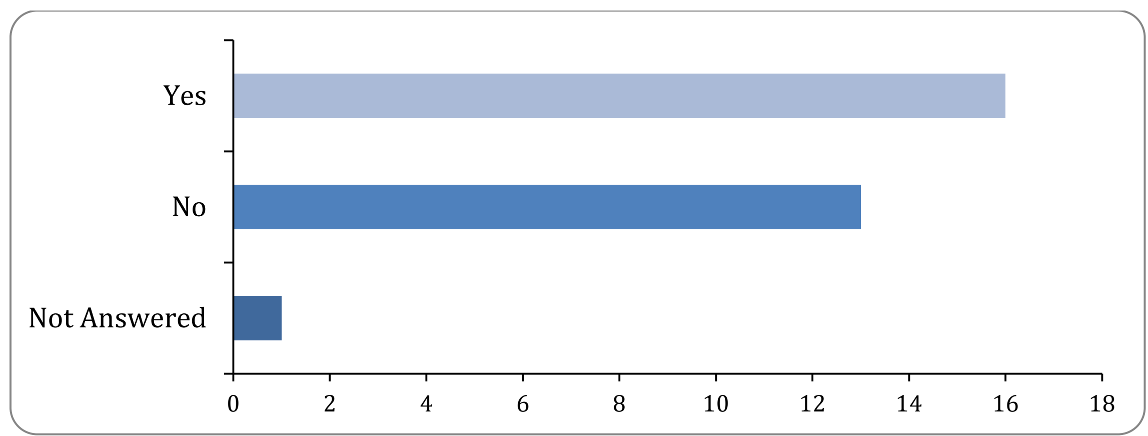
Do you have any comment about the Workforce section?

There were 9 responses to this part of the question.

1	Are the plans not developed yet? By March '16 was a long time ago.
2	Collaborative culture is definitely not happening
3	In order to up skill, train and develop workforce issues around recruitment and retention need to be addressed.
4	Lack of resources and experience needs addressed
5	Long overdue — assuming it delivers improvement
6	Revised could say for period covered and how often the plans will be updated
7	Target date removed?
8	Where is the timescale and regular review period to ensure continued effectiveness?
9	Why

Do the changes to Section 9 – Participation and Engagement make sense?

There were 29 responses to this part of the question.



Option	Total	Percent
Yes	16	53.33%
No	13	43.33%
Not Answered	1	3.33%

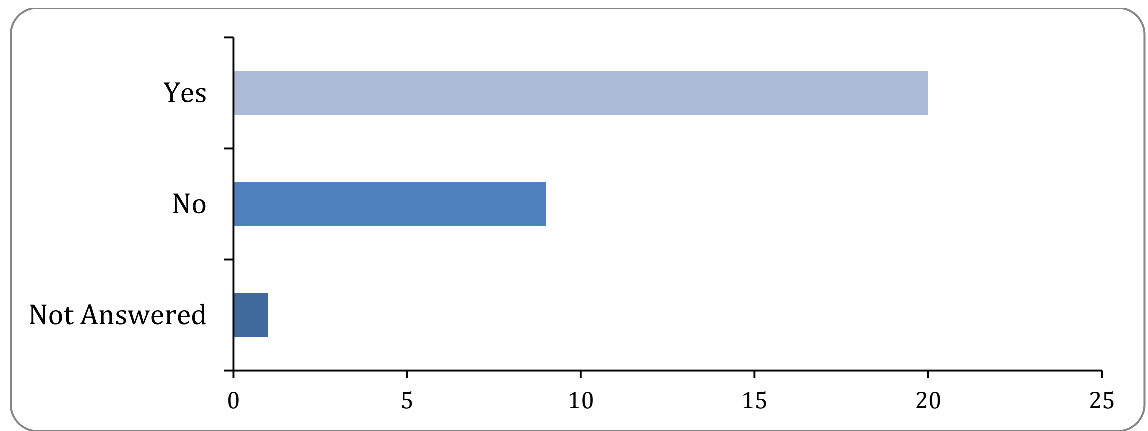
Do you have any comments about the Participation and Engagement section?

There were 10 responses to this part of the question.

1	Again, long overdue, assuming improvements result
2	All dealings are maze like, poorly signposted and confusing
3	Don't understand what difference it will make
4	However, I don't see any timescale commitment or review period to ensure continued effectiveness of any communications and engagement strategy.
5	If 9.2 is removed, the revised 9.3 does not make sense as has no context.
6	not good at communicating updatees and plans to the general community. it is up to the individual to seek information. little proactive informing of the public, just on their website. if not IT savvy difficult to find out what is happening
7	Staff and practitioner engagement events should continue to monitor the effectiveness of recent changes in real terms for the staff on the ground and how the changes are working or not working now
8	Timetable?
9	When will the strategy and action plan be developed
10	Why

Do the changes to Section 10 – Information Sharing make sense?

There were 29 responses to this part of the question.



Option	Total	Percent
Yes	20	66.67%
No	9	30.00%
Not Answered	1	3.33%

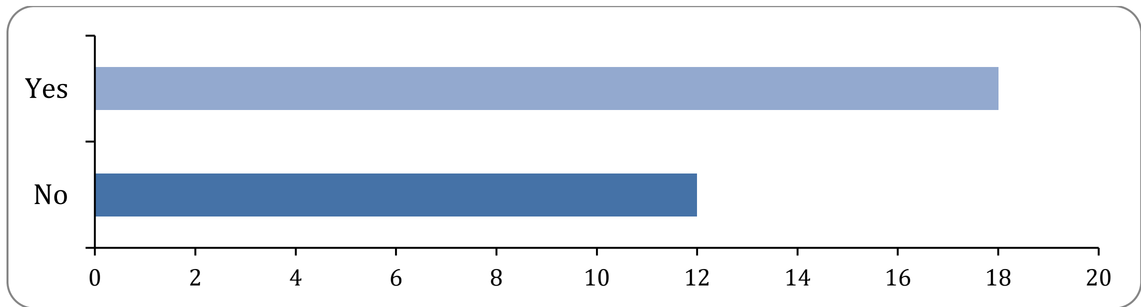
Do you have any comments about the Information Sharing section?

There were 6 responses to this part of the question.

1	Abbreviations such as FOI should be out in full as not all reading this will know this means Freedom of Information.
2	Information requested is dependant on council staff tasked with providing relevant information. Relevant information needs highlighted
3	Information sharing is key to collaborative working…. This is not happening. Even within the NHS there is a lack of relevant information sharing between GP's and other community services which would be beneficial to the treatment of patients
4	Not sure what it will achieve
5	See previous comment
6	Why

Do the changes to Section 13 – Risk Management make sense?

There were 30 responses to this part of the question.



Option	Total	Percent
Yes	18	60.00%
No	12	40.00%
Not Answered	0	0.00%

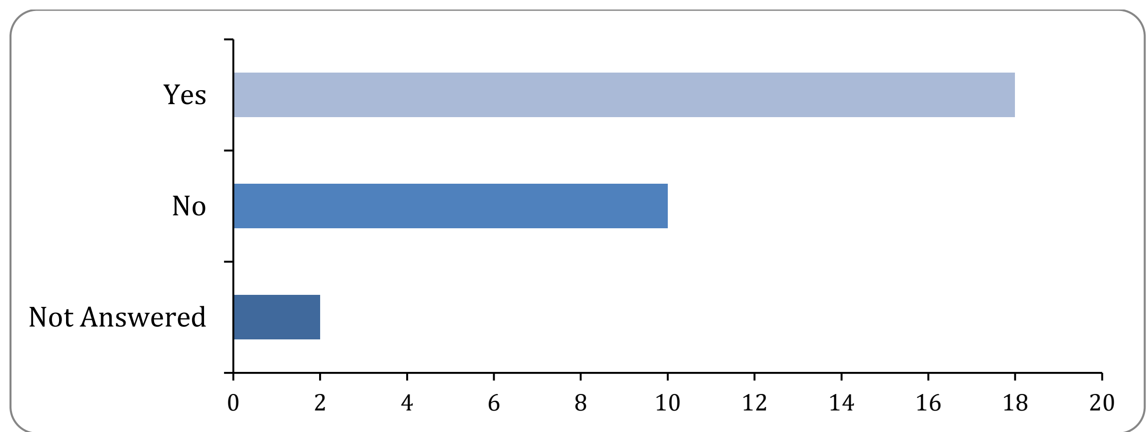
Do you have any comments about the Risk Management section?

There were 6 responses to this part of the question.

1	Again, timescale & review period information is needed.
2	If the strategy 'will include' does that mean there is not one yet? I would hope the 'strategy includes'
3	The register appears to acknowledge risk but not prevent it
4	What on earth does this mean?
5	Where can the risk management be accessed?
6	Why

Do the changes to Appendix 1 - Integration Joint Board Governance Arrangements make sense?

There were 28 responses to this part of the question.



Option	Total	Percent
Yes	18	60.00%
No	10	33.33%
Not Answered	2	6.67%

Do you have any comments about the Integration Joint Board Arrangements?

There were 6 responses to this part of the question.

1	Continuing increase of costs when both senior organisations have Audit Committees
2	Hopefully this will improve the outcomes of vulnerable people
3	Marking one's own homework is contradictory to accountability.
4	Only if outcomes are improved
5	Rubbish
6	You can all have each other's backs

Is there anything else you would like to say about the Scottish Borders Health & Social Care Partnership?

There were 15 responses to this part of the question.

1	Carers are ignored, no one listens to us and no one is prepared to listen to those organisations and charities who plead our cases
2	Do better.
3	Give the over work carers a decent pay rise and give them the support they deserve
4	I am really concerned about various aspects of H&SC provision across the Borders and hope that as part of this consultation these areas will be addressed and improved in terms of service access and provision.
5	Instead of having meetings to talk about improvements, practice what you preach and start doing something positive for the Scottish Borders, too many people are being let down by lack of consistent care, lots of people falling through the net.
6	My experience over almost 3 years has resulted in a huge amount of distrust in officials and decision makers. It will take significant change, action and time to rebuild trust. I know my views are shared by many people so please do not think my views are isolated.
7	no sense of how it is working on the ground and its impact on individuals and communities. information sharing to the public is non-existent, particularly since SBC's newssheet has been scrapped. it is up to the individual to seek out informatio not proactively distributed by the IJB. feels like it is all happening behind closed doors.
8	This format is all very well for those of us who can read and have at least some kind of understanding of what is being said. An Easy Read Version of this would help those with a Learning Disability. It would also give them the opportunity to take part in the feedback should they so wish.
9	This is a paperwork exercise and not an open consultation on the actual difficulties experienced. This information tells me nothing and this survey gathers no relevant information other than if I am capable of reading text. There needs to be equality among the joint working of social and health services (take take take from NHS resources and very little give from social care in return), there needs to be improved communications and actual shared data between the services. Computer systems that are independent of one another do not help. In practice I see no actual joint working in relation to the practicalities of the staff on the front line.
10	To go back to my earlier comments — from the outside there appears to be a fallback position of excuse and limitation. And, very importantly, a confusion about systems and procedures, resulting in often a poor (or even no) outcome for the user.
11	Very, very poor and basic care. For the amount of taxes that we pay, health care delivered is extremely basic .
12	When will we get NHS dentists!
13	Whilst appreciating that Health and Social Care need to work well together it is unclear to me why a third organisation had to be added.
14	Who makes this up.
15	Why are making such an incomprehensible and meaningless consultation ?

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 children's 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.

Health and Social Care Integration Scheme for the Scottish Borders

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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 will 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
HSC Integration Scheme 151215 diagr 1	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
APPENDIX 3 Functions Delegated I 3	Functions delegated by the Local Authority to the Integration Joint Board
Appendix 4 Carers Act.docx 4	Functions delegated by the Health Board and Local Authority to the Integration Joint Board in respect of the Carers Act.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Integration Joint Board membership**
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):

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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.

2.2 Background

The Integration Joint Board consists of 10 voting members, who are 5 Local Authority Councillors and 5 Non Executive Directors of the Health Board.

Members are appointed for a 3 year term and there are no restrictions to reappointment.

2.3 Assessment

It is good practice for the Health Board to reaffirm it's membership of the Integration Joint Board on a 3 year cycle.

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 Health Board and Integration Joint Board business.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to formally endorse the continued Non Executive voting members of the Integration Joint Board as:-

- Karen Hamilton, Non Executive (Chair of IJB Audit Committee)
- Harriet Campbell, Non Executive
- Tris Taylor, Non Executive
- John McLaren, Non Executive
- Lucy O'Leary, Non Executive (Vice Chair of the IJB, Member of the IJB Audit Committee)

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

3 List of appendices

Not applicable

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 2022**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**Andy Carter, Director of Workforce**
Report Author:	**Bob Salmond, Associate Director of Workforce**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Local policy

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 notify the Board of recent consultant appointments offered by the Chair or their deputy on behalf of NHS Borders Board.

2.2 Background

Board members were briefed in December 2017 on revisions to the NHS Borders guidance on medical consultant appointments. As a result, the Chair of the Board or his/her deputy have delegated authority to offer consultant appointments on behalf of the Board.

2.3 Assessment

Since the last report to the Board, 2 new consultants have been interviewed, offered and accepted consultant posts.

New Consultant	Post	Start Date
Dr Gemma Alcorn	Consultant Physician – Medicine for the Elderly	April 2022
Dr Rebecca Woolcock	Consultant Physician – Medicine for the Elderly	April 2022

2.3.1 Quality/ Patient Care

The Senior Medical Staffs Committee receives a quarterly report on forthcoming medical vacancies, new long term Consultant appointments (including locums) and consultant posts filled by long term locums.

2.3.2 Workforce

Successful recruitment to substantive consultant posts supports the sustainability of services.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed in the preparation of this paper. However Equality and Diversity obligations are fully complied with in the recruitment and selection process.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to note the report.

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

3 List of appendices

Not applicable.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**7 April 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 2 March 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, Integration Joint Board minutes 15.12.21

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 15 December 2021** at **10am** via Microsoft Teams

Present:

(v) Cllr S Haslam
(v) Cllr J Linehan
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mr T Taylor, Non Executive
Mr C Myers, Chief Officer
Mrs J Smith, Borders Care Voice
Ms L Gallacher, Borders Carers Centre
Ms G Russell, Partnership Representative NHS
Mr N Istephan, Chief Executive Eildon Housing
Mr S Easingwood, Chief Social Work and Public Protection Officer

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mr R Roberts, Chief Executive NHS
Mrs N Meadows, Chief Executive, SBC
Mr G McMurdo, Programme Manager SBC
Ms J Holland, Director of Strategic Commissioning and Partnerships SBC
Ms S Bell, Communications Manager SBC
Mrs L Lang, Communications Officer NHS
Mr A Bone, Director of Finance, NHS Borders
Ms H Jacks, Planning & Performance Officer, NHS
Mr G Samson, Audit Scotland
Dr T Patterson, Director of Public Health
Ms S Henderson, Planning & Development Officer, NHS
Mr S Burt, General Manager MH&LD
Ms S Brown, Public Member

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr David Parker, Mrs Harriet Campbell, Non Executive, Mr David Robertson, Chief Financial Officer, SBC, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, NHS, Dr Lynn McCallum, Medical Director, NHS, Dr Kevin Buchan GP, Ms Linda Jackson, LGBT+, Mr David Bell, Staff Side, SBC and Ms Juliana Amaral, BAVs.

1.2 The Chair advised that there would be a slight change to the running order of the agenda, with item 5.5 being taken ahead of item 5.4.

1.3 The Chair confirmed the meeting was quorate.

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

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.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the extraordinary meeting of the Health & Social Care Integration Joint Board held on 20 October 2021 were approved.

4. MATTERS ARISING

4.1 **Action 4:** Mr Chris Myers suggested he meet with Cllr Shona Haslam to clarify the data available before bringing it forward to a future meeting. Cllr Haslam agreed to that approach.

4.2 **Action 2020-3:** Mr Tris Taylor commented the action had been marked as complete by 31.03.21. Miss Iris Bishop apologised for the inaccurate sentence and advised that it should have been marked as in progress as the Scheme of Integration light touch review consultation would commence shortly.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. FORMAL APPOINTMENT OF CHIEF OFFICER HEALTH & SOCIAL CARE

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** formally appointed Mr Chris Myers as Chief Officer Health & Social Care.

6. IJB BUSINESS PLAN AND MEETING CYCLE 2022

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2022.

7. SELF ASSESSMENT

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the format of the self assessment form template.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved roll out to the Board and its Committees and Groups to undertake an annual self assessment in the autumn each year with a six week turnaround.

8. IJB STRATEGIC COMMISSIONING APPROACH

8.1 Mr Chris Myers provided an overview of the content of the paper. He suggested the next IJB Development session be used to further discuss the strategic commissioning approach. He noted that the paper had been developed based on discussion at the IJB's Strategic Planning Group.

8.2 Further discussion focused on: assurance that staff governance standards would be adhered too; visibility of unmet need and ensuring planning was taken forward in coproduction with people; directions formulated in coproduction and if necessary resolution pathways followed before directions are issued; planning for success through the alignment of NHS Borders and SBC strategies with the IJB Strategic Commissioning Plan; and adequacy of joint needs assessment resourcing.

8.3 Mrs Jenny Smith welcomed the robust and thorough approach and asked that the membership of the Future Strategy Group included third sector and independent sector representation.

8.4 Mrs Karen Hamilton commented that the IJB Audit Committee had discussed the paper at its meeting the previous week and had been supportive of it. The Audit Committee had also acknowledged the issue of updating the Terms of Reference and were content to take on a monitoring role to provide the IJB with assurance.

8.5 Mr Myers welcomed the discussion and commented that broad engagement with all stakeholders is key, and as a result that the Future Strategy Group (FSG) would support and report into the Strategic Planning Group which contained service users and other experts from the community, third sector, staffside and independent sector representatives. The output from the FSG would be submitted to the Strategic Planning Group (SPG) to assess the plans and directions, and if supportive recommend them to the IJB for approval and issue. However the SPG could also return plans and directions back to the FSG for further consideration by other groups.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and approved the following recommendations:

- That the work of the SIP Oversight Board is realigned to the Audit Committee rather than directly reporting to the IJB.

- That the IJB hold a series of development sessions in partnership with key operational and functional stakeholders to appropriately consider and undertake the planning process.

- That a 'Future Strategy Group' is developed that reports into the Strategic Planning Group to develop Directions and to manage the work associated with the delivery of the new Strategic Developments over the next 12-14 months.

- That the IJB endorse the approach of undertaking a comprehensive Joint Needs Assessment to inform the Strategic Commissioning Plan that will be concluded towards

the end of 2022/23 to support the development of a 3 year Strategic Commissioning Plan for 2023-26.

- That whilst the Strategic Commissioning Plan is focused on the period up to the implementation of the National Care Service, that a series of strategic commissioning assumptions are developed over the longer term to support the business planning processes and sustainability of the IJB's key strategic and operational partners.

- That the Audit Committee oversee a rapid review of the Terms of Reference and a self-assessment of the IJB Committees to ensure that the IJB and these Committees are able to continue to effectively function in the context of the significant level of work required, in line with the IJB's duties outlined in the Act.

- That an additional development session be held to progress the Strategic Commissioning Approach work.

9. DIRECTIONS POLICY AND PROCEDURE

9.1 Mr Chris Myers provided an overview of the content of the report and commented that by providing a more formalised approach to directions a monitoring and review of progress could be undertaken. The IJB Audit Committee had agreed to take on the role of monitoring and reviewing implementation to provide assurance to the IJB that directions were being delivered. The process was based on best practice guidance and national expectations for issuing of directions. The process would also allow all parties to understand the planning assumptions of the IJB and all associated parties.

9.2 Mrs Netta Meadows sought assurance that the process had been checked against the standing orders of the respective organisations especially in regard to budgetary decisions and delegated decisions.

9.3 Mr Myers commented that the standing orders of the partners had not been consulted. He advised that the process was aligned to the Scheme of Integration and the IJB's Standing Orders which were not incompatible with the partners standing orders.

9.4 As the IJB is the commissioning body and the new Future Strategy Group and SPG would produce plans in coproduction with the parties, which the SPG would review and potentially recommend to the IJB, there would be no surprises for either organisation when a direction was issued, as all parties were involved through each stage of the process.

9.5 Operational decisions would remain with the partners and directions would be strategic in nature and at times may reference some operational decisions taken. He assured the IJB that partners would be involved in the decision making process when developing directions.

9.6 Mr Ralph Roberts commented that it was important that in the development of directions at a strategic level, the engagement process was robust and included, service providers as well as the public and service users. He suggested once any organisation received a direction from the IJB it would have the right to advise the IJB

that the direction could not be fulfilled and ask the IJB to reconsider and adjust the direction.

9.7 The Chair welcomed the improved level of transparency that would be achieved through the process.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the content of this report, the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014 and the statutory guidance issued by the Scottish Government in January 2020 in relation to Directions.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Directions Policy and Procedure and IJB Directions template set out in Appendices 1 and 2 of this report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the associated addition to the SBIJB Audit Committee Terms of Reference: The oversight and scrutiny of the implementation of the Strategic Commissioning Plan and the application of the Directions Policy. Monitor and review progress with the implementation of Directions made to partners to ensure that clarity and transparency can be demonstrated and aligned to performance and financial reporting, and escalate key delivery issues to the IJB. Maintain independent oversight of progress against the Strategic Commissioning Plan, and provide assurance to the IJB thereon.

10. DAY SERVICES PETITION AND FUTURE PROVISION

10.1 Mr Stuart Easingwood provided an overview of the content of the report and highlighted that the intention was to design day services with a focus on early intervention and in line with self-directed support requirements.

10.2 Mrs Netta Meadows sought clarification of the scope of the action plan.

10.3 Cllr Tom Weatherston supported the proposal and referenced earlier discussion on coproduction, advising that the public had been unsupportive of the direction of travel, however mechanisms were in place to reach a resolution.

10.4 Mr Tris Taylor enquired if carers were involved in the proposal at a sufficient level to influence the direction of travel initially, especially given there had been a public reaction.

10.5 The Chair commented that in moving forward the Carers Workstream would be asked to undertaken the work, and she enquired if there was a mechanism of engagement with the end users themselves in addition to carers.

10.6 Mrs Lynn Gallacher commented that there were lessons to be learned on the engagement and consultation process for day services . The original transformation of day services had not engaged well to provide an informed direction of travel and that would be remedied through the engagement of the Carers Workstream. She welcomed the recommendation from the SBC Audit and Scrutiny Committee.

10.7 Mr John McLaren commented that previously work had focused on buildings and services provided from buildings, when it would have been more beneficial to have known the needs of carers and service users as the first focus of any transformation.

10.8 Cllr Elaine Thornton-Nicol supported the intention of assisting people in their communities instead of it buildings and suggested the pathway to progress the matter would sit within the Older Peoples pathway group. She commented that the world had changed since 2019 and what might have been right then might not be right as matters were progressed.

10.9 Mr Easingwood, provided reassurance in terms of individuals circumstances, commenting that the first stage of the process was coproduction and the mapping of individuals needs as a starting point and then matching the services to the individuals needs.

10.10 In regard to scope Mr Easingwood commented that the approach was for carers to be supported to access flexible support and information to best meet their needs and choices going forward. The scope was within the remit of the Carers Workstream and would ensure there was clear and transparent engagement.

10.11 Mr Easingwood commented that in regard to buildings, 4 of the 5 locality areas had now moved away from buildings based services, and there were some individuals without the right packages in place that were being reviewed. He commented that as a consequence of the pandemic it was essential to look at the current and future landscape for service delivery moving forward. The needs of individuals and the open and honest conversations with carers and service users about their individual circumstances and what they needed would inform service provision moving forward.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered and agreed to the request made by the Scottish Borders Council Audit and Scrutiny Committee

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the petition papers and Audit and Scrutiny meeting minute

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to task the existing Carers Workstream with the task of undertaking this piece of work, as part of the workstream's new work to develop an Action Plan for Carers in the Scottish Borders. Progress of this work should be reviewed in the first instance by the Integration Joint Board's Audit Committee prior to reporting to the Integration Joint Board.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a future Integration Joint Board Direction for day services is likely to be required as a result

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought a timeline for the work to be taken forward.

11. MEMBERSHIP OF THE IJB

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the change in voting membership.

12. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2021/22 AT 30 SEPTEMBER 2021

12.1 Mr Andrew Bone provided an overview on the content of the report and drew the attention of the Board to the £6.2m deficit for the year end forecast. He further referred to the supporting appendices, breakdown of savings and gap in projections.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the combined forecast adverse variance of (£6.186m) for the Partnership for the year to 31 March 2022 based on available information and arrangements in place to partially mitigate this position;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that whilst the forecast position includes direct 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 **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the position includes additional funding vired to the Health and Social Care Partnership during the first half of the financial year 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 **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that any residual expenditure in excess of the delegated budgets at the end of 2021/22 will require to be funded by additional contributions from the partners in line with the approved Scheme of Integration.

13. STRATEGIC RISK REGISTER UPDATE

13.1 Mr Chris Myers provided an overview of the content of the report and advised that he had met with the Auditors and the Risk Management Team separately.

13.2 The Chair commented that in regard to escalating risks with the external environment it was good to know that something could be done to reduce their risk level a little.

13.3 Mr Tris Taylor welcomed the news that it would be rewritten and suggested it did not provide a systematic overview of the actions being taken to manage risks.

13.4 He commented that in regard to Risk 1 on cultural change it was hard to assess if it had been appropriately managed as it did not have a definition of what was required to be done or by when. He further commented that it did not reflect that low compliance with the Choices Policy remained a key barrier to the discharge strategy. He enquired

if the risk was a feature of the partners risk registers. He further suggested it did not seem a sufficient approach if it was confined to partners to manage risks with stakeholder engagement.

13.5 In regard to Risk 9, Mr Taylor suggested evidence was required on progress and project management and for Risk 10 he commented that the year 2021 was probably a typo and should read 2022.

13.6 The Chair welcomed the comments and suggested members provide feedback to Mr Myers on how to make the report stronger in the future.

13.7 Mrs Jill Stacey commented that the intention was to have a more fundamental review of the IJB strategic risk register, especially in light of the reviews of the Strategic Commissioning Plan and Scheme of Integration. She welcomed Mr Taylor's comments and advised that they would be captured as part of that fuller review. In terms of the appendix she advised that it was a summary report and a fuller report was provided to the Chief Officer with all of the linked actions in terms of mitigating actions and controls. She advised that the format of the report could be expanded for the Board to highlight some of the key mitigating actions being undertaken.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** considered the IJB Strategic Risk Register to ensure it covers the key risks of the IJB;

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the actions in progress to manage the risks; and

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in June 2022.

14. QUARTERLY PERFORMANCE REPORT

14.1 Mr Chris Myers commented that the report had been updated in line with the principles of 'Active Governance' to try and ensure the narrative and the way in which data was presented was more helpful to the IJB members and he thanked Mrs Meriel Carter and her team for enabling the change. Mr Myers commented that in future a key focus on outcomes and delivery would be made more explicit through the performance reports.

14.2 Mr Myers drew the attention of the Board to the key concern of the number of delayed discharges in the system. He advised that there had been an increase in demand and need across the whole system with more people with a greater level of frailty and dependence being requiring support both in hospitals and our communities. He added that the Health and Social Care Partnership teams were continuing to work across the whole system to address the increased demand.

14.3 The Chair noted the huge pressures being felt by all sectors as a consequence of the pandemic and welcomed the partnership approach to addressing increased demand on all services.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the quarterly performance report.

15. INTEGRATED WORKFORCE PLAN

15.1 Mr Chris Myers commented that an interim workforce plan had been formulated and would continue to be further developed by the HR Directors in both SBC and NHS Borders.

15.2 Mr Nile Istephan commented that it was an important piece of work and suggested the independent sector might be included given the continuing recruitment difficulties in all sectors. Mr Myers commented that he would welcome the input of independent providers, third sector and primary care independent providers to ensure a more coordinated approach to recruitment in future.

15.3 Mr Tris Taylor enquired if as the workforce plan developed it would provide a view of the entire workforce that was producing health and care and wellbeing in the Borders including unpaid carers. Mr Myers commented that in terms of unpaid carers they often provided the bulk of care and the Carers Workstream would need to map out the needs of people who were provided unpaid care, to form the basis of the IJB's Strategic Commissioning Plan..

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that Scottish Government DL(2020)28 outlines the requirement for:

- Integration Authorities to ensure a 3 year workforce plan is developed no later than 31 March 2022.
    - This plan should cover the period 1 April 2022 to 31 March 2025.
    - Integration Authorities' Workforce Plans should be published on organisations' websites by 31st March 2022, and a link to each Plan should be forwarded to the Scottish Government's National Health and Social Care Workforce Planning Programme Office by that date

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that HR Directors have been advised that recognising the impact of COVID-19, this deadline may be postponed to a later date in 2022.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that an Interim (integrated) Workforce Plan was submitted to the Scottish Government at the end of April 2021

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** recommended that the Health and Social Care Partnership should continue to develop an Integrated Workforce Plan over the coming months, and report this back to the IJB prior to submission to the Scottish Government.

16. TWEEDBANK CARE VILLAGE

16.1 Mrs Jen Holland spoke to the content of the report and highlighted that it set out the case for change and care needs across the Scottish Borders, especially for older people requiring a provision of care to be given at the right time, in the right place with a focus on possibility rather than disability.

16.2 Mrs Holland advised that SBC had approved the capital allocation for residential care provision and owners and designers of a similar scheme in the Netherlands had met with some IJB members and officials to look at the possibility of replicating facilities in the Scottish Borders on the Tweedbank site. The proposal was for 60 units including outdoor community space and the site would include rehabilitation, assessment, nursing care, palliative care, and dementia care.

16.3 The Chair enquired about the role of the IJB in terms of commissioning for the care to be delivered in the proposed Care Village.

16.4 Mrs Jenny Smith commented that the Impact Assessment was incorrect, which was important in terms of due process, given under item 6 on page 127 it listed Borders Carers Voice. She advised that there had been one workshop in early 2020 which involved Borders Carers Voice and the proposal discussed at that time was not the same proposal presented to the IJB, so very limited discussion had taken place without further engagement and consultation.

16.5 Mrs Lynn Gallacher advised that Borders Carers were also referenced in the report and were at the same session in early 2020 which had been more of an information shared session as opposed to a consultation session and had not had any further engagement on the proposal as it had been progressed. She commented that she was concerned that there was not enough detail in the report to be able to understand the implications of the closure of Garden View and Waverley on staffing, given the model would have more carers than residents and might not meet the care that was required to enable people to stay in their own homes. She sought further information about filling the gap of enabling people to stay in their own homes and how that would impact on the demand for residential care.

16.6 Mr Tris Taylor advised that he was mindful about the role of the IJB in the project and that it was for SBC to provide the buildings and the services were to be commissioned by the IJB. He suggested the outline business case detailed the involvement of carers and third sector in the project but that was not actually the case and it did not mention the engagement of service users. He suggested an options analysis was required given the only other option was the current status quo. He further commented that it was difficult to understand the rationale for moving from a desire to keep people in their own communities and homes where possible, to moving them from their homes and communities to a purpose built facility. It was also not obvious from the outline business case that it would meet the kinds of needs against which the IJB would want to commission. He was concerned that SBC might expose itself to that risk without genuine coproduction having taken place and clear accountability being given to address the actual needs of older people instead of potentially consolidating supply to meet a number of other broader SBC objectives.

16.7 Mrs Netta Meadows assured the Board that people were not removed from their homes, any relocation was done as part of a social work assessment and decisions to provide people with residential care settings were taken carefully, based upon their level of need. In regard to delivering care, the proposal was fundamentally about delivering residential care services to meet the increasing need identified. It would meet the need for older people to be supported to grow old well with the delivery of high quality residential care in better fit for purpose settings. The IJB were responsible for commissioning the provision of residential and nursing care and the new facility would provide a higher quality standard environment.

16.8 Mrs Holland commented that in regard to consultation as the project moved towards the full business case, there would be consultation with key users, carers, families and potential users. She advised that the intention was always to keep people as independent as possible, although some people required 24 hour care and the model was designed to be able to provide that care within a homely environment with social community aspects. An additional 11 beds had been included in the plan to accommodate the closure of Garden View and Waverley. A year ago there had been a need for 180 beds, and a lot of work had been put into discharge to assess and conversations with carers about what was needed for individuals to help people live independently at home.

16.9 The Chair commented that in the longer term the IJB would issue a direction to commission the provision of care within the care village.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the paper presented to Scottish Borders Council on 25th November 2021 and approval of its recommendations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the capital and revenue decision taken by Scottish Borders Council.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the expected growth in demand and current planned mitigations.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that it would issue a direction to commission the provision of care within the care village which would clarify the role and requirements of the IJB from a governance perspective.

17. REVIEW OF LEARNING DISABILITY (LD) DAY SUPPORT SERVICES – MARKET TESTING

17.1 Mr Simon Burt provided an overview of the content of the paper.

17.2 The Chair welcomed the approach to balancing the needs of service users and carers.

17.3 Ms Lynn Gallagher congratulated Mr Burt on the approach that had been taken and suggested there was learning for other services to be taken from it.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress of the learning disability day support review

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the LD service will, on completion of the market testing, seek a commissioning decision from the IJB in the spring of 2022.

18. THE ALLIANCE – HEALTH & SOCIAL CARE IN THE SCOTTISH BORDERS

18.1 Mr Chris Myers referred to the significant work that had been taken forward with the Alliance and other partners and that a number of sessions had been held. The key themes from the sessions had been formulated into a report for the partnership to consider and he advised that the partnership would be working with communities on the outputs of the report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Alliance Report.

19. ALCOHOL AND DRUGS PARTNERSHIP ANNUAL REPORT 2020-21

19.1 Dr Tim Patterson provided an overview of the content of the annual report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Review and highlight Annual Report

20. STRATEGIC PLANNING GROUP MINUTES: 04.08.21

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

21. ANY OTHER BUSINESS

21.1 The Chair advised that there had been no notification of any other business.

22. DATE AND TIME OF NEXT MEETING

22.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 16 February 2022, from 10am to 12noon, via Microsoft Teams.

The meeting concluded at 12.15.

Signature: ……………………………
Chair