Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 30 March 2023** at **10.00am** at the **Volunteer Hall, Galashiels.**

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Chair	Appendix-2023-16
10.03	**3**	**MINUTES OF PREVIOUS MEETING** 02.02.23	Chair	*Attached*
10.05	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.10	**5**	**STRATEGY**		
		NHS Borders Pharmaceutical Care Services Plan Update	Medical Director	Appendix-2023-17
10.15	**6**	**FINANCE AND RISK ASSURANCE**		
		Resources & Performance Committee minutes: 19.01.23	Board Secretary	Appendix-2023-18
		Endowment Fund Board of Trustees minutes: 03.10.22	Board Secretary	Appendix-2023-19
		Financial Plan 2023-24	Director of Finance	Appendix-2023-20
		Provision of resources to the Scottish Borders Integration Joint Board	Director of Finance	Appendix-2023-21
		Finance Report	Director of Finance	Appendix-2023-22
11.00	**7**	**QUALITY AND SAFETY ASSURANCE**		
		Clinical Governance Committee minutes: 09.11.22	Board Secretary	Appendix-2023-23
		Quality & Clinical Governance Report	Director of Quality & Improvement	Appendix-2023-24

		Infection Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2023-25
11.30	**8**	**ENGAGEMENT**		
		Staff Governance Committee minutes: 28.10.22	Board Secretary	Appendix-2023-26
		Public Governance Committee minutes: 10.11.22	Board Secretary	Appendix-2023-27
		Area Clinical Forum Minutes: 29.11.22	Board Secretary	Appendix-2023-28
11.35	**9**	**PERFORMANCE ASSURANCE**		
		NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2023-29
11.45	**10**	**GOVERNANCE**		
		Code of Corporate Governance Sectional Update	Board Secretary	Appendix-2023-30
		Blueprint for Good Governance Update	Board Secretary	Appendix-2023-31
		Board Committee Memberships	Board Secretary	Appendix-2023-32
		Consultant Appointments	Director of HR, OD & OH&S	Appendix-2023-33
		Scottish Borders Health & Social Care Integration Joint Board minutes: 16.11.22; 21.12.22	Board Secretary	Appendix-2023-34
11.59	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 29 June 2023 at **10.00am** at **Peebles Town Hall, Peebles**	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to formally constitute NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

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

2.3 Assessment

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

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

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

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 Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Register of Interests.

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ...KAREN HAMILTON..... *(please insert your full name in capital letters)*

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

Signed- ..... Date ...22.03.23.....

Borders NHS Board

Register of Interests of Board Members

This register has been drawn up in accordance with the Standards Commission for Scotland, Standards in Public Life: Model Code of Conduct for Members of Devolved Public Bodies.
ard Member: Fiona Sandford..... *(please insert your full name in capital letters)*

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

Signed.....Fiona Sandford..... Date ...22.iii.2023.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: TRIS TAYLOR..... *(please insert your full name in capital letters)*

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

Signed ..... Tris Taylor Date ...23.03.23.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ...LUCY O'LEARY.... *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	none
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	none
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	none
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders.	none
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	none
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	none
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	none

Signed.....Lucy O'Leary (via email)..... Date .....22/03/23.....

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 a "bank" employee of Nightingales Home Care Agency Kelso which provides home care assistance to individuals and in particular to those with dementia or requiring palliative care.
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	

Signed... J Ayling ..... Date ... 8th March 2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: Sonya Lam *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	• Self employed in coaching practice with KnowYouMore • NHS Lothian AHP Bank Worker
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	None
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	None
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	None
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	None
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	None
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	• Member of the Chartered Society of Physiotherapy (CSP). Chair of the Professional Awards Panel.

Signed: Sonya Lam

Date: 22 March 2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ...HARRIET CAMPBELL..... *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	Employee of Douglas Home & Co Ltd, 47-49 The Square, Kelso TD5 7HW (part time solicitor). Owner and manager of holiday let, Little Hermitage, Kelso.
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	Chair Borders Organ Donation Committee Chair, Kelso High School Parent Council. Member Borders-wide group of High School Parent Council Chairs.

Signed.....*Harriet Campbell*..... Date .....3.3.23.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ...Kevin Buchan..... *(please insert your full name in capital letters)*

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

Signed...kevin buchan..... Date ...22/03/23.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: DAVID PARKER..... *(please insert your full name in capital letters)*

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

Signed David Parker Date 22 March 2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: RALPH ROBERTS *(please insert your full name in capital letters)*

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

Signed Date 09.03.2022

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ANDREW STEPHEN BONE

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

Signed .... Date .....3rd March 2023.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: DR SOHAIL BHATTI..... *(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	British Medical Association - Public Health Medicine Committee Member
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	Nil
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	Nil
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	Nil
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	Nil
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	Nil
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	Fellow of Faculty of Public Health Fellow of Royal Society of Public Health Fellow of Chartered Management institute Member of Faculty of Medical Leadership and Management

Signed .....SBhatti.....

Date .....23.03.23.....

Borders NHS Board

Register of Interests of Board Members

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

Board Member: DR LYNN McCALLUM *(please insert your full name in capital letters)*

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

Signed Date 15 March 2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: SARAH HORAN

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

Signed:

Date: 2nd March 2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: **JUNE SMYTH**

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	none
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	none
Contracts Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged.	none
Houses, land and buildings Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders	none
Shares and securities Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k.	none
Gifts and hospitality Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership.	none
Non financial interests Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations.	Member of *Managers in Partnership* Trades Union

Signed J S Date 08/03/2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: CHRIS MYERS

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

Signed Christopher Myers

Date 22.03.2023

Borders NHS Board

Register of Interests of Board Members

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

Board Member: ANDREW CARTER

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

Signed *A.N. Carter* Date 22 March 2023

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: GARETH CLARKSON *(please insert your full name in capital letters)*

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

Signed..... Date 22/03/23

Borders NHS Board

Register of Interests of Board Members

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Board Member: LAURA JONES

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

Signed Laura Jones Date 22/03/23

Borders NHS Board

Minutes of a meeting of the **Borders NHS Board** held on Thursday 2 February 2023 at 9.00am in the Lecture Theatre, Education Centre and via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mr T Taylor, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, Non Executive
Dr K Buchan, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr S Bhatti, Director of Public Health
Dr L McCallum, Medical Director

In Attendance:
Miss I Bishop, Board Secretary
Mrs J Smyth, Director of Planning & Performance
Mr A Carter, Director of HR, OD & OH&S
Mr G Clinkscale, Director of Acute Services
Mr C Myers, Chief Officer Health & Social Care
Mrs L Jones, Director of Quality & Improvement
Mr S Whiting, Infection Control Manager
Mrs C Oliver, Head of Communications & Engagement
Dr A Cotton, Associate Medical Director MH&LD
Dr T Young, Associate Medical Director P&CS
Mrs C Wilson, General Manager P&CS
Ms F Doig, Head of Health Improvement & Strategic Lead ADP
Mrs A Wilson, Director of Pharmacy
Ms C Anderson, Health Improvement Lead Children & Young People
Ms N Sewell, Health Improvement Lead
Mr D Knox, BBC Scotland
Mr C Sim
Mr P Kelly, Local Democracy Reporter
Mr A McGilvray, Southern Reporter

1. Apologies and Announcements

1.1 Apologies had been received from Mr D Parker, Non Executive, Dr J Bennison, Associate Medical Director BGH, Mrs S Horan, Director of Nursing, Midwifery & AHP.

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

1.3 The Chair advised that given the subject matter of item 10.3 (Chirnside Brand Surgery) on the agenda she wished to confirm that as the Chair it was at her discretion whether to offer members of the public, groups or organisations attending public Board meetings the opportunity to make a comment in relation to items on the Agenda. Having said that should an individual wish to do so they should understand that such comment would not generate debate or conversation with that person within the Board session.

1.4 As per the Code of Corporate Governance: "Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken." However the Chair confirmed that she was prepared to waiver the 21 day notice on that occasion.

1.5 The Chair confirmed the meeting was quorate.

1.6 The Chair reminded the Board that a series of questions and answers on the Board papers had been provided in terms of fact and clarification. The Q&A would not be revisited during the discussion.

2. Declarations of Interests

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

The **BOARD** noted there were none.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 1 December 2022 were approved.

4. Matters Arising

4.1 **Minute 6: Health Inequalities Report:** Mr Tris Taylor asked that an action be added to the Action Tracker in regard to health inequalities activities being remitted to the Public Governance Committee to provide assurance on health inequalities.

4.2 **Minute 20: Public Protection:** Mr Tris Taylor advised that he had not yet spoken to Rachel Pullman in regard to scrutinising strategic risk around health inequalities.

4.3 **Minute 18: NHS Borders Performance Scorecard:** Mr Chris Myers confirmed that he had given a presentation to the Non Executives Group on delayed discharges drivers and actions.

4.4 **Action 2022-2:** The Public Governance Committee had received the Public Engagement Team report at its meeting held the previous day. The Chair proposed the action be closed on the action tracker.

The **BOARD** noted the Action Tracker and agreed to close action 2022-2.

5. Annual Delivery Plan 2022/23 – Quarter 3 Update

5.1 Mrs June Smyth commented that the Q3 update had been submitted to the Scottish Government the previous week.

5.2 Dr Sohail Bhatti commented that in regard to section 3.4.1 Ukraine, short term health screening services had ended, however the organisation continued to screen arrivals through a more modified system.

5.3 Mrs Harriet Campbell enquired if there was anything in the narrative that should be specifically brought to the attention of the Board. Mrs Smyth assured the Board that in regard to winter assurance all 4 areas had been completed since November.

5.4 Mr James Ayling enquired about the "appreciative enquiry approach" at section 3.3.3. Mr Gareth Clinkscale advised that it was being supported by the clinical director for Theatres and ITU and in terms of an approach to talk and engage with staff, understand their perceptions and ensure there was a solid understanding before commencing with an improvement plan.

5.5 Mrs Fiona Sandford commented that it was a very well recognised methodology for engaging staff and there seemed to be an overlap between that methodology and the Kaizen approach and enquired if different methodology was being used for what was in effect the same thing. Mrs Laura Jones commented that the "appreciative enquiry approach" would form part of the diagnostic element and preparation stage to quality improvement.

5.6 Mrs Lucy O'Leary noted that at section 4.1.5 the additional PCIP funding had not been received and she enquired about next steps. Mr Chris Myers commented that at that point the PCIP Executive were looking at the portfolio of services in the PCIP to see if there were any future gains to be made. It was a very challenging position for GPs who would benefit from more funding for the PCIP and conversations with the Scottish Government about it had been escalated.

5.7 Dr Lynn McCallum commented that it was recognised how much of a risk it was to GPs and locally services were trying to be innovative to provide funding into the PCIP. It was difficult for GPs to take on workload from secondary care that was considered by GPs to be secondary care work.

5.8 Ms Sonya Lam enquired at section 2.9.1 about values based medicine and how the impact of that was measured. Dr McCallum commented that it was imperative to introduce values based medicine. Work was starting in secondary care and would then be rolled out into primary care and this would include looking at outcomes. She anticipated that many of the outcomes would be quality based outcomes and should lead to a reduction in clinical investigations.

The **BOARD** noted the NHS Borders Annual Delivery Plan 2022/23 Quarter 3 update as at 31 December 2022.

6. Child Poverty Annual Report

6.1 Ms Carole Anderson provided an overview of the role of the team in working across NHS Borders and Scottish Borders Council to look at the impact of health and child poverty.

6.2 Mr James Ayling enquired about the measure of success in ensuring those who would benefit most were aware of the range of benefits and services available to them. Ms Anderson commented that a lot of work was taken forward through the financial inclusion and early years' group which looked at engagement with families and monetary benefits, as well as children's charities and health practitioners and there was data on impact of engagement which was invaluable.

6.3 Mr Tris Taylor commented that the Public Governance Committee had a responsibility to provide assurance to the Board on health inequalities and he was encouraged to hear of the usable evidence described by Ms Anderson.

6.4 Further discussion focused on: multiple organisations working together; encouraging people to look to claim benefits instead of waiting for them to ask what might be available; development of an updated joint strategy plan with partners for children in the Borders; collation of data; simplifying the presentation of the data; and all health inequalities arise from childhood.

The **BOARD** noted the report.

7. Health Improvement Annual Report

7.1 Mrs Fiona Doig provided an overview of the content of the report and highlighted: each public health priority and how the work of the team was informed; impact of the work and generational impact on health of the population; and all sessions were delivered through partnership.

7.2 Mrs Harriet Campbell commented that it was an easy to read report and obviously there had been good work done. She enquired to what extent there were any concerns on coordinating the help available and making people aware of the help that would be available to them.

7.3 Mrs Doig commented that the work was all in relation to health inequalities and the child healthy weight was a generic service. Work was linked to deprivation and health inequalities and various services by proxy measure through the families accessing the services. Demographic data was not used for group work and the next stage was to look at how to more clearly evidence inequalities and it was by the nature of partnership that the work was done with those people most in need.

7.4 Dr Sohail Bhatti commented that the public health team had embarked on workshops as a department substantively to refocus on both measurement and activity and to address any anxieties on new measures and impacts. He was keen for them to understand the added value they brought to the public health arena.

7.5 Ms Sonya Lam enquired about the barriers to the delivery of mental health first aid. Mrs Doig commented on the content of the course and that although NHS Borders continued to provide training it was not the national programme of training.

7.6 Mr John McLaren enquired if the report was linked to the Learning Disability and Disabilities Plans. Mrs Doig commented that it was managed through a whole system approach to health inequalities and whilst it might not show in the report there were members of the management team on a range of strategic groups to enhance the links across various strategies including the physical strategy and autism strategy.

The **BOARD** noted the report.

8. Resources & Performance Committee minutes: 03.11.22

The **BOARD** noted the minutes.

9. Audit Committee minutes: 10.10.22

The **BOARD** noted the minutes.

10. Finance Report

10.1 Mr Andrew Bone provided an overview of the report and drew the attention of the board to the reported £10.8m overspend; the recovery plan to recover the outturn position at the end of March to achieve the £12.2m deficit in line with the financial plan; risk on expensive out of area packages for individuals with complex needs; potential of primary care prescribing to exceed the previously forecast position to the value of £1m; and sections 5 and 6 of the report.

10.2 Mrs Lucy O'Leary enquired about the out of area placement and sought an indication of the full year cost of that placement. Mr Bone commented that the Board was incurring an additional £500,000 in year effect, however the costs of complex out of area placements varied according to the individual's needs.

10.3 Mr James Ayling enquired in terms of non core funding to increase income if there were any plans or timescales to renegotiate Service Level Agreements (SLAs). Mr Bone commented that the last few years had been beneficial to the organisation due to the pandemic given it had an arrangement that guaranteed a level of income based on cost. However, as the level of activity has been lower there was a risk that a renegotiation would be made at a lower level. The SLAs were negotiated annually but had been rolling forward without amendment for 3 years due to the pandemic. He suggested it was likely they would be renegotiated next year.

10.4 Mrs Fiona Sandford commented that the high cost out of area placement was regularly discussed at the Clinical Governance Committee and she welcomed the polypharmacy review and enquired if the increase in GP prescribing was due to the amount of secondary care issues that were being taken up by primary care. Mr Bone commented that it was early days in terms of emerging pressures, there were elements of additional demand reflected in the position as well as price fluctuations.

10.5 Dr Lynn McCallum suggested secondary care was impacting on primary care especially in regard to prescribing strong painkillers and further interventions. It was a spiralling situation for GPs. The medicines resource group had identified a significant rise in costs related to drugs. Work on polypharmacy reviews had

identified savings and pharmacy colleagues were proactively looking at what was not adding value.

10.6 Dr Kevin Buchan commented that patients who were not getting procedures done were re-presenting to GPs with requests for further treatment which would not have been the case pre pandemic. The use of mainline drugs was increasing especially analgesics where people were waiting on replacement surgery as well as drugs for low mood. There had been a significant benefit in the running of the Renew service in regard to the burden of ill health and the worsening cost of living crisis.

The **BOARD** noted that the Board was reporting an overspend of £10.80m for nine months to end of December 2022.

The **BOARD** noted the position reported in relation to COVID-19 expenditure and how that expenditure had been financed.

The **BOARD** noted the financial performance expectation set out by the Scottish Government following the Board's Quarter One Review was that the board achieve an outturn performance in line with the Financial Plan (£12.2m deficit).

The **BOARD** noted progress against the actions described within the Financial Recovery Plan submitted to Scottish Government in November.

11. Quality & Clinical Governance Report

11.1 Mrs Laura Jones provided an overview of the content of the report and highlighted: the continued pressure on the team; winter viruses; covid pressures; staff being redeployed to support unscheduled demand; stand down of the elective programme; that the Clinical Governance Committee had felt assured on the work underway to mitigate the risks but were not fully assured on the impact on patients and staff across the system; a detailed look at mortality; and complaints and compliments.

11.2 Mrs Harriet Campbell enquired about the elective programme and if Ward 17 would be opened and protected again. Mr Gareth Clinkscale commented that the elective programme had recommenced and was dealing with a number of urgent cases. In order to open Ward 17 his team were also working through pressures at the front door and levels of sickness absence.

11.3 Mr Tris Taylor commented that as per the action tracker, Laura Jones had provided an update to the Public Governance Committee on complaints resolution.

11.4 Mr John McLaren suggested there should be a process put in place to capture staff concerns. The Chair suggested it be noted on the action tracker as a piece of work to be delegated to the Clinical Governance Committee to pursue.

11.5 Ms Sonya Lam reminded the Board that through the whistleblowing standards concerns could be captured.

11.6 Further discussion focused on: an acknowledgement that it had been the hardest month for the organisation in the last 12 months in terms of impacts on patients and staff across the whole system; there is often a focus on complaints when there are

just as many compliments received by the organisation; clinicians often see more patients than they are job planned to do; weekend working was a big challenge; a move to 7 day working to ensure 7 day flow would incur associated costs; capturing staff concerns; data for the 5 flows to view the whole picture; which disciplines are missing at the weekends that impede system flow; work between the BGH General Manager and Social Care to look at the process for packages of care which are removed on admittance of patients to hospital; and working to open Ward 12 as a transitional care unit.

The **BOARD** noted the report.

12. Healthcare Associated Infection – Prevention & Control Report

12.1 Mr Sam Whiting drew the attention of the Board to: outbreaks; hand hygiene audits; infection control team capacity; and the appointment of a new Infection Control nurse.

12.2 Dr Sohail Bhatti enquired if the Board wished to have sight of infections in the community given the health protection role that his team carried out. The Chair welcomed the suggestion and agreed that the Board should receive that information if it was easily collectable. Dr Bhatti would work with Mrs June Smyth on the data presentation.

The **BOARD** noted the report.

13. Area Clinical Forum Minutes: 04.10.22

The **BOARD** noted the minutes.

14. NHS Borders Performance Scorecard

14.1 Mrs June Smyth provided an overview of the scorecard and highlighted: the revised waiting times trajectory due to reduced funding; the updated delayed discharge trajectory; and that the narrative had been updated for the charts on page 262 of the board papers pack.

The **BOARD** noted the performance as at the end of December 2022.

15. Strategic Risk Register

15.1 Mrs Laura Jones apologised that on page 288 of the board papers pack the reference to the Public Governance Committee (PGC) should be amended to reflect that the PGC agreed that risk should be reframed around the risk associated with public engagement and inequalities. An annual detailed review of the strategic risk register had been completed to ensure it aligned to strategic risk. In relation to governance committees it was reflected in 3 of 4 committees that they were only able to do partial assurance for risk in terms of assurance in relation to systems and processes and no full assurance on the impact of delivery on services or staff.

15.2 Mrs Harriet Campbell commented that at a recent Audit Committee meeting it had been suggested that the Clinical Governance Committee did not have enough risks. Mrs Jones commented that arguably all risks were clinical and many overlapped

and were probably given to 1 committee instead of being shared across committees. Mrs Fiona Sandford suggested she and Mrs Jones pick up the matter as she was keen that the level of risk was never understated.

15.3 Mr James Ayling sought assurance that very high operational risks were linked to strategic risk. Mrs Jones confirmed that they were.

15.4 Dr Sohail Bhatti commented that the General Medical Council were keen to hear of instances of inadequate resources or time to do your job and the prompt from the regulator was to understand the system was under enormous strain and to reflect on that and in terms of clinical risk it would rise to the top through the mechanisms of consultant and clinical professionals appraisals. Dr Lynn McCallum echoed Dr Bhatti's comments.

15.5 Mrs Sandford commented on the importance of escalating to various networks so that the Scottish Government and public understood the level of risk being carried by the organisation. As an anecdote she commented that to hear that the Medical Director was undertaking ward rounds gave a good indication of the level of pressures the whole system was under.

The **BOARD** noted the strategic risk register.

16. Climate Emergency & Sustainability Annual Report 2021/22

16.1 Mr Andrew Bone provided an overview of the content of the report and advised that it was the first annual climate emergency and sustainability report and was a requirement from a policy published by the Scottish Government in November 2021 after the COP26 event. He emphasised that it was historic information and should have been published the previous year but was delayed due to discussions on a Scotland wide basis. The report was currently in a draft status and the format whilst clunky was a prescribed format and there were a still a few pieces of information to be included in the report. He advised that Mrs Harriet Campbell was the Board's sustainability champion and had provided some comments for incorporation in the final version of the report.

16.2 Mrs Campbell suggested the report provided a benchmark against which the Board could measure itself the following year and progressively in order to continually improve.

16.3 Dr Sohail Bhatti congratulated the team on pulling together such a thorough report. He enquired in regard to environmental harm caused by hospital settings, if the mileage of staff, visitors and outpatients was captured and included in business mileage.

16.4 Mr Bone commented that it was in terms of any mileage claims placed through the system. For unrecorded journeys such as patient journeys where the organisation did not provide transport, there was not a mechanism to assess that and in terms of business travel and types of vehicles used there was more analysis to be done.

16.5 Mr Ralph Roberts welcomed the report as a baseline and suggested it be taken into account in developing the financial plan as some elements would require investment.

16.6 Dr Lynn McCallum commented that there was a keen interest in climate change from clinical groups and she and Mr Bone would be meeting with clinicians to support engagement.

16.7 Mr Bone advised that an action plan was being worked up on all the things that needed to be completed for the following year such as some standard reports and a biodiversity report for March 2024.

The **BOARD** approved the publication of the report following finalisation by the Board Executive Team.

17. Chirnside Branch Surgery

17.1 The Chair reiterated that she was willing to waiver the notification rule in regard to public representation should a member of the public wish to speak at the start of the item.

17.2 Mr Ralph Roberts provided an overview of the content of the paper and appraised the Board of the current situation. He advised that the current situation reflected the decisions made and the position in regard to primary care sustainability.

17.3 Mr Chris Myers commented that it was important to recognise that it was unsustainable to maintain both the GP practice and the branch surgery. An extension engagement process had taken place and the conclusion reached was that there were no alternative options other than to close the branch surgery.

17.4 Mrs Cathy Wilson provided the background to the issue and detailed the process that had been followed. The core problem of keeping the Chirnside branch surgery open was to find GPs to sustain the provision of that service and it was compounded by recruitment issues which raised the risk level of safety across the site for the practice and the patients. In effect the closure of the Chirnside branch surgery was the only option to safeguard the Merse Medical Practice.

17.5 Dr Tim Young advised that the option appraisal process had been open and had explored all options however, a failure to attract a partner after a 12-18 month recruitment process made it clear that closure was the only viable option.

17.6 Mr Tris Taylor welcomed the transparency of the process and noted the range of options was narrowed down to a single option that was non-negotiable. He noted that the engagement process had been validated by the Healthcare Improvement Scotland engagement team and took assurance from that. He suggested the Public Governance Committee should monitor the progress of the impact assessment actions.

17.7 Dr Lynn McCallum commented that the whole situation was regrettable. She advised that there was an increase in the emergence of 2C practices across the region which was a significant risk to the delivery of primary care services.

17.8 Mrs Fiona Sandford enquired about the fragility of other GP practices across the area. Dr Young advised that he had submitted a paper to the Clinical Governance

Committee about safe GP practices and if the organisation should do more to measure them to get prior warning of sustainability issues.

17.9 Dr Young commented that the primary and community services team had already commenced work on GP sustainability by looking at the workforce survey of practices to identify which practices were struggling to recruit and which practices would be looking to recruit over the following years.

17.10 Dr McCallum commented that the reality was a level of frustration of public access to primary care as there had been a 33% increase in activity since the pandemic and no increase in staffing and the situation would only become more difficult in the future.

17.11 Mr Roberts commented that all health boards were struggling with workforce issues and it was not a unique scenario to the Borders or Scotland or the UK. There were no short term solutions and it was important to relay the outcomes of local conversations into national discussions.

The **BOARD** endorsed the closure of the Chirnside Branch Surgery.

18. NCS Response

18.1 Mr Chris Myers provided the Board with the background to the request by all three parties, NHS Borders, Scottish Borders Council and the Integration Joint Board, to the Scottish Government to be a pathfinder pilot for the proposed national care service. A response had been received acknowledging the offer to be a pathfinder and he had met with Scottish Government colleagues earlier in the week on behalf of all 3 organisations. The Scottish Government had been keen on the rurality, geography and coterminous nature of the partnership. In relation to the pathfinder request they were keen that areas had good integration arrangements in place and they would be back in touch. Mr Myers advised that he would arrange a joint development session with NHS Borders, Scottish Borders Council and the Integration Joint Board to work through what a pathfinder could look like.

The **BOARD** noted the response.

19. Scottish Borders Health & Social Care Integration Joint Board minutes: 16.11.22, EO 31.11.22

The **BOARD** noted the minutes.

20. Any Other Business

The **BOARD** noted there was none.

21. Date and Time of next meeting

21.1 The Chair confirmed that the next meeting of Borders NHS Board would take place on Thursday, 6 April 2023 at 9.00am at Jedburgh Town Hall, Jedburgh.

BORDERS NHS BOARD: 2 FEBRUARY 2023

QUESTIONS AND ANSWERS – FOR POINTS OF FACT AND CLARIFICATION

No	Item	Question/Observation	Answers
1	Minutes of Previous Meeting	-	-
2	Action Tracker	-	-
3	Annual Delivery Plan 2022/23 – Quarter 3 Update Appendix-2023-1	**Harriet Campbell:** P23 Was there anything in the Winter checklist update that was returned to SG on 29/12/22 that you'd like us to be aware of? If so please could this be raised in the meeting (ie no need for a written answer!).	**June Smyth:** The winter checklist was submitted on 07/11/22. At the time of submission we did not have plans in place for 4 of the items. SG requested an update on these 4 items (below) which we submitted on 29/12/22: • Pathways are in place for patients who are identified as 'frail' and those with respiratory exacerbations, and these are embedded within primary care services, in and out of hours, as alternatives to admissions. Regular MDT meetings are in place to discuss patients with severe COPD. • Plans are in place to support General Practice (and where necessary other independent contractors) and manage sustainability over the winter period • Plans are in place to support General Practice (and where necessary other independent contractors) specifically with reference to contingency arrangements where practices are unable to open due to staffing or other reasons. • A strategy is in place for the deployment of volunteers, making appropriate use of established local and national partnerships. A verbal update will be provided in the meeting.

		P 29 and throughout the update. I'm delighted to see that we have not pulled our punches in describing the challenges faced. This is really clearly written (and highlights areas of success well too). Thank you.	Noted, thank you.
4	Child Poverty Annual Report Appendix-2023-2	-	-
5	Health Improvement Annual Report Appendix-2023-3	-	-
6	Resources & Performance Committee minutes: 03.11.22 Appendix-2023-4	-	-
7	Audit Committee minutes: 10.10.22 Appendix-2023-5	-	-
8	Finance Report Appendix-2023-6	-	-
9	Quality & Clinical Governance Report Appendix-2023-7	-	-
10	Healthcare Associated Infection – Prevention & Control Report Appendix-2023-8	-	-
11	Area Clinical Forum Minutes: 04.10.22 Appendix-2023-9	-	-

12	NHS Borders Performance Scorecard Appendix-2023-10	**Harriet Campbell:** P262 What am I missing? The narrative says the WL numbers decreased for the fourth month in a row but the chart shows August 2493, September 2506, October 2521, November 2564, December 2538. That's only going down between November and December, so either the chart or the narrative is wrong. Which is it? Or do you just mean we are down on where we were in July (when it as 2561)	**June Smyth:** **Update from Kirk Lakie:** Apologies this isn't factually correct. The narrative is wrong. It should note that while we have reduced the overall numbers waiting since a high in June 2022, this is best represented as a stabilisation of total numbers waiting given this has not been a consistent month on month reduction. However we have seen the shape of the waiting list changing with a focus on a reduction in absolute or long waits. The scorecard has been updated to reflect this change and sent to Iris for issuing prior to the Board meeting.
13	Strategic Risk Register Appendix-2023-11	-	-
14	Climate Emergency & Sustainability Annual Report 2021/22 Appendix-2023-12	-	-
15	Chirnside Branch Surgery Appendix-2023-13	-	-
16	NCS Response Appendix-2023-14	-	-
17	Scottish Borders Health & Social Care Integration Joint Board minutes: 16.11.22, EO 31.11.22 Appendix-2023-15	-	-

Borders NHS Board Action Point Tracker

Meeting held on 6 October 2022

Agenda Item: Primary Care Improvement Plan Update

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2022-1	7	Mr John McLaren enquired about workforce risks, the GMS oversight group, the TUPE of staff from GP Practices to NHS Borders, the impact of recruitment of staff on the organisations carbon footprint and any potential cost pressure of the GMS contract. The Chair suggested the questions on workforce raised by Mr McLaren be placed on the action tracker and a direct response be sought. The **BOARD** agreed to add the questions on workforce on to the action tracker.	**Andy Carter**	**In Progress – Update 02.02.23:** Full consultation took place between the staff/their representatives and NHSB Management, facilitated by HR. The Practice-employed staff were formally transferred over to NHSB in the spirit of TUPE (Transfer of Undertakings Protection of Employment Regs) and this meant that they moved over as near to their previous employer pay point as possible, whilst still complying with our commitment to a Living Wage. Financial implications are being built into the Board's Financial plan – to be discussed at the Board development session and future Board meeting.

Agenda Item: Quality & Clinical Governance Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2022-2	12	The **BOARD** agreed that a report on the PET situation in regard to complaints be submitted to the Public Governance Committee.	**Laura Jones**	**In Progress:** Report being prepared for the next meeting of the Public Governance Committee. **Update 01.12.22:** The Patient Experience Team report was due for consideration at the Public Governance Committee meeting scheduled for February 2022. **Complete: 02.02.23**: The Public Governance Committee had received the Public Engagement Team report at its meeting held the previous day. The Chair proposed the action be closed on the action tracker.

Meeting held on 2 February 2023

Agenda Item: 01.12.22: Minute 6: Health Inequalities Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2023-1	4.1	Mr Tris Taylor asked that an action be added to the Action Tracker in regard health inequalities activities being remitted to the Public Governance Committee to provide assurance on health inequalities.	**Tris Taylor, June Smyth**	In Progress

Agenda Item: Quality & Clinical Governance Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2023-2	11.4	Mr John McLaren suggested there should be a process put in place to capture staff concerns. The Chair suggested it be noted on the action tracker as a piece of work to be delegated to the Clinical Governance Committee to pursue.	**Fiona Sandford Laura Jones**	In Progress

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**NHS Borders Pharmaceutical Care Services Plan UPDATE**
Responsible Executive/Non-Executive:	**Alison Wilson; Director of Pharmacy**
Report Author:	**Alison Wilson; Director of Pharmacy**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of the 2022-23 Update to the NHS Borders Pharmaceutical Care services Plan 2021-24 is to provide the Board with updated Action Plan from the original Pharmaceutical Care Services Plan approved in 2021.

2.2 Background

The Pharmaceutical Care Services Plan is a statutory plan which evaluates the current service provision, identifies any gaps and supports any future decision making process on any future application for a new community pharmacy in the Scottish Borders.

2.3 Assessment

Service provision is adequate as seen in original approved Plan.

2.3.1 Quality/ Patient Care

The plan seeks to improve quality of patient care through access to pharmaceutical care through an accessible network of community pharmacies.

2.3.2 Workforce

N/A

2.3.3 Financial

N/A

2.3.4 Risk Assessment/Management

N/A

2.3.5 Equality and Diversity, including health inequalities

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

An impact assessment has not been created for this update to action plans. A new impact assessment will be created with the new Pharmaceutical Care Services Plan 2024-2027

2.3.6 Climate Change

N/A

2.3.7 Other impacts

N/A

2.3.8 Communication, involvement, engagement and consultation

N/A

2.3.9 Route to the Meeting

The Pharmaceutical Care Services Plan Action Plan Update 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.

- Pharmacy Senior Management Team; responsible for areas of the action plan, December 2022 – February 2023.

2.4 Recommendation

The **BOARD** is asked to **note** the update.

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

3 List of appendices

Appendix No 1, Action Plan

NHS Borders Pharmaceutical Care Services Plan UPDATE

Action Plans 2021-2024 – Updated end of 2022-23 for 2023-24

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

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

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

		input/updated. Monitoring will continue as we track the uptake of serial dispensing across practices and pharmacies. The Pharmacy teams in practices are actively pushing serial dispensing in order to help manage workload.
Independent Prescribers (Pharmacy First Plus)	1. Provide support through provision of service specification. 2. Establish clear peer review process. 3. Facilitate and encourage training of pharmacists. 4. Audit provision of service. 5. Establish provision of service in each locality. 6. Establish provision of service in 50% of community pharmacies.	1. COMPLETE - Approval to Practice documentation has been developed to meet the governance needs of NHS Borders. 2. COMPLETE - All PIPs and trainees are invited to attend a two monthly peer review process facilitated by NHS Borders. This has been well attended. Pharmacists share best practice and discuss elements of the service. 3. On-going; supporting pharmacies to identify training required and facilitate accordingly; including providing and attending Teach and Treat Hubs; mental health training. 4. COMPLETE - Prescribing data is provided monthly and reviewed within the peer review session. 5. On-going – 5 pharmacies providing – Lauder, Earlston, Duns, Selkirk and Greenlaw – 3 out of 4 localities covered (West pharmacist is undertaling IP training). 6. 5 out of 29 pharmacies so far = 17%; 2022 x 3 IP pharmacists adds 3 locations = 27%
Public Health	1. Monitor according to national targets for smoking cessation 2. Support engagement between Well Being Service and Community Pharmacies. 3. Monitor formulary compliance for smoking cessation,Emergency Hormonal Contraception and Gluten Free Food Service. 4. Produce regular compliance report for dissemination to Community Pharmacies. 5. Ensure Pharmacy entries are kept up to date on NHS Inform	1. On-going. Regular review of data and provision of training by Wellbeing Service. 2. COMPLETE - Review of activity has resulted in plans for the Well Being Service to provide additional pharmacy support for 2022-23. Includes marketing, advertising, introduction of referral forms and short educational online training sessions. 3. On-going; smoking cessation and emergency hormonal contraception monitored through UCF activity data. Data on patients using the GFF is fedback to community pharmacies to facilitate the annual health check. 4. COMPLETE - This relates to formulary choice for smoking

	6. Support the roll out of the extensions to the sexual health service to include supply of contraception and training on supporting people affected by sexual assault. 7. Support the development of vaccination services via community pharmacies as part of the response to COVID and the roll-out of the Vaccination Transformation Programme.	cessation but as the first choice is no longer available the report is not necessary at this time. 5. On-going; Pharmacies inform NHSB and NHS Inform of any changes to details. 6. COMPLETE – contraception rolled out; training on sexual health being produced by NES 7. On-going; 1 pharmacy delivering travel health services; encouraging more to deliver in 2022. 9 pharmacies delivered flu vaccination services for 2021/22- providing 2,400 vaccinations to end December 2021; other pharmacies do not have the space/staff resources to deliver. A number of pharmacies have signed up t provide a service for 2022/23 and final data not available.
Community Pharmacy Engagement	1. Continue to engage Community Pharmacy in cost efficiency. 2. Work with Community Pharmacies and Practices to implement a test of change to reduce waste medicines. 3. Review how performance data can be supplied to pharmacies improving performance and reducing variance.	1. On-going – data being provided to pharmacies on a regular basis. 2. On-going – campaign started and messages to follow. 3. On-going – data being provided to pharmacies on a regular basis.

2. PLAN for Pharmacy Teams Integrated into GP Practices

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Medicines Management	1. Discharge Letters / ECS improvement work. 2. Getting to the root of medicine issues and solving them 3. IDL Processing. 4. Data collection of monthly activity.	1. On-going; interface QI work continues with Medical Assessment Unit and other stakeholders. Pharmacy Support Staff Obselete Medicines protocol improving accuracy of repeat lists. 2. On-going. 3. Complete Level 1 GPCP contract work occuring across all practices, moving towards completion by PSS and Technicians. 4. Ongoing Monthly activity being manually collated, and linked into national work to streamline data collection.

Serial Prescribing	1. Reducing actioning and signing burden within Practices. 2. Allowing Community Pharmacy to better schedule/spread workload. 3. Encourage steady growth in all practices (a focused project would result in increased seasonal burden at Rx expiry & review time). 4. Patients being systemically selected and ad hoc by Pharmacy team 5. Weekly progress statistics issued to Practices.	1. Ongoing Reducing signing burden by continued increase in serial prescribing in Borders from 4 % to 10%. This work continues as several practices take part in the HIS Acutes Project (Acutes→Repeats→Serial). 2. Ongoing Included in above. 3. On-going; included in above. 4. Ongoing Protocols and training under development to allow extra support from non-clinical staff to underpin and drive serial prescribing. 5. COMPLETE – This is monthly rather than weekly and further work is happening nationally to improve quality of data.
Improvement Work	1. Specific projects for step-wise improvement of previous GP systems.	1. On-going; Unified Prescribing Policy and HIS Acutes Project involvement will continue this year.
Releasing GP Capacity	1. Discharge letter / ECS improvement. 2. Supporting new GMS contract.	1. On-going. 2. On-going.
Medication & Polypharmacy Review	1. A systematic review program will target the highest need medicines management problems. 2. Time and expectation management within practice to allow time to do consistently and effectively.	1. On-going; an experienced member of GPCP team will be leading a Polypharmacy/Realistic Medicine program starting February 2022. Funding taken back to Health Board. 2. On-going with work above.
Specialist Clinics	1. Chronic Pain. 2. Heart Failure. 3. Respiratory. 4. Mental Health. 5. Polypharmacy/Realistic Medicine. 6. Others depending on local needs and capacity.	1. Linking in with Pain Team and with NHS Fife work from February 2022. 2. No plans to take forward 3. Joint working COPD review project competed and presented to Gp Sub. National Strategy parked in NHSB at moment but we will be re-visiting environmental projects (aerosol devices) later in 2022/23. 4. On-going Linking in with Mental Health team to develop and improve local strategy including drug monitoring. 5. On-going An experienced member of GPCP team will be leading a Polypharmacy/Realistic Medicine program starting February 2022.

		6. On-going National Strategies will be re-starting/refreshed as we come out of Covid pandemic. Starting in February 2022 we are benchmarking the National Therapeutic Indicators to establish local KPI.

3. PLAN for Transformed Hospital Pharmacy Services

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Transformation requirements	1. Technology enabled care in 2021 – next phase of ward cabinet rollout to Ward 7, 9, 12, 14, Borders Stroke Unit/Margaret Kerr Unit, Intensive Care Unit, Theatres, Pharmacy Controlled Drugs and 4 x community hospitals. 2. Pharmacy Automated Dispensing System (robotics) January-March 2021. 3. HEPMA – Hospital Electronic Prescribing & Medicines Administration to remove paper based processes from prescribing and medicines administration; improve patient safety and quality of care. Part of national rollout timings. 4. Support advanced practice of pharmacist and pharmacy tehcnicians though investment of education and training for all staff. 5. Support pharmacists to become independent prescribers. 6. Pharmacists integration to clinical multi-disciplinary teams to support safe prescribing and administration of medicines at ward level. 7. Triage processes for pharmacists and pharmacy tehcnicians – complex patients.	1. COMPLETE for 2022; ongoing work for 23/24- Electronic cabinets have been purchased and installation planned for wards. I community hospital installation January 2022; others planned. Awaiting capacity within Estates team to facilitate further installation – cabinets have been in pharmacy for a number of years 2. Ongoing. Business case approved; awaiting other departments to be able to move forward. Installation will result in pharmacy staff released to patient facing roles, better stock control and reduced drug errors. 3. On-going; scoping and engagement work continues in conjunction with IM&T colleagues and other national and regional teams involved in roll-out. Outcomes to be measured – drug errors (prescribing and administration; timeliness and missed doses) and improved medicine communication between secondary and primary care. 4. On-going – Royal Pharmaceutical Society (RPS) published the advanced practice framework end of 2022. Practice lead pharmacy technician appointed to develop clinical practice of pharmacy technicians. 5. On-going; 4 and 5 plan to increase number of pharmacist prescribers and involvement in QI projects and research. We

	8. Review benefits of 7 day pharmacy clinical service. 9. Support local delivery of realistic medicine. 10. 10. Developing new ways of supplying chemotherapy with aseptic unit closure and regional working	currently have 4 pharmacist independent prescribers and 4 in training, with a further 2 starting in early 2023. Developing education and training for technicians has benefits for patient facing roles and support for wards; increase number of checking pharmacy technicians and technicians within clinical services. 6. On-going.Challenges with recruitment and ongoing vacancies. 7. On-going. 8. Benefits continually under review – volume of dispensing at weekends; number of discharge prescriptions processed and impact on on-call service; also digital transformation success. 9. Prescribing guidance being developed as appropriate along with regional formulary work; polypharmacy reviews where appropriate. 10. Ongoing. Planned closure June 2023. Project manager now appointed and new cold store installed to create additional capacity for drug storage.
Discharge Process	1. Digitally enabled, improved communication between secondary and primary care and community pharmacy. 2. Assessment and sign-posting of medicines management support. 3. Development of clinical pharmacy technical roles. 4. Development of discharge processes to meet individual patient requirements. 5. Review clinical pharmacist role in the discharge process.	1. On-going. Awaiting IM&T capacity to support some development work. 2. On-going; using number of referrals received from one pharmacy colleagues as measure.Expansion of medicines management training for clinical technicians to improve equity of access to assessment. 3. 4 and 5 are interlinked and Ongoing; supporting the new band 5 technicians will commence early 2023
Quality Improvement & Performance Measures	1. Defining and communicating the role of Pharmacy services to the wider hospital. 2. Developing performance indicators to ensure workload is efficient and as proactive as possible. 3. Improving medicines governance across BGH	1. On-going, workforce challenges make communication harder 2. Ongoing with IM+T regarding business objects reporting for clinical service; national KPI's being developed through National Acute Pharmacy Group to enable benchmarking

	with identified outcome measures. 4. Development of research skills and advanced practice – in partnership with academia.	3. Ongoing; Audit work being undertaken; challenges with wider input due to workforce pressures in other areas; medicines governance work will develop alongside development of ward-based pharmacy technician roles 4. Ongoing; bank pharmacist supporting clinical team with research (focusing on FTY, HSCP and Mental health)
Modern Outpatient Programme	1. Development of pharmacists working at an advanced level to facilitate complex drug therapies at home with clinical specialities. 2. Facilitate more cohesvie MDT working – advanced practice.	1 – 2 On-going; challenging due to recruitment. Will review again as pharmacists get IP qualification

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

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Data Measurement & Monitoring	1. Using data monitoring to measure adherence to Gluten Free Food Service; smoking cessation and NHS Pharmacy First services.	1. COMPLETE - Senior Prescribing Support Pharmacist undertakes monitoring on a regular basisin conjunction with the teams.
Medicines Reconcilliation	1. Connected to Discharge process in Hospital Pharmacy Services.	1. COMPLETE - IM&T are taking this forward - to send discharge letters, where patient consent is obtained, to community pharmacies. This is being followed up by Pharmacy Project Manager.
Pharmacy Role Awareness	1. Promote NHS Pharmacy First Scotland service. 2. Raise awareness on new approach to accessing urgent care. 3. Continue to promote closer working GP and pharmacist.	1. COMPLETE - Work undertaken as part of Covid pandemic response and reshaping urgent care workstream. Promoting through Communications team. 2. COMPLETE - See above 1. 3. On-going; regular interface work with Practice based teams including pharmacotherapy team to promote joint working.
Quality Improvement in Community Pharmacy	1. Improve service delivery through analysis of community pharmacy activity and services provided.	1. COMPLETE - Senior Prescribing Support Pharmacist is leading and this overlaps with data monitoring above.

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

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Improvement Approaches	1. Increase standard of delivery of care in patients' own homes. 2. Work with Pharmacotherapy Team to review patients' medication support needs & ensure medication reviews. 3. Provide education & advice to Health & Social Care staff on medicines management. 4. Support Health & Social Care staff with complex medicines management assessments. 5. Improve the pharmaceutical care of residents in care homes 6. Review the current service provided by Community Pharmacy and introduce more clinical support to link in with work of Pharmacotherapy Team. 7. Pharmacy led, structured medication review as part of MDT. 8. Pharmacy specialist advice and education on use of medicines/policies/procedures. 9. Medicines waste.	1 – 4, 7-9 IJB 2 year funding for a pharmacy team to work with the H&SCP supporting patients receiving Care at Home – work piloted from November 2022. Current Team = 2 x FT Band 5 technicians, 1 x 0.4 8a Pharmacist 5. G Sutherland currently supporting pharmaceutical care in Care Homes through Realistic Medicine work. Currently no pharmacy technician support for Care Homes. 6. SLWG to form January 2023 to look at standardising the Medicines Management Assessment tool for all sectors across NHSB.

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

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Recruitment and Retention	1. Support Pharmacists to complete the Independent Prescribing qualification and other training available.	1. We have a total of five community pharmacists currently undertaking their IP training. Continue to promote.

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

2021-24 PLAN for Enabling NHS Pharmaceutical Care Transformation

2021/22 - 2022/23 - 2023/24		Updated for 2023/24
Postgraduate career framework	1. Implement Scottish Government recommendations for Independent Prescribers. Check SG target for IPs and set proportional target for NHSB. 2. Provide administration support to enable service provision of Pharmacy First Plus. 3. Establish peer review processes to support high level services 4. Support introduction of Protected Learning Time in Community Pharmacies.	1. Work progressing in line with National Oversight Groups supported by our Education and Training lead Pharmacist/ 2. COMPLETE 3. COMPLETE 4.On-going
Pharmacy technician development	1. Career framework. 2. Developing advanced skills and roles.	1–2 Ongoing. Career opportunities in Surgery, Mental Health introduced and further work will be taken forward when new lead practice technician starts April 2022.

Workforce planning	1. Be responsive to SG policy recommendations and CPS advice following publication of workforce planning data in 2021.	1.On-going
ePharmacy support for all primary care prescribers	1. Review weekly report on pharmacy-led electronic data, feedback to relevant teams and provide associated educational messages. 2. Review data in line with national and local guidelines. 3. Ensure that responsibility is given to NHSB pharmacist who is able to recommend policy development. 4. Develop method of communicating data to CPs.	1-4 COMPLETE
HEPMA	1. Working with other Boards and within NHS Borders to implement HEPMA.	1. On-going; work continues on this project within NHS Borders.
Health Information Access	1. Support and promote safe sharing of information between NHS Borders and GP practices.	1. On-going
Technology enabled care solutions	1. Ensure CPs retain access to ECS. 2. Support use of ECS. 3. Ensure CPs retain access to Near Me. 4. Support use of Near Me. 5. Provide specific training to pilot use of Near Me such as consultations within smoking cessation service and annual check for the gluten-free food service. 6. Facilitate use of Near Me in service provision to Care Homes.	1-6 Access available; continuing to promote use and benefits within Community Pharmacy.
Automation	1. Be aware of and monitor impact of off-site dispensing. 2. Request and review feedback from users of off-site dispensing. 3. Pharmacy Automated Dispensing System	1-2 COMPLETE 3. Waiting for Estates to progress.

	(Robotics) in BGH.	
Clinical decision support tools	1. Provide training on use of shared decision making tools. 2. Access to resources and training.	1-2On-going
Contracting and funding arrangements	1. Ensure responsibility is assigned to NHSB pharmacist to review and determine impact of SG PCAs.	1.On-going
Planning	1. Monitor resilience of CPs - collation of business continuity plans 2. Lessons learned – Covid-19 responses. 3. Be prepared for future emergencies – NHSB responsible pharmacist. 4. Ensure clear policies and procedures for communication pathways.	1. COMPLETE 2.On-going 3. COMPLETE 4. COMPLETE

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Resources & Performance Committee Minutes**
Responsible Executive/Non-Executive:	**Ralph Roberts, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Resources & Performance Committee 2 March 2023

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 19.01.23

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 19 January 2023 at 9.00am via MS Teams.

Present: Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mr J Ayling, Non Executive
Mrs L O'Leary, Non Executive
Ms S Lam, Non Executive
Cllr D Parker, Non Executive
Dr K Buchan, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health
Mr A Carter, Director of HR
Mrs J Smyth, Director of Planning & Performance
Mr G Clinkscale, Director of Acute Services
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement
Ms G Russell, Partnership Rep

In Attendance: Mr K Lakie, General Manager Planned Care
Mrs C Oliver, Head of Communications
Dr T Young, Associate Medical Director, P&CS

1. Apologies and Announcements

1.1 Apologies had been received from Mrs Harriet Campbell, Non Executive, Mr Tris Taylor, Non Executive, Mrs Sarah Horan, Director of Nursing, Midwifery & AHPs, Miss Iris Bishop, Board Secretary, Dr Janet Bennison, Associate Medical Director Acute and Dr Amanda Cotton, Associate Medical Director MH&LD.

1.2 The Chair welcomed Kirk Lakie, General Manager to the meeting who attended for item 6 on the agenda.

1.3 The Chair confirmed the meeting was quorate.

1.4 The Chair reminded the Committee that a series of questions and answers on the papers had been provided in regard to areas of fact or clarification.

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 November 2022 were amended to record the title QI Facilitator for Lynn Morgan-Hastie and with that amendment the minutes were approved.

4. Matters Arising

4.1 **Action 12:** Mrs June Smyth reported that Dr Sohail Bhatti had attended the Public Governance Committee where health inequalities and public health in general had been discussed. A further follow up call with the Mr Tris Taylor, Chair of the Public Governance Committee would take place later that day to confirm if health inequalities would remain on the Committee workplan for a future discussion or be brought forward to the next meeting. The Chair suggested that the Committee consider the action closed as it had been fully demitted to the Public Governance Committee.

4.2 **Action 13:** The Chair commented that Mrs June Smyth had previously advised that the Remobilisation Plan had been superseded by the 22/23 Annual Delivery Plan (ADP) and that quarterly updates of the ADP would be submitted to the Committee. The Chair suggested the item should now be closed. Mrs Smyth commented that the quarterly updates would not necessarily fit with the timeline for the Committee and therefore some would be appear at the full Board instead. In terms of Mrs Sandford's original query regarding the workforce narrative a more tangible narrative around the numerical gap was being included particularly for qualified nursing. In terms of communicating to staff, Mr Andy Carter confirmed that discussions had been taking place with NHS Lothian in regard to bank staff to ensure all staff were captured for communications moving forward. The Chair suggested that the Committee consider the action closed.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 12.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to close Action 13.

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

5. Performance Report

5.1 Mrs June Smyth provided an overview of the content of the report and advised that it illustrated performance as at the end of November 2022 against the Annual Operational Plan. She commented that in the Q&A Mrs Harriet Campbell had sought more up to date information as it felt like some time had passed since November. Mrs Smyth advised that the data in the report was actually 2 weeks ahead of time as it had been brought in outwith the normal timeframe. Further updated information would be provided to the next public Board meeting.

5.2 Mrs Smyth clarified that as highlighted in previous papers, and due to reduced funding the waiting times trajectories were being revisited. Those trajectories were already in place within the service and the delayed discharge trajectory had also been updated. She also referred to the issue around the under reporting of diagnostics and the actions that had been taken forward as per the SBAR attached to the paper.

5.3 The Chair asked that dates be provided against the narrative updates in the report.

5.4 The Chair enquired about waiting times for paediatric surgery and what sort of surgery the 11 might be. Mr Gareth Clinkscale commented that he would be happy to provide the detail however they were unlikely to be clinically urgent cases and were dependent on external provision.

5.5 Mr James Ayling enquired how fundamental the action on the contract supplier for the booking system was in terms of waiting times.

5.6 Mr Ayling further enquired about the impact of the reduction in funding for waiting times.

5.7 Mr Clinkscale commented that the outpatient booking software was run through Microsoft and was an archaic system. The outpatient team were scoping software to create a more efficient process and use the capacity more intelligently. The process was being overseen by the Integration Planning Care Board. In terms of the waiting times funding reduction it equated to over £1m and whilst core posts would be protected the reduction in funding reduced the flexibility in the system as well as additional activity such as outpatient clinics, external capacity and weekend operating.

5.8 The Chair enquired if there was any impact on the theatre workforce plan and Mr Clinkscale advised that there would be no impact.

5.9 Ms Sonya Lam commented that in terms of delayed discharges there appeared to be a consistent rate of removals and she enquired on what basis they were removed and in terms of imaging and waiting times reporting she sought assurance there were no other issues in terms of reporting.

5.10 Mrs Smyth commented that in terms of reporting we could never provide a 100% assurance that something had not been missed, however the diagnostic reporting was a specific issue due to a change over in systems and those extra safeguards and extra checks were in place for any other system change overs in future.

5.11 Dr Tim Young clarified that children referred for paediatric surgery by GPs would be referred in a timely fashion and should confirmation that surgical referrals were being reviewed. Mr Clinkscale assured the Committee that all paediatric surgery referrals were being clinically validated at said times.

5.12 Mr Chris Myers clarified that for delayed discharges that the 30-40% removed for ill health related to 30-40% of the total removals, rather than 30-40% of the total number of people waiting for care. Looking back to 2019 data it had fluctuated at around that rate. There were a range of reasons as to why people were removed due to ill health, including a number who were unfit on referral, and a number who had become unfit and unwell while waiting.

5.13 Dr Lynn McCallum enquired if the clock for each individual was reset each time a patient was removed from the delayed discharge list. Mr Myers replied that the services worked within national definitions to report delayed discharges. As part of that all delayed and non-delayed bed days were aggregated. In addition, if a patient became unfit for discharge and their period of illness was longer than three days, the clock stopped and then re-started when the patient was again ready for discharge.

5.14 Dr Sohail Bhatti commented that given primary and community services (P&CS) were 90%-95% of initial contacts with people on a daily basis there was little performance data in the scorecard. Mrs Smyth advised that the scorecard had previously been a much fuller document and contained a range of P&CS data however the decision was taken to strip it back to the national indicators in order to free up capacity internally to support the turnaround programme.

5.15 Mr John McLaren commented that there was little in the narrative for the 4 hour performance target in respect of the impact on staffing.

5.16 Mrs Sandford commented that at the last Clinical Governance Committee meeting there had been an excellent report from Dr Tim Young about the state of general practice and the Borders and suggested it be circulated to Board members. She also commented that whilst it was difficult to extract data from primary care she suggested it should still be pursued.

5.17 Mrs Sandford then enquired if the answer to the pressures was to open more beds. Dr McCallum was clear that opening more beds was not the right answer, and in the majority of cases treating people in their own homes and community settings would lead to better outcomes for individuals.

5.18 Mr Clinkscale advised the Committee that there was deterioration in the 62 day cancer performance and a number of actions were being taken forward to address the situation. He advised that the issue was predominantly associated with workforce challenges in radiography, CT scanning and endoscopy. He advised that whilst NHS Borders continued to deliver the highest level of 62 day cancer performance in Scotland, he anticipated that deterioration would continue over the next few reporting periods.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of November 2022.

6. Winter Pressures

6.1 Mr Gareth Clinkscale and Mr Chris Myers provided a presentation on the current pressures being experienced in the system presently and the actions being taken to mitigate those pressures. Mr Clinkscale reflected on the previous 12 months and the input of the Centre for Sustainable Delivery, the Boards performance in terms of the emergency access standard performance and the significant workforce challenges. He focused on the improvements that had been made including: the emergency access standard performance; the work that had been taken forward in regard to the nursing workforce; the opening of ward 17 as a protected surgery ward which led to the lowest level of cancelled operations; establishment of the urgent and unscheduled care programme; and the successes around the Kaizen initiative.

6.2 Mr Clinkscale then spoke of the winter planning that had taken place and the measures put in place including: weekend medical cover; weekend AHP cover; overnight staffing in the emergency department; extra healthcare support worker capacity; some targeted enhanced pharmacy capacity; processes for managing flow; and a new duty manager standard operating procedure.

6.3 Mr Myers spoke of the further programmes of work that had been undertaken which included: deployment of a 'Supporting the Right Direction' social work paraprofessional to the Borders General Hospital to increase the focus on the use of self-directed support option

1 - purchase of service from family and friends to people awaiting home care; an increase in the community equipment store capacity; business continuity planning of all social care providers; a reablement pilot in SB Cares that is evidencing a 30% reduction in on-going care needs for people; polypharmacy review service of social care service users; a pilot in Tweeddale to transform overnight care through an on call system and technology enabled care; increased focus on MHO reviews; Home First QI project; and improving bed based respite options.

6.4 Other areas covered in the presentation including: pressures in social care; influenza incidents; COVID-19 patients; norovirus; impacts of sickness absence in staff; crowding in the emergency department; long waits for admission; increased demand on GP services; staff wellbeing and retention; and recovery measures and risks.

6.5 A robust discussion took place and a range of elements were debated further which included: staff well-being; people management capability issues around manager training; clarification of data being raised through the Q&A process; procurement of care support from family and friends; hidden economic inactivity; alignment of pay and recycled employer contributions for the pension issue; lower vaccination booster rates for staff compared to the previous year; percentage increase in AHP capacity; 4 hour performance; and the reablement approach.

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

7. Finance Report

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted the forecast deficit position of £15.7m at the Quarter 1 review and the target of £12.2m. He advised that the Board was current sitting with an £11m overspend. He drew the attention the Committee to paragraph 3.3 in the report and the changes in forecast, specifically the increased pressure in GP prescribing and increased costs in relation to learning disabilities placements out of area. Work was continuing on the Quarter 3 forecast and Mr Bone was confident that he would be able to deliver the target £12.2m deficit by the year end, however he cautioned that it would have an impact on flexibility for the following year.

7.2 The Chair noted the disappointing position regarding prescribing and enquired about the impact of slippage on LIMS. She suggested Mr Bone provide a briefing to the Board outwith the meeting.

7.3 Mr Bone commented that he could manage the flexibility within the 2 years however there would be an issue if the costs exceeded the original plan forecast and from a financial recovery perspective.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board is reporting an overspend of £10.89m for eight months to end of November 2022.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the position reported in relation to COVID-19 expenditure and how this expenditure has been financed.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the financial performance expectation set out by the Scottish Government following the Board's Quarter One Review is that the board achieve an outturn performance in line with the Financial Plan (£12.2m deficit).

The **RESOURCES & PERFORMANCE COMMITTEE** noted progress against the actions described within the Financial Recovery Plan submitted to Scottish Government in November.

8. Finance Strategy

8.1 Mr Andrew Bone provided a high level presentation and commented that the financial plan was a reflection of the challenges being faced by the organisation in terms of how it manifested its expenditure. During the presentation Mr Bone referred to: timelines of submission of key documents to the Scottish Government; submission of the financial plan and financial recovery plan which essentially explained the actions being taken to achieve the targets that had been set; outturn forecast to March 2024 and the best and worst case scenarios; national programme approach; local approach; 3 year scenarios; work to do on level of investments; work to do on budget setting; and work to do on the recovery plan.

8.2 Mrs Fiona Sandford enquired how the public would be made aware of the financial constraints within the NHS.

8.3 Mr James Ayling suggested there was a fundamental mismatch of the core level funding required to maintain the services currently provided.

8.4 Mr Ralph Roberts as the Accountable Officer commented that it was a difficult position to be in and the Board would need to balance the risk it wished to take around finance in the context of the other pillars of governance around quality, safety and workforce. He suggested it needed to be part of a public discourse and play into what society was willing to spend on the NHS and what sort of NHS it expected in return. He advised the Committee that he and the other Health Board Chief Executives were being more assertive with the Scottish Government about the need to put the underlying financial affordability into the public domain. He suggested the discussion at the Board on the financial plan should be held in public.

8.5 The Chair commented that she was fully supportive of the need to be open and transparent with the public on the financial plan

8.6 Dr Lynn McCallum commented that she fully believed that by delivering better care, financial savings could be realised. In doing less, better care could be provided and it was possible that it might only bring demand back into line but that in itself would provide some financial stability.

8.7 The Chairs suggested Mr Bone attend the next Non Executive Group meeting to update them on the consequences of slippage within LIMS and that a paper be produced for the next Committee meeting.

8.8 Mr Roberts asked that Mr Ayling provide a bullet point list of his queries in regard to LIMS to Mr Bone.

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

9. Any Other Business

9.1 There had been no further notification of items to be discussed.

10. Date and Time of Next Meeting

10.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 2 March 2023 at 9.00am via MS Teams

RESOURCES & PERFORMANCE COMMITTEE: THURSDAY 19 JANUARY 2023

QUESTIONS AND ANSWERS FOR POINTS OF FACT OR CLARIFICATION

No	Item	Question/Observation	Answer
1	Declarations of Interest	-	-
2	Minutes of Previous Meetings	-	-
3	Matters Arising	-	-
4	Performance Report Appendix-2023-1	**Harriet Campbell:** Please can we have a verbal update of the position to date (or as near to date as we can be). End of November feels a very long time ago.	**June Smyth:** We are reporting November data due to the timelines and process we have in place for retracting the data from the various patient and clinical information systems we access to produce the report, which takes place on the 12th of the month. This data is then validated by the Business Intelligence Team before being sent through to Planning & Performance on the 16th of the month for the scorecard narrative and cover paper to be populated. The December (or latest available) data will be incorporated into the Performance Scorecard as part of the January Board Papers. Unfortunately, at the time of responding to the Q&A the data was not yet available. Verbal updates may be provided at the time of the meeting if available.
5	Performance Report Appendix-2023-1	**Lucy O'Leary:** P31 OP waiting times: Dermatology seems to be a perennial feature of this. Is there a particular reason why long waits here seem to be more difficult to tackle than in	**Gareth Clinkscale:** Dermatology is Specialty we have struggle to recruit into. While we have some reasonable cover for all clinically urgent work as a priority, and routine

		other specialties? P36 - Delayed discharges: positive signs and the current focus on reducing LOS in the “active treatment” stage as well as LOS of delay is really welcome	skin lesions this leaves capacity to see routine rash patients. Our longest waiting patients are in the main routine rash referrals. We are working to identify a solution, but work force issues are a nationwide problem. Unfortunately, independent providers are also reluctant to support rash activity because of the associated complexity. We are continuing to explore every available option to source additional capacity, and this includes discussion with both NHS Lothian and Fife. Both have their own capacity issues in this area. **Chris Myers:** Thank you. This is being progressed as part of the Discharge without Delay programme and as we roll out the Kaizen approach across wards.
6	Winter Pressures	-	-
7	Finance Report Appendix-2023-2	-	-
8	Finance Strategy - Financial Plan - Financial Recovery Appendix-2023-3	**Lucy O’Leary:** P68 LIMS – I’d appreciate a (short) verbal update on what’s happened here and what’s changed since the Board decision re scheduling of replacement	**Andrew Bone:**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Endowment Fund Board of Trustees Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

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

- Endowment Fund Board of Trustees 30 January 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Endowment Fund Board of Trustees minutes 03.10.22

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Monday, 3rd October 2022 @ 2 p.m. via Microsoft Teams.

Present:
Mr J Ayling, Trustee
Dr S Bhatti, Trustee
Mr A Bone, Trustee
Mrs H Campbell, Trustee (Left at 3.35 p.m.)
Mrs S Horan, Trustee
Ms S Lam, Trustee
Mr J McLaren, Trustee
Mrs L O'Leary, Trustee
Cllr D Parker, Trustee
Mrs F Sandford, Trustee (Chair)
Mr T Taylor, Trustee

In Attendance:
Ms C Barlow, Fundraising Development Manager
Mrs B Everitt, PA to Director of Finance (Minutes)
Mrs C Oliver, Communications Manager
Mrs S Swan, Deputy Director of Finance (Head of Finance)
Mr G Reid, Investment Advisor
Mrs J Smyth, Director of Planning & Performance (Arrived at 3.35 p.m.)
Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Fiona Sandford welcomed those present to the meeting. Apologies had been received from Mrs K Hamilton, Trustee and Mr R Roberts, Trustee.

2. **Declaration of Interests**

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

3. **Minutes of Previous Meeting 6th June 2022**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Tracker

The action tracker was noted.

Update on Professional Indemnity Policy, Interest Bearing Deposit Account and Cover for Cash Balances
Susan Swan spoke to this report which covered issues raised at previous meetings.

Professional Indemnity Policy
Susan provided an update on the market test exercise to source a Professional Indemnity (Management Liability) policy for Trustees. It was noted that Marsh Commercial, the NHS Scotland Framework Insurance Broker, had provided information

on suitable providers to provide cover which would solely be for the Endowment Fund Charity as a legal entity and the Trustees who govern the charity. Susan reminded that NHS Borders Board members are already covered for liability for Board related business activities as part of the NHS Scotland risk sharing scheme for Clinical Medical Negligence and other Risks (CNORIS). It was noted that quotes for the annual premium of the Professional Indemnity Policy are currently being refreshed and expected to be in the range of £1.5k - £2.5k.

Interest Bearing Deposit Account
Susan explained that due to the previous interest bearing deposit account being withdrawn, a new account was required to be set up to operate alongside the existing commercial bank account with the Royal Bank of Scotland. It was noted that an interest bearing deposit account is now operational with the Unit Trust Bank.

Cover for Cash Balances Outwith the Limits of the Financial Services Compensation Scheme (FSCS)
Susan advised that a total of £400k is held in cash for the Endowment Fund across two bank accounts. It was noted that the FSCS protects up to £85k held in an individual bank account, meaning a maximum of £230k could be at risk should these banks fail. Trustees had previously requested that an insurance policy be sourced to protect the monies held outwith the protected limits. Susan highlighted that the NHS Scotland appointed Insurance Broker has confirmed that there are no insurance policies for cash and proposed an alternative, namely a Credit Default Swap. It was noted that further work and discussion is required to deem if this would be appropriate for the Endowment Fund cash balance.

John McLaren referred to the £400k cash held in bank accounts and asked if there was another way of bringing this down to £85k to avoid the requirement of an insurance policy. John also enquired if this had accumulated because bids are not being approved. Susan confirmed that this was not the reason for the amount of cash held and explained that this is due to a number of ongoing schemes and £400k is the lowest level of cash required operationally. Susan highlighted that if further applications for funding are approved this amount may need to be increased.

James Ayling referred to the professional indemnity policy where the issue had arisen as Trustees could be held personally liable. James recalled the Director of Finance confirming that NHS Borders was providing indemnity to Trustees and queried why another policy was being sourced at a cost to the charity. Andrew Bone confirmed that Borders NHS Board had agreed to provide indemnity to Health Board members from any personal liability arising from their role as Trustees, except in relation to fraud or other criminal activities. The issue of cover arises because of the arrangements the Health Board has sought to put in place in order to mitigate this risk and the practical difficulty presented by one organisation seeking to indemnify officers of another organisation. Susan added that to put the correct policy in place would cost Borders NHS Board approximately £10k per annum. James asked for assurance that Trustees currently had in place overall indemnity from NHS Borders. Andrew confirmed that they did. Fiona Sandford suggested that Andrew provide a report to Borders NHS Board asking if these arrangements are to continue and if not revert to the proposal within the paper to secure a professional indemnity policy. Harriet Campbell stressed the need for absolute clarity in the roles and responsibilities between the Endowment Fund and NHS Borders within the report that goes to Borders NHS Board.

James referred to the interest bearing deposit account which had been set up and suggested more of these accounts be opened to limit the risk in the event of banks getting into financial difficulties. Susan advised that a further three accounts would require to be opened to secure the full amount. David Parker questioned the likelihood of the banks failing and indicated his view that he felt this action was not necessary. James felt that, as Trustees, if there was a way of mitigating risk this should be investigated to minimise the loss of any money. Andrew acknowledged that the decision to minimise the number of accounts held had been made previously in relation to workload and that this warranted further consideration.

Trustees agreed that they did not wish to pursue the CDS option as they felt this was too risky and following discussion it was agreed that the banking policy regarding number of accounts held should be based on an assessment of risk and any workload issues highlighted within the options considered for decision. Susan agreed to provide an updated proposal to the next meeting. Andrew advised that he did not regard the risk as sufficient to warrant urgent review before the next meeting and it was confirmed that this was acceptable to trustees.

The Board of Trustees did not agree the Indemnity Policy and asked the Director of Finance to refer this matter back to the Health Board for further discussion.

The Board of Trustees noted the new interest bearing deposit account with United Trust Bank.

The Board of Trustees noted the work in progress and agreed not to pursue a Credit Default Swap for the Endowment Fund cash balances which are outwith the FSCS limit. Further consideration would be given to how banking risks are mitigated and whether additional deposit accounts are required. A revised proposal to be presented to Trustees at their next meeting.

5. **Financial Report**

5.1 *Primary Statements and Fund Balances*

Susan Swan spoke to this item which provided an update position as at 31st August 2022. Susan highlighted that the investment portfolio information within the report was to the 30th June 2022. Susan also referred to the Statement of Financial Activities (SOFA) and the Balance Sheet which provided the level of income received and commitments/areas of spend during the period being reported. Susan referred to the point raised regarding consistency in the language used and noted that she would be taking this on board as part of the work with External Audit who had agreed to support both the Finance and Fundraising Teams to achieve consistency within the reports.

James Ayling referred to the SOFA which recorded investment income at £52k for unrestricted funds with restricted funds being recorded as nil. Susan explained that an apportionment will only be undertaken following approval from Trustees and that a paper would be coming forward in due course.

The Board of Trustees noted the report.

5.2 *Register of Legacies and Donations*
Susan Swan spoke to this item which provided Trustees with an update on all legacies and donations over £5k received to the 31st August 2022. It was noted that there were no grants received during the period being reported.

The Board of Trustees noted the report.

6. **Fundraising**

6.1 *Fundraising Plan 2022/23 – Progress Update*
Karen Wilson spoke to this item which provided a progress update on the 2022/23 Fundraising Plan. It was noted that this encompassed work undertaken by Colleen Barlow with reports also being presented at today's meeting. Karen went on to take Trustees through each of the objectives and provided an update on each of these. Harriet Campbell asked for clarification on how a donation is dealt with if this is made to a specific ward. Karen advised that at the present time when a donation is received and marked for a specific ward/service they would look to find the most appropriate fund for it. If it didn't specify then currently it would go to the unrestricted general fund. Karen went on to explain that this will change as the reorganisation process progresses and it would be the intention to allocate on a more unrestricted basis where it is possible to do this. Karen stressed that when there is an opportunity to speak with donors they are encouraged to make unrestricted donations wherever possible.

James Ayling referred to objective 3, namely to carry out the prioritised recommendations from the National Review as identified by the Endowment Governance Working Group, and enquired why Oxford Hospital Charity had been picked to learn about their structure. Colleen Barlow, who was responsible for this piece of work, advised that this charity had been the only one to respond to her request to share best practice and lessons learned so it was not a deliberate decision.

The Board of Trustees noted the update.

6.2 *Endowment Fund Applications – Update*
6.3

- S*imulation Based Education Programme Application*
- *NB Medical App Application*

Karen Wilson spoke to this item. Karen referred to the covering report which provided an overview of applications in the pipeline and where these were currently at in the process. Karen advised that since the report had been issued one further application had been approved, namely Switching Equipment for Paediatric Occupational Therapy, at a cost of £838 which would benefit patients with cerebral palsy.

Sarah Horan asked for an update on the Clinical Practitioner for Complex Dementia Care funding application, to which she declared an interest, as she was aware following a vote by Trustees there had been a majority vote of 6 – 2 in favour of this. Andrew Bone advised that although the majority of Trustees supported the bid there were still concerns around the distinction between core and non-core elements of the proposal and that it was important that this

distinction was clear in the final agreement. This would be fed back to the applicant.

James Ayling referred to restrictions within the Endowment Charter, which he had previously raised, as he felt the policy appeared to be more restrictive than other charitable funds. Andrew Bone suggested that this be discussed outwith the meeting in conjunction with the Endowment Charter and that a revised charter be brought back to Trustees in due course for approval. This was agreed.

Sonya Lam referred to the application for the Simulation Based Education (SBE) programme as she was concerned that this was a very ambitious plan over a relatively short period of time and she would like to have seen the risks detailed as well as what a sustainability plan would look like.

Harriet Campbell referred to the NB Medical app as she noted this was of low value and was surprised this was coming forward to Trustees for approval. Andrew confirmed that he had requested the application be put to the Trustees having raised a few questions when previously considering the application as part of the scheme of delegated authority. Sohail Bhatti commented that when monitoring applications it would be interesting to note how they mirror against inequalities to address any issues. Fiona Sandford suggested that Sohail discuss further with the Fundraising Team to ensure this point is not lost.

Andrew referred to the point made in regard to core funding and advised that for the SBE programme he was not personally satisfied that there would be an opportunity for this to be funded from core funding and asked Trustees if they would be content to support a project that has no funding after the three year period.

Tris Taylor noted he had no concern around the sustainability, in as much as he did not regard it as a matter for the trustees to resolve, and reminded that the Trustees' role is to encourage the spend of endowment funds.

Sarah highlighted that applicants are completing the templates as required and questioned if a Q&A would be helpful to try and address queries in advance. Karen advised that if the Endowment Advisory Group had met as planned the applicants would have attended that meeting to answer any questions, however as the meeting had been cancelled the applications received today had not followed the normal process. Lucy O'Leary asked if it would be possible for applicants to "buddy up" with neighbouring endowment funds to share the costs and spread the risk. Fiona asked the Fundraising Team to also take this into account.

Fiona suggested that the questions raised be passed back to the applicants and their responses circulated to Trustees. Karen agreed to contact the applicants and email around Trustees for a final decision to be made on the applications.

The Board of Trustees noted the report and awaited further information on the applications before a final decision is made on these.

6.3 *ANP Posts Interim Report*
Karen Wilson spoke to this item which followed a request from Trustees for an annual report and this was the first since the project was initiated.

The Board of Trustees noted the interim report.

7. Funds Management

7.1 *Investment Advisor Report*
Graham Reid spoke to this item. Graham highlighted that since the report had been issued the market had moved significantly and asked Trustees if it would be helpful to receive an up-to-date bullet point summary along with an accompanying paper produced by Investec following recent events. This was agreed and Graham advised that he would be happy to receive any questions via email on the back of this.

The Board of Trustees noted the report and awaited a further update.

8. Governance Framework

This section was taken as the second substantive item on the agenda

8.1 *Endowment Strategy - Update*
Colleen Barlow spoke to this item. Colleen explained that this work was being taken forward taking into account the area identified for improvement at the two Trustees' development sessions, concerns raised at Trustees' meetings and feedback from Fund Managers.

Colleen highlighted that a three step approach to develop the Strategy was being recommended, namely charity reset (step one), monitoring and stakeholder engagement (step two) and evaluation and future priorities (step three). Colleen focussed on the first two steps and firstly proposed using the Endowment Advisory Group (EAG) to its full remit and reminded of the recent expansion of the membership and the potential to expand further. It was the intention to use the EAG to put in place a clear grant making process. For step two this would involve measuring the impact to ascertain how well the charity is meeting its charitable purpose. Colleen stressed the need for stakeholder engagement as part of this step. Sohail Bhatti was keen to maximise heath gain and the impact of this. Sonya Lam added there was not always a clinical outcome so the use of language was important and agreed with "health gain".

The Board of Trustees approved the outlined Theory of Change as the foundation of the short to medium term Strategy for the charity.

The Board of Trustees approved the three step process outlined for driving forward the Strategy.

8.2 *Restricted Funds Review – Update*

- *Negative Balance Funds*
  Colleen Barlow spoke to this item which was part of the restatement exercise. Colleen advised that there are presently 19 funds within the

portfolio which have a negative balance. Colleen explained that there are currently two types of funds, namely restricted and unrestricted, these classifications would be looked at as part of the work with the Finance Team and the External Auditor to ensure they are classified correctly. Harriet Campbell highlighted the historic confusion between restricted and unrestricted donations/legacies and stressed the need for the use of one terminology as she noted the Finance report differed to these reports.

John McLaren enquired about the proposal to transfer funds from the General Endowment Fund against the deficit. Colleen explained that this was strictly in terms of deficits within Endowment Funds and provided an example of how this had happened. It was noted that the restatement exercise had also created deficits.

Harriet reminded of the importance of encouraging donors to make unrestricted donations wherever possible. Karen Wilson advised that donors do like to specify where donations go but agreed that encouraging them to express a wish rather than place a restriction might be a positive half-way house. It was noted that the website, which currently actively encourages a specific fund to be chosen, and mechanism for donations will be reviewed in due course.

The Board of Trustees approved the reclassification of 15 funds from 'restricted' to 'designated' (unrestricted).

The Board of Trustees approved a transfer from the General Unrestricted Fund to finance the deficit incurred on 12 funds (total value £598.35).

The Board of Trustees approved the permanent closure of 15 funds following the transfer.

The Board of Trustees accepted applications to OSCR for Trustee approval at a future meeting.

- *Previously Closed Funds*
  Colleen Barlow spoke to this item which provided an update on the two funds within the portfolio which were previously closed and now have a small balance.

  The Board of Trustees approved a reclassification of one fund from 'restricted' to 'designated' (unrestricted).

  The Board of Trustees approved a transfer of balance of Fund 79 – Zambia Training and Development to The Logie Legacy, Scottish Charity Registered No 047148 in line with the 2017 decision to transfer all funds to this charity.

  The Board of Trustees approved the transfer of the 2019 donation from Fund 63 – Complimentary Therapies Group to Fund 131 – Knoll Community as the appropriate destination for the unrestricted 2019 gift to 'Knoll Hospital'.

The Board of Trustees agreed that guidance be sought on the appropriate accounting for the restatement on Fund 63 and administration charges incurred after the 2019 donation was attributed to that fund.

The Board of Trustees approved the permanent closure of two funds.

- *Space to Grow Project*
  Colleen Barlow spoke to this item which provided an update on the Space to Grow project (Fund 96) which was currently in deficit. James Ayling enquired if there were internal control issues in regard to this overspend. Colleen advised that the work had ended up costing more than originally thought and this highlighted the real need to work with Fund Managers actively and agreed that there should be more controls in place.

  The Board of Trustees approved the classification of funds.

  The Board of Trustees approved the transfer of £1,216.66 from the General Unrestricted Fund to finance the deficit from the restatement exercise in Fund 96 – Space to Grow.

  The Board of Trustees approved the expenditure of £1,893.62 from Fund 192 – Garden Fund toward Fund 408.

  The Board of Trustees agreed to the renaming of Fund 408 'Space to Grow' and record its purpose as 'restricted to the garden project for mental health patients at Huntlyburn'.

  The Board of Trustees approved the permanent closure of Funds 96 and 192.

9. **<u>Capital Spend</u>**

9.1 *Capital Projects Update*
June Smyth provided an update on the capital projects. June advised that the Borders Macmillan Centre was being incorporated within the longer term solution for the BGH and interim improvements were currently being scoped out. In regard to the mammography unit it was noted that there is now a preferred site. June reminded Trustees of approval previously being given for a modular unit to be used for changing facilities. The location identified at that time was the site which housed the testing facility but as this was now being decommissioned it would be assessed if this was still the most appropriate siting in the interim as this would also be part of the longer solution for the BGH. It was noted that the Outdoor Spaces project is progressing well.

June went on to report that there has been an increase in PMO capacity so plans are starting to develop, however highlighted that Estates capacity is still restricted. It was a noted that a discussion on Capital would be taking place at the Board Executive Team meeting the following day and an update would be provided at the next meeting.

The Board of Trustees noted the update.

10. **Any Other Business**

None.

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

Monday, 30th January 2023 @ 2 p.m.

BE
14.10.22

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Financial Plan 2023-24**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance** **Susan Swan, Deputy Director of Finance**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

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

The financial plan has been developed in line with the requirements of the Scottish Government guidance, including the Medium Term Financial Framework, which requires NHS Boards to prepare a three year revenue plan and five year capital plan.

NHS Borders financial plan describes a recurring deficit position (revenue) over the period of the plan. NHS Boards who are unable to present a breakeven revenue position are expected to prepare a Financial Recovery Plan outlining the actions they will take to address this position.

The most recent version of this recovery plan has been submitted to Scottish Government and is attached as Annex to this report.

2.2 Background

NHS Borders remains at stage three on the Scottish Government's Performance Assessment Framework in relation to its financial performance. In March 2020, prior to the COVID pandemic, NHS Borders was reporting a £13.1m financial deficit. Over the three years since that time, progress to address this deficit has been limited and cost pressures have increased.

As at March 2023 this deficit has increased by £10.5m to an estimated £23.6m.

This includes £15.9m of undelivered savings relating to the Board's three year plan set in April 2020 prior to the pandemic. This figure is expected to have grown to £18.9m by March 2023.

Aside from unachieved savings, there are a number of operational pressures impacting across NHS services which contribute to growth in the level of financial challenge faced by the Board in future years.

This includes increased performance backlogs and waits for treatment, workforce shortages, exhaustion of staff, lack of capacity within Social Care, the continued development of new (expensive) treatments, general population changes and demographic impacts, and global economic factors (e.g. energy costs and inflation).

The Board continues to operate above its funded bed base as a result of challenges impacting on patient flow and hospital discharges. High cost agency staffing continue to be deployed to support safe staffing levels and to maintain continuity of care in services. This is particularly challenging within small services, where the Health Board has a limited workforce, as well as services where there are recognised shortages in available workforce at a regional or national level. This includes primary care, where there is an increasing risk to GP sustainability.

Alongside these costs, the actions implemented in response to the pandemic and the consequent reconfiguration of services has had a lasting effect on expenditure. The increased focus on Infection Prevention and Control during the pandemic has highlighted a number of areas where the risks presented by our built environment have required additional investment.

High inflation has impacted on energy, fuel and general supplies costs, and medicines growth continues to be driven by new medicines and treatments, as well as price increases that are significantly above budgeted levels.

2.3 Assessment

Medium Term Financial Plan 2023/24 – 2025/26

The draft plan was submitted to Scottish Government on 9th February 2023 and a revised *final* plan submitted on 19th March 2023. Both submissions were accompanied by update to the Board's Financial Recovery Plan (FRP).

The Resources & Performance Committee discussed the draft financial plan at its meeting on 2nd March 2023.

The plan has been informed by discussions held from November onwards, both at the Resources & Performance Committee and through other forums noted in section 2.3.9, below.

The financial plan remains unbalanced and as such does not meet the requirements of the Scottish Government's Medium Term Financial Framework (MTFF). The MTFF requires that Health Boards achieve financial balance over a three year term, with flexibility of 1% available in any given year.

Given this position it is expected that the FRP will continue to be developed and that the Board's financial plan will remain a live document informed by future iterations of the FRP.

Table 1 provides a summary of the medium term financial plan.

Table 1 – Financial Plan (revenue) 2023/24 – 2025/26

	2023-24			2024-25			2025-26		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
Financial Gap before Savings	(30.4)	(2.2)	(32.5)	(28.7)	(3.2)	(31.9)	(25.3)	(6.4)	(31.7)
Savings Target	5.0	2.5	7.5	7.5	2.5	10.0	7.5	2.5	10.0
Non-Recurrent Measures	0.0	2.5	2.5	0.0	0.0	0.0	0.0	0.0	0.0
Total Savings & Non-Recurrent Measures	**5.0**	**5.0**	**10.0**	**7.5**	**2.5**	**10.0**	**7.5**	**2.5**	**10.0**
Forecast Variance against Core RRL	**(25.4)**	**2.8**	**(22.5)**	**(21.2)**	**(0.7)**	**(21.9)**	**(17.8)**	**(3.9)**	**(21.7)**

The plan describes a projected outturn position of £22.5m at March 2024 which remains broadly stable over the medium term, with a final outturn position at March 2026 of £21.7m.

The position described reflects a worsening in year performance against 2022/23 (projected £12.2m gap at quarter three review).

The main drivers of this increase are in relation to increased cost pressures including energy costs, medicines growth and other non-pay inflation, as well as reduced levels of non-recurrent flexibility and additional COVID support which has offset pressures in 2022/23.

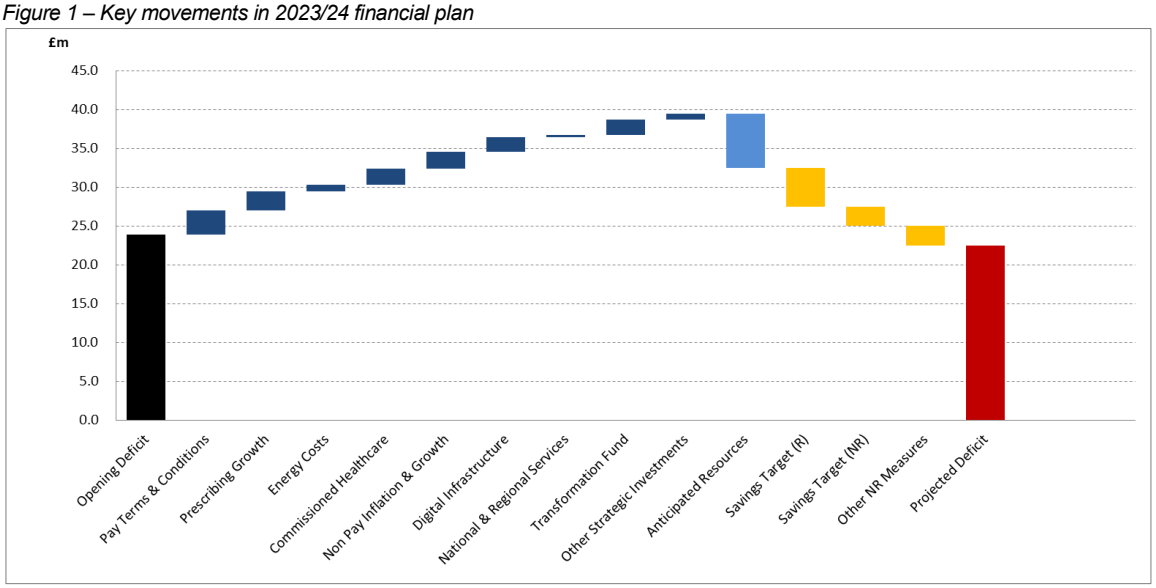
A number of cost pressures previously assumed to be non-recurrent are now expected to have an on-going impact on the Board's financial performance. This includes additional medical workforce required to provide safe minimum staffing levels within hospital settings out of hours, as well as continuation of additional bed capacity and other measures intended to manage the impact of delays to hospital discharge.

The financial performance described in the plan would result in an increased borrowing requirement of £66m in addition to the anticipated £20.5m brokerage projected at end March 2023. By March 2026 the Board is projected to have a repayable brokerage requirement of £86.6m.

The underlying deficit is expected to reduce from £25.4m (March 2023) to £17.8m (March 2026). This position is predicated on delivery of £20.0m recurring savings over three years.

Figure 1 summarises the key movements in the plan.

Figure 1 – Key movements in 2023/24 financial plan



The opening deficit is discussed in section 2.2 and described in further detail within the Board's Financial Recovery Plan.

The Board have been advised to plan on the basis that the cost of pay awards in excess of general uplift allocations will be met by additional Scottish Government allocation. The financial plan is therefore prepared on the basis of a 2% increase to costs, in line with general uplift.

Prescribing growth is modelled at 10% in hospitals and 5% in primary care. As at February 2023 there is an emerging cost pressure in primary care which may present a further risk to the plan. The opening deficit includes an element of this pressure as identified at quarter three review.

Energy cost increases are modelled at a further 30% above the impact in 2022/23. This is in line with current modelling against the Scottish government energy framework contracts.

Other non-pay growth, including commissioned healthcare (out of area service level agreements and high cost packages of care), is modelled on an average 4% across all sectors. This reflects the level of growth experienced in 2022/23, but remains below general inflation and there remains a risk that actual growth in costs may exceed this level. The board retains a risk fund to deal with in year pressures.

The level of recurrent savings is set at 2.0% in 2023/24 and 3.0% p.a. thereafter. Additional non-recurrent savings of 1.0% p.a. are assumed in the plan.

At this stage the Board does not have savings plans identified to deliver the full level of savings outlined in the plan (£20m). Beyond this level the Board would need to identify a further £17.8m in order to achieve a breakeven position at March 2026.

The Financial Recovery Plan outlines the approach the Board will take in order to identify and implement actions to improve its financial sustainability. Initial focus will be on securing savings in the immediate short term in order to deliver the 2023/24 financial plan; thereafter focus will be directed at achieving the £20m recurring savings described in the plan.

The approach to delivery of savings will include enhanced grip & control activities, as well as a blend of local efficiency schemes and broader work streams directed at whole system savings.

The outcomes of the recent benchmarking review will support increased focus on productivity gain; continuing to implement the quality management system will help ensure that clinical services are as efficient & effective as possible.

Longer term work streams will begin to explore the role which a shift towards prevention might play in managing demand for services, and – working in partnership with the IJB – the review of services and clinical pathways will evaluate alternative models of care and consider the future role of our Acute and community hospitals.

As this work progresses it will be necessary to consider how services can be reconfigured within affordable budgets and to engage with patients, staff and the wider community on the choices which may be necessary to achieve this outcome.

Actions to address this situation are described in further detail within the FRP included as Annex 1 to this paper.

Appendix 1 provides further detail of the plan.

Draft Five year capital plan 2023/24

As previously advised to the Resources & Performance Committee, Scottish Government have paused the NHS Scotland capital investment programme during 2022/23 in response to the significant level of forward commitment already proposed through individual board plans, which exceeds the level of capital funds available.

During 2023/24 it is expected that all Health Boards will prepare updated Property & Asset Management Strategies (PAMS) which outline the requirements for capital investment over the long term.

A draft five year capital plan has been prepared based on the existing rolling programmes and immediate commitments carried forward from 2022/23 plan. Further work is underway to assess additional investment requirements over the five year planning horizon.

In order to highlight the potential scale of investment required, indicative figures are included in the capital plan submitted to Scottish government however it is recognised that in order to secure this level of investment the Board will have to complete its PAMS business case submission and will be constrained by the level of resources available at an NHS Scotland level.

Table 3 summarises indicative requirements included within the plan.

Table 3 – Draft Capital Plan commitments 2023/24 – 2027/28

Programme/Scheme	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m	2027/28 £m
Anticipated Resources					
Formula Capital	2.48	2.48	2.48	2.48	2.48
Reinstatement of C/Fwd	1.50				
National Infrastructure Programme	1.90	-	-	-	-
Total Resources	**5.88**	**2.48**	**2.48**	**2.48**	**2.48**
Expenditure Commitments					
Rolling Programmes					
Estates & Backlog maintenance	1.40	1.40	1.40	1.40	1.40
Medical Equipment Replacement	0.25	0.25	0.25	0.25	0.25
IM&T Hardware Life Cycle	0.25	0.25	0.25	0.25	0.25
Other equipment & minor works	0.20	0.20	0.20	0.20	0.20
Capital Planning Team & Support	0.28	0.28	0.28	0.28	0.28
Capital Planning Fees, etc.	0.10	0.10	0.10	0.10	0.10
Completion of Prior Year Projects	1.50				
National Equipment Replacement Programme	1.90	0.10	0.70	0.10	0.30
Planned Expenditure	**5.88**	**2.58**	**3.18**	**2.58**	**2.78**

Projects currently scheduled in 2023/24 include the following:

- Replacement of Endoscopy Decontamination equipment
- CT Scanner Replacement
- Mammography Scanner Replacement
- BGH Waste and Linen Storage project
- Borders MacMillan Centre Pharmacy upgrade
- Primary Care Premises programme

Any further capital resources required to deliver these projects will be discussed through on-going dialogue with SG colleagues and early consideration for slippage against national programmes. At this stage there is no significant risk to delivery as a result of the resource requirements for these projects.

The existing capital pipeline process remains closed pending confirmation of how Scottish Government will address Board requests for additional capital in 2023/24. A register of requests for capital investment is retained by the capital planning team and includes a number of projects not presently able to be progressed.

The Chief Executive, supported by the Director of Finance and Director of Performance and Planning, continues to make representation to Scottish Government in relation to the medium term capital requirements of the board, including:

- Primary Care Health Centre replacement programme
- Borders General Hospital ‘refresh’ including immediate Backlog maintenance requirements
- Review of Mental Health and Community Hospitals infrastructure

Further updates on the Board's Property & Asset Management Strategy and capital plan will be provided to the Resources & Performance Committee.

2.3.1 Quality/ Patient Care

The plan outlines resources and projected expenditure over the next three years (revenue) and five years (capital). These resources are aligned to the board's expected priorities to be set out in the Annual Operational Plan to be finalised by end June 2023.

Priorities within the financial plan have been set on a risk-based approach and the board will continue to explore how this approach can be further refined in future financial planning cycles. The outputs of the this approach have included investment in a number of activities to support patient safety and prevent harm.

The constraints on overall resource, and challenges of unmet demand, will be addressed through the development of individual plans aligned to Scottish government strategy.

Included within the plan is on-going investment in the Board's Change team, including infrastructure to support quality improvement, as well as a transformation fund to support long term strategic change.

2.3.2 Workforce

The plan also includes limited investment in workforce in a number of areas aligned to service risks, however further work will be required over the medium term, in order to fully align the Board's workforce and financial plans and to ensure that both workforce and financial planning demonstrate progress towards improved sustainability.

The plan includes assumptions about the level of workforce availability and consequent use of supplementary staffing (e.g. agency).

2.3.3 Financial

The 2023/24 revenue plan is presented in detail in Appendix 1. Issues related to the plan are described in section 2.3 above.

Further updates will be provided to the Resources & Performance Committee through the quarterly and mid-year review process.

This position will continue to be discussed with Scottish government colleagues in light of the board's status on the performance escalation framework and its requirement to provide assurance in relation to financial recovery action plans and longer term strategy for financial sustainability.

2.3.4 Risk Assessment/Management

Financial sustainability remains on the board's strategic risk register as high risk and a full update to this risk, including mitigating actions, will be implemented following approval of the financial plan.

2.3.5 Equality and Diversity, including health inequalities

The plan outlines how the health board will utilise its overall resources in support of its short and medium term priorities, including core service delivery. Resources are aligned to the board's previously stated service priorities and agreed plans and the adjustments within the plan reflect unavoidable cost pressures and business cases approved at national, regional or local level and which have been subject to individual assessment in relation to their impact on equality and diversity, and health inequalities.

An impact assessment has not been completed because it is expected that assessments are prepared against individual action plans on a case by case basis.

2.3.6 Climate Change

The Financial Recovery Plan includes actions which are aligned to reduction of waste and improved energy efficiency. These actions are being developed through the Board's Climate Emergency and Sustainability Group and will be monitored through that group and by reporting on cash releasing savings via the Financial Improvement Programme.

The net carbon reduction achieved through these actions will be separately reported to the Board's Climate Emergency and Sustainability Group.

2.3.7 Other impacts

There are no other impacts identified.

2.3.8 Communication, involvement, engagement and consultation

No engagement has been undertaken.

The financial plan describes the financial impact of national, regional and local strategies and business cases, together with unavoidable cost pressures, including inflation and other impacts.

Engagement will be undertaken where relevant in relation to individual strategies and business cases described within the plan and through joint working with the Scottish Borders Integrated Joint Board in relation to its updated strategic framework.

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.

- Resources & Performance Committee, 3rd November 2022
- Quality & Sustainability Board, 12th December 2022
- Resources & Performance Committee, 19th January 2023
- Board Executive Team, 24th January 2023

- Board Executive Team, 31st January 2023
- Board Development Session, 2nd February 2023
- Quality & Sustainability Board, 14th February 2023
- Leadership & Management Workshop, 27th February 2023
- Board Executive Team, 28th February 2023
- Resources & Performance Committee, 2nd March 2023
- Area Partnership Forum/Area Clinical Forum, 3rd March 2023

2.4 Recommendation

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

The Board is recommended to approve the Medium Term Financial Plan in order to meet its requirement to set the annual budget for the board.

Given the financial position outlined in the plan does not meet the requirements outlined by Scottish Government, the Board is further recommended to approve version 2.1 of the Financial Recovery Plan (Annex 1) and to seek further update to this document at the end of Quarter One.

3.0 List of appendices

The following appendices are included with this report:

- Appendix 1, Medium Term Financial Plan 2023/24 – 2025/26
- Annex 1, Financial Recovery Plan (Version 2.1)

Appendix 1 – Medium Term Financial Plan 2023/24 – 2025/26

Summary of Revenue Outturn

Revenue Resource Limit (RRL)	2023-24 Recurring £000	2023-24 Non-Rec £000s	2023-24 Total	2024-25 Recurring £000	2024-25 Non-Rec £000s	2024-25 Total	2025-26 Recurring £000	2025-26 Non-Rec £000s	2025-26 Total
Gross Expenditure - Clinical & Non-clinical	311,309	38,869	350,178	312,157	41,486	353,643	313,807	44,736	358,543
Less: Gross Income	23,765	0	23,765	23,765	0	23,765	23,765	0	23,765
Total Expenditure	**287,544**	**38,869**	**326,413**	**288,392**	**41,486**	**329,878**	**290,042**	**44,736**	**334,778**
Less: Total Non-Core RRL Expenditure	0	5,552	5,552	0	5,552	5,552	0	5,552	5,552
Less: FHS Non Discretionary Net Expenditure	13,589	0	13,589	13,589	0	13,589	13,589	0	13,589
Core Revenue Resource Outturn	**273,955**	**33,317**	**307,272**	**274,803**	**35,934**	**310,737**	**276,453**	**39,184**	**315,637**
Baseline Allocation	248,600	0	248,600	253,572	0	253,572	258,643		258,643
Anticipated Allocations: Rec/ Non-rec/ Earmarked	0	36,166	36,166	0	35,266	35,266	0	35,266	35,266
Core Revenue Resource Limit (RRL)	**248,600**	**36,166**	**284,766**	**253,572**	**35,266**	**288,838**	**258,643**	**35,266**	**293,909**
Forecast Variance against Core RRL	**-25,355**	**2,849**	**-22,506**	**-21,231**	**-668**	**-21,899**	**-17,810**	**-3,918**	**-21,728**
Forecast Variance (% of Core RRL)			**-7.9%**			**-7.6%**			**-7.4%**
Anticipated Financial Support			0			0			0

Savings summary	2023-24 Recurring £000	2023-24 Non-Rec £000s	2023-24 Total	2024-25 Recurring £000	2024-25 Non-Rec £000s	2024-25 Total	2025-26 Recurring £000	2025-26 Non-Rec £000s	2025-26 Total
Financial Gap before Savings	**-30,355**	**-2,151**	**-32,506**	**-28,731**	**-3,168**	**-31,899**	**-25,309**	**-6,418**	**-31,727**
Savings Target	5,000	2,500	7,500	7,500	2,500	10,000	7,500	2,500	10,000
Non-Recurrent Measures	0	2,500	2,500	0	0	0	0	0	0
Total Savings & Non-Recurrent Measures	**5,000**	**5,000**	**10,000**	**7,500**	**2,500**	**10,000**	**7,500**	**2,500**	**10,000**
Forecast Variance against Core RRL	**-25,355**	**2,849**	**-22,506**	**-21,231**	**-668**	**-21,899**	**-17,809**	**-3,918**	**-21,727**

Appendix 1 – Medium Term Financial Plan 2023/24 – 2025/26

	2023-24			2024-25			2025-26		
	Recurring £000	Non-Rec £000s	Total	Recurring £000	Non-Rec £000s	Total	Recurring £000	Non-Rec £000s	Total
Additional Funding									
Uplift on baseline	4,860		4,860	4,957		4,957	5,056		5,056
NRAC Adjustment	1,100	0	1,100			0			0
New Medicines Funding		1,063	1,063		1,063	1,063		1,063	1,063
Other new allocations			0			0			0
Additional income			0			0			0
Total Additional Funding	**5,960**	**1,063**	**7,023**	**4,957**	**1,063**	**6,020**	**5,056**	**1,063**	**6,119**
Brought Forward Pressures									
Unachieved Savings (from prior year)	18,871	0	18,871	25,355		25,355	21,231		21,231
AfC Staff	0	0	0			0			0
Medical and Dental staff	0	0	0			0			0
Other Brought Forward Pressures	4,703	324	5,027	50	1,169	1,219	0	2,144	2,144
Total Brought Forward Pressures	**23,574**	**324**	**23,898**	**25,405**	**1,169**	**26,574**	**21,231**	**2,144**	**23,375**
Incremental Pressures									
Pay									
Pay Uplift - AfC	2,380	0	2,380	2,527	0	2,527	2,578	0	2,578
Pay Uplift - Medical & Dental	719	0	719	764	0	764	780	0	780
Pay Uplift - Other	28	0	28	29	0	29	29	0	29
Total Pay Pressures	**3,127**	**0**	**3,127**	**3,320**	**0**	**3,320**	**3,387**	**0**	**3,387**
Non Pay									
Acute Prescribing	1,266	0	1,266	1,393	0	1,393	1,532	0	1,532
Primary Prescribing	1,157	0	1,157	1,215	0	1,215	1,276	0	1,276
Energy Costs	902	0	902	78	0	78	80	0	80
PPP/PFI	0	0	0	0	0	0	0	0	0
Service Level Agreements	1,567	530	2,097	815	530	1,345	831	530	1,361
Digital Infrastructure	1,855	0	1,855	0	0	0	0	0	0
National & Regional Services	281	0	281	93	250	343	500	0	500
Project expenditure	242	2,360	2,602	0	2,210	2,210	0	2,180	2,180
Primary Care Sustainability	200	0	200	0	0	0	0	0	0
HEPMA	0	0	0	125	72	197	261	2,627	2,888
Other Non Pay	2,145	0	2,145	1,244	0	1,244	1,269	0	1,269
Total Non Pay Pressures	**9,614**	**2,890**	**12,504**	**4,963**	**3,062**	**8,025**	**5,749**	**5,337**	**11,086**
Financial Gap Before Savings	**30,355**	**2,151**	**32,506**	**28,731**	**3,168**	**31,899**	**25,309**	**6,418**	**31,727**

FINANCIAL RECOVERY PLAN

2023 - 2026

Version 2.1

16th March 2023

Table of Contents

Contents

Purpose of the Report

This report is prepared in response to the Scottish Government's requirement that Health Boards requiring brokerage[1] support in 2022/23 submit a Financial Recovery Plan which describes how they will meet the requirements of the Medium Term Financial Framework (MTFF) over the three year planning cycle.

The MTFF requires that Health Boards achieve financial balance over a three year term, with flexibility of 1% available in any given year. Financial Recovery Plans are expected to demonstrate how this will be achieved, including plans for repayment of brokerage.

The report provides background and context to the financial challenges faced by NHS Borders and describes actions currently in place - and those in development - which are expected to contribute to addressing these challenges.

[1] 'Brokerage' support is borrowing financed by Scottish Government to achieve a breakeven position during a single financial year. This borrowing is repayable by the Health Board.

Status of the Recovery Plan

Version 2.1 / 16th March 2023

The Board is required to submit a final version of its Financial Recovery Plan alongside its financial plan by 16th March 2023. This iteration of the report (version 2.1) is designated as the 'final' version for purposes of submission to Scottish Government.

Additional content is provided to complete sections remaining work in progress in version 1.0 (submitted 9th February 2023).

Content has been updated to reflect changes in the Board's financial plan, including assumed level of savings, and progress towards development of financial recovery actions.

It remains the case that the Financial Recovery Plan does not yet describe actions which are sufficient to meet the requirements of the MTFF.

As such, it is intended that this will remain a 'live' document and further updates will be prepared in advance of the Quarter One forecast and submission of the Board's Annual Delivery Plan.

Version 1.0 / 9th February 2023

This document remains work in progress. A final version of the plan is expected to be prepared for submission in March 2023.

The Financial Recovery Plan presented here does not describe actions which meet the requirements of the MTFF.

The Board's financial plan describes a worsening financial position over the three year cycle and actions currently identified are sufficient only to arrest the level of increase.

Tradition cost improvement measures and productivity gain will not be sufficient to achieve this objective.

The actions likely to be required to sustainably reduce costs are expected to require whole system transformation and reform to Health & Social Care delivery within the Scottish Borders.

Whether these actions will deliver the scale of change necessary to achieve financial balance remains unclear.

The scoping and development of a transformation strategy is likely to take some time. We will be clear about the timescales for this work in the final version of this plan.

Context

Financial Context

Following publication of the Scottish Government's budget for 2023/24[2] the Director of Health Finance and Governance wrote to Health Boards to set out the details of the budget, and the framework under which financial plans were to be prepared. This letter confirmed the reintroduction of the Medium Term Financial Framework as previously advised during 2022/23, stating:

> "… where Boards are indicating that financial support is required in 2022-23, we have asked Boards to submit financial recovery plans in the new year, setting out a return to financial balance in the next three years."[3]

NHS Borders was placed at Stage 4 of the Scottish Government's Performance Escalation Framework in November 2018[4]. During the course of 2019 the Board worked closely with external support (BOLD Revolutions) to develop its financial turnaround programme. This programme was suspended at the onset of the COVID19 global pandemic and – in common with other NHS Boards – the focus of the board shifted to its pandemic response. Despite this, at April 2021 the Board was moved to Stage 3 of the Performance Escalation Framework in relation to its financial sustainability in recognition of progress achieved to date[5].

Stage 3 of the Performance Escalation Framework is described as 'significant variation from plan; risks materialising; tailored support required'. The response to this level of escalation requires the agreement of a formal recovery plan with clear milestones and accountability, supported by external expert advisors.

NHS Borders submitted its one year financial plan for 2022/23 in March 2022. This plan described a recurring deficit before savings of £19.7m. This deficit was expected to reduce to £15.7m at March 2023, predicated on delivery of £5m recurring savings. Performance at March 2023 was forecast at £12.2m deficit, inclusive of additional non-recurring actions.

At Quarter One review the Board amended its in year forecast to a projected outturn deficit of £13.7m.

Recognising the significant financial challenges faced within Health and Social Care in Scotland, NHS Boards were advised at Q1 review[6] of a need to urgently improve in year performance during 2022/23. As a *minimum*, Boards were required to develop actions to recover financial performance to the level outlined in their financial plan (i.e. £12.2m deficit).

NHS Borders submitted a Financial Recovery Plan (FRP) in November 2022 which described a potential increase to its forecast in year deficit of £15.7m, together with actions identified to recover outturn performance to £12.2m in line with financial plan.

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[2] Scottish Budget 2023-24 published on 15th December 2022.
[3] Richard McCallum Letter to Chief Executives, 15th December 2022.
[4] Paul Gray Letter to NHS Borders Chief Executive, 23rd November 2018.
[5] John Connaghan Letter to NHS Borders Chief Executive, 2nd April 2021.
[6] Richard McCallum Letter to Chief Executives and Directors of Finance, 11th November 2022.

Since this time the actions outlined in the plan have continued to be adapted in response to other emerging pressures and – where necessary – to mitigate actions which are no longer expected to deliver.

As at Month 10 (January) the Board had amended its outturn forecast to a projected deficit of £13.5m as a result of a recent increase to primary care prescribing resulting in a projected increase of £1.7m expenditure on previous plan.

Additional New Medicines funding (NRAC share of increase from £100m to £200m) was not included in the January forecast of £13.5m deficit. This provides an estimated £1.1m improvement to the forecast.

Early indication of February position and further actions currently being identified suggests that some improvement on the £12.2m forecast may yet be possible, however this is unlikely to represent the full impact of the additional New Medicines fund.

A further update to forecast will be confirmed at M11 (February).

The increasing reliance on non-recurrent solutions highlights the impact that pressures emerging within the current year forecast will have on the baseline pressures described in the financial plan.

Operational Context

Emerging from the pandemic we have continued to face a number of significant operational challenges which require both leadership and management focus:

Pressures on both primary and secondary care are exhibited through lack of whole system flow and our access performance; assessment of activity within Primary Care suggests this is very significantly above pre-pandemic levels.

Our workforce remain under significant pressure due to staff turnover and high levels of vacancy, which in turn manifests in both absence and increased risk to patient safety;

Our built environment presents increasing risks in relation to health & safety and infection control due to increasing unmet backlog maintenance and poor functional suitability affected by the design of older buildings.

These issues impact on our ability to fully remobilise services to pre-pandemic levels and affect productivity, performance and capacity to support our financial improvement programme.

A&E performance is regularly below 65% against the four hour emergency access standard. Our Emergency department regularly operates with overnight stays and long waits for admission to inpatient beds results in further disruption to flow on a daily basis.

While both cancer and diagnostics performance are strong when benchmarking to other Health Boards, TTG and Outpatients remain challenging; TTG long waits are in line with Scottish averages however theatre productivity measures benchmark poorly and the Board struggles to protect elective inpatient beds. Outpatient activity levels and proportion of long waits are below national averages.

As at end January we continued to have a small number of patients waiting in excess of two years for their first outpatient appointment and over 1500 waiting in excess of 52 weeks (against a planned national trajectory of zero by end March). This position reflects both recruitment challenges in high volume specialties (ophthalmology, dermatology) and imbalance across a broad range of other specialties where we are unable to source sufficient capacity to achieve performance in line with plan.

Over 130 patients had waits of greater than 2 years for inpatient or day case treatment as at end January against a planned trajectory of zero by end March 2023. In January alone we cancelled 52 elective surgeries due to bed pressures. We remain unable to regularly maintain ring-fenced capacity for elective surgery as a result of boarding from medical specialties.

Increased length of stay in inpatient settings has contributed to a chronic lack of hospital flow which is further impacted by delays to discharge and shortfalls in capacity in social care settings. Where additional resources have been deployed to increase care home capacity this has often been challenging to access, and in some cases has offset loss of capacity across the sector.

Between February 2022 and February 2023 there was little movement in the overall number of delays in our system and an increase in the occupied bed days associated with these delays. Weekly census data (all settings) shows an increase in number of delays from 57 to

63 over that period, with complex patients increasing from 15 to 17. The cumulative length of stay of active delays (i.e. not yet discharged) increased from 36 days per patient to 59 days, with a small number of individual patients accounting for a significant element of this increase.

The level of workforce required to provide additional inpatient capacity and manage emergency waits remains difficult to achieve. Staff turnover (16%) is higher than Scottish average with particular pressures on registered nursing posts. Daily safety briefs regularly report staffing levels which are unsafe at start of day and for which agency staffing is often deployed at short notice and premium cost. Although we have been successful in recruitment of international nurses the impact of introducing new workforce into a busy hospital setting puts further pressure on supervisory staff (i.e. charge nurses) and we have had to implement additional staffing resources to support transition of newly recruited staff.

Our use of agency staffing in senior medical (consultant) workforce is predominantly in relation to hard to fill long term vacancies where sustainability of service is an immediate priority. This includes Acute Medicine and Mental Health, as well as small number of other specialties. Recruitment to medical workforce in both acute and primary care is presenting an increasing risk to NHS Borders as we compete with urban centres for workforce.

Actions to sustain training grade rotas have largely been successful in eliminating agency in this area but present further cost pressure to historic staffing levels. Demands on this staff group have increased as training capacity has been ring-fenced and the challenges of increasing acuity in patients groups has required additional medical support to inpatient wards.

In 2022/23 NHS Borders took over responsibility for running one GP Practice under S2C arrangements. This was the first time this has been required in the Scottish Borders. We have recently agreed the closure of a branch surgery in order to sustain services in another practice. A key priority for our Primary Care team is working with local GPs to improve Practice sustainability with several other practices considered vulnerable in the short to medium term.

Our Annual Delivery Plan will describe actions in place to address the issues described above. There is further detail on our approach to efficiency & productivity elsewhere in this report.

Financial Outlook

Background

A draft three year financial plan was prepared in summer 2022 aligned to the Q1 review forecast. This outlined a position in which the Board's recurring deficit was expected to remain largely stable over a three year period, from £16.4m at March 2023 to £15.1m at March 2025. This position was predicated on 2% annual savings (recurring). A number of pressures not yet fully evaluated were highlighted as non-recurring such that the actual performance forecast for each year was as follows:

	2022/23 £m	2023/24 £m	2024/25 £m
Outturn Forecast *prepared July 2022*	(13.7)	(19.4)	(20.1)

This forecast did not fully reflect factors impacting on the wider economy, notably increasing inflation and energy costs. The publication of the Scottish Government's Resource Spending Review (May 2022) and subsequent UK treasury forecasts has highlighted an enduring volatility to economic forces which impact both directly and indirectly on NHS expenditure. Together with operational issues faced by NHS Boards, there are a number of additional challenges which increase cost pressures beyond the level described in the financial modelling undertaken in summer 2022.

Financial Plan 2023-2026

The Financial Recovery Plan is intended to outline actions to support delivery of financial performance outlined within the Financial Plan.

A draft version of the financial plan was submitted on 9th February 2023. A final version of the Board's financial plan will be shared with Scottish Government alongside this document.

The plan describes the forecast financial performance for the three year period from 1st April 2023 to 31st March 2026. The following table summarises the revenue forecast as presented within the updated plan[7].

	2023-24			2024-25			2025-26		
	R £m	NR £m	Total £m	R £m	NR £m	Total £m	R £m	NR £m	Total £m
Financial Gap before Savings	(30.4)	(2.2)	(32.5)	(28.7)	(3.2)	(31.9)	(25.3)	(6.4)	(31.7)
Savings Target	5.0	2.5	7.5	7.5	2.5	10.0	7.5	2.5	10.0
Non-Recurrent Measures	0.0	2.5	2.5	0.0	0.0	0.0	0.0	0.0	0.0
Total Savings & Non-Recurrent Measures	**5.0**	**5.0**	**10.0**	**7.5**	**2.5**	**10.0**	**7.5**	**2.5**	**10.0**
Forecast Variance against Core RRL	**(25.4)**	**2.8**	**(22.5)**	**(21.2)**	**(0.7)**	**(21.9)**	**(17.8)**	**(3.9)**	**(21.7)**

The plan describes a projected outturn position of £22.5m at March 2024 which remains broadly stable over the medium term, with a final outturn position at March 2026 of £21.7m.

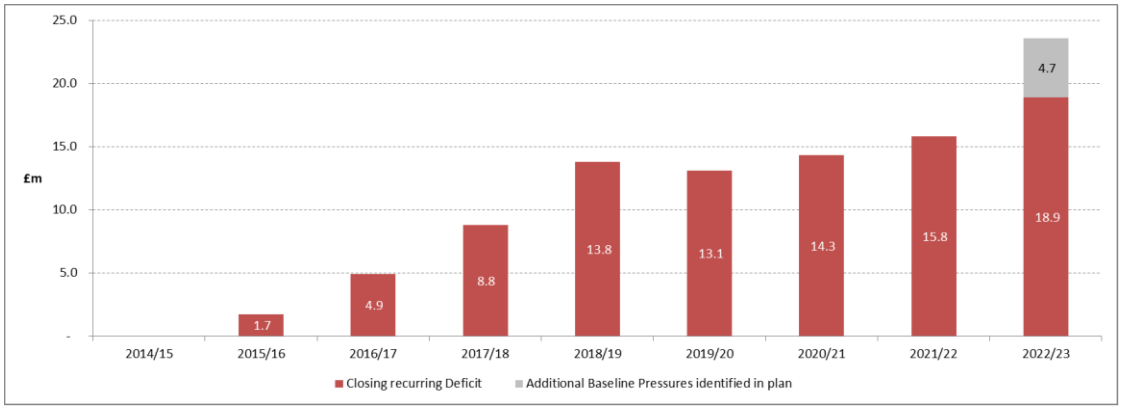
The underlying deficit is expected to reduce from £25.4m (March 2023) to £17.8m (March 2026). This position is predicated on delivery of £20.0m recurring savings over three years.

[7] As per financial plan due for submission 16th March 2023.

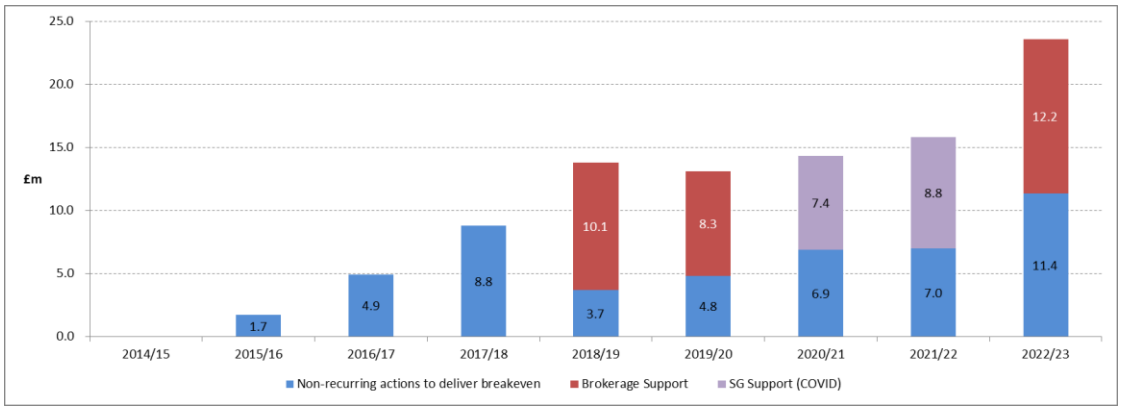
Underlying Deficit

Recurring Deficit (trend)

The following chart illustrates the growth in the underlying recurring deficit from 2015/16 onwards.



Non-recurring actions supported delivery of breakeven until March 2018, with brokerage required in 2018/19[8] (£10.1m) and 2019/20 (£8.3m). For both 2020/21 and 2021/22 additional support was received to offset non-delivery of savings as part of the COVID allocations. The actions required to deliver a breakeven position in each year are summarised below (2022/23 indicative based on current forecast).



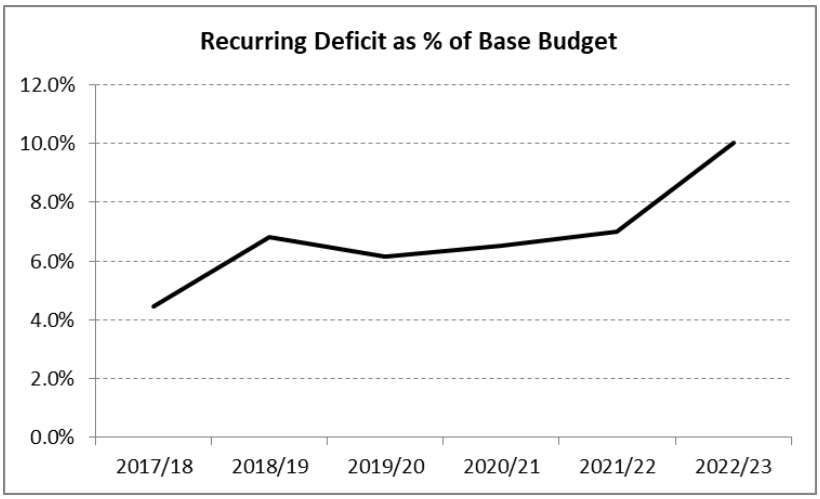
As demonstrated in the chart above, the level of non-recurring actions available within the Board reduced significantly from 2018/19 onwards, reflecting increased recurring delivery in that year. There was an increase in non-recurrent benefits across 2020/21 to 2022/23 which is attributable to reduced activity during the COVID pandemic.

The drivers for increase to deficit in 2022/23 are described in greater detail below.

[8] Brokerage support of £10.1m in 2018/19 was subsequently confirmed as non-repayable following introduction of the Scottish Government's Medium Term Financial Framework effective from 1st April 2019.

Recurring Deficit as % of RRL

Over the past five years the recurring deficit has grown from 4.5% of the Board's recurring base RRL to 10.0%.

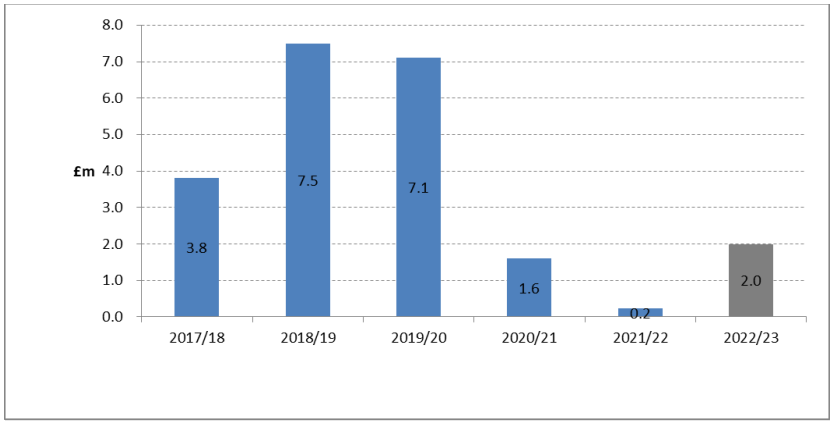


The increase in 2022/23 reflects the recurring impact of changes impacting from the beginning of the pandemic and which had been treated as non-recurring in the preceding two years.

Recurring Savings Delivery (trend)

As illustrated above, there was a slight reduction between 2018/19 and 2019/20 which reflects the significant focus given to the Board's financial turnaround programme. This achieved recurring savings of £7.5m (2018/19[9]) and £7.1m (2019/20), a high watermark for the level of savings achieved within NHS Borders in both the preceding and subsequent years.

The chart below presents the level of recurring savings delivery achieved/forecast by year:



The low level of savings delivery in 2021/22 is indicative of the impact of the pandemic on management capacity. Several attempts were made to reintroduce the Board's Financial Improvement Programme during this year to limited effect as a result of increased pressure on operational capacity and staff turnover within key services (PMO, finance).

[9] Savings delivery in 2018/19 & 2019/20 include elements initiated in each year which were fully delivered over the following year.

Key Drivers

The Board first identified a recurring financial deficit in 2015/16 and by March 2020 at the onset of the COVID pandemic this deficit had grown to an estimated £13.1m. From this point forward the deficit has increased by a further £10.5m, resulting in an opening baseline pressure in 2023/24 of £23.6m.

Narrative to be added

Inflation & Growth

Narrative to be added

Other Pressures

Narrative to be added

Scale of the Challenge

The recurring financial deficit identified in 2023/24 before savings is £30.4m. This equates to c.10% of the Board's overall expenditure, and 12% of our expected RRL baseline at April 2023. There is a further £2.2m of non-recurring pressure identified in year.

By March 2026 the savings required to achieve recurring balance are estimated at £37.8m. The current plan identifies a projected delivery of £20.0m savings, resulting in a recurring deficit of £17.8m after three years.

During the period of the plan there are additional non-recurring pressures of £11.7m.

In 2022/23 we expect to deliver between £2.0 - £2.5m recurring savings, around 1%. We recognise the need to urgently increase the level of savings and have set expectations accordingly. For 2023/24, our internal targets are set at 3% p.a. (2% recurring and a further 1% expected to be non-recurring). We have also set an expectation that our longer term transformation strategy delivers a 10% reduction in our cost base over a 3-5 year period.

We have outlined in our financial plan an expectation that we will deliver £5m recurring savings in the first year of the plan increasing to £7.5m p.a. in years 2 & 3, a total of £20.0m over three years.

This represents 2% in year 1 rising to 3% thereafter (a cumulative 8% over three years). As noted, year 1 assumes a further 1% saving to be delivered on a non-recurring basis.

Delivery of this level of savings will not be sufficient to address the deficit, particularly in light of further growth forecast within years 2 & 3 of the plan.

The level of savings outlined in the plan is broadly consistent with national planning assumptions and aligns with the level of savings delivered in 2017/18 and 2018/19 (the 'high watermark' for savings delivery achieved by the Board in previous years).

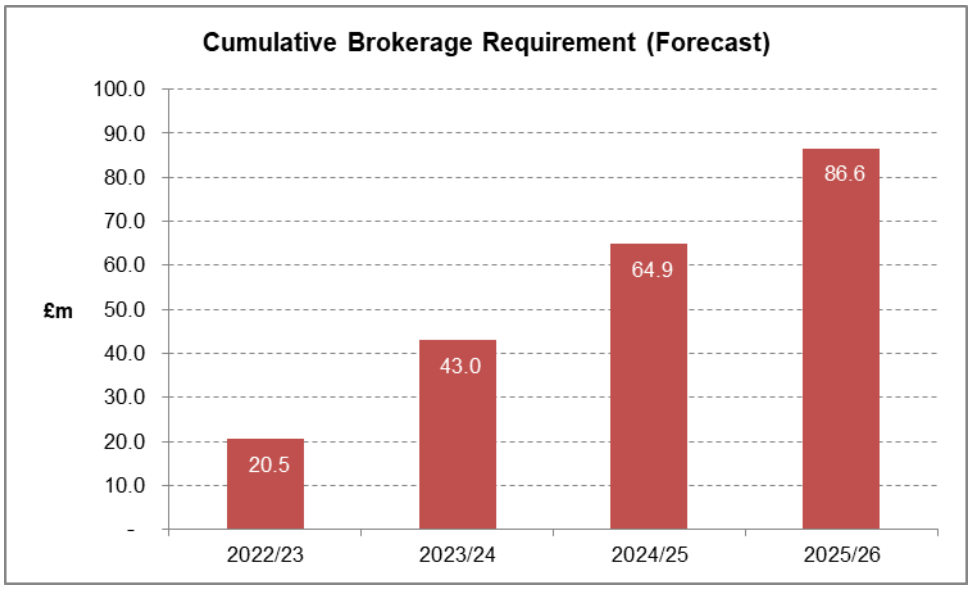
These targets will continue to be reviewed as opportunities are identified and progress to implementation. At this stage there is significant work required to secure savings in the next twelve months, and then to address the detail of savings plans in years 2 & 3 in line with existing target.

Brokerage

NHS Borders is expected to require £12.2m brokerage in order to achieve a balanced financial position in 2022/23. This will increase the accumulated brokerage repayable to Scottish Government to £20.5m, inclusive of £8.3m borrowing required at March 2020.

Although the Board reported a deficit at March 2021 and March 2022, this was supported by additional non-recurring allocations in line with the interim financial framework implemented during the COVID19 pandemic and there is no requirement for repayment attached to these allocations.

Should the financial plan forecast remain unchanged the cumulative brokerage liable for repayment at March 2026 would be £86.6m.

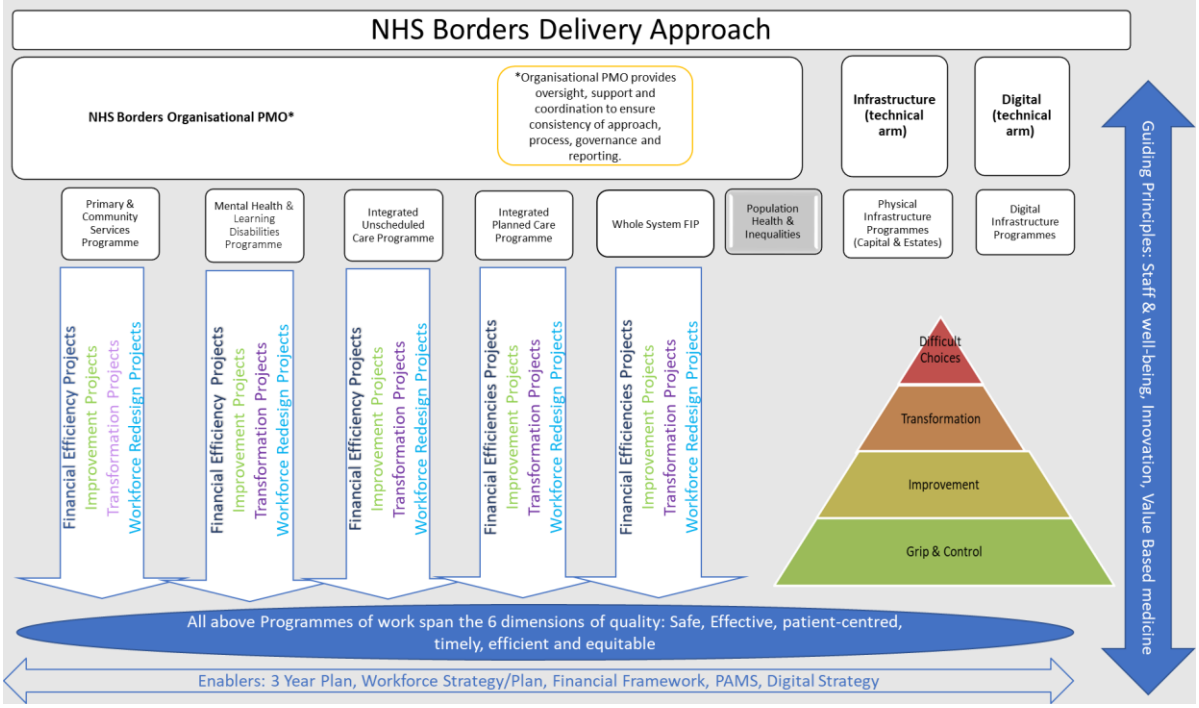


Strategic Framework[10]

NHS Borders aims to align its local planning approach to the national Sustainability & Value framework and three planning horizons.

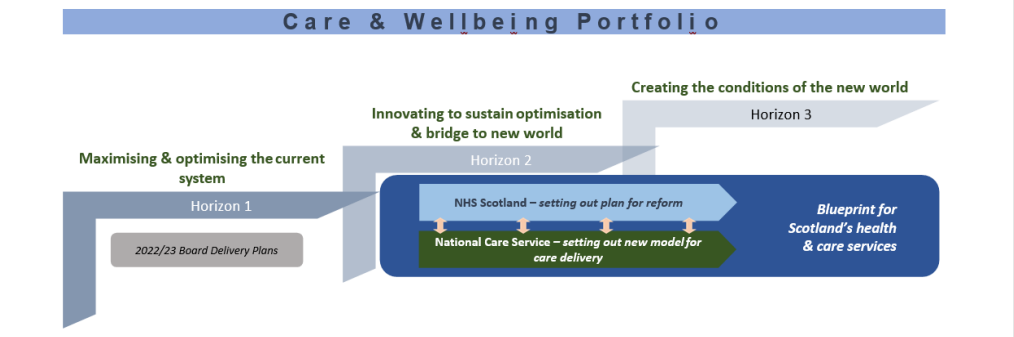
Our governance framework is established to ensure that performance, finance and workforce planning are aligned as closely as possible and that financial recovery is an integral part of both operational service planning and the board's strategic framework.

Our approach to strategic change is described below. This is intended to demonstrate how a Quality Management System (QMS) approach will be applied across all change programmes, and that financial sustainability will be embedded as a core element of all transformation programmes.



Planning Horizons

NHS Borders is developing its operational plans in line with the three horizons approach adopted by NHS Scotland, as follows:



[10] The Strategic Framework chart represents position at September 2022. This chart is currently being update to incorporate revisions to programme architecture from this date.

Operational Planning Framework

Key Principles

The Board has agreed an outline framework to support prioritisation and delivery within its operational planning. This framework has been tested with Business Units during quarter three and is being used to shape the three year operational plan to be submitted in June 2023.

- A minimum requirement for Business Units to release a 2% cash efficiency during 2023/24
- Savings targets not delivered in 2022/23 are expected to be carried forward
- Long term plans should focus on a 10% reduction in costs over future years, inclusive of any cost avoidance or productivity gain
- Staffing levels will need to remain within current overall workforce or reduced / redesigned – any growth will be an exception
- We will remobilise services to pre COVID levels
- Deliver improved productivity & performance
- Seek to reduce risks (particularly ones 'out with tolerance')
- Plans will be developed in line with our Quality Management System and aligned to the six aims of *Efficient, Safe, Effective, Patient Centred, Timely, Equitable, Sustainable*

Sustainability & Value

Arrangements in place to address Sustainability & Value are summarised below.

National Programme	NHS Borders Governance	Chaired by:	Frequency
Sustainability & Value Board	Quality & Sustainability Board	Chief Executive	Monthly
Operational Performance & Delivery Group	Integrated Planned Care Board	Director of Acute Services	Monthly
	Unscheduled Care Programme Board	Co Chair: Medical Director (NHSB) / Director of Social Care (Scottish Borders Council)	Monthly
Climate Emergency & Sustainability Board	Climate Emergency & Sustainability Group	Director of Finance (Executive lead)	Monthly
Value Based Health and Care Group	Currently being established	Medical Director (tbc)	tbc
Financial Improvement Group	Financial Improvement Programme (FIP) Board	Chair: Chief Executive	Monthly
	Financial Improvement Programme (FIP) Oversight Group	Co Chair: Director of Finance / Director of Planning & Performance	Weekly

Developing the Annual Delivery Plan

Workshops held from late 2022 onwards have identified areas for development within the Board's long term strategic framework and Annual Delivery Plan. As described within this report, the approach to financial sustainability is embedded within the principles outlined for operational planning and the development of our transformation programmes.

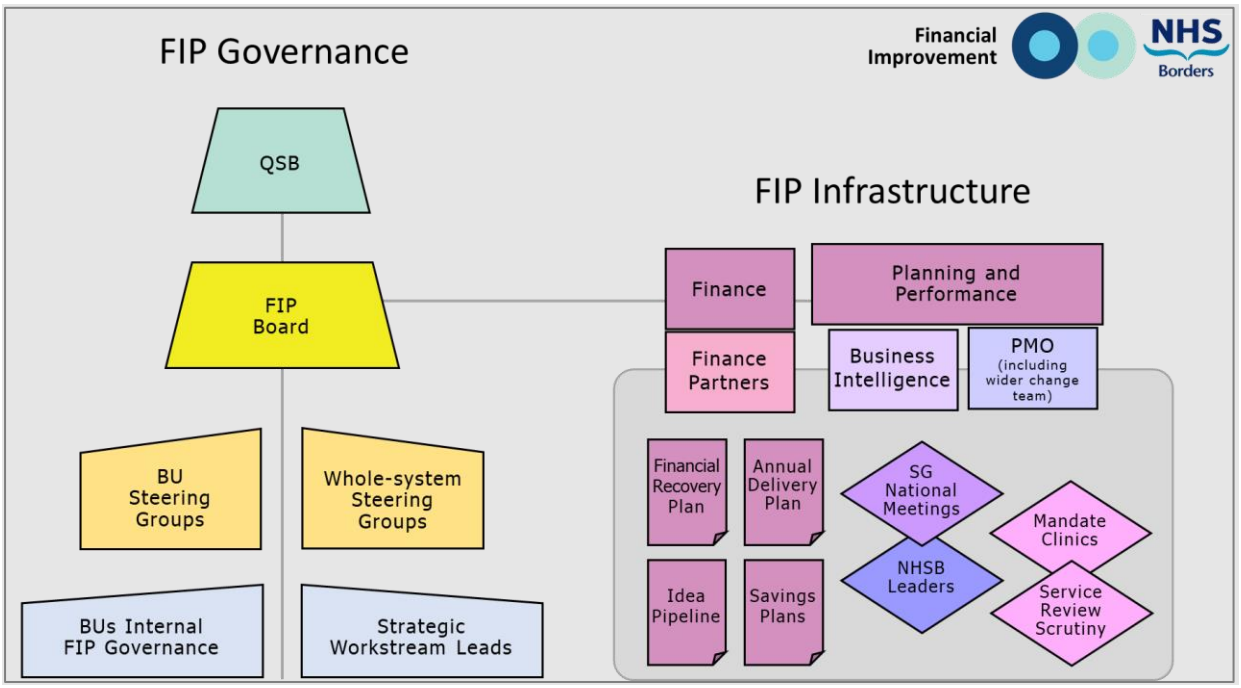
Actions emerging from these workshops have subsequently been collated and grouped to assess those most likely to support financial improvement. A further workshop was held on 27th February 2023 with leadership and senior management in order to refine these proposals and develop the Board's outline work stream programme. The outputs of this workshop are incorporated within the financial recovery actions outlined within this document.

Financial Improvement Programme (FIP)

FIP Governance

A Quality & Sustainability Board (QSB) was established in 2021 to provide oversight to the board's developing Quality Management System (QMS), including long term transformation programmes and the FIP. The QSB is chaired by the Chief Executive and reports to the health board's Resources & Performance Committee (RPC). The QSB meets on a monthly basis and is attended by the executive management team and senior management and clinical leadership from each business unit.

The following graphic describes the FIP architecture and how the FIP is aligned to the Quality and Sustainability Board.



FIP is established as a separate programme reporting in to the Quality & Sustainability Board. A FIP oversight group (previously 'Financial Turnaround Oversight Group') is co-chaired by the Director of Finance and Director of Planning & Performance. This group reviews progress on implementation of the governance and monitoring arrangements for the FIP.

Each business unit attends individual monthly meetings to review progress against the identification and delivery of planned savings. These meetings are chaired by the Chief Executive or Director of Finance, and are attended by Exec. Directors and the senior leadership team of each business unit, supported by PMO and Finance business partners.

The Project Management Office (PMO) established under the previous Turnaround programme has been retained and adapted to support the QMS and FIP programme. Business units report progress on overall development of schemes, including ideas generation, through the monthly FIP meetings with template submission to PMO in advance of each cycle.

Comms & Engagement

We have continued to employ the 'think different' branding agreed through our previous financial turnaround programme (example below).

The FIP was launched with business unit senior leadership on 21st July 2022. A clinical engagement session with primary and secondary care medical leadership was held on 7th September 2022 and a management engagement session for all managers was held on 12th September 2022. Following these sessions we have continued to develop our engagement through a series of on-going workshops with key service staff, including Partnership colleagues.

There remains significant concern about the potential dissonance caused by introducing a high visibility of financial recovery within the organisation at a time when workforce and operational pressures continue to present significant challenges to business as usual and when we are continuing to exhibit high levels of sickness absence attributable to mental health and stress related causes.

A wider 'all staff' engagement plan is now being developed for wider organisational engagement however the implementation of this plan will be considered in the context of the wider operational environment.

PMO Resources

Infrastructure to support delivery of the FIP and the wider QMS is outlined in summary below.

Resources (QMS & FIP)

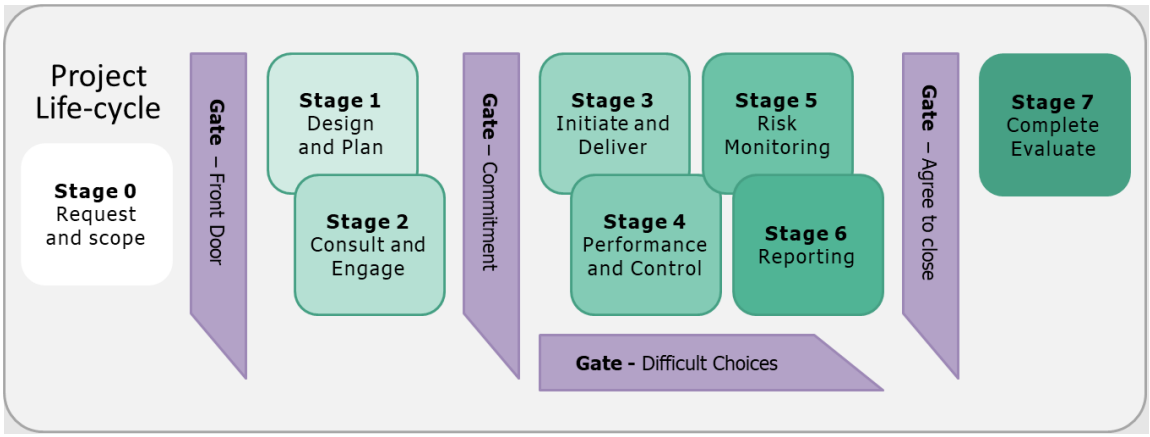
Function	Recurring WTE	Non-Recurring WTE	Total WTE
Project Management Office	7.0	4.0	11.0
Quality Improvement Team	4.4	-	4.4
Finance & Analytics	-	4.0	4.0
OD Support	-	1.0	1.0
Comms & Engagement	-	1.0	1.0
Total Workforce	**11.4**	**10.0**	**21.4**

The majority of the posts described in this structure were recruited towards the end of 2022, with significant turnover and disruption to programme during the earlier part of that year.

Project Implementation Life Cycle

The PMO has adopted a gateway approach to the development, implementation and monitoring of savings opportunities in line with the practice introduced during the Board's earlier financial turnaround programme.

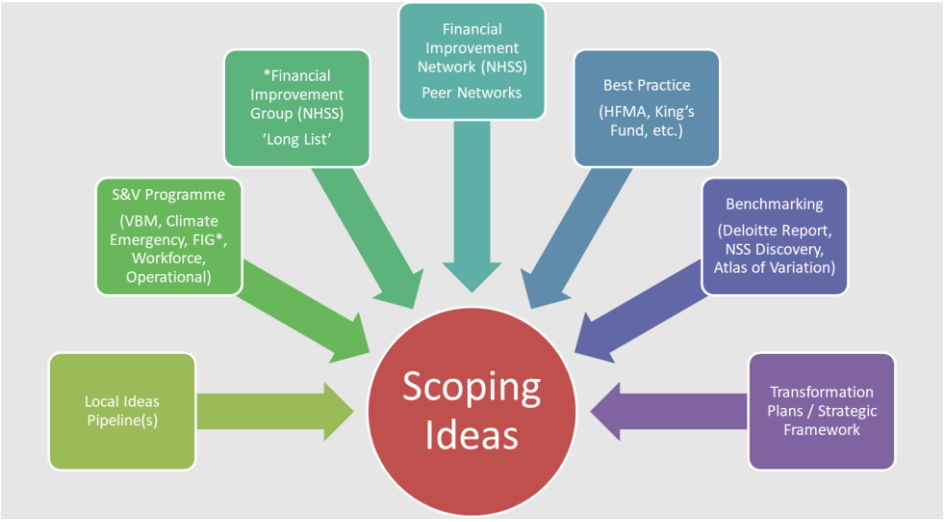
This approach is summarised below:



Identifying Opportunities

We have identified seven key routes by which we will identify potential opportunities. Our PMO has established a 'clearing house' approach to assess each potential opportunity prior to inclusion within our Financial Improvement Programme (FIP).

The graphic below summarises this approach.



Where opportunities are not expected to deliver cash release but may impact on financial planning (i.e. cost avoidance and productivity gain) we will assess whether these require to be tracked by the programme based on an evaluation of the materiality of any potential impact.

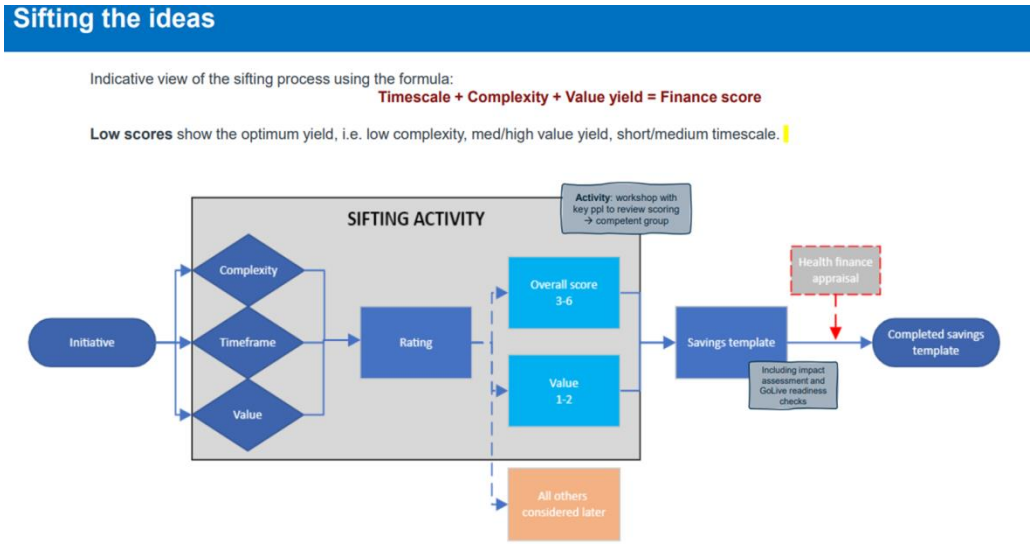
Opportunities 'Pipeline'

All potential opportunities identified through the PMO pipeline approach are logged on a central register pending initial scoping. Once high level scoping and viability is assessed proposed schemes are validated through the mandate process described above.

We are currently establishing revised reporting on pipeline opportunities and intend that progress will continue to be monitored on an ongoing basis through our FIP Board.

Prioritisation of Savings Opportunities

We are implementing a revised approach to support prioritisation of PMO resources. This approach is intended to align to the mechanisms established through the national Financial Improvement Group (FIG) as described below.



Savings Targets

As described under 'Scale of the Challenge', by end of March 2026 we anticipate that in order to deliver a balanced financial position there will be a requirement to achieve a total of £37.8m recurring savings over the three years of the plan. This excludes the additional actions to manage non-recurring pressures estimated at £12.6m over the three year period.

The recurring gap outlined above would require savings of almost 15% to be delivered over the medium term (to March 2026). This level of savings is not considered achievable by NHS Borders Health Board within the time frame of the medium term plan.

Target savings within the financial plan

It is assumed that savings of £20.0m (recurring) will be delivered over the duration of the plan, resulting in an estimated recurrent gap of £17.8m at March 2026. This position is predicated on delivery of 2.0% (recurring) savings in 2023/24[11] and 3.0% p.a. for the following two years.

Savings delivery described in the financial plan is based on high level assessment by the Director of Finance and endorsed by the Board at its financial planning workshop in February 2023. It is intended that this position will continue to be reviewed as opportunities are scoped and implementation plans are fully developed.

Internal savings targets

We have set internal targets of 3.0% with 2.0% assigned to Business Units and a further 1.0% assigned to a work stream approach. Business unit targets are delegated to individual service level aligned to budget managers within the board's scheme of delegation and reflected in financial management reporting.

This approach is intended to provide clarity of expectation to operational and senior management however it is recognised that the FIP will continue to evolve based on assessment of actual opportunities and that this will lead to adjustment in expected level of savings across both business units and work streams.

We expect that an element of this saving will be achieved through non-recurring means, or by cost avoidance schemes. As such, the financial plan has been developed on the basis of 2.0% recurring delivery in year 1 rising to 3.0% in years 2 & 3. As we increase confidence in the identification and planning of schemes we will revisit this assumption.

[11] A further 1% to be delivered non-recurrently in 2023/24.

Scoping Opportunities

SG Framework

The Financial Improvement Group (FIG) has undertaken high level assessment of potential savings opportunities across NHS Scotland. NHS Borders has developed an internal version of this assessment with intention of mapping internal FIP savings plans against this framework in order to understand where there may be further opportunity to be explored. Mapping of local schemes will be undertaken at end Quarter One when it is expected that savings opportunities will have been fully scoped.

Potential Savings Opportunities (NHS Borders)

	Area of expenditure		High Level Estimated Spend 2023/24	High Level Assessment - Savings Potential		NRAC Share of NHS Scotland Estimate
				2%	3%	
1	Prescribing	NHSB FP estimated HCH Drugs + PC Prescribing	43.0	0.9	1.3	1.6
2	Nurse Agency	Agency (forecast spend 2022/23)	2.1	0.0	0.1	0.6
3	Medical Locums	Agency (forecast spend 2022/23)	2.5	0.1	0.1	0.5
4	Non Medical agency	Agency (forecast spend 2022/23)	0.4	0.0	0.0	0.2
5	Digital	NRAC share of national estimate		0.9	0.9	0.9
6	Income generation	NRAC share of national estimate		0.3	0.3	0.3
7	Estates	NHSB Estates non-pays (maintenance, rates, etc. excluding energy/waste)	3.5	0.1	0.1	0.5
8	Energy Management / clinical waste	NHSB Energy (all fuels); waste (including domestic waste)	4.1	0.1	0.1	0.5
9	Procurement	NHSB Non-Pays excluding FHS (includes commissioned healthcare)	36.7	0.7	1.1	1.1
10	Permanent staff	NHSB (recurring) Pay Budgets less Agency costs noted above (excludes 2023/24 uplift)	149.3	3.0	4.5	1.3
			241.6	6.0	8.5	7.6

The potential savings opportunities outlined above have been mapped against the Board's own FIP savings programme for internal monitoring purposes. As further information is made available through the national FIG programme it will be routed through the internal FIP pipeline process to identify whether opportunities are additional to existing programme.

Current Savings Plans

Summary of Current Plans

Savings schemes identified to date are summarised in the following table.

Savings in-Year	2023-24 Recurring £000	2023-24 Non-Rec £000s	2023-24 Total	Risk Rating High £000s	Risk Rating Med £000s	Risk Rating Low £000s
Workforce						
Medical Supplementary Staffing		300	300		300	0
Nursing Supplementary Staffing		200	200	200	0	0
Public Dental Services Workforce Review	130		130		130	0
AHP Leadership Review	100		100		100	0
Service Reviews	290		290		290	0
Other Workforce Schemes	42		42		42	0
Total Workforce	562	500	**1,062**	200	862	0
Procurement						
Internal Audit Fees	10		10		10	0
Shredding contract	14		14		14	0
Total Procurement	24	0	**24**	0	24	0
Prescribing						
Lenolidomide	323		323			323
Product Switches	200		200		200	0
NP Contracts	192		192			192
Off Patent/Generics	250		250		250	0
PAS/PC Rebates (above baseline)	100		100		100	0
Total Prescribing	1,065	0	**1,065**	0	550	515
Estates & Infrastructure						
Boiler House Review	60		60		60	0
Phone Line Rationalisation	40		40		40	0
Waste Management	110		110		110	0
Energy Efficiency	140	250	390	60	330	0
Total Estates & Infrastructure	350	250	**600**	60	540	0
Non-Pay (Other)						
Community Dressings	18		18		18	0
Repatriation of Out of Area MH Patients	231		231	194	37	0
Gala Resource Centre	61		61	61		0
Total Non-Pay (Other)	310	0	**310**	255	55	0
Total Planned Savings Schemes	2,311	750	**3,061**	515	2,031	515
Pipeline - In-Development Stage			0	0		
Pipeline - Identified Opportunity Stage	800		800	800		
Total Pipeline Savings Schemes	800	0	**800**	**800**		
Savings Schemes (Planned and Pipeline)	3,111	750	**3,861**	**1,315**	**2,031**	**515**
Unidentified Savings	1,889	1,750	3,639	3,639		
Savings Target	**5,000**	**2,500**	**7,500**	**4,954**	**2,031**	**515**

Grip & Control

Under the previous financial turnaround programme established in 2019 the board introduced a range of measures in relation to Grip & Control, including vacancy control. These measures have remained in place during the pandemic, however operational pressures have necessitated reprioritisation of management capacity which has led to reduced monitoring and relaxation of workforce controls where significant patient safety or staff wellbeing concerns have been identified.

Measures in place are summarised in the following table.

Domain	Controls in place
Emerging Cost Pressures	All emerging cost pressures are required to be presented to the board's Operational Planning Group in SBAR format with supporting risk assessment. The board holds a contingency reserve for emerging risks which is applied where immediate investment is required in order to mitigate operational issues which are out-with the board's risk tolerance. Investment is on a short term, non-recurring basis with expectation that services develop a sustainable action plan to address on a cost neutral basis (or make separate case via the board's financial planning process). All pressures are peer reviewed and recommendations presented to the Board Executive team for final approval.
Vacancy Management	Vacancy management panels in place to review all vacancies; prioritisation of clinical posts; enhanced scrutiny of long standing vacancies and opportunities for redesign. All non-clinical posts are reviewed and decisions based on service need and workforce risk. The board has set a priority for recruitment to clinical posts. Non-clinical posts remain under consideration for recruitment on a post by post basis following vacancy panel scrutiny. An updated policy for vacancy management was implemented in January 2023.
Medical Agency & Locums	A Medical Oversight Group is chaired by the Medical Director, supported by finance and relevant corporate functions. This group undertakes review of Medical workforce issues and undertakes regular review of medical locum agency usage. Long term locums are appointed based on risk assessment of vacancies and consideration of service business continuity. Increased CDF recruitment from August 2022 was agreed with the intention of reducing reliance on agency to cover short notice shift gaps and longer term vacancies, and to support rota compliance. A review of medical agency locum usage has been commissioned to report by March 2023. Rates in place for agency use will be reviewed as part of this report.
Waiting List Initiatives	The board has an established policy for WLI rates which caps payments at 2 x consultant rate. Opportunities for EPA are considered prior to any WLI use. Waiting list payments are only applicable where there is specific funding (i.e. Access support funds). Monitoring of clinical productivity and actions to ensure delivery of core job planned activity is being reviewed through the Planned Care workstream.
eRostering	We have recently signed the MOU and agreed our implementation timelines with initiation due to begin in March 2023 and deployment by deployment by September 2023. Project governance is currently being established. It is not currently considered viable to accelerate this implementation due to pressures on senior nurses within ward areas.

Domain	Controls in place
Nurse Rostering	Nursing grip & control actions are monitored by the Director of Nursing. As a result of workforce pressures there has been a requirement for supervisory charge nurses to support registered nursing shifts, thereby reducing management capacity to undertake regular monitoring and review of KPIs. In advance of eRostering implementation the board is establishing a 'back to basics' approach to nurse rostering which is intended to ensure readiness for the transition to electronic rosters. Weekly nurse rostering reviews have been established by the Director of Nursing. Associate Nurse Directors review rota sustainability, use of bank & agency staffing, sickness absence, planned leave, etc. through these reviews.
Nurse Agency	Director of Nursing is working to implement the national action plan for Agency nursing. Reporting of Agency use is being reviewed and additional monitoring reports prepared in order to ensure this information is widely available to all relevant managers.
Sickness Absence	HR systems report absence levels to all departments on regular basis. The board has an absence management policy in place in line with national policy. Sickness absence is managed through routine performance reporting, including business unit quarterly review meetings.
Procurement	The board has a high level of adherence to national contracts and use of national distribution centre as its main supplies requisition route. Local contract awards are undertaken in line with relevant legislation. The board's procurement strategy was recently refreshed and is published on its website.
Purchase Order Compliance	Arrangements are in place to maximise Purchase Order compliance through PECOS. Following recent implementation of PECOS in Estates, all areas are now using PECOS either through direct requisitioning or via the board's procurement function. Areas of non-PO spend are in relation to service contracts and other non-goods ordering. A programme of continuous review is in place to ensure that non-PO spend is minimised and exceptions are by approval of the Chief Executive or Director of Finance.
Non-Contract Spend	Non-contract spend is reviewed on an on-going basis by the Head of Procurement. Further work is being developed through the creation of a Procurement work stream within the FIP.
Discretionary Spend	Differential controls are in place for discretionary expenditure, including purchase of stationary, staff training, etc. These controls are monitored at local level and through procurement systems, where applicable. A Discretionary spend policy is currently being developed to further strengthen this approach.
Commissioning	Policies are in place for the management of cross boundary flow activity, including referral criteria. Commissioning of out of area placements are reviewed by a multi-disciplinary ECR panel. A review is currently being undertaken to consider revised management arrangements for high cost placements within Learning Disabilities services. This review is expected to report by end March 2023.
Income Recovery	Income recovery targets are in place for trading account activities such as non-patient catering, laundry, etc. An income review is currently underway and is expected to report in April 2023.

Local Schemes

Leadership workshop

A leadership workshop was held on 27th February 2023 at which senior management and executive directors reviewed local schemes identified to date and highlighted priority areas for further assessment. This work remains in progress. Outputs of this workshop are summarised below.

Scheme Size	Savings Range		Delivery Timeframe		
			2023/24 In Year	2024/25 Medium-Term	2025/26 and Beyond Longer-Term
Small	**£1-£50,000**	**Acute Services**	• N20 Contract • Neurology service review • Pre assessment phase 2 • Specialist nurse teams • Non routine ortho		
Small	**£1-£50,000**	**Primary & Community Services**	• Orthotic Service procurement review	• Review of PDS Admin	
Small	**£1-£50,000**	**Mental Health & Learning Disabilities**	• Admin Review (MH&LD) • Medical Workforce Review • MHOAS (Mental Health Older Adults Services) Service Review • Review Borders Addiction Service and Pathways		• CMHT (Mental Health Older Adults Service (MHOAS) - Trial Dementia screening within a small GP practice within the Borders to assist with Early Diagnosis
Medium	**£50,001-£200,000**	**Acute Services**		• Woman and children's service review	
Medium	**£50,001-£200,000**	**Primary & Community Services**	• AHP Service Review - Structure & Admin	• Dentistry Workforce and vacancies review	
Medium	**£50,001-£200,000**	**Mental Health & Learning Disabilities**	• Psychological Therapy Service, Provision & Pathways - Service Review	• Repatriating provision for LD complex cases	

A number of other potential opportunities were identified aligned to work streams expected to extend across business units. These are described within the *Work streams* section of this report.

Work streams

As at 16th March 2023, scoping work continues to progress with the intention of establishing a broader programme of work streams as outlined below.

Work streams are intended to focus on opportunities for savings which extend across multiple business units. Each of these work streams is expected to have an Executive sponsor who will lead the development and implementation of actions arising within the work stream.

Work streams for Drugs & Prescribing, Procurement and Estates & Facilities have previously been established and it was initially intended that this programme would be extended to cover further work streams in relation to:

- Environmental Sustainability
- Digital Transformation
- Estates Rationalisation
- Corporate Services Review

Existing work streams included within current savings plans are outlined below.

Drugs & Prescribing

Schemes/Activities	Grand Total
	£000s
NP Contract Prices - 2022/23	92
NP Contract Prices - 2023/24	100
Off Patent/Generics	250
PC/PAS Rebates above Base	100
Polypharmacy Reviews (Invest to Save)	
Product Switching	100
Script Switch (Primary Care)	50
Biosimilars/Homecare	
Grand Total	**692**

Procurement

Schemes/Activities	Grand Total
	£000s
Income Generation - Review Trading Accounts	
National Procurement Workplan (Prices)	
Review Contract Register	
Service Contract Review	
Review 3rd Party & Voluntary Org Contracts	
Review Non-Contract Spend	
Product Standardisation (cost/quality)	
Review External Consultancy	
Review Discretionary Spend Controls	
Review Physical Media (Licenses & Subscriptions)	
Stock Management Guidance & Training	
Review Car Leasing	
Price Awareness Campaign	
Grand Total	**0**

Estates & Facilities

Schemes/Activities	Grand Total
	£000s
Clinical Waste Uplift	60
Laundry Energy Efficiency	60
Waste Segmentation (1)	50
Water Condenser Efficiency	80
Energy Rebates [Non-recurring]	250
Income Generation - Advertising	
Income Generation - Review Trading Accounts	
Grand Total	**500**

Initial scoping work towards the development of additional work streams is summarised below.

Workstream	Scope
Corporate Services Review	▪ Review of management structure and admin services, including opportunities for consolidation of admin support teams (e.g. internal help desk services). ▪ Assessment of a 'target' level overheads approach to corporate overheads.
Environmental Sustainability	Further opportunities in relation to: ▪ Waste Management ▪ Energy Efficiency ▪ Green Theatres ▪ Medical gases/propellants ▪ Single use items
Digital Transformation	▪ Near Me & Remote Working ▪ Leveraging benefits of national IT solutions, including O365 and Allocate contracts
Estates Rationalisation	▪ Review of opportunities for joint public sector estate within community settings and corporate functions ▪ Buy/Lease assessment against non-core estate ▪ Review of space utilisation and options for site disposals

During February 2023 further discussion with the Board Executive Team and Quality & Sustainability Board has begun to scope a number of additional work streams which are aligned to the Board's Annual Delivery Plan and expected to impact on both financial improvement and productivity gain. High level scoping documents have been prepared for each work stream and are summarised below.

	Workstreams	Minimum Expectation	Stretch Goal	Baseline £m	1% £m	2% £m	3% £m	10% £m
1	Workforce	No increase in overall workforce costs (except pay award); 20% reduction in Agency spend	2% Cash Release across total workforce (including aligned workstreams)	154.3	1.5	3.1	4.6	15.4
2	Bed Capacity	Reduce bed base to core funded levels	10% reduction in the cost of Inpatient Beds over 3 years	Cash release expected to be predicated on change in overall workforce costs associated with programme baselines. Scoping of detailed schemes is currently being progressed. Delivery will be against the Workforce costs profile reported above.				
3	Pathways & Community Integration	Not expected to deliver change in year 1 of plan. Minimum expectation - cost neutral.	10% reduction in whole system pathway costs					
4	Discharge & Assessment & Re-ablement teams redesign	Reduce costs to match funded base budget.	10% capacity increase at no additional cost					
5	Shared Services – Clinical	Any changes to service model will be cost neutral and will strengthen sustainability of services	Changes will support future service sustainability by maximising productivity gain and/or cash release					
6	Shared Services – Corporate	Focus on cash releasing opportunities (3% minimum saving on baseline spend)	10% Cash release (to NHSB)					
7	External SLAs	Growth in cost limited to national average (all HBs)	Restrict growth to 2%	24.4	0.2	0.5	0.7	2.4
7a	Out of Area Placements	2% Cash release	10% Cost Avoidance	3.0	0.0	0.1	0.1	0.3
8	Site Rationalisation	50% savings from any site closures	80% savings from any site closures	3.5	0.0	0.1	0.1	0.4
9	Prescribing & Polypharmacy	3% Cash release	Restrict growth to 2%	43.0	0.4	0.9	1.3	4.3
10	Service Reviews	2% Cash release	10% reduction in cost base over 3 years	See comments on Workstreams 2-6				
11	Outpatients / Theatres	1% productivity gain annually; aligned to CFSD and National operational effectiveness workstream	NHSS Upper Quartile KPIs	Non-financial benefits to be quantified as 'cost avoidance' and monitored through workstreams.				
12	Climate Sustainability / Energy & Waste	3% Cash release	10% Cash release	3.8	0.0	0.1	0.1	0.4

A full work stream programme is expected to be in place by end Quarter One (30th June 2023).

Potential Productive Opportunities

Benchmarking Review

In summer 2022 the Board commissioned an initial desktop exercise to review available benchmarking information and identify areas of potential productive opportunity. Deloitte LLP were engaged to undertake this review and a final report was provided to the Board in September 2022.

All data prepared to support the report has been provided to the Board, including dashboard analysis prepared in MS365 Power BI tool, enabling the Board to undertake further interrogation of the datasets.

The review considered information available through nationally available datasets including NSS Discovery, Scottish Health Service Cost Book, Atlas of Variation, etc. as well as population estimates and other demographic information from National Registers of Scotland.

The findings of this review are summarised in Appendix 1.

A Benchmarking Group has been established to review the full findings of the report and to undertake additional analysis where required. A full assessment and action plan remains at draft stage and is expected to be finalised by end Quarter One.

Initial areas of focus arising from the review have been identified and are being progressed through strategic programmes, including the Planned Care and Urgent and Unscheduled Care Boards.

Summary of progress to date

The following provides brief summary of key activities from the Board's Planned Care and Urgent & Unscheduled Care Programme Boards following their most recent meetings.

Planned Care Programme Board

The NHS Borders Integrated Planned Care Programme is leading work to develop sustainable elective services in the Scottish Borders and taking forward the development and delivery of a Backlog Recovery Plan. The Programme Board held its latest meeting on 23rd February. The following is an overview of the programme progress.

Key Achievements

- Revised Theatre Schedule that was implemented on the 6th February has been running smoothly, reducing the number of half-day sessions per month by 22 and releasing 11 hours of additional capacity per month.
- The Theatre productivity project has completed the Appreciative Enquiry approach as part of project start up. 60% of Theatre Staff have been engaged in this process. Thematic analysis of the improvement opportunities and staff feedback has also been completed to enable a prioritisation of these to now be developed.
- The proposed Ophthalmology QI project BOSCARD was discussed and supported by the group. The project aims to triple the number of Cataract patient operations over the next 12 months.
- Significant progress on Active Clinical Referral Triage (ACRT), Opt In process and Patient initiated review continues to be made. The opportunity to replicate ACRT process (Opt-In pathway) for PIR has been agreed to be adopted and therefore streamlining this and reducing variation for Central Booking Staff.
- The Deloitte report was considered at this month's Programme Board and further analysis at

workstream level agreed.

Urgent & Unscheduled Care Programme Board

The Scottish Borders Urgent and Unscheduled Care Programme aims to deliver transformational change, system improvement and better patient pathways for the Scottish Borders.
The latest monthly Programme Board took place on the 2nd February '23. The next board is planned for 18th April 23.

Key achievements:

- DWD (Discharge without Delay) project closure report was submitted to board. This workstream has developed supporting documentation and posters for DwD, increased Home First through process review in late 2022 and delivered a number of education workshops across the community. Recently education workshops took place in Hay Lodge CH and Hawick CH. The rollout of DwD will be delivered through a Kaizen programme at a ward level moving forward.
- Project and operational resource was moved to support the MADE (Multi Agency Discharge Event) which has now completed. Learning from the event is being considered by operational leads and will feed into the upcoming Urgent and Unscheduled Care Programme Annual Planning workshop.
- Respiratory Virtual ward - The DPIA has been completed and fully signed off. Software providers Current Health have provided training dates starting 5th April to deliver to the BGH Respiratory team. The pathways are being worked on by Dr MacKay and there will be a session week commencing 27th Feb to document the changes. The warranted environment specification has been provided and are now with IM&T.
- The Surgical HOT clinic trial started week beginning 27th March delivering clinics on Monday, Wednesday, and Friday. Initial feedback from the trial has been favourable as patients are moved out with ED for assessment.
- Hospital at Home - The notes of interest have closed and interviews for the nurse posts will be held on 3rd March 2023. The On boarding process is being worked through. The patient representative has joined the steering group and is providing useful input. The Finance sub group meetings have commenced and they have given direction on data that needs to be gathered to support the future business case.
- The first Urgent and Unscheduled Care Annual Planning workshop is in diary. This event will review progress of the programme so far and set priorities for '23/24 with a focus on sustainability and moving towards to 2023 urgent and unscheduled care vision.

Working with Partners

Background

Over the past eighteen months the Scottish Borders Integrated Joint Board has appointed a new Chair, Chief Officer and Chief Finance Officer. Prior to the appointment of the Chief Finance Officer in September 2022 the post had been vacant for two years, with the Scottish Borders Council Director of Finance performing the functions of Section 95 Officer.

Since this time, the IJB has begun to develop its new strategic framework and both NHS and Local Authority partners are working closely to support the implementation of this framework.

IJB Budget Setting

Due to the timing of the CFO appointment the financial planning for 2023/24 has continued to be led by the partner organisations with the IJBs financial plan being a consolidation of the outputs from each partner. The IJB has confirmed its intention to set an Initial Budget by 31st March 2023 with the expectation that this budget will be finalised by end June 2023. Accompanying this budget will be the relevant directions to partners which set out the strategic objectives relating to delegated functions, including Set Aside for large hospital functions, together with the financial resources within which these objectives are expected to be delivered.

Financial Risk Share Arrangements

The IJB faces the same financial challenges in relation to health-delegated functions as those within the Health Board. HSCP partnership functions continue to be managed as Business Units within NHS Borders management structure, with the exception of Learning Disabilities where a joint service is fully established.

Prior to the pandemic the IJB was already facing significant pressures on health delegated budgets and savings delivery has been limited during that period. In establishing the budget for 2023/24 the Health Board has set out its expectation that the IJB will need to contribute not only to addressing the gap on its own budget, but also to a further share of unallocated savings not previously distributed as targets to individual business units. In addition, the HB has also highlighted the conditions set out in the Scheme of Integration within Scottish Borders, by which support provided by the partners is repayable by the IJB. This is most relevant in relation to the brokerage support provided to NHS Borders, of which an element has been used to support the IJB.

The relationship with the IJB continues to be constructive and all parties remain committed to retaining a collaborative approach to forward planning. As such we anticipate that the final resolution of these aspects of the budget will be best achieved through constructive dialogue and a shared commitment to addressing the underlying problems which drive the financial deficit faced by both parties.

Financial Recovery

The IJB CFO has outlined her approach to financial recovery through a number of key actions which the IJB is looking to implement during 2023/24, including:

- Increased grip & control through enhanced decision making governance
- Establishing the IJBs financial planning approach aligned to the revised strategic framework

- Introduction of a whole system programme budgeting model to be applied across both Health & Social Care
- Review of Set Aside arrangements and governance
- Introduction of a budget review to evaluate options to deliver 'Best Value for every Pound'

We will work with the IJB to support the further development of this approach and will consider how benefits of this approach might be extended into non-delegated functions where relevant.

NHS Borders intends that the approach to savings undertaken operationally should be aligned across both delegated and non-delegated functions in order to ensure consistency of message to operational management teams.

The IJB CFO has been invited to join the Board's Financial Improvement Programme Board and in advance of the quarter one review we expect to work with the IJB to develop the NHS Borders FIP to align the board's savings programme as closely as possible with the IJBs expected approach.

Next Steps

We recognise that further work is required urgently to ensure that the level of savings described in the plan is fully identified.

We will scope savings expected to impact in both the immediate and long term, and seek to embed the actions to improve grip & control and to deliver local and work stream savings.

We will continue to focus on the immediate priority of ensuring that savings plans for 2023/24 are fully assessed and implementation is in place as soon as possible.

This will include ensuring that the work stream approach described in the paper is fully scoped and additional work streams are established within the first quarter of 2023/24.

We also aim to outline the scope of potential opportunities to address the additional savings assumed in the plan over the three years to March 2026.

Our benchmarking work will continue to evolve and we will embed this approach across our Financial Improvement and Transformation programmes to maximise opportunities for both financial improvement and productive gain. We aim to develop an action plan in relation to our Benchmarking Report referenced above by end of quarter one.

We will ensure that the Board's transformation programme continues to focus on the development of the changes required to address long term sustainability across our services.

We will work with the Scottish Borders IJB and other public sector partners to seek opportunities to drive improvement through collaboration. This will include assessment of how we expect to align our programme with the Scottish Borders IJB strategic framework.

We also aim to outline areas where we believe there are opportunities for us to work with regional partners, including Scottish Borders Council and East Region NHS Boards, to achieve greater economies of scale through joint working.

Beyond this, we believe that there will be further savings required which will only be possible through reform of services at a regional or national level, and by identification of policy changes which will fundamentally alter the demand for services which currently drives expenditure.

Appendices to the Report

Appendix 1 – Benchmarking Analysis Report: Summary of Key Findings

BENCHMARKING ANALYSIS REPORT SEPTEMBER 2022

Summary of Key Findings

Report prepared by Deloitte LLP

Workforce		Next Steps
W1	Age structure of the workforce slightly older than Scotland with sickness absence in line with national average	*Workforce is a large area of cost and a number of findings have been identified. We would recommend further investigation and / or the establishment a specific workforce workstream in the FI programme to review in more detail*
W2	Admin and support service WTE are high per 100,000 population and take up a high proportion of overall workforce WTEs (31% of all roles vs 26% for Scotland)	
W3	Admin and support services using fewer B2 and junior grades compared to D&G and Scotland	
W4	Relatively low share of WTE in nursing roles (42% vs 45% in Scotland), with more senior grades B6+ and less use of B2s compared to D&G	
W5	Slow vacancy fill rates with 36% of vacancies over 3 months, compared to 25% in Scotland and 17% in D&G within Nursing and Midwifery, largely driven by roles in the acute (adult) sector.	
W6	Agency expenditure has increased recently, however, data on bank is hard to interpret given change in system (transfer to Lothian bank), however based on informal discussions we understand it has increased too	

Site and Beds		Next Steps
S1	Number of sites per capita is higher than elsewhere in Scotland (Acute Hospital, Community and GP practices) however in line with other rural Boards	*A more detailed review of community and geriatric bed provision maybe required. This should take into account other community based service available to support the elderly population.*
S2	Acute staffed beds per 100,000 have been falling steadily over the past ten years and are broadly in line with peers although reported occupancy at 78% is lower (pre-covid)	
S3	Community staffed beds have remained unchanged over the past ten years and provision is now slightly higher than peers, on a per site basis and per 100,000 population basis. Despite this occupancy remains high.	
S4	Acute medical and surgical beds are lower per capita than peers but this probably reflects high cross boundary flow	
S5	Geriatric medicine beds per capita are very high compared to peers but this may be due to variance in reporting by specialty or reflective of the population makeup of Borders	

Primary Care and Prescribing		Next Steps
PC1	The number of GP practices per capita is slightly higher than Scotland and practices have a smaller list size. This in part reflects the rural geography and is in line with other rural Boards	*Opportunities in relation to General Practice appear limited, however, there remain areas of opportunity in prescribing expenditure in both primary care and the acute sector that are worth pursuing and quantifying further. It is understood that the pharmacy team has the ability to run in depth reports to support this.*
PC2	Average GP list sizes have increased slightly over time, but at a slower pace than the rest of Scotland	
PC3	GP headcount has remained broadly constant, within this there has been a drop in male headcount and an increase in female salaried GPs	
PC4	Overall prescribing expenditure is in line with the Scotland average (cost per 100,000 population). This finding relates to primary care with acute prescribing slightly below average	
PC5	Growth in cardiovascular prescribing spend continues (in line with the rest of Scotland) and will remain a significant cost pressure going forward	
PC6	In four BNF Chapter areas, prescribing costs are outliers compared to the rest of Scotland: Endocrine (hospital spend), Eyes, ENT and Nutrition & Blood (we understand the prescribing team are looking to review Nutrition following a recent hire)	

Mental Health		Next Steps
MH1	Adult Acute Mental Health bed numbers per 100,000 are slightly above average, with admission rates much higher, whilst occupancy rates remain low (significantly below the Royal College of Psychiatrists recommended maximum occupancy)	*Bed benchmarking was undertaken pre Covid and further interpretation is required.* *CAMHS and PT workloads should be reviewed– for example the introduction of CAPA type demand and capacity workload tool* *Further analysis is required for the data behind the high volumes of new outpatient referrals leading to booked appointments, as when coupled with a high rate of return appointments and low uptake of virtual appointment methods could be a significant opportunity area.*
MH2	Older Adult mental health bed numbers per 100,000 registered population are below the Scottish average as are admission rates and occupancy rates.	
MH3	Accepted referrals to Psychological Therapy (PT) and CAMHS per 100,000 registered population are higher than average	
MH4	CAMHS and PT waiting lists are under pressure and now above average in Scotland	
MH5	Borders has a high rate of booked outpatient referrals across all Mental Health specialties	
MH6	Better Quality Better Value (BQBV) indicators highlight a high new to return ratio with an opportunity to reduce 2,500 return appointments	
MH7	There is a relatively low uptake of virtual outpatient appointments across mental health specialties (Child & Adolescent Psychiatry, General Psychiatry [new appointments] and Psychiatry of Old Age)	

Unit Costs		Next Steps
C1	Cost Book analysis (19/20) illustrates the inpatient hospital costs are broadly in line with the Scottish average albeit with General Medicine and Gynaecology unit costs outliers (+38% and +42% respectively)	*We would recommend updating cost apportionment methods to ensure the information is sufficiently robust for opportunity identification.* *The size of the current variations would indicate that some services do have higher than expected unit costs*
C2	Day case unit costs across almost all specialties are significantly higher than the Scottish average (+34%)	
C3	Consultant led outpatient and ED unit costs are significantly higher than the Scottish average (+31%). Nurse led appointment unit costs are lower whilst AHP attendance unit costs are high	
C4	Community service unit costs are broadly in line with the Scottish average, although appear high for both the community psychiatric team and district nursing team (+32% and +45% respectively)	
C5	Theatre unit costs are between 11-19% higher depending on the comparator. Hospital administration and cleaning costs are also higher than average.	

Non-Elective Pathways		Next Steps
NE1	BQBV indicators suggest there are some modest improvements possible in the management of Ambulatory Sensitive Conditions within ED (mainly abdominal conditions)	*Non elective lengths of stay have diverged significantly from Scotland and require urgent review working with HSCP colleagues*
NE2	NSS Discovery indicators illustrate that Borders has a high admission rate from ED (31% vs 26% for Scotland)	
NE3	Length of stay (los) in the acute sector has been increasing particularly across non elective pathways. Average LoS is now over 9 days compared to 5 across Scotland. The increase is driven primarily by General Medicine and Trauma and Orthopaedics	
NE4	Delayed Discharges have steadily increased since an initial fall after Covid special measures were introduced in 2020. Average daily delayed bed days and median length of delay are now above pre-pandemic levels.	

Elective Care		Next Steps
EC1	Opportunities for improvement across elective care LoS appear modest, although average LoS have increased marginally over the Covid period	*Opportunities across the elective pathway are modest but further investigation into hip replacement and Day Case rates should be undertaken. However, it is unclear what impact Covid may have had over the past year*
EC2	BQBV indicators illustrate few opportunities from DNAs or pre operative lengths of stay	
EC3	BQBV procedures of limited value indicate potential savings almost all linked to undertaking more Primary Hips than required for the age standardised population	
EC4	Day case rates are broadly in line with BADS targets, albeit there are opportunities to improve in hip surgery, mastectomy and bladder resection. Comparisons to D&G illustrate they are doing far more day surgery and that there is opportunity above matching the BADS targets.	

Theatre Performance		Next Steps
T1	Session cancellations are very low, despite this Borders has a very high rate of cancelled operations for non clinical/ capacity reasons across all main surgical specialties	*NHS Borders appears a substantial outlier in relation to theatre efficiency. Further understanding of how these metrics are collated and measured should be sought to validate these findings.*
T2	Borders is an outlier in terms of late starts, over runs and under runs. Difficulties are apparent across all main surgical specialties (General Surgery, Urology, Ophthalmology, Orthopaedics, Gynaecology)	
T3	Borders has the slowest average procedure time (95 mins) in Scotland. Only 35 mins relates to operative time giving a Knife to Skin ratio of only 37%	*A programme of scheduling optimisation and improvement will be required*
T4	Theatre utilisation rates are line with the Scottish average but given the above, this metric is clearly masking issues elsewhere	

Outpatients		Next Steps
OP1	Outpatient DNA rates for new patients are slightly below the Scottish average (7.6% vs 8.7%) and slightly higher for returns (12.2% vs 9.8%). New to follow up ratios are mainly better the Scottish average with the exception of mental health specialties (see above)	*Continue to push the modernisation of outpatients including the use of ACRT, with greater use of virtual appointments where clinically appropriate given the rural geography*
OP2	The number of virtual outpatient appointments (video and telephone) is in line with the Scottish average but lower relative to other rural Boards such as Highland and Grampian. For new patients it is currently 14% and 22% for returns	
OP3	A number of specialties are undertaking fewer virtual appointments compared to the Scottish average (respiratory medicine, endocrine, rheumatology and general surgery)	
OP4	Borders has a slightly higher than average age / sex standardised outpatient referral ratio indicating there maybe opportunities for improvements in Active Clinical Referral Triage (ACRT)	

Cross Boundary Flow		Next Steps
CB1	13% of residents who require treatment (by HRG) and 11% of residents requiring outpatient attendances are seen outside of NHS Borders run locations, with the majority being seen in Lothian	*There is limited scope for bringing additional specialties within Borders without significant investment in services. General specialties with a high proportion of cases seen elsewhere are potential targets for repatriation.* *The cases sent to non-NHS Providers should be assessed to ascertain whether they could have been sent to NHS providers and the subsequent cost of this.*
CB2	A number of specialties have no outpatient seen at Borders locations, including Plastics (1,377 patients), Medical Oncology (773 patients) and Neurosurgery (633 patients)	
CB3	No patients required Assisted Reproductive procedures, non-admitted consultations for Immunology and Radiotherapy were seen in Borders	
CB4	Psychiatry of Old Age, Urology and Skin Surgery have all seen patients sent to non-NHS providers	
CB5	Several high volume specialties have a high proportion of cases seen in non-Borders providers such as: Respiratory Medicine outpatients (2,119 outpatients, 54% in Borders), General Surgery outpatients (5,634 outpatients, 70% in Borders) and Eyes and Periorbita admissions (838 inpatients, 63% in Borders).	

Community Services		Next Steps
CS1	With relatively few nationally available datasets looking at community service benchmarks we have little analysis to present	*Conduct local activity and cost benchmarking within community teams to understand potential productive opportunities*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Provision of resources to the Scottish Borders Integration Joint Board**
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:

- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

In line with the Scheme of Integration, NHS Borders Health Board is required to confirm the level of budgetary resources (revenue) available to the Scottish Borders Integration Joint Board for the delivery of health delegated functions.

2.2 Background

Scheme of Integration

Although the Scheme of Integration was reviewed in 2021/22 the financial arrangements were deferred for future review following appointment to the (then) vacant Chief Finance Officer post.

Section 8 of the Scottish Borders Scheme of Integration outlines the expected process by which the IJB budget will be set.

This requires that the Chief Officer and Chief Financial Officer develop a case for the Integrated Budget based on the Strategic Commissioning Plan, and that this case is considered through the financial planning process of the partners (NHS Borders, Scottish Borders Council).

In setting the budget consideration should be given to the level of uplift available to each partner, and any efficiency to be achieved.

As a result of the on-going vacancy to the Chief Finance Officer post during the past two years the Health Board and Council financial plans have been prepared using internal assessment of HSCP cost pressures and with limited input from the IJB. Both partners recognise the need for the IJB to have greater input to their own financial planning processes.

The Chief Finance Officer presented an Initial Budget to the IJB at its meeting on 15th March 2023. This Initial Budget is expected to be finalised by end March following confirmation of the final budget offer from NHS Borders.

A final budget for the IJB will be set by end June 2023 following further dialogue between the IJB and its partners.

Budget Setting Methodology

In 2019/20 it was agreed that the Health Board and the IJB would adopt an equity-based approach to budget setting which would ensure that the IJB budget share was set based on prioritisation of the overall Health Board resources through a single process. This meant that the HSCP delegated budgets and Set Aside budget would be allocated funding for pay awards, non-pay inflation and growth, and cost pressures, on a basis consistent with non-delegated functions.

This principle was reaffirmed by the Health Board in setting subsequent budgets over the previous three years.

The Resources & Performance Committee confirmed the adoption of this approach for the 2023/24 IJB budget at its meeting on 2nd March 2023.

The principles adopted via this 'equity' approach are described in Appendix 2.

2.3 Assessment

Budget Offer

The Health Board will provide baseline resource of £151.76m to the IJB to undertake the functions delegated to it by the Health Board. This includes £28.76m of resources set aside for the large hospitals element. This represents the recurring revenue budget provided to the IJB in 2022/23 plus, as set out in the Board's financial plan, funding for:

- Pay Awards
- Inflation & Growth impacting on medicines, general supplies and other contractual obligations

- Cost pressures and other investments identified through the Health Board's financial planning process

Table 1 provides a summary overview of the resources available to the IJB.

Table 1 – Resources available to the IJB

	HSCP Delegated Functions £000s	Set Aside £000s	IJB Total £000s
Source of Funds			
Base Recurring Budget	120,329	27,921	148,250
SG Uplift	1,777	558	2,335
Share of Other HB Funds	890	280	1,170
Total	**122,997**	**28,759**	**151,756**

The Base recurring budget is indicative, based on the actual recurring budget held within NHS Borders finance systems as at February 2023. Any increase to this budget enacted during 2022/23 will be passed on in full to the IJB at April 2023.

SG uplift is applied at 2% in line with the general uplift available to the Health Board, as set out in the Scottish Government budget published in December 2022.

The share of other HB funds comprises an equitable share of resources in relation to two further elements of funding:

- NRAC population adjustment – expected funds of £1.1m to be allocated to NHS Borders in 2023/24
- Additional recurring budget of £1.3m received in 2022/23 in relation to the proposed H&SC levy. Although the H&SC levy has been withdrawn, Scottish Government has confirmed that NHS Boards will retain this funding.

The share attributable to the IJB has been calculated based on share of recurring base budgets held by delegated & non-delegated functions within the overall health budget.

This excludes additional non-recurring resources to be made available by Scottish Government against strategic portfolios.

The detail of these budgets is presented in Appendix 1.

Table 2 describes the application of these resources to the HSCP and Set Aside budgets.

Table 2 – Budget Allocation, IJB delegated functions

	HSCP Delegated Functions £000s	Set Aside £000s	IJB Total £000s
Application of Funds			
Initial Budget			
Base Recurring Budget	120,329	27,921	148,250
Pay Policy	1,008	490	1,498
Drugs & Prescribing	1,236	303	1,539
Non Pay Uplift	385	27	412
Cost Pressures	3,670	1,337	5,007
Draft Budget	**126,629**	**30,077**	**156,706**
Unallocated Gap 2023/24	(3,632)	(1,318)	(4,950)
Financial Plan 2023/24	**122,997**	**28,759**	**151,756**

Pay uplift is set at 2% in line with the general uplift applied to the Health Board's own budget; however Scottish Government has confirmed that NHS pay awards will be fully funded and I would therefore anticipate that a further increase to these budgets will be made following agreement of the 2023/24 pay settlement. The Health Board will provide the IJB with an increase to its budget in line with its share of this additional resource, once confirmed.

Non-pay inflation and growth is modelled based on principles agreed by the Health Board. The board has provided for a 5% increase to primary care prescribing budgets, in addition to in year cost pressures, reflecting recent growth from a relatively static position in 2021/22. The January 2023 forecast rate for CPI during 2023/24 suggested an average inflation impact of 7.4% however recent forecasts suggest that this position is likely to improve further. NHS cost growth has trended below general inflation during 2022/23, and we have provided 4% for growth across all areas however this position will remain subject to review.

The budget includes a number of elements for which resources are ring-fenced for direct allocation to Social Care functions from within the Health budget. This includes the Social Care Fund at £8.04m and Resource Transfer at £2.78m. As directed by Scottish Government, the Health Board has uplifted these budgets by 2% in line with the general uplift applied to the Health Board's own baseline budget.

Additional Ring-Fenced Funds

It is anticipated that there will be a number of policy directions set by Scottish Government resulting in 'earmarked' recurring and non-recurring allocations in year. These will represent an increase above the base budget[1]. The Health Board will continue to apply ring-fencing to any of these resources which relate to IJB delegated functions. It is anticipated this will include, among others, the following:

- Investment in Adult Mental Health Services and CAMHS
- Primary Care investment funds
- Alcohol and Drug Partnership funding

[1] Some elements of 'earmarked' recurrent funds are incorporated within base budgets. Further detail on these elements is available on request.

Appendix 3 to this letter details the assumptions which have been made within the Health Board's financial plan in relation to additional ring-fenced allocations due to the IJB. These assumptions are indicative only and will be amended as actual allocations are confirmed.

Savings Targets

The level of resources provided includes the balance of unmet savings against targets set in previous years. For the IJB, this represents £4.55m (delegated services) and £0.94m (set aside).

The budget also includes an increase to the level of savings attributed to the IJB of £4.95m [2](£3.63m delegated; £1.32m set aside), being the difference between the *Initial* budget and the level of resources available to finance this budget.

Table 3 – Total Savings Requirement

	HSCP Delegated Functions £000s	Set Aside £000s	IJB Total £000s
Savings Targets B/Fwd	(4,553)	(944)	(5,497)
Unallocated Gap 2023/24	(3,632)	(1,318)	(4,950)
Recurring Gap	**(8,185)**	**(2,262)**	**(10,448)**

In setting this increased target, the Health Board is applying its equity-based approach to budget setting which retains consistency to how budgets are set across delegated and non-delegated functions. The consequence of this approach is that the financial gap identified in the Board's financial plan is allocated directly to the IJB in proportion to the pressures generated by delegated functions.

This approach is in line with the methodology applied prior to the pandemic, however from April 2020 onwards there has been no adjustment to savings targets set within the Health Board, for either delegated or non-delegated functions. There is therefore a further legacy savings target which remains unallocated and is discussed further below.

Delivery of Financial Balance

In setting the final budget for 2023/24 the Health Board will need to agree with the IJB the level of savings expected to be achievable in year, and therefore any level of support requested by the IJB in order to meet its statutory requirement to breakeven. This support may include any additional cost pressures emerging in year.

The health delegated functions of the IJB have been unable to achieve financial balance over a number of years. This is consistent with the wider NHS Board position, where the Board has reported a deficit since 2015/16 and has required additional support and/or repayable brokerage in each year since 2018/19.

[2] Per table 2

The Health Board's Medium Term Financial Plan outlines an expected deficit of c.£22m in 2023/24. As is demonstrated in the delegated budget to the IJB, an element of this deficit relates to HSCP and Set Aside budgets.

The Scheme of Integration provides that should the IJB be unable to present a balanced financial plan it should prepare its own financial recovery plan. The Chief Finance Officer (CFO) has indicated her intention to prepare a plan and health board colleagues will seek to work with the CFO to support development of this plan.

Should the actions identified in the plan not be achieved then the IJB can request additional payment from the partners to support a breakeven position. The scheme confirms that payment will be 'the responsibility of the authority who originally delegated the budget to make the additional payment to cover the shortfall'.

Since the Health Board will be reliant upon additional support from Scottish Government it is likely that the support to the IJB will be made available through brokerage and will require repayment. The Scheme of Integration provides that the IJB 'should make repayment in future years following the same methodology as the additional payment'.

Legacy Savings Target

Although the IJB budget includes a share of historic savings targets not achieved in prior years this position has not been revisited since 2019/20. At March 2020 the Health Board held an unallocated savings target of £8.4m for which distribution had not yet been agreed. Since this time, additional investment in the Board's financial plans has increased this unallocated target to £11.4m with no further distribution of savings targets applied to either delegated or health board retained functions during this period. An element of this unallocated target will relate to investment in IJB delegated functions.

The Director of Finance has written to the Chief Officer of the Scottish Borders IJB to outline his intention to set out a proposal for how this legacy savings target will be attributed in advance of finalising the 2023/24 IJB Budget. At this stage it is envisaged that any actual allocation of this target would be deferred until April 2024 at the earliest.

Repayment of support to the IJB

As noted above, the Health Board has provided support to a breakeven position for the IJB over a number of years. This support has been financed by three main mechanisms – internal flexibility in Health Board budgets; additional non-payable support from Scottish Government; brokerage (repayable) support from Scottish Government.

At end March 2023 the repayable brokerage debt held by the Health Board will be £20.5m. It is likely that this will increase further at March 2024. In each year to which brokerage has been made available to the Health Board, the Board has provided support to the IJB in order to support a breakeven position.

Although no timeframe has been agreed with Scottish Government for repayment of

this borrowing, the Medium Term Financial Framework applicable to NHS Boards would require repayment from the point at which a Health Board has returned to financial balance.

It will be important that the Health Board and the IJB agree the extent to which any element of prior year support is treated in relation to the Health Board's own obligations to repay Scottish Government.

A proposal for the treatment of this borrowing will be developed through further discussion between the executive officers of the Health Board and IJB.

2.3.1 Quality/ Patient Care

This paper sets out the financial resources available to the IJB in relation to health-delegated functions and Large Hospital set aside budgets. Any impact on Quality/Patient Care will be assessed in relation to the directions set by the IJB in relation to the budget.

2.3.2 Workforce

This paper sets out the financial resources available to the IJB in relation to health-delegated functions and Large Hospital set aside budgets. Any impact on Workforce will be assessed in relation to the directions set by the IJB in relation to the budget.

2.3.3 Financial

Financial information is included in the body of the paper.

2.3.4 Risk Assessment/Management

Risks in relation to the Health Board's financial plan are considered through separate risk assessment. Any additional risks arising in relation to the IJB budget settlement will be considered following issue of the IJB directions to the Health Board in relation to its 2023/24 budget.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment has not been completed because it is not required. Any impact arising from the budget offer to the IJB will be considered through the IJBs own governance, and by the Health board following issue of IJB directions.

2.3.6 Climate Change

There are no relevant impacts described in the budget.

2.3.7 Other impacts

There are no relevant impacts described in the budget.

2.3.8 Communication, involvement, engagement and consultation

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

No stakeholder engagement has been undertaken in relation to this budget offer.

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.

- Resources & Performance Committee, 2nd March 2023

2.4 Recommendation

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

Board members are recommended to approve the Initial Budget offer to the Scottish Borders Integrated Joint Board, noting that further work will be undertaken to set a Final Budget by end June 2023.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, IJB Budget 2023/24 – Health Delegated functions and Set Aside
- Appendix 2, IJB Budget Setting – Principles of Equity Based Approach
- Appendix 3, Anticipated Allocations

Appendix 1

IJB Budget 2023/24 – Health Delegated functions and Set Aside

	2023/24 Base Recurring Budget £000s	2023/24 Pay Policy £000s	2023/24 Drugs & Prescribing £000s	2023/24 Non Pay Uplift £000s	2023/24 Cost Pressures £000s	2023/24 Share of Financial Plan Gap £000s	2023/24 Draft Budget £000s
HSCP - HEALTH DELEGATED FUNCTIONS							
Joint Learning Disability Service	3,558	15	0	56	430		4,059
Joint Mental Health Service	19,312	374	25	7	680		20,398
Joint Alcohol and Drug Service	431	4	0	5	0		439
Prescribing	23,432	0	1,172	0	1,150		25,754
Generic Services							
Independent Contractors	31,480	7	0	0	0		31,487
Public Dental Services	4,274	79	0	6	0		4,360
Sexual Health	707	9	24	1	53		793
Community Hospitals	6,493	122	14	5	80		6,714
Allied Health Professionals	8,006	156	0	4	0		8,166
Leadership in Care Homes	0	0	0	0	0		0
District Nursing	4,404	87	0	1	100		4,592
Home First	0	0	0	0	0		0
Out of Hours Service	2,416	46	2	2	143		2,609
PCIP	2,118	37	0	5	0		2,160
Community Based Services	2,552	32	0	19	432		3,035
CVFV Programme	0	0	0	0	0		0
Regional Diabetes	0	0	0	0	0		0
Generic Other	12,795	41	0	215	602		13,653
Resource Transfer	2,722	0	0	54	0		2,776
IJB Reserves	182	0	0	4	0		186
Unidentified savings	(4,553)	0	0	0	0	(3,632)	(8,185)
Total - HSCP Health Delegated Functions	**120,329**	**1,008**	**1,236**	**385**	**3,670**	**(3,632)**	**122,997**
SET ASIDE - LARGE HOSPITAL FUNCTIONS							
Accident & Emergency	3,510	66	8	2	455		4,041
Medicine & Long-Term Conditions	18,328	293	264	20	579		19,485
Medicine of the Elderly	7,027	130	31	4	303		7,495
Unidentified Savings Target - Set Aside	(944)	0	0	0	0	(1,318)	(2,262)
Total - Set Aside Large Hospital Functions	**27,921**	**490**	**303**	**27**	**1,337**	**(1,318)**	**28,759**
GRAND TOTAL	**148,250**	**1,498**	**1,539**	**412**	**5,007**	**(4,950)**	**151,756**

Appendix 2

IJB Budget Setting – Principles of Equity Based Approach

Issue	Principle/Approach
Equity	Resources to the IJB should be issued in line with the board's financial plan, including cost pressures where agreed through the NHSB process.
Uplift to IJB resources	NHS resources allocated via the IJB to Social Care will be transferred inclusive of a share of the board's general uplift (2.0%). This includes the Social Care Fund and Resource Transfer.
Savings Targets	No change will be implemented to savings targets without prior agreement between NHS Borders and Scottish Borders IJB. The IJB share of unmet targets will be rolled forward within the budget. The balance of unallocated savings not distributed within the board's plan will be held corporately pending further discussion. Support to unallocated savings will have 'first call' on board financial flexibility. *This position will be reviewed following preparation of a three year financial plan for NHS Borders, and with cognisance of the IJBs own financial planning process.*
Non Pay Supplies Inflation	Resources available to the IJB will be in line with NHS Borders own financial planning assumptions in order maintain equity of treatment across NHS business units. Provision for uplift on non-pays will be held in an NHS Board reserve pending confirmation of actual impact.
IJB Reserves	The IJB holds ring-fenced reserves in relation to commitments against NHS non-recurrent allocations. Application of any flexibility arising within the IJB reserves will be contingent upon agreement between the NHS Director of Finance and the Chief Finance Officer (IJB). It is assumed that any flexibility identified in relation to NHS commitments will be redirected at bridging slippage against the IJB savings target unless separate agreement is reached.

Appendix 3

Anticipated Allocations

- 'earmarked' recurring and non-recurring allocations anticipated within the Health Board's financial plan which relate to health delegated functions including Set Aside.
- Figures include elements embedded within service base budgets (e.g. GMS).

	Revenue Resource Allocation Description	Recurrent/ Earmarked/ Non-Rec	2023-24	Assumption
	Public Dental Service	Non-Rec	2,645	Per minimum spend profile 2022/23
	District Nurses	Non-Rec	204	
*	Alcohol and Drug Partnerships (ADPs)	Earmarked	1,022	Per 2022/23 allocation (100%)
	Urgent and Unscheduled Care Collaborative	Non-Rec	760	Per 2022/23 allocation
*	Mental Health Funding	Earmarked	TBC	Awaiting confirmation of 2022/23 allocations
*	Primary Care Improvement Fund	Earmarked	3,486	Per 2022/23 allocation (100%)
*	Primary Care	Non-Rec	21,227	Per 2022/23 allocation (100%)
*	Outcomes Framework	Earmarked	1,398	Per 2022/23 allocation
	Primary Care OOH	Non-Rec	107	
	HSCP - Multi Disciplinary Teams	Earmarked	948	Per 2022/23 allocation (100%)
			31,799	
	* include elements incorporated within base budgets			

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Finance Report – February 2022**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager**

1 Purpose

This is presented to the 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

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

2.3.7 Other impacts

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

2.3.8 Communication, involvement, engagement and consultation

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

2.3.9 Route to the Meeting

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

- Senior Finance Team, 10th March 2023
- Board Executive Team, 21st March 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Finance Report for the period to end February 2023

FINANCE REPORT FOR THE PERIOD TO THE END OF FEBRUARY 2023

1 Purpose of Report

1.1 The purpose of the report is to provide board members with an update in respect of the board's financial performance (revenue) for the period to end of February 2023.

2 Recommendations

2.1 Board Members are asked to:

2.1.1 **Note** that the Board is reporting an overspend of £12.50m for eleven months to end of February 2023.

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 financial performance expectation set out by the Scottish Government following the Board's Quarter One Review is that the board achieve an outturn performance in line with the Financial Plan (£12.2m deficit), and although there was a variation from this outturn last month, the Board is now expecting to achieve an outturn of £12.2m deficit.

2.1.4 **Note** progress against the actions described within the Financial Recovery Plan submitted to Scottish Government in November.

3 Summary Financial Performance

3.1 The board's financial performance as at 28th February 2023 is an overspend of £12.50m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for eleven months to end February 2023

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m
Revenue Income	273.94	304.60	254.60	254.88	0.28
Revenue Expenditure	273.94	304.60	254.51	267.29	(12.78)
Surplus/(Deficit)	**0.00**	**0.00**	**(0.09)**	**12.41**	**(12.50)**

3.2 Following additional New Medicines funding received in February and a small number of other adjustments still to be transacted, the expected outturn position should now be back in line with the Financial Plan and Scottish Governments expectations which is an outturn of £12.2m deficit.

3.3 The position reported reflects the pressures related to the on-going increase in the costs associated with GP Prescribing as well as the costs associated with the LD placement both of which are currently continuing in line with expected forecast.

3.4 GP Prescribing still poses a risk to the board meeting the expected outturn of £12.2m deficit, due to the volatility that has been seen in recent months.

3.5 The financial plan identified a projected £5m delivery against savings targets in 2022/23. Savings delivery of circa. £2.1m has been retracted against current year budgets, of which £1.9m is related to the eleven months to end February. Further update on savings plans is provided in section 6 below.

3.6 Core operational performance excluding savings is reporting a £1.79m overspend position to the end of February. As previously reported, the position includes expenditure related to actions implemented during the pandemic which remain in place due to operational pressures in unscheduled care.

3.7 As at end December, a total of £3.35m of expenditure has been released in relation to COVID funds, matched to expenditure reported in the COVID LMP tracker. This remains in line with previous forecast.

3.8 A risk is identified in relation to the funding of COVID expenditure in Social Care following confirmation of adjustment to IJB reserves by Scottish Government. This is described further in Section 5, below.

3.9 Comparison to Forecast

3.9.1 The amended forecast before additional recovery actions was presented in the Board's Financial Recovery Plan (FRP). This described a potential outturn position of £15.7m (deficit). Following a move from the expected forecast during January, which it increased to £13.5m deficit, the Board is now expecting to achieve the outturn position of £12.2m deficit in line with SG direction.

3.9.2 Section 7 of this report describes the actions in place within the recovery plan and how these are expected to impact in future periods.

4 Financial Performance – Budget Heading Analysis

4.1 Income

4.1.1 Table 2 presents analysis of the board's income position at end February 2023.

Table 2 – Income by Category, year to date February 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	297.52	233.08	233.08	-
SGHSCD Anticipated Allocations	(0.17)	(19.78)	0.01	0.01	-
Family Health Services	10.24	14.31	13.46	13.46	-
External Healthcare Purchasers	4.39	4.39	4.04	3.88	(0.16)
Other Income	5.27	6.04	4.01	4.45	0.44
Total Income	**273.94**	**302.48**	**254.60**	**254.88**	**0.28**

4.1.2 As reported in previous months, there continues to be a shortfall on income from External Healthcare Purchasers. This relates mainly to cross boundary flow of Acute patient activity from North of England, where activity continues to fall below pre-pandemic levels. The impact of this has been mitigated in year by agreement of SLA values at historic levels, reducing the risk of material reduction in funding; however there is a high risk that future SLA values will be amended to reflect reduced activity levels.

4.1.3 The over recovery within *Other Income* is in respect of *Scottish Post Graduate Medical Education* (SPGME) and provides an element of offset to additional medical staffing pressures highlighted previously with regard to Medical training grade rotational posts, for which expenditure is reported within clinical boards.

4.2 Operational performance by business unit

4.2.1 Table 3 describes the financial performance by business unit at February 2023.

Table 3 – Operational performance by business unit, February 2023

	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	77.68	70.74	69.78	0.96
Acute Services - Savings Target	(2.11)	(1.58)	(1.45)	-	(1.45)
TOTAL Acute Services	**63.12**	**76.10**	**69.29**	**69.78**	**(0.49)**
Set Aside Budgets	27.04	29.94	27.31	29.42	(2.11)
Set Aside Savings	(1.05)	(0.94)	(0.87)	-	(0.87)
TOTAL Set Aside budgets	**25.99**	**29.00**	**26.44**	**29.42**	**(2.98)**
IJB Delegated Functions	120.93	143.92	126.27	127.19	(0.92)
IJB – Savings	(4.74)	(4.53)	(4.16)	-	(4.16)
TOTAL IJB Delegated	**116.19**	**139.49**	**122.11**	**127.19**	**(5.08)**
Corporate Directorates	34.28	12.22	7.11	7.98	(0.87)
Corporate Directorates Savings	(0.34)	(0.09)	(0.08)	-	(0.08)
TOTAL Corporate Services	**33.94**	**12.13**	**7.03**	**7.98**	**(0.95)**
External Healthcare Providers	29.38	31.91	29.42	28.27	1.15
External Healthcare Savings	(0.39)	(0.11)	(0.10)	-	(0.10)
TOTAL External Healthcare	**28.99**	**31.80**	**29.32**	**28.28**	**1.05**
Board Wide					
Depreciation	5.06	5.06	4.64	4.64	-
Planned expenditure yet to be allocated	13.00	21.90	5.56	-	5.56
Financial Recurring Deficit (Balance)	(12.35)	(8.61)	(7.89)	-	(7.89)
Financial Non-Recurring Deficit (Balance)	-	(2.17)	(1.99)	-	(1.99)
Total Expenditure	**273.94**	**304.60**	**254.51**	**267.28**	**(12.78)**

4.2.2 **Acute services** are reporting a net overspend of £0.49m. This includes a £0.96m under spend on core operational budgets. The main drivers for this under spend continues to be 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 trending underspend had been moving on a lower trajectory than earlier in the year as a result of increased bed pressures. This position also includes retracted recurring savings of £0.53m (£0.58m full year).

4.2.3 **Set Aside.** The set aside budget is overall £2.98m overspent, of which £0.87m relates to non-delivery of savings. This position includes retracted savings of £0.4m YTD (£0.04m full year). 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. Drugs expenditure continues to demonstrate an increasing trend in relation to prescribing for patients with long term conditions managed by hospital based prescribers.

4.2.4 **IJB Delegated**. Excluding non delivery of savings the HSCP functions delegated to the IJB are reporting an overspend of £0.92m on core budgets. The mains driver of the overspend continues to be GP Prescribing, where pressures reflect the combined impact of price and volume growth. The spend in GP Prescribing during February are in line with expectations, however still pose a risk due to the unpredictability in this area.

Alongside the overspend on prescribing, there are also continued overspends relating to locum cover within Mental Health and an increase in the cost of LD placements. The increased costs within the LD placements were identified earlier in the year and the cost of these placements remains in line with forecast.

This reported position includes retracted recurring savings of £0.20m YTD (£0.22m full year).

4.2.5 **Corporate Directorates** are reporting a net overspend of £0.95m. This includes a £0.87m overspend on core budgets. There are retracted savings of £0.25m included in this reported position (£0.27m full year). February saw an increase in the pressures within estates due to increases in the costs of Gas and Electricity, which is both seasonal and price driven.

There continues to be pressures seen due to increased maintenance expenditure as well as costs due to existing cleaning rotas not meeting national standards and a number of actions implemented to enhance infection control measures implemented during COVID pandemic both of which remain in place without identified funding. This issue will be considered further via financial planning.

4.2.6 **External Healthcare Providers.** Within the reported position there are £0.27m of recurring savings retracted (£0.29m full year). Excluding savings there is underspend of £1.15m reported at the end of February. This position is predicated on estimated costs for East Coast Costing Model (ECCM) and Unplanned Activity budgets (UNPACs), where final activity and price baselines have not yet been confirmed. The underspend is largely driven by reduced levels of out of area activity due to capacity challenges in (predominantly) NHS Lothian, with corresponding impact on number of patients waiting for treatment. The current YTD position has benefited from one off credits linked to prior year Unpacs activity.

5 COVID19 Expenditure

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

Table 4 – summary COVID19 expenditure for eleven months to end February 2023

	Allocated YTD Budget £m	YTD Actual £m	YTD Variance £m
Acute Services	0.07	0.07	-
Set Aside	0.01	0.01	-
IJB Directed Services	2.19	2.19	-
Corporate Directorates	1.08	1.08	-
Total NHS Costs	3.35	3.35	-

5.2 Expenditure plans have been reviewed to reduce expenditure where possible in line with the NHS Scotland COVID Financial Improvement Programme.

5.3 It is estimated that there is a further impact of £0.83m in relation to on-going expenditure which was initiated as part of the Board's COVID response but for which there is no longer any direct funding source. This expenditure is reported as variance to core budgets however it continues to be highlighted to Scottish government through the monthly COVID monitoring reports. Costs within this category include on-going 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).

5.4 It was confirmed early in 2022/23 that the financing of all COVID expenditure in 2022/23 would be enacted on a 'cost pooling' basis, with the Scottish Government signalling their intention to retract funding issued in February 2022 from IJB reserves in order to finance the plan for 2022/23. This position has now been confirmed and adjustment to IJB reserves made through the Board's RRL.

5.5 The updated COVID LMP monitoring report at M11 highlights potential risk in relation to IJB expenditure incurred within Social Care. This risk arises due to increase to previous forecast, which formed the basis for the financial adjustment to RRL.

5.6 This issue is highlighted to SG in the Board's FPR monitoring return at M11 and will be flagged through the IJB Chief Finance Officer. The financial risk arises in the Social Care budget within HSCP and is not expected to impact on the NHS Borders financial position.

6 Savings

6.1 As part of the financial plan for 2022/23 it was identified that the Board would seek to deliver £5.0m in recurring savings. Each Business Unit have been asked to

deliver 1% savings on core expenditure budgets, with further savings to be achieved through Board wide programmes including Prescribing savings.

6.2 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 February 2023

	Recurring Savings Target £m	Recurring Savings Achieved £m	Balance of Savings not yet delivered £m
Acute Services	(0.66)	0.58	(0.08)
Set Aside	(0.28)	0.04	(0.23)
IJB Directed Services	(0.49)	0.22	(0.27)
Corporate Directorates	(0.38)	0.27	(0.12)
External Healthcare Providers	(0.32)	0.29	(0.03)
Board Wide	(2.87)	0.70	(2.17)
Total NHS Costs	(5.00)	2.10	(2.90)

6.3 Against the target of £5m, initial scoping indicated recurring savings of c.£3.5m were identified. To date, £2.10m of recurring savings has been retracted covering the period to end March 2023.

6.4 The current year forecast and FPR assumed that savings of £3.5m would be delivered in the current year, an element of which would be non-recurring. The FPR also identified a requirement for up to £1.5m of mitigating actions to address any shortfall on this position. As at M11 it is likely that the full value of these mitigating actions will be required with expectation that there is likely to be minimal additional in-year impact from any further savings delivery in 2022/23.

6.5 The financial plan for 2023/24 and beyond is being prepared on the basis that there will be no significant increase in the delivery of recurring savings achieved by 31st March 2023.

7 Scottish Government Requirements & Brokerage

7.1 As previously advised, Scottish Government have confirmed that the Board is expected to deliver *as a minimum* a financial outturn position in line with its financial plan (£12.2m deficit), and that M11 has reported to Scottish Government that the outturn of £12.2m deficit is expected to be achieved.

7.2 As highlighted in Section 3 the 2 key issues that have emerged since the Q2 forecast were GP Prescribing and costs related to a single Learning Disabilities out of area placement with complex needs where there is no alternative provision available. The on-going pressure in GP Prescribing has increased the potential impact to around £1.8m (as reported last month) and this continues to pose a risk to the achieved of the expected outturn.

7.3 The Financial Recovery Plan submitted to Scottish Government in November identified a requirement for additional actions totalling c.£5m in order to deliver an outturn financial position in line with financial plan.

7.4 The delivery of the amended forecast position remains at risk despite identification of the actions within the recovery plan. Risks reflect on-going variation in business unit operational performance and the delivery risk that is described in relation to the actions in the FRP.

7.5 Progress to date against the recovery actions identified in this plan is summarised below.

NHSB Financial Recovery Plan 2022/23	Financial Recovery Plan £m	Updated FRP Actions £m	Risk	Expected Start Date
Implemented				
National Insurance Rise (1.25%)	0.5	0.5	L	Nov-22
PMO Resource Plan	0.3	0.3	L	Nov-22
Review of Purchase Orders	0.5	0.5	L	Nov-22
Transformation Programme	0.5	0.5	L	Nov-22
Review of IJB Commitments	0.5	0.5	L	Dec-22
Transformation Programme (balance)	0.0	1.5	L	Dec-22
Risk Provision Balance (Additional Action Identified)	0.0	0.8	L	Dec-22
Enhanced Vacancy Controls move to implemented	0.2	0.2	M	Jan-23
	2.5	**4.8**		
On Track				
Target Reduction in Agency Use	0.1	0.1	M	Jan-22
Reduce Stock Levels	0.3	0.3	M	Mar-23
	0.4	**0.4**		
Under Review				
Digital Programme rephasing / LIMS	0.7	0.7	M	Mar-23
Balance Sheet Provisions - additional releases	0.6	0.6	L	Mar-23
	1.3	**1.3**		
No Longer Viable				
Additional Capital/DEL financing (LIMS)	0.9	0.0	H	N/A
	0.9	**0.0**		
TOTAL	**5.1**	**6.5**		

7.6 A number of other actions have been identified and are still being fully quantified; this includes further slippage on reserves.

7.7 To date £4.8m of recovery actions have been implemented. An element of this figure is related to benefits expected in Q4 (January to March).

7.8 Although there remains a number of risks to the financial position, e.g. GP Prescribing as well as a number of allocations yet to be received we are now amending the forecast back to a £12.2m deficit. This updated forecast has been reported to Scottish government as part of the M11 FPR's along with an acknowledgement that there remains the risk that this position could move further in the final month of the year.

8 Key Risks

8.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 3588). 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. The actions required will be described as part of the board's medium term financial plan and associated financial recovery plan. A first draft of this plan will be presented to the committee in January 2023.

8.2 Specific issues likely to impact on the delivery of the financial performance required by Scottish government are reported within the body of the report.

Author(s)

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Clinical Governance Committee Minutes**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality & Improvement**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Clinical Governance Committee 18 January 2023.

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 09.11.22

Borders NHS Board
Clinical Governance Committee
APPROVED Minute

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 09 November 2022** at 10am via Microsoft Teams

Present
Mrs F Sandford, Non Executive Director (Chair)
Mrs H Campbell, Non Executive Director
Dr K Buchan, Non Executive Director

In Attendance
Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Head of Clinical Governance & Quality
Mr G Clinkscale, Chief Executive
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Mrs A Wilson, Director of Pharmacy
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mrs S Flower, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mr S Whiting, Infection Control Manager

Absent
Mr R Roberts, Chief Executive

1 Apologies and Announcements

Apologies were received from:
Ms S Lam, Non Executive Director
Dr J Bennison, Associate Medical Director, Acute Services
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Dr C Cochrane, Head of Psychological Services
Mrs L Pringle, Risk Manager
Dr T Young, Associate Medical Director, Primary & Community Services
Dr A Cotton, Associate Medical Director, Mental Health Services

The Chair confirmed the meeting was quorate.

The Chair welcomed:
Mrs K Hamilton, NHS Borders Chair
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance (shadowing Laura)
Dr S Bhatti –Director of Public Health (1st meeting)
Dr L Keir, Senior Clinical Psychologist (deputising for Caroline Cochrane)
Mrs L Taylor, Macmillan Nurse Consultant and Lead Clinician in Cancer — item 8.1
Michele O'Reilly, Head of Clinical and Professional Development — item 8.3
Dr K Stewart, Chair of Hospital transfusion Committee — item 8.4

The Chair announced that Duty of Candour report had been pulled from the agenda. Mrs Jones confirmed that there had not been clarity from the Scottish Government regarding how the Duty should be applied leading to variation in reporting from Scottish Health Boards. Discussions at adverse event network are scheduled for December to which the Scottish Government have been invited to address some of the key issues and gain clarity.

2 Declarations of Interest

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

The **CLINICAL GOVERNANCE COMMITTEE** noted no new declarations had been made and previous declarations stood.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on **Wednesday 14 September 2022** was approved.

4 Matters Arising/Action Tracker

Matters Arising:
Mrs H Campbell asked that more detail re staffing position in the Mental Health and Learning Disabilities reports had been previously requested. These did not appear to be included. Mr Lerpiniere will ensure these are covered in next report to the Committee.

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. He updated the Committee on the following points since the report. There had been increased compliance with MRSA screening in all areas following improvement work. Improvement had also been seen in areas with poor hand hygiene following focussed support in those areas.

The Chair enquired about progress of CAUTI group, Mr Whiting noted that there had been improvement following preliminary work. The Urinary Catheterisation Policy had been updated along with the information on local intranet site allowing direct liaison between improvement advisors, wards, community hospitals and district nurses. There had also been liaison with care home medication team and education is ongoing.

Mrs Campbell made reference to the rise in flu rates and enquired if this was expected to get worse if so how this would be managed. Mr Whiting reported that although they were expecting a challenging flu season they were not seeing particularly high numbers at present. He did note however that there had been an increase in Respiratory Syncytial Virus Infection (RSV) particularly in the children's area but nothing to raise concern at present.

Discussion followed regarding self auditing on cleaning and importance of cleanliness monitoring also the wider public health campaign around flu vaccination and ongoing winter preparedness activity. Mr Whiting reported that he is having conversation with Estates and Facilities on audit triggers and when they would look more closely at any low audit scoring, this has provided educational opportunities and closer work using national tool to identify

risks. Mrs Hamilton commented that she is looking at ways to reinstate the patient safety executive walk rounds which will feed into this work.

Dr Bhatti gave a brief update on increased incidence of Scarlett Fever, it is thought in part this may be due to heightened awareness and better reporting.

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

5.2 Quarterly HSMR

Mrs Jones provided a brief overview of the content of the report. Covid deaths remain, but the large peaks are not being seen. Learning from all deaths continues through the normal mortality review process. This shapes the work of safety programme in terms of proactive work streams.

Dr Bhatti asked Mrs Jones if access to healthcare was factored into the figures and if the standardised ratio covers the whole population. Mrs Jones commented that annual mortality report looks more closely at differing factors; the data set is fairly rich and can be overlaid against demographics should this be required.

Mrs Campbell asked if there should be concern that the mortality rate for Scotland is decreasing overall but NHS Borders appears to be rising in comparison. Mrs Jones assured the Committee that any unusual movement in figures is investigated fully and Dr Herlihy confirmed that following structured reviews there was nothing unusual showing.

Dr McCallum commented that as pressure on services Nationally continues to increase there has been a significant rise in safety markers; this is a worrying trend and one that will need closer scrutiny. Mrs Jones hoped that the mortality review paper should highlight any areas of concern for NHS Borders. All the other safety measures will be reported in the annual patient safety report to the committee and any areas of concern should be highlighted.

ACTION: Mrs Jones and Dr Bhatti will discuss demographics against mortality figures for future reporting.

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

5.3 Strategic Risk Management

Mrs Jones provided a brief overview of the content of the report and changes in how the risks are being recorded.

Mrs Jones reported, following review of strategic risks, risks one and six will be brought together into an overarching workforce risk for the organisation and linked to the workforce strategy and integrated workforce plan. Risks two and five relating to whole system flow between NHS borders and the Health and Social Care Partnership will be brought together linking delayed discharges and the emergency access standard work.

Concern continues around whole system flow and the impact on care. Infection control risks will be reported in some detail in the January report to the Committee.

Further discussion took place regarding definitions of risks and risk controls and how they are managed, Mrs Jones commented that there had not yet been full remobilisation following COVID and some risks may appear higher than normal, for example in areas like elective surgery and patient flow, it is expected that once full remobilisation is complete we will see a

return to pre COVID figures. The root causes of risks continue to be monitored and actions within our control are put in place, anything out with control is mitigated as best as possible.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents, as much as practicable within resource constraints

6 Patient Safety

6.1 Patient Experience report including SPSO position

Mrs Jones provided a brief overview of the content of the report. She reported there had been significant increase in formal complaints in particular around waiting times. Pressures being seen in NHS Borders are no different from the rest of Scotland, the Patient Experience Team is small and extra capacity has been added to assist but added pressures on frontline staff to respond had been an issue. The Team are expected to meet targets as dictated by National complaints handling process and scrutiny from the Ombudsman. Work is ongoing to look at various options in particular around expectation setting to address pressures; the outcome will be taken through Public Governance Committee. Mrs Jones will keep the Committee updated on progress.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by processes in place recognising current constraints

7 Effectiveness

7.1 Clinical Board update PCS

Mrs Flower provided a brief overview of the content of the report. She commented on the whole system pressures and delays pointing out that the biggest pressures being felt are in the social care sector. Work is ongoing on accurate data on exactly where these pressures are in order to provide a better perspective on what needs addressed.

Actions from the Care Inspectorate are underway and the care home moratoriums will not be lifted until actions are completed. This has had an impact on respite beds and admissions. Solutions are being explored on how capacity can be increased.

The Scottish Government had written to the Board regarding remobilisation of Day Services, work is underway to look at requirements and what can be provided in particular a collaborative approach with partnership is being explored. Mrs Horan added that there are some logistic and resource issue to address before we can get back to what was being provided pre COVID.

There had been further issues felt with the discharge without delay work in the Knoll and Kelso Hospital, predominantly around lack of hours for packages of care, there is poor attendance from Social Work at MDT meetings which has a knock on effect on discharge delays. These issues are being picked up at the weekly delayed discharge meeting to try to increase activity around delays.

Sickness absence remains high.

Risks relating to reliable cars and lack of access to pool cars have been noted, this has an impact on provision of services now noted on the risk register access to lease cars is being revisited.

From and AHP perspective there are significant wait times for speech and language which has had an impact on other services.

Dr McCallum enquired about mitigation of risks when patients are delayed in the system the Committee recognised that decisions on admission to some care facilities in the community are out with our control. Mrs Horan extended an invitation to Dr McCallum to attend the Strategic Care Home Oversight Group to get a feel of what is discussed there. There followed discussion on delays in social work allocation in community hospitals and what is being done to address this, Mrs Flower commented that this is flagged at the delayed discharge meeting, and has been escalated to Chief Officer, Scottish Borders Health and Social Care Partnership. Mrs Horan, Mrs Jones and Dr McCallum will discuss these delays and mitigation of risks from a clinical care and governance partnership perspective and write to the IJB. Dr McCallum requested that Mrs Flower put together an SBAR on these issues to support discussion.

ACTION: Mrs Jones, Dr McCallum & Mrs Horan to discuss delays and risks and write to IJB. Mrs Flower will put together an SBAR on these issues to support discussion with IJB

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured that processes are in place, the Committee is partially assured on outcomes recognising that part of this assurance sits with IJB.

7.2 Clinical Board update Acute taken out of sequence

Mrs Dickson provided an overview of the content of the report. Emergency Department continues to see long queues on a daily basis. Delays in the system also continue to be an issue with no resolution in sight. Delays in Emergency Department have impacted on Emergency Access Standards, access to the Borders Stroke Unit and impacting on expected Governmental targets. Day case surgeries are taking place allowing the organisation to manage some of the waiting list initiatives. Kaizen work continues but sustaining the successes from this work remains challenging.

Staffing issues previously highlighted are improving following recruitment drive with further staff interviews set and those appointed finally getting into posts following background checks. Sickness levels have improved but Mrs Dickson wanted the Committee to be aware that staff continue to work under pressure but they are working with Senior Staff to ensure issues are managed within a timely manner and staff are supported. Senior Management appointments have also been made and regular meetings are taking place on support for improvements, Mrs Dickson will bring more detail on outcomes in future reporting.

Discussion followed on the various initiatives taking place and the apparent success of Kaizen project in MAU recognizing that there needs to be a complete culture change to maintain sustainability. Work also continues on enhanced care observations, improving outcomes for the most vulnerable patients.

Mr Clinkscale gave a brief update on new transitional care ward which will support those patients who are medically fit but still require some assistance before being discharged. He explained that the elderly care unit had predominantly the most delayed discharges so Ward 12 was chosen to house the transitional care patients as it was felt there would be less disruption and displacement for the patients and staff.

Mrs Dickson talked about staff engagement and open sessions with staff, partnership and HR regarding the move from an acute ward to a transitional care ward. It is hoped that these sessions will be an opportunity for concerns to be raised and discussed. Senior Staff are also carrying out one to one discussions with staff when requested. There is now a weekly steering group set up for further discussions. Mrs Horan commented that the Ward will

provide a more appropriate environment for the patients but recognises that this is a massive cultural shift for staff. The medical approach to these patients will run in line with nursing approach and medical input will be provided appropriately as it would be should patients be in a community facility or their own home.

Dr Bhatti commented that from a patient safety point of view he would like to see more information on readmission rates, length of stay and possibly pressure damage if the data is available. Mrs Flower assured Dr Bhatti a sub group had been set up to look at what data should be collected for the evaluation of the Transitional Care Unit. She is linking in with intermediate care colleagues for advice on how the unit will be managed. Mrs Jones confirmed that the weekly safety dashboard reports on pressure damage and re-admissions so that data is available but commented that the report tends to pick up on areas where performance is poorer; she assured Dr Bhatti that pressure damage figures have been stable for a while.

ACTION: Mrs Dickson to add readmissions, length of stay and pressure damage to future reporting

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured. The Committee is assured by the direction of travel towards improvement but recognise there is still a significant amount of work to go before being fully assured on overall outcomes.

7.3 Clinical Board update MH

Mr Lerpiniere provided a brief overview of the content of the report. The service had their end of year meeting with the Welfare Commission with a number of things highlighted essentially relating to a move towards a clinical and care governance framework and issues around Mental Health Act Legislation, he further noted that these issues relate more to social care than healthcare. The Commission highlighted areas for potential improvement that had not previously been cited, a review of these areas is ongoing, Mr Lerpiniere will keep the Committee updated on progress of these improvements. Local inspections of units had taken place and action plans are in place in response to these.

Mr Lerpiniere noted that there had been a change in provision of support for neuro diverse patients which had lead to increase in complaints. He also noted that staff sickness and significant vacancies continued to be issues and he will provide more detail in his next report.

Psychological Services

Ms Keir provided a brief overview of the content of the report. Ms Keir reports that the Terms of Reference for Psychological Services Clinical Governance meetings had been agreed and signed off. Work continues on psychological services National specification and services guide. It is anticipated that these will be complete by end of financial year. The progress of the service will be reported through the Mental Health report to the committee and an annual report on Psychological services will be provided as requested by the Committee.

The **CLINICAL GOVERNANCE COMMITTEE** noted the Mental Health and Psychological Services reports and is assured by the contents, recognising risks relating to workforce highlighted by Mr Lerpiniere.

7.4 Clinical Board update LD

Mr Lerpiniere provided a brief overview of the content of the report, he commented that their biggest issue remains the closure of out of area unit where one of our patients is placed. There has not yet been a suitable alternative established for this individual but they continue to work on finding a resolution.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured on processes but remain partially assured in relation to the individual placed out with area.

8 Assurance

8.1 Cancer Services Annual Report

Mrs Taylor provided a brief overview of the content of the report. She commented that the services had met their waiting times and cancer governance targets, the Service and Clinical Leads have worked hard to sustain the levels of service to ensure these targets are met. Pressures do remain in particular workforce issues in radiology which has effect on reporting as being seen in rest of organisation. Lothian Oncology colleagues are under extreme pressure so the support our systemic anti cancer therapies (SACT) get is limited. This is being taken through the SCAN Cancer Network for resolution.

The service is revisiting risk assessment and will report finding to the Committee once investigations are complete.

Workforce plans are being developed and collaborative work with pharmacy around nurse prescribing and aseptics is ongoing. The Macmillan extension work had been revisited after being on hold and a rapid cancer diagnostic service in conjunction with community services is about to commence.

Discussion followed after a query from Mrs Campbell relating to GP referrals on suspicion of cancer when a patient has other co-morbidities, she asked if GPs are having realistic medicine discussions with the patients on decision to refer. Dr Herlihy briefly touched on the primary/secondary care interface in relation to cancer referrals and the process of active clinical triage alongside realistic clinical discussions at Primary Care level. Mrs Taylor informed the committee of multidisciplinary process once referral is made and the importance of when and at what stage on the patient journey is a realistic medicine conversation appropriate.

Dr Bhatti enquired about what data is collected in relation to cancer, and agreed take up that discussion with Mrs Taylor out with the meeting.

The Chair congratulated the team on meeting targets. Mrs Taylor invited Committee to contact her should they require further information.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents recognising demand on pressures ahead

8.2 Medical Appraisal Annual Report – taken out of sequence

Mrs Jones took the Committee through the report on behalf of Dr Ruth Richmond. She commented that the report confirms revalidations and medical staff appraisals are on track, any deferrals relating to revalidation were only for a short period. The areas to flag to Committee is the reliance on retired staff to perform appraisals which is not sustainable going forward, there are insufficient appraisers and allocated time for appraisals are affected by workforce pressures. These are areas which will require thought on how a return to in-house delivery of appraisal can be achieved. Should there be any questions relating to the report these can be directed to Dr Richmond out with the meeting.

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

8.3 Nursing Education Annual Report

Ms O'Reilly provided a brief overview of the content of the report and the challenges with remobilisation of services post COVID. Rapid training approach had been deployed to increase uptake of resuscitation training and an improvement has been seen. There had been a number of initiatives put in places which have helped improve delivery of training, Ms O'Reilly wanted to assure the Committee that these improvements will continue.

The Chair enquired about the lack of dedicated space for training, Ms O'Reilly informed the Committee that the space previously used for training is no longer available and they are looking at alternatives.

Mrs Jones asked if Ms O'Reilly could provide some information on the approaches to training they are deploying. Ms O'Reilly talked about simulation based education and how this has a far better impact on learning than paper based training. They have also introduced compassionate leadership training and system leadership away days to help improve staff well-being and morale. Mrs Horan commented that they are taking a multidisciplinary team approach to training which works well.

NHS Borders is one of three boards who are quite far ahead in assistant practitioner training which in turn helps with offering skill mixed training a positive career pathways for anyone coming in to the nursing profession. It is recognised that there is a link between well-being and provision of supported education. Dr Herlihy thanked Ms O'Reilly on the work on simulated education reporting that feedback from both nursing and medical staff had been very positive.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the direction of travel.

8.4 Blood Transfusion Annual Report

Dr Stewart provided a brief overview of the content of the report. She noted that Blood Transfusions Policies had been updated in line with Scottish Government's 'Once for Scotland'. Key Performance Indicators (KPIs) are being met. Strategy for Education had been developed for the first time with support from CPD and key staff groups have had Major Haemorrhage training, this will continue. There had been challenges with electronic updates on mandatory training and avenues are being explored to improve this. Other laboratory policies which had been reported as updated had not been through correct process. This has now been sorted with assistance from Clinical Effectiveness Administrator.

The Chair asked if NHS Borders were experiencing blood shortages similar to those reported Nationally. Dr Stewart explained that there are quite often alerts regarding blood shortages but this was the first time she had seen this in the press. She reports that Scotland's blood supplies are healthy. Following press reports Dr Stewart and the team took the opportunity to confirm the Blood Authorization Procedure was in place.

Mrs Jones thanked Dr Stewart for taking up the mantle of Chair of Hospital Transfusion Group and recognised the amount of work she had done to ensure everything post pandemic was back on track. Dr Stewart assured the Committee that direction of travel was positive and they will be fulfilling all the Scottish National Blood Transfusion Service expects of NHS Borders.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured on the positive direction of travel.

9 Items for Noting

The following items were noted by the **Clinical Governance Committee**

- Clinical Governance Committee Meeting dates for 23/24

- Minutes from other Governance Meetings/Committees
    - Public Health Governance Group Meeting (PHGG)
    - Public Governance Group (PGG)
    - Public Protection Committee May & July 22

Omnicell wall Cabinet Project Plan (**Action 14.09.22 7.2 pharmacy report**)

10 Any Other Business

For future business:
Final Joint Inspection report on Adult protection services in the Borders published on the 18th October; The report will be reviewed through the Public Protection Committee and the Critical Services Oversight group (which next meets on the 14th November) and will come to future meeting once Improvement Action plan has been developed.

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 18 January 2022** at **10am** via Teams Call.

The meeting concluded at 12:19

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Quality and Clinical Governance Report**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Authors:	**Julie Campbell, Lead Nurse - Patient Safety and Care Assurance, 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 report relates to a:

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

2.1.1 This exception report covers 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. Quality improvement
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 on the 22 March 2023 and discussed papers from all four clinical boards. Each clinical board continued to raise risks which are placing pressure on the delivery of local services.

2.3.3 Delays across the health and social care system coupled with increased demand resulting from surges in COVID 19 continue to place a significant strain on services. This is resulting in long waits within the Emergency Department. Elective surgeries, with the exception of urgent cancer cases have continued to operate at a reduced level due to the exceptional unscheduled demand and staffing pressures.

2.3.4 The CGC received a report on acute services. Positive steps have been taken to implement the nursing workforce plan supported by the Board in quarter 3 of 2022/23. There has been successful recruitment of a further group of international nurses and progress made in the appointment of pharmacy ward support roles. The committee recognised that these roles will take time to come on stream over the next 3-6months and remained concerned about the strain on registered nursing numbers and the knock on impact this would have to opening a dedicated elective ward. The Primary and community service report and mental health reports also highlighted the continued pressure resulting from national shortages in registered nurses and the impact this is having on the healthcare support workforce and on the ability to provide one to one care where indicated. The committee recognised the impact these pressures have on the nursing team's ability to deliver timely care to every patient every time and the personal impact on our staff. The committee were only able to feel partially assured in this area due to the continued risk this presents but acknowledge

the significant steps taken on a daily basis to management and mitigate risk, as well as, progress made in international recruitment and introducing new roles to elevate the strain.

2.3.5 The CGC reviewed the progress in opening Bordersview within the Borders General Hospital (BGH) providing a transitional care facility for those awaiting discharge to social care. The approach in Bordersview allows for a focus on deconditioning and providing an environment to encourage meaningful activities. The CGC were encouraged by the approach being taken in Bordersview as an interim step to addressing capacity across the system. Primary and Community Services and Mental Health leads highlighted the continued pressure on inpatient beds in their areas resulting from delays. The committee felt a continued emphasis was required on ensuring patients were being cared for in the correct location requiring collective leadership working across health and social care partnership to deliver this recognising the significant pressures social care are also facing.

2.3.6 The acute services report detailed the positive improvements in recruitment to Radiology. This will help to ensure vital capacity into diagnostic services recognising the significant demand on these services and the critical role they play in early diagnosis enabling prioritisation of patients who need rapid treatment. The CGC were concerned around immediate workforce pressures impacting on medical training rotas and the significant risk presented by workforce challenges in haematology, dermatology and breast radiology. Haematology is critical to the functioning of an acute hospital and an extensive piece of work has been done to look at potential options to mitigate risk in the short term whilst a longer term model can be developed. The committee recognised that this is a problem across the country and that solutions to these challenges are likely to require regional collaboration to sustain safe services for our local population. There will also be a continued reliance on locums to sustain urgent work in those services most under pressure and to remain compliant with medical rotas.

2.3.7 The mental health paper detailed the significant workforce challenges emerging in our local psychiatry team. These pressures have been experienced by some other NHS Boards for some time who now have a huge reliance on deliver of psychiatry services through locum models. Borders has been fortunate to retain a strong service but as demand continues to grow for mental health services the emerging medical workforce issues in psychiatry are an area of concern. The primary and community service teams noted that general practice continue to experience challenges with recruitment as considering in some detail at the January 2023 committee meeting. This presents issues around viability of smaller practices if recruitment challenges continue. The committee was keen to continue to keep this and the other areas of workforce pressure under close observation recognising the impact this could have on the safe and timely delivery of services.

2.3.8 Due to the issues relating to workforce, demand and delays outlined above the CGC was only able to agree partial assurance on the report delivered by Primary and Community Services, Mental Health Services and Acute Services.

2.3.9 The CGC considered progress being made by the Learning Disabilities Service in relation to the ‘Coming Home’ report and plans to re-provide suitable care for patients who have been accommodated out of area. The committee were encouraged by progress in this area and assured by the learning disability report.

2.3.10 Annual papers on medical education were considered which detailed some of the challenges ahead in sustaining compliant rota for trainees. The committee heard of the extensive work underway by the medical education team and many staff who taking on training and supervision roles across the service in relation to providing a great training environment in Borders. The committee also noted some areas where due to workforce challenges it was proving difficult to provide focus on training and supervision. Work was underway to address this and the committee felt partial assurance from the report recognising this work had not yet come to conclusion to address the issues detailed.

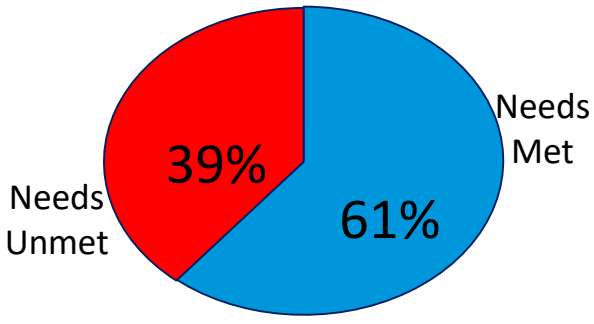
2.3.11 The annual maternity service report was reviewed by the CGC. NHS Borders are currently in the process of completing a service review maternity and paediatric services to ensure these services continue to develop to meet future need. The team have a strong overview of data relating to their service and have used this to inform their key areas for improvement in the coming year. These areas include working on handovers, the maternity early warning system including escalation and work to introduce a birth choices clinic linked to elective sections. The committee were assured by the annual maternity services report.

2.3.12 QUALITY IMPROVEMENT

2.3.13 A wide programme of improvement work continues across many services. Programme Boards for Urgent and Unscheduled Care and Planned Care are running effectively to oversee this work.

2.3.14 Under the direction of the Urgent and Unscheduled Care Programme a Multi-Agency Discharge Event (MADE) was held in January. The MADE brought together teams working across the Scottish Borders Health and Social Care partnership from social care, social work and health to support improved patient flow across the system. The MADE extended over a 2-week period; teams were formed to review patient/services users within acute wards, mental health wards, community hospital wards, intermediate care units and the Home First service using a day of care survey approach.

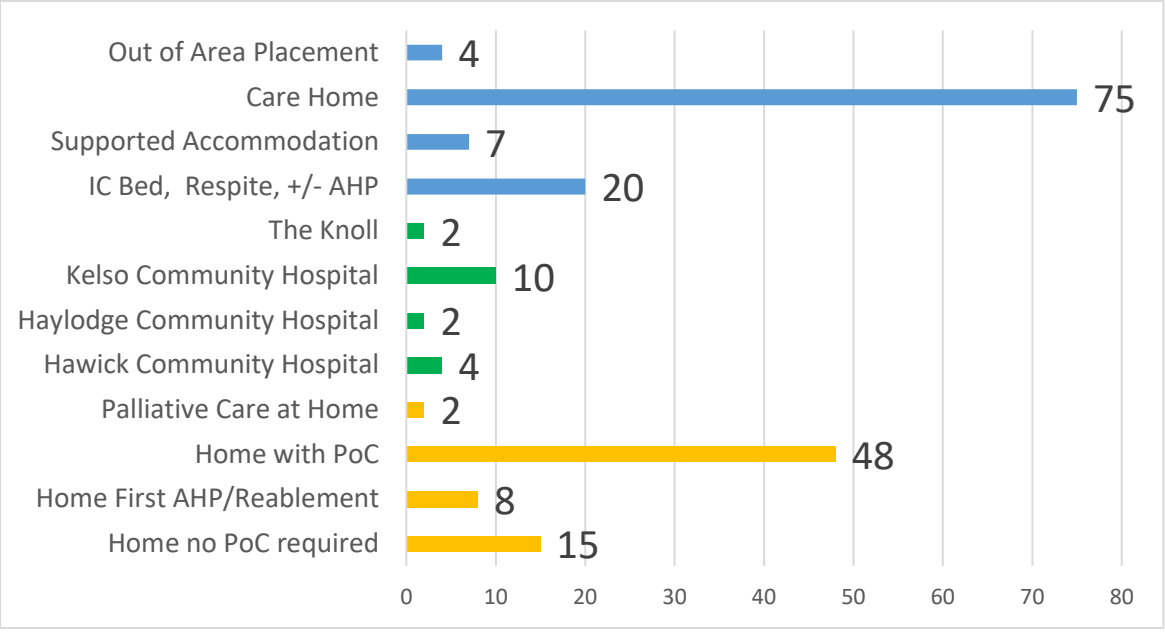
2.3.15 Using the recommended national approach each patient/service user was coded as met or not met with reasons why not (coding). Where applicable a second list was developed to explore most appropriate alternative place of care if deemed not met. Progress for each patient's care was captured during feedback and follow up of action sessions with multi-agency teams present. This involved recognising and unblocking delays, providing challenge to improve and simplify complex discharge processes. The pie chart below details the outcome of all patients reviewed during the made with 61% meeting the criteria for the location they were currently in within the health and social care system and 39% not.



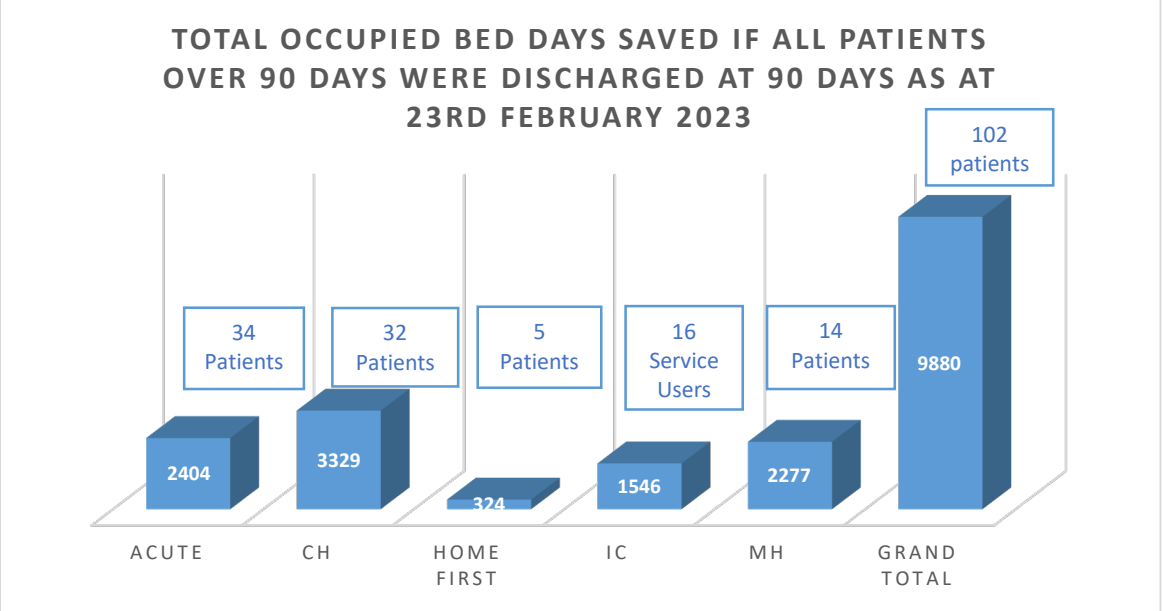
2.3.16 For those who did not met the criteria to be in their current location graph 1 below details the alternative location where the patient should have been. The top four areas include:

- 75 people identified for care home placement and an additional 7 for alternative supported accommodation
- 48 waiting for a package of care
- 20 waiting for entry into intermediate or respite care
- 20 waiting for entry into a community hospital

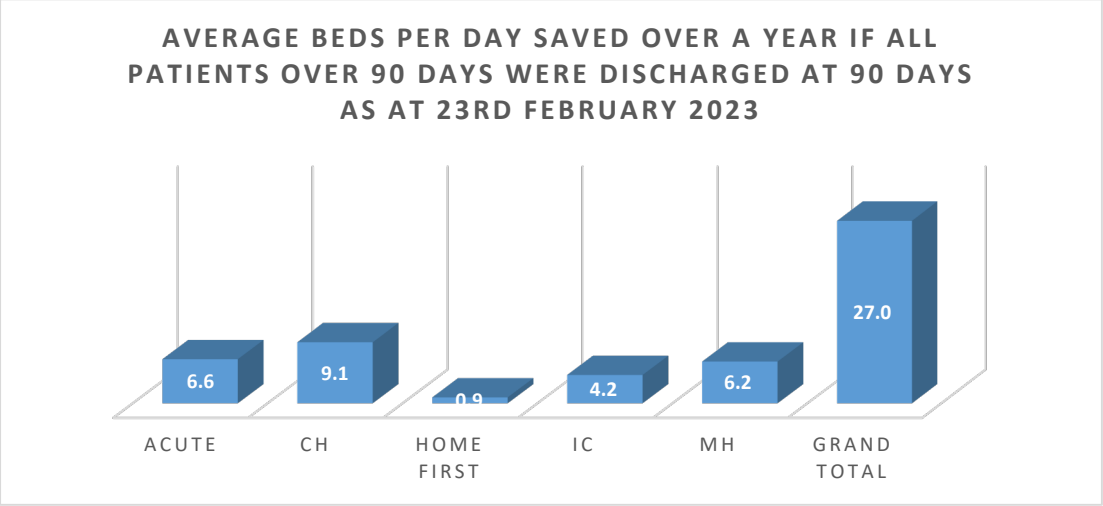
Graph 1:



2.3.17 The outputs of MADE were analysed to consider the impact on inpatient beds if patients who were delayed were moved to the correct place of care after a length of stay of 90 days. Graph 2 details the impact this would have on bed days within the health and social care system:



2.3.18 Graph 3 details this impact in beds saved each day totally 27:



2.3.19 The learning and themes from this work and now being used to shape the key workstreams of the Urgent and Unscheduled Care Programme for 2023/24.

2.3.20 PATIENT SAFETY

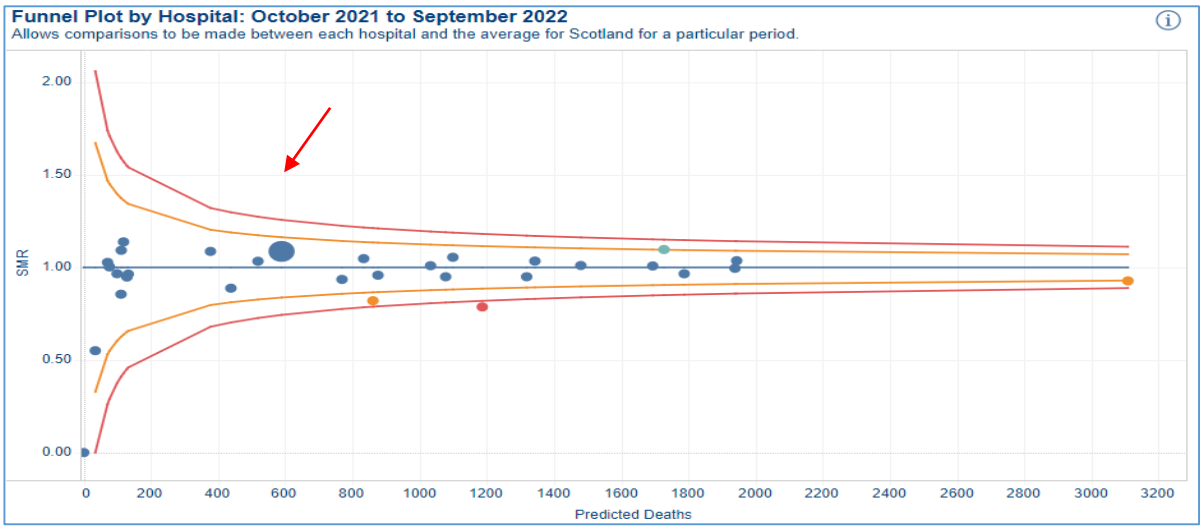
2.3.21 Care Assurance

During the COVID 19 pandemic many NHS Boards stopped collecting process data in relation to core dimensions of inpatient nursing care. However, NHS Borders felt strongly that to ensure patient safety and to understand clinical risk a reduced sample of audits across inpatient areas was important to assure the standard of care at a time of exceptional pressure. The patient safety team have prioritised this work in support of Senior Charge Nurses and Clinical Nurse Managers who would normally hold these responsibilities in recognition of the significant strain on registered nursing capacity. This support has also extended to the review of all major or extreme falls and developed pressure damage of grade 2 and above.

2.3.22 Given the continued extreme workforce and demand pressures the patient safety team has been working with the associate director of nursing for acute services to assess what measures are required to support the delivery of care and provide oversight of quality and risk. This has identified the need for additional collaborative working between clinical management teams and the patient safety team to provide dedicated time in each clinical area on a routine basis with a focus on staff wellbeing, quality of care and patient experience.

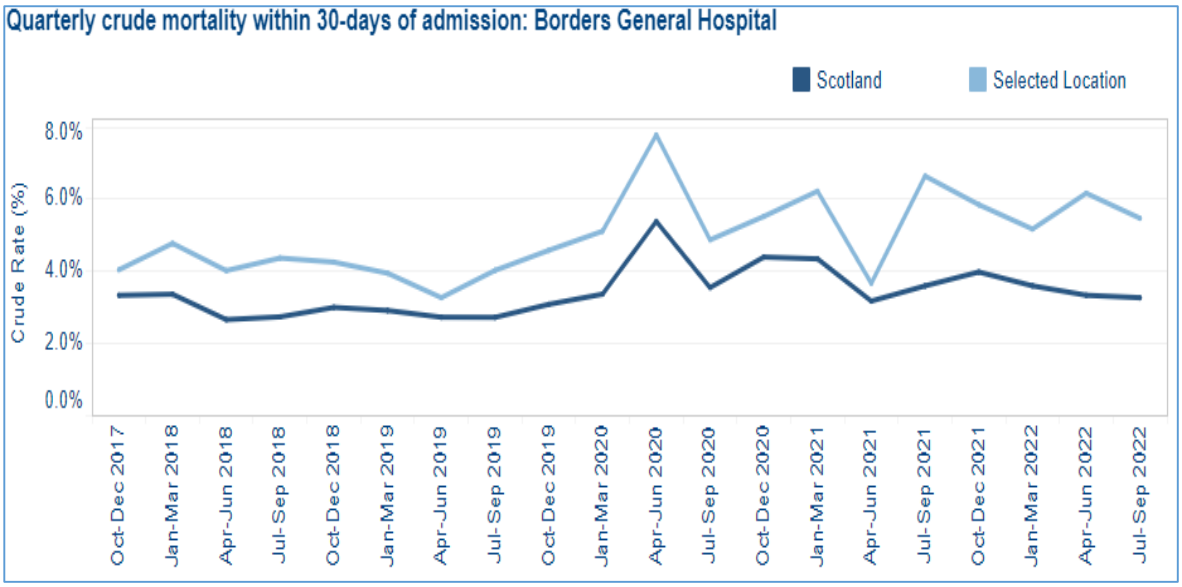
2.3.23 Hospital Mortality

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 15th data release under the new methodology is 1.09. This figure covers the period October 2021 to September 2022 and is based on 640 observed deaths divided by 589 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

2.3.24 NHS Borders crude mortality rate for quarter July 2022 to September 2022 was 5.5% and is presented in graph 4 below:

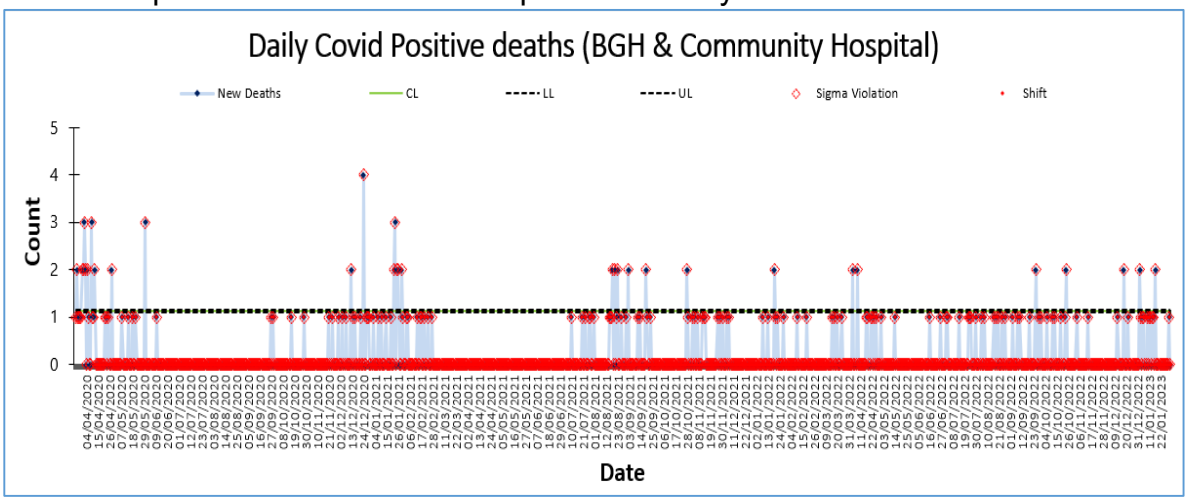


*Contains deaths in the Margaret Kerr Palliative Care Unit

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

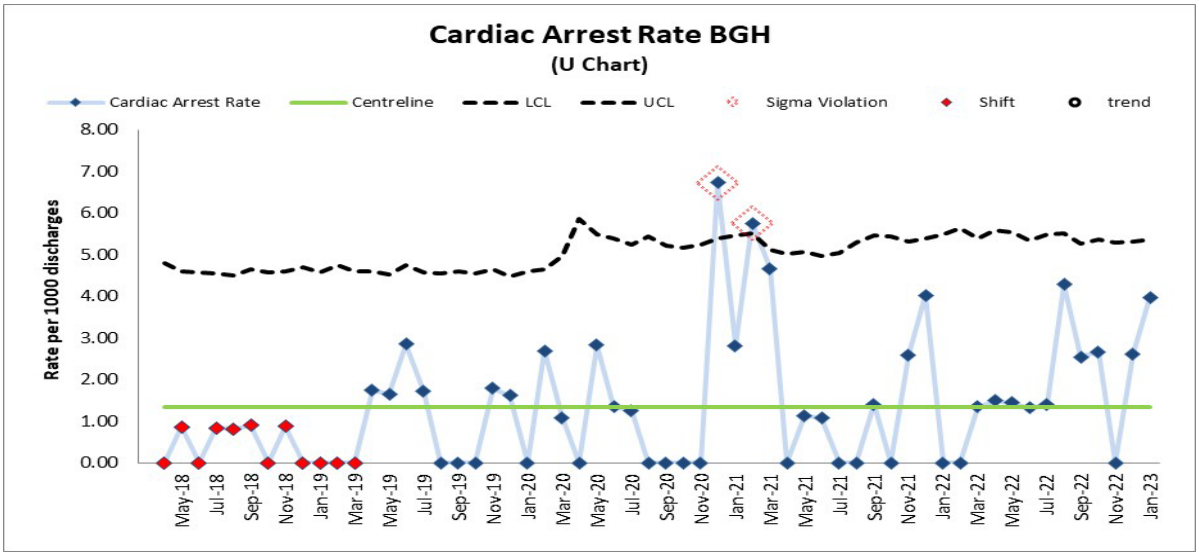
2.3.26 Deaths occurring in COVID waves continue to contribute to the periods of elevated crude mortality. The significant reduction in the denominator, which is the number of admissions to the BGH, has further compounded the elevated rate in quarter 4 of 2019/20 and quarter 1 of 2020/21.

2.3.27 Graph 5 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 31 January 2023:



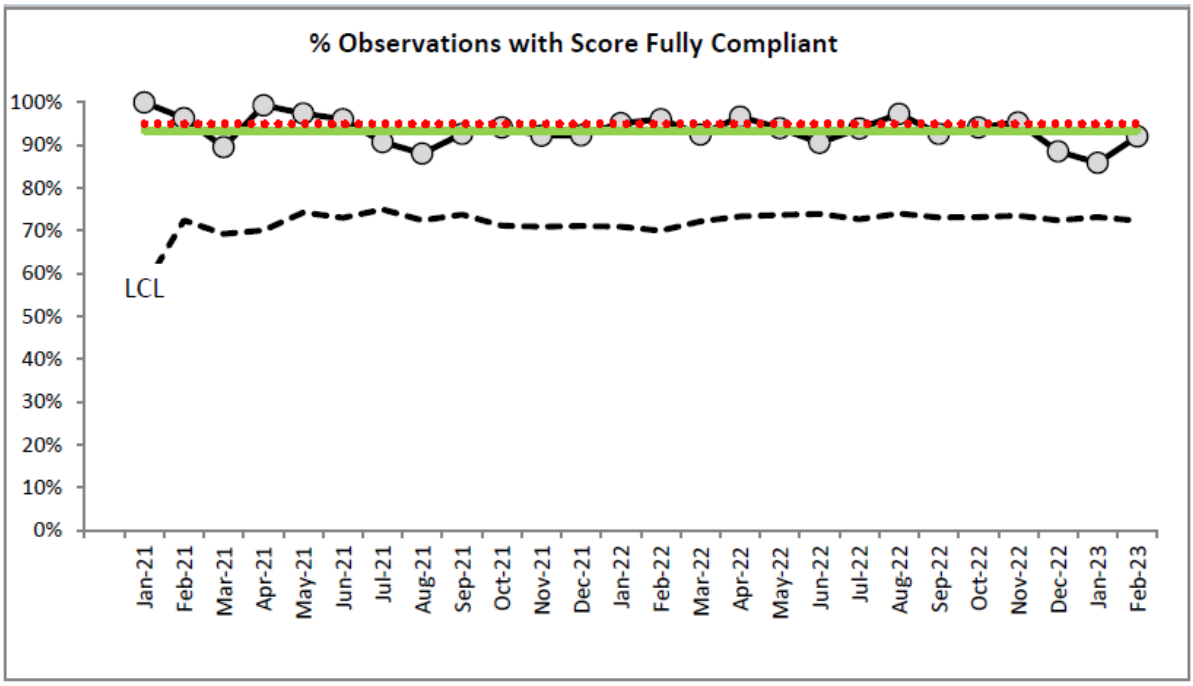
2.3.28 Cardiac Arrests

The Deteriorating Patient (DP) Group continue to meet on a monthly basis. The aim of the group is reducing the incidence of cardiac arrest in hospital and ensure effective systems and processes are in place for care of the deteriorating patient. NHS Borders has a small incidence of actual cardiac arrests and the Patient Safety Team and Resuscitation Officer review each arrest for learning. Graph 6 shows the cardiac arrest rate per 1000 discharges within NHS Borders for the BGH:

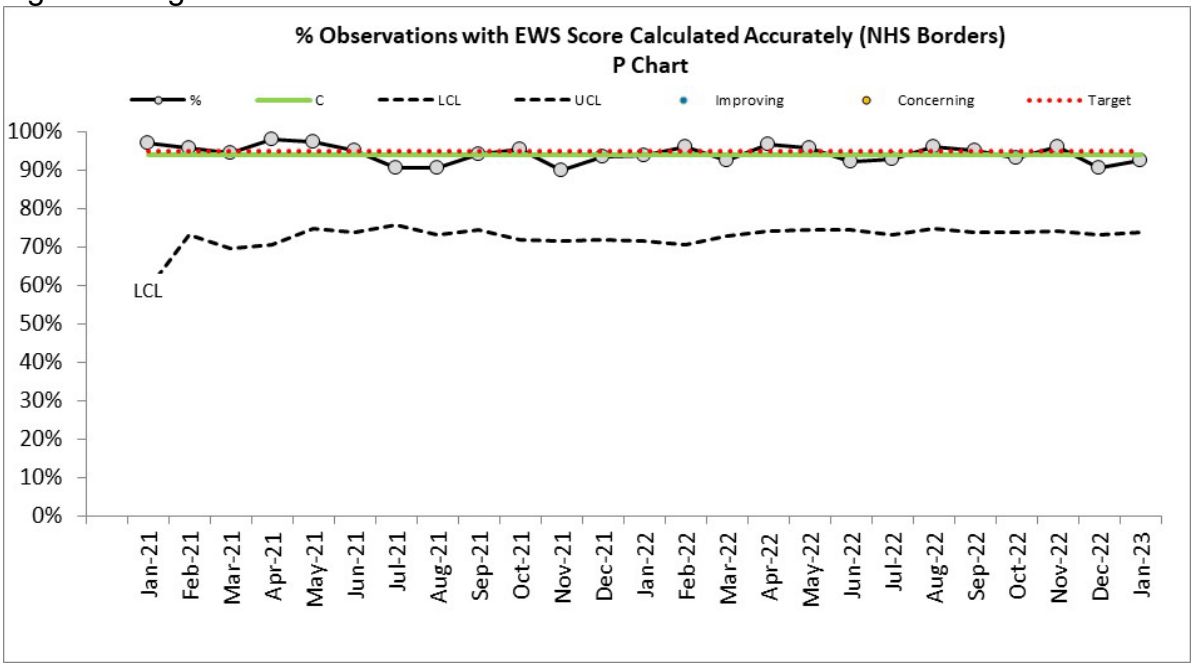


2.3.29 The monthly Ward Quality Audits monitor compliance with completion, escalation and early recognition of deterioration in all adult inpatient areas.

2.3.30 Graph 7 shows the percentage of fully compliant National Early Warning Score (NEWS) observations (against the seven observations required). Compliance remains high showing normal variation:



2.3.31 Graph 8 shows the percentage of NEWS calculated accurately. Compliance remains high showing normal variation:

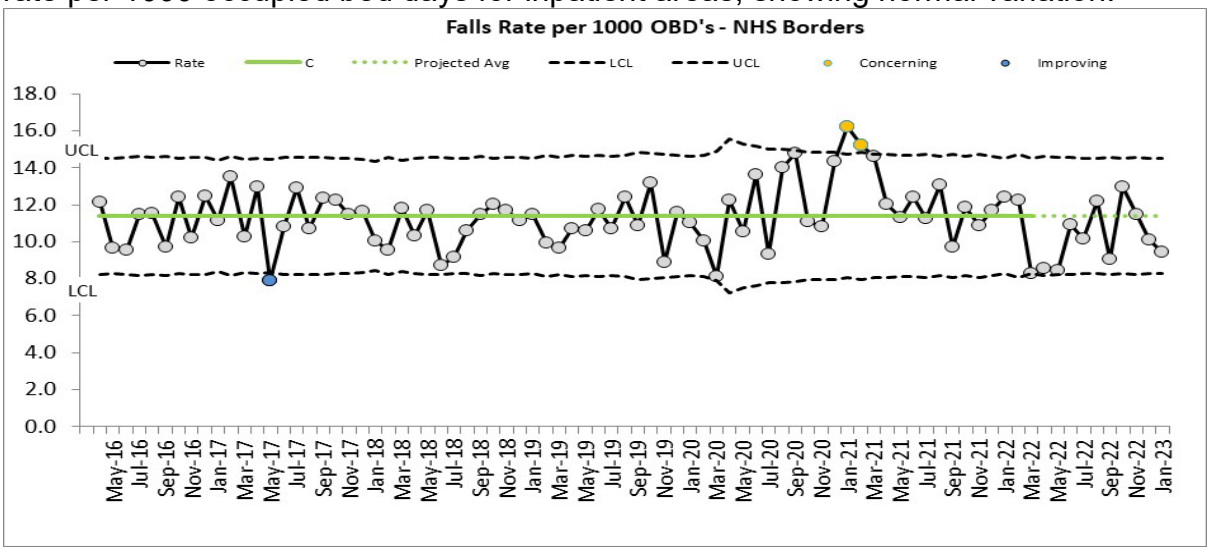


2.3.34 Priorities for the year ahead in this area include continuing to maintain an effective system for recognition and escalation of deterioration in the context on significant workforce and demand pressures. In addition, exploring opportunities to trial e-Observations within the acute setting, embedding treatment escalation plans during inpatient episodes of care and improving the approach to anticipatory care planning across the system.

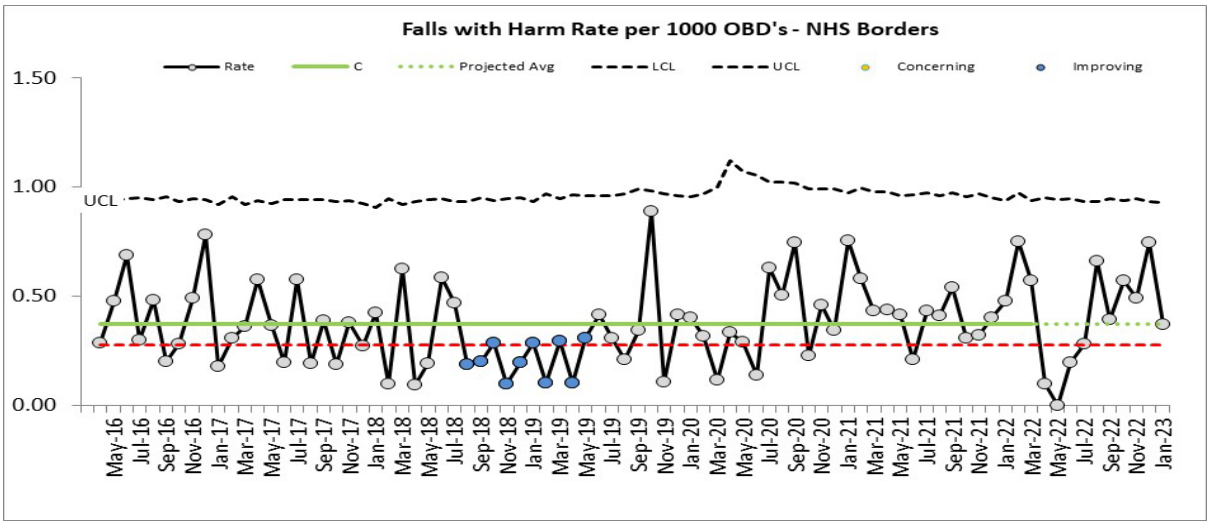
2.3.35 Falls

The main focus for the NHS Borders Inpatient Falls and Management Group continues to be the development of an inpatient prevention and management of falls package. Areas of focus are the Medical Assessment Unit (MAU), Department Medicine of the Elderly Ward (DME 14), Borders Specialist Dementia Unit (BDSU),

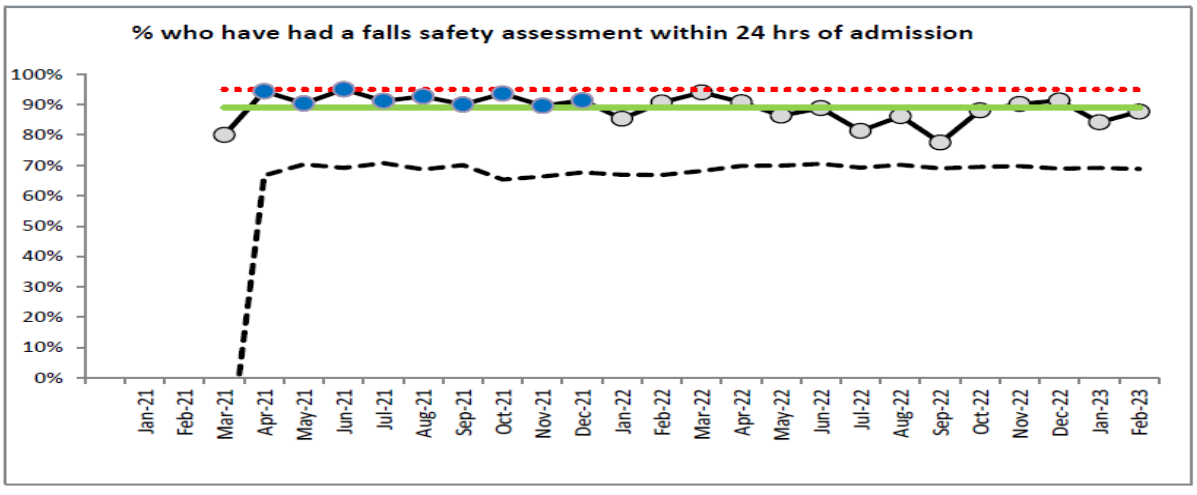
Lindean and Haylodge Community Hospital. Graph 9 shows the NHS Borders fall rate per 1000 occupied bed days for inpatient areas, showing normal variation:



2.3.36 Graph 10 shows the NHS Borders falls with harm rate per 1000 occupied bed days for inpatient areas showing normal variation:



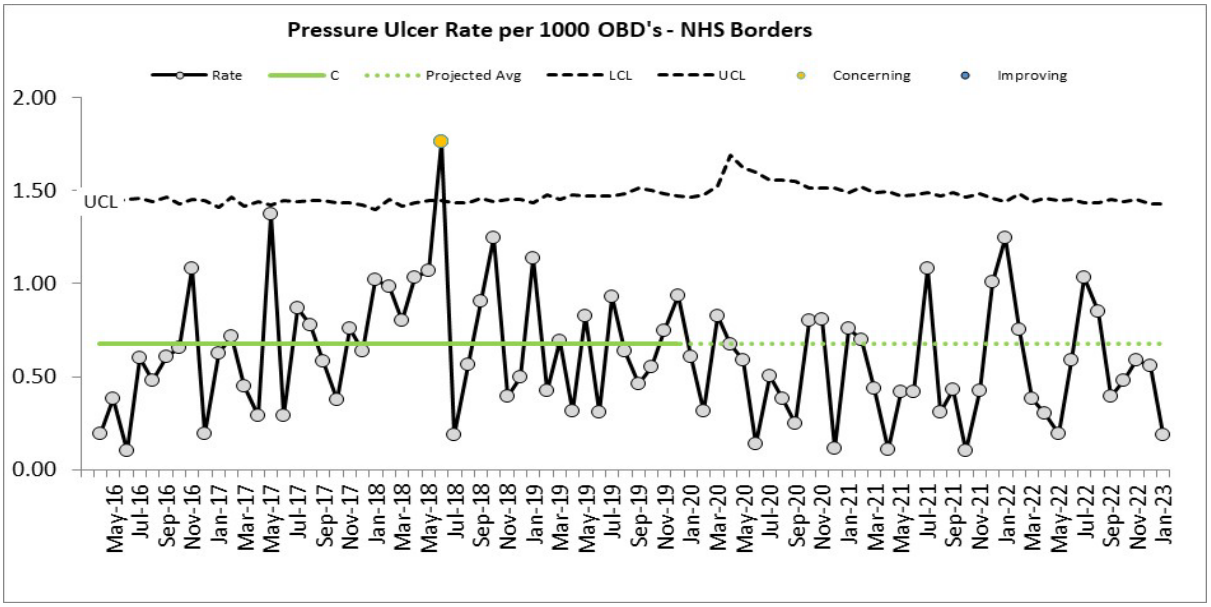
2.3.37 Graph 11 shows the percentage of patients who have their risk of falls assessed within 24 hours of admission showing normal variation and room for improvement:



2.3.38 The Multidisciplinary Assessment and Communication (MAC) booklet has been reviewed to include all members of the Multidisciplinary Team (MDT). The rapid risk assessment section to include falls has been updated with a time frame to guide staff members to complete a MDT Person Centred Falls Bundle within 24 hours of admission where a falls risk is present. There is also guidance now for completing person centred care and a rehabilitation plan for safety and falls and stress and distress. Priorities for the year ahead will be a focus on deconditioning and across inpatient areas and a continued emphasis on the newly introduced enhanced care observation approach.

2.3.39 Pressure Area Care

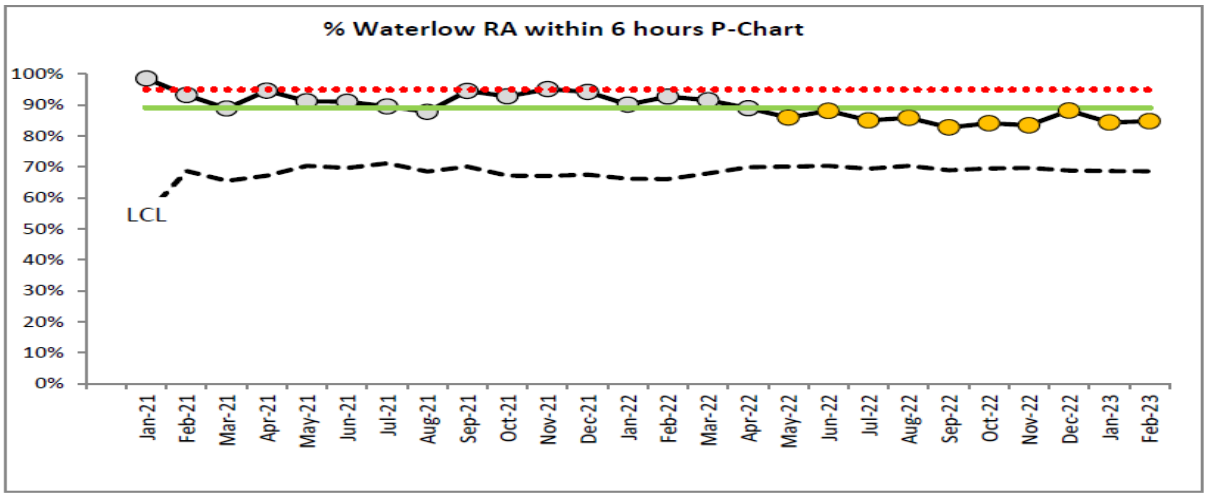
The NHS Borders rate per 1000 occupied bed days of developed pressure injuries has remained stable as detailed in graph 12 below. However, there has been an observed increase in severity of pressure damage and increased referrals to the tissue viability service from both community nursing teams working with patients in their own homes and inpatient areas:



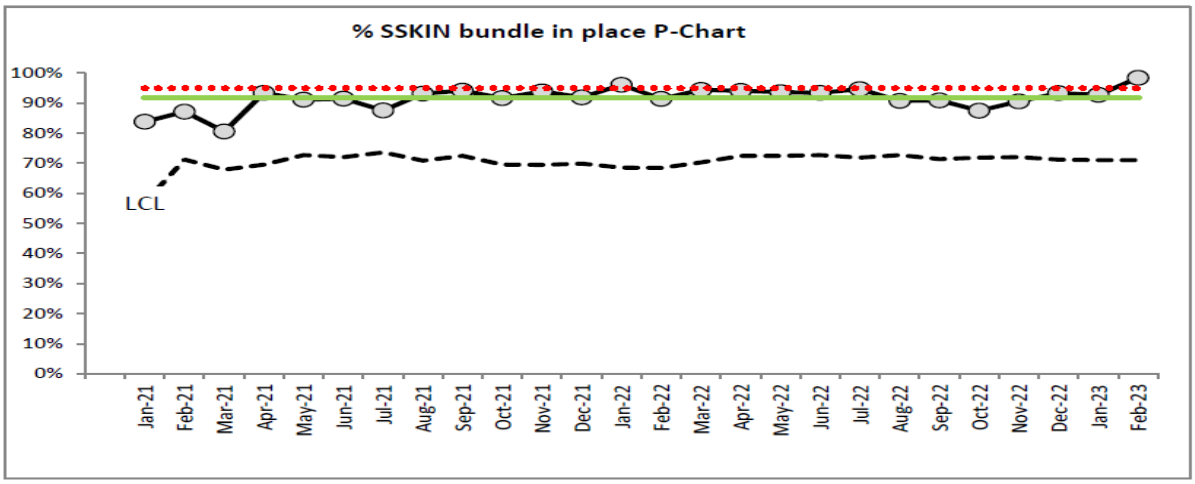
2.3.40 The patient safety team review all grade 2 and above developed pressure injuries within BGH inpatient wards and Senior Charge Nurses complete these in the 4 community hospitals. These reviews are done rapidly to ensure remedial action and learning from each case. A lack of recognition still exists between moisture and pressure damage, both of these issues are being addressed by education. Clinical education continues to be supported by an external provider in addition to the TVN. Wards 4, 12 and 14 have received this ward based education.

2.3.41 Demographically, NHS Borders has a large elderly population; many patients awaiting a hospital bed in the ED are frail and vulnerable. Often patients are admitted following a fall or having had recurrent falls at home; some patients are admitted with inherited pressure damage from home and require preventative measures to be put in place early to reduce further harm. Graph 13 shows the percentage of patients who have a waterlow risk assessment completed with 6 hours of admission. There has been a downward shift in compliance compounded by long waits in the emergency department for some patients awaiting admission. These waits have resulted from significant capacity pressure across the health and social care system. Work is

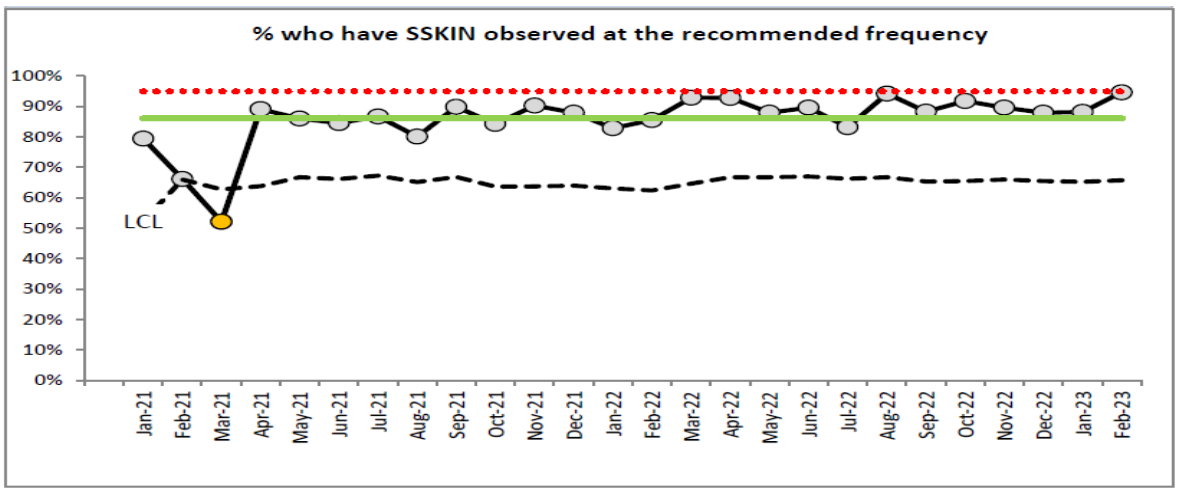
underway to review the risk assessment and care rounding approach in the emergency department to ensure patients awaiting admission have timely inpatient risk assessments carried out and care rounding. This will include oversight from the senior nursing team:



2.3.42 Graph 14 shows the percentage of inpatients who have an SSKIN bundle in place showing high compliance and normal variation:



2.3.43 Graph 15 shows the percentage of inpatients who have SSKIN observed at the correct frequency showing high compliance but with further room for improvement:

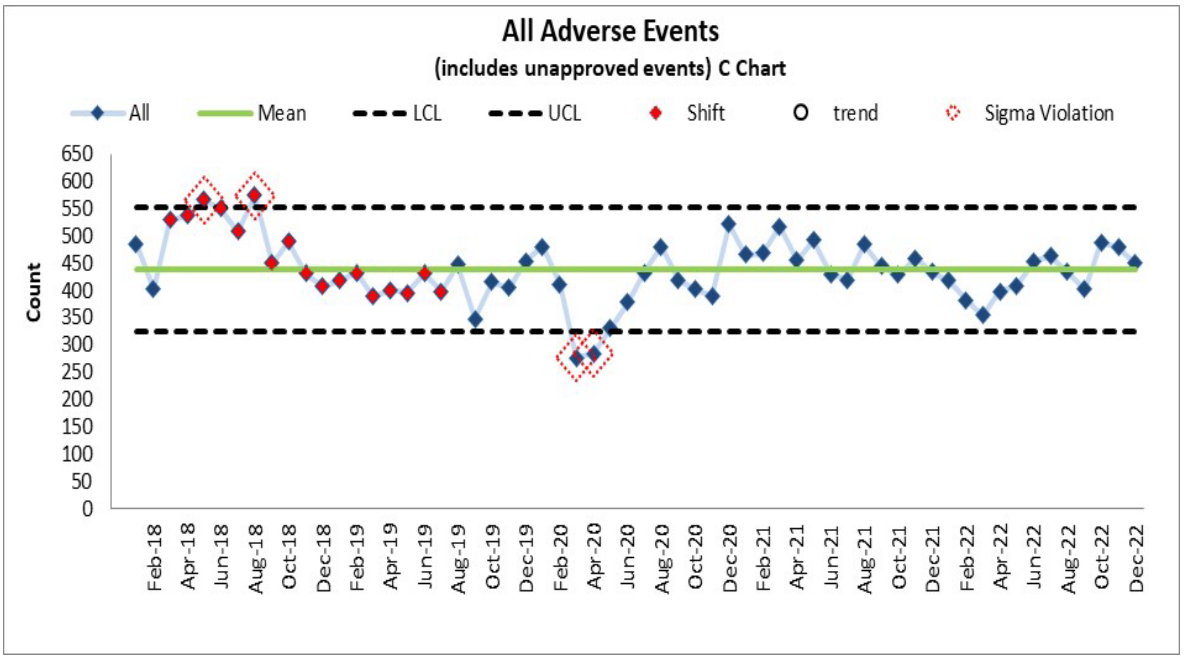


2.3.44 Towards the end of 2022 the TVN started reviewing the East Region Joint Formulary along with NHS Lothian and NHS Fife. This is almost complete and it is hoped it will go live within the next month. The patient safety team and tissue viability nurse are currently part of the Scottish Patient Safety Programme (SPSP) Acute Adult Pressure Ulcers Expert Reference Group and are currently contributing to the national work to refresh the approach in this area.

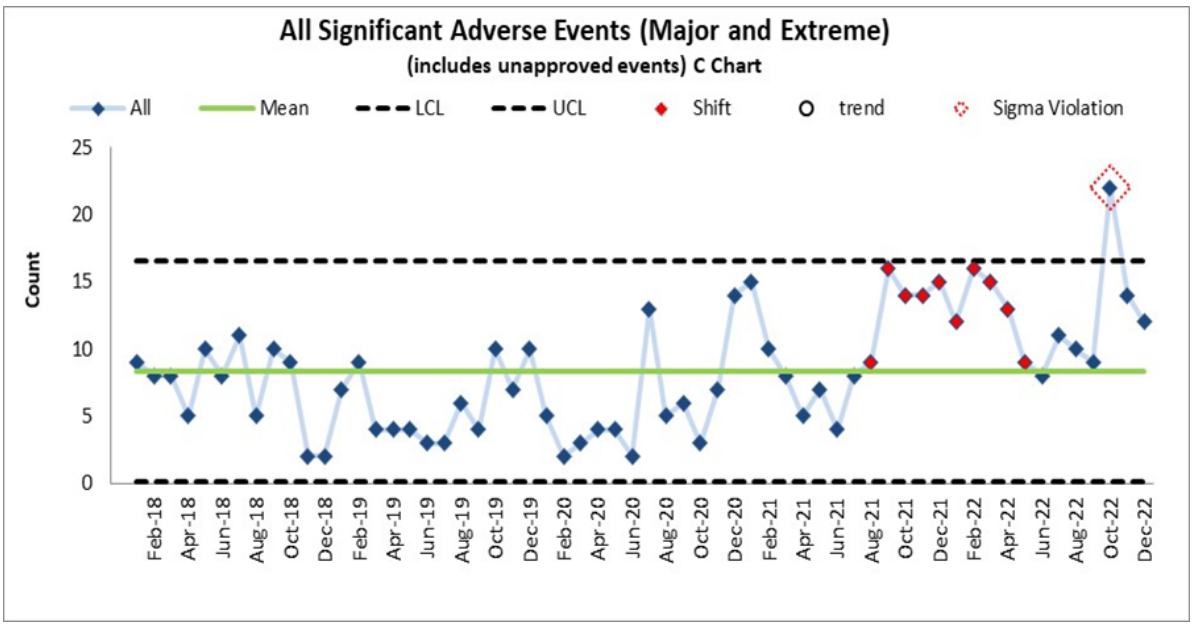
2.3.45 The reduction of developed pressure ulcers will continue to be a priority focus for NHS Borders over the coming year.

2.3.46 Adverse Events

Graph 16 shows all NHS Borders reported adverse events for the time period January 2018 to December 2022. There is an overall downwards trend of reporting adverse events on the adverse event management system since September 2018; this is due to a change in reporting of laundry events rather than constituting a reduction in actual adverse events and the chart has been re-phased at this point to reflect this. There was a significant reduction in the number of reported events in March and April 2020 coinciding with the start of the first wave of the COVID-19 pandemic. Since then the data has shown normal variation and remains within the expected limits:



2.3.47 Graph 17 shows the number of adverse events with a grading of major and extreme. Between July 2021 and May 2022 there was a shift above the mean reflecting the shift observed in acute services. There was a breach of the upper control limit in October 2022 reflecting the pattern observed in Primary and Community Services that month. Severity of grading of developed pressure damage and the points raised in this section above have contributed to this rise:

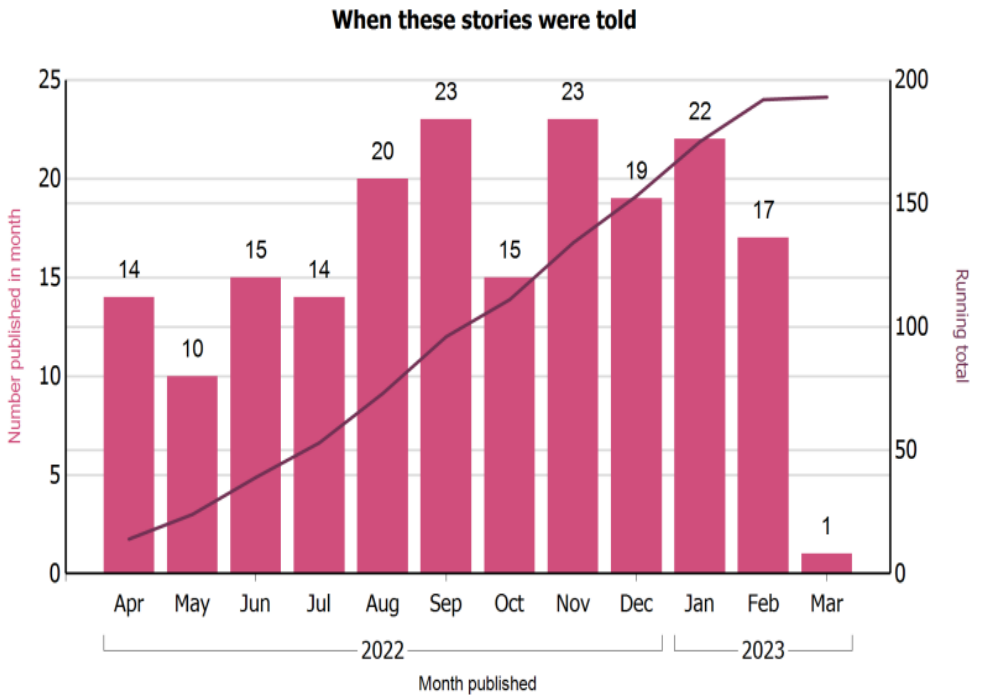


Note: This control chart includes all events with a major or extreme outcome and includes Child Death, Drug Related Death and Suicides whether harm was caused during the delivery of healthcare or not. In addition, inherited pressure damage is also included.

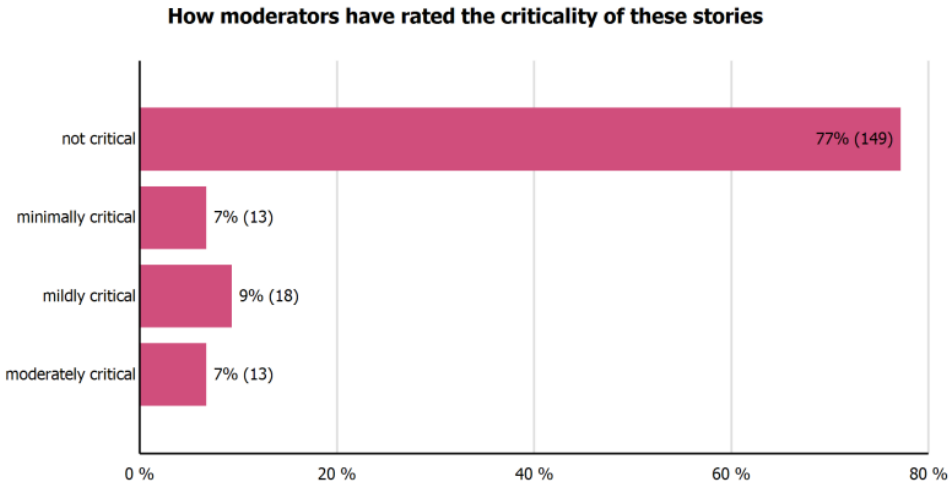
2.3.48 PATIENT EXPERIENCE

2.3.49 Care Opinion

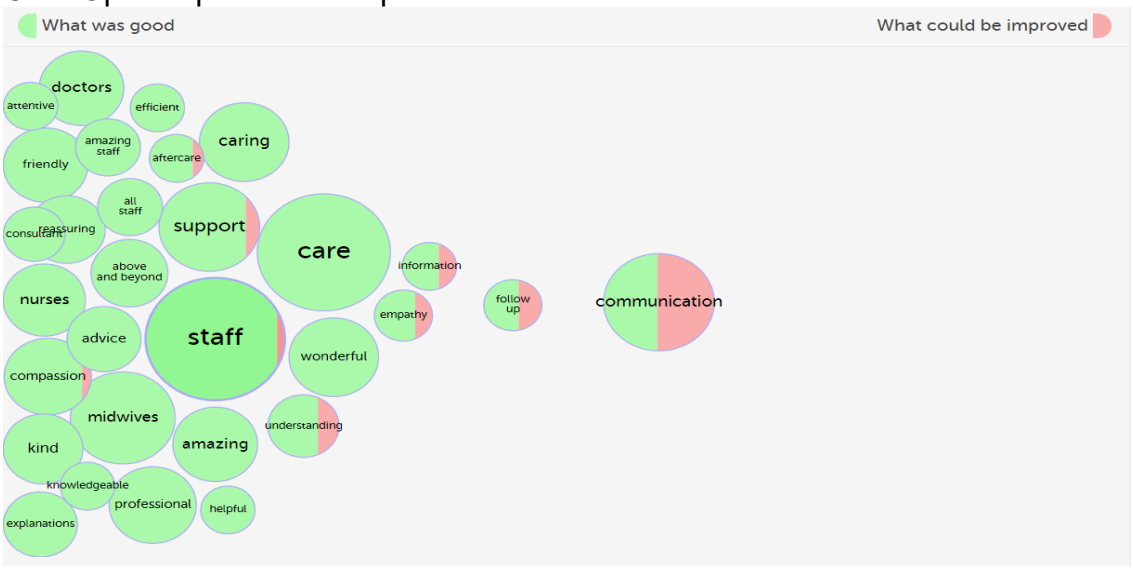
For the period 1 April 2022 to 28 February 2022, 193 new stories were posted about NHS Borders on Care Opinion. The graph 18 below shows the number of stories told in that period. As at 9 March 2023 these 193 stories were viewed 25,166 times:



2.3.50 Graph 19 provides a description of the criticality of the193 stories:



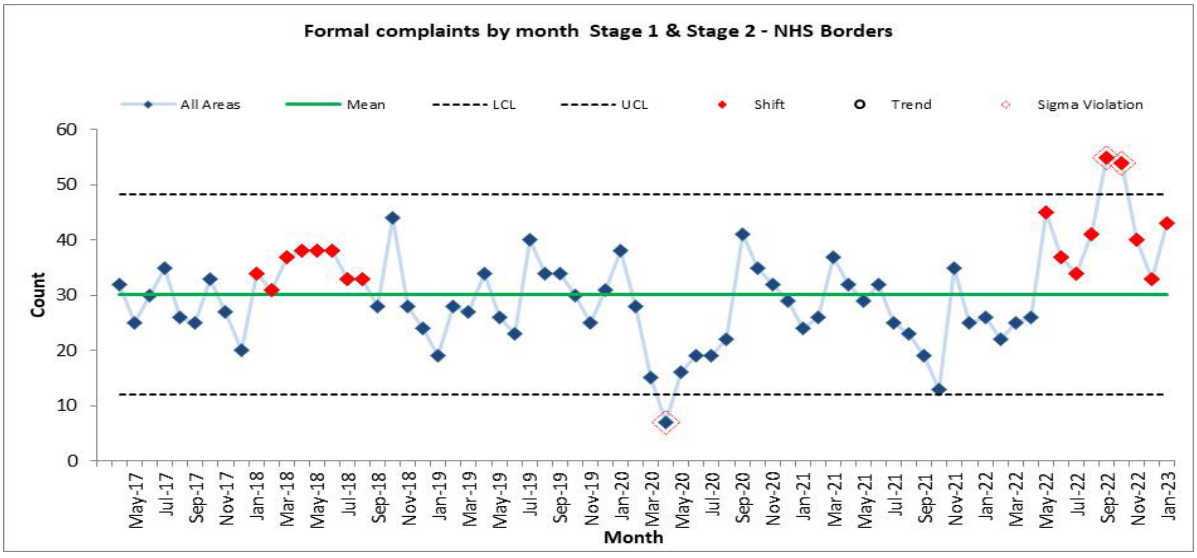
2.3.51 The word clouds below summarise ‘what was good’ and ‘what could be improved’ in Care Opinion posts for this period:



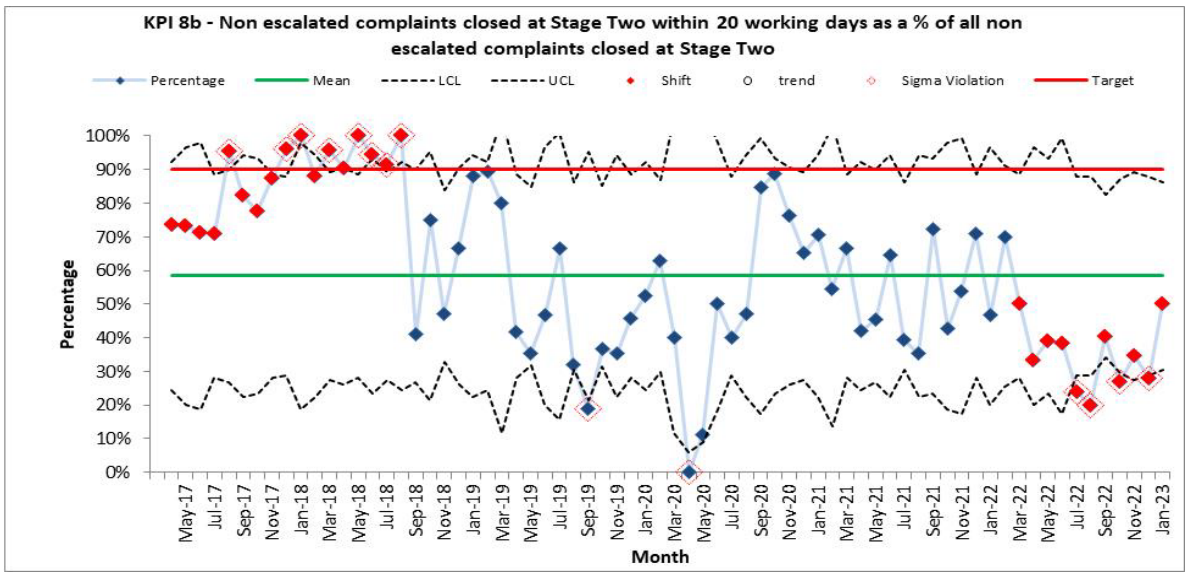
What was good?

What could be improved?

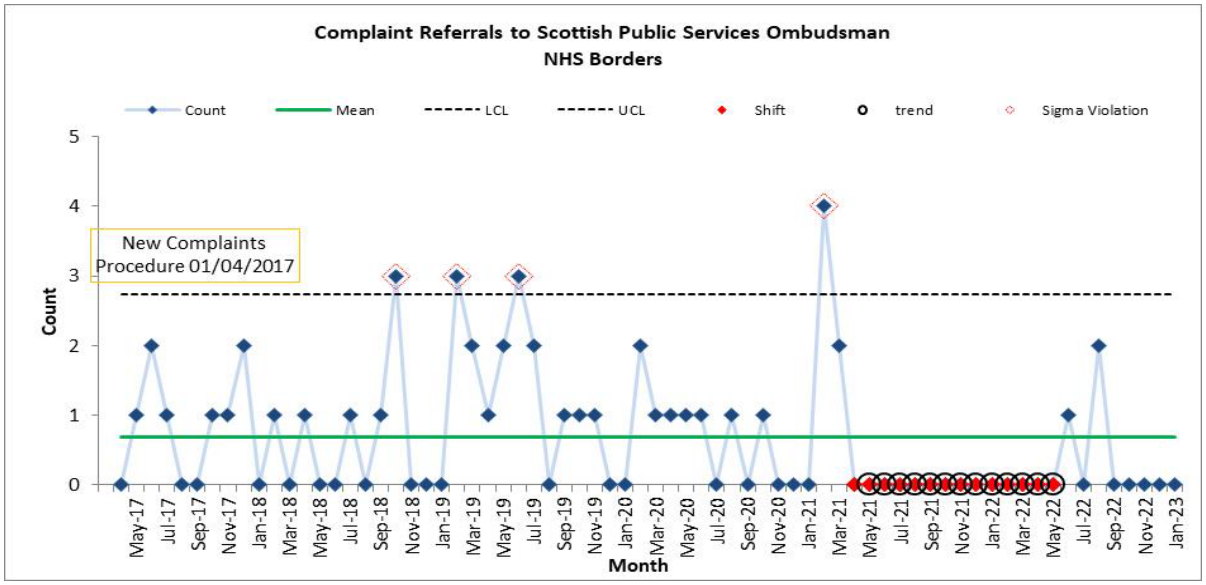
2.3.52 Graph 20 below gives the number of formal complaints received by month. Since May 2022 there has been a 9 month shift about the mean. The ongoing increase in the number of complaints, resulting from the continued pressure within clinical services, is placing a significant workload strain on both the small Patient Experience Team (PET) and frontline staff involved in the review of specific complaints. Additional capacity has been added to the PET team on a short term basis to support this increase in workload and the team are informing complainants of the additional time they may need to process their complaint at this time. However, the additional capacity has not been able to reduce the backlog of complaints sufficiently to take the numbers waiting back to a manageable size to be processed within 20 working days. Therefore, further resource has been agreed and this is currently being put in place. Graph 20 shows the number of formal complaints received:



2.3.53 Graph 21 below shows the percentage of complaints responded to within 20 working days. Front line services are experiencing ongoing clinical pressures which have impacted on the ability of frontline clinical staff to respond to complaint investigations within normal timescales. This together with the increase in the number of complaints has resulted in the PET team being unable to sustainably deliver against the 20 working day target with a 11 month shift below the mean:



2.3.54 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. The SPSO are experiencing the same demand pressures at this time resulting in extended periods for reviews by the SPSO. Graph 22 below shows complaint referrals to the SPSO up to 28 February 2023:



2.3.55 COVID INQUIRY

2.3.56 The Scottish and UK COVID 19 Inquiries have recently formalised how they will work together. An agreement has been published setting out how the Scottish COVID 19 Inquiry and the UK COVID 19 Inquiry will work together. The agreement includes commitments to providing clear information to the public about how each Inquiry will carry out its investigations in Scotland, minimise duplication of work through information sharing and maximise value for money to the public purse. A memorandum of understanding has been signed by both inquiries and formalises the process. Further

detail on this is available on the following link www.covid19inquiry.scot/working-uk-covid-19-inquiry.

2.3.57 The UK COVID 19 Inquiry held a preliminary hearing in relation to Module 3 - Impact of COVID 19 pandemic on healthcare systems in the 4 nations of the UK. NHS Borders together with all the Scottish Territorial Health Boards are a core participant of Module 3. A transcript of the preliminary hearing is available on the UK COVID 19 website https://covid19.public-inquiry.uk/document/transcript-of-module-3-preliminary-hearing-on-28-february-2023/ .

2.3.58 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.

2.3.59 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.

2.3.60 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.

2.3.61 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the need to adjust and remobilise services following the pandemic response.

2.3.62 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.

2.3.63 Climate Change

No additional points to note.

2.3.64 Other impacts

No additional points to note.

2.3.65 Communication, involvement, engagement and consultation

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

2.3.66 Route to the Meeting

The content of this paper is reported to Clinical Board Clinical Governance Groups and Board CGC.

2.4 Recommendation

The Board is asked to:

- note the report

Glossary

Clinical Governance Committee - CGC
Borders General Hospital - BGH
Multi Agency Discharge Event - MADE
Hospital Standardised Mortality Ratio - HSMR
Deteriorating Patient - DP
National Early Warning System - NEWS
Medical Assessment Unit - MAU
Department of Medicine for the Elderly - DME 14
Borders Specialist Dementia Unit - BSDU
Multidisciplinary Assessment and Communication - MAC
Multidisciplinary Team - MDT
Scottish Patient Safety Programme - SPSP
Patient Experience Team - PET
Scottish Public Services Ombudsman - SPSO

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Infection Prevention and Control Report – January 2023**
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 Infection (HAI) against Scottish Government targets.

2.2 Background

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

2.3 Assessment

Healthcare Associated Infection Reporting Template (HAIRT)

Section 1– Board Wide Issues

1.0 Key Healthcare Associated Infection Headlines

1.1 In February 2023, DL (2023)06 was issued by the Scottish Government informing Health Boards that the previously agreed standards and indicators for healthcare associated infection (HCAI) and antibiotic use originally due to be met in 2023 were to be extended by one year to 2024. This is in recognition of continued service pressures, allowing for further consideration on whether the infections currently measured are still relevant for targeted surveillance.

1.2 NHS Borders had a total of 24 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2022 and December 2022, 17 of which were healthcare associated infections.

1.2a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated SAB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (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.

1.3 NHS Borders had a total of 15 *C. difficile* Infection (CDI) cases between April and December 2022; 11 of these cases were healthcare associated infections.

1.3a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 TOBDs by the end of 2023/24 (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.

1.4 NHS Borders had a total of 68 *E. coli* Bacteraemia (ECB) cases between April and December 2022, 32 of which were healthcare associated.

1.4a 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 2023/24 (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 30 healthcare associated ECB cases this financial year.

2.0 *Staphylococcus aureus* Bacteraemia (SAB)

See Appendix A for definition.

2.1 Between April and December 2022, there have been 23 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and 1 case of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 1 shows a Statistical Process Control (SPC) chart showing the number of days between each SAB case. The reason for displaying the data in this type of chart is due to SAB cases being rare events with low numbers each month.

2.3 Traditional charts which show the number of cases per month can make it more difficult to spot either improvement or deterioration. These charts highlight any statistically significant events which are not part of the natural variation within our health system. The graph shows that there have been no statistically significant events since the last Board update.

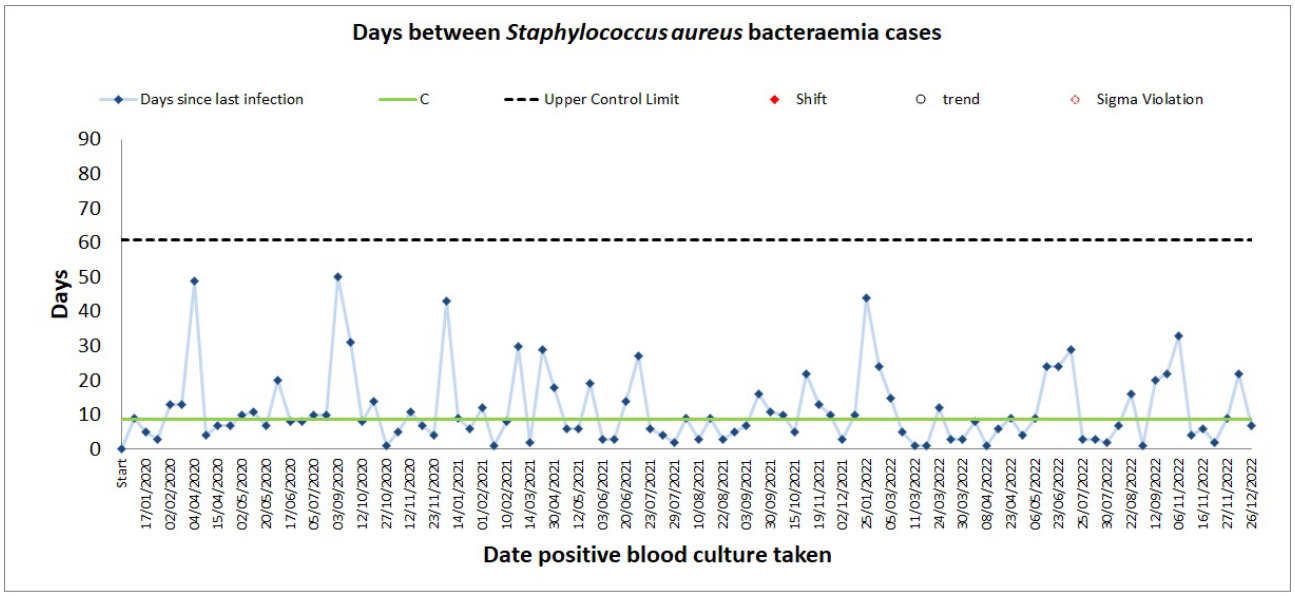
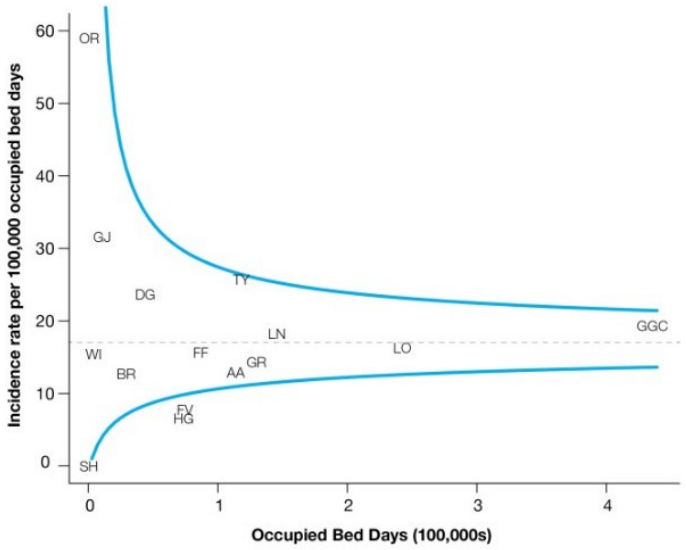


Figure 1: NHS Borders 'days between' SAB cases (January 2019– December 2022)

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 3 2022 (Jul 2022 – Sep 2022).

2.6 During this period, NHS Borders (BR) had a rate of 12.7 which was below the Scottish average rate of 17.1.



Key to NHS Boards

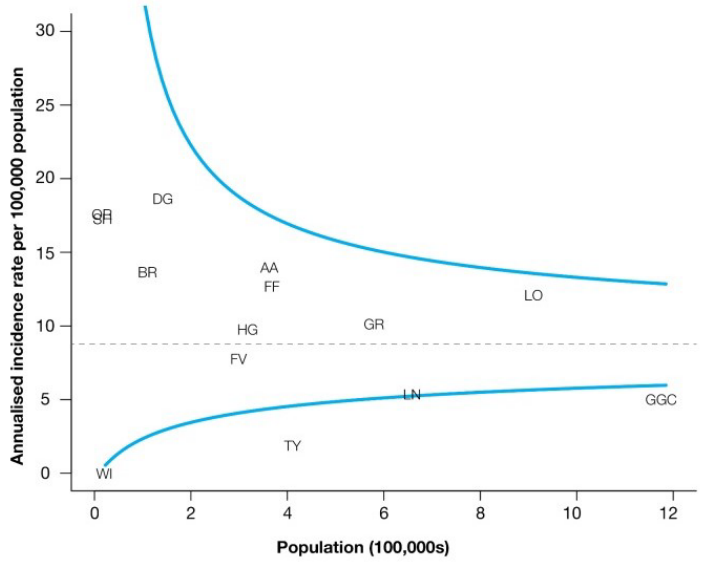
AA = Ayrshire & Arran
BR = Borders
DG = Dumfries & Galloway
FV = Forth Valley
FF = Fife
GR = Grampian
GGC = Greater Glasgow & Clyde
HG = Highland
LN = Lanarkshire
LO = Lothian
NWTC = National Waiting Times Centre
OR = Orkney
SH = Shetland
TY = Tayside
WI = Western Isles

1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 2: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q3 2022

2.7 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.

2.8 Figure 3 below shows a funnel plot of <u>community associated</u> SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q3 2022.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Orkney and NHS Shetland overlap.

Figure 3: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2022

2.9 During this period NHS Borders (BR) had a rate of 13.7 which was above the Scottish average rate of 8.8. 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.

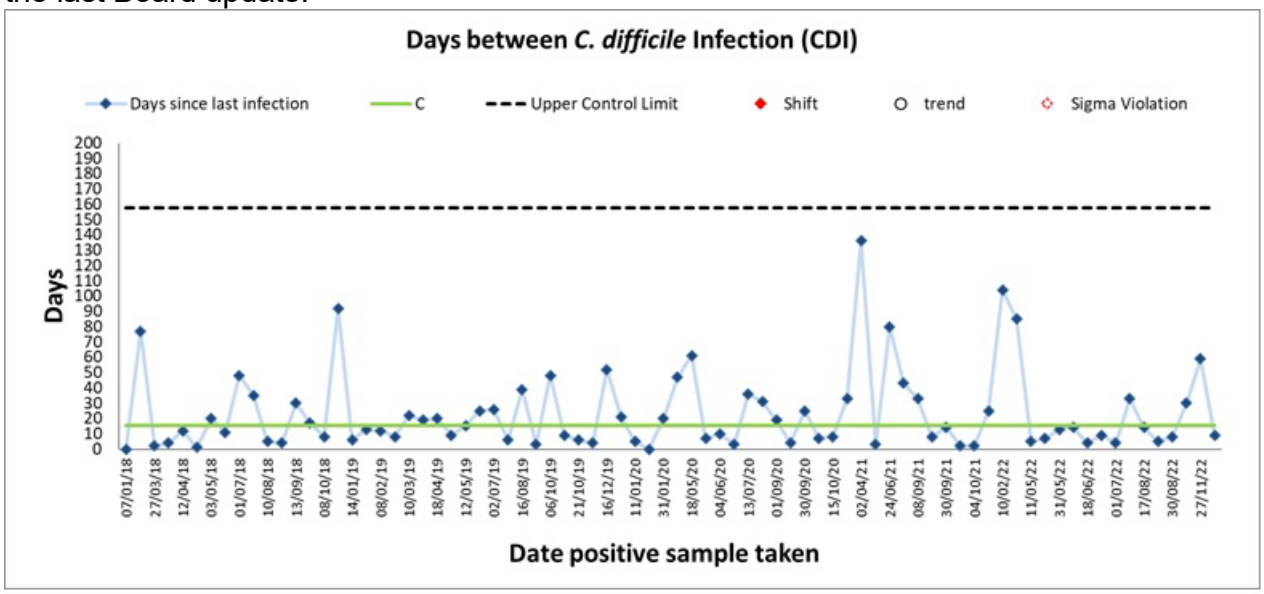


Figure 4: NHS Borders days between CDI cases (January 2018 – December 2022)

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 Q3 2022. The graph shows that NHS Borders (BR) had a rate of 15.9 which was above the Scottish average rate of 13.1 but we were not a statistical outlier.

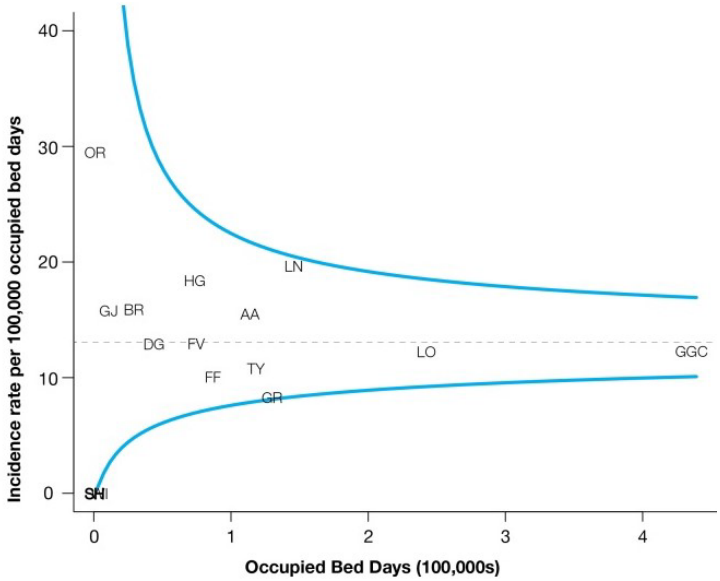


Figure 5: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q3 2022

3.3 Figure 6 below shows a funnel plot of CDI incidence rates (per 100,000 population) of community associated infection cases for all NHS Boards in Scotland in Q3 2022. The graph shows that NHS Borders (BR) had a rate of 3.4 which was below the Scottish average rate of 5.9.

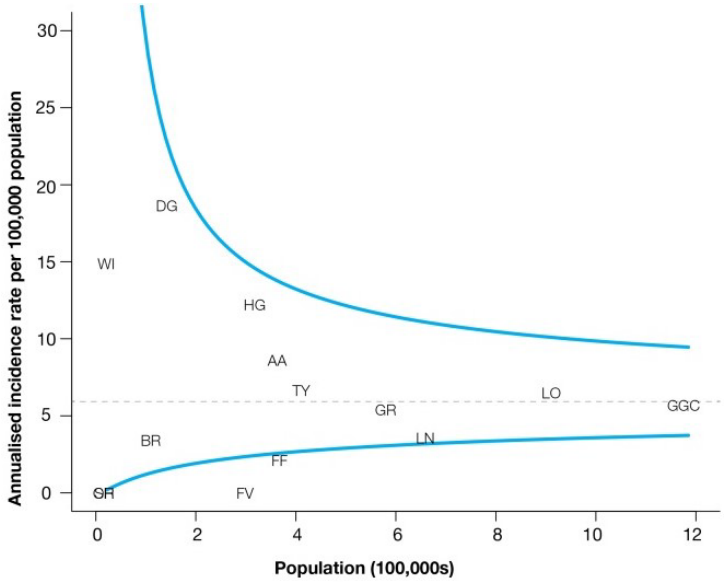


Figure 6: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2022

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.

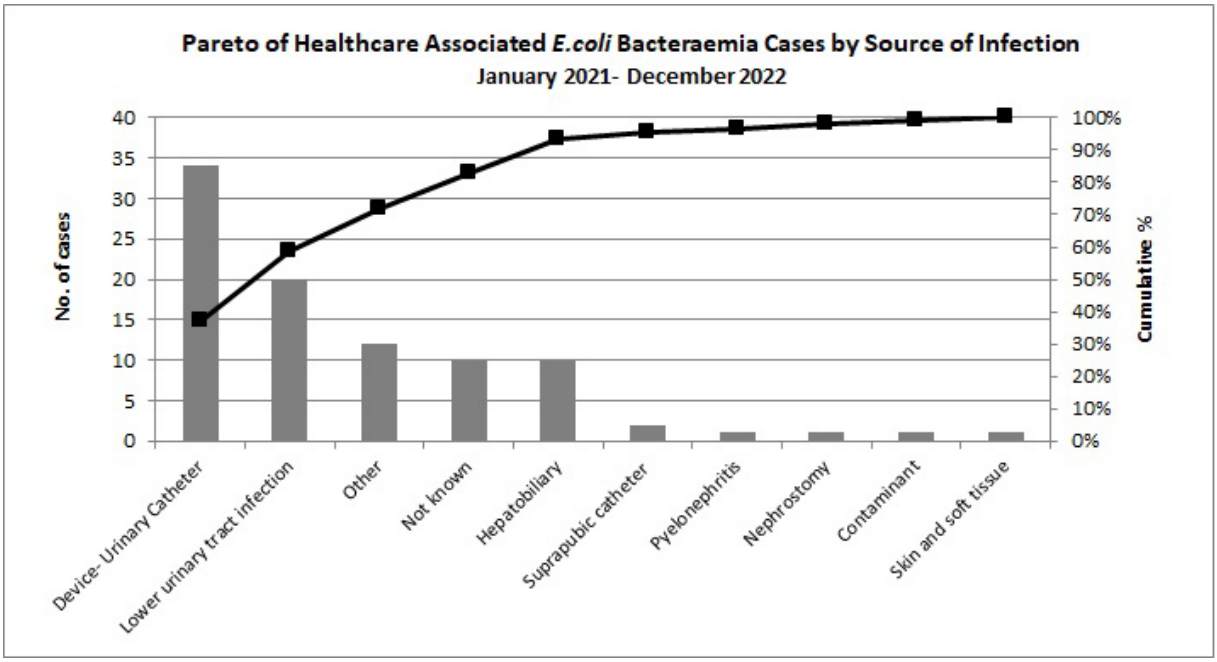


Figure 7: Pareto chart of healthcare associated ECB cases by source of infection

4.2 Figure 8 shows a statistical process chart of the total number of healthcare associated and community acquired *E.coli* bacteraemia (ECB) cases per month. The chart shows that the total number of cases reported per month was within expected limits and there have been no statistically significant events.

4.3 Please note that in contrast to previous statistical process control graphs, Figure 8 is a count of cases per month rather than the number of days between cases.

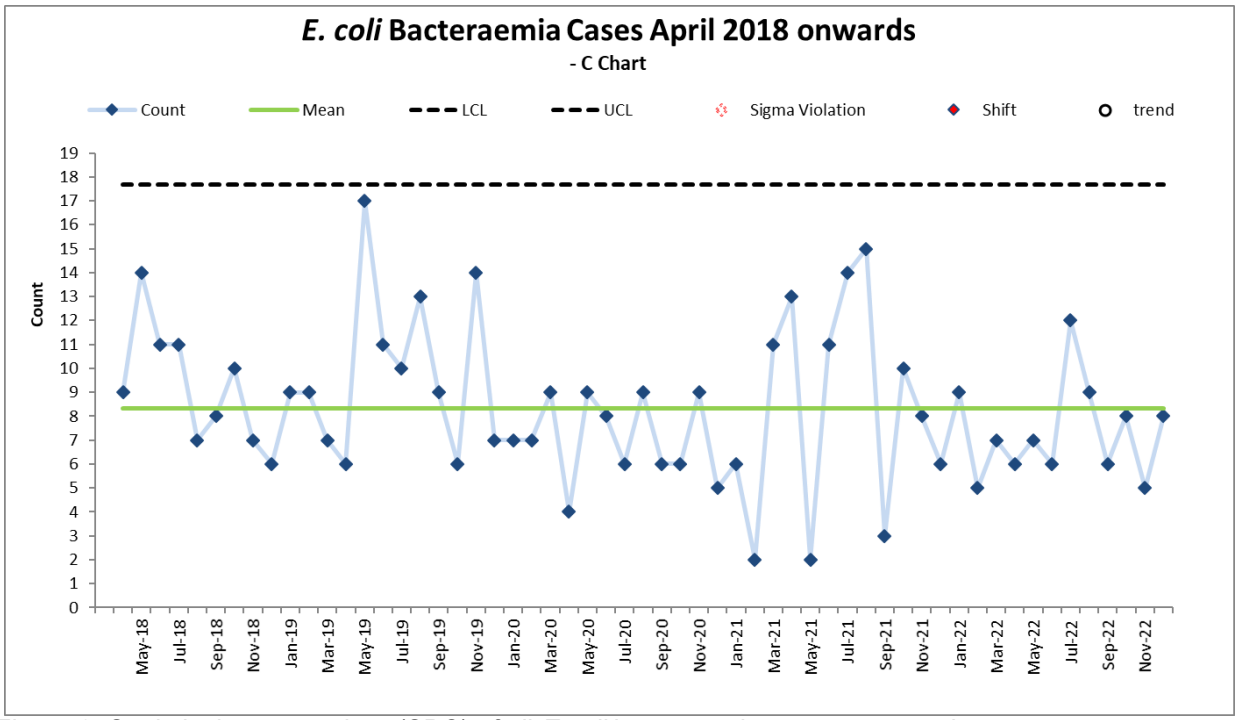
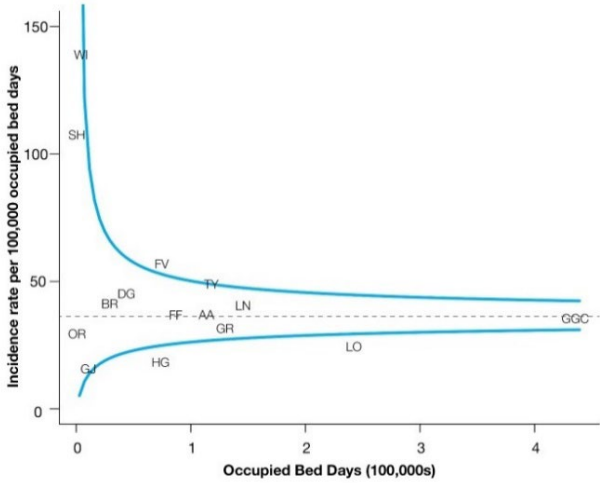


Figure 8: Statistical process chart (SPC) of all *E.coli* bacteraemia cases per month

4.3 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 9 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2022. NHS Borders

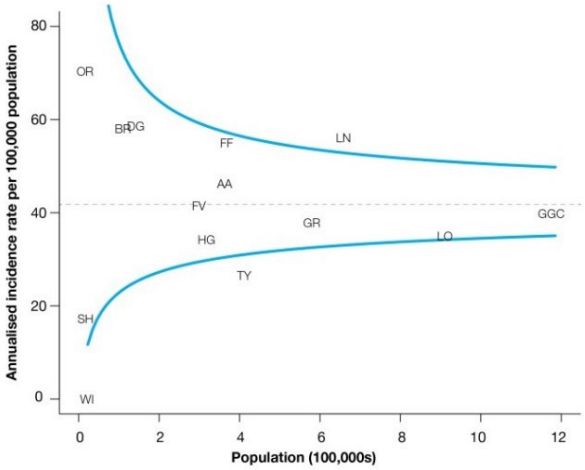
(BR) had a rate of 41.3 for healthcare associated infection cases which was above the Scottish average rate of 36.2 but we are not a statistical outlier.

4.4 Figure 10 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 2022. NHS Borders (BR) had a rate of 58.1 for community associated infection cases which was above the Scottish average rate of 41.8 but we are not a statistical outlier. It is worth noting that community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 9: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2022



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & NRS mid-year population estimates.
2. NHS Borders and NHS Dumfries and Galloway overlap.

Figure 10: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 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 was paused from this date.

6.0 Hand Hygiene

6.1 In February 2023, representatives from our hand gel supplier Gojo visited BGH and completed hand hygiene audits in nine clinical areas. Overall compliance was 51%. Figure 11 shows compliance by staff group.

	February 2023
Nursing	52%
Medical	50%
AHP	78%
Ancillary / Other	28%
All Staff Groups	**51%**

Figure 11: October 2022 - hand hygiene compliance by staff group

6.2 There continues to be over use of gloves which can lead to missed opportunities for hand hygiene.

6.3 As Figure 11 shows, compliance was poor across all staff groups. However the worst performing staff group was Ancillary/ Other. The dominant staff group within this category is General Services.

6.4 General Service supervisors hold meetings with all staff at shift handover times in the morning at 7:30am and in the afternoon at 5pm. An Infection Prevention and Control Nurse has attended these meetings week commencing to provide a focus on the importance of safe practice in relation to hand hygiene and glove usage including a practical demonstration.

6.5 In partnership with Senior Change Nurses, the Infection Prevention and Control Nurses (IPCNs) have started testing a new approach in two wards to support a shift in practice. The IPCNs spend time on the wards and deliver very short (10 minute) focussed education on safe hand hygiene practice and correct glove use. The conversations are informal and have resulted in good engagement - providing staff with the opportunity to ask questions and explore scenarios. As part of the education, there is a high impact demonstration with the IPCN using glow gel on gloves to demonstrate how easily organisms can be spread as a result of poor glove practice. UV light is used to highlight surfaces (including people) that have become contaminated as illustrated in the photograph below.

6.6 The Infection Prevention and Control Team has developed a new poster which has been displayed in clinical areas across NHS Borders. A couple of short videos about appropriate glove use have also been shared across the organisation (see images below).

6.7 The Director of Nursing, Midwifery and AHPs is convening a meeting with senior managers about ownership of hand hygiene compliance at ward level.

6.8 Plans are in place to conduct further audits of compliance in March 2023.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 In December 2022 and January 2023, spot checks were undertaken in a total of 16 clinical areas across NHS Borders with an average compliance of 90.9%.

8.0 Cleaning and the Healthcare Environment

For supplementary information see Appendix A.

8.1 Health Facilities Scotland (HFS) publishes quarterly reports on cleanliness standards and estates fabric across NHS Scotland. The most recently published report covers the period October – December 2022. Figure 12 below shows NHS Borders cleaning compliance against the NHS Scotland average by quarter. In the period October to December 2022, the cleanliness score for NHS Borders was 95.8%. In the same period, the estates score was 97.2%

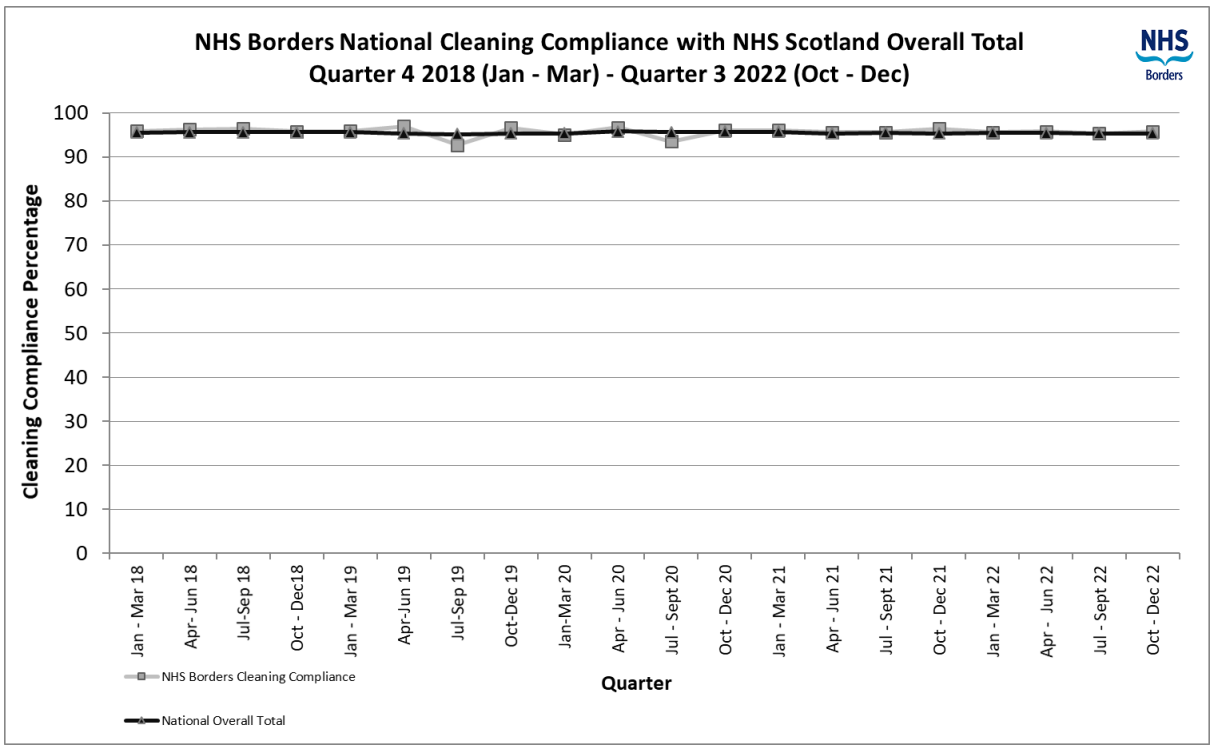


Figure 12: NHS Borders cleaning compliance against the NHS Scotland average by quarter

9.0 2022/23 Infection Control Work Plan

9.1 The Infection Prevention and Control Team provide both a reactive and proactive service. Responding to significant unexpected events or peaks of clinical activity such as outbreak management requires flexing resources away from proactive to reactive activities impacting on Work Plan progress.

9.2 At the time of writing this report (February 2023) there were 7 overdue actions in the 2022/23 Infection Control Work Plan, all of which were assessed as low risk. However, a significant number of additional actions will become overdue by the end of March 2023. Progress and associated risks will be considered at the next meeting of the Infection Control Committee and a further update provided at the next meeting of the Clinical Governance Committee.

10.0 Outbreaks/ Incidents

- **COVID-19**

10.1 Since the last Board meeting, there have been 22 respiratory 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 14th February 2023 is detailed in figure 13. 4 of these incidents occurred in November, 15 in December and 4 in January and all incidents were caused by clusters of COVID-19 except for 1 which was RSV. Any learning from each incident is captured and acted upon in real time where appropriate.

Area affected	Total positive patients	Total positive staff	Total deaths
Ward 12	24	9	X
DME 14	5	0	0
Ward 7	2	0	0
Ward 9	4	0	0
DME14	4	1	X
DME14	7	0	0
MAU	2	0	0
Ward 9	2	0	0
MAU	5	0	0
MAU	2	0	0
Haylodge	7	1	0
Huntlyburn	2	5	0
Ward 9	11	0	0
Ward 17	3	0	0
BSDU	2	5	0
MAU, Ward 4 & Ward 7	15	1	X
BSU	3	0	0
DME14	4	0	0
Ward 7	3	0	0
Ward 4	5	2	0
BSU	2	0	0
Ward 4	10	0	0

Figure 13: Summary of COVID-19 clusters

10.2 ARHAI Scotland produces data on COVID-19 cases by hospital onset status using national definitions (Appendix B). NHS Borders data for week ending 27th November 2022 to week ending 22nd January 2023 is displayed in Figure 14 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 27 Nov 2022 to week-ending 22 Jan 2023, was 117.

	% of total	n =
Non-Hospital onset	7.7%	9
Indeterminate Hospital onset	24.8%	29
Probable Hospital onset	17.1%	20
Definite Hospital onset	50.4%	59
Grand Total	100.0%	117

Figure 14: ARHAI Scotland: NHS Borders COVID-19 cases by hospital onset status

- **Norovirus**

10.3 Since the last Clinical Governance Committee meeting there were 11 Norovirus related incidents between 29th December 2022 and 30th January 2023. A summary of each incident is shown in Figure 15 below. Any learning from each incident is captured and acted upon in real time where appropriate.

Area(s) affected	Number of patients affected*	Number of staff affected
Hawick (Ward closure)	12	4
Ward 4 (Bays 2 & 3)	16	1
DME 12 (Ward closure)	14	6
DME 14 (Bay 1)	2	4
Ward 7 (Bay 2)	1	0
BSU (Ward closure)	3	3
Kelso (Ward closure)	4	3
DME 12 (Bay 1 & 3)	4	0
DME 14 (Ward closure)	6	1
Kelso (Bay 4)	4	2
MAU (Bay 4)	1	0

*Incidents are only reported if at least 1 Norovirus positive result has been received. Symptomatic, unconfirmed cases are included in the totals following confirmation of norovirus.

Figure 15: Norovirus incident summary

- ***Pseudomonas aeruginosa***

10.4 In December 2022, *Pseudomonas aeruginosa* (Pa) was isolated from two patients who were receiving treatment in ITU. One of the patients was colonised and one was treated for Pa infection. There was no evidence of cross-transmission between patients and this number of isolates was not statistically significant for NHS Borders. On the 15th of January 2023, Estates notified the IPCT that Pa had also been isolated from a water testing sample obtained from a clinical hand wash basin in the ward. Immediate action was taken to isolate the water source and a point of use filter was then installed to mitigate the identified risk. Samples were not stored so we are unable to confirm if the patients were linked to the water source.

11.0 Infection Prevention and Control Team Capacity

11.1 Following successful interview, a trainee Infection Prevention and Control Nurse will join NHS Borders on 20th March 2023.

11.2 The Infection Prevention and Control Team have concluded a service review which was presented to the Board Executive Team on the 20th September 2022. The proposed recurring funding will be presented to the Operational Planning Group for consideration.

12.0 Quality Improvement Update

12.1 A combination of prioritising outbreak management, focus on hand hygiene improvement activity and unplanned leave within the Infection Prevention and Control Team have impacted on progress of improvement activity relating to infection screening and PVC practice.

12.2 The Prevention of CAUTI Group continues to meet every 6 weeks to drive the action plan forward. At the March 2023 meeting, the following will be discussed: -

- Evaluation of catheter education that was provided to 57 care home staff in the Scottish Borders.
- Reviewing a fact sheet that has been developed about securing catheters and guide for care staff on Indwelling Urinary Catheter Maintenance.
- Reviewing themes from BECS activity data of phone calls and house visits relating to urinary catheters.
- Availability of bladder scanners in the community

Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of 'Report Cards' that provide information, for each acute hospital and key community hospitals in the Board, on the number of cases of *Staphylococcus aureus* blood stream infections *(*also broken down into MSSA and MRSA) and *Clostridium difficile* infections, as well as cleaning compliance. In addition, there is a single report card which covers all community hospitals [which do not have individual cards], and a report which covers infections identified as having been contracted from out with hospital. The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers
Clostridium difficile infections *(CDI)* and *Staphylococcus aureus* bacteraemia *(SAB)* cases are presented for each hospital, broken down by month. *Staphylococcus aureus* bacteraemia (SAB) cases are further broken down into Meticillin Sensitive *Staphylococcus aureus* (MSSA) and Meticillin Resistant *Staphylococcus aureus* (MRSA).

For each hospital the total number of cases for each month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the "out of hospital" report card.

Targets
There are national targets associated with reductions in *E.coli* bacteraemia, *C.diff* and SABs. More information on these can be found on the UKHSA website:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1081256/mandatory-healthcare-associated-infection-surveillance-data-quality-statement-FY2019-to-FY2020.pdf

Understanding the Report Cards – Cleaning Compliance
Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning and estates compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website:
http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Understanding the Report Cards – *'Out of Hospital Infections'*
Clostridium difficile infections and *Staphylococcus aureus (*including MRSA*)* bacteraemia cases are associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries and care homes. The final Report Card report in this section covers '*Out of Hospital Infections*' and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital.

NHS BORDERS BOARD REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
MRSA	0	0	0	0	0	0	0	0	1	0	0
MSSA	7	5	2	1	4	3	1	1	4	2	3
Total SABS	7	5	2	1	4	3	1	1	5	2	3

Clostridioides difficile infection monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Ages 15-64	0	0	0	0	0	1	0	0	0	0	0
Ages 65 plus	0	0	4	3	1	3	1	0	1	0	0
Ages 15 plus	0	0	4	3	1	4	1	0	1	1	0

Cleaning Compliance (%)

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Board Total	93.8	96.4	94.2	96.2	95.5	93.5	95.06	95.58	95.59	95.81	96.7

Estates Monitoring Compliance (%)

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Board Total	98.0	98.4	98.6	98.6	97.4	97.3	97.6	97.27	97.05	96.85	96.3

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
MRSA	0	0	0	0	0	0	0	0	1	0	0
MSSA	2	1	0	1	1	0	0	0	2	1	1
Total SABS	2	1	0	1	1	0	0	0	3	1	1

Clostridioides difficile infection monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	2	2	0	1	1	0	0	0	0
Ages 15 plus	0	0	2	2	0	1	1	0	0	0	0

Cleaning Compliance (%)

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
BGH Total	95.8	96.4	96.0	95.6	95.5	95.6	95.1	95.5	95.5	95.8	95.9

Estates Monitoring Compliance (%)

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
BGH Total	98.4	98.4	97.4	96.7	97.5	97.3	96.8	97.2	97.0	96.3	97.4

NHS COMMUNITY HOSPITALS REPORT CARD

The community hospitals covered in this report card include:

- **Haylodge Community Hospital**
- **Hawick Community Hospital**
- **Kelso Community Hospital**
- **Knoll Community Hospital**

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	0	0	0
Total SABS	0	0	0	0	0	0	0	0	0	0	0

Clostridioides difficile infection monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Ages 15-64	0	0	0	0	0	0	0	0	0	0	0
Ages 65 plus	0	0	0	0	0	0	0	0	0	0	0
Ages 15 plus	0	0	0	0	0	0	0	0	0	0	0

NHS OUT OF HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	5	4	2	0	3	3	1	1	2	1	2
Total SABS	5	4	2	0	3	3	1	1	2	1	2

Clostridioides difficile infection monthly case numbers

	Mar 2022	Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023
Ages 15-64	0	0	0	0	0	1	0	0	0	0	0
Ages 65 plus	0	0	1	1	1	2	0	0	1	1	0
Ages 15 plus	0	0	1	1	1	3	0	0	1	1	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

Clostridioides difficile infection (CDI)

Clostridioides difficile is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be found at:

http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx

NHS Boards carry out surveillance of *Clostridioides difficile* infections (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for *Clostridioides difficile* infections can be found at:

https://www.hps.scot.nhs.uk/a-to-z-of-topics/clostridioides-difficile-infection/#data

Escherichia coli bacteraemia (ECB)

Escherichia coli (*E. coli*) is a bacterium that forms part of the normal gut flora that helps human digestion. Although most types of *E. coli* live harmlessly in your gut, some types can make you unwell. When it gets into your blood stream, *E. coli* can cause a bacteraemia. Further information is available here:

https://www.gov.uk/government/collections/escherichia-coli-e-coli-guidance-data-and-analysis

NHS Borders participate in the HPS mandatory surveillance programme for ECB. This surveillance supports local and national improvement strategies to reduce these infections and improve the outcomes for those affected. Further information on the surveillance programme can be found here: https://www.hps.scot.nhs.uk/a-to-z-of-topics/escherichia-coli-bacteraemia-surveillance/

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections.

Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be found at:

http://www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by Healthcare Improvement Scotland. More details can be found at:

https://www.healthcareimprovementscotland.org/our_work/inspecting_and_regulating_care/nhs_hospitals_and_services.aspx

APPENDIX B

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

APPENDIX C

National Infection Prevention and Control Manual, A-Z of pathogens: *Streptococcus pneumoniae* https://www.nipcm.hps.scot.nhs.uk/a-z-pathogens/#s (Accessed 13/01/2023)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
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 8 December 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 28.10.22

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting held on Friday 28th October 2022, 13:00-13:25
via Microsoft Teams

Present:	Councillor David Parker, Non-Executive Director (Chair) Mr Andy Carter, Director of HR, OD, OH&S Mr John McLaren, Employee Director Mrs Ailsa Paterson, Assistant Director of Workforce Mr Bob Salmond, Assistant Director of Workforce Ms Claire Smith, HR Team Manager Ms Edwina Cameron, Employee Involvement and OD Lead Mrs Vikki MacPherson, Partnership Lead / Staff Side Chair Ms Karen Lawrie, Partnership Forum Member Ms Marcella Malley, Personal Assistant (Minutes)
Apologies:	Mrs Karen Hamilton, Chair Mr Ralph Roberts, Chief Executive Ms Harriet Campbell, Non-Executive Director Ms Sonya Lam, Non-Executive Director Mrs Jennifer Boyle, HR Manager / Business Partner

1. Welcome, Introduction and Apologies

All committee members present at the meeting were welcomed and apologies were noted.

It was agreed that the meeting was not quorate, however DP and AC decided to progress with the meeting and any agreements made would be reflected in the minutes of the meeting.

2. To Agree Minutes of Previous Meeting

The minutes of the previous meeting, held on Thursday 22nd September 2022, were approved without amendment.

3. Workforce Plan

AC noted that there is an opportunity to consider 2 workforce plans, comprising both the HCSP integrated plan and the NHS Borders component; these have been approved following feedback from partners. AC also stated his apologies for the late circulation of the Integrated Workforce Plan documents to members, however this was due to the fact that the plan needed to be approved via multiple meetings with shareholders. The plan has been presented and approved at APF, Joint Executive meetings and BET; feedback has been collated and acted upon. The help given from SBC colleagues, NHS Borders management and Staff Side was commended.

A presentation regarding the Integrated Workforce Plan was shared with the group. This plan integrates work with both NHS Borders and SBC, with HCSP overlapping both. AC highlighted that this plan is a live, iterative document that can be updated when necessary; it is to be in place for 3 years, although it was noted that it may be difficult to project ahead. 1

single co-produced draft plan had been submitted to the Scottish Government for approval by the end of July of this year, with the SG commenting at the end of September that they were impressed with the integrated nature of the plan; they were supportive of the fact that this had been the first co-produced plan between NHS Borders, SBC and independent and third sectors. The HCSP plan is community based, with the NHS plan being based on a 6-step methodology that has been used for over 10 years. The deadline for publication of the integrated workforce plan is 31st October; the plan is to be published on the SBC and NHS Borders websites, however this will be published as a final consultative draft on the NHS Borders website with a further month available for any additional comments on this. It was suggested that this plan should also be discussed at the next Staff Governance Committee.

AC noted the 5-pillar action plan of plan, attract, nurture, employ and train in relation to the delivery of the workforce plans. Through this action plan, it was suggested that short, medium and longer-term issues and strategies should be addressed. The uniqueness of the Scottish Borders as an area should be highlighted in order to attract staff, with the issue of social housing for key workers also being looked into. Integrated Training & Development solutions are also to be developed, as well as the focus on the health and wellbeing of staff.

AC noted that the current 2 plans appear to be the right approach for this moment in time, however there are aspirations to simply have 1 plan and document in place in the future. It was also stated that this is the first time that the SG have requested a 3-year NHS plan. Further opportunities for integrated working will be made available once timescales have been aligned, with the implementation of the 5-pillar action plan ensuring that priorities should be achieved.

CS noted the positive nature of the relationships and actions developed and taken forward in the past 6 months as a result of the creation of the plan. She also noted that close synergies exist between both documents, with an easier route therefore made available to merge them into 1 plan with naturally joint actions going forward. BS stated that service reviews would be ongoing and noted that action plans would ensure accountability. He also stated that despite the plan covering 3 years, there would be annual reviews of this and would therefore need to be a persistent agenda item at both the APF and Staff Governance Committee. JMc reinforced the importance of both partnership working and the issue of housing availability for workers, whilst praising the plan as a helpful piece of work that has generated much engagement and discussion. DP also commended the plan as being a comprehensive and sound document and congratulated all involved. KL noted the importance of nurture and staff wellbeing within the 5-pillar plan.

AC stated that all parties will prioritise the same ideas of having safe and sustainable services for the local population, attracting more employees to the workforce, making sure services are as connected as possible and generally “getting it right” for local residents. Despite this meeting not being wholly quorate, AC suggested that all present seemed to agree that the plan should be signed off and approved, with the plan also being a feature of the next meeting.

4. Any Other Competent Business

No further competent business was raised.
The Chair thanked all present for attending and closed the meeting.

Date of Next Meeting: Thursday 8th December 2022, 13:00pm via Microsoft Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
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 1 February 2023

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 10.11.22

PUBLIC GOVERNANCE COMMITTEE

Minutes of Public Governance Committee (PGC)
Meeting held on Thursday 10th November 2022 9.30-11.30
via MS Teams

Present: Tris Taylor, Non Executive Director (Chair)
Lucy O'Leary, Non Executive Director
Margaret Simpson, Ability Borders
Graham Hayward, Vice Chair, Public Involvement Partnership Group
Lynn Gallacher, Borders Carers

In Attendance:
June Smyth, Director of Planning & Performance
Sohail Bhatti, Director of Public Health
Clare Oliver, Head of Communications and Engagement
Laura Jones, Head of Clinical Governance
Carol Graham, Public Involvement Officer
Philip Grieve, MH Service Manager
Cathy Wilson, General Manager for P&CS
Fiona Doig, Head of Health Improvement/Strategic Lead – ADP
Kirk Lakie, Hospital Manager Planned Care
Sharon Bleakley, Health Improvement Scotland
Lainey Thomas, Communications Officer
Marion Phillips, Committee Administrator

1. Welcome & Introductions

Tris Taylor welcomed everyone to the meeting and introduced Sohail Bhatti, Director of Public Health

The meeting was recorded for purpose of minutes

2. Apologies & Announcements

Apologies had been received from: Cllr David Parker, Nicky Hall, Chris Lau

The Chair thanked the Committee for their attendance

The Chair advised that the meeting will be quorate

3. Minutes of Previous Meeting:

The minutes from meeting held on 11th August 2022 were approved with one amendment as accurate.

4. Matters Arising and Action Tracker

Adult Changing Facility:
J Smyth updated the Committee that this is still on priority list for capital projects, working through the reprioritisation of what can be delivered before end of this financial year and what may have to be phased into next year. The really urgent capital projects are being completed and should be able to progress on this although it will likely be an interim solution rather than long term permanent one. An update will be brought back in due course.

G Hayward noted that the national website is only listing the facility in Galashiels and if this is incorrect then it needs to be updated. M Simpson to send G Hayward the list of facilities throughout the Borders

J Smyth to check if there are plans to include a changing facility in the new Community Development as part of the Primary School replacement in Earlston, and which will incorporate a replacement Health Centre.

Health Inequalities. This action related to an enhanced programme of health inequalities that was being introduced during second year of Covid. The Board did support this should be a priority but due to capacity issues within existing teams it was unable to progress. It was proposed to hold this until Director of Public Health, Sohail Bhatti came into post and to remove this action. L Gallacher asked if there is a strategic inequalities Board set up that she would like to be involved on behalf of the carers

New Action – S Bhatti to provide assurance that the Committee is mitigating the strategic risk around health inequalities

Care Village:
Letter sent to Chris Myers, Chief Officer, on 11th August and response received, which included an invitation for a representative of the PGC to attend the IJB Audit Committee. The Committee discussed this and agreed to accept the invitation and agreed to the Chair of the PGC acting as the Committee's representative and to feedback on relevant discussions.

F Doig made the Committee aware that there is an Equality & Human Rights Foundation Group which is reference group for the H&SC Partnership for the Board. It looks at the approach to equality impact assessment which links across Health and Equality. The group is meeting for the first time this month and Fiona will be attending.

L Gallacher noted concerns that the model of the care village keeps changing and concerns that this is reprovision of services and not knowing how much more care is going to be provided while other services are being closed. M Simpson commented that Ability Borders do have the same concerns

The Public Governance Committee noted the action tracker.

5. Public Governance Business Items

5.1 Chairs Update

The Chair reported that it had been reported to the Board that the number of patient complaints has increased and the capacity to process them has stayed the same, this means there is a backlog which is impacting on the patient experience team's ability to respond within the time stated. L Jones has been asked to bring a paper back to PGC to be

able to understand the scope of the problem and how the organisation proposes to recover or change the terms around processing and complaints.

The Committee noted the update

5.2 Public Involvement and Engagement Update

C Oliver reported that along with Carol Graham had attended the Borders Care Voice AGM last month. This was useful to meet and get to listen to people with lived experience. The team are looking forward to attending and getting more involved with other similar organisations.

The new evaluation template was used to provide information on the Merse Medical Practice and closure of the Chirnside surgery. It provides an indication of the engagement and involvement that has been undertaken. This is ongoing and there are public meetings arranged these have moved from not announcing a closure, looking at viable options but further information from the partners meant there were no viable options so there was a change of position. Clare noted thanks to Sharon Bleakley for her advice to ensure process were being followed. The team are now focusing on engagement with the Community to look at mitigations and any potential solutions in particular to the access issue that patients previously raised earlier in the year.

Reports from the end of phase 1 of the IJB Strategic Plan for 2023/26 were attached for the Committee to look at.

A joint strategic needs assessment was also attached that has been presented at a number of meetings with good feedback about the engagement exercise undertaken. The next phase of engagement is in the planning process which will be around the draft plan and will be working with the National Development team for inclusion.

A full update will be brought to the next PGC meeting regarding the Public Involvement Pillar and how it moves forward, and this will include new input from S Bhatti in his role as Director of Public Health. Sohail added that as well as being respectful and listening to people that sometimes we have to challenge back and say we do not agree with you. There will need to be work carried out around self-care, self-management and people maintaining themselves to be as healthy as possible, we do not have infinite responses and need to have realistic dialogue with them.

T Taylor commented that the NDTI report on the joint engagement with IJB was helpful but would like further clarity about how does the number of responses per locality map onto the population distribution and is the response rate for the engagement similar in terms of percentage of the population. C Oliver replied that this is what they will be focusing on as phase 2 of the engagement.

T Taylor also enquired about the stakeholder engagement groups and what are known about the Jewish people in the Borders, the report mentions ethnic groups but Jewish can fall between ethnicity and religion.

T Taylor also enquired about the new template and although there is a line for outcomes but nothing for impact and it is not clear whether it is included in the outcomes or looking at what standards we need to apply to what goes into the box around outputs to be sure it demonstrates evidence of impact. C Oliver responded that the template is written from a service perspective and looking for the Business Units to give their thoughts but will consider any changes or additions the committee would like to see.

The Committee noted the update

6. Monitoring & Performance Management

6.1 Clinical Board Updates:

Acute:

K Lakie reported that the new templates have been circulated to various programme Boards and so far, have not had them returned. Hoping to have them completed by the next PGC meeting in February and that the quality of the information, that will come forward in future, will better reflect what the Committee is looking for in terms of assurance.

C Oliver added that involving people presentation is to be given at the new clinical management teams that have been established within Acute. This will give them a framework and support them to fill in the template.

Mental Health:

P Grieve had to leave the meeting for an urgent matter. The paper was noted in his absence.

Primary & Community Services:

C Wilson reported to the group the work on GP sustainability and along with Associate Medical Director has completed a tour of all 23 GP practices to understand what is going on within the practices. This helps understand the demographic and pressures the GPs face and understanding what additional support is needed when planning for GP sustainability around infrastructure. This links in with the public and their perceptions and tying it into national reports being done and using this to plan the strategy. The Scottish Government are aware and keen to see how this develops. Duns Medical Group was not sustainable and using urgent emergency procurement powers NHS Borders was able to take over the practice and keep it running, this is taking energy and effort for the P&CS team to coordinate that. Members of the Primary & Community Services leadership team were due to attend a Public meeting in Chirnside later today to answer any questions face to face.

Dental sustainability in both the Public Dental service and the General Dental Service is being looked at. A paper will be taken to the Exec Team and Communications are prepared for patients to make them aware of the situation regarding waiting lists.

Scottish Government has made Boards aware that there will be a shortfall of funding for the PCIP and there will not be enough funds to do full delivery of the programme. Work is underway with the GP Executive and PCIP Executive to review what is actually possible

The CTAC plan will be going to the programme board later this month, focusing on phlebotomy, blood pressures and weight monitoring.

Ukrainian settlers are staying in 2 hotels at present, and some are quite temporary, and P&CS have negotiated with the local GP practices to be able to provide services for the settlers to register them and provide CHI number to allow access to NHS services. Next step is discussion with Public Health about continuing that service.

C Wilson commented that P&CS are working to be able to carry out forward planning to ensure the public are being appraised on situations and kept up to date.

Public Health:

F Doig reported on the engagement work carried out on Mental Health Improvement and Suicide Prevention to develop new action plan. This action plan is on behalf of the multi-agency steering group which reports to the Mental Health Board and the governance goes through the Board on a regular basis. It is the intention to inform the priorities and actions through peoples lived experience, whether that is experiencing mental ill health, bereaved by suicide or being a carer for someone who has. Borders Care Voice provided support to access these people with lived experience. Through ongoing work with LGBT equality group were able to approach this group. It has been a challenge to engage the visible minorities groups of people at risk in this work.

HIS Community Engagement:

S Bleakley reported that the big focus at present is working out what they will be able to do moving forward with regard to funding restrictions and capacity restrictions. HIS will work with Boards to find out what assistance they need and want. Sharon noted the close working relationship that has developed with Clare, Carol and June which has allowed honest conversations about what might be wanted or needed with regards to support. The focus for HIS is what we are going to do in the future, how we are going to do it and who with.

The Committee noted the all the updates

6.2. RISK

L Jones offered apologies from Lettie Pringle and reported that a regular refresh exercise has been carried out to make sure the strategic risks are identified and appropriately positioned in the organisation. There has been a bit of refinement of some of the risks to ensure they are up to date for the year ahead

.

Laura highlighted there are 2 key risks with a critical role in relation to the PGC, which is the one relating to reducing harm from inequalities and the failure of the Board to effectively engage patients, public and third sector in decision making. The PGC will receive a report in February detailing some of the risks that other committees take more of an ownership role around but where there is a very direct need for accountability to this committee. That will touch on the 5 key risks across the organisation and can bring insight into any of the other risks that are on the fuller Risk Register.

T Taylor commented that the PGC needs to be clear there is a system of control which can monitor whether assurance can be taken on the activity against the risk. Having a framework that the Clinical Boards have agreed is now beginning to address how to capture assurance information on the engagement side and that has been developed and the latest iteration is strong step forward on that, however as suggestion can the reporting framework include some of the inequalities information that could be captured to save the need for an evidence capture system. S Bhatti responded that there is a health inequality impact tool that is in the reporting framework and should make use of what we already have.

The Committee agreed they were assured on the engagement and not assured of inequality which was the same agreement as previously.

7. Teviot Day Service Judicial Review

T Taylor reported that there was a judicial review held on 20th September into SBC decision to close Teviot Day Service and there are lessons learned that could be used to mitigate the risk of something similar happening to NHS Borders.

The judgement considered the closure process in inequalities law. The equalities impact assessment was discussed and how the document was presented, and the competency and sufficiency was found to be not good enough to stand in evidence.

The consultation needs to have certain characteristics and be carried out with an open mind and not prejudge the outcome. It has to include evidence of people who are actually affected by the service.

Lady Carmichael stated that evidence of this work needs to be sufficiently broad and sufficiently deep. It needs to show that all relevant groups have been considered and that groups have people with protected characteristics. It needs to show that prior research has been considered and that evidence from current service users has been solicited and considered.

Need to consider the evidence of impact, what is nature of impact and did it change the delivery model or evaluation model. Need to be clear about the beginnings and the scope of the impact, did it have a minor, moderate or major impact.

Also, crucial to think about how to file that evidence for future use, can it maintain the connection to the actual activity and ensure the dates are correct when it was created and updated etc.

Within the remit of Public Governance Committee, we need to look at how we approach taking assurance that there is sufficient evidence and framing questions to make sure the standards of evidence are being met. Have all the relevant groups been considered, have we looked at research and talked to the actual people affected. Can we evidence that a change has been made as a result and can we evidence the scope of the impact?

L Jones suggested sharing the slides with the Clinical Boards and asking them to consider this as an item on their next meetings as a duty that we have across the organisation. C Oliver commented that if the slides were combined with presentation recently given to Change Team it would be helpful and create a standard operating procedure for people to use.

The Committee noted the update

8. Any Other Business

No other business was raised

9. Proposed Next Meeting Dates – all via MS Teams

Calendar invites will be sent out for the following dates: Wednesday 1st February 10-12, Thursday 11th May 10-12, Thursday 10th August 10-12, Thursday 9th November 10-12 Teams

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Area Clinical Forum Minutes**
Responsible Executive/Non-Executive:	**Kevin Buchan, Non Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Area Clinical Forum 24 January 2023

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Area Clinical Forum minutes 29.11.22

NHS Borders - Area Clinical Forum

MINUTE of meeting held on

Tuesday 29 November 13:00 – 14:00
Via Microsoft Teams

Present: Dr Kevin Buchan, Chair
Gerhard Laker
Martin O'Dwyer
Fiona Sandford
Alison Wilson
Paul Williams
Alison Wilson
Suzie Flower
Iris Bishop
Rachel Mollart
Nicky Hall

Lesley Shillinglaw – Minutes/Action Tracker

In attendance: Lynne Boyle, Keith Allan

1. APOLOGIES and ANNOUNCEMENTS

Welcome to Fiona Sanford joining as Non-Exec for ACF and Gerhard Laker and Martin O'Dwyer

2. Draft Minute of ACF 04.10.22

Agreed as a correct record

3. Matters Arising, Action Tracker and work plan

Action Tracker – updated.

4 Election of Vice-Chair of ACF

Paul Williams elected as Vice Chair of ACF

5. Safe Staffing:

The undernoted points were noted:

- Legislation through parliament in 2019.
- Long pause during Covid.
- Nationally work been going on since teams resumed.
- Health Improvement Scotland will be overseeing safe staffing and Health Care Staffing Programme as part of HIS.
- Humza Usaf announced in June timeline for legislation being implemented. Will be required to report as Board from April 2024.
- Workload tools and self assessment templates and real time staffing resources. (can send if required). Legislation now applies to all clinical professions, including medical, dental, pharmacy. Currently updating workload tools. Only one is EDEM tool which covers ANPs, Medical staff.

- Real time staffing resources being released – will be on TURAS
- Critical Care Real Time Staffing resource.
- Mental Health/LD real time staffing resource (digitalised)
- Maternity/neonatal
- Adult in patient
- Knowledge and skills framework – for anyone in Board.
- Scottish Government Roadshow – cancelled due to unannounced inspection – to be rescheduled early New Year. Learning to come from the inspection last week.
- There is a duty to seek clinical advice on staffing.
- There is a duty to ensure staff are fully trained.

Any areas with workload tools must use the common staffing method – looking at local context of where providing services/any measures of quality/excellence in care/current funded/staffing/vacancies – prior to submitting paper to Board. Could be changing way people work in some setting,

Reference was made to the self-assessment template which all Programme Board members have and the importance stressed that all clinical professional leads to think about how much readiness for implementation

Following a query it was confirmed that this does not extend into primary care and that quarterly reporting to the Board should flag up any issues and the self-assessment template was available to assist with identifying issues. In response to a question regarding who within SG is looking at early stage of the supply side, e.g. who is giving Universities extra funding to train AHPs and nursing etc, it was noted that Jackie Balcan was involved and also to link in with Catherine Breachan.

In addition it was noted that that AHP Services locally utilise tool around AHP in patient for real time staffing which captured staffing and what type of complexity of case load/unmet need. Pharmacy were looking at populating a template next week across all Pharmacy teams

Further it was noted that there was additional funding for pharmacy technicians – 157 across Scotland – now pulled and only 100 posts – 3 allocated to Borders and there was a hope for additional money for next year from GMS Contract.

Action: Pharmacy possible additional money next year from GMS Contract for Pharmacy Technicians – Kevin/Rachel to flag Nationally

6. Private Care Policy.

Keith Allan presented the paper on the Private Care Policy which was a document originally drafted several years ago by Dr A Mordue. It was noted that this had previously been to the Public Governance/GP Sub and ADTC. Keith indicated that this was essentially how we interact with private care and reference was made to the sets of 7 principles. There followed discussion regarding this and the undernoted points:

- Follow up rehab – clarity of Episode of Care
- Principle 6 – could be perceived as “Queue jumping
- Process is Start/Wait to see/On List/Wait
- Pharmacy – Prescribing – Alison Wilson made reference to a separate prescribing document which went via GP Sub which clarifies some elements.

- Example of hip replacement – if patient going to Washington and need for this to be in a contractual agreement.

QSB were asked to look at this document and submit any further comments or questions views via email to Keith Allan.

Action: Any comments re Private Care Policy document via email to Keith Allan

8. **Clinical Governance Committee – Feedback**

Feedback from the last Clinical Governance Committee was outlined as follows:

- Mortality Review reasonably stable. Significant red flags in system around soft markers of distress within system/Complaints/SAERs
- Duty of Candour Discussion from SG around variation Boards and ability for Boards to admit difficulties.
- Acute described sixth set of never events – staffing/discharge from ITU
- Transitional Care in ward 12 – staffing/what will look like.
- Kaisen Work – in MAU/Ward 4
- As complaints rise, timelines for responses out to patients has stretched. Discussion at Board level – whether can vary around SG guidance.
- Focus over past 2 years on 2 main issues delayed discharges/impact on flow and staffing concerns. Concern about lack of care in community is a huge concern.
- Workforce issue: percentage of working population/elderly

9. **Non-Executive Input to ACF**

Fiona will join for next 6 sessions initially to engage with Board.

10. **National ACF Chairs Meeting**

Next meeting 7 December 2022 – will report in January 2023

11. **Professional Advisory Committees:**

(a) **Area Dental Advisory Committee (ADC)**

- Dentistry is 3 groups – Hospital/Public/General. General provides 90% of treatment in borders.
- BGH – Orthodontics/Oral Surgery. Orthodontist left – Locum in post. Post advertised
- Oral Surgery: 2 part time Oral Surgeons

- Public – struggling to remobilise through recruitment/retention. Lost of a lot of staff during pandemic.

- General Dental Services: Remobilised – same issues with recruitment/retention. Increase in expenses – pay not gone up – follow Scottish Dental Fees/unable to charge extra. Materials/Gas/Electricity all gone up – big problem. Question is if SG don't step in and lots go private, who will see 20,000+ patients.

(b) **Area Medical Committee (AMC) & GP Sub Group**

- Workload up
- Staff Exhausted
- Recovery after Covid
- Holding risk in Primary Care due to knock on effect of covid/difficulty remobilisation/waiting lists/patients unable to be diagnosed
- Nationally practices similar who cannot fulfil any more
- Conference on Friday. Difficult forum
- Note: Mergers – other independent contracts e.g. dentistry/ophthalmoloy patients need to seek alternatives e.g. Chirnside -

(c) **Area Ophthalmic Committee (AOC) – update as undernoted**

- Stroke Pathway
- Ophthalmology Referral Guidance in pipeline

(d) **Area Pharmaceutical Committee (APC)**

- Echoing same concerns – lack of pharmacists/staff recruitment. Across Scotland pressure for independent contractors to do more.

(e) **Allied Health Professionals Advisory Committee (AHP)**

- National Education Workforce Review due to be published soon
- Good innovative work ongoing to address challenges.
- Helpful Keith bringing the NHS Care and Private Treatment – good forum for issues like this.

(f) **BANMAC**

SF: Last BANMAC cancelled. Previous meetings changed scope – focussed on looking at papers/research – did help to boost morale and aid discussion. Next BANMAC start of January 2023 will feed back thereafter

(g) **Medical Scientists**

No update provided

(h) **Psychology**

No update provided

12. **<u>Any Other Competent Business</u>**

- Referrals out of Area e.g. referrals into Eye Centre.

Action: Kevin will liaise and seek clarity from Gareth or GM (Acute)

13. Date of Next Meetings: 24 January 2023 1pm – 2pm via TEAMS

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**NHS Borders Performance Scorecard February 2023**
Responsible Executive/Non-Executive:	**June Smyth Director of Planning & Performance**
Report Authors:	**Katy George, Planning & Performance Officer**

1 Purpose

The purpose of this report is to update the Board on NHS Borders latest performance against the suite of performance measures linked to our Annual Delivery Plan for 2022/23. 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 Delivery Plan / Annual Operational Plan / Remobilisation Plan

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

- Safe
- Effective

2 Report summary

2.1 Situation

The scorecard sets out performance as at end of February 2023. Performance against the targets associated with the Annual Delivery Plan form the main body of the document, and previous AOP/LDP measures being moved into appendices for information purposes.

Performance is noted against the updated waiting times trajectories in place as at 28 February 2023. These have been updated to reflect the reduction in funding from

Scottish Government for 2022/23. A revised Delayed Discharge trajectory has also been agreed and is included within this report.

Due to shortened timescales with developing this scorecard, we have been able to update the following sections with February 2023 data and narrative so these sections remain unchanged from the last scorecard presented to the Board's Resources & Performance Committee in February 2023:

- Waiting Time Performance – Outpatients
- TTG Performance
- CAMHS
- Narrative for Delayed Discharges

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. Measures relating to that plan along with some targets / standards from plans in place pre-covid.

2.3 Assessment

We are still unable to meet trajectory targets for Outpatients, TTG, Emergency Care and Mental Health (CAMHS and Psychological Therapies) however summaries for each of these can be found within the scorecard where available updates have been added. We will also begin to add highlights from the Urgent & Unscheduled Care Programme Board within the Unscheduled Care update from next month onwards.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 2022/23 waiting times trajectories and the 'hot topics' of emergency access standard and delayed discharges.

Following a recent request, Health Protection data is currently being reviewed by Public Health, Planning & Performance and Business Information Services with a view for this to be included in future scorecards.

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 February 2023.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 28 February 2023

Month 11

Contents Page

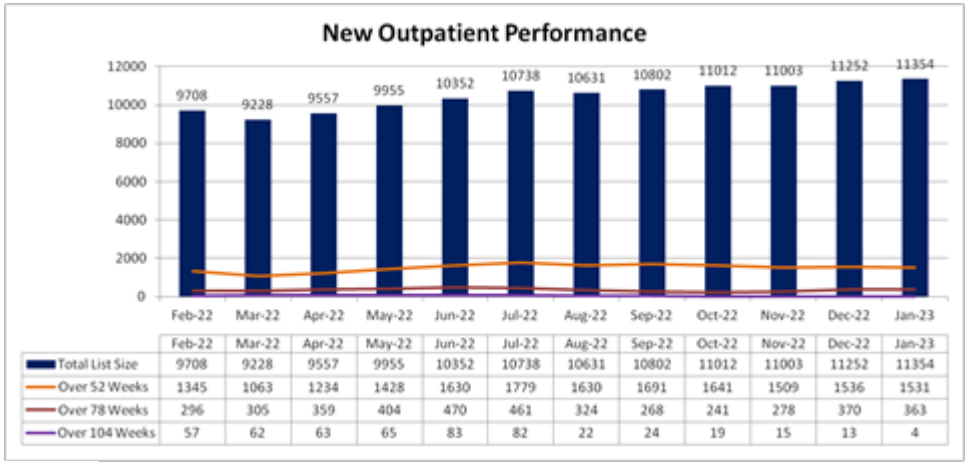
Introduction

As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan aimed at stabilising the system. To supplement this all Boards were required to submit waiting times trajectories but no other formal performance measures were agreed.

This report contains the 2022/23 waiting times performance and hot topic measures and an appendix which demonstrates AOP and Local Delivery Plan (LDP) measures (LDPs were in place as performance agreements between Boards and Scottish Government prior to AOPs and we retain some of the performance standards from those plans). In the current report performance is noted against waiting times trajectories in place as at November 2022. NHS Borders was notified in late 2022 that the amount of waiting times funding allocated to the Board is lower than anticipated; as a result some trajectories have been revised, with performance against these reported in the Board's monthly performance scorecard. A revised Delayed Discharge trajectory has also been developed and similarly, performance against this is reported in the monthly scorecard report to the Board.

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 Total List Size by Weeks Waiting



	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Total List Size	9708	9228	9557	9955	10352	10738	10631	10802	11012	11003	11252	11354
Over 52 Weeks	1345	1063	1234	1428	1630	1779	1630	1691	1641	1509	1536	1531
Over 78 Weeks	296	305	359	404	470	461	324	268	241	278	370	363
Over 104 Weeks	57	62	63	65	83	82	22	24	19	15	13	4

Fig. 1

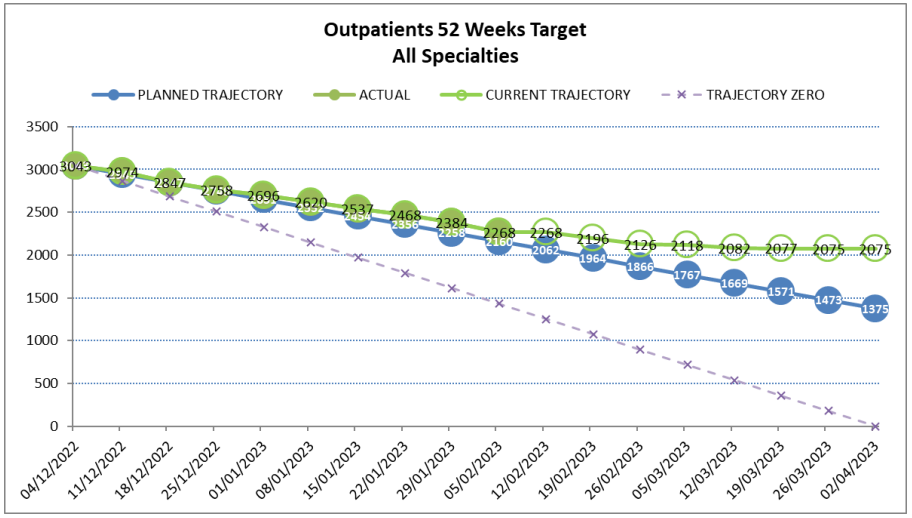


Fig. 2

New Waiting Times Targets **Updated 22.02.2023**

Scottish Government new waiting times targets:

- **No patient waiting over 2 years by end August 2022**
- **No patient waiting over 18 months by end December 2022**
- **No patient waiting over 1 year by March 2023**

The overall OPD list size increased slightly during January (109 patients). As reported last month, overall trend is still heading in the wrong direction.

Performance against 0 patient waiting over 78 weeks (current standard) - as previously reported Ophthalmology and Dermatology are our two high volume specialties challenged in meeting our waiting times standards (accounting for 95%) of all those waiting beyond the current 78-week target. These specialties are also main contributors to us only achieving 70-80% remobilisation. Orthodontics has several waits beyond 78 weeks and this has been due to capacity.

Performance against 0 patient waiting over 52 weeks (by 31st March 2023) - in addition to the specialties struggling to achieve < 78 weeks, cardiology, orthodontics, paediatric surgery, respiratory medicine and urology will require focussed attention over the next two months. Additional capacity has been sourced for some of these specialties. However, given the size of the challenge, particularly dermatology, we predict we will not meet this.

Achievements during December

- **ACRT and Opt-In –** Finalise Trak Process
- **PIR –** configuration of Trak referral source code implementation.
- **Booking Process -** further meeting with Supplier and obtain contract for consideration.
- **Ophthalmology –** induction of new staff into clinic and plan new process for cataract referrals to one waiting list

Plans for January / February

- Clinical validation of > 78 weeks in Urology, Respiratory and Ophthalmology .
- Confirmation of face to face OPD room capacity (slippage)
- Pre-assessment Cataract pathways confirmed and patients appropriately move to correct pathway
- Confirmed OPD capacity plans for specialties
- Explore further options of dermatology capacity
- Recruitment to release two more rooms in OPD
- Advertise Room Booking post
- Explore further improvement to increase number of patients through ophthalmology clinics, ie. patient flow through scans
- Confirmation from IM&T re. Support for Room Booking software integration

TTG Performance Against Trajectory- All Specialties

	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23
Total List Size	2287	2409	2550	2562	2575	2566	2495	2507	2519	2555	2549	2592
Over 78 Weeks	324	336	366	374	411	418	414	376	352	329	323	329
Over 104 Weeks	195	234	231	207	198	192	173	153	145	136	130	131

Fig. 3

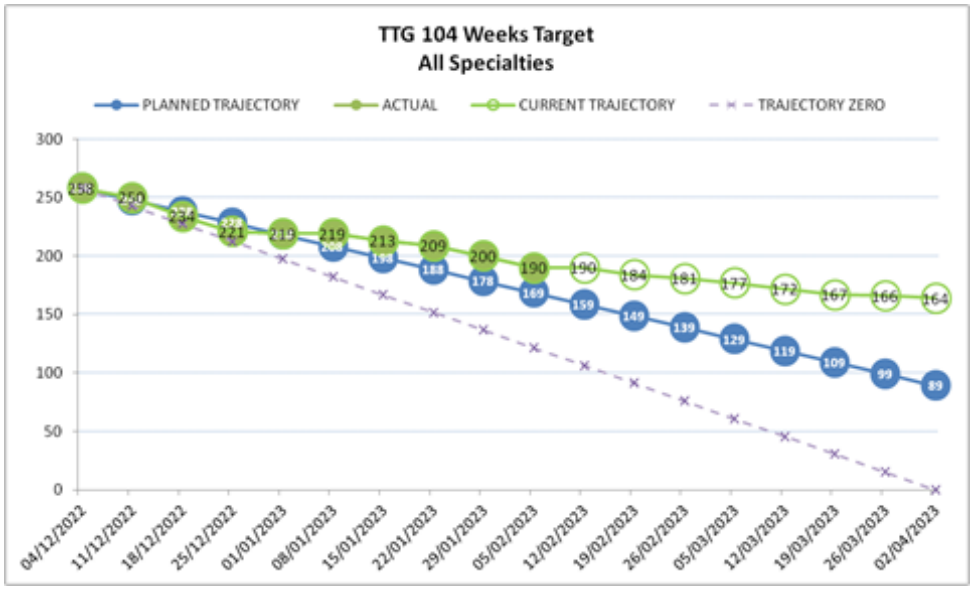


Fig. 4

What is the data telling us?
The waiting list size remains roughly the same as last month with 2592 patients on the waiting list, with the same number of patients waiting over 104 weeks being treated.

It should be noted that the new Scottish Government inpatient/day case surgery TTG targets are:

- **No patient waiting more than 2 years by end September 2022**
- **No patient waiting more than 18 months by September 2023**
- **No patient waiting more than 1 year by September 2024**

Why is this the case & what is being done?

Cancellations in January. The closure of Ward 17 in January as a result of ongoing Ward Staff and Bed Pressures has resulted in the cancellation of a number of elective operations, with priority given to cancer and urgent patients. This has resulted in the cancellation of 52 patients during January, 29 of which were Inpatients and 23 were Day Cases.

104 week TTG Trajectory. The result of the cancellations has meant that the actual trajectory has moved to a more unfavourable position and it is now more challenging to ensure that we can ensure that there are 0 patients waiting over 104 weeks by the end of March 2023 (SG deadline was September 2022). In order to mitigate this risk, the intention is to focus on those specialities that, with some additional focus, can be reduced to 0 over 104 weeks by the end of March; these are General Surgery, Gynaecology, Urology, Oral Surgery & Dental.

TTG Project. A very useful visit was conducted by members of the TTG Project Team to NHS Forth Valley. A variety of ideas will be taken forward in due course, eg moving 'non-GA' procedures out of Main Theatres and into DPU to free up capacity, reconsider our approach and tolerance to 'unacceptable behaviours' within Theatres, consider how we manage patients from Wards to Theatres etc. However, the areas of initial focus will be informed by the results of the 'Appreciative Enquiry' which is nearing completion to ensure that we target those areas of greatest concern to the Theatre Staff.

Updated 21.02.2023

Mental Health Waiting Times CAMHS

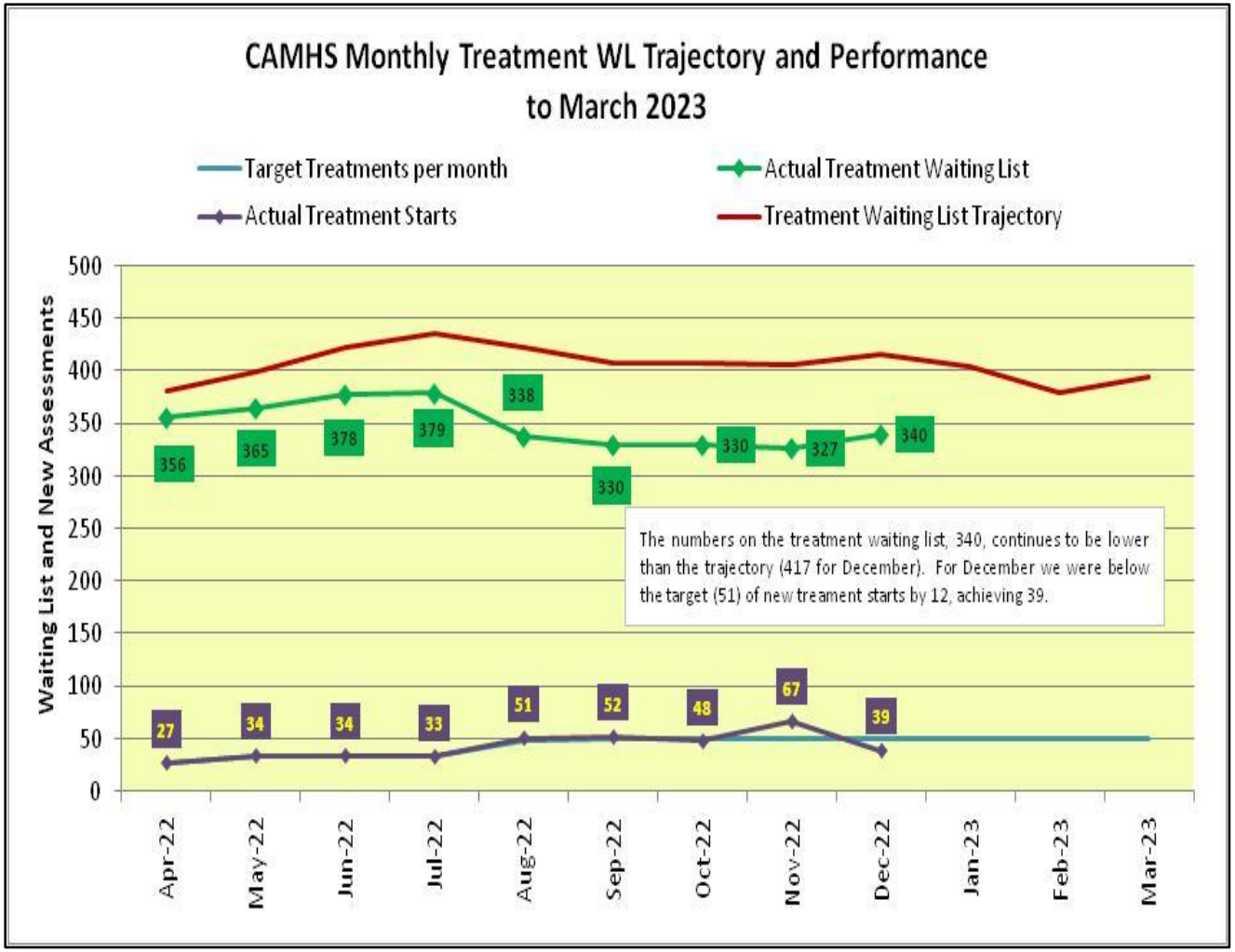


Fig. 5

Note: This is the latest data available as at 31 December 2022. There is a lag time for reporting information due to national submission deadlines.

What is the data telling us?

The number of new treatments to be achieved in December was agreed at 51 but actual achievement was 39, 12 below target. The waiting list increased in December and was sitting at 340 cases to waiting to start treatment which is the below the projection for December of 417.

Why is this the case?

Recruitment initiatives are ongoing, currently we have only two registered nurse vacancies of which we are pleased that we have four applicants for the two posts, short listing and interview processes are currently taking place. The two health care support workers are now in temporary posts for one year as a new initiative to support the registered nurses and are supporting the service really well. Long term sickness absence within nursing continues to present the service with additional challenges. Psychology recruitment to vacant posts is also ongoing with the new starts due to commence in their roles over the next few months. Administration continues to be recruited at 100%. Within Medical staffing there is currently one consultant vacancy. We continue to see high level of accepted referrals into service which impacts on trajectories.

What is being done?

The New Patient Appointments (NPA's) plan which commenced on 13th June continues, and the service targets have 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. A review of the NPA has taken place and an agreement to re-evaluate in 3 months' time has been established with view to increase the number of NPA`s (numbers will be determined at that time). The tagging process continues to allow the team to review patients waiting to access the service, with a view to determining appropriate sign-posting or establishing any possible interventions prior to a first appointment. The tagging process supports the reduction of the number of patients actually requiring access to the CAMHS service and potentially reducing the numbers of those waiting on the list. A new referral template is being currently piloted, again to support if any interventions can be established prior to the first appointment. Access to specialist young person beds continues to be challenging placing demands on the adult acute inpatient service.

Mental Health Waiting Times- Psychological Therapies

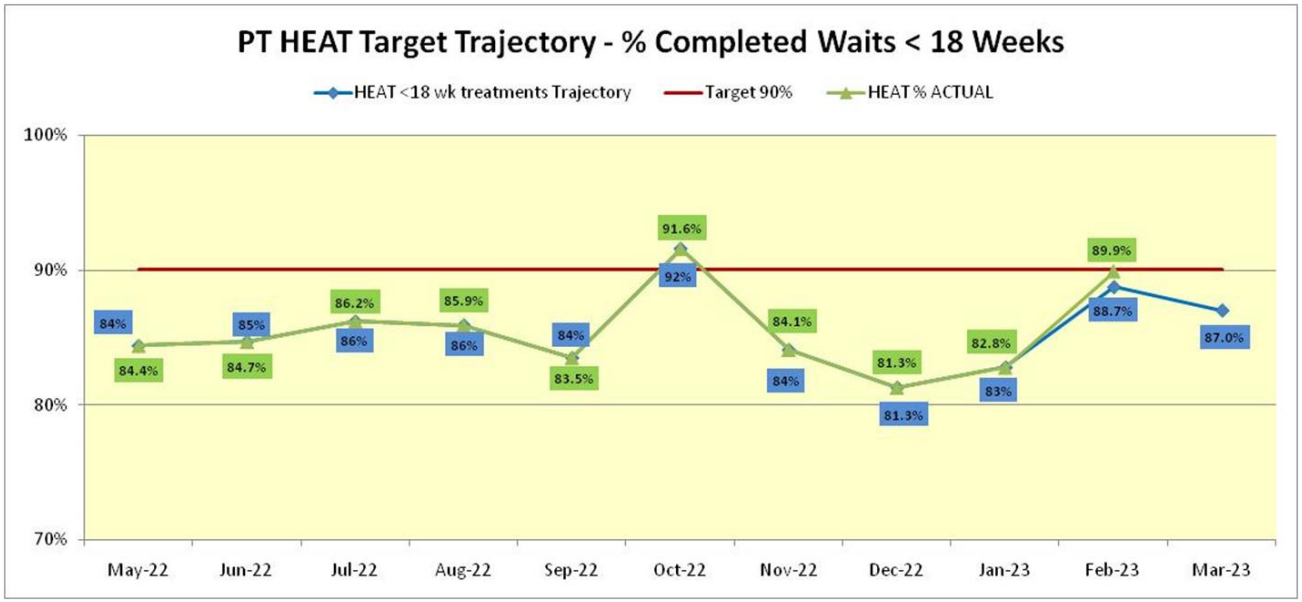


Fig. 6

Note: This is the latest data available as at 31 December 2022. There is a lag time for reporting information due to national submission deadlines.

What is the data telling us? ***Updated 23.03.2023***

This illustrates the HEAT target performance from May 2022 – February 2023 against the trajectory, which was 82.8% for January 2023 (December 2022 81.3%) based on actual performance. This has increased to 89.9% in February 2023.

Why is this the case?

Changes we have made to courses and the festive period have impacted on our performance and trajectory in December. Performance improved in January and February due to new staff coming into posts and utilising some locums. We anticipate performance may be negatively affected by financial constraints and the impact of especially high referral patterns, most notably in adult psychology.

What is being done?

We will be reviewing our annual data for the 2022/23 financial year in April and May, and completing projections for the 2023/24 financial year which will be presented to Access Board in May/June.

It is important for us to review our data for 2022/23 as we made a series of assumptions given the previous 2 years' data was affected by Covid and hence not necessarily representative of normal patterns. As a result of this when we estimated proposed activity, capacity and non-attendances; we put in estimated averages to show a regular pattern.

For 2023/24 financial year we will be repeating DCAQ for all services to reflect changes in referral patterns and ensure our resource is most appropriately focused and utilised.

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance

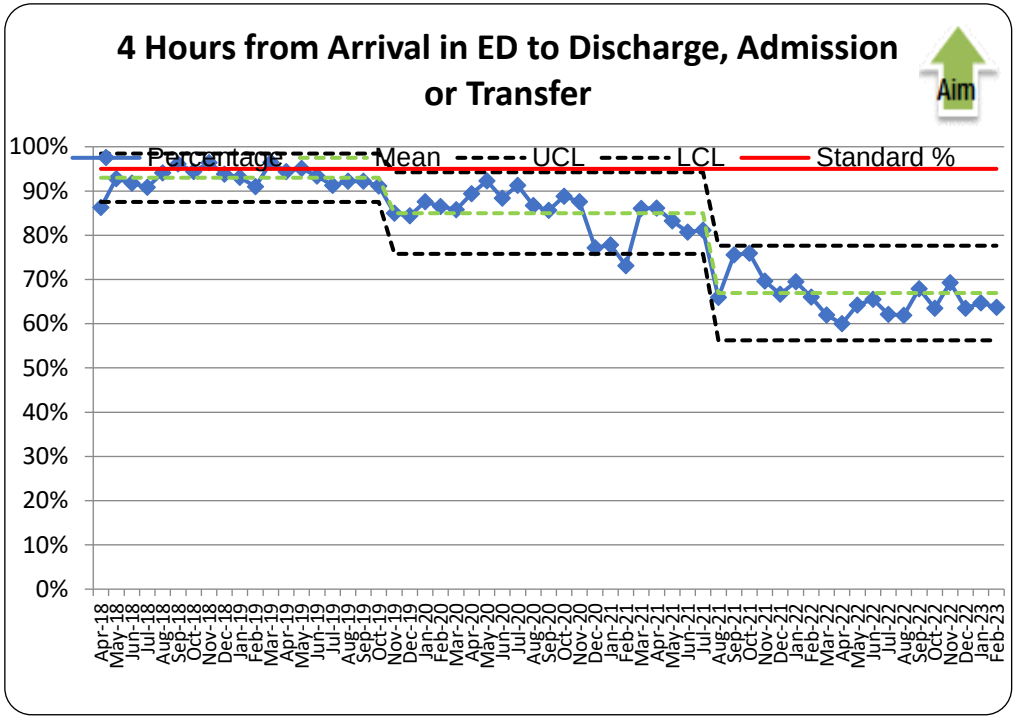


Fig. 7

What is the data telling us?

Performance in the Emergency Department for February 2023 was 60.3% vs 63.2% in January 2023.

We had 2001 attendances with 794 breaches of our emergency access standard in February 2023.

Why is this the case?

The 4-hour emergency access standard ("the standard") is a whole system measure; to either admit or provide definitive treatment and discharge for 95% of unscheduled care patients within 4-hours requires a collaborative approach from all parts of the health and social care system to provide patient flow.

ED patients who require admission experience long waits for a bed greater than 4 hours, 8 hours and 12 hours with 184 patients waiting over 12 hours, and 29 patients waiting over 24 hours. This increase has resulted in Blue ED regularly being opened and red status being declared. The Full Capacity Protocol was also enacted and multiple occasions throughout February given prolonged pressures, high levels of acuity and significant bed waits.

The 4EAS is influenced by a range of factors including, but not limited to:

- the volume of Emergency Department (ED) attendances
- the pattern of arrival of ED attendances i.e. high volumes within a short period causing crowding
- patient acuity
- bed pressures

What is being done?

The Scottish Borders Urgent and Unscheduled Care Programme Board has been established and has commenced a weekly reporting cycle. Other key improvement activities underway include:

- ED Workforce Review -. The review will ensure that the department offers as safe a model as possible to manage the current pressures while considering wider questions such as overnight senior medical leadership and recruitment and retention. The review is due to be presented at Acute Q by April 2023.
- Discharge Hub Kaizen - This kaizen will build on learning and approach from previous successful kaizens and work in a fully formed and seamless multi-disciplinary manner to effectively unblock, problem solve and effectively discharge patients to their next place of care. This work is being progressed by the General manager of PACS and is being supported by the General Manager of Unscheduled Care (Acute).
- Virtual Respiratory Capacity Test of Change - this includes the use of wearable devices for patients with Respiratory infections, enabling early supported discharge. It is planned that the first phase test of change will commence in April 2023. It is expected that this programme will drive down length of stay and support early supported discharge.

Data updated 22.02.2023 &
Narrative 22.02.2023

Delayed Discharge

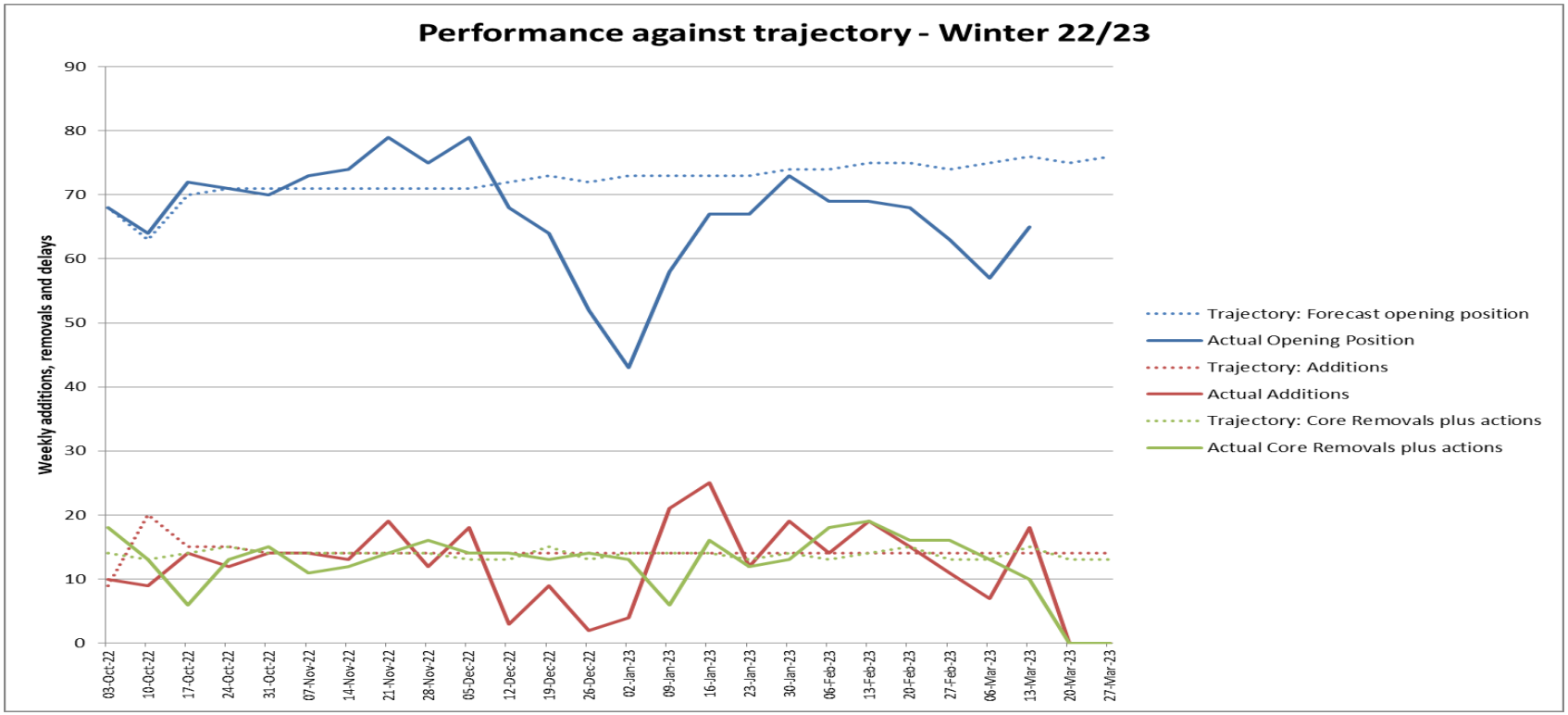


Fig. 8

What is the data telling us?

Current performance is below trajectory. As noted in the previous update, the referral/ addition rate and number of people delayed waiting for care reduced temporarily due to high levels of inpatients with covid and flu in the hospital system between mid December 2022 and early January 2023. As expected, we then experienced a subsequent high rate of referrals once people became fit for discharge.

Why is this the case?

The trajectory set was a pessimistic forecast based on ongoing increasing demand for care from the hospital system, and the potential for a reduction in removals as interim care capacity opened earlier in 2022 was fully occupied. Referrals to care from the hospital system have increased since the beginning of the pandemic from 11.4 / week. Over the 6 months leading up to the trajectory:

- Additions (referrals) were 13 a week but were set to 14 a week from 17 October for this trajectory (297 to date)
    - With actions to reduce demand, we expected 26 less additions from the start of the trajectory to the latest reported week (297 –26=271)
    - 278 people have been referred from hospital and added to the social care waiting list since the start of the trajectory (13.3 / week)
- Core removals were 13 a week but were set to 12 a week for this trajectory from 10 October (253 to date)
    - With actions to increase capacity, we expected 12 more removals from the start of the trajectory to the latest reported week (253+12=265)
    - 286 people have been removed from the social care waiting list since the start of the trajectory (13.6 / week).

Of the 286 removals, 60.5% have been transferred to care, and 39.5% have become unfit. It must be noted that a number of the patients who have been recorded as becoming unfit were unfit for discharge at the point of referral/addition to the waiting list, and as such were inappropriately referred to the waiting list and subsequently removed.

What is being done?

The operational and professional leads in the HSCP Joint Executive met in November 2022 and agreed that there is further work to do to improve discharge process and demand management. There has been a comprehensive Multi-Agency Discharge Event undertaken in the BGH, Mental Health Wards, Community Hospitals, Home First and Interim Care. This had an impact on expediting the discharge plans for a large number of people. There are also plans to undertake a Kaizen in the Complex Discharge Function within the BGH (START and Discharge and Pathways team and their interface with Home First and the Rapid Assessment and Discharge service)

In addition the Scottish Borders Health and Social Care Partnership have managed to get a variation from the Care Inspectorate to bring into place more interim care capacity by using rooms that were not previously able to be used due to their size, through agency cover and successful recruitment, and by converting the function of a number of rooms that required a higher staffing level to a lower level based on accepting people with a lower level of need. NHS Borders with the support of our General Practitioner partners have been able to support the general medical service cover for residents.

However there have been challenges in identifying people who would be suitable for this capacity from a ward perspective due to challenges in the discharge planning process, patient and family refusal and interim care criteria. As a result there is further focus on the discharge planning that is being undertaken at ward and wider HSCP level, and that communications occur with patients to ensure that the use of step-down capacity from hospital is understood to be the safest option for the patient and seen as the norm.

We are working to develop weekly reports for patients with a length of stay of over 21 days to ensure that all MDTs and Clinical Management Teams / Clinical Boards have appropriate overview of progress for all of their longer-stay patients. It is expected that this work will further improve ward discharge process which will reduce occupancy and delayed discharges.

The two tranches of interim care non-recurrent funding from the Scottish Government are ending at the end of this financial year, and as a result the HSCP Joint Executive Team is exploring appropriate mitigations to the loss of this funding from April 2023.

Appendix to Main Performance Scorecard – Performance Against Previous Agreed Standards

Contents Page

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	Nov-22	84.2%	Dec-22	93.1%	↑
	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Nov-22	100.0%	Dec-22	94.1%	↓
	New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Dec-22	7200	Jan-23	7400	↓
	New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Dec-22	1850	Jan-23	1931	↓
	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Dec-22	111	Jan-23	64	↓
	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Dec-22	67.9%	Jan-23	88.4%	↑
	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Dec-22	1202	Jan-23	1073	↑
	CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Nov-22	31.3%	Dec-22	30.8%	↓
	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Dec-22	63.5%	Jan-23	64.7%	↑
	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Dec-22	33	Jan-23	45	↑
	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Nov-22	84.1%	Dec-22	81.3%	↓
	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	Nov-22	100%	Dec-22	100%	↔
	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Dec-22	6.41%	Jan-23	6.91%	↑

Cancer Waiting Times *(please note there is a 1-month lag time for data)*

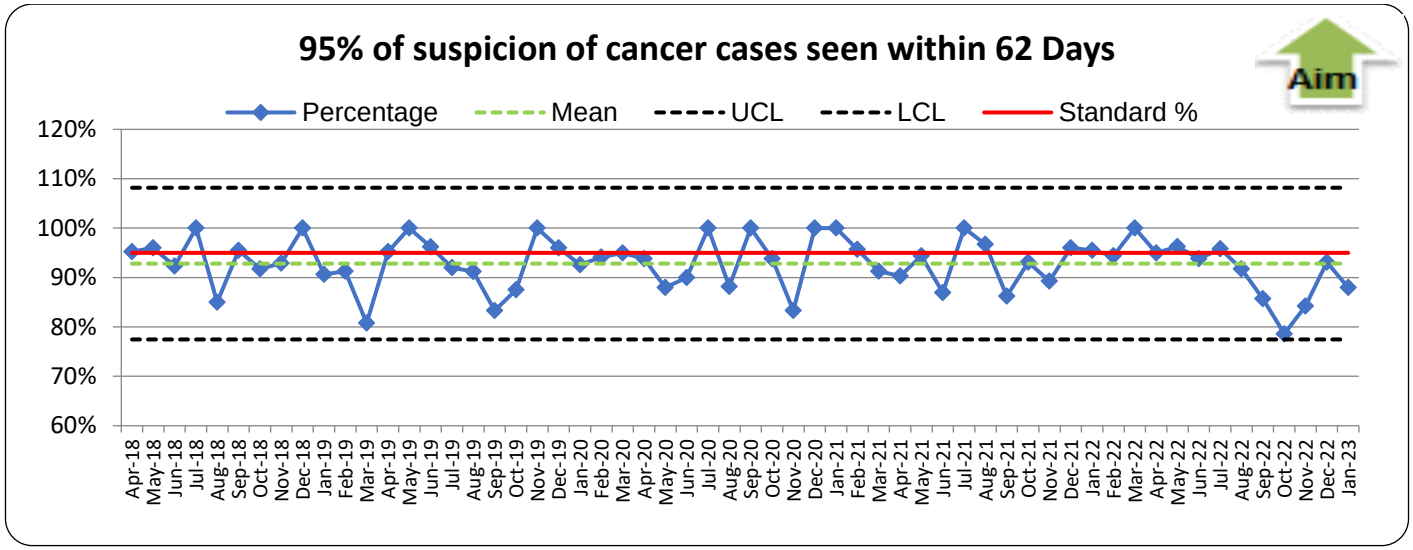


Fig. 9

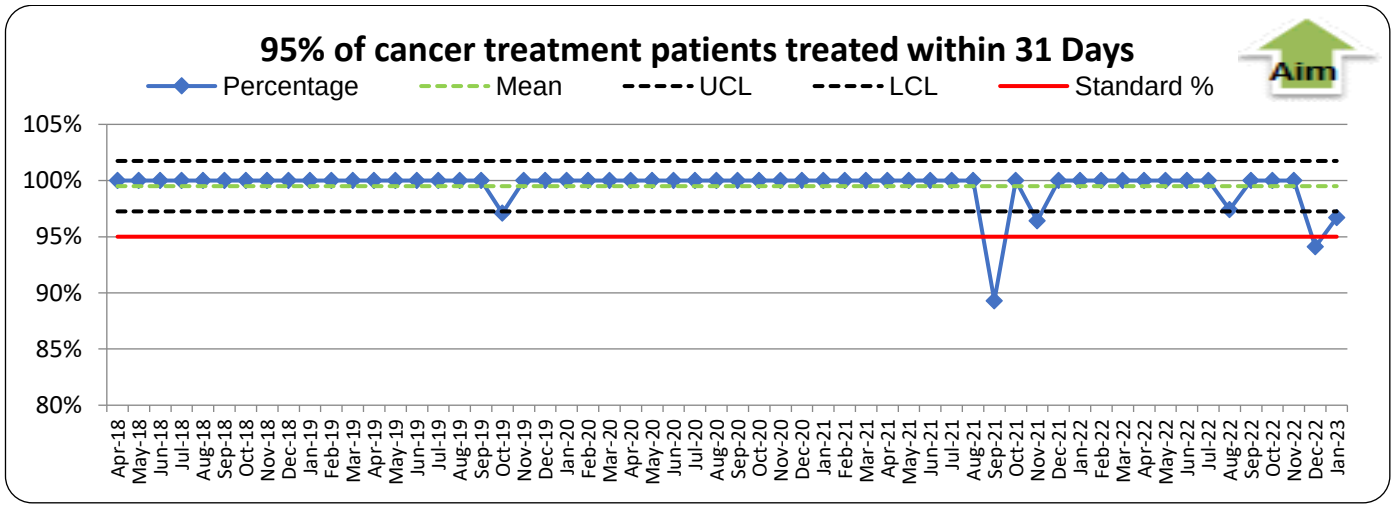


Fig. 10

Stage of Treatment- Outpatients Waiting Over 12 Weeks

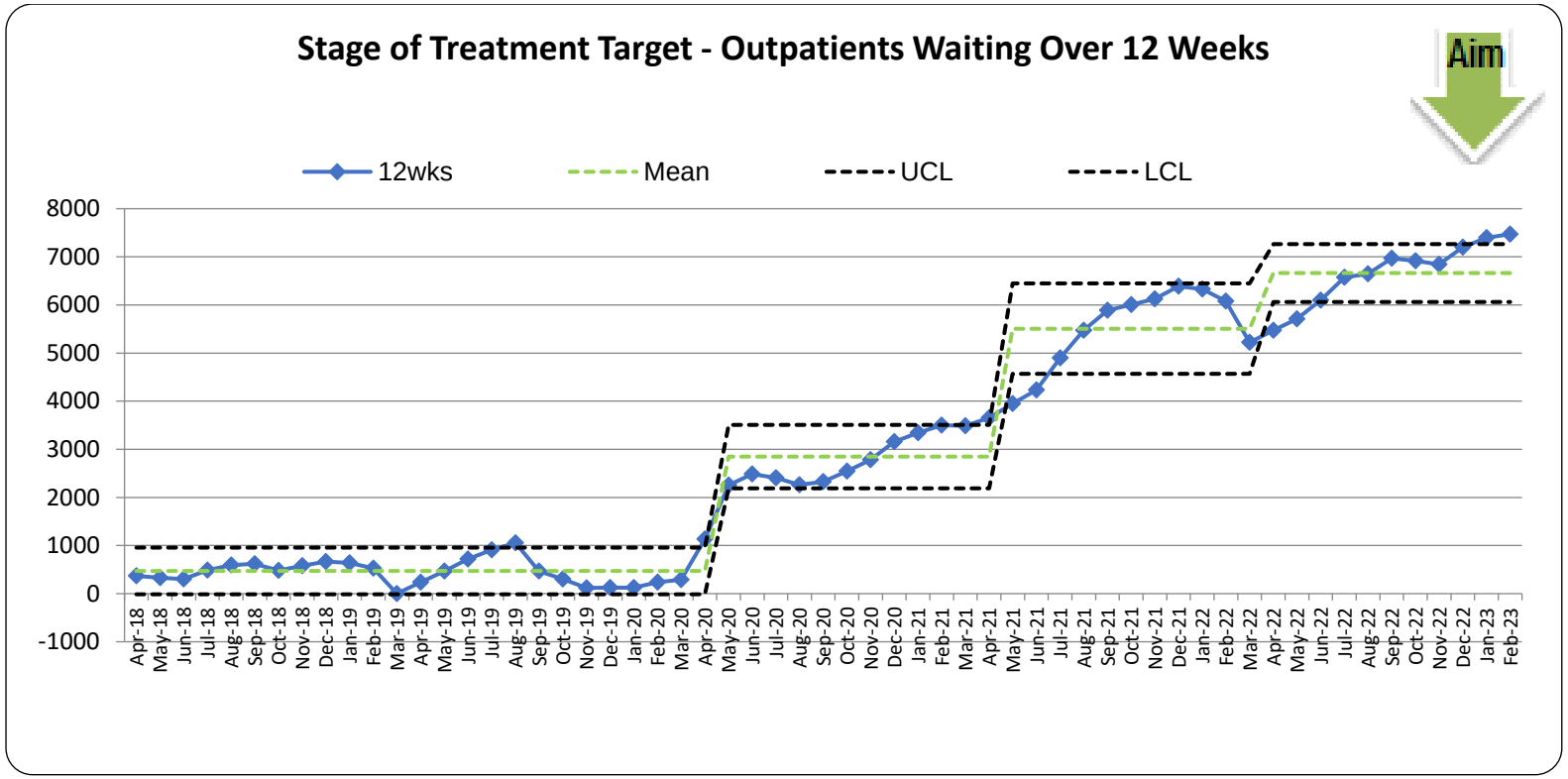


Fig. 11

Stage of Treatment- Inpatients Waiting Over 12 Weeks

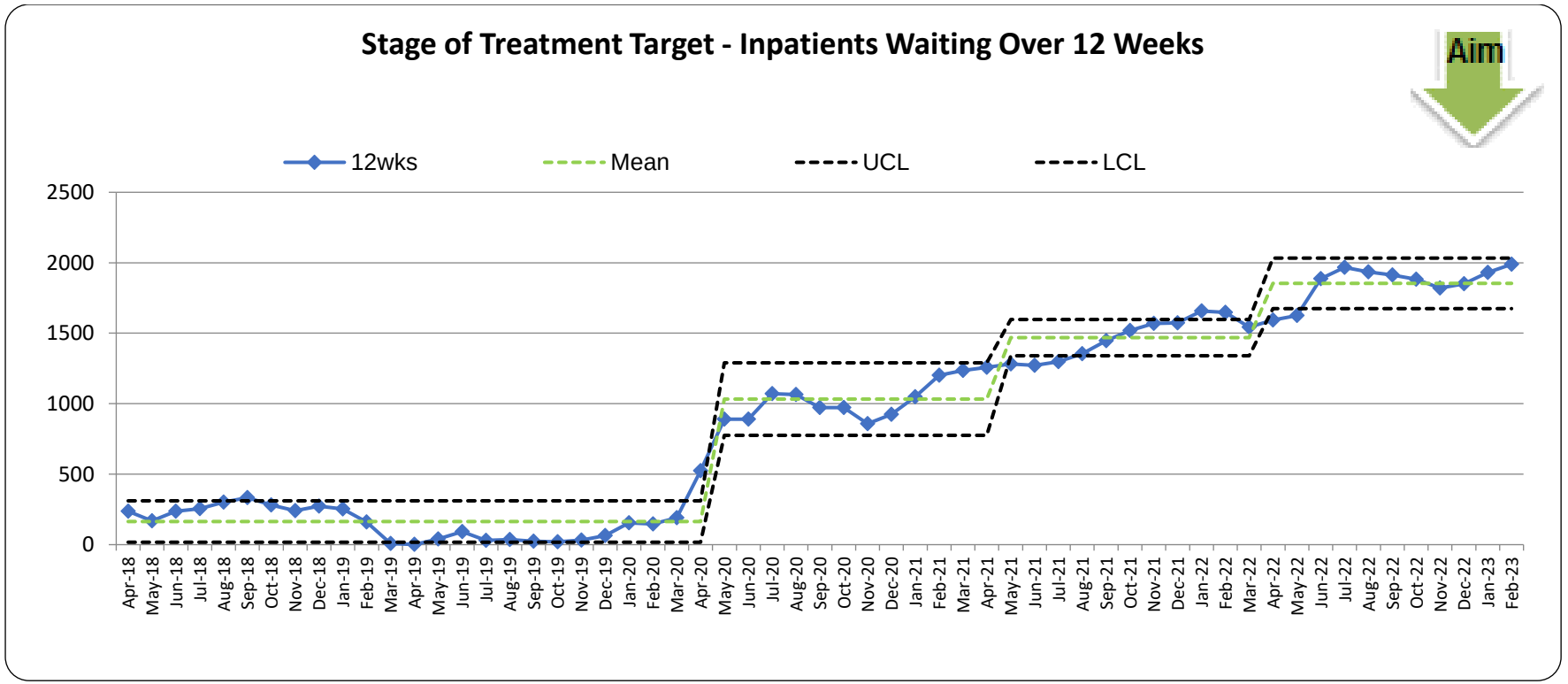


Fig. 12

Patients Treated within the 12 weeks Treatment Time Guarantee

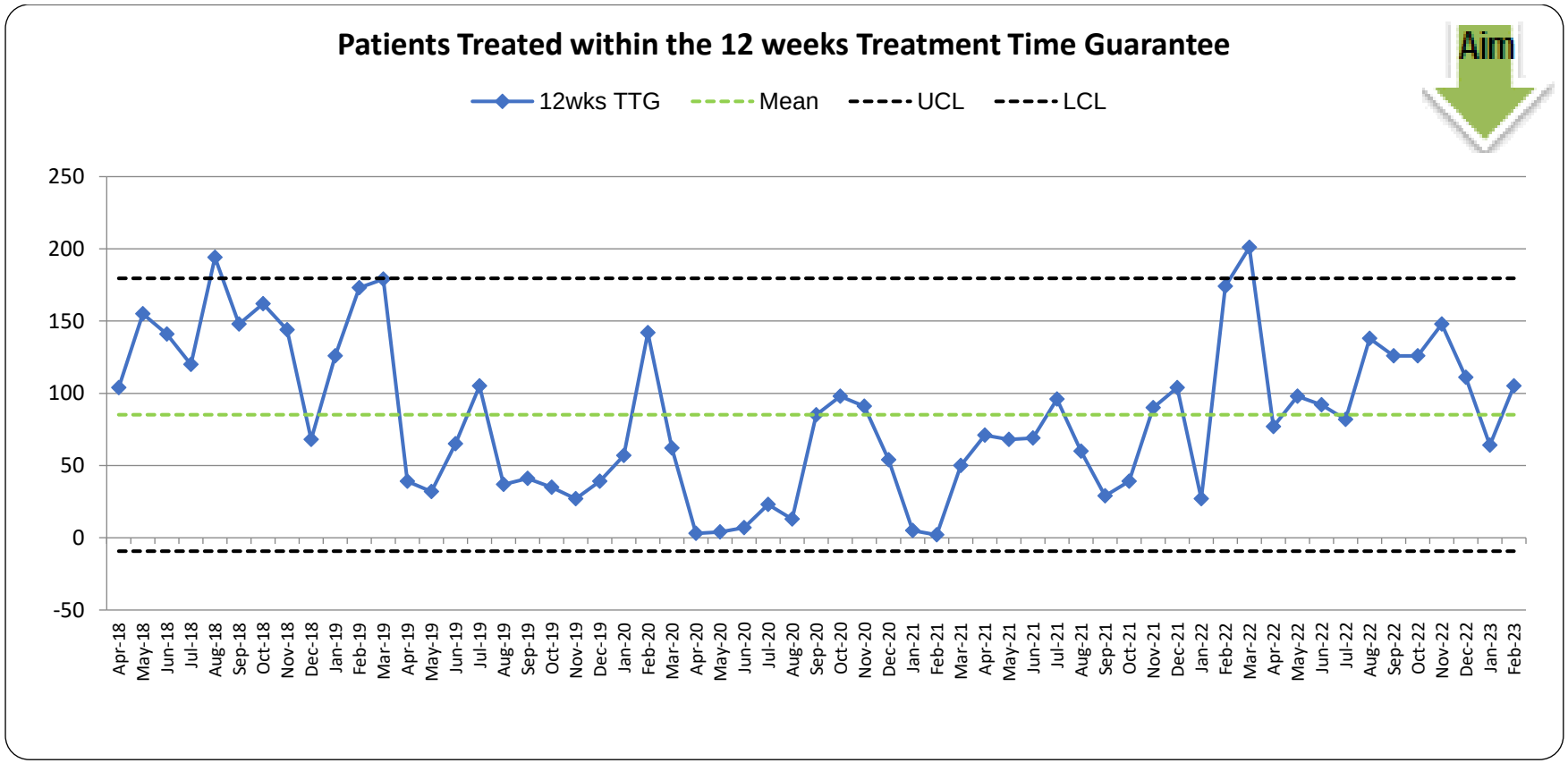


Fig. 13

18 Weeks Referral to Treatment Combined Pathway Performance

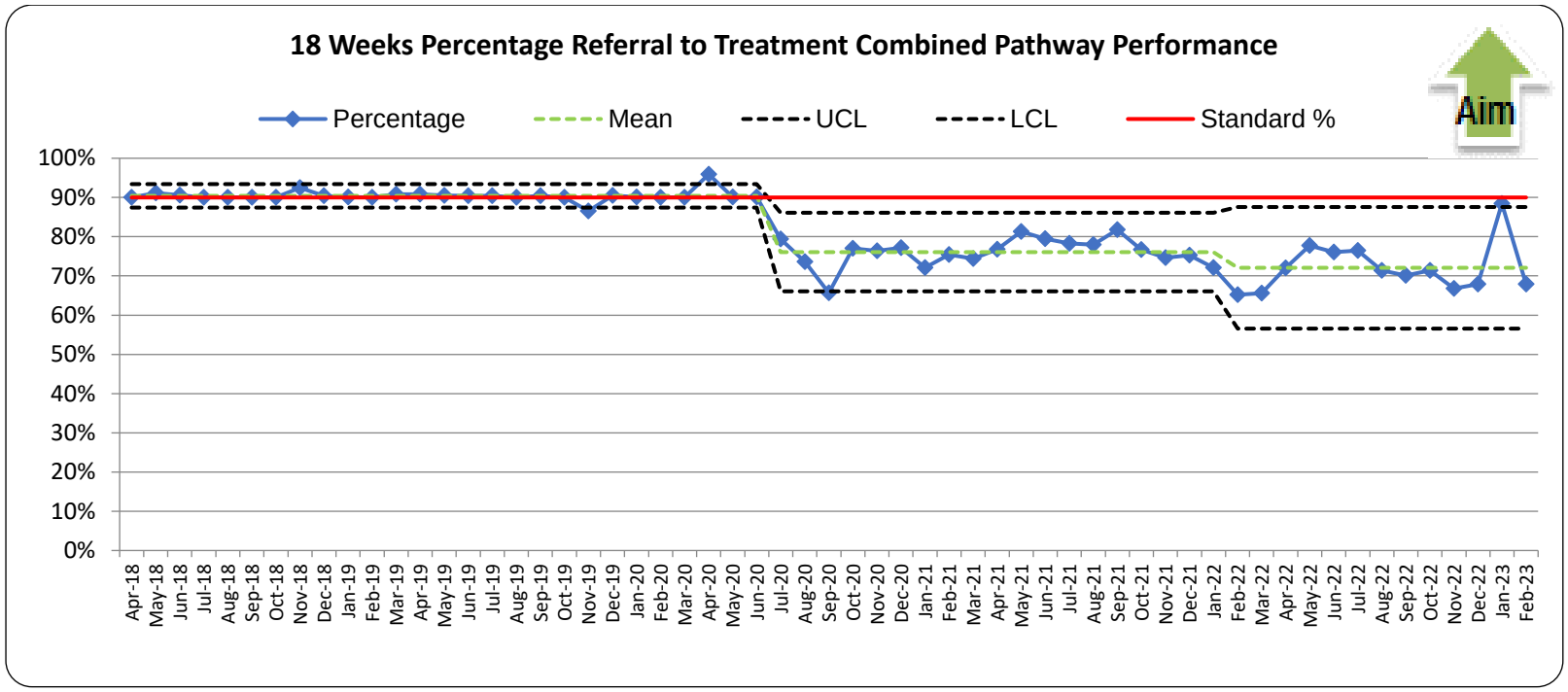


Fig. 14

Diagnostic Waits

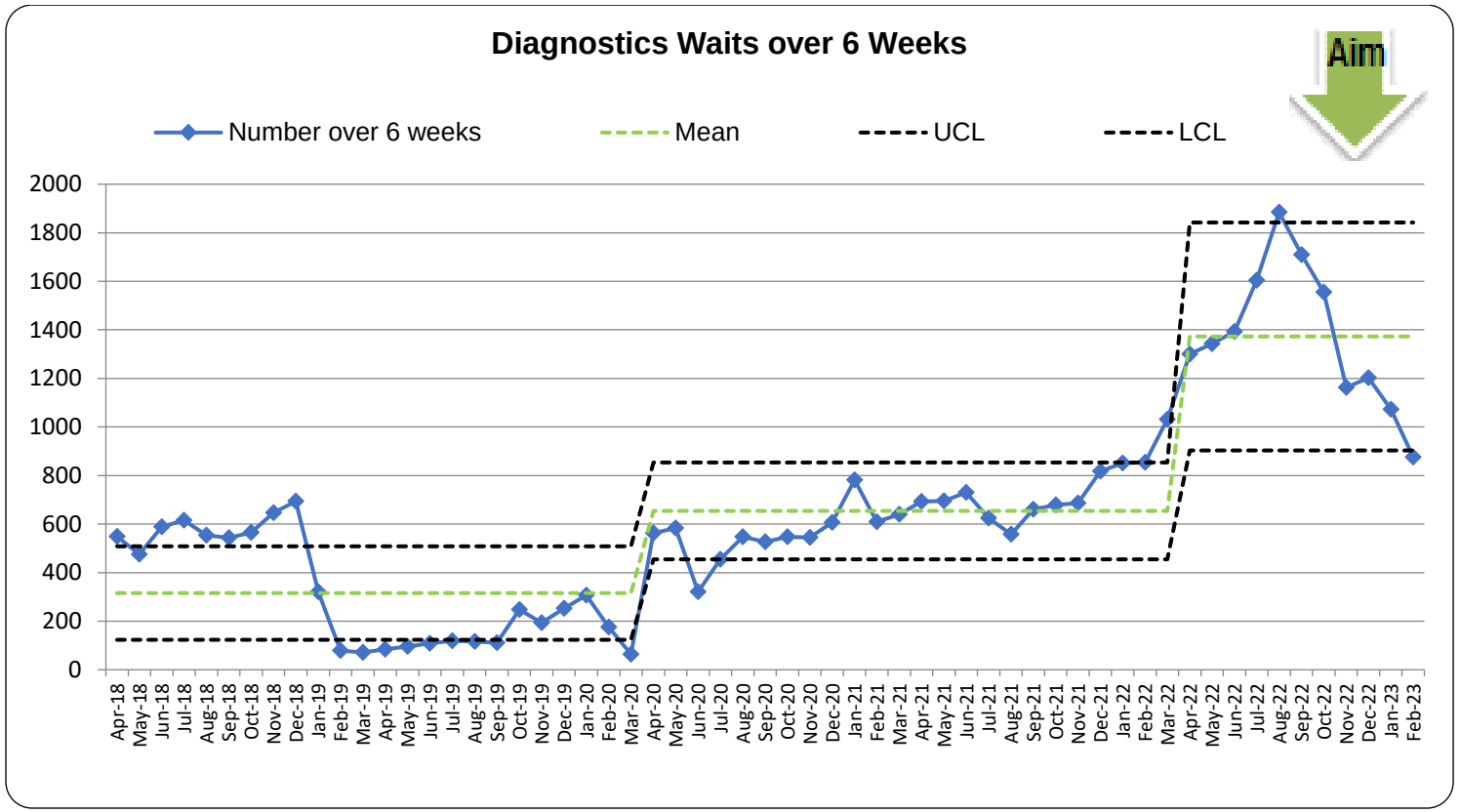


Fig. 15

CAMHS Waiting Times- 18 Week Referral to Treatment

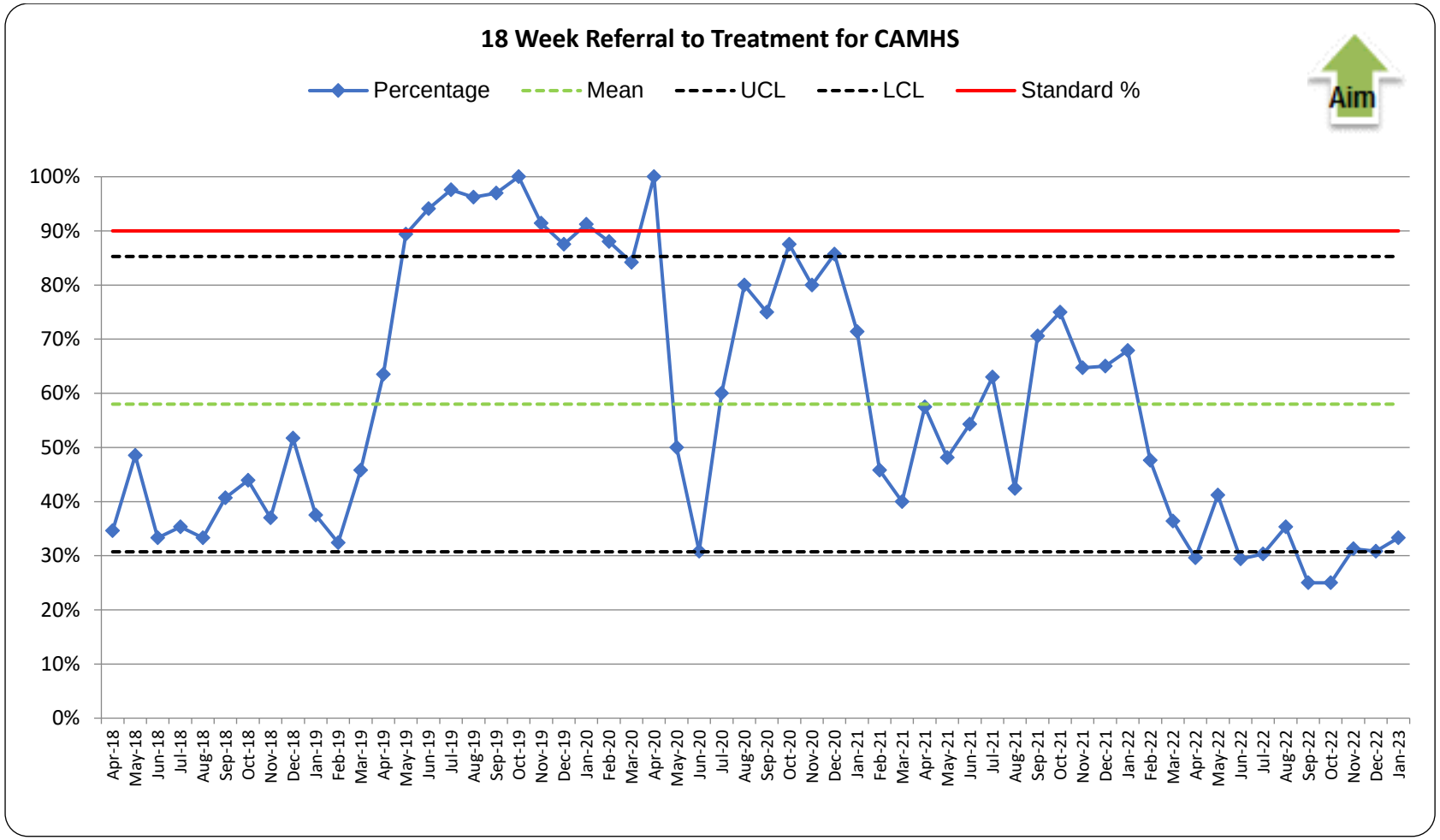


Fig. 16

Psychological Therapies Waiting Times- 18 Week Referral to Treatment

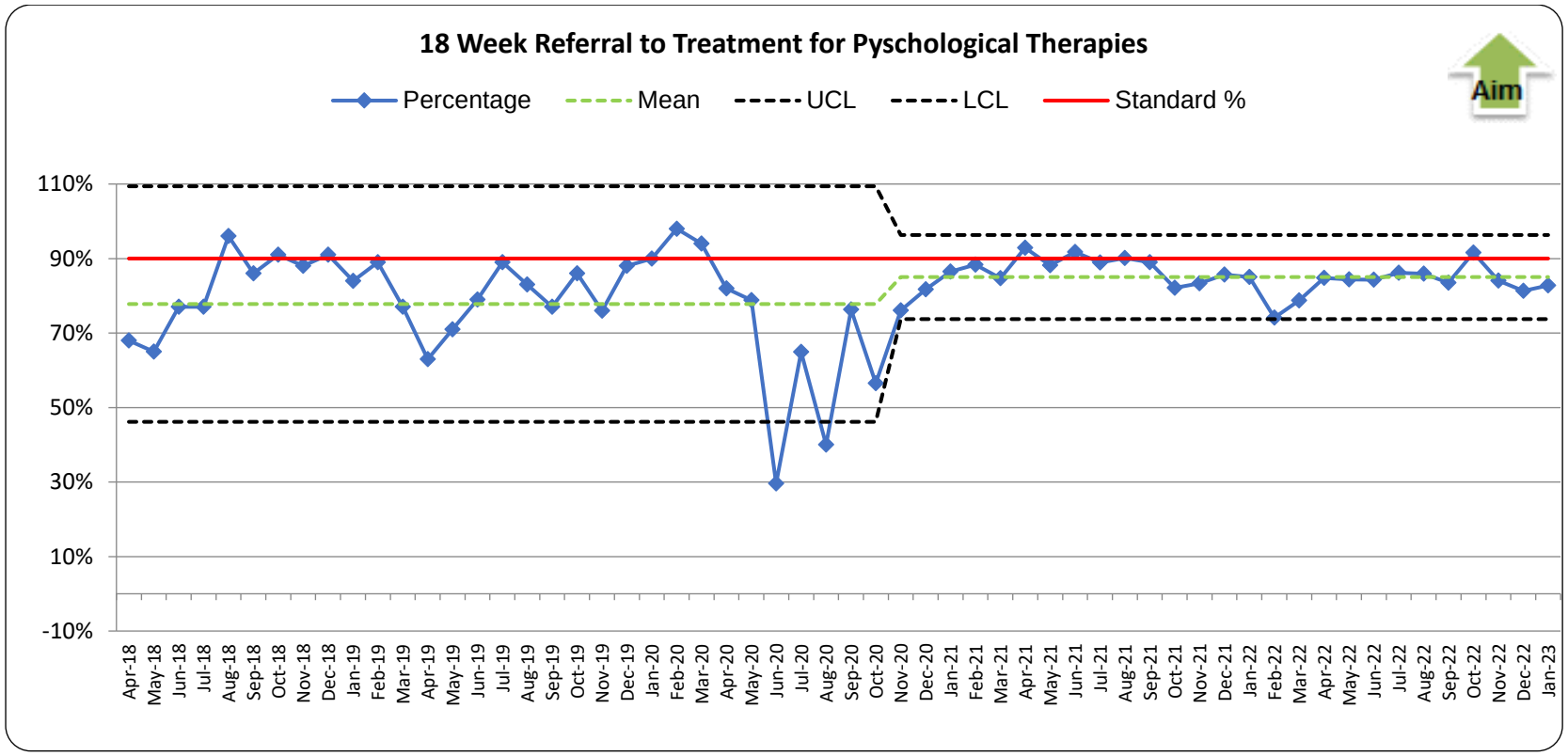


Fig. 17

Delayed Discharges

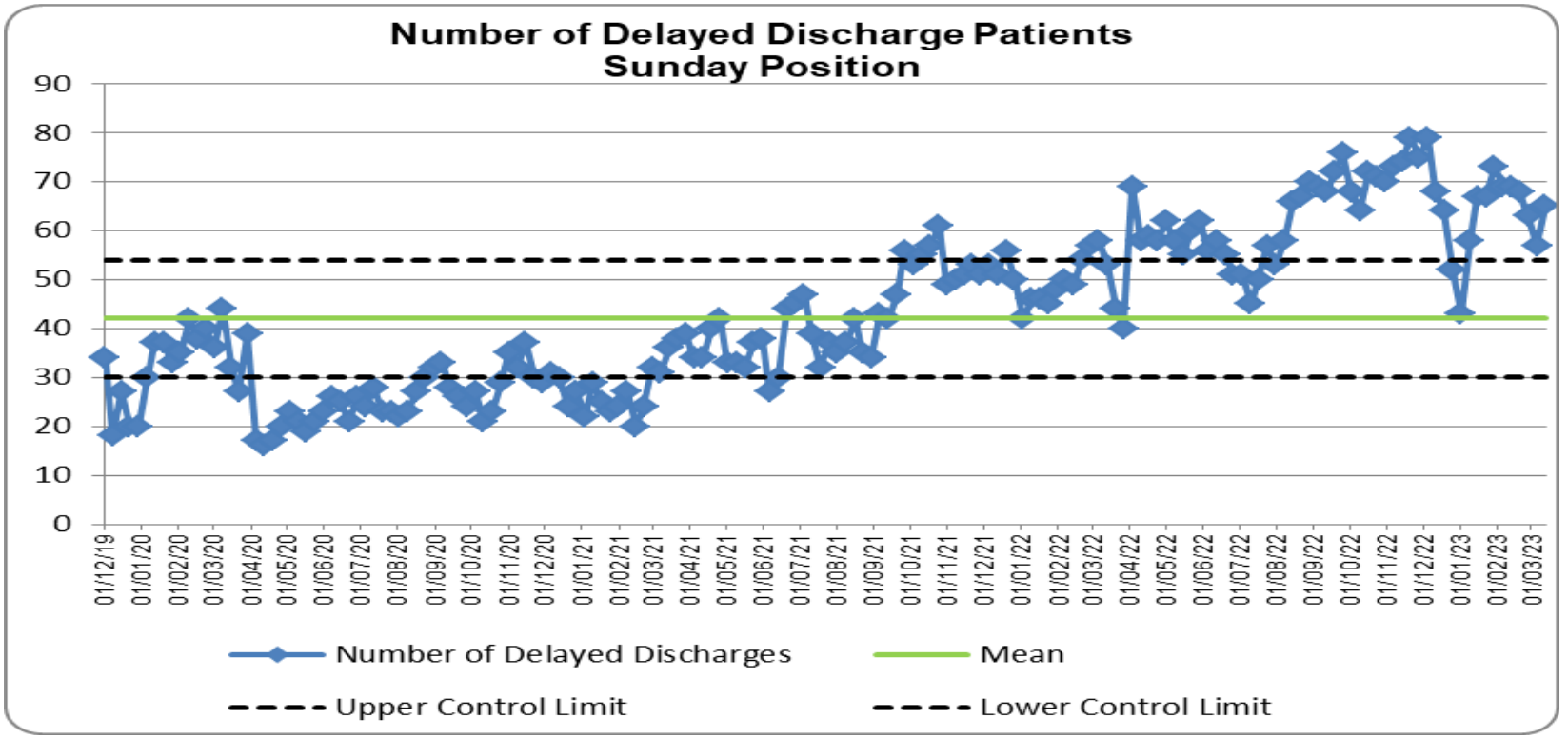


Fig. 18

Fig. 19

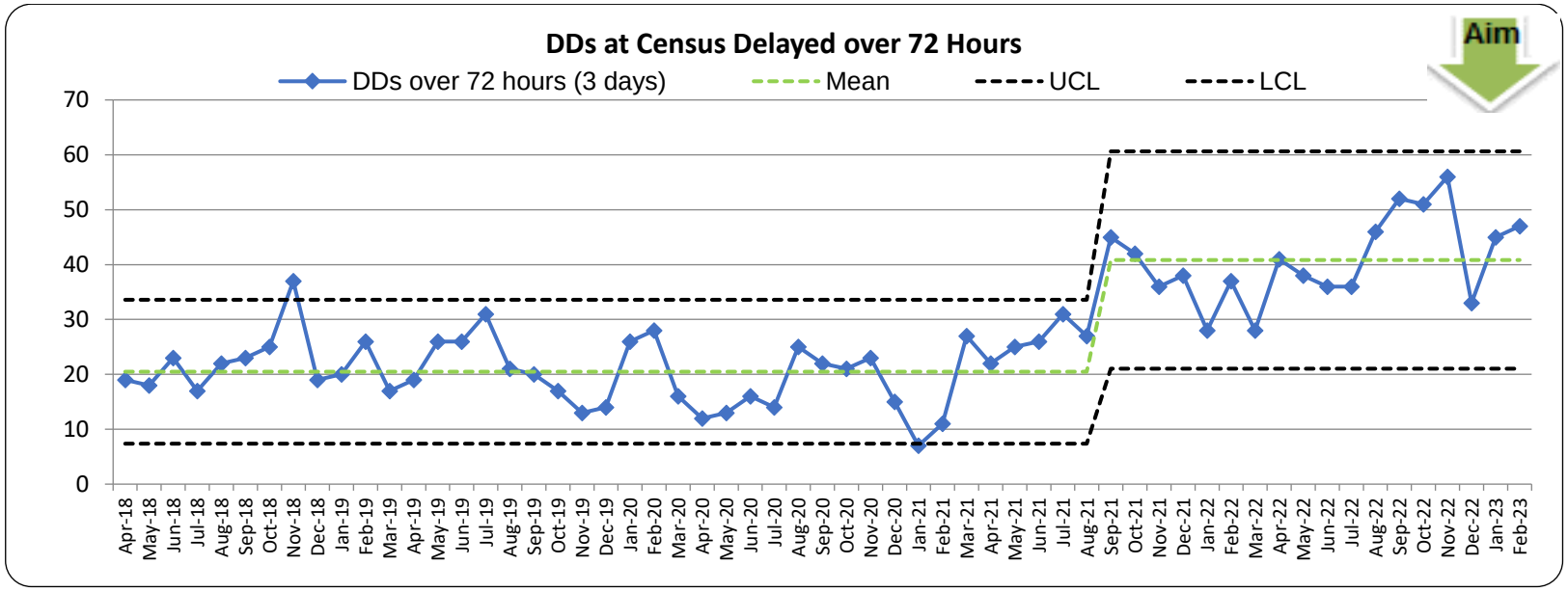
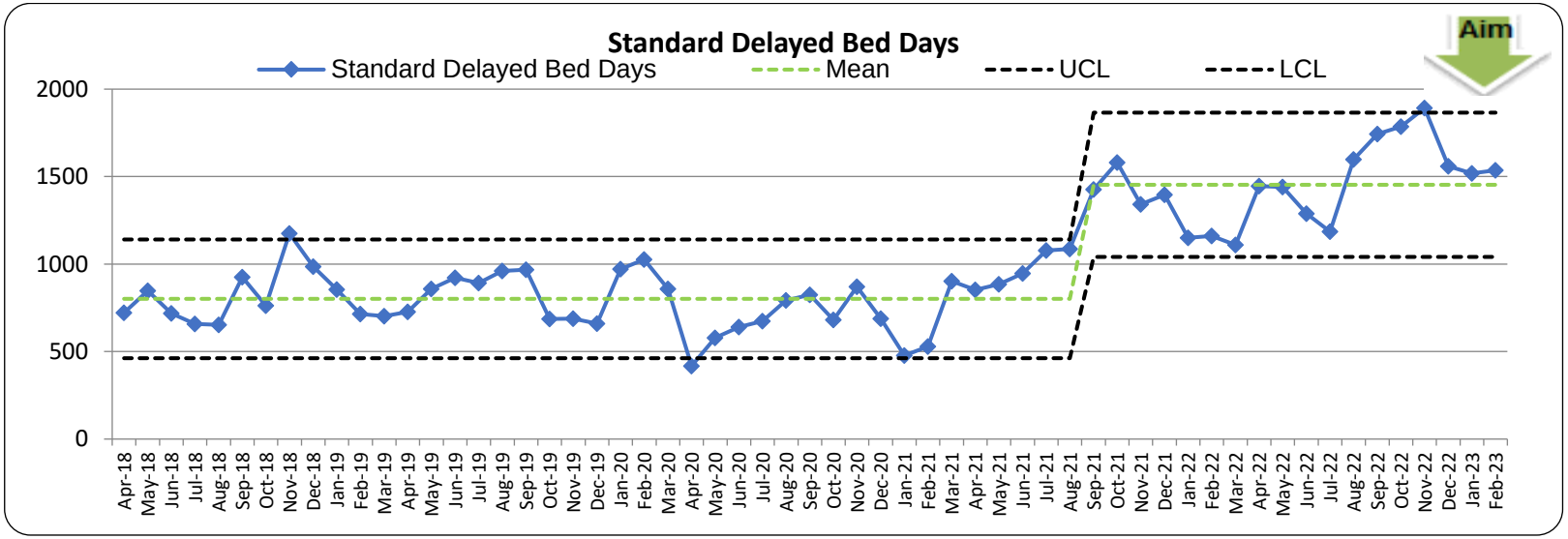

DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
70
60
50
40
30
20
10
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Fig. 20


Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
2000
1500
1000
500
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21 Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22 Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23

Drugs & Alcohol

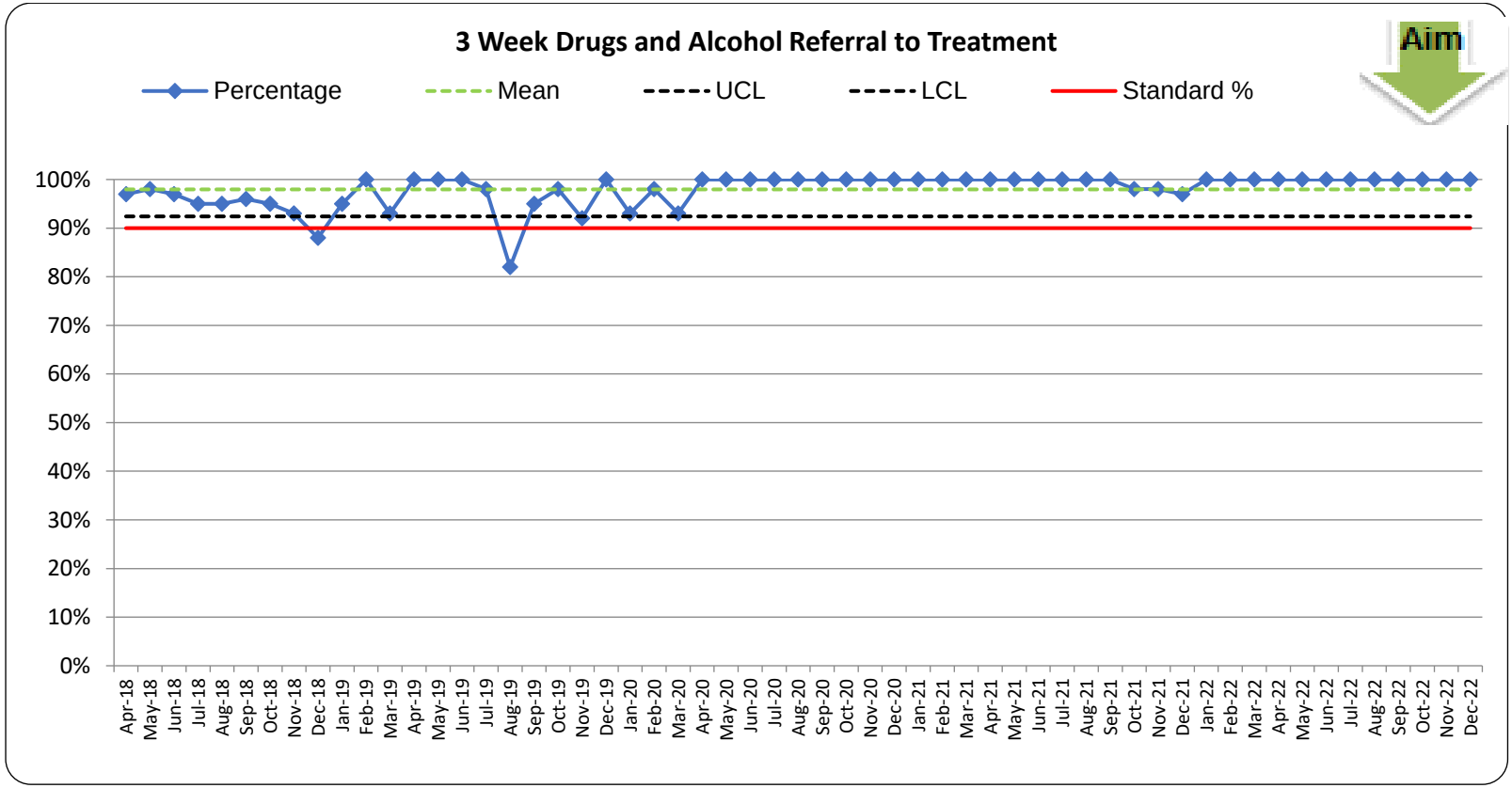


Fig. 21

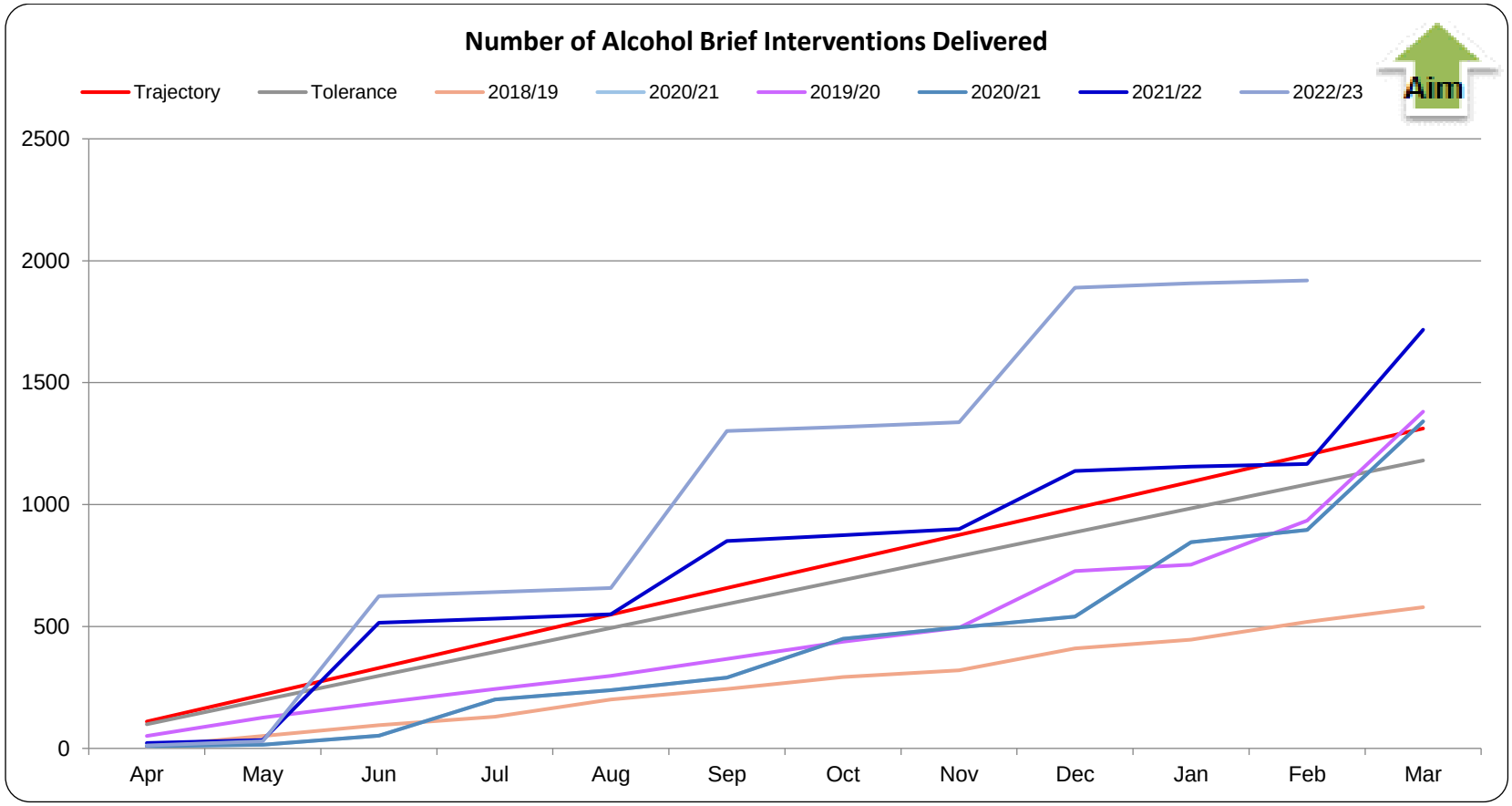

Number of Alcohol Brief Interventions Delivered
Trajectory
Tolerance
2018/19
2020/21
2019/20
2020/21
2021/22
2022/23
Aim
2500
2000
1500
1000
500
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar

Fig. 22

Sickness Absence

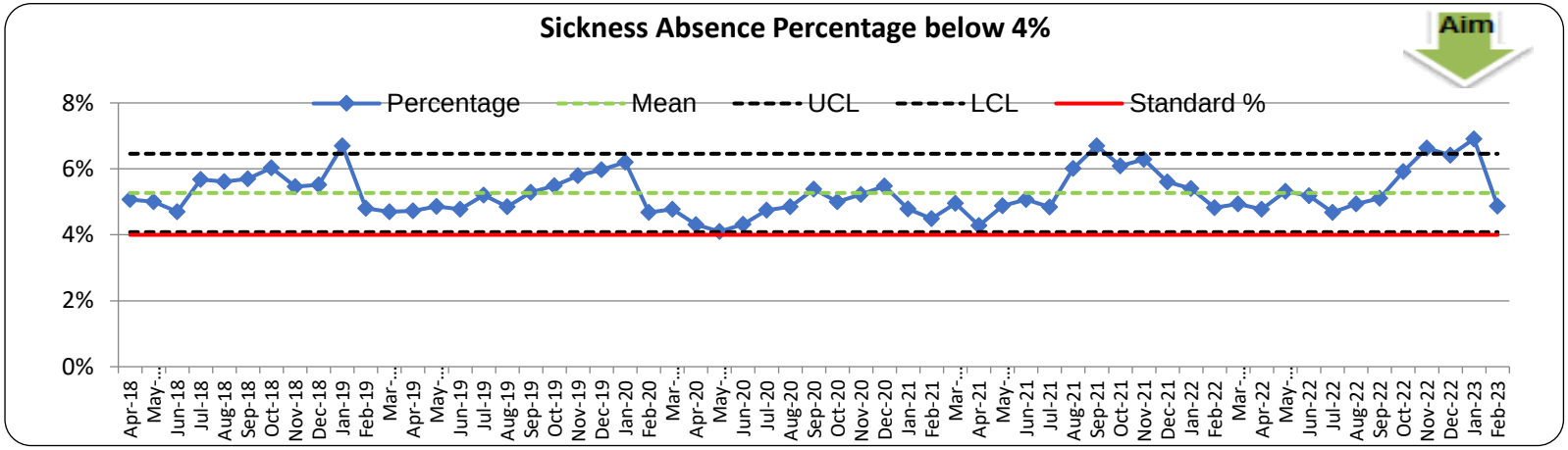


Fig. 23

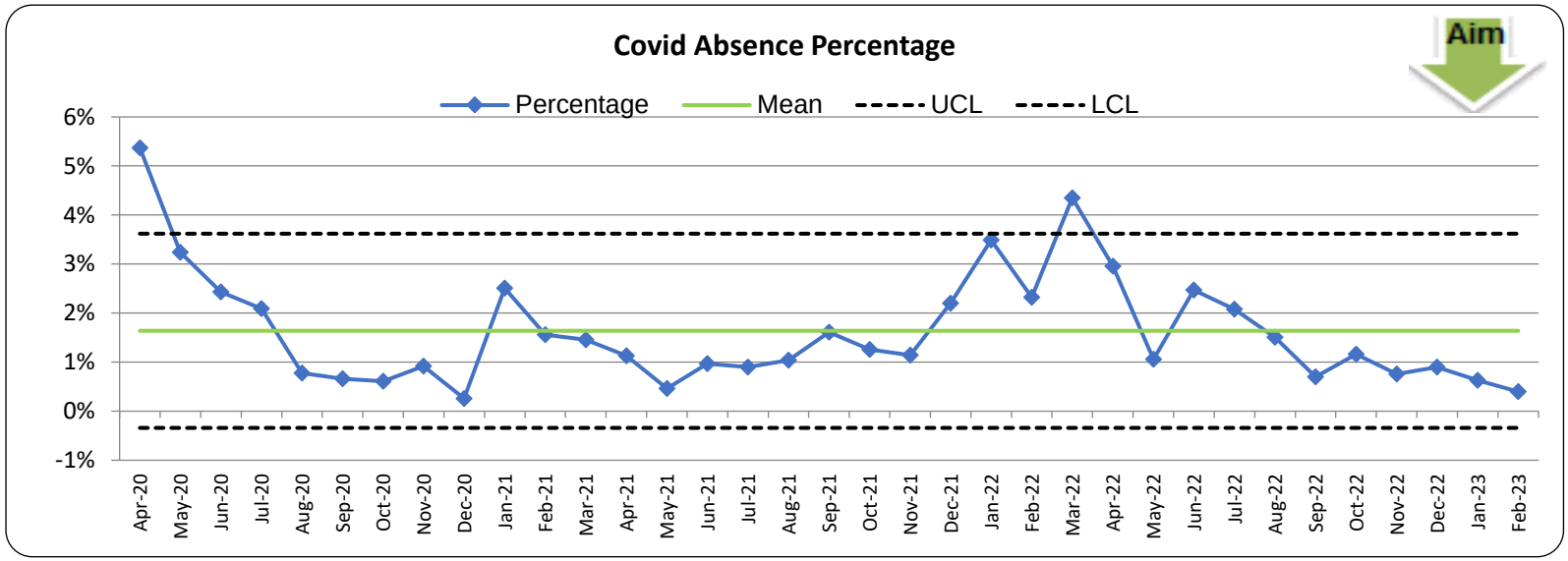


Fig. 24

Smoking Quits *(Please Note: All figures are cumulative. Data is reported quarterly to allow monitoring of the 12-week quit period. There is a 6-month lag time for reporting to allow monitoring of the 12 week quit period.)*

Latest NHS Scotland Performance	NHS Borders Performance (as a comparative)
97.2% (2019/20)	77.4% (2019/20)

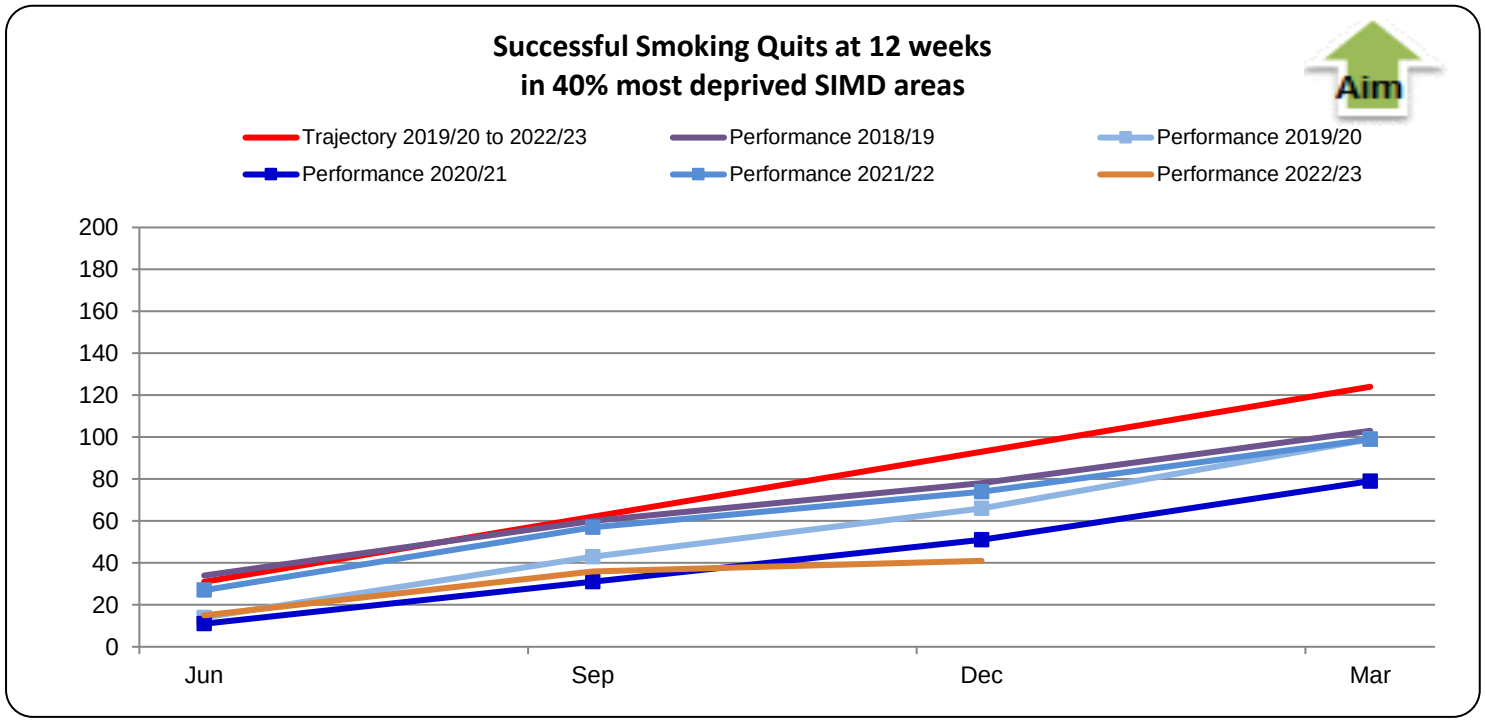


Fig. 25

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Code of Corporate Governance Sectional Update**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Committee for:

- Decision

This report relates to a:

- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

To provide the Board with a sectional update to the Code of Corporate Governance (CoCG) as reviewed by the Audit Committee on 12 December 2022 and recommended for formal approval by Borders NHS Board.

2.2 Background

The Code of Corporate Governance details how the Board organises and governs its business.

The Code of Corporate Governance is required to be updated every 3 years.

The Board on 30 June 2022 reviewed and approved a sectional update to the CoCG (Sections B, D and G).

2.3 Assessment

The Introduction Section of the CoCG has now been refreshed Annex A:-

This section contains minor updates which have been highlighted in yellow.

Section A of the CoCG has now been refreshed Annex B:-

This section contains the revised Terms of Reference for the:

- Resources & Performance Committee (03.11.22)
- Clinical Governance Committee (23.03.22)
- Public Governance Committee (11.08.22)
- Area Clinical Forum (14.06.22)
- Inclusion of the Information Governance Committee Terms of Reference

A full refresh of the Code of Corporate Governance is due to be undertaken this year and will focus initially on Section F, Scheme of Delegation and Section G, Standing Financial Instructions.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Not applicable.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

As recommended by the Audit Committee on 12 December 2022.

2.4 Recommendation

The Board is asked to approve the updated Introduction Section and Section A of the Code of Corporate Governance.

3 List of appendices

The following appendices are included with this report:

- Appendix No A, Introduction Section
- Appendix No B, Section A - How Business is Organised.

CODE OF CORPORATE GOVERNANCE 2020

Approved: **MARCH 2020**

Review Date: **APRIL 2023**

INDEX

4. Delegation of powers for appointments of staff

SECTION G
Standing financial instructions

This section explains how staff will control the financial affairs of NHS Borders and ensure proper standards of financial conduct.

INTRODUCTION

1. CODE OF CORPORATE GOVERNANCE

The Code of Corporate Governance includes the following sections:

Section A – How business is organised
Section B – Members' code of conduct
Section C – Standards of business conduct for NHS staff
Section D – Health & Social Care Integration - Integration Joint Board
Section E – Counter Fraud Policy & Action Plan
Section F – Reservation of powers and delegation of authority
Section G – Standing financial instructions

It uses best practice in Corporate Governance as set out in the Cadbury, Nolan and other Reports, and guidance issued by the Scottish Government Health & Social Care Directorates and others.

The Board reviews and approves the Code of Corporate Governance each year. Sections A to G are NHS Borders Standing Orders. The Standing Orders are made in accordance with the Health Board (Membership and Procedure) (Scotland) Regulations 2001.

Statutory provision, legal requirement, regulation or a direction by Scottish Ministers take precedence over the Code of Corporate Governance if there is any conflict.

2. BORDERS NHS BOARD

Borders NHS Board, 'The Board', means Borders Health Board.

The common name of Borders NHS Board as an organisation is "NHS Borders".

The Board is the governing body of NHS Borders and the single legal entity, accountable to the Scottish Government Health Department and to Scottish Ministers for the functions and performance of NHS Borders.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Board consists of the Chair, Non-Executive and Executive Members appointed by Scottish Ministers to constitute Borders Health Board. (National Health Services (Scotland) Act 1978 as amended).

Remuneration will be paid as determined by Scottish Ministers to the Chair and other Non-Executive Board Members.

Any member of the Board may, on reasonable cause shown, be suspended or removed or disqualified from membership of the Board in accordance with the Regulations identified in Section 1 above.

A member of the Board may resign office at any time by giving notice in writing to Scottish Ministers to that effect.

The overall purpose of Borders NHS Board is to:

- Review and ensure the efficient, effective and accountable governance of NHS Borders;
- Provide strategic leadership and direction;
- Focus on agreed outcomes;
- Work in partnership with the Scottish Borders Health and Social Care Integration Joint Board and Scottish Borders Council to deliver the Strategic Commissioning Plan and associated outcomes.

The Role of the Board is to:

- Provide and improve and protect the health of local people;
- Provide and improve health services for local people;
- Focus clearly on health outcomes and people's experience of NHS Borders;
- Work in conjunction with the Scottish Borders Health and Social Care Integration Joint Board to improve the wellbeing of people who use health and social care services;
- Improve community planning within the Scottish Borders through membership of the Community Planning Partnership;
- Be accountable for the performance of NHS Borders as a whole;
- Involve the public in the design and delivery of healthcare services.

The Functions of the Board are to:

- Set the strategic direction of NHS Borders within the overall policies and priorities of the Scottish Parliament and the Scottish Government, define its annual and longer-term objectives and agree plans to achieve them;
- Delegate functions and related resources to the Scottish Borders Health and Social Care Integration Joint Board in line with legislation (Public Bodies (Joint Working) (Scotland) Act 2014);
- Deliver services as commissioned by the Scottish Borders Health and Social Care Integration Joint Board in line with the agreed Health and Social Care Partnership Strategic Plan;
- Approve resource allocation to address local priorities;
- Ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- Oversee implementation and delivery of the Annual Operational Plan;
- Manage the performance of NHS Borders, including risk management, by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- Appoint, appraise and remunerate senior executives;
- Be responsible for the recruitment, and authorise the appointment of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009;
- Approve governance arrangements for NHS Borders which the Board will discharge including through the Standing Committees of Audit, Resources and Performance, Clinical, Staff, and Public Governance.
- Support the Patient Rights (Scotland) Act and the Person Centred Health and Care Programme for example through the receipt of patient and carer stories.

Responsibilities of Members of the Board include:

- Shared responsibility for the discharge of the functions of the Board;
- Exercise independent, impartial judgement on issues of strategy, resource allocation, performance management, key appointments and accountability, to Scottish Ministers and to the local community;
- Responsibility and accountability for the overall performance of NHS Borders.

3. DEFINITIONS

Any expressions to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

The Accountable Officer is the Chief Executive of NHS Borders, who is responsible to the Scottish Parliament for the economical, efficient and effective use of resources. The Chief Executive of NHS Borders is accountable to the Board for clinical, corporate and staff governance. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government (Public Finance and Accountability (Scotland) Act 2000).

The Act means the National Health Service (Scotland) Act 1978 as amended.

The 2001 Regulations means the Health Board's (Membership and Procedure) (Scotland) Regulations 2001.

The 1960 Act means the Public Bodies (Admission to Meetings) Act 1960, as amended.

The Joint Working Act means the Public Bodies (Joint Working) (Scotland) Act 2014.

Borders NHS Board comprises 10 Non Executives Directors and 5 Executive Directors (Chief Executive, Medical Director, Director of Finance, Director of Nursing, Midwifery & AHPs ~~cute Services~~, Director of Public Health) all appointed by Scottish Ministers. Three of the Non Executive Directors are stakeholder members (Local Authority representative, Area Clinical Forum Chair, Area Partnership Forum Chair). The Chair and 6 Non Executive Directors are recruited through an open public appointment process.

Board Executive Team (BET) is the executive arm of Borders NHS Board. Members of the Board Executive Team are the Chief Executive, Medical Director, Director of Finance, Director of Nursing, Midwifery & AHPs ~~cute Services,~~ Director of HR, OD & OH&S, ~~Workforce~~, Director of Planning ~~Strategic Change~~ and Performance, Director of Public Health, Chief Officer Health & Social Care, Director of Acute Services, Director of Quality & Improvement and the Employee Director is in attendance.

Board Secretary is responsible for ensuring that the Board complies with relevant legislation and governance guidance. The Board Secretary will ensure that meetings of the Board of Directors and its Committees run efficiently and effectively, that they are properly recorded and that Directors receive appropriate support to fulfil their legal duties.

Budget means a financial resource proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Board.

Chair means the person appointed by the Scottish Ministers to lead the Board and to ensure it discharges its responsibilities as determined by Government Ministers. The expression 'the Chair of the Board' is deemed to include the Vice-Chair of the Board if the Chair is absent from the meeting or is otherwise unavailable. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.

Chief Executive means the Accountable Officer of NHS Borders.

Corporate Management means Chief Executive, Director of Finance, Director of Nursing, Midwifery & AHPs ~~cute Services~~, Director of HR, OD & OH&S ~~Workforce~~, Director of Planning ~~Strategic Change~~ & Performance, Director of Public Health, Chief Officer Health & Social Care, Director of Acute Services, Director of Quality & Improvement and Medical Director.

The Operational Planning Group ~~Clinical Executive~~ is the operational delivery unit for NHS Borders. It meets weekly ~~twice per month~~. ~~One meeting per month is focused on cross system operational issues (Operational Board) and the other meeting deals with Strategic issues (Strategy Board).~~ Membership comprises representation from Clinical and Managerial leaders from each of the Clinical Boards and from the Board Executive Team (BET).

Clinical Executive Directors means Director of Nursing, Midwifery & AHPs ~~cute Services~~ and Medical Director.

Committee means a Committee established by the Board, and includes 'Sub-Committee'.

Committee Members are people appointed by the Board to sit on or to chair specific committees. All references to members of a committee is as 'member' and when the reference is to a member of the Board it is 'Board Member'.

Contract includes any arrangement including an NHS Service Level Agreement.

Co-opted Member is an individual, not being a Member of the Board, who is appointed to serve on a Committee of the Board.

Director of Finance means the Chief Finance Officer of the Board.

Ex-officio means "from the office of," intending to convey that something is by virtue of holding office. Any Board members who are "ex officio" (ie the Chair for the purposes of all Committees except the Audit Committee) is entitled to attend those Committee meetings, debate items, and vote at those meetings. They are also counted as part of the quorum at those Committee meetings. Should an ex-officio member be appointed who is not a member of NHS Borders Board and is outwith NHS Borders then whilst they would have the same entitlement to attend meetings, debate items and vote, they would not be counted towards the quorum.

Health & Social Care Partnership means the strategic direction by Scottish Government given to Statutory Organisations (Scottish Borders Council and NHS Borders) for the provision of integrated services across health and social care in the Scottish Borders.

Scottish Borders Health and Social Care Integration Joint Board (H&SC IJB) means the legal entity legislated as part of the Public Bodies (Joint Working) (Scotland) Act 2014.

Meeting means a meeting of the Board or of any Committee.

Member means a person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair and other Executive and Non-Executive Members (Health Boards Membership and Procedure (Scotland) Regulations 2001).

Motion means proposal.

Nominated Officer means an officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.

Non-Executive Member means any Member appointed to the Board in terms of the 2001 Regulations and who is not listed under the definition of an Executive Member above.

Officer means an employee of NHS Borders.

Scheme of Integration means the H&SC IJB partnership agreement with the statutory organisations (Scottish Borders Council and NHS Borders) for the delivery of the Integration Joint Board delegated functions.

Scottish Government means the Scottish Government and is its legal name. All references in this document are to the legal name.

SOs means Standing Orders.

SFIs means Standing Financial Instructions.

Strategic Plan means the Health & Social Care Partnership Strategic Plan as agreed by the Integration Joint Board.

The Code means the Code of Corporate Governance.

Vice Chair means the Non-Executive Member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

4. CORPORATE GOVERNANCE

Corporate Governance is the term used to describe our overall control system. It details how we direct and control our functions and how we relate to our communities and covers the following dimensions:

- Community focus and communication
- Service delivery arrangements
- Structures and processes
- Risk management
- Systems of internal control
- Standards of conduct

Borders NHS Board is responsible for:

- Giving leadership and strategic direction
- Putting in place controls to safeguard public resources
- Supervising the overall management of its activities
- Reporting on management and performance

5. CONDUCT, ACCOUNTABILITY AND OPENNESS

Members of the Board are required to comply with the Members' code of conduct and the Standards of business conduct for NHS staff.

Board Members and staff are expected to promote and support the principles in the Members' code of conduct and to promote by their personal conduct the values of:

- Public service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Openness
- Accountability and stewardship
- Honesty
- Respect

6. UNDERSTANDING RESPONSIBILITIES ARISING FROM THE CODE OF CORPORATE GOVERNANCE

It is the duty of the Chair and the Chief Executive to ensure that Board Members and staff understand their responsibilities. Board Members shall receive copies of the Code of Corporate Governance. The Code of Corporate Governance is made available to the organisation via electronic means on both the internal intranet and external website. Managers are responsible for ensuring their staff understand their responsibilities.

7. ENDOWMENT FUNDS

The principles of this Code of Corporate Governance apply equally to Members of the Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

8. ADVISORY AND OTHER COMMITTEES

The principles of this Code of Corporate Governance apply equally to all Board Advisory Committees and all committees and groups which report directly to a Board Committee.

9. REVIEW

The Board will keep the Code of Corporate Governance under review regularly and undertake a comprehensive review no longer than every 3 years. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulation of the procedure and business of the Board and of any Committee. The Audit Committee is responsible for advising the Board on these matters.

10. FEEDBACK

NHS Borders wishes to improve continuously and reviews the Code of Corporate Governance regularly. To ensure that this Code remains relevant, we would be happy to hear from you with regard to new operational procedures, changes to legislation, confusion regarding the interpretation of statements or any other matter connected with the Code.

Comments and suggestions for improvement are most welcome, and these should be sent to:-

Board Secretary
NHS Borders
Headquarters
Borders General Hospital
Melrose TD6 9DB

Telephone: **01896 825525**
Email: **iris.bishop@borders.scot.nhs.uk**

SECTION A

How business is organised

1. THE BOARD AND ITS COMMITTEES (DIAGRAM)

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

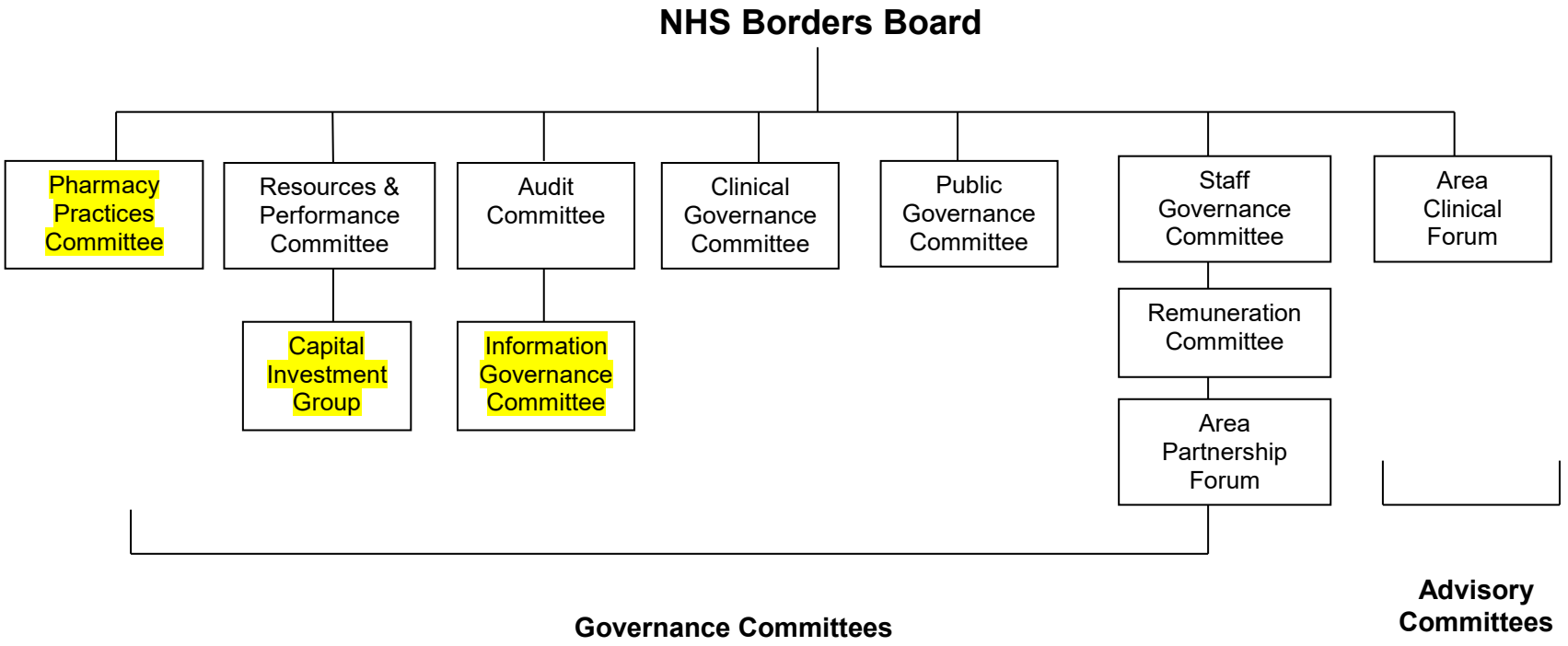
1. General
   Board Members – Ethical Conduct
2. Chair
3. Vice-Chair
4. Calling and Notice of Board Meetings
   - Deputations and Petitions
5. Conduct of Meetings
   - Authority of the Person Presiding at a Board Meeting
   - Quorum
   - Adjournment
   - Business of the Meeting
   - Board Meeting in Private Session
   - Minutes
6. Matters Reserved for the Board
7. Delegation of Authority by the Board
8. Execution of Documents
9. Committees
10. Guidance to exemptions under the Freedom of Information (Scotland) Act 2002
11. Records management

3. STANDING COMMITTEES

1. Establishing Committees
2. Membership
3. Functioning
4. Minutes
5. Frequency
6. Delegation
7. Committees
8. Purpose and Remits
   A. Resources and Performance Committee
   B. Capital Investment Group (sub-committee of Resources & Performance Committee)
   C. Audit Committee
   D. Information Governance Committee (sub-committee of Audit Committee)
   E. Clinical Governance Committee
   F. Staff Governance Committee
   G. Remuneration Committee (sub-committee of Staff Governance Committee)
   H. Public Governance Committee
   I. Area Clinical Forum
   J. Area Partnership Forum
   K. Pharmacy Practices Committee

Section A - Appendix 1: The Heath Boards (Membership and Procedure) (Scotland) Regulations 2001

1. THE BOARD AND ITS COMMITTEES



* The Pharmacy Practices Committee has delegated authority from the Board to meet when there are applications to consider in line with Statutory Instrument 1995 NO 414 (S28)
The National Health (Pharmaceutical Services) Service (Scotland) - Regulations 1995

2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 confirms the matters to be included in the Standing Orders. This is attached for reference at Appendix 1 of this section. The following is NHS Borders' practical application of these Regulations.

STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF BORDERS NHS BOARD

1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Borders NHS Board, the common name for Borders Health Board, and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis, and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development)

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations and any request to co-opt member(s) to the Board. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the

meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Borders NHS Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board Secretary shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board's website.

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. The non-executive member of the Board with the whistleblowing portfolio is excluded from being Vice-Chair. A member who is an employee of the Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Chief Executive or Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason). the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least five times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member which meeting the item will be discussed. If any member has a specific legal duty or

responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

Deputations and petitions

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days

before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has concluded their presentation. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of a Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

The Agenda

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

Decision-Making

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/ or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

<u>Board Meeting in Private Session</u>

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.

- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute.

6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Operational Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Operational Plan, the Board should receive it at a public Board meeting.)
f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: Note: This must be considered when the Board meets in private session. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the

accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)

k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.)
n) Appointment of Consultants.

Within the above the Board may delegate some decision making to one or more executive Board members.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions (Section G) and the Scheme of Delegation (Section F).

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person

authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required, and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members includes some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However if the committee elects to consider certain items as restricted business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A

committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Borders NHS Board and is not to be counted when determining the committee's quorum.

10. Freedom of Information (Scotland) Act 2002

10.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective, so that it includes all records held by the Board prior to 2005 as well as since that date.

10.2 Under FOI(S)A NHS Borders is required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale;
- Maintain a publication scheme of information to be routinely published;
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information.

10.3 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents;
- committee minutes and notes;
- correspondence including e-mails;
- statistical information.

10.4 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

10.5 All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.

10.6 Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002 which is available on the NHS Borders intranet Information Governance site at http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

10.7 Briefings on how to apply exemptions can be found on the Scottish Information Commissioners website at http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

10.8 For further advice on the Freedom of Information (Scotland) Act 2002, processes and application contact the Freedom of Information Officer or Communications Team.

11. Records management

11.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

11.2 Separate guidance has been produced for records management. The NHS Borders Records Management Policy can be found on the NHS Borders Intranet Information Governance site at http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

3. STANDING COMMITTEES

1. Establishing Committees

1.1 The Board on the recommendation of the Chair shall create such Committees, as are required by statute, guidance, regulation and Ministerial direction and as are necessary for the economical efficient and effective governance of the Boards' business.

1.2 The Board shall delegate to such Committees those matters they consider appropriate. The matters delegated shall be set out in the Purpose and Remits of those Committees detailed in Paragraph 8, Purpose and Remits

1.3 The Chair may vary the number, constitution and functions of Committees at any meeting by specifying the proposed variation.

2. Membership

2.1 The Board on the recommendation of the Chair shall appoint the membership of Committees on an annual basis. By virtue of their appointment the Chair of the Board is an ex officio member of all Committees except the Audit Committee.

2.2 The Board on the recommendation of the Chair shall appoint the Chairs of the Governance Committees of NHS Borders Board.

2.3 Any Committee, shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.4 In recommending to the Board the membership of Committees, the Chair shall have due regard to the Committee purpose, role and remit, and accountability requirements as well as the skills and experience of individual Non Executives and any requirements associated with their recruitment. Certain members may not be appointed to serve on a particular Committee as a consequence of their positions. Specific exclusions are:

- Audit Committee - Chair of the Board together with any Executive Member or Officer.
- Remuneration Committee - any Executive Member or Officer.

2.5 The Board on the recommendation of the Chair has the power to vary the membership of Committees at any time, provided that this is not contrary to statute, regulation or direction by Scottish Ministers and is in accordance with the paragraph 2.4 above.

2.6 The Board on the recommendation of the Chair shall appoint Vice-Chairs of Committees. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

2.7 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Chair

recommend to the Board the appointment of a Chair of a Committee who is not a Non-Executive Member, such circumstances are to be recorded in the Minutes of the Board meeting approving the appointment.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be practical by the Chair after the vacancy takes place.

3. Functioning

3.1 An Executive member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek the approval of the Chair to appoint Sub-Committees for such purposes as may be necessary.

3.3 Committees may from time to time establish working groups for such purposes as may be necessary.

3.4 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted members who are not members of the Board, are deemed to be acting on behalf of the Board.

3.5 During intervals between meetings of the Board or its Committees, the Chair of the Board or the Chair of a Committee or in their absence, the Vice Chair shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the terms of reference of the Committee and require a decision which would normally be taken by the Committee. All decisions so taken should be reported to the next full meeting of the relevant Committee. It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

4. Minutes

4.1 The approved Minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information, and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee meeting shall also be submitted to the next meeting of the Committee for approval as a correct record.

4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

5. Frequency

5.1 The Committees of the Board shall meet no fewer than four times a year.

6. Delegation

6.1 Each Committee shall have delegated authority to determine any matter within its purpose and remit, with the exception of any specific restrictions contained in Section F, Section 1 (Reservation of powers and delegation of authority – Matters reserved for Board agreement only).

6.2 Committees shall conduct their business within their purpose and remit, and in exercising their authority, shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the purpose and remit, or in these Standing Orders, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Borders policies and the Code of Corporate Governance.

6.4 The Chair may deal with any matter falling within the purpose and remit of any Committee without the requirement of receiving a report of or Minute of that Committee referring to that matter.

6.5 The Chair may at any time, vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Chair in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to a number of Committees, and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation, which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

7. Committees

- Resources and Performance Committee
- Capital Investment Group
- Audit Committee
- Information Governance Committee
- Clinical Governance Committee
- Staff Governance Committee
- Remuneration Committee (sub-committee of Staff Governance Committee)
- Public Governance Committee
- Area Clinical Forum
- Area Partnership Forum
- Pharmacy Practices Committee

8. Purpose and Remits

A) RESOURCES AND PERFORMANCE COMMITTEE

1.1 Purpose

The Resources and Performance Committee (R&PC) is established in accordance with NHS Borders Board Standing Orders and Scheme of Delegation.

The Resources and Performance Committee is a Standing Committee of the NHS Board.

The overall purpose of the Resources and Performance Committee is to provide assurance across the healthcare system regarding resources and performance, ensure alignment across whole system planning and commissioning, and to discharge the delegated responsibility from the NHS Board in respect of asset management.

The Committee will receive reports, and draft plans for review and response in respect of; Finance, Performance, Capital, Asset Management, national and regional planning groups and the Health and Social Care Partnership strategic plan.

The Committee will oversee the development of a Financial Strategy for approval by the Board that is consistent with the principle of Patient Safety as our number one priority, but with reference to all other national and local priorities.

The Committee will act as the Performance Management Committee of the Board, the Service Redesign Committee of the Board and influence the early development of the strategic direction of the Board.

The scope of resource will include finance, workforce, property and technology.

1.2 Composition

Membership of the Committee shall be:

- Chair of the Board (Chair)
- All Non Executive Directors
- Chief Executive
- Director of Public Health
- Medical Director
- Director of Nursing, Midwifery & AHPs
- Director of Acute Services
- Director of Quality & Improvement
- Director of Finance
- Director of Workforce
- Director of Planning & Performance
- Chief Officer Health & Social Care Integration (accountable for the performance of the partnership and the delivery of the delegated services).
- Partnership Representative

Attendees shall be:

- Board Secretary (Secretariat)

Attendees may be invited to the Committee at the discretion of the Chair and it is anticipated, depending on the issues to be discussed, that other key individuals from the wider organisation will be asked to attend.

The Lead Officer for the Resources and Performance Committee shall be the Chief Executive.

1.3 Meetings

Meetings of the Resources and Performance Committee will be quorate when one third of the whole number of members, of which at least two are Non Executive Members are present.

The Committee will be chaired by the Chair of the Board.

The Committee will meet no less than 4 times per year and conduct its proceedings in compliance with the Standing Orders of the Board.

The Chair of the Committee, in conjunction with the Chief Executive shall set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business or through the Committee Chair.

The agenda and supporting papers will be sent out by the Board Secretary, at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The Committee will be supported by the Board Secretary who will submit the minutes for approval at the next Resources and Performance Committee meeting, prior to submission to the Board.

To avoid the Committee's agenda becoming over-burdened and unmanageable specific pieces of work may be delegated to the appropriate Director, sub group or short-life task and finish groups reporting to the Committee with very specific remits, objectives, timescales and membership.

1.4 Remit

The remit of the Resources and Performance Committee is to scrutinise the following key areas and provide assurance to the Board regarding:

- Whole system strategic planning including oversight of the healthcare services delegated to the IJB;
- Whole system financial planning, including an overview of budgets delegated;
- Compliance with statutory financial requirements and achievement of financial targets;
- Such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- The impact of planned future policies and known or foreseeable future developments on the underlying financial position of the Board;

- To review the development of the Board's Financial Strategy over a three year period and the Board's Annual Financial Plan making recommendations to the Board;
- The Property and Asset Management Strategy and Capital Plans of NHS Borders.
- The Board's performance against relevant targets and key performance indicators linked to the Scottish Outcomes framework.
- Whole system technology planning.
- Whole system workforce planning.

Appropriate governance in respect of risks, as allocated to the Committee by the NHS Board and/or Audit Committee relating to finance, planning, performance and property, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

1.5 Property and Asset Management

To ensure that the Property & Asset Management Strategy is in line with the Board's strategic direction and;

- that the Board's property and assets are developed, and maintained to meet the needs of 21st Century service models;
- that developments are supported by affordable and deliverable Business Cases with detailed project implementation plans with key milestones for timely delivery, on budget and to agreed standard;
- that the property portfolio of NHS Borders and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework, including assessment of backlog maintenance;
- that there is a robust approach to all major property and land issues and all acquisitions and disposals are in line with the Property Transaction Handbook (PTHB);
- to review the Capital Plan and submit to the NHS Board for approval and oversee the overall development of major schemes, including approval of capital investment business cases. The Committee will also monitor the implications of time slippage and / or cost overrun and will instruct and review the outcome of the post project evaluation;
- to review all Initial Agreements, Outline Business Cases and Full Business Cases and recommend to the NHS Board in line with the Scheme of Delegation.

To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance.

1.6 Arrangements for Securing Best Value

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for:

- The planning, appraisal, control, accountability and evaluation of the use of current and future resources.
- Reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review

action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements.
- The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.7 Allocation and Use of Resources

The Committee has key responsibility for:

- Reviewing the development of the Board's Financial Strategy in support of the Integration Joint Board Strategic Plan, Annual Delivery Plan and Regional Delivery Plans, and recommending approval to the Board.
- Reviewing and agreeing the level of budget to be provided to the IJB for the functions delegated and make recommendations to the Board.
- Reviewing the H&SCI Strategic Plan to ensure the outcomes can be delivered within the Board's revenue and capital plans.
- Reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board.
- Monitoring the use of resources available to the Board.
- Reviewing the Property Strategy (including the acquisition and disposal of property) and make recommendations to the Board.

Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment); the review of the Property Strategy (including the acquisition and disposal of property); the review of all business cases coming forward for recommendation to the Board; and for making recommendations to the Board as appropriate on any issue within its terms of reference.

1.8 Strategy Development

The Committee will review the development of the NHS Board's Strategic Plan, ensuring that strategic planning objectives are aligned with the NHS Board's overall strategic vision, aims and objectives.

The Committee will scrutinise the development of all strategies which require approval by the Board, including the Annual Delivery Plan.

The Committee will ensure that strategies are compliant with the duties of the Board in respect of meeting legislative and good practice requirements.

The Committee will also ensure that there is an integrated approach to planning ensuring that workforce, finance and service planning are linked.

The Committee will ensure appropriate inclusion of National and Regional Planning requirements and monitor overall progress with the East of Scotland planning agenda.

The Committee will ensure NHS Borders input, at an appropriate level, to the draft IJB Strategic Plan, and promote consistency and coherence across the system highlighting issues which may impact the delivery of NHS Board aims and objectives.

1.9 Service Redesign/Transformation

The Committee will provide appropriate oversight to significant service redesign including security for cases for change and to ensure this is progressed in a collaborative way working across health, social care and other organisations, with explicit links between service redesign, service improvement, workforce planning and the strategic priorities for NHS Scotland.

The Committee will review and scrutinise all business cases coming forward and recommend for approval by the Board as appropriate.

1.10 Performance Management

The Committee will review the NHS Board Performance Management Framework ensuring it is in line with the National Performance Framework and make recommendations to the NHS Board.

The Committee will review the NHS Board's overall performance and planning objectives, and ensure mechanisms are in place to promote best value, improved efficiency and effectiveness and decision making across the healthcare system

The Committee may, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost-effective level.

The Committee will seek assurance on a rigorous and systematic approach to performance monitoring and reporting across the whole healthcare system to enable more strategic and better informed discussions to take place at the NHS Board.

The Committee will seek assurance as to the adoption of a risk based approach to performance management through routine review. This will focus on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against whole system performance targets.

The Committee will maintain oversight of progress with the implementation of the financial improvement programme, receive reports, receive assurance on effective engagement, and provide support and advice.

1.11 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee.

In order to fulfil its remit the Resources and Performance Committee may obtain whatever professional advice it requires, and require other individuals to attend meetings as required.

1.12 Reporting Arrangements

The Resources and Performance Committee reports to the Board.

The minutes of the Resources and Performance Committee meetings will be submitted to the next meeting of the Resources and Performance Committee for approval.

The minutes will then be presented to the following Ordinary Meetings of the Board for noting.

1.13 Review

The Terms of Reference of the Resources and Performance Committee will be reviewed on an annual basis.

The Resources & Performance Committee shall undertake an annual self assessment of the Committee's work.

B) CAPITAL INVESTMENT GROUP

1 Purpose

The group is established in order to provide a vehicle for management to address the requirements of the Board and its Committees with respect to the development of infrastructure strategy and related capital investment.

The NHS Borders Capital Investment Group (BCIG) will be responsible for the development and management of the Board's Property and Asset Management Strategy (PAMS) and associated capital plan, including prioritisation of resources available to the plan, and the monitoring of progress against same. The group will also undertake review and approval of capital business cases in line with the revised governance framework (to be developed).

2 Key Principles

In undertaking its business, the group will seek to meet the following functions:

- To provide **assurance** to the Board via the Resources & Performance Committee, on the strategic fit, appropriateness and value for money of capital investment, property and asset management proposals presented to it.

- To provide **accountability** by fulfilling its role as a decision-making body of the Board in respect of matters delegated to BCIG under the Board's scheme of delegation, and in making recommendations to the Board in relation to capital investment, property and asset management.

- To provide an **advisory** role to the Board in relation to capital investment or disinvestment issues.

3 Membership

Membership is as follows:

- Director of Finance (Chair)

- Director of Planning and Performance (Vice-Chair)
- Head of Estates & Facilities
- Head of IM&T
- Head of Planning & Performance
- Deputy Director of Finance
- Finance Business Partners
- Acute Services Representative
- Primary & Community Services Representative
- Mental Health & Learning Disabilities Representative
- Corporate Services Representative
- Head of Procurement
- Partnership Representative
- Medical Director (or Representative)

It is the responsibility of members to nominate a deputy if they are unable to attend any meeting.

4 Frequency of Meetings

As a minimum, the group will meet quarterly in line with the preparation of the Board's annual plan and its quarterly review cycle. Additional meetings may be scheduled to address the requirements of the BCIG business plan (to be developed) and to align with the requirements of the Resources & Performance Committee.

The agenda and papers will be issued at least seven working days in advance of the meeting.

5 Attendance

For matters of prioritisation or approval, the meeting must be quorate.

To be quorate each meeting will have a minimum of 1 Director and no less than a total of six members, which must include:

- A member, or nominated deputy, from each Clinical Board (Acute services, PACS, Mental Health/LD)
- A Finance representative
- A Planning & Performance representative
- Head of Estates and Facilities (if Director of Finance not present)
- Head of IM&T (if Director of Planning & Performance not present)

Decisions will be made by consensus. A veto may be exercised by agreement of both Chair and Vice-Chair.

The Group may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

It is the responsibility of the member to read all papers prior to the meeting to ensure the agenda is followed in a timely manner.

6 Remit

The remit of the group is:

- To provide oversight to the development of longer term strategy in relation to the Board's infrastructure requirements, including (but not limited to) the following:

    - Borders Health Campus development
    - Primary Care Premises Strategy
    - Environmental Sustainability & Transport

- To ensure that the Board's Property & Asset Management Strategy (PAMS) is prepared in line with the requirements of CEL 35 (2010), is aligned to the Board's clinical and other relevant strategies, and is subject to review on a regular basis.

- To make recommendation to the Board (and its Committees) in relation to the prioritisation of capital resources through the development of a five year capital plan.

- To provide challenge and scrutiny to business case submissions in relation to the suitability, feasibility and acceptability of the plans described.

- To review and/or approve business cases for capital investment within the limits of delegated authority.

- To ensure that arrangements are in place for the post-project evaluation of capital investments.

- To provide scrutiny to the process associated with the acquisition and disposal of Board assets.

- To review proposed applications for funding, including external and charitable funding, in order to assess and make recommendations as appropriate.

- To make recommendation and/or approve the utilisation of in year slippage arising from the Board's capital plan.

7 Reporting Arrangements

The NHS Borders Capital Investment Group will report to the Board's Resources & Performance Committee.

A Capital monitoring report will be prepared quarterly for review by the group prior to submission to the Resources & Performance Committee.

Specific pieces of work will be delegated to an appropriate officer or to short-life working groups, where appropriate.

8 Sub Groups

The group may constitute such sub-groups as required to meet the requirements of its workplan.

9 Review

Membership and frequency of the Group will be reviewed annually.

The NHS Borders Capital Investment Group shall undertake an annual self assessment of the Committee's work.

C) AUDIT COMMITTEE

1.1 Purpose

- To assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control.
- To provide assurance to the Board that;-
    - an appropriate system of internal control is in place :
    - business is conducted in accordance with the law and proper standards
    - Public money is safeguarded and properly accounted for
    - Governance arrangements are in place to cover the NHS functions which are delegated and the resources which are provided to the IJB are satisfactory, fully utilised, regularly reviewed and updated.
    - Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question
    - Affairs are managed to secure economic, efficient and effective use of resources
    - Reasonable steps are taken to prevent and detect fraud and other irregularities
    - Effective systems of Risk Management are in place
    - Assurance from risk owners that review and mitigation is undertaken for very high risks
    - Effective systems of Information Governance are in place

1.2 Membership

Non Executive Members
4 core members from the non-executive directors, excluding the Chair of the Board, the Employee Director, Chair of Area Clinical Forum and Scottish Borders Council member.

A core non executive member of the Audit Committee shall be appointed as the Chair of the Committee by the Chair of the Board.

Ordinarily the Audit Committee Chair cannot be the Chair of any other Governance Committee of the Board. The Governance Committees are the Staff Governance Committee, Clinical Governance Committee, Information Governance, Public Governance Committee, and Resources and Performance Committee.

Executive Members (In Attendance)

- Chief Executive (as Accountable Officer),
- Director of Public Health (as Lead for Risk Management)
- Director of Finance, Procurement, Estates and Facilities (as Chief Finance Officer),

Attendees

- Chief Internal Auditor

- External Auditor
- Deputy Director of Finance (Financial Accounting)

Other attendees and senior staff may be invited to the Committee at the discretion of the Chair.

The Lead Officer for the Audit Committee shall be the Director of Finance.

1.3 Meetings

The quorum for the Audit Committee shall be two members.

The Chair of the Committee, in conjunction with the Director of Finance Lead Officer for the Committee will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under AOB or through the committee chair.

Meetings shall be held quarterly. A workplan approved on an annual basis by the Committee will identify the key items of business to be discussed at each meeting.

The agenda and supporting papers will be sent out by the nominated PA, at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The Committee will be supported by a nominated PA who will submit the minutes for approval at the next Audit Committee meeting, prior to submission to the Board.

The Chief Internal Auditor or appointed External Auditor may request a meeting of the Committee if they consider it necessary.

The Audit Committee Chair may convene a meeting of the Audit Committee at any time, or, when requested by the Board, and have the power to exclude all others except members from a meeting.

If deemed necessary by the Audit Committee Chair, meetings of the Audit Committee shall be convened and attended exclusively by members of the Audit Committee and/or the External Auditor or Internal Auditor.

The Chief Internal Auditor and the representative of the appointed external auditors shall have free and confidential access to the Chair of the Audit Committee.

1.4 Remit

The main objectives of the Audit Committee are to ensure compliance with NHS Borders's Code of Corporate Governance and that an effective system of internal control is maintained. The duties of the Audit Committee are in accordance with the Scottish Government Audit Committee Handbook and are as detailed below.

Internal Control and Corporate Governance

To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment (including financial and non-financial controls);
- Information Governance and communication;
- Risk Management;
- Control procedures;
- Decision making processes;
- Monitoring and corrective action.

To review the system of internal financial control, which includes:

- Safeguarding of assets against unauthorised use and disposition
- Maintaining proper accounting records and the reliability of financial information used within the organisation or for publication
- Ensuring that the Board's activities are within the law, regulations, Ministerial Direction and the Board's Code of Corporate Governance.
- Presenting an annual Statement of Assurance on the above to the Board, in support of the Governance Statement by the Chief Executive.

Internal Audit

- Appointment of the organisation to deliver Internal Audit services to the Board
- Review and approval of the arrangements for delivery of Internal Audit
- Review and approval of the Internal Audit Strategic and Annual Plan
- Receive and review all Internal Audit reports in line with the Internal Audit Protocol;
- Receive and review management reports on action taken in response to audit recommendations in line with the agreed follow-up process
- Consideration of the Chief Internal Auditor's Annual Report and Assurance Statement
- Review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures
- Ensure that there is direct contact between the Audit Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors
- Collaboratively work with the other partner bodies in support of the functions delegated to the IJB.

External Audit

- Note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors;
- Review the annual Audit Plan including the Performance Audit programme;
- Consideration of all statutory audit material for the Board, in particular:-
  - Audit reports (including Performance Audit studies);
  - Annual Report;
  - Chief Executive Letters;
  - Monitor management action taken in response to all External Audit recommendations, including VFM studies;

    - Review of matters relating to the Certification of the Board's Annual Report and Accounts (Exchequer Funds), Annual Patients' Private Funds Accounts and Annual Endowment Funds Accounts and the Annual IJB Accounts;
- Meet with the External Auditors at least once per year and as required, without the presence of the Executive Directors;
- Review the extent of co-operation between External and Internal Audit;
- Annually appraise the performance of the External Auditors;
- Review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds and Patient Funds Accounts.

Code of Corporate Governance

- Review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation, Standing Financial Instructions and recommend amendments to the Board;
- Examine the circumstances associated with each occasion when Standing Orders have been waived or suspended;
- Review and assess the operation of any Schemes of Delegation;
- Monitor compliance with the Members' Code of Conduct.

Annual Report and Accounts

- Review and recommend for approval the Annual Accounts for Exchequer Funds;
- Review the Annual Accounts for the NHS Borders Endowment Funds;
- Review and recommend for approval the Annual Accounts for Patients' Funds;
- Review the Annual Report for the Board;
- Review at least annually the accounting policies and approve any changes thereto;
- Review schedules of losses and compensation payments.

Other Matters

- Reviewing and reporting on any other matter referred to the Committee by the Board;
- The Committee has a duty to review its own performance and effectiveness, including its running costs and terms of reference on an annual basis;
- It also has a duty to keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention;
- The Committee shall monitor how the Board addresses risk in regard to potential litigation;
- The Committee shall agree the level of detail it wishes to receive from the Internal and External Auditors;
- The Committee shall review the arrangements that the Board has in place for the prevention and detection of fraud.

1.5 Best value

The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, may seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Audit Committee reports to the Board;
- Following a meeting of the Audit Committee, the minutes of that meeting should be approved at the next Committee meeting and then presented at the following Board meeting;
- The Audit Committee should annually, and within three months of the start of the financial year, approve a work plan detailing the work to be taken forward by the Audit Committee;
- The Audit Committee will produce an Annual Assurance Statement for presentation to the Board. The Annual Assurance Statement will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year.
- The Annual Assurance Statement must be presented to the Board meeting considering the Annual Accounts.

1.8 Review

The Terms of Reference of the Audit Committee will be reviewed on an annual basis. The Audit Committee shall undertake and annual self-assessment of the Committee's work.

D) INFORMATION GOVERNANCE COMMITTEE

Introduction: NHS Borders hereby resolves to establish a committee to be known as the Information Governance Committee (the Committee).

Role: To provide assurance to NHS Borders Audit Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

Membership:

Committee membership

- Medical Director
- Caldicott Guardian, Vice chair
- Senior Information Risk Officer [SIRO]
- Chief Clinical Information Officer (CCIO)
- Acute Services representative

- Primary & Community Services representative
- Mental Health & Learning Disability representative
- General Practitioner
- Area Partnership Forum representative
- Finance representative
- Head of IM&T
- Director of Quality and Improvement
- Information Governance & Cyber Assurance Manager

In attendance

- Information Governance Lead
- Data Protection Facilitator
- Freedom of Information Officer
- Cyber Security Manager
- Committee Administrator

Meetings will not be quorate and no business will be transacted if less than 50% of the members or their representatives are present. Members are to nominate a deputy if they are unable to attend.

Others will also be invited to attend as the Committee sees fit.

Frequency: Meetings shall be held not less than 4 times per annum.

In the event of a planned meeting not being quorate, the recommendations of those who attended will be circulated within 7 days of the meeting for agreement by the majority of the Committee.

The Chair may convene a meeting of the Committee at any time, or when requested by the Audit Committee, and has the authority to exclude all others except members from a meeting.

If an event of significance to the Committee arises between meetings, the Director of Planning & Performance (as executive lead for Information Governance), or their nominated deputy, will bring this to the attention of the chair of the Committee.

The agenda and supporting papers will be sent to members at least 5 working days before the date of the meeting.

Any additional papers can be circulated via email.

Authority: The Committee is authorised by the Audit Committee to investigate any activity within its Terms of Reference. It is also authorised to seek any information it requires from any member, employee or agent of NHS Borders. All members, employees and agents of NHS Borders are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Audit Committee to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

Scope: The Information Governance Committee to provide assurance to NHS Borders Audit Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

The duties of the committee are to:

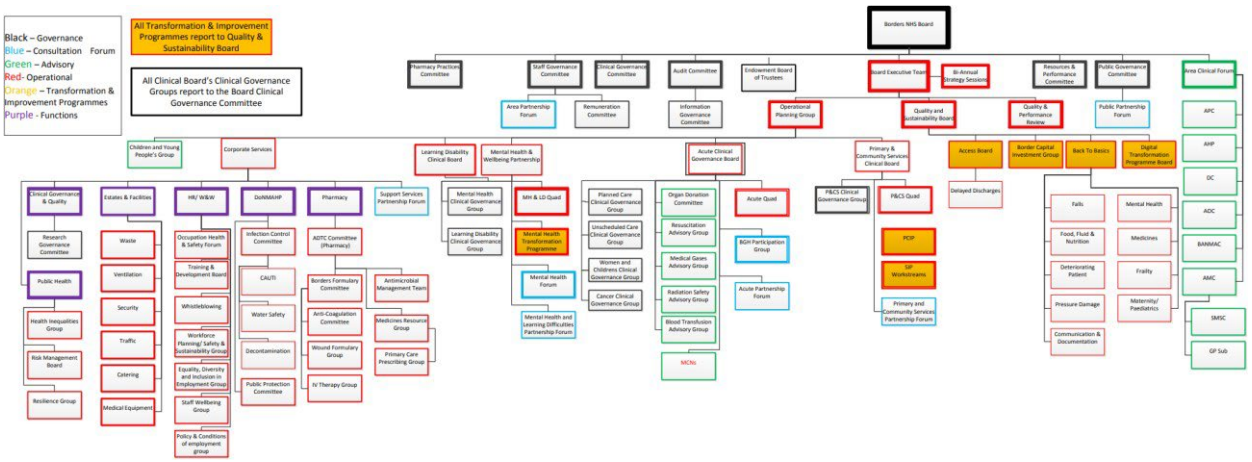
- Ensure that appropriate structures and systems are in place to support and deliver Information governance.
- Assure NHS Borders Audit Committee that these structures are operating effectively
- Ensure NHS Borders complies with UK and Scottish legislation in respect to Information Governance.
- Assist in the development and review of Information Governance policies
- Approve Policies and supporting guidelines as required
- Provide a vehicle for dissemination of Information Governance information with the aim of applying continuity and consistency across NHS Borders.
- Highlight to the Clinical Executive-Operational Group identified trends and developments in Information Governance that may affect the workforce, patients and others.
- Ensure NHS Borders complies with NHS Scotland Information Governance and policies and procedures
- Promote best practice throughout NHS Borders in all Information Governance matters.
- Provide regular reports to NHS Borders Audit Committee by submission of the approved minutes, and report any specific significant problems as they emerge.

These duties will be discharged through a standing agenda, which will include reporting on the following key activities:

- Caldicott / Confidentiality
- Data Protection
- Education, training and staff awareness on Information Governance
- Freedom of Information
- Incident review and monitoring
- IT Security and Cyber Security
- Records Management

These key activities will be amended as required and formally reviewed annually.

Reporting Arrangements



The Committee is operationally accountable to the Clinical Executive with scrutiny and assurance resting with the Board's Audit Committee.

Minutes will be kept of the proceedings of the Committee. The draft minutes are to be circulated, within ten working days to the Chair of the Committee, and within five working days thereafter to members.

The Chair of Committee shall provide assurance on the work of the Committee and the approved minutes will be submitted to the Operational Planning Group meeting for information.

The Committee will conduct an annual review of its role and function.

APPENDIX 1

Definitions

Information Governance means handling information in a confidential and secure manner to appropriate ethical and quality standards. Information Governance is a key issue for all NHS organisations and is fundamental to the effective delivery of health services, particularly as we move towards an electronic health record.

IT Security protects the information and also the physical infrastructure that supports the information from theft or damage to the hardware, software or electronic data, as well as from disruption or misdirection of the services they provide. IT Security also covers the creation of policies and standards to ensure all information is protected.

Cyber Security is solely concerned with preventing electronic attacks against electronic data.

Key Business Areas / Legislative

- Data Protection Act 2018
- Networks and Information Systems Regulations 2018
- UK General Data Protection Regulation
- Freedom of Information (Scotland) Act 2002
- Confidentiality: NHS Scotland Code of Practice

- Public Records (Scotland) Act 2011 – Records Management
- Information Security Standards
- Caldicott Guardianship

E) CLINICAL GOVERNANCE COMMITTEE

1.1 Purpose

To provide the Board with the assurance that clinical governance controls are in place and effective across NHS Borders.

1.2 Composition

a) Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of four Non-Executive Board members, one of whom shall be the Chair of the Area Clinical Forum. One of these members shall be appointed as Chair. Membership will be reviewed annually.

b) Appointment of Chair

The Chair and Vice Chair of the Committee shall be appointed by NHS Borders Board Chair.

c) Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The following NHS Board officers or their representatives will normally attend meetings.

- Chief Executive
- Medical Director
- Head of Clinical Governance and Quality
- Director of Nursing, Midwifery & Allied Health Professionals
- Director of Acute Services
- Director of Public Health
- Director of Psychological Services
- Associate Medical Directors
- Associate Directors of Nursing
- Associate Director of Allied Health Professions
- Head of Midwifery
- Infection Control Manager
- Risk Manager

Others will also be invited to attend as the Committee sees fit.

All Board Members have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

1.3 Meetings

a) Frequency

The Clinical Governance Committee will meet six times a year to fulfil its remit.

b) Agenda and Papers

The Chair of the Committee, in conjunction with the nominated lead Executive and the Head of Clinical Governance and Quality will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business (AOB) or through the Committee Chair.

The agenda and supporting papers will be sent out by the Committee Administrator, seven days in advance of the meetings to allow time for members' due consideration of issues.

c) Quorum

Two members of the Committee, including the Chair, will constitute a quorum. If the Chair is not available, the Vice-Chair will chair the meeting. If neither the Chair nor Vice-Chair is available, the other members will decide who will chair the meeting.

d) Minutes

Formal minutes will be kept of the proceedings by the Committee Administrator and submitted for approval at the next Clinical Governance Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Clinical Governance Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

e) Other

In order to fulfill its remit, the Clinical Governance Committee may, within current financial constraints, obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of board staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

1.4 Remit

The main duties of the Clinical Governance Committee are to receive assurances that clinical governance controls are in place and effective across NHS Borders, on behalf of NHS Borders Board; and that the principles of clinical governance are applied to the health improvement activities of the Board.

a) General

- assure the Board that appropriate structures are in place to undertake activities which underpin clinical governance;

- review the systems of clinical governance, monitoring that they operate effectively and that action is being taken to address any areas of concern;
- review the mechanisms which exist to engage effectively with healthcare partners and the public;
- encourage a continuous improvement in service quality;
- ensure that an appropriate approach is in place to deal with clinical risk management, including patient safety, across the NHS Borders system;
- review performance in management of clinical risk.
- monitor complaints response performance on behalf of the Board;
- promote positive complaints handling, advocacy and feedback including learning from adverse events;
- monitor the processes whereby infections are monitored and controlled;
- monitor mortality in and out of hospital with specific reference to unexpected or unusual deaths;
- receive reports on child and adult protection activities;
- produce an Annual Clinical Governance Report;
- ensure that appropriate action plans are developed, implemented and monitored as a result of published national reports and inquiries; and
- assure the Board that appropriate structures are in place to ensure robust links to the Healthcare Quality Strategy

b) Internal Monitoring

- review the Internal Clinical Governance annual audit priorities;
- make recommendations to the NHS Borders Audit Committee on the requirements for internal audit to support clinical activities;
- receive and consider Clinical Audit Reports along with regular Progress Reports;
- review the actions taken by the Chief Executive, Medical Director and Director of Nursing, Midwifery and Allied Health Professionals on any recommendations or issues arising from Audit Reports; and
- review the effectiveness of the Clinical Audit Programme.

c) External Monitoring

- review Audit Reports from external monitoring bodies in relation to clinical governance; and
- monitor and report to the Board that appropriate actions in relation to external review and monitoring of clinical governance are being taken.

1.5 Risk Reporting

The Committee shall receive reports from relevant service leads within the areas of its remit. As a result of these reports, and considering areas of interest to the Committee, any areas of risk shall be highlighted and reported.

An action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out.

1.6 Best Value

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis. The outcome of this review shall be included in the Annual Report.

1.7 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

1.8 Reporting Arrangements

The Clinical Governance Committee is a standing committee of the Board, and is accountable to the Board and shall formally report to the Board through the Annual Report. Otherwise reporting shall be by exception reporting.

The Chair of the Committee shall submit an Annual Assurance Statement on the work of the Committee to the Board. The timing of this will align to the Board's consideration of the Chief Executive's Statement of Internal Control for the associated financial year.

The Clinical Governance Committee shall undertake an annual self assessment of the Committee's Work.

F) STAFF GOVERNANCE COMMITTEE

1.1 Purpose

To advise the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard; addressing the issues of policy, targets and organisational effectiveness and highlighting any risks in the implementation of the standards. The NHS Reform (Scotland) Act requires Boards to put and keep in place arrangements for the purpose of improving the management of the officers employed, monitoring such management, and workforce planning. This will be demonstrated through achievement and progress towards the Staff Governance Standard through:

- Scrutiny of performance against individual elements of the Staff Governance Standards;
- Data collected during the self-assessment audit conducted under the auspices of the Area Partnership Forum;
- The action plans submitted to, and approved by, the Staff Governance Committee;
- Forms of feedback such as Staff Surveys, imatter;
- Data and information provided in statistical returns reports to the Committee.

1.2 Membership

Membership of the Staff Governance Committee will be:-

- A minimum of four Non-Executive Members, one of which must be the Employee Director.

In addition there will be in attendance:-

- Staff Side Chairs of the Local Partnership Forums
- Staff Governance Champions
- Director of Nursing, Midwifery & AHPs
- Director of HR, OD & OH&S
- Director of Public Health
- Head of Workforce Development & Medical Staffing
- Head of Work & Wellbeing
- Risk Manager
- Safety Manager
- Head of Service Training & Professional Development

The Chief Executive will endeavour to attend at least one Staff Governance Committee meeting per year.

The Committee may invite additional attendees as required by the agenda.

1.3 Meetings

Meetings of the Committee will be quorate when at least three Non- Executive Members are present.

The Chair of the Staff Governance Committee is appointed by the Chair of the Board.

1.4 Remit

- To monitor performance of the Board against the Staff Governance Standard;
- To monitor and evaluate Human Resources Strategies and Implementation plans;
- To monitor pay modernisation processes;
- To establish an Area Partnership Forum that will have the responsibility for facilitating and monitoring the effectiveness of partnership working between management and staff at all levels in NHS Borders and Contractors;
- To develop and approve Employment Policies through the Partnership process;
- To monitor and evaluate the progress of the Staff Governance Committee against the annual Work Plan;
- To provide timely staff governance information required for national monitoring arrangements;
- To provide staff governance information for the statement of internal control;
- To approve and monitor the Workforce Plan.
- The Committee will seek assurance from risk owners that strategic risks relating to workforce are being managed proportionally in line with the risk management process and systems.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Borders NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

1.7 Reporting Arrangements

- The Staff Governance Committee reports to Borders NHS Board.
- Following a meeting of the Staff Governance Committee, the minutes of that meeting should be presented at the next Borders NHS Board meeting
- The Staff Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Staff Governance Committee;
- The Staff Governance Committee will produce an Annual Report for presentation to Borders NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year. The Annual Report must be presented to a Board meeting prior to the Audit Committee considering the Annual Accounts.

G) REMUNERATION COMMITTEE

1.1 Purpose

The fourth edition of the Staff Governance Standard made clear that each NHSScotland Board is required to establish a Remuneration Committee, whose main function is to ensure application and implementation of fair and equitable pay systems on behalf of the Board as determined by Ministers and the Scottish Government and applies to Executives and Senior Managers only.

1.2 Composition

- The Chair of the Board (who will be the Chair);
- The Vice Chair of the Board
- The Employee Director
- Two other Non-Executive Members

In addition there will be in attendance:

- Board Secretary
- Chief Executive
- Director of HR, OD & OH&S
- Associate Director of Workforce

At the request of the Committee, other Senior Officers may also be invited to attend.

All members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

1.3 Meetings

The Committee will meet no less than 3 times per annum**.**

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of HR, OD & OH&S. The Chair may call a special meeting of the Remuneration Committee to address the issue.

Meetings of the Committee will be quorate when three Non-Executive Members are present.

1.4 Remit

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Manager Pay Systems and also to discharge specific responsibilities on behalf of the Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Borders Performance Assessment Agreement and Scottish Government direction and guidance for determining the employment, remuneration, terms and conditions of employment for Executive Directors, in particular:-

- Approving the personal objectives of all Executive Directors in the context of NHS Borders's Annual Delivery Plan, Corporate Objectives and other local, regional and national policy

- Receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors.

Ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for other staff employed under the 'Executive Cohort' and 'Senior Manager' pay systems. The Committee will receive formal reports annually providing evidence of the effective operation of these arrangements.

Promote the adoption of an NHS Borders approach to issues of remuneration and performance assessment to ensure consistency.

Undertake reviews of aspects of remuneration/employment policy for Executive Directors (e.g. Relocation Policy) and other Senior staff (e.g. special remuneration), when requested by NHS Borders Board.

Consider and determine any redundancy, early retiral or termination arrangement in respect of all NHS Borders staff, excluding early retirals on grounds of ill health, and approve these or refer to the Board as it sees fit.

Consider and keep under regular review the arrangements for those NHS Borders staff on external secondments.

To be assured as to the proper processes of the Discretionary Points Committee in the award of discretionary points to eligible specialist, medical and dental staff based on competent recommendations from the appropriate advisory bodies, and to receive reports from the Committee for approval.

To have oversight of the consultant recruitment process on behalf of the Board, who are responsible for the recruitment, and authorisation of appointments of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009.

1.4.1 Confidentiality and Committee Decisions

Decisions reached by the Committee will be by agreement and with all Members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a second and casting vote.

1.4.2 Minutes and Reports

Reports issued to Members will contain full details of the issues to be considered with clear recommendations to the Committee. The minutes will record the decisions reached by the Committee with due regard to confidentiality in relation to individuals.

1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from the Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

1.6 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference, and in doing so, is authorised to seek any information it requires about any employee.

In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and it may require Directors or other officers of NHS Borders to attend meetings.

1.7 Reporting Arrangements

The Remuneration Committee reports through the Staff Governance Committee to the Board;

Following a meeting of the Remuneration Committee the minutes of that meeting shall be marked as “confidential” and made available to the Non Executive Directors.

The Remuneration Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Remuneration Committee.

The Remuneration Committee will produce a high level Annual Report for presentation to the Staff Governance Committee to provide assurance that the Remuneration Committee is addressing appropriate business in line with due process.

The Remuneration Committee will through the Staff Governance Committee provide an annual assurance that systems and procedures are in place to manage the pay arrangements for all Executive Directors and others under the Executive Cohort and Senior Manager pay systems so that overarching Staff Governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential employment issues that are considered by the Remuneration Committee; these can only be considered by the Non-Executive Members of the Board.

The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Staff Governance Committee. This is to ensure that the Staff Governance Committee is in a position in its annual report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Borders.

1.8 Review

The Terms of Reference of the Remuneration Committee will be reviewed on an annual basis. The Remuneration Committee will undertake an annual self assessment.

H) PUBLIC GOVERNANCE COMMITTEE

1.1 Introduction and Remit

The Public Governance Committee has been established as a Committee of the Board to provide assurance to the Board that the requirements of engaging, involving and consulting the public takes place efficiently and effectively in a person centred way in line with statutory obligations and policy requirements.

1.2 Arrangement for Conduct of Business

The Public Governance Committee will operate within the terms of the Board’s Standing Orders, Standing Financial Instructions and the Code of Conduct for Members, and in keeping with the values of NHS Borders.

1.3 Meetings

Frequency

There shall be a minimum of 3 meetings in a year.

Membership

The Public Governance Committee shall consist of:

- A minimum of 3 Non Executive members of the Board appointed by the Board;
- A minimum of 3 independent external members and lay representatives appointed by the Board.

The Chair of the Board shall not be a member of the Public Governance Committee.

Quorum

The quorum of the Committee shall be 4 members of which 2 must be Non Executives of the Board and 2 must be from the independent external and lay representative membership.

Attendance

- Executive Lead for public engagement and involvement
- Head of Communications and Engagement Public Involvement Officer
- HIS-CE Engagement Programme Manager Voluntary Sector Forum representative
- Health & Social Care Partnership representative
- Health Improvement & Equalities representative
- Area Clinical Forum representative
- Clinical Board representatives

Shall normally be in attendance at meetings.

Other officers of statutory and third sector organisations and NHS Borders may attend for specific items of interest as required, such as the Head of Clinical Governance & Quality, third sector representatives.

All Board members are entitled to attend the Committee, except where the Committee determine to undertake business in private.

All Board members are entitled to receive papers one week prior to the meeting for the Committee's consideration.

Where possible at least 50% of the meetings of the Public Governance Committee will be held out with NHS Borders premises

1.4 Key Duties of the Committee

The Public Governance Committee will provide assurance to the Board and Accountable Officer that:

- Reporting and monitoring of Equality and Diversity and Health Inequalities requirements are executed, reported, and monitored in line with applicable legislation and policy recognising the Staff Governance Committee is also vital to governance of staff-sided equalities issues

- Public and patient involvement in service change, improvement and redesign is undertaken and reported and monitored in line with Scottish Government policies and legislative requirements.
- Reporting and monitoring of Community Empowerment (Scotland) Act 2015 Public Participation Requests.
- There is a cross referencing and linkage to the Clinical Governance Committee where appropriate.
- There is a cross referencing and linkage to the Staff Governance Committee where appropriate.
- Accountability structures are in place for any public involvement workstreams.
- There is a sharing of information and issues relating to Human Rights.
- Assurance is sought from risk owners that strategic risks relating to public communication and engagement are being managed proportionally in line with the risk management process and systems.

1.5 Authority

The Public Governance Committee is a mandatory Committee of the Board and is authorised by the Board to:

- Investigate any activity which is within its terms of reference, and in doing so, is authorised to seek any information it requires from any employee. All members and employees are directed to co-operate with any request made by the Committee

- obtain external advice and to secure the attendance at meetings of persons from outside of the Board who bring relevant expertise and experience if the Committee considers this necessary

- consider and endorse/approve relevant board wide policies

- consider relevant risks in regard to communication and engagement and inequalities and whether they need to be escalated to the Board for inclusion in the Corporate Risk Register

1.6 Reporting Arrangements

The Public Governance Committee will report to the Board, and will submit an Annual Report on its activities, outcomes and self-assessment to the Board.

The Public Governance Committee shall annually agree a workplan detailing the work to be taken forward by the Committee during that year.

The Public Governance Committee shall annually review its' Terms of Reference and submit them to the Board Secretary by November each year.

The minutes of the Public Governance Committee will be presented to the Board, and the Chairperson, or nominated deputy, shall advise the Board of any matters of particular significance discussed by the Committee.

I) AREA CLINICAL FORUM (ACF)

The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A

Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- Draw on the full range of professional skills and expertise in their area for advice on clinical matters both locally and on national policy issues;

- Promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process to support the NHS Board in the conduct of its business.

1.1 Purpose

To formulate comprehensive clinical advice to the Board on matters of policy and implementation. The Committee will consult widely with its constituency and the Board. It will be pro-active in:

- reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups;

- the provision of a clinical perspective on the development of the Local Delivery Plan and the strategic objectives of the NHS Board;

- sharing best practice and encouraging multi-professional working in healthcare and health improvement;

- ensuring effective and efficient engagement of clinicians in service design, development and improvement;

- providing a local clinical and professional perspective on national policy issues;

- Ensuring that local strategic and corporate developments fully reflect clinical service delivery;

- Taking an integrated clinical and professional perspective on the impact of national policies at local level;

- Through the ACF Chair, being fully engaged in NHS Board business; and

- supporting the NHS Board in the conduct of its business through the provision of multi-professional clinical advice.

At the request of Borders NHS Board, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- Investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi- disciplinary advice.

- Advise Borders NHS Board of the impact of national policies on the integration of services, both within the local NHS systems and across health and social care.

Authority: The Area Clinical Forum is an Advisory Committee of the Borders NHS Board.

Reporting Arrangements: The Area Clinical Forum will report to Borders NHS Board and submit an Annual Report on its activities to the NHS Board.

The approved minutes of the ACF will be presented in to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken.

Membership: The Area Clinical Forum will consist of the chair, vice chair and another identified representative of each of the statutory Area Professional Committees as follows:-

- Area Allied Health Professionals Committee
- Area Medical Committee
- Area Dental Committee
- Area Optical Committee
- Area Nursing and Midwifery Committee
- Area Pharmaceutical Committee
- Healthcare Scientists Advisory Committee
- Psychologists Team

Others in Attendance: The Committee may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

Sub Committees: The Committee may appoint ad hoc Short Life Working Sub-Committees as appropriate to consider and provide advice on specific issues.

Tenure: Individual members tenure will be determined by the constitution of their parent Committee. If a member resigns or retires, the appropriate Advisory Committee will choose a replacement. Individuals shall cease to be members of the Area Clinical Forum on ceasing to be the Chair, Vice Chair or identified representative of their professional committee.

Officers

Chair: The Committee shall elect a Chair. This shall be on the basis of one vote for each of the Committee members. The Chair shall be elected for 4 years in line with the appointment tenure of Non Executives to the Board. He/she will be eligible for a maximum of 2 consecutive terms of office.

Selection of the Chair will be an open process, and all members may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot (Annex A).

The Chair of the Area Clinical Forum will, subject to formal appointment by the Cabinet Secretary for Health and Wellbeing, serve as a Non-Executive member of Borders NHS Board.

Membership of Borders NHS Board is specific to the office rather than to the person. The normal term of appointment for Board members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

Where the members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Non-Executive member of Borders NHS Board, the new Chair will have to be formally nominated to the Cabinet Secretary as a Non-Executive member of Borders NHS Board for approval.

In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a member of the Area Clinical Forum.

Vice-Chair: The Committee shall then elect a Vice-Chair. The tenure shall be the same as for the Chair.

A Vice Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all members may put themselves forward as candidates for the position. If more than one person puts themself forward an election will be held by secret ballot.

The Vice Chair will deputise, as appropriate, for the Chair, but where this involves participation in the business of Borders NHS Board, they will not be functioning as a Non-Executive member.

Secretary: The Secretary shall be provided by the NHS Board.

Conditions

Interests: Members must declare any pecuniary or other interest which could be construed as influencing the advice given to the NHS Board, and must not participate in discussion leading to that advice.

Removal: An Office Bearer may be removed from office at a meeting of the Committee only if the removal has been included as an agenda item. Such removal would require the agreement of two thirds of the members of the Committee.

Executive Powers: The Chair (or in his/her absence the Vice Chair) will have discretionary powers to act on behalf of the Committee but in doing so is answerable to the Committee.

Membership of the NHS Board: The Chair will be appointed by the Cabinet Secretary as a full member of Borders NHS Board.

Conduct: All members will have due regard to and operate within NHS Borders Code of Corporate Governance.

Standing Orders

Notice of Meetings: The Secretary will ensure that the agenda and relevant papers are issued at least seven days before the meeting whenever possible.

Minutes: The Secretary will ensure that the minutes of the meetings of the Committee are sent to the each member with the agenda and papers of the next meeting.

Meetings: Meetings will be held bi-monthly although the Committee may vary these arrangements to cover holiday months or other circumstances.

Quorum: A quorum of the Committee will be one third of the members. In the event that the Chair and Vice Chair are both absent, the members present shall elect from those in attendance, a person to act as chair for the meeting.

Voting: Where the Committee is asked to give advice on a matter and a majority vote is reached the Chair or Secretary will record the majority view but will also make known any significant minority opinion and present the supporting arguments for both view points.

Alterations to the Constitution and Standing Orders: Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Committee provided notice of the proposed alteration is circulated with the notice of the meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

Any alterations must be submitted to the NHS Board for approval.

ANNEX A

ACF CHAIR ELECTION PROCESS

- Election to be carried out during ACF meeting.
- The current chair will ask for nominations from the ACF members and check nominees willingness to stand for election.
- If there is more than 1 nominee each will be asked to briefly inform the ACF what will be their approach to the role, how they will involve the members and how they will develop the ACF (no more than 5 minutes each).
- Each ACF member will have 1 vote (they may vote for themselves).
- Each member will write their chosen candidate on a paper slip and pass to the secretary.
- The Board Secretary will check the votes and announce the winner.
- In the event of a draw then the Board Secretary will announce this to the ACF.
- Candidates will be asked if they wish to add anything to their earlier statements.
- The ACF members will then vote again.
- If there is a second draw the Board Secretary will announce this and the Chair will ask the members if they are likely to change their vote.
- If not then the decision will be referred to a panel of 3 Non Executive Directors. Candidates will give a short presentation to the panel on their approach to the role, how they will involve the members and how they will develop the ACF.

- The panel will then make a decision and inform the existing Chair.

- Once a decision is made the Board Secretary will then make the appropriate arrangements.

- The ACF Vice Chair will be appointed via the same process

J) AREA PARTNERSHIP FORUM (APF)

1.1 Purpose

The Area Partnership Forum as a strategic body, is responsible for facilitating, monitoring and evaluating the effective operation of partnership working across NHS Borders, and to develop and approve Workforce (ie HR and related) Policies in accordance with agreed timetables and priorities through the partnership process, for adoption of these policies by the Staff Governance Committee on behalf of the Board as the employer.

1.2 Remit

The Area Partnership Forum will:

- Take a proactive approach in embedding partnership working at all levels of the organisation to assist the process of devolved decision making;
- Approve and monitor the implementation of all Workforce Policies (ie HR and related policies);
- Consider and comment on other policies;
- Support the work of the Staff Governance Committee when required;
- Ensure the best Workforce practice is shared across the area;
- Contribute to the development of Strategies and Action Plans to inform the NHS Borders Local Delivery Plan;
- Oversee, monitor and evaluate the processing of staff surveys and staff governance returns to Scottish Government;
- Assess the impact of strategic decisions upon Staff;
- Liaise and ensure a two way communication with the Scottish Partnership Forum;
- Respond to consultation from the Scottish Partnership Forum, its sub groups and supporting infrastructure;
- Ensure that any Workforce strategies and policies are underpinned by appropriate Staff Governance, financial planning, implementation planning and evidence;
- Contribute to local and regional planning arrangements for service and workforce development and delivery;
- Ensure adequate and necessary Facilities arrangements are in place.
- Ensure the views of all Staff Side with an interest in improving local health and healthcare services, local communities and healthcare staff are appropriately heard and considered; (this is in line with national partnership agreements)
- Ensuring Area Partnership Forum members have knowledge and understanding of national health policies and local health issues, and the ability to contribute to strategic leadership and to develop effective working relationships;
- Ensuring all staff, are effectively trained, properly supported and performance is formally reviewed on an annual basis. This statement is in keeping with National

Agreement and is a monitoring role on behalf of the Staff Governance Committee

1.3 Authority

The Forum is authorised by NHS Borders to investigate any activity within its terms of reference.

In order to fulfil its remit, the Area Partnership Forum may obtain whatever professional advice it requires (including that from professional/trade union/national or local representative), and require Directors or other officers of the Board to attend meetings.

The external Auditor and Chief Internal Auditor shall have the right of direct access to the Joint Chairs of the Area Partnership Forum.

The Forum is authorised by the Board to approve employment policies through the partnership process before adoption of these policies by the Staff Governance Committee on behalf of the Board as the employer.

1.4 Reporting Arrangements

- The Area Partnership Forum acts as a sub group of and reports to the Staff Governance Committee;
- Following a meeting of the Area Partnership Forum, the minutes of that meeting will be presented for information at the next meeting of the Staff Governance Committee and approval at the next APF;
- The Area Partnership Forum should annually and within three months of the start of each financial year provide, approve and agree a workplan detailing the work to be taken forward by the Forum;
- The Area Partnership Forum will produce an annual report for presentation to the APF and Staff Governance Committee that will describe outcomes from the Forum during the year.

1.5 Membership

Membership of the Area Partnership Forum shall comprise representatives of management and all recognised staff organisations (Staff Side). [Appendix 1]. For any voting purpose each recognised Trades Union will have one seat/one vote. However all Staff Side representatives are encouraged to attend.

Management and Staff Side should have named members with nominated deputies. Management and Staff Side representatives, including deputies, may attend as observers with the agreement of the joint Chairs. Full Time Officers for recognised Staff Side organisations may attend as an ex officio member.

Membership (and Deputy Membership) is conferred without limit of time subject to acceptable record of attendance and continuing within the position they are accepted on. Membership will be formally updated annually when the Terms of Reference are reviewed.

The Employee Director's Personal Assistant shall ensure that an accurate record of attendance is maintained and absence from three consecutive meetings of the Forum shall result in membership being withdrawn and alternative representative being sought.

Should there then be continued non-attendance of a nominated representative to the APF, the Joint Chairs shall contact the nominated representative and/or (in the case of a Staff Side representative) their relevant staff organisation and clarify if the nominated representative wishes to continue as a member of the APF, or if another nominated representative from that organisation will be replacing them on the APF.

Formal Sub Groups

- Local Partnership Forums x 4
- Terms and Conditions Group
- HR Policy Development Group
- Joint Staff Forum

The Area Partnership Forum will also act as a resource for other groups seeking Staff Side views / opinions relating to NHS Borders development.

The Occupational Health and Safety Forum, as a statutory committee for Health and Safety, will communicate directly to the Area Partnership Forum on matters agreed in partnership with managers and health and safety representatives but is not a sub committee.

1.6 Forum Meetings

1.6.1 Cycle of Meetings

The Forum will meet on an agreed basis, but routinely every 8 weeks, unless otherwise agreed by the Joint Chairs.

1.6.2 Chairing of Meetings

There will be Joint Chairs appointed from the management and Staff Side who will chair meetings of the Forum on an alternating basis. It is the responsibility of the Joint Chairs to agree in advance any agenda items and agenda planning meetings will therefore take place between the Joint Chairs in advance of each meeting of the Forum.

The Employee Director's Personal Assistant will distribute an agenda and supporting papers for each Forum meeting no later than one week before the date of the meeting to all Forum members. Written reports will be required for all agenda items otherwise the matter will not be discussed unless otherwise agreed by the joint chairs in advance.

1.6.3 Quorum

Meetings if the Forum will be deemed to be quorate when:

- a minimum of five members of the management side
- a minimum of five members of the Staff Side are present

1.7 Values

To underpin the working of the Area Partnership Forum, the following values will be adopted and govern the approach taken to consideration of issues, in line with the requirements of MEL (1999) 59:

- mutual trust, honesty and respect;
- openness and transparency in communications;
- recognising and valuing the contribution of all partners;
- access and sharing of information;
- consensus, collaboration and inclusion as the “best way”;
- maximising employment security;
- full commitment to the framework and good employment practice;
- the right of stakeholders to be involved, informed and consulted;
- early involvement of all staff and their trade unions in all discussions regarding change;
- a team approach to underpin partnership working.

The Forum will also promote and act in accordance with the Partnership Standards for NHS Borders.

1.8. Decision of the Forum

Consultation

Any party may request that a matter brought before the Forum be subject to appropriate consultation with management and Staff Side colleagues prior to any final agreement being reached.

Decisions reached by the Forum which impact on the operation of policy and practice will take effect from a date agreed by the parties and will apply to all relevant staff employed within NHS Borders.

Referral

Any matter considered by the Area Partnership Forum which is deemed to fall outwith its terms of reference, or which is subject to Board or Staff Governance Committee approval, will be referred to the Board or Staff Governance Committee on the basis of Area Partnership Forum support. Reference to the Scottish Partnership Forum may also take place as appropriate.

Failure to Agree

In the event of any failure to agree in matters under consideration by the Forum, the matter will be referred via the Joint Chairs to the Staff Governance Committee, who will endeavour to find a way forward.

1.9 Review

These Terms of Reference of the APF will be reviewed on an annual basis and before March of each year.

APPENDIX 1

Management Representatives

The management representatives will be drawn from the senior officers of NHS Borders and will normally include:

- Chief Executive (deputy - Director of Acute Services / Chief Officer)
- Director of Acute Care / Chief Officer (deputy - General Manger)
- Director of HR, OD & OH&S - (deputy - Head of Workforce Planning / Head of Human Resources)
- Head of Workforce Planning (deputy - appropriate HR representative)
- Head of Human Resources (deputy - appropriate HR representative)
- Director of Finance (deputy - Deputy Director of Finance)
- Director of Nursing, Midwifery & AHPs (deputy – Associate Director of Nursing)
- Director of Estates & Facilities (deputy – Deputy Director of Estates)
- General Manager (deputy - Locality Manager / Service Manager / Operational Manager)
- Associate Director of AHPs (deputy appropriate senior AHP)
- Senior Manager – Occupational Health (deputy – Lead Occupational Health Nurse)
- Risk Manager
- Safety Manager
- Communications Manager (deputy – appropriate representative from Communications team)

Other management representatives may attend in response to specific issues under consideration at the Forum

- Staff Side Organisations
- British Association of Occupational Therapy – BAOT
- British Dental Association – BDA
- British Dietetic Association – BDA
- British Medical Association – BMA
- British and Orthoptic Society - BIOS
- Community and District Nursing Association – CDNA
- Community Practitioners and Health Visitors Association
- Chartered Society of Physiotherapy – CSP
- General Municipal Boilermakers Union – GMB Royal College of Nursing – RCN
- Royal College of Midwives – RCM
- Society of Chiropodists & Podiatrists – SCP
- Society of Radiographers – SOR
- UNISON
- UNITE

The Chairs of the Local Partnership Forums attend using either their Trade Union seat or in an ex officio capacity.

Fulltime Union Officials attend in an ex officio capacity.

K) PHARMACY PRACTICES COMMITTEE

Terms of Reference

The Pharmacy Practices Committee is constituted and operates in compliance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995. Statutory Instrument 1995 No 414 (S.28).

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

Made	*6th September 2001*
Laid before the Scottish Parliament	*7th September 2001*
Coming into force	*28th September 2001*

ARRANGEMENT OF REGULATIONS

PART IV

MISCELLANEOUS

12. Revocations

SCHEDULE: Meetings and proceedings of the Board and committees

The Scottish Ministers, in exercise of the powers conferred by sections 2(10), 105(7) and 108(1) of, and by paragraphs 2A, 4, 6 and 11 of Schedule 1 to the National Health Service (Scotland) Act 1978(a), and of all other powers enabling them in that behalf, hereby make the following Regulations:

PART I

GENERAL

Citation, commencement and interpretation

1.—(1) These Regulations may be cited as the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and shall come into force on 28th September 2001.

(2) In these Regulations, unless the context otherwise requires–

"the 1997 Act" means the National Health Service Act 1977(b);

"the Act" means the National Health Service (Scotland) Act 1978;

"Board" means a Health Board constituted under section 2(1) of the Act;

"the Charity Commissioners" means the Charity Commissioners constituted in accordance with section 1 of the Charities Act 1993(c);

"Chief Officer" means the person or persons holding the post of Chief Executive;

"committee" means a committee of a Board and includes "sub-committee"

"contract" includes any arrangement including a NHS contract;

"health service body" means a person or body specified in section 17A(2) of the Act(d);

"meeting" means a meeting of the Board or of any committee;

"member" means a member of a Board and includes the chairperson;

"NHS trust" means a National Health Service trust established under section 12A of the Act(e).

(3) A reference in these Regulations to a numbered regulation is to the regulation bearing that number in these Regulations and a reference in a regulation to a numbered paragraph is to the paragraph bearing that number in that regulation and a reference to the Schedule is to the Schedule to these Regulations.

(a) 1978 c.29; section 105(7), which was amended by the Health Services Act 1980 (c.53) ("the 1980 Act"), Schedule 6, paragraph 5(1)(a) and Schedule 7 and by the Health and Social Services and Social Security Adjudications Act 1983 (c.41) ("the 1983 Act"), Schedule 9, paragraph 24, contains provisions relevant to the exercise of the statutory powers under which these Regulations are made; section 108(1) contains definitions of "prescribed" and "regulations" relevant to the exercise of the statutory powers under which these Regulations are made; paragraph 2A of Schedule 1 was inserted by the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), Schedule 5, paragraph 2; paragraph 4 of Schedule 1 was amended by the 1990 Act, Schedule 5, paragraph 3; and paragraph 11 of Schedule 1 was amended by the 1980 Act, Schedule 6, paragraph 7 and Schedule 7 and by the 1990 Act, Schedule 5, paragraph 7. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

(b) 1977 c.49.

(c) 1993 c.10.

(d) Section 17A(2) was inserted by the 1990 Act, section 30 and amended by the Health Act 1999 (c.8), Schedule 1.

(e) Section 12A was inserted by the 1990 Act, section 31 and amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2, paragraph 46 and by the Health Act 1999 (c.8), sections 46 and 48 and Schedule 4, paragraph 45.

PART II

MEMBERSHIP

Appointment and term of office

2.—(1) All members shall be appointed by the Scottish Ministers.

(2) The term of office of the members shall, subject to regulation 5, be for such period as the Scottish Ministers shall specify on making the appointment.

(3) After the expiration of a term of office a member shall, subject to regulation 6, be eligible for re-appointment.

University members

3. For the purposes of paragraph 2A of Schedule 1 to the Act(a) the Boards in which at least one of the persons appointed to be chairperson or a member must hold a post in a university with a medical or dental school are the Boards in Grampian, Greater Glasgow, Lothian and Tayside.

Remuneration of members

4. Remuneration may be paid, in accordance with such determination as may be made by the Scottish Ministers, under paragraph 4 of Schedule 1 to the Act(b), to the chairperson, a member appointed under paragraph 2A of Schedule 1 to the Act holding a post in a university and any of the other members, except any members holding the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Resignation and removal of members

5.—(1) A member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.

(2) If the Scottish Ministers consider that it is not in the interests of the health service that a member of a Board should continue to hold that office they may forthwith terminate that person's appointment.

(3) If a member has not attended any meeting of the Board, or of any committee of which they are a member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless the Scottish Ministers are satisfied that–

(a) the absence was due to illness or other reasonable cause; and

(b) the member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.

(4) Where a member who was appointed for the purposes of paragraph 2A of Schedule 1 to the Act ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes, the Scottish Ministers may terminate the appointment of that person as a member.

(5) Where any member becomes disqualified in terms of regulation 6 that member shall forthwith cease to be a member.

Disqualification

6.—(1) Subject to paragraphs (2) and (3), a person shall be disqualified for being a member, if–

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere than in Scotland, they have granted a trust deed for the benefit of

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(a) Paragraph 2A was inserted by the 1990 Act, Schedule 5, paragraph 2.
(b) Paragraph 4 was amended by the 1990 Act, Schedule 5, paragraph 3.

their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs;

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body;

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office;

(e) they are a chairperson, member, director or employee of a health service body;

(f) they have had their name removed, by a direction under section 29 of the Act(a), from any list prepared under Part II of the Act and have not subsequently had their name included in such a list;

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application;

(h) they have had their name removed, by a direction under section 46 of the 1977 Act(b) from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list;

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application;

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986(c); or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1)–

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when–

(i) the sequestration of their estate is recalled or reduced; or

(ii) the sequestration is discharged;

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when–

(i) the bankruptcy is annulled; or

(ii) they are discharged;

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when–

(i) that appointment is recalled; or

(ii) the judicial factor is discharged;

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

Appointment and powers of vice-chairperson

7.—(1) For the purpose of enabling the business of a Board to be conducted in the absence of the chairperson, each Board shall appoint a member who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust to be vice-chairperson and any person so appointed shall, so long as they remain a member of the Board, hold office as vice-chairperson for such period as the Board may decide.

(a) Section 29 was amended by the Health and Social Security Act 1984 (c.48), Schedule 8 and by the National Health Service (Amendment) Act 1995 (c.31), section 7 and the Schedule.

(b) Section 46 was amended by the Health Authorities Act 1995 (c.17), Schedule 1 and the National Health Service (Amendment) Act 1995 (c.31), sections 1, 2 and 3.

(c) 1986 c.46.

(2) Any member so appointed may at any time resign from the office of vice-chairperson by giving notice in writing to the chairperson and the members may appoint another member as vice-chairperson in accordance with paragraph (1).

(3) Where the chairperson of a Board has died or has ceased to hold office of where that person has been unable to perform their duties as chairperson owing to illness, absence from Scotland or any other cause, the vice-chairperson shall take the place of the chairperson in the conduct of the business of the Board and references to the chairperson shall, so long as there is no chairperson able to perform their duties, be taken to include references to the vice-chairperson.

PART III

PROCEEDINGS

Meetings and minutes

8.—(1) The meetings and proceedings of the Board shall be conducted in accordance with standing orders made pursuant to regulation 9.

(2) At every meeting of a Board, the chairperson, if present, shall preside.

(3) If the chairperson is absent from any meeting, the vice-chairperson, if present, shall preside, and if the chairperson and vice-chairperson are both absent, the members present at the meeting shall elect from among themselves a person, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, to act as chairperson for that meeting.

(4) All acts of, and all questions coming and arising before, a Board shall be done and decided by a majority of the members of the Board present and voting at a meeting of the Board and, in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

(5) The proceedings of a Board or of any committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member of such committee.

Standing orders

9.—(1) Subject to paragraph (2) and to such directions as may be given by the Scottish Ministers, each Board shall make, and may vary and revoke, standing orders for the regulation of the procedure and business of the Board and of any committee.

(2) Standing Orders under paragraph (1) should include the matters set out in the Schedule.

Appointment and functions of committees

10.—(1) A Board may, and if so directed by the Scottish Ministers shall, appoint committees for such purposes as the Board may determine, subject to such restrictions or conditions as the Board may think fit, or as the Scottish Ministers may direct.

(2) Any committee, but not including any sub-committee, appointed under paragraph (1) shall include at least one member of the Board and may include persons, including trustees of a NHS trust, who are co-opted, and may consist wholly or partly of members of the Board.

(3) Any sub-committee appointed under paragraph (1) may include persons who are co-opted and may consist wholly or partly of members of the Board or wholly of persons who are not members of the Board.

Conflict of interest

11.—(1) Subject to such exceptions and qualifications as may, with the approval of the Scottish Ministers, be specified in standing orders, if a member, or associate of theirs has any pecuniary or other interest, direct or indirect, in any contract or proposed contract (not being a contract for the provision of any of the services mentioned in Part II of the Act) or other matter, and that member is present at a meeting of the Board or of a committee at which the contract or other matter is the subject of consideration, they shall at the meeting, and as soon as practicable after its

commencement, disclose the fact, and shall not take part in the consideration and discussion of, the contract, proposed contract or other matter or vote on any question with respect to it.

(2) The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by this regulation in any case in which it appears to them in the interests of the health service that the disability should be removed.

(3) Any remuneration, compensation or allowances payable to a chairperson or other member by virtue of paragraphs 4, 5 or 13 of Schedule 1 to the Act shall not be treated as a pecuniary interest for the purpose of this regulation.

(4) A member shall not be treated as having an interest in any contract, proposed contract or other matter by reason only that they, or an associate of theirs, has an interest in any company, body or person which is so remote or insignificant that they cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(5) This regulation applies to a committee as it applies to the Board and applies to any member of any such committee (whether or not they are also a member of the Board) as it applies to a member of the Board.

(6) For the purposes of this regulation, the word "associate" has the meaning given by section 74 of the Bankruptcy (Scotland) Act 1985(a).

PART IV

MISCELLANEOUS

Revocations

12. The following Regulations are hereby revoked:–

(a) the Health Boards (Membership and Procedure) (No. 2) Regulations 1991(b)

(b) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993(c)

(c) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998(d)

(d) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999(e).

SUSAN C DEACON
A member of the Scottish Executive

St Andrew's House,
Edinburgh
6th September 2001

(a) 1985 c.66. Section 74 was amended by the Bankruptcy (Scotland) Regulations 1985 (S.I. 1985/1925), regulation 11.
(b) S.I 1991/809.
(c) S.I. 1993/1615.
(d) S.I. 1998/1459.
(e) S.I. 1999/132.

Regulation 9

SCHEDULE

MATTERS TO BE INCLUDED IN STANDING ORDERS REGULATING MEETINGS AND PROCEEDINGS OF THE BOARD AND COMMITTEES

Calling meetings

1.—(1) The first meeting of the Board shall be held on such day and at such place as may be fixed by the chairperson and that person shall be responsible for convening the meeting.

(2) The chairperson may call a meeting of the Board at any time and the chairperson of a committee may call a meeting of that committee at any time or and shall call a meeting when required to do so by the Board.

(3) If the chairperson refuses to call a meeting of the Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of members, has been presented to the chairperson or if, without so refusing, the chairperson does not call a meeting within 7 days after such requisition has been presented, those members who presented the requisition may forthwith call a meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

Notice of Meetings

2.—(1) Before each meeting of the Board, a notice of the meeting, specifying the time, place and business proposed to be transacted at it and signed by the chairperson, or by a member authorised by the chairperson to sign on that person's behalf, shall be delivered to every member or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting.

(2) Lack of service of the notice on any member shall not affect the validity of a meeting.

(3) In the case of a meeting of the Board called by members in default of the chairperson, the notice shall be signed by those members who requisitioned the meeting in accordance with paragraph 1(3).

Conflict of interests

3.—(1) A member shall be excluded from a meeting of the Board or committee in accordance with regulation 11 while any contract, proposed contract, or other matter in which they or an associate of theirs has an interest is under consideration.

(2) The exceptions and qualifications referred to in regulation 11(1) shall be specified.

Quorum

4. No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of members including at least two members who do not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

Conduct of meetings

5.—(1) At any meeting of a committee the chairperson of that committee, if present, shall preside.

(2) If both the chairperson and vice-chairperson (if any) are absent from a meeting of the Board a member, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, chosen at the meeting by the members present shall preside.

(3) If both the chairperson and vice-chairperson (if any) of a committee are absent from a meeting of that committee a member of the committee chosen at the meeting by the other members present shall preside.

(4) If it is necessary or expedient to do so a meeting may be adjourned to another day, time and place.

Voting

6. Every question at a meeting shall be determined by a majority of the votes of the members present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

Records

7.—(1) The names of the members present at a meeting shall be recorded.

(2) The minutes of the proceedings of a meeting including any decision or resolution made at that meeting shall be drawn up and submitted to the next ensuing meeting for agreement after which they will be signed by the person presiding at that meeting.

Suspension and disqualification

8. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

EXPLANATORY NOTE

(This note is not part of the Order)

These Regulations supersede and revoke the Health Boards (Membership and Procedure) (No. 2) Regulations 1991 ("the 1991 Regulations") and their amendments, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998 and the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999.

The Regulations, make provision in relation to Boards established under the National Health Service (Scotland) Act 1978 as to the membership and procedure of these Boards.

Regulation 2 makes provision with regard to the terms of office of members of Boards and regulation 3 makes provision for those Boards which must have at least one member who holds a post in a University with a medical or a dental school.

Regulation 4 deals with the remuneration of the members of Boards and regulation 5 with their resignation and removal from office.

Regulation 6 provides for the circumstances in which a person may be disqualified from membership of a Board. Regulation 7 deals with the appointment of a vice-chairperson of committees and sub-committees of Boards.

In Part III there are various provisions with regard to procedure including provisions as to the meetings of the Boards. Regulation 9 makes provision for standing orders regulating the procedure of meetings of Boards and of committees and sub-committees. Regulation 10 makes provision about the appointment and functions of committees. Regulation 11 makes provision with regard to conflict of interest.

Regulation 12 revokes the 1991 Regulations and all amending instruments as mentioned above which provided for membership and procedure of Boards referred to above.

The Schedule sets out the detail of the matters that must be included in the standing orders made pursuant to regulation 9.

SCOTTISH STATUTORY INSTRUMENTS

2001 No. 302

NATIONAL HEALTH SERVICE

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Blueprint for Good Governance Update**
Responsible Executive/Non-Executive:	**Ralph Roberts, Chief Executive**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness
- Decision

This report relates to a:

- Government policy/directive
- Local policy

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

- Effective

2 Report summary

2.1 Situation

This paper has been developed to provide NHS Board members with an update on the Blueprint for Good Governance.

2.2 Background

The first edition of the Blueprint for Good Governance was published in January 2019 and set out a formal governance model to allow a consistent approach to governance to be developed within each Board.

The Board undertook a self assessment survey and produced an action plan at that time (Appendix 1). The action plan has been kept under review and is attached as a reminder of the outcomes from that initial self assessment. The action plan has been updated for the Board to formally sign off as complete.

Since the first edition Blueprint was issued, work has been progressing at a national level to look at lessons learnt and revised methods of governance following the Pandemic, to define what is meant by good governance. The second edition of the Blueprint was approved by Ministers and issued to NHS Boards on 23 December 2022 and is attached at Appendix 2. Prof John Brown also produced a presentation to support the second edition Blueprint which is attached at Appendix 3.

2.3 Assessment

The second edition of the Blueprint builds on the ethos of active governance that was introduced to NHS Boards in 2019 and covers a number of areas including governance of healthcare, performance frameworks, risk management and collaborative governance.

It also has a greater emphasis on the delivery mechanisms that support governance and the continuous improvement approach needed to ensure governance is responsive to the challenges facing the NHS.

The Board will be required to undertake an annual structured self assessment to review its effectiveness, and identify any new and emerging issues or concerns. The self assessment will be issued by the Scottish Government and take the form of an online survey. A date for the release of the self assessment has not yet been determined.

Should the self assessment be issued over the summer period, the intention would be to collate the findings and draft an action plan for discussion by the Board at its' Development session scheduled for 5 October 2023.

In order to enhance and validate the Boards' self assessment a systematic evaluation of the governance arrangements will be undertaken through an external review commissioned by the Scottish Government every 3 years.

A live streamed session has also been organised for Wednesday 26 April from 10am to 12.30 whereby Richard McCallum and Professor John Brown CBE will be delivering a session on implementation of the 2nd edition of the Blueprint.

2.3.1 Quality/ Patient Care

No quality or patient care issues have been identified.

2.3.2 Workforce

No workforce related issues have been identified.

2.3.3 Financial

No financial issues have been identified.

2.3.4 Risk Assessment/Management

Risk management is an integral part of the active and collaborative approaches to delivering good governance.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

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

This paper has been prepared specifically for the Board and does not require external consultation.

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, 21 March 2023.

2.4 Recommendation

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

The Board is asked to formally **approve** the action plan from the first edition of the Blueprint as complete.

- **Awareness** – For Members' information only.
- **Decision** – Reaching a conclusion after the consideration of options.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, First Edition Blueprint Action Plan.
- Appendix No 2, Second Edition Blueprint for Good Governance.
- Appendix No 3, Blueprint for Good Governance presentation by Prof John Brown.

BLUEPRINT FOR GOOD GOVERNANCE – NHS BORDERS IMPROVEMENT PLAN 2020 – 2023

Blueprint Function	Improvement Action	Lead	Timeline	6 Month Update	RAG STATUS	FINAL COMPLETION 2023
Setting the Direction	Ensure individual and collective ownership by all Board members of the Financial Improvement Programme (FIP).	Chair and Chief Executive	May 2019 with regular review and assessment	Regular updates in place; Finance & Resources Committee fully involved in oversight.	GREEN COMPLETE	**Complete:** FIP now included in the Financial Plan papers received by the R&PC and Board.
	Produce, implement, monitor and review a Communications and Engagement Plan for the FIP and report to the Board on its effectiveness.	Director of Strategic Change & Performance	Commenced in March 2019 – On going.	Update and communications plan for Board on Financial Improvement Programme in place and being progressed.	GREEN COMPLETE	**Complete:** As above
Setting the Direction	Demonstrate support for Scottish Government policies and priorities through implementation of the Board's Clinical Strategy.	Chief Executive	Commenced in March 2019 – On going.	Turnaround programme links to Clinical Strategy. Currently revisiting local strategy implementation and engagement plan.	AMBER – (Turnaround Programme In abeyance due to COVID) COMPLETE	**Complete:** Agreement reached between the Health Board, Local Authority and IJB that there will be one Strategic Plan to sit across all 3 organisations.
Setting the Direction	Approve the financial framework and operational targets for a Strategic Plan to deliver service transformation.	Board	December 2019. The Board agreed in March 2019 to pause the Strategic Plan for 6 months.	Being progressed as part of draft development of 3 year financial plan (due for submission as draft in December 2019).	GREEN	**Complete:** Included in the Annual Delivery Plan.

Blueprint Function	Improvement Action	Lead	Timeline	6 Month Update	RAG STATUS	FINAL COMPLETION 2023
Setting the Direction	Further develop the governance framework and operating principles for IJB interaction (in light of the outcomes of the Integration Self Assessment).	Chief Executive	December 2019	Integration self assessment completed. Action plan in place. Regular sessions with leadership teams in place. IJB Development sessions in place.	GREEN COMPLETE	**Complete:** Introduction of the single Strategic Plan across all 3 organisations will further enhance interactions.
Holding to Account	Review the Key Performance Indicators (KPIs) and information available to the Board to achieve more effective performance management.	Director of Strategic Change & Performance	December 2019	A revamp of the Performance Scorecard information to the Board was undertaken.	GREEN COMPLETE	**Complete:** Performance Scorecard further revamped following active governance session outcomes.
	Ensure that a focussed discussion on understanding of roles is included in the appraisal cycle for all executive and non-executive board members	Chair and Chief Executive	April 2019 – March 2020	Included in Chief Executive/Executive appraisals.	GREEN COMPLETE	**Complete:** Part of Appraisal discussion.
	Develop an agreed Performance framework for the Board that ensures effective Performance management and provides assurance on systems, processes and progress on Strategic objectives	Director of Strategic Change & Performance / Chief Executive	October 2019	Revamped Performance Scorecard report put in place. A more indepth report is provided to S&PC.	GREEN COMPLETE	**Complete:** As above.
	Engage with the National Corporate Governance Steering Group on the opportunity to develop guidance on improved assurance Information systems for use by all Boards and if	Chief Executive	December 2019	To be discussed and agreed at a regional/ national level.	AMBER COMPLETE	**Complete:** National progress was limited.

Blueprint Function	Improvement Action	Lead	Timeline	6 Month Update	RAG STATUS	FINAL COMPLETION 2023
	appropriate offer to support the testing of a national system locally.					
Holding to Account	Provide assurance through the Remuneration Committee that the performance management of executives meets the standards required of NHS Boards.	Director of Workforce	April 2019 – March 2020	Monitored through Remuneration Committee and National Performance Management Committee (NPMC) at a National level.	GREEN COMPLETE	**Complete:** Feedback received from David Garbutt (2022) that NHS Borders performs well in its execution of performance management.
Assessing Risk	Facilitate a comprehensive review by the Board of its Risk Management strategy and implement systems to provide agreed information and assurances to the Board. Agree revised Risk management strategy (following review). Update Board's approach to the identification, recording and assurance of Strategic Risks.	Joint Director of Public Health Joint Director of Public Health Joint Director of Public Health/ Chief Executive	Board Development session fixed for 2 May 2019. June 2019 October 2019	Progressed. Updated Risk Strategy to be agreed at Board in January 2020. Accepted by S&PC on 06.02.2020. Updated Risk Management Strategy & Risk Appetite agreed at Board in December 2019. Revised Risk Management Policy to be approved by Board 04.04.2020.	GREEN COMPLETE GREEN COMPLETE GREEN COMPLETE	**Complete:** Review undertaken and revised approach embedded. **Complete:** Revised Risk Management Strategy approved and enacted. **Complete:** approach revised and enacted.
Engaging Stakeholders	Adopt a corporate vision that prioritises conversations with staff and	Chair	December 2019	Being progressed within updated engagement plan	GREEN COMPLETE	**Complete:** Revised

Blueprint Function	Improvement Action	Lead	Timeline	6 Month Update	RAG STATUS	FINAL COMPLETION 2023
	the public, and evidences changes to organisational process, behaviour and strategy as a result of those conversations.			that is currently being tested and progressed.		Engagement Plan produced.
Engaging Stakeholders	Set up regular active listening clinics by Board members (similar to MSP/MP surgeries) for staff	Chief Executive	December 2019	Regular staff sessions (Blether with the Board) in place. External engagement being put in place (see above).	GREEN (in abeyance due to COVID) AMBER (in abeyance due to COVID)	**Complete:** A new approach has been adopted through Leadership Conversations with staff. **Complete:** Limited progress made.
Engaging Stakeholders	Reinvigorate the Board's Public Engagement arrangements including a revised and updated Public Engagement Forum and Public Governance Committee	Medical Director	October 2019	The Public Governance Committee (PGC) Terms of Reference updated. A proposal to merge the PRG and PPF presented to the PGC. An internal audit on Public Involvement and Engagement has been undertaken.	AMBER COMPLETE	**Complete:** PGC has been reinvigorated.
Engaging Stakeholders	Strengthen the Board's engagement in Borders Community Planning Partnership including development of Community Plans and Locality Plans. Ensure the NHS Board is kept regularly informed about CPP developments and its role in Borders Community Plan and Area Partnership Locality Plans.	Joint Director of Public Health	December 2019	The Chair and Vice Chair are members of the Community Planning Strategic Board. The Board has a yearly update on CPP programmed into its yearly workplan.	GREEN COMPLETE	**Complete:** CPP yearly update is no longer on the Board Business Plan. The single Strategic Plan should fulfil this void.

Blueprint Function	Improvement Action	Lead	Timeline	6 Month Update	RAG STATUS	FINAL COMPLETION 2023
Influencing Culture	Deliver an internal OD programme to include support for leaders in managing across professional and organisational boundaries, developing their ability to influence others and readiness to be influenced by other perspectives and willingness to embrace complexity, ambiguity and uncertainty.	Director of Workforce	March 2019 – September 2020	Project Rise in place for Senior leaders. Team development process in place for Board Executive Team. Series of Board Development sessions in place (agendas being developed).	GREEN COMPLETE GREEN (in abeyance due to COVID)	**Complete:** Compassionate Leadership programme launched. Leadership sessions launched. **Complete**
Influencing Culture	Utilise the joint NHS Borders/Scottish Borders Council development sessions for the IJB / Integration to accelerate the delivery of the Integration outcomes, streamline decision making and maximise efficiencies.	Chief Executive	March 2020	Initial Finance session for all parties on Finance for both NHS Borders and Scottish Borders Council progressed. Further Joint development sessions continually being explored.	GREEN COMPLETE	**Complete.**
Influencing Culture	Promote the cultural characteristics that will support the delivery of the organisation's vision and values.	Chief Executive	March 2020	Revamp of Corporate Objectives to be agreed by the Board 05.03.2020.	GREEN COMPLETE	**Complete:** Corporate Objectives revamped. Leadership programme sessions launched. Compassionate Leadership programme launched.

NHS SCOTLAND

The Blueprint for Good Governance in NHS Scotland

Second Edition
November 2022

Healthier Scotland
Scottish Government

Foreword

In 2018 the Scottish Government recognised the need to ensure that the governance arrangements in NHS Scotland were fit for purpose and keeping pace with the changing policy and financial environment. In response to this challenge, the Director General for Health and Social Care commissioned a review of best practice in healthcare governance. The outcome of the review was a blueprint for an effective governance system that could be adopted across NHS Scotland. The first edition of the Blueprint for Good Governance was published in January 2019 and since then NHS Boards have been adapting this model to meet the needs of their organisation and respond to the challenges faced by the NHS, including the impact of the Coronavirus pandemic.

As NHS Boards look forward to recovering and renewing the health and care system it is important that good governance remains in place to stabilise service delivery while continuing to support the longer term ambitions of service design and reform as part of the Care and Wellbeing Portfolio. To assist Boards in achieving that goal, the NHS Scotland Corporate Governance Steering Group commissioned additional guidance on delivering the approach described in the original Blueprint for Good Governance. The purpose of this document is to share the latest thinking on healthcare governance by publishing a revised version of the Blueprint that will support the NHS as it moves from response to recover and renew.

This second edition of the Blueprint for Good Governance now includes a definition of what is meant by 'good', placing more emphasis on the delivery mechanisms and the need to apply a continuous improvement approach to healthcare governance arrangements. Consideration of the approach to the governance of change now features more prominently in the design of the governance arrangements. The updated guidance also highlights the need for NHS Boards to adopt both active and collaborative approaches to governance.

I would like to thank all those in the Scottish Government, NHS Scotland and the other public and private sector organisations who have contributed to the development of the revised Blueprint for Good Governance. I am particularly grateful to the members of the NHS Scotland Corporate Governance Steering Group for their insight, advice and contribution to the final version of this guide to delivering good governance in healthcare.

Professor John Brown CBE
November 2022

Contents

Supplementary Guidance

1. Introduction

1.1 The purpose of this document is to provide guidance on how to deliver and sustain good corporate governance. While this approach can be adapted and applied to other areas of the public sector, it has been customised for healthcare in Scotland.

1.2 Throughout the document the term healthcare is used in its broadest sense to mean not only the delivery of clinical interventions in response to a known healthcare need but also to cover the much wider, more proactive approach required to address population health improvement and promote health more broadly.

1.3 While the primary audience for this guide is the Board Members and Executive Leadership Teams working across NHS Scotland, it will also be of interest to the UK and Scottish Governments, local authorities, integration authorities, independent (primary care) contractors, and an extensive range of public sector organisations who all have an influence on the health of individuals and communities across Scotland.

1.4 Throughout this guide references to "NHS Boards" should be considered as including the fourteen territorial Health Boards, the six special Health Boards, Health Improvement Scotland and NHS National Services Scotland.

1.5 The guidance reflects the latest thinking and best practice in healthcare governance. It presents a Blueprint for Good Governance that describes the functions, the enablers, the assurance framework, the integrated system and the operating guidance that need to be in place to support good governance. The guidance also aims to improve the effectiveness of governance in the NHS by requiring that the Boards' governance arrangements are subject to continuous review and development.

1.6 The Blueprint provides NHS Education for Scotland and other training providers with a foundation for developing training and development products. It can also be used for providing awareness and information on healthcare governance for a wider community that includes clinicians, managers and other people with an interest in health and social care.

1.7 It is important to acknowledge the requirement that governance arrangements should reflect the needs of the organisation and the environment in which it operates, and NHS Boards should adopt a flexible approach, recognising that their governance systems must take into account the individual circumstances and the specific challenges faced by their organisation.

1.8 Therefore, while it is expected that all NHS Boards adopt the principles, underpinning models and frameworks described in this guide, these should not be seen as prescriptive and Boards are expected to be flexible and adapt them to ensure they have a governance system in place that is at all times appropriate and proportionate for their organisation. This includes introducing temporary changes to governance arrangements that may be required to provide a suitable response to emergency situations, such as those experienced during the Coronavirus pandemic.

1.9 For NHS Scotland to be successful in delivering quality healthcare, good governance is necessary but not sufficient if NHS Boards are to meet or exceed the expectations of their principal stakeholders. To do that, the organisation must also excel at the day-to-day management of operations and the implementation of change.

1.10 Therefore, the guidance provided in this document should be considered in conjunction with the various workstreams and initiatives across NHS Scotland that are focused on managing current operations, recovering from the public health emergency created by the Coronavirus pandemic and redesigning the NHS to meet the demands of the post-pandemic world.

1.11 The guidance begins by highlighting some of the challenges faced by the NHS and '**why**' having good governance is necessary to successfully respond to those challenges. It then goes on to define '**what**' good governance means in relation to healthcare before describing the blueprint for **'how**' this can be delivered, including '**who**' is accountable and responsible for ensuring good governance across NHS Scotland.

2. The Importance of Good Governance

2.1 In common with healthcare providers across the globe, NHS Scotland finds itself operating in an increasingly demanding environment. The impact of demographic change and the growth in long term health conditions at a time of financial constraint meant that the healthcare system was already under significant pressure prior to the Coronavirus pandemic.

2.2 The need to respond effectively to the impact of the public health emergency has added even greater and unprecedented challenges for the NHS. This includes developing the role of the NHS Boards as key 'anchor institutions' in the local and national economy and finding new and innovative approaches to delivering health and social care.

2.3 If the NHS is to address the challenges it faces in improving health at population level and creating a healthcare system that meets the present and future needs of the people of Scotland, the importance of good governance should not be underestimated.

2.4 The **Independent Commission on Good Governance in Public Services**[1] emphasised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes. The Commission also highlighted that weak or ineffective governance fosters low morale and adversarial relationships that lead to poor performance or even, ultimately, to dysfunctional organisations.

2.5 Therefore, it is critical that NHS Boards ensure that robust, accountable and transparent governance arrangements are in place throughout the healthcare system.

2.6 NHS Boards need to be able to demonstrate that their governance arrangements respect and pursue the rights and interests of all their stakeholders, and enable Board Members to hold their Executive Leadership Teams to account for improving population health and addressing health inequalities, while delivering safe, effective and high quality healthcare services.

2.7 Having established why good governance is essential in addressing the challenges the NHS faces in Scotland - but before describing in detail the Blueprint for implementing that approach - it is necessary to have a shared understanding of what is meant by '**good governance**' in healthcare.

1 www.cipfa.org/policy-and-guidance/reports/good-governance-standard-for-public-services

3. The Definition of Good Governance

3.1 A description of good governance that underpins the revised Blueprint has been developed that brings together an updated definition of the '**governance**' of healthcare with a list of the underlying principles that support the delivery of '**good**' governance.

3.2 This description of what is meant by '**good governance**' is further enhanced by explanations of the terms '**active**' and '**collaborative**' in the context of good governance.

The Governance of Healthcare

3.3 The publication of the **NHS Scotland Blueprint for Good Governance**[2] in 2019 described governance as "The system by which organisations are directed and controlled". While this statement was useful in clarifying what was meant by 'governance' in general, it is less helpful when considering what is specifically required to deliver good governance in a healthcare setting in 2022 and beyond.

3.4 Therefore, a more up to date and relevant definition of governance has been developed and approved by the NHS Scotland Corporate Governance Steering Group. The following paragraphs describe the thinking behind the development of this revised definition of 'governance'.

3.5 The **UK Corporate Governance Code**[3] also defines governance as "The system by which organisations are directed and controlled". It expands on that statement by adding that "Governance is about what the board does and how it sets the values of the organisation and is to be distinguished from executive director led day-to-day operational management". This recognises that a good governance system can also help individuals avoid the tension and conflict that can arise in an organisation where the boundaries between roles are not clear.

3.6 **The World Health Organisation and the Royal College of Physicians of Edinburgh's Quality Governance Collaborative**[4] have developed a joint working definition that provides further insight into what excellence in governance means in a healthcare organisation. They describe governance as "The means by which all institutions and organisations involved in the design and delivery of healthcare translate health policy into clinical practice and management in order to improve the quality and efficiency of healthcare. It is the ability to ask the right questions and to implement the right mechanisms to ensure the organisation discharges its duties in

2 www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf
3 www.frc.org.uk/getattachment/88bd8c45-50ea-4841-95b0-d2f4f48069a2/2018-UK-Corporate-Governance-Code-FINAL.pdf
4 www.rcpe.ac.uk/college/QGC

line with its purpose and with focus on good clinical practice". This approach focuses on the governance of clinical practice and emphasises that good governance does not just rely on having systems in place. How well Boards use these systems is a critical factor in the delivery of good governance.

3.7 By bringing these two relevant and helpful definitions together a revised definition of governance in healthcare has been developed for use by NHS Scotland. This definition is expressed as:

> "Governance is the means by which NHS Boards direct and control the healthcare system to deliver Scottish Government policies and strategies and ensure the long term success of the organisation. It is the ability to ask questions and make decisions to improve population health and address health inequalities, while delivering safe, effective and high quality healthcare services. It is to be distinguished from executive-led operational management."

3.8 Governance arrangements in the NHS should include service delivery, change management, workforce, finance, information and asset management. These arrangements must have a clear focus on clinical and care governance, including the governance of clinical research. Particular attention should also be given to educational governance and the governance of the professional standards expected of the clinicians employed by the organisation. (Further advice on educational governance can be found on **NHS Education for Scotland's**[5] website.) All these categories of governance should be considered when NHS Boards determine their arrangements and systems for delivering good governance.

3.9 Having defined what is meant by 'governance' and what should be included in the NHS Boards' governance arrangements, it is helpful to consider next what 'good' looks like in relation to the governance of healthcare.

5 www.nes.scot.nhs.uk

The Principles of Good Governance

3.10 To reflect and describe the latest thinking and best practice in governance in the public sector, ten principles of good governance have been identified. These principles underpin the design of the Blueprint for Good Governance.

3.11 **The Principles of Good Governance can be viewed as an executive summary of what is required to deliver good governance. They are as follows:**

i. Good governance requires the Board to set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture.

ii. Good governance requires a Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships.

iii. Good governance requires that roles, responsibilities and accountabilities at Board and executive level are clearly defined and widely communicated.

iv. Good governance requires an assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.

v. Good governance requires an integrated governance system that co-ordinates and links the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight.

vi. Good governance requires operating guidance that is agreed, documented, widely- communicated and reviewed by the Board on a regular basis.

vii. Good governance requires regular evaluation of governance arrangements to ensure it is proportionate, flexible and subject to continuous improvement.

viii. Good governance requires an active approach that anticipates and responds to risks and opportunities which could have a significant impact on the delivery of corporate objectives, the Board's relationships with stakeholders and the management of the organisation's reputation.

ix. Good governance requires a collaborative approach that ensures the organisation's systems are integrated or aligned with the governance arrangements of key external stakeholders.

x. Good governance requires governance arrangements that are incorporated in the organisation's approach to the management of day-to-day operations and the implementation of change.

3.12 To assist NHS Boards in adopting the Principles of Good Governance, the following paragraphs explain what is meant by an active approach and a collaborative approach in relation to governance in healthcare.

The Active Approach

3.13 Put simply, the active approach to delivering good governance requires Board Members to focus on the right things, consider the right evidence and respond in the right way.

3.14 A more comprehensive description of the active approach to governance has been defined as:

> "Active governance exists when the appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response."

3.15 This approach should not only ensure that Boards can make timely, well-informed, evidence-based and risk-assessed decisions, it will also ensure Board Members can rapidly identify, escalate and manage issues which otherwise might not be seen or understood.

3.16 While an active approach is required to deliver good governance in healthcare, it should be recognised that the NHS is only one of a range of organisations that impacts on the health of the population. Therefore, NHS Boards must also consider how they can influence and interact with the other bodies that have an impact on the delivery of quality healthcare.

The Collaborative Approach

3.17 The NHS works closely with national and local government, integration authorities, independent (primary care) contractors, the private sector, the third sector, charities, academia, communities and citizens to deliver healthcare in a joined up, person-centred manner.

3.18 Consequently, the governance of the organisations that interact with the NHS have a direct impact on population health and the delivery of healthcare services and this must be recognised when designing the governance approach for NHS Boards.

3.19 To assist in the promotion of this approach, the following definition of what collaborative means in relation to governance has been developed:

> "Collaborative governance exists when all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect the needs of each other and work together to integrate or align their arrangements for the governance of the delivery of services and products within the healthcare environment."

3.20 While fully integrating governance can be challenging, it is critical that a collaborative approach to governance is adopted by the key players in the healthcare system to ensure that the end-to- end governance arrangements are understood and aligned in order to achieve the best outcomes for the population and ensure best value in the use of public funds.

3.21 The introduction of the Principles of Good Governance will assist in delivering this approach and the development and communication of a Blueprint for Good Governance that describes the NHS approach to governance arrangements in more detail will further enable the collaborative approach.

4. The Blueprint for Good Governance

4.1 The primary purpose of the Blueprint for Good Governance is to provide guidance on how to deliver and sustain good governance in healthcare.

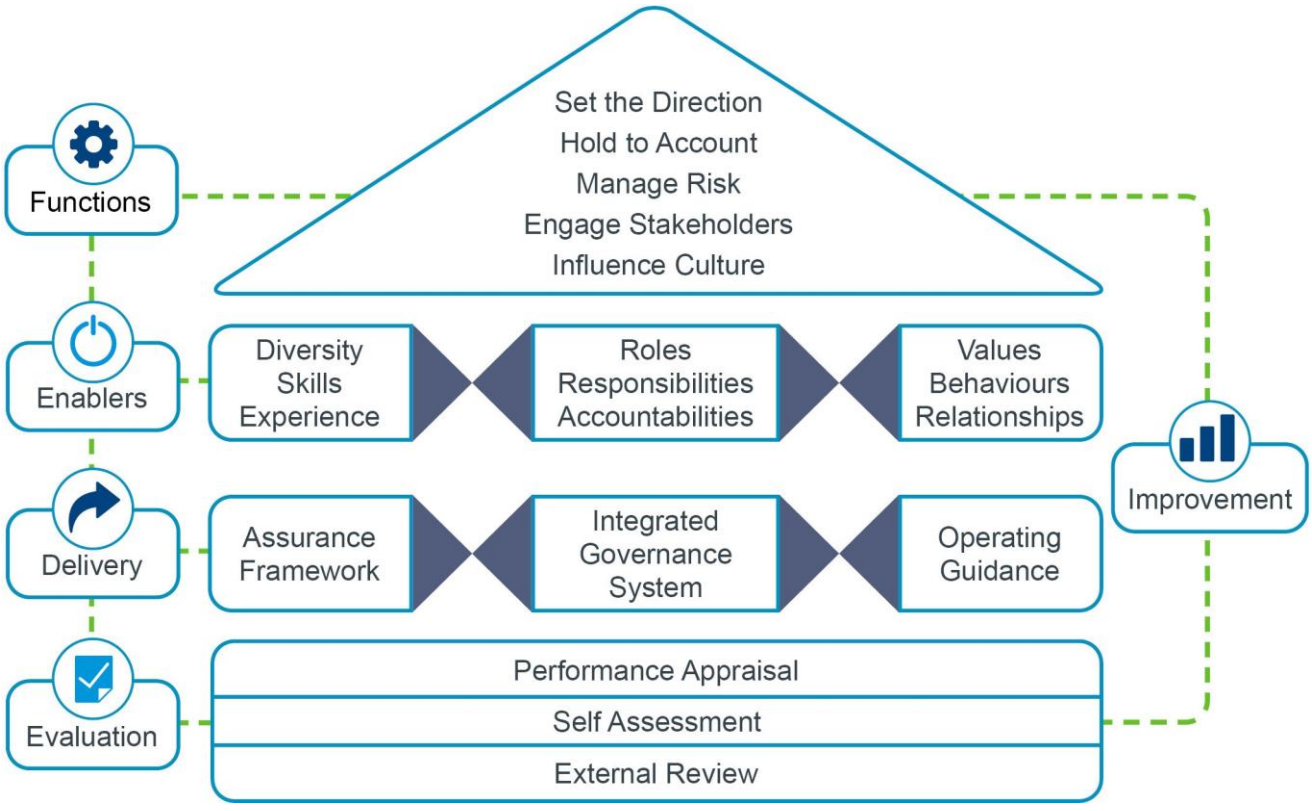
4.2 This model builds on the Principles of Good Governance that describe what good governance looks like and provides more detailed guidance to NHS Boards on the functions and the enablers of good governance. It provides definitions of the assurance framework, the integrated governance system and the operating guidance that also need to be in place to support good governance.

4.3 Adopting the Blueprint also commits NHS Boards to improving the effectiveness of governance in healthcare by requiring that Boards' governance arrangements are subject to regular evaluation and ongoing improvement activity.

4.4 The latest version of the governance Blueprint describes a four-tiered model where each component should be viewed as interdependent and subject to continuous improvement.

The Model

Figure One – The Blueprint for Good Governance



4.5 Ownership of the NHS Scotland bespoke version of the Blueprint for Good Governance rests with the Scottish Government, and accountability for reviewing and refreshing the healthcare model sits with the Director of Health Finance and Governance.

4.6 The following sections of the guide describe the component parts of the Blueprint in more detail, starting with the functions of good governance.

The Functions

4.7 **The Blueprint for Good Governance begins with a definition of the five primary functions of governance. These are described as:**

i. **Setting the direction**, including clarifying priorities and defining change and transformational expectations

ii. **Holding the Executive Leadership Team to account** by seeking assurance that the organisation is being effectively managed and change is being successfully delivered

iii. **Managing risks** to the quality, delivery and sustainability of services

iv. **Engaging with key stakeholders**, as and when appropriate

v. **Influencing** the Board's and the wider organisational culture.

4.8 The following paragraphs define the functions that need to be delivered to ensure good governance is in place.

Setting the Direction

4.9 Board Members are responsible and accountable for setting the overall strategy and direction of the organisation. They are also responsible for encouraging and facilitating innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders.

4.10 To set the direction the NHS Board should provide advice, support and guidance to the Executive Leadership Team by:

- Determining the organisation's purpose, aims, values and corporate objectives
- Approving the corporate strategic and commissioning plans required to deliver the policies and priorities of the Scottish Government
- Setting the operational priorities for the organisation and agreeing the targets for service delivery with the Scottish Government and the Executive Leadership Team
- Allocating the budgets and approving the capital investments required to deliver strategic and operational plans.

4.11 Delivering this aspect of governance is explored further in the supplementary guidance that describes the strategic planning and commissioning component of the integrated governance system.

Holding to Account

4.12 In order to hold the Executive Leadership Team to account the NHS Board requires a clear and accurate picture of current and past delivery of services. This understanding of performance over time is necessary to assist Board Members in identifying systemic change which requires further investigation and be assured that appropriate action plans are in place to address any ongoing performance issues.

4.13 To be assured about the organisation's performance, Board Members must regularly monitor performance, scrutinise results and challenge outcomes. They are required to scrutinise evidence that describes the extent to which:

- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are being delivered to an acceptable level
- Public money is being safeguarded and appropriately accounted and resources are being used to secure 'best value' as set out in the **Scottish Public Finance Manual**[6]
- The requirements of relevant regulations or regulators are being complied with to the necessary standard
- Fair and equitable systems of pay and performance management (as determined by the Scottish Government) are being applied to the reward and recognition of the workforce, including the Executive Leadership Team
- Innovation and transformational change are being delivered and benefits realised
- Continuous improvement and quality management approaches are embedded in all aspects of service delivery and system failures are identified and remediated
- Best practices are shared across the organisation with a learning culture being promoted and nurtured.

4.14 Board Members should aim to be assured rather than reassured about the organisation's performance. This requires Board Members to consider reliable sources of information before being satisfied with the pace and progress in the delivery of outcomes, rather than being advised by others that performance or actions are acceptable.

4.15 Therefore, Board Members must have easy and early access to evidence from a wide range of sources. This requires an effective flow of data, information and feedback at a frequency and in a format that enables Board Members to develop early awareness and understanding of the current situation and the risks and opportunities in the operating environment.

4.16 Delivering this aspect of governance is explored further in the supplementary guidance that describes the assurance information system component of the integrated governance system.

4.17 Effectively holding the Executive Leadership to account not only requires that Board Members have access to the relevant data in the most useful format, an active approach to governance necessitates that data is subject to the right level of scrutiny.

6 www.gov.scot/publications/scottish-public-finance-manual

4.18 To effectively challenge and prompt a worthwhile response it is important that Board Members give due consideration to the tone and manner in which they question the Executive Leadership Team. This includes recognising it is better to ask an open-ended question and to give the respondent time to answer with the appropriate level of detail and nuance.

Managing Risk

4.19 Board Members must have regard to the wider strategic and policy context in which they operate when considering the risks which could have a significant impact on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This also applies to managing the risks to the Board's relationships with key stakeholders and risks to their reputation as a public body.

4.20 Exercising vigilance and managing risk is a key component of the active approach to governance and requires Board Members to be constantly looking forward, as well as looking backwards to hold the Executive Leadership Team to account for service delivery.

4.21 Effective risk management requires that the Board should:

- Agree the organisation's risk appetite
- Approve risk management strategies and ensure they are communicated to the organisation's workforce
- Consider current and emerging risks for all categories of healthcare governance
- Oversee an effective risk management system that assesses the level of risk, identifies the mitigation required and provides assurance that risk is being effectively treated, tolerated or eliminated.

4.22 Focusing on risk will not only assist Board Members to make timely, well-informed strategic decisions that affect the long term future of the organisation, it will also ensure Boards can rapidly identify, escalate and manage issues which otherwise might not be identified or understood.

4.23 Delivering this aspect of governance is explored further in the supplementary guidance that describes the risk management component of the integrated governance system.

Engaging Stakeholders

4.24 To deliver good governance NHS Boards also need to respect and pursue the rights and interests of all the stakeholders in the healthcare system and effective stakeholder engagement is required to establish and maintain public confidence in the organisation as a public body.

4.25 There is a wide range of diverse individuals and communities who can be considered as stakeholders in the NHS. Many of these stakeholders have a keen interest and a major influence in the governance arrangements that exist in the healthcare system. These key stakeholders include:

- The people of Scotland, including their elected representative at the Scottish Parliament, the Scottish Local Authorities and the UK Parliament
- The people who receive the care provided by the NHS, including patients, service users and their families
- The people who are responsible for delivering healthcare, including the Executive Leadership Teams, the workforce employed by the NHS Boards and their Trade Unions and Professional Bodies
- The organisations who are accountable for delivering good governance, including the Scottish Government, the NHS Boards and the Integration Authorities
- The public bodies, private sector, third sector and charitable organisations that interact with and support the NHS, including delivery partners, other health and social care providers and suppliers of services to NHS Boards
- The regulatory bodies such as the Health & Safety Executive, UK and Scottish Information Commissioners, Scottish Fire & Rescue Service, and the Medicines and Healthcare Products Regulatory Agency
- The media who inform and influence public opinion by reporting and commenting on the services provided and the changes proposed to the delivery of healthcare.

4.26 To ensure meaningful engagement with their stakeholders, NHS Boards should ensure that:

- Key stakeholders are identified and the approach to engagement adopted takes into account the stakeholders' interest and influence on the work of the NHS Board
- Appropriate stakeholders are involved in the development of the Board's strategic and commissioning plans, policies and the setting of corporate objectives and operational priorities
- The organisation's purpose, aims, values, corporate objectives, operational priorities and targets are clear, well communicated and understood by all stakeholders, including patients, service users, the public, managers and staff
- The views of the relevant stakeholders are taken into account when designing services and patient pathways.

4.27 Engagement that takes place routinely helps to develop trust between communities and public bodies, fosters mutual understanding and makes it easier to identify sustainable service improvements. Effective stakeholder engagement also assists Boards to create and exploit opportunities to contribute to the Scottish Government's policies on healthcare.

4.28 The duty to involve people and communities in planning how their public services are provided is enshrined in law in Scotland. **The Charter of Patient Rights and**

Responsibilities[7] summarises what people are entitled to when they use NHS services and receive NHS care in Scotland, and what they can do if they feel their rights have not been respected.

4.29 The Scottish Health Council, which operates as **Healthcare Improvement Scotland - Community Engagement**[8], has a key role in supporting NHS Boards and Integration Authorities to meaningfully engage with people and communities to shape national policies and health and social care services. NHS Boards should make use of the resources available to the Community Engagement Directorate to provide assurance that people and communities have been involved in any major service change.

4.30 Therefore, NHS Boards are required to collaborate with Community Engagement to ensure appropriate engagement with local communities throughout changes to services. This is a statutory duty that includes reviewing existing services and planning new services and patient pathways. Guidance on the planning and commissioning of health and social care services is included in the **Planning with People**[9] document published by the Scottish Government and the Convention of Scottish Local Authorities.

4.31 The criticality and potential of community planning in Scotland should be recognised by all NHS Boards. Scotland's community planning mechanisms are particularly relevant to the NHS's wider ambitions to address population health and the underlying causes of inequalities. For this reason, all Boards should take steps to seek assurance that the strongest possible contribution is consistently made to local community planning activities.

4.32 When engaging in community planning activities NHS Boards must also consider their role in promoting community empowerment. In Scotland public service reform and legislation has underpinned community empowerment. **The Community Empowerment (Scotland) Act 2015**[10] included measures which strengthened community planning and community right-to-buy arrangements, and introduced participation requests and asset transfer requests. In July 2019 Audit Scotland published a briefing on **Principles of Community Empowerment**[11]. Empowering communities remains a national priority for the Scottish Government, and all public bodies should be continually developing their systems to facilitate community empowerment. Therefore, NHS Boards should consider how their systems of governance enable and provide assurance on the effectiveness of their approach to community empowerment.

4.33 Delivering this aspect of governance is explored further in the supplementary guidance on strategic planning and commissioning.

7 **https://www.gov.scot/publications/charter-patient-rights-responsibilities-2/documents/**
8 **www.hisengage.scot**
9 **www.gov.scot/publications/planning-people**
10 **www.legislation.gov.uk/asp/2015/6/contents/enacted**
11 **www.audit-scotland.gov.uk/publications/principles-for-community-empowerment**

Influencing Culture

4.34 An organisation's culture comprises its shared values, norms, beliefs, emotions and assumptions about "**how things are and should be done around here**". These 'things' include how decisions are made, how people interact and how work is carried out.

4.35 NHS Boards have a critical role in shaping and influencing organisational culture in healthcare settings. To do this the Board should determine and promote shared values that underpin policy and behaviours throughout the organisation. Board Members must demonstrate the organisation's values and exemplify good governance through their individual behaviours.

4.36 **To ensure the delivery of the organisation's values the Board should encourage and support an organisational culture that reflects the NHS Scotland Staff Governance Standard[12]. These apply to all staff employed by NHS Boards and the Standard requires NHS Boards to demonstrate that staff are:**

i. Well informed
ii. Appropriately trained and developed
iii. Involved in decisions
iv. Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued
v. Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

4.37 **The Staff Governance Standard also requires all NHS staff to:**

i. Keep themselves up to date with developments relevant to their job within the organisation
ii. Commit to continuous personal and professional development
iii. Adhere to the standards set by their regulatory bodies
iv. Actively participate in discussions on issues that affect them either directly or via their trade union/professional organisation
v. Treat all staff and patients with dignity and respect while valuing diversity
vi. Ensure that their actions maintain and promote the health, safety and wellbeing of all staff, patients and carers.

4.38 The Staff Governance Standard should influence and feature in the design and application of all policies and procedures for the management of people by NHS Boards. The ethos of the Staff Governance Standard should also be reflected in the arrangements with private and independent contractors and partner agencies working with the NHS.

12 www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

4.39 Boards must also ensure that the organisation successfully adopts all policies and other best practice in human resource management that is require by the Scottish Government. This includes initiatives such as the **iMatter**[13] staff experience continuous improvement tool and the **National Whistleblowing Standards**[14].

4.40 The Scottish Public Services Ombudsman has taken up the role of the Independent National Whistleblowing Officer. The aim of the role is to make sure everyone delivering NHS services in Scotland is able to speak out to raise concerns, ultimately contributing to ensuring that the NHS in Scotland is as well run as possible. The Independent National Whistleblowing Officer is the final stage of the process for those raising whistleblowing concerns about the NHS in Scotland.

4.41 To support the delivery of this organisational culture, the leadership of the organisation has to be seen as competent and credible, act in the best interest of stakeholders, act at all times with integrity and are reliable in their decisions and actions, in other words they are trustworthy.

4.42 **Therefore the Board must play its part in creating this outcome by recruiting a Chief Executive and Executive Leadership Team who have the ability, ambition, insight and values to deliver a leadership approach that delivers the Staff Governance Standard. This includes ensuring that:**

i. Leaders at all levels are sufficiently visible and give a clear sense of purpose and ambition for the organisation
ii. Leaders help people understand how they contribute to achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets
iii. Leaders set standards, recognise good performance and deal with poor performance when it arises
iv. Leaders encourage people to challenge and look for ways to improve performance and the quality of the services provided
v. Leaders help people identify and make best use of development and career opportunities.

4.43 Having this organisational culture will ensure that NHS Scotland is widely recognised as a great place to work and will generate high level of employee engagement. This will ensure the workforce is focussed on delivering high quality services that are subject to continuous improvement and quality management.

4.44 The next section of the guide considers the enablers to the successful delivery of the functions of good governance.

13 www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter
14 www.inwo.spso.org.uk/national-whistleblowing-standards

The Enablers

4.45 **To facilitate the delivery of the five governance functions, the Blueprint defines the three key enablers for good governance as:**

i. **Acquiring and retaining the necessary diversity, skills and experience** at Board level

ii. **Defining clear roles, responsibilities and accountabilities** for the principal groups and individuals that participate in the governance of healthcare

iii. **Creating relationships** and conducting business in line with agreed values and standards of behaviour.

4.46 The following paragraphs describe each of the enablers in more detail.

Diversity, Skills and Experience

4.47 The Blueprint for Good Governance highlights the importance of diversity and a range of skills and experience at Board level.

4.48 It is the responsibility of the Scottish Government, working with the NHS Board Chair, to ensure the necessary diversity, skills and experience are present across the Board. This includes determining the Board's requirements during the recruitment of new Members and the on-going development of the skills of existing Board Members.

4.49 The recruitment and appointment process is managed by the **Scottish Government Public Appointment Team**[15] who oversee the regulated public appointments process for Ministers.

4.50 The Public Appointments Team follow the Ethical Standards Commissioner's **Code of Practice for Ministerial Appointments to Public Bodies in Scotland**[16]. The Ethical Standards Commissioner and staff have a remit to encourage fairness, good conduct and transparency in public life in Scotland. The Commissioner regulates and monitors the system used to appoint Board Members and their staff play a key role in assuring that appointments are made on merit, using methods that are fair and open and reflect the diversity of Scottish society.

Diversity

4.51 Diversity is a core value at the heart of the day-to-day business of NHS Scotland. NHS Boards are required to hold their organisation to account for the inclusion and diversity strategies that must form part of their staff governance strategy. It is imperative that Boards demonstrate leadership and engagement to support anti-racist work across their organisation, ensuring improvements to equality, diversity and inclusion are continually monitored and challenged.

15 www.gov.scot/collections/public-appointments
16 www.ethicalstandards.org.uk/publication/revised-code-practice-ministerial-appointments-public-bodies-scotland

4.52 To ensure the Board reflects the diversity of their community NHS Boards should support the appointment process by implementing an appropriate attraction strategy which enables the recruitment of a diverse group of Board Members with the skills and experience required to deliver good governance. This includes taking targeted action where appropriate, encouraging and supporting applications from people with protected characteristics that are underrepresented on the Boards of Public Bodies.

4.53 **The Equality Act 2010**[17] defines protected characteristics and the recruitment process must also take into account the **Gender Representation on Public Boards (Scotland) Act 2018**[18] which describes the gender representation objective for a public board as having 50% of non-executive members who are women.

4.54 In addition to reflecting the diversity of the communities they serve, Boards require diversity of thought not only to improve decision-making but also to avoid 'group think', enabling alternative views to be debated and evaluated. If a diverse Board can demonstrate the benefits that come from its expanded knowledge, experience and insight, this should ultimately lead to an improved organisational culture and increased public confidence and trust in the NHS.

4.55 Therefore, whilst it is important to recognise that Board Members are not appointed to represent any particular body or group, there is a clear and welcomed ambition in NHS Scotland to recruit a broad and diverse representation of the population on NHS Boards.

Skills

4.56 NHS Boards require a minimum core set of skills and experience in order to discharge their responsibilities. However, while collectively NHS Boards require certain skills and experience, not every member of the NHS Board will require every skill or experience and Members will bring different levels of skill to the Board.

4.57 The recruitment, training and development of Board Members needs to be focused and built around the skills and experience they require to make an effective contribution to the governance of the organisation.

4.58 In addition to acquiring insight into the organisation and an awareness of its operating environment, Board Members need to be able to deploy a variety of skills that include:

- The capacity to question, challenge constructively and influence decision making
- The capability to recognise, listen to and respect different perspectives
- The ability to analyse and review complex issues, weighing up conflicting opinions and making timely, evidence-based, well-informed and risk-assessed decisions
- The interpersonal skills to communicate and engage with a wide range of organisations and individuals, building relationships, influencing and working collaboratively

17 www.legislation.gov.uk/ukpga/2010/15/contents
18 www.legislation.gov.uk/asp/2018/4/contents

- The confidence and self-awareness to chair, or participate as a member of, key committees that support good governance.

4.59 This definition of the skills required by NHS Boards assists NHS Education for Scotland to develop the induction training, targeted education and development activities required by Boards Members.

Experience

4.60 Board Members also bring a wide range of specialist experience and knowledge to the Board from the public, private, third or voluntary sectors. This can include lived experience of the services provided by the NHS as either a service user or provider. Experience gained in other settings or organisations can equally be of value to the delivery of good governance.

4.61 In addition to any previous experience in a governance role, the list of experience that Board Members can use to support the work of the Board is extensive and can include strategic planning, change management and operations management. Experience and training in financial management and risk management are also relevant to the governance of the NHS, as is human resource management and stakeholder management.

4.62 Board Members' experience also adds to the collective knowledge and understanding at Board level, and this is particularly welcomed around equality, diversity and inclusion, research and innovation, digital and information technology, media and communications, governance and legal issues.

4.63 Consideration should also be given to the extent to which clinicians are represented on the NHS Board. It is critical that Boards have appropriate skills and experience of clinical matters in order to be assured of the safety and quality of healthcare being delivered in both primary and secondary care settings. Having non-executive Board Members from a clinical background can assist in achieving that goal.

4.64 Given the integration of health and social care services in Scotland and the need for collaborative governance, it is also important that some experience of social care is available at Board level in the NHS.

4.65 To support succession planning and the deployment of Board Members to standing committees and other roles NHS Boards should maintain a record of the diversity, skills and experience present in the current Board. Any gaps in the diversity, skills, and experience of the Board should be reflected in the Board's succession planning, highlighted to the Cabinet Secretary when recruiting new Board Members and inform the promotion and advertising of vacancies. Boards may choose to have a Succession Planning Committee to oversee and support this activity.

4.66 The next section of the guide provides more information on '**who**' is responsible and accountable for ensuring good governance by describing the various roles, involved in the governance arrangements for NHS Scotland.

Roles, Responsibilities and Accountabilities

4.67 To support and deliver the functions described in the Blueprint for Good Governance it is essential that there is a common understanding of the roles, responsibilities and accountabilities of the principal groups and individuals that participate in the governance of healthcare.

4.68 Therefore the definitions of roles, responsibilities and accountabilities included in the Blueprint are intended to help the Scottish Government, the NHS Board Members, the Executive Directors and the Board Secretaries identify and deliver their respective functions within healthcare governance.

4.69 Together with the descriptions of the values and standard of behaviours expected of Board members, the definitions of their roles facilitates the performance appraisal of Board Members.

Scottish Government

4.70 The Scottish Parliament is responsible for the legislation that governs the delivery of healthcare in Scotland. The Cabinet Secretary for Health and Social Care has ministerial responsibility in the Scottish Government for the NHS in Scotland.

4.71 The **National Health Service (Scotland) Act 1978**[19] places a duty on the Cabinet Secretary to promote a comprehensive and integrated health service, designed to secure improvement in the physical and mental health of the people of Scotland and the prevention, diagnosis and treatment of illness. The Cabinet Secretary may do anything which they consider is likely to assist in discharging that duty.

4.72 The Scottish Government Directorates for Health and Social Care have responsibility for health policy, the administration of the NHS, social care and public health. This includes setting the standards for governance in NHS Scotland and monitoring the adequacy and effectiveness of the governance arrangements throughout health and social care.

4.73 The Director General for Health and Social Care (who is also the Chief Executive of the NHS) leads the Directorates. With regard to the **Public Finance and Accountability (Scotland) Act 2000**[20] and the **Scottish Public Finance Manual**[21], the Director General is the designated Portfolio Accountable Officer for the Health and Social Care Directorates.

4.74 The Director of Health Finance and Governance has the responsibility for the oversight, development and support of governance arrangements across NHS Scotland and has approved the guidance contained in this document.

19 www.legislation.gov.uk/ukpga/1978/29/contents
20 www.legislation.gov.uk/asp/2000/1/contents
21 www.legislation.gov.uk/asp/2000/1/contents

4.75 The Scottish Government Directorates for Health and Social Care are responsible for various activities within the overall system of governance for health and social care. This includes:

- Developing and implementing law which determines the shape of the public sector and defines the responsibilities and duties of the Scottish Government, public bodies and others for health and social care
- Developing and implementing national strategies and policies and providing support and information to maximise the likelihood of achieving whole-system success
- Recruiting, selecting, appointing and setting the level of remuneration for all members of NHS Boards
- Appointing individuals as Accountable Officers for their organisation (normally the Chief Executive) under the **Public Finance and Accountability (Scotland) Act 2000**[22]
- Developing and implementing a Code of Conduct for Board Members under the **Ethical Standard in Public Life etc. (Scotland) Act 2000**[23] and approving the Code which each body uses
- Developing and promoting good governance practice throughout the system of health and social care. This includes working with NHS Education for Scotland and others to develop and share good practice and provide support and advice on governance matters
- Developing and implementing the performance management framework for health and social care. This involves monitoring and overseeing the performance of public bodies which report directly to the Scottish Government and putting in place a framework of support to those bodies when required to improve and sustainably deliver the required outcomes
- Discharging the Scottish Government's responsibilities as set out in the **Scottish Public Finance Manual**[24]. This includes putting a framework document in place with each public body which sets out its sponsorship relationship with the body and its Accountable Officer.

NHS Boards

4.76 The NHS Boards are legal entities established by the **National Health Service (Scotland) Act 1978**[25] and are required by this legislation to promote the improvement of the physical and mental health and the prevention, diagnosis and treatment of illness of the people of Scotland. To ensure the delivery of this NHS Boards are delegated responsibilities by the Cabinet Secretary to plan, commission and deliver healthcare services and take overall responsibility for the health and wellbeing of the populations they serve.

22 www.legislation.gov.uk/asp/2000/1/contents
23 www.legislation.gov.uk/asp/2000/7/contents
24 www.gov.scot/publications/scottish-public-finance-manual
25 www.legislation.gov.uk/ukpga/1978/29/contents

4.77 To discharge their responsibilities under the 1978 Act, and deliver the Scottish Government policies and strategies for the provision of healthcare, NHS Boards must deliver the functions described in the Blueprint for Good Governance to the standards set by the Scottish Government.

4.78 Therefore, NHS Boards are primarily responsible and accountable for setting strategic direction, holding executives to account for delivery, managing risk, engaging with stakeholders and influencing organisational culture.

4.79 NHS Boards are also held to account by the Scottish Government for:

- Encouraging innovation, driving change and transforming service delivery to better meet the expectations and needs of their key stakeholders
- Adopting an active approach to governance that anticipates and identifies the risks and opportunities facing the organisation, escalating significant issues to the Scottish Government when and where appropriate
- Encouraging a collaborative approach to governance by the key stakeholders in the healthcare system.

4.80 NHS Boards are also expected to actively seek and create opportunities to inform and contribute to the development of Scottish Government policies and strategies for healthcare in Scotland.

4.81 In recognition of the whole-system nature of Scotland's population health challenges, Public Health Scotland is jointly sponsored and has dual accountability lines to both the Scottish Government and to local government via the Convention of Scottish Local Authorities. This is a unique feature for a Scottish public body and requires a commitment to shared decision making, planning and performance management in relation to the work of Public Health Scotland.

4.82 It is important that the Board clearly differentiates its role from that of the Executive Leadership Team. The Chief Executive and Senior Leadership Team should be protected from individual Board Members becoming involved in operational matters. This separation of governance from day-to-day operational management is explored further in the section of the guide on the role, responsibilities and accountabilities of Board Members.

Standing Committees

4.83 To support the work of the NHS Boards a framework of appropriate standing committees should be put in place to support the delivery of good governance.

4.84 Standing committees are established on a permanent basis. They are responsible for the scrutiny of functions, services and matters delegated to them by the NHS Board, making decisions, recommendations and escalating issues to the Board, as appropriate. The standing committees make a significant contribution to the monitoring and evaluation of the progress towards achieving the Board's purpose, aims, values, corporate objectives, operational priorities and targets by providing the time, space and expertise to effectively scrutinise performance across the healthcare system.

4.85 The Board's framework of standing committees must include an Audit and Risk Committee, a Remuneration Committee and a Staff Governance Committee. The territorial Boards and some special Boards are also required to have a Clinical Governance Committee and a Research Ethics Committee. To provide the necessary governance around the regulatory framework for the award of licences for new pharmaceutical premises, territorial Boards must also have a Pharmacy Practices Committee.

4.86 In addition to these mandatory committees Boards may decide to set up additional standing committees to oversee other aspects of the organisation's operations, e.g. Acute Services, Finance and Performance and Population Health and Wellbeing Committees.

4.87 Membership of the standing committees can include non-executive and executive Board Members but the committee must be chaired by a non-executive and have a majority of non- executive members.

4.88 The agenda for the standing committees should be agreed by the committee chair and the lead executive for the committee. The agenda should include standing items to facilitate the work of the committee, including minutes and action logs, regular items as set out in the committee's Annual Cycle of business, e.g., performance and financial reports, risk registers and ad-hoc items that require attention by Board Members.

4.89 Items should be referred to a standing committee if they require input on an issue or risk that has been delegated to that committee. The standing committee members should be encouraged to add value by providing a different perspective on the issues, risks or opportunities faced by the organisation.

4.90 In addition to submitting minutes of their meetings to the NHS Board, the standing committee chairs should highlight to the Board any areas of concern or risks that require escalation to the Board for their further consideration or decision. Standing committees should also provide an annual report of their activity to the Board.

Advisory Committees

4.91 In addition to the standing committees, NHS Boards can also be supported by advisory committees to ensure that Board Members are well-informed on the issues, risks and opportunities facing the organisation.

4.92 To ensure that the views of the workforce are properly and fully considered by the NHS Board, an Area Partnership Forum must be put in place to inform and influence the Board and the Executive Leadership Team's thinking and decision-making on issues affecting the workforce. Membership of the Area Partnership Forum should include representatives of recognised Trade Unions and managers that represent the range of services provided by the organisation.

4.93 In order to harness the knowledge, skills and commitment of the clinical community across NHS Scotland and ensure that appropriate professional advice is available to NHS Boards and encourage clinicians to contribute to the planning and delivery of services, the territorial Boards must also have in place an Area Clinical Forum.

4.94 The Area Clinical Forum should be supported by a range of clinical professional advisory committees, i.e. an area medical committee, dental committee, nursing and midwifery committee, pharmaceutical committee and optical committee. The special Health Boards, Health Improvement Scotland and NHS National Services should develop appropriate arrangements for clinical engagement in accordance with the circumstances of their organisation.

4.95 To provide the NHS Board with advice on issues affecting clinical practice and employee relations the role of the advisory committees should include:

- Engaging with the Executive Leadership Team to provide insight, support and advice on the delivery of services and the implementation of change
- Supporting and advising the NHS Board in their governance of the organisation, including advice on the impact of any proposed changes that effect the employment of staff
- Identifying opportunities for the improvement of services and the wellbeing of the workforce.

4.96 Advisory committees, including the Area Partnership Forum and the Area Clinical Forum, can also play an important role in supporting the NHS Board in discussions with key stakeholders.

4.97 NHS Boards may also decide to set up additional advisory committees to focus on other aspects of the Board's business, such as equality, diversity and inclusion, or climate change and sustainability, where these issues are not already included in the remit of existing standing committees.

Networks

4.98 The NHS makes extensive use of networking to support the delivery and continuous improvement of services and the introduction of innovation and new ways of working. These also help to improve the flow of information across the NHS and establish closer working relationships between key members of the organisation.

4.99 The same approach is applied to the governance of healthcare and in addition to the Board standing committees and the advisory committees, the governance system in NHS Scotland is supported by a range of informal networks.

4.100 These networks provide regular opportunities for the leadership of the NHS to meet informally and consider any issues or risks that may be of concern, including those still to surface through the existing reporting systems. This is a valuable addition to the delivery of good governance through the formal governance arrangements.

4.101 Although the networks are separate from the decision-making bodies and the formal governance system, the benefits of networking to provide peer support, work collaboratively, share best practice, influence stakeholders and improve engagement and communications across the healthcare system is recognised, encouraged and supported by the Scottish Government.

4.102 Within NHS Scotland there are a number of such governance networks, notably the NHS Board Chairs Group and the NHS Chief Executives Group. A Vice Chairs Group, a Whistleblowing Champions Network and an Audit and Risk Committee Chairs Network have also been set up to support healthcare governance across Scotland.

4.103 A similar arrangement has been put in place for the Integration Joint Board Chairs and Vice Chairs. Introducing this network has provided an opportunity to brief and support the Integration Joint Board Members and encourage and facilitate collaborative leadership and the sharing of best practice across the Health and Social Care Partnerships. This has created another space where NHS Board Members can consider the wider context in which we operate and identify cross- system risks to the successful delivery of our services.

4.104 To promote the benefits of networking and improve the wider understanding of the purpose and remit of the networks, it is important that they publish their terms of reference. This helps communicate the work of the network and encourage other stakeholders to engage with them.

Board Chairs

4.105 The Chair of the NHS Board is responsible for:

- Leadership of the Board, ensuring that it effectively delivers its functions in accordance with the organisation's governance arrangements
- Keeping the organisation's governance arrangements and the Board's effectiveness under review
- Setting the agenda, format and tone of Board activities to promote effective decision making and constructive debate
- In the absence of a Succession Planning Committee, nominating Board Members to standing committees, Integration Joint Boards and other roles within the NHS Board and partner organisations. The allocation of roles to Board Members, including the Chair of standing committees, should be formally approved by the full Board
- Developing the capability and capacity of the Board by contributing to the appointment of Board Members; appraisal and reporting on their performance; identifying appropriate training and development opportunities; and ensuring effective succession planning is in place
- Providing performance management and identifying development opportunities for the Chief Executive
- Representing the organisation in discussions with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities and other key stakeholders. This is a responsibility shared with the Chief Executive.

4.106 The Chair is appointed by the Cabinet Secretary following a recruitment exercise undertaken by the Scottish Government Public Appointments Team.

4.107 This description of the role of the Board Chair should be seen as indicative of the role and responsibilities of the Chairs of the standing committees.

Board Vice Chairs

4.108 In addition to that of a NHS Board Member, the role of the Vice Chair includes:

- Deputising for the Chair as required in any of their duties, including representing the NHS Board in engaging with internal and external stakeholders
- Taking the lead on specific areas of the work on behalf of the Board Chair e.g. governance projects or reviews
- Providing advice, support and assistance to the Board Chair in carrying out their responsibilities
- Acting as a 'sounding board' and 'critical friend' to the Chair and the other Board Members.

4.109 The Vice Chair also provides an alternative route for Board Members to raise issues or concerns if they feel unable to do so with the Chair. This is an important part of the checks and balances within governance and accountability. If mediation by the Vice Chair does not resolve the situation, the issue or concern should be escalated to the Scottish Government.

4.110 Following an open selection process and confirmation of their suitability by the Cabinet Secretary, the appointment of the Vice Chair is made by the Board from the publicly appointed Board Members. The Board's Whistleblowing Champion and Board Members who are also employees of the organisation are excluded from this arrangement.

Board Members

4.111 All NHS Board Members are appointed by the Cabinet Secretary for Health and Social Care and the Cabinet Secretary has the authority to terminate their appointment if it is consider not in the interest of the health service that a member of a Board hold continue to hold that office.

4.112 The Board membership consists of non-executive and executive members. There are two broad categories of non-executive Board members: those appointed through the public appointment process after an open recruitment exercise, and those whom the Board's principal stakeholders have nominated for appointment by the Cabinet Secretary.

4.113 The stakeholder members are the Employee Director and, for territorial Boards, the Chair of the Area Clinical Forum and a representative from each of the Local Authorities in the area covered by the NHS Board.

4.114 NHS Grampian, NHS Greater Glasgow and Clyde, NHS Lothian and NHS Tayside also have a stakeholder member to represent the medical school of the Universities of Aberdeen, Glasgow, Edinburgh and Dundee. This reflects the contribution these Boards make to NHS Scotland as the principal teaching Boards in Scotland.

4.115 The executive members for territorial Boards are the Chief Executive, Director of Finance, Nurse Director, Medical Director, and the Director of Public Health. For the special Boards, Health Improvement Scotland and NHS National Services for Scotland the executive membership of the Board can vary to meet their particular circumstances.

4.116 Publicly appointed members can serve a maximum of eight years on the Board. This limitation also applies to the appointment of the Chair and Vice Chair. Stakeholder members are also appointed for specific time periods but can be re-appointed provided the stakeholder body continues to nominate them. Executive members are appointed for the duration of their role.

4.117 NHS Board Members are responsible for:

- Ensuring the Board focuses on developing and maintaining a strategic direction designed to deliver the Scottish Government's policies and priorities
- Providing effective scrutiny, challenge, support and advice to the Executive Leadership Team on the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets
- Contributing to the identification and management of strategic and operational risks
- Bringing independence, external perspectives and impartial judgement to the business of the NHS Board to support timely, well-informed, evidence-based and risk-assessed decision making at Board level
- Upholding the highest standards of integrity and probity and acting in accordance with the principle of collective and corporate responsibility for Board decisions
- Understanding and promoting diversity, equality and inclusion
- Engaging with stakeholders, including patients, service users, the public, managers and staff
- Undertaking ongoing personal development activities.

4.118 Irrespective of the basis of their appointment, their letter of appointment from the Cabinet Secretary advises that, "No Member of the Board is appointed on a representative basis for any body or group."

4.119 While Board members must be ready to offer constructive challenge, they must also share collective responsibility for decisions taken by the Board as a whole. If they fundamentally disagree with the decision taken by the Board, they have the option of recording their concerns in the minutes. However, ultimately, they must either accept and support the collective decision of the Board – or resign. Board decisions should always comply with statute, Ministerial directions (where this is provided for in statute), Ministerial guidance and the objectives of the Scottish Government's Health & Social Care Directorates.[26]

26 On Board: a guide for members of statutory boards - gov.scot **(www.gov.scot)**

4.120 To help them discharge their responsibilities, the Standards Commission for Scotland has issued a range of **Advice Notes**[27]. This includes guidance on a wide range of topics including:

- Use of social media
- Distinguishing between strategic and operational matters
- Bullying and harassment
- Declaration of interests
- Gifts and hospitality.

4.121 The role of Board Members is to provide governance, i.e., setting the direction for the organisation and overseeing the delivery of services. This primarily involves agreeing strategy and policy and holding the Executive Leadership Team to account for the delivery of the Board's purpose, aims, values, corporate objectives, operational priorities and targets. It includes managing risk, engaging with stakeholders and influencing the organisation's culture.

4.122 By comparison, the Executive Leadership Team has the primary responsibility for the implementation of change and the day-to-day management of operations. This involves the design and implementation of new ways of working that exploit research and innovation, and the planning, organising and execution involved in day to day activities and service delivery.

4.123 The line between strategic and operational matters is not always distinct, as strategic objective setting and policy setting is underpinned by operational work. In addition, some operational matters will have strategic ramifications for an organisation in terms of service delivery and risk management.

4.124 Therefore, if in doubt, Board Members should refer to the Standards Commission's advice to avoid becoming inappropriately involved in operational matters. The Board Chair should be consulted if the issue cannot be resolved following a Board Member's review of the Standards Commission's Advice Note.

4.125 It is also important to note that clinical decision making and the medical treatment of specific patients do not fall within the ambit of Board Members' governance duties.

4.126 In addition to discharging the above responsibilities, non-executive Board Members may also be required to support the business of the Board by chairing standing committees and other meetings relevant to the business of the NHS Board.

4.127 Publicly appointed members may also be appointed by the Board to represent the NHS as a voting member of the Integration Joint Boards. If it is not possible to fill the NHS positions from the publicly appointed members, Boards can nominate other members to act as voting members of the Integration Joint Boards. Stakeholder members who are councillors are excluded from this arrangement.

27 www.standardscommissionscotland.org.uk/education-and-resources/professional-briefings

4.128 Many non-executive Board Members also play a part in supporting the Executive Leadership Team's management of the organisation that goes beyond their roles as standing committee members. This can include supporting HR appeals and whistleblowing investigations. Board members may also be asked to act as Chairs for other groups where the NHS is a member.

Board Champions

4.129 The members of the NHS Board and Standing Committees can be supported in their work by a variety of colleagues acting as 'Champions' for a wide range of issues and communities. This could include equality, diversity and inclusion, mental health, whistleblowing, sustainability, global citizenship, smoking cessation, organ donation, healthy working lives and veterans.

4.130 With the exception of the Whistleblowing Champions who are appointed by the Cabinet Secretary to that role, the Champions are appointed by the Board from the non-executive membership of the NHS Board.

4.131 The principal responsibility of the Champion is to take a lead in advocating the NHS Board's commitment to being a learning organisation that focuses on improvement and the implementation of best practice in their particular area of interest. This includes raising the profile of particular issues and supporting the Executive Leadership Team in the development of appropriate policies, strategies and action plans prior to consideration by the Board.

4.132 The Champions are also available to offer a Board Member's perspective to staff networks and management teams, using this as an opportunity to share information and communicate back to the Board.

4.133 The Champions are not responsible for making operational decisions on specific issues or cases. Neither are they expected to lobby the Board for specific outcomes, but rather to ensure that relevant issues are brought to the Board's attention.

4.134 The standing committee Chairs also act as 'Champions' for the remit and functions of their committees and it is important to note that all Board Members should have an interest in the issues being considered by Champions. For example, ensuring that equality, diversity and inclusion are reflected in the Board's thinking and decision making is the responsibility of all Board Members, not just those who have a role as Equality and Diversity Champions.

Chief Executives

4.135 The description of the role and responsibilities of the Chief Executive and the one that follows for the Executive Directors, are based on work commissioned by the Scottish Government to develop a Leadership Success Profile to support recruitment and succession planning at that level of NHS Scotland.

4.136 In addition to their responsibilities as a Board Member, the NHS Chief Executive is also responsible for:

- Overseeing the development of an integrated set of policies, strategies and plans that are designed to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes focusing globally and strategically on developments that will impact upon the provision of health and social care across Scotland, and working collaboratively with Ministers, the Scottish Parliament, the Scottish Government, Local Authorities, Health and Social Care Partnerships, and other key stakeholders to increase alignment and cohesion between government policy and the delivery of health and social care services to local communities.
- Acting as the Accountable Officer for the proper management of public funds and for ensuring the regularity, propriety and value for money in the management of the organisation. Accountability for this function is directly to the Scottish Parliament under **Section 15 of the Public Finance and Accountability (Scotland) Act 2000**[28].
- Providing leadership and day-to-day management of the organisation and its workforce, shaping desired cultural attributes within the NHS, and ensuring the organisation's policies, strategies and plans are delivered on time and within budgets. This includes building strategic and operational capability and accountability amongst the Executive Leadership Team, ensuring collective responsibility for delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Contributing to the delivery of multiple system-wide interventions at regional and national levels, whilst overseeing local delivery of change initiatives by the Executive Leadership Team. This includes encouraging and supporting research and innovation into new ways of delivering healthcare.
- Managing relationships with NHS Board Members, Scottish Government Ministers, the Director General for Health and Social Care, Senior Civil Servants and other key stakeholders involved in the delivery of health and social care. This includes establishing and enabling inclusive and effective networks at local and national level, expanding these beyond NHS Scotland and a purely healthcare focus. This is a responsibility shared with the Board Chair.

Executive Directors

4.137 The NHS Executive Directors are responsible for:

- Providing professional and expert advice and support to the NHS Board and the Chief Executive to assist in the development of the policies, strategies and plans required to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets. This includes ensuring local policies, plans and strategies are aligned to national and regional priorities for healthcare by

28 www.legislation.gov.uk/asp/2000/1/section/15

gathering insights and information from local, regional and national systems and keeping the NHS Board, executive colleagues and their directorate teams up to date with priorities and developments in the delivery of health and social care.

- Managing the integrated and collaborative delivery of services and the implementation of the organisation's plans, projects, programmes and processes within their own leadership teams and across the organisation, enabling leaders at all levels to take responsibility for delivering operational goals and performance. This includes providing collective leadership with executive colleagues for developing and sustaining the optimum culture throughout the organisation, and collaborating with system partners to empower, support and enable integrated frontline teams to operate flexibly towards the delivery of the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.
- Monitoring progress towards corporate objectives, operational priorities and targets for service delivery and managing their relationship with other key stakeholders by providing appropriate information and assurance on performance, expenditure, issues, risks and successes.
- Overseeing the delivery of multiple, interconnected and organisation-wide change interventions. This includes supporting the transformation of services at national, regional and local levels by forging relationships and supporting networks, and by engaging key stakeholders in the long term and mutual benefits of system transformation.
- Supporting the wellbeing of the workforce by providing the necessary support, training, development, and management approach required to deliver the **NHS Scotland Staff Governance Standard**[29].

4.138 Where Executive Directors are also appointed to the Board they have the same accountabilities and responsibilities as the non-executive Board Members. The same level of training and support is available to executive Board Members as is provided for the non-executive Members.

Board Secretaries

4.139 The term 'Board Secretary' is commonly used across NHS Scotland but in some NHS Boards other job titles such as 'Head of Corporate Governance' has been adopted to better describe this role. The following guidance is intended to cover the post, irrespective of the job title.

4.140 The Board Secretary has the lead role in supporting the NHS Board's approach to delivering good governance. They have the primary responsibility for ensuring the smooth operation of the governance arrangements required by the NHS Board.

4.141 The Board Secretary is responsible for:

- Leading the continuous development and implementation of the Board's governance arrangements, including the facilitation of an integrated approach to the delivery

29 www.staffgovernance.scot.nhs.uk/what-is-staff-governance/staff-governance-standard

- of the governance systems and the provision of the operating guidance required to effectively manage these systems
- Providing expert advice and support to the Chair, Chief Executive, Board Members and other stakeholders on governance related issues
- Providing guidance to assist the Board in acting within its legal authority and statutory powers and its Members in complying with the Ethical Standards in Public Life etc. (Scotland) Act (2000) and the Code of Conduct for Members of Health Boards. This aspect of governance is explored further in the section of the guide on the behaviours expected of Board Members
- Ensuring that Board business is conducted in a spirit of openness and transparency and in accordance with any agreed Board protocol
- Communicating details of the Board's governance arrangements to ensure they are widely understood and effectively delivered by all the key players in the governance system.

4.142 Board Secretaries may also be responsible for managing the administrative and secretarial support to the Board and other governance and advisory committees.

4.143 The Board Secretaries have an informal network that facilitates the sharing of best practice and provides support to the creation and maintenance of the operating guidance for the Board and the standing committees.

Values, Behaviours and Relationships

4.144 All the members of the NHS Board should consider what is expected of them individually and collectively in terms of demonstrating the NHS Scotland values and displaying the behaviours expected of a Board Member of a public body. This includes conducting their relationships in a manner that reflects these standards.

Values

4.145 While everyone in NHS Scotland is expected to demonstrate these values, Board Members have an additional responsibility to act as role models for the rest of the workforce.

4.146 **Board Members are expected to demonstrate and uphold the core values of NHS Scotland, as published in the 2020 Workforce Vision 'Everyone Matters'[30]. These are defined as:**

i. Care and compassion
ii. Dignity and respect
iii. Openness, honesty and responsibility
iv. Quality and teamwork.

30 www.gov.scot/publications/everyone-matters-2020-workforce-vision/

Behaviours

4.147 NHS Boards must act morally, ethically and fairly if they are to deliver good governance in healthcare. In common with all public bodies in Scotland, Boards are required to have in place a Code of Conduct that sets out the standards of behaviours expected of their Board Members.

4.148 To support the delivery of the requirements set out in the **Ethical Standards in Public Life etc. (Scotland) Act (2000)**[31], the Scottish Government's Public Bodies Unit has developed a Code of Conduct specifically designed for Members of Health Boards. This not only sets out how the provisions of the Code should be interpreted and applied in practice, it also gives guidance on the rules regarding remuneration, allowances, expenses, gifts and hospitality, lobbying, registration of interests and the confidentiality of information.

4.149 **The Code of Conduct for NHS Board Members is based on the Model Code of Conduct for Members of Devolved Public Bodies**[32] **approved by the Scottish Parliament on 7 December 2021. This has been developed in line with the Principles of Public Life in Scotland. These are:**

i. **Duty** – Members have a duty to uphold the law and act in accordance with the law and the public trust placed in them. They have a duty to act in the interests of the public body of which they are a member and in accordance with the core tasks of that body.
ii. **Selflessness** – Members have a duty to take decisions solely in terms of public interest. They must not act in order to gain financial or other material benefit for themselves, family or friends.
iii. **Integrity** – Members must not place themselves under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence them in the performance of their duties.
iv. **Objectivity** – Members must make decisions solely on merit when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.
v. **Accountability and Stewardship** – Members are accountable for their decisions and actions to the public. They have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.
vi. **Openness** – Members have a duty to be as open as possible about their decisions and actions, giving reasons for their decisions and restricting information only when the wider public interest clearly demands.
vii. **Honesty** – Members have a duty to act honestly. They must declare any private interests relating to their public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

31 www.legislation.gov.uk/asp/2000/7/contents
32 www.standardscommissionscotland.org.uk/codes-of-conduct/members-model-code-of-conduct

viii. **Leadership** – Members have a duty to promote and support the Principles of Public Life in Scotland by leadership and example, to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

ix. **Respect** – Members must respect fellow members of their public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly they must respect members of the public when performing duties as a member of your public body.

4.150 The Standards Commission has produced **Guidance on the Code of Conduct**[33] to help Board Members interpret and adhere to the provisions in the Code and to attain the highest possible standards of conduct.

4.151 NHS Boards must adopt the Code of Conduct, having first obtained Scottish Government's approval for any amendments to the draft proposed by the Public Bodies Unit. The Board should then formally record their acceptance of the Code of Conduct for Members of their Board. This should then be reflected in the Standing Orders required to support their governance arrangements.

Relationships

4.152 Building and maintaining effective working relationships are critical to the delivery of good governance. Board Members should consider and constantly review their own and the NHS Board's relationships with the other stakeholders in the health and social care system.

4.153 Board Members must apply the values of NHS Scotland and the principles of the Code of Conduct for Members of Health Boards in their dealings with fellow members of the Board, its employees and other stakeholders. The Board Chair has a responsibility to ensure that Members receive the necessary support to act in the appropriate manner at all times.

4.154 To support collaborative working relationships and assist in the conduct of Board business a Board Protocol may be introduced to ensure that best use is made of the time and the contribution of the Board Members. Highlighting the rules or etiquette for the conduct of meetings can assist Chairs to ensure the views of Members are heard and meetings are conducted in a manner consistent with the NHS Scotland values and the Code of Conduct for NHS Board Members.

4.155 The introduction of a Board Protocol should also help Members to make enquiry and challenge the executives in an appropriate manner, ensuring a healthy relationship exists between Board Members and the Executive Leadership Team.

4.156 Defining the functions and enablers of the governance approach is not enough to ensure good governance. To embed the Principles of Good Governance, NHS

33 www.standardscommissionscotland.org.uk/guidance/guidance-notes

Boards must also implement, maintain and continuously improve cohesive governance arrangements that are specifically designed to deliver this approach at Board level. The following sections of the guide describe how NHS Boards should go about delivering those aspects of the Blueprint for Good Governance.

The Delivery Approach

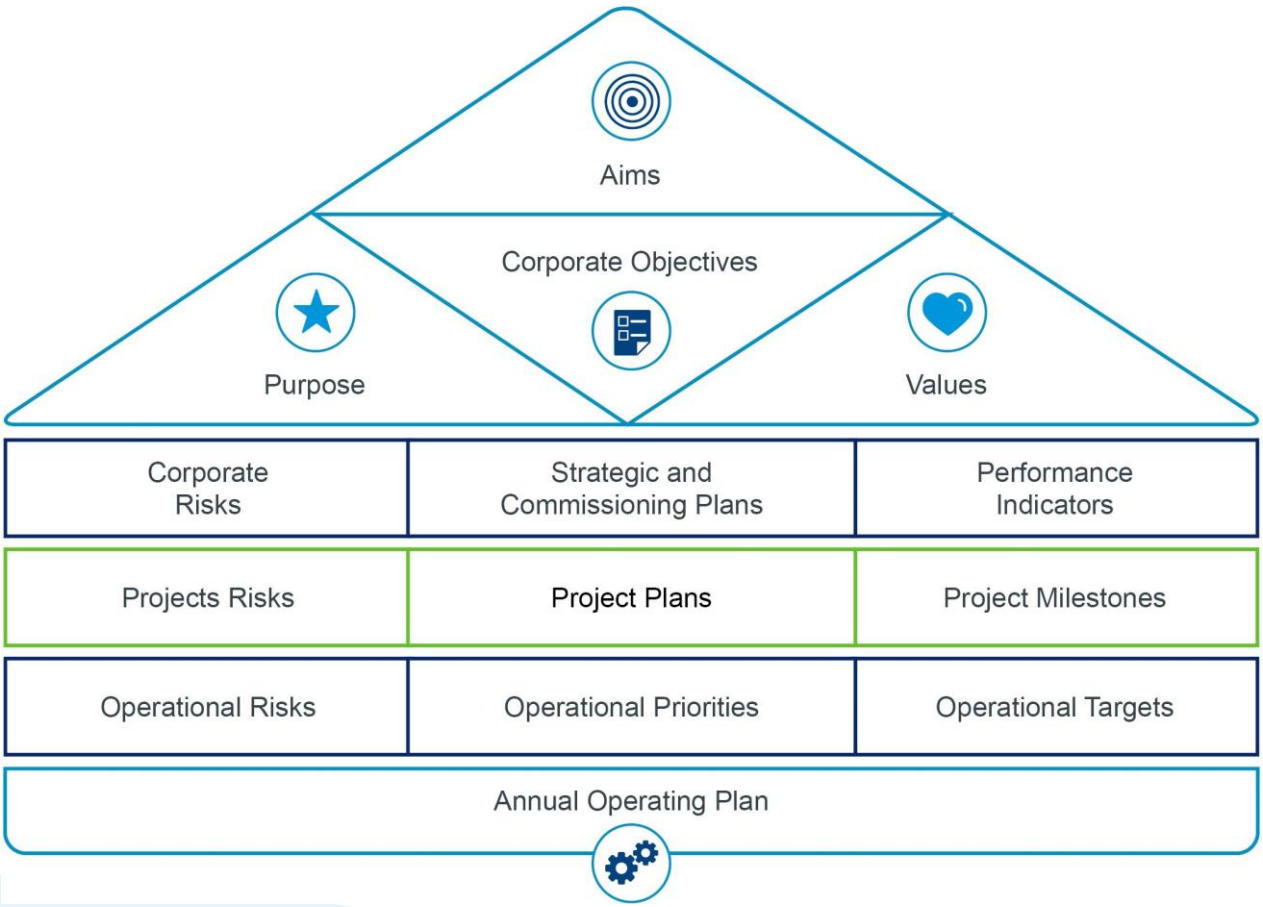
4.157 To support the delivery of good governance NHS Boards should construct an assurance framework and implement an integrated governance system that brings together the organisation's strategic planning, risk management and assurance information systems.

4.158 The assurance framework and integrated governance system must be supported by a suite of operating guidance and it is critical to the delivery of good governance that these arrangements are widely communicated across the organisation.

The Assurance Framework

4.159 Promoting and delivering good governance starts with the development of an assurance framework. This simple model brings together the organisation's purpose, aims, values, corporate objectives and risks with the strategic plans, change projects and operating plans necessary to deliver the desired outcomes.

Figure Two – The Assurance Framework



4.160 The assurance framework is primarily used to identify and resolve any gaps in control and assurance and helps identify any areas where assurance is not present, insufficient or disproportionate in relation to the delivery of the NHS Board's corporate objectives or operational priorities.

4.161 The construction of the assurance framework also ensures the systems introduced for strategic planning and commissioning, implementing change, managing risk and providing assurance information are all aligned and focused on the corporate objectives and operational priorities.

4.162 The assurance framework also describes the performance indicators, change project milestones and targets linked to each of the corporate objectives and forms the foundations for the assurance information system that provides the accountability reports to the NHS Board and standing committees.

4.163 Once completed, the framework provides a clear picture of the links between the outcomes expected by the Board and the strategic plans, transformational change projects and operational plans developed by the Executive Leadership Team to deliver those outcomes. It describes which objectives and what risks are delegated (in the Scheme of Delegation) to each of the standing committees. This ensures that both the delivery of strategic and transformational change and the current operational outputs and outcomes are subject to appropriate scrutiny, at the appropriate level and in the appropriate place within the governance system.

4.164 In practice, the application of the assurance framework means that longer-term strategic issues and risks are considered in a holistic fashion by the Board, with the standing committees focusing on the delivery of delegated, specific corporate objectives, operational priorities and the more immediate annual operating plans.

4.165 To further enhance this approach and support collaborative governance, it is important that the territorial Boards also take account of the strategic and commissioning plans and the annual accountability reports produced by the local Integration Authorities when developing their assurance frameworks.

4.166 Introducing an assurance framework also helps executives, managers and staff better understand how the organisation is governed and their role and accountabilities within the governance system. It emphasises the division of responsibilities between the Board and the Executive Leadership Team.

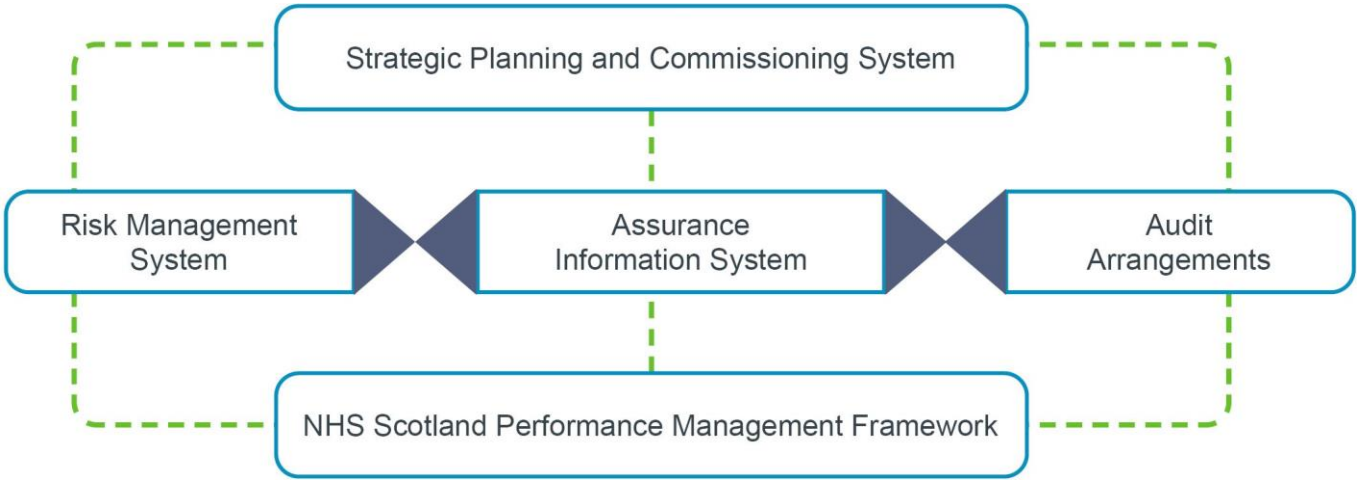
4.167 NHS Boards should go beyond simply constructing an assurance framework to deliver good governance. The framework has to be implemented effectively for it to be of value. This is explored further in the next sections of the guide that relates to the integrated governance system.

The Integrated Governance System

4.168 Integrated governance requires an all-encompassing approach to the delivery of the services provided by the organisation. It brings together the distinct governance systems required to direct and control the management of operations and the leadership of change, and the effective integration of these systems is critical to the delivery of the active and collaborative approaches to governance.

4.169 In NHS Scotland there are five discrete but linked assurance systems that can be considered as the integrated governance system that supports the delivery of good governance.

Figure Three – The Integrated Governance System



4.170 These systems primarily assist the NHS Board in setting the direction, holding the Executive Leadership Team to account and managing risk. They can also play an important part in delivering the assurance required in relation to the stakeholder engagement and influencing culture functions of the Board.

4.171 The Board shares ownership of the strategic planning and commissioning system with the Integration Authorities and has accountability for the risk management system, the assurance information system and the audit arrangements. The Scottish Government owns the NHS Scotland Performance Management System.

4.172 Collectively, these systems provide the Scottish Government, the NHS Board, the standing committees and the Integration Authorities with important information that helps them to be assured that good governance is in place across the healthcare system.

4.173 A more in-depth description of the component parts of the integrated governance system is included in the supplementary guidance attached as an appendix to the guide.

4.174 While the introduction of an assurance framework and the development of an integrated governance system will contribute significantly to the delivery of the active and collaborative approaches to governance, the delivery of good governance also relies on efficient operating arrangements being implemented throughout the organisation. How NHS Boards should achieve this outcome is described in a suite of documents described in the Blueprint for Good Governance as operating guidance.

The Operating Guidance

4.175 The detailed description of the NHS Board's governance arrangements and the guidance on implementing these arrangements are contained in a portfolio of documents that is developed, maintained and communicated by the Board Secretary. It includes Standing Orders, Standing Financial Instructions and the Schemes of Delegation that provide the senior leadership and management of the NHS with their principal operating guidance.

Figure Four – The Operating Guidance

4.176 Additional guidance is available from the Board Secretaries Group to support the efficient delivery of the NHS Board's proceedings and business, including terms of reference for committees and templates for agendas and minutes of meetings.

4.177 Board Secretaries can also provide guidance on how Boards should develop their Annual Cycle of Business for the Board and the standing committees that delivers an integrated work programme and coordinated timetable for Board meetings, Board seminars and standing committee meetings.

4.178 Guidance on the drafting of papers and reports, including security classification and setting the requirements for financial, risk and equality assessments of the impact of options presented to the Board is also required to ensure the smooth operation of Board and committee meetings.

4.179 To supplement the guidance in the Code of Conduct for NHS Board Members, the suite of operating instructions available to Board Members may also include a locally agreed Board Protocol for the chairing, conduct and reporting of meetings.

4.180 In the territorial Boards the operating requirements for those functions delegated to the Integration Authorities are described in the Integration Schemes agreed between the NHS Boards and the Local Authorities. This document also provides Board Members with guidance on the delivery of the collaborative governance arrangements for the healthcare functions delegated to the Integration Joint Board. As such, they should be seen as an important component of the NHS Board's operating guidance.

4.181 With the exception of the Integration Scheme(s), the documents that make up the Operating Guidance should be reviewed annually by the Boards to coincide with the preparation of governance statement that forms part of the Annual Report.

4.182 **The Public Bodies (Joint Working) (Scotland) Act 2014**[34] requires Local Authorities and Health Boards to review their Integration Schemes before the expiry date, which is five years after the scheme was approved in the Scottish Parliament. The Scottish Government is responsible for facilitating parliamentary approval of any revisions to the Integration Schemes.

4.183 In addition to the standard portfolio of operating guidance described above, some Boards may also have other material that describes how the system of governance works within their particular organisation. Board Members should be aware of these local instructions and take them into account when carrying out their role.

4.184 Further information on best practice in healthcare governance can be found at the websites provided by **NHS Scotland**[35] and **NHS Education for Scotland**[36].

4.185 Having considered what needs to be done to ensure good governance, it is important to consider how the NHS Boards and the Scottish Government will determine whether or not this approach has been successful. Therefore, the next

34 www.legislation.gov.uk/asp/2014/9/contents
35 www.nhs.scot
36 www.nes.scot.nhs.uk

section of the guide describes the evaluation process for the governance of NHS Scotland.

The Evaluation Approach

4.186 In order to assess the effectiveness of the healthcare governance system and whether or not it is continuously improving, it is important to have a consistent and systematic approach to assessing and evaluating the NHS Boards' governance arrangements against the Principles of Good Governance.

4.187 The approach to evaluation must provide assurance to the Board, the Scottish Government and the other stakeholders in healthcare that good governance is being delivered across all the categories of governance in healthcare.

4.188 For NHS Scotland the preferred approach to evaluation involves three levels of assessment:

- Appraisal of the Board Members' individual performance
- Self-assessment of the Board's effectiveness
- External review of the organisation's governance arrangements.

These activities should be viewed as a means of supporting personal and Board development, rather than a punitive process.

4.189 The following paragraphs describe each level of the evaluation approach and how they are brought together to inform and drive a programme of improvement activities.

Individual Performance Appraisal

4.190 The Scottish Government is responsible for developing and implementing the performance appraisal system for Chairs and other NHS Board Members.

4.191 The Director General for Health and Social Care carries out the appraisal of NHS Board Chairs on behalf of the Cabinet Secretary. This process includes a self-assessment by the Chair and a 360 degree feedback exercise involving Board Members, executives and other stakeholders.

4.192 The Board Chair reports to the Scottish Government on the contribution made to the work of the Board by its Members. The format of these reports is set by the Government and includes discussions on personal development opportunities that might be used to enhance the individual's effectiveness as a Board Member.

4.193 The NHS Board Chair should consider how any weaknesses in the governance arrangements identified through the individual performance appraisal systems can be addressed by the Board.

Board Self-Assessment

4.194 NHS Boards should regularly review their governance arrangements and annually conduct a structured self-assessment to review their effectiveness, identifying any new and emerging issues or concerns.

4.195 The Principles of Good Governance form the basis of the Board's self-assessment and this exercise should provide a view of the extent to which the Blueprint for Good Governance has been implemented across the organisation. This should include an evaluation of the current status of the systems that support the organisation's governance arrangements.

4.196 To ensure that the criteria against which the Board's assessment is valid, reliable and transparent and reflects best practice in governance, the Scottish Government provide NHS Boards with advice and guidance on how to conduct the self-assessment exercise.

4.197 After critically examining the findings of the self-assessment exercise, the Board should use this information as the baseline and driver for its improvement and development activities.

External Review

4.198 To enhance and validate the Boards' self-assessments, a systematic evaluation of the governance arrangements across the NHS Boards should be undertaken by an external specialist in governance.

4.199 The Scottish Government are responsible for commissioning and managing a programme of structured governance reviews that includes a work plan to evaluate the NHS Boards' governance arrangements at least every three years.

4.200 In undertaking these reviews the external specialist will bring together a range of evidence from a number of sources and include benchmarking the NHS Board's governance with comparative healthcare organisations and the latest thinking on best practice in governance.

4.201 NHS Boards and the Scottish Government can also commission ad hoc thematic reviews of specific areas of governance, e.g., clinical governance or risk management.

4.202 The Board should compare the findings of the external reviews, with the output of the Board's self-assessment exercise and the view of the governance arrangements gained from the individual performance reviews. This combination of information should then be used to inform and support the continuous improvement approach to governance described in the final section of the guide.

The Improvement Approach

4.203 For the governance of healthcare to continuously improve, the approach adopted by NHS Scotland has to be an evolving, iterative and integrated process that is widely understood and adopted by the NHS Boards.

4.204 The following paragraphs describe the quality improvement approach required by the NHS Boards, NHS Education for Scotland and the Scottish Government to ensure that the governance arrangements in NHS Scotland remain relevant and continue to be fit for purpose as the health and social care system evolves over time.

NHS Boards

4.205 Having assessed the effectiveness of the organisations governance arrangements by triangulating information from individual performance reviews, the Board self-assessment and external reviews, the NHS Boards must design and implement a bespoke programme of activities to address the issues and concerns raised by the evaluation process.

4.206 The activities included in the Board's improvement programme should focus on the delivery of the Principles of Good Governance and be described in terms of enhancements to the enablers and delivery systems in the Blueprint for Good Governance.

4.207 The improvement programme must include actions to address any shortcomings in the recruitment, induction, training and development of Board Members that surfaced at individual performance reviews. It must respond to the findings of the self-assessment of Board effectiveness by including work to overcome any weaknesses identified by the Board Members. Any recommendations for improvement in the governance arrangements from external reviews or other sources should also be added to the programme plan.

4.208 The Board's improvement programme plan should be published and details of the progress made to implement the actions outlined in the plan should be regularly reported to the NHS Board and discussed at the NHS Board's Annual Review with the Scottish Government.

NHS Education for Scotland

4.209 NHS Education for Scotland has a significant role in improving the delivery of good governance in the NHS by supporting NHS Boards to respond positively to the findings of the internal and external evaluation of their governance arrangements.

4.210 This support is primarily delivered through a comprehensive programme of development activities that includes a range of support material, training courses, seminars and workshops designed to support NHS Boards in improving their governance arrangements. This includes induction training and broader development opportunities tailored to individual Boards and Board Members' needs, a mentoring scheme for Board members and a development programme for aspiring Chairs and Vice Chairs.

4.211 The training and development material offered by NHS Education for Scotland is regularly updated to reflect best practice in healthcare governance and is supported by a digital portal which offers practical resources to support Board Members' continuous personal development. This is accessed through the TURAS Learn system on the **NHS Scotland Board Development**[37] website and all Board Members are expected to register on the TURAS Learn system and take advantage of the opportunities for developing their skills as Board Members.

4.212 The support provided by NHS Education for Scotland to NHS Boards and individual Board Members is a valuable resource and should be incorporated as appropriate into the Board's improvement programme.

Scottish Government

4.213 To ensure that good governance is being delivered across NHS Scotland in a consistent manner, the Directorate for Finance and Governance works with NHS Boards to achieve continuous improvement in their governance arrangements. This includes commissioning and approving the national induction and the other training and development material on governance in healthcare that is delivered by NHS Education for Scotland and other training providers.

4.214 The Scottish Government also supports the continuous improvement approach by providing advice and guidance to NHS Boards on specific governance issues and its website contains valuable information to support Board Members in delivering their roles and responsibilities.

4.215 To guide and support the improvement of governance in NHS Scotland, the Director of Health Finance and Governance has put in place a Healthcare Governance Advisory Board. This replaces the NHS Scotland Corporate Governance Steering Group.

4.216 The purpose of the Healthcare Governance Advisory Board is to provide leadership, support and guidance to key stakeholders by advising on the development and implementation of the delivery of good governance in healthcare across NHS Scotland. The remit of the Advisory Board includes providing input to the development of the policies and initiatives required to ensure a continuous improvement approach is adopted to governance in NHS Scotland.

37 **https://learn.nes.nhs.scot/17367/board-development**

4.217 The Advisory Board reports to the Director of Health Finance and Governance and its membership includes a Chair appointed by the Scottish Government and representatives from the key stakeholders in healthcare governance. This may include independent advisors to bring an external perspective to the work of the Board and other members of NHS Scotland may be invited to join as and when specific expertise is required on the Advisory Board.

4.218 The description of the support for a continuous improvement approach to governance in healthcare in the previous paragraphs completes the guide to the Blueprint for Good Governance.

4.219 The publication of this document should ensure that Board Members, Executive Leadership Teams and other stakeholders in the governance of NHS Scotland have a shared understanding of the importance and definition of good governance and appreciate the role that active, collaborative and continuous improvement approaches play in the delivery of the Blueprint.

4.220 Although the guide describes the functions, enablers, delivery, evaluation and improvement approaches that make up the Blueprint for Good Governance, supplementary guidance has been appended to this document to provide further, more detailed guidance on the delivery of the Integrated Governance System require to implement and sustain good governance across the NHS.

Supplementary Guidance

A. The Strategic Planning and Commissioning System

A.1 In setting the direction for the healthcare system, strategic and commissioning plans should clearly set out the drivers for change, the consultation and engagement undertaken, and the vision of the future that should result from implementing the strategies and services described in the plans.

A.2 Strategic and commissioning plans must be aligned to the NHS Board's purpose, aims and values. The corporate objectives being supported and the outcomes expected from the delivery of these plans should be clearly stated.

A.3 The development of strategies and changes to service delivery models should include appropriate stakeholder engagement, particularly when a proposed service change will have a major impact. NHS Boards must ensure that when necessary, stakeholder engagement is carried out at the outset of the planning and commissioning process and this engagement is inclusive, proportionate and robust. Advice from **Healthcare Improvement Scotland Community Engagement**[38] is available to NHS Boards to ensure that they have met the national standards for engagement.

A.4 In addition to describing the need for change and the expected outcomes, strategic and commissioning plans should also include details of the business case behind this approach. A cost- benefit analysis of proposed changes gives Board Members one of the key pieces of information required to approve the plans.

A.5 Board Members also require assurance around the implementation of the strategic and commissioning plans. As these will usually require a degree of transformational change, Boards should ensure that the organisation has the capability and capacity to support the delivery of the change projects and programmes. This is necessary to not only deliver the planned changes, but also to ensure the realisation of the benefits expected from the strategic and commissioning plans.

A.6 The Board should seek assurance that implementation plans and change projects and programmes include comprehensive risk assessments, equality impact assessments and communication plans that will support the delivery of strategic plans and change projects and programmes.

38 www.hisengage.scot

A.7 The implementation plans should also be clear about how success will be measured and the governance arrangements for oversight of delivery, including details of the information flows to the Board Members on the progress being made with implementation. This should include any arrangements for evaluation of the effectiveness of new approaches during and at the end of the period covered by the plan.

A.8 It is also important that Board Members consider the extent to which corporate strategies and change projects and programmes take advantage of research and innovation in science and technology.

A.9 Who has the overall accountability for the delivery of the strategy and who are the individuals responsible for delivering specific change projects and programmes should also be considered by Board Members. It will be important that the Board is assured that the organisation has the personnel in place with both the capability and the capacity to meet these requirements.

A.10 NHS Boards should put in place a strategic planning cycle that clearly indicates where and when the Board is involved in considering options, debating risk, giving approval and thereafter in monitoring delivery of the Board's strategic plans. To facilitate this approach, a strategic planning framework should be maintained.

A.11 For each of the strategic and commissioning plans, the strategic planning framework should describe the period covered and the corporate objectives addressed by the plan. It should also identify the stakeholders consulted, the author, the approver and the date approved. Details of the reporting arrangements and the expected date of the next review by Board Members should also form part of the framework.

A.12 Given the close relationship between healthcare and social care services and the integrated approach to delivering these services required by NHS Boards and Local Authorities in Scotland, it is critical to the effective planning and commissioning of primary and secondary healthcare that the plans developed by the Integration Authorities align with the strategic plans approved by the NHS Board.

A.13 **The Public Bodies (Joint Working) (Scotland) Act 2014**[39] introduced a statutory duty for NHS Boards and Local Authorities to integrate the planning and delivery of delegated health and social care functions across Scotland. Therefore, it is essential that NHS Boards play their part in the development of the Integration Authorities strategic commissioning plans as set out in the 2014 Act. This requires Integration Authorities to establish a Strategic Planning Group, and the NHS Board must nominate a minimum of one person to join that group. That requirement should feature in the Integration Scheme agreed between the NHS Board and the Local Authority.

39 www.legislation.gov.uk/asp/2014/9/contents

A.14 The NHS Boards should include details of the Integration Authorities strategic commissioning planning process in their strategic planning framework. This should highlight the dependencies between plans that need to be managed by the NHS Chief Executive and the Health and Social Care Partnership's Chief Officer(s).

A.15 NHS Boards also have responsibilities under the **Community Empowerment (Scotland) Act 2015**[40] for working together with local communities to plan and deliver better services that make a real difference to people's lives.

A.16 The NHS Boards' involvement in the Community Planning Partnerships across Scotland is intended to ensure that service planning is co-ordinated at a local level. Therefore, Boards should take into account the views, ambitions and priorities of the Community Planning Partnership when developing their strategic and commissioning plans.

A.17 This inclusive and collaborative approach to designing and maintaining an overview of strategic planning and commissioning should ensure that the NHS Board can be assured that the organisation's aims are being pursued and the full range of corporate objectives are being addressed by those responsible for the delivery of healthcare in their area.

A.18 The NHS Board's strategic and commissioning plans should be aligned with any relevant operational policies in place to support the delivery of healthcare services. Boards should ensure that operational policies are subject to approval and regular review by the Board and the standing committees. To manage this in a co-ordinated manner a policy framework should be established and maintained for all significant healthcare policies. The policy framework should provide Board Members with the same information on policy development that the strategic planning framework does on strategic and commissioning plans.

A.19 Effective strategic planning and policy development must include assessment of the risks existing in the healthcare system and the next section of the supplementary guidance focuses on that aspect of the integrated governance system.

40 **www.legislation.gov.uk/asp/2015/6/contents**

B. The Risk Management System

B.1 Risk management is an integral part of the active and collaborative approaches to delivering good governance. It enhances strategic planning and prioritisation, assists in achieving corporate objectives and strengthens the Board's ability to be agile in response to the challenges faced by the NHS.

B.2 NHS Boards cannot be entirely risk averse, and having an effective and meaningful risk management system that systematically anticipates and prepares successful responses to the uncertainties faced by NHS Boards is critical to delivering the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

B.3 When considering their approach to risk management, NHS Boards should recognise that it is often not possible to manage all risks at any point in time to the desirable tolerance level. Very often it is also not possible, and not financially affordable, to fully remove uncertainty from decisions. Therefore, Boards should encourage and support a risk culture that embraces openness, supports transparency, welcomes constructive challenge and promotes collaboration, consultation and co-operation.

B.4 The principles and concepts that support effective risk management are outlined in **HM Government's Orange Book**[41] and the **Scottish Public Finance Manual**[42] provides guidance on best practice for risk management in the Scottish public sector.

B.5 Almost all processes, procedures and activities carried out by the NHS carry with them a degree of risk. So, it is necessary for the NHS Board to agree the level of risk with which it aims to operate, based on what it considers to be justifiable and proportionate to the impact on patients, service users, the public, the workforce and the Board. Consequently, understanding and communicating the Board's risk appetite is the first step in constructing an effective risk management system.

B.6 Guidance on the development and use of a risk appetite statement is contained in **HM Government's Risk Appetite Guidance Notes**[43]. Having agreed their risk appetite, NHS Boards must then develop, maintain and continuously improve a risk management system that supports the achievement of the Board's corporate objectives and operational priorities while remaining within its risk appetite.

41 www.gov.uk/government/publications/orange-book
42 www.gov.scot/publications/scottish-public-finance-manual
43 assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1012891/20210805_-_Risk_Appetite_Guidance_Note_v2.0.pdf

B.7 The risk management approach adopted by the organisation must include activities and processes that facilitate the identification of corporate and operational risks and supports the assessment, mitigation, monitoring and reporting of these risks.

B.8 The risk management system should be utilised in a way that assists the NHS Board and the Executive Leadership Team to prioritise available resources to minimise risk to best effect and to provide assurance that progress is being made. This must include the maintenance of a tiered set of operational and corporate risk registers to quantify and prioritise risks which threaten the achievement of the organisation's objectives and priorities.

B.9 The purpose of the risk registers is to achieve greater visibility of exposure to risk across the categories identified in the risk appetite statement and as a result reduce the likelihood that risks will occur or evoke an effective response when risks occur. Therefore, it is important that the risk registers are constantly updated to reflect the dynamic nature of delivering healthcare.

B.10 For the risk registers to be an effective tool for the management of risk it is important that they include an articulation of the risk event itself, details of the underlying causes (including internal and external factors), and the range of consequences should the risk event occur.

B.11 The risk registers should include an assessment of the combination of the consequences of the event (impact) and its probability (likelihood). The impact should be the estimated effect of the risk on the objectives in question. This assessment is focused on scale, scope and resource implications. Likelihood is the estimated chance of the risk occurring. This is focussed on probability.

B.12 Having assessed the risk, the response should be to either treat, tolerate, or terminate the risk. The mitigation actions already taken or proposed to respond to the risks to be treated, should also be described in the registers. This should include the owner of the action, the timescales involved and where the oversight and scrutiny of the delivery and outcome of the mitigation sits within the organisation's hierarchy.

B.13 To highlight the expected changes to the impact and likelihood of the risk materialising, the assessment scores should be included pre and post the mitigation actions.

B.14 The development of business continuity plans are often used to mitigate some corporate risks, including those around the loss of IT systems, disruption to water, gas and electricity supplies, and other failures in the physical infrastructure. These plans are designed to ensure that the organisation can continue to operate and recover should a significant risk materialise. They aim to increase resilience across the healthcare system by responding to identified risks with an impact assessment and contingency plans that have been implemented and tested across the organisation.

B.15 Therefore, NHS Boards must ensure that appropriate business continuity plans are in place, regularly tested and reviewed, and widely communicated with the appropriate stakeholders.

B.16 Where the delivery of services provided by organisations outside of the NHS Board can introduce risk to the delivery of healthcare, it is important that the NHS approach to risk management and business continuity planning recognises this and responds appropriately. This is particularly important in the delivery of integrated health and social care systems and requires Board Members who also sit on the Integration Joint Boards to pay particular attention to the impact mitigating healthcare risks can have on social care services and vice versa.

B.17 The information presented in the risk registers and the business continuity plans should improve decision making and assist the NHS Board to assess whether or not management controls and resources deployed are adequate to effectively manage corporate and operational risks in healthcare.

B.18 Responsibility and accountability for the operation and the oversight of the risk management system should be clearly defined and responsibility for contributing to the management of risks should be included in the job descriptions of staff, the terms of reference of the governance committees and the Board's Scheme of Delegation.

B.19 Not only do NHS Boards require assurance on the effectiveness of their approach to strategic planning and risk management, they need to commission an assurance information system that provides them with the necessary information to give Board Members assurance on the progress being made towards the delivery of the organisation's strategic, operational and financial plans.

C. The Assurance Information System

C.1 The assurance information system should be designed to provide frequent and informative performance and financial reports to assure the Board that it is delivering safe, effective, patient- centred, affordable and sustainable services. This system should deliver relevant, accurate and timely information on a wide range of activities, including:

- Service delivery
- Safety and quality standards
- Innovation and transformational change
- Workforce
- Education, training and development
- Finance.

C.2 NHS Boards should agree with the NHS Chief Executive the contents of the assurance information system required by the Board and the standing committees. This should include information on both the management of current operations and the progress being made to deliver change across the healthcare system.

C.3 How data should be presented in order to assist those preparing papers for Board Members' scrutiny should also be agreed with the NHS Chief Executive and in the case of territorial NHS Boards, with the Health and Social Care Partnership's Chief Officer(s).

C.4 Board papers should show data in a clear, consistent and effective way to ensure that Board Members are able to understand and interpret its significance and receive the level of assurance required. Best practice in presenting data includes:

- Presenting statistical information in charts or tables, rather than in a narrative format
- Including actual numbers rather than percentages, although there will be times where both are appropriate
- Limiting the volume of information shown as charts and tables that have too much information can mean that key messages are lost or difficult to see
- Ensuring units of time are consistent for comparative purposes, e.g., months have variable number of days but weeks always have the same number of days
- Using line charts to measure change or performance over time and if variation is a potential concern, add a target line or convert to a control chart
- Favouring control charts to show if variation is within normal limits and therefore not necessarily a concern
- Describing a position at a point in time by allocating RAG status but these should be used with caution as RAG charts could focus attention on lower priorities
- Benchmarking results using pareto charts which are preferable to pie charts

- Comparing results using funnel charts helps to identify special cause variation, i.e. one not typically expected
- Compiling a whole system view by presenting a series of charts showing different aspects of performance within the same area, giving a more comprehensive and thorough overview
- Including forecasts in tables and charts to describe what results are predicted with the resources available and in the circumstances expected
- Adding trajectories when a changing level of performance over time is required, often by the body commissioning the work.

C.5 Further guidance on the presentation of data to Board Members can be obtained from NHS Education for Scotland's material on the implementation of the active approach to delivering good governance.

C.6 While data and management information provides Board Members with a particular view of the organisation, to deliver good governance this has to be triangulated with other reports and the more qualitative information available on service delivery.

C.7 Therefore, the assurance information system should incorporate other regular internal reports on the operation of the healthcare system, particularly those that reflect patient, service user and staff experience. Examples of this category of assurance information sources would include the following:

- Healthcare Acquired Infection Report
- Complaints Report
- Duty of Candour Annual Report
- Public Health Screening Programme Annual Report
- Vaccination Programme Annual Report
- Child Poverty Action Plans Progress Report
- Research and Development Annual Report
- iMatter Reports
- Whistleblowing Annual Report.

C.8 It is important that this list is seen as simply an example and the majority of reports included are relevant to territorial Boards. Consideration of these reports by the Board or the appropriate standing committee should form part of the Annual Cycle of Business or in the case of the ad hoc reports, be reviewed at the earliest opportunity.

C.9 The Assurance Information System should also incorporate the wide range of external reports available to Boards. These include one-off Audit Scotland reports on various aspects of the health and social care system, Health Improvement Scotland reviews, Care Opinion feedback, Mental Welfare Commission reports, Scottish Public Services Ombudsman's reports, NHS Education for Scotland Deanery Reports and the General Medical Council's reports on the training of junior doctors.

C.10 Board Members should be aware that the specific issues raised in these reports may signal wider concerns. For example, GMC reports on the training of junior doctors can potentially highlight wider issues concerning patient safety and the standard of care, thus providing an opportunity for early intervention and remedial action.

C.11 NHS Boards should also closely scrutinise the reports prepared for the Board's Annual and Mid- Year Reviews with the Scottish Government and pay particular attention to the Annual Reports submitted to the Scottish Government by the Health and Social Care Partnerships. These documents combine to give a comprehensive account of the progress made by the organisation across both Primary and Secondary Care and should provide Board Members with assurance on the progress being made to deliver the organisation's purpose, aims, values, corporate objectives, operational priorities and targets.

C.12 In additional to scrutiny of internal and external reports NHS Boards should also pay attention to the feedback to NHS Boards from the **Sharing Intelligence for Health and Care Group**[44]. This group is responsible for supporting improvement in the quality of care provided for the people of Scotland and its main objective is to ensure that any potentially serious concerns about a care system are shared and acted upon appropriately. The feedback from the group also highlights examples of where things are working well.

C.13 Feedback from a structured visiting programme by Board Members to frontline services and online discussions with patients, service users and staff should also feature in the assurance information system, enabling the quantitative data and the external perspective to be considered against the Board Members' impression of the patient and staff's views of the organisation.

C.14 In addition to having effective strategic planning, risk management and flows of assurance information to the NHS Board, an integrated approach to delivering good governance also relies on having effective internal and external audit arrangements.

44 www.healthcareimprovementscotland.org/our_work/governance_and_assurance/sharing_intelligence.aspx

D. The Audit Arrangements

D.1 The integrated governance system includes the audit arrangements required to provide the Board and key stakeholders with assurance that the system of internal controls is functioning as intended.

D.2 The main contributors to the audit arrangements are the NHS Board, the Internal Auditors, the External Auditors and the Audit and Risk Committee.

D.3 NHS Boards have the primary responsibility for ensuring the proper financial stewardship of public funds, compliance with relevant legislation and establishing effective arrangements for governance, propriety and regularity. This includes ensuring that accurate accounting records are maintained and financial statements are prepared that give a true and fair view.

D.4 **The Code of Audit Practice (2021)**[45] prepared by Audit Scotland sets out the respective functions and responsibilities of the internal and external auditors.

D.5 Internal audit is a function of management and it operates under the **Public Sector Internal Audit Standards**[46]. This defines internal auditing as an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control and governance processes. To deliver these outcomes the role the internal audit team should include:

- Reviewing accounting and internal control systems
- Reviewing the economy efficiency and effectiveness of operations
- Assisting with the identification of significant risks
- Examining financial and operating information
- Special investigations
- Reviewing compliance with legislation and other external regulations.

D.6 To ensure that internal audit is an independent and objective assurance activity, the Board should seek assurance that the internal auditors are independent of executive management and should not have any involvement in the operations or systems they audit. The Head of Internal Audit should report to the Chief Executive or one of their direct reports. They also should report functionally to the audit committee and have right of access to the Chair of the Audit and Risk Committee, the Chief Executive and the NHS Board Chair. These arrangements should be clearly set out in the Board's Standing Financial Instructions and the terms of reference for its Audit and Risk Committee.

45 www.audit-scotland.gov.uk/publications/code-of-audit-practice-2021
46 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/641252/PSAIS_1_April_2017.pdf

D.7 External audit provides independent challenge and assurance on the Board's annual accounts and provide a view on matters relating to regularity, propriety, performance and the use of resources. NHS Boards are assigned external auditors by the Auditor General for Scotland who is a Crown appointment and is independent of Government. The responsibilities of independent auditors are established by the **Public Finance and Accountability (Scotland) Act 2000**[47] and the **Code of Audit Practice**[48] and their work is guided by the **Financial Reporting Council's Ethical Standard**[49].

D.8 The key responsibilities of the external auditors can be summarised as follows:

- To give an independent opinion on the financial statements and other information within the annual report and accounts
- To review and report on the arrangements within the audited body to manage its performance, regularity and use of resources
- To support improvement and accountability.

D.9 To deliver the internal and external audit functions, an annual audit programme should be put in place to deliver a comprehensive portfolio of system audits that ensures the main contributors are all able to meet their statutory responsibilities and the NHS Board and the Scottish Government can be assured on the effectiveness of the management, leadership and governance of the organisation.

D.10 The audit plans included in the programme should document how the internal and external auditors intend to meet their responsibilities and it is important that these plans are joined-up, effective and proportionate. They should be linked to the delivery of corporate objectives and operational priorities and should focus on the areas identified as corporate and operational risks.

D.11 The Board's Audit and Risk Committee has a key role in ensuring the effectiveness of the internal audit functions including:

- Overseeing the selection process for new internal auditors
- Reviewing and agreeing the annual internal audit work plan
- Ensuring recommendations are actioned by the Executive Leadership Team
- Disseminating audit reports to the relevant Board committees
- Encouraging the use of audit reports as improvement tools
- Monitoring and assessing the effectiveness of the audit team
- Making recommendations to the Board for the award of the internal audit contract and the appointment and termination of the Head of Internal Audit
- Overseeing the Board's relations with the external auditors, including reviewing the scope of their annual audit plan.

47 www.legislation.gov.uk/asp/2000/1/contents
48 www.nao.org.uk/code-audit-practice
49 www.frc.org.uk/getattachment/0bd6ee4e-075c-4b55-a4ad-b8e5037b56c6/Revised-Ethical-Standard-2016-UK.pdf

D.12 Guidance on the principles and best practice for the organisation and delivery of Audit and Risk Committees is available in the **Audit and Assurance Committee Handbook**[50] published by the Scottish Government.

D.13 It is important that the Audit and Risk Committee adopt a robust approach to the oversight of the completion of actions identified in the audit reports. Where possible, actions should be dealt with in the current financial year rather than being carried forward from one financial year to the next. Any exceptions to this should be closely scrutinised by the Audit and Risk Committee who should seek assurance that the timeline proposed for addressing the risks or issues identified by the auditors is both reasonable and achievable.

D.14 The final component of the integrated governance system is the NHS Scotland Performance Management Framework. The following section of the supplementary guidance describes this arrangement in more detail.

50 **www.gov.scot/publications/audit-assurance-committee-handbook**

E. The NHS Scotland Performance Management Framework

E.1 As the sponsor of the NHS Boards, the Director General for Health and Social Care has put in place a performance management framework to assist the Scottish Government in ensuring that the NHS Boards are delivering services and targets to the required standards, within budgets and with the appropriate governance.

E.2 The NHS Scotland Performance Management Framework provides five stages of a Ladder of Escalation that provides a model for intervention by the Scottish Government when there are concerns about a NHS Board's ability to deliver the expected standards, targets and governance.

E.3 The model not only describes the stages of performance but also the level of support that would be provided by the Scottish Government Directorates for Health and Social Care at each stage.

Stage	Description	Response
1	Steady state 'on-plan' and normal reporting	Surveillance through published statistics and scheduled engagement of Annual Review and Mid-Year Reviews.
2	Some variation from plan; possible delivery risk if no action.	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring by Scottish Government. SG Directors aware.
3	Significant variation from plan; risks materialising; tailored support required.	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. DG aware.
4	Significant risks to delivery, quality, financial performance or safety; senior level external support required.	Transformation team reporting to Director General and CEO NHS Scotland.
5	Organisational structure/ configuration unable to deliver effective care.	Ministerial powers of Intervention.

E.4 The Ladder of Escalation's use is not limited to specific performance measures and may be triggered by concerns about specific services or broader organisational issues.

E.5 The Performance Management Framework is overseen by the National Planning and Performance Oversight Group, a sub-group of the Health and Social Care Management Board. The Oversight Group considers various forms of intelligence and makes subsequent recommendations to the Health and Social Care Management Board on escalation, de-escalation and/or the provision of enhanced support for NHS Boards.

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The Blueprint for Good Governance
Second Edition

November 2022

The Blueprint for Good Governance in NHS Scotland

The Key Questions

What is governance and what does it include?

Why is it important and what does good look like?

How does it fit with leadership and management?

How do you deliver good governance?

How do you know your governance is good?

The Importance of Governance

- Good governance leads to good management, good performance, good stewardship of public money, good public engagement and ultimately good outcomes.

- Weak or ineffective governance fosters low morale and adversarial relationships that lead to poor performance or even, ultimately, to dysfunctional organisations.

- Therefore, it is critical that NHS Boards ensure robust, accountable and transparent governance arrangements are in place throughout the healthcare system.

The Corporate Mindset

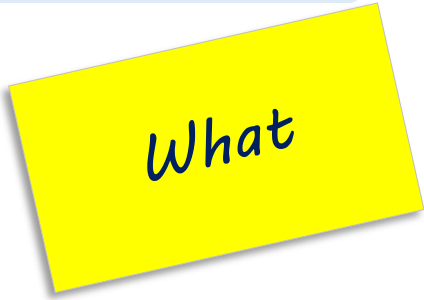
Describing Good Governance

The Governance of Healthcare

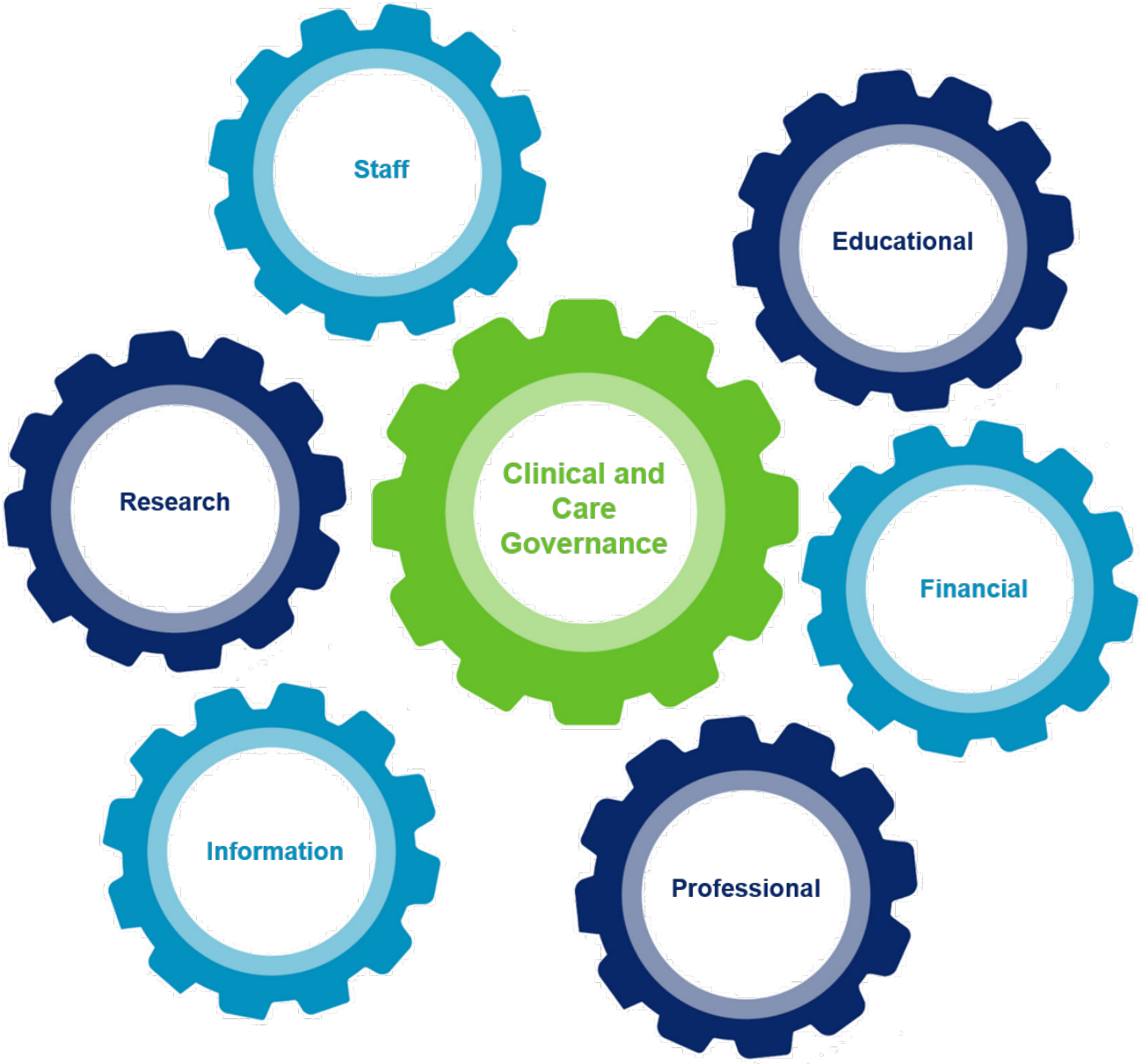
"Governance is the means by which NHS Boards direct and control the healthcare system to deliver Scottish Government policies and strategies and ensure the long term success of the organisation".

"It is the ability to ask questions and make decisions to improve population health and address health inequalities, while delivering safe, effective and high quality healthcare services."

"It is to be distinguished from executive-led operational management".



The Categories of Governance



The Principles of Good Governance

i) Good governance requires the Board to set strategic direction, hold executives to account for delivery, manage risk, engage stakeholders and influence organisational culture.

ii) Good governance requires a Board that consists of a diverse group of people with the necessary skills, experience, values, behaviours and relationships.

iii) Good governance requires that roles, responsibilities and accountabilities at Board and executive level are clearly defined and widely communicated.

The Principles of Good Governance

iv) Good governance requires an assurance framework that aligns strategic planning and change implementation with the organisation's purpose, aims, values, corporate objectives and operational priorities.

v) Good governance requires an integrated governance system that co-ordinates and links the delivery of strategic planning and commissioning, risk management, assurance information flows, audit and sponsor oversight.

vi) Good governance requires operating guidance that is agreed, documented, widely communicated and reviewed by the Board on a regular basis.

vii) Good governance requires regular evaluation of governance arrangements to ensure it is proportionate, flexible and subject to continuous improvement.

The Principles of Good Governance

viii) Good governance requires an active approach that anticipates and responds to risks and opportunities which could have a significant impact on the delivery of corporate objectives, the Board's relationships with stakeholders and the management of the organisation's reputation.

ix) Good governance requires a collaborative approach that ensures the organisation's systems are integrated or aligned with the governance arrangements of key external stakeholders.

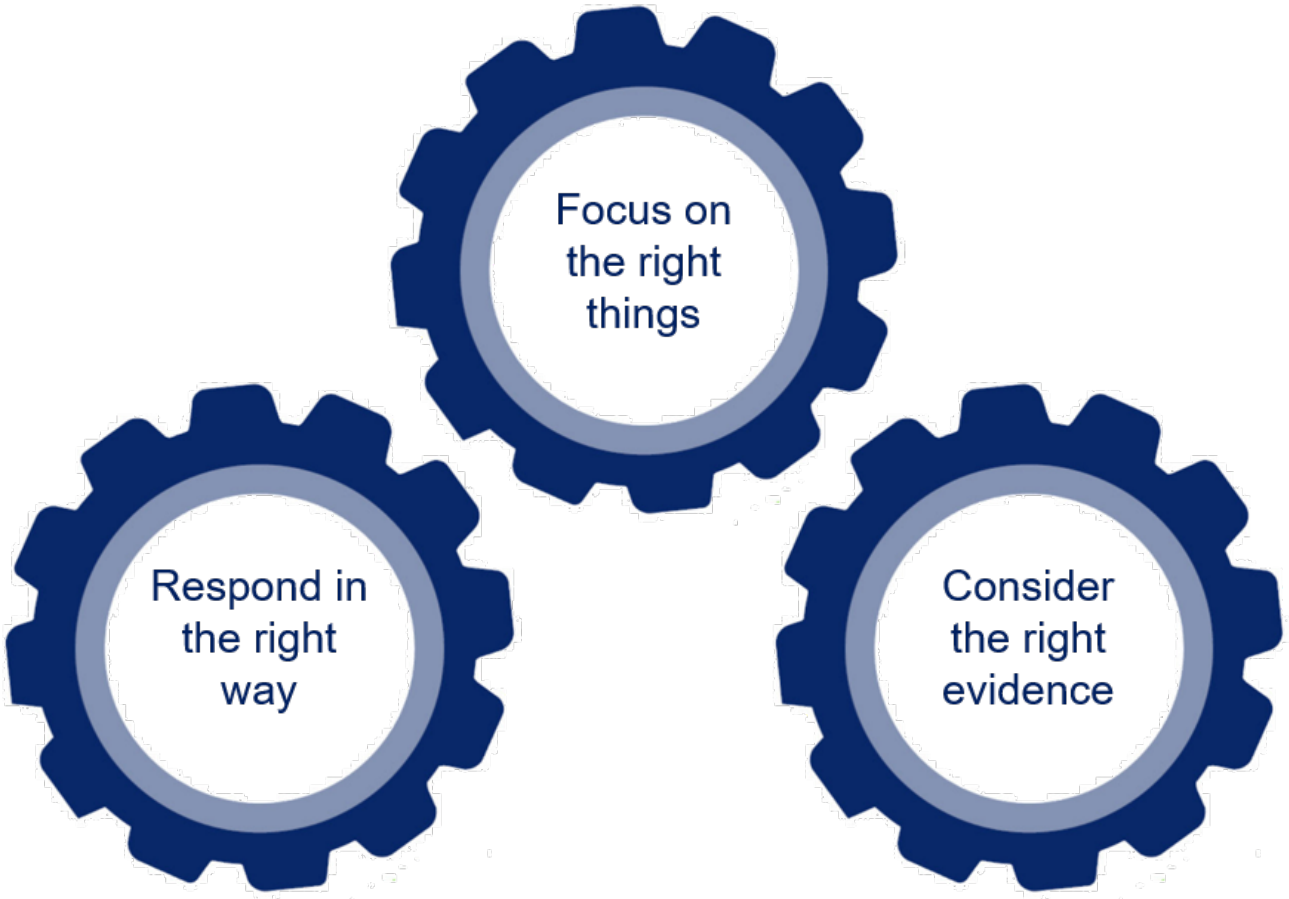
x) Good governance requires governance arrangements that are incorporated in the organisation's approach to the management of day-to-day operations and the implementation of change.

Delivering Good Governance

The Active Approach

"Active governance exists when the appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response."

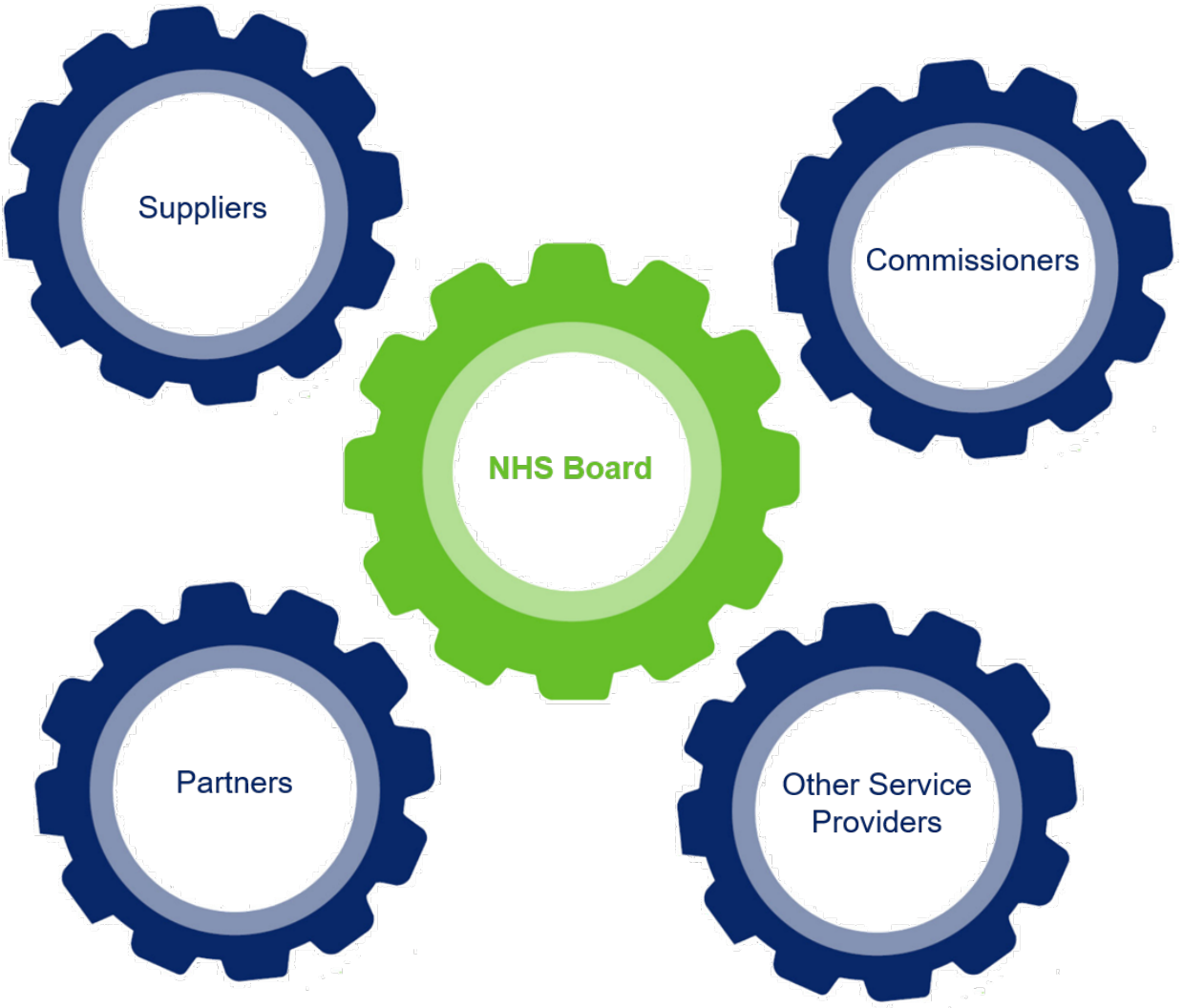
The Active Approach



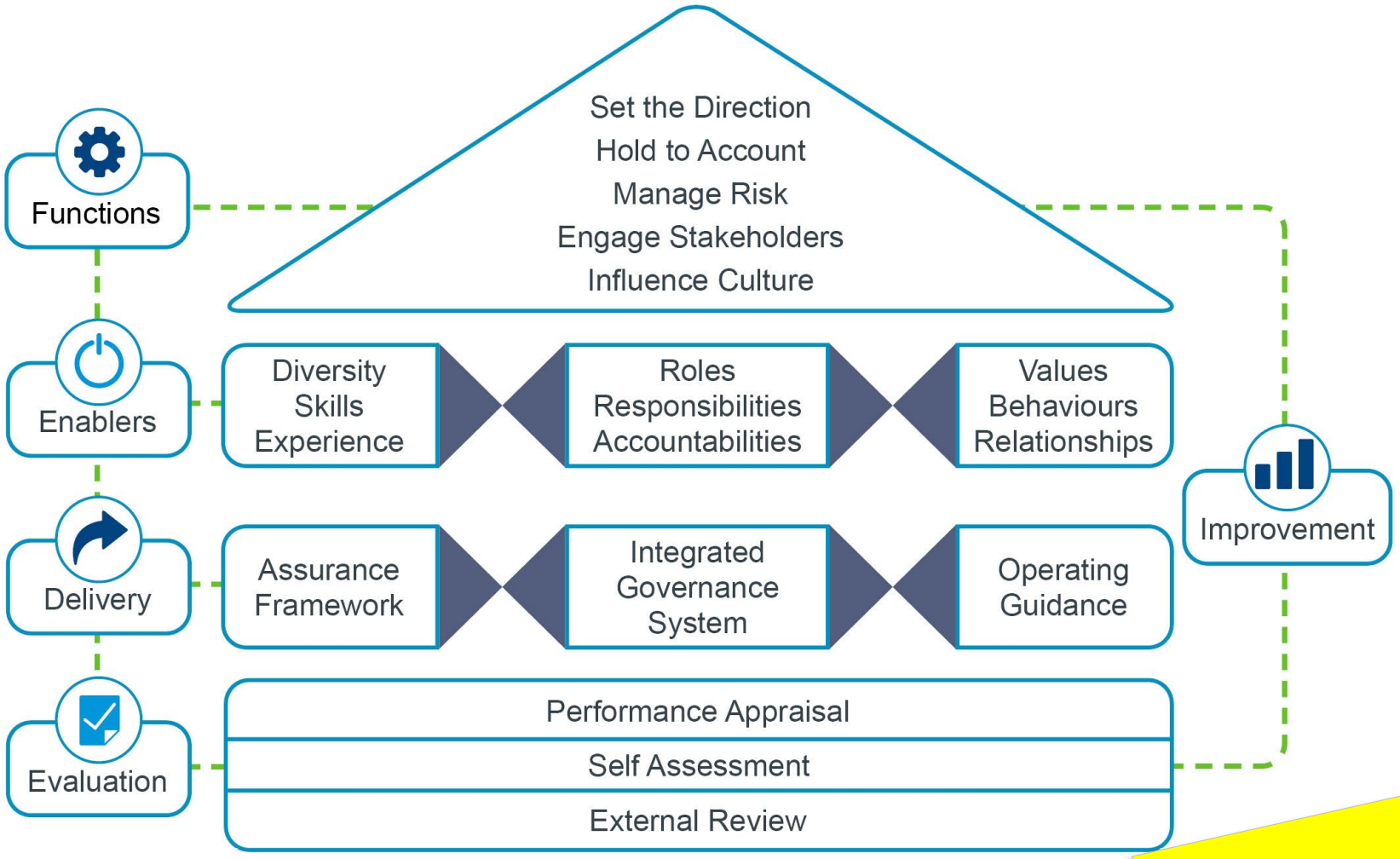
The Collaborative Approach

"Collaborative governance exists when all parties who have an influence in the delivery of healthcare outcomes recognise, understand and respect the needs of each other and work together to integrate or align their arrangements for the governance of the delivery of services and products within the healthcare environment".

The Collaborative Approach



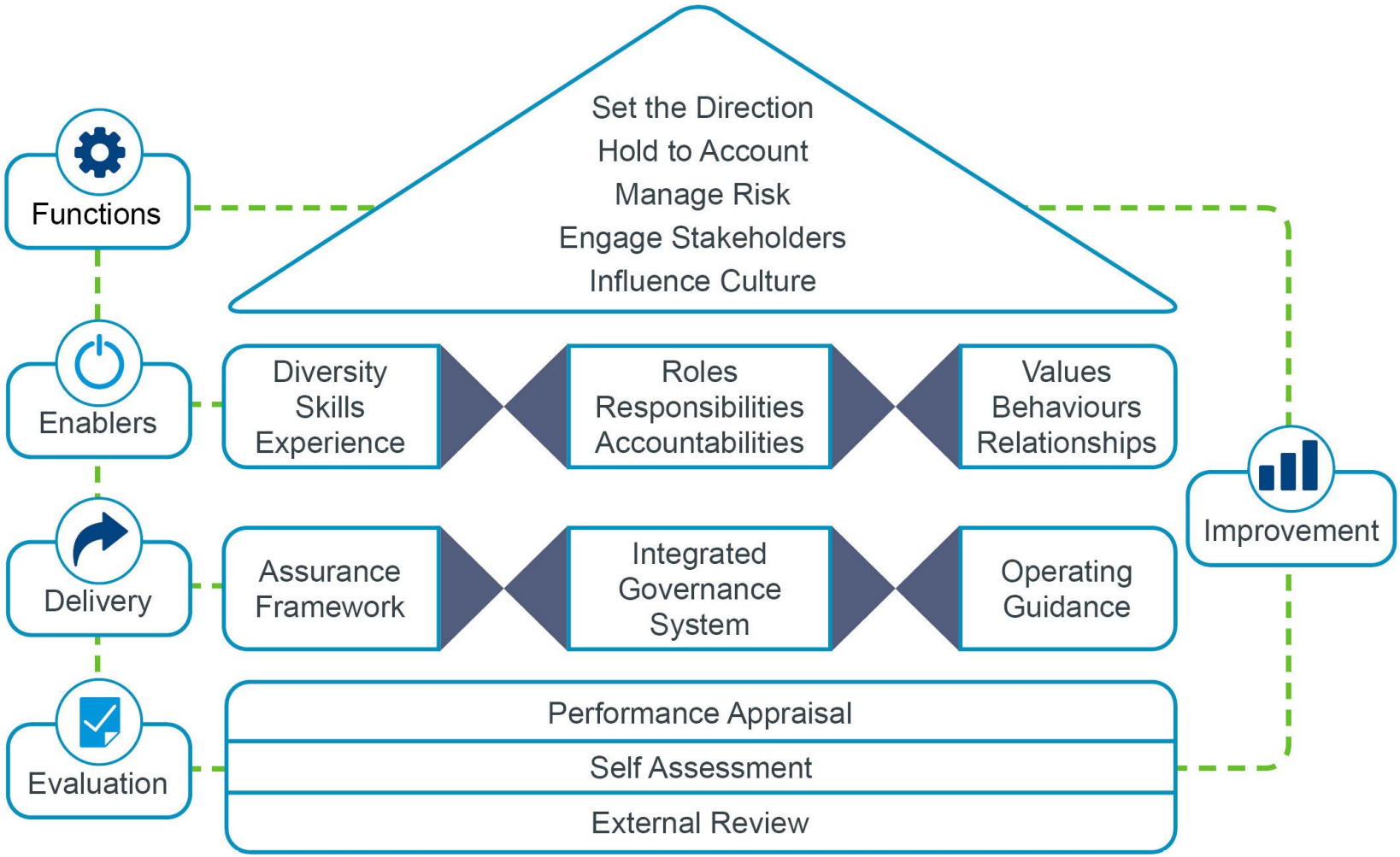
The Blueprint



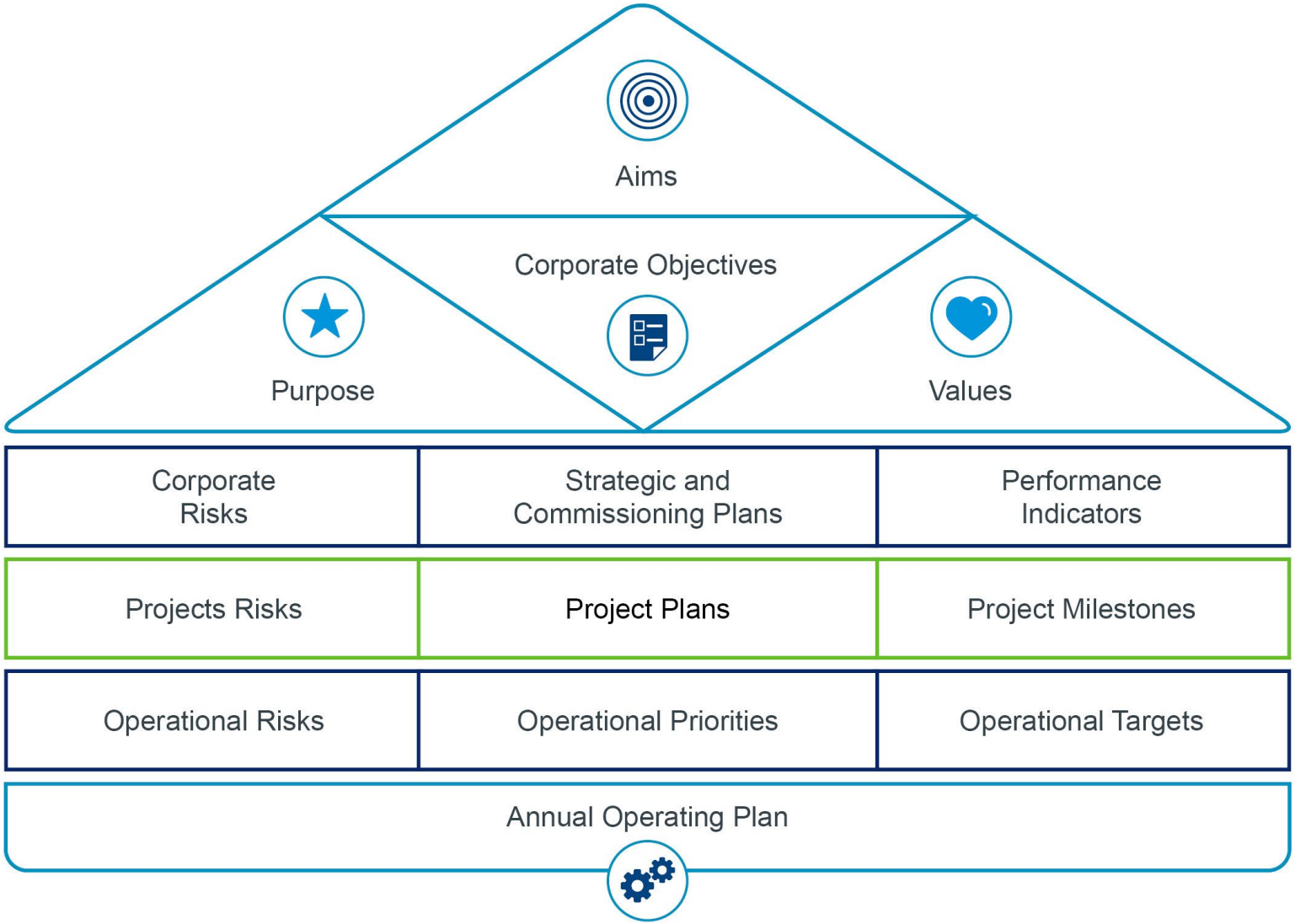
The Changes

- Clearer definition of what ‘good’ looks like in relation to healthcare governance.
- Recognition of the value of adopting active and collaborative approaches to governance.
- More detail on the delivery mechanisms and the evaluation of their effectiveness.
- More emphasis on the strategic nature of the NHS Board and advice on its involvement in operational matters.
- More emphasis on continuous improvements of governance arrangements in the NHS.

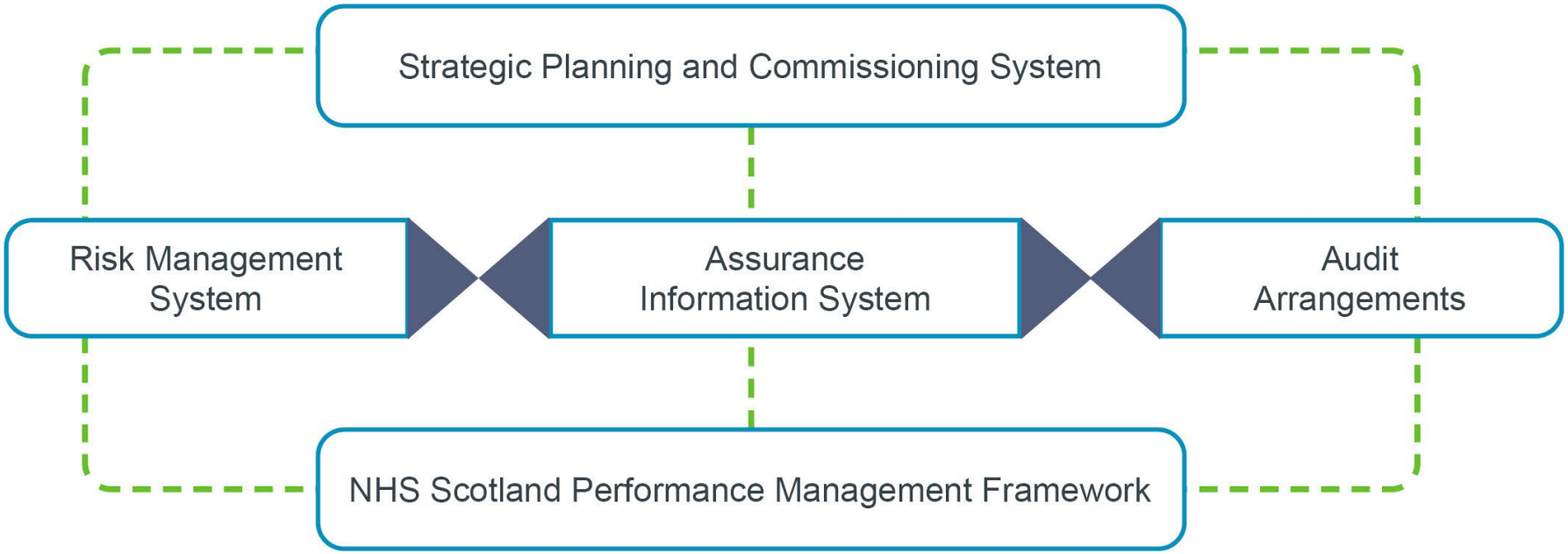
The Blueprint



The Assurance Framework



The Integrated Governance System



The Operating Guidance

Assessing Good Governance

The Assessment Approach

Discussion

Contact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Delivering Better Health

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
Title:	**Board Committee Memberships**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- NHS Board/Integration Joint Board Strategy or Direction

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

- Person Centred

2 Report summary

2.1 Situation

The Chair has agreed the following linkages between Non Executives and other meetings in order to assist with the exposure and visibility of Non Executive members of the Board to the wider organisation:-

- Organ Donation Committee – Harriet Campbell
- IT Champion – Lucy O'Leary

2.2 Background

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

2.3 Assessment

This report provides an update to the changes in Board memberships since those agreed by the Board on 1 December 2022.

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

This report has been produced for the Board.

2.4 Recommendation

The Board is asked to formally **approve** the attendance of Harriet Campbell at the Organ Donation Committee and recognise Lucy O'Leary as the Digital Champion.

3 List of appendices

The following appendices are included with this report:

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

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2023 – 30.03.2023

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

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2023 – 30.03.2023

Name/Cttee	Tris Taylor	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Kevin Buchan (ACF)	Lucy O'Leary (Digital Champion)	Cllr David Parker (LA)	Sonya Lam (Whistle-blowing Champion)	Harriet Campbell (Sustainability Champion)	James Ayling	Exec Lead & Secretariat
Area Drugs & Therapeutics Cttee (ACF Chair)					**C**						DoP DoP PA
Car Park Appeals Panel (1 NED)		**C**									GSM GSM
Whistleblowing Champion								**X**			Scot Gov't
Sustainability Champion									**X**		Scot Gov't
Digital Champion						**X**					Scot Gov't
OCCASIONAL/AS AND WHEN NECESSARY											
Discretionary Points Committee (Annual)			**C**								DHR DDHR
Pharmacy Practices Committee	**C**										MD DoP PA
Dental Appeals Panel (1 NED required at the final escalation stage only)											MD MD PA
ECR Panels (1 NED required at the final escalation stage only)											MD DPH PA
LINKAGES											
Area Clinical Forum			**A**								ACF Chair CEO PA
Mental Health Partnership Board										**A**	GM MH&LD PA
Learning Disability Partnership Board						**A**					GM MH&LD PA
Medical Education Board								**A**			DoME PA
Organ Donation Committee									**A**		Hospital Management
Primary & Community Services Clinical Board											P&CS
Acute Clinical Board											Hospital Management
TOTAL	**6**	**8**	**9**	**6**	**7**	**5**	**5**	**8**	**8**	**8**	

Changes highlighted in pink.

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2023 – 30.03.2023

KEY

C	Chair	DDHR	Deputy Director of HR
VC	Vice Chair	GSM	General Services Manager
X	Member	GM	General Manager
A	Attendee	DoME	Director of Medical Education
CEO	Chief Executive	SBC	Scottish Borders Council
DoF	Director of Finance	ED	Employee Director
DoNMA	Director of Nursing, Midwifery & AHPs	PA	Personal Assistant
DPH	Director of Public Health	CO H&SCI	Chief Officer Health & Social Care Integration
MD	Medical Director	DHR	Director of HR, OD & OH&S
DoQI	Director of Quality & Improvement	CG&Q	Clinical Governance & Quality
BS	Board Secretary	DoP	Director of Pharmacy

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2023 – 30.03.2023

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

Name/Cttee	Tris Taylor	John McLaren (APF)	Fiona Sandford (Vice Chair)	Karen Hamilton Chair	Kevin Buchan (ACF)	Lucy O'Leary (Digital Champion) **(IJB Chair 2022-25)**	Cllr David Parker (LA) **(IJB Vice Chair 2022-25)**	Sonya Lam (Whistle-blowing Champion)	Harriet Campbell (Sustain-ability Champion)	James Ayling	Exec Lead & Secretariat
Scottish Borders Health & Social Care Integration Joint Board (H&SC IJB) (5 NEDs Required)	**XV**	**XV**	**XV**	**XV**		**XV**	**VC** (Appointed in capacity as a Cllr)				**IJB CO BS**
H&SC IJB Audit Committee (2 NEDs Required)				**XV**		**XV**					**IJB CFO BS**
H&SC IJB Strategic Planning Group **(Vice Chair of IJB, Chairs the SPG)**							**C** (Appointed in capacity as a Cllr)				**IJB CO PA**
TOTAL	**1**	**1**	**1**	**2**	**0**	**2**	**2**	**0**	**0**	**0**	

Changes highlighted in pink.

KEY

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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**30 March 2023**
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, 2 new consultants have been interviewed, offered and accepted consultant posts.

New Consultant	Post	Start Date
Dr Jenny Bryden	Consultant Psychiatrist (Rehab Team)	01 May 2023
Dr Sunny Jabbal	Consultant Physician – Respiratory Medicine & General Internal Medicine	August 2023

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:	**30 March 2023**
Title:	**Integration Joint Board Minutes**
Responsible Executive/Non-Executive:	**Chris Myers, Chief Officer Health & Social Care**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The purpose of this report is to share the approved minutes of the Integration Joint Board with the Board.

2.2 Background

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3 Assessment

The minutes are presented to the Board in regard to Freedom of Information requirements compliance.

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

Not applicable.

2.3.7 Other impacts

Not applicable.

2.3.8 Communication, involvement, engagement and consultation

Not applicable.

2.3.9 Route to the Meeting

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

- Integration Joint Board 21 December 2022
- Extraordinary Integration Joint Board 1 February 2023

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 16.11.22

- Appendix No 2, Integration Joint Board minutes 21.12.22

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 16 November 2022** at **10am** in **Committee Rooms 2 & 3, Scottish Borders Council**

Present:

(v) Cllr T Weatherston
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicol
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mrs F Sandford, Non Executive
Mr C Myers, Chief Officer
Mrs H Robertson, Chief Financial Officer
Mr N Istephan, Chief Executive Eildon Housing
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Dr R Mollart GP
Mrs J Smith, Borders Care Voice
Mr D Bell, Staff Side, SBC
Mrs J Amaral, BAVs
Mr S Easingwood, Chief Social Work Officer

In Attendance:

Miss I Bishop, Board Secretary
Mrs L Prebble, PA to Chief Officer
Mrs J Stacey, Internal Auditor
Mr R Roberts, Chief Executive, NHS Borders
Dr S Bhatti, Director of Public Health
Mrs J Holland, Director of Strategic Commissioning & Partnerships
Mrs J Smyth, Director of Planning & Performance, NHS Borders
Ms H Jacks, Planning & Performance Officer, NHS Borders
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Ms L Thomson, Communications Officer, NHS Borders
Mr J Ayling, Non Executive NHS Borders
Ms E Fabry, Project Manager, Scottish Borders Council (SBC)
Ms Shirley Brown

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr David Parker, Elected Member, Cllr Jane Cox, Elected Member, Dr Lynn McCallum, Medical Director, Mrs Lynn Gallacher, Borders Carers Centre, Ms Linda Jackson, LGBTQ, Mrs Laura Jones, Director of Quality & Improvement, NHS Borders, Mr Andrew Bone, Director of Finance, NHS Borders and Mrs Gail Russell, Partnership Representative, NHS Borders.

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 **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of Extraordinary meeting of the Health & Social Care Integration Joint Board held on 31 October 2022 were approved.

4. MATTERS ARISING

4.1 **Action 2021-6:** The Chair noted that the action was a substantive item on the meeting agenda.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. DIRECTION: BUILDINGS BASED DAY SERVICE PROVISION IN TEVIOT AND LIDDESDALE – NEXT STEPS

5.1 Mr Chris Myers provided an overview of the content of the report. He commented that the Integration Joint Board (IJB) had a strategic commissioning plan for 2018-2023 and part of that plan was to reimagine day services. The IJB as the commissioner had the responsibility to commission services and directions against the strategic commissioning plan, however it had not enacted that process in the instance of the Teviot and Liddesdale day service provision.

5.2 He reassured the IJB that over the past year the approach to governance of the IJB had been refreshed: a Directions and Procedures Policy had been put in place; the strategic commissioning approach had been updated and enacted; and an enhanced governance process had been put in place for the IJB in relation to its commissioning role. He also advised that a number of actions had been agreed on the general responsibility of the IJB in terms of equalities and human rights and a full refresh of the Equalities Mainstreaming Report was being undertaken. The Terms of Reference for the Strategic Planning Group (SPG) would be amended to ensure the SPG considered the detail of impact assessments (IA) and looked at consultation in more detail.

5.3 Mr Myers suggested that there would be a financial impact related to the direction before the IJB and the costs were not currently clear. Work would be taken forward on the scope with service users and carers to understand the model required and the Chief Financial Officer was working with partners in SBC and NHS Borders to ensure appropriate provisions were available.

5.4 Mr Myers recorded his apologies to those affected and advised that he and the Chair had agreed to get in contact with those affected in regard to the oversight of the IJB.

5.5 A robust discussion ensued which focused on: contact with unpaid carers to apologise; direct engagement with those affected; was the Teviot spike within the “We have listened report” on the back of the closure; when listening to unpaid carers there may potentially be a requirement for a buildings based solution in the

future; the consultation for the new service would include the involvement of those affected by the closure; agreement on the need for meaningful apologies; would the inclusion of IA and consultation in the SPG terms of reference be adequate to mitigate other risks on how we work in partnership with other Borders communities; were the SPG already considering the Community Empowerment Act implications and risks of participation requests; should non-voting members be made voting members to ensure their voice is valued and improve governance; and workforce supply chain issues and a need to expand the overall pool of people across the partners.

5.6 Mr Ralph Roberts suggested there needed to be clarity on the Direction to be issued which was asking for a piece of work to be carried out. He commented that when the outcome of that piece of work was before the IJB for decision, the IJB would need to make that decision in the context of what the impact would be in relation to all the other services.

5.7 Cllr Robin Tatler enquired if the unpaid carer's survey data was available and if any previous surveys had been undertaken which collected the views of unpaid carers.

5.8 Mr Myers commented that the unpaid carer's survey data was available and he would share it with the IJB for information. He was aware that previous surveys had been undertaken but was not aware of the detail of those.

5.9 The Chair commented that voting and non-voting members were dictated by legislation however she assured the IJB that she valued the input of all views and voices around the table and would always take them into consideration when discussing matters.

5.10 Mr Tris Taylor suggested the direction was not completely clear and enquired if the IJB was being asked to commission a proposal or a service. Mr Roberts commented that the IJB was being asked to commission a piece of work. The outcome of that piece of work would then need to identify any implications on other service provision before the IJB could consider whether or not to commission a service.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the ruling by the Court of Session on the closure of the Teviot and Liddesdale adult day service.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the role and responsibility of the Integration Joint Board in relation to this process.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the response from Scottish Borders Council.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that there was a need for buildings based adult day service provision in the Teviot and Liddesdale locality.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to amend the direction to read "To ask Scottish Borders Council to continue to work to develop a proposal to inform the re-commissioning of the Teviot and Liddesdale day service in line with the need in the locality and to return to the IJB in February 2023 with a plan for what might be delivered."

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the amended Direction to the Scottish Borders Council.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that further work was being undertaken to explore other supports for unpaid carers in line with the results of the unpaid carer's survey.

6. CLIMATE CHANGE DUTIES REPORT 2021-22

6.1 Hazel Robertson provided an overview of the content of the report. The report described the arrangements in place given the IJB did not own any buildings, fleet or undertake any direct procurement. Previous reports had placed reliance on Scottish Borders Council and NHS Borders to fulfil their climate change duties. Those partner reports were being agreed and would be included in the IJB submission report. In moving forward Mrs Robertson suggested the IJB might consider aspects of a wider duty through its commissioning role for sustainable development goals on activities that it commissioned.

6.2 Mr Tris Taylor commented that as a commissioner the element the IJB would be involved in would be the supply chain.

6.3 Dr Rachel Mollart enquired if the cover paper template for the IJB should reference climate change and Miss Iris Bishop confirmed that the new template to be used from January 2023 had been revised and included a section on sustainability.

6.4 Cllr Elaine Thornton-Nicol suggested it should include all journeys that were undertaken on IJB business.

6.5 Mr John McLaren queried the reference to equalities issues.

6.6 Mrs Sarah Horan welcomed the report and suggested from a workforce perspective it was fundamental to what could be done to manage climate change and support staff to feel more greener through the provision of e-bikes or electric cars and a wellbeing of being greener.

6.7 Mrs Robertson commented that the paper was signalling a transition to a different way of reporting on climate change from the IJB. In terms of inequalities she advised that a fuller engagement process would be undertaken and more evidence would be provided.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the legal requirement for the IJB as a Public Body to submit an annual climate change duties report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the attached report which reflects that the duties are undertaken by the Scottish Borders Council and the NHS Board as delivery bodies. Those reports also set out the planned dates for achieving net zero status for our partner bodies.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that future consideration could be given to the contribution that the IJB could make regarding the climate emergency through progressing activity relating to the Sustainable Development Goals.

7. JOINT STRATEGIC NEEDS ASSESSMENT

7.1 Dr Sohail Bhatti provided a presentation to the Board and highlighted: the strategic issues that had been identified through the joint strategic needs assessment and community engagement; life expectancy and healthy life expectancy; ethnicity; deprivation; specialist housing and adaptations; homelessness; smoking, drugs, alcohol and obesity; loneliness; dementia; sight loss and hearing loss; mental health; palliative care; and anchor institutions.

7.2 Cllr Elaine Thornton-Nicol welcomed the presentation and seeing all of the information in one place. She commented that there were many people that might be on medication where it might not be the best solution for them, however she urged caution that judgemental situations were not created for those people that did need medication.

7.3 Discussion focused on: the benefits of social prescribing; early intervention and prevention; supporting people to come away from loneliness; future iterations of the report might have more breadth in terms of realistic medicine, health needs and provision, number of care home hours delivered, and hours for delayed discharges; self declared proportion of the workforce that declares a disability; understanding the needs of minority groups in the local population; not always enough places to signpost people to for social prescribing; and the suggestion to add living wage data to future reports.

7.4 Mrs Jenny Smith sought a commitment that the report would be kept updated moving forward. Dr Bhatti commented that the document was a live document and would be published and would be revised as and when new data was received. He was keen to expand the report as had been suggested and commented that it should be incorporated in everything that was commissioned.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

8. WE HAVE LISTENED REPORT – NDTI

8.1 Mrs Clare Oliver provided an overview of the content of the summary report and highlighted: the engagement process; voices of those with protected characteristics were included; locality focus of the work; effective communication; emerging priorities; and next phase of engagement.

8.2 The Chair suggested it was helpful to have both the Joint Strategic Needs Assessment and the We Have Listened Report together on the same agenda as they were twin pillars of work that would inform the future.

Karen Hamilton left the meeting.

8.3 Cllr Elaine Thornton-Nicol suggested linking into all of the discussion was space planning and what people were missing in their communities, she commented it was the whole holistic approach to humans including the ability to join things up.

8.4 Ms Juliana Amaral commented that community engagement and localities linked with the place making approach was a good opportunity for meaningful engagement to take place across both health and social care. She suggested in moving forward

as the plan was reviewed it would be good to integrate it fully into all aspects of living in society and communities across the Borders and would provide opportunities for health, social care and the third sector to all work together.

8.5 Mr Tris Taylor commented that taking into account strategic directions and the priorities within the strategic plan, how could those priorities be looked at on a locality by locality basis to determine preferences for local communities and then be feed into the overall priorities of the IJB. The Chair suggested it be discussed at the next point of developing strategic priorities.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

9. DEVELOPING STRATEGIC PRIORITIES

Karen Hamilton returned to the meeting.

9.1 Mr Chris Myers provided a presentation on the strategic framework to address strategic issues and highlighted: what had been done so far; emerging priorities; draft mission; workforce; waiting times; preventative and anticipatory planning; unpaid carers; older people; focus on activities that have an impact on services and costs; and next steps.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation and the on-going activity.

10. FINANCIAL OUTLOOK UPDATE

10.1 Mrs Hazel Robertson commented that in building on a forward outlook there was a need to think about how the IJB prepared its budgets and financial planning. Rather than presenting financial information in a spread sheet she was keen to present the information in a doughnut chart and envisaged using that analogy. She further suggested looking at finance in a different way and she was keen to move to a programme management budgeting approach with a marginal analysis in future. She suggested it would enable the IJB to be able to identify those things that would provide the best value for the lowest costs and would help the IJB to redesign resources and services to best effect.

10.2 Mr Tris Taylor enquired if the new doughnut/bagel approach would include participatory budgeting. Mrs Robertson confirmed that she was keen to enable localities to be set up and to work with them on that.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the presentation.

11. MONITORING AND FORECAST OF THE HEALTH AND SOCIAL CARE PARTNERSHIP BUDGET 2022/23

11.1 Mrs Hazel Robertson provided an overview of the content of the report and highlighted that she was forecasting a £6.7m overspend out of a budget of £221m. There were fewer allocations in the current financial year compared to previous years and there were more restrictions on allocations. She was working on a

solution for funding for the next financial year to tackle the biggest service issues facing the partnership.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast adverse variance of (£6.740m) for the H&SCP delegated services for the year to 31 March 2023 based on available information.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the forecast position included costs relating to mobilising and remobilising in respect of Covid-19, and assumed that all such costs would be funded via Scottish Government monies held in the earmarked reserve.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a recovery plan was in development and that any expenditure in excess of delegated budgets in 2022/23 would require to be funded by additional contributions from the partners in line with the Scheme of Integration. Previously, additional contributions had not been repayable.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that set aside budgets continued to be under significant pressure as a result of activity levels, flow and delayed discharges.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the importance of ensuring that the strategic commissioning and planning process currently in progress was used to identify options for change which would improve the long term financial sustainability of the partnership whilst at the same time addressing priority needs.

12. STRATEGIC PLANNING GROUP MINUTES: 24.08.22

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

13. ANY OTHER BUSINESS

13.1 APPOINTMENT OF EXTERNAL MEMBER OF JB AUDIT COMMITTEE: Cllr Tom Weatherston provided a brief overview of the content of the paper.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the appointment of Mr Kai Harrod as External Member of the Scottish Borders Health and Social Care Integration Joint Board Audit Committee to 31 October 2025.

14. DATE AND TIME OF NEXT MEETING

14.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 21 December 2022, from 10am to 12noon through MS Teams and in person in Council Chamber, Scottish Borders Council

Meeting concluded at 12.04.

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 21 December 2022** at **10am** via Microsoft Teams

Present:

(v) Cllr T Weatherston
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicol
(V) Cllr D Parker
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr T Taylor, Non Executive
(v) Mrs F Sandford, Non Executive
Mrs H Robertson, Chief Financial Officer
Mrs S Horan, Director of Nursing, Midwifery & AHPs
Mrs J Smith, Borders Care Voice
Mrs L Gallacher, Borders Carers Centre
Mr S Easingwood, Chief Social Work Officer
Mr D Bell, Staff Side, SBC
Ms G Russell, Partnership, NHS Borders
Ms L Jackson, LGBTQ+
Mr N Istephan, Chief Executive Eildon Housing
Mrs J Amaral, BAVs
Dr R Manson GP

In Attendance:

Miss I Bishop, Board Secretary
Mrs J Stacey, Chief Internal Auditor
Mr R Roberts, Chief Executive, NHS Borders
Mr D Robertson, Acting Chief Executive, SBC
Mrs J Holland, Director of Strategic Commissioning & Partnerships
Dr S Bhatti, Director of Public Health
Mrs J Smyth, Director of Planning & Performance, NHS Borders
Mrs L Jones, Director of Quality & Improvement, NHS Borders
Mr P Williams, Associate Director AHPs, NHS Borders
Mrs C Oliver, Head of Communications & Engagement, NHS Borders
Mrs F Doig, Strategic Lead ADP, NHS Borders
Mrs S Elliott, ADP Co-ordinator, NHS Borders

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr Jane Cox, Elected Member, Mr John McLaren, Non Executive, Mr Chris Myers, Chief Officer Health & Social Care, Dr Lynn McCallum, Medical Director, Dr Rachel Mollart GP and Mr Andrew Bone, Director of Finance, NHS Borders.

1.2 The Chair welcomed Dr Robert Mason GP who deputised for Dr Mollart and Mrs Fiona Doig who would present item 6.5 on the agenda.

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 **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were none.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of meeting of the Health & Social Care Integration Joint Board held on 16 November 2022 were approved.

3.2 The minutes of the Extraordinary meeting of the Health & Social Care Integration Joint Board held on 30 November 2022 were approved.

4. MATTERS ARISING

4.1 **EO Minutes 30.11.22: Minute 4.4:** Mr Tris Taylor asked that a breakdown of the the Carers Act Funding be provided showing how it was being spent and how that compared to what it was intended for. He asked that the matter be included on the Action Tracker.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to include a request for a breakdown of Carers Act Funding on the Action Tracker.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

5. IJB AUDIT COMMITTEE ANNUAL REPORT 2021/22

5.1 Mrs Karen Hamilton provided a brief overview of the content of the report. She highlighted: the self assessment and knowledge and skills framework; and synergy of Chairs of the Audit Committees of the partners to meet to ensure all are working effectively.

5.2 Mrs Jill Stacey spoke to the questions posed by Mr Tris Taylor ahead of the meeting and explained that she has sent a full response to Mr Taylor but highlighted the answers she had provided to the Board which were: the guidance in regard to the nature and scope of the annual report was as described at point 1.2 in the cover paper; exceptional items referred to the IJB included the Audit Committee Annual Report, External Audit Annual Report and unaudited Annual Accounts; in accordance with governance arrangements the approval of the annual accounts was given by the IJB therefore the audit committee was able to recommend their approval to the IJB although the Audit Committee had not been quorate; in terms of skills and knowledge the framework provided in CIPFA guidance had been utilised; due to personal circumstances the lay member of the Audit Committee had been unable to be part of the committee's self assessment process; and in terms of good practice principles a copy of the self assessment checklist and effectiveness toolkit considered by the Audit Committee in December 2021 were forwarded to Mr Taylor.

5.3 Mr Taylor thanked Mrs Stacey for her clarification of the issues he had raised and commented that he had been keen to dig into the detail to understand more about how risk was managed and performance was audited and scrutinised in the context that the IJB had some issues around the judicial review and in the context of

continued financial overspend and the role of the IJB in bringing that back into balance. He suggested the narrative around exceptional matters being referred to the IJB was rather ambiguous. In terms of the lay member attendance he commented that a self assessment without their input seemed to be risking the balance that was to be achieved by having a lay member on the committee and in regard to skills and knowledge he was pleased to see that it would be referenced in future reports.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Audit Committee Annual Report 2021/22 (Appendix 1) which sets out the performance in relation to its Terms of Reference and the effectiveness of the Committee in meeting its purpose and the assurances therein.

6. RESERVES POLICY

6.1 Mrs Hazel Robertson provided an overview of the content of the policy and highlighted that the current level of reserve was in the region of £10m. the policy had been considered by the Audit Committee in detail earlier in the week and was recommended by that Committee for approval by the IJB. She further commented that in approving the policy it would provide the IJB with some additional flexibility around how it identified reserves and held them in the IJB accounts. In regard to the current reserve it was entirely comprised of ear marked funds from allocations from NHS Scotland and the policy would allow the IJB to set aside up to £8m of ear marked reserves from other sources.

6.2 Mrs Fiona Sandford enquired why such high levels of reserves were held. Mrs Robertson advised that the primary reason for the reserves was the late notification of allocations in the last financial year from the Scottish Government in regard to COVID-19 and the reserve was drawn down against for in year costs related to COVID-19. There would still be an in year balance to be carried forward in regard to COVID-19 funding unless the Scottish Government sought its return. The remaining amounts were much smaller and related to other programmes of work.

6.3 Mrs Robertson advised that she intended amending the financial reports format to provide the IJB with more clarity and visibility of what was in the reserves account.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the revised Reserves Policy.

7. SCOTTISH GOVERNMENT MULTI-DISCIPLINARY TEAM FUNDING

7.1 Mrs Hazel Robertson provided an overview of the content of the report. She explained that the allocation had been taken to the Urgent and Unscheduled Care Programme Board (UUCPB) for consideration and 2 projects had been identified, the community equipment store (CES) and the rapid assessment and discharge (RAD) service. There were potential projects identified for the remaining £205k for consideration by the UUCPB.

7.2 Mrs Fiona Sandford enquired if there would be difficulties in recruiting to the RAD service. Mr Paul Williams commented that in regard to the RAD workforce the majority of staff were on fixed term contracts and the investment into the service would enable permanent contracts to be issued and would also provide for stability

and consistency within the service. He did not have concerns in regard to recruitment to that service.

7.3 Mr Nile Istephan enquired if minor adaptations would be part of the CES service. Mr Williams commented that the CES utilised an MDT approach to assess what people needed to return home or remain in their home and that could be minor adaptations or significant pieces of equipment.

7.4 Mr Tris Taylor commented that the funding was specifically about funding posts and enquired if the funding of the CES was an appropriate use of funds. Mr Williams commented that whilst the equipment in the CES sat in one place it was accessed through an MDT approach with the end goal of benefits to the entire team by the improvement in the independence or ability that people had to stay in their own homes and increasing the capacity of the MDT.

7.5 The Chair commented that the UUCPB had not included wider stakeholders such as GPs and carers, in its membership and she enquired how they would be involved in looking at the remainder of the funding. Mrs Robertson confirmed that Mr Chris Myers was in dialogue with the GP executive in regard to GP involvement in the UUCPB and he would also be picking up the inclusion of carers.

7.6 Mr David Robertson supported the recommendations to fund the CES and RAD service and spoke of their effect on the whole system in addressing: prevention to admission; ensuring people could stay in or return to their own homes or the community; support to reduce delayed discharges; and supporting the flow of patients through the whole system.

7.7 Mr Taylor commented that he was keen to understand how the funding would be spent to build capacity for the third sector and also suggested an inclusion in the performance report to indicate performance against the 3 metrics.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the new recurrent funding allocation, its scope and desired impacts.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD noted** the process undertaken to rapidly review potential initiatives.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD noted** the limitations outlined to the process within the paper.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD agreed** in principle to the earmarking of £312k recurrent funding from the allocation for the Community Equipment Store (£159k), and the Rapid Assessment and Discharge Service (£153k), pending further review by the Integration Joint Board's Strategic Planning Group. The Strategic Planning Group would also review associated directions.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD agreed** to the approach of prioritising the £205k remaining MDT funding following further engagement at the Urgent and Unscheduled Care Programme Board with key stakeholders including GPs and carers.

The **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** asked that Mr Chris Myers clarify that GPs and carers had been granted membership of the UUCPB.

8. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

8.1 Mrs Hazel Robertson provided an overview of the content of the report and advised that there was a projected outturn adverse variant of £6.7m which was a slight improvement compared to the same period the previous year. She commented that there had been little progress on savings targets in the partnership and the forecast position included projections for COVID-19. Any remaining unspent COVID-19 funding would be carried forward in the reserves with the caveat that the Scottish Government might ask for its return. In practice if at the end of the year the partnership was in an overspent situation then additional contributions would be sought from the partner bodies in line with the Scheme of Integration.

8.2 Mrs Robertson further advised that the set aside budgets remained under pressure and the annual audit from 2021/22 had highlighted that the partnership were not complying with the guidance on how to deal with set aside budgets. Discussions were being held with NHS Borders on how to implement that guidance more fully.

8.3 In regard to the financial position Mrs Robertson advised that she would be using a programme budgeting marginal analysis methodology in the future to look at individual pieces of investment and make comparisons to identify those that would provide the most benefit to the partnership in terms of the strategic planning approach.

8.4 The Chair enquired about a timescale for the new approach to be taken and Mrs Robertson commented that it would be taken forward as part of the strategic commissioning planning process to cover that 3 year period.

8.5 Mr Tris Taylor welcomed the refresh of the report that would make it more meaningful and engaging and he welcomed a more explicit visibility of carers act funds and also enquired if the risk was recorded that the partners might expect repayment of any additional monies they might have to provide to the IJB. Mrs Robertson advised that the Scheme of Integration was clear that any additional monies provide by the partner bodies could be subject to payback and that was a risk that was carried until such point as the partnership operated within its funding limits.

8.6 In regard to the carers funds, Mrs Robertson advised that she was pulling together a presentation for the next Carers Group meeting to show how the Carers Act funding had been utilised over the past number of years and she would subsequently share that with the IJB for information.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the forecast adverse variance of (£6.740m) for the H&SCP delegated services for the year to 31 March 2023 based on available information.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the forecast position includes costs relating to mobilising and remobilising in respect of Covid-19, and assumes that all such costs will be funded via Scottish Government monies held in the earmarked reserve.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a recovery plan is in development and that any expenditure in excess of delegated budgets in 2022/23 will require to be funded by additional contributions from the partners in line with the Scheme of Integration. Previously, additional contributions have not been repayable.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that set aside budgets continue to be under significant pressure as a result of activity levels, flow and delayed discharges.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed the importance of ensuring that the strategic commissioning and planning process currently in progress is used to identify options for change which will improve the long term financial sustainability of the partnership whilst at the same time addressing priority needs.

9. QUARTERLY PERFORMANCE REPORT

9.1 Mrs Hazel Robertson highlighted the hospital activity data within the report.

9.2 Dr Sohail Bhatti reflected that whilst the report produced overarching data for comparisons across Scotland, there may be benefit in looking into health inequalities and gender through that same lens going forward.

9.3 Mrs Fiona Sandford commented that the fact that really good data was available was very encouraging and she enquired about a narrative around the deteriorating position of occupied bed days. The Chair advised that Mr Chris Myers was keen to develop the report further and was currently undertaking a piece of work in regard to length of stay and occupied bed days before they become delayed discharge figures.

9.4 Mr Ralph Roberts welcomed the report and commented that emergency admissions to hospital were not at the pre COVID-19 levels however it was clear that length of stay in hospital had increased. Even though more input had been put into social care hours the number of delayed discharges had increased, so there was something within the whole system that had to be multi factoral that was failing. He urged using the data to address the drivers of the pressure that was being seen across the whole partnership.

9.5 Dr Robert Manson welcomed the data within the report and commented that in primary care demands and expectations were far exceeding those experienced pre COVID-19. With a 24 hour society where people could order and have deliveries made the following day he surmised the general public were of the expectation that health services operated within the same time sphere. Primary care were the front door for all health services and had reached saturation point which meant people would circumvent NHS24 or GPs and go directly to A&E adding pressure on the hospital system. He emphasised the issues leading to delayed discharges and the knock on effects of patient deterioration and added stress on carers and unpaid carers.

9.6 Mr Tris Taylor commented in terms of carers indicators the latest data showed the highest number of completed carers support plans and he enquired if there were numbers for unmet need. He enquired if there was data available to show if the

position as improving or worsening and he sought clarification that the legend on the Y axis was correct for all of the charts and he noticed that there was little shift in terms of how people felt about finance and benefits in regard to carers support plans.

9.7 Mrs Lynn Gallacher advised that in regard to carers support plans the data reported was captured through the carers census. There was however further data available that could be included in the report. In terms of waiting lists for carers support plans there was no waiting list as all requests were met quickly with a liaison officer allocated to all referrals on receipt and resources were currently stretched to the limit to cope with the increased demand.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the key challenges highlighted.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address the challenges and to mitigate risk.

10. DRAFT STRATEGIC PLAN PROGRESS UPDATE

10.1 Mrs Hazel Robertson updated the Board in regard to the work underway on the strategic commissioning framework and highlighted engagement with the public, staff and other stakeholders and the identification of 6 overarching strategic priorities. The suite of documents would be presented to the Strategic Planning Group before being shared with the IJB by the end of March 2023. In discussions with both SBC and NHS Borders it had been agreed that the plan would be used as a single plan by all those services affected.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the update.

11. CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2021/22

11.1 Mr Stuart Easingwood provided an overview of the content of the report and highlighted the various elements of the report that related to service quality and performance. He advised that the format of the report was dictated by the Scottish Government and that it was a reduced report compared to that produced pre COVID-19 under the original 2017 regulations, which had been revised.

11.2 Dr Sohail Bhatti suggested the report should bear the name of the author and Mr Easingwood agreed to take that suggestion forward for the future.

11.3 Cllr Tom Weatherston recorded his thanks to Mr Easingwood and his Team for the great work that they undertook and the Chair echoed those comments.

11.4 Mrs Laura Jones suggested the data for referrals to social work teams should be included in the IJB performance report.

11.5 Dr Robert Manson commented that as a GP and on behalf of the GP community who worked closely with the social work team, he wished to acknowledge and thank the team for all of their efforts in dealing with many difficult situations and the

positive impact they had on people. He noted that the waiting list figures to the end of March 2022 were 405 and he enquired of the current waiting list figure. Mr Easingwood advised that he would draw down the data and share that with the IJB. He also commented that Mr Chris Myers was pursuing a dashboard to show data for the hospital and community.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Report.

12. BORDERS ALCOHOL AND DRUGS PARTNERSHIP ANNUAL REPORT 2021-22

12.1 Mrs Fiona Doig provided an overview of the content of the report and highlighted the positive performance of services during the period 2021/22 for the first 5 standards and that the next 5 standards were expected to be in place by the end of the 2022/23 reporting year. There had been challenges during the year in terms of funding however all waiting times targets had been maintained.

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the Annual Report.

13. STRATEGIC PLANNING GROUP MINUTES: 01.11.22

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

14. ANY OTHER BUSINESS

The **HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there was none.

15. DATE AND TIME OF NEXT MEETING

15.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 18 January 2023, from 10am to 12noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.