Borders NHS Board

NHS Borders

A meeting of the **Borders NHS Board** will be held on **Thursday, 6 October 2022** at 10.00am in person at **Tweed Horizons.**

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Board Secretary	*Appendix-2022-60*
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 16.06.22 – Extraordinary 30.06.22	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**STRATEGY**		
10.05	5.1	2022/23 Annual Delivery Plan Feedback	Director of Planning & Performance	Appendix-2022-61
10.20	5.2	Annual Review Letter 2020/2021	Director of Planning & Performance	Appendix-2022-62
10.25	5.3	Primary Care Improvement Plan Update	Chief Officer Health & Social Care	Appendix-2022-63
10.35	**6**	**FINANCE AND RISK ASSURANCE**		
10.35	6.1	Quarter 1 Review	Director of Finance	Appendix-2022-64
10.49	6.2	Resources & Performance Committee minutes: 05.05.22, EO 04.08.22	Board Secretary	Appendix-2022-65
10.50	6.3	Finance Report	Director of Finance	Appendix-2022-66
10.59	**7**	**QUALITY AND SAFETY ASSURANCE**		
10.59	7.1	Clinical Governance Committee minutes: 18.05.22, 20.07.22	Board Secretary	Appendix-2022-67
11.00	7.2	Quality & Clinical Governance Report	Medical Director	Appendix-2022-68
11.15	7.3	Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2022-69
11.30	7.4	Food, Fluid and Nutrition Update	Director of Nursing, Midwifery & AHPs	Appendix-2022-70

11.38	**8**	**ENGAGEMENT**		
11.38	8.1	Staff Governance Committee minutes: 23.03.22	Board Secretary	Appendix-2022-71
11.39	8.2	Public Governance Committee minutes: 11.05.22	Board Secretary	Appendix-2022-72
11.40	8.3	Whistleblowing Annual Report 2021/2022	Director of HR & OH&S	Appendix-2022-73
11.45	**9**	**PERFORMANCE ASSURANCE**		
11.45	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2022-74
11.55	**10**	**GOVERNANCE**		
11.55	10.1	Board Meeting Dates & Business Cycle 2023	Board Secretary	Appendix-2022-75
11.57	10.2	Consultant Appointments	Director of HR & OH&S	Appendix-2022-76
11.58	10.3	Scottish Borders Health & Social Care Integration Joint Board minutes: 15.06.22	Board Secretary	Appendix-2022-77
11.59	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 1 December 2022 at 9.00am in person, venue to be confirmed	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to include the declarations of interest for Dr Kevin Buchan, Dr Sohail Bhatti and the revised declaration of interests for Mr James Ayling in the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

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

2.3 Assessment

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 Climate Change

No impact identified.

2.3.7 Other impacts

Regulatory requirement.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

Not applicable.

2.4 Recommendation

The Board is asked to **approve** the inclusion of the declarations of interests for Dr Kevin Buchan, Dr Sohail Bhatti and Mr James Ayling in the Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Declarations of Interests

Borders NHS Board

NHS Borders

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: KEVIN BUCHAN……………. *(please insert your full name in capital letters)*

<table>
<tr><th>Registerable Interest</th><th>Members Interest</th></tr>
<tr><td>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</td><td>GP Partner
O’Connell Street Medical Practice
NHS Borders General Provision of Medical Services</td></tr>
<tr><td>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.</td><td>Nil</td></tr>
<tr><td>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.</td><td>Nil</td></tr>
<tr><td>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</td><td>Nil</td></tr>
<tr><td>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.</td><td>Nil</td></tr>
<tr><td>Gifts and hospitality
Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.</td><td>Nil</td></tr>
<tr><td>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.</td><td>Nil</td></tr>
</table>

Signed……………………………………………….. Date 1 September 2022…………...

Borders NHS Board

NHS
Borders

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	My wife is now an employee of Nightingales Home Care Agency, Kelso which provides home care assistance to individuals and in particular to those with dementia
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.	or requiring palliative care.
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.	

Signed.. Date 30 August 2022.

Borders NHS Board

NHS Borders

Minutes of An Extraordinary meeting of the **Borders NHS Board** held on Thursday 16 June 2022 at 9.00am via MS Teams.

Present: Mrs K Hamilton, Chair
Ms S Lam, Non Executive
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, 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 T Patterson, Director of Public Health

In Attendance: Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mrs L Jones, Head of Clinical Governance & Quality
Mrs C Wilson, General Manager P&CS
Ms S Laurie, Communications Officer
Mrs D Corner, Project Manager, IM&T
Mrs C Lyall, Planning & Performance Officer

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Harriet Campbell, Non Executive, Dr Lynn McCallum, Medical Director, Mr Gareth Clinkscale, Director of Acute Services, Mr Andy Carter, Director of HR & OH&S, Mr Chris Myers, Chief Officer Health & Social Care and Mr John McLaren, Non Executive.

1.2 The Chair welcomed Mrs Laura Jones, Director of Quality & Improvement to her first meeting of the Board in her new role.

1.3 The Chair to welcomed Cllr David Parker back to the Board for a new 4 year term, following his successful nomination as the Local Authority Stakeholder Non Executive on the Board.

1.4 The Chair welcomed a range of other attendees to the meeting including.

1.5 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

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2.2 Mr Tris Taylor declared that he was registered with the Earlston Medical Practice and offered to remove himself from the meeting for the discussion of that matter.

The **BOARD** noted the verbal declaration by Mr Tris Taylor, Non Executive.

3. Laboratory Information Management System (LIMS) Masterlab Replacement Business Case

3.1 Mrs June Smyth provided an overview of the content of the paper and highlighted that the current Laboratory Information Management System (LIMS) was over 25 years old and no longer fit for purpose. NHS Borders was part of a national consortium with other Health Boards to seek a new LIM system and an outline business case and tender process had been undertaken and a preferred supplier had been identified. She drew the attention of the Board to the local implementation costs and the risks and mitigations being taken forward should the transfer to the new supplier not meet the required timeline.

3.2 The Chair enquired if consideration had been given to the compatibility of systems for increased data sharing and the likelihood of being able to recruit the workforce required.

3.3 Ms Sonya Lam enquired about the initial costs for training staff.

3.4 Mr Andrew Bone advised of a typographical error in the finance table in that it should read £70k not £700k. He further advised that part of the roll out plan was that training would be provided to staff from a central resource.

3.5 Mrs Smyth commented that in terms of data sharing the nationally contracted service would improve the opportunity to share data across and between Health Boards and there had been no issues flagged during the development of the business case in regard to compatibility with other systems in Health Boards. In terms of recruitment the general recruitment risks applied.

3.6 Mr Tris Taylor commented that there appeared to be an inequity under the current system with its variable provision and he was keen that any attention to extracting delivery of care or delivering a positive outcome was recorded as a contribution to health inequalities.

3.7 Mr James Ayling enquired if there had been any work on exploring the capacity of the supplier and their financial position and sought assurance on what would happen should the supplier fail.

3.8 Mr Bone commented that the procurement of the preferred supplier had been undertaken at a national level through NHS National Services Scotland and the process around that procurement had a substantial number of elements to it including financial and resilience.

3.9 Mrs Alison Wilson enquired why a regional approach had not been pursued and what the current costs were as it looked like a potential cost saving. Mrs Smyth commented that it was a regional approach and NHS Borders would be part of the East Region consortium.

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3.10 In terms of the costs Mr Bone advised that the Scottish Government had agreed to provide capital funding for the licences required with implementation costs being covered centrally. The cost to NHS Borders would be £70k for hosting and training fees. There was a benefit to the Board in terms of the model being participated in and there was a step increase in costs from a historic level.

3.11 Mrs Sarah Horan commented that from a clinical perspective it would allow clinicians to review results in one place regardless of where the patient had been for care and from a patient perspective it would reduce the repeat of bloods and tests being done in each Health Board.

3.12 Ms Lam enquired if GPs would also be able to access the information and Mrs Horan confirmed they would.

3.13 Ms Lam enquired of the rationale for the other Health Boards that had not signed up to the contract. Mr Bone advised that they had commenced a previous procurement exercise and were not keen to exit their contract ahead of its expiry.

The **BOARD** noted the national Full Business Case.

The **BOARD** noted SG funding for non-recurring capital and revenue implementation costs.

The **BOARD** approved for inclusion in the Digital Portfolio, Clinical Information Systems Programme, the estimated financial implications in implementing the replacement on laboratory information systems, primarily:

- The estimated capital expenditure of £0.07m including VAT. This includes supplier implementation costs
- The estimate non-recurring revenue expenditure of £0.65m including VAT to cover additional services, NHS Borders portion of National Team costs and NHSB project implementation costs
- Note reduced recurring revenue expenditure of £1.1m including VAT, assuming a fully hosted service. There may be opportunity to further reduce recurring revenue to by hosting in house, with approach on hosting to be agreed with eHealth.

The **BOARD** endorsed members of the Labs Consortium Group working on a regional instance of a laboratory information management system for the East Region (Lothian, Fife and Borders) and the resource implications of this strategy. (The Scotland-wide Labs Consortium involves 11 Boards in a procurement and implementation project.) NHS Borders will implement governance which works locally and regionally feeding into the national implementation board.

The **BOARD** endorsed the proposed governance and management approach for LIMS implementation as set out in the FBC post contract award.

4. Earlston Medical Practice

Mr Tris Taylor withdrew from the conversation.

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4.1 Mrs June Smyth provided an overview of the content of the report and commented that the GP practice were supportive of the proposal.

4.2 Mr Andrew Bone spoke to the financial elements of the proposal and the pathway to work collaboratively in the future.

4.3 The Chair enquired about the terms HFM and SFM and Mr Bone advised that HFM stood for hard facilities management and SFM stood for soft facilities management and explained the differences.

4.4 Ms Sonya Lam commented that it would have been helpful to have seen the non financial options appraisal for clarity. She further enquired about what the future model would be and what flexibility would be available to meet that future model.

4.5 Mrs Cathy Wilson commented that in regard to future proofing primary care had a 5 year vision that aligned to the primary care improvement plan (PCIP) and involved the integration of patient centred care. Discussions with various stakeholders had taken place to ensure the proposal linked to the integration agenda where the health and social care partnership were headed.

4.6 Mrs Alison Wilson commented that she was unsure that the room numbers were sufficient and gave the example that pharmacy would need 6 rooms for their support staff and she also enquired about bookable rooms and how flexible they would be in terms of suitability for consultations or near me arrangements.

4.7 Mrs Wilson further enquired if the new building option and figures were averaged over 30 years. Mr Bone commented that the different components of the build were over different length of times, such as the foundations were over 70 years and the lease was over 30 years.

4.8 Mrs Wilson enquired about any year on year costs. Mr Bone advised there were estimated additional costs of £170k per year.

4.9 Mrs Lucy O'Leary enquired about the vision for any additional primary care services to be delivered in the next 2-3 years.

4.10 Mrs Wilson commented that pharmacy services were part of the conversation under the PCIP umbrella and she committed to being smarter about office space and consultation space for pharmacists. The intention was to use more technology to empower pharmacists and back office staff to not require the physical space in the building. The intention was that the integration elements would be shared spaces, soft conversations, a multi-disciplinary team approach to patient care. The PCIP set out various elements across 3 years, and CTAC treatment rooms, wound dressing and phlebotomy would be delivered in year 1, more services currently provided in secondary care would be delivered in years 2 and 3.

4.11 Mr James Ayling commented that it was clearly aligned to the way health care would be delivered in the future and in regard to the net revenue cost of £170k per year he equated that to the salary of a senior consultant and compared that cost to the extra benefit the population would receive in supporting the proposal.

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4.12 Mrs Sarah Horan commented that she was supportive of the project and the intention to bring together the health and education communities.

4.13 Cllr David Parker commented that it was helpful to receive the financial summary and the site being purchased was a new facility, significantly better that the current facility. He welcomed the colocation initiative and that it would be sited with the local school and new play park. He thanked Mrs June Smyth and her team for the work carried out with GPs on all of the options available and influence on the building design. He noted there had been extensive roadshows held and there had been zero objections to the project.

4.14 The Chair echoed Cllr Parkers' comments in regard to the work undertaken.

4.15 Mrs Smyth thanked Cllr Parker for his comments and highlighted a couple of points including: future proofing; local housing; local businesses; local population demographic; and flexibility of space. Mrs Smyth assured the Board that all of the work would be taken forward in line with all NHS guidance and contracts and she put on record her thanks for the support her staff had received from SBC staff especially the architects.

The **BOARD** reached a conclusion after the consideration of options outlined in the paper.

The **BOARD** approved the new Medical Practice build within Earlston Community Campus, on a lease agreement from SBC for 30 years, details of which were outlined in the paper.

5. External Review – Benchmarking & Efficiency

5.1 Mr Andrew Bone provided an overview of the content of the paper and highlighted several elements including: development of the financial plan; identification of all opportunities to progress savings plans; move to financial sustainability; benchmarking; business intelligence analytics; national framework; tender process; and commissioning of consultants.

5.2 The Chair enquired if it was appropriate to commission when only a single bid had been received. Mr Bone confirmed that it was at the discretion of the Board to be able to do that.

5.3 Mrs Sarah Horan enquired of the scope. Mr Bone commented that the piece of work would be to commission stage 1 to look at high level nationally available data sets. Specifically it would look at anyone treated by NHS Borders or resident in the Scottish Borders and treated elsewhere.

5.4 Mrs Laura Jones reminded the Board that previously there had been a tendency to focus on acute care where the organisation was data rich instead of the whole system and she suggested it would be helpful if it was directed across the whole system to get a view in terms of population provision across all services. She gave the Board the example that the organisation did not have tiers for medical grade medics therefore it was possible the organisation might look inefficient when in fact it was probably more efficient. Mr Bone clarified that the scope would be the whole system.

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5.5 The Chair enquired to what extent there was capacity available to describe the specification of what the organisation wanted the consultancy to look at, as it was important to look beyond the low hanging fruit to the things that were more complex.

5.6 Mr James Ayling commented that he was supportive of the proposal as he determined that it would send an important message to stakeholders that the Board was taking a good practice physical steps approach to deal with its fragile financial position. He enquired if once the report was received there would be enough resource to act quickly on the findings. Mr Bone commented that acting quickly would be a challenge.

5.7 Ms Sonya Lam commented that the Board had done the same thing before and enquired about the learning from that and if there were actions identified then that had not been pursued. In terms of future viability the organisation had to transform to do something different and there would realistically be a need to invest in that transformation and to be cognisant of workforce limitations.

5.8 Mrs Alison Wilson enquired what had happened with the learning from BOLD and questioned what added value would be delivered above that of the Centre for Sustainable Delivery (CFSD) work. She further commented that public perception of spending on consultations could be viewed as negative given the substantial deficit the organisation continued to carry after the BOLD review.

5.9 Mrs June Smyth commented that BOLD had brought in an approach to financial turnaround and financial improvement and a way of working that had been adopted by the Scottish Government and that was the learning that had been taken from it. The review had been challenging and had focused on short term gains and not longer term transformation. The current proposal was to identify areas of opportunity and extend the work that the CFSD had carried out and to build into the expertise and capacity of the local business intelligence team.

5.10 Ms Lam commented that she would accept the consensus decision however she remained unconvinced given for £45k the Board could appoint someone for a year, the added value was still unclear and how to take the findings forward also remained unclear.

The **BOARD** reached a conclusion after the consideration of options.

The **BOARD** approved consultancy costs of £45,000 in relation to the proposed Benchmarking & Efficiency review.

6. Any Other Business

No further business had been identified.

7. Date and Time of next meeting

7.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 30 June 2022 at 9.00am in person at Tweed Horizons.

The meeting concluded at 10.34am.

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Borders NHS Board

NHS
Borders

Minutes of a meeting of the **Borders NHS Board** held on Thursday 30 June 2022 at 9.00am via MS Teams.

Present:

Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Mr J Ayling, Non Executive
Cllr D Parker, Non Executive
Mrs A Wilson, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Dr T Patterson, Director of Public Health

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of HR & OH&S
Mr G Clinkscale, Director of Acute Services
Mr C Myers, Chief Officer Health & Social Care
Dr A Cotton, Associate Medical Director MH&LD
Mr S Whiting, Infection Control Manager & Laboratory Service Manager
Mrs C Oliver, Head of Communications & Engagement
Ms J Feathers, Medical Solutions Division
Mr D Knox, BBC Scotland
Mr J Hislop, Border Telegraph
Ms S Downie, Joint Health Improvement Team
Mr R Dickson

DRAFT

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Harriet Campbell, Non Executive, Ms Sonya Lam, Non Executive, Mr John McLaren, Non Executive, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, Mrs Laura Jones, Director of Quality & Improvement and Dr Janet Bennison, Associate medical Director, BGH.

1.2 The Chair recorded the thanks of the Board to Mrs Alison Wilson who would conclude her term of office as a Non Executive of the Board at the end of July.

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

1.4 The Chair confirmed the meeting was quorate.

1.5 The Chair reminded the Board that as it was planned to be a meeting in person a Board Q&A had not been produced in advance of the meeting.

2. Declarations 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 declarations of interests for Dr Tim Patterson, Dr Lynn McCallum, Mr Tris Taylor and Mr John McLaren in the Register of Interests.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 7 April 2022 were approved.

4. Matters Arising

4.1 **Action 3:** Mr Chris Myers confirmed there was no further update.

4.2 **Action 4:** Dr Tim Patterson provided an update and advised that the programme was developing. An appointment process for the Regional Leadership Team was progressing and further discussions were required in regard to what the service would do and how it would be funded.

4.3 Mrs June Smyth commented that an update report was due to be submitted to all Health Boards involved in the regional service in August and if available would be submitted to the Extraordinary Resources & Performance Committee meeting scheduled for 4 August 2022.

4.4 Mr Tris Taylor reminded the Board that there had been a lack of information in regard to public engagement having been carried out. Dr Patterson commented that those comments had been fed back to the Board and they had responded that it had been felt that the public would not notice any changes so there were no plans for public engagement, however staff engagement continued to be progressed.

The **BOARD** noted the Action Tracker.

5. Aseptic Pharmacy Dispensing Service Provision

5.1 Mrs Alison Wilson provided an overview of the report and highlighted several elements including: toxicity assessment; prefill capacity and wastage; and pentamadine.

5.2 The Chair enquired in regard to the ventilated room if there was any risk analysis taking place to help inform a decision. Mrs Wilson commented that NHS Lothian had undertaken the risk analysis as they had put in a ventilated room and that had been their solution to the use of pentamadine.

5.3 The Chair recorded her thanks to Mrs Wilson for all the work undertaken by her and her team to take aseptic pharmacy dispensing forward in NHS Borders.

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The **BOARD** approved the decision to continue with planning for the new Aseptic Pharmacy Dispensing Service Provision noting the additional discussions that had taken place with NHS Lothian.

6. 2022/23 Annual Delivery Plan Commissioning Letter

6.1 Mrs June Smyth provided an overview of the content of the commissioning letter. She explained that during the pandemic the Board Annual Operational Plans had been stood down and remobilisation plans had been formed. It had been confirmed that a one year Annual Delivery Plan would be commissioned for 2022/23 to enable the Scottish Government to support the system as it continued to stabilise following the pandemic and remobilisation of services.

6.2 Mr James Ayling enquired if an analysis of risk could be woven into the actions proposed.

6.3 Mrs Smyth advised that there was a section within the Annual Delivery Plan that described risk in terms of the plan and that it would be widened to include the risks attached to the key deliverables once they were agreed.

6.4 Mrs Fiona Sandford commented that it was critical to speak truth to power and to be realistic about what could and could not be done within constrained budgets. She also suggested that the Board should be sighted on the dangers of not innovating and investing and what the consequences of that would be given the constraints on budgets.

6.5 Dr Lynn McCallum commented that the reality was that not all services as currently offered could be maintained and services would need to transform and potentially do less and a prioritisation process had been put in place. She further advised that she held daily conversations with clinicians in regard to innovation and what could be reduced with the least amount of risk. She further emphasised that it was critical for services that risk sat with the organisation and not with individuals.

6.6 Mr Ralph Roberts echoed the points made by Dr McCallum and emphasised that the organisation was moving into a very challenging period in being able to delivery the requirements of the annual delivery plan as well as planning ahead for the medium and longer term.

The **BOARD** noted the letter.

7. Resources & Performance Committee minutes: 03.03.22

The **BOARD** noted the minutes.

8. Audit Committee minutes: 21.03.22

The **BOARD** noted the minutes.

9. Endowment Fund minutes: 24.03.22, 16.05.22

The **BOARD** noted the minutes.

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10. NHS Borders Annual Report and Accounts

10.1 The Chair advised that the item had been deferred due to various reasons, including time for their review by the external auditors.

11. External Annual Audit Report

11.1 The item was deferred to the Extra Ordinary Resources & Performance Committee meeting on 4 August.

12. NHS Borders Endowment Annual Accounts

12.1 The item was deferred to the Extra Ordinary Resources & Performance Committee meeting on 4 August.

13. NHS Borders Private Patients Funds Annual Accounts

13.1 The item was deferred to the Extra Ordinary Resources & Performance Committee meeting on 4 August.

14. Clinical Governance Committee minutes: 16.03.22

14.1 Mrs Fiona Sandford commented that it was important that the Board should take note of the items that the Clinical Governance Committee had not been assured about, specifically patient flow and staffing, which would be covered in reports later on the agenda. She also advised that the Committee had been partially assured on some smaller matters.

The **BOARD** noted the minutes.

15. Quality & Clinical Governance Report

15.1 Dr Lynn McCallum provided an overview of the content of the report and highlighted some key elements including: significant risks and issues in regard to patient flow; significant outbreaks of COVID-19 in the Borders General Hospital; issues with staffing levels and social care capacity; clinical risk in the Emergency Department due to it reaching maximum capacity on a regular basis; improvement work being carried out to address patient flow issues; assurance that a gap analysis had been taken forward against the Ockendon Report and no issues had been highlighted; and significant challenges in meeting the 20 day response time for complaints.

15.2 Mr Tris Taylor commented that he was mindful of the demand on clinical colleagues and their lack of capacity to contribute to complaint investigations and resolutions as well as health and safety incident reporting.

15.3 Mr Ralph Roberts commented that the Board should be cognisant of the impact that missing targets and staff not producing the service they wanted to provide had on those staff whose wellbeing was being affected. He further commented that it was a similar picture across all of NHS Scotland.

15.4 The Chair recognised the importance of the report and noted that the consequences for the organisation would be owned by the Board.

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The **BOARD** noted the report.

16. Healthcare Associated Infection – Prevention & Control Report

16.1 Mr Sam Whiting provided an update to the content of the report and advised that: there was an increase in COVID-19 patients which was impacting on the Infection Control Team; Hay Lodge hospital had been closed to admissions; Ward 9 in the Borders General Hospital (BGH) had been closed to admissions; there was COVID-19 outbreaks in 3 care homes; and the minimal changes that had been put in place as a consequence of DL (2022) 13 Transition from the Scottish Winter 2021/22 Respiratory Infections in Health and Care settings.

16.2 Mrs Lucy O'Leary enquired of any impact following the lifting of COVID-19 requirements for the public. Dr Lynn McCallum commented that given staff were members of the public when outwith work and able to mingle without restrictions, but were then subject to restrictions when in work given the nature of health services and the vulnerability of patients within the acute sector, it was a difficult situation from a health perspective to manage.

16.3 Mrs O'Leary enquired about the level of electives that had been cancelled compared to pre pandemic levels. Mr Gareth Clinkscale commented that the baseline was half of surgical delivery was being delivered at pre pandemic levels, however it would reduce further given the absence of staff and infections in the hospital due to the resurgence of COVID-19.

16.4 Mr Tris Taylor commented that given COVID-19 patients were being placed in side rooms to mitigate infection and the BGH had an old hospital layout, what the expectation was of where the organisation could be if it had a new hospital campus like NHS Dumfries & Galloway, and how stark the difference was.

16.5 Dr McCallum commented that the layout and age of the BGH had been an on-going issue both pre and during the pandemic with the inability to have enough side rooms to isolate infectious patients. The capacity available was always utilised to best effect and to minimise risk in the Emergency Department.

16.6 Mr Whiting commented that in NHS Dumfries & Galloway they had 100% single room occupancy to assist with reducing the risk of transmission, whereas in the BGH once singe rooms were at capacity patients would be cohorted together into 6 bedded bays, although there remained further complexities in terms of patient gender.

16.7 Mr Clinkscale commented that the availability of side rooms impacted on patient flow and the benefit of a new hospital with single side rooms would benefit the delivery of the elective programme as well as unscheduled care.

16.8 Mr Andrew Bone commented that it is unlikely that there would be an opportunity for a new hospital in the next 10-15 years however the Scottish Government have recognised the requirement for a major refurbishment of the existing Borders General Hospital, which would be expected to include consideration of how space can be fundamentally reconfigured to achieve the impact of a 'new hospital' within the existing facility. Mr Bone added that there would be other considerations

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included in any new hospital build request such as revenue consequences and the ability to recruit and retain staff to work within the new hospital.

16.9 Further discussion focused on: educating the public on infection control; the majority of the public reverting back to normal behaviour when pandemic restrictions were lifted; difficulties with recruitment within the infection control team; educating the public on using NHS24, Pharmacists, GPs instead of presenting directly at the Emergency Department; manage of COVID-19 patients in the BGH via side rooms; and a comparison of nosocomial infection outbreaks with NHS Dumfries & Galloway.

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

17. Area Clinical Forum Minutes: 30.11.21, 05.04.22

The **BOARD** noted the minutes.

18. Area Clinical Forum Annual Report

18.1 Mrs Alison Wilson provided an overview of the content of the Annual Report.

18.2 Mrs Lucy O'Leary enquired how the ACF engaged with both health and social care. Mrs Wilson commented that the ACF was not required to engage with social care as it was an Advisory Committee to the Health Board, however it had previously tried to involve social work colleagues but that had not gained any traction.

18.3 Mr Chris Myers commented that the health and social care partnership were developing a clinical and care governance framework across the partnership in line with best practice.

18.4 Mrs Wilson further commented that the ACF Terms of Reference had been revised to increase the number of members of the ACF to Chairs, Vice Chairs and a representative from each of the Advisory Groups and to also open up the ability of all of those members to stand as Chair of the ACF.

The **BOARD** noted the ACF Annual Report.

19. NHS Borders Performance Scorecard

19.1 Mrs June Smyth provided an overview of the content of the report which was presented in the new format.

19.2 The Chair welcomed the change in format.

19.3 Mr James Ayling enquired about waits of over 52 weeks in endoscopy and why the independent facility was not being used to reduce urgent waits. Mr Gareth Clinkscale commented that in terms of endoscopy the independent contract capacity was being prioritised for urgent activity. The longest waits for endoscopy were waiting for surveillance activity and the endoscopy team were working on a recovery plan.

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19.4 Mr Ayling also enquired about the rationale of being able to protect elective capacity in August when it could not be protected up to June. Mr Clinkscale advised that in terms of protected elective capacity, work had been taken forward on the creation of elective wards through the acute recovery programme and it was anticipated that it would lead to an ability to protect elective capacity in August.

19.5 Dr Lynn McCallum commented on balancing the risk of those waiting on elective procedures in the community and those presenting in the Emergency Department requiring urgent care and procedures against the background of COVID-19, limited staffing and limited space.

19.6 Mr Ayling enquired how that balance of risk was applied for people bedded in the Emergency Department whilst vacant beds were being protected for elective activity. Dr McCallum commented that it was a real challenge on a daily basis on balancing keeping the elective programme going and recognising the long waits in the Emergency Department and the issues with patient care, staff absence and staff exhaustion.

The **Board** noted performance as at end of May 2022.

20. Code of Corporate Governance Sectional Update

20.1 Miss Iris Bishop provided an overview of the content of the updates to the Code of Corporate Governance.

The **BOARD** formally ratified the Members Code of Conduct, which was agreed by the Board via email in May 2022.

The **BOARD** approved updated Section B, Section D and Section G of the Code of Corporate Governance.

21. Scottish Borders Health & Social Care Integration Joint Board minutes: 02.03.22

The **BOARD** noted the minutes.

22. Any Other Business

22.1 No further business had been identified.

23. Date and Time of next meeting

23.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 6 October 2022 at 9.00am in person at Tweed Horizons.

23.2 The Chair further advised that there was an intention to hold an Extraordinary Borders NHS Board meeting on 4 August 2022 to approve the Annual Report and Accounts.

The meeting concluded at 10.28am.

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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. **Update 30.06.22:** Mr Chris Myers confirmed there was no further update.

Meeting held on 2 December 2021

Agenda Item: Matters Arising

Action	Reference	Action	Action to be	Progress (Completed, in progress, not

Number	in Minutes		carried out by:	progressed)
4	4.1	**Minute 6.8: Regional Health Protection Service:** Dr Tim Patterson suggested an agreed model would likely be available later in the year and an update be provided in March. The Chair asked that a progress report be provided to the March Resources & Performance Committee meeting.	**Tim Patterson**	**In Progress:** Item scheduled for Resources & Performance Committee meeting to be held on 3 March 2022. **Update:** A progress report was not provided and depending on progress nationally a full report was anticipated for the November Resources & Performance Committee meeting.

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. **Update:** This subject matter has now been deferred to the October Board Development session to allow the Board to focus on risk and strategy at the June session. **Update:** This subject matter has now been deferred to the December Board Development session.

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.

				Update: With the appointment of a new Director of Public Health this subject matter has now been deferred to the December Board Development session

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**NHS Borders Annual Delivery Plan 2022/23**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Author:	**Katy George, Planning & Performance Co-Ordinator**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Delivery Plan 2022/23

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper is to seek approval from members of the NHS Borders Annual Delivery Plan for 2022/23, referred to as ADP, alongside the feedback letter received from Scottish Government and our Delivery Planning Template.

2.2 Background

On 27th April 2022, NHS Borders received a letter from Scottish Government commissioning the development of a 2022/23 Annual Delivery Plan.

The submission date for the Annual Delivery Plan was the 30th June 2022. A subsequent extension was made to the submission date, which was changed to the

29th July 2022. NHS Borders was able to meet this new deadline date and submitted the plan on 21st July 2022. The plan is attached as **Appendix 1** and was signed off by the Chief Executive and Chair on behalf of NHS Borders Board.

2.3 Assessment

The plan focusses on a limited set of priorities which will enable the system and workforce to recover from the pressure experienced over the last two years, whilst taking forward improvement work heading into the Winter months.

The 2022/23 Service Priorities to be outlined were:

- Recruitment, retention, and wellbeing of our Health & Social Care Workforce
- Recovering Planned Care and looking to what can be done to better protect planned care in the future – complementing the information already submitted on activity levels for inpatient and day case
- Urgent and unscheduled care – taking forward the high impact changes through the refreshed collaborative
- Supporting and improving social care
- Sustainability & value

Following submission of the plan members of the Board Executive Team met virtually with Scottish Government on the 19th August 2022 to discuss the submission.

A formal feedback letter was received on 22nd September 2022 (letter attached as **Appendix 2)** on NHS Borders Annual Delivery Plan & the Delivery Planning Template confirming that on the basis that their feedback will be incorporated into the Quarter 2 update, Scottish Government approve and recommend that the Annual Delivery Plan can be presented to the Board for approval.

Areas of good work planned for 2022/23 highlighted in the feedback letter include:

- The Compassion Focused Therapy pilot is an innovative approach which reflects priority of Pain Informed Care at the national level. The team is keen to understand progress and learning to inform national approach on this Action.
- Progress made with the establishment of the Renew service and plans to progress to an ageless service.
- Consistently strong approach to cancer here and throughout the pandemic.
- Comprehensive consideration of both NHS Job families and Social Care Professional roles with informative narrative content.
- Good work underway to support timely discharges. It is encouraging to see the adoption of Planned Date of Discharge and Home First service.

Information that Scottish Government would like to see included in the Quarter 2 update have been outlined below:

- Deliverables within ADP template to explicitly address each of the six priority areas within the commissioning guidance.
- Inclusion of specific timescales and milestones for each deliverable, with the understanding that these may need to be refined between each year.

- Showcase Realistic Medicine work that is ongoing within the organisation.
- Detailed information on specific work around Health Inequalities, or how deliverables will address inequalities.
- Ensure that the ADP is regularly reviewed to ensure they are deliverable within current financial envelopes and from expected available staffing levels.
- Inclusion of high-level actions relating to the implementation of MAT standards.
- Expectation for delivery planning templates to include key actions for Winter.

It should also be noted that Scottish Government will issue separate feedback on the Three-Year Workforce Plan which will include relevant comment on plans for Recruitment & Retention.

The Delivery Planning Template **(Appendix 3)** will be used to monitor the progress of the deliverables set out within the Annual Delivery Plan and will be updated ahead of the Quarter 2 update being submitted.

The Quarter 2 update of the Annual Delivery Plan and the Delivery Planning Template is due for submission by the 28th October 2022. It should be noted that a Q1 return has been submitted along with the Annual Delivery Plan, which was based on RMP4, however the Annual Delivery Plan and Delivery Planning Template supersedes the information within this. This document will be circulated for information separately.

Considering the change in funding allocations since the submission of NHS Borders Annual Delivery Plan, the trajectories that have been included within the plan may need to be revised appropriately. The current trajectories have been added as **Appendix 4**.

Other areas of the plan may also have been affected by the evolving financial position since the submission of the Annual Delivery Plan.

2.3.1 Quality/ Patient Care

The Annual Delivery Plan covers deliverables that promote Safety, increase Effectiveness, and are Person Centred.

2.3.2 Workforce

The Annual Delivery Plan gives a high-level overview of NHS Borders Workforce Plan, however a more detailed Three Year Workforce Plan in also in development.

2.3.3 Financial

The Financial Plan underpins the performance targets for the year and the Annual Delivery Plan. The plan references the Financial Improvement Programme and the challenges associated with managing the backlog in a financially restricted environment.

2.3.4 Risk Assessment/Management

The narrative within the Annual Delivery Plan highlights any particular risks to the achievement of the targets, and the plans in place to minimise such risks.

2.3.5 Equality and Diversity, including health inequalities

Services will carry out HIIA's as part of delivering 2022/23 ADP key deliverables.

2.3.6 Climate Change

None identified.

2.3.7 Climate Change Other impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

The Annual Delivery Plan along with the Delivery Planning Template was developed through workshops with Business Units, members of the Operational Planning Group, Board Executive Team & the Chair of NHS Borders.

2.3.9 Route to the Meeting

The Annual Delivery Plan was developed in conjunction with service and clinical leads and was 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.

- Operational Planning Group 11th July 2022
- Health & Social Care Partnership 11th July 2022
- Board Executive Team 12th July 2022
- Chief Executive 13th July 2022
- NHS Borders Chair 20th July 2022

The feedback letter from SG was/will be presented to the following meetings:

- Operational Planning Group 27th September
- Board Executive Team 4th October

2.4 Recommendation

That the Board **formally approve** the NHS Borders Annual Delivery Plan 2022/23 as at September 2022

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Annual Delivery Plan 2022/23
- Appendix 2, Scottish Government Feedback Letter
- Appendix 3, NHS Borders Delivery Planning Template
- Appendix 4, NHS Borders 2022/23 Trajectories

Annual Delivery Plan

2022/23

July 2022

DRAFT

Table of Contents -

1. Introduction	4
2. Setting the Scene	4
3. Staff Wellbeing	6
4. Recruitment & Retention of our Health and Social Care Workforce	7
5. Recovery & Protection of Planned Care	11
6. Urgent & Unscheduled Care	20
7. Mental Health Services	23
8. Supporting & Improving Social Care	30
9. Delayed Discharge	32
10. Sustainability & Value	33
11. Key Risks	35
12. Summary	36
13. Appendices	36

Glossary –

Abbreviation	Meaning
ACP	Anticipatory Care Plans
ACRT	Active Clinical Referral Triage
ADHD	Autism and Attention Deficit Hyperactivity Disorder
ADP	Alcohol & Drug Partnership
AHP	Allied Health Professional
ANP	Advanced Nurse Practitioner
BAS	Borders Addiction Service
BECS	Borders Emergency Care Service
BGH	Borders General Hospital
BI	Business Intelligence
BRAN	Benefits, Risks, Alternatives (do) Nothing
BRP	Backlog Recovery Plan
CAMHS	Child & Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapies
CCE	Colon Capsule Endoscopy
CfSD	Centre for Sustainable Delivery
CMHT	Community Mental Health Team
CPD	Continued Professional Development
CYV	Collecting Your Voices
DACS	Digital Asynchronous Consultation System
DME	Department of Medicine for the Elderly
ECG	Echocardiogram
FIP	Financial Improvement Programme
GP	General Practitioner
GRC	Gala Resource Centre
HIIA	Health Inequalities Impact Assessment

DRAFT

HSCP	Health & Social Care Partnership
ICU	Intensive Care Unit
IPCB	Integrated Planned Care Board
JCVI	Joint Committee for Vaccination and Immunisations
LMP	Local Mobilisation Plan
M&M	Mortality and Morbidity
MAT	Medication Assisted Treatment
MDT	Multi-Disciplinary Team
NDIP	National Dental Inspection Programme
NDTI	National Development Team for Inclusion
NGJH	National Golden Jubilee Hospital
NRAC	NHS Scotland Resource Allocation Formula
NTC	National Treatment Centre
OH	Occupational Health
OH&S	Occupational Health & Safety
PIR	Patient Initiated Review
PMO	Project Management Office
PT	Psychological Therapies
RDS	Right Decision Service
RM	Realistic Medicine
RMP3	NHS Borders Remobilisation Plan 2021/22
RMP4	NHS Borders Mid-Year Update to Remobilisation Plan 2021/22
RSV	Respiratory Syncytial Virus
SBC	Scottish Borders Council
SDS	Self-Directed Support
SOP	Standard Operating Procedure
SPR	Specialist Registrar in Public Health
TEPS	Treatment Escalation Plans
TTG	Treatment Time Guarantee
VTP	Vaccination Transformation Programme
WSS	Workforce Specialist Service

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1. Introduction

1.1 This document and subsequent appendices set out NHS Borders' Annual Delivery Plan (ADP) for 2022/23.

1.2 At the time of writing this plan, delivery is based on the assumption of previous resource agreements. We note the letter of 14 July 2020 from John Burns, Chief Operating Officer – NHS Scotland and Richard McCallum, Director of Health Finance and Governance, which sets out Scottish Government's expectations regarding 2022-23 Priorities and Finance Planning for health. This letter was received whilst our ADP was being finalised and as such has not yet been factored into the priorities and plans as set out in this document and the appendices. We will need time to reassess our plans in light of this correspondence and feedback from Scottish Government.

2. Setting the Scene

2.1 Our reality

2.1.1 NHS Borders operates throughout the Scottish Borders which has a remote and rural geography. There is an aging population with many people living with multiple health conditions and a shrinking work age population which magnifies the shortage of staff being faced nationally. The workforce that we do have are exhausted from the continued and sustained pressures being faced by our services.

2.1.2 Our estate is aging and this adds additional complexities to our ability to fully recover our services and backlog maintenance issues remain a challenge due to a lack of suitable facilities to decant services to.

2.1.3 NHS Borders still carries a financial deficit from before the pandemic which is covered in more detail in section 9 of this document.

2.1.4 At the time of writing this annual plan we continue to face unprecedented demand, capacity and fatigue. We are concerned about our staff and are very aware of the frustration building within our communities. We also continue to see COVID-19 admissions. Our emergency department continues to be under extreme pressure and reluctantly planned routine operations have had to be cancelled and remain under daily review. Everything possible is being done to continue with emergency and urgent cancer surgery during this time. Workforce challenges, staff sickness, recruitment challenges and delayed discharges continue to impact on our whole health and care system and our ability to provide services to the quality that we expect, as well as remobilise our elective programme.

2.1.5 Our priority remains in stabilising our system so that we can start to recover, remobilise and plan for the medium term. It should be recognised, however, that given ongoing system challenges and pressures many of the deliverables and milestones outlined in the delivery plan attached to this document are at the proposal and scoping stage.

2.2 Impact of the Pandemic

2.2.1 The requirement to still work with some limitations in line with Scottish Government guidance for health care settings means that we continue to see fewer patients at one time than we did prior to COVID-19, which impacts on our ability to deliver services.

2.2.2 When we do see our patients there is evidence of “Non COVID-19 Harm” as people have deteriorated during the pandemic.

2.2.3 There is a significant backlog of patients awaiting diagnosis or treatment and we anticipate that is will take a number of years to clear this backlog. Please see the section on Planned Care further on within this document for further detail.

2.2.4 There is significant impact on staff wellbeing and staff retention as they have had no break to recover from pandemic due to ongoing system pressures and staffing levels being depleted.

2.3 Recovery & redesign

2.3.1 The ongoing challenges of responding to the pandemic, whilst stabilising, recovering and remobilising are having a significant impact on our workforce and treatments of other illnesses and conditions. This means that we are not delivering the levels of service or outcomes that we would want them to be.

2.3.2 Our reality tells us that we need to redesign and transform our services as we move forward both with this plan and through the development later this year of our medium-term (3 year) plan. We are and will continue to apply learning from the pandemic into our planning moving forward.

2.3.3 Whilst we remain committed to ensuring that the experience of our staff, patients and service users is central to delivery and development of services, we have not had the opportunity to actively engage with the wider public during the development of this ADP. We have had light touch engagement with some of our public involvement members to sense check the plans. Broader and wider engagement with patients, the public, carers and other stakeholders will be undertaken as we develop the medium-term Plan.

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3. Staff Wellbeing

3.1 Our remobilisation plans for 2021/22 outlined the significant work that was being undertaken to support staff wellbeing during the ongoing pandemic. To build on this we are now refreshing our Staff Wellbeing Plan. This will be a vital component of a wider NHS Borders Health & Social Care Workforce Strategy and will sit alongside our Integrated Workforce Plan. The plan will describe interventions aimed at supporting our workforce to work through the remainder of the emergency response phase and will set out plans for the medium-longer term, including learning to live with COVID-19 and building resilience to face any future adversity/challenges.

3.2 Occupational Health and Safety (OH&S) Services have enhanced resources to meet the ongoing additional demand as a result of the pressures facing staff. OH&S continues to offer onsite support, 1:1s and sessions with departments, in addition to bespoke interventions tailored to staff needs and requests. Stress and resilience training, Working Health Matters and Managing Mental Health for Managers courses and resources have been revamped to be more accessible to staff, moving away from classroom and workshop-based delivery wherever possible.

3.3 We continue to have a dedicated Staff Psychologist who can offer specialist psychological support for those dealing with the impact of traumatic situations, or those with a history of mental health issues and who may benefit from high intensity psychological intervention. Support is available through 1:1 support, as well as talks and guidance to teams. Examples include compassionate wellbeing workshops and psychological debrief following difficult workplace events.

3.4 We have also increased our offering with regards to coaching and mentoring for staff through our internal Coaching Network.

3.5 NHS Borders continues to operate a Staff Wellbeing Group populated by a range of management, clinical and staff-side representatives. The group has agreed projects to support the physical and mental health wellbeing of NHS Borders staff and is currently progressing a Spaces Project, which sets out to identify and establish fit-for-purpose indoor and outdoor spaces for staff to use during their rest breaks. Areas will promote a relaxing environment for staff, allowing them to decompress during the working day. The group has also facilitated the provision of hot beverages/snack boxes/water bottles to hard-pressed areas at peak points of the pandemic, along with the provision of free menstrual products for patients, visitors and staff. Recognising that staff in busier areas find it challenging to take their breaks, we have increased our internal communications to remind staff and managers to support staff taking breaks. Later this year the group will commence a complimentary therapies project and a new active travel project.

3.6 We continue to actively seek feedback from staff to help inform our remobilisation and stabilisation efforts. Our Collecting Your Voices initiative (2020 & 2021) captured how it feels to deliver care in the current environment and its output still

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influences work in the wellbeing arena, as does feedback from the recent iMatter survey. Staff side also recently issued a staff side survey which sought to understand key issues around how it feels to work in NHS Borders and to seek ideas to address and resolve any of the challenges. This has been shared with the Board Executive Team (BET), Area Partnership Forum (APF) and the Staff Wellbeing Group. The chair for the Staff Wellbeing Group and Lead for Collecting Your Voices (CYV) are working collectively to bringing the outputs into mainstream decision processes.

4. Recruitment & Retention of Our Health & Social Care Workforce

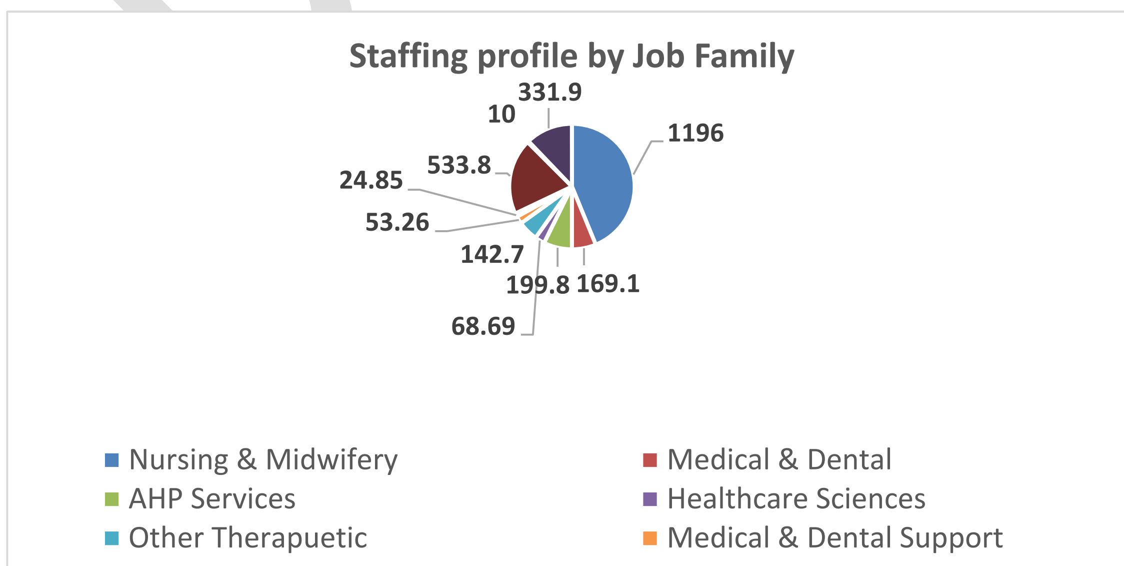
4.1 Workforce Plan

4.1.1 Our 3-year Workforce Plan (the Scottish Borders Health & Social Care Workforce Plan, 2022 – 2025) will be published in line with the timescale from the Scottish Government i.e. no later than 31 October 2022.

4.1.2 The plan will be a joint submission between NHS Borders and the Health & Social Care Partnership and aims to support the continued remobilisation of our services. The plan will also highlight opportunities for working differently due to our experiences of the pandemic. There will be close collaboration with all partners (e.g. Scottish Borders Council, independent providers, the voluntary sector and NHS Borders) in the co-production of the workforce plan to include the wider health & social care workforce. Previously, under CEL 32 (2011) NHS Boards were required to produce an annual workforce plan. the move to a longer term and integrated workforce planning cycle is very much welcomed. We recognise the considerable value moving to a longer-term integrated workforce planning cycle which allows better alignment with strategic planning timescales and reduces factors inhibiting effective workforce planning.

4.2 Key Workforce information

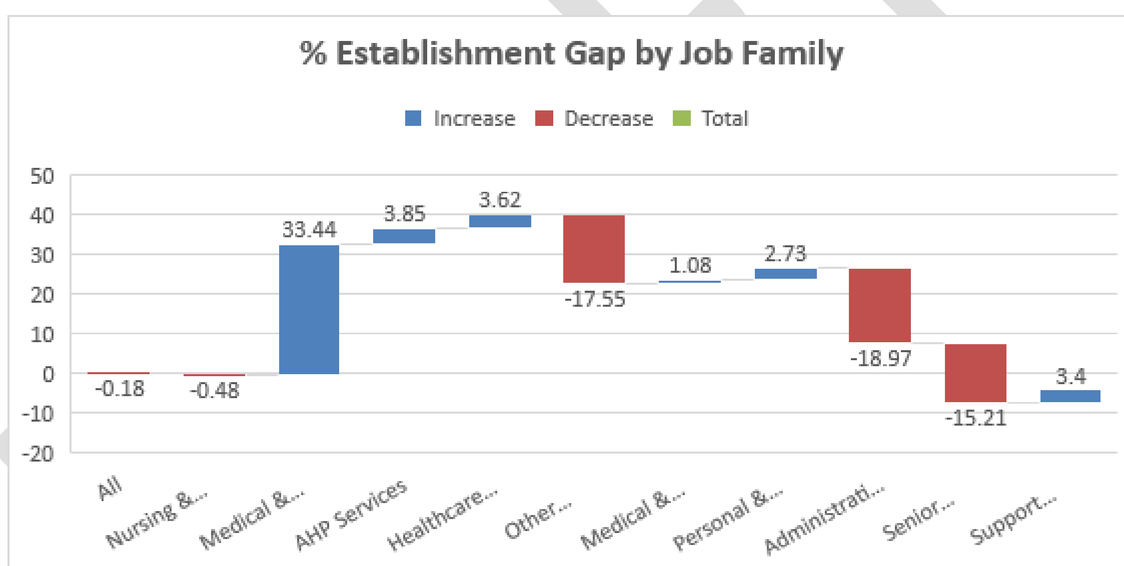
Table 1 - Current Staffing Profile by job family per WTE



4.2.1 In 2021/22 the Whole Time Equivalent (WTE) of NHS Borders workforce is almost in balance with our funded establishment (see table 2). However, within this supplementary staffing across all staff groups accounts for 377 WTE (14%). A key challenge over the next year is therefore to shift this supplementary staffing to substantive posts with stable long-term employment, therefore increasing the sustainability and stability of our workforce.

4.2.2 Table 2 below illustrates that although the overall gap between funded establishment and WTE is -0.18%, (equating to 5 WTE over establishment), there is significant variation across the staff groups with Medical and Dental having 33.4% fewer WTE than funded establishment, compared to Administrative Services which have 18.97% higher WTE than funded establishment.

Table 2 - Current Establishment Gap by job family

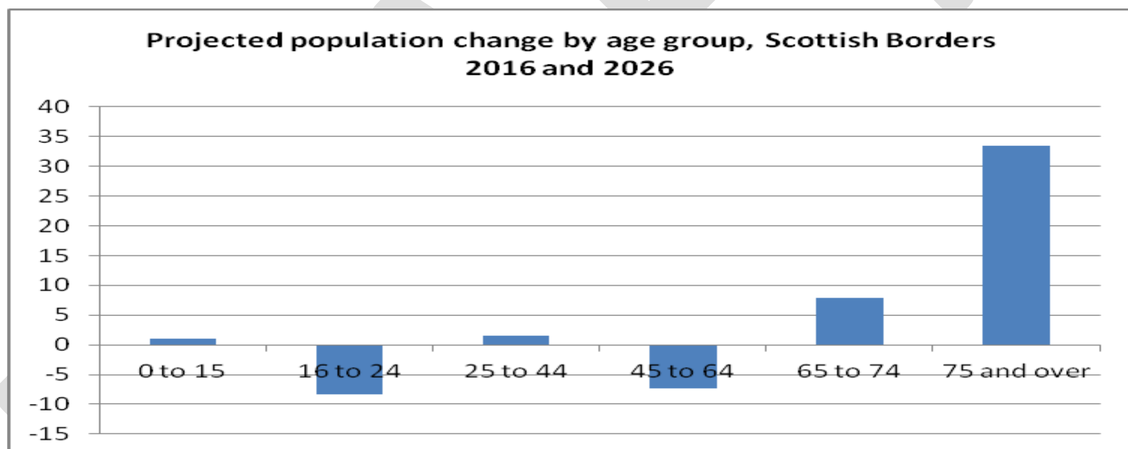


4.2.3 A multi-disciplinary and multi-agency workforce planning group has been established which meets weekly to prepare the initial draft of the 3-year workforce plan and there is oversight from a monthly steering group with Director level involvement. Our shared objective is to prepare a local workforce plan that meets the 5 pillars of the National Workforce Strategy for Health & Social Care Workforce Strategy in Scotland.

4.2.4 The key is understanding the workforce journey for Health & Social Care staff as demonstrated by the five pillars of Plan, Attract, Train, Employ and Nurture (PATEN):

4.2.5 The major challenge in Scottish Borders continues be the ageing workforce which reflects the demographics of the Scottish Borders general population:

Table 3 Projected Population Change



4.2.6 The ageing population will have a significant impact on our services as there will be a rise in the number of people with multiple and complex long-term conditions increasing the demand on health and care services. There is also a consequent workforce and labour market implication as the population of working age reduces. We recognise services over the longer term need to be transformed to take account of this trend of a reducing available workforce and some of our aspirations such as developing 7-day services or new advanced roles Advanced Nurse Practitioner (ANP) roles for example) will require on-going review and potential modification.

4.2.7 Workforce planning is essential to ensure a proactive approach to delivering care in this changing demographic environment. In simple terms the ageing population will not only change the service demands, it will also be reflected in the availability of the health and social care workforce. To sustain services, we need to be innovative in our employment practices and continue to strive to be employers of choice, to ensure that we continue to attract the right people, in the right places, for the right

job. This means we will also seek to attract the younger workforce within the Scottish Borders, succession plan and retain our staff to build our workforce for the future.

4.2.8 There will be a greater need for role development and training of Advanced Nurse Practitioner (ANP) posts and Advanced Allied Health Professional (AHP) posts with independent prescribing responsibilities. This will help to address reduced medical cover, and the current challenges around a smaller recruitment pool of core clinical roles in Nursing, Midwifery and AHPs (NMAHP). We are also working closely with Scottish Borders College to explore the potential for reviewing skill mix to include further development and training of Band 4 Assistant Practitioner roles. This year will also see continued implementation of the Nursing and Midwifery Workload and Workforce Planning Tools and real time staffing resources, with a potential expansion of the tools when the legislative timetable for Safe Staffing is confirmed; likely to be later this calendar year.

4.2.9 This year we will modernise our Marketing and Branding strategy; improving our social media presence to sell Borders as good place to live and work for both local candidates and those from further afield. By the end of 2022 we aim to have recruited 12 Registered General Nurses from overseas to work on medical, medicine for the elderly (DME) and, surgical wards as well as in theatres. We are also reviewing international sources for other hard to recruit professions within AHPs. Lack of availability and affordability of private rental accommodation locally is proving a limiting factor in attracting and retaining both UK and overseas workers. Recently representatives from NHS Borders and Scottish Borders Council met to review joint approaches to recruitment and high on the action-list is future joint approaches to housing for key workers in the Public Sector.

4.2.10 The final implementation phase for the East of Scotland regional recruitment service is scheduled for 27 July 2022. From that date NHS Lothian will be the provider of all transactional recruitment services to 5 Health Boards in the consortium. Along with our partner NHS Boards we will be seeking the benefits of returns to scale from high volume recruitment allowing managers to focus on innovative recruitment and attraction methodologies.

4.2.11 Alongside our absolute commitment to patient safety, the welfare and safety of staff will always be a top priority. In addition to national and local OH&S provision NHS Borders operates a partnership led Staff Wellbeing Group. this group has been involved in enhanced counselling/psychological support to staff, the organisation of staff rest areas, provision of hot beverages/snack boxes/water bottles to hard-pressed areas, and provision of free menstrual products.

4.2.12 Emerging from the Pandemic and with an uncertain financial outlook NHS Borders will implement further measures to ensure best value from the workforce. This will include the refreshing of our vacancy control process following our previous process being partly stood down in April 2020. The purpose of a Vacancy Control panel is to

DRAFT

scrutinise applications to recruit to posts and ensure that all posts approved for recruitment are essential.

4.2.13 We participate in several employability schemes to provide employment opportunities to those who faced barriers to employment. These have recently included Kick Start and the Job Creation Fund where we provide 6-month job placements across areas including Domestic Services, Catering, Speech and Language therapy and Healthcare Support Workers. We support Modern Apprenticeships; Graduate Apprenticeships and this year will provide Foundation Apprenticeship placements for the first time in partnership with Borders College and Social Care partners. NHS Borders also continues to support Project Search which is a yearlong programme to support young people with Autism or Learning Disabilities into employment.

5. Recovery & Protection of Planned Care

5.1 Delivery against 2022/23 Planned Care Plans

5.1.1 Initial recovery plans were submitted to Scottish Government (SG) in February alongside the funding required to deliver the supporting activity projections. These included expected demand and activity profiles across outpatient, Treatment Time Guarantee (TTG), Diagnostic and Endoscopy waiting activities.

5.1.2 On request initial proposals were adjusted down to work within a funding envelope consistent with the waiting times funding allocation provided to NHS Borders in 2021/22 and projected for 2022/23. Activity and associated waiting times trajectories were adjusted accordingly to reflect this funding envelope.

5.1.3 The primary objective for elective services during 2022/23 has been to stabilise the overall waiting time position where possible, particularly in respect of outpatients and diagnostics wait times, and reduce overall waits as capacity allows. Activity in Radiology is at pre-pandemic levels, with outpatient activity expected to return to pre-pandemic levels by July 2022.

5.1.4 Expectations in respect of elective surgical capacity were more circumspect with plans to recovery to pre-pandemic activity levels by March 2023, accepting that we may see overall patient numbers and waiting times in most specialties increasing as available capacity is prioritised to urgent cases. To support recovery significant additional independent sector support has been requested as part of waiting times bids for both Ophthalmology and Orthopaedics.

5.1.5 We have recovered to 90% of baseline outpatients activity by the end of the first quarter of 2022/23 for most outpatient specialties. With the support of additional capacity from waiting times we had aimed to stabilise and then reduce waiting times

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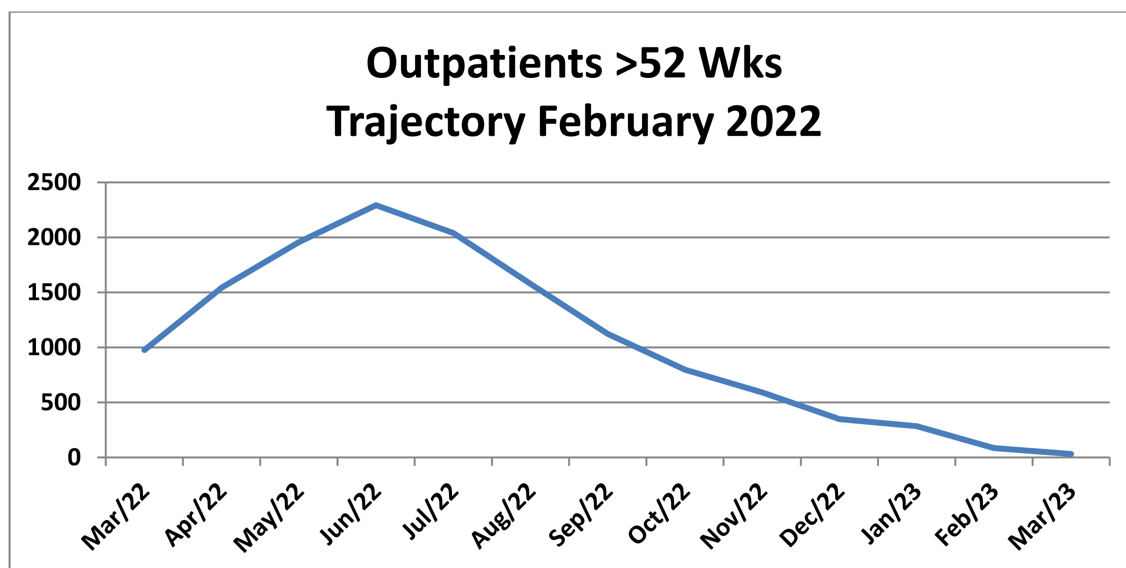
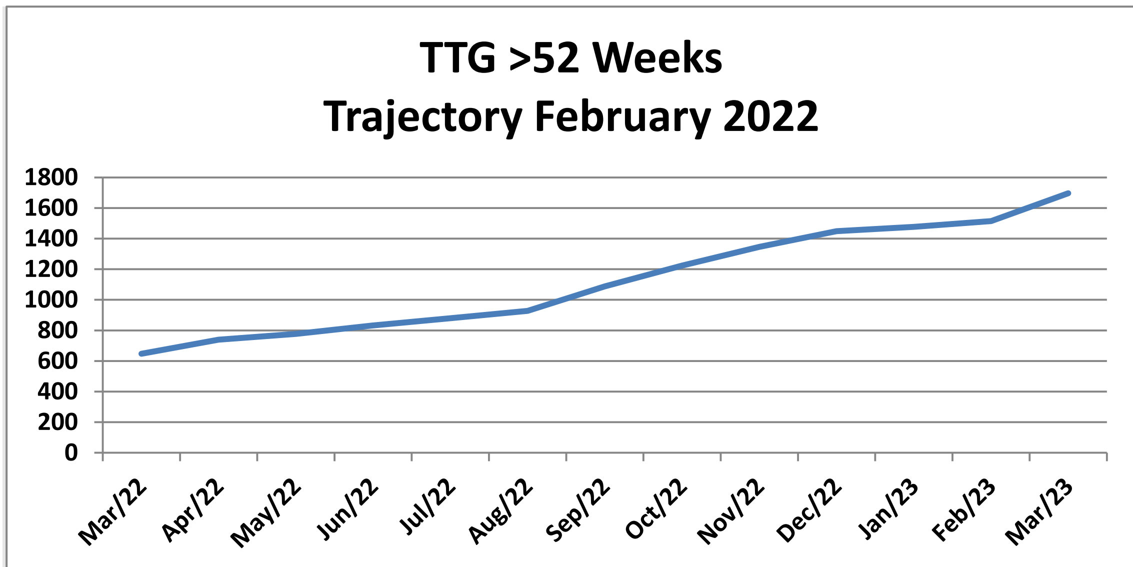
in outpatients moving towards a maximum wait of 52 weeks by the end of March 2023 in most Specialties.



Following the recent announcement of updated national targets for long wait patients we are currently working through our plans to adapt these local trajectories. This will be an iterative process in conjunction with the Scottish Government.

5.1.6 Recovering elective surgical capacity to pre-COVID-19 levels will take to the end of 2022/23. This reflects the significant investment required in recovering workforce numbers in theatres and in establishing day case and inpatient capacity sufficient to support available capacity. From a baseline of 50 - 70% of pre-pandemic activity in between the period March – May 2022 we will work to recover core capacity gradually during the year. We aim to return to 100% of pre-pandemic activity levels by the end of March 2023. NHS Borders ability to meet this aim will be dependent on unscheduled care, COVID-19 and workforce pressures. While we will supplement capacity during 2022/23 with the use of NGJH and the Independent Sector, we are currently expecting to see the overall size of waiting lists to continue to grow until we are able to recover and then maintain elective capacity. Following the recent announcement of updated national TTG targets for long wait patients we are currently working through our plans to adapt these. This will be an iterative process in conjunction with the Scottish Government. We will accelerate timescales wherever workforce numbers permit.

5.1.7 We will work closely with colleagues in unscheduled care teams to plan for winter in a way that ensures that plans minimise the risk of interruption to elective service given the clinical and social impact of extended elective surgical waits. The graph below outlines NHS Borders' trajectory for 2022/23. However, given the recent letter received from John Burns regarding Long Waits Targets, this is currently being assessed and will be updated to reflect this in due course.



5.1.8 We will work to maintain waiting times in Radiology, and with the support of waiting times funding extended session times in both CT and MRI into evenings and weekends by quarter 3 and as recruitment allows. We will continue to utilise additional capacity in both CT and MRI at the National Golden Jubilee Hospital (NGJH) and have planned to use a mobile MRI scanner for an additional 12 weeks during 2022/23, reflecting an expectation that we will see demand increasing significantly.

5.1.9 We plan to install a replacement CT scanner and mammography machine during 2022/23, in addition to installing a digital x-ray machine purchased to support improved productivity and throughput.

5.1.10 We will work to reduce the number of routine waits in endoscopy that that have developed over the course of the last 2 years. With funding secured from cancer waiting times we will appoint a Trainee Nurse/AHP Endoscopist to build capacity and resilience into this key service. Interim capacity will be sourced from independent providers until we can develop local capacity sufficient to meet current levels of demand.

5.2 Returning to and moving above 2019/20 baseline of activity

5.2.1 As noted, outpatient capacity will be recovered during quarter 2 of 2022/23, however elective surgical will not be returned to baseline capacity until the start of 2023/24. Whilst Radiology capacity has returned to pre-pandemic levels, endoscopy capacity will be problematic until we are able to appointment and train further operator capacity. We will see our endoscopy unit operating at 80% of core capacity for the majority of 2022/23 as plans are delivered to improve this position.

DRAFT

5.3 Taking full advantage of high-impact changes and transformation opportunities

5.3.1 Over the last 2 years services have had to adapt and embrace new ways of working. We plan to capitalise on this work, to support recovery and redesign outpatient services further to create outpatient capacity. An element of this will include prioritising service reviews, using the Team Service Planning approach to design new models of care. The approach will be supported by Clinical Management Teams and liaison with national Specialty Delivery Groups and build on the input from the Centre for Sustainable Delivery (CfSD).

5.3.2 Our Outpatient Delivery Steering Group will identify, prioritise and develop workstreams and workplans to deliver the overall outpatient improvement plan.

5.4 Reducing Outpatient Waiting Times

5.4.1 There is a plan in place for additional activity through the Waiting Times allocation to address longest waiting patients. NHS Borders will see further capacity released to reduce waiting times through implementation of specialty pathways, opt in, education, Active Clinical Referral Triage (ACRT) and Patient Initiated Review (PIR).

5.4.2 Working alongside primary care, our acute sector will consider further specialty pathways suitable for "Opt In". Health information to patients is critical for these pathways to allow them to make informed decisions. The Project Team will work on ensuring that there is robust information portal which has been clinically validated and putting in place standardised processes to administer the pathways.

5.5 Active Clinical Referral Triage (ACRT)

5.5.1 Most specialties are now undertaking enhanced vetting following focussed work in 2021/22 to achieve this. During 2022/23 NHS Borders will focus on standardising the vetting process (outcomes) on the patient information system to facilitate consistent and reliable reporting of ACRT. Specialties will progress further local pathways to maximise ACRT and in doing so clinicians and managers will work collaboratively with the National Specialty Delivery Groups and other improvement forums at the Centre for Sustainable Delivery. There is a clear commitment between primary and secondary care locally, via the Clinical Interface Group, that patients will be vetted to optimal pathways contributing to improving access.

5.6 Centre for Sustainable Delivery (CfSD) Heat Map

5.6.1 NHS Borders has begun work to develop and automate a reporting function for the heat map. Throughout 2022/23 they will also work closely with CfSD to further develop, analyse and discuss outcomes and improvement plans. As part of this work, NHS Borders is looking forward to linking in with other NHS Boards, sharing learning to support service improvement.

5.7 Patient Initiated Review (PIR)

5.7.1 Several specialties have implemented Patient Initiated Review (PIR). There is a plan in place to further roll out PIR providing patients with control over their follow-up, with direct access back into specialist care.

5.7.2 Implementation of ACRT and PIR have a dedicated project manager and will be measured via our regular submission of the local Heatmap. NHS Borders has begun work to develop and automate a reporting function for the Heatmap. Throughout 2022/23 they will also work closely with CfSD to further develop, analyse and discuss outcomes and improvement plans. As part of this work we are looking forward to linking in with other NHS Boards, sharing learning to support service improvement.

5.8 Opt-In

5.8.1 Working alongside primary care, NHS Borders acute sector will consider further specialty pathways suitable for "Opt In". Health information to patients is critical for these pathways to allow them to make informed decisions. The Project Team will work on ensuring that there is robust information portal which has been clinically validated and standardised processes in place to administer the pathways.

5.9 Patient Validation

5.9.1 As part of our initial response to increasing waiting times NHS Borders amended processes for writing to patients to ensure that all patients on Outpatient and TTG waiting lists were contacted directly to:

- Apologise for the ongoing delay
- Reassure patients that they remain on a waiting list and provide details of their waiting list entry
- Provide contact details should they wish to discuss their clinical condition
- Request that they let us know if they no longer required an appointment

5.9.2 We have amended this process more recently to extend the policy to contacting patients directly at 26-week intervals for the duration of their wait. This has been implemented for TTG waits, and the booking team are working with our Business Intelligence (BI) team to put in place processes for those in Outpatient queues.

5.9.3 We are exploring the potential use of technology like the NetCall system to support and streamline this process, particularly for volume outpatient waits, but we have yet to make a final decision on it cost effectiveness given implementation and ongoing support costs.

5.10 Clinical Validation

5.10.1 We have re-established our clinician led Clinical Prioritisation Board which follows the Clinical Prioritisation Framework that was developed during the pandemic to ensure that the most significant decisions about allocation of resources is clinically led.

DRAFT

5.10.2 The framework consists of the following:

- A process for reviewing competing service demands in a structured and objective way
- A Clinical Oversight Group, with a membership of the most senior clinicians within the organisation assessing critical allocation of resources and remobilisation of services
- Local Clinical Prioritisation processes, including an Elective Surgical Prioritisation Group

5.10.3 Clinical Prioritisation takes a lead on establishing a consistent process for the active management of patients waiting.

5.10.4 This will include agreement on the consistent use of clinical priority groups and an agreement on a sensible approach to clinical management and review for the longest waiting patients. The first meeting of this group was held in early June 2022 and will meet every two weeks until we are confident we have appropriate processes fully implemented.

5.11 Cancer

5.11.1 We have recently appointed to two Cancer Care Co-ordinator roles, who came into post in June 2022 to provide the single point of contact service. With support from Macmillan, we have also appointed to a fixed-term Pathway Navigator post, whose key role will be to support development and implementation of the new service.

5.11.2 These roles will be embedded in the Cancer Information and Support Team and will be accessible to all patients who are diagnosed with cancer. Part of the support offered will be sign-posting to relevant clinical services, and they will also work closely with the Improving Cancer Journeys team when these are appointed to provide non-clinical support.

5.11.3 We would anticipate that these posts will help to address some of the issues around Health Inequalities that exist around our services, and this has been highlighted in the Health Inequalities Impact Assessment (HIIA) that was undertaken following the development of NHS Borders' refreshed draft Cancer Strategy document.

5.12 Colon Capsule Endoscopy (CCE) and Cytosponge

5.12.1 Cytosponge has been embedded in NHS Borders for some time, and a Colon Capsule service commenced from April 2022. It is estimated that approximately 80 patients per year will be referred for each test, and that this will have a small but worthwhile impact on waiting times.

DRAFT

5.12.2 Capacity for Colonoscopy and Endoscopy capacity remains challenging, and funding additional weekend capacity during 2022/23 has been included in Waiting Times plans.

5.12.3 In the longer term we are seeking to develop a Nurse Endoscopist role, and in the interim seeking a locum Consultant to provide additional weekday capacity.

5.13 Working collaboratively nationally with CfSD and Clinical Leadership Teams

5.13.1 We will continue to work with CfSD building on the support provided during 2021/22. Our Clinical Management Teams will engage with national specialty groups to progress pathways, ensuring that opportunities are sustainably implemented locally. Our clinical teams recognise the value of the CfSD learning and development sessions and will be engaging in these during 2022/23.

5.14 National Treatment Centre Programme (NTC)

5.14.1 We will continue to work with the NTC Delivery Group and support work aimed at identifying how capacity will be utilised nationally to ensure an equitable reduction in waiting times across NHS Boards. NHS Borders is not currently developing capacity funded from the NTC programme.

5.15 Supporting Patients to wait well

5.15.1 The acute service will continue to work closely with primary care colleagues to improve information available to patients at the point of referral on a speciality and procedure specific basis. Initial consideration has been given to work we can do in relation to musculoskeletal services, particularly alternative pathways options and guidance on rehabilitation, and self-help information and guidance. However, there is potential benefit across a range of medical and non-surgical pathways, and there is work planned to look at clinical validation routines between primary and secondary care, and how that can feed improvement into referral support systems (RefHelp) and signpost or support patients better in the future while also reducing demand into primary and secondary care. This will ensure only those who need to wait are waiting, and overall waits are minimised.

5.15.2 We have initiated conversations with AHP, Health Advisory and Mental Health colleagues on how we can support patients where surgery is required to wait well, and how to access services that will maintain their physical and psychological wellbeing while waiting. This will ensure the best possible outcomes for patients at the point of surgery.

5.15.3 NHS Borders will establish a programme for the proactive contact of long waiting patients at 26-week intervals to ensure that they are receiving the care and support that they required while they are waiting. This will include sign posting to Well Being and Healthy Living services, psychological services, and pain support as required.

5.16 Recovery of Diagnostic activity

DRAFT

5.16.1 Recognising staffing challenges we are working with our Radiology Department on developing a longer-term workforce plan for Diagnostic services aimed at sustaining services and extending operational capacity. This will include increasing evening and weekend working across all imaging modalities, and on meeting acceptable turnaround times for reporting images obtained. We have worked with the national access support team to ensure that additional capacity has been made available using mobile units, particularly MRI. We are also referring patient to the NJGH where possible.

5.16.2 We continue to experience capacity issue across both colonoscopy and upper GI scopes. This is primarily an issue with practitioner capacity. We are looking to train Nurse Practitioners to increase operational flexibility and capacity during 2022/23, but it is unlikely we will see benefits before 2023/24 given training requirements. We will continue to seek independent sector support to ensure urgent waits are maintained at acceptable level and to maximise the benefits available from Cytosponge and Colon Capsule. We are likely to continue to see extended routine Endoscopy waits as urgent work is prioritised to available capacity. We will continue to work with the relevant clinical teams to maximise available capacity as current workforce issue allow.

5.17 Integrated Planned Care Board

5.17.1 The challenge to achieve new Scottish Government waiting times targets is significant. Recovery of the waiting times backlogs will require new ideas and changing how NHS Borders delivers services. Productivity improvements, Primary-Secondary care collaboration and changes to clinical models will all be required to close the gap. To achieve this, NHS Borders will establish an Integrated Planned Care Board (IPCB) is established to oversee the development of a NHS Borders Backlog Recovery Plan (BRP) that sets out how NHS Borders will achieve waiting times targets.

5.17.2 The BRP will:

- Describe critical actions required to recover waiting times and how these actions will translate to capacity. This will enable close management of projects aimed at increasing capacity to ensure delivery.
- Articulate expected levels of external capacity, workforce changes and productivity gains required to meet waiting times targets up to September 2024.
- Include specialty level plans for those services with greatest backlogs; plans that have been developed with clinical teams. It is imperative that the challenge is shared with our wider clinical workforce if effective solutions are to be identified and delivered.
- Describe trajectories to meet national targets so that progress can be actively managed.

- Provide a clear plan for NHS Borders staff and key stakeholders on how the waiting times backlogs will be recovered.
- Describe how we will support and communicate with patients waiting for assessment or treatment on waiting lists.

5.17.3 A meeting was held with key stakeholders from each NHS Borders clinical board on the 21st of June 2022 to consider what benefit the establishment of an Integrated Planned Care Board (IPCB) could bring. Stakeholders identified the following areas of focus for a new IPCB:

- Overview and support both development and delivery of a Backlog Recovery Plan (TTG, OP, Diagnostic and non-Scottish-Government-reported), including the actions identified in the Annual Delivery Plan under development. Ensure backlog recovery is delivered taking a whole-system approach and engages all appropriate stakeholders.
- Productivity; detailed work to ensure resource is utilised to best effect and that the organisation is making the most of available capacity.
- Application of Clinical Prioritisation taking a whole-system approach; prioritising capacity in in partnership between secondary and primary care so treatment is delivered where outcomes will be best. Clinically led focus on realistic medicine.
- Effective communication with our public; sharing realistic waiting times at every point of the patient pathway to support making the right decisions. Being open and honest about service access.
- Focussing on pathways between Primary, Community and Secondary Care; to ensure pathways add value and are designed around our patients.
- Supporting patients to wait well; designing holistic support for patients waiting that incudes pain management and access to Mental Health care.
- Develop best practice in demand : capacity management and use of technology to support recovery.
- Lead the development of sustainable Planned Care Services over the next 4 years.

5.17.4 The IPCB will take forward the development of the BRP with focus on those areas described above. A workshop with consultants and General Practitioners was facilitated by the Medical Director on 22nd June 2022. This workshop considered the waiting times backlog, the performance and financial challenge facing NHS Borders. A number of potential solutions were born from this clinical cross-system focus. The IPCB would provide a framework for delivery to support clinicians with solutions to the waiting times challenge. The IPCB will be a key programme of work that sits within the scope of our overall Quality & Sustainability Board (Q&SB).

6. Urgent & Unscheduled Care

6.1 National Urgent and Unscheduled Care collaborative eight high impact changes

6.1.1 NHS Borders completed the Urgent & Unscheduled Care Collaborative Eight High Impact Changes self-assessment in early June 2022. The self-assessment identified three high impact areas for focus: Discharge without Delay, Virtual Capacity and Redesign of Urgent Care.

6.1.2 Within Borders we have a well-established team leading the rollout of Discharge without Delay, and over 2022/23 the team plan to improve patient flow by clarifying and simplifying discharge pathways. This work will support mirror work to develop integrated community teams that are better linked to hospital activity.

6.1.3 Building on the successful COVID-19 Virtual Ward trial earlier in the year, new alternatives to acute hospital admission will be developed to allow patients to receive the care they need at home. Hospital @ Home capacity will be created starting with older person's pathways before rolling out to other patient cohorts.

6.1.4 Further work will be undertaken to modernise urgent care pathways to ensure people living in the Scottish Borders can access the right urgent care in the right place at right time - recognising the importance of having a multidisciplinary team (MDT) approach in and out-of-hours within their community/locality. The Borders Urgent Care Centre and Borders Emergency Care Service (GP out of hours) will complete an options appraisal to identify a sustainable future model for these urgent care services.

6.1.5 On the 24th June 2022 NHS Borders, Scottish Borders Council and the Scottish Borders Health & Social Care Partnership held a workshop to develop a local Urgent and Unscheduled Care Programme. The programme will progress the priority areas identified as part of the self-assessment exercise referenced earlier, alongside a fourth priority which is to develop Integrated Community Teams. The programme team are now undertaking an extensive mapping of the health and social care system as a basis to identifying next steps and developing these priority areas into programmes of work.

6.1.6 Within the Borders General Hospital (BGH) the overall Unscheduled Care Programme will enter phase 2 from July 2022 and seek to build on phase 1 which delivered over the first 90 days of 2022/23. The second phase of this programme will redesign BGH urgent care pathways, continue the productive ward and Discharge without Delay workstreams that aim to increase pre-12 discharge and reduce length of stay, review the Emergency Department workforce model, and to complete the Medical Admissions Unit Frailty model.

6.2 General Practice sustainability / Primary Care strategy

6.2.1 Over 2022/23 we plan to develop a Primary Care strategy which will be developed in collaboration with GPs to reduce GP workload and increase recruitment and retention by making Scottish Borders an exciting and positive place for current and future GPs to practice. Areas for attention within this include:

- Improving our understanding of current capacity and demand
- Redefining Scottish Borders GP role in the Community
- Supporting workforce planning
- Adopting an equitable approach for all 23 practices across the Scottish Borders
- Investing in fit for purpose premises and IT infrastructures
- Understanding sustainability issues and the financial implications for GPs

6.3 Primary Care Improvement Plan

6.3.1 NHS Borders is working to support by reducing GP workload by successfully implementing the transfer of non-expert medical generalist tasks to the Health Board to all GPs to focus on their core role.

6.4 Care Home Visiting Service

6.4.1 NHS Borders is working on the Development of a well-established, autonomous, specialised and responsive team of Advanced Nurse Practitioners empowered to make clinical decisions for Care Homes residents.

6.5 E-Consult

6.5.1 E-Consult is an example of a Digital Asynchronous Consultation System (DACS) which allows patients to communicate at any time of the day with practices on clinical and non-clinical matters. It is currently in use within both the GP practices in Peebles, and is due to be rolled out across other GP practices in the Scottish Borders.

6.5.2 It significantly improves patient access and feedback from patients has been positive. From a practice point of view, it has had a positive impact on resilience and capacity. It is an essential tool to ensure that patients receive the right care, from the right person, and at the right time & the right place.

6.6 Work closely with local Communities to address Health Inequalities

6.6.1 A joint needs assessment has recently been commissioned by the IJB within Borders which is due to report out in the autumn. This will help inform a refreshed Strategic Commissioning Pan which will be developed for 2023/24 and beyond. A key component of this work is engagement with local communities and locality groups. The National Development Team for Inclusion (NDTI) have been commissioned to undertake this piece of engagement work, supported by our Public Involvement & Engagement Team and third sector partners. The aim is to ensure patient, users and carers experiences are central to the delivery and development of services including

DRAFT

unscheduled care, through a cycle of feedback, evaluation and involvement in service design and change. This will include targeting groups identified through Health Inequality Impact Assessments (HIIAs).

6.7 Integrated approach to the Urgent Care Service

6.7.1 As described under 6.1, an Urgent and Unscheduled Care Programme has been established to lead improvement and transformational change across Heath and Social Care services. This programme will include the Redesign of Urgent Care and development of integrated urgent care services. Several workshops will be held over the course of August to map the Urgent and Unscheduled Care system. The output of this exercise will form the basis for transformational work to improve pathways for patients.

6.8 Clearing backlog of in routine Dental Care

6.8.1 NHS General Dental Service Practices in the Borders are increasing capacity to meet the demand of their registered patients with activity currently being delivered at 81% of pre-pandemic capacity. The use of additional equipment and the changes to Infection Prevention and Control guidance has increased capacity to manage routine care including examinations alongside demand for unscheduled care. Alongside this processes to deliver additional funding for ventilation, speed reducing handpieces and other equipment along with recruitment incentives aimed at attracting to rural dental officers have been developed.

6.8.2 There have also been two successful Scottish Dental Access Initiative Grants applications approved to open new practices is Kelso and Berwickshire which will further increase access within the Borders.

6.8.3 Combined Practice Inspections that were due during 2020 and 2021 are now complete and 2022 inspections are up to date.

6.9 Reducing oral Health Inequalities amongst Children

6.9.1 There has been a rapid remobilisation of the Childsmile programme in NHS Borders with the recruitment of an additional fixed term Oral Health Support Worker. All children that are referred for a general anaesthetic, relative analgesia or behaviour management are offered a referral for Childsmile support.

6.9.2 The 2022/23 funding for 0-3-year-olds to promote the benefits of regular toothbrushing allows for packs to now be given to all children via their Health Visitor at their 8-month, 13-15 month and 27–30-month universal visit, as well as the 4-month visit. All children now receive three packs as opposed to two packs at the ages of 2,3 and 4, with childminders receiving an allocation of up to twelve packs for children in their setting.

DRAFT

6.9.3 Within the Borders 85% of nurseries are now back toothbrushing and the focus in 2022-23 is to increase input into all primary schools.

6.9.4 We are conducting a test of change in the National Dental Inspection Programme (NDIP) Team incorporating fluoride varnish in two schools during NDIP, one schools in SIMD1 and the other being an additional support needs school. The fluoride varnishing programme is also being remobilised in targeted schools. The NDIP Team follow up on children for whom have received generic letters for gross caries (category A) and for those with decay present (category B) to ensure they gain access to dental services.

7. Mental Health Services

7.1 Mental Health Transition and Recovery Plan

7.1.1 Our Mental Health & Learning Disabilities Clinical Board is committed to implementing a whole system approach to supporting urgent and unscheduled care.

7.1.2 We have successfully established our Renew Service in October 2020, with the aim of offering a “see and treat” model for mild to moderate anxiety and depression using evidence based psychological therapies. Building on this we are collaborating with multiple stakeholders on improving capacity for mental health assessment, care and support within our Primary Care settings. Our aspiration, subject to resources, is to expand this service to become ageless with a priority focus on supporting our Children and Young People under the age of 18.

7.1.3 Through transforming our service, the Borders Crisis team will strengthen pathways in and out from primary and unscheduled care services. Our collaboration with Borders Emergency Care Service (BECS) allows referrals to be taken directly and we are investing in ANPs to support work on our Unscheduled Care Pathways and Personality Disorder Pathway. We have identified a gap in people suffering from trauma and Neurodevelopmental Disorders and will be working to look at pathways that provide support to this cohort. We will look to deliver a robust support plan by moving towards anticipatory care planning for those that meet the criteria.

7.1.4 Our Community Rehabilitation service has been directed by the Integrated Joint Board to re-provide the rehabilitation supported housing service to more suitable accommodation which will provide an enhanced model of support. Providing the enhanced community rehabilitation will allow us to reduce the length of stay in out of area specialist hospitals and accommodation whilst also allowing us to repatriate patients to the Borders.

7.1.5 Recruitment and retention of staff, particularly within the Mental Health sector in the Scottish Borders is at a challenging point and it is likely this may impact implementation plans, should recruitment campaigns take longer than anticipated as

DRAFT

staff and patient safety must be considered above all else. The service is also currently looking at different skill mixes and experience to help reduce staffing gaps.

7.1.6 The impact on demand and therefore capacity of mental health services because of the pandemic is not yet fully understood nor the possible impact on the long term provision of healthcare services. This is being monitored nationally and locally within NHS Borders.

7.1.7 NHS Borders is working to address growing health inequalities by:

- Following Medication Assisted Treatment (MAT) Standards
- The development of Mental Health Primary Care Services for under 18s
- Establishing Outreach Programmes for hard-to-reach communities
- Working with our stakeholders on service redesign
- Scoping of the development of accessible digital hubs within localities to increase accessibility and help provide trauma informed environments
- Delivering a centralised service that has the flexibility to respond to the demand across the 5 localities of the Scottish Borders. We anticipate that areas of most deprivation will provide the highest demand across central Borders
- By ensuring that we gather and review data to establish areas of under representation
- Communicate and promote our services widely and consistently focussing on equality groups that are currently under represented
- By ensuring that we fully maximise the totality of resources through review and avoiding overlap and duplication

7.2 Reducing harm from drugs and alcohol and reducing drug deaths

7.2.1 NHS Borders has successfully implemented MAT Standards 1-5. Achieving a ‘maintenance’ status will require local reporting systems to be developed as there is no national solution.

7.2.2 Work to implement the other standards is taking place this year and includes a test of change funded by a grant to enhance skills in Alcohol & Drug Partnership (ADP) commissioned services in psychologically informed approaches. We are also recruiting an additional Advanced Nurse Practitioner and piloting an approach to work with Primary Care to implement primary care interventions e.g. Echocardiogram (ECG) in Borders Addiction Service (BAS).

7.2.3 Recruitment to new posts is challenging due to both the availability of suitably qualified and experienced staff and also the recruitment of locally employed staff to roles in national teams

7.3 Improving pathways for people with alcohol problems and for access to residential rehabilitation

7.3.1 During the exploratory phase of work to improve our pathway to access to residential rehabilitation we have identified a need to improve pathways for people with alcohol problems. This includes routes in and out of hospital and planned in-patient detox . Work on this is due to complete by March 2023.

7.3.2 The residential rehabilitation pathway is in development and the action plan associated with this work includes a need to raise awareness of eligibility for individuals and staff. Final approval of the pathway scheduled for Alcohol & Drugs Partnership (ADP) Board in August 2022. Awareness raising will take place from July 2022-March 2023.

7.3.3 Clinical staff (including Borders General Hospital staff) are key contributors to this work, and this is challenging to manage without impacting on patient care. There is a risk this cannot be completed if staff are unable to participate due to pressures within their services.

7.4 Alcohol related deaths audit

7.4.1 We will seek to commence a review of alcohol related deaths this year through a Specialist Registrar in Public Health (SPR) as a stand-alone project as there is no local capacity to undertake this work. There may be no uptake from the cohort of SPR in which case the action will be deferred.

7.5 ADP communication / lived and living experience involvement

7.5.1 There is an ongoing need to ensure people with key stakeholders in the wider system are aware of the role of alcohol and drugs services and routes for referral. We are increasing our communications activity include scheduling general and bespoke ‘meet the services’ 30 mins sessions; twice yearly ADP bulletins; briefing for teams; Drugs Trends Monitoring Continued Professional Development (CPD).

7.5.2 We are also working to further improve the influence of people with lived and living experience within ADP structures and services.

7.5.3 Statutory and third sector partners are experiencing high demand and may not have capacity to engage. People with lived and living experience may face barriers to participation.

7.6 Health Inequalities

7.6.1 People with drug and alcohol problems are some of the most vulnerable and marginalised in our community. Life expectancy and healthy life expectancy for our people is lower than the general population.

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7.6.2 It is also the case that people with lived and living experience stigma and barriers to accessing services.

7.6.3 The work outlined above to implement low barrier treatment via MAT and improved pathways; improved communications and involving people with lived experience aims to mitigate some of the inequalities.

7.8 Recruitment and Retention within Mental Health Services

7.8.1 Having identified that we are entering a challenging time in recruitment to posts not just locally but nationally, we are continually reviewing how we can best reach suitable workforce to come and work for us. We are participating in recruitment fairs across high schools and reviewing our standard advert for mental health posts.

7.8.2 We are also encouraging our services to have "away days" to build relationships with most areas having a space for reflection/rest/recuperation within their services. We actively promote our Space to Grow Garden as a space for not only for patients but also staff and are reviewing training opportunities for staff and proactively reaching out to disciplines rather than waiting for staff to come forward.

7.8.3 Where possible we promote and support "retire to return" and have reviewed our shift patterns within the inpatient setting. For example, our in-patient staff wanted a return to 12-hour shifts and this has now been implemented as a result.

7.8.4 We promote, where possible, working from home/blended approaches as this offers increased flexibility for attracting and retaining staff for work/life balance and service delivery.

7.8.5 We are rationalising our allocated endowment funds across mental health services and thereafter will have an emphasis on spend relating to Staff Wellbeing, Training and Development and innovation.

7.9 Child and Adolescent Mental Health Services (CAMHS)

7.9.1 We continue to receive additional support from the Scottish Government in relation to our CAMHS service. The leadership team with support from the organisation's Project Management Office (PMO) have developed a strategy to address the on-going challenges to meet the national Referral to Treatment HEAT standard of 18 weeks. They have also implemented several additional service updates which have included: Stakeholder engagement, referral quality and pathways, website development, and progression within the neuro-development pathways. They have also successfully eradicated the neurodevelopmental backlog.

7.9.2 Recruitment continues to be a challenge for the CAMHS service. Current posts advertised include nursing and psychology (Although the latest nursing recruitment initiative appears to be going well with several applications received). A review of

DRAFT

the workforce has allowed innovative thinking to progress with the recruitment of Health Care Support Workers and allied Health Professionals (Band 7 Dietetics) on a temporary basis and we will adopt a test of change approach in relation to impact and contribution to the overall service outcomes.

7.9.3 CAMHS Trajectories for 2022/23 have been submitted to Scottish Government and we are currently awaiting feedback for these.

7.10 Adult Community Mental Health Teams (CMHTS)

7.10.1 The main challenge we face within our Adult Community Mental Health Teams is the back log of neurodevelopmental referrals. On examination it has been recognised that current demand outstrips our capacity and a different approach to manage this is required. With the use of funding via the National Autism Implementation Team we have progressed a waiting times initiative to support both Autism and Attention Deficit Hyperactivity Disorder (ADHD) referrals currently waiting for assessment.

7.10.2 NHS Borders are commissioning a service to signpost to those on the waiting list for additional information and support groups, including diagnostics. We have reviewed our ADHD clinical pathway and working in collaboration with out GP partners are nearing the completion of an ADHD pathway which will see an improved clinical pathway to ensure only those that meet secondary care criteria with impaired function and complexity will access services for assessment and diagnosis. Adopting a self-help and support pack for those presenting to primary care will ensure that all interventions and supports have been explored prior to referral to secondary care mental health services.

7.11 Urgent and Emergency / Unscheduled Care within Mental Health Services

7.11.1 As highlighted earlier, Borders Crisis Team has now embarked on our transformation programme (service review) and have completed their initial mapping session. Data packs as part of the service review have been completed and are currently being reviewed. This will progress to complete a service review document for consideration of outcomes and findings to the wider mental health services and key stakeholders.

7.11.2 Further information can be found within the Unscheduled Care section of this plan.

7.12 Psychological Services

7.12.1 We are currently revisiting our Psychological Therapy (PT) PT Heat target trajectories which will be submitted to our Access Board and then onto SG. All our services are working at capacity, and we continue to experience strong and increased demand.

DRAFT

7.12.2 Renew is facing some workforce pressures between August and January due to vacancies. We are actively recruiting to these but anticipate delays due to the time of year.

7.12.3 We have completed our objectives for the current year as follows:

- Improving flow through the system so that people have timely access to treatment
- Improved patient journey through all psychological services – increasing joined up working and improving access to psychological therapies with fewer barriers
- Develop clear Standard Operating Procedures (SOPs) for all psychology services resulting in clear roles, consistency and streamlined admin processes
- Develop our professional identity;
- Develop a recruitment and retention strategy to ensure we are able to staff our services and ensure NHS Borders Psychology Service is a positive and attractive service for our current staff as well as those we would like to attract
- Support the wellbeing, growth and professional development of all working in psychology services
- Review psychology services in relation to the SG PT/PS specification document due later this year
- Establish a digital team who will lead and manage all CBT interventions
- Establish a clear pathway of co-production with people with lived experience
- Lead and advise on trauma informed training and service development in NHS Borders

7.13 Primary / Scheduled Care Interface

7.13.1 We continue to collaborate with GP's, primary care colleagues and key stakeholders in identifying a model to expand primary care mental health services in line with government funding and directives to establish an ageless service with a single point of access. We have submitted our funding proposal for Year 2 of the funding and wait for feedback.

7.13.2 We plan a stakeholder workshop for adult services in September and are actively working with key partners to scope out and continue to develop the model for a primary care service for those who are under 18.

7.14 Perinatal and Maternity Mental Health Services

7.14.1 The Perinatal and infant mental health service was established in February 2021 when several posts were recruited following a successful application for SG funding. Ring fenced time has been allocated to enable a specialist resource within the work of our community teams and outreaching to maternity services. We have psychiatry

DRAFT

within our adult CMHT, our Addictions service and Liaison psychiatry in addition to infant psychiatry within CAMHS. We have additional resources for nursing, occupational therapy and psychology who are working closely together as well as with midwifery and health visiting colleagues and third sector. We are achieving a great deal from a clinical perspective and have responsive resources to support women and their partners. Our progress against implementation of the national recommendations is very positive, the next move being to establish feedback and monitoring to ensure we are achieving positive patient outcomes. We have this week launched a questionnaire relating specifically to this area of work to enable us to complete accurate data capture and report accordingly.

7.15 Health Inequalities

7.15.1 The arrival of the Covid-19 pandemic in 2020, and associated restrictions on face-to-face service delivery, resulted in the temporary closure of one of our day services, Gala Resource Centre (GRC) to allow the redeployment of staff elsewhere. This was seen as an opportunity to review the centre by examining its role and function, identify unmet need, and consider how these needs might be best met in the future. This review is informed by the local mental health strategy, one of its key objectives being to ensure that people with mental health needs in the Scottish Borders are able to access the right support, at the right time, in the right place.

7.15.2 A workshop was held 11th May 2021 attended by a wide range of stakeholders across the Health and Social Care Partnership. This was followed up by a number of small focus groups where people with lived experience of mental ill health were invited to share their views. Two main areas of unmet need were identified:

- Those with severe mental ill health
- Those with a diagnosis of Emotionally Unstable Personality Disorder

Other areas included:

- Eating disorders
- Autism
- Young people and transitions
- ADHD
- Medium to long term complex cases

7.15.3 A direction was issued from the Integrated Joint Board earlier this year for an overall Mental Health needs assessment to be conducted and we await further information for this to progress and the stakeholder event and associated identified unmet needs will contribute to this overall assessment.

8. Supporting & Improving Social Care

8.1 Addressing Social Care assessment backlog and support provided

8.1.1 Within Scottish Borders Council (SBC) the Adult Social Work teams have worked to manage risk at a community and hospital level in line with increased demand. The numbers of people waiting for assessment are reviewed at a locality and Borders wide basis routinely, and this information has been used to support the management of services. In addition, the information has been used to inform the development of a business case for additional Social Work and associated staff in line with the additional national allocation of funding for Adult Social Work, for which recruitment will commence shortly.

8.2 Business Continuity and Innovation

8.2.1 Business Continuity plans were reviewed and an Outbreak Protocol was developed which incorporated the development of an outbreak team, this team moved around services as and when required in a 'specialist' role. As well as this Cross Service Risk assessments were also developed.

8.2.2 Technology Enabled Care (TEC) options were considered to reduce the need for face-to-face contact, MS Teams and Total Mobile continues for staff engagement and some aspects of monitoring.

8.3 Development of remote peer-support for staff in Care Homes.

8.3.1 All eligible staff have been encouraged to register with 'Togetherall' to promote peer support. The Council's Occupational Health service has also supported when required as support for traumatic experiences and the use of MS Teams continues.

8.4 Supporting Telecare Service Redesign

8.4.1 SB Cares (which is operated by SBC) has established a TEC Program of work which will address the above. Our community alarm upgrade project is one example.

8.4.2 By 2025 BT Open Reach are migrating everyone in the UK to digital phone lines. This means that we are required to replace all our current analogue alarms (1500 units) to new digital units within the next 3 years. This presents us with an excellent opportunity to provide our clients with a new digital TEC home hub, enabling us to provide a more integrative approach in supplying digital equipment. We can start to provide clients with equipment that will be tailored to their specific health and social care needs and provide us with the data to be proactive, preventative and efficient in our solutions.

8.5 Self-Directed Support (SDS)

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8.5.1 The Borders Health & Social Care Partnership (HSCP) are exploring, with service users to encourage an increase in the uptake of the following options:

- Option 1 – a direct payment, which is payment to a person or third party to purchase their own support
- Option 2 – the person directs the available support
- Option 3 – the local council arranges the support
- Option 4 – a mix of the above

8.5.2 Historically the hospital has used option 3, which was the preferred choice given the time it took to recruit/appoint personal assistants and therefore delaying the discharge process. With CoSLA guidance sent out in March 2022 the option of direct payment without assessment was to be considered however this has not been without challenges with some Local Authorities raising this directly with CoSLA.

8.5.3 Appointment of the Support In Right Direction (SIRD) worker can support better understanding of the use of exceptional circumstances under option 1 of the Act. This permits the patient or their representative (if they hold Power of Attorney) employing a family member to take on work on a paid basis as a personal assistant.

8.5.4 Scottish Borders is one of six area HSCP pilots currently to look at how SDS can be used more flexibly across localities and within hospital systems. Positive examples and learning from other authorises can be reflected across the Scottish Borders HSCP landscape.

8.6 Work to strengthen collaboration between Social Care and Primary Care

8.6.1 *"Committed to working collaboratively to improve the quality of life of People" – 2022 Vision*

8.6.2 Each of Scottish Borders' five Localities has had a daily Multi-Disciplinary Team (MDT) huddle for more than a year. As services re-focus on remobilisation, it was identified that consistent attendance from each key services could enable and strengthen this established MDT approach and help maximise its full potential. On 30th June, a Health and Social Care Partnership Leadership event was held entitled "Reigniting Localities". Health and Social Care Senior Managers, Clinical Consultants and third sector representatives were in attendance.

8.6.3 The group was asked to consider where change was needed through case analysis followed by a vision exercise (see above) and to refocus on outcomes. The event was well received with managers committed to attend an upcoming locality huddle the following week. They also committed to developing a comprehensive referral pathway road map to help identify further potential for synergy working. In addition, the Leadership Group will be looking into launching a weekly frailty focused MDT panel in one locality to hopefully secure the involvement of various clinical consultants.

DRAFT

8.7 Social Care improvement work

8.7.1 Work has commenced to develop more seamless and integrated community health and social care services across the Scottish Borders, and it is expected that this work will be concluded by the end of the financial year. As part of this we will refine our common assessment process.

8.7.2 Work is progressing to expand the reablement function into our in-house social care provider, and to integrate this with the NHS Borders Hospital at Home service which will improve our approach and capacity for reablement and reduce demand. Again, this work should conclude by the end of the financial year.

8.7.3 The IJB has commissioned the development of a community polypharmacy service for social care service users and this service will help support the realistic medicine agenda, reducing risk to service users, and reducing medicines related visits which will enhance our capacity available for others.

9. Delayed Discharge

9.1 NHS Borders continues to face significant challenges with delayed discharges, demand for care has outstripped the capacity available this was due to both an increased demand for social care with increased dependence of those referred from our hospitals and the community and reduced capacity in social care, predominantly due to workforce issues and COVID-19 impacts.

9.2 The Health and Social Care Partnership (HSCP) is working on immediate and longer-term actions to ensure that more people can be cared for in a more appropriate setting when they are medically fit for discharge:

- Extra residential care capacity is being procured to assist with this, and HSCP teams will work with these settings to support these settings
- The HSCP is working closely with independent care sector and third sector providers to support ongoing sustainability, and has on a number of occasions over the past few months supported providers in its capacity as provider of last resort
- The IJB and HSCP is increasingly focusing on admission avoidance, including initiatives on polypharmacy support for social care service users, hospital at home, the development of a virtual ward, the development of the community geriatric model and developing a more integrated community team approach.
- Work has been progressing on Discharge without Delay.
- We have established an Urgent and Unscheduled Care Programme Board which will work to progress further actions relating to reducing and supporting unscheduled care.
- The Acute Recovery programme is undertaking work around reducing length of stay in hospital and it is expected that this will help to reduce demand for care. The IJB and HSCP is increasingly focusing on admission avoidance,

DRAFT

including initiatives on polypharmacy support for social care service users, hospital at home, the development of a virtual ward, the development of the community geriatric model and developing a more integrated community team approach.

9.3 The anticipated impact of these actions has been factored into a new trajectory which has been signed off by the HSCP Joint Executive. It is important that a whole system approach continues to be adopted to ensure that we effectively reduce the number of people waiting for care in our hospitals.

10. Sustainability & Value

10.1 Deliver within available resources & achieve financial balance

10.1.1 Prior to the pandemic NHS Borders had introduced a Financial Turnaround Programme in order to address its financial deficit. For the past two years this programme was paused in order to direct resources toward our COVID-19 response. We remain on Stage 3 of the Government's Performance Escalation Framework in relation to our financial sustainability and as we look to emerge from the pandemic our financial outlook remains challenging.

10.1.2 Our financial plan for 2022/23 identifies an in-year deficit of £12.2m. This position is predicated on delivery of £5m savings, with a further £8.5m to be delivered through board flexibility (review of accruals, provisions, reserves and phasing of financial planning commitments).

10.1.3 The Financial Plan was prepared prior to recent discussions which have highlighted the scale of the forecast deficit at an NHS Scotland level, including additional financial pressures in relation to COVID-19 expenditure, Pay policy, and SG portfolio commitments. We recognise the requirement to identify additional measures to mitigate financial pressures in 2022/23 and we will include an assessment of available opportunities within our Quarter One Review.

10.1.4 A key constraint remains our management and supporting infrastructure to support service delivery against our plan. This will present a further challenge as we seek to identify options to manage the increased financial gap.

10.1.5 We have established the governance for a refreshed Financial Improvement Programme (FIP) through our Quality & Sustainability Board. We have introduced a revised framework for development and monitoring of savings plans, including local targets and whole system workstream and will be launching this approach with Business Units by end July.

10.1.6 In order to support this programme we have reviewed our supporting infrastructure and have agreed a resource plan for our Project Management Office (PMO), including additional support to business analytics and finance teams. Vacancies to existing posts within our PMO have created a temporary shortfall in resources

however and there is a deficit in our capacity to support existing projects which is unlikely to be fully resolved before mid-year. Recruitment is presently underway to a number of key posts.

10.1.7 Savings identified in our financial plan were indicative based on high level assessment of potential opportunities. Our current 'ideas log' shows potential opportunities of £5m however the majority of these remain at Gateway 0 (i.e. not yet fully scoped). Through our FIP we aim to increase the level of opportunities identified, and to drive progress towards development and implementation of delivery plans.

10.1.8 We have commissioned a Benchmarking review in order to identify potential productive opportunities to increase the scope and value of opportunities identified. This report will conclude in September and it is likely that opportunities will not impact on short term (current year) plans. We are also establishing a number of transformation programmes to identify the choices the board will need to consider to achieve long term sustainability

10.1.9 Work is underway to review all areas of the COVID-19 response plan and to set revised parameters for expenditure in line with available resources. Redeployment processes are underway for staff on fixed term contracts and all other staff temporarily deployed to COVID-19 related functions are now being returned to core services on a risk assessed basis. A revised expenditure plan is expected to be prepared by end June.

10.1.10 We are working with the Scottish Borders IJB to assess how the IJB reserves can support management of the IJB financial deficit in year although we recognise that the majority of these reserves are committed on a ring-fenced basis to SG portfolio priorities.

10.2 Value based approach by tackling unwarranted variation & providing personalised care

10.2.1 Key stake holders have been identified to form a Realistic Medicine (RM) network and an action plan created and submitted to SG RM. NHS Borders communication team have developed infographics to increase awareness of realistic principles and in particular shared decision making and BRAN (Benefits, Risks, Alternatives (do) Nothing). Further development of this network is planned for 2022/23 with a focus on increasing awareness of RM principles amongst colleagues by the development of an RM programme of education within our Continuing Medical Education (CME) programme and increasing public awareness by engagement through our public pillar of Quality Management System.

10.2.2 RM is the basis of our recovery plans in planned care with a focus on MPP adaptation in many services in particular Patient initiated review (PIR), Active clinical referral triage (ACRT) and the EQUIP hernia pathway supported by our Out Patient Department (OPD) remobilisation group.

DRAFT

10.2.3 All hospital protocols are being updated and moved to the Right Decision Service (RDS) platform and the RDS team locally are working with primary care Colleagues to develop a REF-HELP tool kit on this platform for updates protocols for primary care to support patient management and referral pathways.

10.2.4 Treatment Escalations Plans (TEPS) have been embedded in secondary but need ongoing education for staff in the appropriate and continued use of these plans. Next stage to introduce into the community is under way. Anticipatory Care Plans (ACP) are being used in DME in the form of RESPECT documentation and further development is required for a local version of ACP.

10.2.5 Promoting a culture of openness and honesty to reduce risk and harm by ensuring that Mortality and Morbidity (M&M) departmental meetings have appropriate governance structures and dissemination of learning. Currently the medical department M&M has been developed using the Scottish Morbidity and Mortality guidance. Next steps are to ensure all M&M are using a consistent approach with a wider organisational governance and quality assurance in place to improve organisational learning. There are further plans to develop an M&M dashboard to support case selection.

11. Key Risks

11.1 It should be noted that at the time of developing this plan we continue to face significant pressures across the system. This may impact our ability to deliver everything we have set out in this narrative and within the accompanying delivery plan, within appendix 1. Workforce challenges, staff sickness, recruitment challenges and delayed discharges continue to impact on our whole health and care system and our ability to provide services to the quality that we expect, as well as remobilise our elective programme.

11.2 A strategic risk is documented within our corporate risk register highlighting the risks associated with the failure in implementing RMP4 and the ramifications this could have throughout NHS Borders. This will now be reviewed and updated to reflect our position when submitting this ADP. The strategic risks is complemented by documented operational risks within services, highlighting risks which include, but are not limited to, clinical risks, occupational health and safety risks, financial and projects risks and corporate risks.

11.3 We remain ready to respond to any future COVID-19 waves and re-activate response plans if required. COVID-19 will become our Business as Usual and will very much form part of our plans moving forward as we look to stabilise our health and care system. Winter is fast approaching and therefore will prolong the current challenging situation for many months. Planning to ensure our system can manage this as effectively as possible is underway.

11.4 Underpinning all the activities in this plan is the risk that there are insufficient resources available to support delivery, whether this be financial, workforce, or physical infrastructure. It is not possible to fully segment each element of the plan and protect capacity and resources without considering the need to balance whole system risk; this will result in re-profiling of resources on a needs basis at short notice. This continued volatility means that our confidence in delivery of the plan remains low and we are actively working to identify further mitigations to improve this assessment.

12. Summary

12.1 Our key priority remains stabilising our system so that we can start to recover, remobilise and then develop our medium-term plans. As has been outlined in this plan, due to continued operational pressures some of the service changes we aim to implement during 2021/23 are still at scoping stage. In addition, there are many real risks that may impact on our ability to deliver the planned improvements outlined in this plan and attached delivery plan.

12.2 During the pandemic, changes in how services operate and are delivered that previously would have taken months/years were implemented within days and weeks. We now have a much greater reliance on digital services, on self-management, on working remotely and on explicitly prioritising some forms of care above others. NHS Borders has also shown an ability to re-engineer and re-provide at a pace that did not exist previously. This work has also shown the importance of working effectively and at speed with our partners in the wider public sector, the third sector, and the private sector. We hope that in implementing and delivering this plan and in starting to develop our medium-term plan we will see challenging but exciting opportunities to progress with new and improved models of care that will provide high quality care for our patients and communities and job satisfaction and pride for our workforce.

DRAFT

13. Appendices

Appendix 1 - NHS Borders Annual Delivery Plan Delivery Plan Template

NHS Borders
Delivery Planning Ten

Appendix 2 - NHS Borders RMP4 Q1 22/23 Update

NHS Borders RMP4 -
Q1 22-23 Progress U|

NHSScotland Deputy Chief Operating Officer
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Scottish Government
Riaghaltas na h-Alba
gov.scot

22 September 2022

Dear Ralph and June,

2022/23 Annual Delivery Plan and Quarter 1 Update

Firstly, I am writing to express my thanks to you, your team and partner organisations for the significant work in developing your 2022/23 Annual Delivery Plan (ADP) and for your time in our recent feedback session. Although we are still working to more formally align our service, workforce and financial plans, it was extremely helpful to have this discussion alongside our respective workforce colleagues.

As referenced in our commissioning letter for this ADP, and in response to feedback from Boards, we set out a key set of national priorities to enable our system and staff to recover from the incredible pressure experienced over the past two and a half years whilst we start to take forward improvement work to strengthen the resilience of our services for any future Covid 19 waves and the demands of this coming winter.

2022/23 Service priorities

- Recruitment, retention and wellbeing of our health and social care workforce
- Recovering planned care and looking to what can be done to better protect planned care in the future - complementing the information already submitted on activity levels for inpatient and day case.
- Urgent and unscheduled care – taking forward the high impact changes through the refreshed Collaborative
- Supporting and improving social care
- Sustainability and value.

These plans play a key role in good sponsorship and governance and this reduced set of national priorities were also designed to provide more flexibility for Boards to develop plans which meet their local needs within that national context.

After reviewing your plan, we have set out below key points of feedback. We would ask that you reflect this feedback in preparing your next quarterly update. On the basis that this feedback will be incorporated in the Quarter 2 update, I am content to recommend that the Plan now be presented to your Board for their approval.

Specific Feedback on Plans

Your Plan has been assessed by policy colleagues from across Health and Social Care and this will inform the regular engagement that they have with Boards. These

assessments have highlighted much good work planned for 2022-2023 including in the following areas:

- The Compassion Focused Therapy pilot is an innovative approach which reflects priority of Pain Informed Care at the national level. The team is keen to understand progress and learning to inform national approach on this Action.
- Progress made with the establishment of the Renew service and plans to progress to an ageless service.
- Consistently strong approach to cancer here and throughout the pandemic
- Comprehensive consideration of both NHS Job families and Social Care Professional roles with informative narrative content
- Good work underway to support timely discharges. It is encouraging to see the adoption of Planned Date of Discharge and Home First service.

In relation to areas for improvement, we understand the considerable system pressures faced by Boards and, in light of this, the need for ADPs to be agile in response.

Following our feedback meeting in August (note provided), I do not intend to provide much Board specific feedback other than some notes on the ADP template. It is not necessary to submit a separate RMP4 update, please just include the deliverable that are continuing into Q2 in the rest of the ADP. Where deliverables have been completed these can be deleted. Do please also combine all separate sheets within the excel document into one sheet. This greatly helps with our analysis and allows us to more easily assess the plan as a whole.

We would also highlight the additional points:

- Please ensure that the deliverables outlined within your ADP template explicitly addresses each of the six priority areas within the commissioning guidance.
- To support monitoring of progress against the plans, we would request that you include specific timescales and milestones for each deliverable. I understand that these may need to be refined between updates however inclusion of intended timelines and milestones will enable us – and you - to track progress, or any variation, throughout the year.
- The realistic medicine policy team has highlighted that they are aware of much good work ongoing with local Realistic Medicine teams but that this hasn't been pulled through and reported within many of the ADPs. Please use the ADP as an opportunity to showcase this, linking work in any RM action plan to the wider work in the ADP.
- Weaving work to reduce health inequalities through everything we do remains a key aim for Scottish Government. Most plans would benefit from more detailed information on specific work around health inequalities or more specificity around how deliverables will address inequalities, particularly how the Boards' work will impact specific disadvantaged groups.

In addition to the feedback set out above, Boards should also ensure that their plans consider and respond to the following points.

- All Boards are facing a challenging financial position and we note that, at the time plans were developed, there was considerable uncertainty around expected allocations. We would ask therefore that ADPs are regularly reviewed to ensure that they are deliverable within the current financial envelope and from within expected available levels of staffing.
- Boards will be aware that following the Letter of Direction which was issued on 23 June 2022 by the Minister for Drugs Policy, signed Implementation Plans are due to be returned to the SG by 30 September 2022 detailing how the MAT standards will implemented in areas over the next 4 years. In addition all areas have been asked to provide their progress on implementing the standards for Jul – Sep by 21 October 2022. Please include high level actions relating to the implementations of MAT standard in your Q2 update
- We will also expect your delivery planning templates to be updated to include key actions for winter. There will be a Health and Social Care Winter Overview for 2022-2023 published in early October and we will be writing to Boards alongside this seeking assurance on winter readiness. This letter, when it comes, should inform your updates to your delivery planning template

As discussed in our recent meeting, SG Workforce colleagues will be issuing separate feedback on your Three Year Workforce Plan, which will also include relevant comment on your plans for Recruitment and Retention.

Quarter 2 Review and Progress Updates

The next quarterly update to your Annual Delivery Plan are due for submission to Scottish Government on **28 October 2022**. Please note that there will be no separate commission for these updates, which should incorporate the feedback noted within this letter.

The updated Delivery Planning Template should include updated or new deliverables as required and progress updates for each deliverable. In addition updates should be made to ensure that all deliverables have clearly defined milestones and a clear understanding of the risks and mitigations in place. Where milestones and timescales change over the year, this should be recorded in the progress update column.

In order to provide context for your annual delivery planning templates, Boards should also include a brief summary setting out:

- Key achievements in Q1 and Q2 - with particular regard to the national priority areas
- Key challenges/barriers to progress – with particular regard to the national priority areas
- How barriers to progress are being addressed
- Where there are a significant number of deliverables assessed as amber, red or suspended/cancelled, or this applies to a major priority piece of work, then the narrative should include a high level commentary on the reasons for this and the proposed actions to address this.

If you have any questions, please contact the Health Planning and Sponsorship team at healthplanningandsponsorship@gov.scot.

Yours sincerely

PAULA SPEIRS
NHSScotland Deputy Chief Operating Officer – Planning and Sponsorship

Region	Board	Priority Area *select from drop down list*	Service Area	Reference	Jun'22 status	Key Deliverable - Name and Description	Key milestones	Progress against deliverables end June 22	Lead delivery body	Key Risks	Controls/Actions	Outcome(s)	Major strategies/ programmes the deliverable relates to	Impact of deliverable on health inequalities
East	NHSB	Urgent and unscheduled care	Whole System	2022-BOR1	Amber - in progress	Front Door Model including a range of projects such as redesigning urgent care, ambulatory care, referral processes, minor injury units, BUCC & BEC	Complete options appraisal for BUCC and BECs PDSA collaboration with SAS - part of RUC Expand Minor Injuries appointments into the community - dependant on CTAC work Review and communicate referral process - part of Ambulatory Care workstream	Project and steering group meetings in diary for BUCC and BECs options appraisal Delivery group set up for Redesign of urgent Care programme of work Pathways and referral work which feeds into the UC delivery group	HSCP	Capacity, including workforce	Early planning and communications	Moving activity out of the Emergency Department and Scheduling activity	NHS Borders Unscheduled Care Delivery Programme	Will be assessed as project develops
East	NHSB	Urgent and unscheduled care	Acute Services	2022-BOR2	Proposal	Develop & Scope Future Bed Model	Will be determined once this work is scoped	N/A	Health Board	Not yet known	Not yet known	To enable service planning and agreed bed capacity across the organisation	This will support multiple planning both locally, regionally and nationally	The outputs of this work will support the services to plan for Health Inequalities
East	NHSB	Urgent and unscheduled care	Whole System	2022-BOR3	Green - on track	Winter Plan	Over the course of quarter 2 a Winter capacity plan will be established	Winter Planning Board convened	HSCP	Capacity, including workforce & beds	Early planning & Clinical Prioritisation	To cope with demand & capacity over the Winter period	Integrated Unscheduled Care & Planned Care Programmes	
East	NHSB	Urgent and unscheduled care	Mental Health & Learning Disability Services	2022-BOR4	Amber - at risk, requires action	Review Borders Addiction Service and Pathways	MAT standards 1-5 achieved, progressing recruitment to ANP to support clinical pathways between adult CMHT and BAS	BAS have achieved Medication assisted standards (MAT) 1-5 1. All people accessing services have the option to start MAT from the same day of presentation. 2. All people are supported to make an informed choice on what medication to use for MAT, and the appropriate dose. 3. All people at high risk of drug-related harm are proactively identified and offered support to commence or continue MAT. 4. All people are offered evidence-based harm reduction at the point of MAT delivery. 5. All people will receive support to remain in treatment for as long as requested.	Health Board	Current accommodation does not support the entirety of team or colocation with We Are With You	Allocated funding of approx. £320K	Reduction in drug related deaths, timely access to treatment, improved patient experience and pathway	NHS Borders Community Models of Care Programme	People with an addiction are marginalised within society - same day prescribing of Opiate replacement treatment - quicker access to treatment. Es Team - rapid response to those at high risk of drug related death
East	NHSB	Urgent and unscheduled care	AHP Services	2022-BOR5	Green - on track	AHP Major Trauma Pathway Development	Established trauma pathways and patient reporting outcome measures	Recruited complete Educational programme in development Engaged with regional rehab work Development of vocational rehab pathway	Health Board	None noted at present		Established smooth pathways Improved patient experience	NHS Borders Pathways Programme	Timely access to service
East	NHSB	Urgent and unscheduled care	Whole System	2022-BOR6	Amber - at risk, requires action	RAD front door frailty. Development of 7 day service in line with Discharge Without Delay	Ability to meet ongoing clinical demand across 7 days	Current advanced practice pilot within ED	Health Board HSCP	Funding		Meet ongoing clinical demand across 7 days	NHS Borders Planned Care Programme	7 day service
East	NHSB	Urgent and unscheduled care	Primary & Community Services	2022-BOR7	Amber - at risk, requires action	Implementation of PCIP	Delivery of Memorandum of Understanding 2 (MoU2), CTAC and Pharmacotherapy	Funding gap of £2.6m remains preventing further progress to CTAC as permeant funding required to pay GP workforce to Health Board Ongoing project management support needed to continue progress	HSCP	Capacity, workforce & funding	PCIP Executive Committee Deployment of additional project workforce to support, additional focus from our PCIP Exec Committee	Delivery on increased Primary Care activity and reduced patient waits/ better patient outcomes. Improved sustainability for GPs	NHS Borders PCIP Programme Primary Care Improvement Plan Managing increased primary care demand / delivering increased primary care activity GP Sustainability Reshaping Urgent Care	Timely access to service
East	NHSB	Urgent and unscheduled care	Primary & Community Services	2022-BOR8	Proposal	District Nursing Review	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Efficient workforce Sustainable service	NHS Borders Service Review Programme	Will be assessed as project develops
East	NHSB	Recovering planned care	Whole System	2022-BOR9	Amber - at risk, requires action	Continue remobilisation plans across all of our clinical services including backlog recovery	Milestone for acute? AHP outpatient services - delivering pre-covid access standards and clinical outcomes	Remobilisation continues with reviewed timeframes.	Health Board HSCP	Capacity, workforce & funding	Access Board & Waiting Times	Improved waiting times and clinical outcomes	NHS Borders Planned Care Programme	
East	NHSB	Recovering planned care	Whole System	2022-BOR10	Green - on track	Discharge Without Delay	Implementation of: - Planned Date of Discharge (PDD) across the whole system - Home First Principles - Pathways Based Approach to Discharge Planning	Project lead in place with additional support provided from NSS and unscheduled care QI facilitator and DWD national team Plan is for it to feed into the Unscheduled Care Programme Board	HSCP	Capacity of staff - may result in selays to implementation and may impact the overall sucess of the programme Subsequent to the identified risk above - Project lead backfill then unavailable June/July due to unexpected leave	Mitigating Actions: DwD Programme Lead in communications with strategic leads regarding forward planning for the DwD Programme. Awareness/Escalation: Escalation	#NAME?	Borders Unscheduled Care Programme Board Borders Planned Care Programme	Timely access to services
East	NHSB	Recovering planned care	Women's and Children's Services	2022-BOR11	Green - on track	Recommence National Best Start Programme	To develop and submit Best Start implementation plans to implement recommendations for local delivery	Implementation plans currently in development	Health Board	Capacity & workforce	Assessing priority of recommendations	Continuity of care	NHS Borders Planned Care Programme	Continue roll out of community of carer with particular focus on women and families experiencing social complexity and or women with poorer maternity outcomes
East	NHSB	Recovering planned care	Women's and Children's Services	2022-BOR12	Amber - at risk, requires action	Complete Maternity Service Review	To stabilise workforce	Options developed to reduce key workforce risks	Health Board	Timescales & workforce availability	Prioritising workforce stabilisation	Medical rota will be compliant	NHS Borders Service Review Programme	Will be assessed as project develops
East	NHSB	Recovering planned care	AHP Services	2022-BOR13	Green - on track	Speech and Language Therapy Education Review	Service delivered within core SLT budget	Engagement with SBC regarding Education provision Development of universal and targeted service provision Re-establish core service provision as opposed to enhanced service provision	Health Board			Core service will be delivered within the financial envelope	NHS Borders Service Review Programme	
East	NHSB	Recovering planned care	Mental Health & Learning Disability Services	2022-BOR14	Amber - at risk, requires action	Review of Psychological Therapy Service, Provision & Pathways		We are currently working on our PT Heat target trajectories which will be submitted to Access Board and SG. All of our services are working at capacity and we continue to experience strong and increased demand across the piece.	Health Board	Not meeting HEAT target	Access Board & Waiting Times	Timely access to psychological therapy & to maintain heat target	NHS Borders Service Review Programme	Improved and timely access to psychological therapies
East	NHSB	Recovering planned care	Primary & Community Services	2022-BOR15	Amber - at risk, requires action	Remobilisation of Primary Care Dentistry		NHS GDS progress, 80% of pre-pandemic activity at end of June 2022 PDS progress remains limited due to increased unscheduled care and difficulties in delivering key PDS function in relation to priority groups routine care, in particular where routine GDS is not provided by NHS GDS contractors	HCSP	Delay to patient care Undiagnosed disease Progression of chronic conditions Increasing oral health inequalities Recruitment	Access Board & Waiting Times Action plan in relation to recruitment	Timely access and to meet standards	Managing increased primary care demand / delivering increased primary care activity NHS Borders Community Models of Care Programme	Timely access to service Review in relation to developing workstreams
East	NHSB	Recovering planned care	Primary & Community Services	2022-BOR16	Proposal	Opportunities for rebalancing PDS and GDS	Kelso Dental Service Option Appraisal	No specific update	Health Board	Not yet known	Not yet known	Not yet known	Managing increased primary care demand / delivering increased primary care activity NHS Borders Community Models of Care Programme	Timely access to service
East	NHSB	Recovering planned care	Mental Health & Learning Disability Services	2022-BOR17	Amber - at risk, requires action	CMHT (rehabilitation) – Community Rehabilitation Team – supported living proposal project	Expected implementation of new model grade 5 accommodation September 2022	Near to completion some delays relating to lease agreement between Eildon and care provider	HSCP	If lease agreement cannot be concluded it may jeopardise progression with no alternative	tentative discussion with SBHA to source potential properties as a back up	Not yet known	NHS Borders Community Models of Care Programme	Improved living accommodation for marginalised group of patients with long term mental health conditions
East	NHSB	Recovering planned care	Mental Health & Learning Disability Services	2022-BOR18	Proposal	Review of LD Service Day Provision	To scope out the work required	Not yet started	HSCP	Not yet known	Not yet known	Improved provision of Day Services	NHS Borders Community Models of Care Programme	
East	NHSB	Recovering planned care	Primary & Community Services	2022-BOR19	Amber - at risk, requires action	CTAC – scoping of delivery models	Expected delivery timeframe early 2023. Being rolled out in a phased approach as per Scottish Government extension.	Funding gap of £1.6m remains preventing further progress to CTAC Ongoing project management support needed to continue progress Preparatory work ongoing: Service specification drafted, workforce model in development, engagement with Practices started regarding TUPE of Practice staff, data analysis of capacity/demand, IM&T service and technology requirements scoped, communication strategy drafted.	HSCP	Capacity, workforce Recurring funding gap of £1.6m	PCIP Executive Committee	Improved clinical pathways, improved patient experience, timely assessment & intervention	NHS Borders PCIP Programme Primary Care Improvement Plan Managing increased primary care demand / delivering increased primary care activity GP Sustainability Reshaping Urgent Care	Timely access to service
East	NHSB	Recovering planned care	Mental Health & Learning Disability Services	2022-BOR20	Amber - at risk, requires action	CMHT/CAMHS – development of pathways within Children & Adults Mental Health Services, including eating pathways		Significant progress has been made within camps regarding their clinical pathways and in particular the NDD pathway. Work progresses to rationalise internal processes and other pathways for other elements of the clinical service. Service review has commenced for adult CMHT and plans to conclude the end of August.	Health Board	Reduced or poor patient experience	CAMHS Specification, Scottish Government support	Improved clinical pathways, improved patient experience, timely assessment & intervention	NHS Borders Pathways Programme	Timely access to service
East	NHSB	Recovering planned care	Whole System	2022-BOR21	Amber - at risk, requires action	Establishment of Long Covid Pathway	Establish clear pathways for those living with long covid	Funding bid approved to establish a pathway coordinator	Health Board	Funding	Prioritising within Year 1 plan	Improved clinical pathways	NHS Borders Pathways Programme	Will be assessed as project develops

East	NHSB	Recovering planned care	AHP Services	2022-BOR22	Green - on track	Development of AHP Pathways & Services. This includes restructuring of community AHP rehab services, development of primary care roles, reviewing acute rehabilitation needs, developing CYP services.	Undertake a review and scope all work into one AHP programme	Ongoing service specification development Workforce and skill mix review Focus on locality based service delivery	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service Improved pathways Skill Mix	NHS Borders Pathways Programme	Will be assessed as project develops
East	NHSB	Recovering planned care	Primary & Community Services	2022-BOR23	Proposal	Scoping of Frailty Improvement Plan including Home First	Undertake a review and scope all work into one programme	A number of work workstreams have all been pulled into one programme of work which is under development - Home First - RAD - Elements of OPP - Falls Prevention - Eat Well, Age Well - Frailty MDT - Care Home Visiting	HSCP	Capacity to undertake review	Prioritising within Year 1 plan	Improved clinical pathways, improved patient experience, timely assessment & intervention	NHS Borders Pathways Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Acute Services	2022-BOR24	Proposal	Review leadership, roles & MDT engagement	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Workforce Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Acute Services	2022-BOR25	Proposal	Complete Diagnostics Workforce Plan	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Workforce Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Acute Services	2022-BOR26	Proposal	Biochemistry Regional Model	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Workforce Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Acute Services	2022-BOR27	Proposal	Microbiologist Medical Workforce Model	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Workforce Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Primary & Community Services	2022-BOR28	Amber - at risk, requires action	GP Sustainability	To stabilise workforce - undertake a review and scope all work into one programme.	Project Launch completed in May. Agreement to look at the following 6 themes: - Data workstream: understand the growing needs of the population and the growing GP workforce - Redefining the GP role within the Scottish Borders in terms of sustainability - Workforce planning - Equity - Fit of Purpose premises & IT infrastructure - Understanding financial stability for GP practices Significant project delivery timescales delays due to funding	Health Board GP's	Lack of project support Lost of GP confidence – GP workload pressures and workforce planning Lack of Financial budget confirmation leading to inability to enable workforce plan Recurring funding shortfall of £1.6M	Prioritising within Year 1 plan	Sustainable service Recruitment & Retention	NHS Borders Workforce Programme	Will be assessed as project develops
East	NHSB	Recruitment and retention	Acute Services	2022-BOR29	Proposal	Neurology Service Review	Undertake a service review	Not yet started	Health Board	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Service Review Programme	Will be assessed as project develops
East	NHSB	Sustainability and value	Whole System	2022-BOR30	Proposal	Robust Savings plan for 2023/24	Identify savings initiatives	Not yet started	Health Board	Capacity, timescales & ability to identify opportunities	Service reviews and wider staff engagement	Savings identified	NHS Borders FIP Programme	Will be assessed depending on initiatives
East	NHSB	Sustainability and value	Whole System	2022-BOR31	Proposal	Review of our estate	Undertake review of all of our sites	Primary Care Premises in development	Health Board	Timescales & capacity	Prioritisation of workplan	Improved premises	NHS Borders Capital Programme	Will be assessed as appropriate
East	NHSB	Sustainability and value	Mental Health & Learning Disability Services	2022-BOR32	Amber - at risk, requires action	Option Appraisal of PT Data Reporting System		Ongoing and in progressing with Business Intelligence/Waiting Times team and Planning & Performance		Inaccurate recording		Accurate recording of national waiting times	NHS Borders Service Review Programme	
East	NHSB	Sustainability and value	Mental Health & Learning Disability Services	2022-BOR33	Amber - at risk, requires action	Job Planning Opportunities		All medical staff have progressed to electronic job planning consideration will be given to expand this to other cohorts	Medical Staff	None noted at present		Efficient workforce	NHS Borders Workforce Programme	
East	NHSB	Sustainability and value	Mental Health & Learning Disability Services	2022-BOR34	Green - on track	Oral Health Needs Assessment	Approved by IJB	Oral Health Needs Assessment approved by IJB	HCSP Health Board				Updated strategic plan for Oral Health	Will be assessed as appropriate
East	NHSB	Social care	Primary & Community Services	2022-BOR35	Green - on track	Ukraine Response	Setting up health screening workstream with clinical staff to undertake screening	2 members of staff identified Health Screening questions set up Inbox for referrals set up Accelerating Health Screening over summer period prior to children starting school in August	HSCP	Access to the Government portal but data sharing agreement unsure at the moment We potentially have unscreened Ukraine settlers living in the Scottish Borders therefore increased risk		Improved public health	NHS Borders Pathways Programme	Will be assessed as appropriate
East	NHSB	Social care	Primary & Community Services	2022-BOR36	Green - on track	Locality Hubs	Undertake a review MDT locality hubs	Leadership away day completed in July to reignite locality MDT model in post-covid era and strengthen this established MDT approach and help maximise its full potential	HSCP	Capacity to undertake review	Prioritising within Year 1 plan	Sustainable service	NHS Borders Service Review Programme	Will be assessed as project develops

NHS Borders

Annual Delivery Plan Trajectories

Meeting with Chair & Non Executives

20th July 2022

4-5pm

Proposed Agenda for meeting

NHS Borders

Time	Item	Speaker
4:00 – 4:05pm	Welcome & Introductions	Ralph Roberts
4:05 – 4:10pm	Brief update of ADP to Non-Execs	June Smyth
4:10 – 4:20pm	CAMHS Trajectory	Gary Ward
4:20 – 4:30pm	Psychological Therapies Trajectory	June Smyth
4:30 – 4:40pm	Acute Trajectories	Gareth Clinkscale

NHS Borders

CAMHS Trajectories

Gary Ward

Updated Trajectory

NHS Borders

Key Assumptions

- Recovery and Renewal Funding from Scottish Government
- Full Compliment of Nursing, Medical, Psychology, AHP and Admin staff
- Numbers of accepted referrals will stabilise
- Continued access to suitable rooms/accomodation (through local and central booking systems)
- Sickness absence rates remaining low

Key Risk & Challenges

NHS Borders

- Increased new patient waiting list (ND, Core Mental Health, Psychology)
- Potential of internal waiting list for full assessment and treatment (ND, Core Mental Health and Psychology)
- Delays in reviewing already established ADHD patients
- Decreased Community working (staff being utilised in RTT`s and NPA)
- Decreased Interagency work (Single Point Access, OOH crisis)

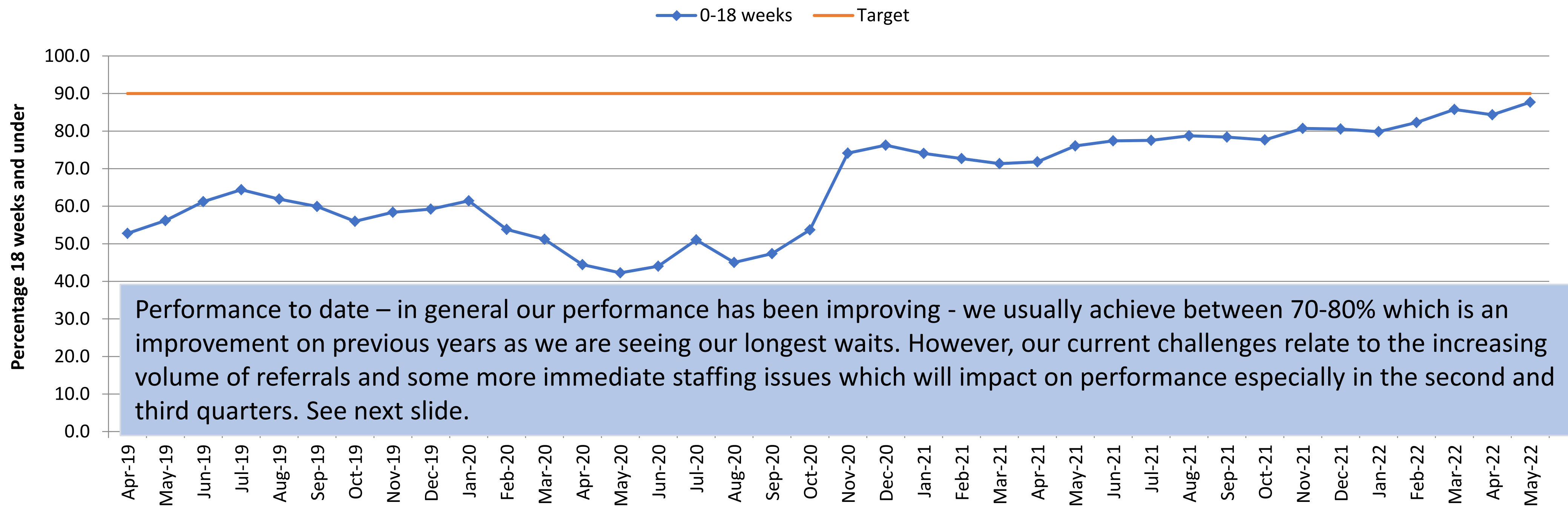
NHS Borders

Psychological Therapies Trajectories

Caroline Cochrane

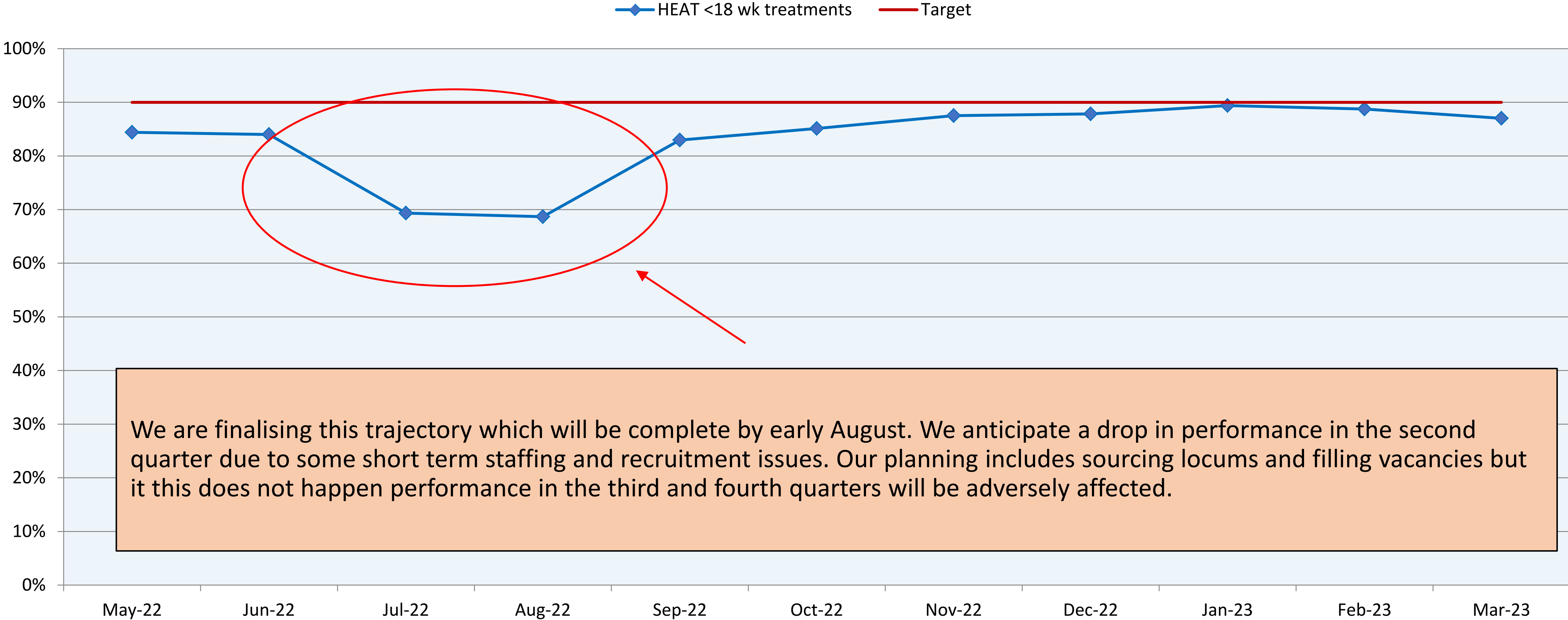
Updated Trajectory – Psychological therapies

- LDP RTT Heat target – 90% of all psychological treatments will start within 18 weeks of referral.



Trajectory – May 22- March 2023 Psychological therapies

NHS Borders



Key Assumptions

NHS Borders

- Receiving SG funding and this being recurring
- Recruiting to vacant posts and sourcing locums to cover gaps
- Referral rates do not significantly increase and performance is as per job plans
- Staff sickness rates stay at usual rates
- Covid/winter will be manageable

Key Risks & Challenges

- Current recruitment environment is challenging where demand is outstripping supply and increased movement.
- Impossible to recruit to fixed term posts *and*
- Need to over recruit to some posts due to natural career progression but can be difficult in current financial environment – if not gaps in recruitment affect performance.

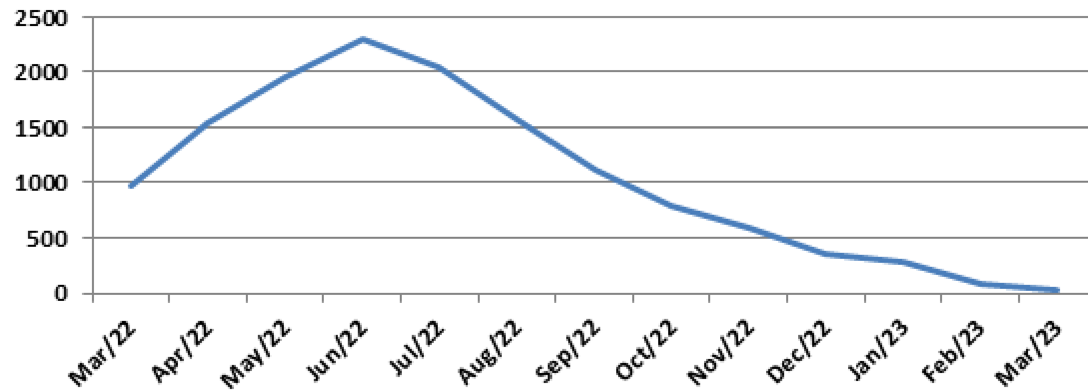
NHS
Borders

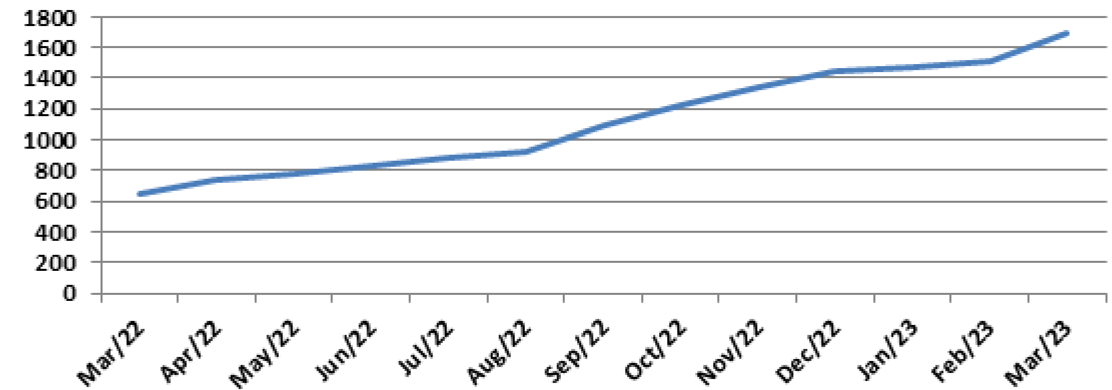
Acute Trajectories

Gareth Clinkscale

Updated Trajectory – Acute Services

NHS Borders





Emergency Access Standard

- Achieve national average by October 2022

Cancer

- Maintain 62 day performance (> 95%)
- Maintain 31 day performance (> 95%)

NHS Borders

Outpatients & TTG

Outpatients

- **2 year** waits for outpatients in most specialities by end of **August 2022**
- **18 month** waits for outpatients in most specialities by end of **December 2022**
- **1 year** waits for outpatients in most specialities by end of **March 2023**

TTG

- **2 year** waits for inpatient/day cases in the majority of specialities by **September 2022**
- **18 month** waits for inpatient/day cases in the majority of specialities by **September 2023**
- **1 year** for inpatient/day cases in the majority of specialities by **September 2024**

Key Assumptions

NHS Borders

- Receive identified level of Scottish Government Waiting Times funding and usual Unscheduled Care funding
- National support to deliver TTG activity for limited number of specialties
- Delayed Discharge trajectory delivers by end Sept' '22 and beyond
- Nursing workforce plan delivers required staffing levels
- Outpatient demand returns to pre-pandemic levels
- Emergency Department attendances do not exceed pre-pandemic levels
- Winter demand does not exceed previous years

Key Risks & Challenges

- Future COVID-19 waves impacting significantly on staff absence
- Seasonal pressures and ability to protect elective programme
- Leadership capacity to deliver BAU and meet performance challenge
- Fragile service models in new context
- Recruitment market
- Culture

NHS Borders

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**NHS Borders Annual Review Letter 2020/21**
Responsible Executive/Non-Executive:	**June Smyth, Director of Planning & Performance**
Report Author:	**Carly Lyall, Planning & Performance Officer**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Scottish Government Feedback Letter

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

- Performance

2 Report summary

2.1 Situation

This paper is to provide members with feedback from the Cabinet Secretary for Health and Social Care's letter following the Board's Annual Review with the Chair and Chief Executive of NHS Borders on 5th July 2022.

2.2 Background

The NHS Borders Annual Review for 2020/21 was held virtually on the 5th July 2022 with Karen Hamilton, the Chair of Borders Health Board and Ralph Roberts, the Chief Executive both in attendance. Humza Yousaf, Cabinet Secretary for Health and Social Care led the review and was supported by John Burns, the Chief Operating Officer of NHS Scotland. The Annual Review was carried out virtually in light of the current COVID-19 Pandemic Response, with no public meeting being carried unlike pre-pandemic.

The Annual Review process is intended to ensure the rigorous scrutiny of NHS Boards' performance whilst encouraging as much dialogue and accountability between local communities and their Health Boards as possible.

Every year, following the Annual Review of NHS Borders Scottish Government summarise the performance of the Health Board by letter (See Appendix 1).

This year's letter from Humza Yousaf, Cabinet Secretary for Health and Social Care, is positive and pays tribute to the ongoing efforts in these continuing unprecedented and unremitting pressures.

Achievements highlighted include:

- Mr Yousaf was most grateful for the outstanding efforts of local staff to adapt and maintain key services during 2020/21, in the face of unrelenting pressures while responding to the Covid-19 pandemic.
- Performance against the 31-day standard was consistently strong.
- Performance against the 62-day standard was more challenged but has been consistently at, or above, the national trend.
- It was positive to note that Psychological Therapies workforce grew slightly between March and December 2021.
- Financial position - following the review of escalated Boards in March 2021, the Board has been de-escalated from level 4 to level 3 on the Performance Framework in terms of its financial position, however it remains challenging.
- Mr Yousaf was pleased to note the ongoing positive engagement and contribution of the Area Clinical Forum, Area Partnership Forum and patient/carer stakeholders.

Areas for improvement commented on by Mr Yousaf from the Annual Review of performance in the year 2020/21 included:

- The increase in both outpatient and TTG waiting times since March 2020, particularly for routine assessment or surgery, means the Board had not reported meeting the RTT standard since June 2020.
- Frequent high occupancy, limited bed capacity and continuing staffing gaps (for a number of reasons inc. Covid) have been contributing to lengthy delays in the Emergency Department resulting in poor Emergency Access Standard.
- Delayed Discharges.

2.3 Assessment

It is hoped that by the time of the next Review we will be free of some of the more extreme recent pressures and able to focus fully on local service recovery and renewal. Mr Yousaf was nonetheless, under no illusion that the NHS continues to face one of the most periods in its history and are grateful for the ongoing efforts to ensure resilience. Scottish Government will continue to keep local activity under close review and provide as much support as possible.

2.3.1 Quality/ Patient Care

The feedback covers deliverables that promote Safety, increases Effectiveness and are Person Centred that will dovetail into performance for the year ahead.

2.3.2 Workforce

None identified.

2.3.3 Financial

The Financial Plan underpins the performance targets for the year and the Annual Delivery Plan (ADP). The Plan references the Financial Turnaround Programme and the challenges associated with managing the backlog in a financially restricted environment.

2.3.4 Risk Assessment/Management

The narrative within the ADP highlights any particular risks to achievement of the targets, and the plans in place to minimise any such risks.

2.3.5 Equality and Diversity, including health inequalities

NHS Borders Annual Review 2020/21 complies with the Board's Equality and Diversity requirements.

2.3.6 Climate Change

None identified.

2.3.7 Other Impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

The Self Assessment document which informed the discussion at the Annual Review was developed through contributions from service leads, members of the Operational Planning Group, Board Executive Team, Chair of the Area Clinical Forum and Chair of the Area Partnership Forum.

2.3.9 Route to the Meeting

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

- Operational Planning Group, 26th September 2022

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Annual Review - Ministerial letter

Cabinet Secretary for Health and Social Care
Rùnaire a' Chaibineit airson Slàinte agus Cùram Sòisealta
Humza Yousaf BPA/MSP

Scottish Government
Riaghaltas na h-Alba
gov.scot

E: cabsecHSC@gov.scot

Karen Hamilton
Chair
NHS Borders

Via email: karen.hamilton@borders.scot.nhs.uk

4 July 2022

Dear Karen

NHS BORDERS ANNUAL REVIEW: 5 JULY 2022

1. Thank you for attending NHS Borders' Annual Review with Ralph Roberts, the Board's Chief Executive, on 5 July 2022 via video conference. I am writing to summarise the key discussion points.

2. In the same way as last year, in-person Reviews have not proved possible as a result of the Covid-19 pandemic and associated pressures. Nonetheless, Annual Reviews remain an important part of the accountability process for the NHS and, as such, we have arranged for Ministers to hold appropriate sessions with the Chair and Chief Executive of each Board via video conference. I was supported in the meeting by John Burns, the Chief Operating Officer of NHS Scotland.

3. The agenda for this year's round of Reviews had been split into two sections to cover: a look back from 2020/21, including the initial response to the pandemic; and a look forward, in line with the Board's resilience and mobilisation plans.

Look back: including the initial response to the pandemic

4. You provided a helpful overview of the Board's initial response to the pandemic from late February 2020. This required an unparalleled, immediate and radical restructure of both services and ways of working across the NHS in Scotland, including in NHS Borders. The Board's response and recovery planning process involved the rapid reconfiguration of local health and care services across acute, primary and community settings, including a significant increase in the use of technology, such as *Near Me*, to deliver care outside hospitals or clinic settings, alongside effective, whole system working.

5. I was happy to visit Borders General Hospital on 12 April to thank local staff for their efforts during the pandemic; to visit the A&E Department, the palliative care centre, maternity unit and dementia unit. Staff at every level have consistently performed above and beyond the call of duty to support both local services and the national effort: for instance, with the unprecedented *Test & Protect* and vaccination programmes, as well as the crucial support and clinical oversight provided to local care homes.

Scottish Ministers, special advisers and the Permanent Secretary are covered by the terms of the Lobbying (Scotland) Act 2016. See www.lobbying.scot

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disability confident LEADER

6. An example of this had been the medical physics staff who had worked innovatively and tirelessly in the initial stages of the pandemic to bolster vital critical care capacity by converting anaesthetic machines to ventilators; alongside other largely unsung heroes, such as those who had been instrumental in establishing the new community pathways; and ensuring that key services, such as district nursing and health visiting, had been maintained throughout. Indeed, it is through the consistent dedication and commitment of local health and social care staff, under largely unrelenting pressures, that we have ensured that the NHS has not been overwhelmed at any point during the pandemic, to date. As such, I would want to once again formally record our deep appreciation to all local health and social care staff for their outstanding work, and give them an assurance that we will continue to do all we can to support them.

7. In terms of the impact of Covid-19 and associated activity, during the financial year 2020/21 (Apr-Oct) NHS Borders had experienced/operated: 132 Covid positive cases in beds; 18 positive cases in ICU; 20,664 A&E attendances; 1,018 theatre operations; 1,788 emotional wellbeing appointments; and *9,168* Near Me appointments. You confirmed that this very significant activity, and the service adaptions, such as the remarkable increase in virtual outpatient appointments had been delivered via a highly effective, whole system command structure in Borders: ensuring appropriate oversight and governance alongside delivery.

8. The need to establish capacity to meet the Covid-19 demands placed on health and social care required significant changes in the level of planned care available during 2020/21. During the first Covid-19 wave all planned surgery, with the exception of cancer, was paused. The increase in both outpatient and TTG waiting times since March 2020, particularly for routine assessment or surgery, means the Board had not reported meeting the RTT standard since June 2020. The Board went into last winter with significant challenges, brought about by Covid pressures and already holding a number of long term vacancies; with the workforce further depleted by sickness, self-isolation and redeployment to ensure safe staffing.

9. All Health Boards had seen unscheduled care pressures fall in the first phase of the pandemic, with the restrictions having a significant impact on attendances. As restrictions were eased following the initial lockdown, attendances had risen; and Boards faced new pressures in A&E Departments and receiving wards due to the higher acuity of some presentations, alongside the maintenance of appropriate infection control measures and streaming of patients. Frequent high occupancy, limited bed capacity and continuing staffing gaps (for a number of reasons inc. Covid) have been contributing to lengthy delays. Delayed discharge has also been a marked issue: with an increase in the complexity of home care packages required and collaboration with planning partners has been challenging as a result of resourcing issues in relation to home care staff and increasing the number of care home beds. Local performance against the 4-hour standard for the week ending 26 June 2022 was 64.1% against a national average of 67.5%. In terms of the longest delays, there were 49 patients staying over 12 hours, compared to 6 in the equivalent pre-pandemic week from 2019.

10. The management of cancer patients and vital cancer services has remained a clinical priority during the pandemic and NHS Borders performance against the 31-day standard was consistently strong; whilst performance against the 62-day standard was more challenged but has been consistently at, or above, the national trend.

11. NHS Borders was one of seven Boards escalated for enhanced improvement support for Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies performance. An ambitious CAMHS plan is in place prioritising the longest waits; however, recruitment will be essential to sustain the planned level of activity. We were pleased to note the Psychological Therapies workforce grew slightly between March and December, 2021.

12. Following the review of escalated Boards in March 2021, the Board has been de-escalated from level 4 to level 3 on the Performance Framework in terms of its financial position. NHS Borders received £7.9 million and £8.8 million of non-repayable support in 2020-21 and 2021-22, respectively, to deliver breakeven. Prior to the pandemic, NHS Borders received £8.3 million of brokerage in 2019-20. The local savings-focused Programme Management Office had made a significant impact following its inception in 2019 but was paused during the pandemic to redeploy resources; the programme has not been fully re-started and the Board are considering what further resource is required to do so. Government Health Finance officials continue to engage regularly with the Board.

13. All Boards will need to learn from the pandemic experience and adapt; ensuring that the remarkable innovation and new ways of working demonstrated underpin the local strategy for a sustainable future. We also asked the local Area Clinical Forum, Area Partnership Forum and patient/carer stakeholders to provide brief updates ahead of the Review and were pleased to note the ongoing positive engagement and contribution of these groups; the Board will need to harness this and ensure full staff and wider stakeholder support and engagement for the longer term recovery and renewal phase.

14. To summarise, we are most grateful for the outstanding efforts of local staff to adapt and maintain key services from 2020/21 for the benefit of local people, in the face of unrelenting pressures. We must also recognise that the initial pandemic response, which necessitated the prioritisation of Covid, emergency and urgent care, meant that there has inevitably been a regrettable increase in non-Covid health and wellbeing harms, alongside a significant and growing backlog of non-urgent, planned care; and that, despite the success of the vaccination programme, we face ongoing risks around the disease, alongside a range of other pressures that are likely to continue to have a significant impact.

Forward look

15. Ensuring that the NHS was not overwhelmed had been of paramount importance in the first phases of the pandemic and, given the myriad of pressures facing us, Boards remained on an emergency footing until the end of April 2022. The Government had supported NHS Board planning for the most recent winter via the Health and Social Care Winter Overview, published on 22 October. The approach was based on four principles: maximising capacity; supporting staff wellbeing; supporting effective system flow; and improving outcomes. It outlined how we would: protect the public from the direct impact of Covid-19 and other winter viruses; support our staff to deliver high quality care; increase capacity and maintain high quality integrated health and social care; support the public through clear and consistent messaging to make sure they access the right care, in the right place, at the right time; and use digital and financial enablers to achieve these objectives.

16. This approach, supported by the Adult Social Care Winter Plan, is backed by £300 million of recurring funding, aimed at ensuring we have a well-staffed, well-supported and resilient health and social care system. The new multi-year funding will support a range of measures to maximise capacity in our hospitals and primary care, reduce delayed discharges, improve pay for social care staff, and ensure those in the community who need support receive effective and responsive care.

17. Most NHS Boards, including NHS Borders, had faced a very difficult winter and the subsequent peak in Omicron hospitalisations resulted in unprecedented and sustained pressures on local services, particularly at Borders General Hospital. There have been high attendances coupled with increased acuity, alongside limited staffing and bed capacity.

18. As noted above, NHS Borders A&E performance remains challenging and we note the work underway locally as part of a range of improvement programmes, including the continued development of the local Redesign of Urgent Care programme, Flow Navigation Centre, Discharge without Delay, and Interface Care.

19. A long term local pressure point has been workforce availability and the Board had undertaken a range of actions to mitigate the associated risks, including a plan to recruit international nurses; of which, 5 nurses have already been appointed with two further cohorts of overseas nurses due to start in August and October 2022. Further to this, you confirmed that two radiographers are due to start with NHS Borders in the autumn.

20. We also remain very conscious on the cumulative pressures on the health and social care workforce and recognise the full range of actions NHS Borders is taking in terms of the wellbeing and resilience of local staff. You confirmed that the Board has established a range of support measures for staff in order to promote personal resilience, help prevent mental health issues developing, and to promote overall wellbeing in the workplace. These measures will also play a pivotal role during the essential recovery period, ensuring full staff support and engagement in the longer term recovery and renewal phase. This will also be material in terms of the local staff recruitment and retention efforts.

21. Whilst the recent focus has necessarily been on resilience (not least in response to the Omicron wave), we remain ever conscious of the backlog of elective care and associated harms. We continue to assist NHS Boards, including NHS Borders, with their plans for recovery, in light of the more than £1 billion of targeted investment driving the remobilisation of our NHS; as part of our Recovery Plan, announced in August 2021.

22. Whilst the Board continues to be pressured for inpatient beds we noted the planning currently underway to open up a separate area to protect elective capacity; however, it was acknowledged that staffing these beds remains a challenge. The Board has also been supported by a new agreement to deliver a cohort of colorectal cancer cases at the Golden Jubilee National Hospital; alongside additional support for orthopaedics and cataract surgery.

23. In terms of cancer, the Board are developing an action plan to implement the refreshed *Framework for Effective Cancer Management*, published in December 2021. Monthly progress and monitoring of the Board's action plan to implement the Framework is in place to ensure all eight key elements are embedded. The funding of £214,763 will be aligned to areas where a difference can be made in long waiting times and reducing the backlog of patient waiting for diagnosis.

24. We noted the pressures relating to the increasing number of local patients that require neurodevelopmental formulation and/or diagnosis; and the Board's plans to mitigate any associated risks, as far as possible. Progress against the revised trajectories for CAMHS and Psychological Therapies waiting times will be monitored monthly as part of routine engagement meetings with the Government's Mental Health Performance Unit.

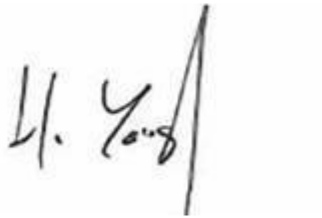
25. 2022/2023 presents a further financial challenge against a backdrop of remobilisation, recovery and the ongoing impact of Covid. The key financial risks are primarily driven by local operational pressures, including acute prescribing, energy costs and digital investment. The Scottish Government will continue to regularly engage with the Board to monitor your position and to assist with longer term financial planning.

Conclusion

26. I hope that by the time of the next Review we will be free of some of the more extreme recent pressures and able to focus fully on local service recovery and renewal. I am, nonetheless, under no illusion that the NHS continues to face one of the most periods in its history and are grateful for your ongoing efforts to ensure resilience. We will continue to keep local activity under close review and provide as much support as possible.

27. I want to conclude by reiterating my sincere thanks to the NHS Borders Board and local staff for your sustained professionalism and commitment, in the face of unprecedented and unremitting pressures over the last couple of years, for the benefit of local people.

Yours sincerely



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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Primary Care Improvement Plan update**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Chris Myers, Chief Officer Health & Social Care**

1 Purpose

This is presented to the Board for:

- Awareness
- Discussion

This report relates to a:

- Emerging issue
- Government policy/directive
- NHS Board/Integration Joint Board Strategy or Direction

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

- Effective

2 Report summary

2.1 Situation

This paper sets out the situation relating to the impacts of the tightening of available financial resources as outlined in the Resource Spending Review on the Primary Care Improvement Plan.

Good progress has been made locally with the implementation of the Primary Care Improvement Plan (PCIP) with excellent tripartite arrangements between the NHS Borders, General Practitioners and the Integration Joint Board. This progress is outlined in the Primary Care Improvement Plan's 2021/22 Annual Report (The PCIP Annual report available from the following link).

We are now at a stage where a lack of funding has constrained our ability to deliver the Primary Care Improvement Plan in line with the Memorandum of Understanding 2. This has been escalated to the Scottish Government who have indicated that further funding is not available.

2.2 Background

The 2018 GMS contract arose out of necessity. Nationally, general practices were faced with unprecedented level of challenge in terms of sustainability – national recruitment issues and increasing demand for appointments resulted in practices struggling to deliver the service at the level they aspired to achieve.

In recognition of the severity of the situation, it was hoped that by creating a system where tasks are directly realigned to a more appropriate professionals would help relieve GP pressures.

National funding was to provide new staff employed by Health Boards that would be dedicated in improved patient-centred care. A new multidisciplinary primary care system could allow other health care professions to develop and grow in community based care. For GPs, it would go beyond just the easing of workload pressures. It would allow GPs to focus on being an expert medical generalist role at the heart of the community multidisciplinary team. This would aim to improve patients' quality of care, increase GP job satisfaction, and ensure more seamless delivery of health and social care services.

Development of Primary Care Multi-Disciplinary Teams is a contractual issue as it is a prerequisite to the delivery of the GMS Contract. The development of these services were agreed under a Memorandum of Understanding between General Practice, the Scottish Government, Integration Joint Boards and NHS Boards. Adequate levels of resourcing are clearly a pre-requisite to the delivery of the GMS Contract, in resourcing the development of Primary Care Multi-Disciplinary Teams to develop and support General Practitioners in their role as Expert Medical Generalists.

Since 2018, workstreams were created to deliver new services, including Vaccinations, Community Treatment and Care (CTAC), Pharmacotherapy, Musculoskeletal, Mental Health, Pharmacotherapy and Community Link Workers. Within the funding envelope available, the PCIP Executive Committee pushed with the implementation of key workstreams to deliver services to practices – scrutinising every spend and overseeing progress, ensuring that decision made were having a meaningful impact on GP workload and benefiting patients in an equitable manner.

Work continued to develop these workstreams throughout the Covid-19 pandemic in the recognition of the very pressing requirement to meet the increased needs of our population and General Practice throughout the pandemic.

A second Memorandum of Understanding (MoU2) would later ask that Integration Joint Boards and Health Boards prioritise three services for delivery: Vaccinations, CTAC and Pharmacotherapy. Prior to this revised edition, the Scottish Government's Primary Care Improvement Funding (PCIF) allocation for the Scottish Borders had already been committed to funding other workstreams first. The PCIP Executive Committee had judged that based on work demand analysis, services such as Mental Health, Musculoskeletal and Urgent Care would provide immediate relief to local GP workloads. It is important to note that the MoU2 also states that Integration Joint Boards and Health Boards should not defund established

workstreams to address shortfalls for the three priority services. This raised the risk of securing funding for full delivery of the contract.

2.3 Assessment

Our view from the Memorandum of Understanding is that the Scottish Government is responsible for resourcing this programme and we expected the funds to come in to honour the contract. Broadly speaking, the roles of the Integration Joint Board and NHS Borders are to commission and deliver the Primary Care Improvement Plan respectively in line with local needs under the national framework, which is resourced by the Scottish Government.

Whilst not responsible for funding the contract, should the priority workstreams not be delivered, Integration Authorities and Health Boards are required to compensate General Practitioners to deliver activity that will no longer be contractually obliged, at rates yet to be negotiated by the BMA and Scottish Government. However in the first instance, due to the national recognition of a delay in the full implementation of the GP contract, the Scottish Government has agreed to funding of two sustainability payments to GPs. The first such payment has been made and there is currently not a firm timescale for the second payment.

In the 15 June 2022 Integration Joint Board, a forecast financial deficit of £2.511m from 2023/24 was presented; primarily risking the successful delivery of both Community Treatment and Care and Pharmacotherapy services. As the resources associated to the Primary Care Improvement Plan had been fully committed; the Integration Joint Board requested further local review of the potential to further maximise local impacts of spend on the Primary Care Improvement Plan, and an Extraordinary IJB was set up for 17 August 2022 to consider the position further.

In preparation of the Extraordinary IJB meeting called for August 2022 to further examine the financial risk, a detailed review into each workstream was undertaken. This review led to an in-depth look into workforce projections with clinical leads re-applying skill mix analysis of each key role within service structures in an attempt at reducing cost without compromising patient care and to validate value for money. This work was supported by the Health and Social Care Partnership Chief Nurse and also by the NHS Borders Director of Nursing, Midwifery & Allied Health Professionals. The revised financial shortfall now stands at £2.372m.

In addition, the Chief Officer, Health and Social Care, escalated the situation to the Scottish Government's Primary Care Division, outlining that good progress had been made in the Scottish Borders to implement the Primary Care Improvement Plan, that the recurrent funding had been fully committed, and that there was a forecast deficit of £2.372m from 2023/24 onwards to deliver against the commitments outlined in the Memorandum of Understanding 2.

In response, the Scottish Government has confirmed that £170m nationally would be made available for 2022-23 plans. This represents an increase of £15m from £155m and equates to around £319k for the Scottish Borders, which does not cover the forecast gap. The Scottish Government have now outlined the funding arrangement for future years in an allocation letter which sets out the level of funding and how funding will be issued, in two tranches.

For 2022/23, we received confirmation of an allocation of £3.648m for the Primary Care Improvement Fund. This was an improvement on our working assumption of £3.2m.

Reserves brought forward from 2021/22 must be used first before pulling down additional funds.

Following this escalation, the Chief Officer wrote back to the Scottish Government to outline that funding would not be sufficient to allow for the full progression of the Memorandum of Understanding 2 priority areas. As a result, Officials joined a Primary Care Improvement Plan Executive Committee meeting on 8 September, where there was a full discussion about our successful local approach, and local progress. It became apparent that at this stage, the Scottish Government are not in a position to commit to extra funding to support the full implementation of the Memorandum of Understanding 2. As a result, this leaves a remaining £2.372m deficit and the Chief Officer agreed to escalate this to the national GMS Oversight Group on behalf of the tripartite Primary Care Improvement Plan Executive Committee comprising NHS Borders, General Practice and the Integration Joint Board.

The Integration Joint Board then considered the situation further on 21 September 2022, and a Direction was issued by the Integration Joint Board to NHS Borders on Friday 23rd September. This Direction requests that the programme is managed within the available resources. This will require the PCIP Executive Group to reprioritise the use of available recurrent funding, and to do this is done in keeping with IJB commissioning and decommissioning processes. The direction also asks the PCIP Executive Group to identify the risks and issues associated with insufficient funding and to develop a mitigating strategy. This Direction is enclosed in Appendix 1.

Whilst the Scottish Government is responsible for funding the GMS Contract, both NHS Borders and the Integration Joint Board recognise, and are sympathetic of the impacts of the current position relating to non-delivery of the contract for General Practitioners in the Scottish Borders, and the associated risks that this presents.

However it is important to note that both organisations are starting from a position of overspend, and it is recognised that financial constraints in the Borders will get more challenging in the context of inflationary pressures, minimal allocations to Health Boards / Health and Social Care Partnerships over the next 4 years, and of the situation that we are now seeing played out in relation to the consequences of the Resource Spending Review. A discussion has been proposed with the GP Executive about whether there are further steps that can be taken locally to move closer towards contract delivery, within the context of these challenging financial constraints.

The Primary Care Improvement Plan Executive Committee and Integration Joint Board have proposed the re-prioritisation of existing PCIP commitments in line with the Memorandum of Understanding 2, however proposals for any decommissioning will need to go through the IJB decommissioning process which will ensure appropriate consideration of the impacts on various communities (service users, staff, partners, unpaid carers).

2.3.1 Quality/ Patient Care

As the financial constraints limit development, there is the potential that Primary Care services are unable to responsively meet demand, and that General Practitioners cannot fulfil their role as ‘Expert Medical Generalist’ outlined in the contract. This will impact on the quality of patient care received across the Borders.

2.3.2 Workforce

There is a potential workforce risk in relation to the re-prioritisation of workstreams. It is hoped that the use of the PCIP Executive Committee governance, and the IJB decommissioning / commissioning engagement processes that these risks will be reduced.

2.3.3 Financial

The financial risk is being managed by ensuring that the programme is managed within the available resource, and that the PCIP Executive Committee work to identify any further financial risks. In addition, there is a financial risk that NHS Borders is required to compensate General Practitioners for non-delivery of the Memorandum of Understanding 2. However, this position and any potential rate are yet to be negotiated between the BMA and the Scottish Government.

2.3.4 Risk Assessment/Management

- Risk of non-delivery against GMS Contract – to be escalated to the GMS Oversight Group
- Associated sustainability risk for Primary Care (General Practice)
- Workforce risk – as outlined above
- Financial risk – as outlined above

2.3.5 Equality and Diversity, including health inequalities

A Healthcare Inequalities Impact Assessment for the whole PCIP programme has been undertaken. In addition, for new workstreams, service specific Healthcare Inequalities Impact Assessments have been undertaken to ensure that the services appropriately ensure that the new services are not discriminating in their approach, that they widen access to opportunities, and promote the interests of people with protected characteristics.

2.3.6 Climate Change

Not recruiting to the full staff complement is expected to reduce the potential carbon impacts.

2.3.7 Other impacts

No other impacts of note.

2.3.8 Communication, involvement, engagement and consultation

- There have been monthly Primary Care Improvement Plan Executive Committee meetings involving General Practice, NHS Borders and Integration Joint Board representatives, who have consulted with relevant stakeholders, and fed back into these discussions.
- In addition, consultation has occurred as part of the workstream specific Integrated Impact Assessments

2.3.9 Route to the Meeting

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

- This has been recently considered by the Health and Social Care Integration Joint Board on 21 September 2022, 17 August 2022, and 15 June 2022.

2.4 Recommendation

This is presented to NHS Borders Board members for:

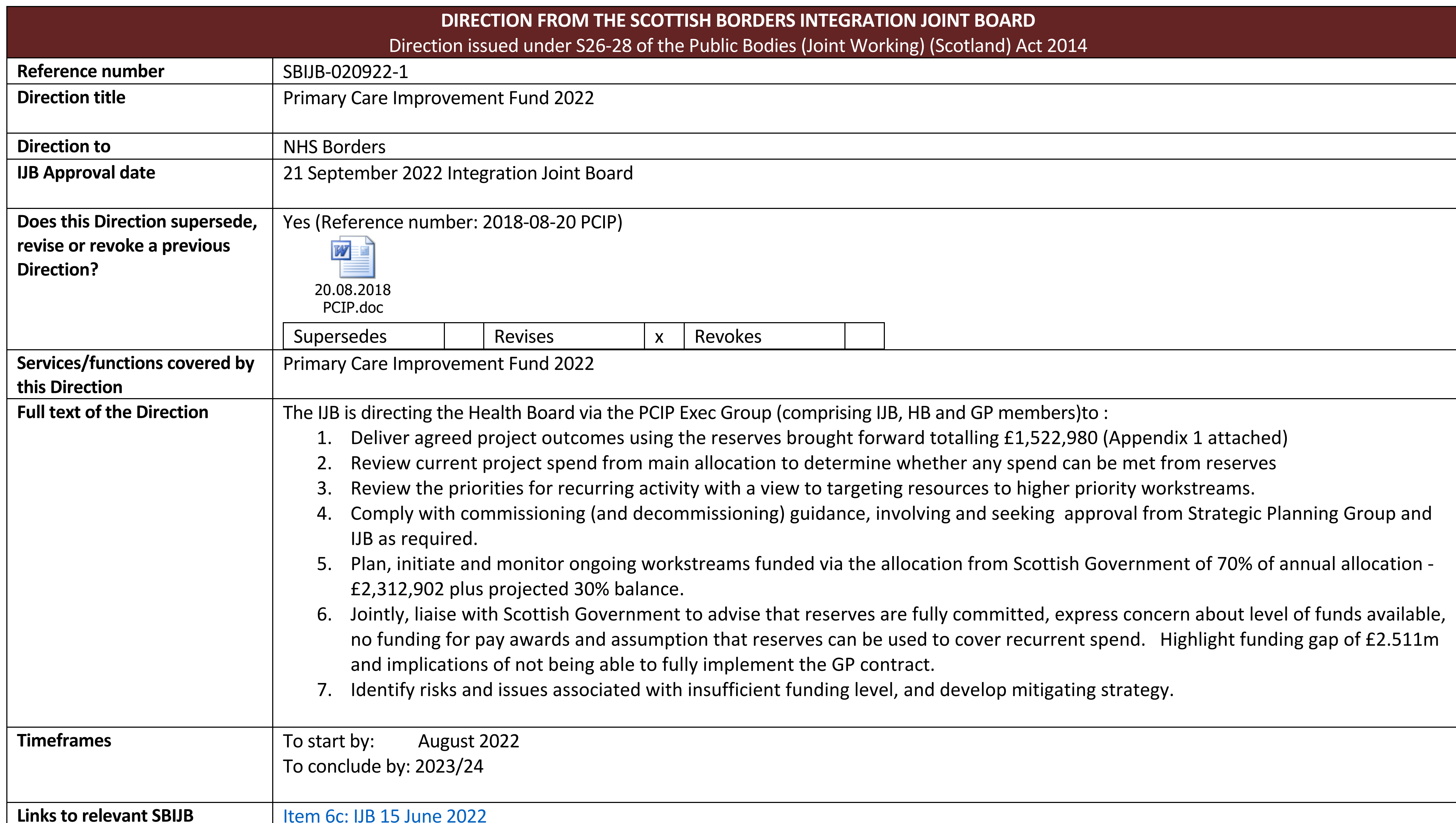
- **Awareness and discussion**

3 List of appendices

The following appendices are included with this report:

- Appendix 1. Primary Care Improvement Plan Direction from the Scottish Borders Health and Social Care Integration Joint Board to NHS Borders

Appendix 1. Primary Care Improvement Plan Direction from the Scottish Borders Health and Social Care Integration Joint Board to NHS Borders



DIRECTION FROM THE SCOTTISH BORDERS INTEGRATION JOINT BOARD Direction issued under S26-28 of the Public Bodies (Joint Working) (Scotland) Act 2014	
Reference number	SBIJB-020922-1
Direction title	Primary Care Improvement Fund 2022
Direction to	NHS Borders
IJB Approval date	21 September 2022 Integration Joint Board
Does this Direction supersede, revise or revoke a previous Direction?	Yes (Reference number: 2018-08-20 PCIP) 20.08.2018 PCIP.doc Supersedes: [ ] Revises: x Revokes: [ ]
Services/functions covered by this Direction	Primary Care Improvement Fund 2022
Full text of the Direction	The IJB is directing the Health Board via the PCIP Exec Group (comprising IJB, HB and GP members)to : 1. Deliver agreed project outcomes using the reserves brought forward totalling £1,522,980 (Appendix 1 attached) 2. Review current project spend from main allocation to determine whether any spend can be met from reserves 3. Review the priorities for recurring activity with a view to targeting resources to higher priority workstreams. 4. Comply with commissioning (and decommissioning) guidance, involving and seeking approval from Strategic Planning Group and IJB as required. 5. Plan, initiate and monitor ongoing workstreams funded via the allocation from Scottish Government of 70% of annual allocation - £2,312,902 plus projected 30% balance. 6. Jointly, liaise with Scottish Government to advise that reserves are fully committed, express concern about level of funds available, no funding for pay awards and assumption that reserves can be used to cover recurrent spend. Highlight funding gap of £2.511m and implications of not being able to fully implement the GP contract. 7. Identify risks and issues associated with insufficient funding level, and develop mitigating strategy.
Timeframes	To start by: August 2022 To conclude by: 2023/24
Links to relevant SBIJB	Item 6c: IJB 15 June 2022

report(s)	[Item 5a: IJB 17 August 2022] [Item 6a: IJB 21 September 2022]
Budget / finances allocated to carry out the detail	Reserves £1,522,980 PCIP allocation £2,312,902 plus 30% balance Note that PCIP allocation does not include inflation – for 2022/23 this is funded from reserves
Outcomes / Performance Measures	Implementation of the GP contract – full implementation of all workstreams is not possible within the funding provided. Project and workstream specific outcomes and performance measures
Date Direction will be reviewed	November 2022 Audit Committee, February 2023 Audit Committee

APPENDIX 1.1 Reserves commitment to non recurring spend

Non-Recurrent Funding

A summary of commitments made by the PCIP Executive Group against the non-recurring allocation is summarised in the table below:

Commitments	Resource Directed £	Actual Expenditure to 30 April 2022 £	Forecast Expenditure to 31 March 2023 £
ANP Training	82	2	82
CTCS Programme Management	54	0	54
CTCS Admin Support	15	3	15
CTCS General Allocation	545	7	545
PCIP Project Management	72	0	72
PCIP Comms / Engagement	25	0	25
VTP	200	0	200
System Acquisition & Installation	276	0	276
Provision for 22/23 pay inflation and drift	254		254
Total Commitments	**1,523**	**12**	**1,523**
Funded by:			
Additional NR Allocation	(1,097)		(1,097)
Non-Recurring Carry Fwd	(426)		(426)
Total Funding	**(1,523)**		**(1,523)**
Remaining for Direction	**0**		
Total Forecast Slippage / Uncommitted			**0**

APPENDIX 1.2 Recurring spend plan 2022/23

Recurrent Funding

A summary of 2022/23 funding, investment and forecast expenditure position on the Partnership's PCIP is detailed below:

Workstream	PCIP 3-Year Recurring Investment £'000	Actual Expenditure to 01 April 2022 £'000	Forecast Expenditure to 31 March 2023 £'000	Surplus / Slippage / (Deficit) at 31 March 2023 £'000
VTP	16	0	16	0
Pharmacotherapy	879	75	888	(9)
CTAC	121	0	121	0
Urgent Care	883	59	792	91
FCP	528	46	545	(17)
Mental Health	669	52	618	52
Community Link Workers	150	13	150	0
Central Costs	49	0	40	9
Total Expenditure	**3,296**	**245**	**3,170**	**126**
Funded by:				
2.13% of £155m	(3,296)			
Drawn Down Share			(3,170)	(126)
Total Funding Requirement	**(3,296)**		**(3,170)**	**(126)**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Quarter One Review – SG Response**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

NHS Borders has now received response from Scottish Government in response to its Quarter One Financial Performance Report and outturn forecast. This response includes clarification on minimum expected financial performance outcomes in 2022/23 together with additional guidance on the development of the board's medium term financial plan and forecast.

This paper is intended to update the board on the key messages within this response and to advise on next steps.

2.2 Background

An update to the forecast financial outturn was prepared as part of the board's Quarter one review and reported to the Resources & Performance Committee at its meeting on 1st September 2022. This position described a movement from the board's financial plan forecast deficit position from £12.2m to £13.7m.

Table 1, below, summarises the key movements from financial plan as presented to the committee.

Table 1 – Summary, Quarter One Review

Forecast Outturn Variance at 31st March 2022	Financial Plan £m	Q1 Forecast £m
Business Unit Performance	2.00	(0.58)
COVID19	-	(0.91)
Operational Performance	***2.00***	***(1.49)***
Savings Target - Business Unit	(8.73)	(8.73)
Savings Target - Unallocated	(11.88)	(11.88)
Savings Delivery	5.00	5.00
Non-delivery of Savings	***(15.61)***	***(15.61)***
Net Flexibility *after investments*	1.32	3.40
Total	(12.29)	(13.70)

An initial forecast was submitted to the Scottish Government at end July in line with the month three Financial Performance Reporting timetable. The position reported to the committee in September remained in line with this draft forecast.

The forecast submission to Scottish Government included further detail in relation to anticipated funding, progress towards savings identification and delivery, and actions available to deliver increased flexibility within the forecast.

A summary of key risks to the forecast were reported, highlighting in particular the ongoing challenges arising from unscheduled care and workforce pressures, together with volatility within the current economic environment.

Following finalisation of the Q1 forecast a further issue emerged in relation to the replacement of the Laboratory Management System. In order to ensure business continuity a rapid migration to a new system was agreed with expected delivery by end March 2023. The financial impact of this migration is anticipated to be up to £2.8m over three years with the majority of expenditure incurred in year 1 (2022/23). It is likely that the forecast will increase by up to £2.0m to £15.7m deficit although an element of this increase may be mitigated through re-profiling of existing digital programme commitments. An update will be provided at Quarter Two review.

2.3 Assessment

Scottish Government provided a detailed response to the board's quarter one review by letter issued on 12th September. This letter summarises expected actions to be progressed in response to the financial challenges faced by the board and at an NHS Scotland level. It is understood that the requirements outlined in the letter are in line with those advised to all other Health Boards who are reporting a projected outturn deficit.

The full letter is provided as an appendix to this paper.

The key points raised within are as follows:

- All health boards are expected to deliver an outturn position in line with their financial plan, inclusive of any cost impact arising from COVID.

- A short term recovery plan detailing actions in place to deliver this position is required by **30th September 2022**[1].
- All health boards reporting a forecast deficit are required to prepare a full recovery plan detailing a trajectory to achieve a breakeven position over the medium term (three years) as part of their **Annual Delivery Plan submission for 2023/24**.
- Financial support to delivery of a breakeven position will be on a **'brokerage'** basis, i.e. will require repayment in future years. The letter advises that any such borrowing in 2022/23 will be adjusted from future allocations.

Further detail is provided within the letter in relation to Elective Care and other relevant programmes. This includes summary information on the establishment of a number of national programmes focussed on: sustainability and value, optimising capacity and financial improvement.

There is no clarity within the letter with regard to repayment of previous borrowing (£8.3m) arising from brokerage made available in 2019/20 (pre-pandemic). As previously reported, non-recurring support has been made available on a non-repayable basis in 2020/21 and 2021/22 to support a breakeven position.

Actions Required

A short term recovery plan is currently being developed in line with the expected submission for 30th September. Following discussion with SG colleagues this timescale has been extended to 5th October. The recovery plan will be discussed by the board executive team (BET) at its meeting on 4th October.

There are further actions arising from the emerging national workstreams which are being considered both within the immediate (short term) recovery plan and as part of the longer term Financial Improvement Programme and wider grip & control agenda. This includes review of arrangements for the management of supplementary staffing, including agency staff, and arrangements in place for the review of recruitment to vacant posts.

A timetable for the development of the medium term recovery plan will be presented to the Resource & Performance committee in November.

2.3.1 Quality/ Patient Care

The impact of actions required in response to the letter has not yet been considered. This will be evaluated through the development of the recovery plans and other relevant actions.

2.3.2 Workforce

The impact of actions required in response to the letter has not yet been considered. This will be evaluated through the development of the recovery plans and other relevant actions.

[1] Deadline of 30th September extended to 5th October by agreement with SG finance colleagues.

2.3.3 Financial

Financial matters are described in the body of the paper and its appendix.

2.3.4 Risk Assessment/Management

No separate risk assessment has been undertaken at this stage. The risks outlined in the Board's quarter one review will be reviewed and updated through the preparation of the required plans.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been prepared because it is not required at this stage.

2.3.6 Climate Change

No impacts have been identified.

2.3.7 Other impacts

No other impacts have been identified.

2.3.8 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders where appropriate: No engagement required.

2.3.9 Route to the Meeting

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

BET Strategy Group – 27th September 2022
BET Operational Meeting – 4th October 2022

2.4 Recommendation

- **Awareness**

3 List of appendices

The following appendices are included with this report:

'NHS Borders Quarter 1 Financial Position,' Scottish Government Letter, 12th September 2022

Health Finance, Corporate Governance & Value Directorate
Richard McCallum, Director

T: 0131-244 3475
E: richard.mccallum@gov.scot

Ralph Roberts
Chief Executive
NHS Borders
By email

cc. Andrew Bone, Director of Finance

12 September 2022

Dear Ralph

NHS Borders Quarter 1 Financial Position

Following conclusion of our detailed quarterly financial review of the NHS Scotland position, I am writing to confirm expectations of NHS Borders in 2022-23 and beyond. The scale of financial risk across the Health & Social Care Portfolio is greater than in any previous year and a number of Boards are reporting a deteriorating financial position since the start of the financial year. This, coupled with continued operational pressure ahead of winter and ongoing negotiations on a pay settlement for Agenda for Change staff, means that significant action is required to deliver financial balance in year.

It is clear from our review that delivering financial balance across the system will be very challenging and that some Boards may require financial support in year to deliver balance. Any financial support will be provided on the same basis as pre-pandemic - in that it will need to be accompanied by a recovery plan and will be repayable in full by the Board. Having been paused over the last two years, financial considerations will also need to form part of future decisions relating to the NHS Board Performance Escalation Framework.

From our engagement with NHS Borders, it is clear that there are a number of key financial risks including the Laboratory Information Management system, slippage against planned savings and reliance on agency and locums to address workforce pressures. We will continue to work closely with the Board to monitor these risks and understand the action required to mitigate any adverse financial consequences.

I expect that NHS Borders are working to the following financial outcomes in this financial year;

- Delivery of at least the position set out in the Boards March 2022-23 financial plan, inclusive of the cost impact of Covid, as a **very minimum**. Following Quarter 1 reviews with the Director of Finance, we request that where delivery of this position was indicated as not being possible in your Quarter 1 returns, that an action plan to set a path to this position by 31 March 2023 is prepared and returned to Scottish Government by 30 September. This plan should include an assessment of the risks associated with the implementation of the actions set out in the plan.

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- Where delivery of financial balance is not possible without support from Scottish Government, all Boards in this position will require to develop a financial recovery plan to set a path to return to financial balance and within a period not greater than three years. These financial recovery plans will form a key part of your Annual Delivery Plan submission for 2023-24. Boards should note that any financial support made available in 2022-23 would result in an adjustment to future year funding.

We acknowledge the challenges that Boards will be experiencing at this time and in requesting the above actions our performance and finance teams will be available to jointly advise and assist you and to ensure early and pro-active engagement.

In support of developing your local Board plans, I would highlight the following:

Elective Care Plans

Following the submission of Board plans and a review of activity delivered during Quarter 1 and 2, colleagues from the Planned Care Team will arrange to meet with you to discuss your current performance and to confirm the funding for Quarter 3 and 4. This will include agreeing with you the further steps required to progress the implementation of CfSD initiatives (including Active Clinical Referral Triage (ACRT), Patient Initiated Review (PIR) and Enhanced Recovery After Surgery (ERAS)) and to ensure that you have plans locally to optimise existing capacity. We would expect that this will result in revisions to the plans submitted and greater focus being given to the utilisation of core capacity.

Funding to meet expenditure incurred during Quarters 1 and 2 to treat long waiting patients will be provided as agreed, subject to the appropriate diligence being undertaken in conjunction with you.

Sustainability and Value Collaborative

We shall shortly be standing up the Collaborative and further details will be shared with you. This will require all Boards to establish local governance arrangements to reflect the four key workstreams that will be included in the Collaborative.

- Being environmentally and socially sustainable *(NHS Scotland Climate Change and Sustainability Strategy)*
- Delivering better value care *(Value Based Health and Care)*
- Making effective use of resources *(Financial Improvement)*
- Optimising capacity and managing demand within available resources *(Operational Delivery)*

In the meantime we would expect that Boards will be engaged and supporting the implementation of the following:

Optimising Capacity – implementation of the Unscheduled Care High Impact Productive Opportunities and the CfSD clinical pathway programmes as reflected in the recently issued heatmaps (Active Clinical Referral Triage (ACRT), Patient Initiated Review (PIR) and Enhanced Recovery After Surgery (ERAS) in Scotland).

Financial Improvement – implementation of the local actions that have been identified by the working group established to review a national approach to reducing agency nursing spend. We shall shortly be establishing a number of other supporting workstreams which will focus on medical locums, medicines and prescribing and corporate services. These workstreams will not replace the requirement for each Board to identify and implement their own local savings plans, and it is expected, for example, that Boards will be applying rigorous vacancy controls, with a pause on non-frontline services unless there are exceptional circumstances.

I would again like to take this opportunity to thank you and your team for your support as part of the Quarter 1 review and to confirm we remain committed to working with you in developing your local Board plans. Recognising the challenges set out, I wanted to ensure Chief Executives had sight of this letter in advance of the Chief Executives meeting on 13 and 14 September, when these matters will be discussed further.

Yours sincerely

Richard McCallum, Director of Health Finance and Governance

NHS Borders

Meeting: **Borders NHS Board**

Meeting date: **6 October 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 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Extraordinary Resources & Performance Committee 4 August 2022
- Resources & Performance Committee 1 September 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 05.05.22
- Appendix No 2, Resources & Performance Committee Extraordinary minutes 04.08.22

Borders NHS Board

NHS Borders

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 5 May 2022 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
Mr T Taylor, 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 G Clinkscale, Director of Acute Services
Mr C Myers, Chief Officer Health & Social Care
Mr A Carter, Director of HR

In Attendance: Miss I Bishop, Board Secretary
Mrs C Oliver, Head of Communications
Mr K Allan, Associate Director of Public Health
Dr A Cotton, Associate Medical Director MH&LD
Dr J Bennison, Associate Medical Director BGH
Mrs E Dickson, Associate Nurse Director Acute
Mr K Lakie, General Manager Planned Care
Mrs J Stephen, Head of IM&T
Mr K Messer, IM&T Delivery Manager
Mrs M Carter, Analytical Business Intelligence Services Team Lead
Mr K Bryce, IM&T Programme Manager
Mr B Urquhart, Analytical Business Intelligence Services Team Lead

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Lucy O'Leary, Non Executive, Cllr David Parker, Non Executive, Dr Tim Patterson, Director of Public Health, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs and Dr Tim Young, Associate Medical Director P&CS.

1.2 The Chair welcomed Mr Keith Allan, Associate Director of Public Health to the meeting who deputised for Dr Tim Patterson.

1.3 The Chair welcomed a range of attendees to the meeting including Mrs Jackie Stephen, Head of IM&T who would speak to the Digital Update and Target Operating Model item on the agenda.

1.4 The Chair confirmed the meeting was quorate.

1.5 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.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there were none declared.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 3 March 2022 were approved.

4. Matters Arising

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

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

5. NHS Borders Remobilisation Plan 2021/22 (RMP4) Quarter 4 Update

5.1 Mrs June Smyth provided an overview of the content of the report and advised that the update had been submitted to the Scottish Government the previous week. She highlighted that preparation of a 3 year plan continued although the requirements for 3 year plans for workforce and finance had been stood down.

5.2 Mr Tris Taylor enquired about CAMHS and inequalities and what the scale of the current unmet need in children for those services was and how that mapped to inequalities priorities. He was keen to understand the sense of organisational risk exposure and if it had been adjusted for the appropriate inequity. It was noted that age was a protected characteristic.

5.3 Mr Taylor welcomed the local digital strategy and asked that the Public Governance Committee be sighted on it and the target date.

5.4 Mr Taylor then enquired about the inequalities piece of work that had been "paused" and sought confirmation of that status. Mr Ralph Roberts assured the Committee that inequalities work was part of the core function of the Public Health Department. The element of inequalities work that had been paused related to creating a more assertive approach to health inequalities, which was placed on hold due to capacity issues, the pandemic and service pressures over the autumn and winter. He commented that one of the transformational programmes for the following year would be on health inequalities which was consistent with the Scottish Government ambition.

5.5 Mr Taylor commented that since the pandemic had begun inequalities had disproportionately affected outcomes for people and had affected some of the most vulnerable. He suggested it looked like nothing had been done by the organisation other

than to produce a plan and not enacted it. He suggested the Board was in a moral conundrum given health inequalities as a core value of the organisation.

5.6 Mr Roberts accepted Mr Taylor's analogy of the situation and reminded the Committee that the organisation had been under emergency powers for 2 years and had focused over the winter period on service pressure responses and he suggested he would welcome a challenging conversation on health inequalities as part of the 3 year plan progression.

5.7 The Chair suggested the matter be discussed further outwith the meeting and clarification provided on the Public Governance Committee role in health inequalities. She asked that the matter be recorded on the Action Tracker.

5.8 Mr John McLaren enquired in regard to AHP services, the reasons for their status being Red and if it was solely down to the relocation and pressure on the estate. Mrs Smyth advised that the AHP office space had been relocated from the Borders General Hospital (BGH) to the Education Centre to allow an outpatient clinic space for orthopaedics to be realised. She understood the change in location had not impacted on AHP clinical activity but she suggested she raise the query with Mr Paul Williams outwith the meeting for clarification.

5.9 Mr McLaren suggested it had been more than the AHP management team that had been relocated and he understood the orthopaedic space had been a temporary measure. He advised he was concerned at the range of estates issues that were impacting on services.

5.10 The Chair suggested the issue in regard to the orthopaedic space being a temporary measure and impacting on the AHP team be followed up outwith the meeting.

5.11 Mr Ralph Roberts suggested the estates issues were taken to the wider prioritisation of the capital plan, rather than linking them to the overall year 1 plan instead of looking at the impact on individual issues such as AHPs. He also noted that it linked back to the PAMs update provided to the last Board Development session.

5.12 With regard to Mr Taylors question about the CAMHS service Dr Amanda Cotton advised that there were 352 patients waiting on the CAMHS waiting list and all emergency cases were seen, so there were no urgent or emergency cases on the waiting list. The longest wait was 54 weeks, however a new clinical leadership and new medical staff were in place and had brought the internal waits for children waiting for neurodevelopmental assessments down to zero. She further advised that the service included a range of needs on the waiting list that were not included in some other Health Boards, such as children with LD who were included on the CAMHS list and other cases seen by psychiatrists here but would be dealt with by paediatrics in other Health Boards. She suggested that it did represent an unmet need and highlighted that the issue was not in terms of funding or support but was about recruitment.

5.13 Mrs Harriet Campbell suggested that she was concerned about the reduction in waiting times as it removed the lower tiers from the waiting lists and in effect deferred them back to local communities and schools with an effect on inequalities.

5.14 Dr Cotton commented that it was not about taking people of the waiting list it was about assessing children to understand the underpinnings of their needs and to get those needs met. She recognised that not all of those on the waiting list would have their needs met by CAMHS as sometimes the conditions was not for the CAMHS skill set and resources. In

regard to unmet need she clarified that the intention was to look at unmet need and meeting that through the development of mental health and wellbeing services and the care setting.

5.15 Mrs Fiona Sandford asked that the Committee be kept up to date on progress and the Chair requested that it be added to the Action Tracker.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Q&A.

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

6. NHS Borders Performance Scorecard March 2022

6.1 The Chair welcomed the new layout of the report.

6.2 Mrs June Smyth thanked the committee for their feedback on the new format and welcomed further feedback as the report evolved further.

6.3 The Chair commented that the narrative was really helpful and related to the snapshot in time and enquired at what point the narrative was updated from the previous point in time.

6.4 Mrs Fiona Sandford commented that a discussion had been held at the Clinical Governance Committee meeting the previous week which had focused on delayed discharges and recruitment and the Committee had asked that their concerns be escalated to the Board through the Resources & Performance Committee. The Committee had been keen to understand if a formal action plan had been formulated to address the delayed discharges issues.

6.5 Mr Gareth Clinkscale commented that there was a section on delayed discharges in the presentation to be given later on the agenda where Mr Chris Myers would pick up the matter. He also advised that there was a formal action plan in place.

6.6 Mrs Sonya Lam welcomed the new format of the report and enquired about the success criteria and if there had been a distinct change sighting outpatient numbers as an example. The Chair highlighted that areas of improved performance were highlighted at point 2.3 on the cover paper where it showed the projected and actual improvements achieved.

6.7 Mr Clinkscale commented that significant work had been taken forward to manage demand through the access collaboration programme.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Q&A.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted performance as at end of March 2022.

7. Digital Update & Target Operating Model

7.1 Mrs Jackie Stephen provided an overview of the content of the report. She highlighted several elements including: an increased expectation on the use of digital; increased expectations on the information technology teams; gaps in service provision; a need to preserve current systems; taking advantage of transformation opportunities; over 50% of the team were employed on short term contracts and there had been a heavy usage of contractors over the previous 2 years to plug skills gaps; there were a number of risks in protecting and

securing current systems; the delivery of technology for services through the Target Operating Model (TOM); and the risks associated with not progressing the TOM

7.2 Mr John McLaren commented that IM&T was a service that worked very hard in the background and nobody really saw it until there was an issue. He commented that it should not be taken for granted and was keen that the fixed term contracts were moved to permanent contracts to support the service. He reminded the Committee that the staff had risen to various challenges around providing new technological solutions during the pandemic and urged the Committee to show them they were valued.

7.3 Mrs Fiona Sandford enquired if the proposal was ambitious enough as the only way to really transform services was through heavy investment. She also sought a timescale to the project and sought assurance that the right level of clinical engagement had been achieved.

7.4 Dr Lynn McCallum commented that every clinical transformation required a digital solution and she was fully supportive of the proposal.

7.5 Mrs Stephen commented that in terms of being ambitious enough the paper presented was based on what was known was coming over the horizon and she would have preferred to have been more ambitious with a partnership model looking outside to see what else could be innovated. She commented that in terms of clinical leadership, Ms Cathy Kelly was reviewing the clinical model.

7.6 Mr Tris Taylor commented that he thought the money had been quantified as well as the benefits which were listed in a qualitative way and he asked that the benefit analysis be further developed to quantify the return on investment.

7.7 Ms Sonya Lam enquired about the state of readiness in terms of transformation of the whole system as digital could be a catalyst and a support for that. She further enquired what would need to be done radically differently across the system including digitally and if the organisation had the capacity and headspace to be able to do that, as well as what the timescale was to do that in.

7.8 Mrs Stephen commented that in terms of benefit she agreed with Mr Taylor that there was a need to quantify the benefits and work together across teams to achieve that. At present she advised there was no available capacity to dig into the benefits as quantifying it took more effort collectively as a service. In terms of transformation she commented it would only be enabled if services worked together with the digital team and commitment had to come from both sides to gain the headspace to think, bring it altogether and to plan better up front in order to be more certain of the outcomes that could be achieved.

7.9 Mrs Alison Wilson commented that she supported the proposal and noted the medical input and enquired where the nursing input was to the programme given much of it was about transactions around HEPMA. She further suggested there may be many digital solutions for nursing professionals that could enhance their ability to fulfil their roles.

7.10 Dr McCallum commented that when she spoke of clinical leadership she was fully inclusive of the broad range of health professional groups such as nursing, AHPs, doctors, indeed any who were clinically facing professionals.

7.11 In relation to Ms Lam’s point about transformation Dr McCallum commented that the Acute Recovery Board had progressed some really phenomenal work by thinking differently and

taking incremental steps to make a difference to the way patient care was delivered and she suggested empowering people to make a change was a key to transformation success.

7.12 Mrs June Smyth recorded her thanks to Mrs Stephen and her team for the service reviews they had undertaken in the background and the very detailed work and challenges they had overcome to be able to bring forward the proposal as well their input to the 3 year delivery plan.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Q&A.

The **RESOURCES AND PERFORMANCE COMMITTEE** discussed the contents of the paper and the implications for services and the public in Borders. They focused on the risk profile and the balance of the service and operational risks of not implementing a new funded workforce for Digital compared with the financial risk of proceeding and the potential benefits to be gained.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed that the first stage of stabilising the Digital workforce was implemented. That was that the staff on fixed term contracts were given appropriate contractual status and that NHS Borders Board understood and accepted the associated financial risk of £825k.

The **RESOURCES AND PERFORMANCE COMMITTEE** noted that further work would be undertaken to present a three year delivery plan at a future Board meeting. That would include detailed planning of the phasing of the workforce, a proposal for a technical partnership and a proposal for clinical input to the Digital delivery plans.

8. Financial Strategy

8.1 Mr Andrew Bone shared contextual information with the Committee and highlighted several elements during the presentation including: 3 key tests; analysis, decision making, implementation; medium term financial framework pre pandemic and pre Ukraine; UK Treasury 5 year forecast; Audit Scotland overview of NHS in Scotland; Scottish Government Budget 2022-23; how we spend our money; expenditure trends; recurring deficit; and resource consumption.

8.2 Discussion focused on a range of topics including: workforce costs; difficulties to recruit; national treatment centres; commissioning of healthcare; speaking truth to power to Scottish Government; transformation required investment; radical ideas to delivery efficiency savings;

8.3 Mr Ralph Roberts commented that there was a need to look radically at the financial situation as it and workforce were the 2 major issues for the organisation. He suggested he was trying to speak Truth to Power with the Scottish Government via regular meetings as well as pushing them to produce a clear service plan for what Scotlands' Health Service would look like moving forward.

8.4 The Chair commented that the Board Chairs also had the same honest conversation.

8.5 Mrs Wilson commented that in order to be radical some investment was required in transformation and referred to the earlier discussion on digital transformation.

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

9. Finance Report

The **RESOURCES AND PERFORMANCE COMMITTEE** noted the Q&A.

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

10. Access Performance Update

10.1 Mr Gareth Clinkscale shared contextual information with the Committee and highlighted several elements during the presentation including: pre COVID performance; Overview of recovery; cancer; TTG; emergency access standard; current position; COVID-19 impact; deconditioned readmissions; staff burnout; and key enablers.

10.2 He further advised that the pre pandemic performance was likely to take years to recover, with the 12 week performance on TTG and outpatients not expected to fully recover until 2026. He suggested the current year was about service stabilisation through investment in leadership and management development.

10.3 Further discussion focused on: surgery remobilisation; update on key centre for sustainable delivery actions; 4 year plan and backlog recovery; development of treatment centres: progression of recovery programme around outpatients; ED emergency access standard; ED 4 hour target compliance: DOCA+ equated to 89 patients (46%) who did not require an acute bed; acute recovery programme 5 priority tasks; and delayed discharges.

Mr Tris Taylor departed the meeting.
Mrs Harriet Campbell departed the meeting.
Mr Andy Carter departed the meeting.

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

11. Any Other Business

11.1 There was none.

12. Date and Time of Next Meeting

12.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 1 September 2022 at 9.00am via MS Teams

The meeting concluded at 11.28am.

RESOURCES & PERFORMANCE COMMITTEE: 5 MAY 2022

QUESTIONS AND ANSWERS

No	Item	Question/Observation	Answer
		DECLARATIONS OF INTEREST	
1	Declarations of Interest	-	-
		MINUTES OF PREVIOUS MEETINGS	
2	Minutes of Previous Meeting 03.03.22	**Harriet Campbell:** Have we now got Waiting Times Database information?	**June Smyth:** This is still a work in progress. The data extracts from Trak are complete and being tested. There are interim measures in place to ensure mandatory reporting is submitted while we work through the prioritised reports and production of dashboards in partnership with the service. There will be many opportunities to improve the quality and breadth of reporting for Waiting times once the fundamentals are in place.
3	Minutes of Previous Meeting 03.03.22	**Karen Hamilton:** Noted – no comment	-
		MATTERS ARISING	
4	Action Tracker	**James Ayling:** There is no action point re RMP Quarter 3 referred to in the minutes at item 5.2. I had enquired what lessons had been learnt from the Treatment and Care pilot and a response was to be provided outwith the meeting.	**June Smyth:** We have now had an update from the service as per below: The phlebotomy pilot allowed the CTAC project team to test out systems and processes required in the new CTAC delivery model. This included IT systems (which involved labour intensive work arounds due to the lack of GP OrderComms), booking/admin requirements in terms of staffing numbers for a booking hub and to understand what would be involved in a phased roll out of a hub and spoke model. When

			a detailed plan, based the proposed hub and spoke approach, was presented to PCIP Executive Committee they felt would not be equitable and there could be significant issues around patient access and potential inequalities. These discussions resulted the project being halted until the strategic direction could be agreed and for full scoping of new delivery model (of all CTAC treatments being offered to all Practices through CTAC Centres and Practice CTACs) to take place.
5	Appendix-2022-7 **NHS Borders Remobilisation Plan 2021/22 (RMP4) Quarter 4 Update**	**Harriet Campbell:** P30. If NHSB was supposed to deliver 'pharmacotherapy level one service will be in place by April 2022' and this has been achieved, why is it not marked as complete? What update should we be expecting and what further work is being done/planned? P30 older people's pathway – what are the new timetables likely to be and do these need to be agreed/approved. Is there an impact on patient care in the meanwhile that needs to be monitored or mitigated. This doesn't seem to feature in the risks, but I'm not clear why? P30 last row relates to delayed discharges. Can this really be seen as 'green'? Work is undoubtedly being done, but	**Alison Wilson:** A level 1 service is being provided in every practice so this should be marked as complete. What we are reviewing is the extent to which we are providing a level 1 service as the funding resource has been reduced over the years and recruitment was delayed. The deadline for the contract has now been extended to March 2023. We are reviewing the data we have available to assess progress and have submitted a request to purchase Albasoft, which would make data extraction more efficient. **Chris Myers:** Further information on the Older People's Pathways project will be provided. **Chris Myers:** You are correct in that delayed discharges should not be described as green.

		I'm not sure are yet seeing results.	To clarify, the Progress described in the Scottish Government's RMP4 template relates to the activities listed in each row, rather than the key deliverable.
		P31 AHP – It seems that not much progress has been made here. A detailed response on this – although without any timescales - was given at the last R&PC meeting but it's not clear from the update what progress has been made since then if any. What are the reviewed timescales and are they realistic?	**Paul Williams:** The Red RAG associated with AHP remobilisation is in relation to the initial timescales given as part of RMP3. It has been agreed to adjust timescales in line with other NHSB services and to acknowledge the significant amount of work that has been ongoing to deliver AHP services, this will likely lead to an Amber status moving forward. In future updates this item will be divided to better represent the ongoing challenges within AHP services, namely significant clinical backlog in some services, and the changing complexity of patient presentation which is influencing service delivery. It is clear that previous service delivery models are no longer fit for purpose in several services and a creative approach is required to deliver AHP services that will meet the ongoing needs of our communities
		1 - P32 CAMHS recruitment. Do we need to start thinking more creatively about the roles we recruit to and if there are ways of attracting staff that we haven't yet thought about (sorry that's a bit vague but this seems to be a consistent problem – and not just in CAMHS, obviously – so am wondering if we need to think differently).	**Philip Grieve:** 1 - CAMHS have progressively considered alternative approaches to recruitment. Due to a national shortage of nurses we implemented development posts to support band 5 nurses to progress to band 6 with a supportive educational plan to get staff to that specialised level (this has an impact on resource within service). Historically we only advertised for mental health registered nurses, however we now advertise the posts as mental

			health practitioners and is open to mental health/Learning disability and children's nurses/general nurses. We are also considering an introduction of health care support workers that have never been featured within the service before. Psychology is in a similar position re shortages nationally and therefore have reviewed banding and considered an increased banding approach to attract staff (financial implication) and indeed a review of lower bandings to increase the workforce e.g. psychology assistants.
		2 - 'the potential detriment of other community services' What detriment? What services? What mitigating actions have been taken?	2 – This refers to internal moves from other speciality teams within mental health e.g. attract internally from another mental health team leaving a deficit in the team they leave and then encountering the national shortage and challenges relating to recruitment. Mitigation is difficult as we cannot stop employees applying for posts
		3 - What has happened to proposals to reduce CAMHS waiting lists as highlighted as a possibility by Ralph to non-Execs a couple of weeks ago? – is this ithe 'waiting times initiative' referred to at the top of p33?	3 – CAMHS and mental health leadership team met with SG last week and proposed a waiting times initiative relating to the 18 week RTT HEAT target and will commence at the end of May
		4 - There are two items under CAMHS on which we have no update – patient involvement and comms and several on which there is no progress. Is there any hope of progress?	4 – stakeholder meetings have been embedded within service and continue to be in place this is a forum for families to contribute to service development
		5 - P33 and following…similarly there are several other	4/5 – The implementation of the CAMHS

		areas on which there is 'no progress to report'. Internally this is concerning but am also wondering how SG will take this? 6 - Psychological services backlog – new projections by March 22. Have these been completed? P40 Do we as a board need to give direction on inequalities work? This question was asked and answered at the last RPC meeting and we were told the programme was not prioritised for funding. Does this actually mean it has been abandoned in favour of the 'alternative approach outlined in June's response (p13) and if so why are we not just saying this? If not, do we need to give it the focus it clearly deserves?	specification is a considerably large piece of work and the service has to take a staged approach to deliver all that has been asked by the specification and SG. The service has to deliver and also needs capacity to progress the significant changes required to meet the standards. SG is fully aware of the current position and other elements have had to be on hold to address the current 6 – there has been reporting issues within the EMIS system and BI are progressing to address this **June Smyth:** We are in the process of identifying programmes of work which the Quality & Sustainability Board will oversee and are proposing that one of the programmes is around Population Health & Inequalities. This isn't yet scoped out but in doing so we will revisit what was proposed for the enhanced programme to assess if we can no look to take this forward. The BAU health improvement activities led by Public Health continue to be delivered (recognising that they were impacted by COVID during the pandemic).
6	Appendix-2022-7 **NHS Borders Remobilisation Plan 2021/22 (RMP4) Quarter 4 Update**	**Karen Hamilton:** Noted – I assume the change from a 3 year plan to a more immediate Annual Delivery Plan is of no real consequence to the work plan and resources required to complete this task? The stated delivery objectives remain the same?	**June Smyth:** As part of planning for the 3 year plan the Planning & Performance Team are currently working through each business unit's priorities including previously committed projects, Financial Turnaround Schemes and RMP4 key deliverables to understand if they are still to be delivered and in which year, the plan is to continue with this work as we develop the one

			year plan and in anticipation for the longer term plan being commissioned
7	Appendix-2022-8 **NHS Borders Performance Scorecard March 2022**	**Lucy O'Leary:** P65-68 CAMHS and mental health. Find this presentation confusing. Page titles are "waiting times" – so the lower the better. Chart titles and aims arrows are "treatments" – so the higher the better assuming that there are lots waiting. Think the page titles just need a small edit? P76 drug & alcohol 3 week RTT chart – not sure why the aim is to get worse - unless this automatically kicks in because we are over the standard? BUT … these small pedantries aside this report is a big step forward and I appreciate the "why?" text even if as yet it's not been possible to populate that for some of the big ticket items – thank you	**June Smyth:** Noted thank you **Meriel Carter:** Noted, the arrow will be amended for the next paper.
8	Appendix-2022-8 **NHS Borders Performance Scorecard March 2022**	**Harriet Campbell:** General Personally I prefer the AOP presentation to the RMP4 trajectories which seem a little arbitrary. Helpful to have both though. I really like the narrative in with the charts – and it would be helpful going forward if this could be fleshed out on pages where it hasn't been. I think for the public board meetings in particular the 'why is this the case' and 'what is being done' sections are hugely positive for public engagement. Can I clarify – p51 the arrows compare with the previous month but don't necessarily relate to the numbers on the same chart – eg diagnostic endoscopy the position is better than trajectory but still red because last month the numbers were better (but we don't have those numbers). Am I the only one who finds this a bit confusing?	**June Smyth:** Feedback is noted thank you and we will continue to refine format; Planning & Performance and the BI Team are currently working with business units to establish most effective way of retrieving narrative with service lead input The RAG status is based on the target/standard achievement. Page 50 in the Introduction explains the colour coding, e.g. if outwith the standard or the trajectory towards it by 11% or over the RAG status will be Red. The RAG status does not relate to the previous month's data, only the arrows show direction of travel,

		It is a separate issue but as I understand it the definition of 'treated' within CAMHS doesn't necessarily mean that patients aren't still waiting – they may have been seen and referred on for specialist assessment (and this counts as 'treated'). They may in fact then wait some considerable time for that follow up. Is that right? Where is that shown on the metrics? If you just look at these numbers I think we get a false impression of all being rather better in CAMHS than I think it actually is. That said, the narrative is helpful in explaining that there has been a real focus on the neurodevelopmental backlog which is very good news. Who has set/is monitoring the upper and lower control limits on these charts or are they actually meaningless – p56 for instance it seems to me unthinkable that the UCL in April 19 could have been 7000 – and it has been arbitrarily lifted to fit with current circumstances.	i.e. better or worse from the previous month. **Philip Grieve:** This is correct and with the waiting times initiative there is a risk that internal waits will increase as a service we are preparing for this in relation to monitoring and reporting, we will be adding this to the risk register and this was highlighted to SG on their visit. **Meriel Carter:** Control limits on Statistical Process Control charts are set automatically by the data range as these charts look at all data points they have a wider range. We can implement shifts in the data to look at the changes in data over time when there is a clear alteration in trend (effectively looking at the mean and control limits over shorter timescales in the chart). We will evaluate these for the next report and implement shifts where appropriate.
9	Appendix-2022-8 **NHS Borders Performance Scorecard March 2022**	**Karen Hamilton:** Good to note improved trajectories although I understand we would all wish them to be further improved. Overall I like the new layout – well done we are getting somewhere! P57 of pack – sorry to see 12 week TTG rising although I appreciate it is well below trajectory. P65 of pack – we need to work more on CAHMS performance – any solutions on the horizon? P71 etc of pack – continued challenge with DD numbers –	**June Smyth:** Noted and thank you See answers above **-**

		obviously this is critical to patient flow and we must remain focussed on this in terms of patient safety across NHSB.	
10	Appendix-2022-8 **NHS Borders Performance Scorecard March 2022**	**James Ayling:** Cover paper: Clause 2.3 Assessment . This section only highlights significant improved areas of performance in March 2022 against RMP4 Trajectories. It should also highlight significant areas which have got worse…otherwise its not balanced and not the right info at the right time. The numbers for New Outpatients waiting longer than 52 weeks and for –New Inpatients waiting longer than 12 weeks appear to have been reversed assuming that the figures in the scorecard are the right way round. Can you please explain why in some cases the projections are vastly in excess of the actual numbers e.g. i.e. 9177 v actual 5177 and 762 v actual 362. For patients waiting longer than 52 weeks for endoscopy the projected number was 3 and the actual number is 31. I can't immediately see how that happens. The table in the appendix to the Digital Update Report being presented to this meeting shows "Waiting Times Database Reprovisioning " extending into May. I presume this refers to the failure of the access database referred to in earlier meeting. If it is the case that this is still being remedied are we able to rely on and gain assurance from the waiting time details in this performance scorecard.	**June Smyth:** Noted for future cover papers **June Smyth:** we will look into this and respond separately **June Smyth**: The services have carried out various improvement initiatives following the submission of RMP4 projections. In terms of endoscopy we will enquire of the service and circulate a response outwith the meeting. **Meriel Carter:** We have been able to report utilising existing Trakcare data which is validated by the WT Team. New interim reports have been written for this purpose. The "Waiting Times Database Reprovisioning" project has been commissioned to produce long term quality data reporting for Waiting Times and to fulfil the recommendations of the Waiting Times Review.
11	Appendix-2022-9 Digital Update &	**Lucy O'Leary:** P84-85 the staff pie charts present a very clear picture of	**June Smyth/Jackie Stephen:**

	Target Operating Model	the need to move away from short term contracts and I am fully supportive of the move to get more of the team on permanent contracts to support stability and development – modernisation of IT and digital transformation is not going to be falling off the agenda any time soon	Thank you – your support is hugely appreciated by all of us in Digital
12	Appendix-2022-9 Digital Update & Target Operating Model	**Harriet Campbell:** What is the finance team take on this please? Perhaps not for this meeting – and only a tiny part of the whole digital offering but just to flag - I have a concern that with patient-facing digital services we must ensure that we are not exacerbating inequalities for patients who cannot access digital services for whatever reason.	**Andrew Bone:** I am supportive of the objectives outlined in the paper, specifically the intention to reduce reliance on contractors and increase stability of overall workforce. The investment required to support digital programmes at the pace and scale we require is not currently in place, however I do believe on balance of risk that the first stage proposed in the paper (i.e. permanent employment of existing fixed term staff) is a sensible choice which can be managed by offsetting against non-recurrent resources we would expect to receive over next few years and further mitigated by staff turnover. Beyond this point, I think the decisions for further investment need to be influenced by the wider discussion on longer term financial planning. **June Smyth/Jackie Stephen:** Completely agree – patients need multiple ways to engage with services and EQIA will be important for each thing we implement.
13	Appendix-2022-9 Digital Update & Target Operating Model	**Karen Hamilton:** Cover paper 2.3.2 Fixed term contracts over 2 years. Presumably staff in this situation have employment rights? If so can you briefly articulate what they are?	**June Smyth/Jackie Stephen:** Yes they have rights after two years which are the same as permanently contracted staff. So they'd be entitled to be on redeployment if funding for the

		2.3.4. Risk – is risk heightened in relation to Ukraine/Russia conflict adding weight to the argument?	post's ceased and redundancy payments etc. Yes I think the increasing cyber threat does add weight to the need to get this area better supported and to keep our technology at the latest levels of refresh to increase security.
14	Appendix-2022-9 Digital Update & Target Operating Model	**James Ayling:** I think this is an excellent overview of the position. I have read that S Gov are looking for a 3% reduction in digital funding as efficiency savings yet see digital as the way forward. I don't know how relevant however that is here as we are looking at workforce costs as opposed to capital /infrastructure costs and don't know how this is categorised. Are we a stand alone case or is there a similarly serious situation in other health boards which might determine if we need to go it alone or have a concerted case for investment in digital? Is there any opportunity (if permissible) for partnering with the private sector in any way ? A huge question but possibly shared returns from efficiency savings flowing from digital solutions? I strongly support the paper.	**June Smyth/Jackie Stephen:** As I understand it many other boards also rely on non-recurring SG funding for staffing costs so a reduction is likely to be relevant to us. I'd need to check to what extent and whether we are an outlier in that respect. It is frequently pointed out by my colleagues in financial discussions about the strategies fund so SG Digital are aware. Partnering options – it certainly could be explored. I do think we'd need to be in better shape to deliver our side of any agreement though – sometimes it's the capacity of services to engage and adopt leading to low benefits realisation as much as our internal Digital capability. We'd need to be ready as a whole organisation to adopt this approach. Thank you for your support – we really appreciate it.
15	Presentation Financial Strategy	-	**-**
16	Appendix-2022-10 Finance Report	**Harriet Campbell:** I note the slight underspend – can this be retained/used?	**Andrew Bone:** We won't confirm final figures until our accounts are audited, and we may need to make slight amendments to address any issues arising in the audit, so I would normally expect to report a surplus at this point to give us some margin for adverse movements.

			Assuming no adjustments then the mechanism would be that funding reverts to Scottish Government and it is their decision whether funds are reallocated. In this instance I would not expect it to be reinstated. It arises because we estimated the level of additional support required to breakeven, which has been allocated by SG, and our actual position was slightly improved. Overall however important to note that without that support we would have been c.£8m overspent.
17	Appendix-2022-10 Finance Report	**James Ayling:** We have a projected deficit of at least £12.2m for 2022/23. S Gov. have reintroduced the performance escalation framework. We now need savings not just potentially identified but actually in the process of being scoped and then realised. We need to move on past the point of relying on releasing provisions and accruals and use of board contingency reserves. My wishlist would comprise : 1.A detailed schedule of opportunities for progression showing anticipated savings and timescales say 1-3 years against business depts... I assume PMO have something like this in place. 2. Reporting against this schedule at each R & P meeting. Perhaps this could incorporate current enhanced reporting being provided to S Gov.	**Andrew Bone:** Comments are helpful and I would agree with your summary. We do not yet have the schedule of opportunities with timescales and anticipated savings but this is now beginning to be developed and I would anticipate update to next RPC will include this level of detail, along with the reporting referenced in point 2. We are also finalising resource plans (point 3) and should be in a position to confirm within next 4-6 weeks.

		3. Sufficient resource given over to PMO and Finance Dept. (inc external consultancy) to achieve 1 and 2 . I realise that patient services are key but we also have a responsibility to deliver financial balance . We have increasingly refined score cards for regular monitoring of health related performance and there is a sound argument that technically in any event financial health(sustainability /savings) should be reported in a similar fashion. As Committee/Board members I consider that we require that info to fulfil our fiduciary obligations. Whilst I'm sure this is in line with management and particularly Finance thinking I want to reiterate this point as I feel we really need to grasp this .	
18	Presentation Access Performance Update	-	-

Borders NHS Board

NHS Borders

Minutes of an **Extraordinary** meeting of the **Resources and Performance Committee** held on Thursday 4 August 2022 at 3.00pm via MS Teams.

Present:

Mrs K Hamilton, Chair
Mrs F Sandford, Vice Chair
Ms S Lam, Non Executive
Mr J Ayling, Non Executive
Mr T Taylor, Non Executive
Mrs L O'Leary, Non Executive
Cllr D Parker, Non Executive
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Mr A Bone, Director of Finance
Mr A Carter, Director of HR

In Attendance:

Miss I Bishop, Board Secretary
Mrs C Oliver, Head of Communications
Mrs L Jones, Director of Quality & Improvement
Mr K Lakie, General Manager Planned Care
Mr K Messer, IM&T Delivery Manager
Mr K Bryce, IM&T Programme Manager
Mr B Urquhart, Analytical Business Intelligence Services Team Lead
Mrs G Butterfield, Planning & Performance Officer
Mrs L Taylor, Macmillan Nurse Consultant
Ms S Cosens, Programme Manager, NHS Lothian
Ms L Carruthers, Head of Oncology Physics, NHS Lothian
Ms C Reid, Associate Medical Director & Consultant in Palliative Medicine, NHS Lothian

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Harriet Campbell, Non Executive, Mr John McLaren, Non Executive, Dr Kevin Buchan, Non Executive, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, Dr Janet Bennison, Associate Medical Director BGH, Dr Amanda Cotton, Associate Medical Director MH&LD, Dr Tim Young, Associate Medical Director P&CS, Mrs June Smyth, Director of Planning & Performance, Mr Gareth Clinkscale, Director of Acute Services and Mr Chris Myers, Chief Officer Health & Social Care.

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

1.3 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

The **RESOURCES AND PERFORMANCE COMMITTEE** noted there were none declared.

3. Minutes of Previous Meeting

3.1 The minutes of the previous meeting of the Resources and Performance Committee held on 5 May 2022 were approved.

4. Matters Arising

4.1 **Action 11:** A presentation and discussion would take place with Non Executives ahead of the next Board meeting to discuss the use and boundaries of the Q&A.

4.2 **Action 12:** The action was in progress.

4.3 **Action 13:** The action was in progress.

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

5. Edinburgh Cancer Centre Initial Assessment

5.1 Mr Kirk Lakie provided a brief introduction to the item and highlighted that it was a proposal to develop a replacement for the Edinburgh Cancer Centre through a regional approach. NHS Lothian were looking for NHS Borders to formally approve the work undertaken to date which would allow them to take an initial agreement back to the Scotland Government for consideration and the Scottish Government agreed to the proposal it would then move to the next stage of a capital project.

5.2 Ms Sorrel Cousins provided a powerpoint presentation that described the background and current status of the proposal.

5.3 Discussion focused on a range of elements including: repatriation of breast cancer surgery back to NHS Borders; a small cohort of specialist breast cancer patients would be referred to the new Edinburgh Cancer centre; financial responsibility for the treatment of patients remained with the patients Health Board; increased expense in the use of novel therapies; revenue running costs against a background of a large financial deficit for NHS Borders; the cost and use of novel therapies was a national as well as local issue; costs associated with cancer transformation work; nurturing the local workforce with education, knowledge and skills to ensure patients are treated safely outwith the new Edinburgh cancer centre; succession planning; expanding the range and access to therapies closer to home; need to ensure digital infrastructures were in place for future service provision; and what would happen if the Initial Agreement was not supported.

5.4 Mr Ralph Roberts commented that the Initial Agreement could be viewed as part of NHS Borders future service planning in terms of workforce, planning, capital planning and the development of the Borders General Hospital site. In terms of affordability it would be a challenge however the current status quo was not sustainable and any cost increases would need to be mitigated.

5.5 Mr Tris Taylor commented that the information was all contained within the documentation but had not been summarised clearly. He noted the capital costs were a matter for NHS Lothian and not NHS Borders and suggested it was likely that due to increases in inflation that those costs would rise considerably. He questioned how the project could be supported given the current financial constraints and lack of clarity on revenue detail and how it would be funded.

5.6 Mr Andrew Bone commented that NHS Lothian were responsible for the planning and delivery of a regional service which would have implications for neighbouring Boards. NHS Borders would need to consider the implications for itself as well as being mindful of the need to progress with a full programme of planning models to support a reprovision of the BGH in 10 years time. In terms of costs there was limited capital money available from the Scottish Government and that had been recognised at a political level where they had an aspiration to increase the capital budget over the current political term of office and recognised that a considerable amount of funding would be required for the NHS. The revenue implications had been calculated on current costs and were notional as there was not enough known on the projection of treatment costs and demographics. Mr Bone explained that the next stage in the process would be the Outline Business Case and then a Full Business Case to move to a final decision about the associated investment and costs.

5.7 Ms Colette Reid emphasised that the decision required was around the re-provision of the Cancer Centre to support oncology services across the South East of Scotland and cancer costs would increase regardless of what decision was made.

5.8 Mr Roberts reminded the Committee that as the project progressed there would be further break points in the process. He suggested the costs of a new building and the increasing costs of cancer services should be differentiated.

The **RESOURCES & PERFORMANCE COMMITTEE** supported the Edinburgh Cancer Centre Initial Assessment, with the following provisos included:

- Regional engagement and joint working should continue through the development process to finalise and shape the final service model.
- Partner Boards must work with NHS Lothian to minimise the revenue cost of new centre, and provide challenge to give appropriate assurance that these are delivering value for money.
- A regional approach to workforce planning will be required to minimise the impact and ensure appropriate staffing across the region.
- Appropriate consideration is given to how the proposal can be developed to reduce the requirement for travel by Borders residents, including:
  - Ensuring that virtual activity is increased to reduce the number of appointments where travel to Lothian is required. To support this and ensure that opportunities are maximised IT input to the project from an early stage will be essential.
  - Consideration is given to developing services in the east of Lothian where they are more accessible for Borders' patients.
  - A request for confirmation of how the location for a second Radiotherapy will be decided in developing Option B3.

6. Digital Target Operating Model

6.1 Mr Kevin Bryce provided an overview of the content of the report and highlighted the cost of the daily rate currently being paid to contract workers in contrast to the costs of permanently contracted staff.

6.2 The Chair enquired if the Vacancy Authorisation Form (VAF) monitoring process had been followed. Mr Bryce advised that the VAF process had not been used as the posts were external contractors, contracted through the procurement process.

6.3 Mr Andrew Bone advised that the VAF process was an internal process. He suggested there was a heavy reliance on external contractors to address the core digital services and delivery of projects in the Road to Digital programme. What had been previously put in place was a programme of investment built on a stream of non recurring sources of funding over a number of years. The market place for IT professionals was positive and he anticipated turnover in IT professionals in the future, but at the present time there were likely to be individuals keen to secure a permanent contract given the current economic climate.

6.4 Discussion focused on: progressing with the Target Operating Model; identification of key posts to be filled; value for money; potential recruitment agencies finders fees; engagement with Borders College to ensure there is talent in the pipeline for the future; growing our own talent internally; apprentice schemes for school leavers; stabilisation of the IT workforce; and hybrid working arrangements.

The **RESOURCES & PERFORMANCE COMMITTEE** approved the proposal that IM&T replace day rate contractors with employed posts as per the SBAR as soon as possible and that the financial recurring cost is factored into financial plans.

7. Any Other Business

7.1 Laboratory Information Management System: Mr Ralph Roberts advised the Committee that the organisation was in the process of agreeing a contractual position for a new LIMS either in terms of calling off the framework contract or agreeing an interim model with the existing provider. A risk assessment was currently being undertaken and Central Legal Office were reviewing the contractual arrangements. There would be a requirement for an Extraordinary meeting of the Board to agree the final position by 19 August 2022.

7.2 National Care Services Bill: Mr Ralph Roberts advised the Committee that a survey had been issued to collect together thoughts on the National Care Services Bill. The responses to the survey would help inform a response from NHS Borders. An informal discussion of the Bill would also be held with Non Executives on 17 August 2022.

8. Date and Time of Next Meeting

8.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 1 September 2022 at 9.00am via MS Teams

The meeting concluded at 4.50pm.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Finance Report – August 2022**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

The report describes the financial performance of NHS Borders and any issues arising.

2.2 Background

NHS Health Boards operate within the Scottish Government (SG) Financial Performance Framework. This framework lays out the requirements for submission of Financial Performance Reports (FPR) to SG which include comparison of year to date performance against plan with full review of outturn forecast undertaken on a 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 and it is expected that, where relevant, these issues will be raised through the relevant reporting line.

2.3.2 Workforce

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

2.3.3 Financial

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

2.3.4 Risk Assessment/Management

The paper includes discussion on financial risks where these relate to *in year* financial performance against plan. Long term financial risk is considered through the board’s Financial Planning framework and is not relevant to this report.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Climate Change

None identified.

2.3.7 Other impacts

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

2.3.8 Communication, involvement, engagement and consultation

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

2.3.9 Route to the Meeting

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

- Senior Finance Team, 27th September 2022
- Board Executive Team, 4th October 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 August 2022

FINANCE REPORT FOR THE PERIOD TO THE END OF AUGUST 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 August 2022.

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** that the board is reporting an overspend of £8.39m for five months to end of August 2022.

2.1.2 **Note** the position reported in relation to COVID-19 expenditure and how this expenditure has been financed.

2.1.3 **Note** the revised projected deficit for 2022/23 of £13.7m, following the Quarter one review.

3 Summary Financial Performance

3.1 The board's financial performance as at 31st August 2022 is an overspend of £8.39m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for five months to end August 2022

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Revenue Income	273.94	275.57	115.64	115.64	-
Revenue Expenditure	273.94	275.57	99.45	107.84	(8.39)
Surplus/(Deficit)	**0.00**	**0.00**	**(16.19)**	**(7.80)**	**(8.39)**

3.2 Core operational performance excluding savings is reporting a £0.53m overspend position to the end of August. This includes c.£375k of expenditure previously reported as COVID related and which remains unfunded in line with Q1 review and revised SG planning assumptions.

3.3 The financial plan identified a projected £5m delivery against savings targets in 2022/23. As at end of August, £0.22m of savings have been retracted from budgets with a full year effect (to end March) of £0.55m. Progress towards identification of full savings plans is described in section 6 below.

3.4 The reported position has been adjusted to recognise anticipated funds in relation to COVID recovery plans. This funding is assumed based on indicative allocations advised by Scottish Government. Actual budget settlement will be determined

following agreement on the release of funds held in IJB reserves. The level of funding assumed at end August is £1.8m.

4 Financial Performance – Budget Heading Analysis

4.1 Income

4.1.1 Table 2 below, presents analysis of the board's income position at end August 2022.

Table 2 – Income by Category, year to date August 2022/2023

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Income Analysis					
SGHSCD Allocation	254.21	504.05	105.92	105.92	-
SGHSCD Anticipated Allocations	(0.17)	(250.75)	-	-	-
Family Health Services	10.24	12.28	6.31	6.31	-
External Healthcare Purchasers	4.39	4.39	1.87	1.74	(0.13)
Other Income	5.27	5.60	1.54	1.67	0.13
Total Income	**273.94**	**275.57**	**115.64**	**115.64**	**-**

4.1.2 There is a shortfall on External Healthcare Purchasers which is a continuation of the decrease to elective activity patient flows between health boards during the course of 2021/22, which continues into 2022/23. The SLA for 2022/23 has been signed at the same levels as 2021/22 which mitigates the risk of further reduction previously highlighted in the financial plan. This risk remains a concern for future years since activity remains below levels agreed.

4.1.3 The over recovery of income within Other Income is linked to income received in respect of Scottish Post Graduate Medical Education income and provides an element of offset to additional medical staffing pressures highlighted previously with regard to Medical training grade rotational posts.

4.2 Operational performance by business unit

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

Table 3 – Operational performance by business unit, August 2022

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	65.23	74.01	30.75	30.50	0.25
Acute Services - Savings Target	(2.11)	(1.98)	(0.83)	-	(0.83)
TOTAL Acute Services	**63.12**	**72.03**	**29.92**	**30.50**	**(0.58)**
Set Aside Budgets	27.04	28.11	11.95	12.81	(0.86)
Set Aside Savings	(1.05)	(1.05)	(0.44)	-	(0.44)
TOTAL Set Aside budgets	**25.99**	**27.06**	**11.51**	**12.81**	**(1.30)**
IJB Delegated Functions	120.93	134.03	58.92	58.92	-
IJB – Savings	(4.74)	(4.51)	(1.89)	-	(1.89)
TOTAL IJB Delegated	**116.19**	**129.52**	**57.03**	**58.92**	**(1.89)**
Corporate Directorates	34.28	13.96	(9.38)	(9.19)	(0.19)
Corporate Directorates Savings	(0.34)	(0.21)	(0.09)	-	(0.09)

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
TOTAL Corporate Services	**33.94**	**13.75**	**(9.47)**	**(9.19)**	**(0.28)**
External Healthcare Providers	29.38	30.32	12.96	12.69	0.27
External Healthcare Savings	(0.39)	(0.33)	(0.14)	-	(0.14)
TOTAL External Healthcare	**28.99**	**29.99**	**12.82**	**12.69**	**0.13**
Board Wide					
Depreciation	5.06	5.06	2.11	2.11	-
Planned expenditure yet to be allocated	13.00	11.71	0.10	-	0.10
Financial Recurring Deficit (Balance)	(12.35)	(12.85)	(4.95)	-	(4.95)
Financial Non-Recurring Deficit (Balance)	-	(8.26)	(1.04)	-	(1.04)
Board Flexibility	-	7.56	1.42	-	1.42
Total Expenditure	**273.94**	**275.57**	**99.45**	**107.84**	**(8.39)**

4.2.2 **Acute services** are reporting a net overspend of £0.58m. This includes a £0.25m under spend on core operational budgets. The main drivers for this under spend is in relation to staffing vacancies within Labs, General Surgery, Orthopaedics and Ophthalmology as well as a continuation of reduced spend on supplies, which is linked to the reduced levels of activity. The underspend is substantially less than in previous reporting periods as a result of increased bed pressures managed across the BGH site. This position also includes retracted recurring savings of £0.05m (£0.13m full year).

4.2.3 **Set Aside.** The set aside budget is overall £1.30m overspent, of which £0.44m relates to non-delivery of savings. Unscheduled care services are the main cost driver, exhibiting significant variance from agreed staffing budgets due to enhanced staffing arrangements in place to support A&E and additional agency and supplementary staffing deployed to augment inpatient areas, including boarding of patients overnight in the emergency department. In addition to this, increased drug expenditure on long term conditions is flagged as an emerging pressure at Q1 review.

4.2.4 **IJB Delegated.** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting a breakeven position on core budgets. This reported position includes retracted recurring savings of £0.09m YTD (£0.23m full year) and continued underspends relating to a reduction in primary care services expenditure within public dental services, along with vacancies within Allied Health Services offset. These underspend are offset by overspends in Mental Health Agency Locum costs, required to cover vacant posts, high costs relating to LD placements, which remains at a higher level whilst alternate placements are sought, as well as overspend in prescribing due to increases in drugs tariffs linked to supply shortages. The prescribing issue remains uncertain and may impact further on future forecasts; additional analysis is being undertaken in advance of the Quarter two review.

4.2.5 **Corporate Directorates** are reporting a net overspend of £0.28m. This includes a £0.19m overspend on core budgets. There are retracted savings of £0.05m included in this reported position (£0.13m full year). Maintenance costs across the NHS Borders portfolio has resulted in the current overspending position, this level of spend is not expected to continue at this level each month. Underspend linked to vacancies within Director of Nursing provide offset to some areas of additional

pressure including staffing pressures related to implementation of regional HR arrangements.

There is an emerging cost pressure in relation to domestic services which relates to updated Infection control guidance on national cleaning standards. This was flagged as a risk in the financial plan and quarter one review and has been highlighted by a number of other health boards. The cost pressure is manifesting since July following cessation of additional funding support from COVID budgets. The full impact of this pressure will be outlined following conclusion of local review.

4.2.6 **External Healthcare Providers.** Excluding savings there is an underspend of £0.27m reported at the end of August. This position is based on estimates within the East Coast Costing Model (ECCM) and Unplanned Activity budgets (UNPACs) as pricing and final activity baselines have not yet been agreed. These arrangements relate predominantly to tertiary services and out of area referrals for Acute services. Within the reported position there are £0.03m of recurring savings retracted (£0.7m full year).

5 COVID19 Expenditure

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

Table 4 – summary COVID19 expenditure for five months to end August 2022

	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Acute Services	0.04	0.04	-
Set Aside	0.01	0.01	-
IJB Directed Services	0.87	0.87	-
Corporate Directorates	0.88	0.88	-
Total NHS Costs	1.80	1.80	-

5.2 The number of agreed spending plans in relation to COVID spend have reduced going into 2022/23, and work in underway to reduce these further in line with changes communicated via Scottish Government. 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 is in line with the expected Local Mobilisation plans.

5.3 This reported position outlined above is based on these agreed spend plans, where funding is allocated on the basis of nationally directed or locally agreed services.

5.4 In addition, there is a further estimated c.£375k of expenditure not reported in this table which relates to costs incurred within core expenditure which are indirectly related to COVID expenditure but for which no funding has been agreed. This includes ongoing arrangements for additional workforce in the Emergency department introduced during the pandemic, as well as the additional cost of 7 additional assessment beds in MAU. Other bed pressures are not reported against COVID and are attributed to unscheduled care pressures (i.e. delayed discharges).

6 Savings

6.1 As part of the financial plan for 2022/23 it was identified that the Board would make £5.0m in recurring savings, with Business units being asked to make a percentage of their overall savings as recurring savings during 2022/23. Table 5 below shows the recurring savings targets allocated to each area and the full year achievement of those targets.

Table 5 – summary recurring savings achieved as at August 2022

	Recurring Savings Target £m	Recurring Savings Achieved £m	Outstanding Target £m
Acute Services	(0.66)	0.13	(0.53)
Set Aside	(0.28)	-	(0.28)
IJB Directed Services	(0.49)	0.23	(0.26)
Corporate Directorates	(0.38)	0.13	(0.25)
External Healthcare Providers	(0.32)	0.07	(0.25)
Board Wide	(2.87)	-	(2.87)
Total NHS Costs	(5.00)	0.55	(4.45)

6.2 There has been £0.55m of recurring savings retracted in August (covering the full year impact to end March).

6.3 Recurring plans totalling £2.35m (full year) are currently being scoped however these plans have not yet progressed through the Gateway 1 evaluation within the FIP implementation pathway. Staffing shortages within the PMO has affected the ability to progress with some of these plans, and recent recruitment should aid in starting to take these forward, however service engagement is required to fully progress these savings to the point of retraction.

6.4 It remains a key objective that recurring savings of £5m full year effect are identified and implemented by end March 2023. Non-recurring actions are being explored to increase confidence against in year targets and mitigate the risk that there is a shortfall in delivery in the current year.

7 Key Risks

7.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 3588).

7.2 This position will only be addressed once the board have identified and implemented actions to deliver cash-releasing savings at a scale and over a timeline acceptable to Scottish Government. Further update on this issue will be provided to the committee through regular performance reports in 2022/23 and through the development of the board's three year financial plan.

7.3 The strategic risk has been revised following approval of the board's one year plan and supplementary risk analysis of service specific financial risks is described further in the Quarter one review.

Author(s)

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NHS Borders

Meeting: **Borders NHS Board**

Meeting date: **6 October 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 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Clinical Governance Committee 20 July 2022
- Clinical Governance Committee 14 September 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 18.05.22
- Appendix No 2, Clinical Governance Committee minutes 20.07.22

Borders NHS Board
Clinical Governance Committee
Approved Minute

NHS Borders

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 18 May** 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
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Dr T Patterson, Joint Director of Public Health
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing Acute Services
Mrs K Guthrie, Associate Director of Midwifery/GM for Women & Children Services
Mr G Clinkscale, Director of Acute Services
Mrs L Pringle, Risk Manager
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:

Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr C Cochrane, Director of Psychological Services
Mrs S Horan, Director of Nursing Midwifery & Allied Health Professionals
Dr J Bennison, Associate Medical Director, Acute Services

The Chair welcomed Ms C Abrami, Infection Control Nurse, shadowing Mr Whiting.

The Chair confirmed the meeting was quorate.

2 Declarations of Interest

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

The CLINICAL GOVERNANCE COMMITTEE noted there were no new declarations of interest and the previous declarations from Ms Lam and Mrs Campbell still stood.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 16 March 2021 was approved.

4 Matters Arising/Action Tracker

Mr Clinkscale commented on a previous discussion regarding Emergency Access Standards, TTG, outpatients and delays in the system and that it might be helpful for the Committee to have a session, specifically around workforce. It was decided however that this subject should be dealt with at Board level and this had been communicated previously.

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

5 Patient Safety

5.1 Infection Control Report

Mr Whiting provided a brief overview and updated a couple of areas since report was written. Mr Whiting drew attention to last year's workplan and a number of incomplete actions, he stated that these remain incomplete largely due to increased clinical activity and changes in National Covid Guidance. Key points related mainly to addressing infection control educational gaps in the organisation. The other incomplete actions related to the Queen Elizabeth University Hospital inquiry recommendations and gap analysis. Mr Whiting will be factoring these into this year's work plan.

He noted that there had been a number of norovirus outbreaks since the report had been written but was happy to report that there were no further ward closures at present.

Discussion followed where several points were raised including:

Moving from self-audit of hand hygiene. Ms Lam asked why this would change compliance with hand hygiene, Mr Whiting commented that moving away from self-audit and using external audit would highlight better where there were areas of concern relating to compliance and enable infection control to address why this was occurring. Compliance was noted to increase when NHS Borders moved towards self-audit and recent external audits conducted by hand gel suppliers had noted and decrease in compliance. Infection control team have commenced some baseline audits in order to see if this will continue to be the case, findings will be included in next Committee report. Dr McCallum commented that we should be mindful of the limitations within the infrastructure that can have an impact on good hand hygiene.

Scottish Government targets, Mrs Campbell enquired about SAB targets and if these needed to be revisited. Mr Whiting commented that the timescale to achieve targets had been extended by a year due to recent focus on COVID.

The Clinical Governance Committee is fully supportive of infection control plans.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising the processes in place and challenges ahead.

5.2 Quarterly HSMR

Mrs Jones provided a brief overview of the content of the report.

Discussion followed where several points were raised including crude mortality figures, Mrs Jones assured the committee that NHS Borders figures are aligned to the Scottish trend and within normal limits. Mrs Jones commented that the next quarter would give a better insight into any themes or trends in particular those unique to Covid.

Dr McCallum commented that although assured with the reviews carried out relating to deaths in the organisation she would like some insight into place of death in particular with the pressures in ED at present. Mrs Jones will include more detail in relation to this in her next paper.

Further discussion took place on this subject, Drs McCallum and Herlihy noted that there are many challenges ahead in ED and it is important that there is an overview of all the themes relating to deaths within NHS Borders.

ACTION: Mrs Jones to ensure there is more details on place of death in next HSMR report .

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

5.3 Strategic Risk Management

Mrs Pringle provided a brief overview of the content of the report. Following comments at previous meeting regarding risks relating to staffing, which originally sat with the Staff Governance Cmmittee. This risk now sits with the Cinical Governance Committee. Mrs Pringle drew attention to new section in report, she asked if there were any further risks they would like to see to be assured on both process and outcome.

Discussion followed where several points were raised. Mrs Campbell enquired about care in appropriate settings and if there were gaps between us and other boards and if so where are these gaps highlighted. Mr Roberts commented that this was a discussion the board executive team had been having but felt that these issues should sit with the Integrated Joint Board for assurance, Mr Clinkscale gave a brief overview of the issues and risks at hand. The Committee should formally document their concerns relating to risks with the Chair of the IJB.

ACTION: Mrs Jones & Mrs Sandford to write to IJB regarding risk concerns.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents and await further clarity, they do recognise the ongoing effort from staff.

6 Person Centred

6.1 Patient Experience Report (including SPSO Position)

Mrs Jones provided a brief overview of the content of the report. She commented that complatins remain within normal limits. She highlighted response times are falling below target but this was partially due to frontline pressures, the team are working on stabilising this. All Ombudsman actions have been completed.

Discussion followed relating to clinical ‘headspace’ to respond to complaints particualry when clinical demand is so high.

Ms Lam commented on themes from SPSO but Mrs Jones noted that there had been none identified but she did comment that underlying theme in all complaints was communication.

Dr McCallum mentioned she had discussions with the Clinical Directors on how communication could be improved.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the process but still uncomfortable with the outcomes

7 Effectiveness

7.1 Clinical Board update (Primary & Community Services)

Mrs Flower provided a brief overview of the content of the report. She noted that option appraisal for BUCCS will commence this week. Conversations are ongoing on how care homes are utilised in particular relating to easing capacity in community following the commissioning of extra beds in Peebles Nursing Home and Know South beds being used differently. Work is ongoing on how this information is captured as at the moment they are not seeing a true picture.

One care home is under review by care commission. A deeper investigation has commenced on falls and staffing remains an issue, in particular following a recent COVID outbreak. There has been increased pressures on district nursing teams in relation to diabetic patients needing support at home, further work on how this can be addressed is underway.

Following recent adverse event relating to SACT, gaps were highlighted and issues were quickly addressed, showing that the adverse event reporting was effective.

Discussions followed where several points were raised including a request for an update on CTAC. Mrs Flower will pick this up in next report.

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

7.2 Clinical Board update (Mental Health Services)

Mr Lerpiniere provided a brief overview of the content of the report. Work done to allow additional beds in Knowe South had been successful. Lindean work continues. Mr Lerpiniere noted that following a thematic review of complaints communication remains a top issue.

He highlighted the Mental Welfare Commission report and consultation on extra funding to develop under 18s PC/MH team to support those who fall between tier 2 and tier 3, the Committee suggested that the finding should be shared with the Board. Dr McCallum has asked Caroline Cochrane to present proposal to the Board.

Mrs Campbell highlighted the adverse events and asked if there was a concern or any particular themes. He will highlight these in future reports, as it was felt following discussion, it was too soon to have a clear picture on adverse events or any themes therein.

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

7.3 Clinical Board update (Learning Disabilities)

Mr Lerpiniere provided a brief overview of the content of the report. He gave an overview on out of area placements and as previously reported they keep constant contact with these

clients, he noted that bringing clients back to Borders remains a challenge.
Mortality review continue with a focus on assuring that LD patients are not disadvantaged clinically, recognising that accessing care at appropriate times is difficult for some LD patients.

Discussion took place around the difficulties in having realistic medicine conversations in this client group.

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

7.4 Clinical Board update (Acute Services)

Mrs Dickson provided a brief overview of the content of the report. She noted that they continue to see significant pressures in the system. ED adverse event, which occurred recently is being reviewed and the results of DOCA will be investigated. Key actions to reduce length of stay, remove activity from ED and create protected elective capacity remain a priority within the continuing challenges.

Mrs Jones commented on the startling number of delays noted in the DOCA report, which highlights lack of resilience with a knock on effect on performance elsewhere in the system. Mr Clinkscale commented on the work with HR looking at workforce for the next 4 years, focusing on skill mixes and models of care with a tactical and strategic objective.

Focus at present is on stabilising the system before any additional capacity required to increase surgery alluded to in recovery plan and alleviate backlog. Work on integrated workforce plan will be essential going forward.

Dr McCallum gave an overview on the situation with Out of Hours Services, (BECS/ BUCCS), this appears to be an issue Nationally more obviously in the Borders due to the size and flexibility of the workforce. It is increasingly difficult to find medical cover and concerns have been raised about the use of advanced nurse practitioner or specialist nurse roles to plug any medical availability shortfall, these roles are not autonomous and need supervision, which is often not happening due to lack of cover. The team have significant gaps on a regular basis. The above concerns and issues have been entered on the risk register and an options appraisal has been commissioned.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents but recognise all the hard work taking place towards a solution to issues raised.

8 Assurance

8.1 Maternity Services and Severe Maternal Morbidity Annual Update

Mrs Guthrie provided a brief overview of the content of the report.

Discussion followed where several points were raised. Mrs Sandford requested an update on where we sit compared to the rest of Scotland. Following the Ockenden report

recommendations, Mrs Guthrie commented that given birth in the UK and Ireland is overall safe and deaths are very rare and as a board our maternity services perform well.

Maternity services have been benchmarked, in particular in line with recent Ockenden report. Any gaps or recommendations only partially met will be addressed in service review.

All harm is reported via DATIX and adverse events are reviewed and reported to the board. Discussion followed and the Committee agreed it would be useful for assurance purposes that an update on maternal and infant harm would be useful. Mrs Guthrie agreed that they would provide a more comprehensive report for future meeting. The Chair asked if the report would include where we sit within Scotland in terms of stillbirth numbers. Mrs Jones commented that it is often difficult to compare in terms of numbers in relation to the Ockenden report as the report scope was so huge but we can certainly report in relation to trends, further discussion followed relating to reviews and open transparent discussions including patients and families following and incidence of harm.

Mrs Campbell commented that our c-section rates had increased and asked if there was a reason for this. Mrs Guthrie commented that this had been noted and was being investigated nationally. Locally VBAC clinics are being set up which hopefully will give a more informed choice to patients and will hopefully help reduce elective c-sections.

Further discussion took place following regarding joint responsibilities relating to training and governance arrangements with Lothian. Mrs Guthrie commented that MDT meetings are attended well across the board and governance processes are robust. Training had been paused for 6 months during Covid but has now restarted. Patients transferred to Lothian are done so after meeting their strict criteria.

Monthly meetings take place with Heads of Midwifery in Scotland and the Scottish Government to ensure equity of services across Scotland.

The Committee thanked Kirsteen for her comprehensive report.

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

9 Items for Noting

Acute Services Clinical Governance Board Minute February 2022

Learning Disability Services Clinical Governance Group Minute March 2022

Primary & Community Services Clinical Governance Group Minute April 2022

Mental Health Services Clinical Governance Group Minute December 2021

Public Governance Group Minute November 2021

Public Protection Committee Minute January 2022

Items presented above were noted by the **CLINICAL GOVERNANCE COMMITEE**

10 Any Other Business

There were no further items of competent business to record.

11 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on Wednesday 20 July 2022 at 10am via Teams Call.

The meeting concluded at 12:16

Borders NHS Board
Clinical Governance Committee
Approved Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 20 July** 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
Mr R Roberts, Chief Executive
Dr L McCallum, Medical Director
Dr T Young, Associate Medical Director, Primary & Community Services
Mr G Clinkscale, Director of Acute Services
Mrs S Horan, Director of Nursing, Midwifery and AHPs
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing, Acute Services
Mrs K Guthrie, Associate Director of Midwifery/GM Women & Children's Services
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:
C Cochrane, Director of Psychological Services
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Dr J Bennison, Associate Medical Director, Acute Services
Dr T Patterson, Joint Director of Public Health
Mrs L Pringle, Risk Manager

The Chair welcomed:
Mrs C Oliver, Head of Communications (attending in an observational role)
Mrs F Doig, Head of Health Improvement/Strategic Lead ADP
(deputising for Dr T Patterson (item 7.1)
Mrs D Keddie, Deputy Hospital Manager (item 6.5)

The Chair confirmed the meeting was quorate.

The Chair announced
item 7.1 will be taken out of sequence after item 5.3
item 7.3 Work & Wellbeing report not presented, therefore this item has been deferred to next meeting.

2 Declarations of Interest

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

The CLINICAL GOVERNANCE COMMITTEE noted there were no new declarations of interest and the previous declarations from Ms Lam and Mrs Campbell still stood.

3 Minute of Previous Meeting

The following corrections were made:

item 5.2 Quarterly HSMR Report
'Discussion followed where several points were raised including crude mortality figures, Mrs Jones assured the committee that NHS Borders figures are aligned to the Scottish trend and within normal limits. Mrs Jones commented that the next quarter would give a better insight into any themes or trends in particular those unique to Covid '

item 7.4 Clinical Board update (Acute Services)
'Dr McCallum gave an overview on the situation with Out of Hours Services, (BECS/BUCCS), this appears to be an issue Nationally more obviously in the Borders due to the size and flexibility of the workforce. It is increasingly difficult to find medical cover and concerns have been raised about the use of advanced nurse practitioner or specialist nurse roles to plug any medical availability shortfall, these roles are not autonomous and need supervision, which is often not happening due to lack of cover. The team have significant gaps on a regular basis. The above concerns and issues have been entered on the risk register and an options appraisal has been commissioned.'

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 16 March 2022 was approved following above corrections.

4 Matters Arising/Action Tracker

Mrs Campbell asked if there was an outcome of Care Inspectorate's review of local care home reported in previous Primary & Community Services update. Mrs Flower reported that the investigation is now closed and the home is being supported.

Mrs Horan offered to contact the care Inspectorate to invite them to attend a non executive awareness session relating to their work with the Care Homes. The Chair commented that they would raise the question at the Non –executive session tabled for today.

Discussion took place regarding ethical issues relating to international recruitment, NHS Borders will take their steer from Scottish Government.

There were no further matters arising and the action tracker was updated accordingly.

5 Patient Safety

5.1 Infection Control Report

Mr Whiting provided a brief overview of the content of the report highlighting a couple of points in the paper as follows.

Due to ongoing impact of COVID it had been difficult to further develop infection control workplan, some preparatory work has been done including gap analysis against recently published standards for infection control and this will feed into the workplan.

Transition to winter respiratory pathways have been completed, these changes have been minor.

Mrs Sandford enquired about impact of CAUTI group in terms of improvements. Mr Whiting commented that the group was fairly recently re-established and starting to be become more effective. An action plan had been developed and implementation of those actions is underway. There is a significant amount of activity around understanding the data to see where the barriers are to improvement.

Following comment from Ms Lam discussion took place regarding Norovirus outbreaks compared to Covid outbreaks and any commonalities. Mr Whiting commented that it was less likely to see recurring themes due to rapid onset of symptoms and ease of spread within a bay, in particular due to the layout of bays.

Mrs Campbell shared her concern relating to actions from last year's workplan not been completed and wondered if the team should be more realistic about this year's plan particularly in light of recruitment difficulties. She also questioned if it was likely to reach targets for SAB and CDiff by April 2023. Mr Whiting agreed that there had been challenges, particularly with the continuing impact of COVID, recruitment issues and a fairly new team and that investing time in education to get all up to speed will not be a quick journey.

Mr Whiting gave the Committee an update on the changes in reporting to the Scottish Government which has increased significantly which has had an impact on the team, it is expected that these issues will be included in the upcoming service review. Mrs Horan noted that the outcome of the service review will be significant. Legacy and workload will be noted in the review.

Discussion followed relating to pressures in the Health Services and volume of reporting and targets to meet in general. In particular the significant pressures around infection control and ability to respond to significant events like COVID. Mrs Sandford enquired about risk relating to these pressures and when the risks associated with inability to provide the expected levels of care to would be reported to the Scottish Government.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured the team are heading in right direction despite complications.

5.2 Adverse Events Report

Mrs Jones provided a brief overview of the content of the report. She explained how DATIX adverse event recording system works at present and noted there was National Work taking place to revise the framework in reporting to make for a more consistent approach in reviewing adverse events. Mrs Jones hopes to have a bit more clarity for the next report to the committee. She does note however that all major & extreme events are considered for review in NHS Borders and all child deaths, suicides and drug deaths are investigated and reported through governance groups to inform any improvement plans.

Discussion followed relating to pressure damage data and Mrs Jones offered to provide more detail on the pressure damage charts for next report.

Ms Lam reported that feedback from two members of medical staff indicated they find Datix a clunky system which provides little feedback but that the Trickle App provided them with an easier mechanism to raise and resolve concerns. Her question was if staff were using the Trickle App, how would they decide when to log a concern onto Datix v the Trickle App. She also commented that the data in the report is only up to April and asked if the Committee could have an update, Mrs Jones explained the delay in reporting was to allow for time to investigate fully any harm that may have been caused. There is a weekly dashboard which Mrs Jones is happy to share if this is a requirement of the Committee.

Discussion took place regarding Trickle and the success that Dr Herlihy is seeing in relation to concerns being shared relating to medical education, ways to extend the use of Trickle are being researched but it was acknowledged that Trickle has limitations in particular around governance issues. Testing on the system has been proposed.

Mrs Wilson commented that learning and feedback from DATIX might help with using the system. Mrs Jones reported that DATIX will be re-procured Nationally which may give NHS Borders the chance to have input on local adaptations.

ACTION: Mrs Jones will provide more detailed graphs on pressure damage in next report

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

5.3 Maternal/Infant Harm Update

Mrs Guthrie provided a brief overview of the content of the update. Mrs Horan commented that an initial report in Scotland submitted to Executive Nurse Directors Group highlighting overall benchmarking and recommendations in particular around training providers of ongoing education for obstetric staff is being reviewed and once this is agreed at National level a report will come back to the Committee.

A discussion followed where several points were raised including decreased length of stay and the impact on patient experience. Mrs Guthrie commented that there had been new techniques introduced which shortened length of stay and gave patients a better experience. More care is being provided in the Community so length of stay is reduced. There was discussion regarding workforce, Mrs Guthrie commented that they do not have an issue with vacancies as seen in the Acute sector and although they do have a skill mix issue, with a robust preceptorship programme in place to support newly qualified midwives it is felt that by September they should be back up to funded establishment.

Further discussion took place relating to birth options in Borders, following a comment from Mrs Campbell regarding making sure women are listened to throughout their journey, Mrs Guthrie assured the Committee that this is the case in NHS Borders. It is not something that is happening throughout Scotland but there is work ongoing to assure support is there across the Scottish Boards.

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

6 Effectiveness

6.1 Clinical Board update (Mental Health Services)

Mr Lerpiniere provided a brief overview of the content of the report. He reports concern around Huntlyburn accepting patients out with criteria and whilst it is a designated pace of safety it is a general adult psychiatry ward and bringing those who fall out with that remit can pose significant challenges for the team. There are some suspicions that this may be causing issues in recruiting to Huntlyburn, work is ongoing to resolve these issues.

Work is also ongoing in CAMHS towards improving the service including recruitment of dietician, the trial of a healthcare support worker and presentation of a newsletter leading towards a much more dynamic, thoughtful and positive proactive service.

Ms Lam enquired about apparent increase in adverse events and the correlation with hosting patients out with criteria. Mr Lerpiniere has investigated these events and so far they have not seen any connection, the spikes appear to be in relation to a couple of particularly difficult patients. Dr McCallum commented that there needs to be a whole system approach to tackle difficult patients.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents and that the highlighted issues of concern are being managed.

6.2 Clinical Board update Learning Disabilities Services

Mr Lerpiniere provided a brief overview of the content of the report, he commented that the out of area client is now requiring a different placement due to unit due to be closed in mid to late August, alternative placements are being explored. Regular meetings are taking place relating to this issue. Discussion followed regarding what the alternatives could be should a placement not be found before the unit closed.

The Committee agreed that this was a difficult situation and look forward to an update at future meeting. Mr Lerpiniere assured the Committee that they would do everything in their gift to make sure the move would not be at the detriment to the client.

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

6.3 Clinical Board update (Primary & Community Services, including Hydrotherapy update)

Mr Williams gave a brief verbal update on the remobilisation of hydrotherapy services. In the short term it had been agreed that this will be at the unit in the Borders General Hospital but solutions for long term options are being explored. Impact on delivery of care has been noted and this is on the Capital Planning work stream. A timescale has not been confirmed.

Mrs Flower provided a brief overview of the content of the Primary & Community Service Report, following an earlier question by Ms Lam, she reports that they now have a lead Nurse Practitioner in post who is looking to put Governance frameworks in place to protect Nurse practitioners ensuring they are working within their scope. They are also introducing bespoke training for those seeing children within the community setting.

There had been some further concerns regarding one of the Care Homes, this is being addressed and work is ongoing. Currently there are five care homes with restricted access due to further outbreaks of Covid, pressures remain high on all services in the community having a knock on effect on delayed discharges. Focus continues on discharge planning in the hope of relieving these pressures in the system.

Staff workforce is under review to ensure correct skill mix, this review will go through the Integrated joint Board to determine funding before recruiting to vacant posts.

Mr Williams gave an update on the AHP services which are facing the same challenges and delays as elsewhere in the organisation. He cites the more concerning trends are the increase in waiting times for Children & Young People's Services and access to Hydrotherapy.

Discussion continued further relating to staffing and provision of AHP services which has a major impact on delayed discharges. Ms Lam asked if there were difficulties in being able to recruit in NHS Borders. Dr McCallum commented that AHPs are an essential part of providing safe and effective care and any deficit in the team has a massive knock on effect on flow, especially heading towards the winter months. The Committee asked Mr Williams to look at the gaps and see where these issues could be solved, the Committee also enquired if there was a summary of issues and gaps being prepared for the Board.

Mr Williams confirmed that there were national workforce challenges, in particular within Physiotherapy, international recruitment is being considered. They are also currently looking at skill mix within the services to see if they can close any gaps in terms of ratios of registered and unregistered practitioners within teams.

Mrs Horan agreed that they would look at a deep dive into the service to look at these issues and they would produce a report for the committee, Mr Williams will add regular AHP services updates to the Primary & Community report and an annual report will be added to the Committee workplan and gaps added to the risk register as appropriate.

Ms Lam enquired about CTAC funding but agreed to contact Mrs Flower directly to discuss her concerns.

ACTION: Mr Williams to include AHP reporting in regular Primary & Community report. Miss Laing will discuss additional report with Mrs Jones and add to Committee Workplan

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents in particular concerns regarding delayed discharges and AHP issues.

6.5 Clinical Board update (Acute Services)

Mrs Dickson provided a brief overview of the content of the report highlighting that Acute Services were feeling the same pressures as the other areas. There had been an increase in Covid activity in the last few weeks putting further pressures on already stretched staff. Recruiting to vacant posts continues but delays in doing this is having an impact across the piste. Recent Day of Care Audit highlighted areas of concerns; work is ongoing to address these. Reducing length of stay, reducing ED activity and increasing elective capacity continue to be priorities.

Discussion took place regarding ring fencing wards for elective surgery and also those who are delayed in the system who need less medical support. It was acknowledged that although this is something being discussed it comes with its own challenges in particular how these areas could be staff and what the correct skill mix would be. Mr Clinkscale commented that a 'delayed discharge' area was considered previously but there were challenges in finding patients who fit the criteria, this however could be an option again. He did note that there had been some movement across the system and length of stay was reducing but

acknowledged that the increase in Covid activity was proving to be challenging.

Dr McCallum would like to note the huge efforts of the acute team and thank them for continuing to work tirelessly for our patients.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report, although not assured on the contents due to the significant level of delays and the impact on staff and ability to effectively deliver the service; they recognise the immense efforts on working towards a resolution.

6.5 Stroke Services Update

Mrs Keddie provided a brief overview of the content of the report. Discussion followed regarding the difficulties faced re-establishing stroke pathway and processes following displacement of the unit and staff due to Covid outbreak. Staff have specific training needs and NHS Borders have reached out to Chest, Heart & Stroke to assist. The stroke coordinator role has now been appointed. The Neurovascular element of patient pathway has also been an issue but this has now been addressed and the pathway is being monitored. An action plan has been put in place and results of this will be reported back to the Committee.

Further discussion took place regarding the Committee's concern that despite having highlighted Stroke Services issues over the last year there has been no improvement; in fact the figures make for uncomfortable reading and the service appears to have deteriorated despite best efforts. The Committee shared their concern on the impact this will be having on remaining staff.

Mr Clinkscale commented that management team shared the Committee's concern, highlighting further challenges that the team had faced during the pandemic and commended Mrs Keddie for recent activity to re-instate the pre-pandemic structures to support the service. Mr Clinkscale agreed more frequent reporting to the Committee should provide the assurance they are seeking.

ACTION: Mr Clinkscale to provide more regular reporting via the Acute Services report to the Committee

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents but recognise the ongoing work to support and improve the service.

7 Assurance

7.1 Maternal & Child Health Annual Report – taken out of sequence in section 5

Mrs Doig attended to answer any questions the Committee may have on the report.

Ms Lam enquired as to whether NHS Borders meet their Statutory Obligations and if there were KPIs to measure success and outcomes. Mrs Doig reports that there are subgroups across NHS & SBC who meet regularly to ensure policies and processes are kept up to speed. Mrs Doig acknowledges that some areas are more difficult than others in terms of variants in reporting but these areas are being progressed with a little work still to do. They have made strides towards providing feedback platforms for children to share how they feel about care received. Governance structures to support implementation of The Promise require further work following review from independent care commission.

Mrs Doig assured the Committee that actions are being progressed and any concerns will be escalated. There are no particular KPIs in place, she does however report that there is a workplan for the Maternal & Child Health Committee which will focus their work and the development of actions and outcomes will be done over the year.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents recognising that there is still some work to do.

7.2 Realistic Medicine

Mrs Jones provided a brief overview of the content of the report. She commented that there has been a concerted effort to keep the Realistic Programme running throughout the pandemic. This has proved difficult in terms of reaching milestones. There has been a significant amount of work around outpatient settings, work on Mortality & Morbidity processes and the learning form these and the use of and access to clinical policies, guidelines, protocols and procedures with the launch of the Right Decision Services App. The focus going forward will be to progress the programme and work on issues like engagement with the public, frailty pathways and anticipatory care plans. Mrs Flower has made some inroads with the care homes on anticipatory care and Dr Young and Mrs Jones have had some conversations with GPs.

Discussion followed relating to operational issues in Realistic Medicine and progress towards helping ease pressures across the system but it is recognised that this is a long term culture change.

Mrs Sandford initiated further discussion relating to public expectations and what could realistically be provided appropriately and how we communicate this to the public. Dr Young commented that he hoped the Realistic medicine programme would help reduce variation from practice to practice.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents noted the huge amount of work required going forward.

8 Items for Noting

8.1 Naloxone effectiveness in overdose across Scotland

Dr Patterson was unable to attend meeting to answer any questions relating to this report. Mrs Sandford will liaise directly with Dr Patterson regarding questions she. Any further questions can be relayed via Miss Laing as necessary.

Mrs Wilson commented that we need to be careful when reporting in relation to MAT Standards and Recommendations so we do not look like we are working out with legislation in relation to controlled drugs. Electronic prescribing was accepted during Covid but we should have reverted back to pre Covid prescribing. This issue was not highlighted in the Naloxone report, Mrs Jones is concerned that this communiqué will be missed so has asked Mrs Wilson to have a look back through the papers and highlight to Mrs Jones where she felt this issue has been raised..

ACTION: Mrs Wilson to have a look back through the papers and highlight to Mrs Jones where she felt this issue has been raised.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report

9 Any Other Business

Mrs Wilson noted that there had been a paper at the Operational Planning Group relating to a freeze on capital funding, she has asked that the Committee be cited on anything that has a clinical governance issue in relation to that position.

Mrs Jones commented that Mr Bone has been asked to provide a paper linked to the state of our estate in relation to infection control Mrs Jones will ask him to touch on status of capital planning. Mr Roberts commented that he wanted the Committee to be clear that there was not a freeze on Capital Planning.

10 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 14 September 2022 at 10am via Teams Call.

The meeting concluded at 12:30

NHS Borders

Meeting: **Borders NHS Board**

Meeting date: **6 October 2022**

Title: **Quality and Clinical Governance Report – September 2022**

Responsible Executive/Non-Executive: **Laura Jones, Director of Quality and Improvement**

Report Authors: **Susan Cowe Quality Improvement Facilitator - Person Centred Care, Justin Wilson Quality Improvement Facilitator - Clinical Effectiveness**

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 effectiveness
2. Research and innovation
3. Patient safety
4. Patient experience
5. COVID Inquiry

2.1.2 The Board is asked to:

- note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee

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, across the health and social care system.

2.3 Assessment

2.3.1 CLINICAL EFFECTIVENESS

2.3.2 The Board Clinical Governance Committee (CGC) met in September 2022 and discussed papers from all three clinical boards. Each clinical board continued to raise risks which are placing excessive pressure on patient access and staffing.

1. **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.
2. **core deficits in registered nurses** to staff core and additional beds required to accommodate patient delays particularly within acute services. This is driven by the national recruitment challenges in this area but is a significant pressure in acute given the necessity to continue to operate with around an additional 50 unscheduled care beds to accommodate system delays.

2.3.4 The CGC escalated to the Board their lack of assurance in two areas 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. As a result, there has been a significant piece of work carried out look at work underway to mitigate risk and what additional steps could be taken with Board support reduce these risks further.

2.3.5 The CGC noted the steps already taken to mitigate clinical risk resulting from registered nursing workforce pressures in adult acute wards. Including the impact these steps are having on the use of supplementary staffing. The considered the additional mitigations to augment ward nursing teams in the medium term to support safe patient care and improve staff wellbeing. It was noted that the Board Resource and Performance Committee have approved funding of £271k to establish new models of working in the medium term to reduce risk. The CGC felt they had reached a point of partial assurance in relation to the work underway to reduce risk resulting from workforce pressures and the need for additional beds to support unscheduled flow. The wish to continue to monitor this closely as the actions are put into place.

2.3.6 The CGC however wished to ensure this matter was raised again formally with the Integrated Joint Board to ensure concerted action were being taken to address the significant delays in the system and the impact these are having on patient care and safety.

2.3.7 The CGC also considered papers from Primary and Community Services and Mental Health and Learning Disabilities. Key areas of pressure were noted in relation to the

Allied Health Professional workforce where vacancies are proving difficult to fill. This is presenting pressure to delivery of AHP services and is requiring prioritisation to areas of greatest need. GP practice resilience was also highlighted to the CGC. A series of practice visits are currently underway and resilience and workforce issues are being considered as part of these visits. The CGC will consider papers on both areas at a future meeting focusing on the workforce pressures and mitigating actions to address clinical risk.

2.3.8 RESEARCH AND INNOVATION

2.3.9 The CGC considered the annual report on research and innovation activities. NHS Borders is continuing to remobilise non-covid research and it is expected the portfolio will continue to grow as services recover. Borders General Hospital is due to open as a site in a multi-centre orthopaedic trial relating to hip fracture in October 2022 and this will be the first study in this area for several years.

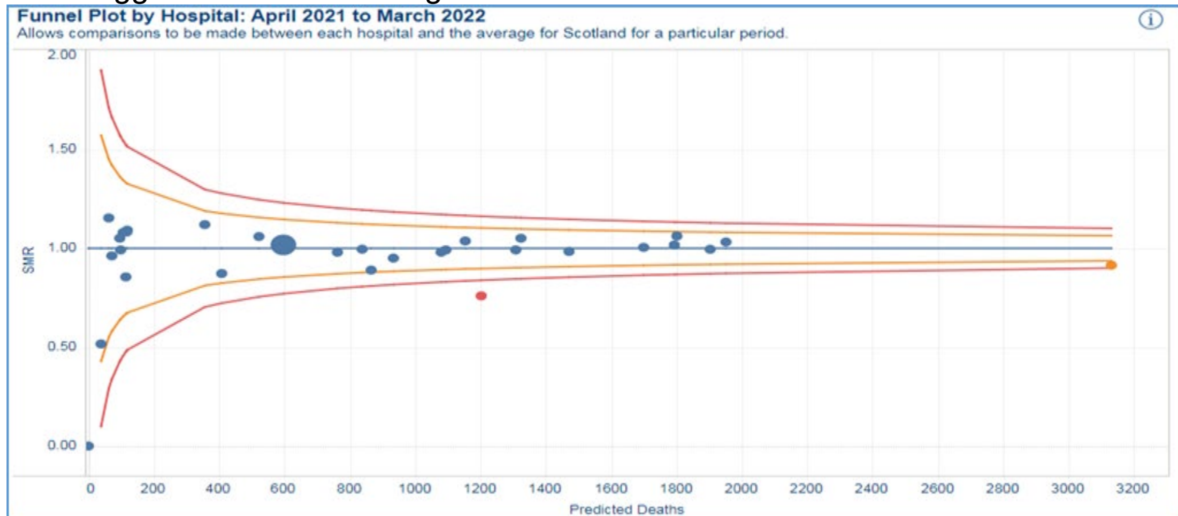
2.3.10 NHS Borders was approached by the Scottish Government to be a test site for the HeartFlow Fractional Flow Reserve Computer Tomography (FFRCT) cardiology innovation project. The study had been run in Western Isles for a year and was extended to NHS Borders and NHS Forth Valley. This is a test of an innovation that is already being implemented as a service in England but more evidence is required prior to implementation across NHS Boards. At present CT angiography results can be inconclusive for degree of flow limitation in patients with coronary artery plaque identified on CT angiography. This can result in cardiologists referring patients for invasive angiography. Evidence suggests that 60% of these investigations are unnecessary. By referring scans to Heartflow FFRCT it may improve the diagnosis of obstructive or non-obstructive coronary arterial disease. The study aims to test whether the evidence is accurate and the cost benefits for health boards in reduction of invasive angiography whilst delivering a faster diagnosis to patients.

2.3.11 At national level Scottish Health and Industry Partnership (SHIP) has been developed by the Scottish Government to identify through Demand Signaling key areas where innovation could be developed to improve health service improvement and delivery as part of the national RECOVERY plan. NHS Borders is working alongside NHS Lothian and NHS Fife to identify key innovative solutions. Key areas at the moment are children and young adult’s mental health, stroke and diabetes. In addition, NHS Borders representatives attended a workshop to develop a national drones project which has been awarded £10m to scope out potential to use drones to deliver healthcare such as labs test and aseptic pharmacy.

2.3.12 The Chief Scientist Office has recently held a call to create 9 new Innovation Fellows and after a competitive interview process 3 fellowships have been awarded in the South East region, with all 3 boards (Lothian, Borders and Fife) submitting successful applications. This was the first round of this new scheme which mirrors a similar fellowship for researchers which has run for a number of years. The fellows will help raise the profile of innovation within the region and it is hoped will encourage new innovation projects to be developed locally within NHS Borders. The Border fellow will focus on an innovation project in stroke care.

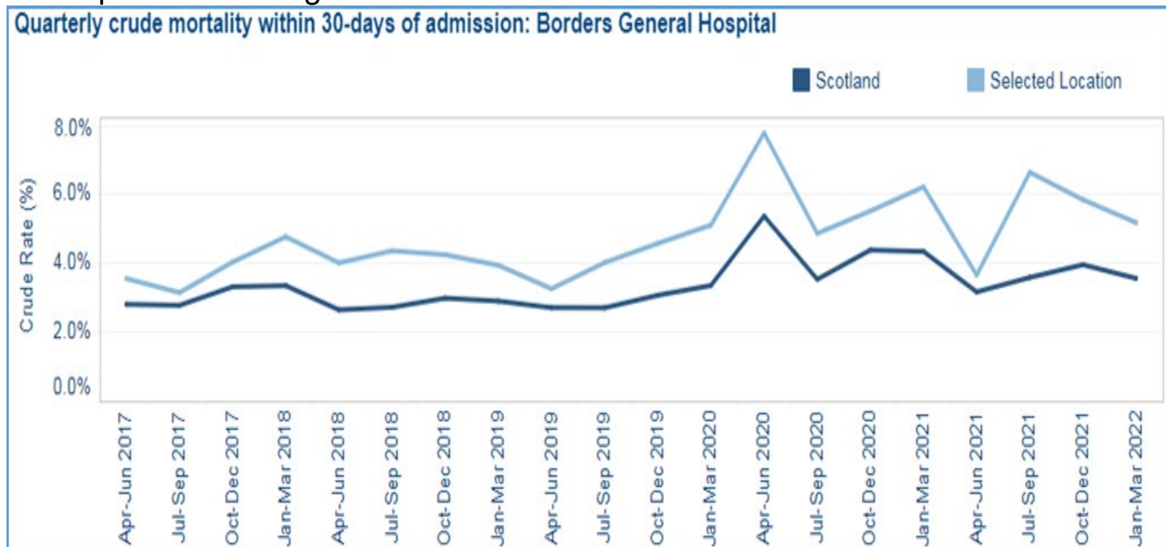
2.3.13 PATIENT SAFETY

2.3.14 NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 13th data release under the new methodology is **1.02.** This figure covers the period **April 2021 to March 2022** and is based on 607 observed deaths divided by 597 predicted deaths. The funnel plot in Figure 1 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

2.3.15 NHS Borders crude mortality rate for quarter January 2022 to March 2022 was **5.2%** and is presented in Figure 2 below:

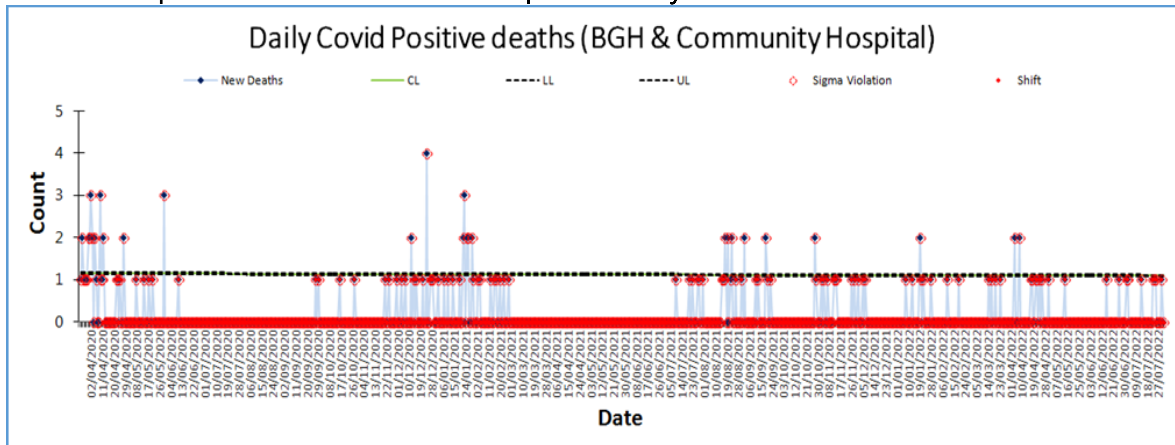


*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.16 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.

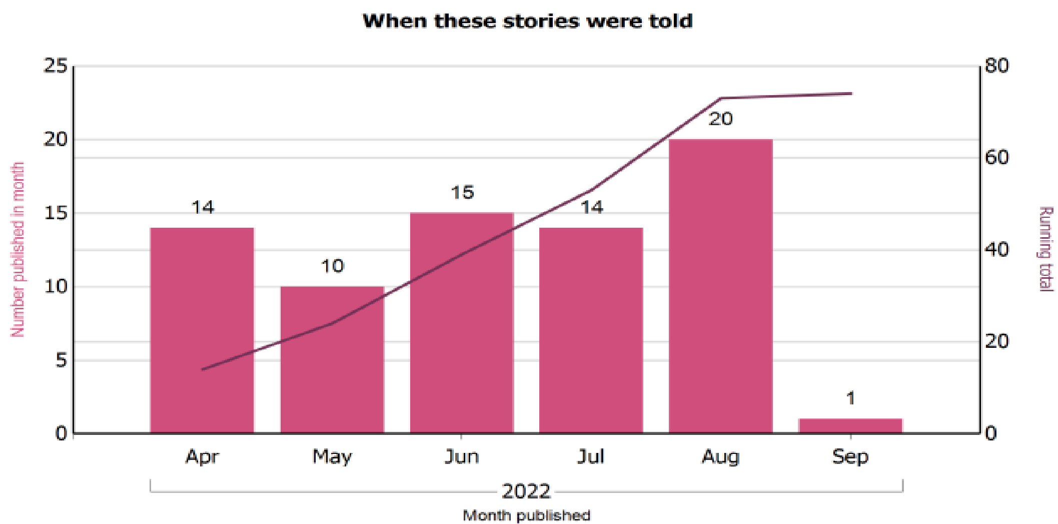
2.3.17 Deaths occurring in waves 1, 2 and 3 of the COVID 19 pandemic have contributed to the elevated crude mortality rates in quarter 4 of 2019/20; quarters 1, 3 and 4 of 2020/21 and quarter 2, 3 and 4 of 2021/22. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in quarter 4 of 2019/20 and quarter 1 of 2020/21.

2.3.18 Figure 3 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 31 July 2022:

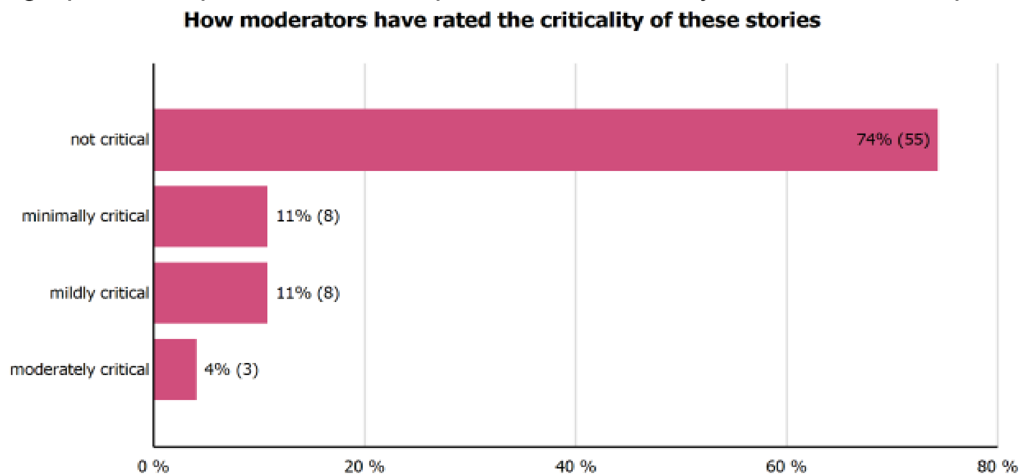


2.3.19 PATIENT EXPERIENCE

2.3.20 For the period 1 April 2022 to 31 August 2022 74 new stories were posted about NHS Borders on Care Opinion. The graph below shows the number of stories told in that period, as at 23 September 2022 these 74 stories had been viewed 9,762 times:



2.3.21 The graph below provides a description of the criticality of the 74 Care Opinion stories:

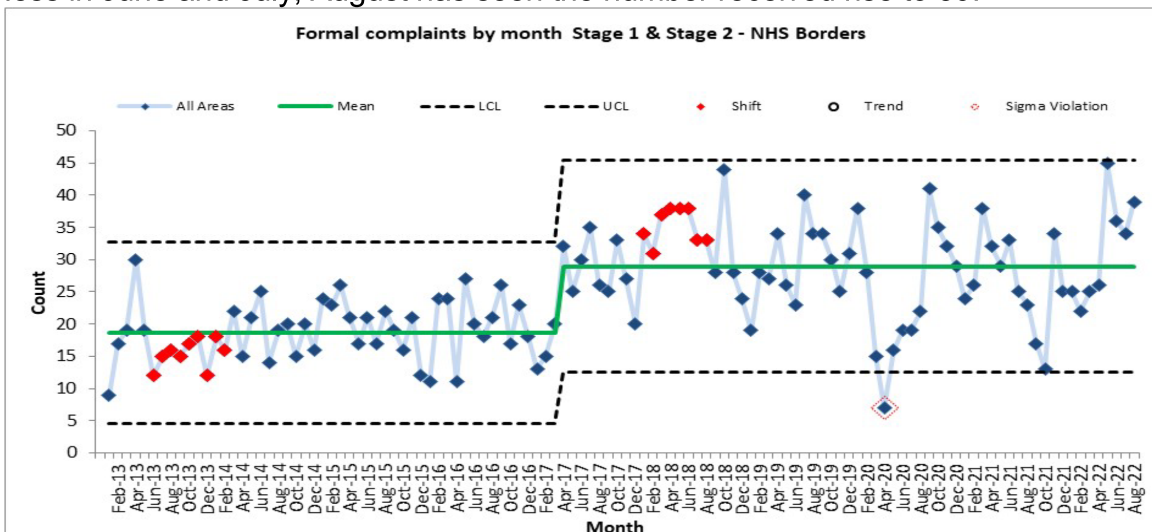


2.3.22 The word clouds below summarise what people felt was good and what could be improved in their Care Opinion posts about NHS Borders for this period:

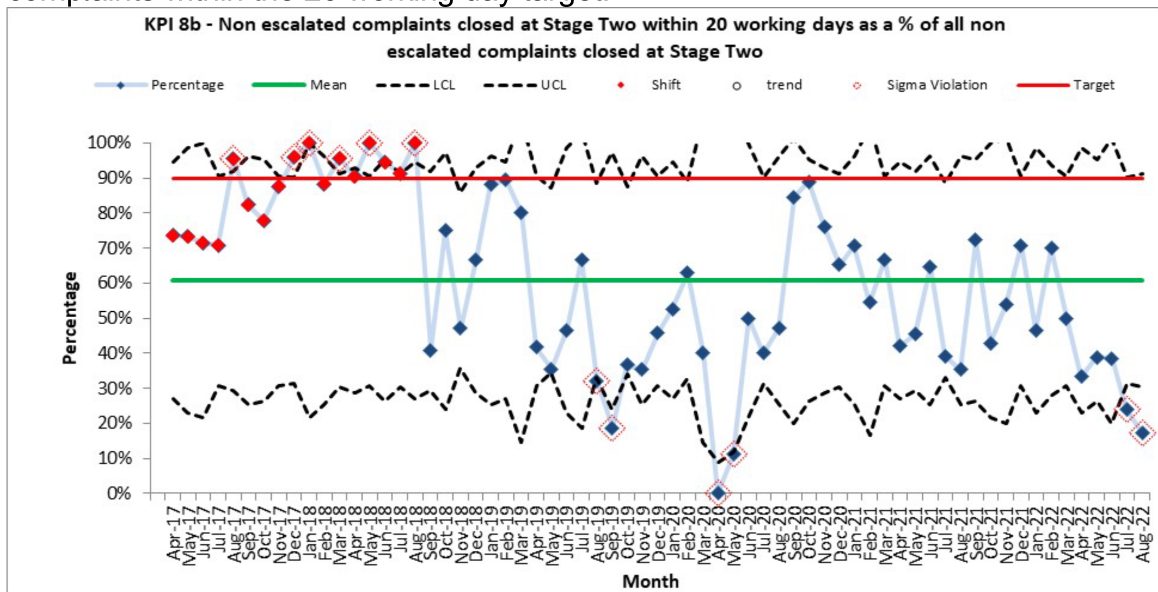
What was good?

What could be improved?

2.3.23 The graph below gives the number of formal complaints received by month. The number of complaints being received is within normal limits. However, during May 2022 45 complaints were received. This is the highest number received in one month to date reflective of the ongoing service pressures. Whilst the number received was less in June and July, August has seen the number received rise to 39:

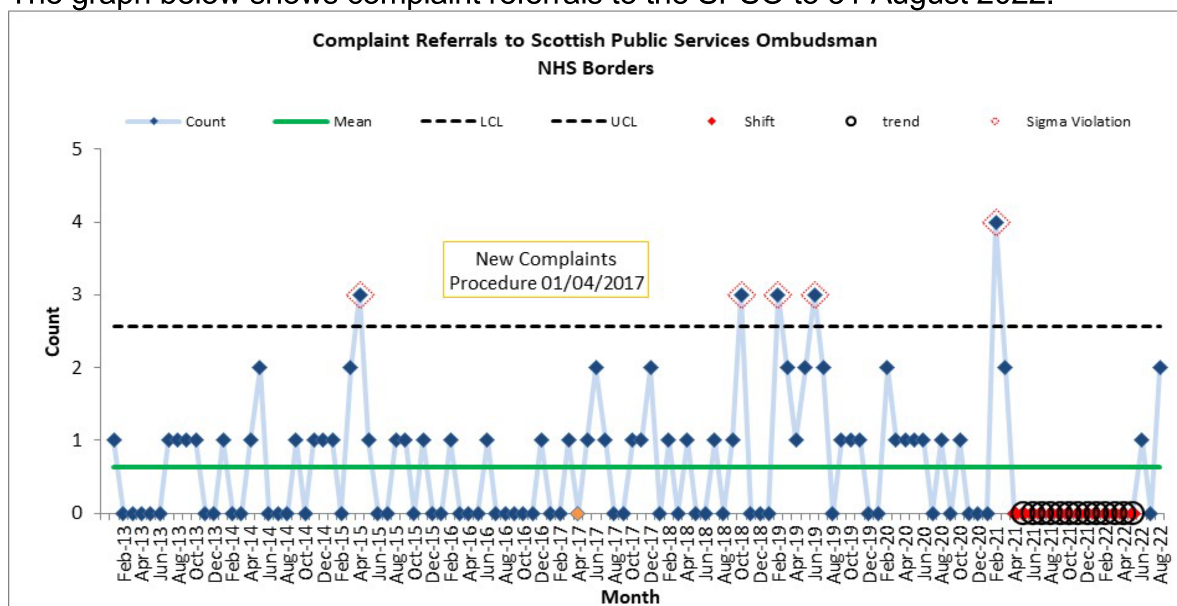


2.3.24 The graph below shows the percentage of complaints responded to within 20 working days. As front line services continue to prioritise the on-going response to the COVID 19 pandemic clinical pressures have impacted on the ability of frontline clinical staff to respond to complaints investigations within normal timescales. In addition to this there has been a rise I complaints in the last 4 months placing a significant strain on the small patient experience team. Additional capacity has been added to the team to deal with this increase in demand but this has had a further impact on ability to respond to complaints within the 20 working day target:



2.3.25 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.

2.3.26 The graph below shows complaint referrals to the SPSO to 31 August 2022.



2.3.27 COVID INQUIRY

2.3.28 Both the UK and Scottish Covid Inquiries have commenced. The Central Legal Office (CLO) has set up a team to deal with preparations for the Inquiry and to provide advice to all of the territorial and special Boards in Scotland. CLO are providing training sessions and have established monthly meetings for all Health Boards which NHS Borders are part of. A session is being held in October and will focus on the Inquiries powers in relation to the recovery of documentation, retention of documentation, Do Not Destroy letters, and the differences between the Scottish and UK Inquiries.

2.3.29 Quality/ Patient Care

Following the impact of the COVID 19 pandemic services continue to recovery and respond to significant demand with heightened workforce pressure across health and social care. This has required adjustment to core services and non-urgent and routine care. This prioritisation has necessitated the step down of services resulting in increased patient waits and a backlog of demand. The ongoing unscheduled demand and delays in flow across the system remain an area of concern with concerted efforts underway to reduce risk in this area.

2.3.30 Workforce

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. 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.

2.3.31 Financial

Service and activities are being provided within agreed resources and staffing parameters, with additional resources being deployed to support the recovery from the pandemic response and resulting pressures across health and social care. As outlined in the report the requirement to step down services to prioritise urgent and emergency care has introduced waiting times within a range of services which will require a prolonged recovery plan.

2.3.32 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the need to adjust and remobilise services following the pandemic response.

2.3.33 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.

2.3.34 Climate Change

No additional points to note.

2.3.35 Other impacts

No additional points to note.

2.3.36 Communication, involvement, engagement and consultation

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

2.3.37 Route to the Meeting

The content of this paper is reported to Clinical Board Clinical Governance Groups and Board Clinical Governance Committee.

2.4 Recommendation

The Board is asked to:

- note the report

Glossary
Clinical Governance Committee - CGC
HeartFlow Fractional Flow Reserve Computer Tomography - FFRCT
Scottish Health and Industry Partnership - SHIP
Hospital Standardised Mortality Rate - HSMR
Borders General Hospital - BGH
Scottish Public Services Ombudsman - SPSO
Central Legal Office - CLO

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Infection Prevention and Control Report – April 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 12 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2022 and July 2022, 7 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 2022/23 (using 2018/19 as the baseline). Based on TOBDs for the period April 2021 – March 2022, our new target rate equates to no more than 19 healthcare associated SAB cases per financial year.

1.2 NHS Borders had a total of 8 *C. difficile* Infection (CDI) cases between April and July 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 2022/23 (using 2018/19 as the baseline). Based on TOBDs for the period April 2021 – March 2022, our new target rate equates to no more than 11 healthcare associated CDI cases per financial year.

1.3 NHS Borders had a total of 31 *E. coli* Bacteraemia (ECB) cases between April and July 2022, 12 of which were healthcare associated.

1.3a The Scottish Government 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 2022/23 (using 2018/19 as the baseline) and with a total reduction of 50% by the end of 2024/25. Based on TOBDs for the period April 2021 – March 2022, our new target rate equates to no more than 30 healthcare associated ECB cases this financial year.

2.0*Staphylococcus aureus* Bacteraemia (SAB)
See Appendix A for definition.

2.1 Between April and July 2022, there have been 12 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 0 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.

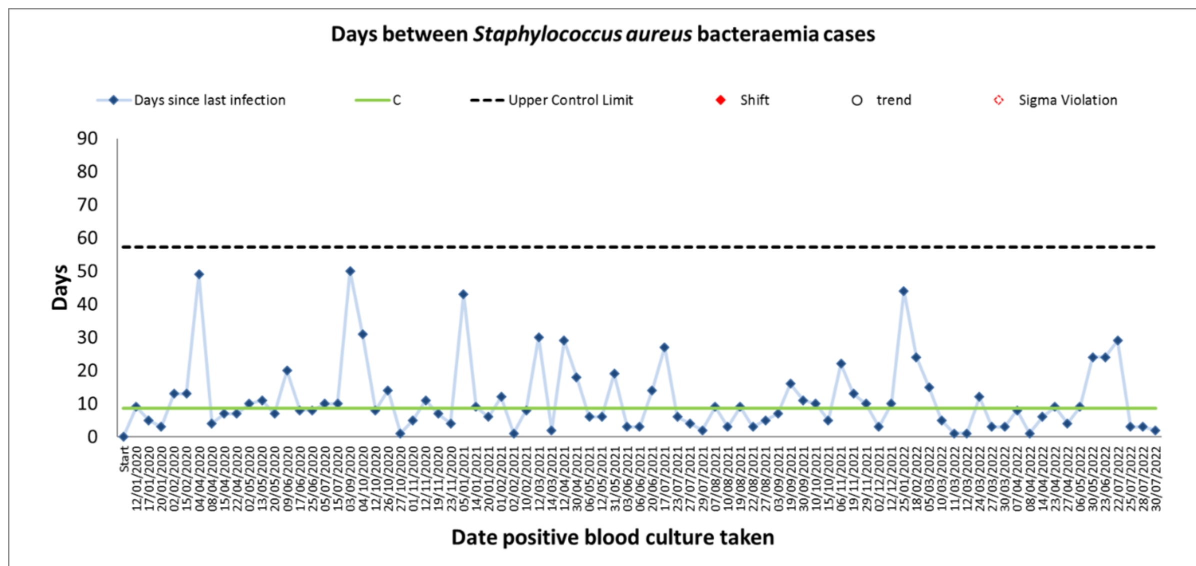
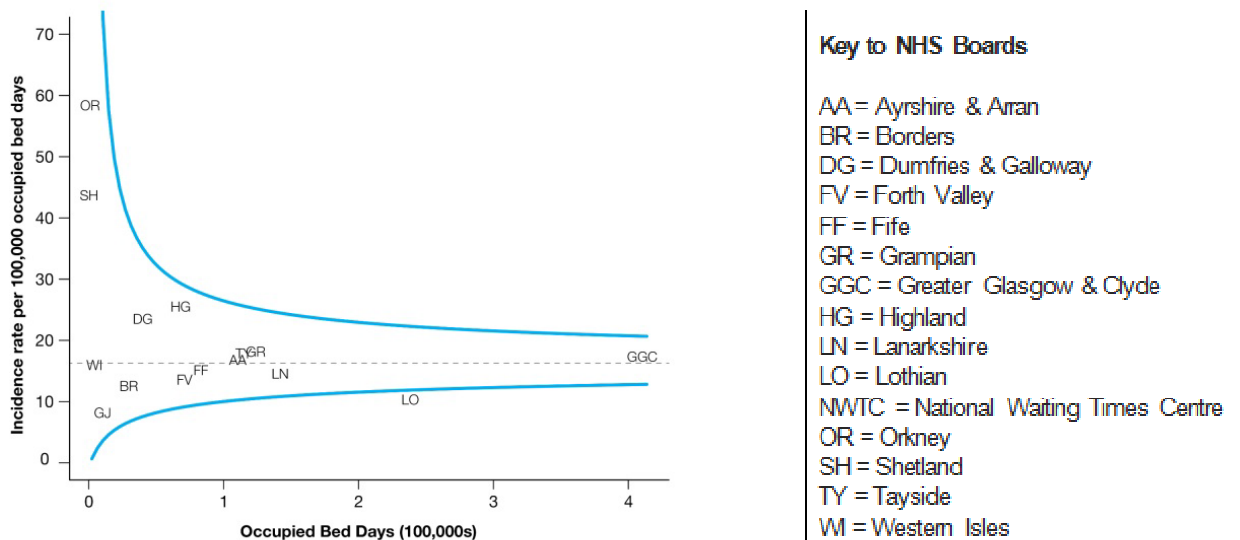


Figure 1: NHS Borders 'days between' SAB cases (January 2019– July 2022)

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 healthcare associated SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 1 2022 (Jan 2022 – Mar 2022).

2.6 During this period, NHS Borders (BR) had a rate of 12.6 which was below the Scottish average rate of 16.3.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Ayrshire & Arran, NHS Grampian and NHS Tayside 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 Q1 2022

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 from the rest of Scotland.

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 Q1 2022.

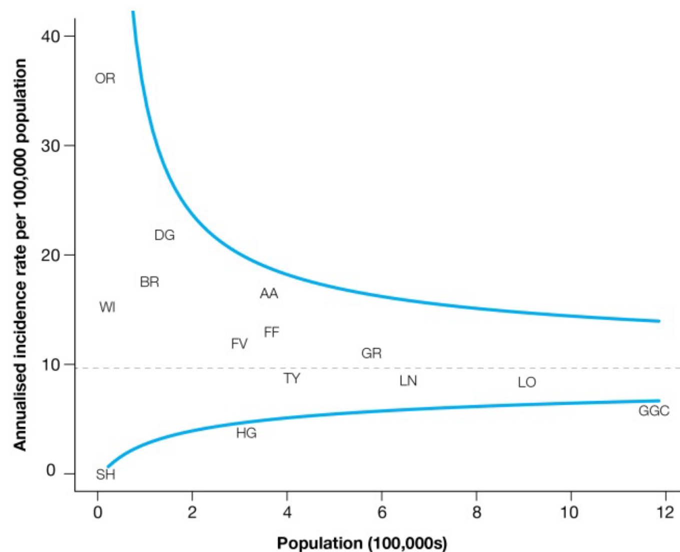


Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q1 2022

2.8 During this period NHS Borders (BR) had a rate of 17.6 which was above the Scottish average rate of 9.6, however 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.

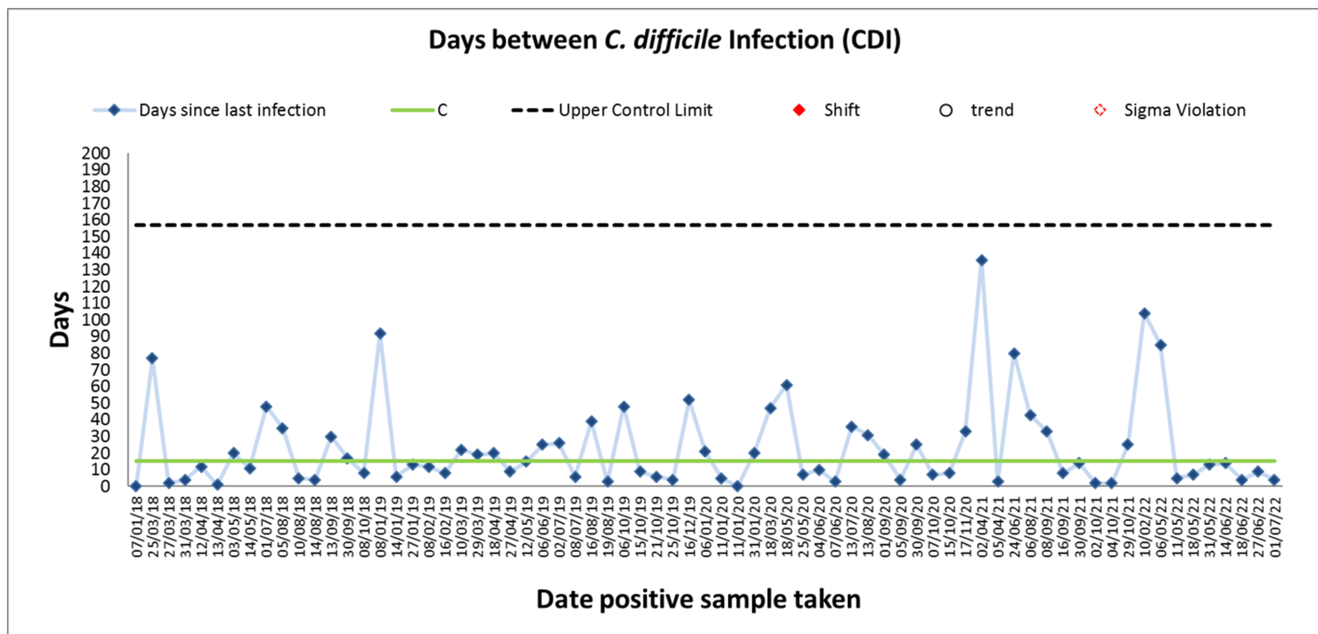


Figure 4: NHS Borders days between CDI cases (January 2018 – July 2022)

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 healthcare associated infection cases for all NHS Boards in Scotland in Q1 2022.

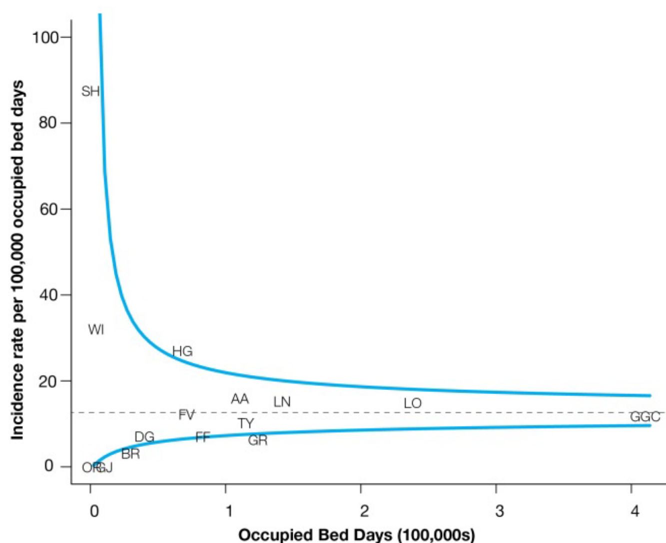
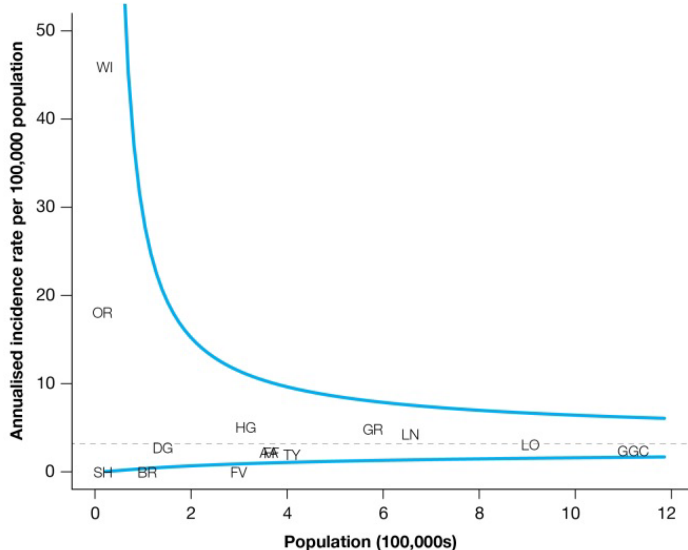


Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q1 2022

3.3 The graph shows that NHS Borders (BR) had a rate of 3.2 which was below the Scottish average rate of 12.6.

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 Q1 2022.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Ayrshire & Arran and NHS Fife overlap.

Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q1 2022

3.5 The graph shows that NHS Borders (BR) had a rate of 0 which was below the Scottish average rate of 3.2.

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.

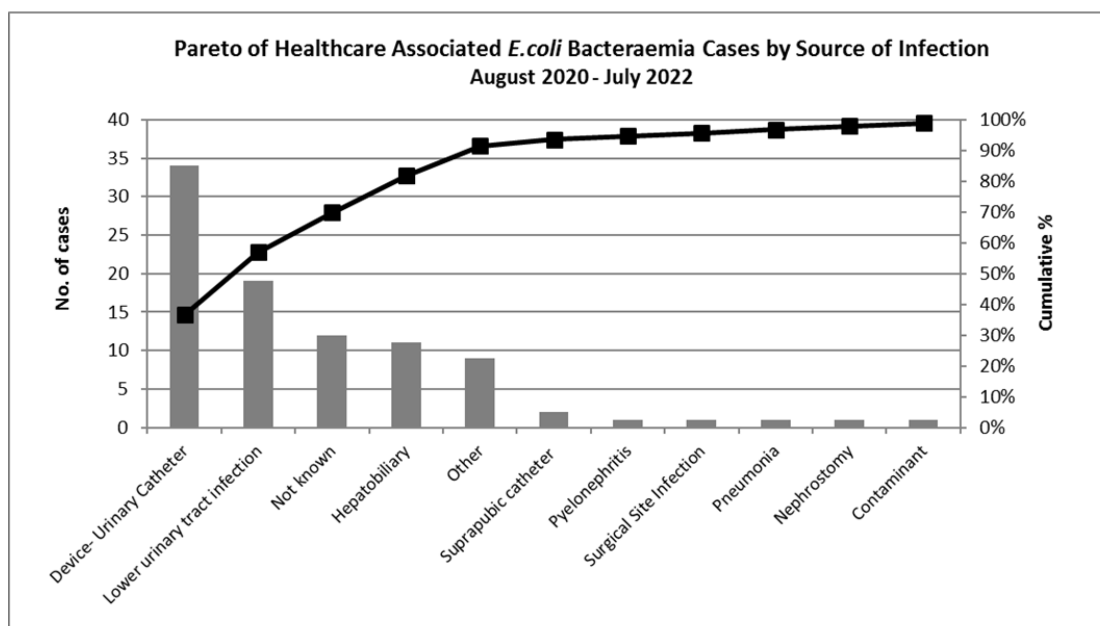
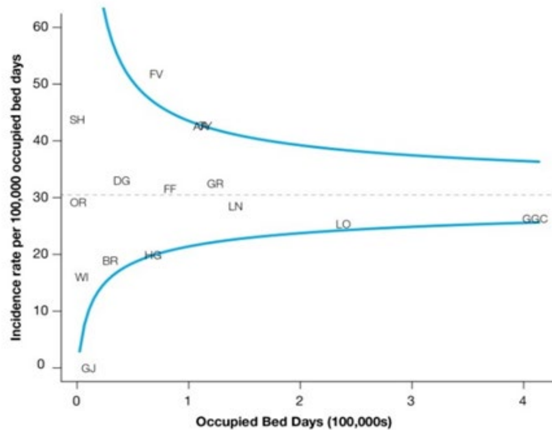


Figure 7: Pareto chart of healthcare associated ECB cases by source of infection

4.2 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 8 below shows a funnel plot of healthcare associated ECB infection

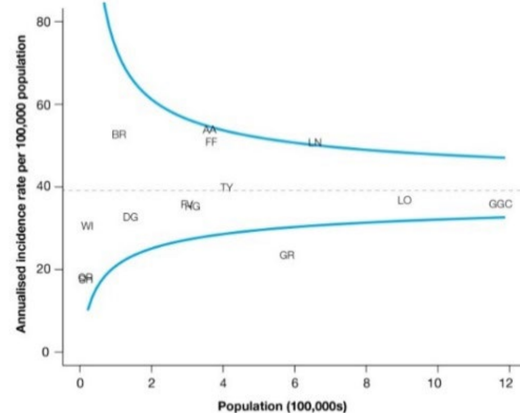
rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q1 2022. NHS Borders (BR) had a rate of 18.9 for healthcare associated infection cases which was below the Scottish average rate of 30.5.

4.3 Figure 9 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q1 2022. NHS Borders (BR) had a rate of 52.8 for community associated infection cases which was above the Scottish average rate of 39.2; 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.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Ayrshire & Arran and NHS Tayside overlap.

Figure 8: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q1 2022



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Forth Valley and NHS Highland overlap as do NHS Orkney and NHS Shetland.

Figure 9: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q1 2022

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 Hand hygiene compliance monitoring is now gathered during infection control spot checks and external audits such as those conducted by our hand gel supplier, GoJo. An initial baseline audit in inpatient areas area has been completed.

6.2 Given the known human factors associated with conducting audits, an apparent reduction in hand hygiene compliance compared with self-audit data was expected. In addition, the context in which clinical areas are working has never been more challenging with significant demand for services alongside severe staffing shortages.

6.3 In the last month of wards conducting self-audits, overall hand hygiene compliance was 98%. The outcome of the recent audit was overall compliance of 73% across all areas.

6.4 One of the recurring issues noted was an over-use of gloves. National (and local) evidence has identified the risks associated with this, both to the individual, as well as their colleagues, patients and visitors.

6.5 To support improved practice in relation to inappropriate glove usage, PPE guidance for staff has been updated in line with national guidance.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 In June and July 2022, infection control spot checks were undertaken in a total of 10 clinical areas across NHS Borders with an average compliance of 87.9%.

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 continues to progress actions to improve the accuracy of monitoring and reporting through this national system.

9.0 2022/23 Infection Control Work plan

9.1 The 2022/23 Infection Control Work Plan has been approved by the Infection Control Committee.

9.2 The Infection Prevention and Control Team provide both a reactive and proactive service, with some aspects of the reactive workload having a level of predictability. Responding to significant unexpected events or peaks of clinical activity such as outbreak management would be achieved by flexing resources away from proactive to reactive activities impacting on Work Plan progress.

9.3 There are currently no overdue actions in the 2022/23 Work Plan.

10.0 Outbreaks/ Incidents

COVID-19

10.1 Since the last Board meeting, there have been 13 COVID-19 clusters for which a Problem Assessment Group (PAG) and/or Incident Management Team (IMT) has

been held. A summary for each closed cluster as at 31st July 2022 is detailed in the table below.

Areas affected	Total positive patients	Total positive staff	Total deaths
Ward 7	7	0	0
Ward 12	2	0	0
Knoll Community Hospital	11	4	0
Ward 9	20	4	1
Ward 4 & Ward 5	2	0	0
Haylodge	9	0	0
MAU	2	0	0
DME 14	3	0	0
Ward 12	2	1	0
Ward 7	3	0	0
Ward 12	6	0	0
Lindean	2	2	0
MAU	4	0	0

Figure 10: Summary of COVID-19 clusters

10.2 It was noted that high community prevalence of COVID-19, relaxation of restrictions for the general public and hospital visiting being re-instated meant it was not always possible to ascertain if COVID-19 infections were exclusively linked to the ongoing incident or if they were an incidental community acquired finding.

10.3 ARHAI Scotland produces data on COVID-19 cases by hospital onset status using national definitions (Appendix B). NHS Borders data for week ending 22nd May 2022 to week ending 24th July 2022 is displayed in Figure 11 below.

Hospital Onset COVID-19 Cases by Hospital Onset Status
Summary

For NHS Borders, the total number of hospital onset COVID-19 cases reported to ARHAI Scotland, with specimen dates from week-ending 22 May 2022 to week-ending 24 Jul 2022, was 92.

	% of total	n =
Non-Hospital onset	20.7%	19
Indeterminate Hospital onset	28.3%	26
Probable Hospital onset	9.8%	9
Definite Hospital onset	41.3%	38
Grand Total	100.0%	92

Figure 11: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

Norovirus

10.3 From 3nd June 2022 – 18th August, there was 1 Norovirus related incident. A summary of this incident is shown in Figure 12 below.

Area(s) affected	Type	Number of patients affected	Number of staff affected
Kelso (Room 3 & 4)	Norovirus	2	2

Figure 12: Summary of Gastrointestinal/Norovirus Incidents

Acinetobacter baumannii

10.4 Carbapenem-resistant *Acinetobacter baumannii* (CRAB) was isolated from two patients who had been in ITU during the same period. It was established that the index patient was colonised on admission following repatriation from an ITU abroad; the second patient was found to be colonised following routine screening- neither patient was treated for infection. Isolates were sent to the reference lab for whole genome sequencing which confirmed that the isolates were indistinguishable and strongly supported an epidemiological link.

Clostridioides difficile

10.5 The Infection Prevention and Control Team recently identified cross transmission of *C.difficile* between two patients who were located on DME Ward 14 at the same time. The index case was in a multi-bedded room until the positive laboratory result was received at which point they were transferred to a side room which was adjacent to a side room with the second patient who subsequently tested positive. Samples from each patient were sent to an external reference laboratory for typing and the samples were indistinguishable based on their typing.

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

11.0 Infection Prevention and Control Team Capacity

11.1 Following the departure of a trainee Infection Control Nurse, the vacancy is currently being advertised. 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 The following quality improvement projects have been identified as a priority for progression and an update on each project is provided below:

Invasive device – urinary catheters	Urinary catheters remain the primary cause of healthcare associated *Escherichia coli* bacteraemia (ECB) cases. The Prevention of CAUTI Group action plan has been agreed and is updated at each meeting which is held every 6 weeks. Data analysis has been undertaken on the Catheter Passport survey with themes identified and actions incorporated into the above action plan.

	Catheter point prevalence is in progress across NHS Borders incorporating Acute, Community Hospitals, Care/ Nursing Homes, District & Treatment Room Nurses. Data analysis for this is currently underway. NHS Borders has drafted a proposed definition for CAUTI which is currently out for consultation with the Prevention of CAUTI group prior to implementing for infection surveillance. NHS Borders Urinary Catheterisation Policy is undergoing significant review with publication and re-launch planned for October 2022.
Invasive device – PVC documentation	Review of the documentation is required following feedback from the staff survey completed in one medical ward. Educational support is planned within this ward to progress this improvement work.
Hand hygiene	Work is required across NHS borders inpatient areas to ensure that each patient bed space has alcohol based hand rub (ABHR) bed-end dispensers. Following a trial in MAU, it was identified that movement of beds off the ward resulted in bed-end dispensers moving with the bed and not being replaced. Implementing across inpatient sites will improve reliable access to bed-end dispensers. NHS Borders hand gel supplier - Gojo representative visited BGH on 23/08/22 and delivered hand hygiene feedback and education in clinical areas. The IPCT has commenced a new project to target over-use of gloves and the impact on performing hand hygiene at the appropriate opportunities.
Infection Control screening documentation	A successful application for Cohort 32 of the Scottish Coaching and Leading for Improvement Programme (SCLIP) has been made by the Quality Improvement Facilitator for Infection Control. The infection screening clinical risk assessment into Trakcare has been identified as the improvement priority for this programme.

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections (also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections *(CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA).

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets
There are national targets associated with reductions in *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 infections and *Staphylococcus aureus* (including MRSA) bacteraemia cases are associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
MRSA	0	0	0	1	0	0	0	0	0	0	0
MSSA	3	2	3	1	1	1	7	5	2	1	4
Total SABS	3	2	3	2	1	1	7	5	2	1	4

Clostridioides difficile infection monthly case numbers

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Ages 15-64	0	1	0	0	0	0	0	0	0	0	0
Ages 65 plus	3	2	0	0	0	1	0	0	4	3	1
Ages 15 plus	3	3	0	0	0	1	0	0	4	3	1

Cleaning Compliance (%)

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Board Total	93.9	95.8	96.8	96.1	96.3	93.4	93.8	96.4	94.2	96.2	95.5

Estates Monitoring Compliance (%)

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Board Total	98.1	98.7	98.7	98.7	98.9	99.0	98.0	98.4	98.6	98.6	97.4

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
MRSA	0	0	0	1	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	1	2	1	0	1	1
Total SABS	0	0	0	1	0	1	2	1	0	1	1

Clostridioides difficile infection monthly case numbers

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	1	0	0	0	1	0	0	2	2	0
Ages 15 plus	0	1	0	0	0	1	0	0	2	2	0

Cleaning Compliance (%)

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Board Total	95.6	96.6	95.3	97.1	96.3	96.0	95.8	96.4	96.0	95.6	95.5

Estates Monitoring Compliance (%)

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Board Total	95.5	97.4	97.7	98.1	97.9	98.6	98.4	98.4	97.4	96.7	97.5

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Haylodge Community Hospital**
- **Hawick Community Hospital**
- **Kelso Community Hospital**
- **Knoll Community Hospital**

Staphylococcus aureus **bacteraemia monthly case numbers**

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 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**

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 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**

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	3	2	3	1	1	0	5	4	2	0	3
Total SABS	3	2	3	1	1	0	5	4	2	0	3

Clostridioides difficile **infection monthly case numbers**

	Sept 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	June 2022	July 2022
Ages 15-64	0	1	0	0	0	0	0	0	0	0	0
Ages 65 plus	3	1	0	0	0	0	0	0	0	0	0
Ages 15 plus	3	2	0	0	0	0	0	0	0	0	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Climate Change

None identified

2.3.7 Other impacts

None identified

2.3.8 Communication, involvement, engagement and consultation

This is a regular bi-monthly update as required by SGHD. As with all Board papers, this update will be shared with the Area Clinical Forum for information.

2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the 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 : https://www.nhs.uk/conditions/staphylococcal-infections/

MRSA: https://www.nhs.uk/conditions/mrsa/

NHS Boards carry out surveillance of *Staphylococcus aureus* blood stream infections, known as bacteraemia. These are a serious form of infection and there is a national target to reduce them. The number of patients with MSSA and MRSA bacteraemia for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Staphylococcus aureus* bacteraemia can be found at:

https://www.hps.scot.nhs.uk/publications/?topic=HAI%20Quarterly%20Epidemiological%20Data

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:

https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

Escherichia coli bacteraemia (ECB)

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by Healthcare Improvement Scotland. More details can be found at:

https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

APPENDIX B

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:	**6 October 2022**
Title:	**Food Fluid and Nutrition Update**
Responsible Executive/Non-Executive:	**Sarah Horan, Director of Nursing, Midwifery and AHP's**
Report Author:	**Elaine Dickson, Associate Director of Nursing Acute**

1 Purpose

The purpose of this paper is to assure the Board that the planned activity relating to Food Fluid and Nutrition is being delivered with an improvement focus and that this is evident throughout NHS Borders in relation to the Health Improvement Complex Nutritional Care Standards.

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive
- Local policy

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

- Safe

2 Report summary

2.1 Situation

An unannounced inspection was carried out by Healthcare Improvement Scotland in June 2017. A robust plan was implemented following this to address actions which were required. This was presented to the board on 17th January 2019. The purpose of this paper is to update the board on continuing progress against the Health Improvement Scotland Complex National Care Standards

2.2 Background

The Associate Director of Nursing for Acute is currently the Lead for Food, Fluid and Nutrition across the Board.

The Food Fluid and Nutrition Strategy Group meet on a monthly basis and is chaired by Elaine Dickson and co-chaired by Vanessa Hamilton Dietetic Service Lead.

2.3 Assessment

Governance and Leadership for Nutritional Care – like many other strategy groups the FFN Strategy Group meetings have at times been suspended /cancelled due to operational demands. These meetings have now recommenced and are scheduled monthly.

2.3.1 Quality/ Patient Care

Training in relation to Food, Fluid, Nutrition, MUST has recommenced as part of Developmental Days being held for staff which commenced in August, with dates arranged throughout September and October.

A review of Band 2, 3 and 4 national framework role descriptors are being reviewed to identify who can undertake which roles in relation to supporting mealtimes and patient nutrition, recognising that delays in care have occurred previously.

Speech and Language Therapy (SLT) have developed yellow swallowing recommendations charts for use; these have now been laminated and are testing within the Medical Assessment and Stroke Unit.

Paediatric and Adult dieticians are looking at whether it would be possible to develop one enteral feeding document which would cover both groups of patients as opposed to separate documents for each patient group.

Food Fluid and Nutrition Care Policy is in process of being updated, with only 2 items remaining to be updated.

The Multidisciplinary Assessment and Communication booklet is currently being updated to provide cleared instruction in relation requirement for nutritional assessment and additional space for capturing data for longer stay patients.

The collated ward Audit information relating to must has shown improvement from last year across 6 of the questions currently measured against. (Appendix 1)

2.3.2 Workforce

Two Quality improvement facilitators have been employed on a permanent basis and will continue to support improvement in nursing practices relating to Nutrition and Fluid Management.

Speech and Language Therapy had been experiencing challenges due to vacancies within their team however they have recently appointed to vacant post.

2.3.3 Financial

No financial impact

2.3.4 Risk Assessment/Management

Incidents and adverse events in relation to Food Fluid and Nutrition continue to be reported through DATIX which allows for thematic review and development of improvement plans if required.

2.3.5 Equality and Diversity, including health inequalities

An Impact assessment has not been carried out

2.3.6 Climate Change

No impact on climate change/carbon footprint/etc.

2.3.7 Other impacts

No Other impact

2.3.8 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.

2.3.9 Route to the Meeting

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

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Must ward quality audit data

Appendix 1 – MUST ward Quality Audit Data

	MUST April 2021 - August 2022	Numerator	Denominator	NHS B
Q1	MUST completed within 24 hrs of admission	3227	3643	88.6%
Q2	Has the patients usual weight been recorded	1995	3643	54.8%
Q3	Is STEP 4 of MUST calculated correctly (using BMI, weight loss, disease effect) to complete the score?	3314	3643	91.0%
Q4	Based on the MUST score are all sections of STEP 5 completed accurately?	3102	3643	85.1%
Q5	Has the MUST assessment of weight been recorded a minimum of once per week	1975	2429	81.3%
Q6	Has weight been plotted on graph	2616	3643	71.8%
Q7	Has the scales used been recorded	2102	3643	57.7%
Q8	If the patient has a MUST of 1 or above, has a food record chart been introduced	816	1080	75.6%
Q9	If the patient has a MUST of 2 or above, have they been referred to a Dietician	648	854	75.9%
Q10	Where the patient has a MUST of 1 or above, has a person centred care plan been developed	672	1075	62.5%

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Staff Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Andy Carter, Director of HR & OH&S**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Staff Governance Committee 23 June 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 23.03.22

NHS Borders

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Wednesday, 23rd March 2022, 14:30-16:30
via Microsoft Teams

Present: Councillor David Parker, Non-Executive Director (Chair)
Mr Andy Carter, Director of Workforce
Ms Sonya Lam, Non-Executive Director
Mr John McLaren, Employee Director
Mr Bob Salmond, Associate Director of Workforce
Mrs Jennifer Boyle, HR Manager / Business Partner
Ms Edwina Cameron, HR Manager / OD Partner
Mrs Vikki MacPherson, Partnership Lead / Staffside
Mrs Josie Gray, Personal Assistant (Minutes)

1. Welcome, Introductions and Apologies

Councillor Parker welcomed everyone to the meeting.

Apologies were noted from Mr Ralph Roberts, Mrs Ailsa Paterson, Mrs Vikki Hubner, Mrs Karen Hamilton, Ms Harriet Campbell, Mrs Alison Wilson, Mrs Yvonne Smith, Ms Gail Russell & Mrs Karen Lawrie

2. To agree Minutes of Previous Meeting

The minutes of the previous meeting, held on 14 December 2021, were agreed without amendment.

3. Matters Arising

The Chair asked the group for any matters arising not on the agenda. Sonya Lam mentioned Strategic Risks and noted it was agreed at the last meeting to include this as a standing agenda item. Harriet Campbell's comments at the last meeting around equality and diversity were referenced and it was also agreed for this to be an item on the next agenda.

The SGC was asked to note this update.

3.1 Promotions inside workforce

Bob Salmond referred to the categorisations of promotions by gender and banding for analysis of internal promotions and our ability to achieve higher potential within NHSB. Bob confirmed the majority of promotions were permanent, noting some fixed term / secondment opportunities within Testing and Vaccination Teams. Band 8a had achieved a promotion by the end of period (November 2019 – October 2021) with Band 7 seeing the least, suggesting a ceiling within workforce promotion. Majority of promotions were seen within female employees with 35-45 years of age the most likely to achieve a promotion. This group is asked to consider the opportunities for promotion across all bands as part of our strategy going forward. Bob raised concerns around ability to interrogate this payroll data to assess promotions by ethnicity and disability, noting the next Workforce Annual Report due is for 2022-23.

Sonya Lam acknowledged Bob's comment around access to data for ethnicity and disability and went on to question around banding and percentages of staff of ethnicity sitting within these bands. Bob went on to explain payroll data included age, gender & band but noted

unable to extract ethnicity and disability. Ethnicity within our workforce can be broken down, however, would not indicate an internal promotion within the last two years. Equal opportunities have endorsed mainstreaming of reports and give assurance we can analyse data for ethnicity and disability going forward, however, important to note this was not possible for this amount of data.

John McLaren understood that promotion was more prevalent for females rather than male noting comparison within gender and reflected a reasonable level of equality, noting NHS are usually 80/20 female to male population within workforce. John complimented Bob on the breakdown of the data and appreciated the information and easy way it is laid out, noting the unlikelihood of coming up with disability data until the Equality, Diversity & Inclusion in Employment (EDI) Group have reviewed further how staff report their disabilities, noting if we analysed this data now it could read as false.

Bob referred to variation of male / female and noted not significant variation and that it is as expected considering gender of workforce. Bob confirmed self declaration of disability, was being looked into by the EDI group next for a truer picture of workforce statistics.

Sonya queried in relation to National Workforce Strategy, in terms of baseline and what we are aiming for our workers in terms of ethnicity and disability and asked what assurances we can get in the collation of this data to ensure aims of strategy are inclusive. Bob noted a very low base of statistics for initial reporting and made reference to the importance of the EDI Group efforts around this.

Andy Carter confirmed data sets exist around ethnicity and disability and is committed to providing an update on known data sets, unknown data sets and those who preferred not to say. Highlighting this is about movement of promotion within the organisation and noted the challenges around identifying equality within promotion. It was agreed for this to be an item on the next SGC agenda.

The SGC was asked to note this update.

3.2 Whistleblowing – recording activity inside PACS / IJB, Raising Whistleblowing Concerns – a guide for staff & Whistleblowing Governance Group Terms of Reference V4
Andy Carter confirmed a conversation is needed into the Integrated Joint Board (IJB) with himself, Sonya Lam & Chris Myers to firm up how to capture workforce data within the IJB. Sonya confirmed discussions have taken place around integration to the IJB and into the commissioning of the document and Strategic Commissioning Plan. The Whistleblowing Governance Group (WGG) is looking at how we get information from the IJB, Primary Care and other stakeholders and how to get this strategically positioned within the Integrated Strategic Plan. The Chair enforced everyone has to be comfortable with procedures, ensuring elements around whistleblowing are exemplar and supported this plan.

The SGC was asked to note this update.

4. Review and agree Whistleblowing Governance Annual Report
Andy Carter confirmed the requirement to come up with a Whistleblowing Annual Report, noting this is a first attempt. Looking over the last year, since the Independent National Whistleblowing Officer (INWO) Standards were introduced on 1st April 2021, Andy was delighted to confirm that Sonya Lam has been appointed as NHSB Whistleblowing Champion and Chair of the newly established WGG. Andy made reference to the Terms of Reference for the WWG as well as the Raising Whistleblowing Concerns papers included in the paper pack. Andy confirmed trained managers within NHSB and 62 members of NHSB staff have been through this training but looking to increase this number. 15 people have signed up to being Whistleblowing Confidential Contacts and will also be taking up this training, noting these Confidential Contacts have come from a wide range representing different teams and groups within the Scottish Borders. Plans are to hold an event end April / early May to introduce these staff.

The report also highlights that NHSB has had a single whistleblowing case since INWO standards introduced, this case revolved around appropriate access to systems and patient confidentiality with the investigation concluded within two months, noting this is a complex case which is not closed due to interests of an involved party.

In summary Andy confirmed the report provides an overview of what we have done over the last year, with introduction of INWO Standards, how we are trying to build our capability as an organisation and a note of the single whistleblowing case.

Sonya Lam noted that the timing of the report meant it cannot be taken to next Board meeting but anticipates within the next six months, allowing for a fuller report, noting only a single whistleblowing case. Standards around Key Performance Indicators (KPIs) need to be looked at to ensure we meet them and our attention needs to be around learning of our processes and confidentiality, noting an observation of what confidentiality means in a small remote and rural NHS Board, in relation to bigger boards. Delayed timing of report going to the Board will allow the WGG to look at this in more detail and then the SGC to review and offer assurance to the Board.

John McLaren picked up on Sonya's last point, stating whilst we can't be fully assured on application of INWO standards, we can be assured on amount of work put in to get us to this position and asked the SGC to be assured around amount of work put in so far, noting part way through the process. Roll out of Confidential Contacts would offer further data to provide further assurance.

The SGC were asked to note this update.

5. National Workforce Strategy

Andy Carter confirmed the National Workforce Strategy for Health & Social Care in Scotland was meant to be launched last year, pre Christmas but finally launched on Friday 11th March 2022, noting this is early days.

Andy Carter talked the SGC through his Summary Highlights, providing a quick run down by the sections in the strategy; Recovery, Growth & Transformation, making reference to our ability to bounce back from Covid, to grow the workforce, to be able to respond to the waiting lists and waiting times and to transform into something more effective and efficient. Andy went on to point out a key statement in the strategy "*this Workforce Strategy sets out a national framework to achieve our vision of a sustainable, skilled workforce with attractive career choices where all are respected and valued for the work they do*" which sets out our vision to be a gold standard exemplary employer with pipelines coming in and where people working for us are faced with no harm.

Andy confirmed with regards to the resourcing agenda, recognising NHSB are not getting the staff we need, we need to look at doing things differently, following the five key pillars of the strategy; to Plan, Attract, Train, Employ and Nurture.

Andy welcomed this strategy, noting it as a good start to borderise it, embrace it locally and add our own flavour to it. National feedback has recognised that not all professional groups are represented within this strategy; AHPs, Corporate departments etc, noting the tight consultation period.

Part 1 of the Strategy outlines the vision (*quoted above*) and five key values for the health and social care workforce; Continual improvement, Engagement, Honesty, Co-design and Accountability. It was noted that these values will co-exist alongside NHS Scotland's existing values of care and compassion, integrity, teamwork etc.

The strategy also recognises the outcomes, ensuring our workforce is inclusive and diverse, linking in with discussions already had around equality, diversity and inclusion. It goes on to mention an exemplar of fair work. Andy referenced the Convention of Fair Work which takes a lot from best practice industrial relations from across Scotland (public and private sector).

Further outcomes to embrace are to ensure "*our workforce is skilled and trained as well as being heard at the heart of transforming health and social care services; to ensure they are enabled and equipped to support the delivery of projected growth in demand of services and has a working environment that provides strong leadership, promotes wellbeing and supports people to grow and develop their capabilities*".

The tri-part ambition of the strategy is around recovery, growth and transformation and includes the five Pillars of the Workforce Journey; Plan, Attract, Train, Employ and Nurture. Andy highlighted that each of these have short, medium and long term actions, reflecting ongoing activity around integrated workforce planning, international and ethical recruitment, plans to increase numbers of undergraduate places throughout Scotland and is a critical part of the strategy to embrace locally.

With regards to Plan and Attract, Andy pointed out the need to consider alternate routes to keep the pipeline for health and social care going, championing of visible diversity and recruitment from overseas.

In terms of Training, Andy highlighted the importance of succession planning, specifically related to some more senior posts but is pointed out that this is key to all posts throughout the organisation.

Employ refers to the National Care Service and the Scottish Governments intention to establish this by the end of the parliamentary term (2026), stating social workforce is split across an economy of providers who are finding it increasingly difficult to recruit and retain staff, noting we are all within this perfect storm scrambling for the workforce we need.

Nurture is about kind and compassionate leadership. Andy noted this is already being taken forward within our Quality Management System in NHSB with the pillars of staff engagement, leadership and business processes. Andy referred to poor workplace cultures, commonly recorded for reasons people leave organisations as well as poor management, noting we still have high levels of absence due to the latest Covid variant. Need to embrace wellbeing, supportive measures as well as environment factors, being aware of the workload and demands placed upon staff.

Part 2 Implementing Strategy, highlights the importance of leadership roles to operationalise this strategy. Andy confirmed conversations are taking place within the Executive team and will add to profile of the strategy since launch and will be planning the best effect of aspirations from this strategy.

The Chair thanked Andy and agreed this as a really good summary and on how we want to implement it locally.

Sonya Lam complimented Andy's rapid run through of the National Workforce Strategy for Health and Social Care. Sonya went on to raise concerns around the pace of implementation, noting constraints around ability to attract and retain staff and encouraged

operationalisation of this as soon as possible. Sonya stated if we are transforming services then this should be the basis for change to the workforce and noted the role of NHS education within this in terms of how we transform and change education, noting this is a big ask and to use the NHS Academy (NSS) as a potential useful resource alongside an increase in educational leads. Nurture, we have worked on this and need to accelerate to ensure people feel valued and can flourish and queried how we do more of this, of existing and future workforce, making reference to learning environment of workforce. Sonya referenced the need to sort out our digital resource stating if we are not digitally capable we can't maximise the use of technology.

John McLaren thanked Andy for his presentation, stating a good breakdown of the strategy. John made reference to the word *nurture*, noting we mustn't let this cloud our judgement and need to focus on keeping staff as a key part of developing this strategy locally. Our commitment to staff wellbeing has been well documented and needs to be at the centre of everything we develop within culture and organisational strategies; noting national workforce strategy does not demonstrate this enough. John reiterated that Staffside are keen to work alongside HR to ensure that this strategy is meaningful and felt by the whole organisation and not just something we think we've achieved, making reference to some work groups who may not feel change.

Andy agreed the need to move this on at pace, acknowledging that recruiting and retaining staff is a limiting factor, noting transforming is referenced in the strategy and need to carve out time and energy to focus on this. Andy agreed we need to get close to NSS and ensure they are delivering. Andy agreed staff need to be made to feel more looked after and cared for and acknowledged burnout in staff from two years of successive waves of Covid, noting a good experience will entice people to apply for posts versus a bad experience that won't. Feedback on the strategy highlighted the minimal reference to digital, not enough, but hopes are to take this forward more locally. Andy went on to state staff wellbeing is very important and we must care for our workforce and agreed more work is needed around this.

Andy confirmed a recent conversation with external HR Directors indicated that all agreed things are tough right now and lots of teams are tired. Still doing fire fighting and this is a big proactive strategic paper which needs galvanised and need to build trust within the workforce, noting some trust recently eroded due to recent pressures. Need to improve resilience and capability within middle management and need to make this strategy work for NHSB across all services and landscape to ensure it is all linked together.

John made further comment around burnout within the organisation, making reference to another element of concern around aging workforce and pointed out with this comes health issues and significant care issues, noting impact from Covid and how we manage our services, recognising staff and patients have been waiting for services for a long time with conditions getting worse and stated it is important to think about this within the strategy. The Chair and Sonya agreed with this point raised and queried how we can improve the populations health in general.

Sonya made reference to an email she received from Harriet Campbell following the Clinical Governance Group last week, highlighting the lack of staff and medical training and Harriet had asked if the SGC need to be sighted on this as part of our response to the strategy, asking how do we galvanise this and what are the timescales? Andy stated he needs to have further discussions with the Executive team with regards to next steps for this strategy, how we go forward, and confirmed updates will be brought back to the SGC.

Andy asked the Chair how this strategy is landing with local authorities and within social care. The Chair confirmed it has been well received and confirmed a want to deliver collectively as best we can, agreeing national strategies should be looked at from a far to implement locally. The Chair referenced the ongoing work around whistleblowing and integration reiterating that there is a willingness to work collectively together to deliver on this, noting the Borders is a small place with great teams and an opportunity here to do something different and special, to perhaps lead Scotland, noting this is a key piece of work and will discuss again in IJB and future SGC.

The SGC was asked to note this update.

6. Review and agree Staff Governance Committee Annual Report 2021-22

Edwina Cameron confirmed this report was a factual representation of the SGC, what it has achieved and the attendance, submitted annually as part of the scheme of delegation, noting the note from this meeting is to be added and asked the SGC for their approval of this report.

Sonya Lam referred to the narrative of what was discussed and queried what the outcomes are, making reference to the Scottish Government's monitoring report of the five standards. Edwina confirmed this report is collated along with other committee reports to assure the board that each committee has met their standing orders. Edwina made reference to local elections and the delay in response from the Scottish Government monitoring and confirmation of any actions that can be brought back, reiterating that this report is purely a factual document.

Edwina and Josie Gray agreed to ensure today's agenda is added and the final report submitted

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The SGC was asked to note this update.

7. iMatter – National Analysis

Jenifer Boyle stated the purpose of the paper provided is to highlight the national health and social care report published at the end of February 2022, giving us an opportunity to compare and contrast NHSB iMatter performance against other boards across NHS Scotland.

NHS Scotland's engagement in the iMatter process has dropped significantly with the national response dropping by six percentage points. NHSB received a 52% response rate, down 1% from 2019, versus NHS Orkney receiving the highest response rate of 65%; a static performance for NHSB. NHSB action plan completion saw a significant drop of 22% but still gives 48% completion rate, noting NHSB usually achieves around 70% completion rate. NHSB are still sitting very high in comparison at 6% higher than the national completion rate.

iMatter goes live again on 30th May 2022 and starting the process of engagement with staff, encouraging electronic completion as well as sub-level reporting to allow managers to review across their remit to monitor performance. Jennifer confirmed iMatter will now be moving to Edwina Cameron, which sits nicely with Edwina's portfolio of OD work and Collecting Your Voices.

The Chair thanked Jennifer for her helpful update.

Sonya Lam thanked Jennifer for her hard work and asked in terms of reporting why was the timescale reduced from 12 weeks to 8 weeks? Sonya went on to ask once action plans are uploaded, how do we ensure teams enact and what difference does it make? Jennifer acknowledged the 8 week shorter response window could have impacted but pointed out that in the past most responses are usually submitted within 6-8 weeks, therefore anticipated

timescales were brought forward. In terms of cycle to see if enacted, the responsibility sits within each team and if no improvement seen then an engagement drop is expected in the following year, noting the new sub level access will prompt managers of low engagement within their services allowing them to support teams to progress.

Andy Carter thanked Jennifer and is looking forward to working with Edwina on iMatter. Andy confirmed he was disappointed with some of the statistics around action plan completion and engagement levels. Looking ahead, where we will improve on pillars of staff governance, engagement, training and providing a safe environment for staff, Andy is hopeful our iMatter performance will improve.

The Chair gave huge thanks to Jennifer noting her passion and commitment and acknowledged that Edwina is taking over iMatter, adding that the SGC will fully support her. Clearly we need to do more over engagement and the Chair suggested a specific session at SGC around iMatter to look at what we can do to support engagement going forward. It was agreed to pencil in a workshop around iMatter out with this group and the SGCs commitment was noted.

The SGC was asked to note this update.

8. Workforce Dashboard

Bob Salmond shared the Staff Governance Workforce Dashboard Quarterly Report for March 2022, noting a shorter presentation as getting towards the end of the workforce statistics accounting period, based on the financial year, stating that the annual workforce report (expected May / June 2022) would show turnover and the KPIs on appraisals better.

The sickness absence rate in January 2022 was up from January 2021 but down month-on-month from a peak in September 2021. Noting this reports full sickness absence including Covid special leave, the report highlighted that in January, over a 12 month period, special leave has peaked at nearly 9% with the Covid aspect of this 3.49%. NHSB journey since April 2020 identifies peaks in January 2021 & January 2022 for Covid absence. Despite Covid, Mental health is the most prevalent reason for absence and continues to be high and increased again in the winter period. Muscular skeletal has increased similarly, lower than in Autumn but trended upwards in last month.

Recruitment seeing high activity processed 78 posts in comparison to 21 posts advertised pre-pandemic. Performance against 8 week to interview target sees a 63% achievement rate for posts filled. Since June 2021 national statistic looking at how long it takes to recruit staff from approval to commencing, against 116 day KPI, shows we achieved this target most months with an average of 107 days.

Bob requested any feedback on particular workforce statistics the SGC wished to be assessed in next financial year.

Sonya Lam queried around Covid rates and asked from January 2022 if have this had gone up or down? In reference to mental health and muscular skeletal reasons Sonya went on to ask if we have done all we can do or are there barriers, noting numbers quite high? Bob confirmed that weekly attendance reports over the last few weeks will show a peak in Covid absence due to the new BA2 Omicron variant, noting front line staff have found it particularly challenging over the last few weeks, with pressures on patient flow across the system and waits in ED exasperated by staff absence and clusters of Covid within the BGH and Community Hospitals; therefore, the next quarterly report is expecting a peak within the graph. In terms of the reasons for sickness, Bob acknowledged many interventions over the

last two years of Covid and the focus on staff wellbeing but stated there is no doubt it is a significant cost to the organisation and the mental health and wellbeing of our workforce.

Andy Carter stated he was Executive On-Call this week and noted lots of gaps within BGH wards and services as well as Primary and Community and Corporate Services. Andy confirmed recent conversations have taken place with Sarah Horan (Director of Nursing, Midwifery & AHPs) and Lynn McCallum (Medical Director) and the National Wellbeing Hub, highlighting lots of resources; specialist service for registered health professionals for mental health support, psychological intervention and first aid, coaching support and Swartz Rounds. Activity is going on to make direction to the support available clearer to our workforce in order for them to get support as quickly as possible.

Edwina Cameron agreed with Andy, referencing the work around psychological support with Caroline Cochrane and confirmed working together to get pictorial landmarks for staff to direct them appropriately; noting together working ensures smoother hand over when pass-over from coaching to additional psychological support is required. More and more staff are seeking coaching when stuck and tired, giving them an opportunity to stop and breath. Edwina confirmed work is underway with the Scottish Borders Council (SBC) around spaces for listening, working with managers in health and social care around providing the right support and a report is planned to look at what staff are saying and what we have in place.

John McLaren stated one of the challenges around signposting to the correct place was the time taken in recognising the need for resource, stating that frequently by this time the staff member is not working and do not have access to electronic resources or the NHSB *intranet*. John asked how we can ensure this access is on the *internet* to improve access, highlighting some obvious points of failure due to pressures and management needing more support in providing their staff with access to these resources and asked the SGC to consider this.

In relation to staff absence and the limited access to procedures, John felt that the organisation needs to discuss what we need to do to bring back staff safely and more timely, having considered all risk factors, and fast tracking staff through the services they need access to. John agreed there was a strong argument on both sides (patients / staff) but believes it's time to take this forward as part of staff wellbeing, noting this is not about jumping queues but proactive management of sickness absence. John asked the SGC to consider where we take this organisationally to take this forward.
Edwina confirmed the need to communicate and confirmed she would look at provision of support resources wherever we can on the intranet and internet. In terms of surgical procedures, Edwina understands that staff do get faster access to services if consultants agree and agreed we should look at this to support staff further.

Sonya Lam asked around the use of the 'Trickle App' by medical staff in terms of health and wellbeing. John confirmed this was being used currently and is coming up for renewal, pending a decision around funding from Endowments. Edwina confirmed the Trickle Ap is to remain within the training grade doctors as they have engaged really well. Recognising the success within this group of staff, going forward NHSB is looking at this for other groups as part of Collecting Your Voices. Bob endorsed Edwina's comments around training grade doctors being more IT literate, noting this group are the most surveyed part of our workforce (iMatter and National General Medical Council (GMC) Training Survey), and noted the need to prioritise feedback from the National GMC Training Survey as it is crucial in order to get this response right in terms of our commitment to the training authorities (Deanery & NHS Education for Scotland) and a quality training environment for our training grade doctors.

Sonya went on to comment around KPIs and workforce, referencing the action plan for the new workforce strategy and need to take new KPIs out of this. Sonya asked the SGC to look at this and consider what KPIs we would use for culture. Andy agreed the development of new KPIs in line with the new workforce strategy. In terms of culture, Bob made reference to the integrated workforce plan, delayed since March 2021, confirming it will be published in draft form by July 2022 and expecting nationally driven KPIs; stating our yearly workforce projections will be part of this workforce plan. The Chair thanked Bob for this, noting they will be interesting statistics to see.

The SGC was asked to note these updates.

9. Staff Governance Committee Meeting Schedule 2022-23

The SGC schedule was shared, noting it is intertwined with the WGG schedule, with the next SGC scheduled for Thursday 23rd June 2022

The SGC agreed the schedule for future meetings.

10. Any Other Competent Business

The Chair noted this was his last meeting before the local elections commence and thanked members of the SGC for their input and support, recognising the transformation of the SGC and felt he was leaving it in a better place than he found it. Andy Carter expressed his hopes for Councillor Parker in the coming local elections and his expectations that Councillor Parker will continue to Chair the SGC and thanked him for his involvement.

The Chair closed the meeting by thanking members for attending.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 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 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Public Governance Committee 11 August 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 11.05.22

PUBLIC GOVERNANCE COMMITTEE

NHS Borders

Minutes of Public Governance Committee (PGC)
Meeting held on Wednesday 11th May 2022 9.30-11.30
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive Director
Chris Lau, Volunteer Centre
Lynn Gallacher, Borders Carers Centre
Margaret Simpson, Ability Borders
Graham Hayward, Vice Chair, Public Involvement Partnership Group

In Attendance:
June Smyth, Director of Planning & Performance
Clare Oliver, Head of Communications and Engagement
Carol Graham, Public Involvement Officer
Nicola Macdonald, Clinical Service Manager - Vaccination
Lynn McCallum, Medical Director
Karen Hamilton, Chair NHS Borders (left meeting at
Philip Grieve, MH Service Manager
L Pringle, Risk Manager
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting. Graham Hayward who is deputising for Fiona McQueen, Nicola Macdonald who is deputising for Cathy Wilson, Karen Hamilton attending as per the role of NHSB Chair

The meeting was recorded for purpose of minutes

2. Apologies & Announcements

Apologies had been received from: Cllr David Parker, Sharon Bleakley, Graeme McMurdo, Nicky Hall, Kirk Lakie

The Chair thanked the Committee for their attendance

The Chair advised that the meeting was quorate.

3. Minutes of Previous Meeting:

Section 5.1 – last paragraph – should read relevant HIIAs to come to this committee

The minutes were approved with that amendment included

4. Matters Arising and Action Tracker

Action 45 - Adult Changing Facility: This is to be reassessed as location of test & protect tent is needed to be reinstated as carpark rather than location for changing facility. There is no capacity within the PMO team to be able to provide a project manager at the moment. It is in the capital plan for this current financial year and will be prioritised. The original working group will be reconvened and locations will be re-assessed. As a priority it will be picked up in the first tranche of projects to be reallocated for activity. M Simpson will send designs to J Smyth for information.

Action 54 - Health Inequalities: This is now complete

Action 55 - Impact of Engagement: Impact evaluation metrics in strategy or approach to be included within last reporting period to be added to template. Working with the Public Involvement Pillar and involving the business units looking to ensure that all engagement is going to have metrics built into it to demonstrate how successful the engagement has been. A framework is being put in place. Further discussions are required regarding the information on the template to be able to give committee assurance or demonstrate the value of an engagement. Leave on action tracker

Action 57 - HIS Community Engagement. They have offered to give presentation to committee in August on role of supporting change and media service change. Leave on action tracker

Action 58 - Public Health Attendance. Confirmation that Fiona Doig will be able to attend the meetings from August and if not available will field a deputy.

Action 60 - Governance Development Session. Further discussion with Committee about roles and responsibilities linked back to the Terms of Reference. Leave on action tracker

The Public Governance Committee noted the action tracker.

5. Business Agenda Items:

5.1 Chairs Update

T Taylor informed the Committee that the items on the agenda form his update at this meeting and therefore will be discussed in due course.

The Committee noted the update

5.2 Public Involvement and Engagement Update

C Oliver highlighted to the Committee of a section in her report that listed some of the meetings that the team attend as part of their remit. There is a good cross section of third sector and voluntary meetings and workshops. We are focusing on building networks and relationships in these areas and looking to understand how we can work together, co-produce and collaborate.
There is lot of engagement work taking place across the organisation as we start to remobilise and recover. Service review work has been undertaken and working with partners in the individual business units ensuring we are there at beginning involving the public or other relevant stakeholders in the work they are doing. We can then make sure we

have public, patient, service user representation, relevant third sector and voluntary sector input into any service change planned.

A report from recent Public Involvement Pillar Workshop held in April, this has really good engagement and participation from the members and we are continuing to work on that. We are focusing on how we can use the What Matters to You Day in June and linking that with conversations with the public in relation to engagement on strategic plan.

A presentation that was given to the Future Strategy Group was attached. This is group who are a programme board and a subgroup of the IJB in relation to work required to be done on the refreshed strategic plan covering the period 2023-2026. Starting a conversation with the public about what is important to them now so we can look alongside the data provided by LIS, which is offshoot of Public Health Scotland, to inform the joint strategic needs assessment. Clare gave assurance to the Committee that they did challenge the Future Strategy Group around initial timescales set against commencement to engagement work. The timescale was such that the planning phase of the engagement was not adequate, the committee agreed and this will enable us to get everything in place before we embark on this piece of work. We continue to have resource challenges around our capacity to undertake engagement with NHS Boards and across the wider partnership. We have put out tender externally and 2 proposals have come in from providers in the third sector, they would support us to undertake this engagement. The benefit of engaging with external organisation to support this work is that they would be working with our third sector partners and membership of this group to ensure we can reach into networks, such as carers and volunteers. Further updates will continue to come to this Committee.

L O'Leary asked in regard on comment from Public Pillar Stakeholder Coalition that said time was against them at the meeting. As we move from remote to face to face meetings how will they manage the impact on level of ambition for such a large programme of work and how will they engage and get people to engage with them as we go forward. C Oliver replied that the outsourcing of work to external partners will be helpful. They will look at strategic planning to inform the plan within the timescale. We would probably look at organising meetings within each locality and the format of the meeting would be tailored around the audience we would be engaging with and also whether it is face to face or using MS Teams. Virtual meetings are easier to arrange but are aware that we will need to go to the communities too.

L Gallacher stated that the care village have asked her for engagement about what the building should look like but there has not been engagement whether a care village is the right approach and where the money should be invested within this. It feels like the first step been missed. J Smyth responded that she has now joined the Care Village Programme Board that SBC set up to oversee the development of 2 care villages. At the most recent Programme Board the Terms of Reference was revisited including all subgroups and the engagement group. SBC have acknowledged that when the decision was made to create the 2 villages in Tweedbank and Hawick that they had not undertaken the pre-engagement work that they should have done and recognise now that they need to do that. They will take the conversations to the communities and have engagement with communities, carers and the local population. We will also ensure there is good health representation at the various subgroups.

J Smyth also added that NHS Borders was unaware of these decisions until after SBC announced the 2 facilities. There is timeline attached to development of business case which is driving this work to be done at significant pace. We will be able to influence the type of engagement activities that happen now. The exact model is yet to be determined but IJB is commissioning the development via SBC and they are committed to these 2 new facilities. M Simpson confirmed that Ability Borders had heard nothing about the

development either and they are getting feedback from public about the need to collaborate with partners.
L O'Leary stated that the IJB is the body that will be commissioning the model of care and what happens in the care villages and to provide reassurance that there have been discussions about how we do engagement as an integrated board with health and social care and would suggest inviting the Chief Officer Chris Myers along to a future meeting. L McCallum suggested that this group should formally feedback the discussion from this meeting to Chris Myers. Lynn also added that there has been concern about the lack of clinical engagement and the geriatricians and older mental health team would be beneficial, we were unable to influence this earlier but there are definite plans to engage as we move forward.
C Oliver added that SBC have reached out to external providers to look at undertaking some of the engagement and consultation work.

T Taylor suggested that members list the key things they would like contained in the correspondence by end of this week, he will then draft a letter and circulate it to the group. Need to be specific about what we would like to see here and whether we are able to ask that.

The Committee noted the update

6.1 **Terms of Reference:**

The committee approved the Terms of Reference with the suggested amendments. The updated Terms of Reference to be sent to the Committee for formal approval and then for submission to Board Secretary for next update of the Code of Corporate Governance.

The Committee noted the update

6.2 **Self-Assessment Exercise:**

Follow up from discussion at last meeting. We have invited HIS to give presentation at August meeting around what they can do to support Boards and what Boards are responsible for as well in terms of involvement and engagement.
There was reference to Committee Chairs and Committee Secretariats getting together and if this committee is supportive we could suggest this and ask our Board Secretary to arrange something.

Another suggestion was about holding development sessions for Committee members. It is common practice for committees to take development time out as well as doing normal committee business. It gives chance to talk about things in more detail and revisit the aims and purpose of the committee, particularly as new members join the committee. We are proposing to do this on the back of the self-assessment. We do recognise that time is precious and rather than put additional commitments into diaries, we are proposing to allocate some development or discussion space within each committee meeting. Taking 45 minutes for in-depth discussion or presentation relating to the aims of the committee and then the business as usual things like Public Involvement and Engagement Update and the Business Unit updates.

The first session would be from Health Improvement Scotland around their role, remit and support and their major service change rules that Boards have to comply with. We could then have something to do with Health inequalities which is linked to one of the strategic risks that sits under the remit of this committee. The was reference from last meeting about human rights based approach and we could look to go into more detail on that later this

year. If there are any other areas that the Committee would like to spend more in-depth time on we could accommodate that within the business cycle.

T Taylor asked the members if they want to provide a development session to make sure we are regularly updated on legislative and policy requirements in respect of health inequalities and public engagement. Tris asked if the committee were content to take some of the development time within existing meetings and are there partners we could work with locally from this committee or elsewhere to give a specific or national perspective. G Hayward responded that he would prefer a local perspective.

J Smyth commented that following the HIS presentation in August they could look for feedback to see if this approach worked, also June will discuss with the Business Units to make sure that their updates are received and focussing on any key questions that committee members have to be able to give time needed for more free flowing discussion.

The Committee noted the update

6.3 **Strategic Risk Exercise & Risk Register: Lettie Pringle attended**

First bi-annual report of 2022/23 to this committee on strategic risks relating to public engagement and inequalities. The purpose of this report is to inform the committee of the 2 risks currently under their remit where it is a requirement to provide a level of assurance to the Health Board as to whether these risks are managed appropriately and proportionately.

The last time this report came to this group in September 2021, assurance was not given as it was felt you did not have sight of all the risks that affected public governance. The report has been adjusted so that it does have inclusion of updates from risk owners. A further recommendation is included to ask members if that are any further strategic risks they would like to discuss at future meetings. A full strategic risk register is included to assist in discussion.

There are 3 levels of assurance that can be given, assured / partially assured / not assured.

T Taylor commented that there is action plan for the public involvement risk based on the quality management system pillar work. Updates have been brought to this committee about the development and ongoing work and is assured on this risk.

The health inequalities risk, there are some concerns as there is nothing in the action plan to address the gap where we are not allocating resources proportionate to need with respect to inequalities. Also note that there is lot to be scrutinised on this risk but no details have been set before this committee in the last year. Tris noted that there is no assurance on this risk.

L Pringle reminded the committee that we are not able to give assurance for one risk and not another and in report to Health Board we give 1 level of assurance. Tris confirmed that the committee are partially assured.

There are 5 risks on the register that may be of interest to this committee and Lettie to bring back to future meeting:

- Risk 2958 Public Involvement in remobilisation
- Risk 1585 Effectiveness of Partnership working
- Risk 1593 Implementation of Clinical Strategies
- Risk 1589 Missing financial targets
- Risk 3405 Digital provision

The Committee noted the paper

7. Monitoring & Performance Management

7.1 Clinical Board Updates:

Acute: Report for noting, apologies were received for K Lakie and was unable to field a replacement for the meeting. Any questions or comments regarding the report can be emailed and shared virtually.
C Oliver shared that they have been supporting the Acute team with the Women and Children Service review. There has been excellent response from the public and we have had a number of volunteers who we do not currently work with. Kirk to bring more reflective report on Engagement activities.

Cancer Service Update: The Committee have received updates on Cancer services historically and has been on our workplan. The Acute team developing refreshed cancer strategy which will require more engagement as it starts. This will develop further across the whole system which will include some engagement work and Carol Graham has been involved in conversations. The Planning Team are also supporting this going forward and our local strategy will link into Lothian regional development of Edinburgh Cancer Centre, which will impact some of our patients and involve engagement activities. Further updates will come to this meeting.
C Lau commented that it would be interesting to see the group analysis of feedback and comments from patients which will inform the development of the services and what improvements have been made.

Mental Health: Philip Grieve attended the Committee.
Scottish Government had delegated funds for Mental Health and Well Being within Primary Care. Steering Group meetings are in place and there will be local oversight group and a wider stakeholder event will take place. We are working closely with Clare's team on public engagement co-production and looking at strategy for the next 4 years.

Within Adult Community Mental Health Teams there was multi agency collaboration which has been referenced in previous reports, around the staying well actions plan for people with difficulties, a local launch will be organised.

There are ongoing meetings in relation to Peer Worker and Volunteer collaborative to present paper for Mental Health Community funding in August. This will allow larger scale peer to peer training of 30-45 peer workers and volunteers which will continue to contribute and support the formation of a peer collaborative within the Scottish Borders.

Working with carers and internal services to collate feedback as part of reinstated transformation programme aligned to the Adult Community Mental Health Team.

With regard to the perinatal element of our service we are liaising with Nurture in the Borders to have people with lived experience to the overall strategy and champions group.

Gala Resource Centre has had small group discussion about the proposal that is currently in the options appraisal process and there has been continuous communication with people who have lived experience.
Borders Addiction Service have set up residential working group which involves 2 members of service and at least 1 service user. Have reached out to the service user to see if can secure their input and support into Borders Addiction local operational meeting too.

CAMHS have moved the stakeholder reference group, which is families and young people contributing to the redesign and progression improvement of the CAMHS service, this is now become business as usual within the service.

Working closely with Borders Care Voice in relation to carrying out an equalities and impact assessment on our recent 'did not attended' policy and 'second opinion' standard operating procedure.

C Oliver noted that MH are leading the way around collaborative working together and thanked them for working collaboratively with her team.

C Lau added it is good to be in touch with Care Voice and Health in Mind, they are good networks to get into. Chris asked what support would be in place for Ukraine refugees. Philip responded that an information pack has been developed for refugees when they come into the country. NHS Borders has a Ukrainian refugee oversight group to support this. MH would align this to normal clinical care pathway to access our services accordingly.

M Simpson commented that Ability Borders funded a specialist team to provide training and try and get some per training of young people with addictions so that they can support each other. This is piece of work we have found really beneficial and useful for them. Margaret to send copy of update and information to Philip, Clare and Fiona Doig.

Primary & Community Services: Nicola Macdonald attended for Cathy Wilson.

Earlston Health Centre - following a public consultation event in September feedback was received and collated by SBC. A follow-up is planned for 20th June 2022 now that the planning consent has been granted and plans for the public to see will be held in the medical practice. Consultation work will continue when we get final approval from the Board with local engagement and design elements.

Kelso General Dental Service practice application bid is being progressed and is ongoing.

Primary Care Improvement Plan workstreams are progressing well and the Community Treatment and Care Programme Board is now established with public member sitting on it.

Vaccination, the Covid spring/summer booster for 75s is due to complete on 30th June and the autumn/winter booster is planned to start in September alongside care homes and mass vaccination clinics. We have received confirmation for the Chief Medical Officer to deliver adults but not children. Awaiting feedback from the JCVI with regard to running Covid and Flu clinics together and we expect to hear later this month. Planning is underway for Shingles and clinics should commence mid-June.

External contractors have been commissioned to source shop front venues in the 5 identified locations. These were identified in conjunction with SBC at beginning of Covid for equalities using deprivation codes and where the higher populations were. Still working with SBC and Live Borders for planning for remainder of this year. When the new venues have been identified it will make it easier for members of the public to get to them.

Undertaking a Remote and Rural options appraisal in May for Newcastleton Practice, as this has been identified under the Scottish Government Urban Rural Classification where it would be best interest for the patients for the GP practice to continue giving vaccinations. Once the options appraisal is complete it will be sent back to Scottish Government for final decision.

Public Health: Report was submitted and no attendance at the meeting. There were no comments on the report

T Taylor thanked Philip and Nicola for attending and commented that it would be helpful to understand more about the scope of engagement and the Community Mental Health and Wellbeing work and are people being consulted or is there co-production. Across all the reports it would be useful to have some quantitative data even for the purposes of starting discussions.

The Committee noted the all the updates

7.2 Healthcare Improvement Scotland Community Engagement:
Report was submitted Sharon Bleakley has submitted her apologies. There were no comments on the report.

The Committee noted the update

8. Any Other Business:

Nothing to report

9. Future Meeting Dates 2022

11th August 9.30-11.30am

10th November 9.30-11.30am

All via MS Teams

NHS Borders

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Whistleblowing Annual Report 2021/2022**
Responsible Executive/Non-Executive:	**Sonya Lam, Whistleblowing Champion**
Report Author:	**Andy Carter, Director of HR and OH&S**

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

2 Report summary

2.1 Situation

The Board of NHS Borders is required to note the whistleblowing activity which has taken place in the preceding year. Whistleblowing is an important facility for NHS Borders employees, students, volunteers and independent contractors; allowing individuals to raise issues of concern with management, whilst providing employment protections for doing so.

2.2 Background

The Independent National Whistleblowing Officer (INWO) and associated National Standards became operational in Scotland on 01 April 2021.

Whistleblowing is defined in the Public Services Reform (Scottish Public Services Ombudsman) Healthcare Whistleblowing Order 2020 as:
"When a person who delivers services or used to deliver services on behalf of a health service body, family health service provider or independent provider (as defined in section 23 of the Scottish Public Services Ombudsman Act 2002) raises a concern

that relates to speaking up, in the public interest, about an NHS service, where an act or omission has created, or may create, a risk of harm or wrong doing."

This includes an issue that:
- has happened, is happening or is likely to happen;
- affects the public, other staff or the NHS provider (the organisation) itself.

2.3 Assessment

2.3.1 Quality/ Patient Care

Whistleblowing is a vital early warning facility for staff to address their concerns of alleged wrongdoing, where they feel that local line management are not giving an issue(s) appropriate attention.

2.3.2 Workforce

The opportunity to *blow the whistle* when an employee, student, volunteer or contractor sees or hears something which makes them feel uncomfortable is an important component part of the broader cultural framework. Colleagues are encouraged to speak up if they come across a matter which they feel demands further attention.

2.3.3 Financial

To not have a facility to blow the whistle on matters such as fraud or theft can expose servicer users, NHS Borders colleagues and the wider organisation to substantial risk.

2.3.4 Risk Assessment/Management

Whistleblowing is incorporated into the strategic risk *'failure of the organisation to have a culture, systems and processes in which staff feel safe and confident to speak up'.*

2.3.5 Equality and Diversity, including health inequalities

Whistleblowing is a facility affording all colleagues, regardless of background the opportunity to raise matters of concern to them which may be in public interest.

2.3.6 Climate Change

Actual or anticipated harm to the environment is a legitimate grounds for whistleblowing.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

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

- During planning & preparation for bringing in the new Standards, a short-life Implementation Group was established including representatives from the Higher Education sector and NHS Borders volunteering.
- The Whistleblowing Governance Group has been established to oversee application/awareness of the National Standards, to monitor whistleblowing activity and to consider learning from cases, when they arise.

2.3.9 Route to the Meeting

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

- The Staff Governance Committee considered an earlier version of this paper at its September 2022 meeting, offered feedback and approved its route to Board.

2.4 Recommendation

This paper is presented to the Board to comply with the INWO National Standards and is for the awareness of Board Members.

3 List of appendices

The following appendices are included with this report:

- Appendix Annual Whistleblowing Report 2021/2022

Whistleblowing Annual Report 2021/2022

1. Summary

1.1 In the period 01 April 2021 to 31 March 2022, NHS Borders has had one case of whistleblowing taken forward by an employee and a number of matters attended to as business as usual interventions.

1.2 In the same timeframe, a Whistleblowing Governance Group has been established and its' terms of reference agreed. The group is chaired by a Non-Executive Director of the Board, operating in the Whistleblowing Champion role.

1.3 In the same timeframe, a network of Whistleblowing Confidential Contacts has been established and appropriate training delivered.

1.4 During 2022/2023, NHS Borders will engage in further work to publicise the role of the Confidential Contacts and strive to make sure that more managers, supervisors, staff, students and volunteers understand what whistleblowing is and how concerns are taken forward. There will be further engagement with different parts of the independent contractor landscape to embed the INWO Standards.

2. Background

2.1 The new role of Independent National Whistleblowing Officer (INWO), which is to be undertaken by the Scottish Public Services Ombudsman came into effect on 01 April 2021. This provides a mechanism for external review of how a Health Board, primary care or independent provider has handled a whistleblowing concern. On the same date the National Whistleblowing Standards were formally published, and the "Once for Scotland" Whistleblowing Policy went live.

2.2 The National Whistleblowing Standards (the Standards) set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in these services, whether they are directly employed by the NHS or a contracted organisation.

2.3 The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow. Health Boards have particular responsibilities regarding the implementation of the Standards:

• ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
• ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
• working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

2.4 To comply with the whistleblowing principles for the NHS as defined by the Standards, an effective procedure for raising whistleblowing concerns needs to be: *'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'*

2.5 A staged process has been developed by the INWO. There are two stages of the process which are for NHS Borders to deliver, and the INWO can act as a final, independent review stage, if required.

• **Stage 1: Early resolution** – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
• **Stage 2: Investigation** – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

2.6 The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

• Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
• The experience of all those involved in the whistleblowing procedure
• Staff perceptions, awareness, and training

3. Areas Covered by this Report

3.1 Since the go-live of the Standards in April 2021, processes have been put in place in NHS Borders to gather whistleblowing information raised across all NHS services to which the Standards apply.

3.2 Within NHS Borders and the Health and Social Care Partnership (HSCP) any concerns raised about the delivery of a health service by the HSCP should be reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Borders. The Chief Officer for Borders Health & Social Care Partnership has specific responsibilities for concerns raised within and about primary care service provision. Mechanisms are in place to gather information from our primary care contractors and those local contractors who are not part of wider National Procurement contracts managed by NHS National Services Scotland.

4. Implementation & Raising Awareness

4.1 NHS Borders formed a working party to implement the Standards. The group started meeting at the end of 2020 and included representatives from Communications, HR, Occupational Health & Safety, University sector, Volunteering and Clinical Governance. The group was chaired by the Director of Workforce and stood down once the Standards were in place.

4.2 NHS Borders began raising awareness of the Standards with staff from March 2021 via Staff Involvement, Staff Share, All Line Manager emails and by attendance at significant staff meetings e.g. Medical Staff Forum.

4.3 Managers, supervisors, staff, students & volunteers were encouraged to complete the Turas training modules.

4.4 NHS Borders HR intranet pages have been updated to reflect the requirements of the new Standards, and include a staff guide to raising concerns.

5. Our Plans for 2022/2023

5.1 NHS Borders has transitioned from a policy known as 'Whistleblowing Arrangements' to the 'Guide for Staff on Raising Whistleblowing Concerns.' The former policy offered the Employee Director and Director of Workforce as the two main points of contact for significant whistleblowing cases. Whilst NHS Borders is not one of the larger Health Boards, with more than 3,000 staff and students, it was considered sensible to create a network of Confidential Contacts. Fourteen members of staff have stepped forward to be trained as Contacts. They represent a range of different job families and are based in different locations throughout the Health Board. There will be ongoing training & development of this network throughout 2022/2023.

5.2 NHS Borders intends to use the Speak Up Week in October 2022 to further raise the profile of whistleblowing, to publicise the Confidential Contact role & how to get in touch with them, and how to access training/information materials.

5.3 The Whistleblowing Governance Group (comprising Non-Executives, Directors, trades unions and Confidential Contact representatives) will continue to meet throughout 2022/2023 and intends to hear from Service Areas on how they have implemented the Standards, publicised the Standards and how they have handled any cases they may have had. Whilst there has been little whistleblowing activity within NHS Borders, the Health Board will better establish its quarterly reporting infrastructure; both to the Board locally and to INWO.

6. Whistleblowing Activity 2021/2022

6.1 There has been a single case of whistleblowing lodged during 2022/2022. The broad theme of the original whistleblowing concern was patient confidentiality. This led to a Stage Two investigation. The contact was made in early September 2021 and the final responses/letters from the organisation were issued to the parties in early November 2021. The parties were notified that it was not possible to adhere to

the INWO Standards timeframes (concluded in 20 working days) and this was due to the intensity of COVID workload at the time and lack of availability of an investigator. Following investigation, the whistleblowing concerns were not upheld. There was insufficient evidence to uphold the whistleblower's concerns. There has subsequently been a complaint made by one of the parties on how the case was handled. At time of writing, INWO are investigating this complaint.

6.2 There have been a number of concerns expressed by different parties which can be classified as business as usual. They were serious matters raised by staff which were attended to by members of the Borders Executive Team (BET). This included concerns expressed by a number of Senior Charge Nurses in the Borders General Hospital, senior Emergency Department staff, staff employed in the Medical Assessment Unit (MAU) and staff employed within Palliative Care. A combination of the Chief Executive, Medical Director, Director of Nursing & Midwifery and AHPs and Director of HR met colleagues involved, addressed the concerns and relayed what work was ongoing to resolve matters. Most matters revolved around the way services were configured during the COVID waves, work intensity and available resources. There is a paper trail linked to all of these engagements.

6.3 There was one concern expressed during 2021 which started through the whistleblowing route and then was channelled into the HR Policy framework. It considered the way one worker was engaging with another worker and was more appropriately handled through the Grievance Policy.

6.4 No anonymous concerns were received during 2022/2023. Anonymous concerns cannot be raised under the Standards and cannot be investigated by INWO.

7. Learning, Changes or Improvements to Services or Procedures

7.1 There was some organisational learning from the single whistleblowing case. It is not possible to expand further as there is a risk of identifying the parties involved in an organisation of NHS Borders scale.

7.2 There will surely be learning from the complaint which the INWO is handling.

8. Conclusions

8.1 NHS Borders is on an improvement journey around Whistleblowing and will be investing significant effort in developing the Confidential Contact Network further and providing an appropriate forum for those staff to share their experiences in a safe and confidential manner. Some Confidential Contacts have expressed an interest in developing skills in workplace mediation; skills deployed when workers experience difficult working relationships in an attempt to resolve differences of opinion.

8.2 Moving forwards, the co-ordination of whistleblowing activity may be moved from within the HR and OH&S Directorate to another directorate. HR are often involved in investigating matters and advising panels on a range of remedial actions, where things have been found to be in need of a management response. HR staff do

not wish to be compromised in this process and wish to retain a neutral position and facilitate good whistleblowing practice.

8.3 NHS Borders will explore the viability of commissioning whistleblowing investigating work from external parties including commercial bodies, charitable organisations or neighbouring Health & Social Care employers.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**NHS Borders Performance Scorecard August 2022**
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 waiting times trajectories submitted to Scottish Government as part of our Annual Delivery Plan for 2022/23, formal feedback in relation to the trajectories has yet to be received.

The scorecard also reports key targets and standards that were included in previous Annual Operational Plans (AOPs) and Local Delivery Plans (LDP).

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):

- Safe
- Effective

2 Report summary

2.1 Situation

For the purpose of reporting August 2022 performance the scorecard has been updated to reflect 2022/23 waiting times trajectories and "hot topics" in the main body of the document, and previous AOP/LDP measures being moved into appendices for information purposes.

2.2 Background

In 2022/23 Scottish Government moved away from commissioning any further remobilisation plans and instead commissioned a one year Annual Delivery Plan aimed at stabilising the system. To supplement this all Boards were required to submit waiting times trajectories but no other formal performance measures have been agreed, although RMP4 was rolled forward by Scottish Government for quarter one of 2022/23, whilst Boards developed their plans. It should be noted that some of the trajectories contained within the scorecard are subject to further refinement as we receive feedback or further messaging from Scottish Government.

2.3 Assessment

This is the first meeting that this further developed scorecard has been presented to NHS Borders Board and it remains 'work in progress' whilst this format is finalised and until we hear further from SG re any further monitoring arrangements for the ADP which was submitted as a draft at the end of July 2022.

Where services have been able to provide it, narrative is now contained within the body of the scorecard rather than within the cover paper and the narrative focuses on 2022/23 waiting times trajectories and hot topics which are currently:

- Emergency Access Standard
- Delayed Discharges

Any gaps in narrative this month are due to the scorecard being developed further, as set out above coupled with operational pressures within services. Service leads are continuing to work with Planning & Performance team members to develop a robust process for collating this narrative going forward.

2.3.1 Quality/ Patient Care

The 2022/23 waiting times 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 (HIIA) has been completed as part of RMP3/4 and services will carry out HIIAs as part of delivering 2022/23 ADP key deliverables.

2.3.6 Climate Change

None Highlighted

2.3.7 Other Impacts

None Highlighted

2.3.8 Communication, involvement, engagement and consultation

This is an internal performance report and as such no consultation with external stakeholders has been undertaken.

2.3.9 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** – performance as at the end of August 2022.

2 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 31st August 2022

Month 5 - August 2022

Contents Page

Area	Page
Introduction	3
Outpatient Waiting Times	4
Treatment Time Guarantee	5
CAMHS	6
Psychological Therapies	7
Emergency Access Standard	8
Delayed Discharge	9
Previous Performance Measures Appendix	10

Introduction

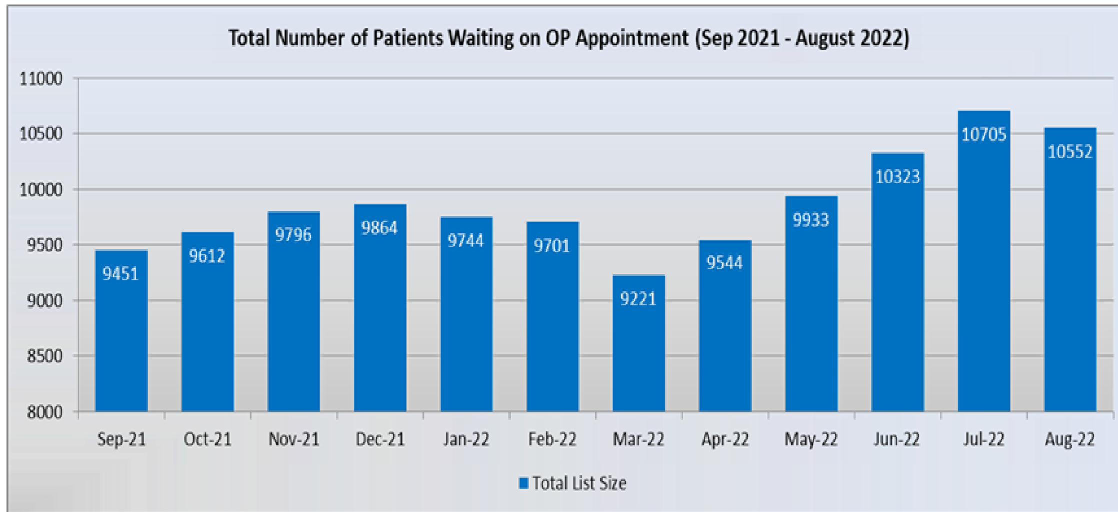
As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one year Annual Delivery Plan aimed at stabilising the system, to supplement this all Boards were required to submit waiting times trajectories but no other formal performance measures have been agreed.

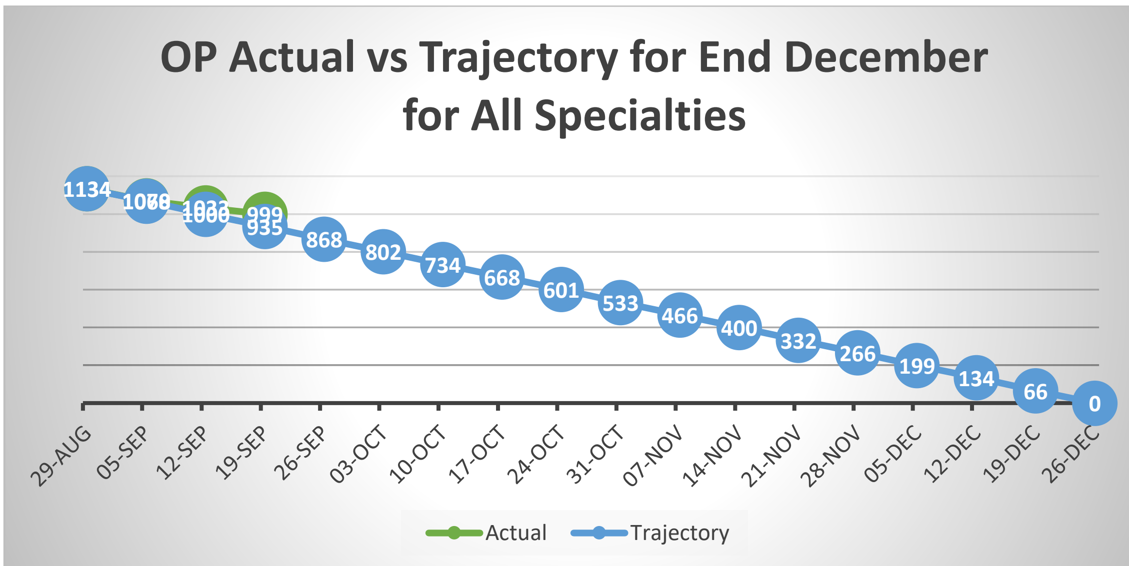
This report contains the 2022/23 waiting times performance and hot topic measures and an appendix which demonstrates AOP and LDP measures.

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).

Waiting Time Performance

Outpatient Performance Against > 104 Week Trajectory- Planned V Actual





What is the data telling us?

The outpatient waiting list size currently sits at 10,552 which is more than double to that pre-covid. The national target was to have no patients over 104 weeks for the majority of specialties which was achieved.

Why is this the case?

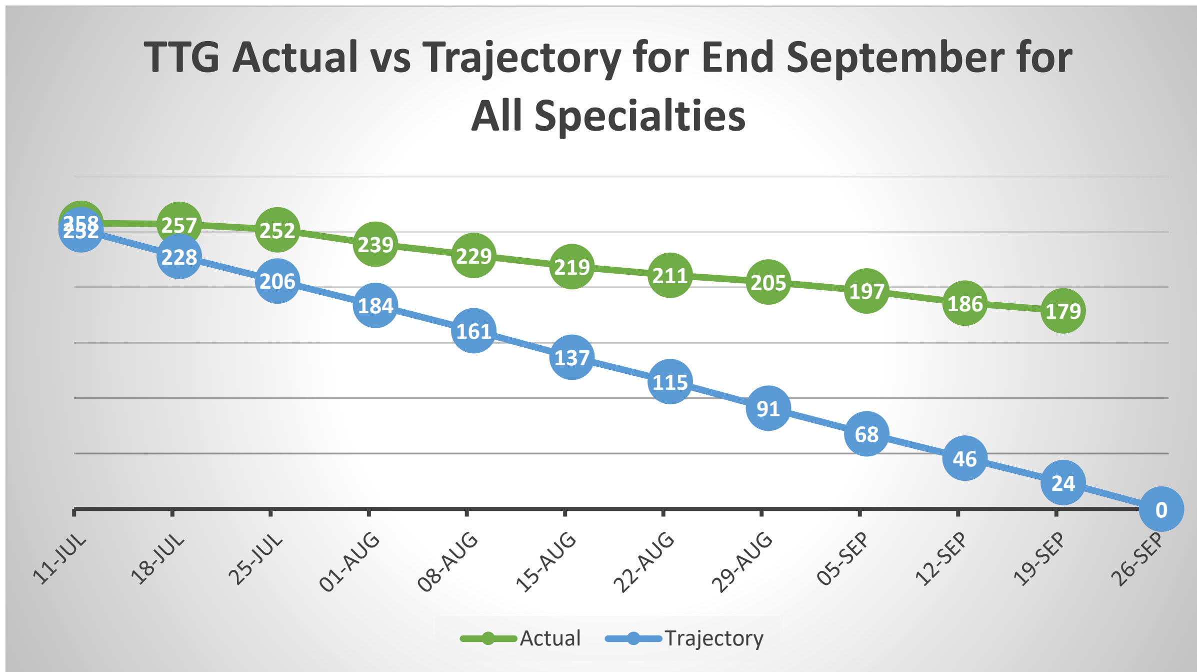
The 5 patients included 3 patients that were unavailable and 2 patients who cancelled appointments at late notice and so for whom we were unable to rebook in time.

The service is now working towards the second outpatient standard of no patient waiting over 78 weeks by the end of December 2022.

What is being done?

- Work is underway collating all specialty requests for outpatient rooms with an aim to accommodate all requests, including trainees with the aim of increasing activity.
- Development of a new booking process and compliance review process to ensure that all rooms are utilised, this will improve room availability and capacity.
- The majority of specialties have/are implementing Active Clinical Referral Triage and Patient Initiated Review. One the critical factors in this piece of work is the standardisation of these processes to reduce variation and enable us to monitor and improve patient pathways.
- The service plans to meet with Centre for Sustainable Delivery in during October to assess progress and prioritise support.
- ENT and General Surgery are in the final stages of implementing “Opt In” pathways with a view to providing good patient information so that patients can make informed choices to opt into specialist services, the hope is that this will reduce unnecessary appointments in the future.
- Services will be working with specialties to identify how clinical

TTG Performance Against Trajectory- All Specialties



What is the data telling us?

Currently there are 2463 patients are on the waiting list awaiting surgery. This represents a stabilisation in the numbers of people waiting. It is anticipated that there will be 150 patients who have waited over 104 weeks by the end of September 2022 (national target was to have no patients over 104 weeks in the majority of specialties).

Why is this the case?

While activity is well below core capacity, we have seen a consistent performance over a number of months which has allowed for the stabilisation. There continues to be reduced operating due to staff shortages in all areas and availability of inpatient beds, both contributing to our ability to remobilise to pre-covid levels.

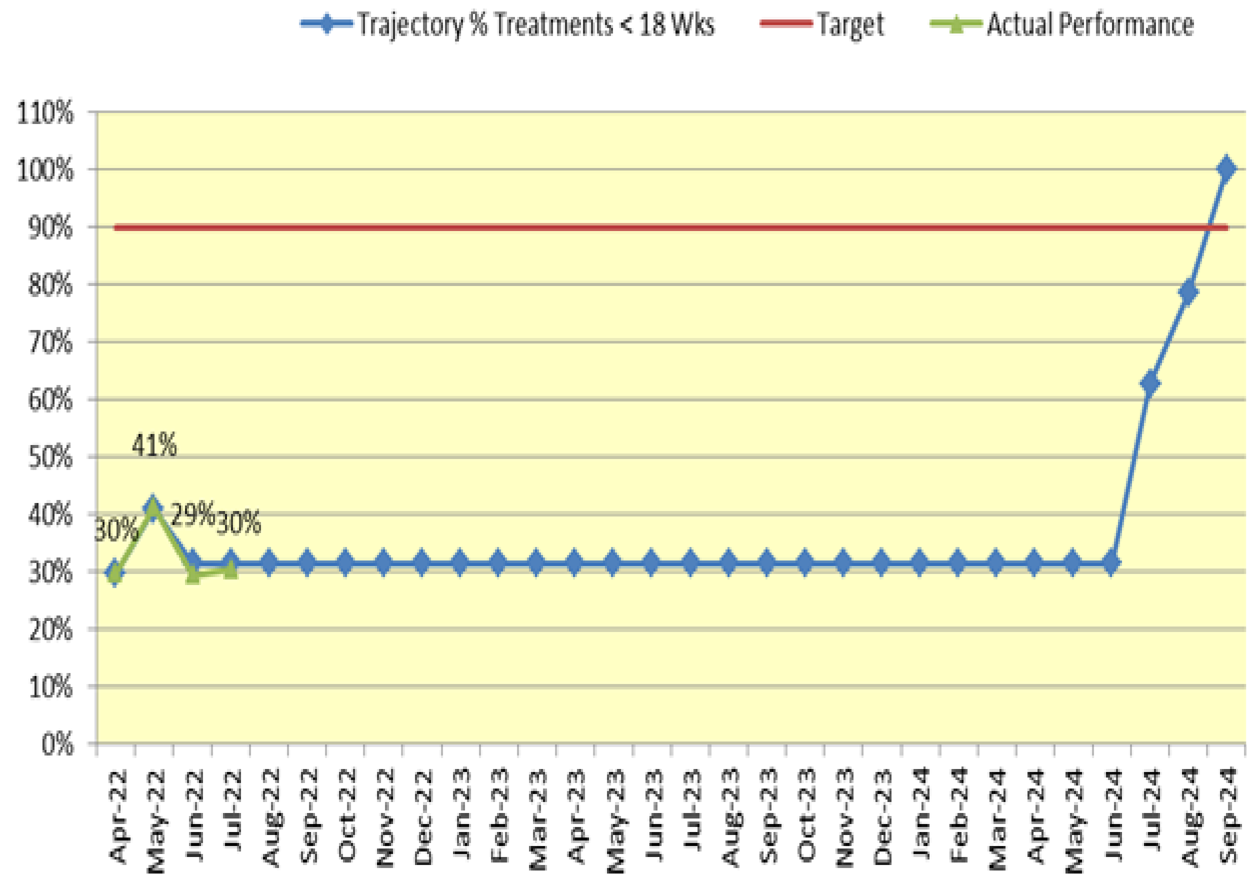
What is being done?

Ward 17 opened in August to increased day cases with two more phases planned:

- Weekday 23 hour admissions for patients requiring an overnight stay for part of the week being accommodated by **17th October 2022**. This will require a planned reduction of 6 inpatient in Ward 9 from 14th October 2022 to facilitate.
- Fully opening to support Inpatient elective operating over 7 days by **14th November 2022**. This will require a further planned reduction of 10 beds between the 17th October and 14th November to facilitate.

This will support increased operating activity by 10% in turn supporting treatment of our longest waiting patients.

Mental Health Waiting Times CAMHS



What is the data telling us?

In July the service achieved 30% of patients treated within 18 weeks, which has met the trajectory of 30%.

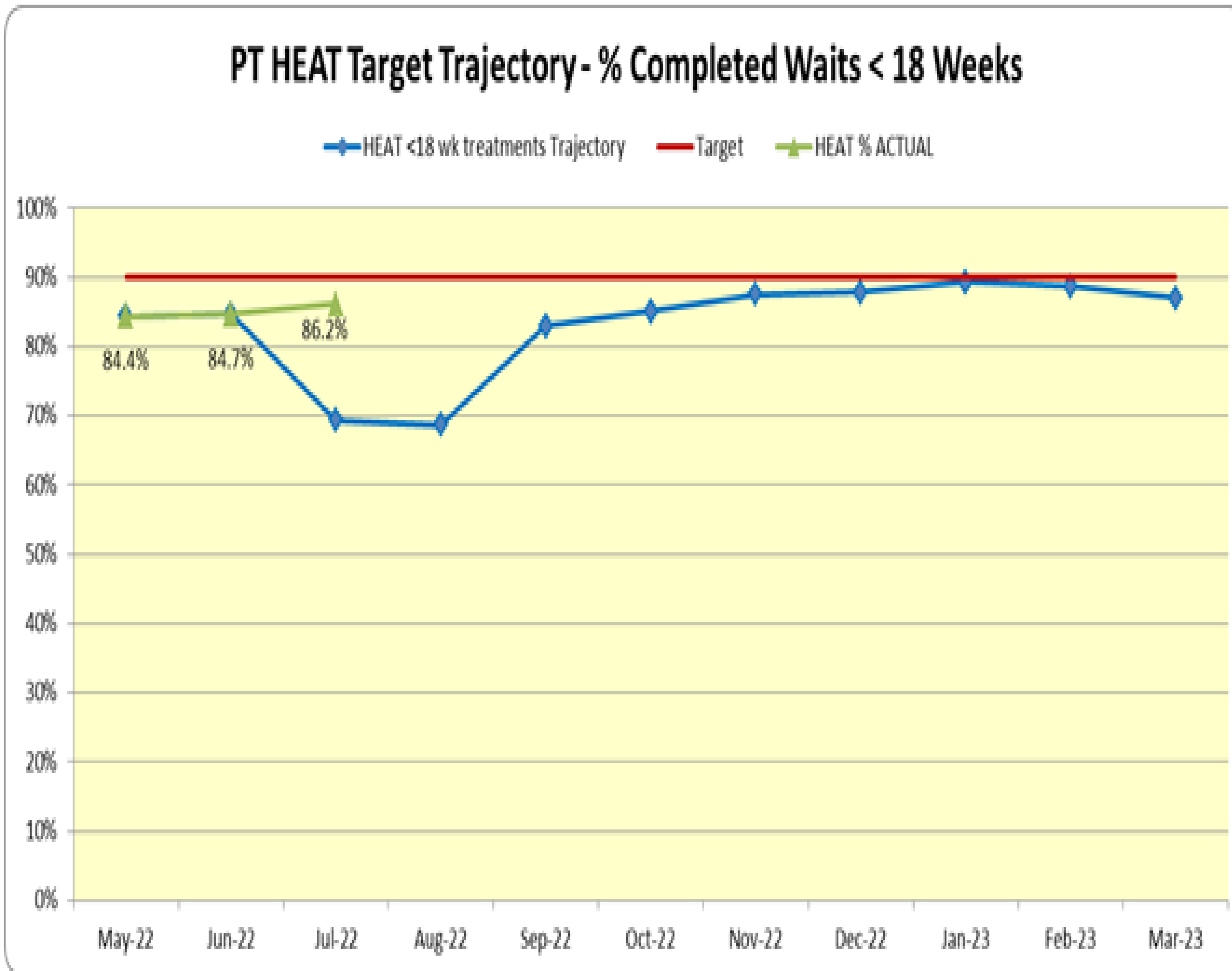
Why is this the case?

The Service has actioned a planning and waiting times initiative, this process was completed, and the first appointment letters were sent out week commencing 16th May. A robust recruitment initiative is ongoing with 82% of nursing staff in post and the remaining 18% waiting to start or vacant posts. Psychology is 69% with 31% either due to start or vacant posts. Administration is now 100% recruited. Medical is currently 100% recruited

What is being done?

The plan for New Patient Appointments (NPA's) commenced on 13th June and the service has been seeing 12 new patients per week (included in the 12 appointments 2 are urgent/unscheduled care appointments) this plan will be in place in order to see a minimum of 12 new patients per week 52 weeks of the year, this will be across all disciplines with a review in 6 months from commencement. A tagging process has been completed to determine those patients waiting to access the service with a view to determining appropriate signposting or establishing any possible interventions prior to a first appointment. This tagging process would be to support the reduction of the number of patients actually requiring access to the CAMHS service and potentially reduce the numbers of those waiting on the list. Access to specialist young person beds remains a challenge and continues to place a demand on the adult acute inpatient service.

Mental Health Waiting Times- Psychological Therapies



What is the data telling us?

In June the service saw 220 patients for their first appointment, 31 patients had waited longer than 18 weeks.

Why is this the case?

The group course programme is progressing well in both primary and secondary care and an improvement piece of work commenced in August 2022 to improve the regularity of courses being offered, we anticipate improving performance in 2023.

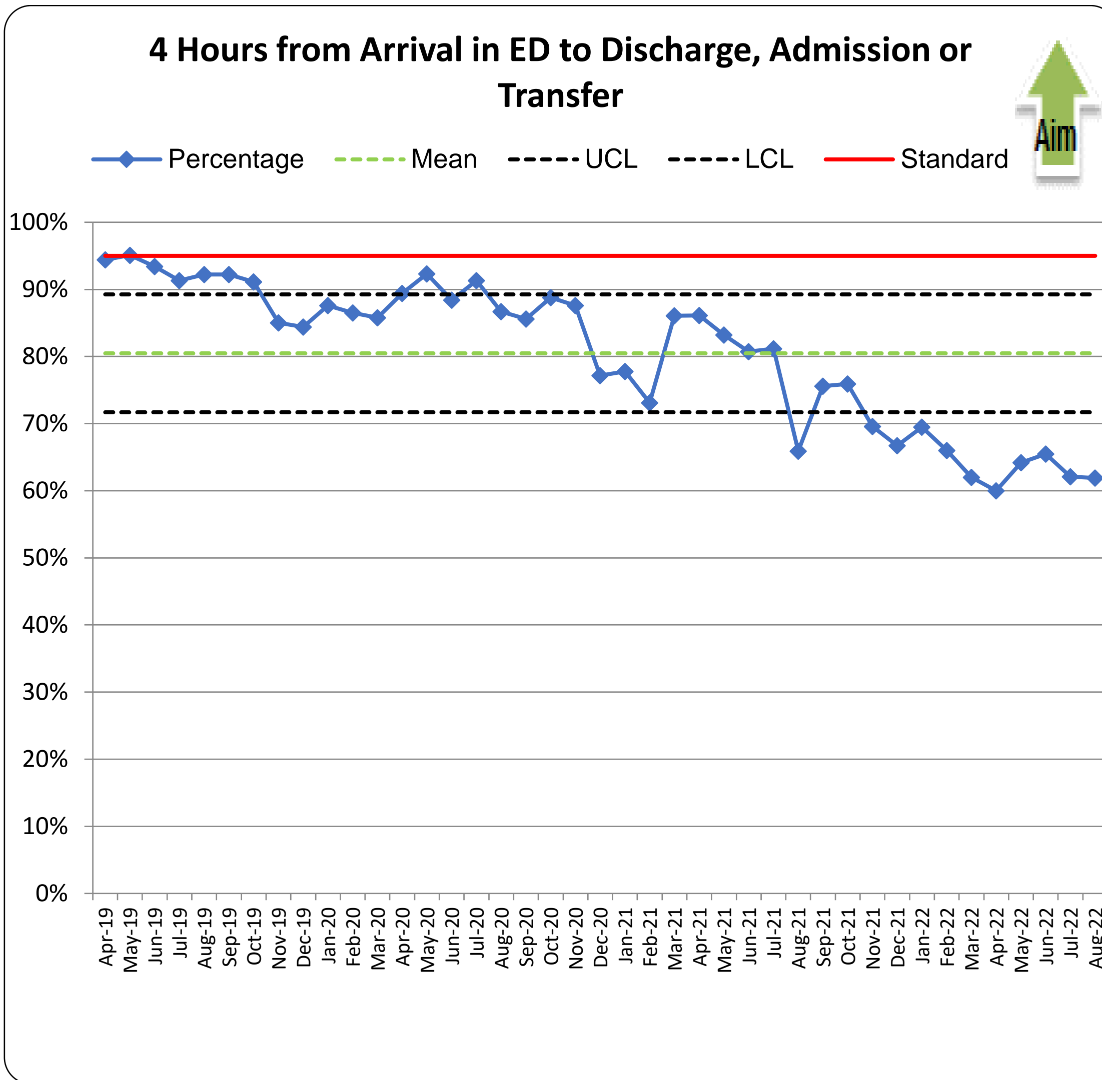
Due to staffing fluctuation in the Renew service and the impact COVID-19 has had on seasonal variation there may be a need to revisit the trajectory in October 2022.

What is being done?

The service is working to seeing the longest waits and significant progress has been made with those waiting for treatment over 26 weeks and 52 weeks.

Unscheduled Care Performance

4 Hour Emergency Access Standard Performance



What is the data telling us?
Performance in the Emergency Department for August 2022 was 64.61 % vs 62.2% in July 2022. This is an improvement of 3.5% on the previous month and a deterioration of 9% on August 2021.

We had 2851 attendances with 1009 breaches of our emergency access standard.

Why is this the case?

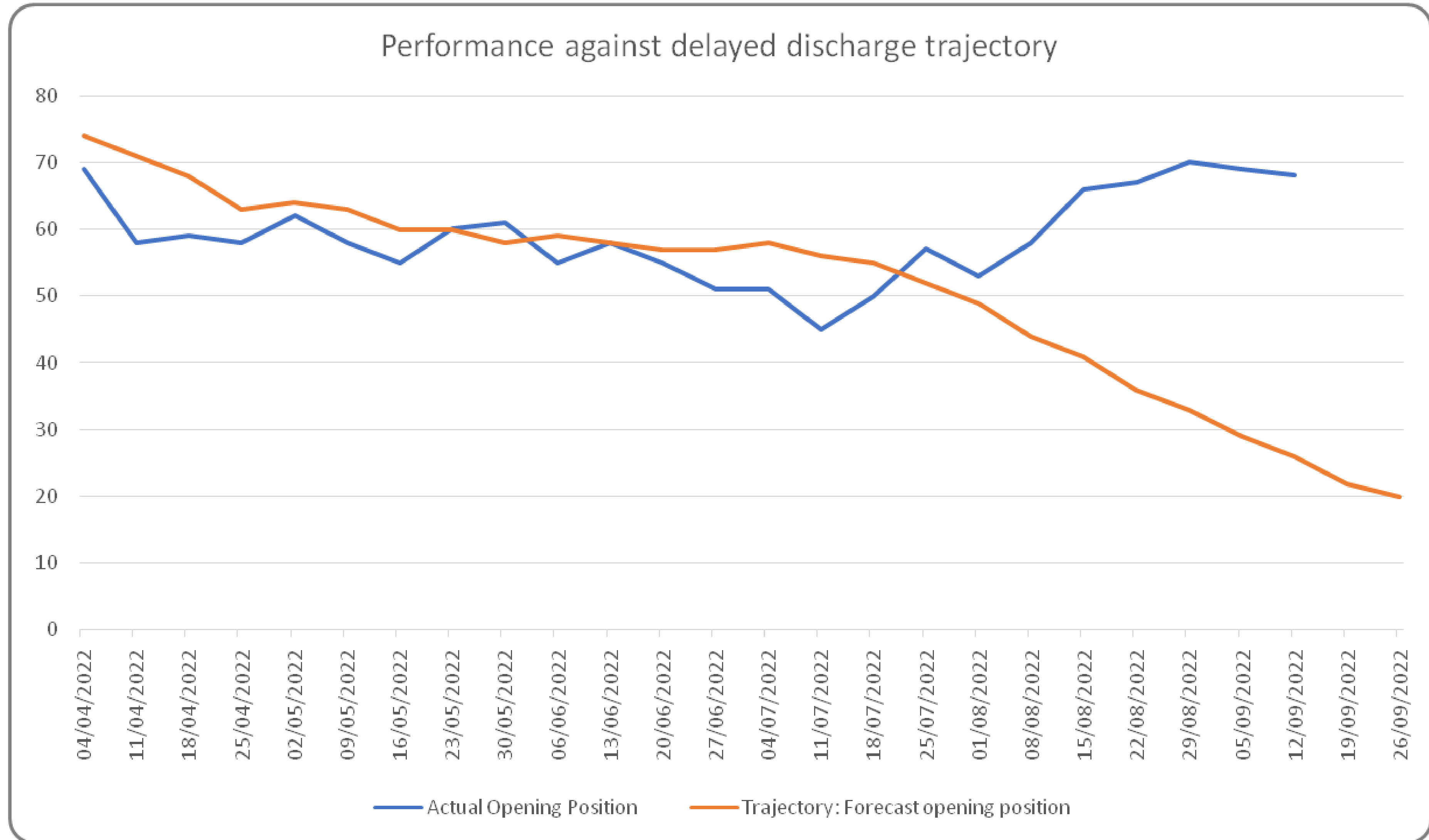
During the first half of August ED patients who required admission experienced long waits for a bed greater than 4 hours. This increase has been down the increased acuity that patients presented with alongside a lack of flow from MAU, Ward 7 and 9. There were two instances of a Full Capacity Protocol being enacted to relieve congestion in ED.

What is being done?

The Scottish Borders Urgent and Unscheduled Care Programme Board has been established and held its inaugural Programme Board meeting. This board will lead patient flow improvement and transformation across Health and Social Care. A full paper outlining the scope of the Board is planned for Resources and Performance Committee November 2022. Other key improvement activities underway include:

- In September a Kaizen event was launched within the Medical Assessment Unit (MAU) - this is aimed at facilitating rapid discharge and reducing MAU length of stay to improve flow from ED, early indications suggest this is having a positive impact and we anticipate this will be reflected in September 22 reported performance.
- A review is underway to revisit escalation triggers in Acute Services with a SLWG to ensure they remain adequate for ED ahead of winter – this is an MDT SLWG which will seek ratification from a wider MDT group once agreed by the working group. Small scale changes have been adopted in the way escalation is enacted by changing the duty manager model to a site lead model and ensuring escalations are made to SACT who have oversight of all moves

Delayed Discharge



What is the data telling us?

Current performance is above trajectory.

Why is this the case?

An average of 15.2 removals per week were needed to get us from our starting trajectory of 74 to 20 over a 25 week period. Due to significant risks and pressures in both health and social care, there was a loss of 51 against the planned removals from across bed based, non-registered care and increased flow initiatives. A number of mitigating measures have been offset by other pressures.

The drivers for delayed discharge and patient flow issues are complex and multifactorial, and span the HSCP. These include workforce / sustainability, associated impacts on capacity; service and system processes; along with challenges associated to increased demand and need.

Workforce - Workforce pressures across the HSCP are significant. Staff often migrate from the independent care sector to in-house care sector to health roles due to the respective terms and conditions.

Service and system processes - We also have a range of other significant challenges related to processes at a service and system level.

Demand - Demand continues to increase, and weekly additions continue to grow from 11.4 per week last year to 16.25 a week over past 8 weeks. Average weekly additions over the current trajectory have been 13.0 a week.

What is being done?

The Health and Social Care Partnership is working on a range of immediate and longer term actions to ensure that more people can be cared for in a more appropriate setting when they are medically fit for discharge.

Access to social care has been prioritised to the hospital system, but this leads to increased community unmet need. There has been significant work to increase efficiency (e.g. working with partners and reducing travel times), and over the last year have increased our homecare capacity by 16% (from 9,284 hours to 10,767 hours a week). We also have 46 interim care beds in place, with 37 commissioned externally and 9 in Deanfield.

There is extensive work ongoing to recruit. There have also been sustainability payments put into place to support social care provider sustainability in the context of current inflationary and economic pressures.

The HSCP Senior Management Team has undertaken a diagnostic of these issues and the associated problem statements and a large number of actions are being delivered and fed into the Urgent and Unscheduled Care Programme Board.

A new delayed discharge trajectory is currently being set to cover the period up to the end March 2023, assuming 14.0 average additions a week. A number of health and social care actions are being considered from a risk, feasibility and impact perspective.

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Contents Page

Area	Page
AOP/LDP Performance Key Metrics	20
AOP/LDP Performance Charts	21

Key Metrics Report – AOP Performance

Current Performance Key

R	Under performing	Current performance is significantly outwith the trajectory/ standard set	Outwith the standard/ trajectory by 11% or greater
A	Slightly Below Trajectory/ Standard	Current performance is moderately outwith the trajectory/standard set	Outwith the standard/ trajectory by up to 10%
G	Meeting Trajectory	Current performance matches or exceeds the trajectory/standard set	Overachieves, meets or exceeds the standard/trajectory, or rounds up to standard/trajectory

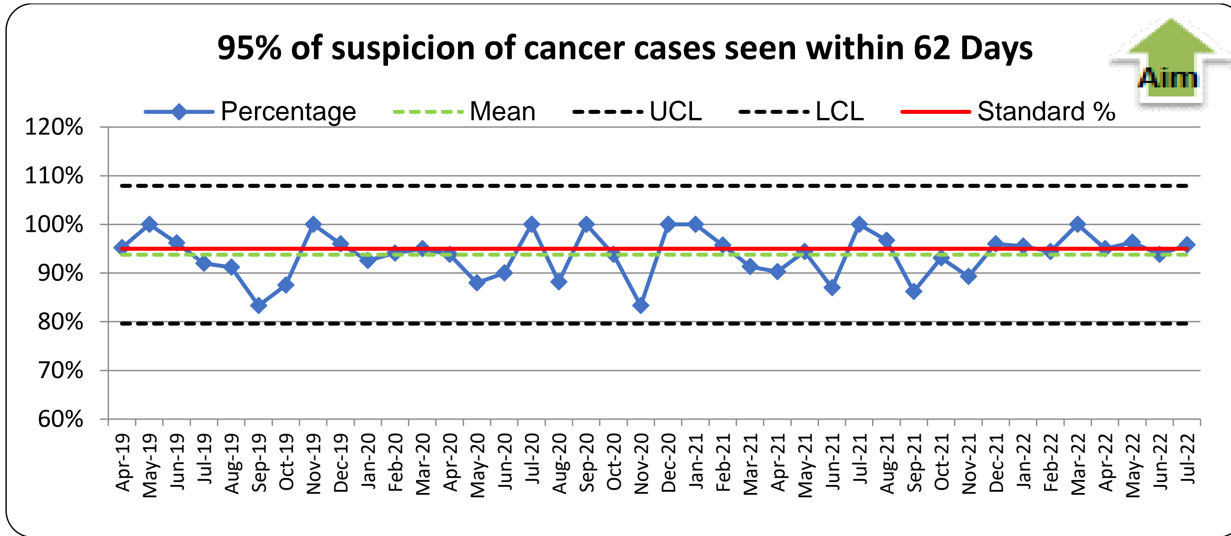
Symbols

Better performance than previous month	↑
No change in performance from previous month	↔
Worse performance than previous month	↓
Data not available or no comparable data	-

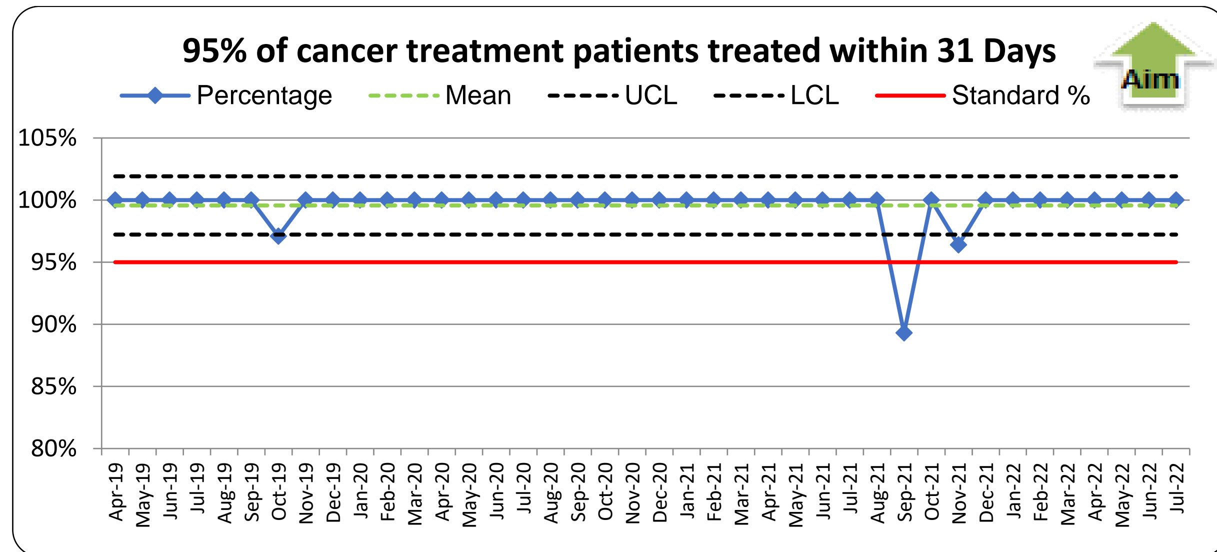
Key Metrics Report Annual Operational Standards

	Measure	Target/ Standard	Period	Position	Period	Position	RAG
Annual Operational Plan Measures	Cancer waiting Times - 62 Day target	95% patients treated following urgent referral with suspicion of cancer within 62 days	Jun-22	93.8%	Jul-22	95.8%	↑
	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Jun-22	100.0%	Jul-22	100.0%	↔
	New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Jul-22	6572	Aug-22	6645	↓
	New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Jul-22	1968	Aug-22	1936	↑
	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Jul-22	82	Aug-22	138	↓
	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Jun-22	76.1%	Jul-22	76.5%	↑
	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Jul-22	962	Aug-22	1884	↓
	CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Jun-22	29.4%	Aug-22	30.3%	↑
	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Jul-22	62.1%	Aug-22	61.9%	↓
	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Jul-22	36	Aug-22	46	↓
	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Jun-22	84.3%	Jul-22	86.2%	↑
	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	May-22	100%	Jun-22	100%	↔
	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Jul-22	4.70%	Aug-22	4.94%	↓

Cancer Waiting Times

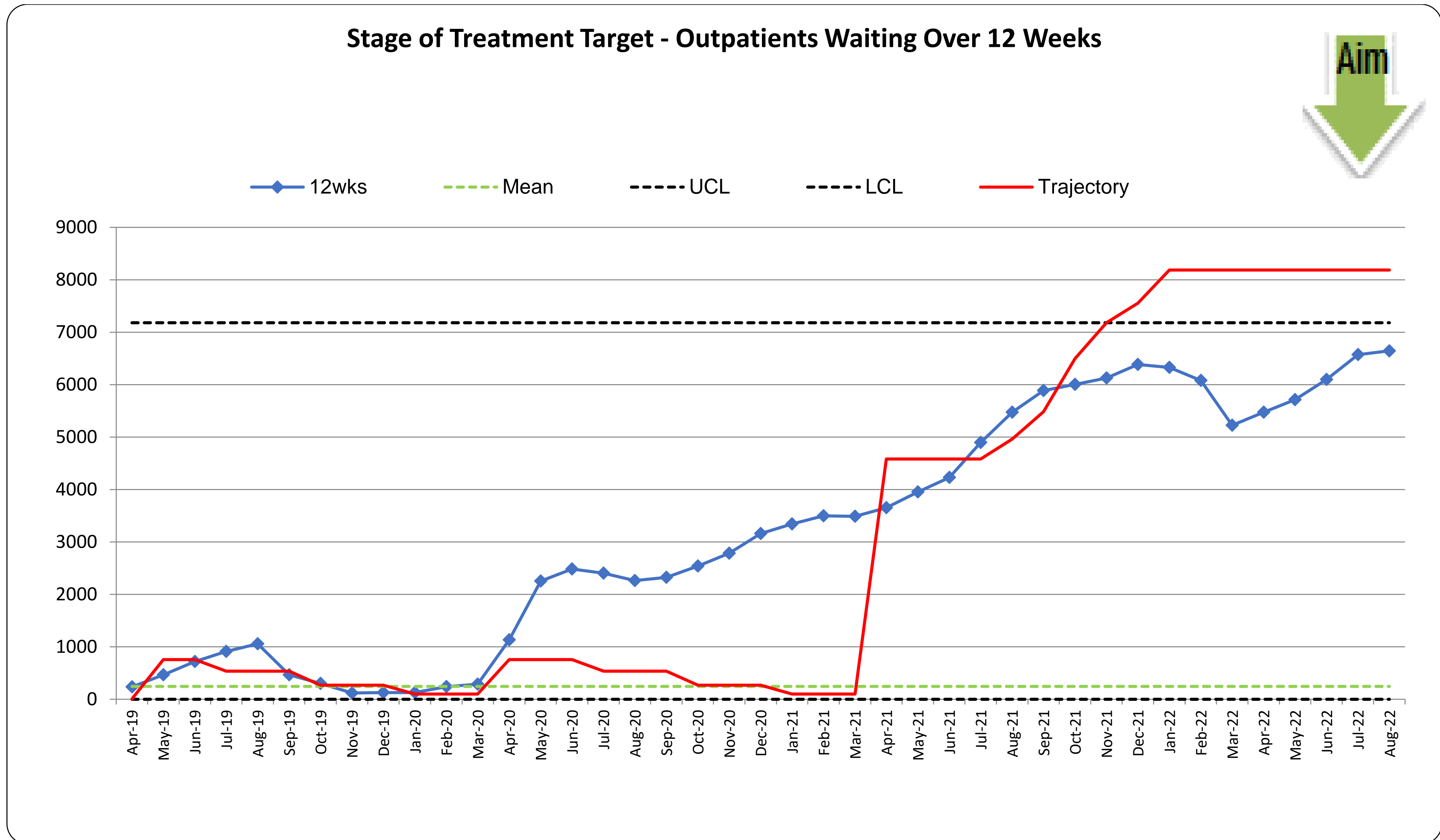


Latest NHS Scotland Performance
83.1% (Jul - Sep 2021)

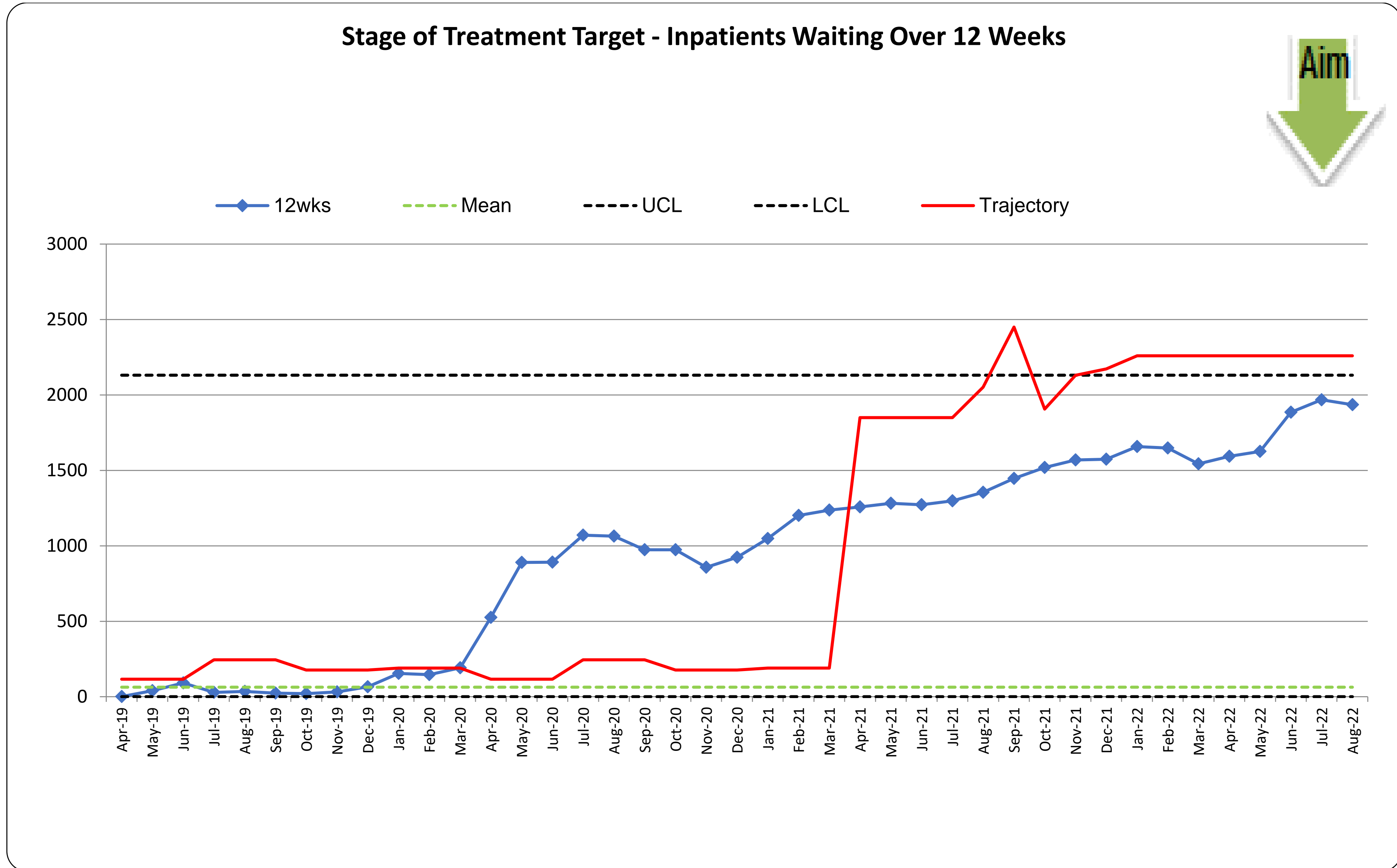


Latest NHS Scotland Performance
96.7% (Jul - Sep 2021)

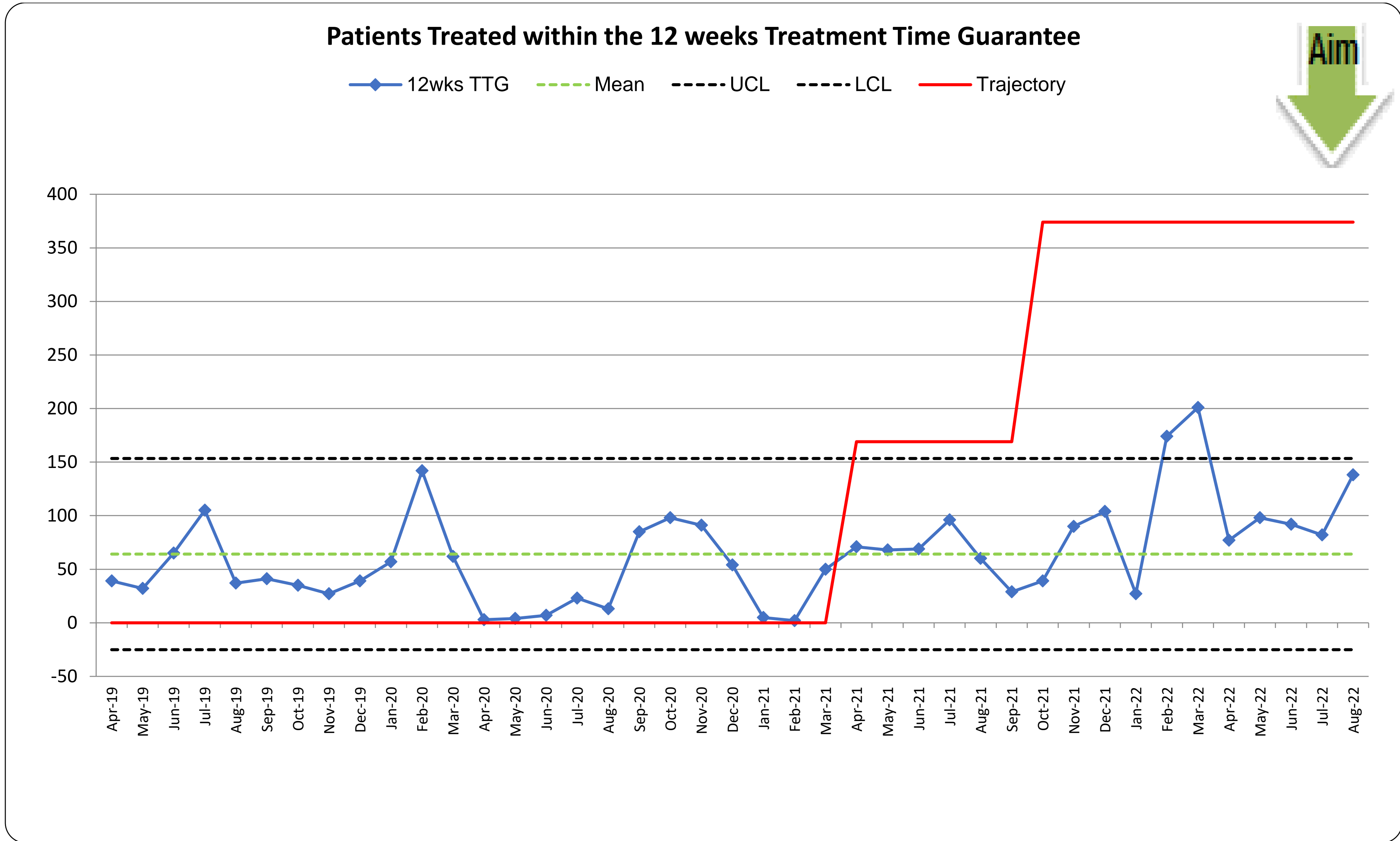
Stage of Treatment- Outpatients Waiting Over 12 Week



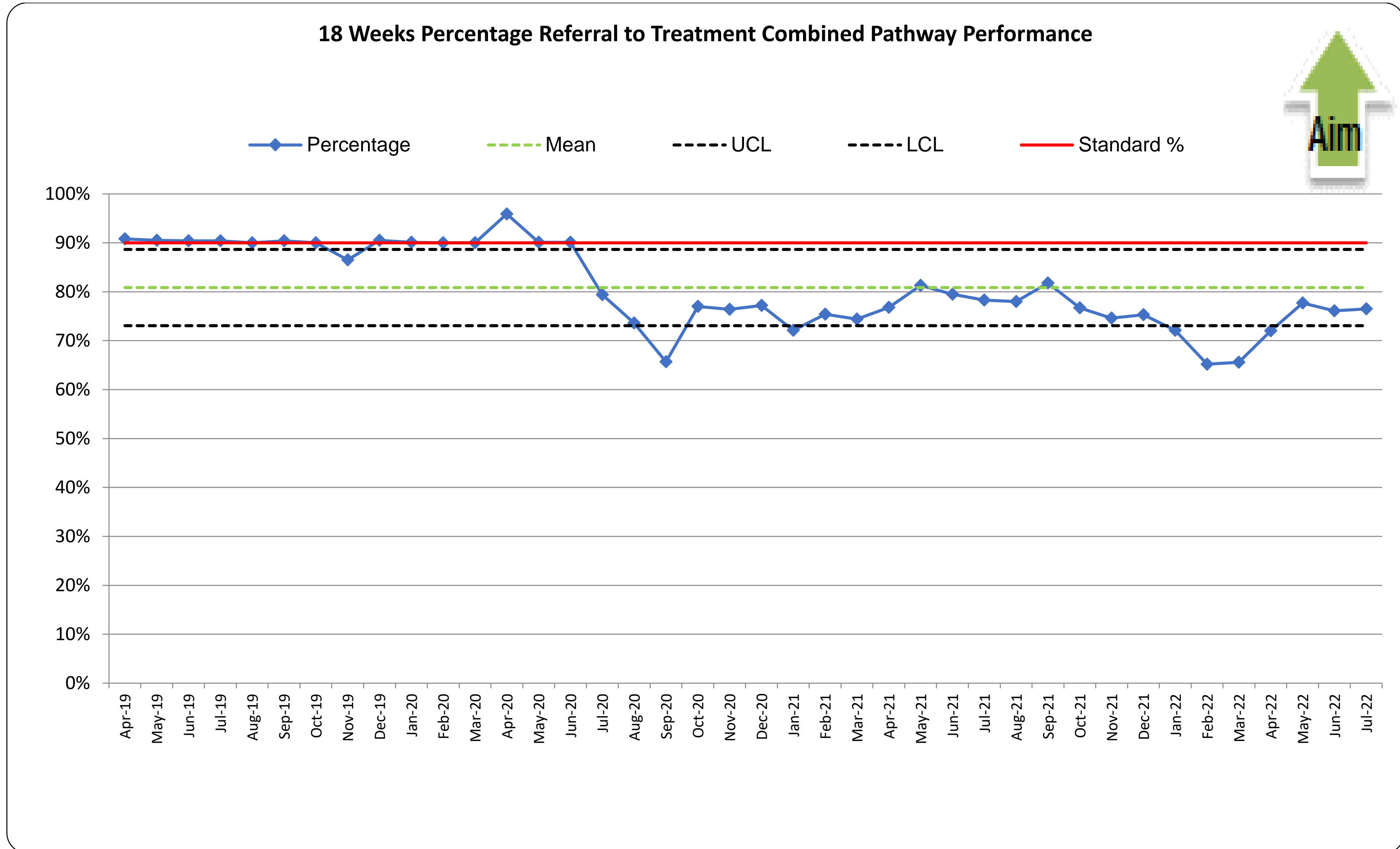
Stage of Treatment- Inpatients Waiting Over 12 Weeks



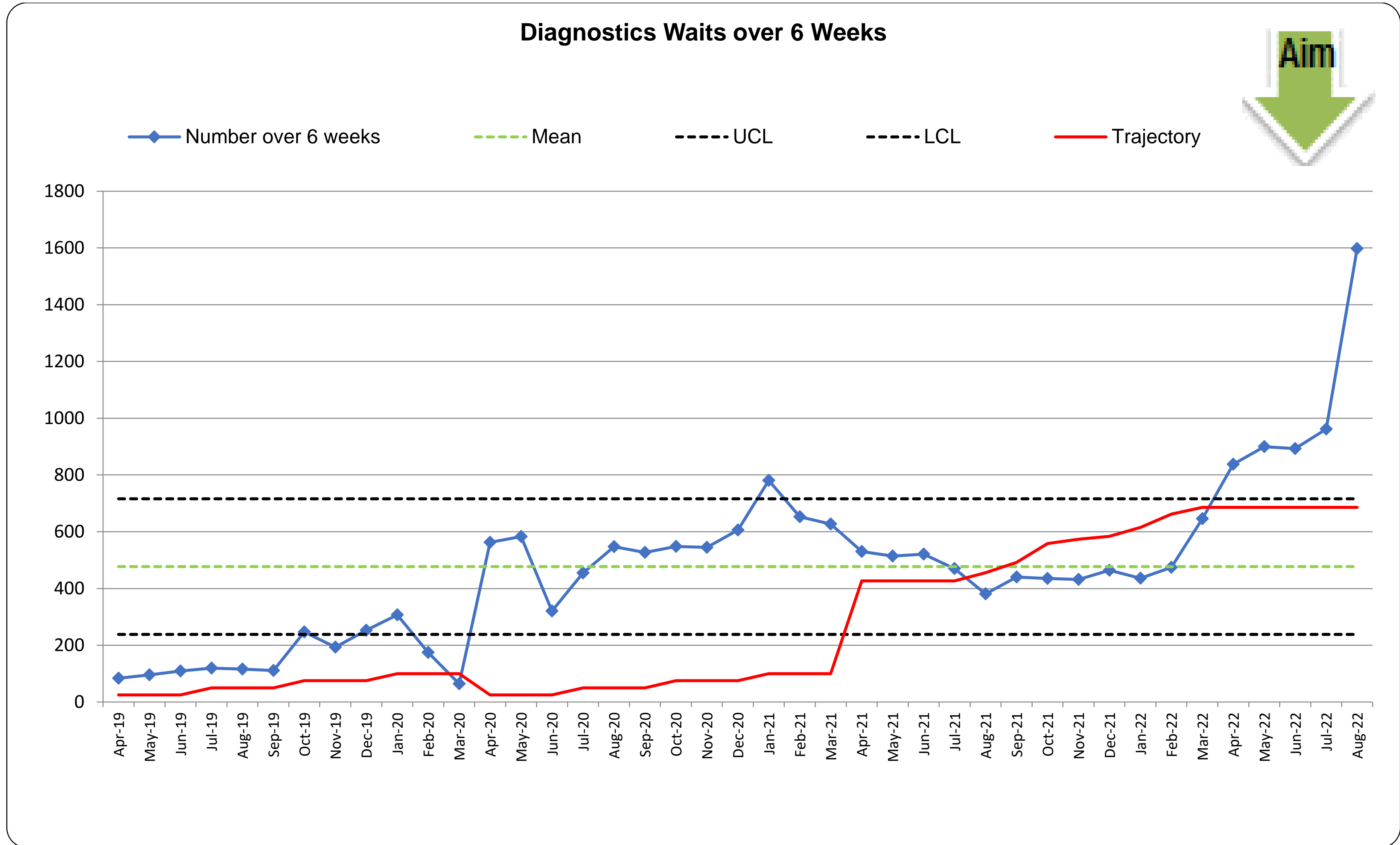
Patients Treated within the 12 weeks Treatment Time Guarantee



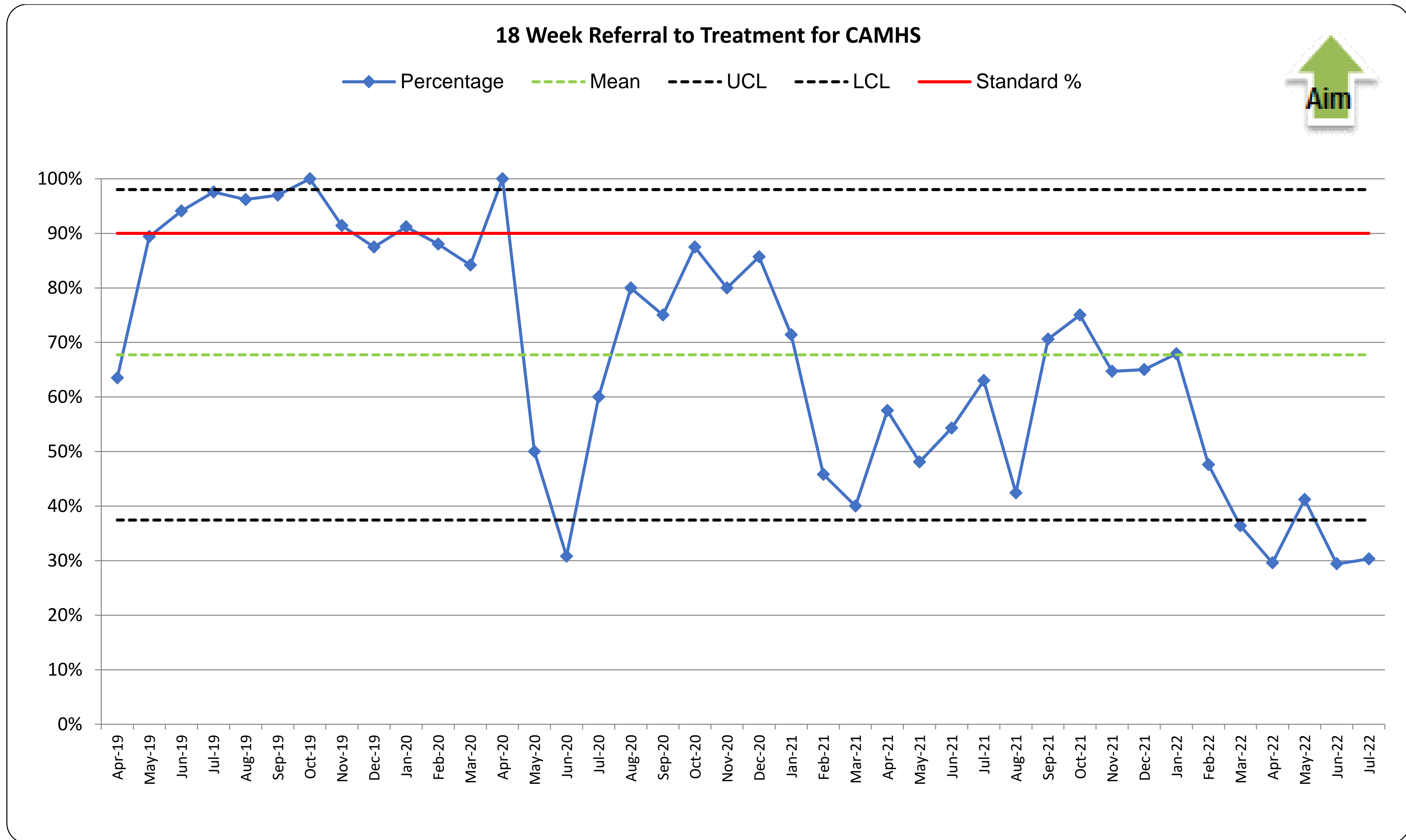
18 Weeks Referral to Treatment Combined Pathway Performance



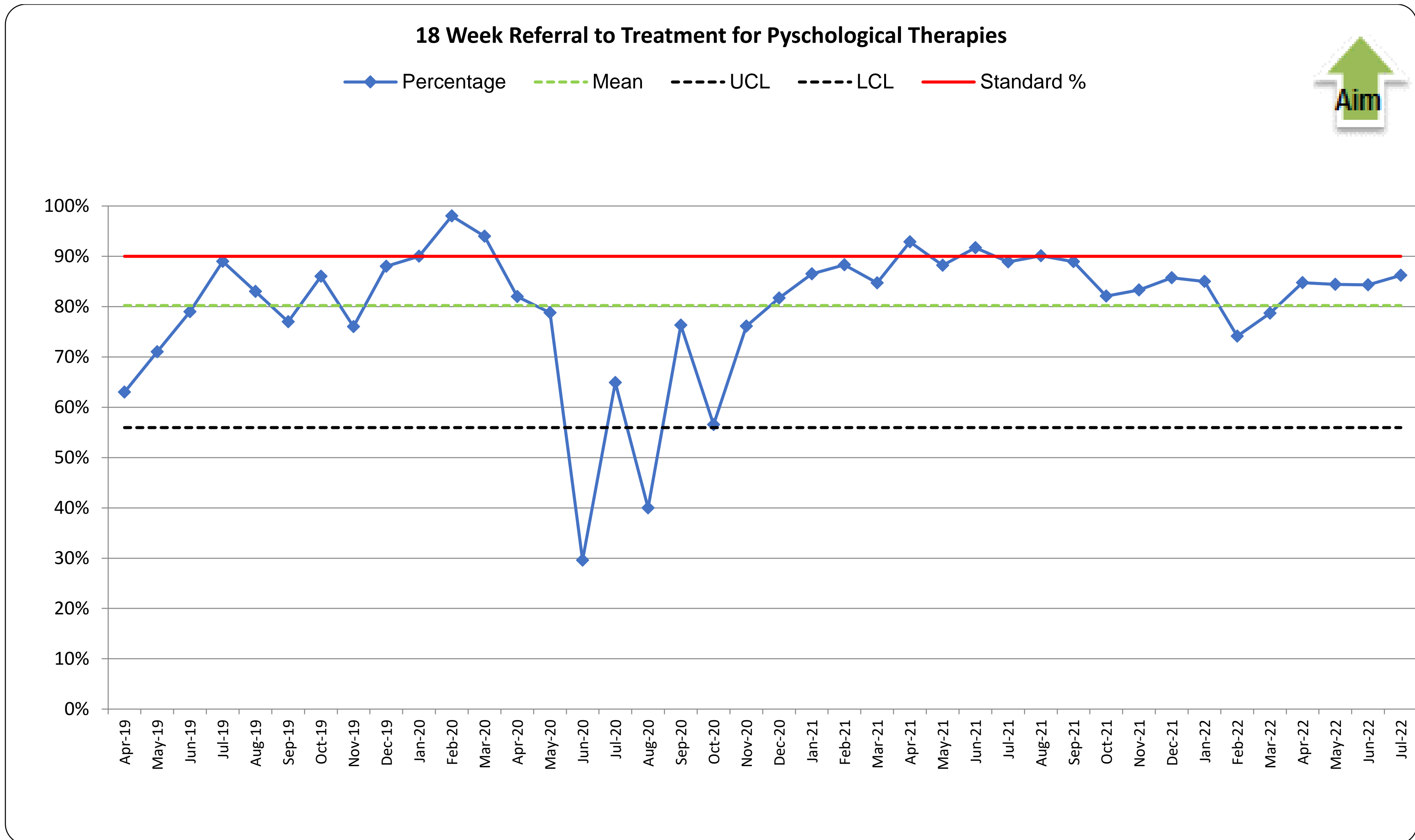
Diagnostic Waits



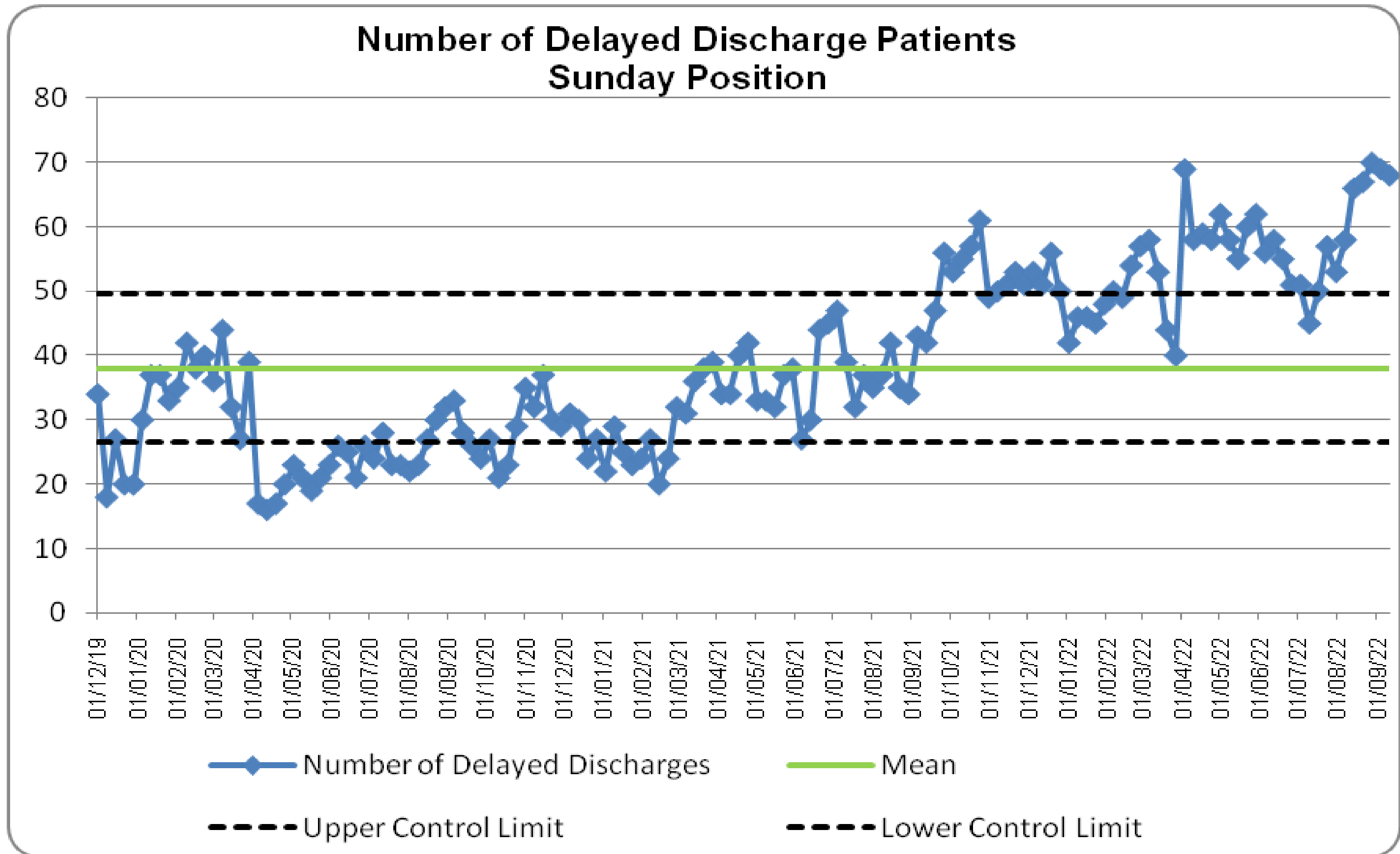
CAMHS Waiting Times- 18 Week Referral to Treatment

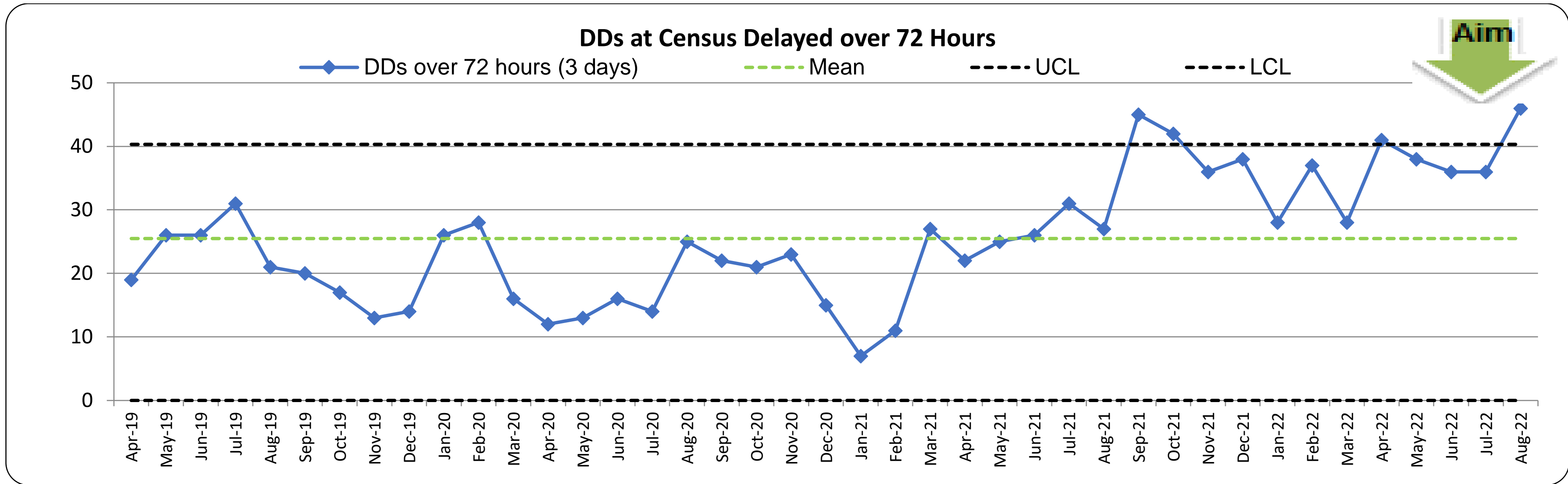


Psychological Therapies Waiting Times- 18 Week Referral to Treatment



Delayed Discharges




DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
50
40
30
20
10
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
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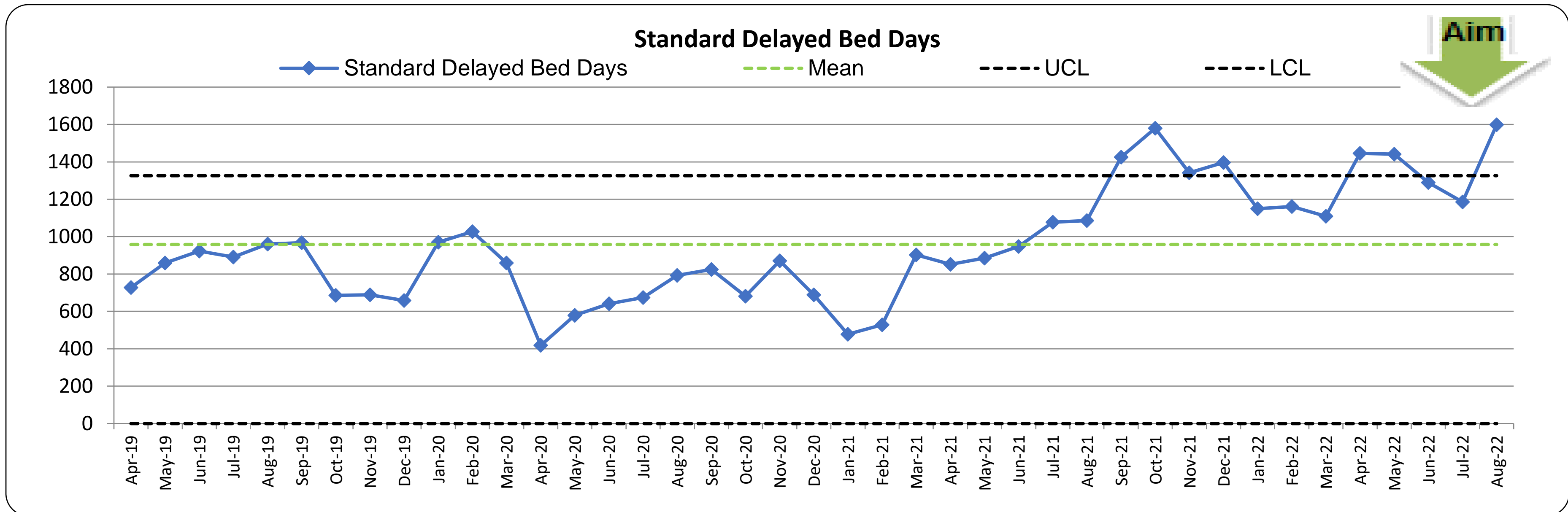
Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
1800
1600
1400
1200
1000
800
600
400
200
0
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
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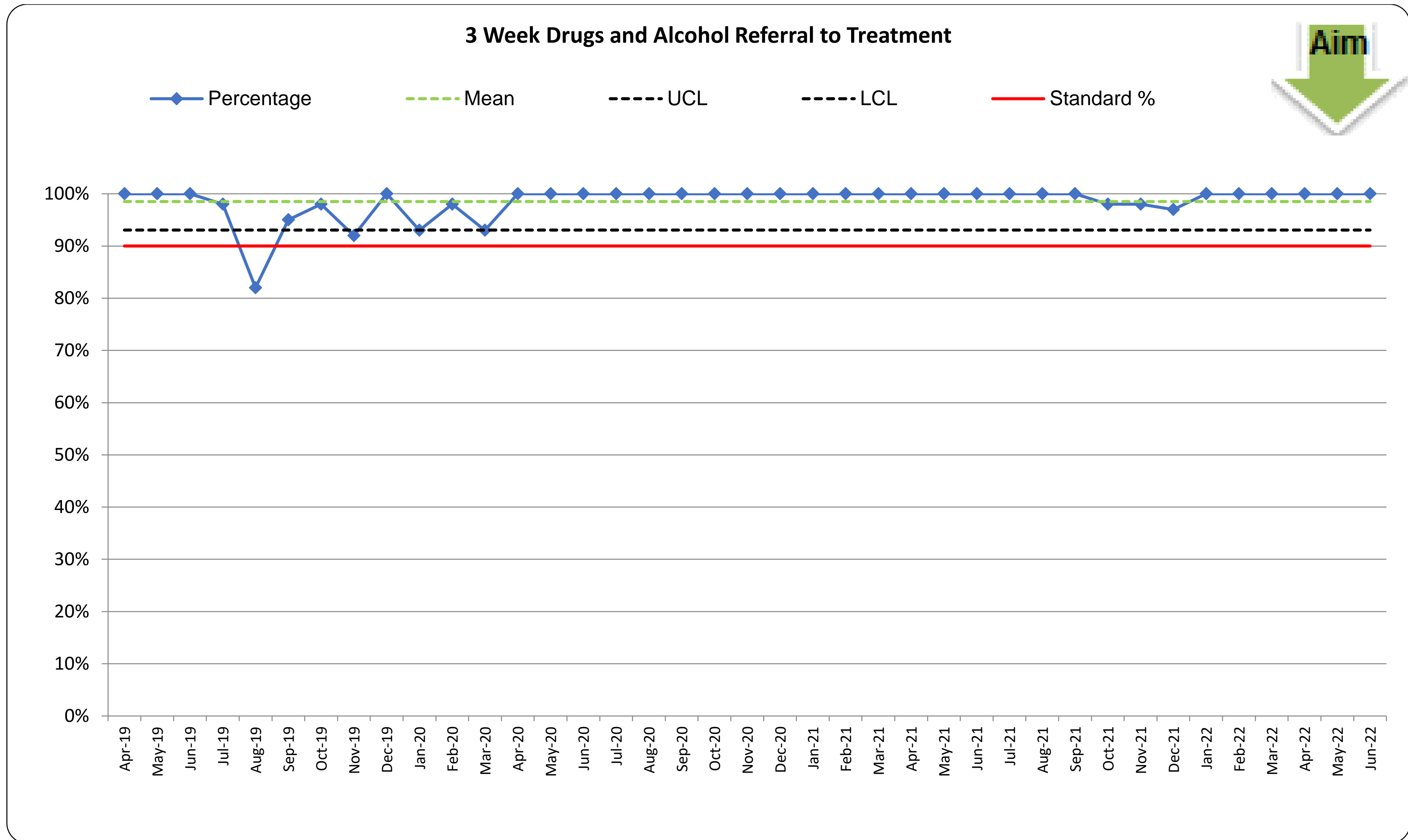
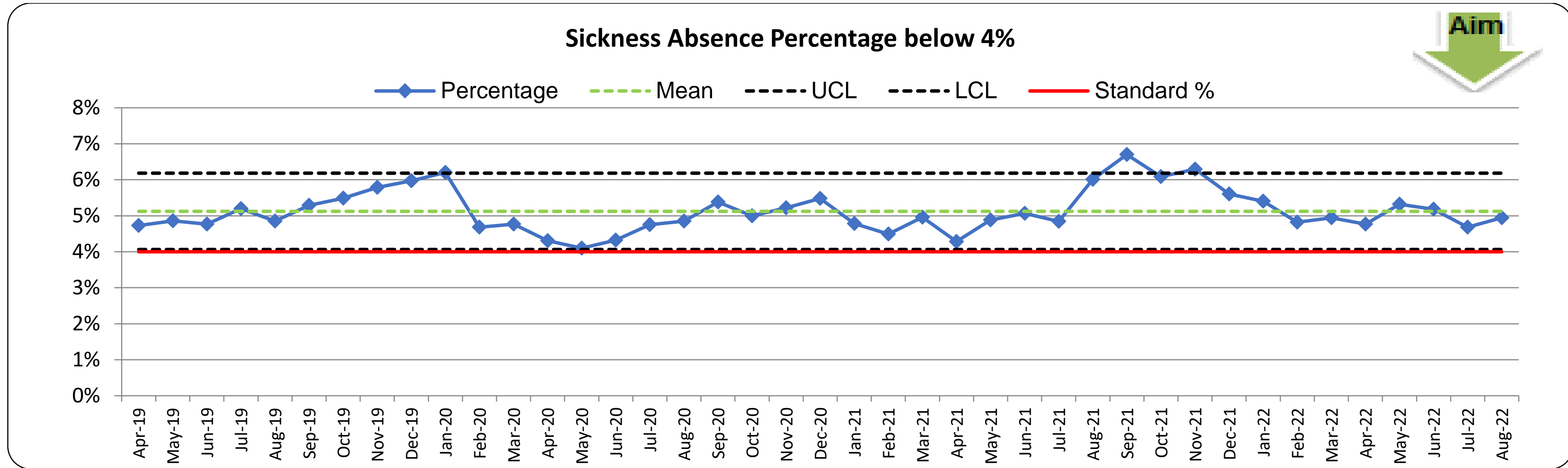
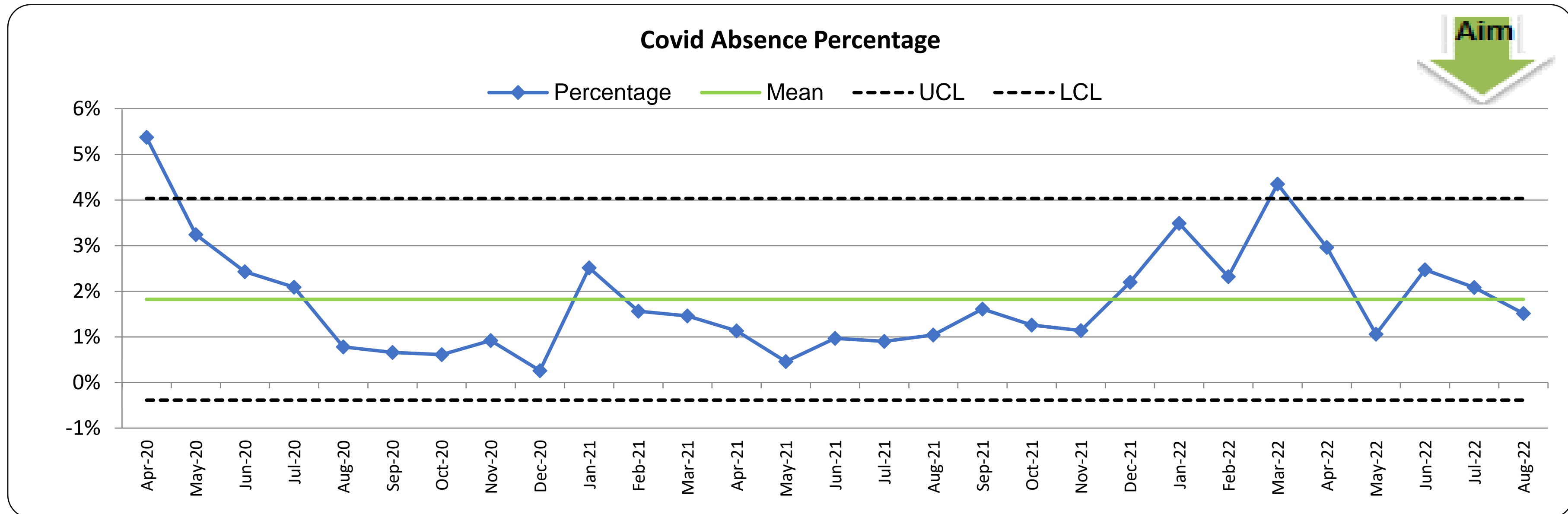
Drug & Alcohol



Number of Alcohol Brief Interventions Delivered

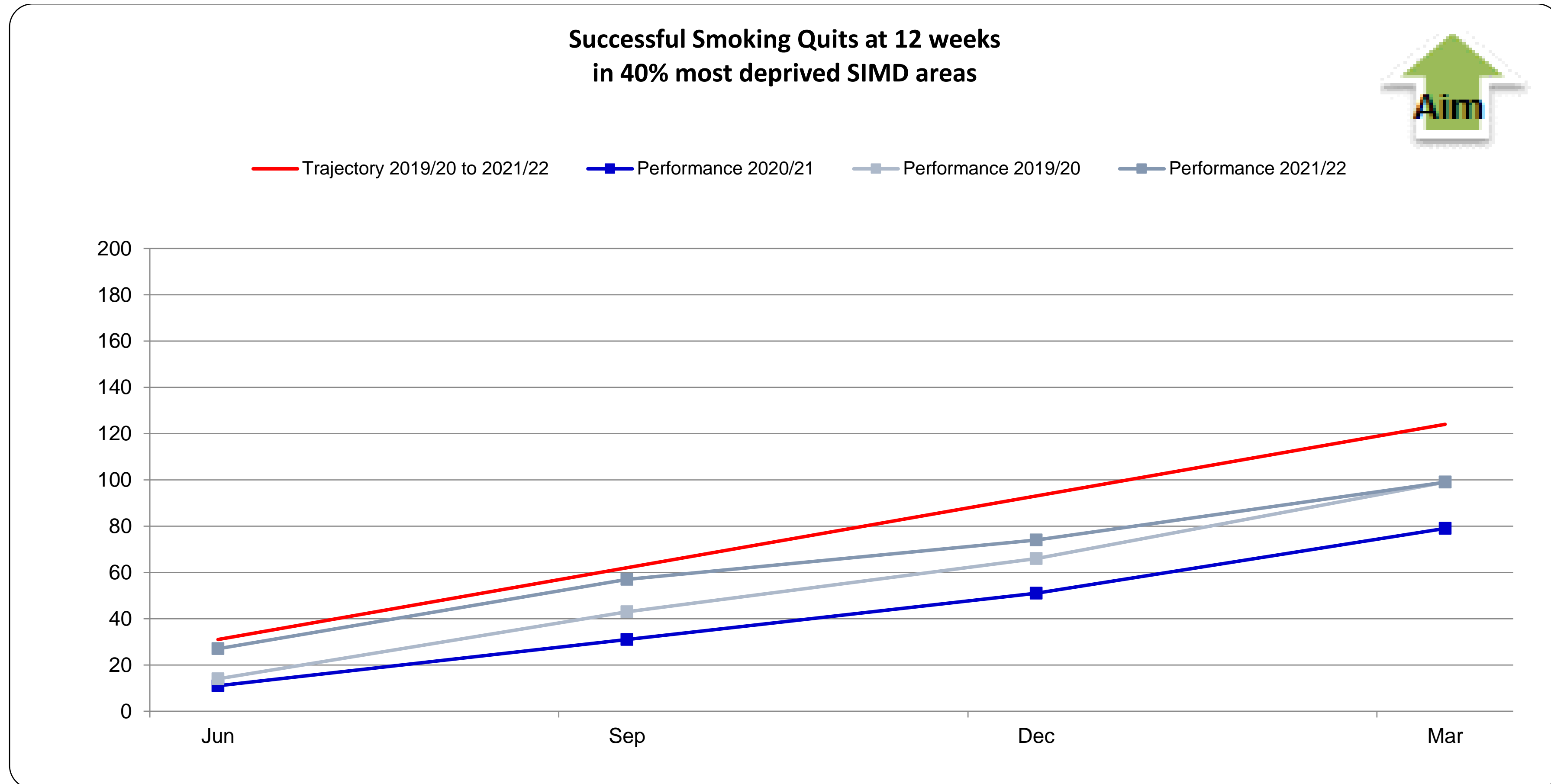
Sickness Absence





Smoking Quits

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)



NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Board Business Plan**
Responsible Executive/Non-Executive:	**Iris Bishop, Board Secretary**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan
- Emerging issue
- Government policy/directive
- Legal requirement
- Local policy
- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to provide the Board with a focused and structured approach to the known business that will be required to be conducted over the coming year.

2.2 Background

To deliver against targets and objectives, the Board must be kept aware of progress on a regular basis. The Board has a governance responsibility around

performance, requiring assurance that targets will be met and that any action required to be taken to keep the organisation on course will be managed properly. The Board will seek such assurance through the Resources & Performance Committee of the Board.

For clarification and in the context of guidance set out in "On Board – A Guide for Board Members of Public Bodies Scotland" "How can the Board get through its business efficiently?":-

> *"Board meetings should always have a manageable and prioritised agenda, an agreed duration and – perhaps – an estimated length of time for each agenda item.*
>
> *It is important that the agenda is properly focused. It must reflect the Board's two fundamental purposes – the long term (mission, strategy and planning) and monitoring performance. There will be some issues reserved to the Board, such as major capital spend decisions, and these must be on the agenda. However, it is important that the agenda is not clogged up with detail, even if it is just items "for noting". It will be all too tempting to dwell on the easy unimportant things and not concentrate on the big issues."*

2.3 Assessment

Public Board Meeting Agendas

Public Board meeting agendas will be focused on main clinical and strategic issues (apart from the standing items listed at those headings) at each meeting in order to facilitate strong debate of items.

Board Development

Board Development sessions have been scheduled for the afternoon after each public Board meeting. A programme of content will be worked up to ensure these sessions are used to the benefit of the Board.

Attached at Annex A is the Business Cycle for 2023 which has been formulated to capture the known business that the Board will be expected to address during 2023.

The Business Plan will remain a live document and will evolve further and flex where appropriate, to ensure the Board can meet its statutory and regulatory requirements.

Meeting Dates 2023

Tabled below are the proposed meeting dates for 2023.

- The Borders NHS Board will meet on 5 occasions.
- The Borders NHS Board will schedule 1 Extraordinary meeting in August should it be required.
- The Board will undertake Development sessions on 5 occasions.
- The Resources & Performance Committee (R&PC) will meet on 5 occasions.

Meeting	Jan	Feb	Mar	Apr	May	June	Jul	Aug	Sept	Oct	Nov	Dec
Public Board		2		6		29		17EO		5		7
Development Session		2		6		29				5		7
Resources & Performance Committee	19		2		4				7		2	

- Public Board meetings – 9.00am to 11.00am
- Development Sessions – 2.00pm to 5.00pm
- Resources & Performance Committee – 9.00am to 11.00am

It is proposed that the meetings remain scheduled for the first Thursday of each month wherever possible in order to ensure reporting cycles for data collection are maximised. Meetings will also be held in person whenever possible with the use of hybrid facilities or full MS Teams whenever necessary.

Due to the need to ensure that the Annual Accounts are duly signed off by the Board in line with statutory requirements the June Borders NHS Board meeting will be pushed back to the last Thursday of the month (29 June).

In line with previous years it is proposed that there are no Borders NHS Board, Resources & Performance Committee, or Board Development sessions held in July.

Policy/strategy implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

The SBC Full Council meetings cycle has been taken into account when identifying dates.

2.3.1 Quality/ Patient Care

Patient Safety/Clinical Impact implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.2 Workforce

Staffing implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.3 Financial

Resource implications will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

2.3.4 Risk Assessment/Management

Risk assessment will be addressed in the management of any actions/decisions resulting from the business presented to the Board.

The risks of falling outwith the financial and performance reporting cycle have been recognised and minimised.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Board Executive Team, 27 September 2022

2.4 Recommendation

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

The Board is asked to **approve** the Board meeting dates schedule for 2023.

The Board is asked to **approve** the Board Business Cycle for 2023.

3 List of appendices

The following appendices are included with this report:

- Appendix No1 Business Plan 2023

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1	**BORDERS NHS BOARD BUSINESS PLAN 2023**													
2	**Item**	**Recurrence**	**Owner**	**2 February BOARD**	**2 February DEV**	**6 April BOARD**	**6 April DEV**	**29 June BOARD**	**29 June DEV**	**17 August EO Board**	**5 October BOARD**	**5 October DEV**	**7 December BOARD**	**7 December DEV**
3	**Minutes**	monthly	Board Secretary											
4	**Action Tracker**	monthly	Board Secretary											
5	**Clinical Governance & Quality Update**	public	Director of Quality & Improvement											
6	**Healthcare Associated Infection Control & Prevention Update**	public	Infection Control Manager											
7	**Finance Report**	public & R&PC	Director of Finance											
8	**NHS Borders Performance Report**	R&PC & Public	Director of Planning & Performance											
9	**Statutory & Other Committee minutes**	public	Board Secretary											
10	**Consultant Appointments**	public	Director of Workforce											
11														
12	**Patient Story**	each meeting	Director of Quality & Improvement											
13	**Register of Interests**	yearly	Board Secretary											
14	**Remobilisation Plan /Annual Delivery Plan (includes winter plan and financial plan)**	yearly	Director of Planning & Performance / Director of Finance											
15	**Code of Corporate Governance Refresh**	3 yearly	Board Secretary					Full refresh						
16	**Joint Public Protection Annual Report (replaces the separate Adult and Child Protection Reports) (Goes to CGC first for assurance and then the Board for noting)**	yearly	Director of Nursing & Midwifery											
17	**Child Poverty Annual Report (as per Child Poverty (Scotland) Act 2017 - Board required to publish annual report by June each year**	yearly	Director of Public Health											
18	**Strategic Risk Register**	yearly	Risk Manager	**2022**					Strategic Risk		Strategic Risk Register			
19	**MOP Outturn (End of year Report 2022/23)** (No longer do a mid year report)	yearly	Director of Planning & Performance											
20	**NHS Borders Annual Report and Accounts**	yearly	Director of Finance											
21	**NHS Borders Endowment Annual Accounts**	yearly	Director of Finance											
22	**NHS Borders Private Patients Funds Annual Accounts**	yearly	Director of Finance											
23	**Board Committee Memberships**	yearly	Board Secretary											
24	**Board Meeting Dates & Business Cycle**	yearly	Board Secretary											
25	**Annual Review Letter and Action Plan**	yearly	Head of Performance & Planning	Dependent on timing of Annual Review										
26	**Alcohol and Drug Partnership Annual Report** (Goes IJB first and then NHSB for noting)	yearly FOR NOTING goes to IJB	Director of Public Health / Chief Officer											
27	**Corporate Objectives**	3 yearly - FOR APPROVAL	Director of Planning & Performance									Draft 2023-2026	2023-2026	
28	**DPH Annual report**	2 yearly	Director of Public Health											
29	**Progress on Mainstreaming the Equality Duty & Equality Outcomes**	2 yearly	Director of Public Health											
30	**Equality Outcomes Report:** to publish on website	4 years	Director of Public Health					Due 2023						
31	**Medical Education Report** (yearly to CGC first in January each year then the Board)	yearly to CGC first	Medical Director											

	A	B	C	D	E	F	G	H	I	J	K	L	M	N
32	**Pharmaceutical Care Services Plan 2023 -** The NHS (Pharmaceutical Services) (Scotland) Amendment Regulations 2011 (SSI 2011/32) amended regulations so that NHS Boards are obliged to publish Pharmaceutical Care Services Plans and monitor their plan annually to reflect changes in service provision or service need.	yearly (3 yearly)	Director of Pharmacy											
33	**Financial Plan**	Done in R&PC?	Director of Finance											
34	**Resource to the IJB 23/24 (Delegated Budget)**	yearly	Director of Finance											
35	**Board to formally sign off integration board membership (NEDS)**	every 3 years	Chair			Every 3 Years due 2025								
36	**Counter Fraud Services**	every 2 years	Director of Finance											Due 2024
37	**External Annual Audit Report**	yearly	Gillian Woolman, Audit Scotland											
38	**Logie Legacy - Zambia Twinning Partnership Annual Update**	yearly	Director of Public Health											
39	**Primary Care Improvement Plan (PCIP)**	Yearly	Chief Officer								Annual Update			
40	**Health Improvement Annual Report**	yearly	Director of Public Health											
41	**Blueprint of Corporate Governance Update**	yearly	Board Secretary			Awaiting national							6 month update	Prep for Self Assessment in
42	**Health & Care (Staffing) (Scotland) Act 2019 - Annual Report on complaince for submission to Scottish Government**	yearly	Director of Workforce								Awaiting timeline from Scottish Govt			
43	**Hydrotherapy Pool**		Paul Williams taking forward,											
44	**Appointment of Internal Auditors**		Director of Finance											
45	**iMatter**		Director of Workforce											
46	**The Organisation - Strategy - ADP, 3 yr Fin Plan, 3 yr Wk Plan, Vision & Values, Strategic Aims**		Chief Executive											
47	**PAMs**	yearly	Director of Finance											
48	**Regional Health Protection Service Update**	as and when	Director of Public Health											
49	**Whistleblowing (reporting through SGC) Annual Report to the Board**	annual	Director of Workforce											
50	**Scheme of Integration Consultation**	Due 2026	Chief Officer											
51	**ACF Annual report**	yearly	Director of Pharmacy											
52														

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**6 October 2022**
Title:	**Consultant Appointments**
Responsible Executive/Non-Executive:	**Andy Carter, Director of HR & OH&S**
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, 4 new consultants have been interviewed, offered and accepted consultant posts.

New Consultant	Post	Start Date
Ms Sarah Taylor	Consultant Oral Surgeon	01 August 2022
Dr Sohail Bhatti	Director of Public Health (Consultant in Public Health Medicine)	26 September 2022
Dr Rachel Hogg	Consultant in Palliative Medicine	07 October 2022
Dr Jennie Higgs	Consultant Psychiatrist (West CMHT)	01 December 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 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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:	**6 October 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 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Extraordinary Integration Joint Board 17 August 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 15.06.22

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board held** on **Wednesday 15 June 2022** at **10am** via Microsoft Teams

Present:

(v) Cllr D Parker (Chair)
(v) Cllr R Tatler
(v) Cllr T Weatherston
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive
(v) Mrs H Campbell, Non Executive
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
Mr C Myers, Chief Officer
Mrs J Smith, Borders Care Voice
Dr K Buchan GP
Ms L Gallacher, Borders Carers Centre
Ms V MacPherson, Partnership Representative NHS
Mr D Bell, Staff Side SBC
Mr N Istephan, Chief Executive Eildon Housing
Mr S Easingwood, Chief Social Work and Public Protection Officer
Dr L McCallum, Medical Director

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Internal Auditor
Mrs N Meadows, Chief Executive, SBC
Mr A Bone, Director of Finance, NHS Borders
Mrs H Robertson, Chief Financial Officer Designate
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Ms S Flower, Chief Nurse Health & Social Care Partnership
Ms S Bell, Communications Officer, SBC
Mrs C Wilson, General Manager P&CS
Dr C Cochrane, Director of Psychological Services and Head of Psychology Speciality
Mrs J Smyth, Director of Planning & Performance, NHS Borders
Mr S Burt, General Manager, Mental Health & Learning Disability Services
Mrs S Henderson, Planning & Development Officer, Learning Disabilities Service
Mrs M Walker, BAVs
Mr A McKenzie, Lead Pharmacist, Community Pharmacy
Ms H Jacks, Planning & Performance Officer, NHS Borders
Mr A McGilvray, Southern Reporter
Mr D Knox, BBC
Mrs Morag Muir, Locum Consultant in Dental Public Health

1. APOLOGIES AND ANNOUNCEMENTS

1.1 The Chair advised that she would Chair the meeting in her capacity as Vice Chair of the IJB until approval of Item 5.1 on the agenda was agreed, when she would then assume the full role of Chair of the IJB.

1.2 Apologies had been received from Cllr Jane Cox, Mr John McLaren, Non Executive, Ms Juliana Amaral, BAVs, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, NHS, Ms Linda Jackson, LGBTQ+ and Mr Ralph Roberts, Chief Executive NHS Borders.

1.3 The Chair welcomed Mrs Hazel Robertson to the meeting who would be taking up the position of Chief Financial Officer on 1 August 2022. A paper referring to the appointment had been added to the agenda at Any Other Business so that the IJB could formally make the appointment as per regulations.

1.4 The Chair to welcomed a range of attendees including: Mrs Morag Walker who was deputising for Juliana Amaral as part of the Borders Third Sector Interface and BAVS (Berwickshire Association of Voluntary Services); Mr Simon Burt, General Manager MH&LD services, Mrs Susan Henderson, Planning & Development Officer, Learning Disabilities Service; Mrs Cathy Wilson, General Manager, Primary & Community Services; Mrs Morag Muir, Locum Consultant in Dental Public Health; Mr Adrian Mackenzie, Lead Pharmacist, Community Pharmacy; and Mrs Caroline Cochrane, Director of Psychological Services and Head of Psychology Speciality

1.5 The Chair confirmed the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

2.2 Mrs Harriet Campbell declared that as the Chair of the Parent Council at Kelso High School she had an interest in the Item regarding CAMHS and the renew programme.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the verbal declaration made.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 2 March 2022 were approved.

4. MATTERS ARISING

4.1 **Action 2020-2:** As Renew appeared as part of the PCIP substantive item on the meeting agenda the action was marked as complete on the Action Tracker.

4.2 Mrs Harriet Campbell enquired if monitoring dates for the directions issued by the IJB would appear on the IJB action tracker. Mr Chris Myers assured the Board that monitoring dates would be planned through the Audit Committee.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. MEMBERSHIP

5.1 Miss Iris Bishop presented the membership paper to the Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the current membership of the IJB.

5.2 Cllr Tom Weatherston proposed Cllr David Parker be nominated as Vice Chair of the IJB. The proposal was seconded by Cllr Elaine Thornton-Nicol.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** confirmed the Chair, Mrs Lucy O'Leary and Vice Chair, Cllr David Parker of the IJB.

5.3 Cllr Tom Weatherston proposed Cllr Jane Cox be nominated as Chair of the IJB Audit Committee. The proposal was seconded by Cllr David Parker.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** confirmed the membership of the IJB Audit Committee: Cllr Jane Cox, Cllr Tom Weatherston, Mrs Karen Hamilton, Mrs Lucy O'Leary.

5.4 Mrs Karen Hamilton asked that the current IJB membership and tenure periods be provided to the IJB. Miss Iris Bishop advised she would action the request.

5.5 Mrs Jill Stacey commented that the Audit Committee Terms of Reference required further updating to include the role of the Audit Committee in monitoring the commissioning plan and directions policies.

6. CODE OF CONDUCT

6.1 Miss Iris Bishop presented the revised Code of Conduct to the Board.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** adopted the new model code of conduct.

7. DIRECTION - COMMISSIONING OF DAY SERVICES FOR ADULTS WITH LEARNING DISABILITIES

7.1 Mr Simon Burt provided an overview of the content of the paper and highlighted several elements which included: range of services provided; some individuals directly commission services; 5 buildings were in scope; impact of COVID-19; day services; increase in higher levels of needs; 90% of services were commissioned to the

independent sector; and suggested commissioning of 5 year contracts with 2 year add on provision.

7.2 Mrs Lynn Gallacher commented that it would have been helpful to have engaged the carers workstream in the proposals and she supported the 5 year contract for commissioning proposal.

7.3 Mrs Harriet Campbell enquired if people were being missed, given numbers had been reducing pre COVID-19 and with the direction of travel to move out of buildings, people might not realise services were available to them.

7.4 Mrs Jenny Smith enquired about savings targets being met if a building was required and if there was unmet demand how that would be identified and proposals flexed to address it.

7.5 Ms Susan Henderson confirmed that carers, families and stakeholders had been engaged with at the outset of the project with much consultation done through independent organisations. The model had been built on the basis of the evidence gleaned from the consultation and engagement process. There were currently 2 families involved in the specification work and 2 families involved in the tender evaluation process.

7.6 Mr Burt advised the Board that engagement with carers had focused on the carers of those with learning disabilities to ensure their opinions were heard. In terms of unmet need he advised that the remobilisation of day services had remained an issue and there were gaps for those who required day time support. However, he anticipated the new model would fill those gaps with the new commissioned services once COVID-19 restrictions were fully lifted. With regard to demand, numbers were reducing and he suggested this was due to the broader range of choices available to individuals through self directed support and direct payments.

7.7 Mr Chris Myers commented that there had recently been some negative press suggesting the IJB would be closing learning disability day services and he emphasised that was not the case and the proposal was about commissioning a new service model.

7.8 Cllr Tom Weatherston supported the direction of travel and enquired about the continuity for individuals involved in areas of change.

7.9 Mrs Gallacher suggested it was time for a review of local area coordination, given there were some mixed messages being provided locally.

7.10 Mr Burt confirmed that transition planning would take place to ensure continuity of change would be provided and he would also ensure the carers workstream were involved in the on-going review. He also welcomed the suggestion of a review of local area coordination.

7.11 Mr Myers suggested the Strategic Planning Group be tasked with the local coordination review. He further clarified that as the Learning Disability services was an integrated

service the direction would be issued to both Scottish Borders Council (SBC) and NHS Borders to ensure NHS Borders supported the direction of travel being taken.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue a Direction to Scottish Borders Council and NHS Borders to re-commission the Learning Disability Day support services from the market.

DIRECTION: To re-commission a new model of Learning Disability Day Services by going to the open market in line with the relevant papers agreed at the Integration Joint Board on 15 June 2022.

8. DIRECTION - HEALTH BOARD DEVELOPMENT OF THE ORAL HEALTH PLAN

8.1 Mrs Morag Muir provided a brief overview of the content of the paper.

8.2 The Chair sought clarification that the direction was to move on to produce the plan and in addition to make sure oral health was sewn into the strategic commissioning plans.

8.3 The Chair enquired if links to oral health and more general health was something that was being teased out in the plan as it developed.

8.4 Mrs Muir commented that there were many links between oral health and general health such as diet, smoking and alcohol. She further advised that oral health was being recognised as a key part of overall health care.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** ratified the report for publication and wider dissemination.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to include oral health in their strategic commissioning plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to commission the Health Board/Public Health Directorate to develop a strategic plan for oral health and dental services.

DIRECTION: To provide planning and performance, communications and public engagement support for the development of the Oral Health Plan, which will be based upon the 2020 Oral Health Needs Assessment. This includes support for:

- The production of an Oral Health Plan based on the priorities identified by the Oral Health Needs Assessment
  - Planning and Project Management support (NHS Borders)
  - Re-establishment of the Dental Services and Oral Health Strategy Group
  - Consultation and engagement with stakeholders, staff and partners on the draft plan (NHS Borders)
  - Communications support (NHS Borders)

It is expected that the plan will be referred to in the broader revised IJB Strategic Commissioning Plan once complete.

9. DIRECTION - PHARMACY SUPPORT TO SOCIAL CARE SERVICE USERS

9.1 Mr Adrian McKenzie provided a brief overview of the content of the paper.

9.2 Dr Lynn McCallum highlighted the significant spend on 5 individuals and that the way to release funds was to close beds. The quantification of bed day savings had not been worked through. She further supported the project and was cognisant of the potential positive impact on both patients and carers.

9.3 Mrs Karen Hamilton highlighted the challenges in recruiting social care staff and enquired if there was a confidence to recruit and have sufficient resource in terms of pharmacy staff to take the project forward.

9.4 Mr McKenzie commented that recruitment would remain a challenge.

9.5 Mr Andrew Bone commented that the benefits in the paper in terms of opportunities to alleviate pressure on the bed base and assist with system flow were to be welcomed. He suggested realistically there would be zero cash release savings as savings would be about opportunity costs and using resources differently. He suggested the project was about pump priming a change in working arrangements and there was funding within the IJB reserves that had been carried forward in relation to Multi-Disciplinary Teams that could be utilised to deliver the project for an initial period. He suggested it was important to be clear on how the benefits would be monitored and delivery demonstrated for any future investment.

9.6 Mrs Jenny Smith supported the project and was interested in the secondary aim of supporting the workforce with learning around medication. She commented that any efforts and offers around medication training, guidance and leadership for the third and independent sector workforce would be welcomed.

9.7 Mr Chris Myers commented that the direction contained a regular review and annual review by the Audit Committee and suggested the review process would assist in identifying the cash release versus productivity gains throughout the project. He also commented that the direction was to be issued to both SBC and NHS Borders. SBC had been included in the direction in the context of appropriate engagement with the social care sector.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue the Direction.

DIRECTION: To work in partnership to develop an integrated polypharmacy support service for all adult social care service users, provided by all providers.

It is expected that an integrated impact assessment will be undertaken prior to commencing work on this initiative, to inform the development of the programme.

It is expected that any associated savings as a result of this commission are identified and flagged to the Integration Joint Board Chief Financial Officer. The Integration Joint Board will determine at a later stage how the productivity gains from this development should be used, and whether they be recycled and used to increase capacity in the system, or used to contribute to a further reduction in the delegated services budget. Decisions about the recurrence of this initiative will be made following 2 reviews of the initiative by the Integration Joint Board Audit Committee and a review by the Integration Joint Board.

10. 2021-22 ANNUAL PERFORMANCE REPORT & 2022-23 COMMISSIONING PLAN

10.1 Mrs Chris Myers presented the draft report and highlighted several elements which included: a focus on the commissioning role of the IJB; focus on national health and wellbeing outcomes; strategic implementation plan actions; 2022/23 outline of areas requiring improvement in performance; hospital at home; development of common geriatric model; and areas not expected to achieve full deliver this year against the ambitions.

10.2 Dr Lynn McCallum enquired if the lower admission rate quoted was due to the fact that people were bedded in the overcrowded ED awaiting admission. She questioned in regard to care at home that the report suggested that occupied bed days had increased and spend on acute care had decreased. In terms of quantitative date the indicator figure at 19 appeared misleading given there were more delayed discharges in the system than in previous years.

10.3 Mr Myers commented that point 19 related to the year 2020/21 and he suggested he would follow up on the other points raised outwith the meeting. He commented that the validated figures within the report were for the year 2020/21 as the figures for 2021/22 were not yet nationally validated.

10.4 Mrs Lynn Gallacher commented that in regard to carers support it was clear their satisfaction levels had consistently reduced since 2018. She urged the IJB to acknowledge that it related to the closure of buildings and day care centres, respite opportunities and the inability of carers to access care packages. She suggested it was not just a financial issues but also a workforce and capacity issue and she welcomed the needs assessment that was being undertaken.

10.5 Dr McCallum commented in regard to the acceptability of the data that it portrayed an inaccurate picture of less pressure and spend in the health care system and she asked that the report reflect the current position, target performance and pressures being faced by the health service. She accepted that the validated data was out of date but urged that the current position be included.

10.6 The Chair suggested the Chief Officer message should acknowledge that the data included in the report did not reflect that current reality for health and care services.

10.7 Mr Myers welcomed the comments and suggested amendments be made to the report and that it be circulated to the IJB for approval via email.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Performance Report for 2021-22.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the commissioning plan for 2022-23.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to receive a revised version of the report for approval via email.

11. DIRECTION – 2022-23 FINANCIAL PLAN

11.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements which included: increase on baseline for overall resource; context around Scheme of Integration around how budgets were set and monitored for the IJB; level of savings required at £7.1m across all of the functions including those in the set aside for large hospital function as well; milestones outlined of the recovery plan for the partnership does not include set aside function; level of reserves; and potential repayment of financial gap in future years.

11.2 Mrs Lynn Gallacher requested sight of the detail of the £2.4m Carers Act Funding received by SBC within the budget. Mr Bone commented that he believed the funding was directed at SBC and had been ring fenced separately and was therefore not within the reserve or the budget as it would be administered through SBC.

11.3 Mrs Harriet Campbell noted that the Direction mentioned the “delivery plan” and she enquired what that plan was. Mr Chris Myers confirmed that it was the “commissioning plan” and he would amend the direction accordingly.

11.4 Cllr David Parker commented that the Carers Act Funding was not part of the IJB funding and was held separately by SBC. He committed to providing a note on the specifics of the carers act funding and detail of where it was held and what it was used for, outwith the meeting.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the 2022/23 budget in line with resources agreed with the partners.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** endorsed the approach to development of an HSCP Recovery plan to address savings targets and the status of work towards this plan.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the risks described in the paper.

DIRECTION: The Scottish Borders Health and Social Care Integration Joint Board commissions NHS Borders and the Scottish Borders Council to deliver services within the budgets and under the framework outlined in Item 5.7 of the 15 June 2022 Integration Joint Board.

NHS Borders and the Scottish Borders Council are expected to work in partnership with Scottish Borders Health and Social Care Integration Joint Board Chief Financial Officer and Chief Officer to facilitate the development of an HSCP Recovery plan to address savings targets, and to share progress against the Recovery plan with the Integration Joint Board.

In addition NHS Borders and the Scottish Borders Council are expected to work to develop an integrated transformation projects and a wider programme in line with the detail noted in the Delivery Plan outlined in the 2022/23 Annual Report (Item 5.6 of the 15 June 2022 Integration Joint Board), and the new developing Strategic Commissioning Plan.

It is expected that all new transformation plans will be brought to the Integration Joint Board via its Strategic Planning Group to ensure that they are appropriately consulted upon and align to the aims of integration and outcomes that are being sought by the Integration Joint Board.

12. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

12.1 Mr Andrew Bone provided an overview of the content of the report. The overall position reported for the IJB was an underspend of £913k operationally across the budgets (predominantly social care functions). He emphasised that the IJB would be in a break even position at the year end.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

13. STRATEGIC RISK REGISTER UPDATE

13.1 Mr Chris Myers provided an overview of the content of the report and assured the IJB that risks were identified, managed and monitored.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the progress made to reframe the IJB Strategic Risk Register to reflect the remit of the IJB.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the previous risks contained in the IJB Strategic Risk Register have been archived as they focus on partnership risks.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further risk update will be provided in September and December 2022.

14. PRIMARY CARE IMPROVEMENT PLAN UPDATE

14.1 Mrs Cathy Wilson provided a presentation to the IJB on the work that had been carried out over the previous year.

14.2 Mr Andrew Bone noted the singular financial gap and advised the IJB that to date a resolution to that gap had not been identified. There was on-going dialogue with the Scottish Government in regard to additional funding. He commented that NHS Borders had a significant financial deficit and any further investment or delivery from within existing resources would increase the deficit further. There had been a shortfall in the

funding made available to the PCIP and he urged the IJB not to sign up to additional levels of commitment unless additional funding was made available by the Scottish Government.

14.3 Cllr David Parker supported the proposal not to sign up to additional funding at that stage.

14.4 Mr Chris Myers commented that the IJB had to be financially sustainable and work towards breakeven. He suggested a process was required to be worked through to understand what the financial gap was in the context of additional allocations that may or may not come from the Scottish Government. He further suggested the IJB work with NHS Borders to look at how to ensure all the workstreams were as cost effective as possible and to review skill mix and look at where the opportunities were for transformation.

14.5 Mr Myers suggested a further paper be brought back to the IJB following that process to ensure the IJB were clear on any impact on delivery of the contract.

14.6 Dr Kevin Buchan commented that the contract had not run as had been expected and continued to be difficult to put down in practice. He advised that the Scottish Government had made a payment to practices and individual contractors and those that had not met the targets had not received a second payment due to a lack of funding which had left practices with a financial gap. It was a picture that was endemic across Scotland as the initiative had been underfunded centrally. In the Borders the initiative had been progressed aggressively and the infrastructure of CTAC remained an issue to resolve. He commented that there was a lot of disquiet in the GP cohort in Scotland on how to move forward and the SGPC were considering walking away from the contract.

14.7 Mrs Wilson commented that the main concern with CTAC was that it was underfunded and a risk for GPs. Work had been progressed on the TUPE of staff from practices, but the main issue for GPs remained the lack of recurring funding and potential risk to them. A lot of trust and goodwill had been built up during the PCIP initiative which was now being undermined.

14.8 Mr Myers suggest a paper be worked up and brought to the next meeting to look at the issues in more detail in terms of what the IJB should be doing to reduce the risk.

14.9 Cllr Elaine Thornton-Nicol noted that it appeared to be a level of crisis and rather than wait for a paper for the next meeting she suggested an extraordinary meeting be called to discuss the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report, the risks, and actions being undertaken to reduce the risks.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** sought the development of a direction immediately to NHS Borders to undertake further work to build the IJB's level of assurance that all opportunities to understand and reduce the cost pressure had been

explored, so that an update can be brought back to an extraordinary meeting of the IJB to inform its approach to financial planning for 2023/24.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a further update would be provided to the IJB in September.

15. MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

15.1 Mr Simon Burt advised that the Scottish Government had committed recovery renewal funding to Health Boards and partnerships for mental health and wellbeing services within primary care over a period of 4 years. The funding was targeted specifically at certain areas such as CAMHS. Proposals were to be drawn up and submitted to the Scottish Government for review with successful proposals securing funding.

15.2 Mrs Caroline Cochrane provided an in-depth presentation into the local Renew programme and highlighted several key elements which included: good collaboration between mental health and primary care; see and treat model; average of 300 referrals per month; a range of evidence based interventions are offered; centralised service for those of 18+ age group; digital service commenced during the pandemic; and feedback from service users was very positive.

15.3 Dr Kevin Buchan commented that the Renew programme had been a great success with GPs and clients having a positive experience with the service and he welcomed it as a step away from GPs prescribing anti-depressants. Dr Buchan advised the IJB of the current gap in child mental health needs and the distress that it caused to children, families and GPs.

15.4 Mrs Harriet Campbell welcomed the initiative and urged the inclusion of SBC education in it.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted for reference this 4-year programme.

16. STRATEGIC PLANNING GROUP MINUTES: 02.02.22

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

17. ANY OTHER BUSINESS

17.1 The Chair advised that there was one item of any other business in regard to the appointment of the Chief Financial Officer and a late paper had been issued (Appendix-2022-20).

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** formally approved the appointment of Hazel Robertson as Chief Financial Officer of the Health & Social Care Integration Joint Board with effect from 1 August 2022.

17.2 The Chair recorded the thanks of the IJB to Mr David Robertson and Mr Andrew Bone who had covered the position of Chief Financial Officer to the IJB previously.

18. DATE AND TIME OF NEXT MEETING

18.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 21 September 2022, from 10am to 12noon, via Microsoft Teams, however an extraordinary meeting would be called in August 2022.

The meeting concluded at 12.15.

Signature: ……………………………
Chair