Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 1 February 2024** at 10.00am in the Lecture Theatre, Headquarters/Education Centre, BGH and via MS Teams

AGENDA

Time	No		Lead	Paper
10.00	**1**	**ANNOUNCEMENTS & APOLOGIES**	Chair	*Verbal*
10.01	**2**	**REGISTER OF INTERESTS**	Board Secretary	Appendix-2024-1
10.02	**3**	**MINUTES OF PREVIOUS MEETING** 07.12.23	Chair	*Attached*
10.03	**4**	**MATTERS ARISING** Action Tracker	Chair	*Attached*
10.05	**5**	**STRATEGY**		
10.05	5.1	Medium Term Financial Plan Update	Director of Finance	Appendix-2024-2
10.30	5.2	Property Update	Director of Finance	Appendix-2024-3
10.32	5.3	Director of Public Health Annual Report	Director of Public Health	Appendix-2024-4
10.55	**6**	**FINANCE AND RISK ASSURANCE**		
10.55	6.1	Resources & Performance Committee minutes: 02.11.23	Board Secretary	Appendix-2024-5
10.56	6.2	Audit & Risk Committee minutes: 18.09.23	Board Secretary	Appendix-2024-6
10.57	6.3	Risk Appetite Policy	Director of Quality & Improvement	Appendix-2024-7
11.05	6.4	Finance Report	Director of Finance	Appendix-2024-8
11.10	**7**	**QUALITY AND SAFETY ASSURANCE**		
11.10	7.1	Clinical Governance Committee minutes: 22.11.23	Board Secretary	Appendix-2024-9
11.11	7.2	Quality & Clinical Governance Report	Director of Quality & Improvement	Appendix-2024-10
11.25	7.3	Healthcare Associated Infection – Prevention & Control Report	Director of Nursing, Midwifery & AHPs	Appendix-2024-11

11.30	**8**	**ENGAGEMENT**		
11.30	8.1	Area Clinical Forum Minutes: 03.10.23	Board Secretary	Appendix-2024-12
11.31	8.2	Time for Change Summary – Community and Staff Engagement	Director of Planning & Performance	Appendix-2024-13
11.35	**9**	**PERFORMANCE ASSURANCE**		
11.35	9.1	NHS Borders Performance Scorecard	Director of Planning & Performance	Appendix-2024-14
11.45	**10**	**GOVERNANCE**		
11.45	10.1	Scottish Borders Health & Social Care Integration Joint Board minutes: 15.11.23	Board Secretary	Appendix-2024-15
11.46	10.2	Board Committee Memberships	Chair	Appendix-2024-16
11.48	10.3	NHS Borders Climate Emergency & Sustainability Annual Report 2022/23	Director of Finance	Appendix-2024-17
11.58	10.4	Consultant Appointment	Director of HR, OD & OH&S	Appendix-2024-18
11.59	**11**	**ANY OTHER BUSINESS**		
12.00	**12**	**DATE AND TIME OF NEXT MEETING**		
		Thursday, 4 April 2024 at 10.00am in the Lecture Theatre, Headquarters/Education Centre, BGH and via MS Teams	Chair	*Verbal*

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Register of Interests**
Responsible Executive/Non-Executive:	**Karen Hamilton, Chair**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Government policy/directive

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

- Person Centred

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to include the declarations of interest for Mrs Lynne Huckerby and Ms Lynne Livesey in the formally constituted NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

2.2 Background

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

2.3 Assessment

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

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

2.3.1 Quality/ Patient Care

Not applicable.

2.3.2 Workforce

Not applicable.

2.3.3 Financial

Not applicable.

2.3.4 Risk Assessment/Management

Regulatory requirement.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Climate Change

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 **approve** the inclusion of the declarations of interests for Mrs Lynne Huckerby and Ms Lynne Livesey in the Register of Interests.

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Declaration of Interests Mrs Lynne Huckerby
- Appendix No 2, Declaration of Interests Ms Lynne Livesey

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: LYNNE HUCKERBY *(please insert your full name in capital letters)*

Registerable Interest	Members Interest
Remuneration Remuneration by virtue of being • employed or self employed • the holder of an office • a director of an undertaking • a partner in a firm • undertaking a trade, profession or vocation or any other work • allowances in relationship to membership of an organisation	
Related undertakings Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held.	TRUSTEE DIRECTOR MCLAREN LEISURE CENTRE
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 lynne Huckerby Date 15/11/23

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 LYNNE MARGARET LIVESEY *(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	Royal Institution of Chartered Surveyors Standards and Regulation Board Independent Member Professional regulatory body
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..... Date 09/01/24

Borders NHS Board

Minutes of a meeting of **Borders NHS Board** held on Thursday 7 December 2023 at 9.00am in the Lecture Theatre, Education Centre and via MS Teams.

Present:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Ms S Lam, Non Executive
Mrs L O'Leary, Non Executive
Mrs H Campbell, Non Executive
Mr J Ayling, 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

In Attendance:
Miss I Bishop, Board Secretary
Mr A Carter, Director of HR, OD & OH&S
Mrs L Jones, Director of Quality & Improvement
Mr C Myers, Chief Officer Health & Social Care
Mrs L Huckerby, Interim Director of Acute Services
Mrs S Errington, Head of Planning & Performance
Mr S Whiting, Infection Control Manager
Mrs H Borland, Interim Director of Nursing Professional Support
Mrs C Oliver, Head of Communications & Engagement
Dr A Cotton, Associate Medical Director, Mental Health & LD
Dr N Campbell, Consultant MH&LD
Mr B Joshi, General Manager Unscheduled Care
Mrs E Dickson, Associate Nursing Director Acute
Mrs R Pullman, Nurse Consultant Public Protection
Dr J Bennison, Associate Medical Director, Acute
Mr S Burt, General Manager, Mental Health & Learning Disabilities
Mr D Knox, BBC Reporter

1. Apologies and Announcements

1.1 Apologies had been received from Mr T Taylor, Non Executive, Mr G Clinkscale, Director of Acute Services, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Mrs J Smyth, Director of Planning & Performance and Mr P Lerpiniere, Interim Director of Nursing, Midwifery & AHPs.

1.2 The Chair welcomed a range of attendees to the meeting including Mrs Steph Errington, Interim Director of Planning and Performance, Mrs Lynne Huckerby,

Interim Director of Acute Services and Mrs Hazel Borland, Director of Nursing professional support as well as members of the public and press.

1.3 The Chair took the opportunity to record the thanks of the Board to Mrs Sonya Lam, Non Executive for her service to the Board and especially with her whistleblowing responsibility.

1.4 The Chair confirmed the meeting was quorate.

2. Declarations of Interests

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

The **BOARD** approved the inclusion of the revised declarations of interests for Harriet Campbell in the Register of Interests.

3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 5 October 2023 were approved.

4. Matters Arising

4.1 **Action 2023-4:** Progress had been made and the action remained live with the intention that it would be concluded by the next Board meeting.

The **BOARD** noted the Action Tracker.

5. Emergency Department Workforce Review

5.1 Mr Ralph Roberts introduced the item and advised that the Emergency Department workforce Review and the Mental Health and Learning Disabilities Medical Workforce Plan, together were the most significant high risk staffing issues that the Board had.

5.2 Mr Chris Myers commented that the Emergency Department (ED) was a core function of the hospital and the paper was in relation to the impact on workforce activity and addressing staffing issues and was not focused on flow through the department and the hospital.

5.3 Mrs Laura Jones commented on the external context and the significant investment in EDs that some other Boards had made over the past 5-6 years.

5.4 Dr Lynn McCallum provided the clinical perspective of the current ED and the level of risk being carried.

5.5 Mr Andrew Bone set out the decision making process in relation to the financial plan and the code of corporate governance and whether the Board were content to include the business cases in the 2024/25 financial plan. He also explained that the financial plan would be required to meet the conditions set by the Scottish Government (SG) and that investments set out in the plan would therefore require

SG approval. He emphasised that bringing forward significant cases for investment where there were financial challenges would require a need to have a longer term reform of local systems. In terms of the ED current model it was unsustainable and the Board needed to balance the risk between workforce, safety and finance. He commented that if the Board made the decision to proceed this should be considered an interim position pending development of a longer term plan for the ED, the model of the acute hospital as a whole and given the constraints on finance it would need to be undertaken within sustainable financial and workforce parameters.

5.6 Mrs Hazel Borland commented that given the context and case load of patients and clients through the ED was very different, the way forward was to build resilience and enable a safer hospital and ED particularly in the overnight period. She reiterated the ask was about the core ED functions. Other EDs were considering the provision of AHPs at the front door to triage and turn around patients and move them to the community and colleagues would be considering that pathway in 2024 as well as alternative care pathways and the reintroduction of some of the care pathways that were in place pre the pandemic. She urged the main consideration was to balance risk, finance and ensuring the hospital was safer especially in the ED.

5.7 A robust discussion ensued that raised a number of issues including: fewer senior doctors in the ED; increased admission rate which was significantly above the majority of peers and comparative bed pressures; cost of consultant led ED is higher than our peers; comparison of the overspend in ED compared to the investment proposal; what would the difference be for staff and patients if there was flow in the system; if we invest we reduce the risk and how does that help performance; all flow including medical and surgical flow is through our ED but not in other Boards; other EDs are consultant led 24/7; the lack of consultant presence disables the ability to redirect patients to other pathways; given the overspend in the ED and need for further investment was the original budget set at the right level; is the core funding formula correct for the funding allocation to NHS Borders; difficulties with local demographic and funding formula and potential to send Scottish Government, press and public a list of the services that will need to be stopped to remain in budget; and the need for a discussion about a more preventative and more self managed environment where care is provided in a different way and we may even commission it.

5.8 Mr. Bone commented that all Health Boards, including NHS Borders, are within 0.8% of parity against the existing NRAC formula and that any change to this formula would be unlikely to fully address the current deficit.

5.9 Mr Bhav Joshi commented that the paper demonstrated the decoupling of performance and safety and the reverting back of none core components for the ED pre pandemic and that addressing the workforce issues would not fix performance but removing things would. The workforce component of the plan was to provide stability to the hospital and have a tolerated level of risk which would allow the ED workforce to operate with clarity and consistency and senior decision making would undoubtedly improve safety.

5.10 Mrs Jones commented that the team were looking at savings schemes to contribute towards the plan and that they had a significant insight into how to remodel the

service, change the admission profile and have a different senior decision makers model.

5.11 Mrs Sonya Lam welcomed the discussion and commented that whilst she understood the rationale behind the paper, there had been interim support put into the ED and that had been inconsistent, and she questioned what difference that had made and if it had decreased the risk. She was unable to support the proposal at that time.

5.12 Mr Roberts suggested the recommendations be approved along with caveats of: acknowledging and recognising that a safe ED would be sustained in the current system; acknowledging an emphasis in the longer term would be to understand how an ED would fit into the overall strategy of the Borders General Hospital (BGH) going forward and what that would mean for other services; agree the recommendations to be placed into a draft financial plan and not progress the implementation until the financial plan was signed off; and if there were immediate priority decisions to be made in the meantime, they be raised with the Board as a matter of priority.

The **BOARD** noted the significant safety issues detailed within the paper (and ED Workforce Review sections 2.2 - Strategic Context, and Section 3.2 - Drivers for Change) and that a safe ED would be sustained in the current system.

The **BOARD** noted the interim arrangements put in place since 2020 (including during covid) which were not substantively funded.

The **BOARD** supported the planned future actions and strategic vision for urgent care pathways and acknowledged an emphasis in the longer term would be to understand how an ED would fit into the overall strategy of the Borders General Hospital (BGH) going forward and what that would mean for other services.

The **BOARD** supported the Recommendations/preferred option described within the ED Workforce Review) and agreed that the recommendations be placed into a draft financial plan and that implementation would not be progressed until the financial plan had been signed off.

The **BOARD** agreed that the future model of delivery in the ED would need to be further considered in line with the acute services strategy, and the unscheduled care programme and if there were immediate priority decisions to be made in the meantime, they would be raised with the Board as a matter of priority.

6. Mental Health and Learning Disabilities Medical Workforce Plan

6.1 Dr Amanda Cotton provided an overview of the content of the paper and highlighted several elements which included: senior psychiatry staffing levels; risks to mental health functioning performance; unaffordability due to instability; areas of particular instability and risk; out of hours rota cover gap; and growing the middle grade workforce roles to move to a more resilient staffing model over time.

6.2 Dr Lynn McCallum reinforced Dr Cotton's comments and advised that there were significant national issues with mental health services, particularly psychiatry staffing. However in a small Board with a small team the loss of psychiatry staff

meant there was no ability to sustain services. The proposal before the Board would be more attractive to consultants and would enable sustainable psychiatry services for the future.

6.3 Mr Simon Burt also commented that the current situation had a negative impact on the rest of the mental health services provided and professional groups and lead to retention and recruitment difficulties as services were not operating as they should be.

6.4 Mrs Harriet Campbell enquired if the proposal was to agree to invest now or to add the investment proposal to the draft financial plan. Mr Andrew Bone confirmed that the decision sat in the same context as the previous paper, ie financial plan approval would still be required; the paper did not however increase the overall cost basis, but did shift from expensive use of agency to a more sustainable workforce model, but at a permanent increase to establishment; and the financial risk of a decision at the meeting was relatively less challenging, and he was therefore more comfortable with an earlier decision.

6.5 Mrs Sonya Lam enquired about the level of confidence in being able to recruit. Dr Cotton advised that she had no confidence in being able to fill the consultant vacancies with consultants, but she remained confident that being able to grow doctors from within the service into autonomous role like new speciality doctors would be possible and achieve a sustainable solution for the future.

6.6 Further discussion focused on: provision of administrative support which had an impact on the retention of medical staff; over medicalising of mental health illnesses; recognition of the role of Dr Cotton in maintaining services through an exceptionally difficult and challenging period; recognition that the Clinical Governance Committee had not been able to provide the Board with assurance in regard to psychiatric services; movement of services from hospitals to investing in communities; and the next biggest challenge will be changing the neuro-development support model.

The **BOARD** considered its' level of appetite to support the proposal, which would be used to inform the payment offer from NHS Borders to the Integration Joint Board.

The **BOARD** supported the funding of a CDF/SR doctor in CAMHS at a cost of £95,000 to contribute to the first-on-call out-of-hours rota and support resilience to the CAMHS senior staffing.

The **BOARD** supported the funding of the junior staffing to a 'headcount' of 10, which included the doctor noted above and assumed an average 9 wte across the service. The additional cost of a further £95,000 would be offset by instances where both BAS and GAP CT1s were provided by the deanery with LTFT working across the group and costs incurred currently to fill out-of-hours gaps (unquantified).

The **BOARD** noted the unfunded PA at a cost pressure of £57,500 which was supporting current deficits within MHOAS. If stability as per the plan had been achieved, consider the need for replacement.

The **BOARD** agreed the organisation should close the 3-session funding gap for Liaison Psychiatry, at a cost of £48,000, allowing full focus of time to the General Hospital

priorities and in order to retain the full-time consultant. It was the opinion of the Mental Health Board that it should not be drawn from core Mental Health funding.

The **BOARD** recommended a Specialist Doctor role be advertised in MHOAS which if successful could allow an SD to be moved to the adult service. If unsuccessful, further supports to the service would be necessary.

The **BOARD** recommended that a Specialist Doctor role be advertised for CAMHS and if that was unsuccessful, additional SD time be sought to 'grow' towards the Specialist Doctor role, to a maximum of 1.6 wte.

The **BOARD** recommended a Specialist Doctor role be advertised in GAP and that a model of 3 SD doctors supporting 4 consultants, or 4 SDs growing towards the Specialist Doctor role with the support of a minimum 3.0 wte consultants be adopted. As the adult service was currently below that floor, further short-term supports would be needed.

The **BOARD** recommended that substantive consultants undertaking additional out-of-hours shifts should be offered time off (1 hour per additional weekday shift; 2 hours per weekend shift) in order to support wellbeing and sustainability. Cross cover and impacts on daytime activities should be monitored.

The **BOARD** noted that previous recommendations had been made around retention of senior doctors within service including establishing adequate administrative support and re-establishing the consultant role as consultative and clinical leader of their teams; further recommendations may result from ongoing work in that area. Dedicated administrative support for all senior doctors should be expedited.

7. Resources & Performance Committee minutes: 07.09.23

The **BOARD** noted the minutes.

8. Endowment Fund Board of Trustees minutes: 07.08.23

The **BOARD** noted the minutes.

9. Finance Report

9.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several key elements including: overspend after 7 months was £15.6m; forecast position was £22.5m; £1.85m of savings had been delivered to date against a £5m target, with a forecast of £3.5m to end March 2024; feedback received from the Scottish Government on the Quarter 2 forecast review; ongoing dialogue with the Scottish Government on financial recovery; Scottish Government request to improve our outturn position to £17.8m from £22.5m; and the total NHS Scotland financial position.

9.2 Discussion focused on: costing services that will need to be cut and sharing that with the Scottish Government to gain political support; recognition of the financial situation of health and social care across Scotland; need to up our game in progressing against our financial position; involvement of business units in service redesign and financial reductions; staff exhaustion; clinical engagement; what is the least safe thing to stop doing at the current time; value based healthcare;

polypharmacy; knock on effect of reducing acute services on community services especially GPs; and take a radical approach to demedicalisation of issues across the country.

9.3 Cllr David Parker commented that the Board needed to understand what a balanced budget would look like in order to eliminate the deficit and he was keen to see the list of services required. Engagement with the public and raising issues with the Scottish Government would then be the priority. He was aware that politicians would not want to cut services but if they had a list of priorities and reasons they would be able to make an informed decision. He suggested providing the Board with a full list of services and what a balanced budget would look like and then developing strategies to achieve a balanced budget, instead of looking at services in isolation.

9.4 Mr Ralph Roberts commented that work would be progressed with business units to see what a balanced budget would look like. Decisions were a feature of the financial plan and the Board would move to a place of being able to make significant decisions 1-2 times a year through a more structured approach with annual planning sessions.

The **BOARD** noted that the Board was reporting an overspend of £15.36m for seven months to end of October 2023.

The **BOARD** noted the position against the revised Q2 forecast outturn of £22.511m at year end, and the risks to achieving that outcome.

The **BOARD** noted the position reported in relation to recurring savings delivered year to date (Section 5).

10. Clinical Governance Committee minutes: 13.09.23

10.1 Mr James Ayling enquired about medical appraisals and the anomaly between the minutes and the ED Workforce paper that suggested the majority of staff had not undertaken appraisals in the past 3 years.

10.2 Mrs Laura Jones commented that the paper received by the Clinical Governance Committee had been specifically in relation to medical appraisals and not the wider workforce.

10.3 Dr Lynn McCallum confirmed that as the Responsible Officer she could assure the Board that medical appraisals were undertaken and the practice was heavily regulated. She confirmed that the minute was correct.

The **BOARD** noted the minutes.

11. Quality & Clinical Governance Report

11.1 Mrs Laura Jones provided a brief overview of the content of the report and highlighted: the emerging risk on the medical model of community hospitals; patient experience demand; the UK and Scottish COVID inquiries; and the additional capacity in the patient experience team who were working hard to return to the 20 working day response standard for complaints.

11.2 Dr Lynn McCallum commented that from the end of March 2024 the GP Practice in Kelso would no longer fulfil the medical cover contract for Kelso Community Hospital and there was a similar situation at the Knoll Community Hospital with the geriatrician due to retire at the end of March 2024, meaning that both hospitals would have no medical cover from the beginning of April 2024. The last day of care audit had identified that 75% of patients in the community hospitals were in the wrong place as they did not require on-going medical care. There was an opportunity to do things differently in the future and the public were aware of the conversations taking place about Community Hospitals.

11.3 Mrs Fiona Sandford commented that the Clinical Governance Committee were concerned about the performance of the Stroke Unit in terms of delayed discharges and admissions. The Stroke Unit was a microcosm of the dangers of delayed access for stroke patients.

The **BOARD** noted the report.

12. Infection Prevention and Control Report

12.1 Mr Sam Whiting drew the attention of the Board to page 8, section 5 surgical site surveillance and advised that there had been a period of unplanned leave and he was looking at addressing single person dependency in the future. He also highlighted section 6 in regard to doctors hand hygiene and that compliance was improving through the use of formal communication to Clinical Directors and the Infection Control Team were undertaking an educational session through the Grand Round. The next round of hand hygiene audits would dig into the granularity for grade and location to assist further improvement activity. In regard to section 9 of the report he highlighted the Infection Control workplan and short term challenges with resources.

12.2 Further discussion focused on: the trajectory for c.diff was unlikely to be achieved in terms of a reduction by March 2024, especially given the small numbers involved; suggestion that hand hygiene compliance is included in annual appraisals for medical staff; and observations and fluctuations in hand hygiene compliance.

The **BOARD** noted the report.

13. Public Protection Annual Report

13.1 Mrs Rachel Pullman provided an overview of the content of the report and highlighted the key areas of inspection activity and that areas for improvement were included in improvement plans and were being monitored by the Care Inspectorate.

13.2 The Chair enquired if there were timescales set against the actions in the improvement plan. Mrs Pullman confirmed that there were.

13.3 Mr Chris Myers commented that there had been significant work undertaken on public protection with two major inspections having taken place.

13.4 Chair remind the Board that the underpinning message was that Child and Adult Support and Protection was everyone's business irrespective of role or position in NHS Borders.

The **BOARD** noted the report.

14. Public Governance Committee minutes: 10.08.23

14.1 Mr James Ayling enquired if the equalities mainstreaming report had been published. Dr Sohail Bhatti confirmed that it was being finalised and would be available in a few weeks and would be issued for virtual approval.

The **BOARD** noted the minutes.

15. Area Clinical Forum Minutes: 15.08.23

15.1 Mrs Fiona Sandford commented that she had been present at the meeting. Miss Iris Bishop advised that she would ensure the minutes were amended accordingly.

The **BOARD** noted the minutes.

16. NHS Borders Performance Scorecard

16.1 Mrs Steph Errington provided an overview of the content of the report and advised that there had been a short fall of delivery against a number of trajectories including outpatients, emergency care, and mental health waiting times and key actions and priorities had been identified in an attempt to improve performance in those areas. Cancer waiting times performance remained strong and there had been no significant movement since the previous report.

16.2 Mr Chris Myers commented that work was being taken forward in regard to the Child and Adolescent Mental Health service (CAMHS) to look at re-triage into the national definitions of categories 1 and 2 which had supported performance. There was also activity being undertaken to support people waiting to be seen to achieve the national requirement by March 2024.

16.3 Further discussion focused on: the movement of the planned assessment unit to Ward 17; protection for day cases and work towards a 23 hour stay; protected beds for Orthopaedics; pressures in ED; moving towards the sustainability of 8 cataracts per list; new dermatology model was working and sourcing external expertise; challenges around the integration of Home First and Social Care; an undulation in referrals week by week from hospital to care services; focusing on discharge process and discharge programme and processes to reduce inappropriate demand; and surge planning.

The **BOARD** noted performance as at the end of October 2023.

17. Consultant Appointments

The **BOARD** noted the report.

18. Scottish Borders Health & Social Care Integration Joint Board minutes: 20.09.23

The **BOARD** noted the minutes.

19. Any Other Business

The **BOARD** noted there was none.

20. Date and Time of next meeting

20.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 1 February 2024 at 10.00am in the Lecture Theatre, Education Centre, Borders General Hospital and via MS Teams (hybrid).

Borders NHS Board Action Point Tracker

Meeting held on 29 June 2023

Agenda Item: Mainstreaming Report

Action Number	Reference in Minutes	Action	Action to be carried out by:	Progress (Completed, in progress, not progressed)
2023-4	7	The **BOARD** agreed to remit the report to the Public Governance Committee on 10 August for scrutiny with a commitment to publish the document immediately after the meeting.	**June Smyth Tris Taylor**	**In Progress:** The Public Governance Committee reviewed the document and provided comments and feedback at its meeting on 10th August. The Committee agreed that an updated version will be considered virtually by members before the document is published. **Update 07.12.23:** Progress had been made and the action remained live with the intention that it would be concluded by the next Board meeting.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Medium Term Financial Plan Update**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Effective

2 Report summary

2.1 Situation

NHS Borders is required to submit a draft three financial plan for 2024/25 to Scottish Government by 29th January 2024 and final plan by 11th March 2024.

The draft financial plan is not available at time of preparation of this paper. This paper describes the initial forecast outlook for 2024/25 and actions required to complete the development of the draft, and final, financial plans.

2.2 Background

2023/24 Financial Plan

The financial plan approved by NHS Borders Health Board on 30th March 2023 set out a three year forecast outturn position as follows:

2023/24 plan approved by NHS Borders Health Board March 2023

	2023/24 £m	2024/25 £m	2025/26 £m
Forecast Outturn (including savings)	(22.5)	(21.9)	(21.7)

This plan was predicated on delivery of 3% recurring savings in 2024/25 & 2025/26.

The revised financial plan for 2024/25 and beyond includes consideration of movement from this position in relation to the level of savings delivered during 2023/24 as well as cost pressures emerging in year.

These pressures have seen a deterioration in the underlying recurrent position for the board in 2023/24 and actions to mitigate this include release of flexibility that would otherwise have been available to support plans in future years.

Developing the 2024/25 plan

The financial planning process and timetable were presented to the Resource & Performance Committee on 2nd November 2023, noting that Scottish Government timescales had not yet been confirmed in relation to the submission of 2024/25 and longer-term financial plans.

A draft forecast outlook for 2024/25 was presented to the Resources & Performance Committee at its meeting on 18th January 2024. This position is described in further detail under Section 2.3 below.

During quarter three several correspondences have been received from Scottish Government which set out the financial operating framework and timescales for development of the financial plan. These are summarised below.

Quarter Two Review

The Board received response to its quarter two outturn forecast (2023/24) on 27th November 2023. This letter including confirmation that the Board's performance escalation status had been reviewed and remained at Stage three of the refreshed NHS Scotland Support and intervention framework. This update stated that the Board remain subject to additional support from Scottish Government and that 'in order to reach a stage de-escalation could be considered a material movement on the position would have to be evidenced, with a credible medium term recovery plan to ensure a return to financial balance'.

Further to this, the letter emphasised the extant arrangements under the Scottish Public Finance Manual within which spending outside available resource is not permitted; any additional funding made available to support delivery of a breakeven position would be made on the basis of a repayable loan (i.e. brokerage).

Financial Planning Guidance

The Scottish Government wrote to NHS Boards on 4th December to provide guidance for the submission of medium term delivery plans and financial plans. This letter described the process and timescales for submission and provided supplementary

guidance on planning assumptions. The key timescales described in the letter were as follows:

- Draft Financial Plan submission by 29th January 2024
- Three-year delivery plan submission by 7th March 2024
- Final Financial Plan submission by 11th March 2024

In line with earlier guidance, this letter confirmed that Health Board financial plans were required to cover the three years 2024/25 to 2026/27 and to include:

- a clear programme of work and supporting actions to achieve the target of 3% recurring savings on baseline budgets;
- an improved forecast outturn position compared to your forecast outturn position reported at the start of 2023-24.

Issue of local planning guidance

On 15th December 2023 a further letter set out expectations for NHS Borders financial plan. The letter set out an approach to financial recovery aligned to both local and national planning frameworks and advised that the level of financial support available in previous years was no longer sustainable and that action was required to reduce this in future years. This included a cap to the level of brokerage available to the board in 2024/25, set at 'a very maximum of £17 million, with the cap reducing in future years'; other Health Boards subject to performance escalation have received similar notification.

Where these plans are likely to impact on annual delivery plans Board's are advised to engage with Scottish Government to ensure that the implications of these actions are fully understood.

Scottish Government Budget

Following publication of the draft Scottish Government budget on 18th December 2023, a letter was received setting out the expected level of resources available to NHS Boards in 2024/25, including summary of changes to the NHS Borders baseline Revenue Resource Limit.

Territorial NHS Boards will receive a total increase of 4.3% above 2023/24 baseline. This resource covers the costs of 2023-24 pay deals and confirms recurring support for sustainability and population adjustment (NRAC) made available during the current financial year. All amounts received in relation to the 4.3% uplift relate to 2023-24 non-recurring funding now made available on a recurring basis.

Additional funding of £1.5 million is made available to NHS Borders in relation to NRAC parity. This is the only additional resources confirmed within the letter; there is no general uplift. Cost pressures and inflation are therefore expected to be managed within the revised baseline level set during 2023/24, amended for NRAC adjustment.

Boards are advised to plan on the basis that any pay settlement for 2024/25 will include separate funding. At this stage, planning guidance advises Boards to omit any uplift in relation to pay policy from both costs and anticipated funding from draft financial plans.

Where ring-fenced allocations are made available in relation to policy commitments Boards are to assume that funding will be in line with 2023/24, unless separately notified. Scottish Government continue to review portfolio commitments and there remains a risk that this position will change moving forward.

2.3 Assessment

Financial Outlook 2024/25

A draft financial outlook for 2024/25 has been prepared based on an assessment of the recurring opening deficit brought forward from 2023/24, and including forecast additional resources and expenditure commitments, together with high level assumptions regarding the level of savings likely to be delivered in 2024/25. This position is summarised below.

	R	NR	Total
	£m	£m	£m
Opening Gap	(30.2)		(30.2)
Additional Commitments	(15.0)	(4.4)	(19.4)
Additional Resources	1.5	1.6	3.1
	(43.6)	***(2.8)***	***(46.5)***
Recovery Actions			
Savings Target - 3%	9.0	0.0	9.0
Financial Flexibility		2.5	2.5
Recovery Actions	***9.0***	***2.5***	***11.5***
Operational Performance		*3.0*	*3.0*
Forecast Outturn	***(34.6)***	***2.7***	***(32.0)***

This position provides an indication of the scale of the financial challenge facing the Board in 2024/25. Further work is being undertaken to review assumptions and identify actions to improve the forecast across all areas of expenditure. Work towards a financial recovery plan is described below.

Key Drivers

Opening Gap

The opening gap represents the underlying recurring deficit carried by the Health Board, i.e. the difference between ongoing operational expenditure and the level of funding available recurrently to the Board. This position has increased from the 2024/25 plan due to reduction in the level of recurring savings projected to be delivered in 2023/24, together with a number of additional cost pressures impacting in year. The key movements are: a reduction of £1.5m against target savings (£3.5m delivery against projected £5m); in year growth in drugs & prescribing costs (£4m) above level set out in the financial plan; increase in commissioning costs of out of area packages of care and reduced level of income from inflow of patients from out of area. Set against these pressures is the additional £2.5m sustainability and NRAC funding received in May 2023 and made recurring within the 2024/25 Scottish Government budget.

Additional Commitments

Drugs & Prescribing. Expenditure has increased by c.8% during 2023/24. Should this trend continue there would be a further increase of £3.6m during 2024/25.

New Medicines. NHS Borders received £5.4m in 2023/24 in relation to new medicines funds as share of £250m available nationally. This position was a significant increase on levels of funding available in previous years however it is expected that funding will reduce to £80m nationally in 2024/25 as a result of variation in pricing agreements with pharmaceutical companies. This will result in a projected reduction of £3.7m funding to a revised budget of £1.7m. The forecast outlook assumes that there is no corresponding reduction in expenditure and that this is therefore a direct increase to cost pressures in year.

A detailed exercise is being undertaken to evaluate the impact of new medicines costs in 2024/25. At this stage it is assumed that expenditure growth related to new medicines would be included within the overall impact of drugs & prescribing growth identified above.

CNORIS. The Clinical negligence and other risks indemnity scheme operates to manage litigation risks across NHS and associated public bodies within Scotland. Increases to overall levels of provision are projected to increase contribution in 2024/25 from £70m nationally (NHS Boards) to £100m; the impact of this increase to NHS Borders is estimated at £0.4m.

Energy Costs. The impact of energy increases over the past two years has been partially mitigated through the national framework agreements in place across NHS Scotland, which have ensured that energy contracts are secured in advance at capped price levels. This has resulted in a lower overall growth rate in prior years but with delayed impact on pricing agreements moving into 2024/25 and beyond. Current projections indicate a further increase in 2024/25 across utilities contracts of 11.5%.

Non Pay growth & Inflation. The overall impact of non-pay cost growth has been modelled based on CPI inflation projections for the year to December 2024 (2.7%). This is modified for areas where there are known variations from CPI (e.g. rates, catering).

Healthcare Commissioning. NHS Borders spends around 10% of its overall resources on services provided out of area by NHS and other providers. This is typically in relation to specialist services not able to be provided locally. Provider costs are forecast to increase at 5% as a result of overall cost pressures. There remains significant uncertainty regarding this position.

Commitments from 2023/24 plan. There are a number of commitments made in the previous years financial plan where the full year effect of these commitments impacts in 2024/25; in addition, time-limited commitments made on a fixed term, multi-year basis, are reflected in the forecast. This includes the board's project management office and project support costs (e.g. implementation of digital systems such as eRostering).

National & Regional commitments. Pressures on national services such as Adult Renal Transplant and the National Heart Failure service are financed by individual health boards on the basis of population share. Risk share arrangements for very high cost medicines (ultra-orphan drugs) are projected to increase in 2024/25 as new Cancer

therapies are introduced. Although included within the draft plan, there is ongoing dialogue at national level around the affordability of investments on an NHS Scotland basis.

Local Investment priorities. There are £2.9m commitments arising from strategic business cases presented to the NHS Borders Health Board for approval during 2023/24.

This includes £1.6m in relation to Primary Care improvement plans for which funding is expected to be available non-recurrently to support a pilot development; further investment priorities have been identified in relation to emergency medicine and mental health services.

Within emergency medicine there has been an increased pressure on the Borders General Hospital Accident & Emergency department and the current workforce model is no longer sustainable. An interim model has been agreed which would enhance staffing within the department pending review of longer term service configuration.

For mental health, increased medical vacancies have resulted in risk to service sustainability and a revised workforce model has been developed which mitigates this risk and reduces reliance on expensive agency staffing solutions.

Cost Pressures. Ongoing cost pressures impacting on performance in 2023/24 are reflected in the forecast. This includes £1.9m in relation to 'surge' capacity (i.e. additional hospital beds) and increased clinical supplies and property maintenance costs (c.£2.5m total). These pressures are in relation to both increased activity and pricing. A full review of cost pressures is being undertaken to assess options for how these costs can be mitigated.

Additional Resources

Against these additional cost pressures there is no significant increase to the Board's available resources. The Scottish Government budget includes an increase of £1.5m in relation to NRAC but all other resources are in line with funding received in 2024/25 and as highlighted above, the expected reduction to new medicines funding presents a further pressure to the forecast.

Funding is anticipated in relation to the PCIP investment following confirmation from Scottish Government that the NHS Borders bid was successful. The detail of this plan remains to be finalised. At this stage it is assumed that funding will match forecast expenditure.

Financial Recovery Actions

Scottish Government have set out a budget which highlights the constraints on public sector spending overall.

The scale of the deficit facing NHS Borders is now at a level which is no longer sustainable either locally or at a national level. The Health Board remains an outlier within NHS Scotland due to the scale of its deficit, however the issues described above are consistent with pressures impacting across the wider health system.

As such, the actions required will go beyond traditional financial improvement activities and productivity gain and will require structural reform impacting on how services are configured and delivered in future.

The draft financial outlook includes initial assumptions in relation to financial recovery actions however it is clear that this position will require significant additional action in order to meet the level of performance set out by Scottish Government. The current forecast describes an expected deficit of £32m (an increase of £10m on previous plan). This is £15m above the maximum level of brokerage available to the Board (£17m).

The forecast includes an assumption that areas of underspend within current budgets will be retained during 2024/25 pending review of longer term requirements. This reflects a level of offset against the cost pressures described above.

The forecast also assumes delivery of 3% savings in line with national planning guidance. Plans remain in development and an update will be provided to the Resources & Performance Committee in February. Savings delivery in 2023/24 is forecast at c.1.5% of base budget, indicating the scale of improvement required.

The development of the Board's financial recovery plan continues to be supported by Scottish Government and additional resources have been confirmed to support the Director of Finance to establish a task force approach to this plan, to be progressed during February and March. Despite this, there is a significant risk that schemes required to fully address the challenges set out above will continue to be developed beyond end March and that this will impact on timescales for delivery.

Actions are already in place on a short-term basis to restrict expenditure during 2023/24 and extension of these arrangements will be considered by the Financial Improvement Board in February. Current actions include pause on all non-clinical recruitment, as well as further controls in relation to overtime in non-clinical areas, and freeze on discretionary expenditure (e.g. furniture, fittings and equipment). Where enacted, exceptions are considered in relation to risks arising from patient safety or business continuity.

Approval of the Plan

Given the situation outlined above there is a risk that the Scottish Government will not support the plan unless it describes actions sufficient to achieve the target level of performance set out in planning guidance. This may in turn result further impact on the Board's ability to make investment decisions in relation to risks outlined in the plan.

The draft financial plan will be reviewed by the Resources & Performance committee on 7th March prior to submission to Scottish Government on 11th March and presentation to the Board for approval on 4th April.

2.3.1 Quality/ Patient Care

As per section 2.3.3.

2.3.2 Workforce

As per section 2.3.3.

2.3.3 Financial

The financial recovery plan will include areas where difficult decisions are required impacting on how services and care is delivered in future, including potential restrictions to access and/or availability of services. The implications of the financial position are that the Board will need to consider how it balances financial and non-financial risks and that decisions will be required which – without mitigation - may impact adversely on quality/patient care, workforce, performance and safety. It is expected that the full impact of these choices will be assessed, and appropriate engagement undertaken where required, prior to any implementation.

2.3.4 Risk Assessment/Management

At this stage a risk assessment has not yet been undertaken.

2.3.5 Equality and Diversity, including health inequalities

At this stage no impact assessment has been undertaken.

2.3.6 Climate Change

At this stage no impact has been identified.

2.3.7 Other impacts

It is likely that the actions required to deliver the level of savings necessary will include areas where further public engagement will be required. This will be considered once options have been identified and developed for further review.

2.3.8 Communication, involvement, engagement and consultation

The draft financial outlook was presented to the Area Partnership forum and Area Clinical Forum on 26th January 2024.

An engagement plan is presently in development.

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, 18th January 2024

2.4 Recommendation

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

The Board are asked to note the position regarding the draft financial outlook and the further work required to develop the financial plan and financial recovery plan, and timescales associated with this work.

3 List of appendices

There are no appendices to the report.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Property Update**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Andrew Bone, Director of Finance** **Brad Herbert, Head of Estates Projects**

1 Purpose

This is presented to the Board for:

- Awareness
- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan
- Local policy

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

This paper requests that the Board formally endorse a contract awarded in December 2023 which supports completion of the 2023/24 capital plan.

2.2 Background

In order to meet timescales for the delivery of projects included within the 2023/24 capital plan Board Members were asked in December 2023 to approve via email award of a contract to Redpath Construction Limited. The value of this contract was £1.247m (£1.496m including VAT) and therefore requires Board approval in line with the Scheme of Delegation (Section F, Code of Corporate Governance).

The contract was awarded under the Scottish Public Sector Minor Building Works Contract (reference NP827/23) and tender arrangements were undertaken by NHS Borders procurement via the Public Contract Scotland online portal. Tender evaluation was supported by the Board's appointed contract advisors (Thomson Gray). There were five tenders submitted and the successful bid was the lowest price tender and was considered the most economically advantageous in combination with the quality score applied to each bid.

The contract covers three separate projects as follows:

- Macmillan refurbishment and reconfiguration (phase I)
- Mammography scanner replacement and relocation
- Fire safety works (bin & linen storage facilities)

A single contract award was made in consideration of a number of factors including:

- Health and safety concerns in relation to presence of multiple contractors on site concurrently
- Flexibility in scheduling contractor works across multiple projects on concurrent timelines
- Ease of engagement with key NHS personnel in Estates, Capital planning
- Financial efficiency in relation to supervision of works, etc. through a single contractor

Although a single contract is awarded, each individual project has a separate budget. The Macmillan refurbishment project is financed through charitable contributions (fundraising and direct contribution from MacMillan); other projects are included within the NHS Borders capital budget for 2024/25.

Additional information was supplied to Board members following an informal briefing held on 20th December. This included a full tender evaluation report.

Following this briefing the Director of Finance requested Board members provide individual approval via email to allow the contract award to proceed in advance of the next Board meeting. This was necessary in order to meet the timescales for contractor engagement and on-site presence.

10 responses approving the contract award were received from board members, including the Chair and Chief Executive. Responses included seven non-executive members and three executive members. There were no responses in dissent.

2.3 Assessment

Following the exercise seeking individual approval from Board members in December the contract was awarded to Redpath Construction Ltd in line with the recommendation. Works included in this contract are due to commence in February 2024 and complete by May 2024.

Noting the guidance in relation to capital investments, the NHS elements of this contract were discussed with Scottish government colleagues in December and a

profile of expenditure has been agreed that is in line with the schedule of works set out in the contract.

Although agreed, there is a risk that funding deferred from the 2023/24 programme will not be reinstated in 2024/25 due to the overall capital position of NHS Scotland. Should this risk be manifest, mitigation would be through reprofiling of the 2024/25 capital programme, for which detailed work is not yet complete.

This paper recommends that the Board endorse the basis on which the contract award has been made, noting support of individual members as described in section 2.2, and formally approve the contract via homologation (retrospective approval).

2.3.1 Quality/ Patient Care

Completion of the projects covered by this contract will result in an improvement to the quality of the built environment within the scope of the areas addressed by projects in scope.

2.3.2 Workforce

The contract award will have a positive impact on the workload of the capital planning team through consolidation of three individual projects allowing for efficient project management.

2.3.3 Financial

The financial aspects of the contract are covered through existing budgets including charitable contributions. Budgets set for the project include 10% contingency for variation in overall costs.

2.3.4 Risk Assessment/Management

The works covered by the projects in scope for this contract will provide mitigation against existing risk highlighted on the Board's risk register in respect of fire safety; support delivery of the Radiology equipment life cycle replacement programme; and address phase I of the Macmillan Centre improvement plan which seeks to address capacity challenges and enhance the patient experience within the unit.

Risks associated with the projects are covered through individual project risk registers. There are no high or very high risks identified in relation to delivery of the projects.

2.3.5 Equality and Diversity, including health inequalities

Impact assessments are undertaken in relation to the Board's property strategy and capital plans. No impact assessment is undertaken in relation to this paper which covers arrangements in place for delivery of existing plans.

2.3.6 Climate Change

There are no specific elements to the projects in scope which are directly related to climate change adaptation or mitigation of climate risks.

All projects undertaken by NHS Borders estates & capital planning teams consider how any impact on climate can be mitigated as part of the project scope. The contract award is made via national contracts in place for construction works within public sector buildings and these contracts include specific requirements of contractors in relation to compliance with climate change duties.

2.3.7 Other impacts

Projects will be managed to avoid any adverse impact on patient care however it is recognised that any works undertaken within healthcare facilities are likely to temporary arrangements to support business continuity whilst works are undertaken. These arrangements are subject to local project management and staff engagement.

2.3.8 Communication, involvement, engagement and consultation

Capital projects are undertaken in line with the Board's capital plan. The projects identified within this paper were approved as part of the Board's capital plan for 2023/24 and in all cases are projects which were carried forward from prior year plans due to challenges in delivery as a result of the COVID pandemic.

Non executive members were briefed on the proposed contract award at an informal session on 20th December 2023. No formal consultation has been undertaken.

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.

- None

2.4 Recommendation

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

Board Members are requested to retrospectively approve (i.e. homologate) the award of a contract for capital works to value of £1.496m (including VAT) to Redpath Construction Limited.

3 List of appendices

The following appendices are included with this report:

- None

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Director of Public Health Annual Report**
Responsible Executive/Non-Executive:	**Dr Sohail Bhatti**
Report Author:	**Dr Sohail Bhatti**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Report

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

- Person Centred

2 Report summary

2.1 Situation

This report, “Real Action for Prevention”, is presented by the Director of Public Health for noting by the board. Our DPH started in post September 2022 so this report highlights activity of the Public Health Department over all of the year 2023 and provides context and suggestions for putting prevention at the forefront of our efforts going forward. This report establishes what prevention means to the public health profession and thus can be used as a point of common understanding with partners.

2.2 Background

Section 1 provides detail of the DPH vision for public and population health in the Scottish Borders and section 2 includes reports from the Joint Health Improvement Team, Alcohol and Drugs Partnership, Screening Team, Oral Health report and the Joint Health Protection Plan (joint with SBC).

2.3 Assessment

This is an important time for public health in the Borders and in Scotland. Public Health Priorities are not just for public health departments to deliver. We need to be tackling the fundamental causes of health inequalities. This means working through our partnerships with others and thinking about how we work with local communities to shape our efforts.

The DPH will be bringing our strategy, Tackling Health Inequalities in the Scottish Borders (THIS Borders) to public attention in the next few months but we have already begun by bringing together stakeholders and partners in a series of workshops to share our emerging findings and to help shape the way the evidence is presented and prioritised.

2.3.1 Quality/ Patient Care

Positive impacts – value-based patient-centred preventive care will improve health at a population level.

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

An impact assessment has not been completed because this is linked to our overall strategy to reduce health inequalities across the area.

2.3.7 Communication, involvement, engagement and consultation

No stakeholder groups have been consulted in the writing of this report as it presents an approach to community engagement, development and health improvement going forward.

2.3.8 Route to the Meeting

This is the first presentation of this DPH report.

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Joint Health Improvement Team Annual Report
- Appendix 2: Alcohol and Drugs Partnership Annual Report
- Appendix 3: The Joint Health Protection Plan
- Appendix 4: The Annual Report on Screening
- Appendix 5: Report on Oral Health

REAL ACTION FOR PREVENTION:

a vision of population health in the Scottish Borders

Report of the Director of Public Health 2023
NHS Borders

FOREWARD

I am delighted to share with you the Director of Public Health Report for 2023, which is my first report for the Scottish Borders. A number of logistic challenges meant that we are slightly later than intended, but we aim to catch up this year! As you might expect, this is a team effort taking the skills and knowledge of many people within the department.

The report is in two sections:

- The first section that focuses on prevention bringing to the attention of our partners the variety of primary, secondary and tertiary prevention interventions available. I want to help address some of the lack of clarity I have found, with terminology often presented as prevention/early intervention but meaning different things entirely.

- The second section shares some of the work of the department of Public Health carried out in 2023. We are an outward facing organisation that seeks to lead, encourage, co-ordinate and improve the efforts of local organisations, groups and allies to improve the health and wellbeing of everyone that lives, works or is educated in the Scottish Borders.

  These reports specifically are:

  * Joint Health Improvement Team Annual Report
  * Alcohol and Drugs Partnership Highlight Annual Report
  * Joint Health Protection Plan
  * Screening Programmes Report
  * A report on Oral Health

This is an important time for public health in Borders and in Scotland. Public Health Priorities are not just for public health departments to deliver. We need to be tackling the fundamental causes of health inequalities, including prevention. This means working through our partnerships with others and thinking about how we work with local communities to shape our efforts. We will be bringing our strategy, Tackling Health Inequalities in the Scottish Borders (THIS Borders) to public attention in the next few months but we have already begun by bringing together stakeholders and partners in a series of workshops to share our emerging findings and to help shape the way the evidence is presented and prioritised. This report is therefore a prelude for that work, but is nonetheless important as it also firmly establishes what prevention means to the public health profession and thus used as a point of common understanding with partners.

Dr Sohail S Bhatti
Director of Public Health
NHS Borders

CONTENTS

The Case for Prevention in Acute Times

What is prevention?

The concept of prevention is one of the fundamental pillars of Public Health and government policy. In broad terms, the three most discussed types of prevention are primary, secondary and tertiary which were concepts introduced in the late 1940s.

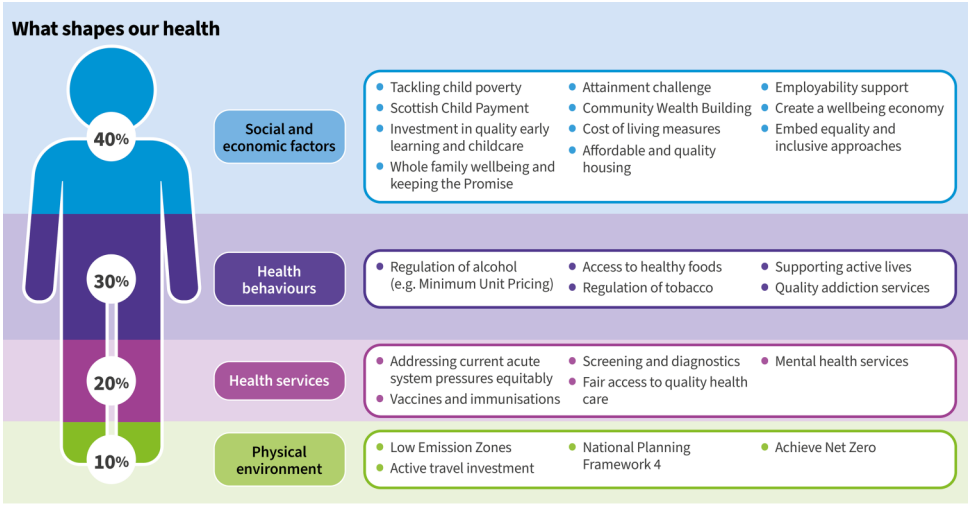
Primary prevention is where action is being taken to stop a condition, disease or illness ever occurring within an individual who is at risk. The target group is usually healthy people who are free of the issue in question but who have associated risk factors. Examples of primary prevention include immunising older adult care home residents against COVID, influenza and shingles (older people). Other examples include seatbelt legislation (drivers and passengers), stopping smoking in public spaces (workers) or violence, as a societal issue.

Secondary prevention is where action is being taken to detect the early signs of a specific disease or issue and intervene before symptoms can develop. The target group are those who have a disease (or precursor to the disease) but are apparently healthy with no visible symptoms. Examples of secondary prevention include screening programmes, redesigning streets to reduce traffic speeds, controlling blood pressure and managing high cholesterol to prevent vascular disease.

Tertiary prevention is where action is being taken to reduce the impact of a disease that has already manifested in an individual, prevent any further deterioration, maintain quality of life, improve function and minimise suffering. The target group are those with an established disease or condition. Examples of tertiary prevention include regular reviews (blood sugar, feet, eyes) for people with type 2 diabetes, providing domestic violence refuges, addressing homelessness and cardiac rehabilitation programmes.

Primordial prevention is a newer concept that was introduced in 1978 which focuses on preventing the development of risk factors for diseases and health problems before they even arise. Unlike primary prevention, which aims to prevent the onset of a specific disease or condition in individuals who already have risk factors, primordial prevention targets the root causes and underlying conditions that create those risk factors in the first place. Examples of primordial prevention strategies include:

- **Health education and promotion**: Providing individuals with accurate information about healthy behaviours, such as proper nutrition, regular physical activity, and avoiding addictive substances, can help prevent the development of chronic diseases such as heart disease, stroke, and cancer.
- **Environmental interventions**: Addressing environmental factors that can contribute to disease, such as air and water pollution, hazardous chemicals, and unsafe housing conditions, can help reduce the risk of developing certain health problems.
- **Policy changes**: Implementing policies that support healthy choices, such as taxes on unhealthy foods and beverages, restrictions on tobacco advertising, and increased access to parks and recreational facilities, can create a healthier environment for everyone.
- **Early childhood interventions**: Providing support and resources to families during pregnancy and early childhood can help ensure that children have a healthy start in life and are less likely to develop chronic diseases.



Source: Public Health Scotland

Adapted from The Kings Fund (**https://www.kingsfund.org.uk/publications/vision-population-health**)

If we take the example of drug use and of addiction to opioid drugs, education for children and young people about the harms of drugs to avoid even trying them is primary prevention. Legislation to limit harmful supply or access would be primordial prevention. Limiting the supply of drugs through criminal justice work are secondary preventive activities. Ill-health and death are prevented by the distribution of naloxone (the antidote to opiate overdose) as well as effective treatment and can be considered tertiary prevention.

One of the key things is that prevention is not restricted to disease or clinical issues, though that is where these concepts originated. Prevention approaches and concepts can be applied to a broad range of activities, and often require engagement across the whole of society as a result. Heart disease, for example, is still the biggest cause of death in the Scottish Borders. A preventative approach would tackle the issue using all domains of prevention.

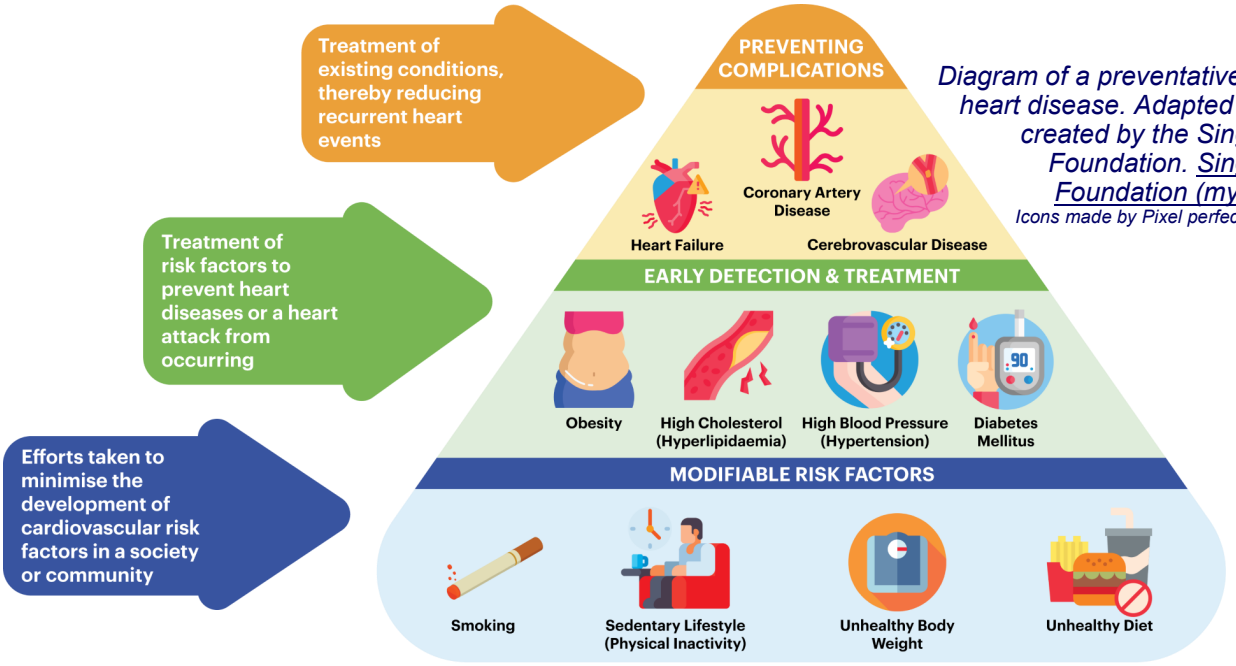


Diagram of a preventative approach to heart disease. Adapted from a figure created by the Singapore Heart Foundation. Singapore Heart Foundation (myheart.org.sg)
Icons made by Pixel perfect and Freepik from www.flaticon.com

Evidence for a preventive approach

Prevention activities have a reduction impact on mortality (death rates) and also on morbidity (rates of illness). Mortality rates are a useful measure of population health; they are unequivocal and easy to measure through death registration data. In 2020 in Scotland, 27% (21.6% in Borders) [1] of all deaths were considered “avoidable”, that is, they could have been avoided by preventative interventions [2]. People who lived in the most deprived areas in Scotland that year were four times more likely to die of a preventable disease than those who lived in the least

deprived areas. In this context, calls for greater focus on preventive care are coming from across the system: from the Christie Commission on the future delivery of public services in 2011 [3] the Health Inequalities Policy Review in 2013 [4], the Scottish Chief Medical Officer's report 2023 [5], and the NHS Long Term Plan [6] in England. Ten years after the publication of landmark work "Fair Society, Healthy Lives" [7] Professor Michael Marmot reiterated his recommendation that preventative strategies are a vital tool to reduce and prevent health inequalities. When acute services (such as hospital wards and package of care provision) are under extreme pressure, as they have been during the COVID pandemic and the recovery phase, there is a drive towards providing and funding immediate care services in response to immediate population demands. Unfortunately, this creates an endless cycle of crises with little prospect for prevention. Prioritising prevention within health and social care is beneficial for organisations and for individuals and it could be argued, for the health of our NHS overall. When we intervene early in chronic diseases to manage and limit complications, we reduce pressure on emergency, acute and frontline services by stabilising patients before they reach a crisis point. Hospital stay is inherently risky, for example, due to the presence of hospital acquired infections, and the potential for errors and mistakes. When we support people to maintain their health and live independently at home, we reduce the number of admissions and decrease the length of stay in hospital. By helping to build up social networks for people in the community, using community development approaches, we encourage care in the community, and avoid admission to hospital. Prevention leads to a better quality of life for more of the population, by increasing the years spent in good health [8] and also sustain & support independent living.

There are clear economic benefits to a prevention approach. Reduced service pressures and a healthier population will lead to significant financial savings, societal benefits, and allows resources to be redistributed to other areas of need. A study by the University of York [9] aimed to try to quantify the difference in cost per Quality Adjusted Life Year (QALY) for public health interventions versus general NHS treatments. A QALY is a way of measuring one year lived in perfect health. They found that for preventative work, the cost per QALY was £3,800, compared to £13,500 for treatments. This supports the position of Public Health Scotland, the King's Fund and UKHSA; that investing in preventative work is of economic benefit [10].

What is a QALY?

A QALY, or Quality-Adjusted Life Year, is a unit of measurement used in health economics and healthcare decision-making to assess the value and impact of medical treatments, interventions, or healthcare programs. It combines both the quantity and quality of life gained as a result of a particular healthcare intervention. QALYs are used to compare the effectiveness and cost-effectiveness of different healthcare interventions.

The concept of a QALY is based on the idea that not all years of life are equal in terms of health and well-being. A year of perfect health is considered to be equivalent to 1 QALY, while a year of less than perfect health is valued at less than 1 QALY, typically on a scale from 0 (equivalent to death) to 1 (perfect health). For example, if a person's health-related quality of life is reduced to 0.5 due to a medical condition or disability, that year would be equivalent to 0.5 QALY. A value in £s can be attributed to 1 QALY.

Here's how the calculation works:

Determine the health state or quality of life associated with a particular medical condition or intervention, often on a scale from 0 to 1, where 0 represents death and 1 represents perfect health

Estimate the number of years a person is expected to live in that health state or condition.

Multiply the quality of life score by the number of years to calculate the total QALYs gained.

Scottish burden of disease

In many ways this report is a response to the data published in the most recent Scottish Burden of Disease (SBOD) Study November 2022 [11]. The SBOD study was set up to monitor Scotland's population health, by measuring differences in harm from causes of disease, injury, and death across the entire life course.

The report suggests that, despite an overall projected decline in the population in Scotland by 2043, disease burden could increase by over 20% with subsequent impact on the need for, and provision of, health and social care. This assumes no substantial change to current dietary, exercise and other lifestyle habits of the population. Leading causes are expected to continue to be cardiovascular diseases, cancers, and neurological diseases. A King's Fund publication has noted "huge sums will be wasted if high levels of preventable illness hit over the next two decades" [12].

Primary prevention first

Among the different methods of prevention, primary prevention appears to have the best outcomes and the better return on investment. Primary prevention can be described using the analogy of a river:

There is an oft quoted parable (a version of which was originally credited to the sociologist, Irving Zola [13] that tells of a man and woman fishing downstream. Suddenly a person comes down the river struggling for life. The fisherfolk pull her out. Then another comes and again must be rescued. This happens all afternoon and the fisherfolk are getting very tired from constantly pulling people from the river. Eventually they think, "We need to go upstream and find out why so many people are falling in the water". When they go upstream, they find that people are drawn to the edge to look at the river, but there is no safe way to do this. Many of them fall. The fisherfolk go to the community leaders and report the number of people who have fallen into the river. They also report that this is due to the lack of a protective barrier on the cliff. Community leaders build a wall behind which people may safely view the water. Some still fall, but there are many fewer victims to rescue. This is the "moving upstream" analogy for prevention. Instead of expending all resources and energy on rescuing people, why not stop the problem from even happening? This is not to say that the problem can be eliminated, but there may be fewer people to rescue downstream. The upstream analogy describes primary prevention - this key concept in our public health approach.

Preventive efforts are very cost-effective. Public Health Scotland have recently published on the public health approach to prevention [14], which highlights the benefits of primary prevention. In 2016/17, a typical one day stay in a hospital bed (in England) cost an average £586 [15]. Systematic review evidence has shown better return for investment for primary preventative measures (£34 for health protection such as immunisation programmes, and £46 for legislative interventions such as smoking ban, for every £1 invested). For secondary and tertiary prevention, the return is estimated at £5 for every £1 invested.

Given that primary and primordial preventative strategies are concerned with stopping people developing illness, they require input from across all elements of society: healthcare, local government, third sector, industry, the community, and individuals themselves. Collaborative working is the best way to address the social, cultural, economic, structural, environmental and commercial determinants (upstream factors) that lead to illness for those living in the Borders. [16].

Mobilising a preventative system across Scottish Borders

Our NHS and its support system is a dedicated and systematic approach to health care, based in evidence and leadership. We need to have a preventive system which operates in the same way that is just as strong: co-ordinated, evidence-driven and able to offer sustainable improvement to the health of the whole Scottish Borders population. We need to work together as individuals and as an organisation to effect change. A preventive system has been defined as the "people, processes, activities, settings and structures that can protect and promote and health of individuals and communities." [17]

Prevention in healthcare

As already acknowledged, while the NHS carries out much established preventive work, in times of extremis, the acute pressures of the day can demand time and focus. Public Health wants to enhance and expand prevention activities in the NHS. We know our population's health is in decline, as we grow older as a group. We need to step back, plan, and act now to prevent worsening of the NHS's current situation. The best way to take the pressure off the hospitals is to ensure fewer people need to attend at all!

We can start with developing the role of NHS Borders as an Anchor Institution; establishing our role as a force for good through our actions in relation to our workforce, procurement, land and assets. NHS Borders currently employs 3496 staff (a whole time equivalent of 2783); when we focus on getting it right for our employees we are operating in a way that generates health for the people working in the NHS beyond the diagnostic and treatment services we provide. Each employee is part of a family unit, so the benefits and support we provide them has the potential to spread much more widely throughout our population.

Supporting clinicians to focus on prevention and population health can provide professional satisfaction and reduce frustration, and potentially burnout [18]. There can be a strong frustration when clinicians feel unable to address the underlying cause of many of the health problems they encounter among their patients; when they must "send them back to the conditions which made them sick" [19].

There are opportunities we can take to truly embed prevention in routine health delivery. We can identify chronic conditions early and maximise and support self-management through the inherent skills in prevention of our primary care colleagues. We can make sure our health service delivery does not further exacerbate the health inequalities that already exist (indeed, a national Public Health Action Team is focussed on actions to prevent this).

We can expand our social prescribing offer in the Borders to support people to self-manage and co-produce their own health. Social prescribing connects people to activities, groups, and services in their community to meet the practical, social and emotional needs that affect their health and wellbeing. As defined by Public Health Scotland, social prescribing is "*commonly used in primary care settings and provides non-medical options for primary care staff to draw on to support their patients' health and wellbeing, including their mental health. Social prescribing - is an approach used to support self-management.*"

It is primarily used for connecting people to non medical sources of support or resources within their community. It can also be used by professionals working in other services and enhances the holistic approaches to addressing health, wellbeing and mental health problems [20].

What is Social Prescribing?

According to the King's Fund: social prescribing, also sometimes known as community referral, is a means of enabling health professionals to refer people to a range of local, non-clinical services. The referrals generally, but not exclusively, come from professionals working in primary care settings, for example, GPs or practice nurses.

Recognising that people's health and wellbeing are determined mostly by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health [21].

Another way to think of this is that it represents primary prevention. If done in a systematic, evidence-based and connected way it has the potential to take out much demand for health and social care. Approximately 3,000 consultation per week in general practice are primarily for social reasons in the Scottish Borders.

Embedding prevention in the work that they do, often in difficult circumstances, is the only rational way to reduce future work pressures. These should be underpinned by ensuring staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services. As the Director of Public Health, I am happy to work with colleagues to discuss and develop these ideas further. Behaviour change is difficult, so the liberal use of dashboards and ranking tables will help keep the focus, but only on areas where objectives are SMART (Specific, Measurable, Achievable, Realistic and Time bound). Here are some of the measures I would recommend that our colleagues in NHS Borders undertake:

In settings such as the community (in people's own homes), for primary care and attendances at the Emergency Department:

- All activities should be designed to minimise health inequalities.
- Continue to identify people who will benefit from support of the NHS Borders Wellbeing Service.
- Encourage, promote and measure attendance at health promoting events, and collect information on the impact of those events on future behaviour & health.
- Implement ways of measuring social connectedness and encourage more connectivity as a way of building community networks that reduce isolation and improve skills/knowledge.
- Smoking cessation should be particularly targeted at those with most to gain (e.g. people with existing respiratory conditions such as bronchitis or asthma). We must support smokers to substitute less harmful activities at the very least and support them to quit where possible.
- Alcohol screening to identify people drinking outwith guidelines and support them to only drink alcohol within the low-risk guidance and consider trying low or no alcohol alternatives. We should promote zero-alcohol events.
- Promote drug avoidance and effective rapid treatment/resolution through collaboration with partners as well as improve messaging at target groups through social media.
- Implement a deprivation measurement/dashboard to see the impact on our population of our interventions.

- Self-care: improving physical resilience and balance across our population, especially older people e.g. Yoga/Tai Chi, Pilates.
- Self-care: encourage the appropriate use of services including NHS24 by promoting messages and working with groups connected by a common desire to promote health and wellbeing (social movement through a network of networks).
- Self-care: encourage walking and active travel using interventions that target people appropriate for their life stage.
- Ageing Well – anticipatory care planning for old age; promote power of attorney; develop support systems for minor illnesses by empowering self-help groups; and have in place rescue arrangements for collapse/falls before they are needed. These should be targeted to those most likely to need admission in the coming year (50% chance or more), and this should be assessed annually. It is important that we create space for people to plan ahead, and discuss what a good old age looks like, and what a good death might be. By planning for these eventualities, we can share and discuss difficult circumstances more openly. We encourage women to plan for a good birth, so it seems strange that we do not plan for other inevitable health challenges.
- Starting Well – promote breast-feeding, target smoking/drinking in pregnancy, improve uptake of vaccinations especially in areas/groups where uptake is poor, healthy weight should be promoted/supported through homes, nurseries and schools, identify those with delayed development and provide proportionately more services in these.
- Support the wellbeing of residents through mental health promotion activities.
- ALISS should be widely used in primary care.
- A Key Information Summary (KIS) can be created for each patient to extract information to be made available for other people and services looking after the patient and enables the creation of 'anticipatory care plan' which helps people and their carers plan ahead for any changes in their health needs KIS summaries, anticipatory care/ future care planning [22]
- We can medicalise normal wear-and-tear issues too readily. A social prescribing system is needed that connects and supports our citizens to de-medicalise many of the issues related to ageing. This needs to be a systematic arrangement and provide an evidence-based Social Wellness Service. Across the Scottish Borders there are already around 100 people working in the area, but are dispersed and not working to a common purpose or goal. Approximately 3,000 consultations per week in general practice and community care are primarily due to social reasons; some of these also attend the Emergency Department. A Social Wellness Service would give agency to people to manage many of their own problems and should be urgently implemented to help support the scarce resources in the NHS. Modelled on General Practice, it should be accessible to all, when needed, but with the aim of building capability and capacity to support self-care and enhanced problem solving.

What is ALISS?

ALISS, a local information system for Scotland, aims to make information about sources of support for health and wellbeing easy to discover. Its foundations lie in the lived experience of people trying to find local services, clubs, groups, and activities to help them live well [23].

ALISS enables people to work together to make information more widely available and easily findable through a variety of digital channels. ALISS is a coproduced, web-based system for finding and sharing information about community assets across Scotland.

For in-patient and out-patient services

- Stop Smoking – monitor all, and encourage harm minimisation by using alternatives such as nicotine replacement. A critical point of behaviour change is becoming a patient, and we should use Making Every Contact Count - an approach to behaviour change that utilises the millions of day-to-day interactions that organisations and individuals have with other people to support them in making positive changes to their physical and mental health and wellbeing [24]
- Embed routine enquiry about money worries and signpost to welfare and benefits advice (Money Worries App).
- Alcohol screening and brief intervention – record and review on a regular basis as this can be subject to change, and consider working with peer-led support.
- Everyone should be entitled to an annual medication review. Not all medications work as intended nor are taken in an effective manner due to side-effects.
- Support to reach target BMI (Body Mass Index). This might include dietary supplementation for those under or a peer-led programme of managing weight loss.
- Measure & protect ambulatory capacity when under treatment. At each important contact, capacity should be assessed to show where declines have occurred (and displayed graphically to help visualise the trajectory).
- Being in a bed should be a last resort; a dashboard of time spent in bed should be the normal way of surveillance in wards to encourage rapid mobilisation.
- Discharge planning needs to be measured in terms of effectiveness. Hospitals are a risky place for vulnerable people so in-patient time should always be minimised, recorded and reviewed. Lessons should be learnt and good practice disseminated.
- Future care planning for all.
- Strength and balance training – falls avoidance should be part of every routine contact.
- Promote power of attorney so everyone has had at least one recorded discussion at least every three years, and more frequently when needed. Broaching the subject by a healthcare professional is likely to be more acceptable than from a relative.
- Promote Value-Based Health and Care - a values-based conversation about future planning of health would use the acute reason for attendance, when appropriate, to have a wider discussion about self-care and keeping well. Each discharge should include an anticipatory care plan for the next decade. For older attendees, this might also include an opportunity to think about power of attorney and planning for a good old age.
- Patients often spend a long time waiting; can we not utilise this time to educate, inform and engage those people in improving their underlying well-being, when appropriate and safe to do so? Could we expand use of audio visual equipment in this regard?
- We operate a medical model, but often overlook the social functioning aspects of people's illness. We should routinely collect Patient Reported Outcome Measures [25] when providing or beginning treatment so we can assess how well we have done in restoring social functioning for our patients.

For our staff (and their families, when appropriate)

Consider having department/ward dashboards (aggregated/average figures):
- Vaccination coverage.
- Screening access.

Consider having ranking tables across organisational sub-units for:
- Steps/activity.
- Competitions that encourage team building. Have, at least annually, a wellbeing event for the service area/department.
- Routinely offer of referral to smoking cessation, healthy weight and emotional support resources/ Wellbeing Service. Recording of such data will help others coordinate efforts and pick up themes and trends when presented in aggregate.

- Raise awareness of sources of local support for those with concerns about the alcohol use of themselves of those close to them.
- Routinely enquire about money worries and signposting to welfare and benefits advice, as well as the Money Worries App.
- Build a safe space to discuss disability, gender and race and help staff self-identify and thus access support that is available.
- Use of standing desks for those seated most days, and allowing movement every hour, especially those working remotely, will generate the myokines that support muscle, bone and immune functioning. It may be helpful to set targets for steps per day at work, and monitor and report on them through regularly updated dashboards.

Prevention interventions in social and community care

- Isolation is particularly problematic and can be aggravated by loss of hearing and sight. Everyone should have these assessed at least annually, and any deterioration addressed proactively.
- Alcohol screening and brief interventions should be widely available and routinely assessed.
- Social functioning is a key driver for wellbeing, both physical and social. Interventions that encourage connecting with others (using communities of common interest) to address isolation will yield improved outcomes. Linking across generations is a valuable adjunct: young children respond well to older people and this is often reciprocated. Initiatives such as "adopt a grandparent" have evaluated well. The more diverse and richer the social environment is for a person, the greater is the resilience against future illness and need for admission.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those with high fat, salt and/or sugar.

For social care

As employer/commissioner

- Proactively raise awareness of modifiable health risk factors and signpost staff providing care to sources of support and advice.
- Encourage increased physical activity whilst in work, and support/encourage such activities outside of work. Use of standing desks for those seated most days, and allowing movement every hour, especially those working remotely, will generate the myokines that support muscle, bone and immune functioning.
- Setup collaborative methods to encourage behaviours that encourage wellness; peer support works best to encourage and support long-term behaviour change.
- Develop an understanding and process for promoting good respiratory hygiene to prevent spreading colds and other infections.
- Develop a strategy for quickly identifying stress at work situations and managing issues such as carer responsibilities e.g. flexible working.

For the client group

- It is important to monitor trends; surveillance showing deterioration and thus opportunities to limit the harm before becoming a crisis, and indeed to reverse the trend are needed and charted. All carers should therefore have knowledge of and access to simple measures they can employ to address common issues; they should feel confident to work across boundaries to deliver patient-centred care.
- The carers and relatives of clients are an important source of support and advice. Have we adequate and routine measures in place to meet their wellbeing needs including their health-related behaviours? Are these collected and measured, and actions taken to pick up trends or gaps?

- Assess everyone with respect to harmful behaviours (smoking, alcohol consumption etc.), record and monitor with annual reviews. Have their biometrics on a dashboard that is shared with all carers will ensure collective ownership.
- Regularly assess balance, frailty, and vision/hearing. These change with time, and proactive assessment (at least annually) will pick up issues before they become disabling.
- Social functioning is a key driver for wellbeing, both physical and social. Interventions that encourage connecting with others (using communities of common interest) to address isolation will yield improved outcomes. Linking across generations is a valuable adjunct: young children respond well to older people, and this is often reciprocated. Initiatives such as "adopt a grandparent" have evaluated well. The more diverse and richer the social environment is for a person, the greater is the resilience against future illness and need for admission. Loneliness is a particular issue for individuals needing social support, and their often-limited mobility means specific interventions are needed for this set of groups.
- Whilst opportunities to encourage more physical activity can be scarce, even those with limited or no mobility can carry out specifically designed activities in a chair.

Partnerships and community development

Given that so many factors outside of the health service influence the health of Borderers, multiagency partnerships are essential to address the wider determinants of health. This was captured in a widely shared and supported model first espoused by Dahlgren & Whitehead in 1991 [26]. Public Health will need to strengthen our work with transport, housing, town planning, social services and food systems. We know how important our work with community third sector and advocacy groups is; these groups understand local need and experience so they can use community assets to make the most of health-benefitting opportunities. There are many excellent examples of community-based preventative work across the Scottish Borders described in this report.

Source: Dahlgren and Whitehead (1991)

We know that social prescribing is a whole population approach that works particularly well for people who:

- Have one or more long term conditions.
- Who need support with low level mental health issues.
- Who are lonely or isolated.
- Who have complex social needs which affect their wellbeing.

Social prescribing link workers also support existing community groups to be accessible and sustainable, and help people to start new groups, working collaboratively with all local partners. We are lucky to have a strong sense of community in the Scottish Borders, and a large cohort of our population are active and able older adults. One preventive approach to partnerships and community development will be to tap into the potential of the community in the Scottish Borders, working to develop sustainable new peer support.

Partner institutions

Scottish Borders Council (SBC) is the lead place-maker locally and has a duty to promote wellbeing for residents. There is strong evidence that our health can be affected by both the working environment, our environment where we live as well as our genetics. Workplace interventions to improve health and wellbeing are applicable to all employers although it is recognised that in different industries and settings there may be unequal access to the following opportunities to prevent ill-health and improve the wellbeing of our employees. It is especially our anchor institutions that will drive and set the tone for others. The biggest anchor institutions here are NHS Borders (NHSB) and SBC but not exclusively so. I therefore suggest the following interventions for our anchor institutions as employers, to promote prevention, having previously described more specific interventions for NHSB.

Primary Prevention

- Access to well paid jobs.
- Flexible working opportunities.
- Train managers in supporting mental health and wellbeing including suicide prevention.
- Ensure employees are involved in decision making.
- Promote vaccination and screening programmes.
- Follow healthy eating principles for provision of food and drink.
- Encourage in work physical activity (e.g. walking meetings, taking proper breaks).
- Adopting smoke free grounds policies.
- High blood pressure is a stealthy, hidden cause for early death and disability. This is entirely preventable, but needs specific support to identify cases. The use of self-administered mechanisms has greatly improved access to information, and if this is supported by appropriate occupational health access, could generate longer and more fulfilled lives for those who would otherwise succumb unexpectedly from heart attacks or strokes.

Secondary Prevention

- Monitor sickness absence to understand causes and take action to reduce variation and the underlying causes.
- Implement supportive absence policies.
- Support access to health services such as stop smoking services.

Tertiary Prevention

- Access to occupational health and wellbeing services.
- Flexible working opportunities (including support for carers).

It is important to address the needs of children. They are our future and efforts at prevention and reducing health inequalities begin here. Therefore, any intervention needs to target children and their developmental needs. I am disappointed that I have not been as engaged as I would like to be with those who lead our education department. I look forward to doing so in the coming year. To encapsulate some of the many things I hope to collaborate with them on I make just a few key suggestions:

- Review/update substance use policy for schools to incorporate particularly regards vaping (covers alcohol, drugs and tobacco).
- Increase the uptake of school meals as evidence indicates that this improves educational attainment.
- Measure the Adverse Childhood Experiences (ACEs) of children in the transition from primary school to help tackle health inequalities early and prevent the lifelong harm that can result.
- Ensure compliance with the Nutritional Requirements for Food and Drink in Schools (Scotland) regulations in all education settings and endeavour to locally source as much food as possible. This can prevent oral health problems as well as promote healthy weight.

Borders College and other education institutions also play a role in improving the health of our residents, with most wishing to train to take up better employment opportunities. They may also wish to consider the following, and certainly to open a dialogue with public health to see where we can support and collaborate:

- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Equip staff to discuss self-referral to Wellbeing Service to support healthy behaviours and emotional wellbeing.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those which are high fat, salt and/or consumables, maximising locally produced foodstuffs.
- Consider alcohol free events and promotion of low/no alternatives.
- Promote physical activity, whether through set piece sports events or other social occasions.
- Promote and support breastfeeding.
- Consider allowing premises to be used as shared community spaces outside of standard operating times. If we want to create a health and promoting culture amongst our residents it would help if local groups can utilise some of the facilities to promote their activities.

The planning department of SBC has a significant role in place-making and controls access to harmful activities through its licensing functions. I would suggest the following interventions, which can be the basis of a future dialogue and collaborative work:

- Restrict advertising of products high in fat, sugar or salt by the local authority via transport networks, or third parties on council-owned assets and events.
- Use the licensing system to improve the local food environment.
- Robustly apply the Alcohol Licensing Objectives including protecting and improving public health and protecting children and young persons from harm.

The cultural and sports life of a community shapes many collective activities in any place. The importance of sport is that it encourages physical activity, but also brings people together, even those who would not otherwise engage in competitive physical activities. Cultural events and dances can help bring entire families together. The prime agent that delivers these for residents is Live Borders. This has faced some challenging times, and its scope to deliver additional work may be significantly reduced. However, I would welcome an opportunity to engage with Live Borders to:

- Help them participate in and contribute to social prescribing through the integrated Social Wellness Service.
- Use community spaces and events to host health promoting activities. For example, in other areas, libraries have hosted immunisation sessions. Community spaces have been utilised for community groups, but I would like to turn these groups into agencies that also promote wellbeing and good health so we can build a social network of networks that become the constituent parts of social movement for health.
- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Use a data driven approach to prioritise increasing physical activity in those who are least active.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those with high fat, salt and/or sugar.

All of us need a shelter, and for most of us this is the home we live in. These homes are an important component of place-making, and the policy set by SBC is a key driver to encourage provision of safe and health promoting homes. We know that many of our homes are old and are difficult to heat. We know that people can be lonely and isolated in their homes due to disability and illness but also due to the distributed nature of our population and the varying challenges in using public transport. I look forward to continuing our dialogue with the housing policy unit. However, we have over 12,000 households that rent from the registered social landlord (RSL) sector. These agencies expend much effort in ensuring that tenants, especially those in need, are supported. I therefore make the following suggestions by way of commencing a dialogue with this area:

- Ensure staff understand the impact of health inequalities and stigma experienced by people and groups which lead to barriers to accessing services.
- Equip staff to discuss self-referral to Wellbeing Service to support healthy behaviours and emotional wellbeing. We should work together to create smoke-free homes, and work to ensure that houses meet the Scottish Housing Quality standard.
- Ensuring food and drink available is in line with healthy eating guidance and avoids those which are high fat, salt and/or consumables.
- RSLs should take a census of all their residents, not merely their tenants, so we have a more complete understanding of the group that they look after. Sharing this information may help the health and social care system provide more targeted and pre-empt potential admissions with early intervention. Working with GP colleagues may help us develop a system of early warning: some GP colleagues have claimed that they can predict homelessness two or three years in advance of it taking place.
- RSLs should look to collaborate with the potential Social Wellness Service, as social prescribing will help build greater resilience amongst their tenants.
- RSLs should look, in their role as employers, how they can meet the suggestions previously made for their staff and I look forward to supporting them to operate as Anchor Institutions.

Private businesses are a key driver for the economic wellbeing of our communities. We recognise the challenge for private business currently and that smaller businesses have issues of scale when adopting the recommendations for employers. The pandemic, the changes brought about by EU Exit, and then the cost of living crisis have all had an impact on the profitability of this sector. Small businesses, in particular, can feel isolated and unsupported.

- There has been an increase in the proportion of food consumed out of the home in Scotland and in 2021 the average was three out of home trips per week, mostly from fish and chip shops and other takeaways. It is often the case that out of home food comes in larger portions compared within the home. The sector can help by reducing the portion size of unhealthy options and making it easier to choose healthier options through, for example, using lower calorie versions of usual ingredients [27]. This is particularly of importance in supplying food to children.
- Promoting and supporting breastfeeding whenever possible.
- Making lavatories available for our ageing population (Just Can't Wait scheme).
- Participating in wellbeing activities when held locally.
- High nicotine content and single-use vaping products have been shown to be particularly addictive and problematic. The sector should pre-emptively try to reduce their commercial reliance on these types of products – working as a whole system would mean no-one would lose out by not stocking such items.
- Make sure every employee carries out sufficient physical exercise to maintain their health and wellbeing. There is good evidence that 10,000 steps a day is a target to aim for to maintain both physical and mental health, accepting that those who stand all day, are getting their allocation without walking.
- Consider promoting the Money Worries App to help support staff who may be struggling with finance, due to the cost of living crisis.
- There is no wealth without health, as identified by the City of London Corporation. We are happy to work collaboratively with business partners to tackle the commercial determinants of health [28] and therefore also prevention activities that concern our entire population.

Communications and community engagement

Strong effective communication involves a clear dialogue with the public. Our prevention agenda in Public Health is clearly aligned with the recent "Time for Change" community engagement work on-going across the Borders.

Time for Change advises people can take action to support their own health by:

- Getting vaccinated
- Use NHS Inform for advice
- Future care plans for the frail
- Connect with others socially
- Participate in Waiting Well
- Move more

And these actions will be supported by the following initiatives currently being carried out by NHS Borders:

- Value based health & care
- Pharmacy first
- Right place, right care
- Oral health care strategy
- Patient initiated review
- Waiting well
- Social prescribing

We when work together to use evidence-based dissemination strategies we can communicate clear risk-factor based advice to the right people, in a way that is clear and easy to understand. We can have a conversation between the NHS and our service users as equals and partners to discuss what matters most to the individuals in our population and how we can best support people to stay well. We can also work with our partners in the Integrated Joint Board and Community Planning partnership to participate in their initiatives, and help develop the ones that will support our THIS Borders strategy. We want to work more closely with the other anchor institutes to help promote wellbeing and health through better prevention.

ALISS (A Local Information System for Scotland) is a free, national digital programme that enables people and professionals to find and share information on organisations, services, groups, resources and support in their local communities and online. Anyone can use it to find information about activities such as support groups, fitness classes and social clubs. ALISS also includes information about health and social care services. We are working with senior colleagues to ensure that ALISS is our 'go to' resource for people in Borders to know what is available in their area.

Evaluation and monitoring

High-quality evaluation is an essential part of preventive programmes and their implementation. If we can increase our evaluation in Borders of our local initiatives across defined settings then we can inform opportunities for scaling up at a national level. This is going to be most impactful if we can include health economic evaluation of our initiatives, and there is a backdrop of easily accessible and transparent sharing of best practice across Scotland.

We are currently working on developing data indicators for wider social and environmental determinants of health that we can consistently report on across our Health and Social Care Partnership. Using the Scottish Indicators of Multiple Deprivation index has limitations when applied to our rural population in the Borders. When we have reliable data for priority populations locally, we can better measure differences in health and wellbeing outcomes. This is essential for when we come to decide what to invest, and importantly what to disinvest in, in the longer term.

Environment: flooding and climate adaptions

The climate crisis is a health crisis. Work is on-going across NHS Borders to share environmental sustainability between portfolios and work across sectors to develop a Climate Adaptations plan led by Facilities. We are working with national colleagues at Public Health Scotland to share and understand best practice in this area. Of particular concern to Borders are the risks of flooding and the impact on the food system when many of our population are involved in agriculture for their employment. We need to act now to prevent and mitigate the impact on the physical health, mental health and employment opportunities of Borderers.

Local activity

Our Joint Health Improvement Team's (JHIT) Annual Report is presented to reflect each of Scotland's six Public Health Priorities and aims to share highlights or insights into the work of our skilled and experienced team members. The overall aim of JHIT is to reduce inequalities in health by promoting good health throughout the life stages: building capacity and capability within our communities and workforce and creating a healthier future for all.

The Alcohol and Drugs Partnership (ADP) is a partnership of agencies and services responsible for reducing the harms associated with alcohol and drug use. This year's ADP annual report focuses on the key outcomes we want to deliver, and summarises the data from last year's activity.

The Joint Health Protection Plan (JHPP) with Scottish Borders Council describes our health protection community activity and details our action plan. The health protection function across the South East of Scotland has undergone major changes in the last six months, and continues to protect the public from communicable disease and environmental hazards working as one regional team during the day-time and with local cover at night and weekends.

The NHS Public Health Annual Screening Report for 2020-23 details the delivery and uptake for the six screening programmes. It has been a challenging time for screening with the impact of the global pandemic and a high degree of national activity including the development of new standards for the bowel screening programme, and an on-going audit into cervical screening.

As with many other aspects of health, the most important factors for maintaining good oral health sit outwith healthcare or dental services. Recognising that for some people their life circumstances can place them at increased risk of poor oral health, NHS Borders have an active Oral Health Improvement Team who work closely with various partners and agencies to help create environments which support oral health. In response to an oral health needs assessment undertaken in 2018, a Strategic Plan for Oral Health and Dental Services is in advanced stages of development and will be implemented from April 2024.

Conclusions and recommendations

Conclusions

This is an important time for public health in Borders and in Scotland; we are now living post-COVID and well into the 'recovery phase'. Public Health Priorities are not just for public health departments to deliver; we need work closely together to tackle the fundamental causes of health inequalities. Our partnerships with others and developing ideas about how we work with local communities will shape our public health efforts going into 2024 and beyond.

Recommendations

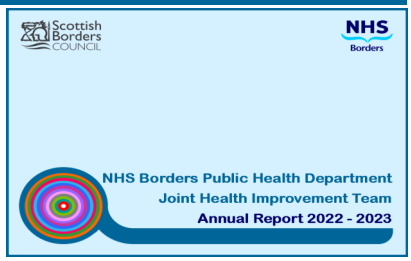
1. We need a **strong leadership focus on Prevention**, and this needs to be connected to mainstream work within the NHS Board. An indicative ring-fenced budget, no matter how small in the early years, will galvanise interest and action, and could act as a catalyst for change. Working collaboratively with SBC may open up opportunities for change and improvement for future years. All this could be overseen by a dedicated Board or Committee which we need to consider would give this work the heft and importance it needs and deserves.
2. We need to work collaboratively with our **Anchor institutions** and get **Health in All Policies** clearly established. Public health advice on health matters is a necessity for those whose business is not health, but even there, prevention is not something that can be carried out without planning and consideration for consequences. Most of the activities we carry out as service providers have an impact on health and wellbeing. It would be risky, if not dangerous, if we carried out complex interventions such as surgery without appropriate support and oversight by skilled surgeons. It is therefore also true for activities that impact on health and wellbeing of the whole population and groups within them. The Public Health Department is keen to engage and help support change, using evidence-based approaches.
3. We have clearly identified that the health and social care system is under increasing demand. The demographics of our population is that which Scotland will experience in 2054. We are therefore living in Scotland's future. **It is imperative that as people age, they age well**, and are equipped to deal with minor ailments. Social Prescribing and working closer with primary care is the route to more self-management and to decrease demand for healthcare. A more profound conversation about the safety of healthcare is also needed, as small dispersed services provided by a few experts is not sustainable. The size and scale of our healthcare infrastructure needs to change to diminish the harms that people are suffering due to the myriad ways complex healthcare can let people down. Smaller services have less resilience overall and as the quantum of care is less, experts can become deskilled in rarer diseases and interventions.
4. We need to back a solution for **social prescribing at scale**. We need a service that can provide for the needs and demands of around 3,000 consultations per week. Many of these may well be from a smaller cohort of people in need making multiple contacts. Until we have a cohesive way to support these individuals which diverts them away from healthcare, our system will continue to struggle. A Social Wellness service is the obvious solution which links together elements of Live Borders, the NHS Wellbeing Service, What Matters Hubs, Local Area Co-ordinators and also the disparate components within RSLs that support people to manage at home. By working together in a seamless way and across all our towns and communities, working with the faith sector, community groups and third sector colleagues through Borders Community Action, we can begin to tackle the issues of seeking medical solutions for social problems. This will take time, which is why action to make this happen needs to be expedited.

All these actions will be supported by the THIS Borders Strategy which will be coming to the Board shortly. This is a way to embed health inequality reduction in everything that we do. This needs to be sustainable and carried out at scale, which is why it is emerging from cross-agency discussions.

Public Health Activity in Scottish Borders 2023

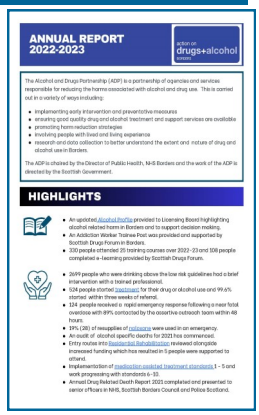
JHIT Annual Report

Attachment 1



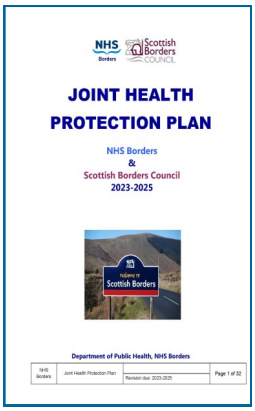
ADP Highlight Annual Report

Attachment 2



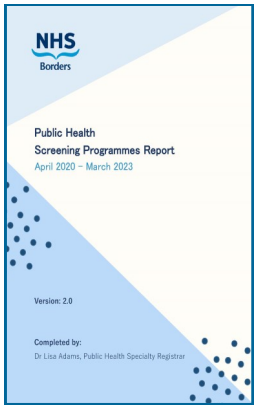
Joint Health Protection Plan

Attachment 3



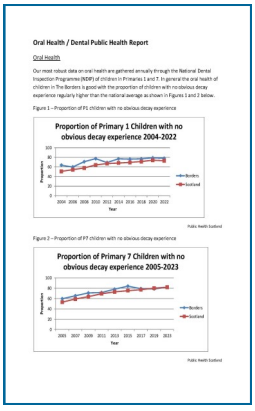
Screening Programmes Report

Attachment 4



Oral Health Report

Attachment 5



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9.	https://www.york.ac.uk/media/che/documents/papers/researchpapers/CHERP166_Impact_Public_Health_Mortality_Morbidity.pdf
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NHS Borders Public Health Department

Joint Health Improvement Team

Annual Report 2022 - 2023

Contents

Introduction

This year's Public Health - Joint Health Improvement Team's (JHIT) Annual Report is presented to reflect each of Scotland's six Public Health Priorities and aims to share highlights or insights into the work of our skilled and experienced team members. On that basis not all of our work is presented within the report.

The overall aim of JHIT is to reduce inequalities in health by promoting good health throughout the life stages; building capacity and capability within our communities and workforce and creating a healthier future for all.

While we continue to see the impact of the COVID-19 pandemic on our communities, staff and services, during the year we have been able to refocus our delivery with staff in the team and have enjoyed the opportunity to work on-site and in the office on a hot-desking basis and welcomed the opportunities for shared thinking and innovation that brings.

Throughout the year we have been able to offer more 'in person' opportunities to deliver, for example, community groups and activities. We have also actively taken steps to re-engage with our partners and publics through participating in a range of events including the Hawick Festival of Wellbeing, the Scottish Borders Social Enterprise Chamber Annual Conference, Borders college Fresher's Fair where we have been able to raise awareness of activities that promote and improve health and wellbeing by engaging people in conversations about their health; sharing information and resources and signposting to local and national sources of support. We also welcomed the opportunity to attend the NHS Borders Workforce Conference and share some of information with colleagues. We expect to reap the benefits of these renewed connections throughout 2023-24.

We have welcomed a new Director of Public Health into the department and are collectively looking forward to new opportunities for different ways of working to make the best impact we can to promote health and wellbeing in Borders.

Fiona Doig
Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership

NHS Borders Public Health Department
Joint Health Improvement Team (JHIT)

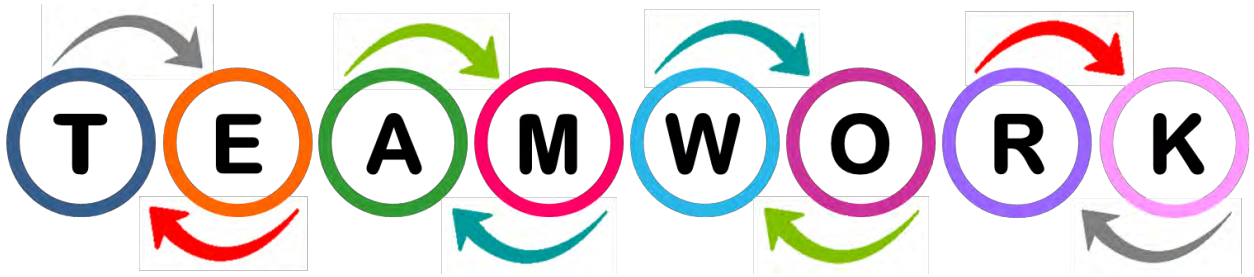
JHIT is part of NHS Borders Public Health Department and the staff team includes members from both NHS Borders and Scottish Borders Council.

Our team is led by the Head of Health Improvement/Strategic Lead Alcohol and Drugs Partnership.

We have three lead roles who support their dedicated teams in the following areas:

Public Health Lead for Children and Young People/Child Health Commissioner	Public Health Lead for Mental Health/Wellbeing Service Lead	Health Improvement Lead for Communities
• **Maternal & Infant Nutrition** • **Child Healthy Weight** • **Emotional Health and Wellbeing** • **Children's Rights** • **Substance Use Education** • **The Promise** • **Child Poverty & Financial Inclusion** • **Young People's Engagement**	• **Wellbeing Service** • **Adult Mental Health and Wellbeing** • **Health Promoting Health Service (on hold)**	• **Health Inequalities and Anti-Poverty Work** • **Food Security, Physical Activity and Diabetes Prevention** • **Communities** • **Older People**

This work is delivered with the support of our Administration Team.



Public Health Priorities for Scotland

Public Health Priorities

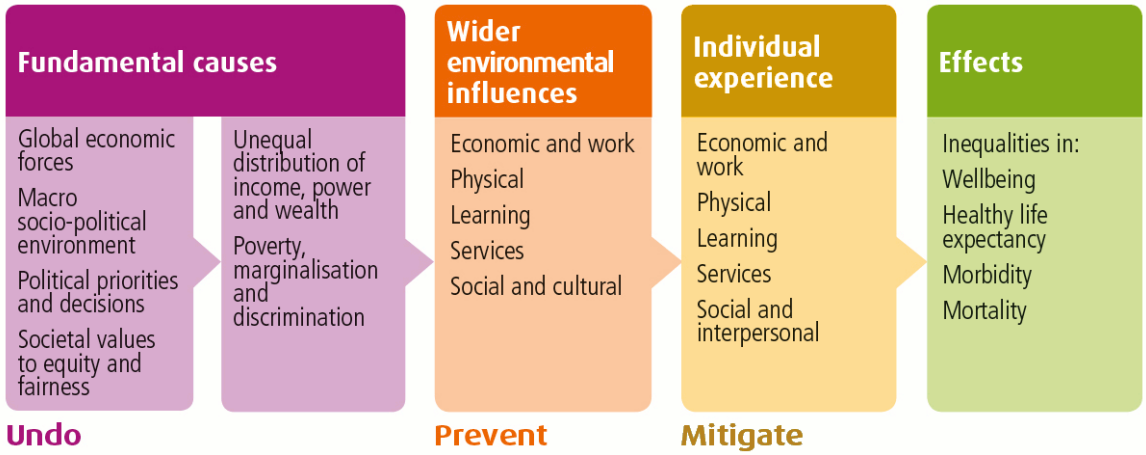
The Scottish Government has agreed a clear set of related and inter-dependent priorities for Scotland which are:

1. A Scotland where we live in vibrant, healthy and safe places and communities
2. A Scotland where we flourish in our early years
3. A Scotland where we have good mental wellbeing
4. A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs
5. A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all
6. A Scotland where we eat well, have a healthy weight and are physically active

The agreed priorities reflect public health challenges to focus on over the next decade to improve the public's health.

Public Health Scotland

Health inequalities are the unfair and avoidable differences in people's health across social groups and between different population groups. The gaps between those with the best and worst health and wellbeing still persist, and some are expected to increase due to the impact of COVID-19 pandemic. For example, in the most recent data at the moment the difference in life expectancy in Borders for women in the most deprived communities compared to least deprived is 13.9 years (76.4 compared to 90.3) while for men it is 10.6 years (73 compared to 83.6).



As the diagram shows, significant influences on health inequalities are due to what is referred to as the 'fundamental causes', or 'structural causes' of inequality such as geopolitical, environmental; and income distribution and unlikely to be impacted at a local level. However, at a local level, including within JHIT, we can seek to prevent wider environmental influences such as the impact of planning, for example, safe walking or cycling routes. We can also work to mitigate the impact of inequalities on individuals, families and communities through activities such as training and skills building.

Activities Overview and Data

Money Worries App

- Total downloads **1627**
- Year 2 - 22/23 downloads **899**
- Year 1 - 21/22 downloads **448**
- Testing phase downloads **280**

Walk It

- Walks **1228**
- Participants **10,868**
- Walk Leaders trained **78**
- Dementia Friendly Walks **31**

Fit4Fun Families

- Referrals **57**
- Under 5's **11**
- 5 - 11 years **33**
- 12 - 18 years **13**

Healthy Start Vitamins

- Women's **1399**

Vitamin D

- Women's **1243**
- Children's **2543**

Quit Your Way (Apr - Jan 23)

- Quit attempts **369** (524 in 2021-22)
- Successful quits at three months post quit date **101*** (152 in 2021-22)

Data for 40% most deprived areas in Borders

- Quit attempts **224** (314 in 2021-22)
- Successful quits at three months post quit data **68*** (99 in 2021-22)
- Three month quit rate: **30.4%** (31.5% in 2021-22)

(*Number of successful 3 month quits subject to change due to reporting lag for quit dates set February-March 2023)

Local Delivery Plan - Our LDP target is based on quits in the most deprived 40% of the Borders population (effectively SIMD 2020 1 and 2) rather than all quits.

Breastfeeding in the Borders (BiBs)

- Volunteers **31**
- BiBs requests at discharge **332**
- Overall support from Bibs **740** families (covers discharge rota, maternity ward, and local groups)

Wellbeing Service

- New referrals **1378**
- Average **115** per month
- Consultations **8108**

Community Food Work

- Reached **349** families

JHIT Training

- Participants **467**
- Courses **38**

Training and Capacity Building

The table below presents the range of courses and number of people who attended these across the Public Health Priorities.

Public Health priority area	Participants & Courses Offered
1 - A Scottish Borders where we live in vibrant, healthy safe places and communities	**Participants - 3** • Biteable 121
2 - A Scottish Borders where we flourish in our early years	**Participants - 133** • Infant Feeding and Relationship Building • Child Healthy Weight Toolkit • Solihull - Understanding Trauma • Solihull - Foundation
3 - A Scottish Borders where we have good mental wellbeing	**Participants - 274** • Be Suicide ALERT • Mental Health Improvement / Suicide Prevention Informed Level • Public Mental Health • Six Ways to Be Well • Mental Health First Aiders Induction • Living Works START • Applied Suicide Intervention Skills Training (ASIST)
4 - A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs	**Participants - 30** • Smoking Cessation in Pregnancy • Smoking in Dental Health
5 - A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all	**Participants - 21** • Money & Pensions Service (MAP) Money Guiders Training
6 - A Scottish Borders where we eat well, have a healthy weight and are physically active	**Participants - 6** • Royal Environmental Health Institute of Scotland (REHIS) Elementary Food and Health

2022 - 23 Data
467
individual attendances
compared to 463 in 2021-22

Training and Capacity Building

Children, Young People and Families Training Highlights

Child Healthy Weight (CHW) toolkit training has been updated and condensed and continues to be offered to new staff including health visitors, school nurses and support staff. Aim of training is to provide: An introduction to the CHW Toolkit and its contents. Aim of training is to provide an introduction to the CHW Toolkit and its contents. This ensures a consistent, standardised and systemic approach to CHW locally. Participants have reported an increased knowledge, understanding and awareness of the CHW standards, current nutritional and physical activity guidelines and the CHW service. They have also reported increased confident and understanding of raising the issue of health weight with families.

NHS Education for Scotland (NES) Healthy Beginnings: The MAP of Health Behaviour Change learning program has continued to be developed and offered as an early intervention and prevention approach to child healthy weight for Early Year's practitioners. The training program covers how to structure a behaviour change conversation and use techniques with parents/carers to support healthy lifestyles changes for children and the whole family according to family's circumstances. Participants demonstrate increased knowledge and confidence in raising the issue of CHW and contributory factors. In 2022 - 2023 the program was updated and new sections added in partnership with NES in response to the recommendations identified in the 2021 - 2022 evaluations.

Infant Feeding and Relationship Building is delivered in partnership between the JHIT and the Infant Feeding Team. This is a mandatory course for all Midwifery and Health Visiting staff, and is also open to others who work within early years who might benefit from gaining knowledge and understanding around infant feeding and how to best support families.

Solihull 2 Day Foundation Training is available for anyone who works will Children, Young People and Families, particularly with a focus on early years. The training has a strong focus on infant brain development, it covers the core Solihull principles of containment, reciprocity and behavioural management, and supports participants with putting theory into practice.

Communicating with Our Public

We maintain four social media pages to provide engagement, support and information through various topics and themes from a number of services and partnerships predominantly, local to the Scottish Borders:

Small Changes Big Difference target audience is health and social care professionals including the third sector. The messaging aims to engage in difficult topics and conversations and to refer people to relevant services offering support and signposting to the Wellbeing Service.

Last year we introduced new graphics and messages were introduced to communicate tools for improving emotional health and wellbeing, support to stop smoking and leading a healthier lifestyle.

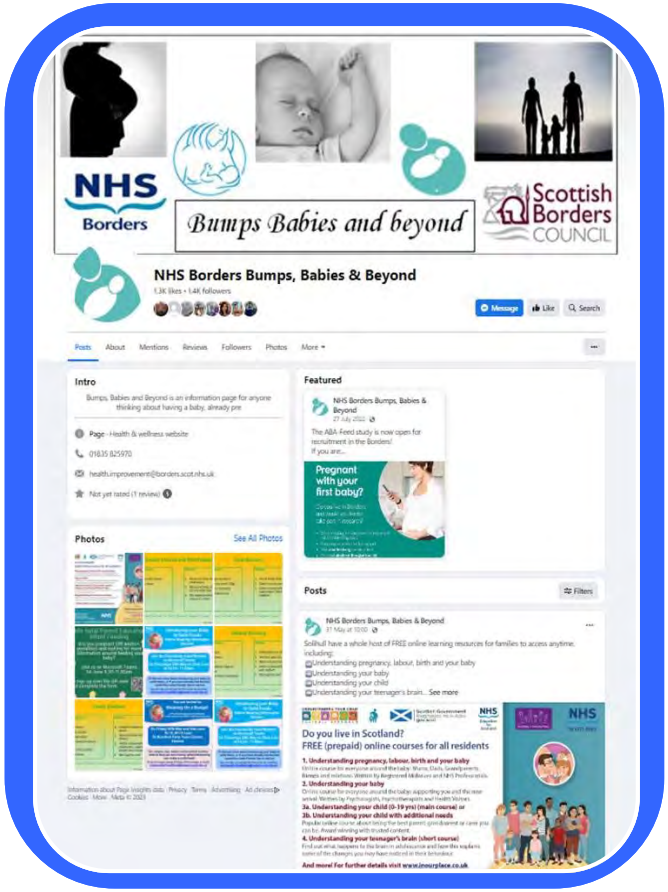
So far in 2023 the best received posts in terms of reach on Small Changes Big Difference were in relation to this period mental health, suicide prevention, food and health and cost of living.

The Wellbeing Service target audience is the public / older audience, with the messaging on building trust and recognition, and calls to action link to engaging with the service. Engagement with this account is mostly female with those aged 35 - 54 accounting for 53% of the followers. Posts to Small Change, Big Difference are shared across this platform which also includes advice re screening campaigns.

Wellbeing Service pages reach and engagement has doubled since 2021 and now has over 2000 followers.

Our two maternal and infant nutrition pages **Breastfeeding in Borders** and **Bumps, Babies and Beyond** have a more targeted audience but enable us to engage with mums and families to share positive infant feeding messages.

98% of the audience for our BiBs page is 44 years or under.



Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Whole Systems Approach (WSA) Eyemouth

Rather than being the sole responsibilities of individuals, overweight and obesity are the result of a complex web of interrelated factors (policy, environmental, social, economic, cultural and biological) across systems, which lie beyond individual control.[1] Despite this, however, many interventions continue to place emphasis on approaches that focus on individual behaviour change.[2]

Whole Systems Approach is defined as applying systems thinking and processes that enables "an on-going flexible approach by a broad range of stakeholders, to identify and understand current and emerging public health issues where, by working together, we can deliver sustainable change and better lives for the people in Scotland".[3]

Scottish Borders was invited to participate as a pilot area for Whole Systems Approach, through their involvement in the East of Scotland Partnership for the Prevention and Remission of Type 2 Diabetes. The area is one of eight early adopter areas in Scotland and Eyemouth was identified as the town to pilot the approach. Eyemouth adopted a community led Whole Systems Approach to supporting and promoting healthy weight, eating well and being physically active with a focus on children and health inequalities.

The following themes and actions were prioritised through the Whole Systems Approach process.

Priority Theme 1 **Communication**	Priority Theme 2 **Family Participation and Learning**	Priority Theme 3 **Outdoor Activities**
Action 1 Eyemouth Living Publication	**Action 2** Book Boxes	**Action 5** Visual Map
	Action 3 Play Spaces	**Action 6** Junior parkrun
		Action 7 Cycling
	Action 4 Community Lunch	**Action 8** Outdoor Activities, Including Cooking

WSA has been ongoing as a process since January 2021 with considerable levels of time, commitment and enthusiasm from:

- The local groups and community members who have implemented the local projects
- The Working Group and project leads who have driven the planning and delivery as well as being focused on evaluation and shaping the report
- The Governance Group who have offered strategic support and enabled work on the ground to happen
- National support that has offered opportunities for networking, sharing of skills, training and guidance when needed

[1] Butland, B., Jebb, S., Kopelman, P., et al. (2007) Foresight. Tackling obesities: Future choices - Project report. Government Office for Science, London, 1-161. Available **here**. Rutter, H., Cavill, N., Bauman, A., & Bull, F. (2019). Systems approaches to global and national physical activity plans. Bulletin of the World Health Organization, 97 (2), 162–165. **https://doi.org/10.2471/BLT.18.220533**

[2] Leeds Beckett University (2022) Systems Approaches, **Obesity Institute Website**

[3] Public Health Reform. (2019). Whole System Approach for the Public Health Priorities; Local Partnerships and Whole System Approach Overview. Public Health Reform. Available **here**

Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Highlights of Whole Systems Approach

- Over 14,000 copies of Eyemouth Living distributed and this is now embedded as regular business of Eyemouth Development Trust
- 1544 individual attendances took place at the Community Café in 11 months of operating
- Book boxes are now available and accessible in public spaces for children that are focussed on health and wellbeing, generating an enthusiasm for more boxes to be provided specifically to early years settings
- Families have provided feedback about local play spaces and upgrades, seeing action being taken as a result and feeling enabled to influence the environment
- Local young people have engaged in conversations about physical environments and what supports their health and wellbeing. They have used digital mapping software and are being provided with an exciting opportunity to create a lasting legacy in the form of a clay mosaic map that will be installed in Eyemouth
- The launch of the first junior parkrun in the Scottish Borders, with 113 individual children taking part between August and April and 59 volunteers supporting the event, with numbers consistently rising
- A programme of cycling support that is wide ranging and has involved significant networking with local and national partners, 19 stakeholders were involved in a local meeting to build existing provision, we may also see children in Eyemouth wearing bespoke high visibility vests soon
- A resource pack of outdoor nature connection activities created which is hosted on the Outside the Box website. 12 group leads trained in Eyemouth with a number of additional requests for training

Reflections

A Celebration Event for WSA took place in Eyemouth in May involving Governance Group, Working Group and Local Action Groups. In reflecting on the experience of implementing WSA people attending identified the importance of:

- Identifying key stakeholders and those who could provide influence in the community at an early stage and ensuring commitment of time and resources from partners
- Effective engagement through early promotion and ongoing networking to build connections and joint work
- Understanding and mapping of community resources
- Working in a defined community of appropriate size to support the work
- Funding to allow development of activities
- Longer timescales
- Governance structure worked well

Links to other resources and reports:

https://www.obesityactionscotland.org/whole-systems-approach/

https://www.publichealthscotland.scot/our-organisation/about-public-health-scotland/supporting-whole-system-approaches/

Priority 1

A SCOTLAND WHERE WE LIVE IN VIBRANT, HEALTHY AND SAFE PLACES AND COMMUNITIES

Community Justice Greenhouse Project

JHIT have provided continuation funding to the Community Justice Service (CJS) Eastlands Greenhouse Project for 2022 - 2023. CJS colleagues have incrementally built on previous partnership success and linked into the Scottish Borders Community Food Grower's Network. This has contributed to a wider distribution of produce and relationships with new partners including; Broomlands Primary School, Kelso, Café Recharge, We Are With You and Greener Melrose Seed Exchange.

The bulk of the produce grown has continued to be distributed through Action for Children and Early Years Centres networks. Activities have supported children and families to eat a more balanced and nutritious diet through the food security activities of a range of Scottish Borders partners including:

Burnfoot Community Hub	**Low & Slow Cooking Programme**
Galashiels Focus Centre	**Salvation Army Food Parcels**
Langlee Carnival	**School Holiday Programmes**
Langlee Primary School	**Selkirk Cooking Group**

The produce has also been used to support REHIS Cooking Skills programmes for men and women through core CJS services. Health Improvement staff have integrated information about the NHS Borders Money Worries App within these sessions to raise awareness of local and national sources of support about Money, Health, Housing and Work.

Overall, this work continues to reflect early intervention and prevention through 'good food' activities that support the maintenance and development of relationships between children, families and support services.

Evaluation information can be triangulated to demonstrate the collective impact of this project:

- **Service Users** shared their insights into the development of knowledge, skills and experience, translating this learning into everyday life and being able to give something back to the community
- **Health Improvement staff** fedback on the direct impact for service users and themselves, reflecting on behaviour change in relation to their own food choices and distributing produce to children and families through partners
- **Galashiels Early Years Centre** fedback on the positive impact of having a supply of fresh produce to support their larder provision, distributing surplus food through activities and the school playground to prevent food waste and offering fresh produce as a snack for children
- **Action for Children** fedback on the positive impact of vegetable distribution providing insights into home cooking as a family, making the most of the produce and the produce that families enjoyed the most

The CJS project has made a difference for all those involved.

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Free Vitamins Distribution

JHIT continues to support the distribution of the Scottish Government provision of free vitamins supplements to pregnant & breastfeeding women and to all children under 3 years.

Pathways for distribution include community midwifery, hospital midwifery and health visiting services and direct orders from JHIT.

Social media posters have been developed to share this information across services and to the wider public.

Healthy Start vitamins are available for all pregnant women. Each vitamin tablet contains folic acid, vitamin C & vitamin D, supporting a pregnant woman's general health. Additionally these vitamins lower the chance of babies having spinal problems, help the body's developing soft tissue and bones.

Vitamin D supplements in adults supports the health of bones and teeth whilst in infants and children helps bones and muscles to develop properly.

In 2022 - 2023 we distributed 2643 vitamins to women and 2543 to children. An increase on last year.

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Children's Rights

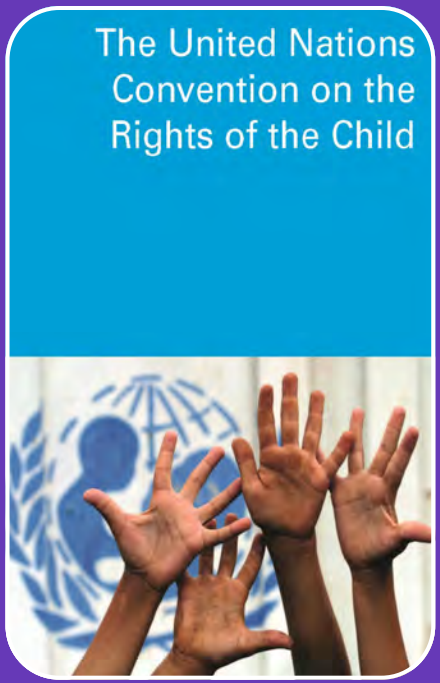
JHIT is committed to ensure all children, young people and their families have their rights valued, realised, protected and respected.

Promotion and awareness work will continue on children's rights and The Promise supporting article 43 of the UN Convention on the Rights of the Child (UNCRC) Incorporation Bill.

There will be a launch of Care Opinion Monkey as a place for children to share experience of healthcare therefore supporting the implementation of UNCRC article 12.

UNCRC Article 12

All children have a right to have their views heard and for it to be taken seriously.



Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Breastfeeding in the Borders (BiBs)

In total there are 31 active volunteers 21 that have been trained in 2022 - 2023

BiBs Breastfeeding in the Borders

Support is offered in the following areas:

- On the maternity ward
- Over the phone
- At home
- At one of our local breastfeeding groups, or a venue of your choice

Discharge Rota

There were **824** births within NHS Borders from April 2022 - March 2023.

Of which 656 were breastfeeding mums, 332 said 'yes' to BiBs on discharge, with 230 individuals continuing engagement

There are up to 18 volunteers on the discharge rota who have responded to women over a period of time.

Participants Feedback

"It was great to have someone contact me it gave me my confidence back"

"Grateful for my HV who recommend BiBs"

"Incredibly supportive service"

Local Groups

In April 2202 the local face to face groups were restarted. There are now **7** groups up and running with variability of weekly, 2 weekly and monthly. 449 parents and babies engaged with local groups during this time.

11 of our BiBs volunteers are involved with face to face groups totalling to 328hrs of their time

The reasons for attending included: social interaction, advice on mastitis; cluster feeding; blocked ducts; positioning and attachment.

Maternity Ward

In December we were able to introduce volunteers back into the maternity ward, we currently have 6 volunteers orientated to maternity, SCBU, and children's ward, since December there has been 25 visits from volunteers who have engaged with 61 women with over 26hrs of volunteering time.

Priority 2

A SCOTLAND WHERE WE FLOURISH IN OUR EARLY YEARS

Breastfeeding Friendly Scotland

The Breastfeeding Friendly Scotland scheme is a Scottish Government supported national scheme, but implemented locally by NHS Boards which aims to:

- Provide women with positive experiences of breastfeeding when out and about, enabling mothers to feel confident and supported
- Raise awareness of the Breastfeeding etc. (Scotland) Act 2005 and the Equality Act 2010
- Ensure that organisations are aware of their responsibilities under this legislation

Since the scheme launched in 2019, across the Scottish Borders, 40 businesses/organisations have signed up to the scheme.

In December 2022, Borders College signed up, ensuring their premises is breastfeeding friendly for staff, students and the local community.

ABA Feed Research Trial

NHS Borders are currently taking part in a national research trial, ABA-Feed. The ABA-Feed study is a large UK-wide, randomised control trial, testing out a new way of supporting women feeding their first baby. This new way is called the 'ABA-feed intervention'.

The ABA-feed intervention starts when a woman is around 30-weeks pregnant. The Infant Feeding Helper arranges to meet the woman before she has her baby. The purpose of this meeting is for the Infant Feeding Helper and the woman to get to know each other and to discuss how the woman is thinking about feeding her baby. At this meeting (which can be face to face, or via video or phone call), the Infant Feeding Helper develops a 'Friends and Family' diagram with the woman to explore what support the woman has available to her, and also gives the woman a leaflet outlining the support available in the local area.

Once the baby is born the Infant Feeding Helper texts or calls the woman to see how she is getting on, daily for the first two weeks, and then less frequently until the baby is 8 weeks old.

To take part, women must live within The Scottish Borders, and must meet the following inclusion criteria:

- Pregnant with their first child
- Singleton pregnancy
- Aged 16 years or over
- Provided informed consent
- Gestation age from 20+0 to 35+6 (inclusive) weeks gestation

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Mental Health Improvement and Suicide Prevention

Adults Mental Health Improvement and Suicide Prevention

A 3 year action plan; Creating Hope in the Scottish Borders; has been developed by the multi-agency Mental Health Improvement and Suicide Prevention Steering Group, taking a Public Mental Health approach. Public engagement took place to inform the Action Plan and the Action plan was published in November 2022.

The four programme areas identified:

- Promoting mental health and wellbeing
- Preventing suicide and self-harm
- Reducing mental health inequalities
- Improving the lives of people experiencing and recovering from mental ill health

Work that has informed some of these programme areas include:

- Training
- Communication, engagement and awareness raising
- Targeted work

Communication, Engagement and Awareness Raising

The level of good quality and accessible information about mental health and wellbeing has increased in a number of ways, some activities that were carried out were:

- Partnering with Health in Mind to do a 'takeover' of Wallaceneuk Park Run during Mental Health Awareness Week to highlight the mental health benefits of coming together as a community to exercise - over 70 runners, joggers, walkers and volunteers participated
- Live Borders were commissioned to host a series of creative workshops for the Scottish Mental Health Arts Festival this was attended by 31 people
- John Gibson's #OneManWalkingOneMillionTalking walk from Land's End to John O'Groats was supported to raise awareness for suicide prevention as he passed through the Borders, hosting an event attended by approximately 70 people in Jedburgh and facilitating a NHS24 Breathing Space film about John's story
- The Breathing Space bench at Burnfoot Hub in Hawick was launched, the bench was the fifth one to be launched in the Borders
- Autumn and Winter campaigns were focused on poverty and mental health, a bespoke 'Cost of Living Crisis' resources was developed for protecting and supporting mental health and for preventing suicide, these were shared widely, and 6000 printed copies passed to community resilience volunteers via the Community Councils

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Targeted Communities

- Working in partnership with NHS24 Breathing Space, Scottish Rugby and Quarriers a successful campaign was ran with several rugby clubs in the Borders, the campaign involved Kelso RFC, Gala RFC, Jed-Forest RFC, Selkirk RFC, Melrose RFC and Hawick RFC – each club took part in one or more activities relating to the promotion of mental health and wellbeing, training in mental health improvement and suicide prevention, developed support systems within the club and produced a club-wide action plan around mental health and wellbeing
- Working in partnership with Borders College and the NHS Borders Wellbeing Service a pilot of a 'Menopause Café' was launched, recognising the impact on mental health for women at the peri-menopausal or menopausal stage of life, five café events were held, each attended by between 12 - 25 women with more joining online for presentations
- The fourth annual Memorial Event for People Bereaved by Suicide took place at Haining House, Selkirk in November 2022, the event was well attended and was supported by Quarriers, SOBs and the Samaritans

Adult Communities Mental Health and Wellbeing Funding

We were a key partner in the allocation of the Adult Communities Mental Health and Wellbeing Funding that was part of the Scottish Government's response to the mental health impacts of Covid-19. Alongside Third Sector Dumfries and Galloway who were administering the fund, we contributed to both the Steering Group and Scoring Panel that distributed over £280,119 in Round 2 of the Communities Mental Health and Wellbeing Fund.

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

Community Mental Health - Children and Young People (C&YP)

Our overall aim is to embed the Community Mental Health and Wellbeing Supports and Services Framework; Taskforce and Scotland's Youth Commission on mental health recommendations with a focus on early intervention and prevention for C&YP aged 3 - 18yrs.

Our Outcomes

- To have good mental health and well-being in our children and young people
- Build capacity and capability within our communities and workforce, creating healthier future and life chances
- Every child and young person in Scotland will be able to access local community services which support and improve their mental health and emotional wellbeing
- Every child and young person and their families or carers will get the help they need, when they need it, from people with the right knowledge, skills and experience to support them, this will be available in the form of easily accessible support close to their home, education, employment or community

Within The Scottish Borders this early intervention and prevention work is led by multi-agency partners within the Community Mental Health and Wellbeing Supports and Services Project Board and Operational Team; JHIT are represented on both groups. The work highlighted below is developed by the programme.

New Services

Kooth is now available to all Scottish Borders Primary 6 and Secondary pupils via a link on their Inspire iPads. The service has been available in the Scottish Borders since June 2021. Figures reported in March 2023 the system was accessed 1901 times by 537 service users.

Togetherall is available to our S5 and S6 pupils via a link on their Inspire iPads and is available to all those 16yrs+ with a Scottish Borders postal code. From April 2022 – March 2023 there have been 769 registrations, with accessed figures of 1412.

When asked the question about Kooth & Togetherall
"Would you recommend this service?"

100% of those who replied said YES they would recommend the service.

Priority 3

A SCOTLAND WHERE WE HAVE GOOD MENTAL WELLBEING

New developments

- 148 students completed the Mental Health Ambassadors training in 2022 - 2023
- Scottish Borders Multi-Agency Self Harm Guidance review, completed in 2022 - 2023
- Trauma Informed Practice Training as been completed by Social Work and Health Visitor colleagues
- Resources purchased from Edinburgh City Council enabled delivery of Young Minds Matter programme to all pupils in S1 - S4.
  - Young Minds Matter aims to allow young people to explore what influences their mental health and wellbeing through a range of teaching and learning strategies
  - The programme will better equip young people with the skills to cope when they experience difficulties, setbacks and challenging times
  - To date, 4876 pupils S1 -S4 have undertaken these sessions in academic sessions 2021 - 22 and 2022 - 23.

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Jenny and the Bear

2022 - 2023 was the first year for delivery of Jenny and the Bear, as part of a co-ordinated local approach to reducing the harmful effects of smoking which includes **Quit Your Way** and **Smoke Free Homes**. It focuses in particular on second hand smoke which also links with the Scottish Government's **"Take it right outside"** campaign. We know that second hand smoke is particularly harmful for children, as well as pregnant women and others with long term heart and or breathing conditions.

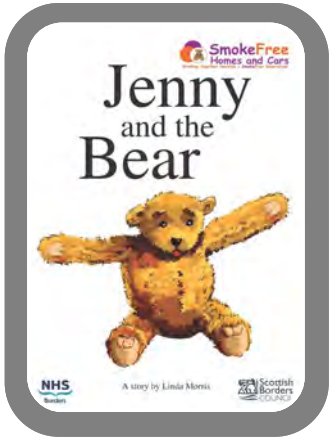
Children breathe faster than adults, which means they take in more of the harmful chemicals in second-hand smoke. They're even more sensitive to smoke than adults because their bodies are young and still developing. Research shows that babies and children exposed to a smoky atmosphere are likely to have increased risk of:

- Breathing problems, illnesses and infections
- Reduced lung function
- Wheezing illnesses and asthma
- Sudden and unexpected death in infancy (SUDI)
- Certain ear, nose and throat problems, in particular middle ear disease

There is also an increased risk of developing:

- Bacterial meningitis
- Bronchitis
- Pneumonia
- Acute respiratory illnesses

*(information from **NHS Inform**)*



Jenny and the Bear is a Primary 1 based resource which consists of a locally produced video of the story being read, story booklets and a "name the bear" competition. The main focus is a story about a little girl and her teddy which offers the opportunity to increase awareness about the effects of second hand smoke on children and what parents/carers can do to ensure their children are not exposed to its harmful effects while focussing on rewarding positive behaviours, and consideration for others. NHS Borders has permission to adapt the resource created by NHS Greater Glasgow and Clyde.

Teachers show the video, or can read the story, to children in the classroom and afterwards each child is issued with a story booklet of their own to take home and read with their family.

93% of Scottish Borders primary schools signed up to deliver the programme with a potential reach of 1289 P1s (and some older children in composite classes).

Evaluation indicates that at point of delivery Jenny and the Bear has been a success with it being generally well received, and the children engaging and understanding the take home messages. Planning is currently underway for 2023 - 2024 delivery.

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Wellbeing Service

The service provides evidence based, early interventions to support lifestyle change to increase physical activity, reduce weight and eat healthily, quit smoking and improve emotional wellbeing.

The service is currently delivered by 1 to 1 appointments lasting from 30min to 1hr via telephone, video call and face to face in GP surgeries.

Along with advice and support the advisers will provide resources and signpost to other service that will be of benefit to the patient for additional support. These may include LIVE borders, NHS Borders Dietetic Service, community groups and many more.

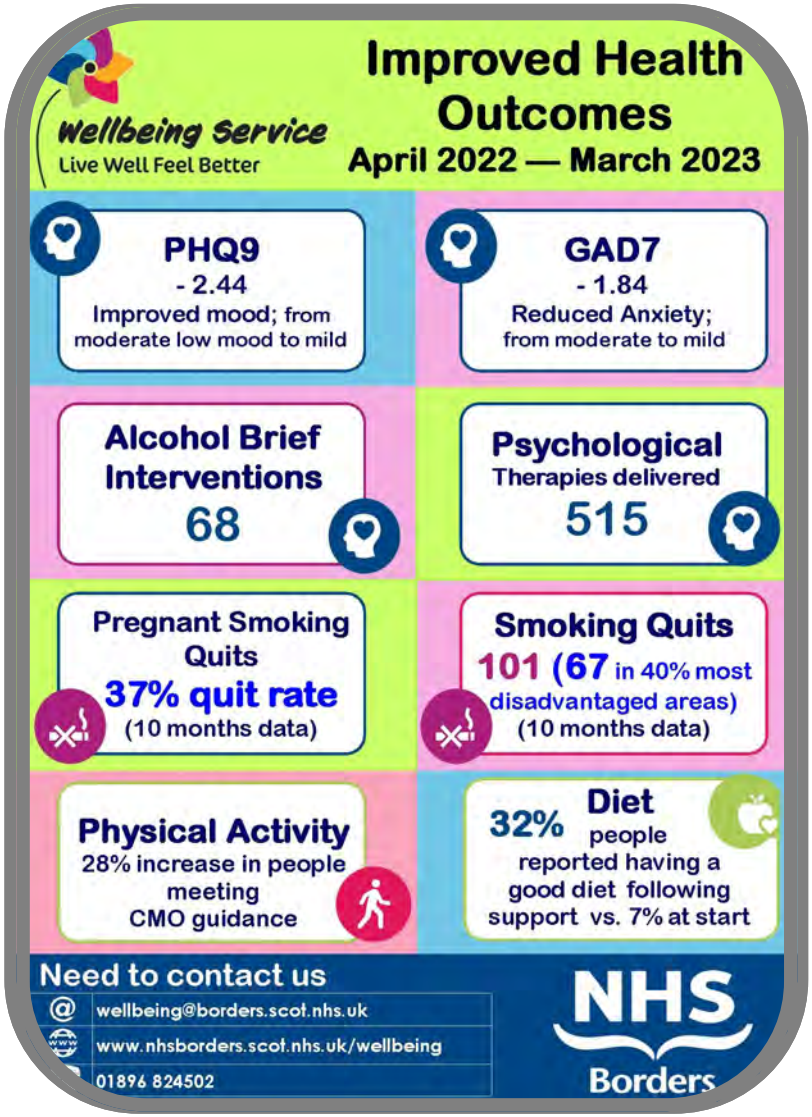
Referrals

The Wellbeing Service is embedded into primary care and operates across the Borders.

We received 1670 new referrals from 1 April 2021 to 31 March 2022 and 1378 from 1 April 2022 to 31 March 2023.

The reduction in referrals may be attributed to the visibility of the service from post Covid. From September 2022 advisers have spent a minimum of 1 day per week in person at their practice. The service will continue to look at promotion for the service in the next year.

It has been noted that the referrals for emotional wellbeing and smoking have reduced.



Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

Care Opinion

Care Opinion is an online platform which allows people to share their experiences of using our service in a safe and simple way. We use these stories to help inform service improvements. Care Opinion builds on our existing patient feedback methods.
A number of patients used Care Opinion over the last year to leave feedback on our service; one of these comments is below:

"The well-being service made lots of suggestions for improving my mood, including yoga, mindfulness and exercise. Crucially, they were there to advise when things did not work, or I lost motivation. They helped me sustain the practice until I could manage on my own. Without this service my recovery would have been even more prolonged. I really feel that my mind is different now, but I recognise that I need to continue to practice what I learned every day to prevent the stresses building again. Removing stress from my life has allowed me to use my energies in a more productive way. I can't thank them enough."

Smoking Cessation

In order to improve quit rates across the Borders, we have been focusing on the following key areas:

Smoking in Pregnancy - through training and intensive peer support we have continuing to improve the skills of advisers. We have increased service capacity to support this population with plans to roll out a training and support model across the whole Wellbeing team. We continue to work closely with midwifery; a number of midwives have completed VBA for raising the issue of smoking and we hope to follow this up with additional training later in the year.

Dental - we have worked closely with dental to develop a NES approved CPD module around Smoking VBA. It is hoped this will improve dental staff confidence in raising the issue of smoking with their patients and increase referrals into the Wellbeing Service.

Other on-going work - focusing on vulnerable groups including an awareness session with a community parents group and a number of CLD workers having completed the ASH Scotland training module'. Raising the issue of smoking in a money advice setting'. This will promote confidence in raising the issue of smoking and encourage further referrals into the Wellbeing Service for the future year.

In addition there has been a drive in the last year to work more closely with other regions in Scotland in the designing and delivery of smoking cessation interventions – e.g. Nationally accessible training via National Centre for Smoking Cessation and Training (NCSCT), SC Coordinators Network and National Smoking in Pregnancy group. This has increased information and skill sharing and has improved the number and quality of training options.

Priority 4

A SCOTLAND WHERE WE REDUCE THE USE OF AND HARM FROM ALCOHOL, TOBACCO AND OTHER DRUGS

There has been an increase in patients moving from tobacco to e-cigarettes. Many e-cigarette users are now accessing stop smoking services to quit their e-cigarette, and recording this alongside our tobacco quits is a continuing challenge for stop smoking services nationally.

Wider Work

Service involvement in 2022 - 2023 projects:

Wellbeing Service link project with Galashiels Job Centre (JC) - Wellbeing adviser attended Galashiels Job Centre on 3 occasions (Sept, Oct and Dec). Attendees were booked on the day to be seen, with consent. Posters were displayed in Job Centre and Job Coaches were sharing information about our Service visit with clients they thought would be interested.

At appointments people were discussed reasons for self-referrals and were provided with a range of resources from our service. Adviser also shared information about places were clients may be signposted to i.e. We are with You, Health in Mind, Cruse Scotland, LIVE Borders.

Social Media - we continue to promote our service on social media and this past year developed a range of graphics to try and increase engagement.

Wellbeing Service Feedback

Annual summary 2022 - 2023

% of people very satisfied with the service received	72%
% of people would use the wellbeing service in the future if the needed help again (*I think so/definitely*)	92%
% of people who feel their health has improved in the last 12 weeks (*yes, a little/lot*)	85%
% of people who feel their mood has improved in the last 12 weeks (**yes, a little/lot*)	87%

Priority 5

A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

NHS Borders Money Worries App

NHS Borders have continued to work in partnership to build on the successful development of the Money Worries App. The App is a digital directory with links to national and local sources of help with: **Money; Health; Housing and Work**. Data has been obtained from Google Firebase and Apple Store Connect, these are analytical tools key to the success and growth of the Money Worries App. Data for 2021 - 2023 confirms a total of **1,627** Downloads.

Testing Phase - 01.01.21 to 31.03.21			
Activity	**Android**	**IOS**	**Total**
Total Users/downloads	129	151	280
Screen Views	694	173	867
Sessions	233	205	438
Year 1 - 01.04.21 to 31.03.22			
Activity	**Android**	**IOS**	**Total**
Total Users/downloads	208	240	448
Screen Views	1,500	649	2,149
Sessions	736	591	1,327
Year 2 - 01.04.22 to 31.03.23			
Activity	**Android**	**IOS**	**Total**
Total Users/downloads	620	279	899
Screen Views	11,000	338	11,388
Sessions	1,800	679	2,479

The data confirms App users are engaging in more than one session, this suggests they are accessing support in more than one area. This also provides an indicator of the range of support needs people have across the wider social determinants of health including; Money, Housing and Work. When compared with the data for 2021, the data for 2022 reflects a significant increase in downloads, screen views and sessions. It is uncertain why there has been an increase in downloads, this may be a due to an increase in App promotions to build greater awareness locally. We have invested time in showing people how to download and view the App.

We have continued to offer training for partners across a range of settings and increased our face to face engagement with the public, staff and partners at community events to:

- Raise awareness of the App
- Encourage 'real-time' download
- Enable staff to signpost people to the App

Training insights during 2021 - 2022 confirmed

- Staff are confident to talk about money
- Sessions have raised awareness of income maximisation support

Priority 5

A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

We have built on our training offer in partnership with the Money & Pensions Service to provide quality assured Money Guiders Training. The first multi-agency cohort provided 25 health and social care staff with access to this self-directed learning opportunity. It is now our intention to roll this training out through our networks and continue to build capacity for having holistic conversations about health and wellbeing, including money.

Participant Feedback

"I found modules 4 & 5 most useful and I am intending to complete further competencies, but I have not started this yet"

"Many thanks again to yourself and to our MAPS Colleagues. I have already used the training by signposting with the money helper website and look forward to learning more"

"In terms of referring to CAB, I will no longer be hanging around as the course has helped me recognise my own boundary. Previously I would have hummed and hawed over whether to refer or not but the course has helped me recognise when it is best to send someone to a specialist and will now be doing it right away"

"Allowed an opportunity to reflect on own skills such as active listening as well as remembering to park own bias at the door and deal with the situation at hand"

Download the App

GET IT ON Google Play

Download on the App Store

Priority 5

A SCOTLAND WHERE WE HAVE SUSTAINABLE, INCLUSIVE ECONOMY WITH EQUALITY OF OUTCOMES FOR ALL

Low and Slow Project

Low and Slow was developed as a way to address health inequalities for families and individuals who may experience food and fuel poverty.

Project Aims

- Reduce food and fuel inequalities by promoting and supporting the use of energy efficient cooking methods, with a focus on nutritious meals
- Help householders live in affordably warm homes by tackling issues that can lead to high energy bills and fuel poverty

Objectives

- Provide participants with a slow cooker, nutritional low cost recipes and food preparation skills reflecting the principles of **Eatwell Guide**
- Increase participant's awareness of energy use within their own homes
- Signpost participants for further support, training and life skills opportunities

Rollout of Project

Building on the success of the 2021 Low & Slow Pilot Project, Scottish Borders Council Cost of Living Fund enabled the roll out of this approach during 2022 - 2023. Low and Slow was facilitated in partnership across

- Hawick and Burnfoot
- Newcastleton
- Galashiels
- Peebles (digital engagement with YouTube clips)
- Innerleithen & Eyemouth

Projects Have

- Engaged a total of 86 participants
- Distributed 85 Slow Cookers
- Provided access to the Affordable Warmth Service (Changeworks)

All participants have enjoyed engaging with the Low & Slow programme in their community. Feedback is positive in terms of reducing social isolation and developing social connectedness as well as increasing cooking skills and addressing food and fuel poverty.

Case Study

One of the Volunteer Befrienders from the Galashiels Area Foodbank has achieved her REHIS Elementary Food Hygiene Certificate and is planning to complete further free training through the Cyrenians.

The Volunteer shared that she feels better prepared to take the next step in supporting the local community having completed the training. This has also increased her confidence, communication skills and people skills.

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Borders Child Healthy Weight Service

Fit4Fun Families

The service continues to offers support to children, young people and their families aged 0 - 18 years to eat well and be active.

We work with individuals and families, at their own pace, to identify specific goals that they would like to achieve, to give them the best support.

Pathways are in place to support access into the service with options of self-referral or referral into service. Support to fill out referral form is available if required.

Once referral received the Child Healthy Weight Management Team will triage into the most appropriate programme and level of support. Fit4Fun Families is delivered by an experienced team in either a group or 1:1 setting depending on requirements and is available both face to face and via NearMe.

Children, young people and families are encouraged to provide feedback following completion of the programme through options of verbal communications, evaluation and/or care opinion/monkey.

Family Quote

"My daughter has just completed the Fit4fun course and has learnt so much! The sessions have always been informative, well paced, and helped her understand the importance of reading labels and making healthier food choices.

She was able to set her own goals, pick her own exercises and was given appropriate activities to complete between sessions, but with no pressure.

The information pack we received was outstanding, it was very helpful to have our own visual of what was being spoken about. The included recipe book has been well used!

I would recommend this course to anyone who feels their child would benefit from non judgemental guidance and support around food and healthy eating".

Scottish Borders
Fit4Fun Families

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Paths to Health - Walk It

The aim of the Walk It project is to support and develop health walks across the Scottish Borders. Walk It forms part of the national Paths for All initiative to improve Scotland's Health. The project is co-funded by NHS Borders and Scottish Borders Council.

Objectives

- Encourage exercise as part of a healthy lifestyle
- Promote walking as an accessible way to get fit and manage stress
- Create safe, social and inclusive walks
- Build links with partners and networks
- Recruit, train and support volunteers
- Have Fun!

In 2022 - 2023 Walk It gained some additional funding from Paths for All which was used to develop a training pathway for Walk It Volunteers, this includes:

- Walk leader training
- First aid training
- Strength and balance training
- Dementia friendly training
- Basic map reading and navigations
- Outdoor leadership

Walk It data is collated locally by walk leaders, this information is shared with Paths for All for their national database. The figures below demonstrate the impact of Walk It over the last two years:

Walk It Data			
Activity	**2021 - 2022**	**2022 - 2023**	**% Change**
Total number of led walks	772	1,228	+59%
Total number of participants	7552	10,868	+43%
Walk leaders trained	84	78	- 7%
Dementia friendly walks	26	31	+19%

Walk it ran one less generic walk leader training course in 2022 - 2023, this has resulted in a very slight reduction of 6 participants. Walk It plans to add a new All Accessibility Walking training course in 2023. This course aims to increase participants confidence in supporting the inclusion of people with disabilities, impairments and long-term conditions in Health Walks.

walkit
walk your way to health & happiness

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Early Years, Children, Young People and Families Team Community Food

Community Food Workers (CFWs) work with 0 - 18 year olds and their families, in a range of settings and deliver nutrition sessions on a variety of topics such as:

- Weaning
- Eating well for growth and development (all ages and stages)
- Cookery skills and cooking on a budget
- Healthy breakfast, lunch, snacks and family meal ideas, recipes, tips and advice
- Fussy eating
- Drinks awareness
- Food, mood and well being

The majority of our groups now run in person, however, we continue to offer virtual weaning sessions once a month in addition to face to face weaning. 27 families attended our virtual weaning sessions in the year and 70 attended the face-to-face.

CFWs develop resources, signpost, and actively promote and support communities to eat well, be active and feel good.

CFWs offer training and support to staff working with children and young people to enable them to continue supporting families to eat well.

Participants Feedback

"I enjoyed making food I would never usually buy and meeting new people"

The sessions *"helped me use more ingredients (I hadn't used before) when cooking"*

Specialist nutrition sessions are delivered including sessions with Postnatal Depression Borders (PND) which offers peer support and increases participants confidence, knowledge and skills in cooking healthy family meals.

Participant feedback

"It was great to find out what foods/ meals are good for young children"

"I really enjoyed cooking together and meeting other parents"

"Really enjoyed coming to the sessions to find out what is suitable for my child (8 months) I also discovered more things I would eat myself"

We also so promote the early years work through the Bumps, Babies and Beyond Facebook page.

Priority 6

A SCOTLAND WHERE WE EAT WELL, HAVE A HEALTHY WEIGHT AND ARE PHYSICALLY ACTIVE

Langlee Breakfast, Bumps, Babies and Toddlers Group

Following successful partnership working with Community Learning and Development (CLD) in the Langlee area, JHIT was asked to address the cost of living crisis in a holistic, person-centred way by co-delivering a community based breakfast club with the Bumps, Babies and Toddler Group. Funding was awarded to the Group through the Cost of Living Fund (SBC).

Aims and Objectives

- Provide a nutritious breakfast and raise awareness of good nutrition
- Provide information and sign post families to relevant organisations
- Emphasise the need for bonding, routine, boundaries, nurture and play
- Peer learning and support

What We Did

- Provided a nutritious breakfast reflecting the **Eatwell Guide**
- Invited speakers to positively engage with parents e.g. Weaning
- Shared resources, including: Money Worries App, Six Ways to be Well and PND information booklets, healthy eating guides and recipes
- Provided a safe space for parents to bond with their child through free play, nursery rhymes and stories and engage in peer learning and support

Attendance Data - January 13th - March 31st 2023			
Registered Adults	**26**	**Sessions Delivered**	**15**
Register Children *(2 started as bumps)*	**26**	**Breakfasts Provided**	**230**

Participants Feedback

"Feels good getting out of the house … look forward to Friday"

"Helped my anxiety and mental health"

Next Steps

- Produce an evaluation report
- Aim to transfer ownership to parent volunteers by the end of June 2023
- Ongoing co-ordination and capacity building support provided by CLD

Looking Forward / Next Steps

During 2023 - 2024 we will continue to build on existing work to include:

Mental Health Improvement/ Suicide Prevention

To further develop the delivery of our action relating to Mentally Healthy Communities and Suicide Safer Communities through community workshops to build on the concept of 'thriving', connecting up across the children's, young people's and adult's programmes, putting in place the building blocks of a social movement that will nurture positive environments within communities, create hope, empower people to thrive and contribute to building a 'wellbeing society'.

Further promote the Time, Space and Compassion principles which takes a person centred approach to suicidal crisis and has been developed by people and services who regularly come into contact with people experiencing suicidal crisis.

Promote healthy relationships for children and young people through supporting research which aims to understand the views of parents and carers about relationship, sexual health and parenthood (RSHP) education and re-launching the C-Card condom distribution scheme and associated training.

Supporting NHS Borders Staff Wellbeing Week.

Eating Well and Staying Active

We are looking forward to Fit4Families High school transition sessions June 2023 providing sessions for P7 pupils transitioning into high school covering topics such as importance of breakfast, healthy snacks/drinks and looking at lunch options open for pupils.

We will be supporting good practice in Borders Breakfast Clubs that have received funding from partners to ensure Healthy Eating in Schools: A guide to implementing the Nutritional Requirements for Food and Drink in Schools (Scotland) Regulations 2020 is implemented when providing food and drinks at a breakfast club within an education setting.

Looking Forward / Next Steps

Children's Rights and Delivering the Promise

Promotion and awareness work will continue on children's rights and the promise supporting Article 43 of the UNCRC Incorporation Bill. There will be a launch of Care Opinion Monkey as a place for children to share experience of healthcare therefore supporting the implementation of UNCRC Article 12: All children have a right to have their views heard and for it to be taken seriously and we will be undertaking a training needs survey with staff to help inform our approaches.

Organisational Development

Public Health is in a period of transition through which we aim to ensure that the interventions and services we offer are in line with the community needs post-COVID.

In addition the team is facing significant challenges through changes in the funding arrangements for the Fit4fun Families service and Wellbeing Service.

We are committed to ensuring that our staff are supported throughout these changes and that communities and stakeholders involved are aware of the rationale and need for change and can influence our future provision.

We will continue to ensure that we offer evidence based practice to support the health and wellbeing of our population in Borders.

Need to contact us

@ health.improvement@borders.scot.nhs.uk

✉ Joint Health Improvement Team, Scottish Borders Council HQ, Newtown St Boswells, TD6 0SA

☎ 01835 825970

ANNUAL REPORT 2022-2023

action on drugs+alcohol BORDERS

The Alcohol and Drugs Partnership (ADP) is a partnership of agencies and services responsible for reducing the harms associated with alcohol and drug use. This is carried out in a variety of ways including:

- implementing early intervention and preventative measures
- ensuring good quality drug and alcohol treatment and support services are available
- promoting harm reduction strategies
- involving people with lived and living experience
- research and data collection to better understand the extent and nature of drug and alcohol use in Borders.

The ADP is chaired by the Director of Public Health, NHS Borders and the work of the ADP is directed by the Scottish Government.

HIGHLIGHTS

- An updated Alcohol Profile provided to Licensing Board highlighting alcohol related harm in Borders and to support decision making.
- An Addiction Worker Trainee Post was provided and supported by Scottish Drugs Forum in Borders.
- 330 people attended 25 training courses over 2022-23 and 108 people completed e-learning provided by Scottish Drugs Forum.

- 2699 people who were drinking above the low risk guidelines had a brief intervention with a trained professional.
- 524 people started treatment for their drug or alcohol use and 99.6% started within three weeks of referral.
- 124 people received a rapid emergency response following a near fatal overdose with 89% contacted by the assertive outreach team within 48 hours.
- 19% (28) of resupplies of naloxone were used in an emergency.
- An audit of alcohol specific deaths for 2021 has commenced.
- Entry routes into Residential Rehabilitation reviewed alongside increased funding which has resulted in 5 people were supported to attend.
- Implementation of medication assisted treatment standards 1 - 5 and work progressing with standards 6-10.
- Annual Drug Related Death Report 2021 completed and presented to senior officers in NHS, Scottish Borders Council and Police Scotland.

- Borders in Recovery Community has expanded over the previous year securing funding to allow recruitment of two community officers and expansion of recovery cafes across Borders.
- Recovery Coaching Scotland has provided self coaching courses with referrals open to drug and alcohol services.
- Borders Lived Experience Forum has provided formal feedback on the Residential Rehab Pathway, Injecting Equipment Provision Leaflet, ADP Strategic Plan and Scottish Government Alcohol Marketing Consultation.
- Borders Engagement Group met weekly and provided samples of drugs to WEDINOS Service for testing to generate local drug trend information. The group has also provided feedback for ADP partners on their experiences which have been shared with relevant services.

- 122 referrals to the dedicated Children and Families support service Action for Children Chimes Service.
- We Are With You provided support for 77 adults impacted by a loved one's substance use.
- Information on support for family members made more accessible highlighting both local and national support.

CHALLENGES

Stigma and confidentiality concerns can be heightened in a rural area. Services are offered stigma training, support with recommended language, and the promotion of NHS Inform drug and alcohol stigma campaign.

OUTCOMES

Fewer people develop problem drug and alcohol use.
Risk is reduced for people who take harmful drugs and drink excessively.
People at most risk have access to treatment and recovery.
People receive high quality treatment and recovery services.
Quality of life is improved for people who experience multiple disadvantage.
Children, families and communities affected by substance use are supported.

MORE INFORMATION

JOINT HEALTH PROTECTION PLAN

NHS Borders
&
Scottish Borders Council
2023-2025

Department of Public Health, NHS Borders

Table of Contents

1. Preface

This Joint Health Protection Plan (JHPP) for NHS Borders and Scottish Borders Council has been produced in accordance with the part 1 guidance for the new Public Health (Scotland) Act 2008.The main purpose of the JHPP is to provide an overview of health protection priorities, provision, preparedness and to support the collaborative arrangements that exist between NHS Borders and the Scottish Borders Council (SBC).

1.1 Geographical extent of Plan

This Plan covers NHS Borders Health Board area which is co-terminus with SBC.

1.2 Statutory responsibility

The responsibility for development of the JHPP lies with NHS Borders.

1.3 Authors

The Plan has been produced by the NHS Borders Public Health Department Team and SBC Regulatory Services.

1.4 Governance arrangements

This JHPP will be shared for approval of the Board Executive Team of NHS Borders and the Corporate Management Team of SBC.

1.5 Status

This Plan covers the period April 2023 to March 2025 and will be reviewed on a two-yearly basis. It will be available to the public on the NHS Borders and SBC websites and in other formats on request.

2. Overview of the Borders

The Scottish Borders is the seventh largest local authority in the UK (7th out of 434) by area and is more than twice the size of all but the top 10. In Scottish terms, the Scottish Borders is the sixth largest local authority (6th out of 32) behind Highland, Argyll & Bute, Dumfries & Galloway, Aberdeenshire and Perth & Kinross.
The Scottish Borders consists of one local authority area. It is located in the southeast of Scotland bounded by Lothian, Dumfries and Galloway and South Lanarkshire to the West, Cumbria and Northumberland to the South. It covers an area of 4,732 square kilometres and is a mix of mainly rural developments.[1]

According to the mid-2021 population estimate, the Scottish Borders will have a population of 116,020. This is an increase of 0.7% from 115,240 in 2020 over the same period in Scotland the population increased by 0.3%.[2]

Between 2001 and 2021 the 25-44 group saw the largest percentage decrease (-22.9%). The 65-74 age group saw the largest percentage increase (+52.8%).[2]The average age of the population of the Scottish Borders is projected to increase as more people are expected to live longer. With the over 75s projected to see the largest percentage increase +29.6%. In terms of size however the 45–64 year-olds remain the largest age group.

[1] http://www.scotlandscensus.gov.uk
[2] https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2020

3. The Public Health Act 2008

The Act amends the law on public health, setting out the duties of the Scottish Ministers, health boards and local authorities to continue to make provision to protect public health in Scotland. Before the Public Health Act 2008, the powers to control communicable disease lay with local authorities, subject to the advice of the designated medical officer. This new Act assigns functions on corporate basis – health board or local authority – and sets out where specific levels of professional 'competency' are required. In broad terms health boards are now responsible for control for communicable disease involving persons and local authorities are responsible for control of communicable disease involving premises. Action is not confined to notifiable diseases but is to be taken on knowledge or suspicion of 'significant' risk to public health.

In summary the Act does the following:

- Replaces previous arrangements for the notification of infectious diseases and the reporting of organisms with a system of statutory notification of suspected or diagnosed infectious diseases, of health risk states and of organisms.
- Defines a "public health investigation" and sets out the powers available to investigators and how they may be appointed.
- Defines the public health functions of health boards and local authorities.
- Specifies statutory duties on health boards and local authorities with regard to the provision of mortuary and post-mortem facilities.
- Enables the Scottish Ministers, by means of a regulation making power, to give effect to the International Health Regulations 2005, as they affect Scotland.
- Gives a power to the Scottish Ministers to require, by regulations, operators of sunbed premises to provide information to the users of those premises about the effects on health of the use of sun beds.
- Amends existing legislation in respect of statutory nuisances.

4. Control of Communicable Disease in the Borders

The Communicable Disease and Environmental Health functions of NHS Borders and Scottish Borders Council aim to:

- Reduce preventable illness and death from communicable disease.
- Identify potential outbreaks of communicable disease at an early stage so that effective control measures can be put in place as soon as possible, to improve the ability to prevent further outbreaks.
- Work with other agencies to reduce any adverse environmental impact on health.

5. Health Protection Planning Infrastructure

NHS Borders and SBC Environmental Health maintain a number of plans to support the health protection and environmental health functions. Some of these are developed jointly between the agencies while others are produced for internal use.

6. Emergency Planning

NHS Borders and Scottish Borders Council need to ensure that robust arrangements are in place to manage major incidents through emergency planning including business continuity plans with clear accountability arrangements. The Civil Contingencies Act 2004 established a new legislative framework for civil protection in the UK. This act placed clear roles and responsibilities on those organisations with a part to play in preparing for response to emergencies. NHS Borders and SBC continue to update their major emergency procedures in accordance with new national guidance (Preparing Scotland: Scottish Guidance on Preparing for Emergencies. https://ready.scot/how-scotland-prepares/preparing-scotland-guidance#:~:text=Preparing%20Scotland%20is%20a%20set,detailed%20guidance%20on%20specific%20matters.

Emergency planning arrangements within NHS Borders are monitored by the NHS Borders Resilience Committee and by the SBC Corporate Management Team.

7. Collaborative arrangements

Organisational arrangements are in place to facilitate good collaborative working between NHS Borders, SBC and other health protection partners including Animal Health Services, Scottish Water and other utility companies, the FSA and SEPA. As part of emergency planning arrangements, Borders agencies are represented at a number of Strategic Co-ordinating Groups (SCG) as well as multi-disciplinary Groups established to manage any specific incident or outbreak. NHS Borders Clinical Governance Committee has representatives from all the main stakeholders involved in communicable disease control and environmental health. Other relevant groups include:

- NHS Borders Infection Prevention and Control Committee
- NHS Borders Blood Borne Virus Group
- Borders Vaccination and Immunisation Committee
- NHS Borders TB Group
- NHS Borders Resilience Committee
- Climate Change and Sustainability Committee
- East of Scotland Health Protection Development Groups

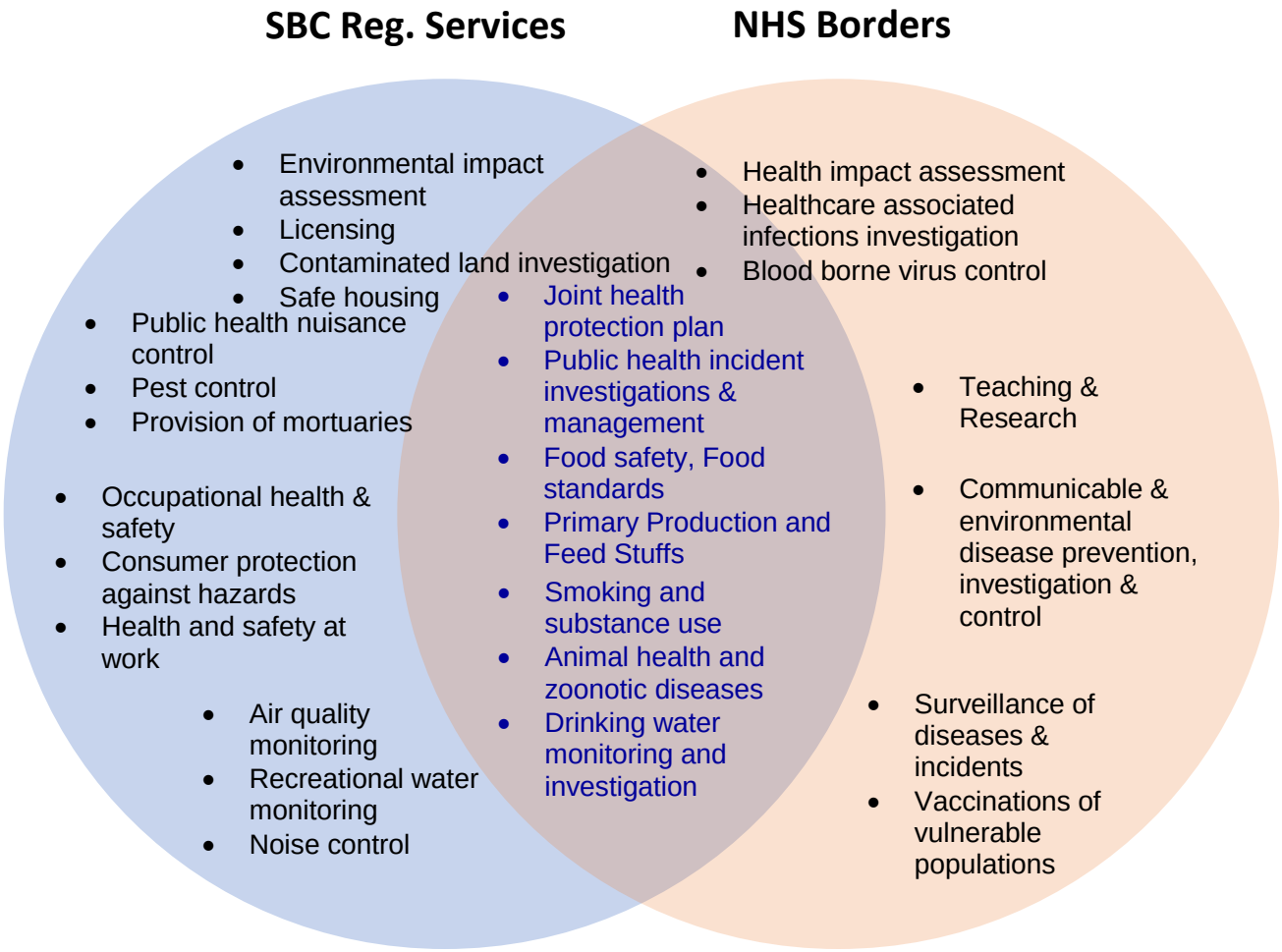


Figure 1: An illustrative summary of the joint working and areas of collaboration between NHS Borders and the SBC Regulatory Services

8. Resources and Operational Arrangements

8.1 Staffing

The Public Health Department, NHS Borders and Scottish Borders Council Regulatory Services Department have specialist staff ready to respond to incidents around the clock. They gather and interpret local information to create a picture of diseases and other hazards to plan and coordinate their work. These functions require a multidisciplinary and interagency response and as a result Public Health and Regulatory Services colleagues work closely with other organisations including NHS Borders clinical services, Scottish Water, Scottish Government Animal Health Service, Scotland's Rural College, Scottish Environment Protection Agency, Food Standards Scotland and the Health and Safety Executive.

Public Health Scotland health protection staff provide technical expertise in emergency response, disease tracking and control, and chemical, radioactive, and biological hazards. The national microbiology network, including national reference laboratories, provide laboratory analysis as required.

The staffing arrangements for the NHS Public Health Department and for the SBC Regulatory Services are given in Table 1 below. Table 1 also shows which members of staff are designated as 'competent persons' for the purposes of the Public Health Act (Scotland) 2008. These individuals are able to use the powers contained in the Act if appropriate.
Please note from December 2023 the daytime Health Protection Function will be delivered by the East Region Health Protection Team (ERHPT). This will cover Borders, Fife, Forth Valley and Lothian with a single point of contact and agreed standing operating procedures which will provide greater resilience to the Health Protection function.

Table 1: Staffing arrangements and the numbers of 'Designated Competent Persons' as designated under the Public Health etc. (Scotland) Act 2008.

Staffing	No	Roles and Responsibilities in relation to health protection	Designated Competent Person	Management/ Professional/ Technical
NHS Borders Staff				
Director of Public Health, NHS Borders	1	Accountable officer for Health Protection function and provides strategic direction and collaborative leadership. Also support for investigation and control of outbreaks and contributes to the out of hours rota and holiday cover.	yes	Professional
Consultant in Public Health	2 (1.7 WTE)	Main focus is wider public health but contributes to out of hours rota and holiday cover. Currently providing duty health protection consultant cover for situations out of the scope of the East Region HPT.	yes	Professional *Please note 0.5 wte funding has been given to the EoS Health Protection Service*
Senior Clinical Nurse Manager Health Protection /Immunisation Co-ordinator	1	Health protection strategic and operational activities for activities out of scope of the East Region HPT. Immunisation co-ordinator Provides support for BBV/TB and contributes to the out of hours rota.	yes	Professional *Please note the majority of the functions this role currently covers will become part of the East Region HPT*
Health Protection Nurse Specialist	1	Health Protection operational activities including investigation of incidents and cases, information gathering, response to queries, contact tracing, advice to patients and clinicians	no	Professional *Please note this band 7 role will become part of the ER HPT* and on call will be required, but not as competent person
Specialist Registrar	0.6	The Public Health Department is a training department and the Specialist Registrars spend part of their time undertaking health protection training.	no	Professional
Project Support	1	Administrative support to health	no	Technical

Staffing	No	Roles and Responsibilities in relation to health protection	Designated Competent Person	Management/ Professional/ Technical
Officer		protection function		
Scottish Borders Council Staff				
Regulatory Services Manager	1	Service manager for a number of regulatory functions within three teams	no	Management/ Professional
Principal Regulatory Services Officers	4	Operational team managers	yes	Management/ Professional
Environmental Health Officers		Operational Environmental Health Officers in Amenity & Pollution, and Food Health & Safety Teams	yes	Professional
Wider Partners				
Resilience Manager	1	Strategic and operational development of resilience - emergency planning and business continuity functions.	no	Technical

8.2 IT and Communications Technology

Effective IT and communications technology is vital to facilitate health protection work, including the management of incidents and outbreaks. HPZone is a national system used by health protection teams to manage incidents, outbreaks and cases of communicable disease and environmental hazards. Within HPZone there is a link to the Scottish Health Protection Information Resource (SHPIR) managed by Public Health Scotland (PHS) who update the site with relevant health protection alerts and guidance in relation to relevant incidents, outbreaks and environmental hazards.

8.2.1 IT and Communications Technology available to NHS Borders

IT and Communication Technology available on site to facilitate health protection work is shown in Table 2 below. Adaptations to allow home and remote working are frequently utilised by health protection staff.

Table 2: IT and Communication Technology available to NHS Borders staff

	Public Health staff
Hardware	
Desktop and laptop computers	✓
Printers (black and white and colour)	✓
Photocopiers	✓
Fax machines	✓

Office and mobile telephones/email	✓
Single page scanner	✓
Document feed scanner	✓
Mobile broadband access	✓
Personal digital assistant	✓
Pagers (with text screen)	✓
Audio-teleconferencing equipment	✓
Video-conferencing equipment	✓
Teaching aids	✓
Software	
MS Office 365	✓
Email	✓
Dictaphone	✓
SIDSS (Scottish Infectious Disease Surveillance System)	✓
Access to local computer networks and to the world wide web	✓
HPZone	✓
NHS Borders intranet	✓
Access to electronic information resources and databases – ECOSS (Electronic Communication of Surveillance in Scotland), SCI Store (to access laboratory results), SCI Gateway, SHPIR (Scottish Health Protection Information Resource), TRAVAX (travel advice), Toxbase (toxicology database), SEISS (Scottish Environmental Incident Surveillance System), NHS Scotland e-library, NHS Education for Scotland.	✓
Access to NHS Borders e-health (IT) team which, if required, can set up a health protection operations room.	✓
Support from and access to members of organisation communications teams	✓
Access to resources provided by NHS24 and NHS Inform	✓

8.2.2 IT developments

During the Covid pandemic, IT developments allowed wider collaborative working, to support the management of outbreaks the National Services for Scotland developed Case Management System (CMS) and an Outbreak Management Tool. This has since been stood down. Microsoft Office 365 has also been developed and utilised for Teams Meetings and for sharing sensitive confidential information in line with Information Governance and Data Sharing agreements between NHS Borders, SBC and wider relevant partners.

8.2.3 IT and Communications Technology available to Scottish Borders Council

Critical Business processes for Food and Communicable Disease are all stored on a shared server. Functionality for remote access to Council servers exists as required. Information on service requests and registered food businesses is maintained electronically on the 'Uniform' Environmental Health Module and a 'Uniform' Private Water Supply module is currently being developed to hold information on Type A private water supplies. Access to these systems is available throughout SBC premises and options for remote access are planned. All Regulatory Services staff are supplied with mobile phones and there are provisions for food and communicable disease emergency contact.

Guidance is available on:

- Access to internet
- Access to internal electronic information system
- Out of hours communicable disease procedure in Out of Hours cases
- SHPIR
- UK Health Security Agency (UKSHA)

8.3 Out of hours response arrangements

8.3.1 NHS Borders

NHS Borders Public Health Department organises an out-of-hours rota of 'competent officers' as defined under the Public Health Act 2008 (see Table 2 above) and officers are contactable via the Borders General Hospital switchboard on 01896 826000.

8.3.2 Scottish Borders Council

Environmental Health staff from the Food Health & Safety team operate an essential out of hours rota which is accessed through the Council's 'Border Care' Service, on 01896 752111. This Service is restricted to food and communicable disease emergency provision.

8.4 Reviewing Health Protection Standard Operating Procedures (SOP) or guidance.

NHS Borders Health Protection Team uses a manual “action prompts” and a Contacts Directory of relevant stakeholders who may be required to liaise with for significant sporadic infectious diseases and major outbreaks. This is moving to use of the ‘Regional Manual’. The health protection team operate by starting with local prompt cards but always refer to national guidance. (NB PHS has a Guidance Team who continually review and update guidance as part of its work plan.)

Debriefs for significant incidents or major outbreaks are held to learn lessons from how they have been managed and put in place recommendations to improve future responses. These debriefs may be multi-agency and multi-disciplinary or internal, as appropriate.

8.5 Staff knowledge, skills and training

Corporate arrangements are in place for ensuring the maintenance of knowledge, skills and competencies for staff with health protection duties.

8.5.1 NHS Borders

Health Protection staff organise regular Continuing Professional Development (CPD) updates for other members of the Public Health Department and Board staff as appropriate.

NHS Borders, in line with NHS Borders Learning & Development Strategy and Business supports CPD requirements for medical staff and the NHS Agenda for Change ‘Knowledge and Skills Framework’ (KSF). For non-medical staff the individuals concerned are responsible for records of these arrangements. Managers also hold regular appraisal meetings to support CPD.

8.5.2 Scottish Borders Council

All staff are encouraged to log learning and personal study etc. as part of a scheme of continuing professional development.

All Environmental Health Officers (EHO) are expected to ensure that CPD requirements are maintained and are encouraged to do this through a recognised professional organisation.

EHO are encouraged to attend training or update events organised by NHS Borders, PHS, Royal Environmental Health Institute of Scotland, Food Standards Scotland, Health and Safety Executive or joint events.

9. Capacity and Resilience

9.1 NHS Borders

The Board maintains day to day health protection services to a high standard and has systems in place to anticipate potential incidents. Expert groups and communication links are established internally and with partner organisations. This helps ensure that staff are kept up to date with health protection issues, procedures are kept current and health protection services can be tailored to local demographics.

To improve resilience, the Directors of Public Health for Lothian, Borders, Fife and Forth Valley have agreed to a regional Health Protection service – the ERHPT which is now live during office hours. Now implemented, most aspects of the NHS Borders Health Protection function will become part of the ER HPT. This service will take over the statutory Public Health (Health Protection) responsibilities within hours initially and once established will also include out of hours.

The Public Health Department will continue to undertake health protection audits as appropriate to ensure that the quality of services is maintained and that lessons are learned from incidents and outbreaks.

Whilst the Borders has dealt very well with outbreaks and incidents in recent years, the Health Protection team has been stretched by increasing demands such as the Covid 19 pandemic and community communicable disease outbreaks and incidents. It would be remiss not to note that there have been several substantial delays to the commencement of regional working in the East; this has had the outcome of NHS Borders requiring mutual aid from NHS Fife and NHS Lothian It is anticipated that the East of Scotland Health Protection Service will ensure there is a resilient health protection function.

9.2 Scottish Borders Council

The Council operates a business continuity process and have contingency plans and arrangements in place to maintain service standards.

To support core and emergency functions approximately 50% of Regulatory Services staff are available at any one time. Informal mutual assistance arrangements are in place with neighbouring local authorities.

10. Public Involvement, Communications and Feedback

10.1 NHS Borders

The NHS Borders' Health Protection staff are involved with the public in a variety of ways and work in partnership with the Joint Health Improvement Team who support Health Protection in providing information and advice on public health risks and issues. The Team also has regular contact with the public via general educational messages sent out as a preventive measure during an incident or outbreak and with individuals when they are 'cases' and 'contact of cases' (e.g. sending 'inform and advise' letters to members of the population as appropriate). The NHS Borders HPT work closely with our corporate communications colleagues to prepare reactive and proactive media releases as needed, and responses to media queries.

10.2 Scottish Borders Council:

Public involvement takes place largely during individual interaction with cases and contacts of cases, and general educational messages sent out as a preventive measure during an incident or outbreak. For example, in cases of gastrointestinal disease, most direct interaction with the public out with hospital settings is undertaken by Regulatory Services staff. Other relevant interactions with the public occur through:

- Routine programmed inspections of businesses in the borders.
- Responding to Service Requests across a broad range of regulatory duties.
- Routine and on request monitoring of private water supplies.
- Promoting a range of Regulatory Services functions at public and community events.
- Delivering Food Hygiene courses to improve skills of food handlers and other relevant staff working in the food industry.
- Participation in educational projects which can be undertaken in partnerships.

11. Joint Health Protection Plan Action Plan

A number of priority issues for this Plan and agreed actions have been agreed for the 2023-2025 period and these are shown in Table 3 below. Progress of these actions will be reviewed at the Public Health Protection Group quarterly meetings.

Table 3: Health Protection Priorities 2023-2025

	Source	Outcome	Workplan	Agencies involved
1.	National priority	Reduce Vaccine Preventable Diseases	• After the supply of clean drinking water, immunisation is the most effective public health intervention for preventing illness and deaths from infectious diseases. • Although vaccination is a well-established intervention, ensuring vaccine uptake remains high remains a key priority. There are currently a number of challenges facing health care services with respect to maintaining high uptake rates. These include the re-emergence of diseases such as measles, the emergence of new outbreaks, service re-organisation and the increasing risks posed by rising vaccine hesitancy across nations. • NHS Borders implemented the Vaccination Transformation Programme (VTP) completed in 2022 which is the delivery model for vaccination through NHS Boards. • The aim is to build on the already successful vaccination programme across Scotland. We seek to further increase vaccination uptake and it is critical that the benefits afforded by successful immunisation programmes are not put at risk by structural changes in delivery. Data on uptake is monitored both locally and nationally (via PHS Discovery) with the model being used to measure uptake and areas for improvement.	NHS Borders/ Scottish Borders Council/ Scottish Water

2.	National priority	Reduce the incidence of Tuberculosis (TB)	• TB remains a leading cause of morbidity and mortality worldwide and disproportionately affects the vulnerable members of our communities due to their ethnicity or life circumstances which exacerbate existing health inequalities. • Over recent years there has been a considerable reduction in TB incidence in Scotland, but this picture is changing. Our most vulnerable populations are at highest risk of TB. However, the predominant challenge facing low TB incidence countries is that of latent tuberculosis infection (LTBI) the majority of active cases are the result of 'reactivation' of LTBI. • The Health Protection Teamwork in partnership with Respiratory Medicine and the Microbiology Consultant in NHS Borders to ensure the Scottish Tuberculosis (TB) Framework is implemented. There is a monthly multi-disciplinary meeting to review the management of both new active TB cases and latent TB ensuring cases and contacts are identified and provided with the appropriate treatment and follow up.	NHS Borders
3.	National priority	Progress action towards Hepatitis (HCV) elimination	• The Scottish Government has HCV elimination plan where each Board has a target to identify and treat HCV. • Sexual health and blood-borne viruses (SHBBV) have been significantly impacted by the pandemic. The Scottish Government Published a Re-set and Rebuild-sexual health and BBV services recovery plan which has a number of outcomes and the aim is to eliminate Hep C by 2024. • The new Sexual health and blood borne virus action plan: 2023 to 2026 was published by Scottish Government in November 2023. • Health Protection work in partnership with Borders Addiction Service, We Are With You and Sexual Health to identify cases of Hep C and to ensure they are supported on a treatment plan which is led by our Gastrointestinal Consultant and Lead Nurse.	NHS Borders 3rd sector

7.	National Priority/ Local	Food control	• EHOs undertake the duties as statutory food authority in protecting food safety in the food industry and deliver the councils food safety plan.	Scottish Borders Council
4.	National And Local Priority	Hep B Look Back	• The Health Protection Team will act as a Single point of contact for the Hep B look back exercise. • Health Protection team have developed a local pathway to ensure patients identified are provided access to testing in a timely manner and will report outcomes from the eligible cohort to the National Incident Management Team.	NHS Borders
8.	National Priority/ Local	Monitoring and Improving Drinking water quality	• Collaboration between all three agencies and Scottish Water in the monitoring and improvement of public and private water supplies. • Work with DWQR to deliver the requirements on Private Water Supplies. • SBC work with supply owners and users through a risk assessment process to continue supply infrastructure and water quality.	NHS Borders and Scottish Borders Council
5.	National priority	Addressing health inequalities	• NHS Borders Public Health have a new health inequalities plan (Tackling Health Inequalities in the Scottish Borders). Wider public and stakeholder engagement is planned. • Access to employment • Access to affordable healthy food • Access to affordable transport • Access to suitable housing • How to support fuel poverty.	NHS Borders
9.	Local priority	Control Environmental Exposures which have an adverse impact on health	• Tackle the effects of antisocial or excessive noise in the community. • Deliver on air quality standards within the local authority area. • Review approaches to swimming pools and spas to ensure appropriate controls are in place regarding infection control. • Blue-green algae – Promotion of safe usage of recreational waters where there is a risk of BGA, implementation of signage and responding to incidents that occur.	NHS Borders, Scottish Borders Council
6.	National priority	Minimise the risk to the Public from Shiga toxin-producing *E. coli* (STEC) infection	• Public Health Scotland are currently reviewing the Guidelines for the identification and management of E.coli STEC, once published this will be implemented in the Borders. • Progress Contaminated Land strategies and ensure land is made suitable for use through development management. • Monitoring of bathing water quality (designated beaches/lochs) with SEPA. • Scottish Water monitors the safety of public water supplies and SBC Environmental Health monitors Private Water Supplies and ensures that public health interventions are taken for any failing drinking water supplies, • Apply the regulations for legionella safety in public buildings. • The HPT along with EHO promote the safe practices and procedures where there is contact with livestock at animal parks and farms. • Monitor the levels of lead in drinking water in public buildings especially schools and in relevant private establishments such as nurseries. EHOs monitor sampling. • SBC EHO ensures the implementation of recommendations on the safe use of agricultural ground for recreational events.	NHS Borders Scottish Borders Council Scottish Water
10.	Local priority	Resilience to respond to Pandemic through effective multi-agency response	• Review business continuity plans and Pandemic plans in light of the learning from the COVID-19 pandemic. • The HPT lead on investigations of cases of STEC and use national guidance to manage any cases or outbreaks ensuring the implementation of appropriate control measures.	NHS Borders Scottish Borders Council and wider partner agencies

11.	Local Priority Regional	Health Protection Resilience	• Participate in the East Region Health Protection Service. • Support development of standing operating procedures for the Regional Service. • Provide resource on an NRAC basis as agreed by Directors of Public Health • Ensure there is resource for areas out of scope for the Regional Health Protection service for example Blood Borne Virus, TB and Immunisation Co-coordinator.	NHS Borders/East of Scotland Health Protection Service
12.	Local priority	Enhance recovery planning for a major incident	• Review and further develop the generic Recovery Plan outlining multi-agency responses. • Contribute to Regional Resilience Partnerships. • Specific training in respect of Scientific and Technical Advisory Committees (STAC) to NHS and LA staff.	NHS Borders/ Scottish Borders Council

13.	Local priority East Region Health Protection	Effective and proportionate arrangements in place to protect public health	• Revise joint health protection policies and procedures using national guidance for example PHS Management of Incidents and Outbreaks • Review existing arrangements/plans as a routine part of each incident that occurs. • Undertake specific exercises for the purposes of training and evaluation of contingency plans relating to water and waste-water incidents and the recovery phase following an incident. • Consider key performance standards for the response, investigation and actions for public health incidents https://publichealthscotland.scot/publications/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/management-of-public-health-incidents-guidance-on-the-roles-and-responsibilities-of-nhs-led-incident-management-teams/ • Link with the East of Scotland Health Protection Service to develop joint training in managing incidents/outbreaks and chairing these meetings such as STAC. • To investigate and take appropriate action in response to service requests which have the potential to impact adversely on the environment or to public health.	NHS Borders Scottish Borders Council East Region Health Protection Service

14.	Local priority	Reducing the impact of tobacco, alcohol and other harmful substances on public health	• Continued regulation of the smoking ban in enclosed and public places including NHS premises. • Trading standards have an enforcement remit for underage sales with EHOs supporting them. • Continued work lead by the Alcohol and Drug Partnership with licensed trade in respect of responsible drinking and minimum pricing. • Continue regulatory work on age-related sales activity of cigarettes and other products. • Promotional campaign targeted at reducing the under-age sale of tobacco and vaping products to children and young adults.	NHS Borders/ Scottish Borders Council and Partners

15.	Local priority	Strong and Safe Communities	• To investigate and implement effective controls to minimise the spread of suspected and confirmed cases of communicable and notifiable diseases in the community. • The protection of the vulnerable in communities from the impact of cold calling and rogue traders.	NHS Borders Scottish Borders Council
16.	Local priority National	Screening	• Support the uptake to the national screening programmes. • Ensure Key Performance Indicators are met • Support any adverse events associated with screening i.e. cervical screening audit.	NHS Borders
17.	Local priority	Education and advice programme	• Raising awareness of the Outdoor Code and communicable disease and controls through improved public information. • Ensure there are links on NHS Borders and SBC to NHS Inform. • Where possible, consider and coordinate seasonal promotions and awareness raising campaigns e.g. a summer campaign highlighting the risks of ticks and barbecues. • Increase awareness of health protection issues with local businesses through use of alternative enforcement plans.	NHS Borders Scottish Borders Council
18.	Local priority	Preventing and minimising the spread of infection	• Investigation of suspected and confirmed cases of communicable disease and implementation of appropriate controls to prevent further spread. • Monitoring trends by enhanced surveillance and reporting. • Implement the national microbiology strategy locally and ensure appropriate access to testing in the public analyst labs. • Ensure public health actions are taken to minimize risks from zoonotic Infections reported by Scottish Veterinary Service (SVS).	NHS Borders Scottish Borders Council

18.	Local priority	Preventing and minimising the spread of infection	• Investigation of suspected and confirmed cases of communicable disease and implementation of appropriate controls to prevent further spread. • Monitoring trends by enhanced surveillance and reporting. • Implement the national microbiology strategy locally and ensure appropriate access to testing in the public analyst labs. • Ensure public health actions are taken to minimize risks from zoonotic Infections reported by Scottish Veterinary Service (SVS).	NHS Borders Scottish Borders Council
19.	Local Priority/ National Priority	Environmental Health	• EHO have responsibility for enforcing health and safety at working within establishments under enforcement regulations, setting priorities and targeting interventions.	Scottish Borders Council
20.	Local Priority	Horizon Scanning and Emerging infections	• Be aware of new and emerging infections and plan how to minimise their impact locally e.g. Mpox, iGAS.	NHS Borders Scottish Borders Council
21.	Local priority	Minimise the adverse impact Of climate change	• Work together to mitigate the effects of climate change. • Support partners and Scottish Government in meeting climate change and net zero targets.	NHS Borders Scottish Borders Council
22.	Local priority	Animal health and zoonosis	• Respond to current and emerging diseases such as the risks from avian influenza. • Deal with the illegal import of animals. • Carry out animal health and welfare enforcement activities in accordance with Framework Agreements. • Improve preparedness to deal with animal health disease outbreaks. • Update and Publish Local Rabies Pathway as per PHS Guidance.	NHS Borders Scottish Borders Council

23.	Local/ Regional	Workforce planning and resilience	• Training and support in incident management and response including STAC training. • Support the transition to the ERHPT.	NHS Borders Scottish Borders Council ER Health Protection
24.	Local priority	Water safety plans	• Progress water safety plans.	NHS Borders Scottish Borders Council SEPA
25.	National priority	Coordinated approach to public health	• Actively participate in the ERHPT. • Actively participate in the PHS Health Protection Network and associated governance groups to promote a coordinated approach to protecting public health and developing new guidance and systems.	NHS Borders Public Health Scotland

Appendices

Appendix 2: Communicable Disease and Environmental Health in the Borders

Minority ethnic population

Source: Figure 9 at https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/population/population-estimates/mid-year-population-estimates/mid-2020

Table 2 provides an overview of ethnicity in Borders compared to Scotland

These data are also available for the individual local authorities, shown in table 4.

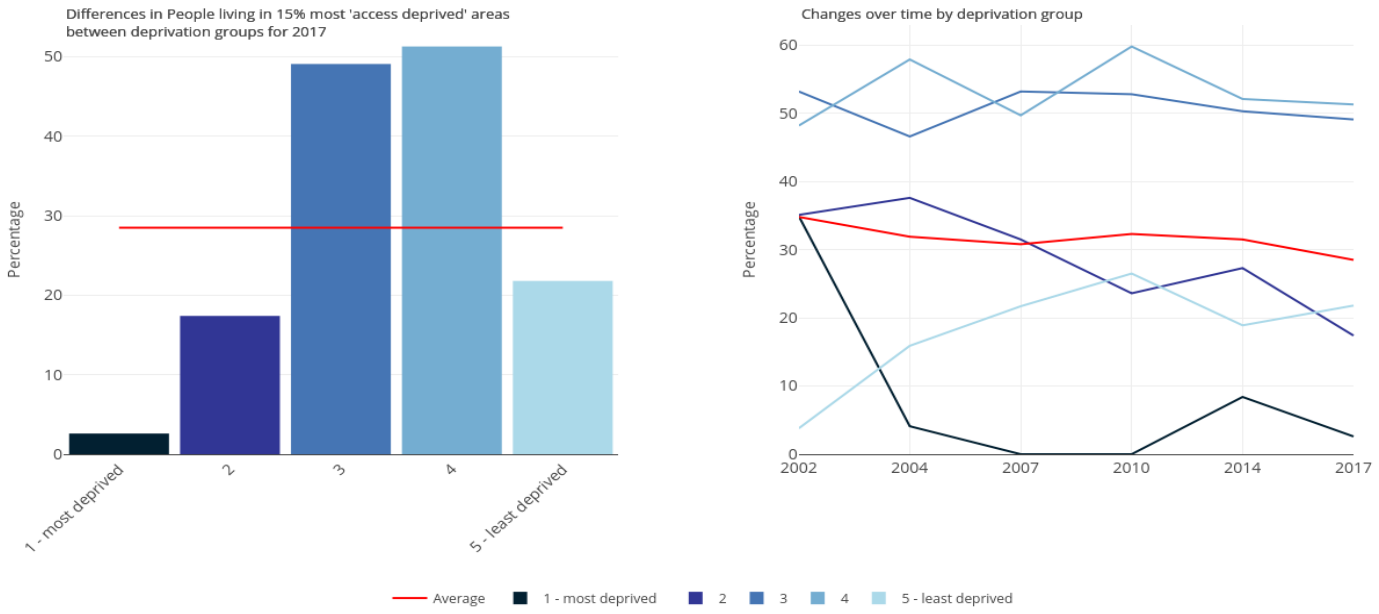


Table 4: Overview of deprivation in Scottish Borders compared to Scotland, Scot PHO Health and Wellbeing Profiles 2022

Area	MaleLE (years)	Female LE (years)	Income deprived (%)	Children in low-income families (%)	Adults claiming IB/SDA/ESA (%)
Scottish Borders	79.14	82.51	18.1	12.6	16.7

Source:http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool

Table 2: Overview of ethnicity in the Scottish Borders compared to Scotland, 2011 Census:

Ethnicity	Scottish Borders	Scotland
	Number	Scotland
White Scottish	78.8%	84%
White other –British	16.4%	7.9%
White Irish	0.7%	1%
White Polish	1.1%	1.2%
White other	1.7%	2%
Asian	0.6%	2.7%
Minority–ethnic other groups	0.6%	1.3%

Source:http://www.scotlandscensus.gov.uk/en/censusresults/downloadablefilesr2.html

Minority ethnic groups makeup 4%of the Scottish Borders population; this is relatively small but not dissimilar to the 5.4% across Scotland. The white polish/white other population is the largest minority ethnic group at 2.8% which is similar to the s the national figure of 3%

(**Table 3**).

Source:http://www.scotlandscensus.gov.uk/en/censusresults/downloadablefilesr2.html

As per 2011 census, only 5.2% of the population in the Scottish Borders have their country of birth outside the EU (4% in Scotland).

Employment

76% of people are economically active, just below the Scotland rate, average earnings are lower. The economy must focus on its areas of competitive advantage – niche manufacturing (in textiles particularly), tourism, construction, farming and production, processing and retail of food and drink. Within these key sectors, a challenge will be to grow their value – in terms of wealth and employment creation and generating revenues from export sales. The fragility of the local economy is reflected in the deteriorating performance statistics that indicate a declining trend in the number of people employed in the key sectors of the economy and are corroborated by increasing trends in both claimant count and unemployment rates. Indeed, the current unemployment data suggest that when the more recent sector employment data is published the downward trend will be maintained. Just under 90% of business sites in the Scottish Borders are micro-enterprises with 0-9 people employed in them and the Scottish Borders economy is more reliant on micro-business activity for employment reflecting the reliance on farming, hotel/ restaurants, retail and construction activity. And while manufacturing is represented, and is a traditional strength of the local economy, lower-value manufacturing faces strong competition from low-cost economies in the global economy. In addition, the area has a higher proportion of people employed by the public sector, and as it contracts there is likely to be a deterioration in local demand for goods and services as disposable incomes fall in real terms, and a corresponding ripple on some of the key sectors of the economy.

Health and Deprivation

Overall Multiple Deprivation rank of 6,976. The most-deprived Data zone in Scottish Borders is Central Langlee in Galashiels with an overall Multiple Deprivation rank of 264. The least-deprived Data zone in Scottish Borders is, the Caledonian Road/ Springhill Road in Peebles with an Overall Multiple Deprivation rank of 6,917. Scottish Borders' most-deprived neighbourhoods are already known-about and have changed little, or even become slightly worse, since the 2016 Scottish Index of Multiple Deprivation.

The 3 Scottish Borders Data zones that are amongst the most deprived 10% in Scotland are in Langlee and Burnfoot, same as 2016. A further 6 Data zones are

within the 20% most deprived in Scotland; these are also in Langlee and Burnfoot but also in other parts of Hawick and in Bannerfield in Selkirk.

At the other end of the deprivation scale, the three Data zones that fall into the least-deprived 10% in Scotland are in Peebles and Melrose as well as neighbourhoods within Innerleithen, Kelso, Lauder, West Linton and the rural area around Clovenfords, are amongst the least-deprived 20% in Scotland.

Central Langlee and all of Burnfoot have become relatively more deprived since 2016.

The Commercial Road area of Hawick is more deprived in 2020 than it was in 2016. Overall, Multiple Deprivation has either stayed the same or got slightly relatively worse overall since 2016 – or has failed to improve as fast as it has improved in other neighbourhoods in Scotland. 9% of the Scottish Borders population is "income-deprived" in 2020, which is lower than the Scottish average of 12%, just as it was in 2016. In general, Income Deprivation in Scottish Borders has either got worse or failed to improve in Scottish Borders since 2016, both in the most-deprived neighbourhoods and in the less-affected neighbourhoods, compared with other parts of Scotland.

- 8% of the Scottish Borders population is employment-deprived in 2020, which is lower than the Scottish average of 9%, as it was in 2016.

- Central Langlee once again has the highest levels of Employment Deprivation, followed by Bannerfield and Burnfoot. Employment Deprivation is generally highest in Hawick but there are also pockets in Kelso and Coldstream. There is evidence that the gap between the most- and the least-employment deprived neighbourhoods is widening.

- More of the worst-affected neighbourhoods in Scottish Borders have got relatively worse since 2016 by Scottish standards than have got better. All of Burnfoot has high levels of Education Deprivation, same as 2016 and has generally got worse, as have other parts of Hawick and part of Eyemouth. Education Deprivation in Langlee has improved. There has been a slight increase in Education Deprivation in a number of previously less-deprived neighbourhoods. Health Deprivation in Scottish Borders is becoming more

polarised, with the overall less-deprived neighbourhoods getting healthier and the most-deprived becoming relatively sicker. Most of Langlee, another part of Galashiels, all of Burnfoot and Bannerfield have amongst the worst health deprivation in Scotland. These vulnerable neighbourhoods have persistent health deprivation which is getting relatively worse by Scottish standards. There is a strong association between Health Deprivation and overall Multiple Deprivation, suggesting that improving public health is key to reducing Multiple Deprivation.

Appendix 2 - Communicable Disease and Environmental Health in the Borders

1. Notifiable Disease in the Borders

The Department of Public Health is made aware of cases of Communicable Disease in a number of ways:

- from notifications made by general practitioners and other doctors when they suspect or become aware that a person is suffering from any of the 28 infectious diseases which they are required by law to notify to the health board
- from microbiological reports of certain organisms and diseases received from laboratories based in hospitals
- ECOSS (needs written in full)
- PHS Alerts and notifications

2. Significant public health incidents or outbreaks in the last two years

A communicable disease (CD) outbreak can be defined as:

- Two or more persons with the same disease or symptoms or the same organism isolated from a diagnostic sample, who are linked through common exposure, personal characteristics, time or location
- A greater than expected rate of infection compared with the usual background rate for the particular place and time

A CD incident may comprise of one of the following:

- A single case of a particularly rare or serious disease
- A suspected, anticipated or actual event involving microbial or chemical contamination of food or water

Table 2 below briefly summarises outbreaks reported to the Department of Public Health during 2023. Most were investigated and managed informally within the department with the assistance of other NHS Borders staff, partner agencies and individuals. Occasionally there is a need to formally convene an ‘outbreak control team’ for more significant events.

Table 2: Significant public health incidents or outbreaks 2023

Incident/Outbreak	Main issues
Water26 situations	
	Failures Lead 10 Cryptosporidium 2 Copper 1 Iron 4 Pesticide (asulam) 1 Chemical spill in drinking water 1 Chlorate 1 E-coli & Coliform water failure 3 Nitrate failure 1 Mains update 1 Aluminium 1
Specific Diseases	**Cases from (01/01/2023 – 22/12/2-2023**
Campylobacteriosis	210
Clostridium difficile infection	18
Clostridium perfringens infection	11
Covid 19	889
Cryptosporidium	17
Diphtheria Corynebacterium ulcerans	1
E.coli	55
Entamoeba dispar infection	3
Gastroenteritis	15
Giardiasis	3
Haemophilus influenzae infection, non-type B or unspecified	3
Haemophilus septicaemia	1
Hep B (Acute and chronic)	16
Hep C (acute and chronic)	53
Hep E	3
HIV	1
iGAS (Invasive Group A Streptococcal) infection	6
Influenza A, Swine	3
Meningococcal infection	3
Mycobacterium infection,	6

Incident/Outbreak	Main issues
unspecified	
Norovirus Infection	84
Pneumococcal infection	3
Pseudomonas infection	1
PVL-associated staphylococcal infection	1
Respiratory syncytial viral infection	4
Salmonellos	20
Streptococcus A/Scarlet Fever	443
Toxic effect of other specified substance(s)	1
Tuberculosis	6
Varicella	10
Yellow Fever	1

NHS Borders

Public Health Screening Programmes Report

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Version: 2.0

Completed by:

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Public Health Department NHS Borders
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Contents

Executive Summary

Screening programmes aim to find a disease, or precursors to a disease before a person becomes visibly unwell with symptoms. Those identified by screening can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition.

The scope of screening services provided by NHS Borders is determined largely by the UK National Screening Committee (UKNSC). NHS National Services Scotland, is responsible, in conjunction with NHS Boards, for taking forward appropriate national screening developments, as well as the coordination and monitoring of the programmes.

The screening programmes that currently take place within Scotland are:

- Abdominal Aortic Aneurysm Screening
- Bowel Screening
- Breast Screening
- Cervical Screening
- Diabetic Retinopathy Screening
- Pregnancy and Newborn Screening

This annual report provides information about the screening programmes offered to residents in NHS Borders for the time period 1st April 2020 to 31st March 2023 where available. The purpose of this report is to review the operational performance data for each programme, highlight any areas of good practice, and identify any relevant service improvements required.

The Covid-19 pandemic is core to the timeframe of this report and had significant impact on all of the screening programmes. They were paused for at least 3 months, and following this had issues with backlog and delays, exacerbated by staff illness, reduced capacity, enhanced infection control procedures and isolation requirements.

Looking across all of the screening programmes, NHS Borders tends to perform quite well in comparison to Scotland and other health boards. In particular, uptake in the AAA, bowel, breast, and cervical programmes in Borders was consistently higher than the Scottish average over the last three years. Furthermore, uptake in the AAA, bowel and breast programmes in the health board did meet the required national standards or KPIs.

On the other hand, there are areas where performance against national targets was below standard. Cervical screening uptake did not meet the national standard for the last two years, and there is a wide variation in uptake within this programme across age categories. Other areas where NHS Borders falls below national standards include colonoscopy referral times, and quality of USS scanning in the AAA programme.

It is worth noting the stark differences in uptake that were seen across deprivation categories in the AAA, breast, bowel and cervical programmes. Uptake is much lower in the most deprived areas of the Borders compared to the least deprived.

Data issues were also noted as a problem within some of the programmes. There were no available national formally published KPIs for the DES programme for the last 3 years due to Covid-19, a new IT system and a change in screening pathway. Significant issues were also seen with meeting the national standards for the Pregnancy and Newborn Screening programme in Borders due to data problems. Historically it has been difficult to gather data for all of the pregnancy and newborn KPI's within Borders due to the scattered nature of the data across teams, systems and borders, as well as the inefficient maternity IT system (BadgerNet).

There is much to be celebrated however, with a great deal of good practice highlighted throughout the report. This includes work to improve accessibility of screening in the Borders through location and time availability, as well as staff and community training and engagement. In addition, screening offers a point of contact with services for many people who may otherwise not have a requirement to access healthcare. Within Borders, there are approximately 180,000 potential screening encounters over a 3 year period, which provide an important opportunity to be able to enact 'Making Every Contact Count', and utilise screening interactions to deliver other health and wellbeing information.

There are projects and developments occurring across many of the different screening programmes going forward. Notable mentions nationally include the development of new standards for the bowel screening programme, and an ongoing audit into cervical screening in those who are listed as having had a total hysterectomy.

Locally, work has begun on a new project related to defaulting on cervical screening during pregnancy. In addition, a data quality project is being scoped out within pregnancy and newborn screening, with the hope that this will lead to a discussion of the most effective and efficient ways of managing and reporting on this data going forward.

Recommendations for future work include dedicated focus on the quality and availability of data for the pregnancy and newborn programme, and wide buy-in from across Borders for both the upcoming Equity in Screening Action Plan, and the Health Inequalities Strategy, to ensure than any highlighted inequalities can be addressed in useful and enduring ways.

Introduction

Screening programmes form part of secondary prevention strategies; they aim to find a disease, or precursors to a disease before a person becomes visibly unwell with symptoms. Those identified by screening can then be offered information, further tests and appropriate treatment to reduce their risk and/or any complications arising from the disease or condition. The aim is that the earlier the disease is identified, the more likely that intervention will be successful, leading to less pressure on services overall and a better quality of life for more of the population. Furthermore, screening offers a point of contact with services for many people who may otherwise not have a requirement to access healthcare. This provides an important opportunity to be able to enact 'Making Every Contact Count', and utilise the huge number of potential screening encounters in the Borders to deliver other health and wellbeing information.

The screening programmes that currently take place within Scotland are:

- Abdominal Aortic Aneurysm Screening
- Bowel Screening
- Breast Screening
- Cervical Screening
- Diabetic Retinopathy Screening
- Pregnancy and Newborn Screening

This annual report provides information about the screening programmes offered to residents in NHS Borders for the time period 1st April 2020 to 31st March 2023 where available. The purpose of this report is to review the operational performance data for each programme, highlight areas of good practice, and to identify any relevant service improvements required. The report will also note changes to local and national policy in the delivery of screening services, as well as putting focus on any inequalities that are observable within the programme KPI or standards data. This is vitally important to acknowledge and address, as it can lead to a widening of inequalities in health outcomes due to lack of early diagnoses and interventions within certain groups of the population.

Quality and Governance

The scope of screening services provided by NHS Borders is determined largely by the UK National Screening Committee (UKNSC), which advises Ministers, the devolved National Assemblies and the Scottish Government on all aspects of evidence for screening.

A Scottish Screening Committee was created in 2017, to review the implementation of all UK National Screening Committee recommendations in Scotland. NHS National Services Scotland, is responsible, in conjunction with NHS Boards, for taking forward appropriate national screening developments as well as the coordination and monitoring of the programmes.

In NHS Borders, each of the screening programmes is supported by a local multidisciplinary planning team with a remit to monitor performance, uptake and quality assurance in delivery. It is a local priority to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes.

Successful delivery of screening programmes relies on a large number of individuals from across Scottish Borders working together. This includes primary and community care, as well as council colleagues, housing services, emergency services such as police and fire, and third sector organisations. For some programmes, partnership is also required with staff based in other Health Boards.

Most programmes have a national governance group which is comprised of board screening coordinators alongside other vital service partners. These meet to discuss planning and operational issues. For programmes which are managed more locally such as the Pregnancy and Newborn service, there is an NHS Borders Steering group which is coordinated and chaired by the board screening coordinator and has representatives from across paediatrics, obstetrics and laboratories.

Impact of Covid-19

At the onset of the first lockdown in March 2020, all of the screening programmes, except for pregnancy and newborn, were paused. The first services to recommence were abdominal aortic aneurysm and cervical (June/July 2020), followed by breast and diabetic eye screening in August 2020, and finally bowel in October 2020.

Most of the programmes took a prioritisation approach to re-starting, with those most at risk being invited first.

The pause within the screening programmes led to a backlog of people waiting to be screened.

This backlog was further exacerbated by longer appointment times across the programmes due to enhanced infection control procedures, temporary re-centralisation of services to the BGH in some of the programmes, alongside workforce issues due to Covid-19 illness and isolation requirements. Furthermore, DNA rates and non-attendance at screening increased during and following this period due to changes in the attitudes and behaviours of the population towards attending healthcare sites, and the perceived risk involved with doing so.

The increase in demand within the services led to some specific adaptions. For example:

- Within the AAA, DES and breast programmes, extra clinics were put in place, and the breast service introduced a new additional mobile unit.
- The breast service booked two patients into each time slot. This created a more efficient use of clinical time as both clients can be accommodated within the allocated time, and if one client does not attend there is at least an alternative client present.
- When routine recall resumed, Borders DES was in a favourable position to recover quickly as DES clinics operated 7 clinics a week from the BGH. To increase clinic uptake,

patients were telephoned to remind them of their appointment, and cancellations filled where possible. Patients who failed to attend were sent an open invitation to limit appointment wastage.

- The bowel service moved invitation dates back, meaning that people do not always receive a screening kit when they expect to, and a similar process was employed within the DES programme and the cervical programme. For the cervical programme, the 6 month delay will remain until after the next smear test. Therefore, unless women proactively ask for a smear test on time, those affected will receive an invite 6 months later than before their pre-Covid pause adjusted recall date, which has potentially introduced an inequality into the programme.
- The breast service made the decision to exclude all women aged over 70 from the previously available 3-yearly self-referral process. Since October 2022, self-referral access to breast screening has once again been available to women aged 71-74, or aged 75 years and over who have had a previous Breast Cancer diagnosis.

Abdominal Aortic Aneurysm

The aorta is the largest blood vessel in the body, and carries blood from the heart down through the abdomen to the rest of the body. The section of the aorta that lies within the abdomen can swell, and this is termed an abdominal aortic aneurysm (AAA). In many cases, those with an AAA are unaware and experience minimal or no symptoms. The risk of an AAA is that over time, the wall of the aorta where the swelling has occurred becomes weakened, increasing the risk of rupture and subsequent death. There are certain risk factors which have been identified as increasing the likelihood of an AAA occurring. These include smoking, age, sex (men at more risk), family history, high blood pressure, high cholesterol, and Caucasian background[1]. It is estimated that 5% of men in Scotland between 65 and 74 years old have an AAA[2], and that AAA deaths account for 2% of all deaths in men aged 65 years and older in England and Wales[3].

AAA screening looks to identify AAA in men aged 65 years old and over, with the aim of reducing deaths from their rupture. The screening test is an ultrasound scan of the abdomen. This is a painless and non-invasive test which takes approximately 10 minutes to complete.

It is thought that in Scotland, up to 170 lives each year are saved because of the AAA screening programme, and that screening for an AAA in the eligible group by ultrasound scanning reduces death from a ruptured AAA by 50%[2].

Eligibility

Men across Scotland in their 65th year of age are invited to be screened for AAA. Men over 65 years of age, who have not been screened previously, can refer themselves to the screening programme[4].

Trans-women are eligible for AAA screening. Trans-women are automatically invited to participate in screening if they haven't changed their CHI number to reflect their female gender, or if they changed their CHI number to reflect their female gender on or after 14th June 2015. Trans-women who changed their CHI number before 14th June 2015 can contact the screening centre to self-refer[4].

Trans-men are at lower risk of AAA, but if they have changed their CHI number they will be automatically invited to attend[4].

Individuals who are non-binary and were assigned male at birth should attend AAA screening and will be automatically invited if they have not changed their CHI number[4].

[1] Public Health Scotland: Abdominal Aortic Aneurysm Screening
[2] Healthcare Improvement Scotland: Abdominal Aortic Aneurysm Screening
[3] British Society of Interventional Radiology: Aortic Aneurysms
[4] Public Health Scotland: AAA screening pathway and FAQs

Service delivery in NHS Borders

The AAA Screening programme is a collaborative/partnership model with NHS Lothian. NHS Borders commenced delivery of the screening programme in August 2012.

AAA screening is currently available at the Borders General Hospital (BGH), as well as several community venues (Duns, Kelso, Pebbles and Hawick), delivered by sonographers. All invitations for eligible people are issued by a joint call-recall centre in NHS Lothian.

Areas of good practice

AAA screening has attempted to be as accessible as possible, and so ultrasound scanning occurs across five sites in the Borders.

The number of failed scanning encounters was noted to be high during this 3 year period, and so this was investigated, and led to additional lead scanner training.

Challenges

As with all the screening programmes, and noted in the introduction, the Covid-19 pandemic was a huge challenge, with some of the after effects still being felt and managed.

A higher than usual number of failed encounters was a challenge during the time period of this report (April 2020 – March 2023), but extra training was put in place to try to improve the scanning quality. In addition, in Autumn 2023, new scanning equipment was introduced with improved penetration. The anatomy of the individual/abdominal adipose can affect the quality of imaging.

Since NHS Borders screening recommenced at the end of July, there has been no access to Peebles Health Centre or Kelso Health Centre. Upon review of the facilities, the carpet flooring throughout each setting was deemed an infection control risk and should be replaced. This work is due to be completed before the end of the year. To absorb some of this lost capacity additional clinics have been running from BGH and Hawick.

Follow up and treatment

Participants are informed of their result verbally during the appointment. This is followed up with a letter within a few weeks.

If no aneurysm is detected, then the person is discharged from the screening programme.

If an aneurysm is identified, follow up depends on the diameter of the aneurysm. Just over 1% of people screened have a small sized aneurysm (3cm to 4.4cm across), and around 0.5% of people screened have medium sized aneurysms (4.5cm to 5.4cm across)[5]. The likelihood of an aneurysm rupturing at these sizes is minimal, and so treatment is not required immediately. Those with small aneurysms are invited to attend annual monitoring screens, and those with medium sized AAAs are invited for quarterly monitoring screens[5].

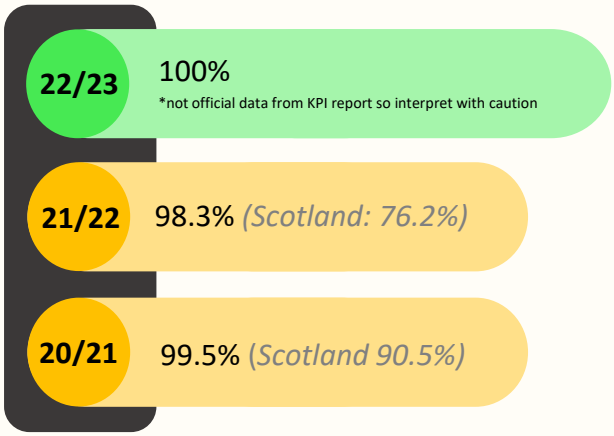
[5] NHS: Abdominal Aortic Aneurysm Screening

If a large aneurysm is detected (measures 5.5cm or more across), a referral is made to vascular specialist services in Lothian for further investigation and consideration of treatment[5]. Around 0.1% of men screened have a large AAA[5].

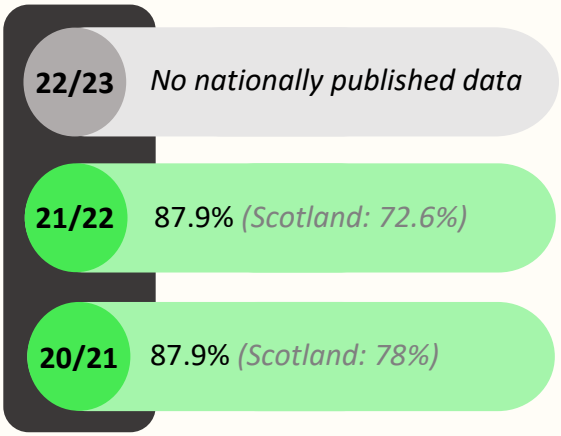
Sometimes, the aorta cannot be visualised on a scan. If this occurs, the participant will be invited for a second screen which will be at the BGH. If it is not possible to see the aorta on the second scan, local policy is to carry out a third scan using a high spec machine at the BGH, and this result is shared with the participant and their GP.

Uptake of AAA screening in NHS Borders

Percentage of NHS Borders residents offered screening before age 66yrs 3months



Percentage of NHS Borders residents tested before age 66yrs 3 months



The percentage of those offered screening before 66 years and 3 months appeared to decrease slightly between 2020/2021 and 2021/2022, although across both of these years, Borders performance was still better than Scotland overall, and did meet the essential national standard. The decrease was due to several clinics being cancelled as a result of staff absences (which has a significant impact in a small board such as NHS Borders), as well as reduced capacity within the programme due to appointment length increases to allow for Covid-19 infection control procedures. Reassuringly however, this percentage has tentatively improved in 2022/23 and has potentially met the desirable national standard.

Ideally individuals should also be tested before 66 years and 3 months. Borders was above the desirable national standard for this in both 2020/21 and 2021/22, as well as performing better than Scotland's average figure. Data regarding 2022/23 will be published in March 2024 and was not yet available at the time of writing.

	Percentage tested before age 66 and 3 months *2020-2021*	Percentage tested before age 66 and 3 months *2021-2022*
1 *(Most deprived)*	84.2%	83.8%
2	86.5%	83.1%
3	86.5%	87.2%
4	89.4%	89.9%
5 *(Least deprived)*	95.3%	94.4%

Table 1 Percentage of NHS Borders residents tested before 66 years 3 months by deprivation quintile for 2020/21 and 2021/22

Uptake of AAA screening tests can also be shown by deprivation quintile. In Borders, there is a clear trend of uptake increasing as deprivation decreases. In 2020/21, uptake of AAA testing met the desirable national standard in all quintiles except for the most deprived one.

In 2021/22, the desirable national standard was also not met in the second most deprived quintile – a decline in performance. Uptake also declined across all deprivation categories except for the 3rd. This is shown visually in the graph below. It is worth noting that other inequalities do exist within the screening programmes, despite not being included within national performance measures. These include differences in uptake due to age, sex, accessibility, ethnicity, language and learning difficulties.

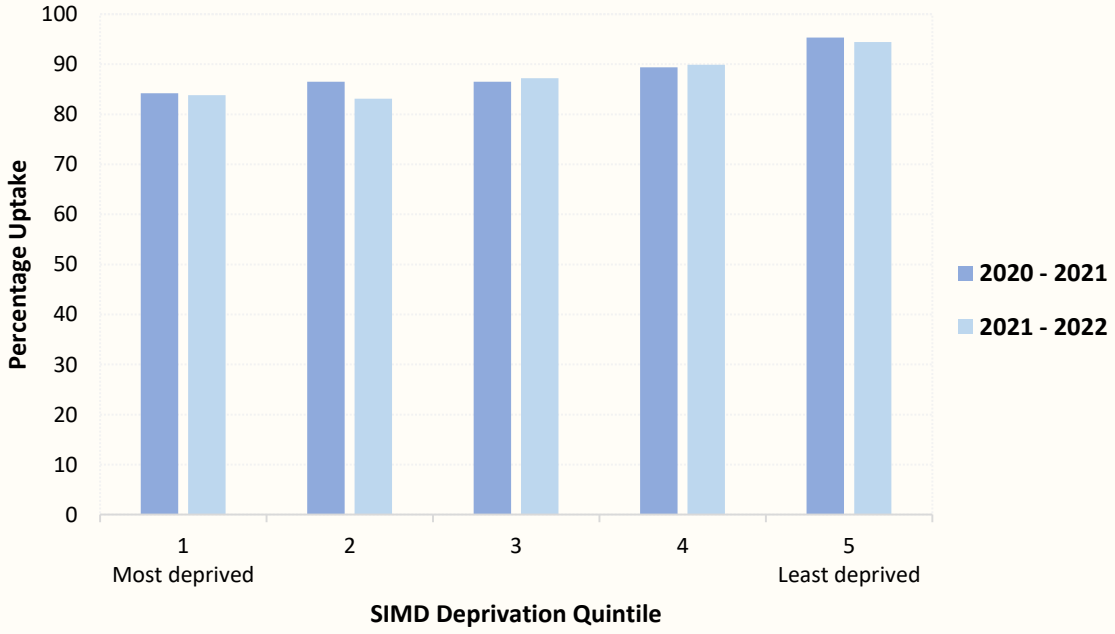
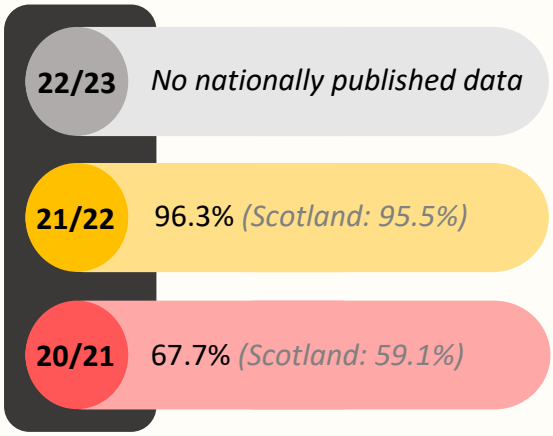


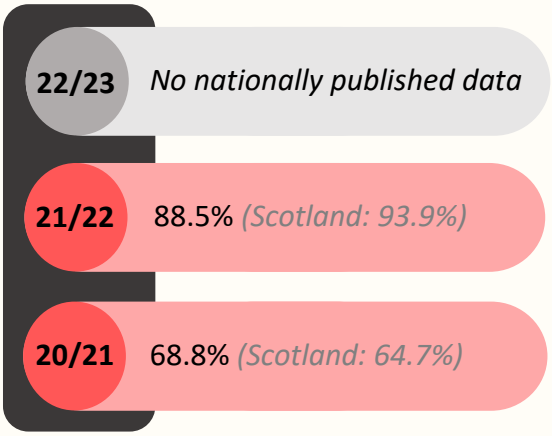
Figure 1 Percentage of men who had AAA screening within NHS Borders by age 66 years and 3 months, by deprivation quintile between March 2020 and April 2022

Percentage of NHS Borders residents tested within 6 weeks of due date for:

Annual surveillance



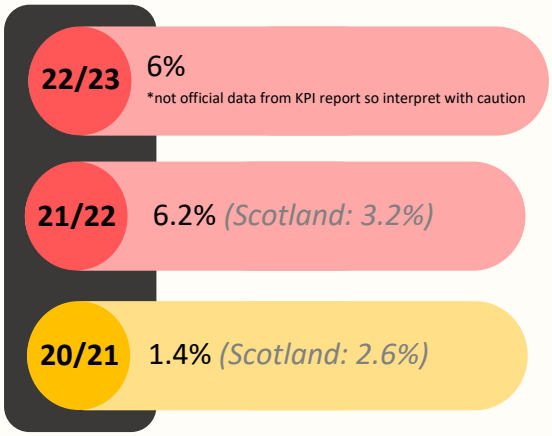
Quarterly surveillance



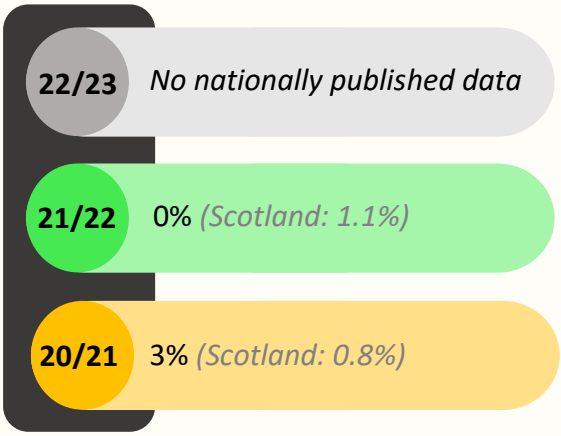
For those men who require ongoing surveillance at the Vascular department in NHS Lothian, the target is that they are screened within 6 weeks of the date of either their annual or quarterly surveillance. In 2020/21, Borders performed below the essential target for both quarterly and annual surveillance, but this decline in percentage was also reflected nationally. The percentage improved to above essential level for annual surveillance in 2021/22 and remained above the national average. Although the percentage also improved for quarterly surveillance in 2021/22, Borders did not meet the essential standard for this, and performance was lower than the national average. A small number of people who DNA or reschedule can affect this KPI disproportionately in a small board such as NHS Borders. Data regarding 2022/23 will be published in March 2024 and was not yet available at the time of writing.

Screening performance and outcomes

Percentage of screening encounters where aorta couldn't be visualised in NHS Borders residents



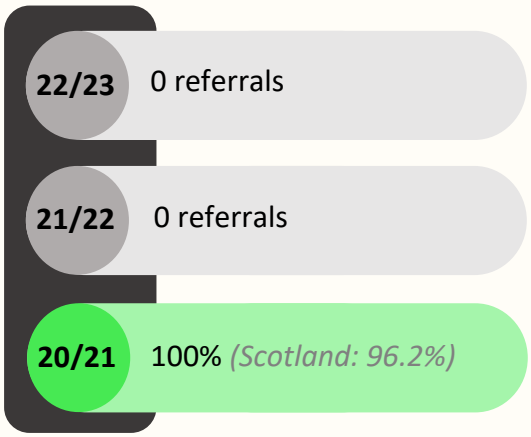
Percentage of screened images that did not meet quality assurance and required immediate recall



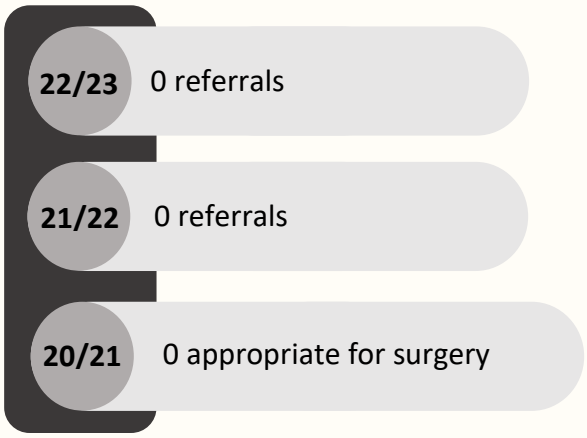
In 2020/21, there were minimal encounters where the aorta could not be visualised, and performance was better than the national average. The percentage of failed encounters

increased in 2021/22, rising above the national average and meaning that Borders did not meet the essential target for this. The percentage has remained high in 2022/23. Again, the small numbers that are being processed in NHS Borders can cause a disproportionate effect on KPI performance with only minor numbers of failed encounters. Data regarding 2022/23 will be published in March 2024 and was not yet available at the time of writing.

Percentage of NHS Borders residents with AAA ≥ 5.5cm seen by vascular specialist within two weeks of screening



Percentage of NHS Borders residents with a AAA deemed appropriate for intervention, operated on within 8 weeks



In Borders, there were no urgent vascular referrals as a result of screening in 2021/22 or 2022/23. This meant that no individual required intervention within 8 weeks. The 30 day mortality rate from AAA surgery is only available for the whole of Scotland, and it can be seen that this figure is lower for endovascular repair compared to open surgery.

30 day mortality rate across Scotland for AAA Surgery 2016/17 – 2020/21:

Identified risks

There is a risk noted around the inability to meet the essential target for KPI 3.2 (percentage of men with AAA ≥ 5.5cm deemed appropriate for intervention who were operated on by vascular specialist in Lothian within eight weeks of screening). As all men are referred for specialist intervention in Lothian, this is outwith the control of Borders.

NHS Borders Radiology department staff carry out the AAA USS scans, and are only resourced for a set number of clinics per annum. They helpfully always provide more when it is needed, but this is a fragile agreement if their own service is struggling. This means that there is a risk that patients may breach target.

Adverse events

There has been an issue identified with new AAA scanning equipment. An algorithm in the software is inappropriately “rounding” patients results on the screen, but not on their result letter.

This means that surveillance patients may be inadvertently given incorrect information about their recall status/ frequency, or may be incorrectly advised that they will be referred to vascular services, if they have either of the following measurements:

- 2.95: patient may be advised they have a AAA when they will actually not be marked for recall
- 4.45: patient may be advised they will be recalled in 3 months; however, they will be recalled in 12months
- 5.45: patient may be advised they will be referred to vascular services, but will be recalled for screening in 3month

Screeners all are aware of this workaround, and the risk to patients is low, but it is likely that a software fix may not be in place for another 6 months.

Bowel

In Scotland, bowel cancer is the third most common type of cancer. Approximately 4,000 people are diagnosed with bowel cancer each year in the country[6].

Bowel cancer screening aims to detect the disease in the early stages before symptoms appear and when treatment is more likely to be effective, leading to improved outcomes. If detected at the earliest stage, more than 9 in 10 people will survive for 5 years or more[7].

The bowel screening test is the only screening test to be performed at home at the moment. It involves sending a stool sample to the screening centre, using materials provided in the post. The test used is called a faecal immunochemical test (FIT) and it measures the amount of blood in the sample. Levels of blood above the determined programme threshold may indicate a higher risk of pre-cancerous growths (polyps) or other changes in the bowel.

Eligibility

Everyone across Scotland between the ages of 50 and 74 years old is invited to take the test every 2 years. Those over the age of 75 years old can also self-refer for a test by calling the bowel cancer screening helpline. This needs to be requested every 2 years if wanted, as there is no routine automatic recall in this age group.

Service delivery in NHS Borders

Bowel cancer screening is managed centrally within Scotland, with the Scottish Bowel Cancer Screening Centre being located in NHS Tayside. The laboratory and helpline are based at the screening centre, and all call-recall is handled from this central location.

The test kits are sent out to the address that a person has used to register with their GP. It is possible to request a replacement kit if a mistake has been made, or it has been misplaced, by using an online form or contacting the screening centre.

NHS Borders is responsible for delivering the diagnostic pathway for participants who have received a positive result.

Areas of good practice

Within NHS Borders, bowel screening patients can currently be offered a weekend appointment for colonoscopy, if appropriate for the individual patient, from Waiting Times Initiative Funding. This both increases capacity within the system, and provides better accessibility for this diagnostic test.

[6] NHS: Bowel Screening
[7] Cancer Research UK: Why early diagnosis is important

The pre-assessment stage of the referral process to colonoscopy continues to work well, with 90% of patients being offered a telephone pre-assessment appointment with a nurse within 14 days of referral.

NHS Borders consistently has one of highest uptakes in bowel screening of any mainland Scotland health board.

Challenges

Achieving the waiting time target for colonoscopy continues to be challenging, with only 25% of patients offered a colonoscopy date within 31 days of receipt of a positive screening test in 2022.

As with all the screening programmes, and noted in the introduction, the Covid-19 pandemic was a huge challenge, with some of the after effects still being felt and managed.

Follow up and treatment

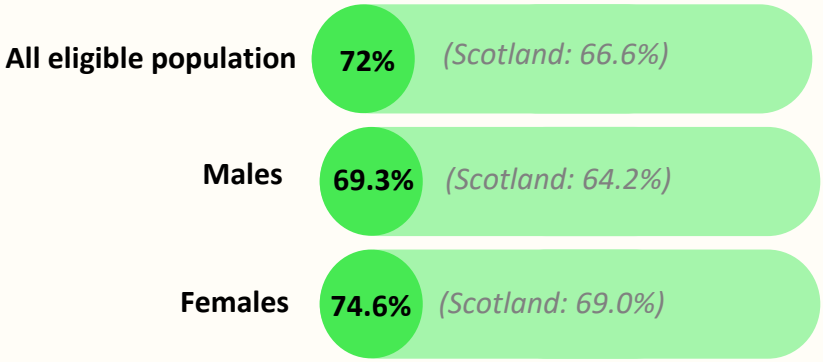
The Scottish Bowel Cancer Screening Centre aim to send individual's their results within 2 weeks.

If the test is negative, no further investigation is required and the person can continue with routine screening every 2 years.

If the test is positive, then further assessment is required. Approximately 1 in 50 people who take the screening test require further investigations[6]. The Bowel Screening IT System (BoSS) refers the patient for this further investigation at their local colorectal cancer service. This usually involves a colonoscopy as an outpatient[8]. This is an examination of the internal parts of the bowel using a small flexible camera. Of those people who have a colonoscopy as a result of bowel screening, 1 in 10 will have bowel cancer[6].

Uptake of bowel screening in NHS Borders

Percentage uptake of bowel screening in NHS Borders
1st Nov 2020 – 31st Oct 2022:



[8] NSS: Bowel Screening

The percentage uptake of bowel screening in NHS Borders for 2020 – 2022 was overall higher than the national figure. The uptake was greater in females than in males, but across both groups, NHS Borders performed above the Health Improvement Scotland (HIS) standard of 60%.

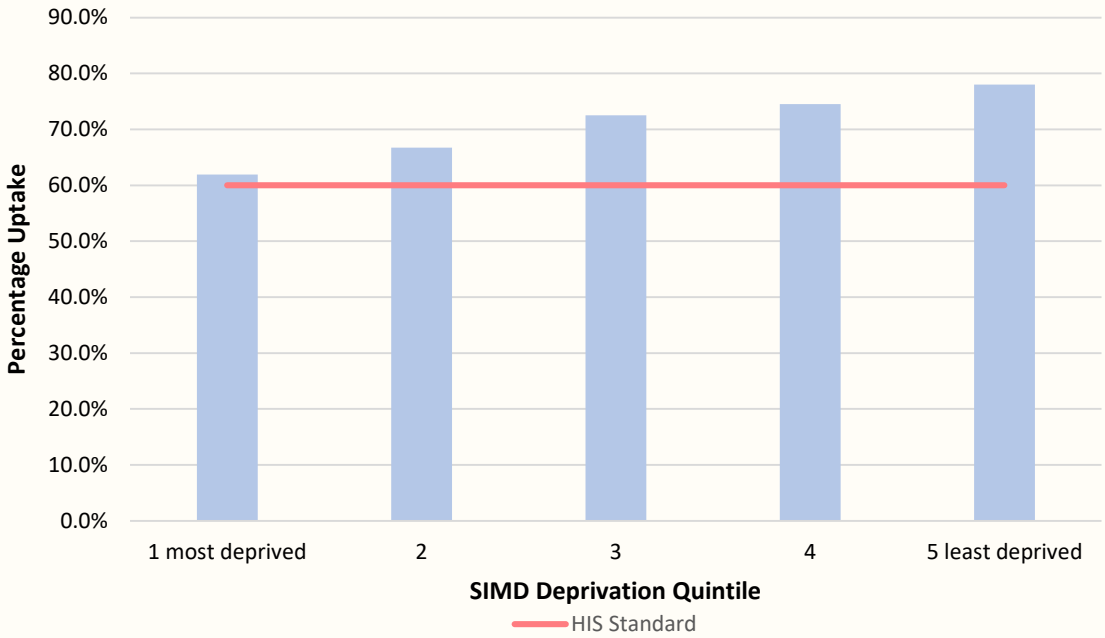


Figure 2 Uptake of bowel screening for NHS Borders between 1st Nov 2020 and 31st Oct 2022, by deprivation category

Uptake can also be reviewed by deprivation category. Bowel cancer uptake in Borders between 2020 and 2022 showed a strong trend by deprivation, with lowest uptake in the most deprived group, and best uptake in the least deprived group.

Uptake across all the deprivation quintiles was above the HIS standard of 60%, and higher than the equivalent Scottish figures. It is worth noting that other inequalities do exist within the screening programmes, despite not being included within national performance measures. These include differences in uptake due to age, sex, accessibility, ethnicity, language and learning difficulties.

Screening performance and outcomes

Screening test positivity

	Percentage of those screened who had a +ve result *(2019/21)*	**Percentage of those screened who had a +ve result** *(2020/22)*
Males	3.28%	3.32%
Females	2.29%	2.33%
All	2.77%	2.80%

Table 2 Percentage of people with a positive screening test result for both sexes, by two-year reporting period in NHS Borders

Within Borders in 2020/22, 2.8% of those who took part in bowel screening had a positive result and would have been referred for colonoscopy. This has increased slightly from the previous 2-year period. More males than females who participated in bowel screening had a positive result within the most recent, and previous 2 year periods.

Colonoscopy timeliness and completion

Of all those who were referred for colonoscopy in Borders following a positive screening test result in 2020/22, 80.9% had a colonoscopy performed, which was higher than the national figure of 74.5%.

In 2020/22, only 28.7% of people who were referred for colonoscopy in Borders had the test performed within 4 weeks of referral. The majority had their colonoscopy between 4-8 weeks of being referred (64.6%), with a small percentage waiting more than 8 weeks for the test (6.8%). As can be seen from the graph below, there was a greater percentage of those in Borders having their colonoscopy earlier than the Scottish equivalent figures, but some other boards had higher proportions of individuals having their colonoscopy within 4 weeks of referral.

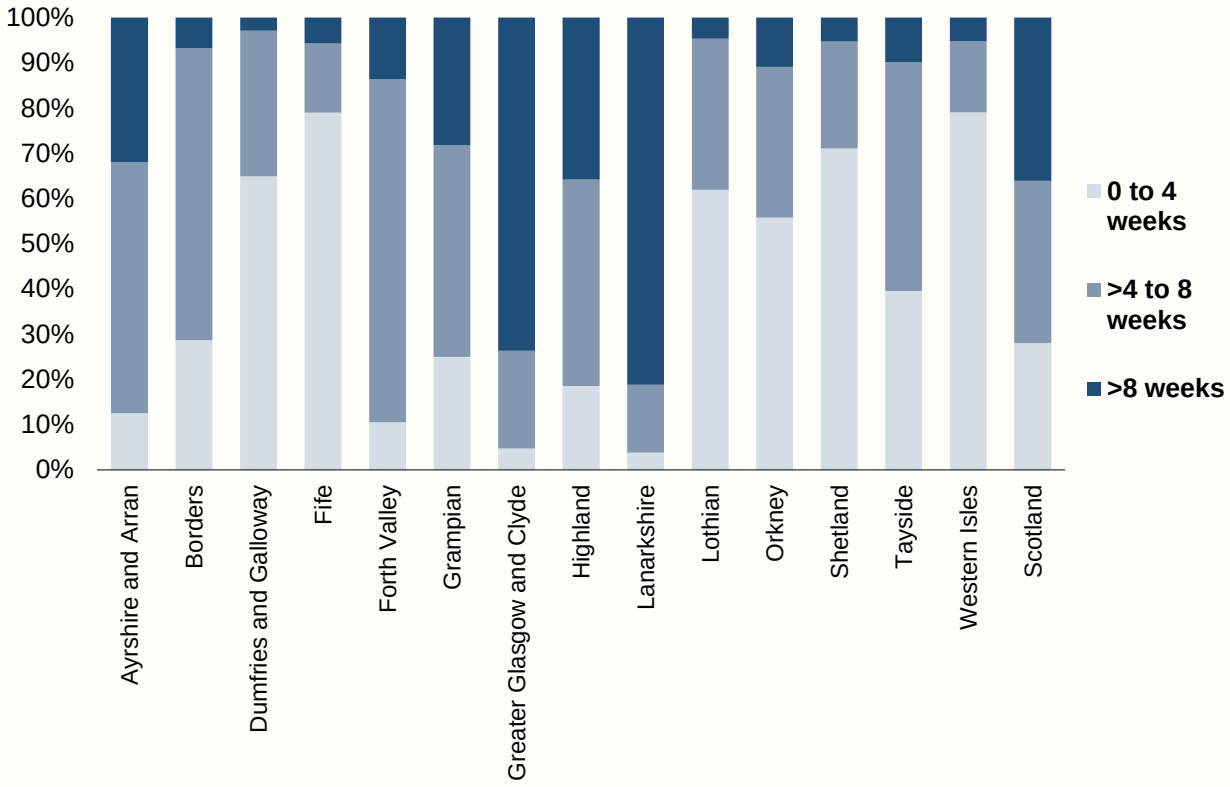


Figure 3 Time from screening test referral date to date colonoscopy performed, by NHS Board for 2020/22

Percentage of NHS Borders residents who had a completed colonoscopy 1st Nov 2020 – 31st Oct 2022:

92.8% *(Scotland: 94.1%)*

Of those who had a colonoscopy performed in Borders, 92.8% had a 'completed' colonoscopy where the scope extended the length of the bowel and visualised the caecum. This is greater than the 90% HIS standard target. However, Borders was still the 3rd worst performing health board for this measure, and completion rates were lower than the national figure. This is possibly due to the lower completion rates within the Board in females (89%) compared to males (95.6%).

In 2020/22 there were no recorded colonoscopy complications within NHS Borders.

Cancer detection and staging

Within NHS Borders, 0.113% of people who participated in bowel screening in 2020/22 had a colorectal cancer detected, with more males (0.133%) than females (0.095%) having a cancer diagnosed. This is higher than the Scottish detection rate of 0.110%.

Dukes Staging	Percentage of people with colorectal cancer *(2020/22)*
Dukes A	39%
Dukes B	24.4%
Dukes C	31.7%
Dukes D	4.9%
Unknown or not yet been supplied	0%

Table 3 Percentage of people with colorectal cancer, by Duke's stage in NHS Borders for 2020/22

Everyone who was diagnosed with colorectal cancer in Borders in 2020/22 had a recorded Duke's stage, with the most common stage being Dukes A (the least advanced). Less than 1% of individuals in the Borders who participated in bowel screening were diagnosed with polyp cancer, adenomas or high risk adenomas. The most common location for colorectal cancer to be found in individuals in Borders was the colon (53.7%), followed by rectum (34.1%), and finally the rectosigmoid junction (12.2%). Borders had more cancers than Scotland in the rectosigmoid junction and rectum, but fewer in the colon.

Positive predictive value for adenoma in NHS Borders residents
1st Nov 2020 – 31st Oct 2022

44.7% *(Scotland: 43.6%)*

One of the more specific HIS standards for bowel screening was the positive predictive value of the screening test for adenomas. This is the percentage of people with adenoma, out of those with a positive screening test and a colonoscopy performed. In Borders for 2020/22 this was 44.7%, which was higher than Scotland and above the HIS threshold of 35%. The remaining positive predictive values for different conditions are shown in the table below for interest.

Dukes Staging	Percentage of people with colorectal cancer (2020/22)
Colorectal cancer	6%
Adenoma	44.7%
High risk adenoma	7.1%
High risk adenoma or colorectal cancer	13.1%
Adenoma or colorectal cancer	50.7%

Table 4 Positive predictive values for different diagnoses in those with a positive screening test and colonoscopy performed in Borders for 2020/22

Identified risks

As detailed above, the time from positive FIT screening test to colonoscopy referral continues to be a challenge within NHS Borders. The majority are taking place between 4-8 weeks, when this should ideally be <4 weeks.

Adverse events

No adverse events were identified during the time period of this report.

Breast

In Scotland, breast cancer is the most common type of cancer for those assigned female at birth (AFAB). It is estimated that 1,000 people die from breast cancer each year in the country[9].

Breast cancer screening aims to detect the disease early, when symptoms are minimal or non-existent. The objective of this is to allow for early intervention, to hopefully improve survival rates from the cancer. Individuals are 5 times more likely to survive if the disease is found at an early stage[10].

Breast cancer screening involves performing a mammogram (x-ray) of the breast tissue. Two x-rays are taken of each breast. The appointment usually lasts no longer than 30 minutes.

Eligibility

All women between the ages of 50-70 years old are invited to participate in breast screening every 3 years. Women aged over 71 years old are outwith the routine screening age for this programme. During Covid-19, there were caveats placed on women above this age being able to self-refer, but since October 2022, women between the age of 71 and 74 years, as well as those who have previously had breast cancer can again self-refer for screening by contacting their local screening centre. This is the Southeast Scotland Breast Screening Centre for Borders residents. 2% of programme capacity is allocated for this.

AFAB non-binary people and trans men who haven't had breast removal surgery are automatically invited to breast screening if they have not changed their CHI number to reflect their male gender, or if their CHI number was changed after 14th June 2015. If their CHI number was changed before this, they can self-refer for screening by contacting the local breast screening centre.

Trans-women and AMAB non-binary people who are taking hormones are automatically invited for breast screening if they have changed their CHI number to reflect their female gender after 14th June 2015. If their CHI number has not been changed, or the change occurred before this date, they can also self-refer for screening.

Service delivery in NHS Borders

The Scottish Breast Screening Programme (SBSP) is divided into 6 screening centres. The Borders region is in the South East Scotland area, which is based in Edinburgh. The South East Scotland Breast Screening Programme (SESBSP) is directly commissioned by NSD. NHS Lothian is the host board, with local and regional partnership working with the SESBSP centre. The

[9] NHS: Breast Screening
[10] PHS: Breast Screening

service is provided through mobile units[11]. The Scottish Breast Screening Programme uses a national IT system to manage the call and recall of women for breast screening. Each of the territorial boards is responsible for planning, delivery and governance of the programme to eligible women resident within their board area.

SESBSP invites Borders women by their GP practice. The screening centre alerts local GP practices that they are attending a certain area, and obtains a list of eligible patients from them as well as information about patients' mobility. Appointments are then bulk allocated, although individuals have the option to change their appointment if required. If people move into the area whilst the GP practice is still 'open' to screening, then they will receive an appointment. The mobile units last visited Galashiels in September 2020 and will return in the autumn 2023.

Areas of good practice

The breast screening programme decided to split the visits to Borders into two within a three year screening cycle, in order to help with acute service pressures.

Following resumption of the programme during the Covid-19 pandemic, several adaptions were made to improve capacity. An additional mobile unit was added in January 2021, weekly Saturday clinics were introduced, and appointments were booked with 2 patients to each time slot. The last measure created a more efficient use of clinical time as both clients can be accommodated within the allocated time, and if one client does not attend there is at least an alternative client present

There are robust methods in place to follow up those who have been referred for further investigation at the breast centre in NHS Lothian, but who have not responded or attended.

Wireless connectivity was installed in the mobile units. This enables them to be managed by two Assistant Practitioners rather than a Senior Radiographer with an Assistant Practitioner. Images can now be transferred directly to the screening centre to check image quality remotely. This use of assistant practitioners also allowed greater flexibility to react to staff shortages.

Succession planning is undertaken proactively; One member of the Senior Radiography team became qualified to Film Read and was promoted to Band 7. Meanwhile an existing Advanced Specialist Radiographer was appointed Consultant Radiographer within the department.

The programme successfully trialled insertion of Saviscout surgical localisation markers into all grade 4 and 5 lesions to be referred to Borders or Lothian for treatment. This has removed the need for individuals to attend tertiary centres in advance of their day of surgery.

Since May 2022, those resident in the Borders who are diagnosed with non-palpable lesions have been referred to their home board for treatment. To enable this change, the Edinburgh

[11] NSS: Breast Screening

Breast Screening Multi-disciplinary meeting is now held on Microsoft Teams to allow surgeons and radiologists from Borders and Forth Valley to attend.

Within Borders an initiative has been established called Bridging the Gap, to raise awareness of breast screening amongst people with learning disability. Those who are excluded or opted out have the opportunity for further discussions and accurate recording of their decision.

Challenges

The National Adverse Event management process required a re-read of approximately 2,500 images by the South East Scotland reading team. This resulted in a delay to routine reading. Additional hours out with core time was offered, however the reading team were not in a position to provide this additional capacity.

As with all the screening programmes, and noted in the introduction, the Covid-19 pandemic was a huge challenge, with some of the after effects still being felt and managed.

Prior to the pause in screening during the Covid-19 pandemic, the 20% growth in the eligible population across the South East of Scotland meant that service was already unable to deliver all screening appointments within 3 years and 3 months of previous appointments.

Follow up and treatment

During the screening appointment, a decision will be made about whether the images obtained are of sufficient quality. If they are not, then several more images are taken.

Results are usually sent by letter within 3 weeks, with the individual's GP also receiving a copy.

The images are reviewed by two specialists. If they disagree about the results of the mammograms, then a third reviewer is used. If they are also unsure about the results, a technical recall is issued and an appointment arranged for further imaging.

If both reviewers agree that the mammograms are normal, then a negative result is issued and the individual will continue to have routine breast screening.

If both reviewers agree that there is an abnormality on a mammogram, then further investigation is required. Approximately 1 in 20 people who have a mammogram will require further tests[9]. The individual will be invited to the specialist breast centre in NHS Lothian, and may have a breast examination, more mammograms, an ultrasound scan and/or a biopsy. Only 1 in 5 of those who have further investigations as a result of screening will have breast cancer[10].

Uptake of breast screening in NHS Borders

Percentage uptake of breast screening among NHS Borders residents 2018/19 – 2020/21

78% *(Scotland: 73.2%)*

In Borders, 78% of the eligible population had breast screening in the 3 year cycle between 2018/19 and 2020/21, which was better than the Scottish figure and met the essential national target.

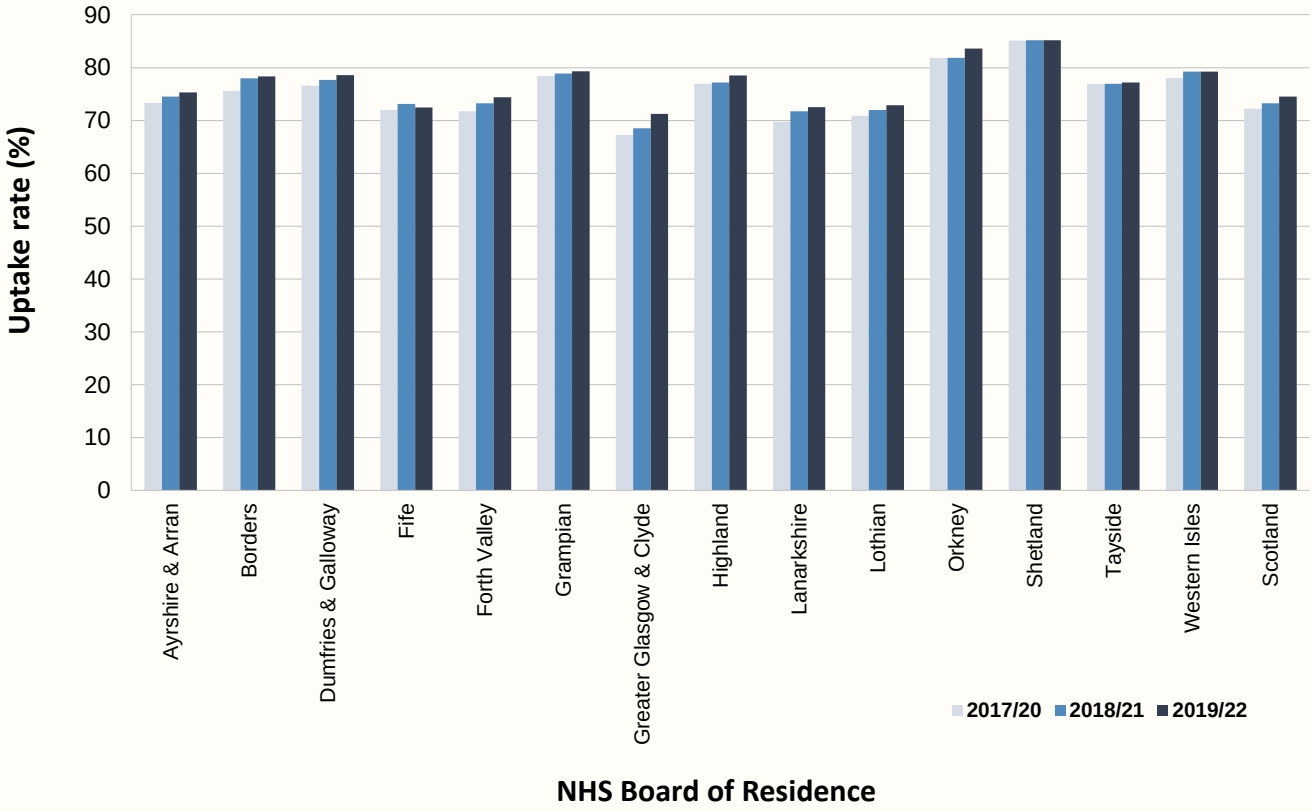


Figure 4 Three yearly uptake of breast screening across the health boards in Scotland for 2017/20, 2018,21 and 2019/22

The graph above shows the 3 yearly uptake of breast screening across the health boards in Scotland for 2017/20, 2018,21 and 2019/22. It highlights that uptake in Borders has been increasing across each of those 3 yearly periods.

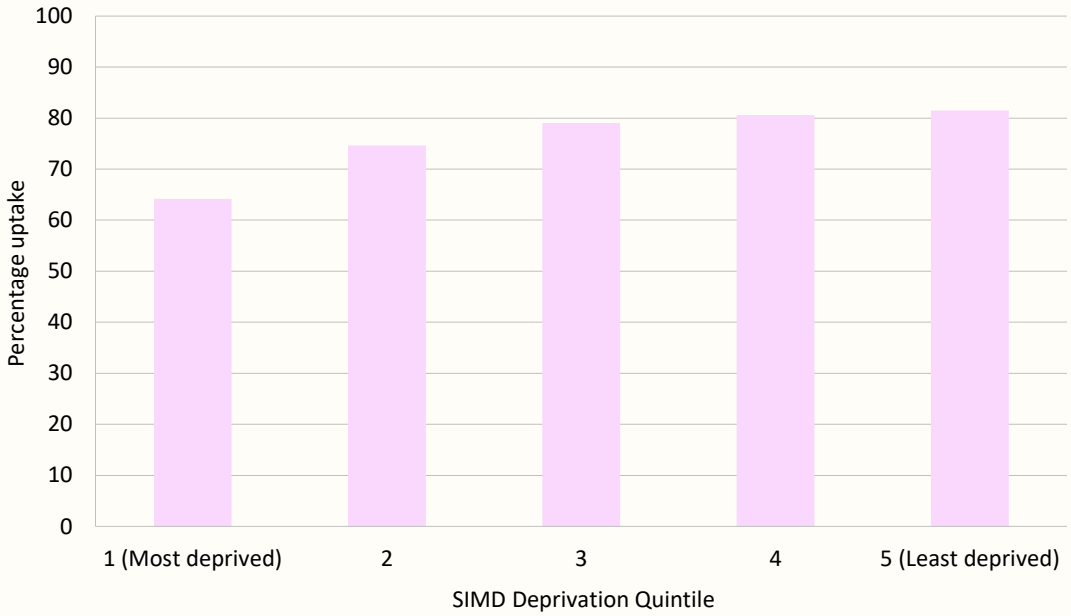
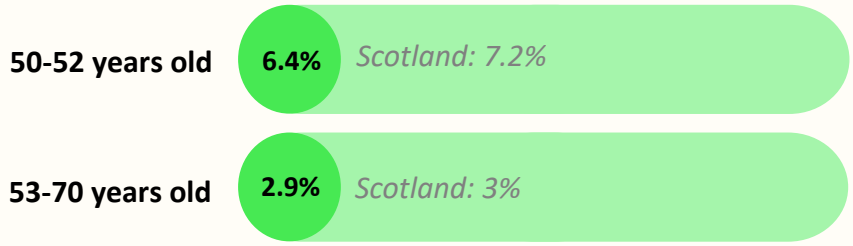


Figure 5 percentage uptake of breast screening in each deprivation category for Borders between 2019 and 2022

Uptake can also be reviewed by deprivation category. In NHS Borders, uptake is lowest in the most deprived quintile and increases as deprivation improves. NHS Borders is not meeting the minimum standard for those within the most deprived category (70%), and yet meeting the desirable target in the two least deprived groups (80%). It is worth noting that other inequalities do exist within the screening programmes, despite not being included within national performance measures. These include differences in uptake due to age, sex, accessibility, ethnicity, language and learning difficulties.

Screening performance and outcomes

Percentage of screened women in NHS Borders who were referred for further assessment 2018/19 – 2020/21



Between 2018/19 and 2020/21 in Borders, the percentages of screened women referred for further assessment were reassuringly below the required minimum and desirable thresholds.

	Number of women at their first screening (50-52 yrs old)	Number of women at subsequent screenings (53-70 yrs old)
Non Invasive Cancer detected	1 (0.7 per 1,000)	13 (1.8 per 1,000)
Invasive Cancer detected (<15mm)	5 (3.4 per 1,000)	36 94.9 per 1,000)
Invasive Cancer detected (all)	10 (6.8 per 1,000)	52 (7.1 per 1,000)

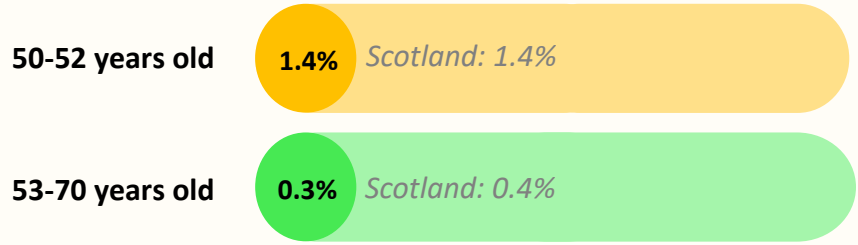
Table 5 Breast cancer detection rates through breast cancer screening for 3 year cycle from 2018/19 to 2020/21 in Borders

Between 2018/19 and 2020/21 in Borders, there were 62 breast cancers detected through the screening programme, of which 41 were less than 15mm in size. There were 14 non-invasive cancers detected in the same time period.

Detection rates for Borders for all of these categories were reassuringly above the minimum and desirable standards, and were all above the Scottish figures except for non-invasive cancer rates in the younger age group.

The standardised detection ratio (SDR) for the breast screening programme in Borders for this 3 year cycle was 1.6, which was above both the minimum (>=1.0) and desirable targets (>=1.4) as well as being the same as the Scottish figure.

Benign biopsy rates in NHS Borders
2018/19 – 2020/21



Some women who are referred for further assessment following screening have a biopsy taken, but are not diagnosed with breast cancer – instead they have a benign condition. The benign biopsy rates for Borders between 2018/19 and 2020/21 were below the essential and desirable thresholds for those having subsequent screens, but only met the essential target for women having their first screen.

Identified risks

The SESBSP maintains a risk register for the service on the DATIX system. As the service is coordinated and managed by Lothian, there is no separate process within NHS Borders.

Mortality and Morbidity (M&M) meetings are held quarterly within the service.

Adverse events and near misses are actively managed, reviewed for learning and are also recorded on DATIX.

Adverse events

In Summer 2022, four replacement mammography units within the Scottish Breast Screening Programme were suspended from clinical use due to continued sub optimal quality of breast images produced from the mammography equipment, combined with concerns that there were lower cancer detection rates for women screened on these units. No NHS Borders patients were screened on these units.

In September 2022 there was a problem with GP practice merges on SBSS, whereby eligible women were not moved over to the correct new GP practice as a result of a practice merge. This resulted in women remaining on a closed practice, and while still able to be recalled, may not have been recalled at the same time as the new practice or not invited appropriately for breast screening. Borders patients were not affected by this incident.

Cervical

Cervical cancer is the most common cancer in young women in Scotland (aged 25-35 years old). Approximately 6 women across the country are diagnosed with this cancer every week[12].

The majority of cervical cancers are caused by human papilloma virus (HPV). A lot of women carry this virus, and many clear it from their body themselves. A small number however (1 in 10 infections[13]) are harder to clear and eventually over many years, they may cause changes to the cervix. The aim of screening is to detect individuals who have HPV, so that further investigation for early pre-cancer cell changes can be carried out. These changes can then be monitored or treated, with the aim of reducing the number of people developing cervical cancer and mortality rates from this disease.

The test involves a healthcare professional taking samples of cells from the cervix. This is usually carried out local GP practices and the appointment takes 15-20 minutes.

Eligibility

Cervical screening is routinely offered to women with a cervix in Scotland between the ages of 25 and 64 years, every 5 years. Those up to the age of 70 will receive an invite if they are in non-routine screening. This is where screening results have shown the need for more investigation or follow up.

AFAB non-binary people and trans men who still have their cervix are automatically invited to cervical screening if they have not changed their CHI number to reflect their male gender, or if their CHI number was changed after 14th June 2015. If their CHI number was changed before this, they can self-refer for screening by contacting their GP.

Trans-women and AMAB non-binary people who have changed their CHI number to reflect their female gender after 14th June 2015 will be automatically invited to screening but they do not need to attend as they do not have a cervix and so are not at risk of this type of cancer.

Service delivery in NHS Borders

Eligible individuals receive an invitation for screening through the post, and most screening tests are performed within primary care. Since 30th March 2020, the programme has changed so that all samples taken are first tested for high risk human papillomavirus (HPV) that is found in 99.7% of cervical cancers. If HPV is found, then the sample will be looked at under a microscope to detect any changes to the cells.

Oversight for call-recall in the cervical screening programme is managed within local boards, with support from a national IT system called SCCRS (Scottish Cervical Call Recall System). This

[12] PHS: Cervical Screening
[13] NSS: Cervical Screening

multi-module platform coordinates the call-recall functions; GP smear taking, colposcopy and laboratory information[13].

Areas of good practice

Since January 2017, in order to improve uptake of cervical screening within staff in NHS Borders, the Public Health Screening team have arranged clinics for employees who are due, or overdue a smear. These are in the evenings, just outside of working hours, to enable better accessibility for staff.

Within Borders an initiative has been established called Bridging the Gap, to raise awareness of cervical screening amongst people with learning disability. Those who are excluded or opted out have the opportunity for further discussions and accurate recording of their decision. Furthermore, the new learning disability health check now had a question explicitly about cervical screening in the assessment.

Challenges

NHS Borders is a rural and small board, which can lead to difficulties in choice for women who do not wish to attend their local GP practice for their routine smear.

There are now only two national laboratories who analyse and process cervical smear tests. Initial demand modelling for cytology is being reviewed nationally, as the labs have struggled to meet the two-week time-to-result KPI, due to the cytology test bottleneck. This can be distressing for screening participants, some of whom are waiting 2 – 3 months for their result.

As with all the screening programmes, and noted in the introduction, the Covid-19 pandemic was a huge challenge, with some of the after effects still being felt and managed.

Colposcopy waiting times in Borders are usually well within national targets, but have recently come under pressure in line with other health boards.

Follow up and treatment

Results of the screening test should be reported by the screening laboratory within 2 weeks, and posted to the individual.

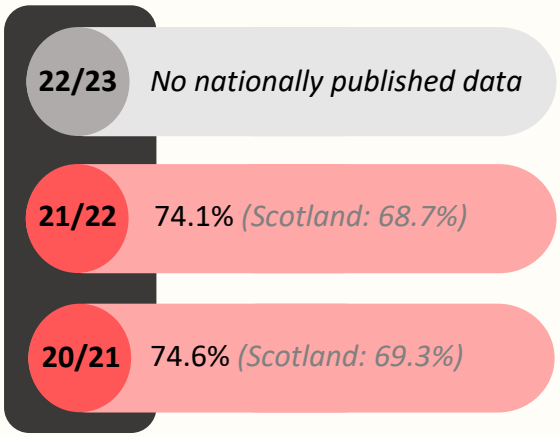
If no HPV has been found on the sample taken, then the individual will be placed back into routine screening and invited again in 5 years. If HPV was found, but there were no cell changes seen, then a further invite is issued after 12 months, in order to check if the HPV has been cleared.

If both HPV and cell changes are seen on the sample, then a referral is made to a specialist clinic for further investigation. This is usually to have colposcopy where the cervix can be looked at in greater detail.

Finally, if the sample result was unclear for any reason, then the individual is asked to return for another screening appointment in order to get another sample to process.

Uptake of cervical screening in NHS Borders

Percentage uptake of cervical screening among NHS Borders residents



The uptake of cervical screening in Borders has been declining over the past 4 years of available data. Uptake was 77.3% in 2018/19 but only 74.1% in 2021/22. It is difficult to know if this is due to interruption of the programme and other impacts of the Covid-19 pandemic. A similar trend has been seen across Scotland, although uptake locally is still higher than the Scottish average (68.7% in 2021/22). The HIS standard for coverage is a minimum of 80%, and so Borders did not meet this target in 2020/21 or 2021/22. National data regarding 2022/23 has not yet been published, and so was not available at the time of writing.

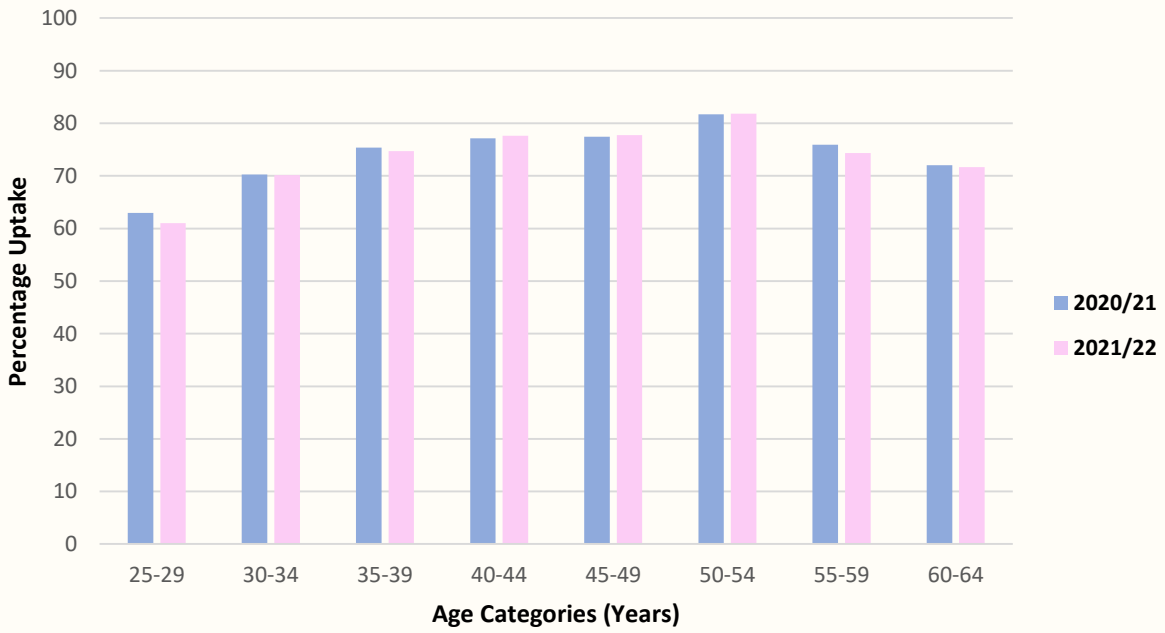


Figure 6 Percentage uptake of cervical screening within NHS Borders, by age for 2020/21 and 2021/22

There is variation in uptake of cervical screening by age in Borders, with lowest percentages seen in the 25-29 year age group (61%) and 60-64 year age group (71.6%) in 2021/22. This pattern is the same as the one observed in 2020/21, although the uptake has dropped over those two years across almost all age groups. The trend is also seen across Scotland, although Borders did perform better than the Scottish average for all age groups in 2021/22.

Not only do inequalities in uptake exist across age categories within the cervical screening programme, they also exist across deprivation categories.

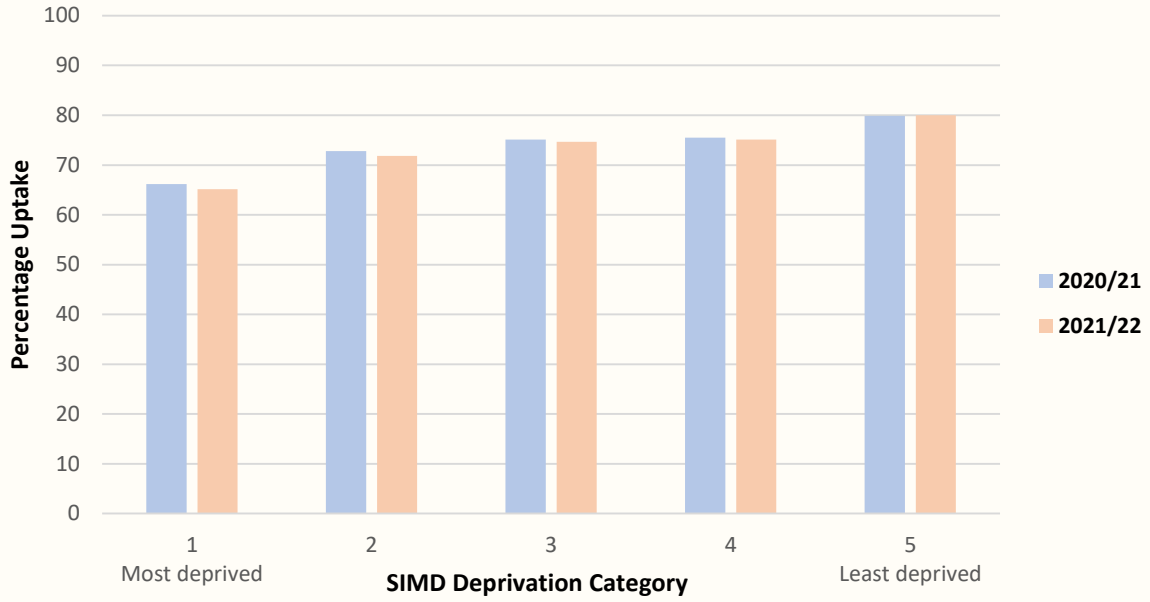


Figure 7 Percentage uptake of cervical screening within NHS Borders, by deprivation quintile for 2020/21 and 2021/22

Uptake of cervical screening shows a very clear trend in Borders, with uptake being lowest in the most deprived parts of the population (65.1% in 2021/22) and highest in the least deprived (80% in 2021/22). This is a gap of 14.9% between the most and least deprived areas of Borders.

This trend was observed in 2020/21 as well, with uptake decreasing across the two years for almost all categories except for the least deprived. The HIS standard of 80% uptake was only achieved in the least deprived category in 2021/22. It is worth noting that other inequalities do exist within the screening programmes, despite not being included within national performance measures. These include differences in uptake due to age, sex, accessibility, ethnicity, language and learning difficulties.

Finally, uptake of cervical screening can be analysed by HPV vaccination status. This vaccine was introduced in 2008 and is now offered to all individuals between 11 and 13 years old in Scotland. In 2021/22, uptake in screening amongst those 25-31 years old who were fully vaccinated was 70.4% in Borders. Uptake was only 61% in those of the same age with incomplete vaccination, and was even lower (45.8%) in those with no HPV vaccine history. This may be due to immunised women being more aware of the risk of cervical cancer as a result of contact with the immunisation programme.

Screening performance and outcomes

The average turnaround time for results coming to NHS Borders varied between 15 and 17 days across Q1-Q4 in 2021/22. This was similar in 2020/21, although Q1 in this year had an average of 12 days.

There is a HIS standard that requires a minimum of 80% of individuals receive their screening results within 14 days from the date of the sample being taken. This information is not available for Borders specifically, but some information does exist for the 2 laboratories in Scotland.

In 2021/22, the turnaround time for 95% of all screening tests processed within Scotland varied between 18 and 38 days across the quarters. The range was slightly wider in 2020/21, with turnaround time varying between 14 and 43 days that year.

The number of new cases of cervical cancer diagnosed each year is very low in the Borders and fluctuates from year to year, as would be expected given the small numbers.

Identified risks

There is a risk to resilience within the call-recall function of the cervical screening programme in Borders. The team is small and so any absence has a significant impact on function.

There is a risk noted around opportunistic cervical screening samples taken within BGH wards for in-patients by staff who do not have access to SCCRS. This is alongside variation in clinical standards and correct procedures.

There is a risk that out of date vials will be used for cervical smear taking within the BGH and GP practices.

There is a risk that pregnancy exclusions are not being applied consistently in SCCRS, which means that screening opportunities could be missed.

Adverse events

There was a national incident in June 2021 regarding individuals who had a sub total hysterectomy being incorrectly excluded from the cervical screening programme. All of these people have since been identified and invited for assessment, with no cancers found. This audit was extended to include all women with an SMR code of total hysterectomy and a no cervix exclusion in SCCRS. To date in Borders, two women from over 4000 audited have been found to have been inappropriately excluded from cervical screening as they did have a cervix. This audit will be completed by March 2024.

In spring 2022, two GP practices used an out-of-date vial for cervical smear taking, and so the patients had to be invited for another smear test with the standard 3 month recovery period.

In January 2023, Monklands screening lab discarded a sample that had not yet had cytology due to an I.T. upgrade issue. Three Borders patients had to be invited back for screening due to this. In the same month, a practice nurse had taken a sample for a patient but had not printed the label at the time of the consultation. They entered another patient's notes shortly after this and created a sample label for the wrong patient. The patient had to return for a repeat sample.

Diabetic Eye Screening (DES)

The Diabetic Eye Screening programme (DES) was formally known as the Diabetic Retinopathy Screening Programme. The programme aims to check for diabetic retinopathy, which is a condition caused when high blood sugar levels can damage the small blood vessels in the retina.

People with both type 1 and type 2 diabetes are at risk of developing the condition and often there are no symptoms in the early stages of the condition. If the damage is not treated then it can lead to serious complications, including blindness. Untreated diabetic retinopathy is one of the most common causes of sight loss in working age people[14].

The screening test involves a screener taking a digital photograph of the back of the eye to detect any damage and this can take between 10 to 30 minutes. The retinal images are then downloaded for assessment and grade assignment in Optomize, the DES IT system.

Eligibility

Everyone diagnosed with diabetes, and on the SCI Diabetes database, over the age of 12 years old is invited to have DES every 2 years if they are at low risk of sight loss. Those who are at high risk of sight loss should be invited every 6-12 months for screening. Pregnant women are invited three times during/post pregnancy, due to the risk of gestational diabetes.

An individual's image grading outcome and screening history are used to determine their risk profile.

Service delivery in NHS Borders

NHS Borders commissioned NHS Lothian in 2008 to provide programme management, retinal image grading, and call-recall admin services for the Borders DES programme. NHS Borders provides the DES screeners and cameras.

The DES service currently screens at the following locations:

- Borders General Hospital
- Coldstream Health Centre
- Eyemouth Health Centre
- Hay Lodge Health Centre, Peebles
- Hawick Community Hospital
- Hawick Health Centre
- Jedburgh Health Centre
- Kelso Community Hospital
- Knoll Hospital, Duns
- Selkirk Health Centre

[14] PHS: Diabetic eye screening

The DES programme in the Borders is delivered by two (1.95 WTE) screeners, supported by Borders Screening Team, as well as NHS Lothian's Princess Alexandra Eye Pavilion programme manager, graders, and call-recall admin, who manage all screening appointments for Borders screening participants. NHS Borders Ophthalmology Department provide all OCT (Optical coherence tomography) 3D imaging for the DES programme in the Borders, as the low numbers eligible for OCT imaging following DES screening are too low to justify the procurement costs of an additional screening OCT machine.

Where a satisfactory retinal image cannot be obtained by the screeners, patients are asked to make an appointment with a local community optometrist for a slit lamp examination, who feed the results into the DES programme admin.

Areas of good practice

The Borders community optometrist model for DES slit lamp examination widens access to screening across the Borders, enabling those with poor mobility and limited access to affordable public transport to attend a relatively local optician for a screening slit lamp examination rather than having to travel to the Borders General Hospital for an Ophthalmology appointment.

Screening is delivered in a variety of community locations to make it accessible and practical. There are also monthly Saturday clinics for people who have trouble accessing clinics during the working week. Furthermore, the DES programme aims to accommodate inpatients in the BGH who have missed their screening appointment, usually on the same day that this is flagged to the team.

Patients invited to the programme are given a phone call to remind them of their appointment, and to discuss any issues with attending the appointment. This has often led to elderly patients being given an appointment much closer to home than the one they originally received from the Lothian call-recall office.

Challenges

The pool of optometrists that have been accredited by the Borders Ophthalmology Department to provide slit lamp examinations for the DES programme has declined greatly since pre-Covid. Reasons include retirement, staff turnover and financial pressures. The current screening slit lamp fee is £15 and has not been reviewed since the implementation of the DES programme in 2008. Several optometrists have either opted-out of the slit lamp programme, or intend to do so if the fee cannot be increased in line with the standard eye test which is currently £45.

Current pressures in the NHS Borders Ophthalmology department mean that although there are Optometrists willing to be accredited for Borders DES slit lamp examination, there is currently no agreement when this can be achieved. This could result in more patients being referred to Ophthalmology for a DES slit lamp examination in future.

The size and population of NHS Borders only supports the use of two screeners. This means that staff absence can have a large impact on the ability to provide screening in the board.

As with all the screening programmes, and noted in the introduction, the Covid-19 pandemic was a huge challenge, with some of the after effects still being felt and managed.

Follow up and treatment

Results are usually sent to patients within 4 weeks. Individuals' GP and diabetic specialist also receive a copy of the results.

If the result is unclear when it is being reviewed by the team, then the person will be invited back for another test.

If no retinopathy is found on the screening test, and this is the first time this has occurred, they will be invited back for screening after 12 months. From the second time onwards, the screening interval increases to 2 years.

If minor changes are found on the retinopathy screen, then the individual is usually recalled after 6-12 months for monitoring.

Finally, if more significant changes are found, then the individual is referred to a specialist eye clinic for further assessment and investigations. Approximately 1 in 25 people who have the screening test will be referred for further investigations[15].

Uptake and screening performance of DES in NHS Borders

Since the programme moved from Vector to Optomize IT system in June 2020, there have been no official published KPIs for the DES programme. This is due to many, compounding reasons.

Optomize went live during the pause in national screening programmes for Covid-19. The recall dates of those on routine recall were moved back 12 months to enable users to become familiar with the new system whilst coping with the restart of screening in a position of significantly reduced capacity. However, this made it very difficult to recall patients as no-one was technically due for screening, and the call-recall team had to manually search for patients. It emerged the DES collaborative did not order a like for like replacement I.T. system and a stream of fixes and developments were needed for equivalent functionality, particularly in the reporting capabilities. Optomize is still in its embedding phase with work on producing a reliable set of DES KPI's ongoing, and as such, no official KPIs have yet been published.

DES Screening uptake was severely affected after the programme restarted again in August 2020, post Covid-19 lockdown. There was an initial focus on high-risk patients, including pregnant and newly diagnosed, which increases by approximately 5% each year. Across Scotland the numbers being invited and screened was significantly reduced due to staffing issues, closure and slow reopening of screening venues, infection control procedures, social distancing and isolation requirements. The barriers to participating in this programme, or any of the screening programmes were huge across the country and all of these factors

[15] PHS: Diabetic Eye Screening

contributed to the low uptake and consequent DES backlogs across Scotland. Specifically, within the Borders, the service had to be centralised to the BGH at the time. This meant that a lot of people were unable or unwilling to travel long distances for a screening appointment (particularly on public transport), and there was also hesitancy around attending a hospital setting and the perceived risks involved with this, particularly for people who already had long term health problems such as diabetes and may have been shielding.

Furthermore, the above sits alongside changes made to the screening pathway in the DES programme from 1st January 2021. Revised screening intervals (RSI) were introduced, and low risk patients, who met the criteria, were given a 2 year recall. To avoid distorting the demand curve, this was phased in gradually, using a random allocation algorithm, across Scotland and not by Board. This gradual phasing in of the RSI affected the accuracy of the KPI denominator. The proportion allocated either a 1 year or 2 year screening interval varied in each Board, making the establishment of an accurate denominator difficult and a conversion formula had to be applied. Since the RSI has been implemented fully, it has now emerged that recalling patients early, to smooth the bow waves in the demand curve created by Covid-19, results in some patients reverting back to a 1 year recall interval in error.

All of these factors are complex and interlinked. They have understandably meant that no official KPI report has been published as yet. In the meantime, the call/recall office continues to monitor the performance and safety of the programme, using management performance reports. The next KPI report for this programme is due next year, and it is hoped that the 2023/24 report will provide greater clarity about the ongoing performance of this screening programme both within Borders and across Scotland.

Governance and regulation

The NHS Borders Board Screening Coordinator and Screening Services Manager attend the quarterly Lothian DES Governance meeting.

Prior to Covid-19 the NHS Borders Diabetes Managed Clinical Network (NHSB MCN) provided governance for our DES programme. The NHSB MCN has not yet resumed since Covid-19, and so resumption of a Borders DES Governance group has proved difficult. However, it is hoped that a governance meeting we be held in the next quarter to include an Ophthalmology and a Diabetic Team representative.

Internal (IQA) and External Quality Assurance (EQA) activities are undertaken by all image graders, with level 3 graders being assessed by the External Quality Assurance (EQA) system provided, and hosted by Aberdeen University. All graders must participate in at least 3 out of 4 rounds of the EQA scheme; however, its main purpose is to show that an equitable and high quality grading standard is maintained across all 9 grading centres in Scotland.

Identified risks

There is an identified risk around the capacity of Ophthalmology and Diabetes Consultants to attend governance meetings around their clinical workload.

As detailed above, service delivery resilience can be challenging with only two DES screeners in post.

A risk is noted around clinic transport for the programme, as the current DES transport is diesel. NHS Borders policy may require DES to procure an electric vehicle in the near future, and funding will be required for this.

There is a lack of capacity within the Ophthalmology department to process and perform new slit lamp accreditation requests which reduces the number that can be performed in the community, and increases demand further on the Ophthalmology department.

Adverse events

An IT system user error in August 2021 led to 29 Borders patients who were newly registered onto the DES Optimise IT System in August and September 2021 not being sent an invitation for their first Diabetic Eye Screening (DES) within 90 days by the Lothian call-recall office. Fortunately, those who went on to attend a screening appointment showed no evidence of harm, and no referrals to Ophthalmology were necessary.

Pregnancy and Newborn

Pregnancy and newborn screening involves a variety of different tests, offered to mother and baby, at stages throughout pregnancy and in the early neonatal period.

There are three primary purposes of pregnancy and newborn screening tests:

- To identify whether a woman has a condition that could harm her baby without treatment during the pregnancy or shortly after birth.
- To identify whether the baby has, or is at risk of, conditions such as neural tube defects, sickle cell disorders and thalassaemia.
- To identify if the baby's development is normal, and whether they have conditions that require treatment in utero, shortly after birth, or will limit the baby's chance of survival.

Eligibility

All pregnant mothers and newborn babies within the UK are eligible for screening at specified time points during pregnancy and after birth.

Service delivery

Pregnancy screening is integrated into routine maternity care for pregnant woman. Most screening blood tests are carried out by community midwives at antenatal appointments in local venues, but sometimes are performed by hospital midwives within the maternity department at the Borders General Hospital (BGH). Ultrasound scans for fetal anomalies are performed by sonographers at the BGH.

Newborn screening is offered to all babies born within NHS Borders. Hearing tests are carried out at the BGH, and bloodspot tests are usually performed at home by community midwives (although some may occur within the hospital setting if a baby is an inpatient at the time of the test). Movers in to the Board under the age of 12 months are offered a bloodspot test in Ward 15 Ambulatory Care if they cannot provide their health visitor with a bloodspot result.

Areas of good practice

With regards to the blood spot testing programme, Midwifery produced a local training guide, engaged in training sessions, one to one supervision and introduced new lancets in an effort to mitigate the persistent number of avoidable repeat tests within Borders.

Delays in transit time of some screening samples was greatly affected by national Royal Mail postal strikes this year. The BGH lab arranged blood bike transportation of blood spot screening samples for most of the strike dates, and within the community consideration is given to when certain antenatal clinics are booked, so that blood samples can be posted in a timely fashion (taking into account both Scottish and English bank holiday dates).

The newborn hearing screening programme in Borders is now located on the Pregnancy Assessment Unit. Two more maternity staff (band 4) have been trained which provides cover later in the day, and has reduced the need for extra clinics. There are clinics on Saturdays and

occasional Sundays, which may be beneficial for some families where a parent returns to work before the hearing screening appointment date.

Challenges

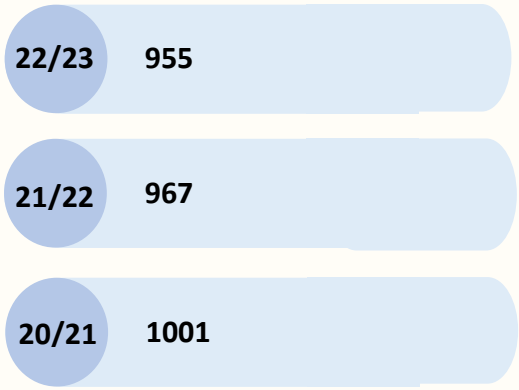
Over the past few years there have been some specific challenges within the pregnancy and newborn screening programme. Postal strikes, and the Royal Mail service in general have impacted on the timely delivery of blood tests to the appropriate laboratories.

The conflict in Ukraine saw movement of families into Borders from that area. It was difficult to locate these families at times, often resulting in extremely challenging deadlines for the test to be taken. It was also very difficult to explain the blood spot test to these families, and the reason why it was important.

Uptake, performance and clinical outcomes

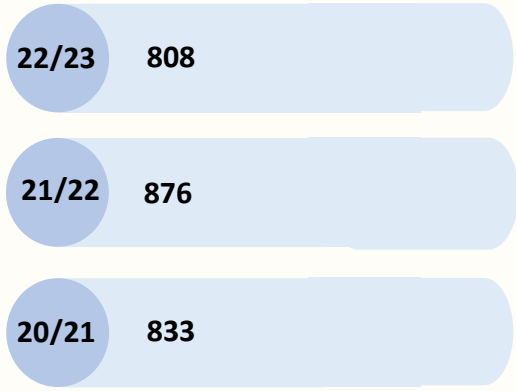
Much of the data that we have available around screening was taken from BadgerNet. The quality of the information that could be pulled from the IT system was uncertain and so the figures detailed below may not be a fully reliable representation of the KPI achievement for the last three years. This appears to be mostly due to issues around the use of BadgerNet and how to appropriately record information so that KPI figures can be pulled.

Number of booking appointments in NHS Borders



The data about booking appointments is from BadgerNet - it was not possible to know whether this figure included miscarriages, terminations, or movers into/out of the area, and so that should be kept in mind when reviewing the data.

Number of live births in NHS Borders



In 2020/21 there were 833 live births in NHS Borders. Of these, 68 babies were resident in another health board and so their ongoing care was the responsibility of that health board, leaving 765 babies for whom NHS Borders was responsible for ongoing care.

In 2021/22, there were 56 babies who were resident in another health board, leaving 820 the responsibility of NHS Borders.

In 2022/23, 64 babies were resident out of the area and so only 744 were the responsibility of NHS Borders in terms of going care.

Screening tests in pregnancy

Condition	Rationale	Test and Timing
Haemoglobinopathies	Haemoglobinopathies such as sickle cell disease and thalassaemia are inherited blood disorders that are passed on from parents to children genetically[16]. They are serious and life-long conditions, where people can experience severe pain, anaemia, and infections. Screening for these illnesses aims to allow early treatment for the baby in order to prevent damage to their liver, heart, and spleen. https://www.nhsinform.scot/healthy-living/screening/pregnancy/blood-tests-during-pregnancy	Maternal blood test and Family Origin Questionnaire (FOQ) *Sometimes a paternal blood test is also offered, as this can provide more accurate screening results* During or shortly after first midwife visit (before 10 weeks)
Hepatitis B	This virus is transmitted via contact with bodily fluids, in this context – from mother to baby during birth. The virus attacks the liver, causing inflammation and sometimes liver failure, scarring and/or cancer. Chronic disease is more likely in babies and children who are infected with the virus[17]. Screening aims to reduce the number of babies who have hepatitis B, and subsequently develop severe liver disease. https://www.nhsinform.scot/illnesses-and-conditions/stomach-liver-and-gastrointestinal-tract/hepatitis-b/	Maternal blood test Between 8-12 weeks
Syphilis	Syphilis is a bacterial illness that can be transmitted from a mother to her baby during pregnancy and/or childbirth. If a woman has syphilis during pregnancy (at any of its three clinical stages), there is a risk of the unborn baby developing congenital syphilis. Screening aims to reduce the number of miscarriages and stillbirths due to syphilis. It also aims to reduce the number of babies born with congenital syphilis as this can lead to serious life changing or life altering problems.	Maternal blood test Between 8-12 weeks
HIV	Human Immunodeficiency Virus is a virus which is transmitted through bodily fluids, in this context - from mother to baby during pregnancy, birth and breastfeeding. This virus attacks elements of the immune system, weakening it and making a person susceptible to both common and rarer infections and illness. Screening aims to reduce the number of babies born with HIV, and therefore the associated consequences of living with this illness.	Maternal blood test Between 8-12 weeks

[16] NHS: Blood tests during pregnancy
[17] NHS: Hepatitis B

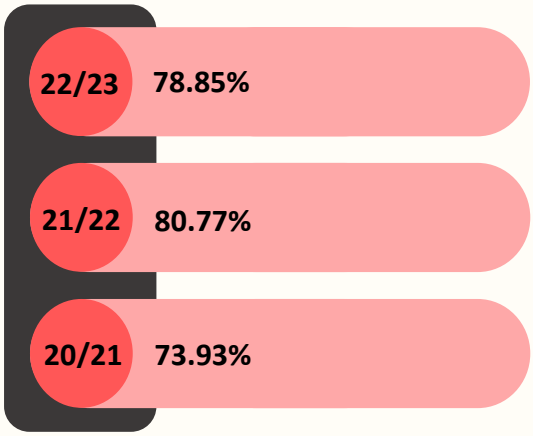
Condition	Rationale	Test and Timing
Down's Syndrome, Edward's Syndrome and Patau's Syndrome (trisomy 13, 18 or 21)	These syndromes are genetic conditions, most of which are caused by a chance mutation. In all of these syndromes, the baby has an extra copy of a particular chromosome (chromosomes are where genetic material is held in the body, and we usually have a pair of each of the 23 chromosomes). Pregnancies where the baby has a form of Edward's and Patau's syndrome have a higher risk of miscarriage and stillbirth. Those who survive can have severe medical problems, and some may have a form which is life-limiting. Down's syndrome is not considered to be a life-limiting condition, but children born with this can have a higher risk of certain medical conditions. Screening for these syndromes allows families to make informed and supported decisions about the risk of their baby having the conditions, and offers the choice of going on to have an invasive diagnostic test.	Maternal blood test and ultrasound scan *Can choose to screen for all, some, or none of the conditions* Between 11-14 weeks *If the woman is between 14-20 weeks, then they can only be screened for trisomy 21, and only with the blood test*
Fetal anomaly	This test is a detailed ultrasound scan, usually performed by a sonographer. The fetal anomaly ultrasound scan identifies serious fetal anomalies which are incompatible with life or associated with morbidity. It also identifies anomalies which may benefit from intervention during the pregnancy, or soon after the birth of the baby. The scan can be dependent on the position of the baby, maternal weight, fluid around the baby and scarring in the abdomen from previous procedures. It also is unable to identify anything that might develop later on in pregnancy, or any problems that aren't structural in nature.	Ultrasound scan Between 18-21 weeks

Condition	Rationale	Test and Timing
	Conditions that can be identified at the fetal anomaly screening include: • Anencephaly • Open spina bifida • Cleft lip • Diaphragmatic hernia • Gastroschisis • Exomphalos • Serious cardiac anomalies • Bilateral renal agenesis • Lethal skeletal dysplasia • Edwards syndrome • Patau's syndrome Detecting any developmental issues during pregnancy allows for early support to be offered to parents in order for them to make informed decisions. It also enables interventions to be carried out in utero if required, and for plans to be made around birth and early life with the aim of improving outcomes.	

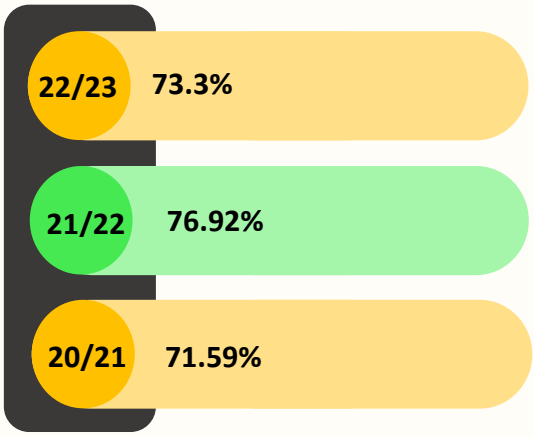
Haemoglobinopathies

The percentage of women offered haemoglobinopathy testing increased slightly in 2021/22 (90.61% to 92.86%) but then declined again in 2022/23 (91.83%). It is unclear whether the pregnancies that were recorded as not being offered testing were genuinely not offered or whether this was not recorded correctly on the BadgerNet.

Percentage of pregnancies in NHS Borders where a haemoglobinopathy screening result was available



Percentage of pregnancies in NHS Borders where the screening result was available by 10 weeks + 0 days



The percentage of pregnancies where a screening test result for haemoglobinopathies was available also increased in 2021/22 but declined slightly again in 2022/23, though not to as low as 2020/21. In none of these years however was the essential national target met.

Women should receive a haemoglobinopathy screening result by 10 weeks + 0 days' gestation. In 2020/21 and 2022/23, the essential national target for this was met. In 2021/22 there was again an apparent increase compared to the other two years, and the desirable national criteria was met in this time period.

	Total number on whom an antenatal screening sample was performed	Number of women with an abnormal haemoglobinopathy screen at any gestation
April 2022 – March 2023	869	342
April 2021 – March 2022	884	254
April 2020 – March 2021	894	200

Table 6 The number of women who had a haemoglobinopathy screening result, and the number of abnormal results in NHS Borders for April 2020 - March 2021, April 2021 - March 2022 and April 2022 - March 2023 (BadgerNet)

The number of women with an abnormal result at screening has been increasing over the last three years, and understandably, so too have the number of babies born to mothers with an abnormal result.

We have not been able to obtain information regarding the completion of the Family Origin Questionnaire due to resourcing issues within our local laboratory.

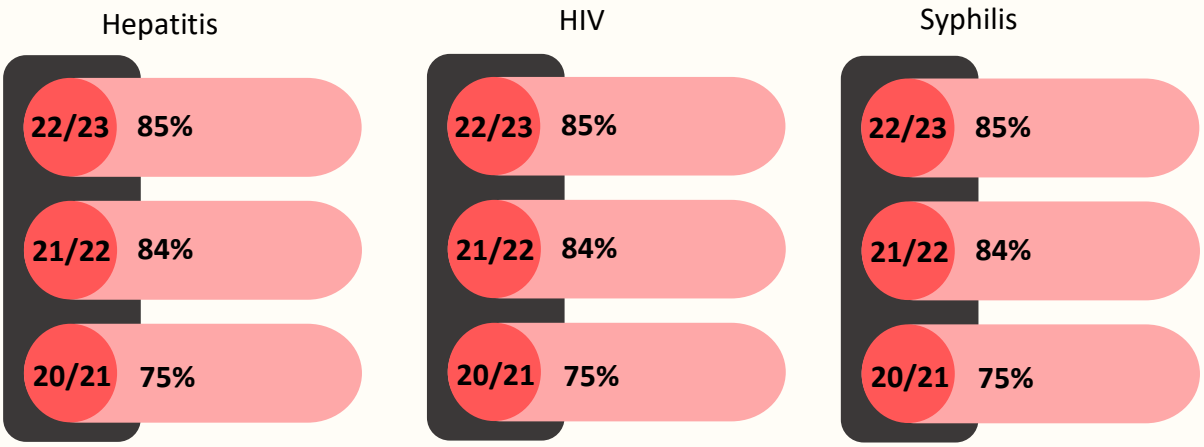
We were also unable to obtain numerator data for the final KPIs in this section (timely offer of prenatal diagnosis, timely reporting of newborn positive screen, and timely receipt into specialist care) as the information was not available to pull within the local IT system.

Infectious Disease Screening

There are three tests offered for infectious diseases in the first trimester; hepatitis B, syphilis and human-immunodeficiency virus (HIV).

The percentage of women offered hepatitis B, syphilis and HIV testing in NHS Borders has remained fairly similar over the past 3 years, with a slight increase in 2021/22 (91% to 93%), and then decline again in 2022/23 (92%).

Percentage of pregnancies in NHS Borders where a screening result was available



The percentage of women who have had a hepatitis B, syphilis and HIV screening result available in NHS Borders has been the same each year for the past three years. It is not surprising that these are the same, given that the tests are offered and conducted at the same time if consent is given.

For each of these three tests, the percentage of pregnancies with a result available has been increasing. This is potentially due to a decline in the number of women who had a test performed but no result available (decreased from 143 in 2020/21 to only 58 in 2022/23). The numbers of women who were recorded as not having been offered these tests has varied over the last years (92 in 2020/21, 67 in 2021/22 and 77 in 2022/23).

We were unable to access data regarding test turnaround times due to resourcing within our local laboratory.

We were also unable to obtain numerator data for certain KPIs for hepatitis B (treat/intervene, timely assessment of women with hepatitis B, and timely neonatal vaccination and immunoglobulin) as the information was not available to pull within the local IT system.

There have been no cases of maternal syphilis or HIV recorded over the last three years on the IT system or within our sexual health service, and so the last KPI for syphilis (3.3 – treat/intervene) as well as HIV (4.3 – treat/intervene) is not applicable.

Down's Syndrome, Edward's Syndrome and Patau's Syndrome

There are no national targets for the coverage of trisomy 13, 18 or 21 screening in Scotland. In Borders, the percentage of eligible women for whom a completed trisomy 13, 18 or 21 screening result was available from the first trimester has varied across the years from 2020 to 2023; 58% in 2020-2021, rising to 68% in 2021-2022 and dropping a little again to 65% in 2022-2023.

	% of screens in Second trimester
April 2022 – March 2023	9.3%
April 2021 – March 2022	8.7%
April 2020 – March 2021	13.7%

Table 7 Percentage of second trimester screens (trisomy 13, 18 and 21) for NHS Borders between 1st April 2020 and 31st March 2023 (Down's syndrome screening laboratory)

Ideally screening should take place in the first trimester, but a small percentage of women are screened in the second trimester. The percentage in NHS Borders has been improving over the past 3 years and is consistently below the Scottish figures, which is the preferred situation.

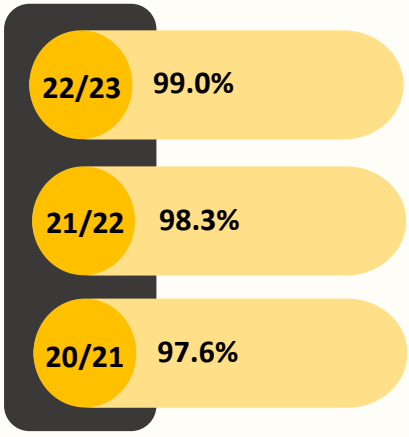
	Percentage who declined Down's syndrome screening	Percentage who declined Edward's and Patau's syndrome screening
April 2020 – March 2021	14%	15%
April 2021 – March 2022	12%	11%
April 2022 – March 2023	17%	7%

Table 8 Number and percentage of women who declined screening for Down's syndrome, and Edward's/ Patau's syndrome between April 2020 and March 2021 (BadgerNet)

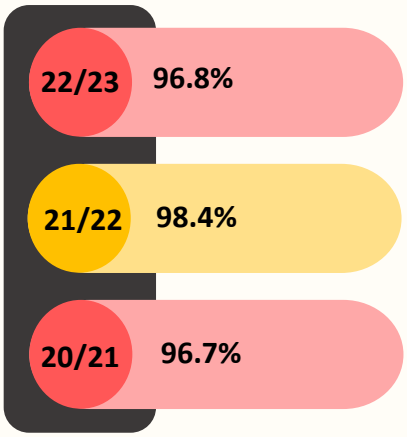
The figures in the table above show the percentage of women who have declined screening for both Down's syndrome and Edward's/Patau's syndrome, which were taken from BadgerNet. It is unclear how well this is documented within the IT system, and reliability is slightly called into question by the differences in decline rates between the syndromes (given that the screening for these syndromes is offered at the same time).

Percentage of completed request forms for trisomy in NHS Borders

First Trimester



Second Trimester



A request form for trisomy screening is considered incomplete if it is missing any of the following information: sufficient information for the woman to be uniquely identified, woman's correct date of birth, maternal weight, family origin, smoking status, ultrasound

Within NHS Borders, there has been an improvement in the percentage of complete request forms for first trimester trisomy screening over the past 3 years, with all year's meeting the essential national target for this. There had been an improvement in the second trimester request forms between 2020/21 and 2021/22, but this has declined again in 2022/23. NHS Borders only met the essential national target in 2021/22 for second trimester screening.

All samples sent by NHS Borders were within the correct gestation – none were sent at gestations that were considered too early or too late.

	Number of samples arriving too late for analysis
April 2022 – March 2023	5
April 2021 – March 2022	4
April 2020 – March 2021	4

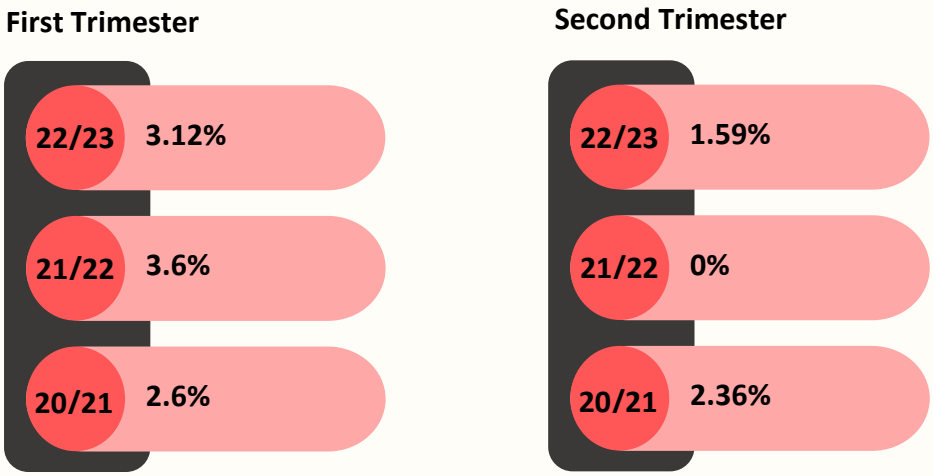
Table 9 Number of samples arriving late to the lab from NHS Borders in 2020/21, 2021/22 and 2022/23

There is a consistent pattern of some samples arriving at the laboratory too late for analysis (samples have 72 hours to arrive at the laboratory, after which due to sample degradation they are unable to be analysed and a further sample is required for analysis).

Issues within the postal service are felt to be the major factor in samples not being transferred to the laboratory within the appropriate timeframe. Official postal strikes from May 2022 had

a notable significant impact on the delivery of samples, but there have been ongoing problems with the standard of the postal service out with this timeframe.

Screen Positive Rate for Trisomy 21 in NHS Borders



The screen positive rate for trisomy 21 screening in the first trimester in NHS Borders declined a little between 2021/22 and 2022/23, but the rate across all three of the previous years has not met the essential national target.

For second trimester screening, the total percentage of women with an increased chance of any of these syndromes rose between 2021/22 and 2022/23, but Borders was again out with the national essential range. These lower results may be associated with a lower than expected detection rate.

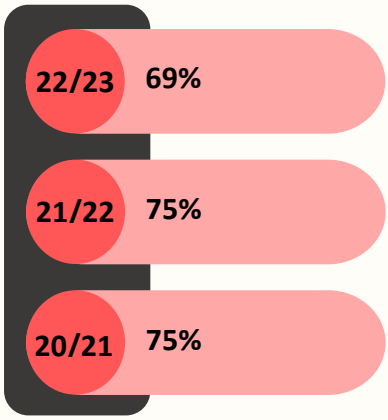
It is important to note due to the size of NHS Borders, the numbers actually screening positive for these syndromes are very small. The percentages should therefore be interpreted with caution.

It was not possible to obtain details about the time to intervention within Borders – that data could not be pulled from the IT system.

From the information recorded on BadgerNet it appears that every woman who was given a higher chance result over the past three years chose to not have any further testing. This means that no pre-natal diagnosis for Down's syndrome was performed, and so KPI 5.7 is not applicable.

Fetal Anomaly Scan

Percentage of women being scanned between 18+0 and 22+6 weeks in NHS Borders



The percentage of women being scanned within the target range of 18+0 weeks and 22+6 weeks has declined between 2021/22 and 2022/23. The number with no scan data recorded in BadgerNet has increased over the last 3 years (162 in 2020/21, 191 in 2021/22 and 245 in 2022/23), so this may be a potential explanation for the apparent drop in percentage of women scanned within the target timeframe.

The number of women having a fetal anomaly scan, but outside of the target window declined from 84 in 2020/21 to 48 in 2021/22. This remained stable at 49 in 2022/23.

There were very low numbers of pregnancies with a fetal anomaly detected over the past 3 years, although they have been increasing slightly (3 in 2020/21, 8 in 2021/22 and 11 in 2022/23).

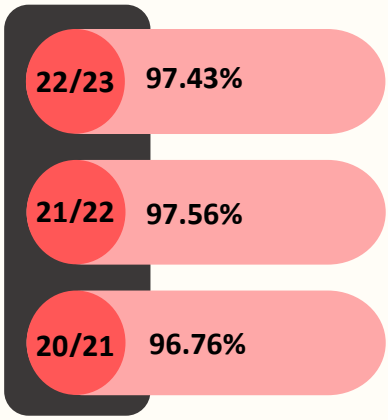
Although we were able to find out the number of scans that had an anomaly detected, we were unable to obtain data specifically regarding serious cardiac anomaly (and how many went on to have this confirmed). We were also unable to obtain data for time to intervention post-scan, as well as diagnosis as this requires referral to a tertiary centre (which for NHS Borders means a referral out of Board).

Screening tests in newborn period

Condition	Rationale	Test and Timing
Hearing	There can be many reasons for hearing loss in neonates and early childhood, from genetic causes to infections. It can be difficult for parents and carers to identify reduced hearing in this age group, and so a formal hearing test is offered in the first few weeks of life, in order to identify those with a likelihood of hearing loss. The aim of this test is to detect any problems with hearing as early as possible. This means that support and information can be offered to families (who often have not experienced hearing loss before) in order for babies to have a better chance of developing language, speech and communication skills.	Earpiece in baby's ear, or sensors on their head/neck with an earpiece or headphone in or over their ear First few weeks of life
Blood spot test	The blood test aims to detect nine serious inherited conditions that are not identifiable from physical examination alone. These diseases are associated with various issues such as developmental problems, learning difficulties, growth restriction, anaemia, pain, breathing problems, digestive issues, life-threatening illness and even death. Detecting these conditions early enables early treatment which can improve health, and prevent severe disability and/or death. The blood spot test screens for: • sickle cell disease • cystic fibrosis (CF) • congenital hypothyroidism (CHT) • phenylketonuria (PKU) • medium-chain acyl-CoA dehydrogenase deficiency (MCADD) • maple syrup urine disease • isovalericacidaemia (IVA) • glutaricaciduria type 1 (GA1) • homocystinuria (HCU)	Blood test from a baby's heel 5 days after birth

Hearing

Percentage of babies' resident in NHS Borders being screened within 4 weeks of birth

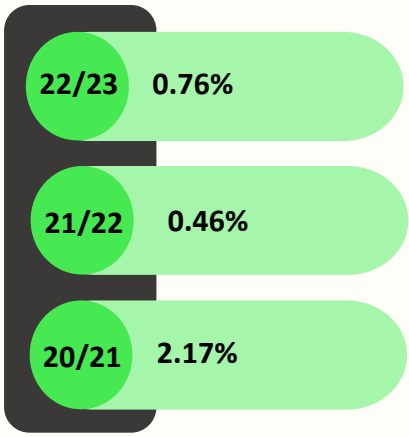


Within NHS Borders, the percentage of babies having screening within 4 weeks of birth has been consistently around 97% for the past 3 years.

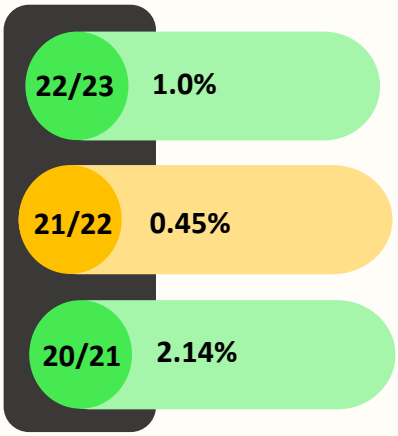
The lowest was in 2020/21, and this appears to be due to more babies missing their appointment (8 babies missed an appointment during that time frame, compared to 3 in 2021/22 and 1 in 2022/23). This is potentially related to Covid-19, as April 2020 - March 2021 was at the peak of the pandemic.

A large number of the remaining babies are either out of coverage area (8 in 2020/21, 7 in 2021/22 and 8 in 2022/23), or had their test after 4 weeks (8 in 2020/21, 10 in 2021/22 and 8 in 2022/23). Other less common reasons for not being screened include death, parental decline and the test being contraindicated.

Percentage of babies' resident in NHS Borders who do not show a clear response in both ears at AABR1



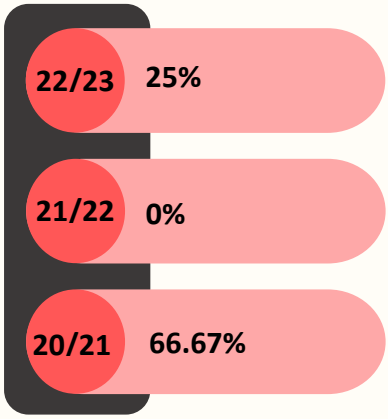
Percentage of babies' resident in NHS Borders who required an immediate onward referral to audiology



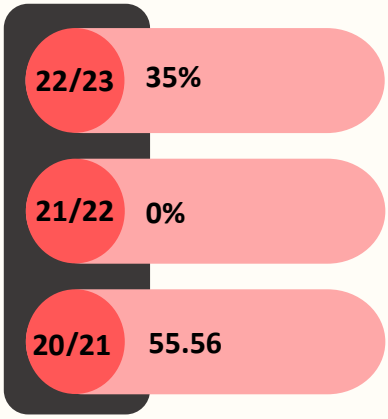
The proportion of well babies who did not show a clear response in both ears at the first test (AABR is the test type used in Borders) has been within the desirable range for all three years. The percentage of babies screened who required an immediate onwards referral to audiology has also been within essential limits for the past three years, and within the desirable range for the last two years.

Percentage of babies' resident in NHS Borders requiring audiology referral who:

Received an appointment within 4 weeks of screen or by 44 weeks gestational age



Attended an appointment within 4 weeks of screen or by 44 weeks gestational age



Only 2/3rds of the babies who required an onward referral in 2020/21 received an appointment within 4 weeks - the remaining babies were offered an appointment but it was out with the 4 week window. During the same year, just over half of babies requiring audiology review babies attended an appointment within 4 weeks. Of the remaining babies, only 2 didn't attend at all, the rest were seen but out with the 4 week window.

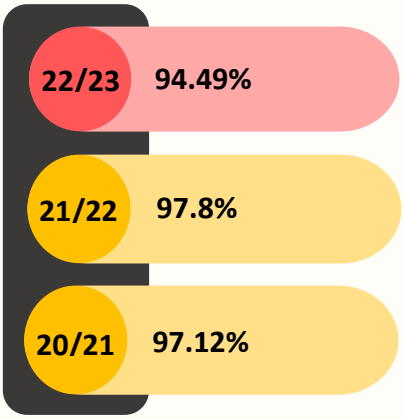
In 2021/22 a very small number of babies were referred (4). None of these babies were offered an appointment within 4 weeks and so none were seen within 4 weeks. 3 of the babies did attend an appointment at a later date, and the outcome of the 4th baby is not known.

In 2022/23, 25% of babies were offered an appointment within 4 weeks. The remaining babies were all offered an appointment but out with the 4 week window. In the same year, 25% of babies attended an appointment within 4 weeks, with the rest being seen but at a later date.

There is the potential that some of these delays were due to recovery in waiting times within the audiology service after the peaks of Covid-19. The numbers are very small with regards to these performance indicators however and so it is difficult to infer any meaningful patterns or trends.

Blood spot test

Percentage of babies' resident in NHS Borders with a bloodspot test result by 18 days of age

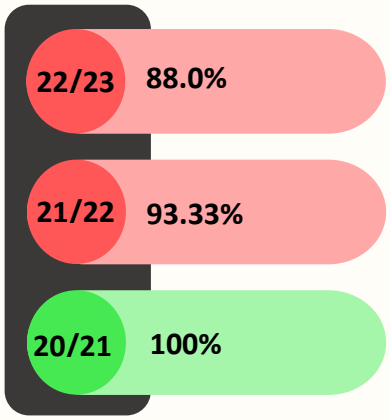


In 2020/21, most babies for whom NHS Borders was responsible had a blood spot test result recorded (99.7%), however, only 97.12% had a blood spot result recorded by 18 days of age. The reason for some blood spot tests being recorded after 18 days of age is likely due to the high number of avoidable repeat tests that were noted in that same year.

In 2021/22, 99.8% of babies for whom the board was responsible had a blood spot test recorded, but only 97.8% of these was within the 18 day time frame. Similarly, in 2022/23, 99.7% of eligible babies had a blood spot test recorded, but there was a decline in the percentage completed by 18 days of age – this dropped to 94.49% which was out with the essential national target level.

A partial explanation for this decline in performance may be that 33 of the 39 babies whose blood spot test was recorded after 18 days of life were born in November and December 2022. This was when there were postal strikes, and may explain the delay in the results being obtained. Furthermore, during this year, as a result of the conflict within Ukraine, there were babies who moved into NHS Borders from that region. It was difficult to initially locate some of these older babies and their parents, and also challenging to communicate with them vital details such as where they had to take their baby for the blood spot test. In one instance a community nurse was required to attend a hotel to explain the importance of the test and to take the blood spot test from a particular family.

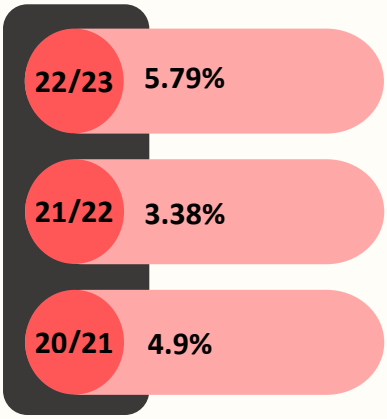
Percentage of movers-into NHS Borders who had blood spot recorded within 21 days of notifying the move



It is important that systems are in place to identify babies without a blood spot test in a timely fashion. In the Child Health Records Department (CHRD) in NHS Borders, a report is run on SIRS which can then be downloaded the next day, so that overdue reports can be chased up. This is performed twice a week (run on a Friday, downloaded on a Monday, and run on a Wednesday, downloaded on a Thursday).

One of the reasons that children may not have a blood spot test recorded is movement into the country, or from one health board to another. For this reason, CHRD keep track of babies who move into NHS Borders and their blood spot status. Performance on this measure in 2020/21 was 100% for Borders and within desirable national levels. Performance has declined over the last 2 years and fallen outside of the essential national criteria.
The reasons why a result was not recorded within 21 days are mostly due to the baby having a blood spot test but outside of the required window.

Percentage of samples requiring an avoidable repeat in NHS Borders



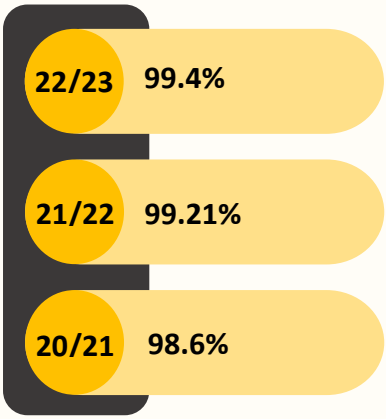
Samples which have an avoidable failure cause unnecessary pressure on the system, delays, work for staff (including laboratories), and distress for families. In all three of the previous years, Borders has been outside of the essential national target for these.

The most common reasons are due to an insufficient sample being sent to the laboratory or a missing/incorrect CHI number. Other reasons include incorrect application, sample being

from a baby who was < 4 days old, sample was compressed/not dried, samples being too long in transit, and finally the use of an expired card.

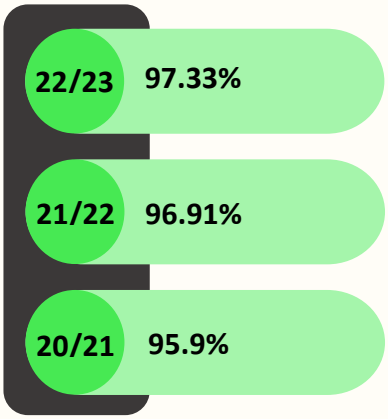
Levels in 2022/23 were the highest of the three years. Most of the increase was due to insufficient samples being sent – these were double that of the previous year. More samples were also delayed in transit compared to previous years.

Percentage of samples with a missing CHI number in NHS Borders



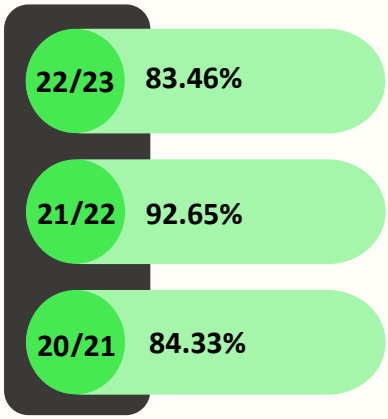
The number of samples with a valid CHI number has been slightly increasing over the last three years due to staff having a colleague double check the form where practicable.

Percentage of first blood spot samples taken between 96-120 hours of life in NHS borders



Across the previous 3 years, the majority of blood spot samples are being taken within the correct age range in NHS Borders, meeting the national desirable criteria. The percentage has also been improving across this time frame.

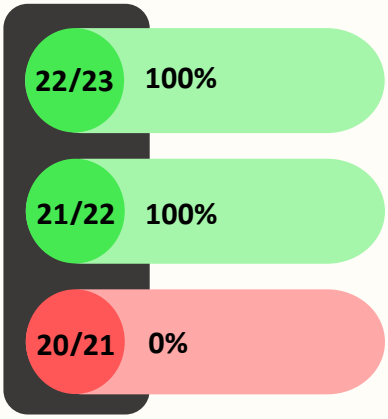
Percentage of blood spot samples received less than or equal to 3 working days of sample collection in NHS Borders



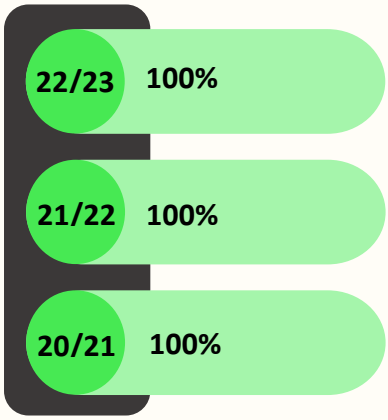
In 2022/23 there was an increase in the numbers of blood samples that were delayed in transit. Covid-19 is likely to have played a significant role in the 2020/21 low figures, but it is difficult to know the exact cause behind the decline again in 2022/23. It is possible that the postal strikes were a factor in the delay between collection and receipt in the laboratory. The team are careful about when clinics are scheduled, and consider both Scottish and English bank holidays when arranging blood tests, due to the fact that they need to be posted to the relevant labs.

Percentage of second blood spot samples taken in NHS Borders for:

Raised IRT (cystic fibrosis test) between 21 - 24 days of life

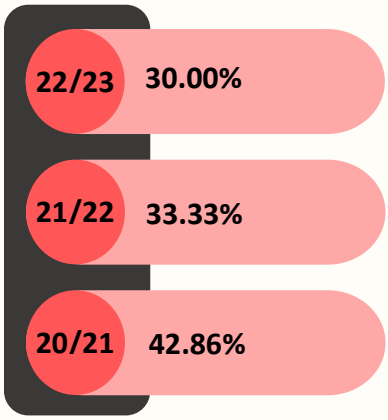


Borderline TSH between 7 - 10 days of life



With regards to second blood spot samples, and the age range at which they are taken, it is very difficult to interpret or extract any meaningful trends because the numbers in question are incredibly small. It can be highlighted that in 2021/22 and 2022/23, any repeat blood spot tests that were required for cystic fibrosis or congenital hypothyroidism were taken in the correct age windows.

Percentage of second bloodspot samples taken on or before day 28 for preterm infants (or on day of discharge if it comes before this)



Additionally, second blood spot samples for preterm infants should be taken on or before day 28 (or on day of discharge if it comes before this). Across all three years, NHS Borders is performing less well for this, and the percentage has been worsening over the three years. The blood samples appear to be taken later than required. Again, however, the numbers being analysed are very small, and so it is difficult to come to reliable conclusions regarding these.

Across all three of the years, for Scotland, 100% of all screen positive infant metabolic diseases (excluding homocystinuria), and screen positive congenital hypothyroidism were referred onwards within 3 working days.

The data is not available for NHS Borders specifically, but it would follow that the board was also at 100% for this performance metric.

Within NHS Borders between April 2020 and March 2023 there has only been one positive result from the blood spot tests. This baby was referred onwards and seen by 9 days of age.

Identified risks

There are certain risks that have been identified and are under continual review within the pregnancy and newborn screening programme in NHS Borders. This information has been taken from the local risk register.

- Within the sonography department there is a risk of lack of staffing causing interruption to the fetal anomaly scanning programme. The sonography workforce is proactively managed, along with their workload to mitigate this risk. There are further risks that a screening result might be inaccurately interpreted or documentation incomplete. This is kept under review, helped by the small team who work closely together, sharing best practice.
- There is a risk that women may miss the opportunity to have screening. This risk is mitigated by keeping staff training up to date, and having clear protocols and guidance for the screening programme.
- There is a risk that samples may be delayed in getting to the relevant laboratories. Clinics are planned around Scottish and English bank holidays, courier and transport

needs are regularly reviewed, and NSD are currently reviewing their logistical role in coordinating courier transport.

- There are challenges around collecting robust local data to monitor the pregnancy and newborn screening programme. Plans are in place to look at the data collection and reporting process going forward, with a public health practitioner currently working on a data quality project in this area, and creating a BAU process for maternity.
- There is a risk that screening results may not be acted upon. This ties into the work above around monitoring the data, and auditing whether or not any positive results have been actioned.
- There is a risk that a baby may miss the opportunity for blood spot testing. There are robust checks within the child health records department to monitor blood spot testing, and follow up any babies who do not have a blood spot test recorded until a result is obtained.
- There was a risk identified due to the lack in UNHS screening manager cover, but an interim manager has since been appointment to the role.
- There is a risk that during the transition to a new CHI system, a period of downtime could impact on the blood spot screening programme and cause babies to be missed. This was discussed nationally and reassurance was given that the downtime would be minimal.
- There is a risk that that the Board Screening Co-ordinator is not notified of an incident or adverse event, particularly when staff change job role. It was decided that maternity services and child health staff need to inform the Board Screening Co-ordinator, the Screening Services Manager and the Director of Public Health of any impending, actual or near miss screening incidents or adverse events within our Board immediately upon discovery.
- There was a final risk noted about patients receiving outdated information if the leaflets on BadgerNet were not kept up to date. It was noted that the leaflets on BadgerNet are automatically updated by Clevermed.

Adverse events

There has been one adverse event in 2022/2023. NHS Borders identified that there were three babies referred for onwards audiology assessment who had a delay in receiving an appointment for diagnostic investigation in Lothian due to a misunderstanding around the correct protocol. A PAG was held to investigate the concerns and develop actions to prevent any further occurrences of this issue. As a result of this, a new screening SOP for protocol, communication and escalation within the hearing screening programme was to be implemented. In addition, there was an action to strengthen the communication across the programme with stakeholders including robust clear communication pathways between NHS Borders and NHS Lothian regarding any policy procedural changes.

Equality

Across all of the screening programmes it is a policy to make them as accessible as possible. Screening is provided as close to home as is feasible within the resources available. For example, the breast and DES programmes use mobile units which visit different areas of the Borders, the cervical programme is carried out through primary care, and the AAA programme uses some community venues to provide options across Borders. In many programmes, appointments are also available in evenings or weekends, in order to improve accessibility.

In addition to this, Borders is in the process of developing an action plan to respond to the PHS Equity in Screening Strategy which will focus directly on the equity of programmes in the Board, as well as a Health Inequalities Strategy which has scope over all of health, healthcare and outcomes, including screening.

Furthermore, there are some specific initiatives that have been taking place within Borders to improve accessibility and screening uptake for all of the population. These include the Confident Conversations initiative with the Wellbeing Service and Health Improvement Team, staff training sessions, and outreach education in the community. There is also work being carried out with the learning disability community to enhance communication and reporting around screening (Bridging the Gap initiative, and ensuring that specific screening programme attendances are explicit questions within the new Learning Disability annual assessment questionnaire).

This year's cancer screening inequalities grant is funding a project which will focus on the impact pregnancy has on cervical screening uptake and defaulting in NHS Borders. Work is beginning in August 2023, and recommendations will be made which will involve midwives, health visitors, GP admin and call-recall to reduce the number of pregnant women who default from cervical screening during pregnancy and do not attend for screening after delivery. This group are at high risk of not being invited again until 5 years after their last invitation.

Conclusion

Looking across all of the screening programmes, NHS Borders tends to perform quite well in comparison to Scotland and other health boards.

In particular, uptake of screening in the AAA, bowel, breast and cervical programmes in Borders was consistently higher than the Scottish average over the last three years. Furthermore, the AAA (April 2020 – March 2023), bowel (Nov 2020 - Oct 2022) and breast (April 2018 - March 2021) programmes in the health board did meet the required essential national targets laid out in the HIS standards and KPIs with regards to screening uptake during their respective time frames.

On the other hand, there are areas were performance was below required national HIS standards and national KPIs.

The percentage of those taking part in cervical screening in NHS Borders following an invitation in both 2020/21 (74.60%), and 2021/22 (74.1%) did not meet the national standard of 80%. In addition, there is a wide variation in uptake within this programme across age categories (61% in 25-29 age group, compared to 71.6% in 60-64 age group in 2021/22).

Furthermore, it is worth noting the stark differences in uptake that are seen across deprivation categories in many of the programmes. The latest data shows that the gap in uptake of screening between the most and the least deprived areas of Borders was 10.6% for AAA, 17.3% for breast, 16.1% for bowel and 14.9% for cervical screening. In most cases, uptake in the most deprived category does not meet the national standards in Borders, whereas it is comfortably attaining them within the least deprived groups. Although not measured within national standards or KPIs, nor readily available in national data, it is known that there are many other inequalities that are also experienced within the screening programmes. These include differences in uptake due to accessibility (particularly felt in rural areas like the Borders), ethnicity, language barriers and learning difficulties. Much work will be done to reduce these inequalities through the action plan that NHS Borders will be producing in response to the PHS Equity in Screening Strategy.

Participants that receive a positive bowel screening result are normally referred for further investigation to endoscopy services within NHS Borders. Further investigation waiting times remain challenging, with the majority of patients within NHS Borders being referred between 4-8 weeks, whereas this should ideally be under 4 weeks. It should be noted that although these waiting times are challenging, Borders is still performing better than Scotland for bowel screening participants when it comes to colonoscopy investigation waiting times.

It is important that any tests a patient has are accurate and complete. Two programmes are worth noting here; within the AAA service, Borders had more USS encounters where the aorta could not be visualised compared to Scotland, and the colonoscopy completion rate in Borders was lower than Scotland.

Many of the issues highlighted within this report where NHS Borders does not appear to meet national standards or KPIs could be attributed to the Covid-19 pandemic, and backlog of patients as a result. Other barriers to meeting some of the standards include postal issues, or problems with national laboratories that are out of the control of the local board.

Data access and quality are another issue that has been flagged whilst compiling this report. There have been no formal published KPIs for the DES programme during the time period that this report is concerned with. This is not Borders specific - it is a national issue and due to a multitude of compounding factors including Covid-19, a new IT system, as well as a change to the screening pathway, all of which occurred in the last 3 years. A report is due next year, and locally, performance and safety is being managed with management performance data within the call-recall office.

Significant issues also exist with meeting the national standards for the Pregnancy and Newborn Screening programme in Borders. This has been raised before through the clinical governance and quality committee, however, the challenge remains around providing assurance of this programme due the scattered nature of the data across teams, systems and borders, as well as the fact that the maternity IT system (BadgerNet) is not set up in the most effective or efficient way to extract required information. Therefore, the task of measuring the performance of the programme requires a large amount of intense resource, which is not dedicated, and this remains a high risk to providing assurance to the board around the performance of this programme.

Finally, it is worth highlighting some of the areas of good practice that are being seen within the different programmes. Accessibility is being improved, with appointments being offered in different areas of the Borders where possible, as well as at different times of day and weekends. Within the DES programme, appointments are accommodated for inpatients in the BGH, and telephone contact made with invitees to reduce DNAs. There are initiatives which try to improve uptake of screening such as Confident Conversations, specific staff screening training, outreach community education sessions, and specific learning disability work to improve conversations around screening in this group, alongside more accurate recording of decision making.

In addition, given that screening provides the opportunity to meet and engage with those who may not otherwise attend a healthcare setting, it is important to note the huge number of potential encounters that the screening programmes in Borders offers. If everyone who was eligible for screening in the health board participated in the relevant programmes, this would equate to just over 180,000 points of contact over a 3 year period (see table 10 below). This is a fantastic example of ‘Making Every Contact Count’, where screening provides a platform to promote other areas of health and wellbeing, as well as sign-posting to local services.

Screening programme	Average number of eligible individuals in Borders in a screening cycle
AAA	859 yearly
Bowel	45,748 2-yearly
Breast	13,108 3-yearly
Cervical	27,523 yearly
DES	5,554 yearly
Pregnancy	974 yearly
Newborn	776 yearly

Table 10 Average number of eligible individuals for each of the screening programmes in Borders for a typical screening cycle

Looking forward

There are projects and developments occurring across many of the different screening programmes going forward.

In light of the National Services Division review of Breast Screening, the service has been considering what framework of services might best meet the needs of the South East Scotland population and demography. The conclusion is that the service would be very keen to lead on a trial of the Satellite Screening Centre concept, along with a pilot of post-code based invitation if that were feasible.

Nationally, there are new standards in consultation for the bowel screening programme. More locally, a bid was submitted for cancer research UK funding from Borders which has reached the final stages. The aim of this funding is to deliver and evaluate a targeted service innovation project to improve colorectal cancer outcomes.

The DES programme has launched a national appointment SMS reminder service, as well as online booking, but neither are yet to be implemented by NHS Borders or Lothian. There is also the aim for DES collaborative training for screeners (level 3 diploma) to recommence in 2024. In addition, NEC are developing a software tool to assist call-recall managers to smooth the distorted demand curve following Covid-19 recovery. There is also work in development around analysing and publishing KPIs for this programme, following the significant changes seen over the last 3 years.

Within the cervical screening programme there is a national audit ongoing, regarding women listed as having a total hysterectomy. There is also work in progress to create a colposcopy to SCCRS interface which will improve the quality of data in SCCRS and reduce the requirement

for duplicate data entry. Scottish Government is also awaiting the results of the NHS England self-sampling studies (HPValidate), to decide whether this should be incorporated into the national cervical screening programme. As mentioned previously, more locally work has begun on a new project related to defaulting on cervical screening during pregnancy.

Finally, a data quality project is being scoped out within pregnancy and newborn screening, with the hope that a public health practitioner within the team will spend time looking at the quality of the pregnancy and newborn data, leading to a discussion of the most effective and efficient ways of managing and reporting on this data going forward.

Recommendations

- Work is required around the data quality and availability for the pregnancy and newborn programme. The process and software needs to be reviewed, alongside possible training for those on the frontline around data entry into the IT system. Assurance of the performance of this programme remains challenging, dedicated resource should be part of this.
- Given the stark differences in uptake in most of the programmes across deprivation categories, wide buy-in from across the Borders is requested for both the Equity in Screening strategy action plan, and the Health Inequalities Strategy to ensure that these differences can be addressed in useful and enduring ways. These will include plans to improve uptake across all of the programmes, but particularly the cervical and DES programmes where uptake is below national targets.
- Continuation of quality of the AAA USS, and colonoscopy tests should be reviewed locally to decide if further training is required to improve non-completion rates.
- Waiting times for colonoscopy remains challenging, this should continue to be monitored closely with clear escalation routes.
- Await formally published KPIs for the DES programme, assisting the national process for this where necessary, and cascading the results once available.
- Overall strengthen the monitoring and evaluation of all of the programmes, with dedicated resource for each programme. This could be enhanced with use of IT and the development of screening dashboards which update regularly, and from which data can be pulled easily.

Appendices

Summary of NHS Borders AAA screening programme data, and performance against national standards (April 2020 – March 2023)

		Essential / Desirable	April 2020 - March 2021	April 2021 - March 2022	April 2022 - March 2023
1.1	Percentage of eligible population who are sent an initial offer to screening before age 66	Essential ≥ 90% Desirable 100%	99.50%	98.30%	100.00%
1.2a	Percentage of eligible population who are tested before age 66 and 3 months	Essential ≥ 75% Desirable ≥ 85%	87.90%	87.90%	
1.3a	Percentage of eligible population who are tested before age 66 and 3 months by Scottish Index of Multiple Deprivation (SIMD) quintile	Essential ≥ 75% Desirable ≥ 85%	1: 84.2% 2: 86.5% 3: 86.5% 4: 89.4% 5: 95.3%	1: 83.8% 2: 83.1% 3: 87.2% 4: 89.9% 5: 94.4%	
1.4a	Percentage of annual surveillance appointments due where men are tested within 6 weeks of due date	Essential ≥ 90% Desirable 100%	67.70%	96.30%	
1.4b	Percentage of quarterly surveillance appointments due where men are tested within 4 weeks of due date	Essential ≥ 90% Desirable 100%	68.80%	88.50%	
2.1a	Percentage of screening encounters where aorta could not be visualised	Essential < 3% Desirable < 1%	1.40%	6.20%	6.00%
2.1b	Percentage of men screened where aorta could not be visualised	Essential < 3% Desirable < 1%	1.00%	5.00%	
2.2	Percentage of images which did not meet the quality assurance audit standard and required immediate recall	Essential < 4% Desirable < 1%	3.00%	0.00%	
3.1	Percentage of men with AAA ≥ 5.5cm seen by vascular specialist within two weeks of screening	Essential ≥ 75% Desirable ≥ 95%	100.00%	N/A	N/A

3.20	Percentage of men with AAA ≥ 5.5cm deemed appropriate for intervention who were operated on by vascular specialist within eight weeks of screening	Essential ≥ 60% Desirable ≥ 80%	N/A	N/A	N/A
4.1	30-day mortality rate following open elective AAA surgery	Essential < 5% Desirable < 3.5%	2.1% all of Scotland 2016/17 - 2020/21		
4.2	30-day mortality rate following elective Endovascular Aneurysm Repair intervention	Essential < 4% Desirable < 2%	0% all of Scotland 2016/17 - 2020/21		

Summary of NHS Borders bowel screening programme data, and performance against national standards (1st Nov 2020 - 31st Oct 2022)

		Essential / Desirable	1st Nov 2020 - 31st Oct 2022
HIS Standard	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited	60% of men	69.30%
		60% of women	74.60%
HIS Standard	Overall uptake of screening by deprivation category: First quintile	60%	61.9%
	Overall uptake of screening by deprivation category: Second quintile	60%	66.8%
	Overall uptake of screening by deprivation category: Third quintile	60%	72.5%
	Overall uptake of screening by deprivation category: Fourth quintile	60%	74.5%
	Overall uptake of screening by deprivation category: Fifth quintile	60%	78.0%
	Percentage of people with a positive screening test result	N/A	2.80%
HIS Standard	Time from screening test referral date to date colonoscopy performed (95% in < 31 days)	95% in < 31 days	28.70%
	Percentage of people with a positive screening test result going on to have a colonoscopy performed	N/A	80.90%
HIS Standard	Percentage of people that had a completed colonoscopy	90%	92.80%
	Percentage of colonoscopic complications	N/A	0%
	Percentage of people that had a cancer detected	N/A	0.11%
	Percentage of people with colorectal cancer staged as Dukes' A	N/A	39%
	Percentage of people with colorectal cancer staged as Dukes' B	N/A	24.40%
	Percentage of people with colorectal cancer staged as Dukes' C	N/A	31.70%
	Percentage of people with colorectal cancer staged as Dukes' D	N/A	4.90%

	Percentage of people with colorectal cancer staged as Dukes' Not known	N/A	0%
	Percentage of people with colorectal cancer where the stage has not yet been supplied	N/A	0%
	Percentage of people with colorectal cancer that has a recorded stage	N/A	100%
	Percentage of people screened that had a polyp cancer detected	N/A	0.036%
	Percentage of cancers that were polyp cancers	N/A	31.70%
	Percentage of people with adenomas detected	N/A	0.845%
	Percentage of people with high risk adenomas detected	N/A	0.13%
	Positive Predictive Value for colorectal cancer	N/A	6%
HIS Standard	Positive Predictive Value for adenoma as the most serious diagnosis	35%	44.70%
	Positive Predictive Value for high risk adenoma as the most serious diagnosis	N/A	7.10%
	Positive Predictive Value for high risk adenoma as the most serious diagnosis or colorectal cancer	N/A	13.10%
	Positive Predictive Value for adenoma as the most serious diagnosis or colorectal cancer	N/A	50.70%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the colon	N/A	53.70%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the rectosigmoid junction	N/A	12.20%
	Percentage of people with a colorectal cancer that is a malignant neoplasm of the rectum	N/A	34.10%

Summary of NHS Borders breast screening programme data, and performance against national standards (April 2018 - March 2021)

		Essential / Desirable	April 2018 - March 2021
Attendance rate (percentage of women invited)		Essential ≥ 70% Desirable ≥ 80%	78.00%
Invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 2.7 Desirable ≥ 3.6	6.80
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 3.1 Desirable ≥ 4.2	7.10
Small (<15mm) invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 1.5 Desirable ≥ 2.0	3.40
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 1.7 Desirable ≥ 2.3	4.90
Non-invasive cancer detection rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential ≥ 0.5	0.70
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential ≥ 0.6	1.80
Standardised Detection Ratio (SDR) (observed invasive cancers detected divided by the number expected given the age distribution of the population)		Essential ≥ 1.0 Desirable ≥ 1.4	1.60
Recalled for assessment rate (percentage of women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential < 10% Desirable < 7%	6.40%
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential < 7% Desirable < 5%	2.90%
Benign biopsy rate (per 1000 women screened)	Initial screen (Prevalent) in response to first invitation (50-52 years old)	Essential < 1.5 Desirable < 1.0	1.40
	Subsequent screen (Incident) (previous screen within 5 years) (53-70 years old)	Essential < 1.0 Desirable < 0.75	0.30

Summary of NHS Borders breast screening programme data, and performance against national standards (April 2020 – March 2022)

		Essential / Desirable	1st April 2020 to 31st March 2021	1st April 2021 to 31st March 2022
HIS Standard	Overall uptake of screening - percentage of people with a final outright screening test result, out of those invited	80%	74.60%	74.10%
HIS Standard	Overall uptake of screening by deprivation category: First quintile	80%	61.90%	65.14%
HIS Standard	Overall uptake of screening by deprivation category: Second quintile	80%	66.75%	71.84%
HIS Standard	Overall uptake of screening by deprivation category: Third quintile	80%	72.50%	74.65%
HIS Standard	Overall uptake of screening by deprivation category: Fourth quintile	80%	74.51%	75.09%
HIS Standard	Overall uptake of screening by deprivation category: Fifth quintile	80%	77.99%	80.02%

Summary of NHS Borders pregnancy and newborn screening programme data, and performance against national standards (April 2020 - March 2023)

		Essential / Desirable	April 2020 - March 2021	April 2021 - March 2022	April 2022 - March 2023
1.1	Haemoglobinopathies: Antenatal Coverage	≥ 95.0%/ ≥ 99.0%	73.93%	80.77%	78.85%
1.2	Haemoglobinopathies: Timeliness of antenatal screen	≥ 50.0%/ ≥ 75.0%	71.59%	76.92%	73.30%
1.3	Haemoglobinopathies: Completion of Family Origin Questionnaire	≥ 95.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
1.4	Haemoglobinopathies: Timely offer of prenatal diagnosis (PND) to women at risk of having an affected infant	TBD	Unknown	Unknown	Unknown
1.5	Haemoglobinopathies: Timely reporting of newborn screen positive	≥ 90.0 % / ≥ 95.0%	Unknown	Unknown	Unknown

1.6	Haemoglobinopathies: Timely receipt into specialist care	≥ 90.0 %/ ≥ 95.0%	Unknown	Unknown	Unknown
2.1	Hepatitis B: Coverage	≥ 95.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
2.2	Hepatitis B: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
2.3	Hepatitis B: Treat/Intervene	≥ 97.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
2.4	Hepatitis B: Timely assessment of woman with Hepatitis B	≥ 70.0%/ ≥ 90.0%	Unknown	Unknown	Unknown
2.5	Hepatitis B: Timely neonatal vaccination and immunoglobulin	≥ 97.0%/ ≥ 99.0%	Unknown	Unknown	Unknown
3.1	Congenital Syphilis: Coverage	≥ 95.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
3.2	Syphilis: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
3.3	Syphilis- Treat/Intervene	≥ 97.0%/ ≥ 99.0%	N/A	N/A	N/A
4.1	HIV: Coverage	≥ 90.0%/ ≥ 99.0%	75.00%	84.00%	85.00%
4.2	HIV: Test turnaround time	≥ 95.0%/ ≥ 97.0%	Unknown	Unknown	Unknown
4.3	HIV: Treat/Intervene	≥ 97.0%/ ≥ 99.0%	N/A	N/A	N/A
5.1	Down's syndrome: Coverage	N/A	N/A	N/A	N/A
5.2	Down's syndrome screening: Test turnaround time	First Trimester: Only available for all of Scotland			
		Second Trimester: Only available for all of UK			
5.3	Down's syndrome screening: Completion of laboratory request forms	≥ 97.0% / 100.0%	First Trimester: 97.6%	First Trimester: 98.3%	First Trimester: 99%
			Second Trimester: 96.7%	Second Trimester: 98.4%	Second Trimester: 96.8%

5.4	Down's syndrome screening: Time to intervention	≥ 97.0% / ≥ 99.0%	Unknown	Unknown	Unknown
5.5	Down's syndrome screening: Test performance – Screen Positive Rate (SPR) singleton pregnancies only	First Trimester: 1.8-2.5% / 1.9-2.4%	2.60%	3.60%	3.12%
		Second Trimester: 2.5-3.5%/ 2.7-3.3%	Second Trimester: 2.36%	Second Trimester: 0%	Second Trimester: 1.59%
5.6	Down's syndrome screening: Test performance – Detection Rate (DR)	Only available for East of Scotland			
5.7	Down's syndrome screening: Diagnose	N/A			
6.1	Fetal Anomaly: Coverage of the fetal anomaly ultrasound	≥ 90.0%/ ≥ 95.0%	75.00%	75.00%	69.00%
6.2	Fetal Anomaly: test performance of the fetal anomaly ultrasound	≥ 50.0% for each serious cardiac anomaly	Unknown	Unknown	Unknown
6.3	Fetal anomaly: Time to intervention (18+0 to 20+6 fetal anomaly ultrasound)	≥ 97.0%	Unknown	Unknown	Unknown
6.4	Fetal anomaly: Diagnose	90.00%	Unknown	Unknown	Unknown
7.1	The proportion of babies eligible for newborn hearing screening for whom the screening process is complete by 4 weeks corrected age.	> 98% / > 99.5%	96.76%	97.56%	97.43%
7.2	The proportion of well babies tested using the AOAE protocol who do not show a clear response in both ears at AOAE1.	< 27% / < 22%	N/A	N/A	N/A
7.3	The proportion of well babies tested using the AOAE protocol who do not show a clear response in both ears at AOAE2.	< 6% / < 5%	N/A	N/A	N/A

7.4	The proportion of well babies tested using the AABR protocol who do not show a clear response in both ears at AABR1.	< 15% / < 12%	2.17%	0.46%	0.76%
7.5	The proportion of babies with a screening outcome who require an immediate onward referral to audiology for a diagnostic assessment.	< 3% / < 2%	2.14%	0.45%	1.00%
7.6	The proportion of babies with a no clear response result in in one or both ears or other result that that requires an immediate onward referral for audiological assessment who receive an appointment for audiological assessment within the required timescale (within 4 weeks of screen completion or by 44 weeks gestational age).	> 97% / > 99%	66.67%	0.00%	25.00%
7.7	The proportion of babies with a no clear response result in in one or both ears or other result that that requires an immediate onward referral for audiological assessment who attend for audiological assessment within the required timescale (within 4 weeks of screen completion or by 44 weeks gestational age).	> 90% / > 95%	55.56%	0.00%	25.00%
8.1	Newborn Blood Spot: Coverage (NHS Board responsibility at birth)	≥ 95.0% / ≥ 99.0%	97.12%	97.80%	94.49%
8.2	Newborn Blood Spot: Coverage (Movers in)	≥ 95.0% / ≥ 99.0%	100.00%	93.33%	88.00%
8.3	Newborn Blood Spot: Avoidable repeat tests	≤ 2.0% / ≤ 1.0%	4.90%	3.38%	5.79%
8.4	Newborn Blood Spot: Timely identification of babies with a null or incomplete result recorded on the Child Health Information System (CHIS)	Ideally daily, minimum weekly	Twice a week (run on a Friday, downloaded on a Monday, and run on a Wednesday, downloaded on a Thursday)		
8.5	Newborn Blood Spot: CHI number is included on the bloodspot card	≥ 98.0% / ≥ 100.0%	98.60%	99.21%	99.40%
8.6	Newborn Blood Spot: Timely sample collection	≥ 90.0% / ≥ 95.0%	95.90%	96.91%	97.33%

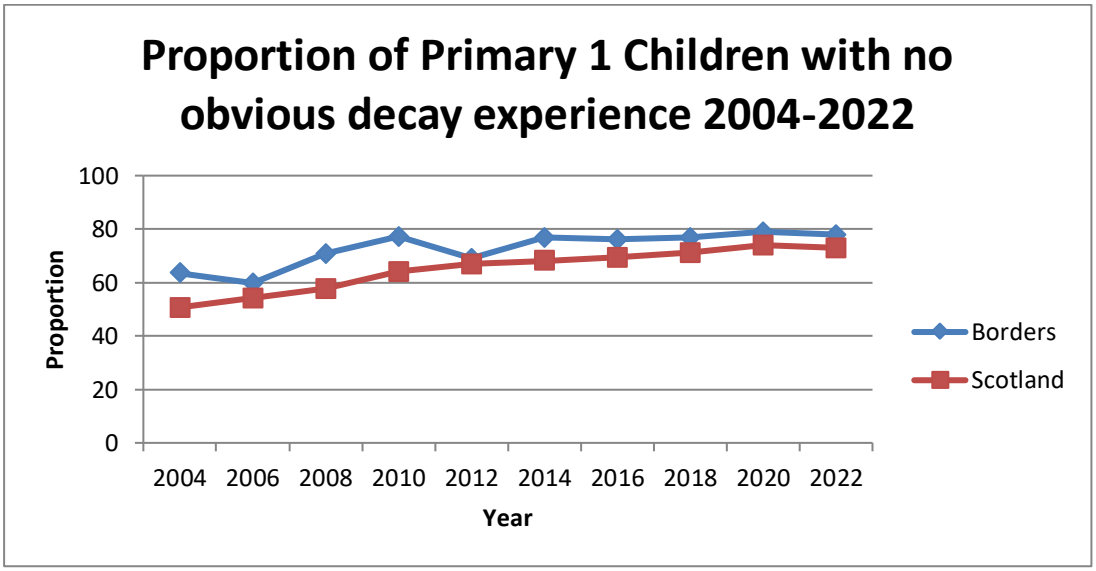
8.7	Newborn Blood Spot: Timely receipt of the sample in the laboratory	≥ 95.0% / ≥ 99.0%	84.33%	92.65%	83.46%
8.8	Newborn Blood Spot: Timely taking of a second bloodspot sample for CF screening	≥ 95% / ≥ 70%	0.00%	100.00%	100.00%
8.9	Newborn Blood Spot: Timely taking of a second bloodspot sample following a borderline CHT screening	≥ 95.0% / ≥ 99.0%	100.00%	100.00%	100.00%
8.10	Newborn Blood Spot: Timely taking of a second bloodspot sample for CHT screening for preterm infant	≥ 95.0% / ≥ 99.0%	42.86%	33.33%	30.00%
8.11	Newborn Blood Spot: Timely processing of CHT and IMD (excluding HCU) screen positive samples		100.00%		
8.12	Newborn Blood Spot: Timely entry into clinical care		100.00%		

Oral Health / Dental Public Health Report

Oral Health

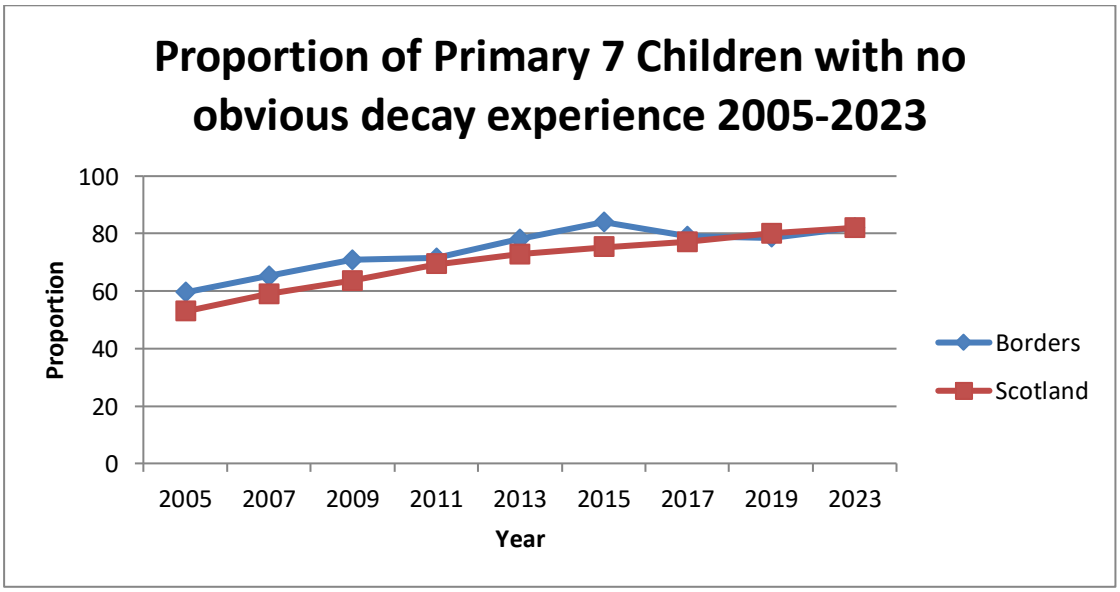
Our most robust data on oral health are gathered annually through the National Dental Inspection Programme (NDIP) of children in Primaries 1 and 7. In general the oral health of children in The Borders is good with the proportion of children with no obvious decay experience regularly higher than the national average as shown in Figures 1 and 2 below.

Figure 1 – Proportion of P1 children with no obvious decay experience



Public Health Scotland

Figure 2 – Proportion of P7 children with no obvious decay experience

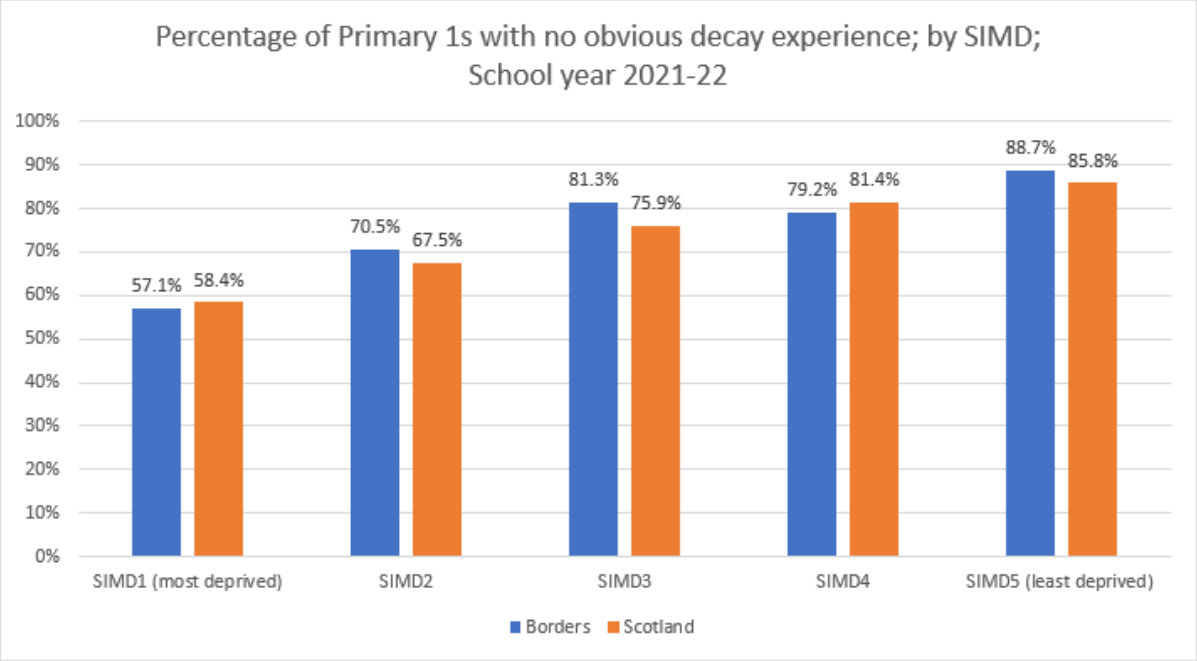


Public Health Scotland

The most recent NDIP report (school year 2022-23) shows that in the Borders 82% of Primary 7 children had no obvious decay experience, which is comparable to Scotland as a whole. This is encouraging and is a marked improvement on 2005 when these figures were only 59.5% in The Borders and 52.9% in Scotland, however almost 20% of children do still experience dental decay and action is required to bring this down further.

We know that children living in areas of deprivation are at increased risk of dental decay and analysis of the P1 NDIP data from 2021-22 at Health Board level (Figure 3) demonstrates the gradient between oral health of children living in the most and least deprived areas in The Borders. Any action to reduce decay experience must therefore focus on supporting those at greatest risk.

Figure 3 – Primary 1 "no obvious decay experience" by SIMD, Borders and Scotland



Public Health Scotland

Adult oral health has also improved though data are less readily available. We know that these improvements mean that many more adults are retaining their own teeth into older age. While this is hugely positive, it does generate an increased need for dental care, including for teeth which have undergone complex restorative treatment and require ongoing maintenance. Additional complexities arise as this ageing dentate population develop co-morbidities, frailty or dependencies which can impact on provision of dental care and ability to maintain oral health on a day-to day basis.

Dental Services

Dental services in The Borders continue to operate under significant pressure. A national shortage of dental professionals has compounded longstanding recruitment challenges in

the area, impacting on the availability of dental services. Emergency dental care remains available to anyone with an urgent dental problem, either through their usual dentist or, if unregistered, through the Borders Emergency Dental Service.

As at 30th September 2022, 83.4% of children and 84.4% of adults in the Borders were registered with an NHS dentist, slightly lower than the national average of 87.2% of children and 97.3% of adults. Recent access challenges have seen a reduction in the numbers of young children registered with an NHS dentist, most likely because very few practices have been accepting new patients since many of these children were born.

The majority of NHS dental care is delivered by independent dental contractors in the General Dental Service (GDS) ("high street" dental practices). The Public Dental Service (PDS) has a remit to provide dental care for vulnerable populations who cannot be treated in routine general dental services. In the Borders the PDS have played a valuable role in delivering access to dental care for members of the general population where availability of GDS has not been able to meet the level of demand. As access challenges have increased, it is important that PDS capacity is managed to ensure that those most in need of this service are prioritised.

Over the past 18 months two new NHS general dental practices have opened in The Borders which has helped to increase capacity, though levels of demand remain high. A new system for NHS dental care was introduced in Scotland on 1st November 2023. This has facilitated a move to a more patient centred approach with recall intervals (time between check ups) tailored to the individual patients' oral health status and a simplification of the fee structure. It remains early days for this new system but it is hoped that this will bring increased stability to the sector and over time support increased access to NHS dental care.

Prevention

As with many other aspects of health, the most important factors for maintaining good oral health sit outwith healthcare or dental services. On a day to day basis brushing teeth at least twice a day with fluoride toothpaste, eating a diet low in sugar, avoiding smoking and limiting alcohol intake will help prevent dental problems. These factors become even more important in times when dental services are under extreme pressure.

Recognising that for some people their life circumstances can place them at increased risk of poor oral health, NHS Borders have an active Oral Health Improvement Team who work closely with various partners and agencies to help create environments which support oral health. The main body of work for the team is delivery of the five national oral health improvement programmes:

Childsmile – for children, taking a proportionate universalism approach to improve the oral health of all children, with a particular focus and enhanced input for those at greatest need. Childsmile work closely with dental services, health visitors, education establishments and

other children's services supporting toothbrushing in the home and through supervised toothbrusing programmes as well as offering advice and support to families and encouraging dental attendance.

Open Wide – for adults with additional care needs. Since the national programme was launched in 2019 the team in NHS Borders have developed strong networks with support agencies as the programme becomes established. Oral health support and advice, including toothbrushing are supported

Caring for Smiles – for dependent older people. Focussed initially on care homes, the programme provides training to care staff to enable them to deliver daily oral care to maintain healthy mouths for those who require support with this important task. The NHS Borders team actively seek to expand the reach of the programme working with care homes but also across other health and care settings

Mouth Matters – for people in prison and **Smile4Life** for people experiencing homelessness are delivered in parallel with a focus on the most vulnerable communities through working with partner agencies such as the Dept of Work and Pensions, addictions services and other local groups.

Despite a pause in these programmes when staff were redeployed to other areas during the COVID pandemic, remobilisation of the programmes has been very successful and the team constantly seek to expand and develop to deliver the best possible support and prevention of dental disease.

Strategic Direction

In response to an oral health needs assessment undertaken in 2018, a Strategic Plan for Oral Health and Dental Services is in advanced stages of development and will be implemented from April 2024. The overarching twelve year plan will be divided into three yearly action plans. The plan will deliver on four key themes based on the ten priorities identified by the needs assessment as outlined in Figure 4 below.

Figure 4 – Vision, Themes and Priorities for NHS Borders Strategic Plan for Oral Health and Dental Services 2024-36

OUR VISION:

Everyone in the Borders will enjoy excellent oral health as a key part of their overall health and wellbeing.

THEMES	Maximising oral health	Access to dental care	Developing pathways	Partnership working
PRIORITY ACTIONS	Raising the profile of oral health	Maintaining and improving access	Meeting the needs of ageing patients	Raising the profile of oral health
	Maintaining and improving oral health	Encouraging recruitment and retention	Meeting the needs of dental priority groups	Maintaining and improving oral health
	Meeting the needs of ageing patients	Developing the role of the Public Dental Service	Developing the Public Dental Service workforce	Meeting the needs of ageing patients
	Meeting the needs of dental priority groups		Developing patient pathways to dental services	Meeting the needs of dental priority groups
	Networking and engagement with dental teams and wider partners			Networking and engagement with dental teams and wider partners

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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 18 January 2024

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 02.11.23

Borders NHS Board

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 2 November 2023 at 9.00am via MS Teams.

Present: Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Mrs L O'Leary, Non Executive
Mr J Ayling, Non Executive
Dr K Buchan, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mr A Carter, Director of HR
Mr C Myers, Chief Officer, Health & Social Care
Mrs L Jones, Director of Quality & Improvement

In Attendance: Miss Iris Bishop, Board Secretary
Mrs C Oliver, Head of Communications
Mrs F Doig, Head of Health Improvement
Dr A Cotton, Associate Medical Director, MH&LD
Mrs F Laidlaw, Head of Facilities
Ms L Shadburn, Grant Thornton Auditors

1. Apologies and Announcements

1.1 Apologies had been received from Mrs H Campbell, Non Executive, Mr T Taylor, Non Executive, Cllr D Parker, Non Executive, Mrs S Lam, Non Executive, Mrs J Smyth, Director of Planning & Performance and Mr G Clinkscale, Director of Acute Services, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Dr S Bhatti, Director of Public Health, and Mr J McLaren, Non Executive.

1.2 The Chair welcomed Mrs F Doig, Head of Health Improvement who deputised for Dr S Bhatti.

1.3 The Chair welcomed Mrs F Laidlaw, Head of Facilities and Ms L Shadburn from Grant Thornton Auditors.

1.4 The Chair commented that Mr J Leitch, National Clinical Director and Mr J Harden, Deputy National Clinical Director had visited NHS Borders on Monday 30 October. He had provided positive feedback from his visit and was aware of the pressures that services were operating within and the stress that it caused staff.

1.5 The Chair confirmed the meeting was quorate.

2. Declarations of Interest

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

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 7 September 2023 were approved.

4. Matters Arising

4.1 Mrs Fiona Sandford commented that she was keen to revisit the discussion on prioritisation of scheduled verses unscheduled care. Mr Ralph Roberts commented that it remained relentless in terms of pressure on services and staff. He remained concerned about the pressures in the Emergency Department which were both unreasonable and unsustainable.

4.2 Dr Lynn McCallum commented that it was important that the Committee were sighted on how pressurised it was for the staff and she advised the previous week had been one of the hardest ever and basically the Emergency Department had been running as a ward. Some whole system incident team meetings had been called to alleviate some of the pressures and had been successful to a degree, but there was further action to be taken across the whole health and social care landscape.

4.3 The Chair commented that she was aware of the work that was ongoing in regard to balancing the spread of risk across the system.

4.4 Mr Andy Carter drew the attention of the Committee to the impacts of such a pressurised system on staff which included: an increase in staff sickness; increase in management and self referrals to occupational health services; an increase in staff to staff disputes; and ultimately an increased level of staff turnover.

4.5 Dr Amanda Cotton commented that when the whole system stepped up to support secondary care with its pressures, it also had an impact on those services especially those providing community care services where patients would experience longer waits in their patient journey.

4.6 Mrs Sandford enquired if there was any kind of informal visibility the Non Executives could provide to the staff to show that the Board were fully supportive of them and understood the pressures they were operating under. Mr Roberts commented that he would consider what possibilities there might be and get back to Mrs Sandford.

4.7 **Action 2023-6:** Mr Ralph Roberts apologised to the Committee that he had been unable to meet with Mrs Jones due to other pressures and consequently the action continued to remain ongoing.

4.8 **Action 2023-3:** Mr Roberts advised that work on implementation continued. Mr Andrew Bone referred to the timelines for the LIMS project and advised that it continued to slip as a programme and the key issues was the capacity within the Laboratory Team to undertake the user testing of the system. The original go live date of October 2023 had been postponed and was likely to be beyond March 2024. Constructive discussions had taken place with

Clinisys and no penalties had been applied to the slippage which was being driven by NHS Borders. The next meeting was due to take place on 17 November. Mr Bone advised that there was some cost pressure on the budget and both sides were working through some specific technical issues. In terms of the Citadel system that was commissioned nationally, he advised that slippage was also being experienced by other Health Boards with their implementation timelines.

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

5. Performance Scorecard

5.1 The Chair declared that she was currently on the waiting list for a procedure and would therefore refrain from the discussion.

5.2 Mr Ralph Roberts provided an overview on the content of the report and highlighted the improvement in CAMHS performance and the expectation that they would meet the trajectory target by March 2024.

5.3 Mrs Laura Jones drew the attention of the Committee to the prioritisation of planned care and the stabilisation of the inpatient day case list. She advised that the planned surgical assessment area would be moved to Ward 17 to protect it during the winter period with the intention of it being a 23 hour stay area Monday to Friday and beds in Wards 7 and 9 would be used for trauma and orthopaedic patients. She also advised that progress had been made with the Dermatology service through a new workforce model. External capacity was still being utilised at present and significant risks were being carried. In terms of Ophthalmology a significant increase in operating capacity for cataracts had been achieved which would reduce the waiting list over the coming year.

5.4 In regard to cancer targets, Mrs Jones advised that unfortunately there had been a few cases breach the 62 day target in urology.

5.5 Further discussion focused on: fully utilising the £2.4m waiting times allocation; leading NHS Scotland with cataracts performance; pressures in Emergency Departments are the same across the UK; local demography of an older population than the national average; surge plan put in place and is on track; new capacity commissioned for extra nursing beds and enhanced residential care beds on a permanent basis; integration of the discharge team to ensure the discharge kaizen findings are actioned; developing a link worker model; ensuring assessments are started early and over prescribing is challenged; increase in respite capacity due to carer distress; and the significant workforce pressures of 30 Health Care Support Worker vacancies in the acute system.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of September 2023.

6. People Management Report

6.1 Mr Andy Carter provided an overview of the report and commented that the format had been updated following the previous meeting discussion. He drew the attention of the Committee to several elements including: the East Region recruitment service performance indicators which suggested a satisfactory service for NHS Borders; successful international recruitment and radiographer recruitment; turnover since the last report had increased in medical workforce and AHPs; high areas of sickness absence included HCSW on wards and

healthcare science workers; nurse agency usage had reduced as the framework had been introduced; Occupational health referrals had increased with many issues related to outside of work, relationships and cost of living; good progress had been made on statutory and mandatory training compliance; and there were some issues in regard to "did not attends" for face to face training and work was ongoing to address that.

6.2 The Chair enquired if there was any potential for international employees relatives who might want to work within health and social care to be signposted to healthcare support worker or social care positions.

6.3 Mr James Ayling enquired about the contractual arrangements for international employees and if appraisal compliance could be included in the next report. Mr Carter responded that the international recruits were contracted to NHS Borders for a few years and at the end of the contractual obligation he hoped they would wish to continue to work with NHS Borders and not seek employment elsewhere. He also agreed to include appraisal data in the next report.

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

7. Finance Report

7.1 Mr Andrew Bone commented that there had been a significant reduction in nursing agency spend and medical agency costs were also beginning to decrease. He then provided an overview of the finance report and highlighted that the forecast deficit was £22.5m.

7.2 Discussion focused on: medical agency spend; assurance required to hit the financial target; and the significant risks attached to the financial plan.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the board is reporting an overspend of £13.97m for six months to end of September 2023.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the position reported in relation to recurring savings delivered year to date.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that an updated forecast position prepared at Q2 review will be presented separately to the committee.

8. Quarter 2 Review & Financial Forecast

8.1 Mr Andrew Bone commented that the report had been covered in the previous discussion.

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

Dr Kevin Buchan left the meeting.

9. Financial Plan

9.1 Mr Andrew Bone provided a presentation to the Committee and highlighted several elements including: spending review by Scottish Government in May; Budget due to be published in December; expectations for financial planning; medium term plan March 2023; mid year review and underlaying issues; 12 month on-going recurring impact; recurring savings 2023/24; and capacity to do the work on the savings plans.

9.2 Mr Ralph Roberts commented that the key issues for the Board were: challenges around finance would increase; a short fall in capacity to progress matters; currently working on timelines; and the reflection that there was an increasing recognition that the Scottish Government would become tougher around the financial situation over the following months.

Mr Chris Myers left the meeting.

9.3 Discussion focused on: the consequences of the financial plan not being accepted by the Scottish Government; providing budget owners with more responsibility to identify savings and manage their budgets; comparison with other Health Boards deficit positions; effectiveness of the performance escalation framework, at level 3 Scottish Government provide support, at level 4 they provide a team to actively manage financial recovery and at level 5 the position is directly managed by the Scottish Government; impact of being a rural Health Board on the financial position, introducing new systems such as e-rostering and the sustainability of services; and raising the impact of the local demography with the Scottish Government.

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

10. Strategic Risk: Financial Sustainability

10.1 Mr Andrew Bone commented that the paper outlined the risk as currently encapsulated on the risk system. He advised that it would be reviewed again during the financial planning process.

10.2 The Chair suggested that it be brought back to the attention of the Committee if there was any escalation in the risk prior to the financial planning process taking place.

The **RESOURCES & PERFORMANCE COMMITTEE** and the Chair of the Audit and Risk Committee accepted that the risk was appropriately written at the current time and recognised the scale of risk.

The **RESOURCES & PERFORMANCE COMMITTEE** asked that the risk be reviewed again in April 2024 as part of the Financial planning process, to reflect any potential increase in the risk.

The **RESOURCES & PERFORMANCE COMMITTEE** discussed the risk and agreed that they had been provided with a level of assurance which was partial assurance, that had been gained from the report outlining the progress on managing the risk appropriately and proportionately.

11. Strategic Risk: Climate Change

11.1 Mr Andrew Bone introduced Mrs Fiona Laidlaw who was leading on the delivery of the climate emergency and sustainability and the climate change plan.

11.2 Discussion focused on several key elements including: levels of assurance based on the information provided on climate change; strategic risk aligned to the medium term plan; risk rating overall is high; most actions were about the longer term and not the next 3 years so they were interlinked; slippage on actions; and only partial assurance was evidenced.

The **RESOURCES & PERFORMANCE COMMITTEE** discussed the risk and provided a level of assurance which was partial assurance, that had been gained from the report outlining the progress on managing the risk appropriately and proportionately.

12. Climate Emergency and Sustainability Update

12.1 Mr Andrew Bone introduced the update and advised that there was a substantial amount of information provided in order to enable the Committee to take some assurance on the work that had been carried out. He advised that Fi Laidlaw had taken on the lead role around climate emergency and sustainability without any identified resources. He commented that as matters progressed it was likely that resources would be required in future.

12.2 Mrs Fi Laidlaw provided an overview of the update and highlighted that: there was a 7.46% reduction in carbon emissions the previous year; transport had been added to the emissions register; building energy was the largest area to make savings; £1.9m grant had been received from the Scottish Green Decarbonation Scheme; there had been a 4.9% reduction in medical gasses emissions; a reduction in nitroxide emissions; work had progressed with the national green theatres programme which put NHS Borders ahead of many other Health Boards in that initiative; and a travel project had been launched to support visitors, staff and patients to travel differently.

12.3 Discussion focused on: clinical leadership in relation to green theatres and medical gases work; additional resources would be required in future and would need to be balanced against a challenging financial position; work progressing to look at gathering Entinox back from the atmosphere in maternity services; infrastructure and behaviour change and whether medium term or long term risks; and the contribution of Harriet Campbell in her climate change champion role.

The **RESOURCES & PERFORMANCE COMMITTEE** discussed the risk and agreed that they had been provided with a level of assurance which was partial assurance.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the status of the documents presented as an annex to the report and provided comment on the Annual Report (annex 4) which was due for publication at the end of November 2023.

13. Internal Audit - Bank and Agency Staff

13.1 Mr Andrew Bone provided an overview of the content of the report and highlighted the findings of the report in regard to documentation, policies and procedures.

13.2 Mr James Ayling commented that of the 25 items that had been reviewed there had been 24 issues found. He suggested it was disappointing that the service had waited for the internal audit report to point out the issues when it would have known there was non compliance. He suggested there was obviously a lack of monitoring of existing processes.

13.3 Mr Ralph Roberts commented that staff had been moved around the system and things had been stepped down which probably underpinned some of the issues identified by the report. He suggested the introduction of e-rostering would make processes slicker in future.

13.4 Mr Bone commented that some of the issues were due to the specifics of the joint relationship with another NHS body providing part of the service. Neither Board had done

it before and both had made assumptions that the other Board was monitoring the fundamentals of the system.

13.5 Mr Ayling enquired if the joint venture had been looked at from a cost savings perspective.

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

Mrs Laura Jones left the meeting.
Mrs Fiona Doig left the meeting.

14. Business Plan 2024

14.1 Miss Iris Bishop provided an overview of the contents of the report and highlighted that: there would be 5 meetings of the Committee held in 2024 all via MS Teams; the business plan contained known business the Committee would need to address and would remain live and change throughout the course of the year as further business was identified.

14.2 Mr Ralph Roberts commented that a review of scheduled meetings in the last few months of 2023 and first 2 months of 2024 was being worked through and the scheduled meeting of the Committee in February might be cancelled. He would discuss with the Chair in due course.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the Business Plan for 2024.

15. Resources & Performance Committee Terms of Reference

15.1 Miss Iris Bishop provided an overview of the contents of the report and highlighted that it was good practice to review the Committee's terms of reference on an annual basis and there were no revisions suggested to the terms of reference.

The **RESOURCES & PERFORMANCE COMMITTEE** reviewed the Terms of Reference and recommended them to the Board for formal approval as part of the next refresh of the Code of Corporate Governance.

16. Self Assessment

16.1 Miss Iris Bishop provided an overview of the contents of the report and highlighted that it was good practice to undertake an annual self assessment.

The **RESOURCES & PERFORMANCE COMMITTEE** agreed to undertake a self assessment for the period January to December 2023 and submit returns to the Board Secretary by 31 January 2024.

17. Any Other Business

17.1 Mrs Clare Oliver advised that Health Improvement Scotland had published their Unannounced Inspection of NHS Borders Mental Health Inpatient Units report and that NHS Borders had 3 finalists attending the Scottish Health Awards ceremony that evening.

18. Date and Time of Next Meeting

18.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 18 January 2024 at 9.00am via MS Teams.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Audit & Risk Committee Minutes**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Iris Bishop, Board Secretary**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Government policy/directive

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

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

2.2 Background

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

2.3 Assessment

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

2.3.1 Quality/ Patient Care

As detailed within the minutes.

2.3.2 Workforce

As detailed within the minutes.

2.3.3 Financial

As detailed within the minutes.

2.3.4 Risk Assessment/Management

As detailed within the minutes.

2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

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

- Audit & Risk Committee 11 December 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, Audit & Risk Committee minutes 18.09.23

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 18th September 2023 @ 1 p.m. via MS Teams.

Present: Mr J Ayling, Non Executive Director (Chair)
Ms S Lam, Non Executive Director

In Attendance: Mr A Bone, Director of Finance
Mr J Boyd, Director, Audit Scotland
Mrs B Everitt, Personal Assistant to Director of Finance (Minutes)
Mr J Fraser, Public Sector Audit Assistant Manager (Audit), Grant Thornton
Mrs K Hamilton, Chair
Ms S Harold, Senior Audit Manager, Audit Scotland
Mrs S Horan, Director of Nursing & Midwifery (Item 6.3)
Ms H Jacks, Planning & Performance Officer (Item 10.1)
Mrs L Jones, Director of Quality & Improvement
Ms E Mayne, Health Value for Money Director, Grant Thornton
Mr K Messer, IT Delivery Manager (Item 7.2)
Mr G McLaren, Head of Estates (Item 7.2)
Mrs L Pringle, Risk Manager (Items 5.1 and 5.2)
Mr I Ritchie, Non Executive Director, NHS Greater Glasgow & Clyde (Left at 1.45 p.m.)

1. **Introduction, Apologies and Welcome**

James Ayling welcomed those present to the meeting and in particular to Ian Ritchie who was joining as part of the 'Aspiring Chairs' programme.

Apologies were received from Mrs F Sandford, Non Executive Director, Mr T Taylor, Non Executive Director, Mr R Roberts, Chief Executive, Mrs S Swan, Deputy Director of Finance (Head of Finance) and Mr G Clinkscale, Director of Acute Services.

James confirmed that today's meeting was quorate.

2. **Declaration of Interest**

There were no declarations of interest.

3. **Minutes of Previous Meetings – 14th June 2023, 24th July 2023 (Extraordinary) and 10th August 2023 (Extraordinary)**

The minutes were approved as an accurate record.

4. **Matters Arising**

Action Trackers

In regard to the previous requests for risk profiles to compare against NHS Borders, it was noted that a response was still awaited from NHS Dumfries & Galloway. James Ayling felt it would be helpful to make contact one more time to ask if they would be willing to share this. Following discussion Karen Hamilton offered to pick up with the Chair of NHS Dumfries & Galloway if she was supplied with the original communication trail.

Following the meeting a response was received from NHS Dumfries & Galloway that they do not record health and safety risks on their risk register so it would not be possible to benchmark against which closed this action.

In regard to the action around which Governance Committee was the correct one to have oversight of Whistleblowing, Sonya advised that an SBAR had gone to the Board Executive Team in terms of governance arrangements and that she was meeting with the Chair and Chief Executive the following month to discuss this further. Sonya highlighted that it may be necessary to add whistleblowing to the audit plan, particularly in light of the Lucy Letby case.

Emily Mayne advised that such an audit should cover all vulnerable people, not just paediatrics, however as this was an extremely broad agenda the proposal would be to examine that the Board is getting the necessary assurances via the Committee structures in place.

Laura Jones advised that NHS Borders had submitted their response to Scottish Government providing assurance around patient safety and that the Clinical Governance Committee would be going through this in detail at its next meeting as she appreciated that there was no room for complacency. Laura suggested bringing a report with the findings to the Audit & Risk Committee in due course. James agreed to discuss this with Laura and the Chair of the Clinical Governance Committee in the first instance, however if there was insufficient assurance from the findings this could then be added to the audit plan.

The Committee noted the action trackers.

5. **Risk Management**

5.1 *Risk Management Quarterly Report*

Lettie Pringle spoke to this item which was for the first quarter of the year to 30th June 2023. Lettie highlighted the key items from the report where it was noted that a targeted training programme developed by the Risk Team was now in place and the Risk Fund Framework had been implemented to support the risk management activities of the organisation. Lettie referred to the Risk Champions Network which was being put in place and highlighted that the success of this would be monitored by the Operational Planning Group.

Sonya Lam noted that Acute Services were not compliant for having a Risk Management Improvement Plan in place and also had no action plan. Lettie advised that she hoped to see an improvement on this for the next quarter's report due to the Risk Champions Network and the work being undertaken.

Karen Hamilton referred to the risk owners listed on page 16 of the report as she noted some of these were not currently at work and assumed that their risks were being managed in the short term.

James Ayling noted the increase in very high risks. Lettie explained that the biggest driver for this was due to the Risk Champions working with their Clinical Boards.

James also noted that the average timescale for risks being approved onto the risk register was 710 days which was significantly longer than the target of 104 days. Lettie advised that this was primarily due to a few risks having sat waiting on approval for a large number of days and assured that these would drop dramatically once these were approved and the system had been updated. Lettie confirmed that these risks had been escalated to the appropriate approver for urgent action.

James referred to the statement that financial gaps had also been identified as a key theme preventing risk owners from mitigating their risks fully and enquired if there was a different process for those risks caused by a financial gap. Lettie confirmed that these go through exactly the same process and are ultimately escalated to the Operational Planning Group.

James noted that the tendering process for the new Risk system was due to be completed by the end of quarter 2 and enquired if there was an update on this as he had concern around the training requirement that would be associated with this. Lettie advised that she was still not in a position to provide an update on this due to stipulations of the tendering process.

James also referred to risk reference 4450 in regard to exposure when working in the Laboratory and was concerned to see that this had missed the deadline for going to the Operational Planning Group 5 times to date and was now rescheduled for the end of November.

The Committee noted the Risk Management quarterly report.

5.2 *Risk Management Policy*

Laura Jones spoke to this item and advised the Risk Management Policy was being presented as part of a routine refresh. Laura highlighted that changes were required due to the changing landscape within risk management. It was noted that the roles and responsibilities section had been strengthened and reflected the changes within Risk Management as groups and structures have changed since the last review. It was further noted that there was a separate risk appetite which is reviewed on an annual basis by the Board.

Laura confirmed that the policy had been presented to the Operational Planning Group and Board Executive Team and any feedback had been incorporated within the version received.

The Committee supported the Risk Management Policy be presented to Borders NHS Board for approval.

6. **Internal Audit**

6.1 *Internal Audit Plan Update Report*
This item was taken third within the Internal Audit section
Emily Mayne spoke to this report which provided a summary of delivery on the 2023/24 Internal Audit Plan to date. Emily advised that the plan had not progressed as much as she would have liked at this point in the year, however assured that there would be sufficient resources to complete this within the timescales.

Emily noted the recurring theme of capacity issues coming through. Emily further commented on the number of high rated recommendations in recent reports, and the resulting 'no compliance' status of some reports. She advised that management had demonstrated a good level of engagement with audit and a willingness to identify areas where improvement would be likely to be required. Emily advised the Committee that Internal Audit could also be used in an advisory capacity when looking at next year's plan.

Emily welcomed the Committee's challenge on the timescales for the recommendations within the Contract Management Arrangements report and stressed that pushing deadlines into the new financial year would have a detrimental effect.

Andrew Bone referred to the service productivity audit and reminded of discussion earlier in the year about postponing Theatres to next year due to the theatre improvement programme which is currently underway. Laura Jones proposed putting forward Radiology as a diagnostic department had not been audited for some time and agreed that Theatres be postponed to the following year. Sonya Lam agreed with the suggestion to look at a diagnostic department. Due to timescales Andrew suggested that this be dealt with via email rather than waiting to the next meeting. This was agreed.

Laura referred to the emails from Internal Audit requesting updates on recommendations and asked if it could be checked that these are going to the correct people as she was aware these were not always received within her remit. Jamie Fraser agreed to look into this and ensure they are sent to the correct people going forward.

The Committee noted the report.

6.2 *Internal Audit Report – Contract Management Arrangements*
This item was taken second within the Internal Audit section
Jamie Fraser introduced this report and advised that this audit had been requested by management following the issues encountered with the LIMS contract. Jamie highlighted that this had an overall rating of partial assurance with improvement required. The findings ratings were noted as 4 high and 9 medium.

Jamie advised that the objective of the review was to provide an independent assessment of the design and operational effectiveness of NHS Borders' contract management arrangements. Jamie went over the findings which confirmed that fundamentally arrangements were not robust enough and staff

were not aware of their roles and responsibilities in respect of contract management. Jamie also highlighted that there was a high number of contracts past their expiry date which he was surprised at following the issues encountered with the LIMS contract and it did not appear that lessons had been learned from this.

Jamie flagged that management had been challenged on the timescales set for delivery dates, however due to capacity issues they had felt unable to bring these forward so he suggested the Committee receive an interim update.

Sonya Lam recognised there were capacity issues but noted her concern, following the LIMS contract and noting the number of expired contracts highlighted within the findings, of where else there were risks across the organisation.

James Ayling felt that the deadlines required to be brought forward due to the importance of this and was particularly concerned with the March deadline as a lot of the actions fell to Finance and this would be the start of the annual accounts process so he did not feel this was realistic. James also felt it would be reasonable to send a global email around the organisation meantime asking staff to check the expiry dates of contracts they are responsible for and setting out the basic requirements for managing contracts. Andrew agreed this would be done.

Andrew Bone appreciated that there were significant issues to be addressed and would be looking at the deadlines to see if actions could be undertaken earlier, however confirmed that the issues around capacity were correct and that he did not foresee opportunity to make significant changes to the timelines for delivery of the agreed actions. Andrew anticipated that an interim update would be provided to the December meeting.

Andrew also assured that in relation to LIMS a lessons learned exercise would be undertaken which would also see processes being put in place to avoid this happening in future.

Sonya reiterated her concern about the level of risk across the organisation in regard to this. Andrew advised that a short life working group has been set up and they would be looking at the expiry dates for contracts and those at higher risk would be escalated.

The Committee noted the report.

6.3 *Internal Audit Report – Bank and Agency Staff*
This item was taken first within the Internal Audit section
Jamie Fraser introduced this report which had an overall rating of no assurance. The findings ratings were noted as 3 high, 7 medium and 2 improvement.

Jamie advised that the objective of the review was to provide an assessment of the design and operational effectiveness of the arrangements for use of bank and agency staff which is a partnership approach hosted by NHS Lothian. It was noted that there is a lack of an agreed service level agreement (SLA) in place between NHS Borders and NHS Lothian. Jamie further noted that there

was no evidence of KPI reporting on the monitoring of usage and the financial implications arising from this.

Sarah Horan explained that the joint arrangement had been put in place at the start of the pandemic and the SLA, currently in draft, had not been followed through. It was noted that putting a joint bank in place had been fraught with challenges. Sarah was very much aware of the work which required to be undertaken and advised that a short life working group was being set up to focus on the recommendations.

James Ayling was concerned that it appeared to have taken this report to tell us how poorly this was being managed and he felt that there should have been internal procedures in place which would have flagged these.

James also noted his concern in regard to financial sustainability as he would have expected the Financial Improvement Programme to have been looking at this long before now.

Sonya Lam referred to questions previously raised at the Staff Governance Committee around whether the joint bank was working effectively to which they had been advised they would have to wait on the evaluations. Sonya was concerned around the length of time these were taking and was aware that NHS Borders was not getting as big an uptake as NHS Lothian. Sonya felt that not to have an SLA or KPIs in place was disappointing and assumed there would be learning for future collaborations.

Andrew Bone highlighted that having a signed SLA in place would provide a framework but stressed that it would not be a sudden fix to the issues experienced. In regard to the Financial Improvement Programme it was noted that there was only a limited amount of resources and confirmed that they do look at bank usage in respect of costs. Andrew agreed that grip and control needed to be addressed but he did not expect to see significant financial savings in respect of this.

Sarah Horan advised that the Board is in the process of moving to eRostering which would be a live system, however they were still toying with whether or not a regional bank was the best option for NHS Borders.

James referred to working time regulations which was fundamental for the Board to have right and was surprised around the issues identified on the lack of appropriate authorisation of shifts. Sarah explained that this was linked to being a joint bank with NHS Lothian as they did not have sight of the rosters. James enquired if eRostering would help with this. Sarah confirmed that it would make it easier around grip and control with the caveat that the system will only ever be as good as the information input.

Sonya enquired around the timescale for implementing eRostering and if there would be capacity issues for the HR team as she was concerned of the impact.

Andrew noted that as well as HR there would also be challenges for Nursing, Finance and Payroll, however if eRostering was implemented as expected then

it should deliver improved control and productivity gain to the overall management of staff rosters.

Sarah acknowledged that the lack of process was not good enough and NHS Borders was not where it needed to be and although the capacity issues were significant this was not an excuse.

The Committee noted the report and that it would be referred to the Resources & Performance Committee. This would also be escalated to the Board due to the no assurance rating.

7. **Governance & Assurance**

7.1 *Audit Follow Up Report*

Emily Mayne spoke to this item and highlighted that since the last meeting four actions had been identified as being over a year out of date and would require the Committee's attention.

James Ayling referred to the aged actions detailed within appendix 1 and confirmed that he was comfortable in respect of the updates for Estates and Facilities (2.1). Sonya Lam confirmed that she was also content with these. Andrew Bone advised that since the update was provided Scottish Government have clarified that the full PAMS update will not be required until 2025 which gives longer than anticipated so the deadline may be extended in line with this. The Committee were content should this be case.

In regard to Estates and Facilities (2.2-1) James asked, in light of the Reinforced Autoclaved Aerated Concrete (RAAC) issue, if the deadline specified would be achievable. Andrew advised that he was not confident that the Estates Compliance and Risk Team would be in place by the deadline noted of December 2023 and expected this to move into the next calendar year. Following discussion the timeline for this of March 2024 was agreed. Andrew added that he had received update on the status of all property surveys but that this information had not yet been presented to the NHS Borders Capital Investment Group. It was expected that this report will be presented to the group at its next meeting. It was also noted that discussions were ongoing with NHS Assure regarding commissioning a review of the BGH site, however this had also been impacted upon by RAAC and the estimated timeline for this was now summer 2024.

Gavin McLaren went on to provide an update on RAAC following the surveys undertaken the previous week where it was noted that none of the buildings listed as having RAAC were critical and no immediate action was required with any mitigating actions being put in place.

In regard to the Covid19 Governance Arrangements and Remobilisation action (2.3) Laura Jones advised that the Head of Planning & Performance was picking this up in June Smyth's absence and an update would be provided as part of the follow-up process ahead of the next meeting.

Laura added that the GDPR and Information Governance Arrangements action (2.2) was not within the Head of Planning & Performance's remit, however she

would be raising this with the Chief Executive and again an update would be provided as part of the follow-up process prior to the next meeting.

The Committee noted the audit follow up report.

7.2 *Audit Follow Up Process*
James Ayling reminded the Committee of the system asking managers to provide a verbal update on recommendations where timescales had slipped and had been identified by Internal Audit.

Compliance with Scottish Health Technical Memorandum 03-01 Part B – Ventilation Systems Internal Audit Report
Gavin McLaren provided an update and referred to the updated summary sheet recently circulated around the Committee providing an update on progress to date. It was noted that in the next update circulated there would be the addition of a revised implementation date where applicable. It was also noted that those actions which would be ongoing as business as usual would be marked as complete. Gavin went on to provide an update on the progress where it was noted that actions were either in progress or complete.

James Ayling was assured with progress noted within the last update received and noted that the asset surveys would be completed by the end of the month and looked forward to receiving an update in due course.

The Committee noted the update.

IM&T Resilience
Kevin Messer provided an update and advised that further progress had been made and an updated tracker would be circulated around the Committee. It was noted that there was now a full inventory of equipment in place where reliance was placed. Kevin explained that input was required from the Resilience Manager but this post had only been recruited to recently so he would be now picking this up.

Kevin advised that discussion on business continuity testing had also taken place with NHS Dumfries and Galloway and the configuration they use for this is currently being looked into as an option for Borders. Kevin hoped that recommendations would be complete by the end of the calendar year but if not, March 2024 at the latest.

James Ayling asked for an update on resources. Kevin advised that it was taking time to recruit to posts, however if they get the correct people in post they would be in a reasonably comfortable position.

James felt reassured with the update but asked for Internal Audit's opinion. Emily Mayne confirmed that she was comfortable with this but again noted the theme of a lack of capacity across the organisation.

The Committee noted the update.

Estates & Facilities (2.1)
This item was covered under item 7.1.

Estates & Facilities (2.2-1)
This item was covered under item 7.1.

7.3 *Audit & Risk Committee Workplan 2023/24*
Andrew Bone spoke to this item. Andrew highlighted that the main change made since the July meeting was the addition of a further Audit & Risk Committee meeting, making a total of 5 meetings per year plus some other minor changes as discussed and agreed.

James Ayling appreciated that financial matters are dealt with by the Resources & Performance Committee but recalled a recommendation within the External Audit Annual Report that the Audit & Risk Committee have oversight of progress with the financial savings programme. Andrew confirmed that this is a recommendation within the report, however he did not propose adding this to the workplan as the members of the Committee are all members of the Resources & Performance Committee and receive an update at these meetings. James noted his agreement to this as it would be a repetition of information. Andrew further commented that the Committee retains an interest in relation to the adequacy of governance arrangements and systems of internal control in relation to the savings programme, and that this would be considered as part of the Internal Audit plan. Sonya Lam also agreed with this proposal and added that should the Committee need to be made aware of anything this could be escalated as necessary.

The Committee approved the annual workplan for 2023/24.

7.4 *Debtors Write Off Report*
Andrew Bone spoke to this item which followed a recommendation from Internal Audit to strengthen the control framework for income recovery. It was noted that the report provided an update on the debt follow up process and use of the external debt recovery agency. Andrew highlighted that for the period being reported a total of £6.2k of income would be written off as this had been deemed as irrecoverable.

James Ayling enquired if all cases pre pandemic had been referred to the debt recovery agency. Andrew confirmed that all pre Covid debts, which have exhausted internal follow up processes, have been referred to the debt recovery agency. It was noted that some pre Covid continue to be followed up by internal reminder/chase up.

The Committee noted the report.

8. External Audit & Annual Accounts 2022/23

8.1 *Final Patient's Private Funds Annual Accounts 2022/23*
James Ayling reminded that the final Patient's Private Funds Annual Accounts had not been presented at the last meeting along with the Board's Annual Accounts, however these were not of a material amount and had received a clean audit opinion from Thomson Cooper, the External Auditor.

The Committee recommended that the Patient's Private Funds Annual Accounts for 2022/23 be presented to Borders NHS Board for approval on 5th October 2023.

8.2 *Audit Scotland Reports*

No issues were raised on the report detailing where Audit Scotland reports had been distributed across the organisation. The Committee agreed with the recommendation that the Fraud & Irregularity Report for 2022/23 be referred to the Countering Fraud Operational Group.

Karen Hamilton felt that the report would be helpful for sharing with Non Executive Directors, amongst others. Andrew agreed to share the report with Karen going forward for onward dissemination as appropriate.

The Committee noted the report.

9. Fraud & Payment Verification

9.1 *NFI Update*

Andrew Bone spoke to this item which was a standard exercise across the UK undertaken by public sector bodies. Andrew highlighted that 322 out of the 963 matches received had been closed with no potential fraud identified to date.

The Committee noted the update.

9.2 *Fraud Allegations*

Andrew Bone confirmed that there were no new fraud allegations to bring to the Committee's attention.

The Committee noted the update.

10. Integration Joint Board

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

10.1 *IJB Directions Tracker*

James Ayling advised that he had met with the IJB and SBC Audit Committee Chairs to discuss making processes more efficient and to try and avoid duplication. James provided feedback from this and it was noted that the IJB Directions tracker would be presented at each Audit & Risk Committee meeting going forward. This would be in addition to it going to the Board Executive Team and Operational Planning Group.

Hayley Jacks went on to explain that the NHS Borders Directions Policy (appendix 1) and the directions action tracker (appendix 2) had been produced in response to an Internal Audit recommendation to have a documented process to follow as directions are received. It was noted that the policy had been approved by the Operational Planning Group and the Quality & Sustainability Board. Hayley advised that the tracker will be a live document and will be updated as directions are received.

Sonya Lam referred to the directions tracker as she felt the 'outcomes' column was vague and queried how assurance could be taken from this that they had been carried out in accordance to the directions. Hayley advised that the Chief Financial Officer for the IJB oversees the tracker and she would feed back this comment. Haley added that the tracker is now a standing item on the IJB agenda and an updated version would be going to the meeting the following week.

James Ayling did not feel that it was apparent on the tracker whether or not progress has been made and provided an example where there was no update or timeline to note. James noted that there were others which did not have a deadline to ascertain if progress had been made. Andrew Bone felt that there was a need to look further at what is being captured and milestones added so dates can be tracked. Sonya agreed with the comments made by James and Andrew.

Karen Hamilton highlighted that the IJB had only recently started receiving the directions tracker and that it was still a work in progress. Karen agreed to also provide the feedback received to the IJB meeting later in the week.

James referred to the flowchart within the policy document and queried if NHS Borders Audit & Risk Committee should be included within this. Hayley agreed to ask the Chief Officer for this to be incorporated.

The Committee noted the report.

11. **Items for Noting**

11.1 *Information Governance Committee Minutes – 14th June 2023 (Draft)*

The Committee noted the draft Information Governance minutes from the meeting held on the 14th June 2023.

12. **Any Other Competent Business**

James Ayling referred to the dates which had recently been circulated for the 2024 meetings and asked the Committee to respond with availability.

13. **Date of Next Meeting**

Monday, 11th December 2023 @ 1 p.m. via MS Teams.

BE
02.10.23

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Risk Appetite Policy**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Author:	**Lettie Pringle, Risk Manager**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Local policy

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

- Effective

2 Report summary

2.1 Situation

Following the implementation of the Blueprint for Good Governance the risk appetite has been reviewed and updated to align with the Orange Book issued by the UK Government.

Risk Appetite is a matter reserved for the Health Board as per the Code of Corporate Governance and as such the Health Board are being asked to approve the revised Risk Appetite Policy.

2.2 Background

The risk appetite of NHS Borders has been established to provide a framework which enables NHS Borders to make informed decisions on which risks to mitigate by defining tolerable risk levels.

The benefits of adopting the risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making
- Supporting performance improvement
- Focusing on priority areas within NHS Borders
- Informing spending reviews and resource prioritisation processes

2.3 Assessment

Within NHS Borders, the nature of the services provided, changing external demands and fiscal constraints mean it is neither feasible nor practical to fully prevent or mitigate all risks at any point in time.

Risk appetite statements help to inform resource allocation at decision points, and additionally when the organisation periodically reviews its performance.

To gain consistency in the risk management decisions taken across NHS Borders, the risk appetite policy lays out statements which highlight the total risk that NHS Borders can tolerate within its risk profile. The policy also provides a structure for NHS Borders to work within.

2.3.1 Quality/ Patient Care

The Risk Appetite Policy allows risk owners across the organisation to follow a consistent approach to managing significant risks affecting quality and patient care by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.2 Workforce

The Risk Appetite Policy allows risk owners across the organisation to follow a consistent approach to managing significant risks affecting the workforce by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.3 Financial

The Risk Appetite Policy allows risk owners across the organisation to follow a consistent approach to managing significant risks affecting finances by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.4 Risk Assessment/Management

This policy will support the NHS Borders Risk Management Strategy and the NHS Borders Risk Management Policy.

2.3.5 Equality and Diversity, including health inequalities

An impact assessment (stage one) has been completed and is available as appendix 2.

Following advise from Public Health colleagues, it has been noted that while the actual policy might not materially impact on people in terms of protected characteristics, it is likely that the management of some of the risks will.

2.3.6 Climate Change

The Risk Appetite Policy allows risk owners across the organisation to follow a consistent approach to managing significant risks affecting climate change by providing parameters in the risk-taking approach deemed acceptable by NHS Borders and allowing informed decisions to be made based on risk exposure.

2.3.7 Other impacts

No other relevant impacts.

2.3.8 Communication, involvement, engagement and consultation

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

2.3.9 Route to the Meeting

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

- Operational Planning Group, 8 January 2024
- Board Executive Team, 23 January 2023

2.4 Recommendation

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

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Risk Appetite Policy
- Appendix 2 - HIIA

NHS Borders Risk Appetite Policy

File Name:	Risk Appetite Policy
Version Number:	V1.2
Status:	Draft
Prepared By:	Risk Team
Distribution date:	February 2024
Review date:	February 2026
Distribution arrangements:	Intranet

This policy has been approved for NHS Borders

…….. ……..
Chief Executive Employee Director

Approval date:
Authorisation date:

VERSION HISTORY

Release	Date	Author	Comments
Draft 1.0	17th August 2023	Risk Team	1st draft
Draft 1.1	14th September 2023	Risk Team	Amendments following comments
Draft 1.2	28th December 2023	Risk Team	Amendments after statement comments at BET/Board Development Session

AUTHORISING CONTROL

Document Control

Document Name: Risk Appetite Policy
Version Number: v1.2
Date Created: 17th August 2023
Date Last Amended: 28th December 2023
Approved By: *Operational Planning Group, Board Executive Team*
Authorised By: *Healthboard*

Term	Intention
shall	denotes a requirement: a mandatory element
should	denotes a recommendation: an advisory element
may	denotes approval
might	denotes a possibility
can	denotes both capability and possibility
is/are	denotes a description

Contents

Table of Diagrams

1 Introduction

1.1 Risk management is an integral part of good governance and corporate management mechanisms. An organisation's risk management framework harnesses the activities that identify and manage uncertainty, allows it to exploit opportunities and to take managed risks, not simply avoid risks altogether, and systematically anticipates and prepares successful responses.

1.2 Risk appetite statements are key enablers to communicating expectations and ensuring effective decision-making. They should be considered robustly and consistently across NHS Borders. In addition, their consideration may form evidence to inform and support financial planning, financial improvement plans, investment and budget allocation processes.

1.3 This Policy should be used alongside the Risk Management Policy and the Risk Fund Framework.

A. Risk Appetite

2 Definitions

2.1 Risk Appetite

2.1.1 Risk appetite is defined as the "amount and type of risk that an organisation is willing to pursue or retain". [1]

2.1.2 Within NHS Borders, the nature of the services provided, changing external demands and fiscal constraints mean it is neither feasible nor practical to fully prevent or mitigate all risks at any point in time.

2.1.3 The risk appetite of NHS Borders has been established to provide a framework which enables NHS Borders to make informed decisions on which risks to mitigate by defining tolerable risk levels.

The benefits of adopting the risk appetite include:

- Supporting informed decision-making
- Reducing uncertainty
- Improving consistency across governance mechanisms and decision-making
- Supporting performance improvement
- Focusing on priority areas within NHS Borders
- Informing spending reviews and resource prioritisation processes

2.1.4 To gain consistency in the risk management decisions taken across NHS Borders, the organisation will use the risk statements within this policy.

2.1.5 Organisational risk appetite statements highlight the total risk that NHS Borders can tolerate within its risk profile and provide a structure for NHS Borders to work within.

2.1.6 Risk appetite statements help to inform resource allocation at decision points, and additionally when the organisation periodically reviews its performance.

[1] (ISO Guide 73:2009 Risk Management – Vocabulary).

2.2 Risk Tolerance

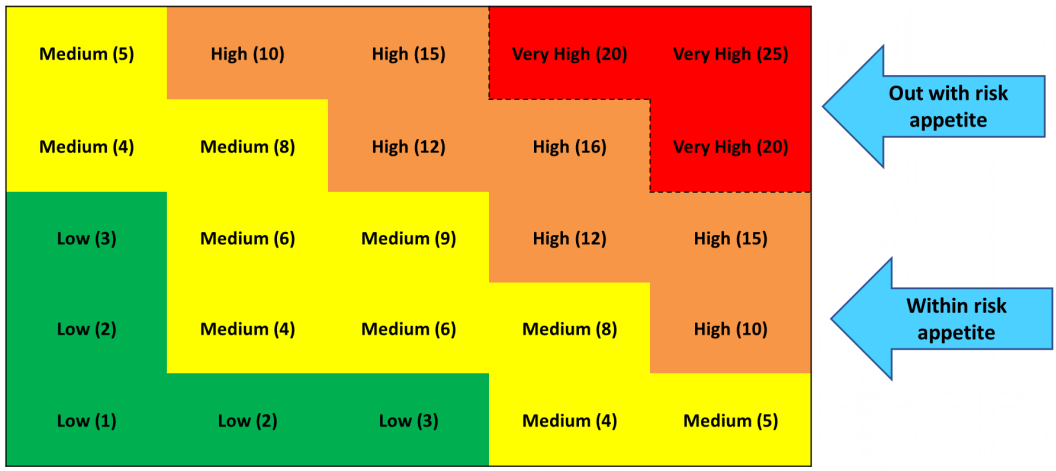
2.2.1 Risk tolerance is "an organisation's readiness to bear the risk after risk treatment in order to achieve its objectives".[1] This relates to the risk level that can be tolerated for each individual risk type.

2.2.2 Risk tolerance is a term that can be defined as an informed decision to accept the consequences and likelihood of a particular level of risk following implementation of an action plan.

2.2.4 The risk appetite process provides greater clarity on the risks NHS Borders wants to manage and those that can be tolerated. It sets the tone from the top for the risk culture across the organisation, ensuring there is a clear message that reflects NHS Borders visions and goals. It ensures that the actual risks are articulated to the organisation and informed decisions can be made.

2.2.5 All risks on the strategic risk register are overseen by the Board Executive Team, and the same risk appetite applies.

2.2.6 Any risks graded as very high risks will follow the risk appetite process.



3 Risk appetite to support effective decision making

3.1 The consequences of a decision being considered might impact several areas, perhaps even in a particular order, and require staff to weigh risks against each other in order to support effective decision making.

3.2 When weighing risks against each other, the organisation shall document what was considered at the time to inform the decision and the balance within the judgment made.

3.3 When decisions are made outside of appetite their justification and evidence should be recorded and reported following the risk management escalation process (**Appendix 1**). If a decision recognised as being outside of appetite is considered necessary, and is appropriately authorised and approved, it will require specific monitoring by the Operational Planning Group, and if necessary the Board Executive Team.

4 Exceptions

4.1 As organisations consider and maintain their risk appetite to reflect context and changing environmental factors, there may be circumstances, such as those experienced dealing with government's response to the Covid-19

crisis, when it becomes necessary to significantly alter the level, nature and balance of risks with which an organisation is willing, or required, to operate to deliver public services for a period of time.

4.2 Where this occurs, it is important that there is openness and transparency of these decisions and arrangements, active monitoring and reporting of consequences and clarity over recovery actions. If the circumstances are expected to endure, if only temporarily, then the Board Executive Team should consider re-stating its risk tolerance levels and review regularly. Likewise if there is a significant deviation from the risk appetite statements, the Health Board should consider reviewing these.

B. NHS Borders Risk Appetite

5 Organisational Risk Appetite Statements for all risks

5.1 All risks will be managed within statutory requirements.

5.2 Clinical risks will be managed in accordance with good clinical practice and clinical governance standards. Clinical risk owners should involve other stakeholders as appropriate.

5.3 Financial risk will be managed to corporate standards and financial policies.

5.4 All risks will be assessed using the electronic risk management system that informs the risk register. Any loss of service/resilience issues/ threats to corporate objectives must be proactively risk assessed and entered on the risk register and, where appropriate, business continuity plans put in place.

6 Risk Appetite Process

6.1 The process is a two-stepped approach whereby any risks graded as very high use the risk appetite process, including risk management approaches, to determine whether a very high risk is outwith organisational risk appetite. Risks deemed outwith risk appetite are highlighted by the risk owner on the risk register and these are then fed into the Operational Planning Group. The current risk appetite to certain types of risks is outlined in **Diagram 4**.

6.2 The Risk Appetite Process still allows risk owners to bring any level of risk on an ad hoc basis to the Operational Planning Group should they decide it requires support at a higher level.

7 Operational Risk

7.1 Very High Operational Risks

7.1.1 It is vital that the risk escalation process (**Appendix 1**) has been followed prior to reporting a very high risk to the Operational Planning Group:

- When a very high risk is identified at a local level, an action plan shall be put in place that is within the remit of that risk owner and the target risk level this will achieve shall be identified;
- If this action plan is unable to reduce the risk level, this should be escalated to the Line Manager who will develop an action plan within their remit to reduce the risk to the target risk level;

- If, after this, the risk level still cannot be reduced, this should be escalated to the quadrumvirate/ Corporate Services Meeting to ensure no additional support can be given before this is escalated to the Operational Planning Group.

7.1.2 As part of the scrutiny provided by the Operational Planning Group (or alternative if deemed appropriate) on whether to invest in mitigating risks, it is important for the membership to review the target risk level. If the target risk level is within risk appetite, the Operational Planning Group may decide that investment is not required following completion of actions put in place.

7.1.3 Where the target level still reflects a very high risk, the Operational Planning Group will be required to scrutinise the actions put in place to decide whether these are sufficient. If they are not, it is within the Operational Planning Groups responsibility to ask for a more robust action plan to be developed by the risk owner and monitor this risk within a time bound plan to ensure actions are being progressed.

7.1.4 If the actions are sufficient and robust, the Operational Planning Group will decide whether investment from the risk fund is the best solution to mitigate this risk or whether further escalation to the Board Executive Team is required.

7.2 High Operational Risks

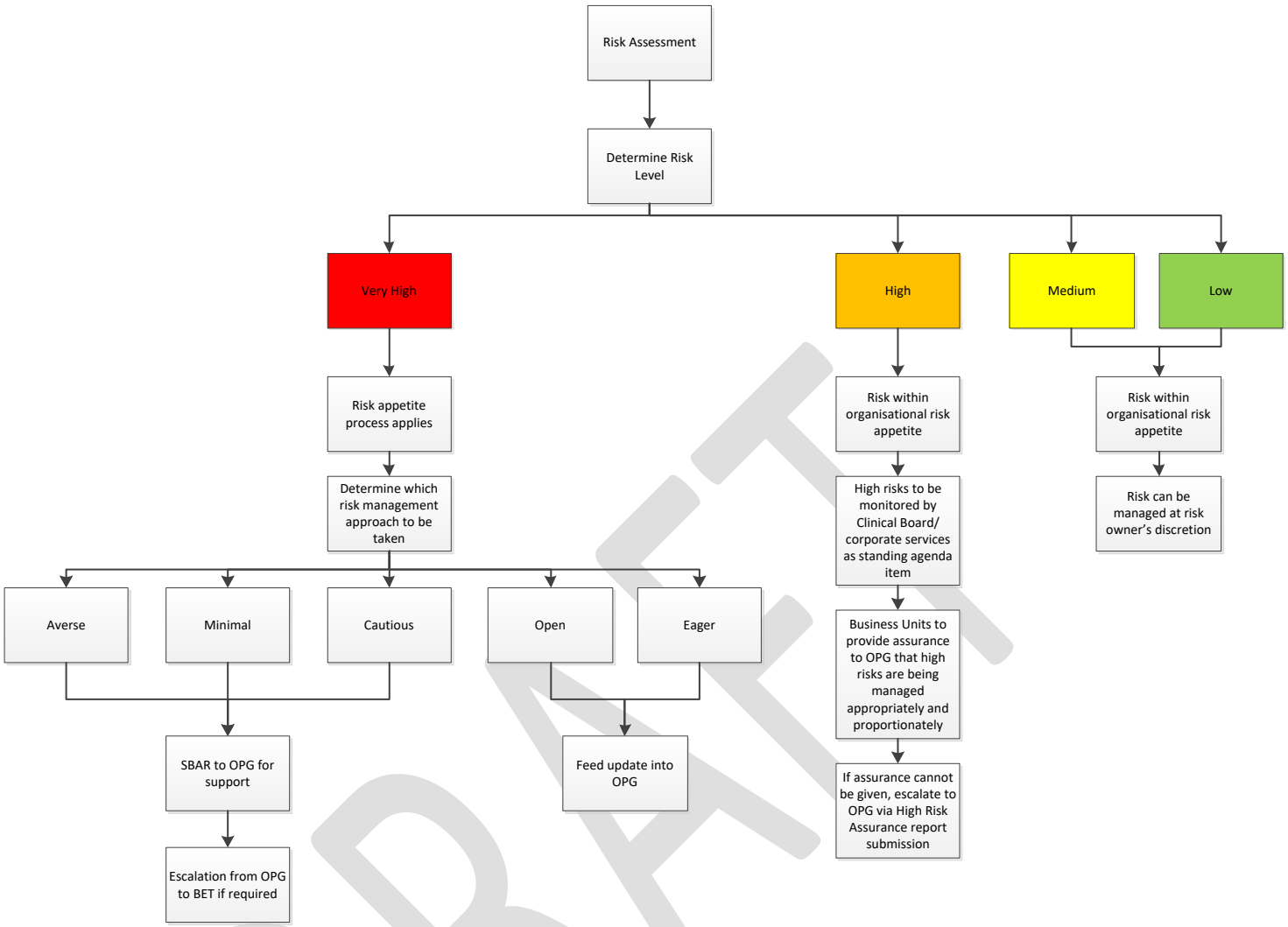
7.2.1 Governance of high risks will be achieved through business units as standing items on Clinical Board/ Corporate Services agendas. These groups will have the responsibility for oversight of high risks within their areas and will require assurance these are being managed appropriately and proportionately.

7.2.2 To support this work, reports on very high and high risks will continue to be fed into the Audit and Risk Committee and Clinical Governance Committee.

7.3 Medium/ Low Operational Risks

7.3.1 Medium and low risks should be managed locally by the risk owner and their management team to ensure that risks are not escalating and any actions are progressed as required.

Diagram 1: Risk appetite process - operational risks



8 Strategic Risk

8.1 Very High Strategic Risks

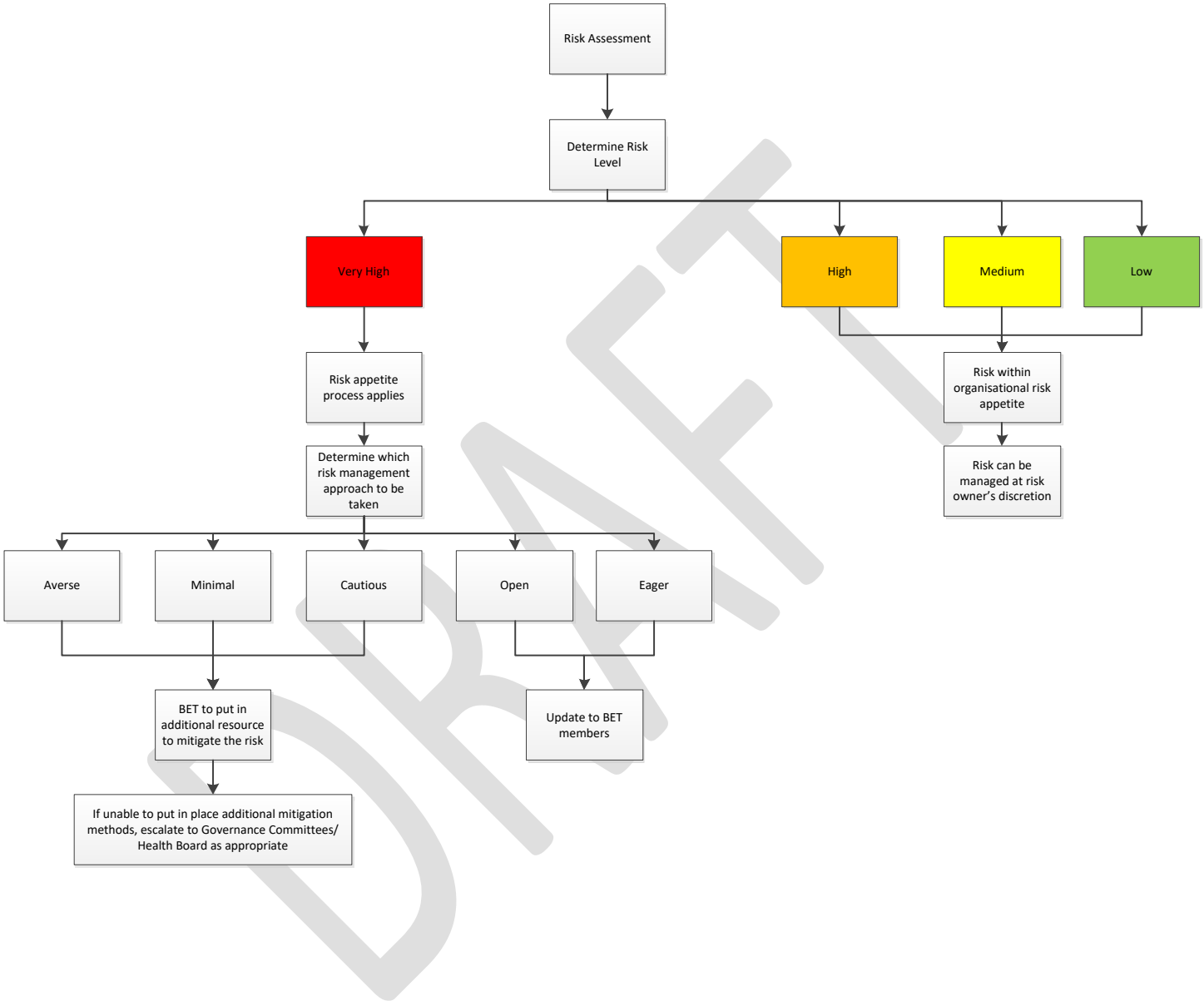
8.1.1 The Board Executive Team should scrutinise risks belonging to other members of the Board Executive Team to ensure that adequate resource is in place to mitigate risk. If it is deemed appropriate and mitigation is not possible, these risks should be escalated to the appropriate Governance Committee/Health Board.

8.1.2 Strategic risks within organisational risk appetite will continue to be fed into the Board Executive Team and Governance Committees as per agreed Committee work plans.

8.2 High, Medium and Low Strategic Risks

8.2.1 High, medium and low strategic risks should be managed locally by the risk owner and their management team to ensure that risks are not escalating and any actions are progressed as required

Diagram 2: Risk appetite process - strategic risks



9 Risk Approach

9.1 The risk approach outlines how the organisation will manage risks outwith the appetite.

9.2 Risks shall be assessed against the risk approach to decipher whether there is flexibility in the category of risk reported, before confirming whether it is within, or outwith, risk appetite.

9.3 It gives flexibility to those risks outwith organisational risk appetite where risk owners can use their discretion to manage a risk down in a set timeframe. Risk owners are given flexibility to put resources into reducing risk levels with the expectation there will be a robust action plan in place to do so within a set timeframe. The current risk approaches are positioned to protect the organisation from risks that could cause damage whilst still allowing positive risk taking to be undertaken to ensure opportunities are realised.

9.4 A decision by the risk owner on how to manage the risk shall be taken to the Operational Planning Group to agree an approach to minimise the risk.

Diagram 3: NHS Borders Risk Management Approach

Risk Approach	Definition	Actions Required
Averse	Avoidance of risk and uncertainty in achievement of key deliverables or initiatives is the key objective.	Risk managed with a robust action plan. No tolerance to risk with a very high risk level.
Minimal	Preference for very safe business delivery options with the potential for benefit/return not a key driver.	Risk managed with a robust action plan. Will tolerate risks for 3 months whilst risk is being mitigated/ reduced to an acceptable level.
Cautious	Preference for safe options and only limited potential for benefit. Willing to tolerate a degree of risk in selecting which activities to undertake to achieve key deliverables or initiatives, where we have identified scope to achieve significant benefit and/or realise an opportunity.	Risk managed with a robust action plan. Will tolerate risks for 6 months whilst risk is being mitigated/ reduced to an acceptable level.
Open	Willing to consider all options and choose one most likely to result in successful delivery while providing an acceptable level of benefit. Seek to achieve a balance between a high likelihood of successful delivery and a high degree of benefit and value for money. Activities themselves may potentially carry, or contribute to, a high degree of residual risk.	Risk managed with a robust action plan. If risk controls cannot be introduced due to lack of resource and its dependence on external factors the risk may be tolerated. An update should be given on progress to the Operational Planning Group within a specified timescale.
Eager	Eager to be innovative and to choose options based on maximising opportunities and potential higher benefit even if those activities carry a very high residual risk.	Risk managed with a robust action plan in place to ensure success. Risk may be tolerated. An annual update should be given on progress to the Operational Planning Group. Residual risks with a very high risk level should be considered through the risk appetite process separately.

Diagram 4: Risk Category - Appetite Statements

	Risk Appetite Statement	Risk Approach
Strategy	NHS Borders has an **eager** stance to risks arising from the pursuit of their strategic objectives, recognising the scale of transformation required to sustain health services.	Eager
Governance	NHS Borders takes a **cautious** stance to governance and is receptive to making and acting upon difficult decisions when the benefits outweigh the risks when clear plans/priorities/accountabilities are in place and where decision-making oversight is proportionate and effective.	Cautious
Operations	NHS Borders has an **open** stance to delivering services supported by innovative solutions and supports decision-making at local level where there is a positive impact on financial sustainability and patient and staff safety.	Open
Legal	NHS Borders has a **minimal** stance to risks arising from a defective transaction or a claim being made (including a defence to a claim or a counterclaim).	Minimal
Compliance	NHS Borders has adopted a **minimal** stance for compliance, seeking a preference for adhering to responsibilities and safe delivery options with little residual risk as far as reasonably practicable within given capacity. This includes risks arising from inadequate, poorly designed, or ineffective/inefficient internal processes resulting in poor quality care, unacceptable risk to patients or staff, non-compliance with standards, poor clinical / professional practice, fraud, error and/or poor value for money.	Minimal
Financial	Our financial decisions are heavily scrutinised, with value for money being a key factor in decision-making. We will accept risks that may result in some very limited financial loss or exposure on the basis that these can be expected to balance out but will not accept financial risks that could result in significant reprioritisation of budgets. As such, NHS Borders has adopted a **minimal** stance for financial risks regarding business as usual, seeking safe delivery options with little residual risk that can only yield some upside opportunities.	Minimal
Competence	NHS Borders has a **minimal** stance to risks arising from the unavailability of sufficient capability or non-compliance resulting in negative impacts on service performance and NHS Borders values. This stance supports informed risk taking in the further development of staff skills where professional statutory and mandatory training requirements are fulfilled in line with their job role responsibilities.	Minimal
People	NHS Borders has a **cautious** stance to risks that affect staff wellbeing, particularly when service delivery is compromised. NHS Borders is committed to ensuring that safe staffing levels are maintained where capacity and resource allows.	Cautious
	Risk Appetite Statement	Risk Approach

	Risk Appetite Statement	Risk Approach
Technology	NHS Borders has adopted an **open** stance to technological risks where proven technologies are considered to enable improved operational delivery.	Open
	An **averse** stance is taken for any risks relating to cyber security, technological fraud and inadvertent or malicious corruption/modification of data on its IT systems.	Averse
Information	NHS Borders has adopted a varied stance to information risk, to reflect the sensitivity of information as defined by NHS Scotland Information Classification. All risks relating to information should adhere to the NHS Borders information governance policies.	
	- Tier 1 (Unclassified/Personal): NHS Borders has adopted a **minimal** stance to limit the potential damage from disclosure of information;	Minimal
	- Tier 2 (Protected/ Official): NHS Borders has adopted an **open** stance, given the need for operational effectiveness, and with risk mitigated through careful drafting and/or limiting distribution;	Open
	- Tier 3 (Highly Sensitive/ Official Sensitive): NHS Borders has adopted an **averse** stance where there will be no tolerance to disclosure of information that would lead to serious risks to the organisation.	Averse
Premises	NHS Borders takes a **minimal** stance to any risks that fail to comply with strict policies for purchase, rental, disposal and construction that ensures producing good value for money.	Minimal
	NHS Borders takes an **open** stance to refurbishment where benefits outweigh the risks and innovative solutions can be realised.	Open
Commercial	NHS Borders takes an **open** stance to risks where commercial partnerships, supply chains and contractual requirements can be strengthened. Innovation is supported with demonstration of benefit / improvement in service delivery. Responsibility for non-critical decisions may be devolved.	Open
Security	NHS Borders takes a varied approach to security risks.	
	NHS Borders has adopted a **minimal** stance to risks causing loss or damage to property, assets, information, or people and are strictly controlled through adherence to policy and procedures.	Minimal
	For risks relating to building security NHS Borders takes a **cautious** stance to support organisational needs for public access to services, with appropriate monitoring measures in place.	Cautious

Inequalities	NHS Borders has adopted a **minimal** stance to inequality risks, ensuring that the majority of patients receive the same quality of care, at the correct time, in the correct manner.	Minimal
Project/ Programme	NHS Borders has an **open** approach to project risks to ensure that they are aligned with strategic priorities within the Medium-Term Plan and successfully and safely deliver requirements and intended benefits regarding time, cost and quality.	Open
Reputational	NHS Borders has adopted an **open** stance for risks allowing for informed decisions that have the potential to expose the organisation to additional medium to long term scrutiny, but only where potential benefits outweigh the risks.	Open

C. Governance

10 Escalation and Governance of risks within risk appetite process

10.1 The escalation and governance of risks, both within and outwith risk appetite, at certain risk levels will feed into and inform current work relating to implementation of a simplified decision-making structure and levels of authority to support the Quality Management System drivers for Business Processes.

Diagram 5: Operational risk escalation and governance

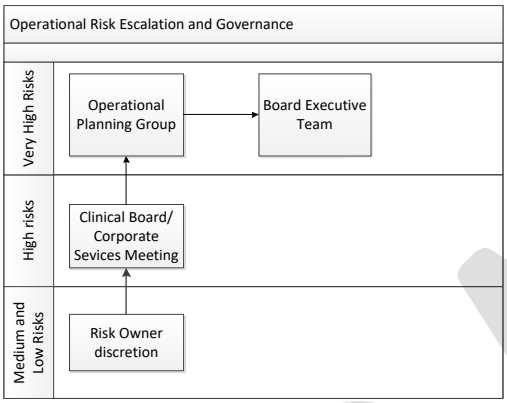
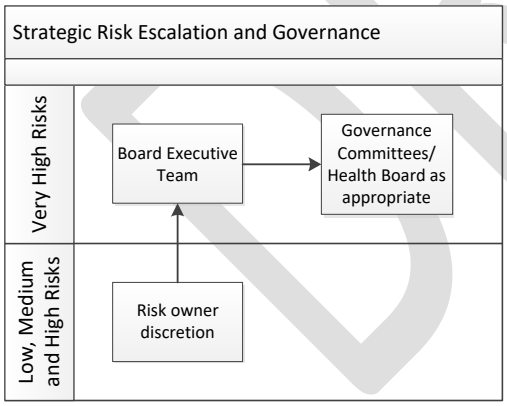


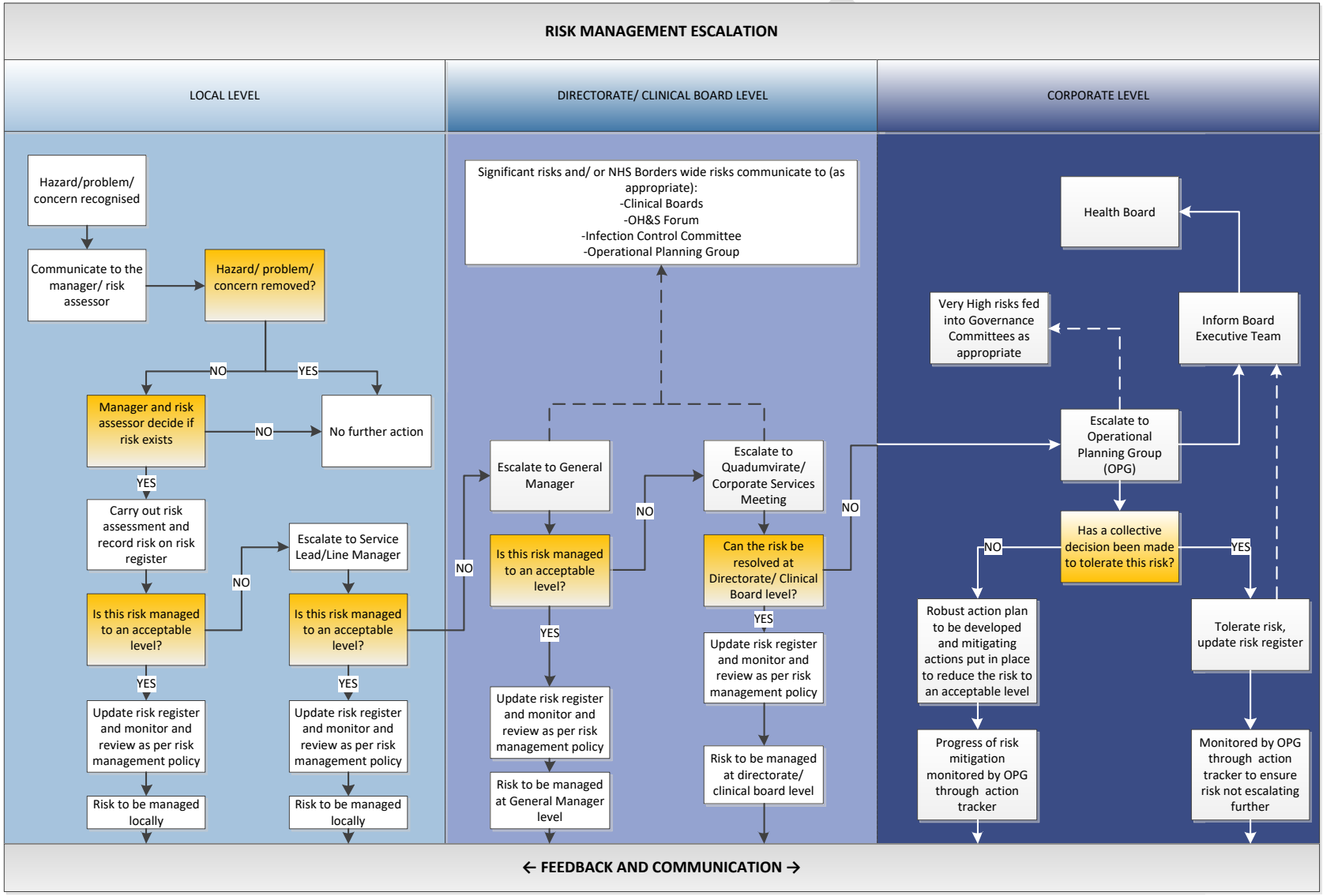
Diagram 6: Strategic risk escalation and governance



11 Internal Audit

11.1 As a key part of the risk management framework and to inform an opinion on the adequacy and effectiveness of governance, risk management and internal control, it is likely that NHS Borders internal auditors will want to review how its risk appetite statements are applied in practice within decision-making. For this reason it is important that Risk Owners and the Operational Planning Group document the factors influencing the decisions they make to ensure transparency and are able to demonstrate the exercise of judgment in seeking to deliver value for money.

Appendix 1 – Risk Escalation Process



Equality, Human Rights and Fairer Scotland Duty Impact Assessment

Stage 1 Proportionality and Relevance

What Integration Joint Board (IJB) report or Partnership decision does this proportionality and relevance assessment relate to:

NHS Borders Risk Appetite

Relevant protected characteristics materially impacted, or potentially impacted, by proposals (employees, clients, customers, people using services) indicate all that apply

Age	Disability Learning Disability, Learning Difficulty, Mental Health, Physical Neurodiversity	Gender	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and Maternity	Race	Religion and Belief (including non-belief)	Sexual Orientation

Equality and Human Rights Measurement Framework – Reference those identified in Stage 1 (remove those that do not apply)

Education	**Work**	**Living Standards**	**Health**	**Justice and Personal Security**	**Participation**

*Supplementary indicators

Main Impacts	**Are these impacts positive or negative or a combination of both**	**Are the impacts significant or insignificant?**

Is the proposal considered strategic under the Fairer Scotland Duty?	No
E&HRIA to be undertaken and submitted with the report – Yes or No **If no – please attach this form to the report being presented for sign off**	**Proportionality & Relevance Assessment undertaken by:** **Name of Officer: Lettie Pringle** **Date: 25.1.24**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Finance Report – December 2023**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Samantha Harkness, Senior Finance Manager** **Janice Cockburn, Finance Business Partner** **Paul McMenamin, Finance Business Partner**

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 periodic basis (i.e. both monthly and through formal quarterly reviews).

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 where required.

2.3.4 Risk Assessment/Management

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

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

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

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

This 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, 16th January 2024
- Board Executive Team, 30th January 2024

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 December 2024

FINANCE REPORT FOR THE PERIOD TO THE END OF DECEMBER 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 December 2023 and to advise members of the updated forecast outturn position (Quarter 3 review).

2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** that the board is reporting an overspend of £16.22m for nine months to end of December 2023.

2.1.2 **Note** the updated Q3 forecast outturn to £20.1m deficit and the risks to this forecast.

2.1.3 **Note** the position reported in relation to recurring savings delivered year to date (Section 5).

3 Summary Financial Performance

3.1 The board's financial performance as at 31st December 2023 is an overspend of £16.22m. This position is summarised in Table 1, below.

Table 1 – Financial Performance for nine months to end December 2023

	Opening Annual Budget	Revised Annual Budget	YTD Budget	YTD Actual	YTD Variance
	£m	£m	£m	£m	£m
Revenue Income	300.90	333.61	248.22	247.67	(0.55)
Revenue Expenditure	300.90	333.61	235.83	251.50	(15.67)
Surplus/(Deficit)	**0.00**	**0.00**	**(12.39)**	**3.83**	**(16.22)**

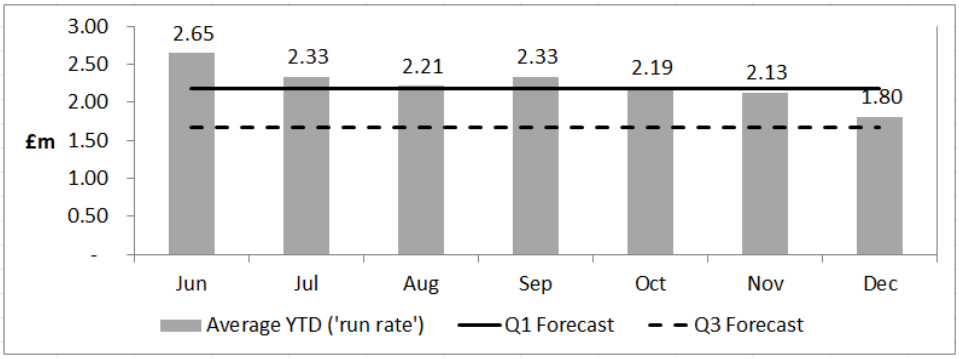
3.2 The Q3 outturn forecast (as at March 2024) has been updated to £20.1m deficit. This revised forecast follows review of operational expenditure, forecast savings, and areas of other potential flexibility including ring fenced allocations, deferred income and balance sheet reserves. This position remains above the expected outturn set out by Scottish Government following the Q2 review. Section 6 details this further.

3.3 The forecast is predicated on extrapolation of current trend on a number of areas of financial pressure (e.g. GP prescribing) which remain subject to variation and which therefore present a risk to the forecast. More recent data on prescribing has indicated a slight improvement on previous trend and this is reflected in the forecast.

3.4 Figure 1 provides an updated 'run rate' against forecast[1].

Figure 1 – Average YTD 'run rate' compared to plan / forecast

[1] Run Rate is calculated as the average monthly variance against budget (i.e. Year to Date variance divided by the number of months)



3.5 The YTD reported position of £16.22m overspend can be extrapolated on a straight line basis (i.e. 12 month pro-rata for the 9 months to date) to an indicative forecast of £21.6m. This would present a position which is £1.53m adverse against the revised Q3 forecast.

3.6 Actions are in place to deliver the improvement required during the period January to March which will achieve the forecast outturn, subject to any further variation in core operational performance. These actions include assumed benefit derived from release of accrued charges not yet realised in the year to date position; further grip & control actions as approved at the FIP board in December.

3.7 The run rate of £1.80m per month (average ytd) will need to meet a target run rate of £1.68m by March 2024 in order to meet the current Q3 forecast and would require to achieve £1.48m in order to meet the Scottish Government's expected outturn position as outlined in Section 6.

3.8 The forecast outturn will continue to be reviewed on a monthly basis with amendment for any significant changes to key variables.

3.9 Drivers for cost pressures are reported in section 4, below.

4 Financial Performance –Budget Heading Analysis

4.1 Income

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

Table 2 – Income by Category, year to date December 2023/2024

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Income Analysis					
SGHSCD Allocation	271.27	308.55	229.80	229.80	-
SGHSCD Anticipated Allocations	9.46	-	-	-	-
Family Health Services	10.24	13.45	10.89	10.89	-
External Healthcare Purchasers	4.68	4.93	3.76	3.20	(0.56)
Other Income	5.25	6.68	3.77	3.78	0.01
Total Income	**300.90**	**333.61**	**248.22**	**247.67**	**(0.55)**

4.1.2 As reported previously, the shortfall in income is related to a reduction in levels of activity through the Northumberland SLA. This shortfall reflects a reduction in activity against the contract baseline, which represents pre-pandemic activity levels.

4.1.3 It is likely that the commissioning body (Northumbria) will reduce the base activity level for future years and the impact of this adjustment will be reflected in the draft financial plan for 2024/25.

4.2 Operational performance by business unit

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

Table 3 – Operational performance by business unit, December 2023

	Opening Annual Budget £m	Revised Annual Budget £m	YTD Budget £m	YTD Actual £m	YTD Variance £m
Operational Budgets - Business Units					
Acute Services	69.07	82.20	61.02	61.03	(0.01)
Acute Services - Savings Target	(1.54)	(0.90)	(0.68)	-	(0.68)
TOTAL Acute Services	**67.53**	**81.30**	**60.34**	**61.03**	**(0.69)**
Set Aside Budgets	28.81	33.10	25.04	26.90	(1.86)
Set Aside Savings	(0.94)	(0.94)	(0.71)	-	(0.71)
TOTAL Set Aside budgets	**27.87**	**32.16**	**24.33**	**26.90**	**(2.57)**
IJB Delegated Functions	125.82	152.91	110.21	111.56	(1.35)
IJB – Savings	(4.33)	(3.70)	(2.77)	-	(2.77)
TOTAL IJB Delegated	**121.49**	**149.21**	**107.51**	**111.56**	**(4.12)**
Corporate Directorates	38.84	48.90	35.24	36.73	(1.49)
Corporate Directorates Savings	(0.05)	(0.54)	(0.41)	-	(0.41)
TOTAL Corporate Services	**38.79**	**48.36**	**34.83**	**36.73**	**(1.90)**
External Healthcare Providers	31.88	36.25	26.69	25.75	0.94
External Healthcare Savings	(0.13)	-	-	-	-
TOTAL External Healthcare	**31.75**	**36.25**	**26.69**	**25.75**	**0.94**
Board Wide					
Depreciation	5.06	5.06	3.79	3.79	-
Year-end Adjustments	-	(14.10)	(14.26)	(14.26)	-
Planned expenditure yet to be allocated	19.74	11.94	5.03	-	5.03
Financial Recurring Deficit (Balance)	(11.33)	(18.79)	(14.02)	-	(14.02)
Financial Non-Recurring Deficit(Balance)	-	(0.28)	(0.21)	-	(0.21)
Board Flexibility	-	2.50	1.88	-	1.88
Total Expenditure	**300.90**	**333.61**	**235.83**	**251.50**	**(15.67)**

4.2.2 **Acute Overall**[2]. The position is £3.26m overspent, of which £1.39m relates to non-delivery of savings.

4.2.3 Key drivers of operational cost pressures remain as per previous reports. This includes: on-going use of premium rate nursing and medical agency (with offset against core vacancies); unfunded inpatients beds; and medicines expenditure.

[2]Budget reporting is categorised as 'Acute Services' covering health board retained functions including planned care and women & children's services, and 'Set Aside' representing unscheduled care functions under strategic direction of the Scottish Borders IJB.

4.2.4 **Acute services** (excluding Set Aside) are reporting a net overspend of £0.69m. The main driver for this over spend is unmet savings which are being offset by continued underspend in pays, mainly related to vacant posts within Nursing & Midwifery. Vacancies are however utilised to offset workforce pressures across Set Aside (see below).

4.2.5 **Set Aside.** The set aside budget is overall £2.57m overspent, of which £0.71m relates to non-delivery of savings.

4.2.6 As previously reported there continues to be no change in the significant financial pressures that are being seen linked to areas of operational pressures within urgent & unscheduled care. This includes additional staffing to support A&E resilience and out of hours provision (including 'blue ED' and overnight waits); and continued use of unfunded beds through the Borders View ward and additional boarding across the BGH site. As at December 2023 there were 22 unfunded beds open within BGH (including 7 MAU beds) and an average of 8-10 patients requiring overnight trolley stays within A&E.

4.2.7 In addition to unscheduled care pressures the Set Aside budget is also impacted by increased hospital prescribing, with overspend in Neurology against high cost medicines.

4.2.8 **IJB Delegated[3].** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an over spend on core budgets of £1.35m. This position is underpinned by a level of on-going vacancy across key service areas largely relating to Dental Services, Allied Health Professionals and Community Nursing and Hospitals, primarily as a result of recruitment challenges. These savings to date partly offset the cost pressures noted below.

Within Mental Health and Learning Disabilities services, the main drivers of financial pressure are the continued use of medical locums (agency) to address a small number but yet significant workforce gaps within medical consultant staffing (Mental Health) and increases to the number and cost of individual packages of care for Learning Disabilities out of area placements.

4.2.9 Within Primary & Community Services there continues to be a significant pressure on Primary Care Prescribing budgets (see below) as well as a shortfall on funding available to support the current Vaccination Programme. In addition, the Home First service continues to operate at a level in excess of available resource. There also continues to be significant pressure on training, equipment and supplies budgets, predominately within Community Nursing and Hospitals, partially offsetting the underspends outlined in the same service areas in 4.2.8 above relating to Pay costs.

[3] IJB Delegated functions are comprised of clinical board business units for Mental Health & Learning Disabilities and Primary Care & Community Services, including AHPs.

4.2.10 **Primary Care Prescribing** – As at M09 the reported overspend is £1.18m representing a favourable movement since M08 of £0.20m. This position remains less assured than at the same period last year, given disruption to normal reporting timescales nationally, although as more frequent information has been made available, the previously reported position has been refined. Current spend is based on estimates reflective of trends in volume / expenditure to the end of September, which is still an additional one / two month(s) behind the normal reporting timescales respectively.

4.2.11 **Corporate Directorates** are reporting a net overspend of £1.49m on core budgets. There is little change to the reasons behind this position as it continues to be largely within Estates & Facilities, with key areas of financial pressure in relation to patient travel (supporting hospital discharge), utilities costs, and additional maintenance expenditure. Actions available to address these pressures are being considered through the Q2 review.

4.2.12 **External Healthcare Providers** Excluding savings there is an underspend of £0.94m. Most areas continue to report underspends at M09 with these underspends linked to reduced activity and changes in the modelling system with the implementation of the new Patient Level Information and Costing System (PLICS) within some of the boards including NHS Lothian. At present this is assumed to be non-recurrent and up to date activity has yet to receive in a number of areas. Scottish UNPACS is overspending due to increases in stem cell and cardiology patients treated within NHS Lothian earlier in the year.

5 Savings Delivery

5.1 Table 4 shows the recurring savings targets allocated to each area and the full year achievement of those targets to date.

Table 4 – summary recurring savings achieved as at December 2023

	Recurring Savings Target £m	**FIP Schemes identified – FYE impact** £m	**FIP Schemes identified – current year impact** £m	**Recurring Savings Achieved** £m	**Balance of Savings not yet delivered** £m
Acute Services	(1.05)	*1.12*	*0.93*	0.63	(0.42)
Set Aside	(1.08)			-	(1.08)
IJB Directed Services	(1.06)	1.02	0.95	0.63	(0.43)
Corporate Directorates	(0.85)	0.18	0.51	0.13	(0.73)
External Healthcare Providers	(0.35)	0.35	0.35	0.35	-
Board Wide	(2.18)	0.89	0.36	0.31	(1.86)
Total NHS Costs	**(6.58)**	**3.56**	**3.10**	**2.06**	**(4.52)**

5.2 Recurring savings targets for 2023/24 were set at 2% plus the balance of savings not achieved against the 2022/23 target on an individual business unit level. Board wide savings relate to targets set against the Prescribing workstream.

5.3 The Financial Plan assumed a minimum delivery of £5m (i.e. 2% of base budget), against which there are recurring schemes identified totalling £3.56m, of which £3.10m is expected to be released during 2023/24.

5.4 As at December 2023, £2.06m has been transacted against budgets. This is in line with the expected profile of savings delivery against the schemes identified to date.

5.5 There is a balance of £4.52m remaining to be achieved against the total budget target, of which £2.94m would be required in order to achieve the position identified in the financial plan. Of this, only £1.04m is identified within current year plans (£1.40m full year effect).

5.6 Key risks to the FIP programme remain consistent with those outlined in the recovery plan, i.e. constraints on operational management capacity and analytical resources, and a dependency upon effective clinical engagement. Of these the most significant remains the demands placed upon operational management capacity due to whole system (operational) pressures.

5.7 Additional actions for further improvement, both recurring and non-recurring, are being considered through the FIP Board meetings. The next FIP Board meeting is scheduled for February 2024 (January meeting cancelled due to operational pressures).

6 Forecast Outturn Position at March 2024

6.1 The Q3 FPR submission includes an improvement to expected year end outturn of £2.4m, taking the expected year end deficit down to £20.1m (from £22.5m). This revised outturn is still £2.3m away from the target set by Scottish Government in December 2023, which set out the expectation that NHS Borders achieve a year end deficit of no greater than £17.8m.

6.2 The movement from £22.5m down to £20.1m deficit has been achieved in part through improvement to operational performance, notably where primary care prescribing forecasts have improved following update to volume and price data from national systems. There remains a delay on information flow in this area and this presents a risk to the Q3 forecast which will continue to be monitored on an ongoing basis.

6.3 The balance of improvement to forecast is achieved through the delivery of a suite of measures including both local and corporate actions. The majority of these measures are non-recurrent and some actions are likely to be unsustainable beyond the end of March 2024**.**

6.4 Control measures introduced in January include the following:

- Pause on all recruitment to all non-clinical roles
- Restriction on use of overtime within non-clinical areas
- Pause on all non-medical and IM&T equipment, furniture and fittings
- Increased discretionary spend controls including further restriction on stationary catalogues

6.5 A revised Grip & Control panel has now been established under the chair of the Director of HR. This group is responsible for considering any escalation of safety or business continuity risks arising from the enhanced control measures introduced in January and is supported by the extant Grip & Control group which continues to review the effectiveness and opportunity for strengthening existing policies and procedures.

6.6 Further measures are now being considered in relation to clinical recruitment, as well as training & development and other areas of discretionary spend excluded from the initial changes implemented above. At this stage there remains significant concern regarding the impact of any further restrictions upon delivery of clinical services. It is likely that any further changes will be implemented as part of the revised process for 2024/25, following impact assessment.

6.7 Additional flexibility included within the Quarter 3 forecast includes resources identified through review of slippage on Scottish Government allocations, assessment of commitments against income and other resources expected to be carried forward to offset future expenditure, review of IJB reserves, and of balance sheet provisions.

6.8 As reported previously, the Director of Finance will set out a revised policy in relation to ring-fenced resources which will restrict any proposed carry forward of resources to areas where there is contractual obligation. This policy will be reviewed by BET in February. The impact of this approach has been assessed and potential releases are included within the forecast.

6.9 The cumulative effect of these measures is insufficient to address the reduction in expenditure required to achieve an outturn performance in line with the Scottish Government's expectations (£17.8m). At time of preparation of this report there are no further actions identified which are expected to contribute to financial improvement measures in 2023/24.

6.10 In summary, it is likely that the Board will be unable to achieve an outturn position in line with Scottish Government expectation. Given the wider NHS Scotland position there may be a risk that the Board will be unable to carry forward resources and income which are ring-fenced against unavoidable commitments (i.e. contractual obligations) and this therefore presents a risk to the financial plan for 2024/25.

7 Key Risks

7.1 Financial sustainability remains a *very high* risk on the board's strategic risk register (Risk 3588). This risk has been updated to reflect the Board's medium term financial plan and financial recovery plan for the period 2023/24 to 2025/26.

7.2 The expected level of financial performance set out by Scottish Government will require actions to be delivered during the period December to March which are not presently identified. It is therefore likely that the Board will fail to meet this level of performance. The potential impact on ring-fenced resources and future commitments is described in paragraph 6.10; and includes the impact on the Board's financial plan for 2024/25 should funding not be carried forward against unavoidable commitments.

7.3 A further risk exists that failure to meet the target level of performance will result in review of the Board's performance escalation status and introduction of further control measures upon the Board.

Author(s)

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NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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 17.01.24.

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 22.11.23

Borders NHS Board
Clinical Governance Committee

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 22 November 2023** at 10am via Microsoft Teams

Present

Mrs F Sandford, Non-Executive Director (Chair)
Ms S Lam, Non-Executive Director
Dr K Buchan, Non-Executive Director

In Attendance

Miss D Laing, Clinical Governance & Quality (Minute)
Mrs L Jones, Director of Quality & Improvement
Dr L McCallum, Medical Director
Dr S Bhatti, Director of Public Health
Mr P Grieve, Associate Director of Nursing, Chief Nurse Primary & Community Services
Mr P Williams, Associate Director of Nursing, Allied Health Professionals
Mr P Lerpiniere, Associate Director of Nursing, Mental Health & Learning Disabilities
Mrs E Dickson, Associate Director of Nursing/Head of Midwifery
Mrs C Cochrane, Head of Psychological Services
Mr S Whiting, Infection Control Manager

1 Apologies and Announcements

Apologies were received from:

Mrs H Campbell, Non-Executive Director
Mr R Roberts, Chief Executive
Mr G Clinkscale, Director of Acute Services
Dr J Bennison, Associate Medical Director, Acute Services
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Mrs L Pringle, Risk Manager

The Chair confirmed the meeting was quorate.

The Chair welcomed:

Mr M Clubb, Director of Pharmacy who was in attendance at his first Committee meeting
Mr C Myers, Chief Officer SBHSC Partnership (items 5.4 and 5.5)
Dr K Stewart, Chair of Blood Transfusion Committee (Item 6.1)
Mrs L Milven, Infection Control Development Facilitator (shadowing Mr Whiting)
Mrs L Chadburn, External Auditor Grant Thorburn (observing)
Mrs R Gardiner, Team Manager Learning Disability Service (observing)

2 Declarations of Interest

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

The **CLINICAL GOVERNANCE COMMITTEE** noted Mrs H Campbell's Law firm represents a current inpatient in NHS Borders Mental Health Unit. Previous declarations stood.

3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 13 September were approved

4 Matters Arising/Action Tracker

There were no matters arising from the previous meeting. 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 noted a couple of corrections to make to the report:

- Page 5, Figure 4 – the graph is a count graph rather than days between. The data is correct and outcome not statistically significant.
- Appendix A – the outbreak summary figure was a combination of suspected and confirmed not just confirmed. Going forward Staff COVID suspected cases will be reported the same way as Norovirus

Mr Whiting reported that staffing issues continue to have an impact on quality improvement and surveillance work. Discussion took place relating to team resilience relating to these activities.

Mr Whiting commented on progression of the CAUTI group, he discussed comparisons with National data relating to E-Coli and urinary tract infections which demonstrated NHS Borders is in line with other Boards and identified those with lower infection rates to see if there is any learning from their methods and drivers. District Nursing catheterisation referrals and rates of E-Coli and staph aureus bacteraemia are being scrutinised to establish any connection and learning from these cases.

Following a query from Ms Lam Discussion took place around improvements in hand hygiene compliance in correlation with support and education from hand gel suppliers. Mr Whiting noted that it was difficult to fully identify a connection but there is a commitment from the suppliers to support education.

Mrs Jones asked what the timescales relating to HIS action plan are, Mr Whiting will include an update on progression towards the plan in January's report.

Ms Lam enquired about hospital acquired e-coli and there followed a discussion regarding any investigations taking place, Mr Whiting commented that they are working alongside Clinical Governance Team to establish causes and links if any, the Committee will be cited on the findings.

ACTION: Include update on timescales relating to HIS action plan in next report

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the systems and processes in place.

5.2 Quarterly HSMR

Mrs Jones reported there was nothing to escalate to the Committee, report is within normal range with crude mortality on trend. There is a morbidity and mortality review taking place today, any emerging themes will be presented to clinical groups. Discussion followed relating to changes in methodology and NHS Borders' ability to look at trends over time. Mrs Jones noted that NHS Scotland's focus was on annual reporting and we would only be concerned if our figures sat out with the funnel chart.

Discussion took place following a question from Ms Lam regarding indicators that would instigate further investigation, Mrs Jones gave an overview of work done with ISD looking at impact of palliative care and triggers which would identify harm against other Boards without a palliative care unit in acute footprint. Dr McCallum provided assurance that they are standardising Morbidity and Mortality reviews within value based medicine programme and findings will be presented to committee in annual mortality report.

Dr Bhatti enquired about how community deaths are reported. Mrs Jones confirmed that the HSMR national report is related to acute services only however NHS Borders did track community mortality, which is reported in weekly safety dashboard, any deviation from norm would instigate investigation.

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

5.3 Risk management Q1 Report

Mrs Jones provided a brief overview of the content of the report. She commented there had been work done on processes relating to very high and high risks. Mrs Jones assured the Committee the majority of high risks have been through the operational planning group escalation process and are being considered in detail with the remaining scheduled for discussion. Risks are scrutinised and decision made to escalate should the adequate controls not be in place. These risks are also escalated to the Board as appropriate.

Mrs Pringle had been working on targeted improvement work and historical risks which have been replaced by new risks and is making good progress. Progress is also being made on areas uploading their risks to risk register ensuring it is up to date and contemporary but more focussed attention is required.

Ms Lam enquired about progress in Q2 which prompted discussion on risks reviews and mitigations. Mrs Jones commented that steady progress was being made in bringing risks down with a hope that status will be brought back to pre-pandemic data.

Dr Bhatti made a reference to impact of streamlining management meetings in order to free up capacity to complete management tasks, Mrs Jones commented that although it might be possible to cut back management meetings it was not possible to strip back the frequency of governance meetings which have a remit for risk management.

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

5.4 Strategic Risk – Whole System Flow

Mr Myers provided an overview of the content of his report. He was keen to express that the risks were very much whole system and not just unscheduled care responsibility, with impacts on patient safety, performance and finance throughout the health and social care partnership.

He commented workforce issues were a key challenge, a number of actions had been taken to address these as outlined in the paper. Risks had been discussed at IJB so all agencies are aware and committed to working towards solutions.

The organisation is currently in line with the delayed discharge and surge reduction plan but are aware that there are further challenges ahead which may impact on this trajectory.

Discussion followed in relation to integration of home first and adult social care and assumed reduction in delays due to foreseen increase in productivity of that service, however following concerns raised by NHS Borders staff side further discussions with Area Partnership Forum are required.

Mr Myers commented that services are stretched and staff are being moved around both in Health and Social Care to mitigate any shortfalls which has a balancing impact throughout services.

Mrs Jones gave a brief update on risks and impacts on scheduled care and flow through the wider system. She touched on steps taken within surgical assessment unit to protect space taking into consideration winter plans and the increase in theatre sessions noting that there had been an improvement on site position but there were still challenges ahead to sustain improvement.

Dr McCallum asked if Mr Myers could give and update on the Kaizen work on delayed discharges and reducing times for social work assessment. He mentioned increase in demand and complexity of cases within a relatively small workforce facing shame challenges as healthcare partners. He updated the Committee on the work in integrating and streamlining discharge teams to provide a multidisciplinary approach. NHS Borders are liaising with NHS Tayside to see if there is learning from their successful discharge systems and processes. The Committee stated they were keen to see updates on data and progress against the work on reducing discharge delays, Mr Myers noted that there is daily capture of the information in hospital system and weekly from community which is key in reducing delays. The Chair commented she was pleased to see this information as it had not been presented to Board, Committee or IJB previously and would like to ensure challenges in referral and assessment delays are escalated to the Board.

Mrs Jones acknowledged Mr Myers has a difficult role in trying to pull all services together to provide a more multi-disciplinary approach, she informed the Committee of plan to have workshop with all sectors to ensure outputs are fed into action plans.

There was further discussion relating to changing focus and both Dr McCallum and Mr Myers want the Committee to understand that flow issues don't just sit with one sector, it requires a whole system approach to solutions.

ACTION: Escalate delays and associated challenges to Board

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents and ongoing work on processes but remain unassured on outcomes

5.5 Strategic Risk – Quality & Sustainability PACS & Independent Contractors

Mr Myers provided a brief overview of the content of the report. Recruiting and retention remain within primary care providers in the Borders. This has a knock on effect on care and demand in secondary care. Measures are being put in place to address this risk as noted in the report. He again highlighted the need to work in partnership as the risk spans across the health and social care partnership. Business Continuity plans across the piste are essential to develop assurance and understanding of individual providers with controls in place to manage risks and reduce impacts. He informed the committee that during COVID a critical functions framework was developed at partnership level looking at health and social care services across the partnership as part of integrated working model. This will assist in aligning business Continuity plans.

Work collectively with GP Subcommittee and GP Executive colleagues is ongoing to ensure delivery of Primary Care Improvement plan from Scottish Government. Mr Myers highlighted the various schemes taking place to address recruitment to rural locations. He cited issues with staff from Primary Care moving in to Secondary Care sector due to better working conditions and the importance of equality of employment in all sectors to ensure a good work-life balance and reduce pressures being felt by the Primary Care workforce.

Issues in dentistry provision have been acknowledged by the Scottish Government with Borders being designated as Scottish dental access initiative area, new practices have been established which will improve dentistry provision locally. Dental Payment reform had also come into play from start of November. Concerns are emerging relating to early oral health these are being discussed at National level

Dr Buchan brought up the difficulties in recruiting GPs to the Borders, discussion followed relating to reasons for these difficulties and possible solutions. The Chair offered to have a discussion with Dr Buchan outside the meeting. Mr Clubb cited the Committee on Community Pharmacy shortfalls and difficulties similar to GPs in recruitment.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents, acknowledging that risks are there but work towards solutions are ongoing

5.6 Duty of Candour – taken out of sequence

Mrs Jones provided a brief overview of the content of the report. She reported that there is still no standard or clarity for Duty of Candour and work Nationally is ongoing. It is a year since the legislation was put in place, during this time awareness in the importance of Duty of Candour in terms of staff compliance had been raised.

As a result NHS Borders have been fully compliant in enacting Duty of Candour as appropriate but there is still work to do around pressure damage cases where there were difficulties in providing evidence that all aspects of the duty were enacted.

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

6 Assurance

6.1 Blood Transfusion – taken out of sequence

Dr Stewart provided a brief overview of the content of the report giving a short presentation on the salient points. Overall performance against key performance indicators set by SNBTS including keeping up with any developments had been maintained. The service had been

working closely with Clinician and Professional Development team to deliver training and SIMS sessions. Challenges had been seen within haematology with no haematologist to lead the Transfusion Service and no lead for laboratory. Workforce challenges had an effect on keeping up with statutory and mandatory training due to shortages. It is hoped once posts are recruited to more robust processes will be in place. Dr McCallum gave update on progress of recruitment of Haematologist, it is hoped that they will take up post by summer. She thanked Dr Stewart for all her hard work recognising how vital the Transfusion Service is to NHS Borders.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured but are assured that concerns are being addressed

6.2 Research & Innovation Governance Annual Report

Mrs Jones provided a brief overview of the content of the report. There had been a slight decrease in research activity but this could be due to workforce issues in some specialties meaning we were unable to open new studies. She hopes this will improve when the workforce stabilises. On the flip side development was being seen in specialty areas where there had been little research previously.

Mrs Jones noted that innovation is growing rapidly, funding needs to be ringfenced for this purpose. Discussion followed regarding NHS Borders being one of the test areas for feasibility study relating to drone activity in health care, Mrs Jones will keep them updated on progress. The Committee congratulated Dr Chan on her Innovation Fellowship.

There followed discussion on exploring use of endowments to support and promote innovation. The Chair agreed that she would look into this as a possibility.

ACTION: Mrs Sandford will explore innovation funding from endowments

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

7 Effectiveness

7.1 Clinical Board update – Acute Services

Mrs Dickson provided a brief overview of the report. She reported pressures across the site had lessened with decreased reliance on ED surge area. Pressures remain in medical areas with significant number of social work delays.

Work is progressing towards increasing elective activity through ring fenced beds. Staffing extra beds overnight may be a challenge if unit needs to remain open out of hours. There is a decrease in pool of nurses coming through training Nationally, this is expected to worsen so increasing international nurse cohort is essential. Discussion followed relating to increase of ringfenced beds for surgical activity.

Mrs Dickson also pointed out compliance in medications management had improved and continues to be monitored on a daily basis.

Auditing of treatment escalation plans in DME had been undertaken, this will be spread no to medical unit and results will be reported to the Committee.

Mrs Jones commented on elective waits from an outpatient perspective, work is underway on cataract activity in ophthalmology and challenges in dermatology which will have an impact

on outpatient lists. She updated the Committee on activity which will be ongoing over the coming year. There had been challenges in women and child health and Mrs Jones has asked Mrs Guthrie to highlight these in the next acute services update to the committee.

Dr Bhatti enquired about getting some of the data broken down into gender to ensure that no one is affected disproportionately. Mrs Jones will pick that up with Dr Bhatti.

ACTION: Update on Women & Child Health Challenges to be include in acute report
Discuss breakdown of data into gender

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents citing concerns relating to patient flow.

7.2 Clinical Board update – Mental Health & Psychological Services

Mr Lerpiniere gave an overview of the paper highlighting that with the support of the executive team there had been a pause in non-urgent assessments to allow for some catch up of the backlog. This is coming to an end and a model to enable a more consistent sustainable approach is being worked on.

Discussion took place relating to the unannounced HIS inspection which had been positive and work had commenced on identified areas for improvement.

Mr Lerpiniere also highlighted that there is a high level strategic plan being developed to support medical staff, this will be presented to the board at their next meeting.

There was discussion relating to the ECT Standards and the concerns surrounding provision of that service, Mr Lerpiniere will work with Dr Campbell and update the Committee as appropriate.

ACTION: Mr Lerpiniere will discuss ECT standards concerns with Dr Campbell and update Committee

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising the ongoing issues in delivery of care.

Unfortunately the Psychological services report had not been available prior to the meeting, this has now been sent on to members. Dr Cochrane provided a brief overview of the service citing concerns relating to waiting times. Members were invited to contact her should they have any questions. There will be an update at the next Committee meeting in January.

The **CLINICAL GOVERNANCE COMMITTEE** noted the update and is partially assured recognising concerns relating to waiting times cited by Dr Cochrane.

7.3 Clinical Board update LD

Mr Lerpiniere provided a brief overview of the content of the report. He introduced Rachel Gardiner, new LD Team Manager.

He commented on the National home implementation programme which supports aspiration to provide care closer to home noting there is a steering group set up to achieve this, recognising that there are significant challenges in reaching
these aspirations ensuring safe care options are provided within resource constraints. Mr Lerpiniere reminded the Committee of the importance of encouraging persons with learning disabilities to take up health screening and providing access to appropriate care and support.

Ms Lam enquired about feedback relating to Mental Welfare Commission visit in November. Mr Lerpiniere provided some informal feedback, the Welfare Commission were on the whole impressed with level of integration and collaboration within a small service. There was further comment on care planning and IT available to support this, a formal report will follow.

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

7.4 Clinical Board update Primary and Community Services

Mr Grieve provided a brief overview of the content of the report. He commented on Community Hospitals position, all four hospitals remain acutely busy and under the same staffing pressures as acute service. Kelso GP's have notified the Board they are handing back medical responsibility which may leave Kelso Community Hospital unstaffed from a medical perspective, a review is underway of all Community Hospitals.

Mr Grieve also highlighted his concerns relating to the Tissue Viability service which is under staffed, there has been a move for additional funding within Primary & Community budget and funding for additional resources had been approved for the coming year, he remarked the service spans across the health and social care footprint and is not the sole responsibility of Primary & Community Services and is keen to explore a whole system approach to future funding. Mrs Jones commented that in relation to pressure damage in particular that a full demand and capacity review would be welcomed and supported by the organisation.

Mrs Jones mentioned on behalf of Mrs H Campbell that a section in the PACS report in terms of pressures and mitigations relating to Home First service would be appreciated. Mrs Campbell would also welcome some information on impact of closure of the Chirnside medical Practice.

The Chair asked Mr Grieve if he could include some information relating to impact of social work assessment delays and any impact a physician associate model would have before the next meeting.

Ms Lam expressed an interest in AHP workforce staffing levels. The AHP annual report is due at the next Committee meeting in January so these figures will be included in that report. Mrs Jones commented that she will also ask that Mr Carter highlights these pressures and financial projections in his report to the Board.

ACTION: Update on impact of closure of Chirnside Practice
Data relating to impact of social work assessment delays
Highlight financial pressures and projections in primary care to Board

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents but aware of the risks the system continues to carry.

8 Person Centred

8.1 Patient Experience update and annual report

The **CLINICAL GOVERNANCE COMMITTEE** agreed that this item would be postponed due to meeting running over.

9 Items for Noting

Minutes from other Governance Meetings/Committees
Public Health Governance Group 22/02/23
Public Health Governance Group 23/05/23

Learning Disabilities Clinical Governance Group 11/10/23
Mental Health Clinical Governance Group 26/04/23
Mental Health Clinical Governance Group 28/06/23
P&CS Clinical Board & Clinical Governance 6/08/23
Public Protection Committee 22/02/23
Public Governance Committee 01/02/23
Public Governance Committee 15/06/23

10 Any Other Business

Clinical Governance Committee Meeting dates 2024/25 – these will be revisited to try and accommodate a change in member availability and will be sent on once dates agreed.

There were no further items of competent business to record.

11 Date and time of next meeting

The Chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 17 January 2024** at **10am** via Teams Call.

The meeting concluded at 12.31

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Quality and Clinical Governance Report – December 2023**
Responsible Executive/Non-Executive:	**Laura Jones, Director of Quality and Improvement**
Report Authors:	**Julie Campbell - Lead Nurse for Patient Safety and Care Assurance, Susan Cowe, Quality Improvement Facilitator - Person Centred Care**

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 key aspects of clinical effectiveness, patient safety and person centred care within NHS Borders.

2.1.2 The Board is asked to:

- note the report and detailed oversight on each area delivered through the Board Clinical Governance Committee (CGC).

2.2 Background

2.2.1 NHS Borders, along with other Boards in Scotland, continue to face extreme pressures on services. Demand for services, remains intense and is exacerbated by significant staffing and financial challenges, across the health and social care system.

2.3 Assessment

2.3.1 Clinical Effectiveness

The Board CGC met on the 17 January 2024 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.

2.3.2 The Annual Report on Allied Health Professionals (AHPs) was considered by the CGC. The report highlighted various items of work being undertaken with aims to improve both patient outcomes and national targets. Waiting times for AHP outpatient services remain in a good position in most disciplines with a particular area of pressure in Dietetics. It was noted however, that whilst AHP vacancy rates in NHS Borders are similar to the rest of Scotland, the boards' turnover rates are slightly higher than other NHS Boards. This staff turnover is having an impact on service delivery due to the requirement of recurring support, supervision and upskilling involved in the hiring of new staff. This has been raised at the National Educational Workforce Review. The CGC were partially assured by the AHP report recognising the ongoing workforce challenges and impact on full local service provision.

2.3.3 General Practice Sustainability was discussed. There continues to be a significant vacancy rate in General Practice (GP) with an ongoing reliance on locums. Several practices are expressing challenges in meeting clinical demand which is resulting in practices handing back contracts for enhanced services and responsibilities for community hospitals. There are risks that practices may need to restrict new additions to their lists, limit practice boundaries and the potential for branch closures. These risks are being actively managed, but they are present and hence the focus on GP sustainability actions. Some positive interest has been received in the new GP career start scheme aiming to attract new doctors into general practice. NHS Borders have also been selected as a demonstrator site for the Primary Care Improvement Programme (PCIP) which is a great opportunity to test new models of work to support the sustainability of general practice in a remote and rural board. The CGC were partially assured by the GP sustainability paper and encouraged by the developments around GP career start and PCIP demonstrator.

2.3.4 The CGC considered a report on the Strategic Risk relating to the Quality and Sustainability Mental Health Services. This risk focuses on the ability of NHS Borders to continue to meet the level of mental health need to ensure effective outcomes for our population in the context of workforce challenges and financial constraints. The conversation built on the early reports from the Mental health and Learning Disability clinical boards detailing the current risks they face. The funding models for mental

health were discussed and the ring fencing of funds and also the non-recurring nature of around 20% of funding for specific initiatives. This presents a significant risk to the sustainability of services reliant on external funding of this nature. The CGC gained partial assurance on this report given the significant workforce risks in mental health services and the growing population need for mental health services as well as access to specialist beds across NHS Scotland.

2.3.5 The CGC considered the annual Drug Death Report. The Scottish Borders have seen a positive reduction in drug deaths in the last year but the report to the committee containing figures for the year 2022 detailed a continued upward trend in the five year rolling average to 17 deaths in 2022. The has been a noted increase in deaths related to cocaine use and also the use of gabapentin/pregabalin. A non-fatal overdose pathway is in place locally and there is wide spread good availability of naloxone due to local improvement initiatives. Each death is reviewed by a muti-agency team to identify learning and make improvements to local services. The CGC were assured by the work underway in this area and progress against the Medication Assisted Treatment standards and emphasised the continued need for an ongoing focus here to drive down drug deaths.

2.3.6 The annual Suicide Report was presented to the CGC including the Mental Health Improvement and Suicide Prevention Action Plan – Creating Hope in the Scottish Borders. The report on suicides in 2022 detailed 16 deaths by probable suicide in the Scottish Borders. The age standardised mortality rate per 100,000 population between 2018-2022 was 15.6 persons in the Scottish Borders compared with 16.8 for Scotland. A higher rate of suicide is observed in males over females but the Scottish Borders like the rest of the country have seen an increase in female suicide. The committee discussed the huge impact that suicide has on families and lifelong harm it can bring. A small number of the people who died by probably suicide were known to local mental health services within the year before death. A Significant Adverse Event Review (SAER) is undertaken where there is a death of a patient who has accessed a mental health service in the year up to their death. The learning from each SAER is used to inform the delivery and development of local services. The local action plan recognises that many people are not known to mental health services and focuses on the community wide actions required to prevent suicide. There is focused work on education to support those in crisis, work to provide safe places and supporting those bereaved by suicide. The CGC were assured by the work underway in this critical area.

2.3.7 The CGC considered a reported from the Director of Finance on the Estate and Infection Control Risks. The report focussed on environmental risks associated with the built environment and progress against detailed actions set out in the last report to the committee. An Environmental Risk Oversight Group has been established to bring focus to this area and is systematically working through key areas to assess risk, progress with remedial action plans, core monitoring and assess any ongoing resource requirements. The Oversight Group has been working closely on ventilation, water safety, decontamination and have recently begun gap analysis work in the areas of security and medical devices. A programme of internal audit has also been commissioned to support these critical topic areas. The report provided an update on key risk areas including Reinforced Autoclaved Aerated Concrete (RAAC) across NHS Borders estate, environmental risks being managed at Haylodge House, flooring risks predominately within outpatient and inpatient areas across the Borders General Hospital and theatre ventilation. Significant progress has been made in the core estates team to stabilise the workforce and build management capacity including the estates and capital planning programme office. The agility workload management tool is

currently under implementation and a plan for a programme of asset condition surveys has been agreed to conclude in June 2024. In addition, a BGH survey and compliance review will begin with initial general condition surveys in January 2024 with NHS Assure supporting this review from April 2024. Estates capacity remains an area of significant pressure given the large workload and risk profile across the estate. This is an area likely to require additional investment to mitigate areas of high and very risk in the years ahead. The CGC were partially assured by the report and the actions underway but recognise the significant risk relating to the estate coupled with workforce and financial constraints.

2.3.8 The CGC received a report on Primary and Community Services. Community hospitals have been affected by COVID 19 outbreaks and continue to have high levels of patients delayed to their next stage of care. This has further compounded the significant pressure on patient flow across the system. Pressure area care was discussed and specially the movement of patients between parts of the health and social care system in relation to the recognition, management and recording or pressure damage. Work is underway to look at improved recording of inherited pressure damage and also to look at the training and education needs across health and social care. Good progress was reported in dental services and in vaccinations and the committee was also appraised of the ongoing testing of the Hospital at Home Service and development of Home First Reablement service. The CGC was partially assured due to the ongoing pressures within primary and community services.

2.3.9 The CGC received a report on Acute services including an update on Women & Childs health and Cancer Services. The acute hospital has continued to experience extreme pressure on inpatient beds. The CGC have been sighted on the significant delays across the health and social care system and the impact this is having on the need for additional surge beds and staffing, as well as, the knock-on impact to sustain elective inpatient services and access to specialist beds such as stroke. The surge plan in place has delivered some reduction in delays but not to the level expected at this point in the plan and the ability to deal with normal winter pressures has therefore proved exceptionally difficult requiring further surge beds within the acute hospital and reduction in elective inpatients. The CGC were briefed on a recent visit from the Health and Safety Executive and also an Adult Support and Protection case which was under review. Steps have been put in place to review ward based medicines management processes and the Associate Director of Nursing was assured that progress was being made in this area. Dermatology continues to be an area of exceptional workforce pressure with a reliance on external medical support. Work is underway to explore new service models and the Scottish Government have been approached for ongoing support. NHS Borders has historically always maintained a very low cardiac arrest rate. Acute services have noticed a slight increase in the number of cardiac arrests in the last year. Each case has been individually reviewed to identify any learning or practice development needs. No specific themes have been identified however a further round table review with clinical experts has been planned to look at this further to ensure no learning has been missed. The CGC were unable to be assured due to the exceptional pressure on acute services and the impact this has on quality of care, patient experience and staff wellbeing.

2.3.10 The CGC were briefed on recent workforce pressures across Women's and Childrens services and the strain this has placed on the small core teams in these areas. There have been some recent positive steps around recruitment and there is extensive work underway to provide support to the teams and build team working and wellbeing as the workforce is stabilised. The committee will receive its annual

deep dive into maternity services at the March meeting. The CGC were assured by the work underway in Cancer services, however recognising the specific areas of pressure the team are actively managing and the growing annual increase in demand for cancer treatments and exponential increases in drug costs posing a significant financial risk.

2.3.11 The CGC considered a paper from Mental Health and Psychological Services. There was a recent unannounced healthcare environment inspection to Huntlyburn. Initial feedback was positive with some small areas of improvement required. The committee will receive an update on any outstanding actions at their next meeting. The committee were updated on progress being made towards the Child and Adolescent Mental Health waiting times target. Areas of pressure within mental health services were reviewed including patient delays within the Borders Specialist Dementia Unit and the ongoing significant pressures in the Psychiatry workforce. Pressure in other workforce areas were also discussed including occupational therapy and psychology. The psychology services have tried to move service models to more online appointments to be innovative in attracting a workforce to sustain clinical demand. The CGC were partially assured by the mental health and psychology reports recognising the strain continued workforce pressures are placing on small services.

2.3.12 The CGC received a report from the Learning Disability (LD) Service. The service await a report from a recent visit from the Mental Welfare Commission. Work is progressing on the 'Coming Home Report' to try and build local provision for complex patients who currently require placement outwith the Scottish Borders area. Solutions are now in the planning for some patients and work is underway to consider models of local provision for the remainder. An update on progress in this area will be included in the next report to the CGC. The CGC were assured by the Learning Disabilities report.

2.3.13 Care Assurance

NHS Borders require a care assurance framework to ensure that teams have assurance that their care is safe, patient-centred and meets the needs of both national programmes and local priorities. Measuring and assuring the quality and standards of care delivered to patients by individuals and teams is a complex process, therefore a quality management system approach is followed to improve efficiency and safety.

2.3.14 Local arrangements are in place and are now being detailed in an NHS Borders Care Assurance framework by the Lead Nurse for Patient Safety. The framework will detail how quality assurance activity should be used to positively inform and drive improvement in line with NHS Borders Board objectives and in line with national programmes to include Excellence in Care (EiC) and the Scottish Patient Safety Programme (SPSP).

2.3.15 For inpatient areas the framework will incorporate the ward quality audit programme which is a self-assessment led by the Senior Charge Nurse and Clinical Nurse Manager who have governance for the clinical area and align to the Senior Charge Nurse Scorecard. Learning from care assurance review will be included and referred to in leadership walk rounds which are attended by the Senior Charge Nurse, Clinical Nurse Manager and Patient Safety Lead Nurse / Quality Improvement Facilitator who are expected to meet at regular intervals to review the data and improvements to

ensure progress is being made within the agreed timescales or to identify if further support is required. Regular updates are thereafter provided to the Associate Directors (Nursing/AHPs/Medical/Midwifery) who play an active role in this system and upward through the agreed governance structures.

2.3.16 Scottish Patient Safety Programme

Health Improvement Scotland (HIS) will visit NHS Borders in February 2024 to discuss the focus on national and local patient safety initiatives. The visit will include NHS Borders local priorities with an update on developments of the programmes and to discuss what support is needed to continue to embed an improvement focus across NHS Borders. Areas to be covered include:

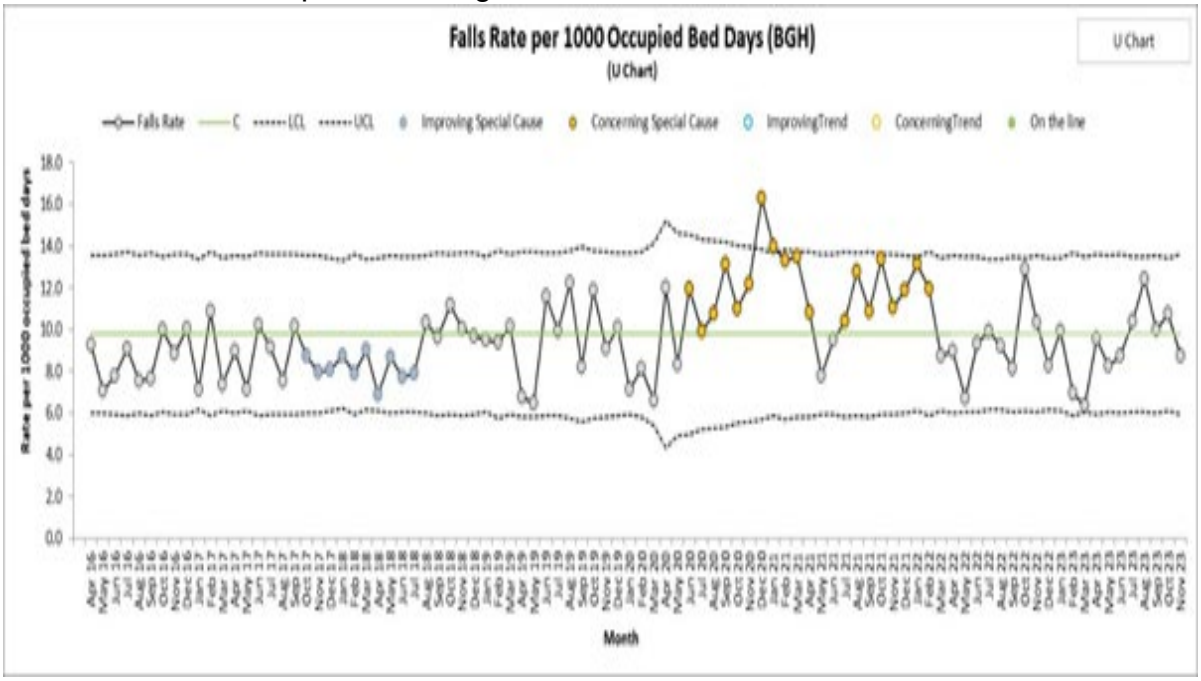
- SPSP Adult Collaborative – Falls / Deteriorating Patient workstreams
- SPSP Perinatal Collaborative
- SPSP Paediatric Collaborative

2.3.17 Falls

The Patient Safety Quality Improvement Facilitator is currently updating the NHS Borders Safe use of Bedrails Policy to be in line with the Medicines and Healthcare products Regulatory Agency Guidance Bed Rails: Management and safe use (Published 30 August 2023).

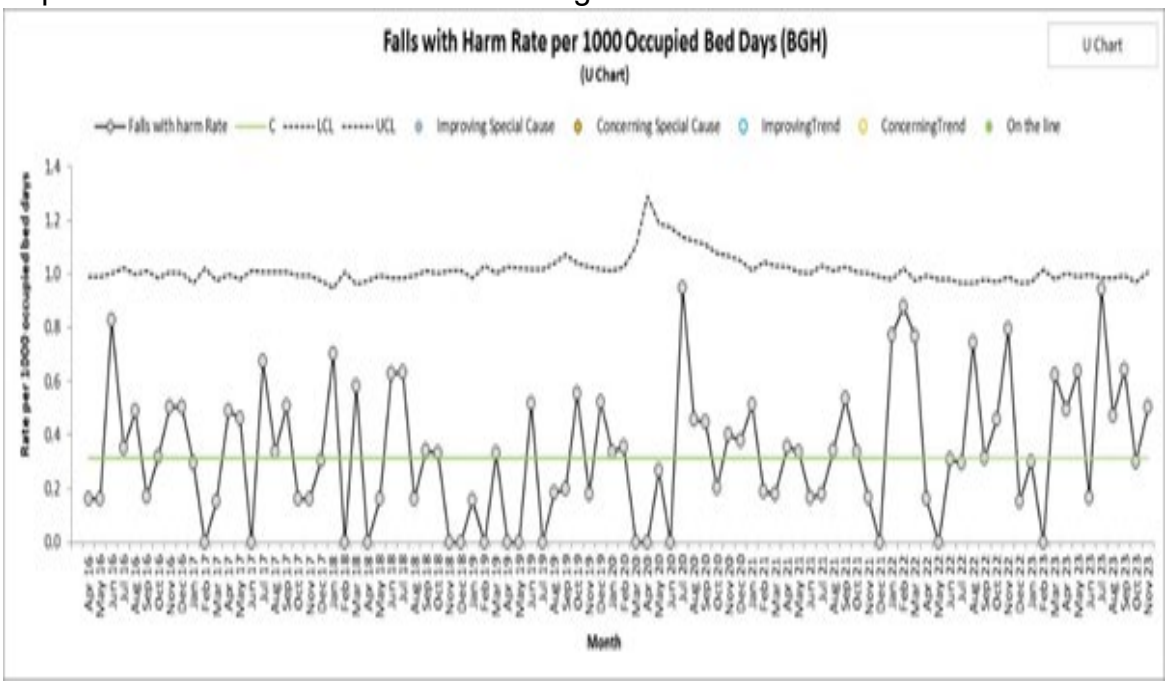
2.3.18 All essential care after an inpatient falls documents is currently being updated with copy right approval from the Royal College of Physicians – National Audit of Inpatients Falls.

2.3.19 Falls data (up to June 2023) demonstrates a 21% decrease from baseline data. Graph 1 shows sustained improvement against the 2020/2021 baseline:



2.3.20 The SPSP have shown interest in learning form this and plan to share learning at their next SPSP national falls network meeting. The Enhanced Care Observations (ECO) project is one of the contributing factors towards the decrease of falls rate locally.

2.3.21 Graph 2 shows falls with harm rate showing normal variation:



2.3.22 To continue to improve our falls with harm rate the Patient Safety Quality Improvement Facilitator continues to provide face to face training, this is delivered at the staff developmental days. Staff education includes reviewing the falls risk assessment, falls bundle, post falls procedure and the falls review tool. Following a review of outstanding Fall Review tools across acute services common learning themes have been generated and include:

- Person centred falls bundle not completed / incomplete / not updated
- Bedrail risk assessment not completed / updated
- Falls prevention and management not recorded or updates on the person-centred care plan
- No Datix completed following fall
- 4AT or TIME Bundle not completed
- Moving and handling assessment / reassessment not carried out / incomplete
- Bedrails policy not being followed (either 0 or 2 bedrails being used not 1)
- Lack of bed and chair sensors

2.3.23 These themes have been shared with the Falls Sterring Group to influence their improvement and educational priorities for 2024/25. A Falls Strategy has been prepared for Board and Integrated Joint Board approval in the coming months which will focus on wider community and muti-agency measures to reduce and respond to falls.

2.3.24 Documentation

The Lead Nurse for Patient Safety and Care Assurance is coordinating a local Clinical Documentation Group, and in collaboration with the Clinical Effectiveness Administrator are preparing a Standard Operating Procedure, Terms of Reference (ToR) alongside supporting documents to guide colleagues when reviewing local clinical documents. A national task and finish group to review NHS Scotland Principles

of Record Keeping (March 2021) is underway which will inform the work of the local Clinical Documentation Group.

2.3.25 The Multidisciplinary Assessment and Communication (MAC) booklet has been updated so that the falls risk assessment can be completed more than once, applying to all falls risk levels and the following question has been added for staff members consideration when evaluating the risk “Is the person unable to reliably use call bell to summon assistance?”

2.3.26 The Quality Improvement Facilitator for Patient Safety in collaboration with NHS Highland are planning to test a new approach to care rounding. NHS Highlands Daily Care Plan and Safe Care Pause documentation will be initially tested in the Care of the Elderly ward (Ward 14) this year.

2.3.27 Medicines

Controlled Drug (CD) checks across acute wards are mandatory, a thematic review and data collection highlighted non-compliance within some acute ward areas. Focus on daily monitoring and compliance with CD checks has commenced. Clinical staff now escalate at the morning hospital wide Safety Brief if CD checks have not been undertaken to ensure that this is done as a priority within their area.

2.3.28 To assist learning from medicine errors reported on our incident reporting system (Datix) the Patient Safety Quality Improvement Facilitator has designed a medicines management tool which can be used as a Category 2 Level 3 review. The tool has been shared with relevant clinical staff for consultation and will be trialled over the next few months.

2.3.29 A focus is being placed on administration of time critical medications following the identification of learning in this area. This learning is also being applied to thromboprophylaxis and antibiotics given the importance of timely delivery of these drugs. These medications have been spotlighted at safety briefs to raise the importance of this area.

2.3.30 An NHS Borders medication management governance group is being formed to support the work detailed above. The group Chair has been identified and ToR designed. The aim is to have the first meeting in February 2024. The group will provide guidance, assurance, and strategic direction on managing and reducing risks to patients from medication related errors. In addition, it will seek to promote a culture of safe medication use within NHS Borders by empowering individuals to contribute to the medication safety agenda.

2.3.31 Pressure Damage

Work is underway to look at the recording of both developed and inherited pressure damage across NHS Borders. The Emergency Department Nursing Assessment has recently been re-designed to include pressure damage with a prompt to signpost staff to adverse event management system to report inherited pressure damage. The Patient Safety Quality Improvement Facilitator is currently updating organisational flowcharts regarding ordering and returning air mattresses to aid staff. They have also been asked to complete an internal audit of all pressure relieving equipment in NHS Borders to establish what is available and what is required.

2.3.32 Documentation when a patient is an inpatient is an ongoing theme to include the usability of the SSKIN bundles. This have been shared with the Tissue Viability Nurse and has been escalated to the Tissue Viability Steering Group, which recommenced in January 2024 where priority themes for 2024/25 were identified. The group are scheduled to meet on a 4-weekly basis.

2.3.33 Following a review of outstanding pressure ulcer investigation tools (PUIT) across acute services common learning themes have been generated and include:

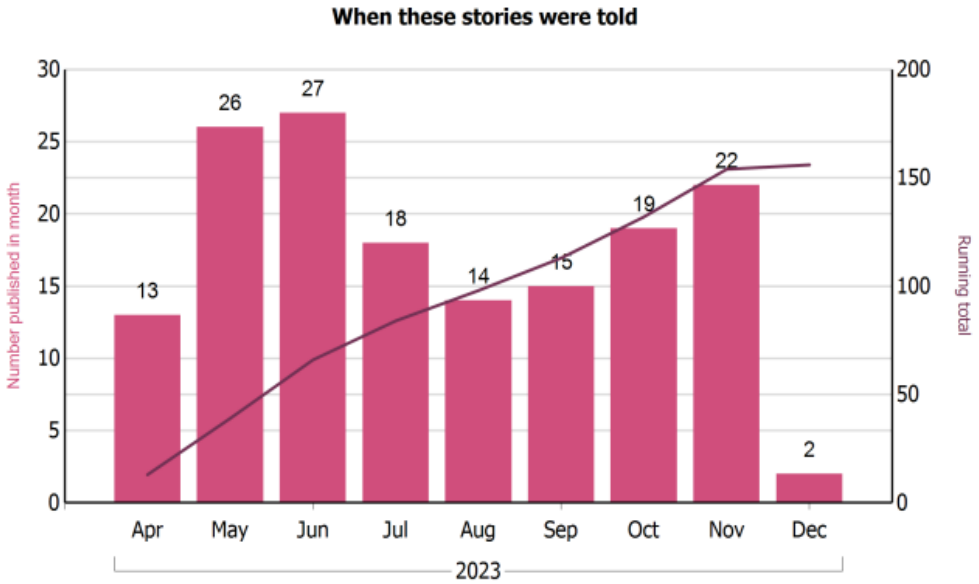
- Understanding the process to order pressure relieving equipment
- Poor documentation, to include risk assessments, care planning and wound management
- Understanding of the process to refer to the topic specialist
- Further education required for tissue viability and VAC management
- Understanding of the Duty of Candour
- A clear escalation plan for staff to refer to out of hours when they are managing a complex wound
- Transitions of care to include handover to community and District Nursing teams

2.3.34 These themes have also been shared with the Tissue Viability Steering Group to influence their priorities for 2024/25.

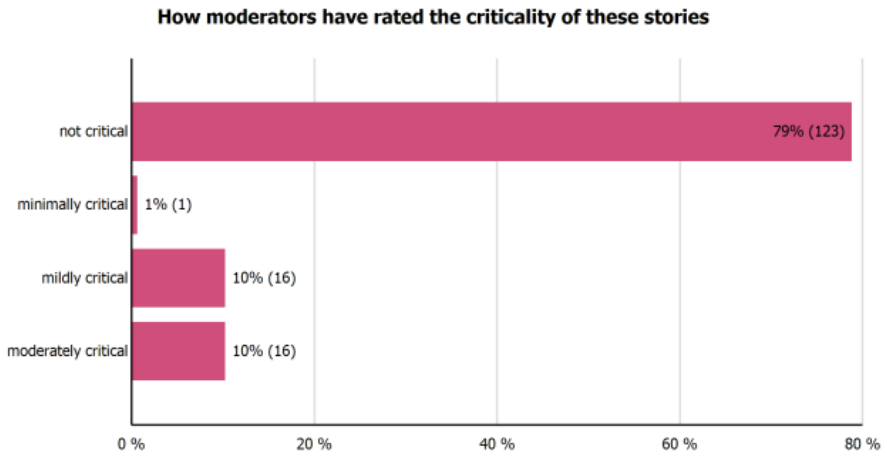
2.3.35 Patient Experience

2.3.36 Care Opinion

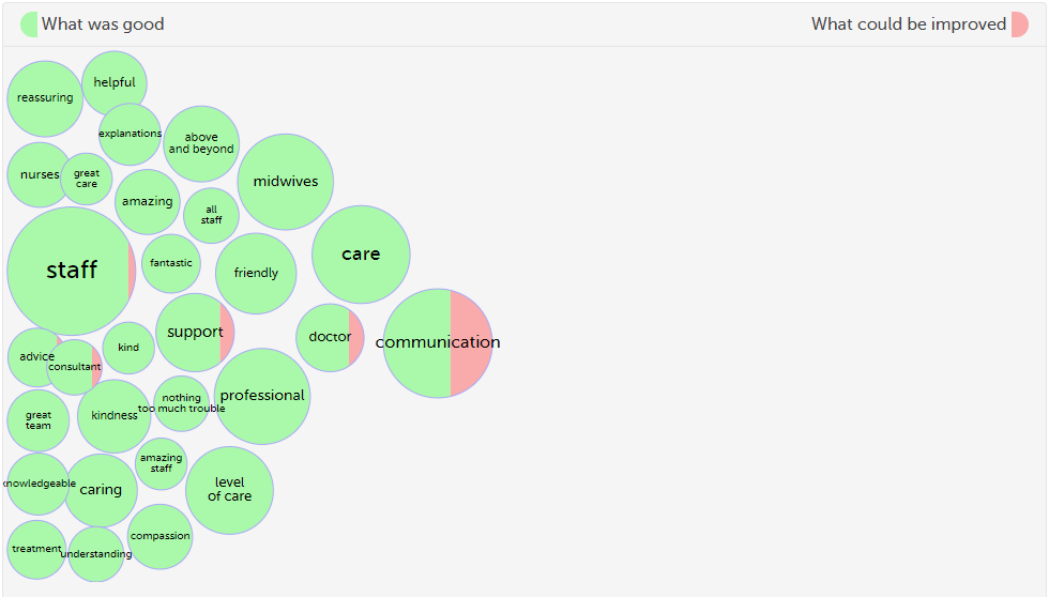
For the period 1 April 2023 to 30 November 2023, 156 new stories were posted about NHS Borders on Care Opinion. Graph 3 shows the number of stories told in that period. As at 8 September 2023 these 154 stories were viewed 16,017 times:



2.3.37 Graph 4 provides a description of the criticality of the 156 stories:



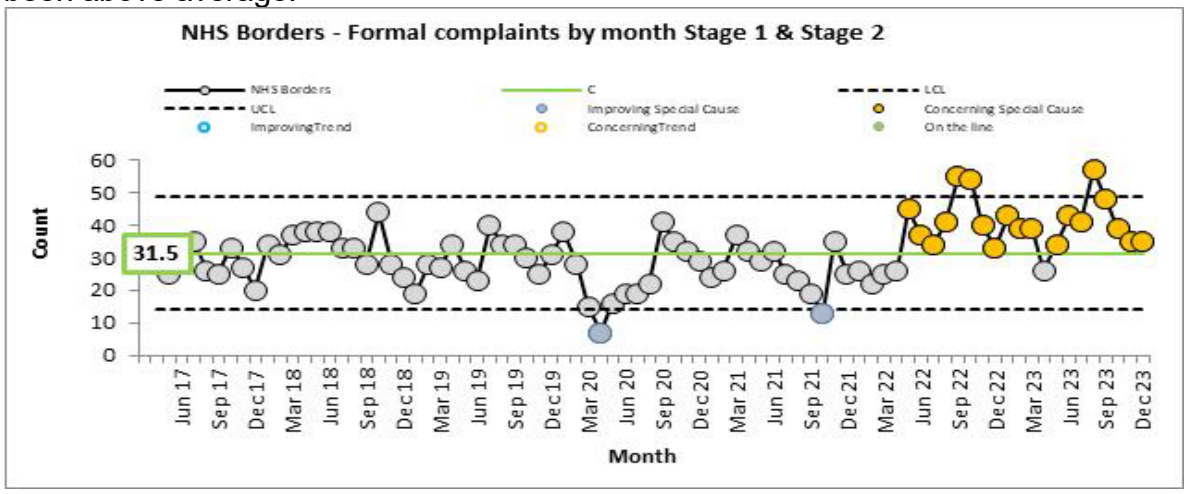
2.3.38 The word clouds below summarise ‘what was good’ and ‘what could be improved’ in Care Opinion posts for this period:



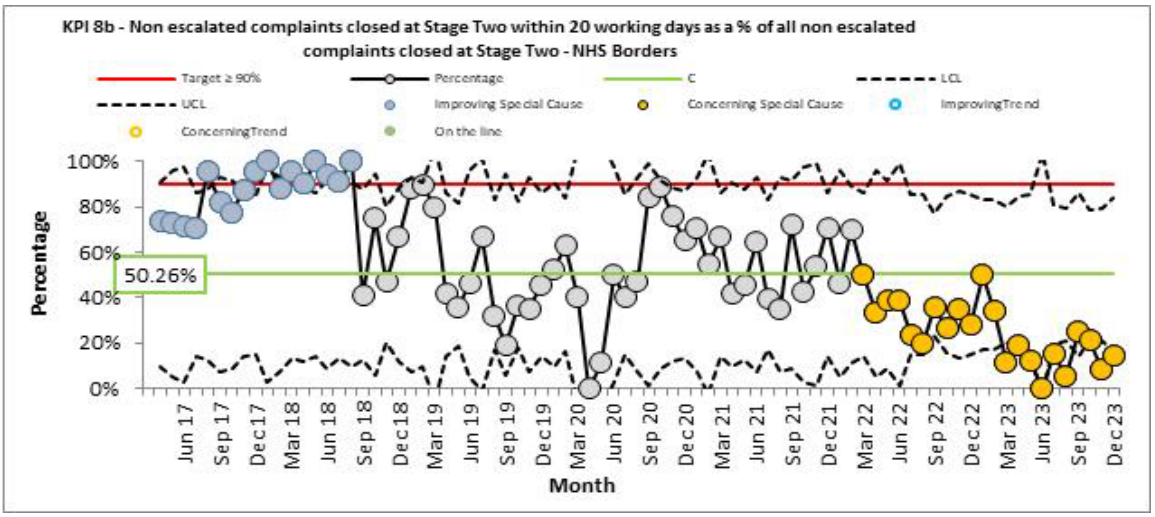
What was good?

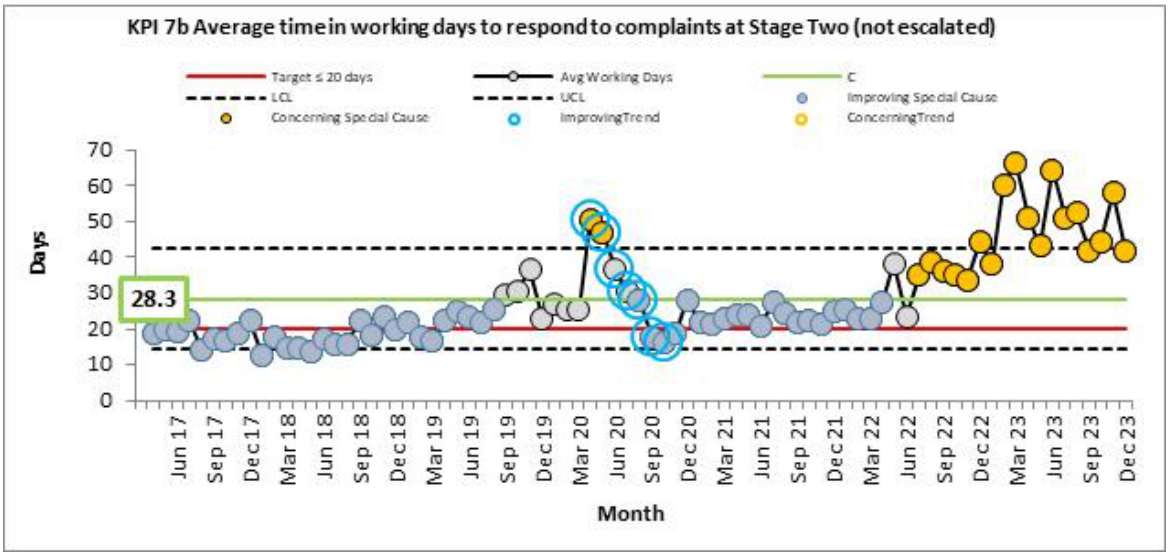
What could be improved?

2.3.39 Graph 5 below gives the number of formal complaints received by month. Since May 2022, with the exception of April 2023, the number of complaints being received has been above average:



2.3.40 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 Patient Experience Team (PET) and frontline staff involved in the review of individual complaints. This has lead to an increase in the timeline for the delivery of a full response to complainants. Graphs 6 and 7 below shows the percentage of complaints being responded to within 20 working days and the average response time in working days for response to stage 2 complaints:

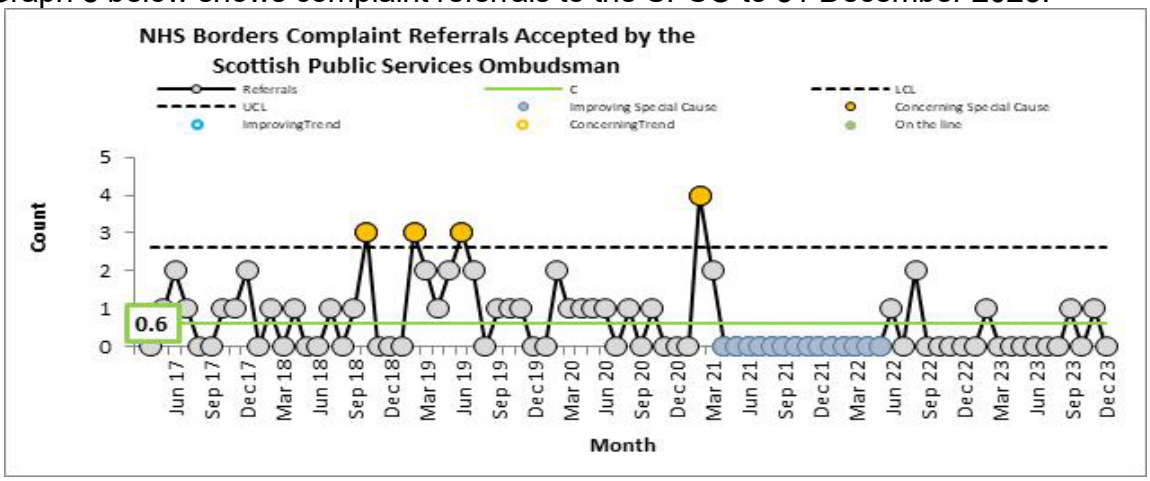




2.3.41 The average response time in working days in December 2023 is sitting at 41 days. Additional capacity has been added to the PET team on a short term basis to support this increase in workload and since October 2023 the team has had additional capacity in place. The PET are now working to meet the new level of demand but also to bring down the number of active complaints awaiting a response with the aim of reducing the length of time patients and families are waiting for a response.

2.3.42 The Scottish Public Services Ombudsman (SPSO) are the final stage for complaints about most devolved public services in Scotland including the health service, councils, prisons, water and sewage providers, Scottish Government, universities and colleges. The additional scrutiny provided by the involvement of the SPSO is welcomed by NHS Borders as this gives a further opportunity to improve both patient care and our complaint handling.

2.3.43 Graph 8 below shows complaint referrals to the SPSO to 31 December 2023:



2.3.44 COVID Inquiries

2.3.45 The Scottish COVID-19 Inquiry Health and Social Care impact hearings began on 24 October 2023.

2.3.46 Public hearings in the UK COVID 19 Core UK decision-making and political governance - Scotland (Module 2A) are taking place in Scotland from 19 January to 1 February 2024.

2.3.47 Quality/ Patient Care

Following the impact of the COVID-19 pandemic services continue to recover 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. 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.

2.3.48 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. Key workforce pressures have required the use of bank, agency and locum staff groups and further exploration of extended roles for the multi-disciplinary team. Mutual aid has also been explored for a few critical specialties where workforce constraints are beyond those manageable locally. There has been some progress locally in reducing gaps in the registered nursing workforce and positive levels of international recruitment. There continues to be an outstanding response from staff in their effort to sustain and rebuild local services, but many staff continue to feel the strain of workforce challenges and this needs to remain an area of constant focus for the Board.

2.3.49 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. This pressure is likely to be compounding by the growing financial pressure across NHS Scotland.

2.3.50 Risk Assessment/Management

Each clinical board is monitoring clinical risk associated with the need to adjust and remobilise services following the pandemic response. The NHS Borders risk profile has increased result from the extreme pressures across Health and Social Care services.

2.3.51 Equality and Diversity, including Health Inequalities

An equality impact assessment has not been undertaken for the purposes of this awareness report.

2.3.52 Climate Change

No additional points to note.

2.3.53 Other Impacts

No additional points to note.

2.3.54 Communication, Involvement, Engagement and Consultation

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

2.3.55 Route to the Meeting

The content of this paper is reported to Clinical Board Clinical Governance Groups and Board Clinical Governance Committee.

2.4 Recommendation

The Board is asked to:

- note the report.

Glossary:
Clinical Governance Committee (CGC)
Allied Health Professionals (AHPs)
General Practice (GP)
Primary Care Improvement Plan (PCIP)
Significant Adverse Event Review (SAER)
Reinforced Autoclaved Aerated Concrete (RAAC)
Learning Disabilities (LD)
Excellence in Care (EiC)
Scottish Patient Safety Programme (SPSP)
Healthcare Improvement Scotland (HIS)
Enhanced Care Observations (ECO)
Terms of Reference (ToR)
Multidisciplinary Assessment and Communication (MAC)
Controlled Drug (CD)
Patient Experience Team (PET)
Scottish Public Services Ombudsman (SPSO)

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Infection Prevention and Control Report – December 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 NHS Borders had a total of 18 *Staphylococcus aureus* Bacteraemia (SAB) cases between April 2023 and October* 2023, 10 of which were healthcare associated infections. (In September 2023, 1 healthcare associated case was sampled at NHS Borders but attributed to a non-NHS Scotland hospital. As per ARHAI Scotland definitions, this case is still counted in our final figures).
* At the time of writing this report, November data was still being validated.

1.1a The Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated SAB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 20 cases. We are currently on target to achieve this as shown in figure 1 below:

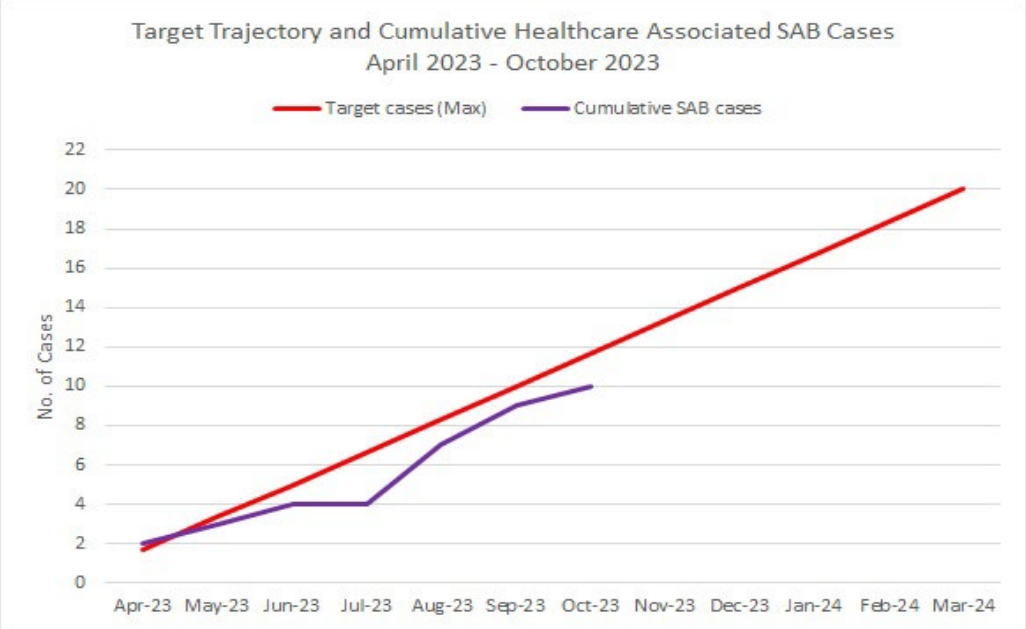


Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

1.2 NHS Borders had a total of 12 *C. difficile* Infection (CDI) cases between April 2023 and November 2023, 8 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 CDI rate per 100,000 TOBDs by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 12 cases. We are currently on target to achieve this as shown in figure 2 below.

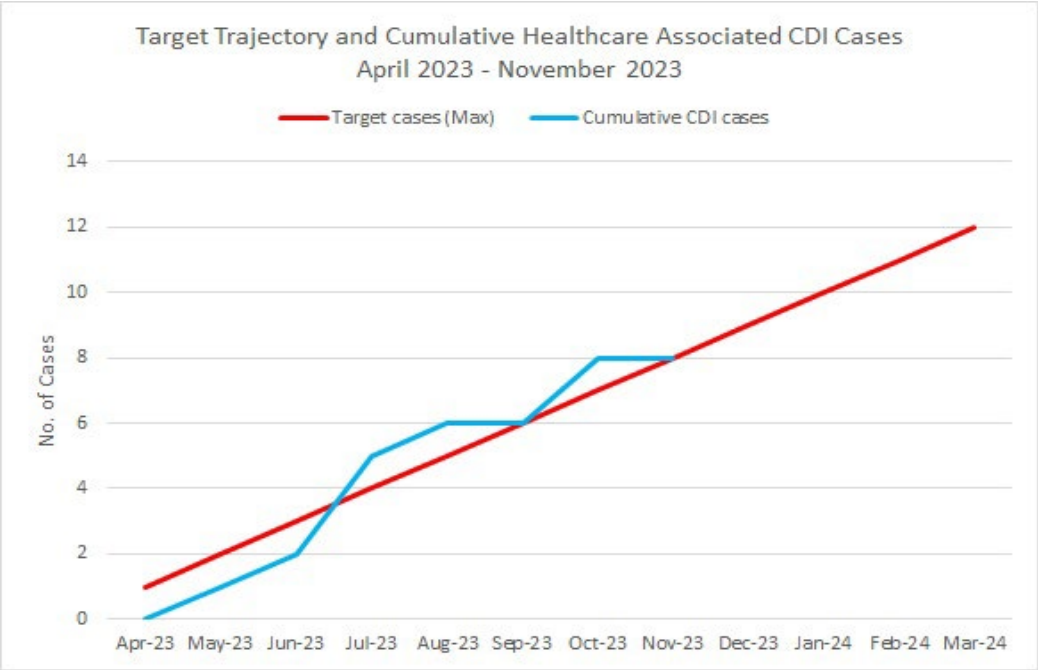


Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

1.3 NHS Borders had a total of 68 *E. coli* Bacteraemia (ECB) cases between April 2023 and October* 2023, 39 of which were healthcare associated.
* At the time of writing this report, November data was still being validated.

1.3a The Scottish Government set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline) which equates to no more than 32 cases. We have not achieved this target as shown in figure 3 below.

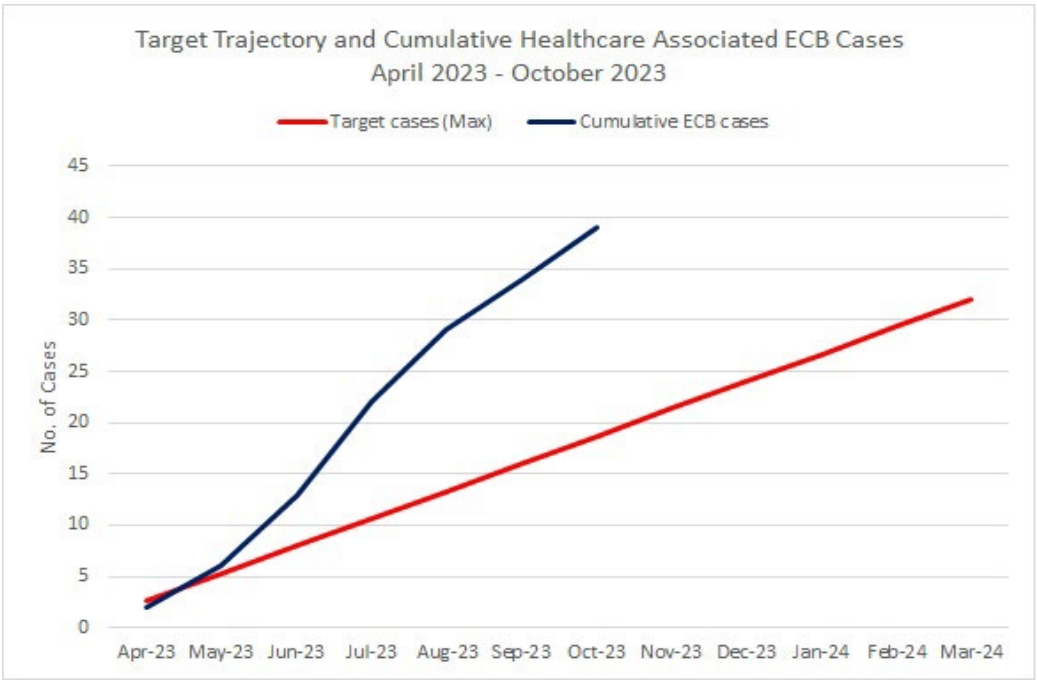


Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

2.0 *Staphylococcus aureus* Bacteraemia (SAB)

See Appendix A for definition.

2.1 Between April and October 2023, there have been 18 cases of Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia and no cases of Meticillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia.

2.2 Figure 4 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.

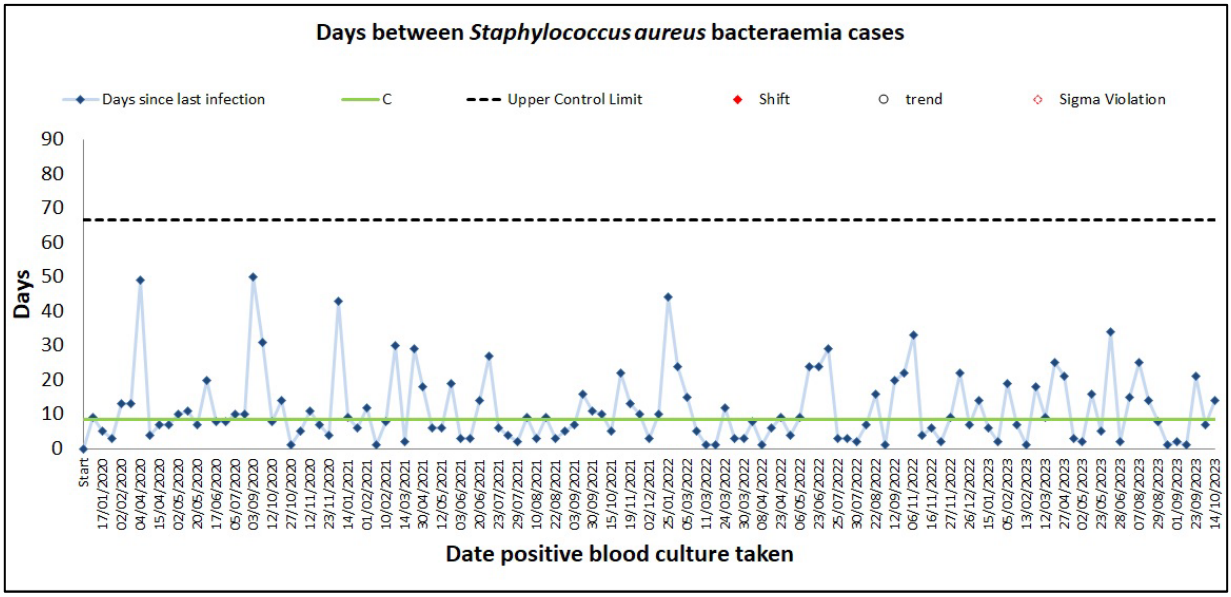


Figure 4: NHS Borders 'days between' SAB cases (January 2019– October 2023)

2.4 In interpreting Figure 4, it is important to remember that as this graph plots the number of days between infections, we are trying to achieve performance above the green average line.

3.0 *Clostridioides difficile* infections (CDI)

See Appendix A for definition.

3.1 Figure 5 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.

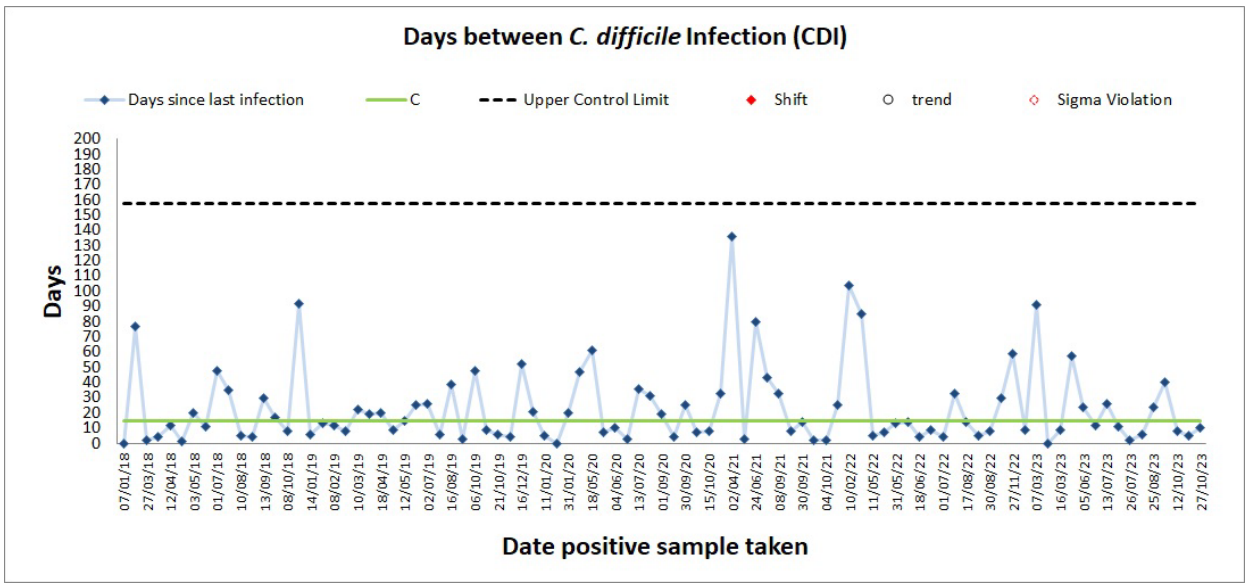


Figure 5: NHS Borders days between CDI cases (January 2018 – November 2023)

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 6 below.

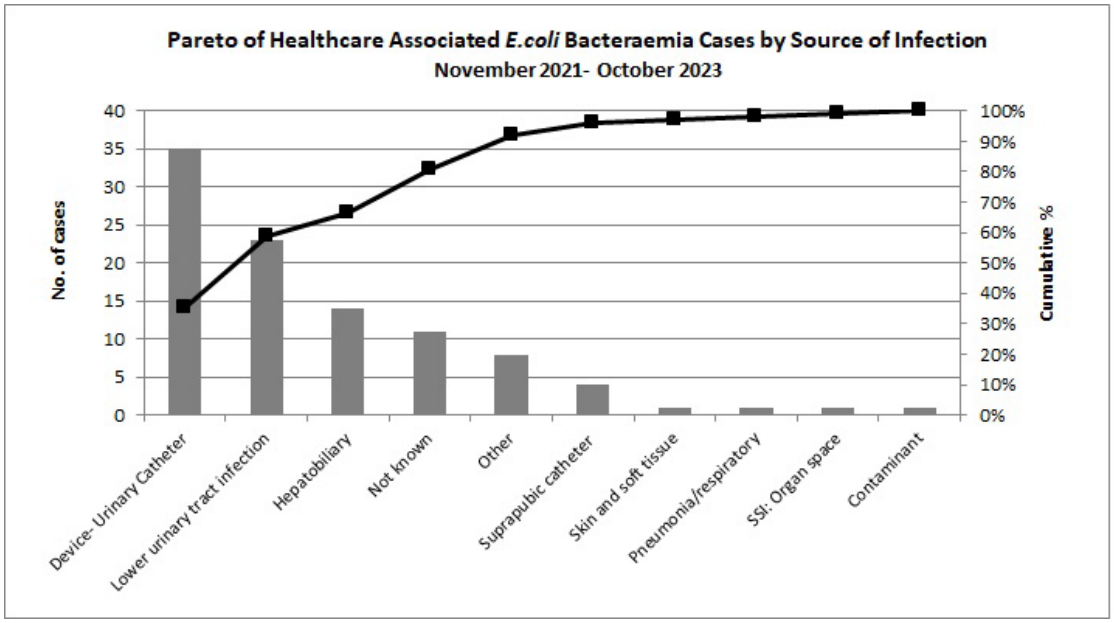


Figure 6: Pareto chart of healthcare associated ECB cases by source of infection

4.2 Figure 7 shows a statistical process control 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. Please note that in contrast to previous statistical process control graphs, Figure 7 is a count of cases per month rather than the number of days between cases.

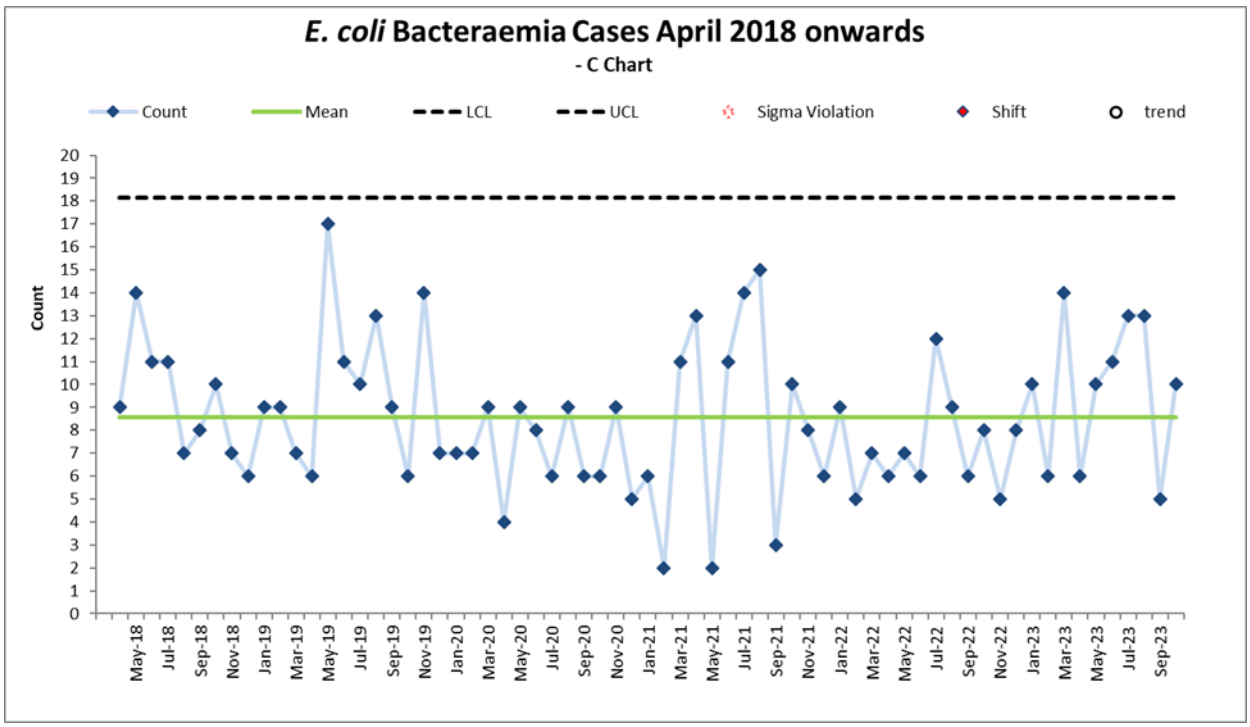


Figure 7 Statistical process chart (SPC) of all *E.coli* bacteraemia cases per month

5.0 NHS Borders Surgical Site Infection (SSI) Surveillance

5.1 The Scottish Government paused the requirement for mandatory surgical site infection (SSI) surveillance on the 25th of March 2020. There has been no indication of a potential date for re-starting national SSI surveillance.

5.2 NHS Borders has resumed SSI surveillance for hip and knee arthroplasty and the latest data up to the end of October is displayed below in table 1 and figure 8.

Table 1

Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) **Jan-Oct 2023**			
Procedure	**Total Ops**	**Total SSIs**	**SSI Rate**
Hip arthroplasty	219	X	2.28%
Knee arthroplasty	118	x	2.54%

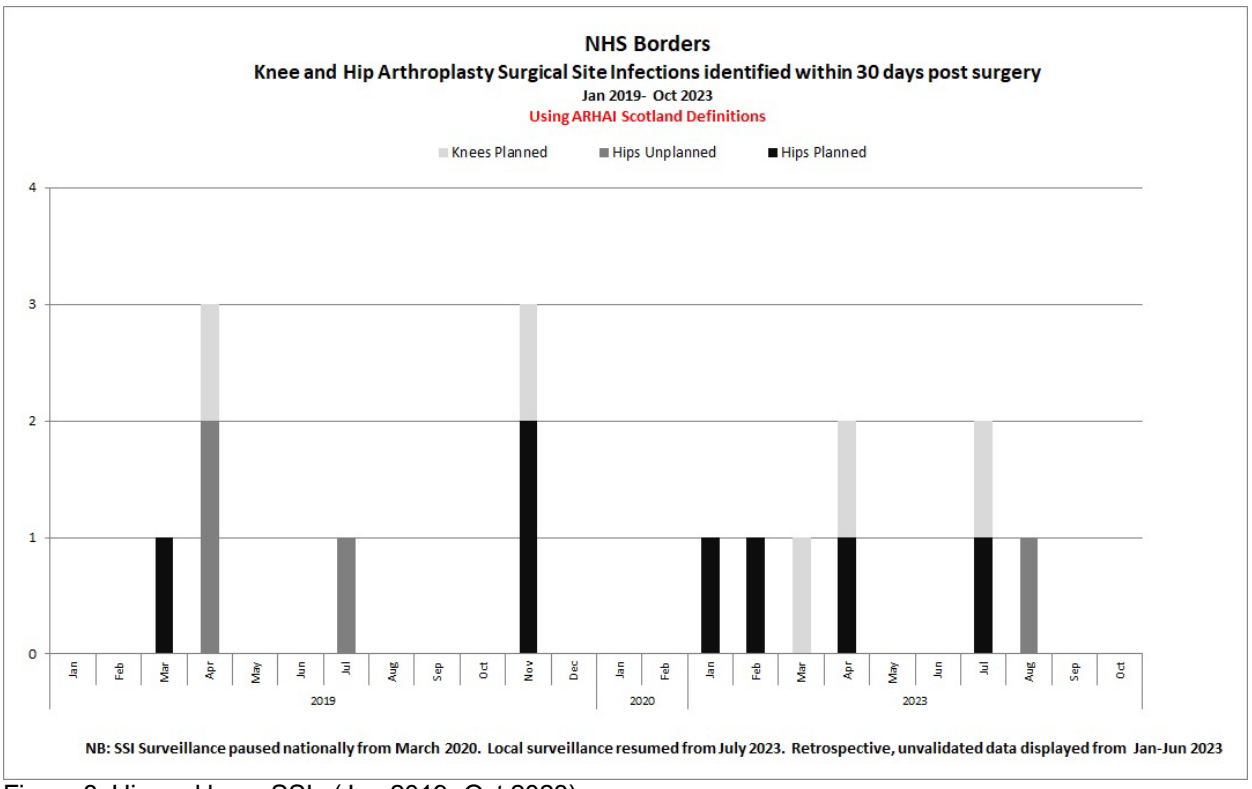


Figure 8: Hip and knee SSIs (Jan 2019- Oct 2023)

5.3 All hip and knee arthroplasty procedures are undertaken in operating Theatre 1. Following the most recent SSI cases, on the 25th August 2023 this theatre was closed for maintenance works including a full clean and check of the ventilation system which is now complete. The theatre re-opened on Monday 11th September 2023 and no further hip or knee arthroplasty SSI cases have been identified up to the end of October 2023. An SSI Task and Finish Group continues to meet to review NHS Borders approaches against national guidance to reduce the risk of surgical site infections.

5.4 Planning for commencement of Caesarean section SSI surveillance is underway following an initial meeting with the service clinical lead.

6.0 Hand Hygiene

6.1 In December 2024, the Infection Prevention and Control Team (IPCT) completed hand hygiene audits in a number of areas across BGH. The table below show the results by staff group.

Hand Hygiene Compliance by Staff Group

December 2023	Opportunities Observed	Opportunities Taken	Compliance by Staff Group
Nursing	140	93	**66%**
Medical	49	27	**55%**
Allied Health Professionals	28	26	**93%**
General Services / Portering	22	18	**82%**
All Staff Groups	239	164	**69%**

6.2 Although there are insufficient data points to identify a trend, it is encouraging to see some improvement in hand hygiene compliance as shown in figure 9 below.

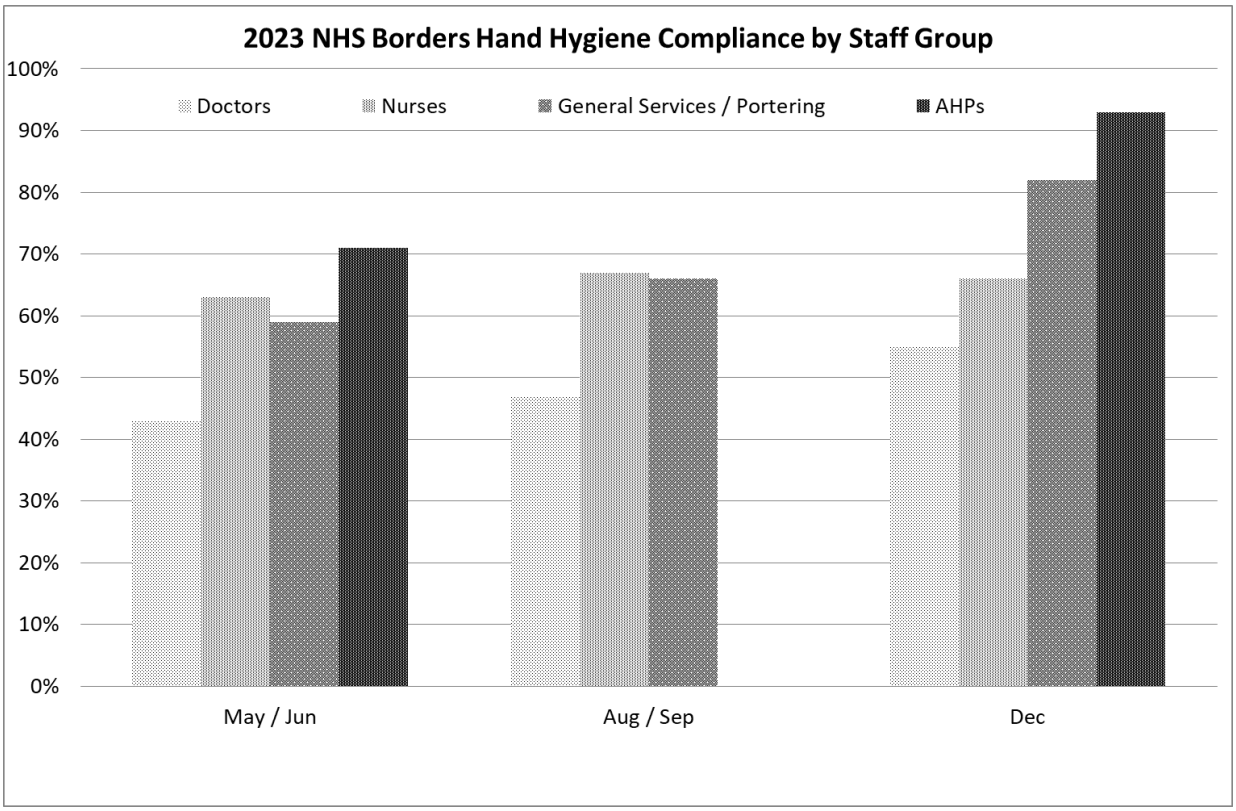


Figure 9: 2023 Hand hygiene compliance by staff group and audit period

6.3 The observations of hand hygiene reflect the combination of staffing and the activities on the ward at the time of the audit. Unsurprisingly, nursing staff (trained and untrained) make up the highest number of hand hygiene observations of 'opportunities' as per the WHO '5 moments for hand hygiene'.

6.4 As doctors have consistently performed less well compared with other staff groups in 2023, efforts were made to increase the number of observations of medical staff in December. The purpose of this is to have greater confidence on the compliance rate of this staff group. Although a greater number of observations of doctors was achieved, due to the factors described above, the number of observations remained low compared with nurses.

6.6 Hand hygiene compliance will continue to remain a priority for improvement activity and monitoring in 2024.

7.0 Infection Prevention and Control Compliance Monitoring Programme

7.1 Between November and December 2023, spot checks were undertaken in a total of 11 clinical areas across NHS Borders with an average compliance of 92%.

7.2 The full infection control audit programme recommenced in March 2023 and is now complete for 2023/24. There were 28 full audits undertaken between March and October 2023 with an average score of 89%.

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 the estates fabric across NHS Scotland. The most recently published report covers the period July – September 2023. Figure 10 below shows NHS Borders cleaning compliance against the NHS Scotland average by quarter. In the period July – September 2023, the cleanliness score for NHS Borders was 95.6%. In the same period, the estates score was 97.5%.

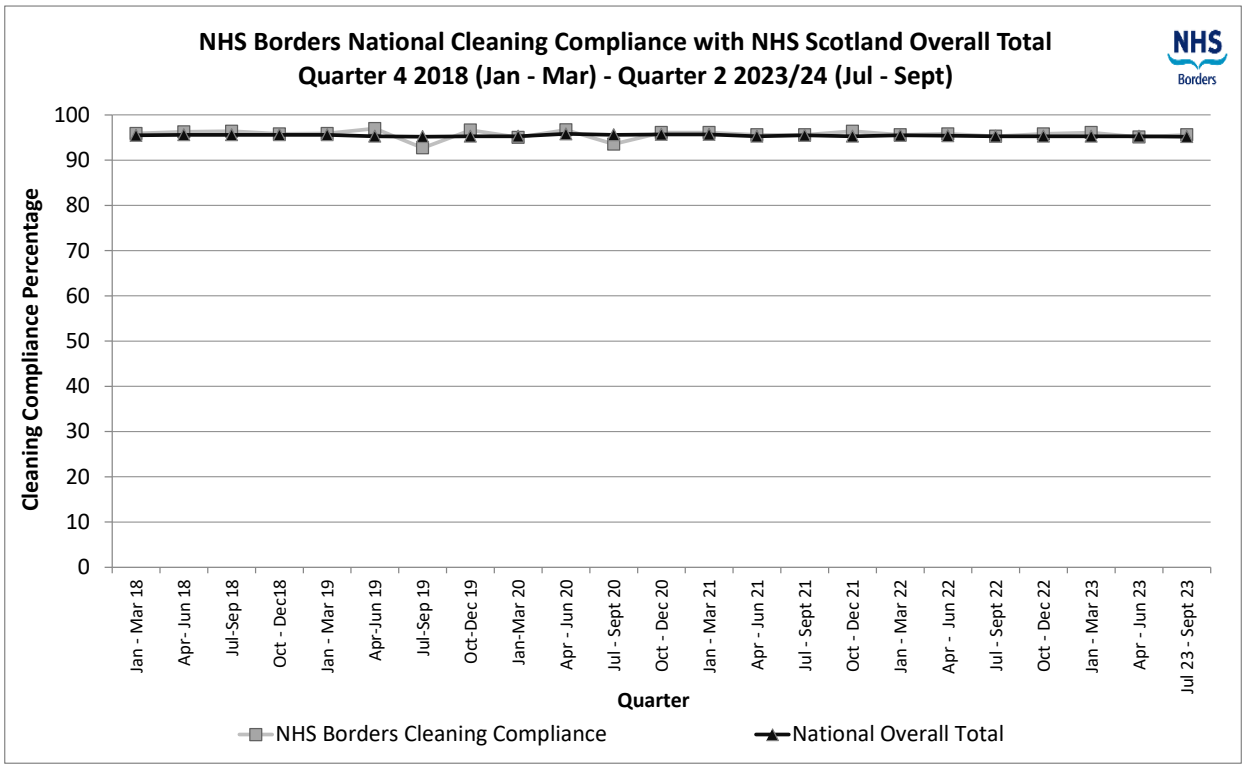


Figure 10: NHS Borders cleaning compliance against the NHS Scotland average by quarter

9.0 2023/24 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 There are currently 10 overdue actions in the 2023/24 Infection Control Work Plan of which 1 was assessed as high risk, 3 medium risk and the remainder low risk. Work is progressing on these actions and further updates will be included in future Board papers. The Infection Control Committee and Clinical Governance Committee continue to maintain oversight on progress against the work plan.

10.0 Outbreaks/ Incidents

- **Respiratory Incidents**

10.1 Since the last Board meeting, there have been 12 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 4th January 2024 is detailed in the table below.

10.2 Learning from each incident is captured and acted upon in real time where appropriate.

NHS Borders clusters as at 04/01/2024 CLOSED INCIDENTS ONLY

Outbreak Start date	Outbreak location(s)	Organism	Positive patient cases	Patient deaths	Suspected/confirmed staff cases
November					
27/11/23	Haylodge	COVID	14	0	X
29/11/23	DME 14	COVID	21	0	X
December					
07/12/23	Ward 4	COVID	13	0	0
07/12/23	DME 14	RSV	X	0	0
08/12/23	Kelso	COVID	X	0	X
11/12/23	Kelso	RSV	X	0	0
11/12/23	Haylodge	COVID	X	0	X
15/12/23	Border View	COVID	13	0	X
18/12/23	Ward 7	COVID	X	0	0
19/12/23	Ward 9	FLU A	X	0	X
26/12/13	MAU	COVID	6	0	X
28/12/23	Ward 4	COVID	X	0	X

Summary of Learning	Learning Outcomes
Site pressures impacting balancing of infection control risk with other patient flow risks	IPCT working with Site and Capacity during each individual outbreak to manage outbreak and utilise beds appropriately

Summary table of Respiratory clusters

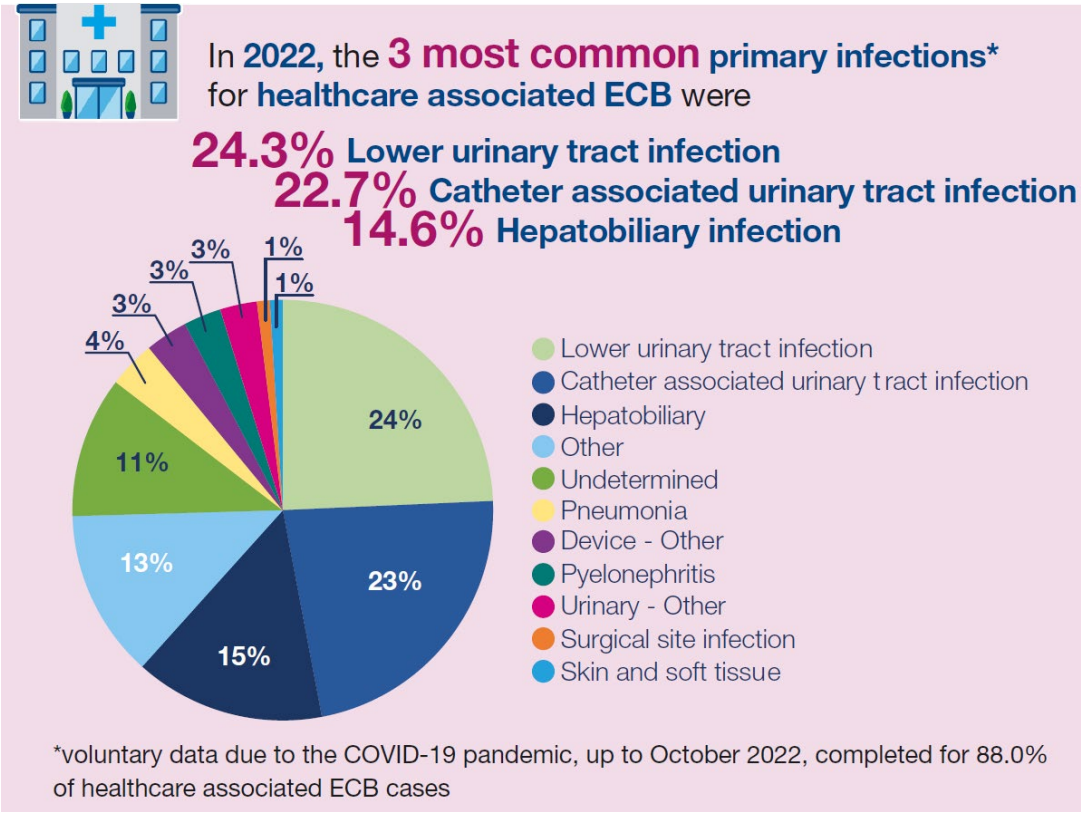
11.0 Quality Improvement Update

11.1 Due to sickness absence and a vacancy in the Infection Prevention and Control Team, it has not been possible to progress with all of the quality improvement work streams. However, work in support of the Prevention of CAUTI Group has been prioritised.

11.2 The Prevention of CAUTI Group last met on the 19th December 2023. At the meeting the Group reviewed progress against the CAUTI Work Plan. There are currently no overdue actions.

11.3 Analysis of various available data sources has been completed and will be considered more fully at the next meeting of the Group to inform further targeted actions for improvement.

11.4 On the 19th September 2023, Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland published their 2022 Annual Report. The national data (copied below from the report) shows catheter associated urinary tract infection to be the biggest cause of E.coli bacteraemia infections where there is a clear association between a specific healthcare intervention (urinary catheter) and infection.



Source: ARHAI Scotland 2022 Annual Report (web link)

11.5 The Group has reviewed a separate report published by ARHAI Scotland in October 2023 showing healthcare associated E.coli bacteraemia (ECB) infection rates by Board. NHS Borders rate is highlighted in red in the table copied below.

Table 6: ECB cases and incidence rates (per 100,000 TOBDs) for healthcare associated infection cases: year-ending June 2022 (YE Q2 22) compared to year-ending June 2023 (YE Q2 23).[1,2,3]

NHS Board	YE Q2 22 Cases	YE Q2 22 Bed days	YE Q2 22 Rate	YE Q2 23 Cases	YE Q2 23 Bed days	YE Q2 23 Rate
AA	201	447,441	44.9	171	469,560	↓ 36.4
BR	39	123,689	31.5	52	127,495	40.8
DG	65	174,268	37.3	78	184,689	42.2
FF	142	343,433	41.3	112	359,690	↓ 31.1
FV	166	295,049	56.3	166	310,418	53.5
GJ	4	49,191	8.1	10	52,121	19.2
GR	178	503,882	35.3	195	532,233	36.6
GGC	521	1,673,187	31.1	613	1,775,666	34.5
HG	68	284,708	23.9	64	303,718	21.1
LN	220	571,171	38.5	249	601,884	41.4
LO	259	971,109	26.7	296	980,283	30.2
OR	5	12,649	39.5	8	13,312	60.1
SH	10	9,488	105.4	8	10,164	78.7
TY	204	463,706	44.0	240	482,652	49.7
WI	11	24,560	44.8	16	24,482	65.4
Scotland	**2,093**	**5,947,531**	**35.2**	**2,278**	**6,228,367**	**36.6**

1. An arrow denotes statistically significant change.
2. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
3. Figures include any updates received following the last publication (see Appendix 2).

Source: ARHAI Scotland Quarterly Report, Apr-Jun 2023 (web link)

11.6 NHS Ayrshire and Arran, NHS Fife and NHS Highland were identified as having low ECB rates for the year ending June 2023. Each of these Boards has been contacted to see if a reduction in CAUTI is thought to have contributed to their low ECB rates and if so, if there has been any CAUTI improvement activity that could be shared.

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

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023
MRSA	0	0	1	0	0	0	0	0	0	0	0
MSSA	2	3	3	2	3	3	2	1	4	4	1
Total SABS	2	3	4	2	3	3	2	1	4	4	1

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Ages 15-64	0	0	1	0	0	1	1	0	0	2	0
Ages 65 plus	0	0	2	0	1	1	2	2	0	2	0
Ages 15 plus	0	0	3	0	1	2	3	0	0	4	0

Cleaning Compliance (%)

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Board Total	96.7	96.7	95.6	94.1	95.6	92.7	95.5	96.7	95.9	95.5	95.9

Estates Monitoring Compliance (%)

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	June 2023	July 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Board Total	96.3	98.0	97.2	98.3	96.9	98.5	97.5	98.3	97.5	98.0	98.1

BORDERS GENERAL HOSPITAL REPORT CARD

Staphylococcus aureus bacteraemia monthly case numbers

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
MRSA	0	0	0	0	0	0	0	0	0	0	0
MSSA	1	1	0	0	1	1	1	0	1	1	0
Total SABS	1	1	0	0	1	1	1	0	1	1	0

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Ages 15-64	0	0	0	0	0	0	0	0	0	1	0
Ages 65 plus	0	0	1	0	0	1	0	0	0	0	0
Ages 15 plus	0	0	1	0	0	1	0	0	0	1	0

Cleaning Compliance (%)

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
BGH Total	95.9	96.6	95.3	95.5	94.7	95.2	95.6	95.9	94.9	95.5	96.2

Estates Monitoring Compliance (%)

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
BGH Total	97.4	97.3	97.3	97.3	96.9	97.3	97.6	97.5	96.9	98.0	98.4

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

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 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

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 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

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023
MRSA	0	0	1	0	0	0	0	0	0	0	0
MSSA	1	2	3	2	2	2	1	1	3	3	1
Total SABS	1	2	4	2	2	2	1	1	3	3	1

N.B. At the time of writing this report, November data was still being validated

Clostridioides difficile infection monthly case numbers

	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023	Oct 2023	Nov 2023
Ages 15-64	0	0	1	0	0	1	1	0	0	1	0
Ages 65 plus	0	0	1	0	1	0	2	2	0	2	0
Ages 15 plus	0	0	2	0	1	1	3	0	0	3	0

2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety

2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

2.3.3 Financial

This assessment has not identified any resource implications.

2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

2.3.5 Equality and Diversity, including health inequalities

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

2.3.6 Other impacts

None identified

2.3.7 Communication, involvement, engagement and consultation

This is a regular bi-monthly update as required by SGHD. As with all Board papers, this update will be shared with the Area Clinical Forum for information.

2.3.8 Route to the Meeting

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

2.4 Recommendation

Board members are asked to:-

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

3 List of appendices

The following appendices are included with this report:

- Appendix A, Definitions and Supplementary Information

APPENDIX 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

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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 23 January 2024

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 03.10.23

NHS Borders - Area Clinical Forum

MINUTE of meeting held on
Tuesday 3 October 13:00 – 14:00
Via Microsoft Teams

Present: Paul Williams, Rachel Mollart, Nicky Hall, Martin O'Dwyer, Rachel Mollart, Gerhard Laker

In Attendance: Fiona Sandford

Apologies: Kevin Buchan, Philip Grieve, Lesley Shillinglaw (meeting will be recorded & transcribed)

1. APOLOGIES and ANNOUNCEMENTS

2. Draft Minute of previous ACF

Minutes approved as a correct record.

Action Tracker/Matters Arising:

3. Clinical Governance Committee

Will feedback at next ACF

4. **Feedback from Annual Review Event 11.09.23**

ACF had opportunity to have a discussion with Caroline Lamb and Jenny Minto. Paul and Rachel, Kevin, Philip and Caroline Cochrane were in attendance from ACF. Session went well and points raised from ACF were received across primary and secondary care. Rachel indicated the importance of receiving feedback from SG following the event.

Action: Lesley will ascertain and ensure ACF have sight of appropriate feedback.

5. **National ACF Chairs Meeting**

Feedback at next ACF

6. **NHS Borders Board Papers**

Nothing to report

7. **Professional Advisory Committees:**

Area Dental Advisory Committee (ADC)

Gerhard Laker intimated not much has changed since last meeting. The SG statement has now been received regarding pay. Financially easier to work with – more slim lined, however still doesn't address recruitment and retention which remains a significant problem. In response to a question regarding dental demand, Gerhard indicated that most dental practices are now at level they were pre-covid. There were a lot of practices retired. Rachel

referred to work by the BMA around Heat Maps for GPs and Consultants – GPs carrying a 10% reduction in vacancies and wondered if a similar piece of work unions could undertake to demonstrate where gaps are within dentistry. Gerhard indicated that BDA would undertake this kind of work.

Area Medical Committee (AMC) & GP Sub Group

AMC: Rachel referred to a discussion around waiting times and "moral injury" to clinicians. If have new idea, difficult process as need to go via various Committees. Would be helpful to have a fast track process for ideas. Private/NHS interface not well established and issues with people not receiving follow up treatment – work around defining how this should go particularly around bariatric surgery and ADHD.

GP Sub – discussions around assisting in services not functioning e.g. dermatology – referrals rising – looking at a tele-dermatology service. Hoping to hold a GP sustainability event in November. New course in St Andrew's for medical students – Scotcom – put 55 students through per year who would have a community focus – very much health & social care training. Looking for practices between Fife and Borders to house/mentor students. Issues within services e.g. gynaecology, dermatology etc which has an impact on primary care.

A**rea Ophthalmic Committee (AOC)**

Nicky referred to meeting on 30.08.23 where folks from RNIB attended and referred to an officer who can assist with people struggling with sight loss to assist with emotional well-being, due to delay at BGH to receive visual aid. Ophthalmology gave update a lot of work going on – large cataract list – trying to remobilise with theatres. Optmetrist who works in BGH – may try and get another one. Additional capacity at Golden Jubilee for cataracts. Chair has resigned now Ian McFadzen, Specsavers. Kevin Wallace, Optometrist Adviser kept folks up to date with latest regulations etc. Some more people doing IP training to allow them to prescribe. Glacauma patients – need to be IP trained as well as additional training.

Area Pharmaceutical Committee (APC)

Financial agreement now in place – NSS Scotland struggling to process prescriptions for payment therefore being paid estimated. Llyods sell off off Pharmacies – either for sale or sold and in process of changing hands. Recruitment and retention not easy. Workload: Lloyds workload leaked out into independent pharmacies. Across community pharmacies a lot of behind the scene pressures. Continuing with flu vaccines this year. Difference is patients can simply go elsewhere. Malcolm Clubb taking over as Director of Pharmacy. Still some issues within supply chain of medicines – particularly ADHD meds – people buying privately.

Allied Health Professionals Advisory Committee (AHP)

Vacancy rates between 5 and 10%. New graduate type roles come to Borders for 12 months and then move somewhere else. Waiting times going up across all specialties as well as financial challenges and savings asks. High sickness absence. Now have an Education Role within AHPs to assist with recruitment e.g. AHP Consultants.

Action: Paul will link in with Kevin and APF to have a shared voice from clinical perspective around guidance around what should or shouldn't be providing within services.

(f) **BANMAC:** No update provided. Will be re-branded

(g) **Medical Scientists**

(h) **Psychology**

8. **Issues for Escalation to CG/Board**

9. **Any Other Competent Business**

Martin referred to how pharmacies can access admin clinical inboxes and highlighted the difficulty in locating these addresses. Most people have now been migrated to NHS.Scot addresses, however you still need to know the name of the person in order to locate. Paul suggested Martin raise a top desk via our NHS B IM&IT

Nicky referred to CIG and correspondence sent round in relation to optometry. Rachel is no longer Chair of CIG – will be altered how CIG runs moving forward. No reason why pharmacy, dentistry couldn't attend with any particular concerns. Wrote a document outlining GP role with what do and don't do. Have asked for it to be distributed widely – will come out jointly from Medical Director and Rachel Mollart.

Within AHP services developing service specifications indicating e.g. what does podiatry do, workforce etc. Been asked to look at what service would look like if only had 90% of budget. Nicky indicated the need to cut down on appointments as well – instead of toing and froing to GPs – could use AHPs e.g. Rachel referred to a document by BMA "Safe Working Guidance for GPs" which refers to how many contacts should have per day and if over that, then considered dangerous level. May be worthwhile looking at that to see if similar work could be done across other services.

Martin O'Dwyer indicated that very long hours being worked to sustain service – a lot of fatigue. A lot of pharmacies closing – difficult situation as patient demand has not changed. SG need to accept that services cannot keep going and going.

12. **Date of Next Meeting**

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**Time for Change Summary – Community and Staff Engagement**
Responsible Executive/Non-Executive:	**Stephanie Errington, Interim Director of Planning and Performance**
Report Authors:	**Clare Oliver, Head of Communications and Engagement**

1 Purpose

This is presented to the Board for:

- Awareness

This report relates to a:

- Annual Operational Plan/Remobilisation Plan

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

The scale of the challenges faced in planning and delivering health and social care services to meet need are unprecedented. There is a significant workforce challenge with an aging workforce in the Borders and national shortages of many staff groups including registered nurses and GPs.

We are also facing significant increases in demand on our services from Demographic change (an increasing elderly population) and the continued development of new treatments, procedures and new medicines.

We are also facing a financial challenge with a projected deficit for NHS Borders at the end of 2023/24 in the region of £22.5 million (under review). As we move into 2024/25

this will increase significantly unless NHS Borders takes further steps to increase short term financial controls and makes decisions on long term efficiencies and service change.

We continue to strive to balance the delivery of safe, quality care within the financial and human resources available to us. We know that we need to start doing things differently to achieve our aims. This may mean making some difficult decisions about the services we provide, including what we do or do not continue to provide, where services are provided from and who they are provided by.

We are committed to involving the public and our partners in the development of options and the decision-making process.

2.2 Background

NHS Borders Service, workforce and financial plans for the next three years are not currently sustainable. Our Financial Recovery Plan has not yet been able to identify the changes that would be necessary to deliver a return to financial balance within the next three years. There is an urgent need to plan for the delivery of savings to address the board's financial deficit over the short, medium and long term.

There is a clear requirement to ensure NHS Borders can demonstrate both financial and non-financial grip and control across all our services, as well as improving our productivity so that we improve our delivery against service performance and quality targets.

We must focus on maximising the use of resources to deliver high quality, safe, effective, efficient, sustainable and affordable patient care – increasing productivity and reducing waste

It is crucial that everyone using NHS resources understands the context within which we are operating, and that the decisions they (staff, patients, partners and communities) make have a financial impact.

The Time for Change engagement programme was designed to help get that message across and took place as a series of conversations across the five localities of the Borders between October and December 2023.

The themes that emerged from the Time for Change conversations will inform the developing Medium Term Plan.

2.3 Assessment

Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change.

Effective community engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people.

Phase One of Time for Change took place between October and December 2023 and included internal (staff) and external (community) engagement.

A full description of the Time for Change activity is included in the Summary Report appended to this cover paper.

2.3.1 Quality/ Patient Care

The workforce and financial pressures currently faced by NHS Borders do, at times, impact on the quality of care that we provide. The Time for Change engagement conversations touched on the options around balancing quality of care, productivity and efficiency against the impact of those pressures.

2.3.2 Workforce

We recognise the impact that ongoing and unprecedented pressures are having on our staff. The Time for Change engagement sessions offered staff the opportunity to feed in their thoughts, ideas and experiences directly to members of the Board.

2.3.3 Financial

The Board will receive a separate paper setting out the initial scale of our current financial gap as we move into 2024/25 and the impact of the draft Scottish Government Budget set out in December 2024. This set out a significantly more challenging budget position than was included in NHS Borders current 3 year financial plan and was anticipated at the start of the Time for Change process.

The financial planning guidance for 24/25 issued by Scottish Government (SG) stipulates a minimum level of 3% recurrent and 1½ % non-recurrent savings must be delivered. However, the current assessment, following receipt of our draft budget, shows that the level of savings will need to significantly exceed this to meet our financial targets.

NHS Borders is currently developing the actions we will need to take to achieve the level of financial improvement required. This will need to include a description of the potential impact on the people who use our services, our Partners and our communities.

2.3.4 Risk Assessment/Management

To be continually assessed.

2.3.5 Equality and Diversity, including health inequalities

Time for Change engagement was planned and conducted in line with the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes.

2.3.6 Climate Change

None identified.

2.3.7 Other impacts

None identified.

2.3.8 Communication, involvement, engagement and consultation

Time for Change demonstrates the Board's commitment to involve and engage external stakeholders.

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 16 January 2024
- NHS Borders Board 17 August 2023
- Board Executive Team 27 June 2023
- Public Involvement Partnership Group 20 July 2023

2.4 Next Steps

Considering the changing financial position, we will now review the output of Time for Change and how we should progress with the planned next phases of engagement.

A further update and recommendation on next steps will be provided to the next Board meeting.

2.5 Recommendation

This item is being brought to the Board for

- **Awareness** – For Members' information & discussion.

3 List of appendices

Time for Change Summary Report (October – December 2023)

NHS Borders

Time for Change Conversations

Summary Report

October 2023 – December 2023

Background

The scale of the challenges faced in planning and delivering health and social care services to meet need is unprecedented.

We continue to strive to balance the delivery of safe, quality care within the financial and human resources available to us, and we know that we need to start doing things differently to achieve our aims.

This may mean making some difficult decisions about the services we provide, including what we do or do not continue to provide, where services are provided from and who they are provided by.

We are committed to involving the public and our partners in the development of options and the decision-making process.

Time for Change

Community engagement is a purposeful process which develops a working relationship between communities, community organisations and public and private bodies to help them to identify and act on community needs and ambitions. It involves respectful dialogue between everyone involved, aimed at improving understanding between them and taking joint action to achieve positive change.

Effective community engagement and the active participation of people is essential to ensure that health and social care services are fit for purpose and lead to better outcomes for people.

The first phase of our Time for Change conversations happened between October and December 2023. The dual aims of the engagement were to describe the reality of the situation that we are facing and obtain information from the public and our staff on what matters most to them.

The information gathered at the sessions is being used in the preparation of NHS Borders Medium Term Plan.

How we did the engagement

Time for Change conversations took place in each of the five localities across the Scottish Borders.

This approach was consistent with the 'We Have Listened' engagement that took place to inform the development of the Health and Social Care Partnership (HSCP) Strategic Framework in 2022/23.

Two conversations took place in each locality. The first was at the Area Partnership meeting with the second conversation following a couple of weeks later with an open community conversation in the same locality.

In addition attempts were made to engage with specialist groups in order to increase participation, influence and voice from people with protected characteristics and lived experiences from across the Scottish Borders.

An overview of attendance at the community conversations can be found at Appendix 1.

A slide deck was prepared to set the scene and inform conversations if required. The content of the slide deck was informed through a co-production approach between Public Members, the Time for Change team and Board Executive Team members. It reflected some key issues/areas of interest that emerged from the 'We Have Listened' engagement exercise that took place during 2022/23 to inform the HSCP Strategic Framework.

In reality it was not necessary to utilise the presentation slide deck to get the conversations started. A summary sheet of the background information was also made available to attendees at the sessions.

Key themes from the conversations

The following themes and issues emerged during the conversations which were predominantly consistent with the previous We Have Listened engagement, although finance was far more prominent this time round.

Resources

- Budget and how it gets allocated to NHS Borders by the government (NRAC)
- Does the budget reflect population needs and demographic profile of the Borders?
- Cuts?
- What decisions are we making / what is being considered for the future?
- Staff retention and recruitment
- Workforce issues
- Use of technology – benefits
- Future use of AI technology
- IT systems and patient communications

Communication

- Poor communication between services
- Poor communications with and from GPs

Services

- Concern about delayed discharges
- Use of Community Hospitals (too limited? / patient profile)
- Concern over future of Community Hospitals
- Importance of Value Based Health & Care
- Comments about care in the Borders General Hospital (BGH) were mostly positive
- ADHD (Attention Deficit Hyperactivity Disorder) referrals
- GP access (particularly in Duns and Peebles sessions)
- Continuity of care
- Ambulance waits and availability of ambulances (Berwickshire)
- Concerns about dental provision

Waiting times

- Backlog and waiting times (impact on patient health and wellbeing)
- Some acceptance of treatment waits
- Waits were an issue for See Hear group (cataracts and low vision clinic)

Social Care

- Lack of availability of care packages
- Lack of availability of Care Home places

Partnership opportunities & personal responsibility

- Early intervention / preventative work including in schools
- Partnership working with Third Sector organisations
- People were interested to hear about what the community can do to play their part
- Opportunities to link in with other work taking place in community settings e.g. Place Making

Feedback from attendees

Community conversations operated on a drop in basis and the team made an effort to speak to everyone as they were leaving to ask them about their experience. Had they found the conversation interesting? How was the format? Did they get to raise their point / ask their question? Was there anything we could do differently?

In general the feedback was really positive, with people particularly grateful for having the opportunity to have direct conversations with members of the Board. The openness and honesty of board members in describing the challenge we are facing was also appreciated.

There was interest from a few attendees about becoming more involved e.g. as an NHS Borders public member. These expressions of interest are being followed up. We were also asked how else we were reaching out e.g via surveys or online events.

Representation

The majority of attendees at the Time for Change conversations were over the age of 55. Age profiles from each session are provided in appendix 1. In addition to the locality based conversations approaches were made to specialist groups to hear the influence and voice from people with protected characteristics and lived experiences from across the Scottish Borders. Meetings with three groups took place (detailed in appendix 1) with further meetings to be arranged once the approach for Phase 2 is agreed.

Information gathered to date will contribute to future Equality and Human Rights Impact Assessments (EHRIAs) taking place in relation to Time For Change.

Staff Engagement

In addition to the public engagement sessions, six Time For Change sessions took place with staff. One in person session in each of the localities on the same day that the community conversation took place, and a session in the BGH. In addition there was a discussion at the online November management engagement session.

With the exception of the session at the BGH which was very poorly attended, there was a good attendance at the management engagement session and generally good uptake in the community settings which was really encouraging. The sessions were run without an agenda and gave staff an opportunity to raise any issues or ask any questions that they wanted to.

It should be noted that the staff conversations took place within the same time frame that the community hospital medical cover review was announced, which had an impact on the issues raised by staff.

Key themes from the staff conversations

Resources

- Budget and how it gets apportioned (NRAC)
- Delays due to problems recruiting care staff
- Under utilisation of staff skills within community settings (including community hospitals)
- Allied Health Professional vacancy rates and inability to recruit
- Pensions
- Job security

Communication

- Needing cooperation of families to help people move on from Community Hospitals

Services

- Concerns about the future community hospitals
- Defining what the Community Hospital is for and what the public perception of the Community Hospital is
- Step down of patients due to backlogs and impact on patient mix
- Lack of consistency in the way Community Hospitals operate

Social Care

- Availability of care placements

Reflection

Time For Change was designed as a public involvement programme which was extended to capture staff views. Although, as the key themes show, there was some consistency with the themes raised by the public, there were some very specific issues raised by staff, particularly in relation to workforce pressures and community hospitals.

Moving forward it has been agreed that the staff engagement element of the Time for Change work will be progressed within the Staff Quality Management System pillar.

Next steps

The themes that came up in the Time for Change conversations will be reflected in the NHS Borders Medium Term plan which is currently being drafted.

Appendix 1

Demographics of Attendees at Community Conversations (excluding Area Partnerships)

Number of Participants								
	Tweeddale	**T&L**	**Eildon**	**Cheviot**	**Berwickshire**	**Total**		
Public	18 * Actual >100	8	13	19	12	70	*Only recorded attendees up to 3pm	
Staff	6	12	6	13	13	50		
Demographics - Public								
Male	8	3	6	12	4	33		
Female	10	5	7	7	8	37		
Age of Participants - Public								
Public	**18-24**	**25-34**	**35-44**	**45-54**	**55-64**	**65-74**	**75-84**	**85+**
	0	2	7	5	7	32	16	1

Special Interest Groups Attended:

- Borders Older Peoples Partnership (28 November 2023)
- See Hear Group (6 December 2023)
- Physical Disability Group (14 December 2023)

Protected Characteristics to be approached for next sessions:

- Young People
- Travelling Community
- LGBTQ+
- Ethnic Groups
- Religion
- Carers

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**NHS Borders Performance Scorecard December 2023**
Responsible Executive/Non-Executive:	**Stephanie Errington, Interim Director of Planning & Performance**
Report Author:	**Hayley Jacks, 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. 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 main body of the scorecard sets out performance as at end of December 2023 against the targets from the 2023/24 Annual Delivery Plan (ADP). The report also includes as appendices performance as noted against some previous AOP/LDP measures, for information purposes.

2.2 Background

In 2022/23 Scottish Government moved away from commissioning any further remobilisation plans following the covid pandemic and instead commissioned a one-year ADP aimed at stabilising the system. New targets and trajectories were submitted to Scottish Government as part of the 2023/24 ADP.

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. On this occasion, narrative to accompany the data for Outpatients and Unscheduled Care has not been available.

Where services have been able to provide it, narrative is contained within the body of the scorecard, focusing on 2023/24 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 Intelligence Services with a view for this to be included in future scorecards.

2.3.1 Quality/ Patient Care

The ADP milestones and 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

Services will carry out HIIAs as part of delivering 2022/23 & 2023/24 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 December 2023.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard

PERFORMANCE SCORECARD

As at 30 December 2023

Month 9

Contents Page

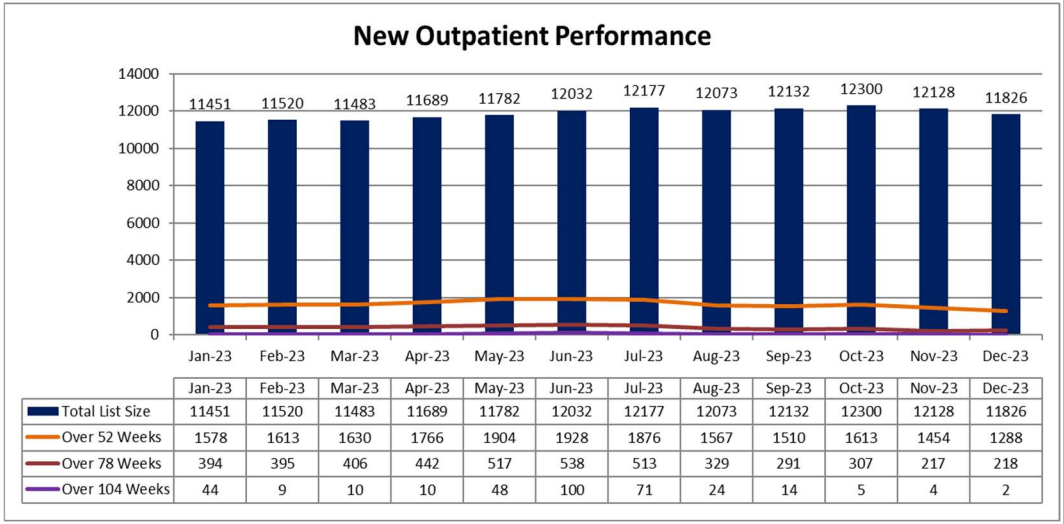
Introduction

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 (ADP) aimed at stabilising the system. As per the agreed ADP for 2023/24, which was brought to the NHS Borders Board August meeting for approval, all Boards were required to submit waiting times trajectories but no other formal performance measures were agreed.

This report contains the 2023/24 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 March 2023.

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



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total List Size	11451	11520	11483	11689	11782	12032	12177	12073	12132	12300	12128	11826
Over 52 Weeks	1578	1613	1630	1766	1904	1928	1876	1567	1510	1613	1454	1288
Over 78 Weeks	394	395	406	442	517	538	513	329	291	307	217	218
Over 104 Weeks	44	9	10	10	48	100	71	24	14	5	4	2

Fig. 1

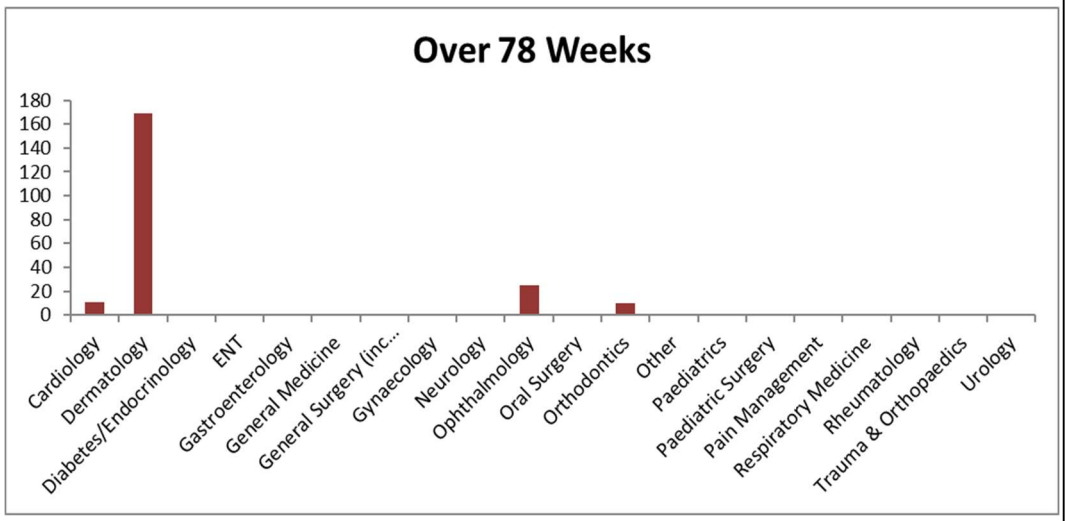
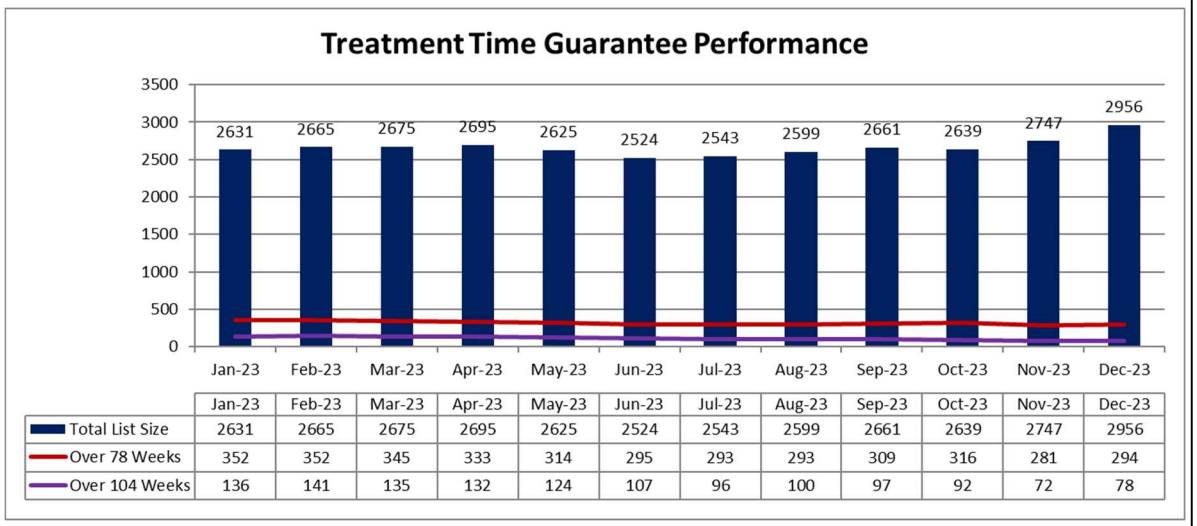


Fig. 2

Awaiting December narrative from service.

TTG Performance Against Trajectory- All Specialties



	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23
Total List Size	2631	2665	2675	2695	2625	2524	2543	2599	2661	2639	2747	2956
Over 78 Weeks	352	352	345	333	314	295	293	293	309	316	281	294
Over 104 Weeks	136	141	135	132	124	107	96	100	97	92	72	78

Fig. 3

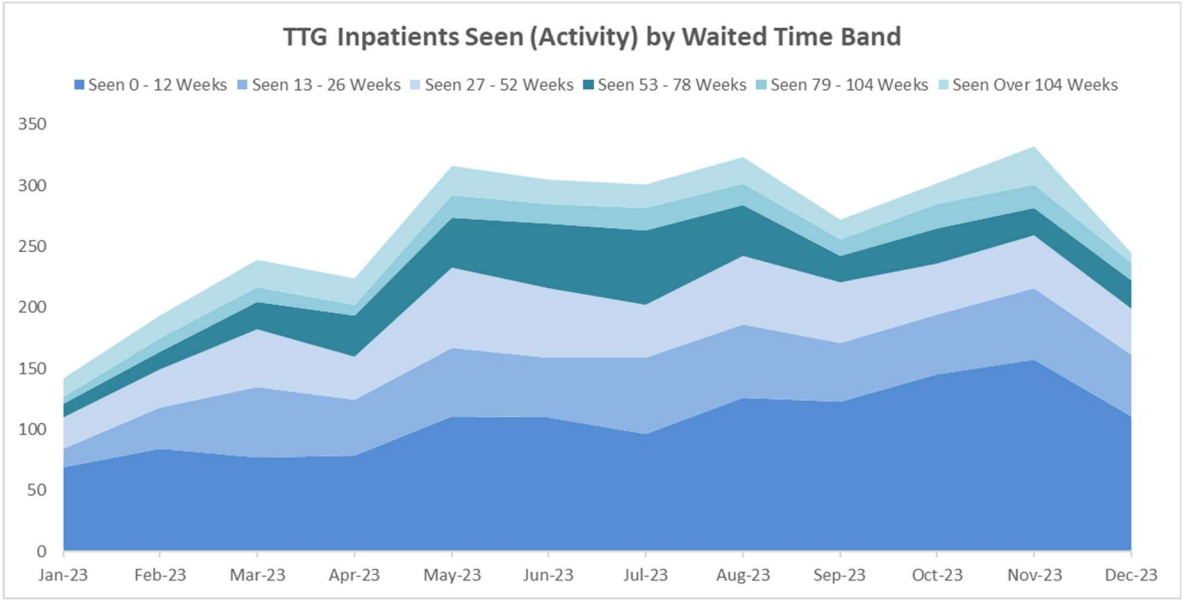


Fig. 4

THEATRES AND CHRONIC PAIN **Updated 24.01.24**

Theatres: The Treatment Time Guarantee (TTG) states that after a diagnosis is made and treatment is agreed, each health board must ensure that patients receive inpatient and day case treatment within 12 weeks. Due to the backlog of patients awaiting surgery, the current target is to ensure that there is a maximum of a 1 year wait for Inpatient / Day Cases in the majority of specialities by the end of Sep 24; this is called TTG 52.

Chronic Pain: The target for Chronic Pain is 18-week referral to treatment.

Performance

Theatres.

- Additions to the IPWL in December were relatively high for the second month in a row with additions of over 500 patients in December. This, combined with low levels of activity in December, resulted in the IPWL increasing by just over 200 patients compared to November.
- Theatre activity levels in December were down at 67% of 2019 levels (80 % over the last 3 months and 72% over the last 12 months). The activity levels were particularly impacted by the cancellation of several high-volume Ophthalmology lists due to sickness amongst Theatre Staff as well as 9 cancellations at the start of December because of an issue with the ventilation system in theatres.

Chronic Pain.

- Reduced clinic activity in December as a result of leave led to an increase in patients on the Waiting List, and an increase in patients waiting over 12 weeks.

Actions complete since last report

IVTs. Confirmation received that IVTs will cease to use the theatre in DPU from end Jan 24. This will increase available capacity for elective operating (4 sessions a week).

Priorities

Staffing. My highest priority is to progress NOC forms to keep the B5 and B4 posts within the Inpatients Team in the Central Bookings Office. The future of the Data Analyst post (end of contract end March) is subject to confirmation; a resolution by end January at the latest is sensible to avoid losing this valuable addition to the team. There has been significant benefit realised from this post over the last 3-4 months.

DPU. Confirm by 26 Jan what additional resource is required so that we can maximise the use of DPU for GA elective surgery.

Synaptik. Finalise the plan to run elective surgery over 6 weekends between the last weekend in February and end of March. This activity will use Waiting Times funding and will focus on the longest waiting patients in General Surgery, Urology and Gynaecology.

NHGJ Travel Costs. Whilst a change in policy has been implemented within CBO to reduce the significant levels of spend involved in sending patients to GJNH, the levels of spend remain high. This will be an area of focus over the coming months to reduce this spend.

Out of Hours Elective Cancellation SOP. Develop a SOP for Elective Surgery cancellations outside working hours.

Anaesthetic Staffing. The new Specialty Doctor (SD) 2022 contract specifies that no more than 40% of hours are worked Out of Hours (OOH), unless the individual adopts to work in excess of this figure. The 4x SDs who work for BGH Anaesthetics Department currently work between 60% and 84% OOH. In the next job planning round in 2024 it is anticipated that this could result in a deficit of 71 OOH shifts. To treat this risk, Specialist Doctors to be recruited; SBAR to be submitted to Q in next few weeks by CD Anaesthetics.

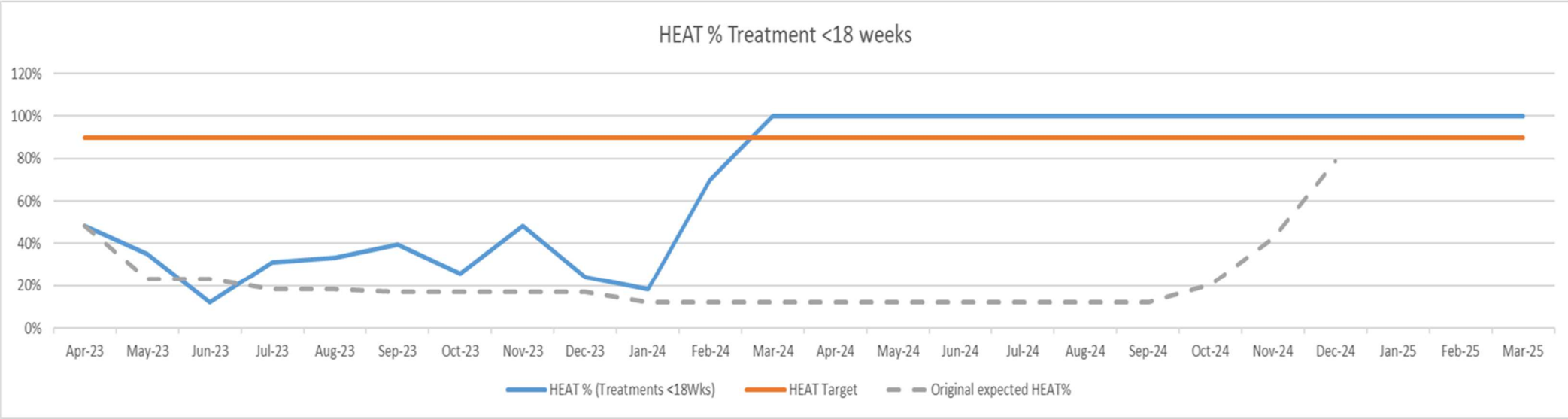
Elective C-Section numbers. Monitor Elective C-Section demand due to increasing numbers of patients / requirement for theatre space.

Communications. There is a requirement to confirm that the letters we send to patients are appropriate; there is concern that they can be ambiguous, lengthy and cause confusion to some patients.

Updated 25.01.24

Mental Health Waiting Times – CAMHS

Fig. 5



What is the data telling us?

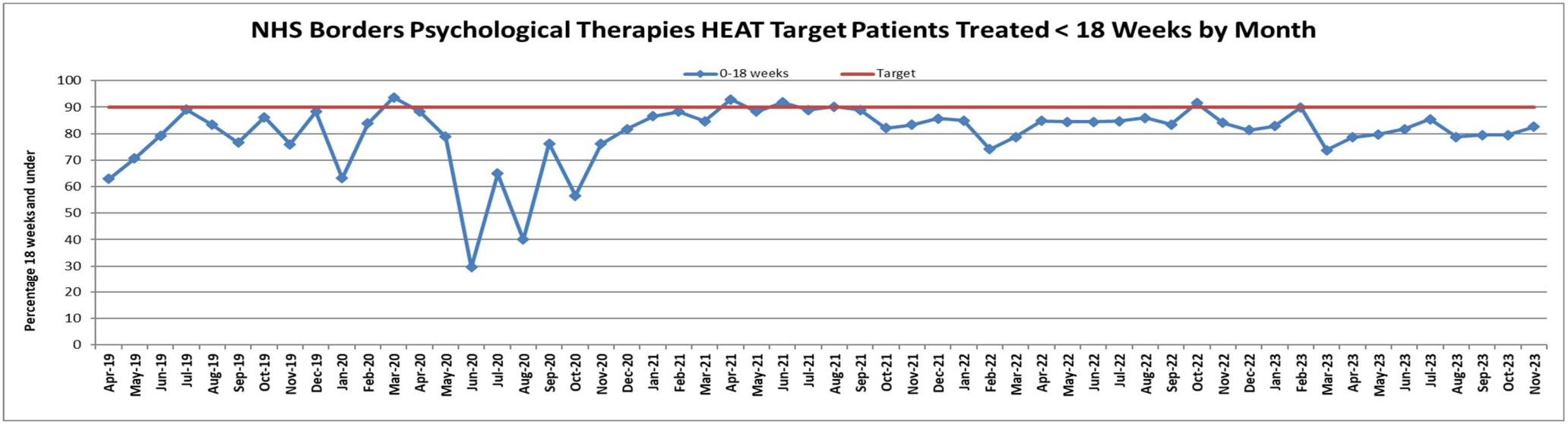
The table shows the current trajectory based on the current projected accepted referrals and number of treatments to be completed (12 New Patient Appointments per week 51 per month) which is currently being weighted in favour of 70% Cat 2 and 30% Cat 1 in order to meet the LDP (Heat target) earlier than originally reported. There has been a decrease in the total number of referrals for December 2023 is 44 compared to 56 for November 2023. There has been a decrease in the number of redirected referrals for December 2023 of 27 compared to 33 for November 2023. The percentage redirected has therefore increased for December 2023 (61.4%) compared to November 2023 (58.9%).

Plan to Reduce CAMHS Waiting Times

- New Patient Assessments (NPA)
  - The service continues with the waiting times initiative of seeing 12 new patients per week. However, in November 23 the service carried out a review of all Cat 1 and Cat 2 cases and re-categorised some patients from Cat 2 to Cat 1. The new categorisation was weighted in favour of Cat 2 (70%) against Cat 1 (30%) this initiative was to reduce the Cat 2 waits and meet the RTT target of 90% sooner than originally predicted.
  - The tagging process is continuous and under constant review against the CAMHS Specification, all patients waiting have been tagged as being CAT1 (ND) or CAT 2 (Core mental health) this allows the team to review patients waiting to access the service, with a view to determining appropriate signposting or establishing any possible interventions prior to a first appointment.
- School Referral Rollout
  - The pilot was a huge success with excellent quality referrals from the 4 pilot schools for ND patients.
  - We have now rolled out ND referrals to 43 schools with only Eyemouth, Cheviot and Teviot (23 schools) to be rolled out in the next phase which hopefully should be finished by March 2024.
- Recruitment
  - Nursing – 1 band 5 nurse post out for advertisement along with 2 band 6 nursing posts. There is one OT post to be advertised internally for 12 months' temp contract.
  - A temporary band 3 admin assistant has been agreed for 6 months and this post will provide administrative support for medical staff in order to release medical time and is now out to advert.
  - The one Medical staffing vacancy has funded an additional speciality doctor on a temporary basis and a clinical development fellow for one year.
- RHCYP Melville Unit (Royal Hospital for Children & Young People)
  - 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



Current activity and performance against HEAT Target

The 18 week RTT HEAT target for Psychological Therapies measures those people who are starting treatment and how long they have waited for this to start.The target is to see 90% of those starting treatment within 18 weeks.

Performance this month towards the PT RTT standard is slightly improved from last month at 82.61 % - last months was 79.39%. In November the service started treatment with 184 patients (165 in October 2023) of which 32 (34 in October 2023) patients had waited longer than 18 weeks for a first treatment appointment (Figure 1).

Our LD psychology service is under great pressure with a known capacity gap. Older adult psychology is also under great pressure due to vacancies and this situation is not likely to improve in the next six months. CAMHS Psychology is also under pressure due to maternity leave. Adult mental health secondary care is under great pressure due to unprecedented and sustained high referrals and vacancies.

Current PT Waiting List

As at 30th November 2023 we have 638 people on our waiting list, a slight decrease of 7 from last month, 91.5% of whom have waited less than 18 weeks. We do not have anyone waiting over 52 weeks. We have 9 people waiting in the 35-52 week range which represent 1.4% of those waiting. Waits over 18 weeks are mainly due to capacity issues and delays in secondary care psychology services, especially older adults, learning disability, substance misuse and adult mental health. For those areas which have had an increase in referrals, we are noticing a build-up of assessments, which will most likely impact on treatment waits.

Workforce

We have some current vacancies and gaps in service that are impacting on our performance. Current vacancies are in adult and older adults psychology. We continue to try to recruit to these posts and are using some locums where possible. We have three members of staff on maternity leave in child psychology/CAMHS.

Updated 23.01.24

Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance

Updated 26.01.24

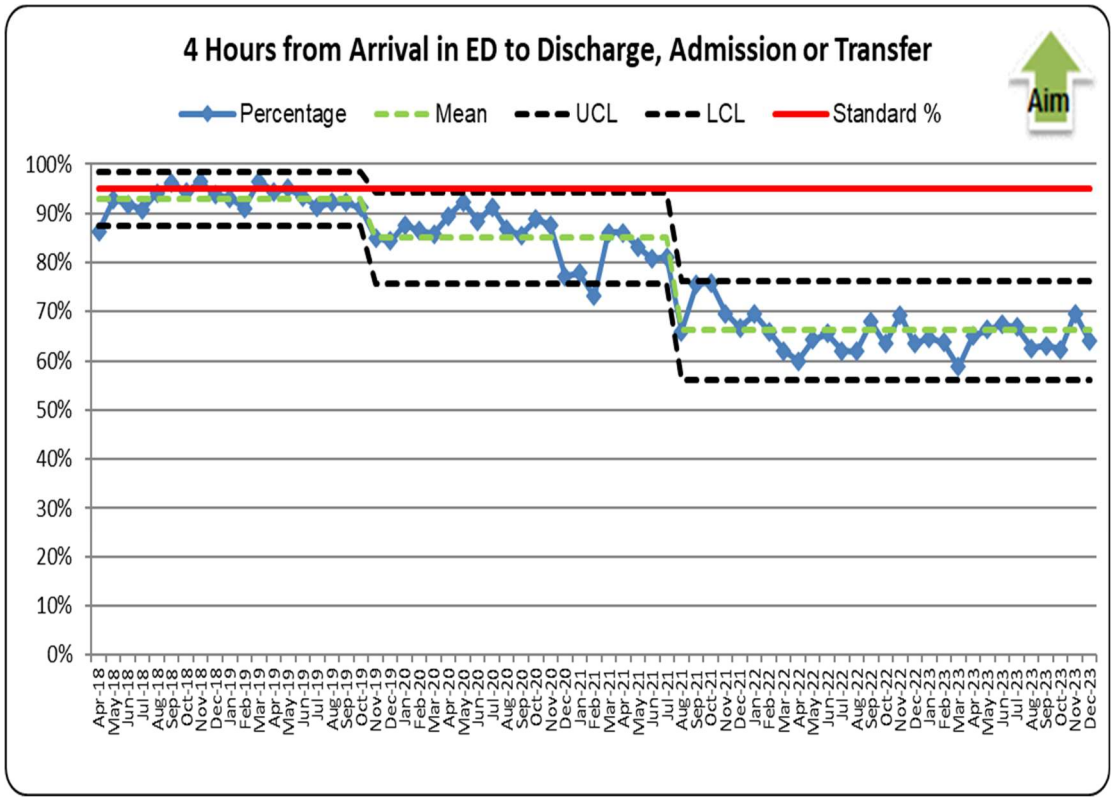


Fig. 7

In December 2023 there were 2534 unplanned attendances to the Emergency Department, with 911 breaches. Performance against the standard was 64.05% vs. 71.7% in November (-7.65%).

The BGH continued to face significant pressures throughout December in relation to patient flow, with blue ED requiring to be open for most of the month and ED occupancy frequently over 100%. This impacted the ability to achieve the EAS, with the site seeing high numbers of 12 hour breaches leading to patients frequently being bedded within the ED department overnight.

The Emergency Department continued to see a high volume of waits over 4 hours in December 2023. This was driven by wider system pressures and this in turn reflects the top 3 breach reasons outlined below:

1. Wait for a Medical Bed- 327 Patients;
2. Wait for Treatment End- 92 Patients; and
3. Wait for ED First Assessment- 79 Patients

There were more days within December that recorded a high number of 12 hour breaches compared to November 2023. During this month there were 4 instances when 12 hour breaches exceeded 10.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Number of Days Where 12 Hours Breaches ≥10	5	6	6	10	7	9	20	2	4
Number of Days Where 24 Hours Breaches ≥10	0	1	0	1	0	0	2	0	0

What is being done?

- OPEL Escalation Framework - The Unscheduled Care Service Management Team have been developing a standardised risk escalation proforma which is aimed at determining the site RAG position, and clear articulation of areas of pressure and concern.
- Bronze/Silver Command - There has also been the introduction of a daily Bronze Command meeting which takes place daily at 12pm and is also stood up at 3pm as and when required. The purpose of Bronze Command is to provide meaningful grip and control/challenge on decision making and provide a platform for escalation from ward teams to senior leadership teams to alleviate barriers to flow and discharge. This was established in November 2023. Silver Command is system wide and has representation from across the system including Social Work, Social Care and Health.
- Integrated Discharge Without Delay was launched in October 2023- key stakeholders have discussed some key points within the DwD Programme with the principal aim of defining what learning and education is needed across our organisation and gathering staff views on next steps. Work continues to progress this programme of work with several events planned in the New Year.
- Surge and Occupancy Plan – System wide plans remain to step down surge beds as delays across the system reduce. This plan continues to be the Board wide and aims to offset hospital capacity with community based capacity to improve flow throughout the Acute system.

Delayed Discharge

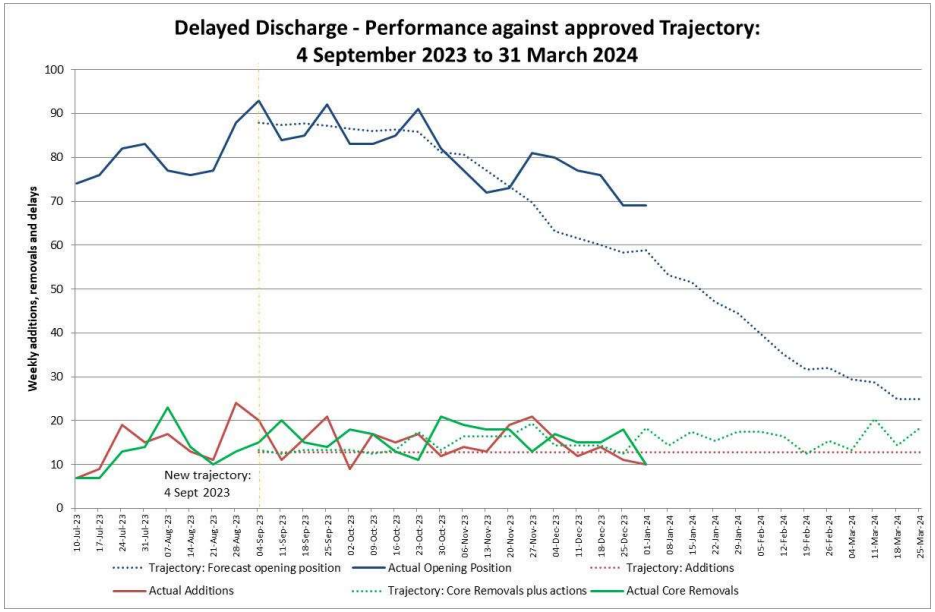


Fig. 8a

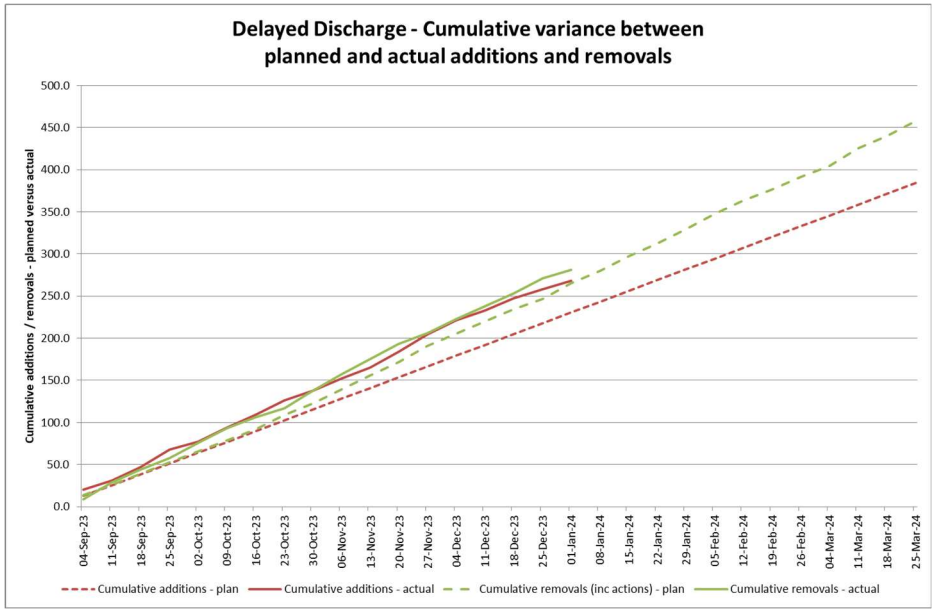


Fig. 8b

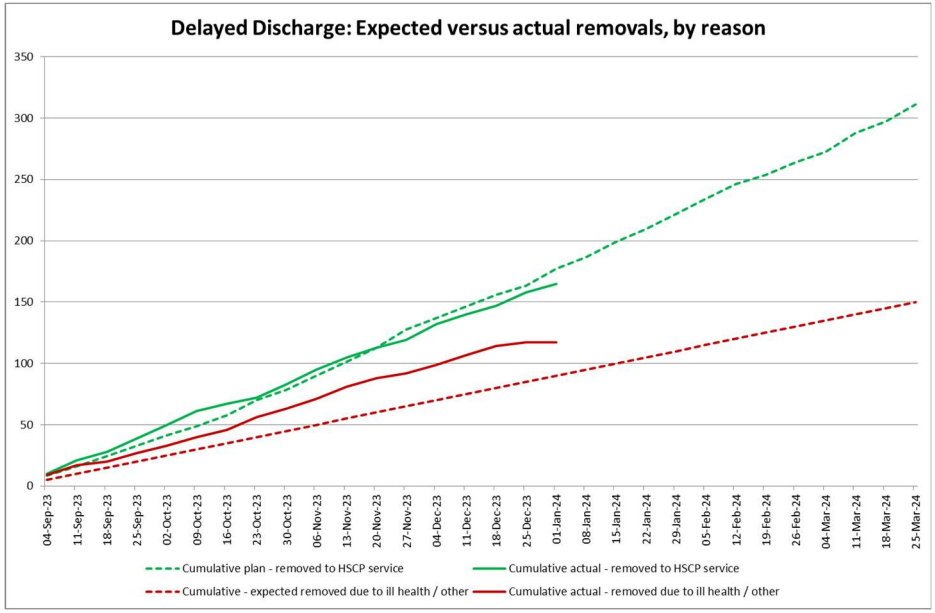


Fig. 8c

What is the data telling us?
The data is telling us that we were 10 delayed discharges above our trajectory in the week commencing 1 January. This increase in delayed discharges is due to 38 more referrals than planned, and 12 less removals to HSCP services than planned. The reduced admission rate is partially offset by the increase in removals due to ill health / other reasons which were 27 higher than planned. This reflects the increased dependence of those added to the waiting list.

Why is this the case?
When exploring the increased level of additions, with support from the NHS Borders Business intelligence team a deeper analysis was conducted covering the period of 21st August to 15th October 2023.

- Within this analysis it confirmed the that a noted increase in additions correlates to those deemed a delayed discharge then becoming unwell and being removed then added back on, sometimes on several occasions.
- A minority of patients in the audit (6) were inappropriately added to the delayed discharge list as they were referrals to Upper Deanfield and Garden View which are marked as intermediate care facilities.

9 of the 12 reduced removals to date related to the assumptions made around the development of medications administration in Home First, which has been delayed. A further 6 reduced delays were also assumed by the end of the trajectory period. This development remains in progress however necessity to ensure appropriate medicine administration governance may mean that the number of reductions falls below the initial assumption.

The remaining 3 relate to access to other HSCP services / commissioned care services. In one of the commissioned settings, staffing vacancies have temporarily reduced capacity (despite use of agency), and in another we have not seen the flow expected.

In terms of further risks associated to the trajectory moving forward, the two main risks of note are:

- Ongoing demand being higher than forecast, which if higher than forecast will have an impact on the number of people waiting for care (delayed discharges).
- The second relates to the integration of Home First and Adult Social Care which is part of the delayed discharge and surge action plan, and had a total impact of 18 reduced delayed discharges between 18/01 and the end of the trajectory.
    - There have been delays involved in this complex transformation project associated to the need to ensure appropriate staff governance and due to the registration of the new integrated service with the Care Inspectorate.

What is being done?
The Integration Joint Board issued a direction on surge planning, which includes a range of further measures to alleviate the pressures, including discharge (home to assess), single assessment, closer working with the third sector and communications promoting community supports, which will all help reduce the demand for social work and social care, get more people onto the right intermediate care pathway, and increase productivity
The national self-assessment for the implementation of discharge without delay principles was completed in September 2023 (Q2) and this will be completed again for the next benchmark (Q3) with a closing date for completion on the 19th of January 2024.

Mitigation actions to the increased demand for care, and the reduced removals to HSCP services are noted below.

Reducing demand:

- In relation to the inappropriate referrals / additions to the delayed discharge list for intermediate care, teams have been asked to add patients to the internal hospital ICF waiting list (code 600) instead of adding to the delayed discharge list.

- Adult Social Work colleagues have been focusing on reducing the number of assessment delays in the Borders General Hospital which will yield a positive impact in terms of ensuring that delayed discharge and associated length of stay is reduced.

Increasing capacity:

- Home First has changed working practices to increase service capacity. These changes have resulted in an increase from approximately 120 patient caseload to 150 patient caseload. Whilst this increase in capacity does not directly translate to an impact on delays, it does impact the ability to reduce length of stay of a broader cohort of inpatients.
- We are working to convert some respite capacity in Saltgreens to interim care capacity
- Home First are currently reviewing staff working patterns to ascertain if a change to rostering would increase capacity
- Community teams have been reviewing their caseloads to create capacity and flow
- Adult Social Care are seeking to expedite internal reablement with the support of NHS AHP staff in order to gain some of capacity currently delayed as part of the integration project. It is expected that this will come onstream in March.
- For the care settings noted above which have had flow issues due to staffing, we would expect this capacity (10 rooms) to come onstream in the next few months as the staffing situation progresses and as we see flow through into both settings.
- The impacts of Hospital at Home and Virtual Respiratory Ward capacity had not been assumed in the Delayed Discharge and Surge Plan. While we would not expect a reduction in people waiting for care who are classified 'delayed discharges,' we would expect to see an additional reduction in occupancy. Hospital at Home capacity will increase from current capacity of 10 to 20 in March. In addition, virtual respiratory capacity will increase by 20, albeit in both cases, at present what the impacts on hospital occupancy will be, while the business case is developed.

Updated 19.01.24

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	Oct-23	83.3%	Nov-23	93.1%	↑
	Cancer waiting Times - 31 Day target	95% of patients treated within 31 days of diagnosis	Oct-23	100.0%	Nov-23	96.7%	↓
	New Outpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Nov-23	7744	Dec-23	7843	↓
	New Inpatients- Number waiting >12 Weeks	Zero patients waiting longer than 12 weeks (maximum)	Nov-23	1728	Dec-23	1819	↓
	Treatment Time Guarantee - Number not treated within 84 days from decision to treat	Zero patients having waiting longer than 84 days.	Nov-23	159	Dec-23	131	↓
	Referral to Treatment (RTT) - % treated within 18 weeks of referral	90% patient to be seen and treated within 18 weeks of referral.	Nov-23	65.2%	Dec-23	65.8%	↑
	Diagnostics (8 key tests) - Number waiting >6 weeks	Zero patients waiting longer than 6 weeks for 8 key diagnostic tests	Nov-23	720	Dec-23	710	↑
	CAMHS- % treated within 18 weeks of referral	90% patients seen and treated within 18 weeks of referral	Oct-23	27.5%	Nov-23	51.7%	↓
	A&E 4 Hour Standard - Patients discharged or transferred within 4 hours	95% of patients seen, discharged or transferred within 4 hours	Nov-23	69.6%	Dec-23	64.0%	↓
	Delayed Discharges - Patients delayed over 72 hours	Zero patients delayed in hospital for more than 72 hours	Nov-23	63	Dec-23	62	↑
	Psychological Therapies - % treated within 18 weeks of referral	90% patient treated within 18 weeks of referral	Oct-23	79.4%	Nov-23	82.6%	↑
	Drug & Alcohol - Treated within 3 weeks of referral	90% patient treated within 3 weeks of referral	Q2 2023/24	100%	Q3 2023/24	100%	↔
	Sickness Absence Rates	Maintain overall sickness absence rates below 4%	Nov-23	6.86%	Dec-23	7.22%	↓

Cancer Waiting Times *(Please Note: There is a 1 month lag time for data)*

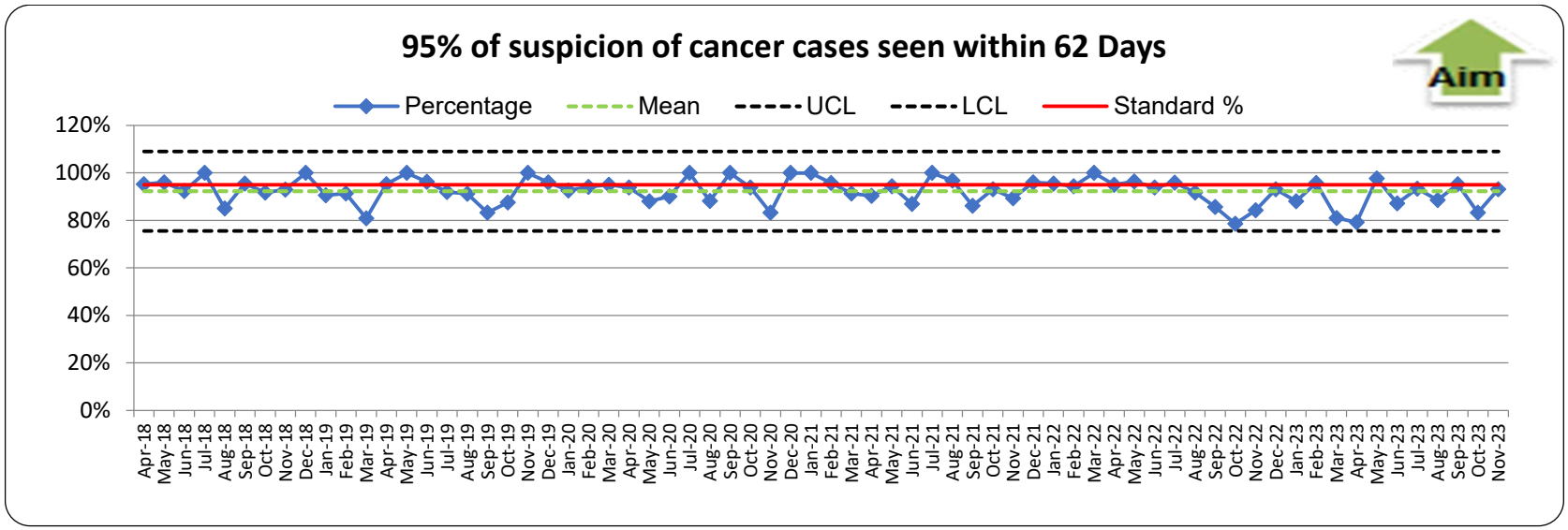


Fig. 10

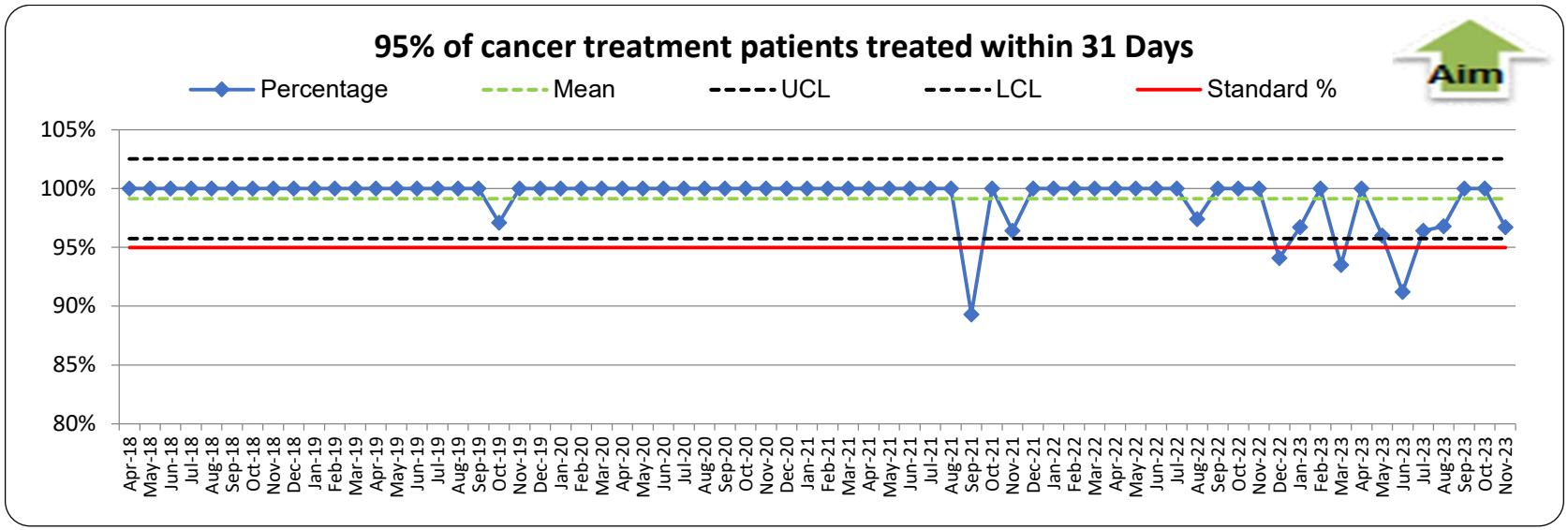


Fig. 11

Stage of Treatment- Outpatients Waiting Over 12 Weeks

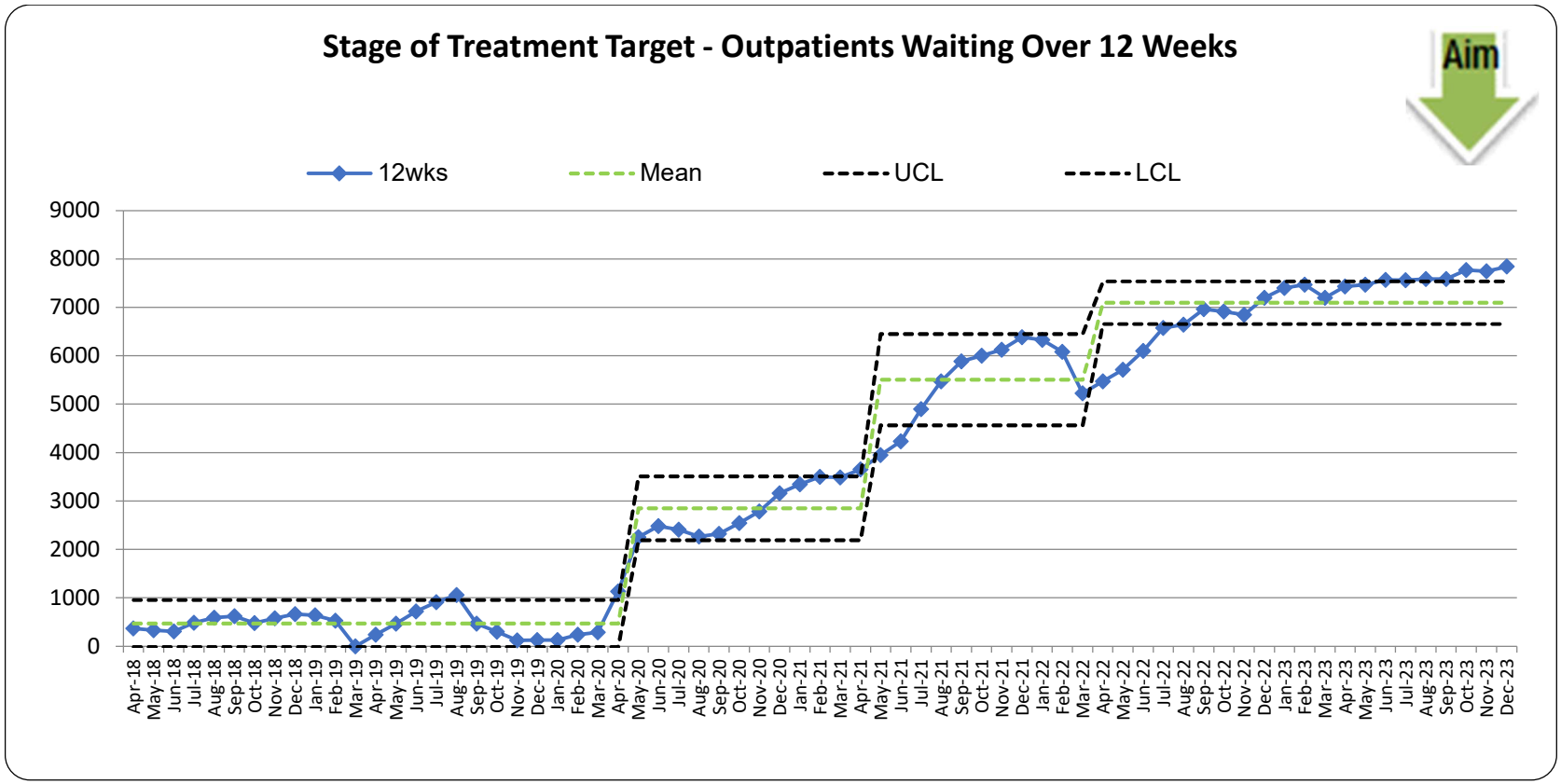


Fig. 12

Stage of Treatment- Inpatients Waiting Over 12 Weeks

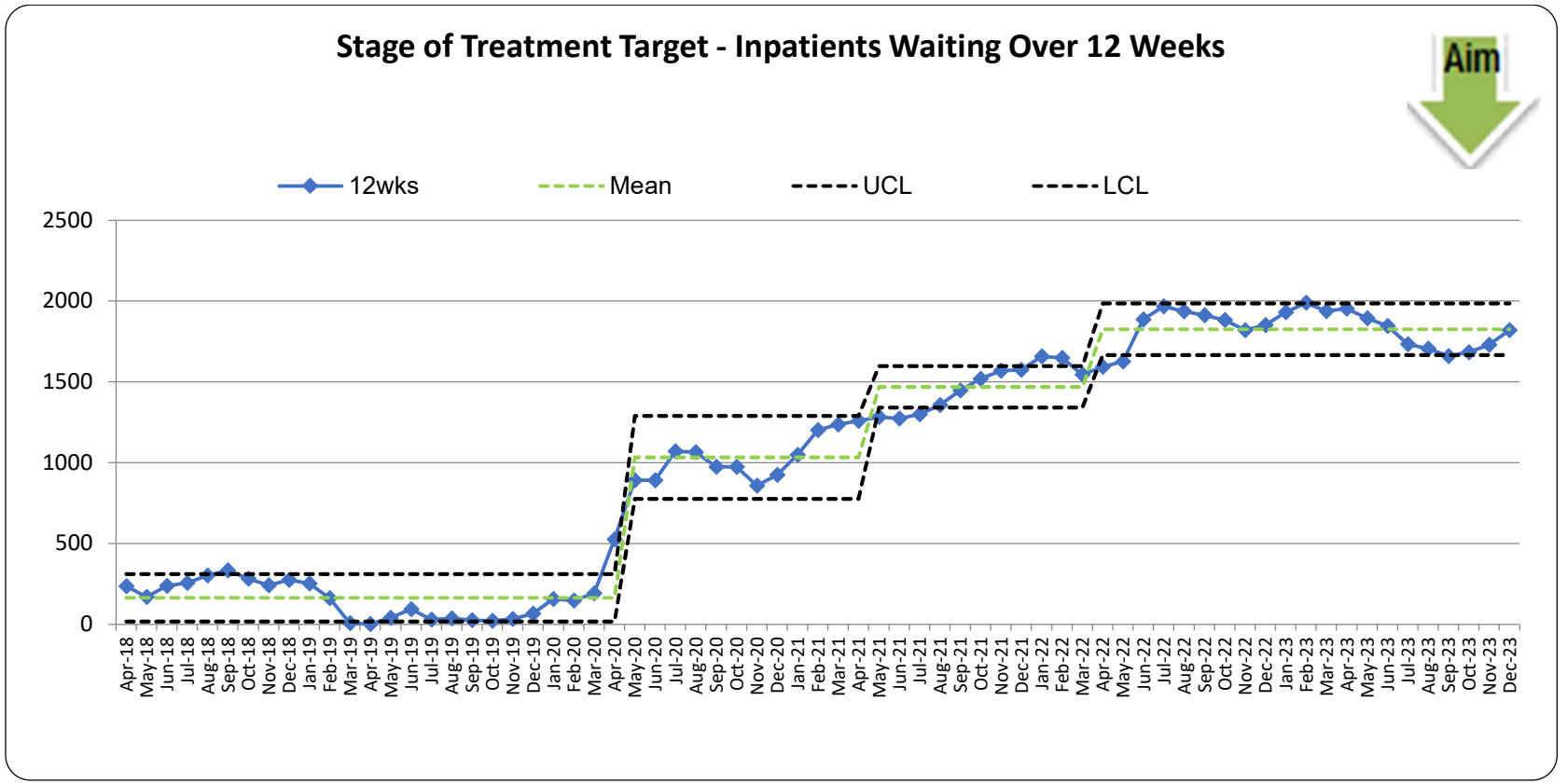


Fig. 13

Patients Treated within the 12 weeks Treatment Time Guarantee

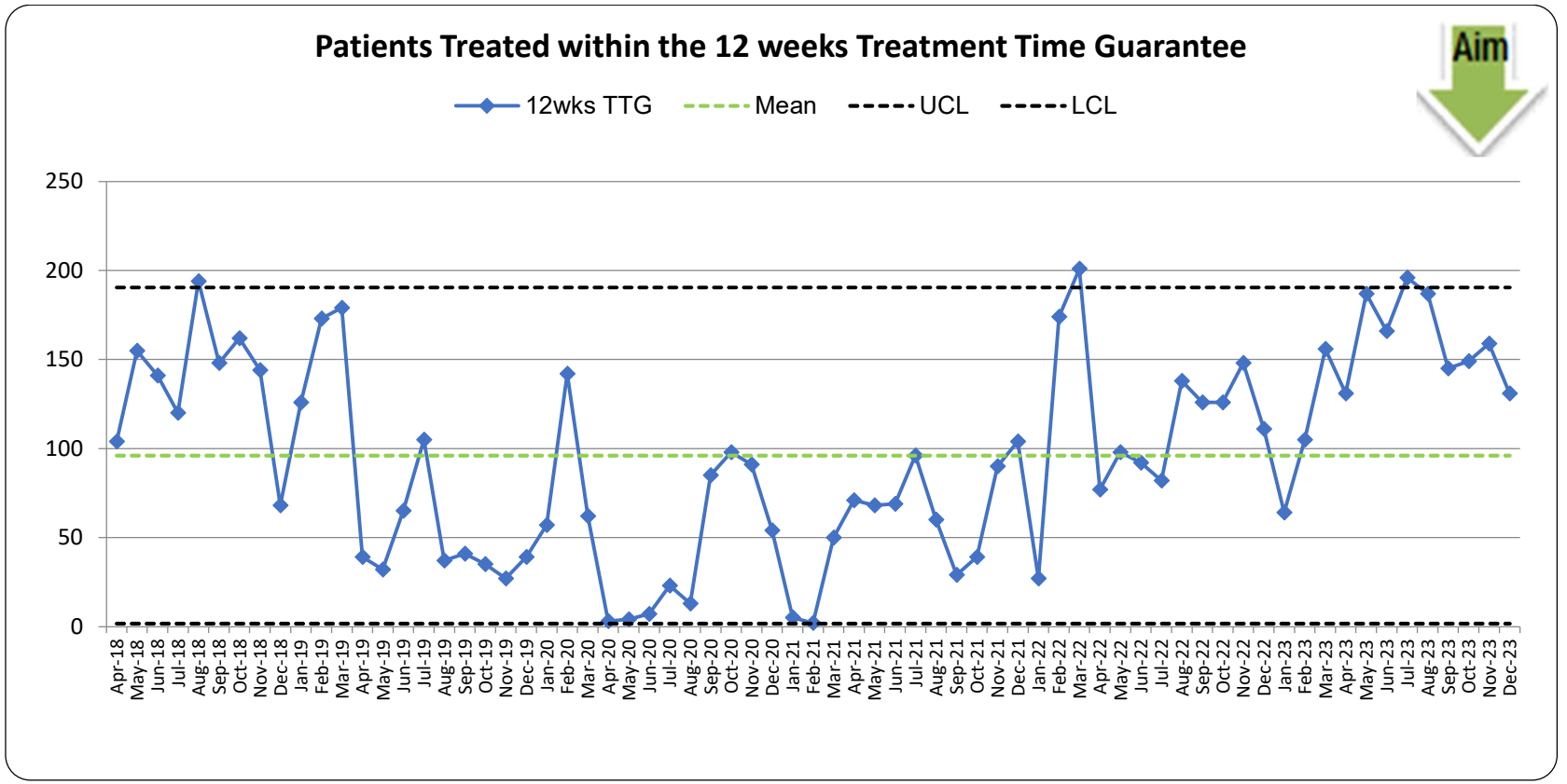


Fig. 14

18 Weeks Referral to Treatment Combined Pathway Performance

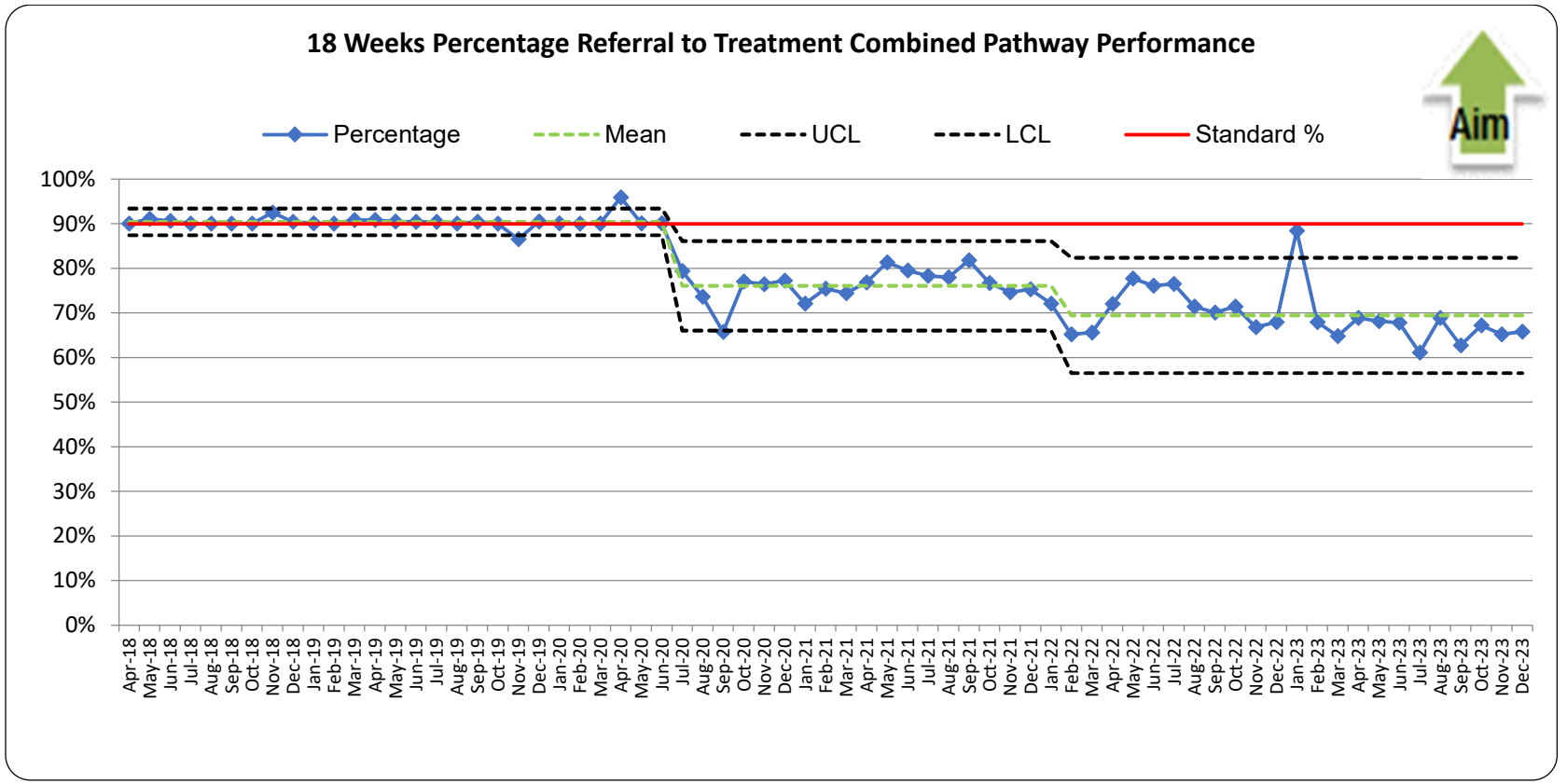


Fig. 15

Diagnostic Waits

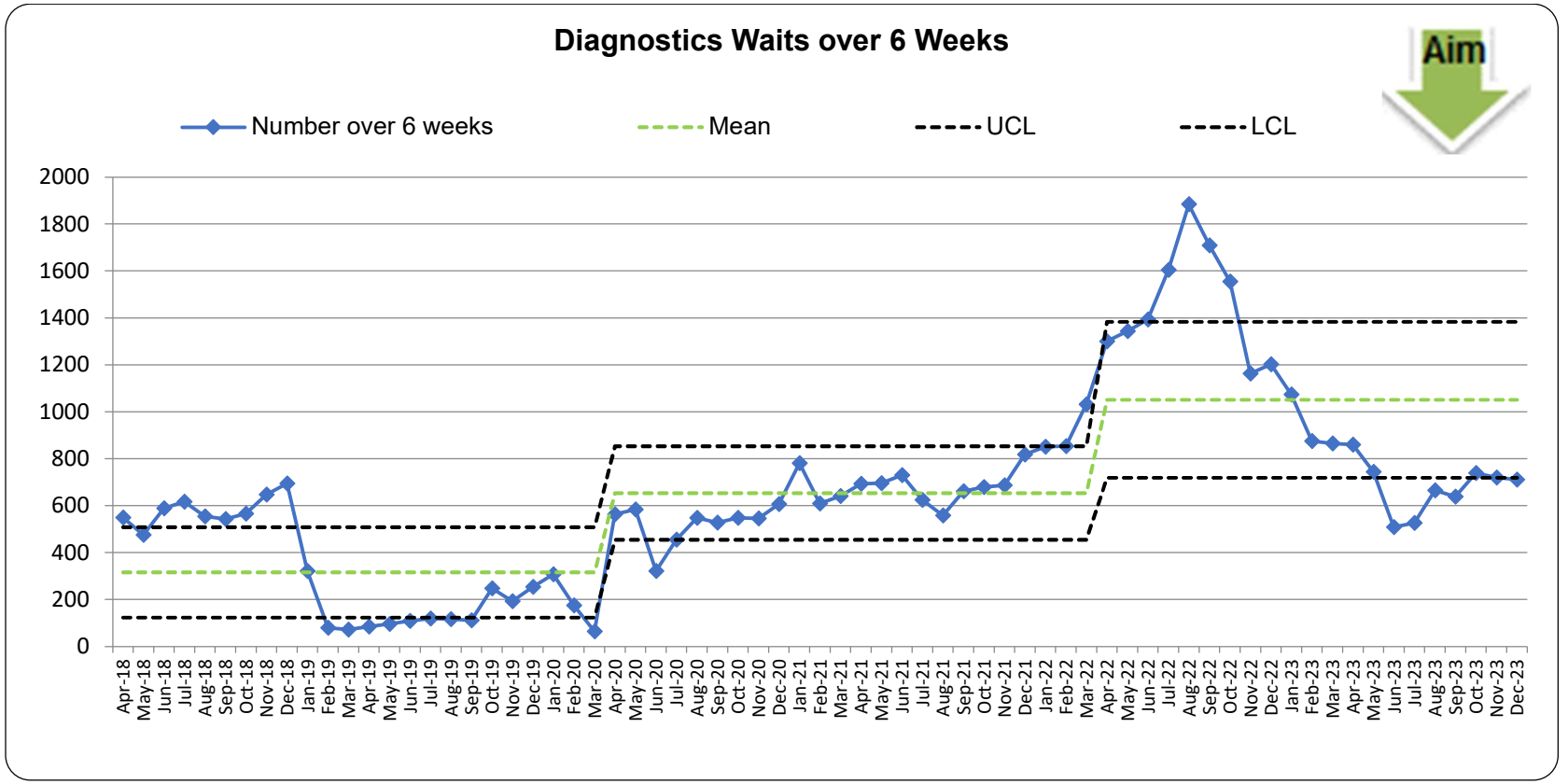


Fig. 16

CAMHS Waiting Times- 18 Week Referral to Treatment *(March-22 data not available at time of reporting due to an issue extracting data from EMIS)*

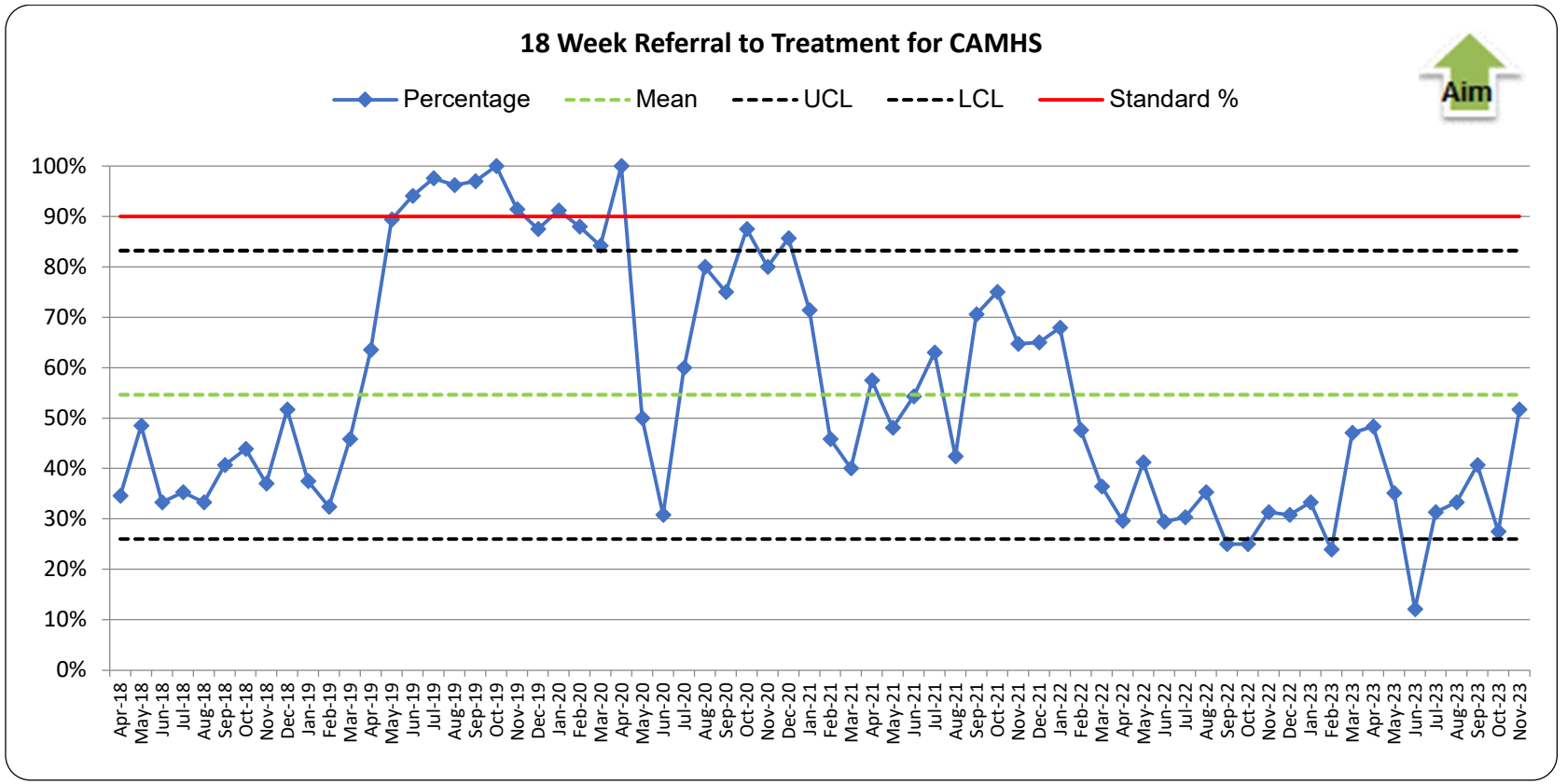


Fig. 17

Psychological Therapies Waiting Times- 18 Week Referral to Treatment *(Please note: From Sep 2019 data includes all PT Services. Renew, the Primary Care PT Service started in October 2020)*

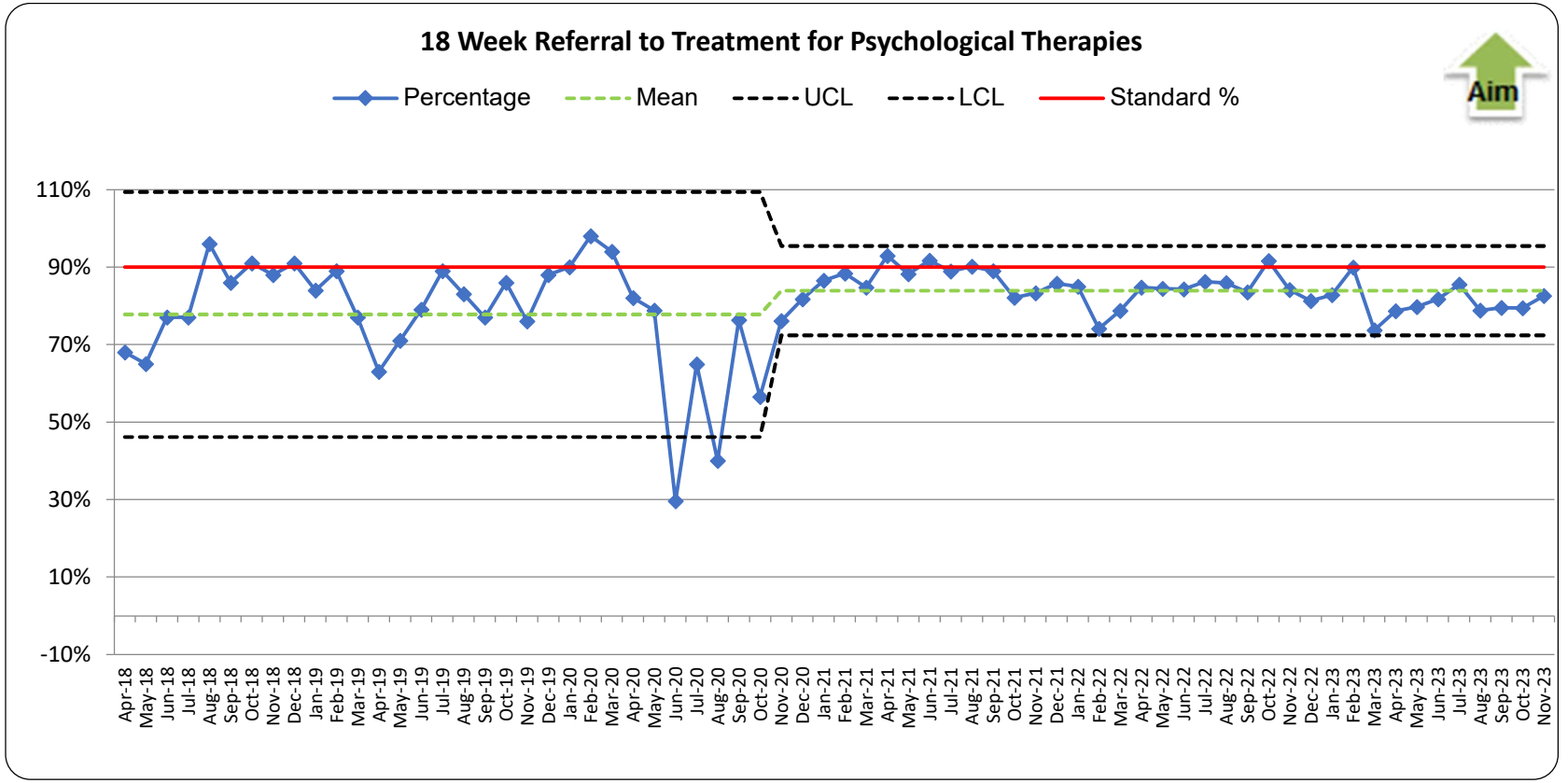


Fig. 18

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

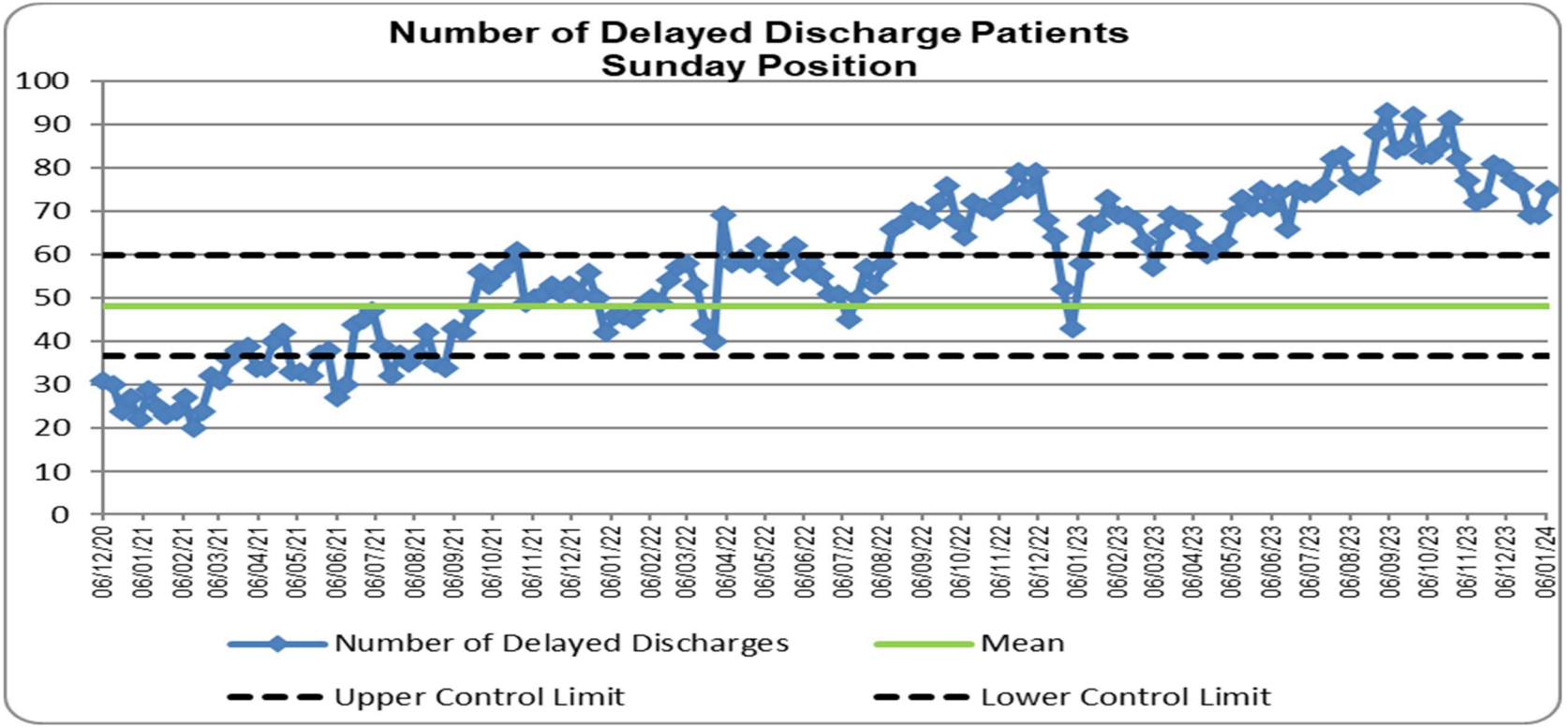


Fig. 19

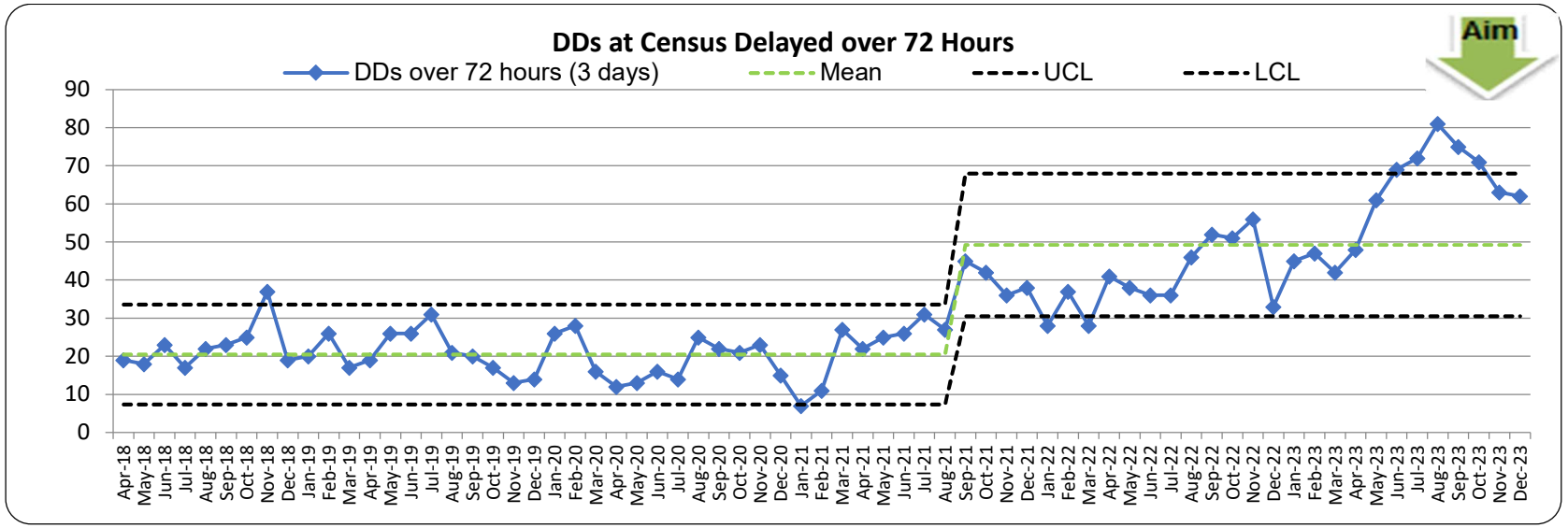

DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
90
80
70
60
50
40
30
20
10
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 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 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Fig. 20

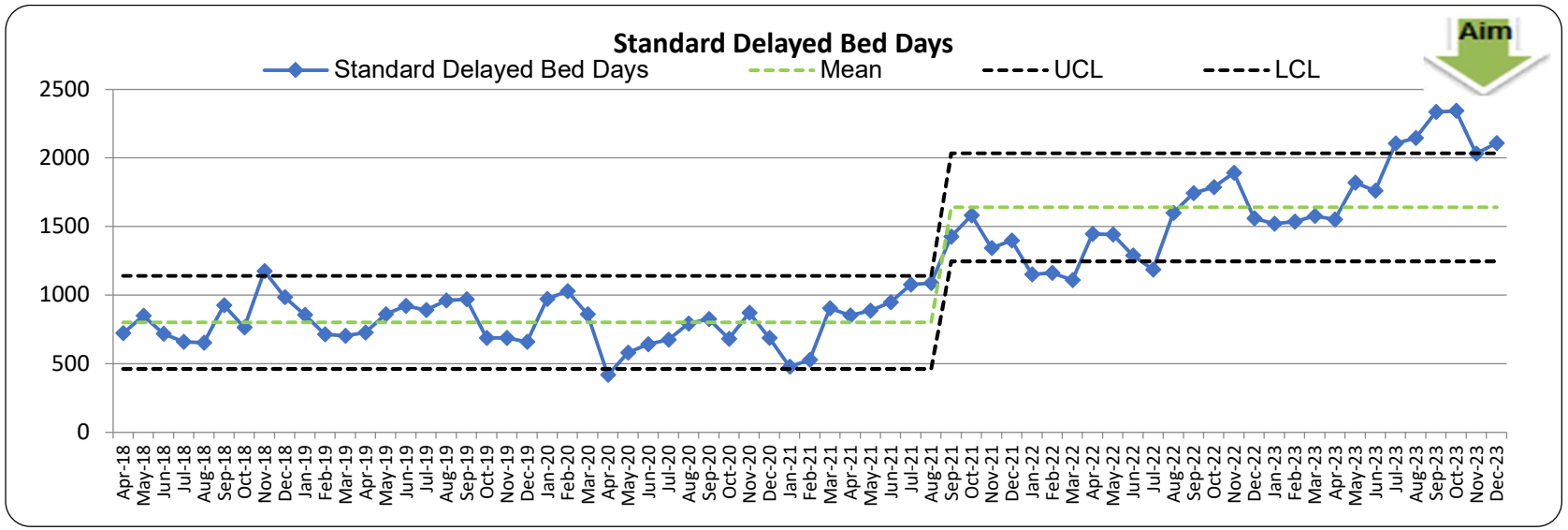

Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
2500
2000
1500
1000
500
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 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 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23

Fig. 21

Drugs & Alcohol *(Please Note: Updates provided Quarterly)*

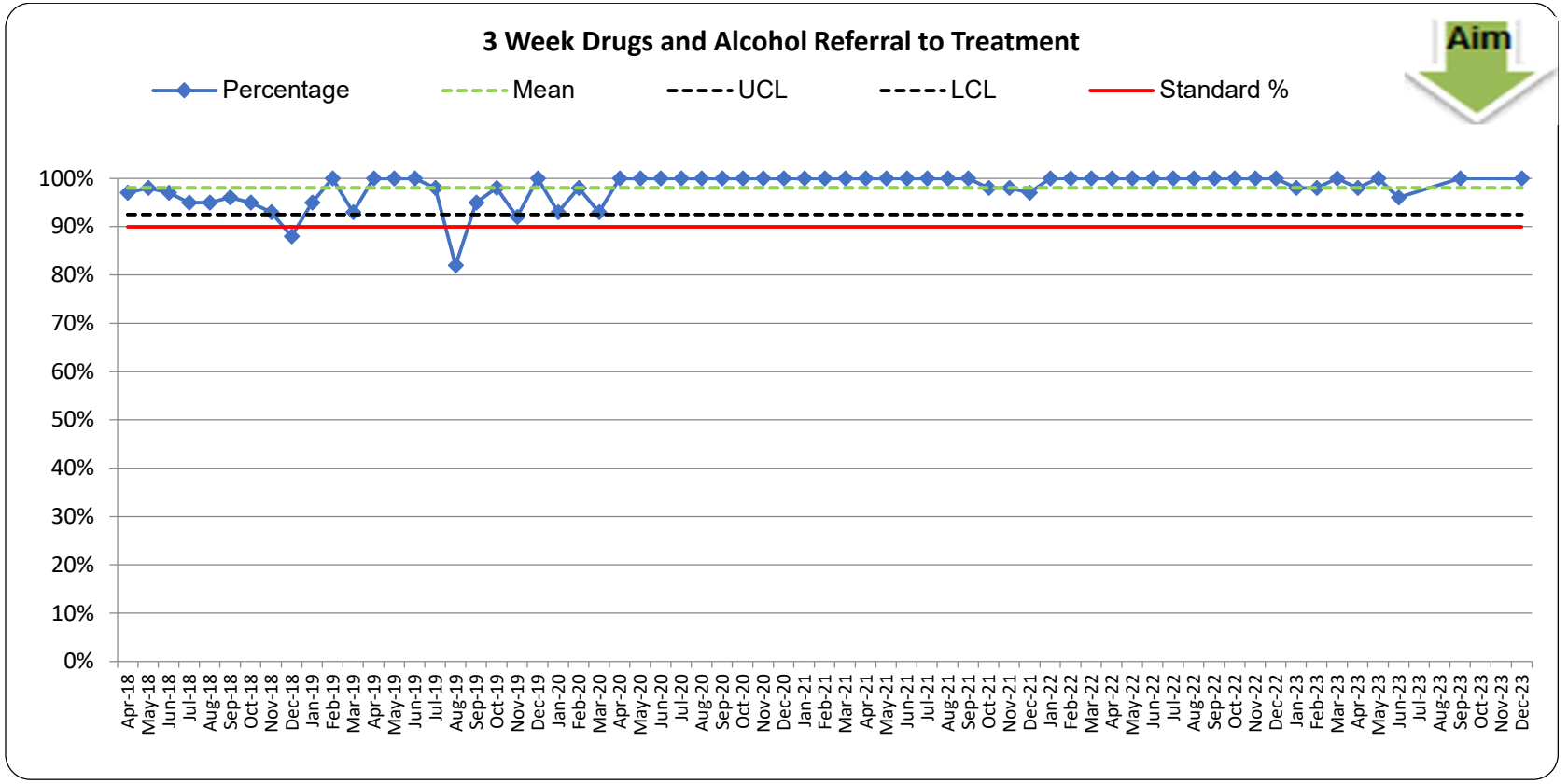


Fig. 22

(Please Note: Standard is 1312 by end of March every year, it then resets back to 0 every April and cumulative reporting starts again. There is a reporting lag in some areas which means that data is not fully reconciled at time of reporting therefore should be treated as provisional.)

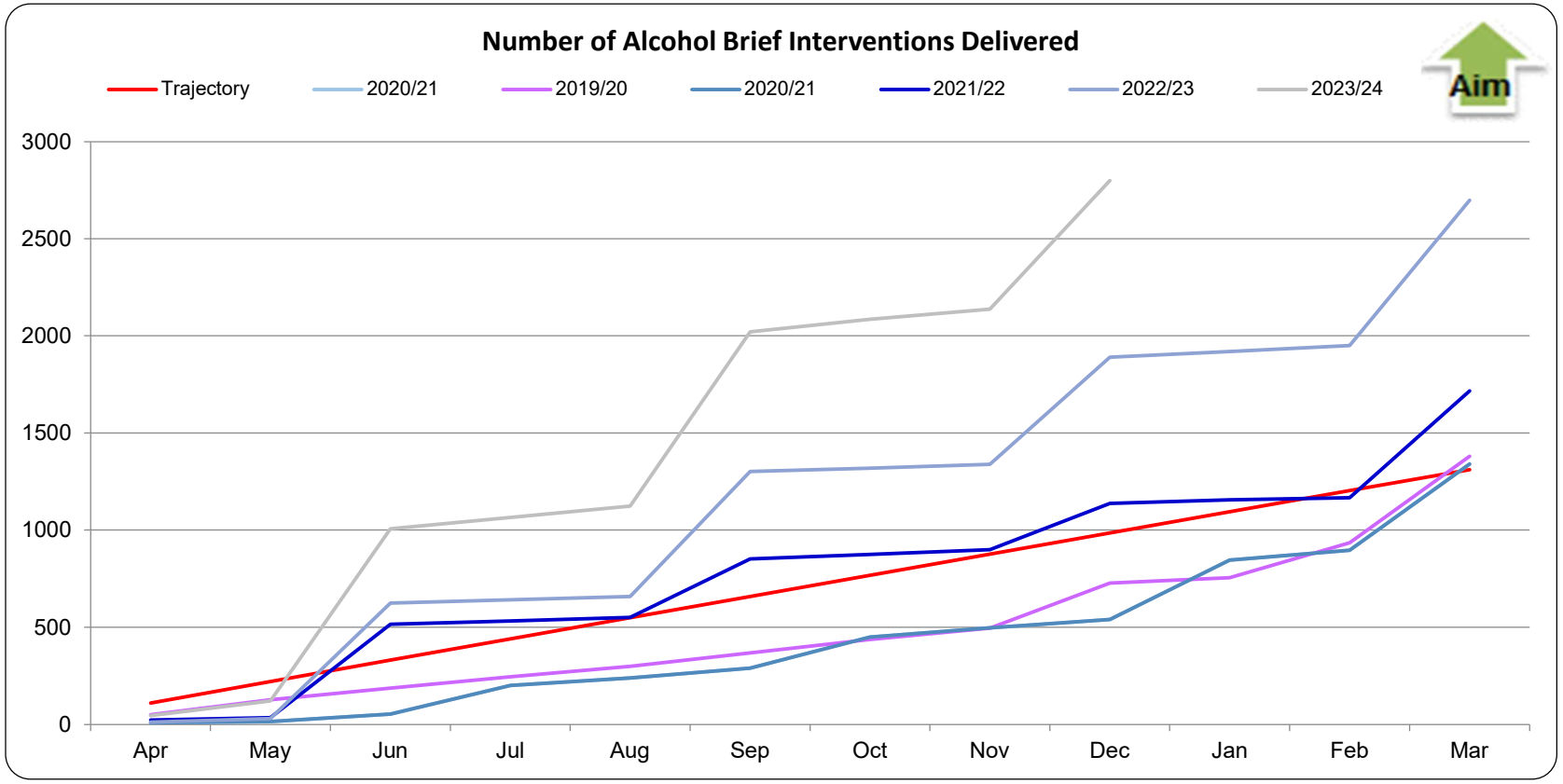


Fig. 23

Sickness Absence

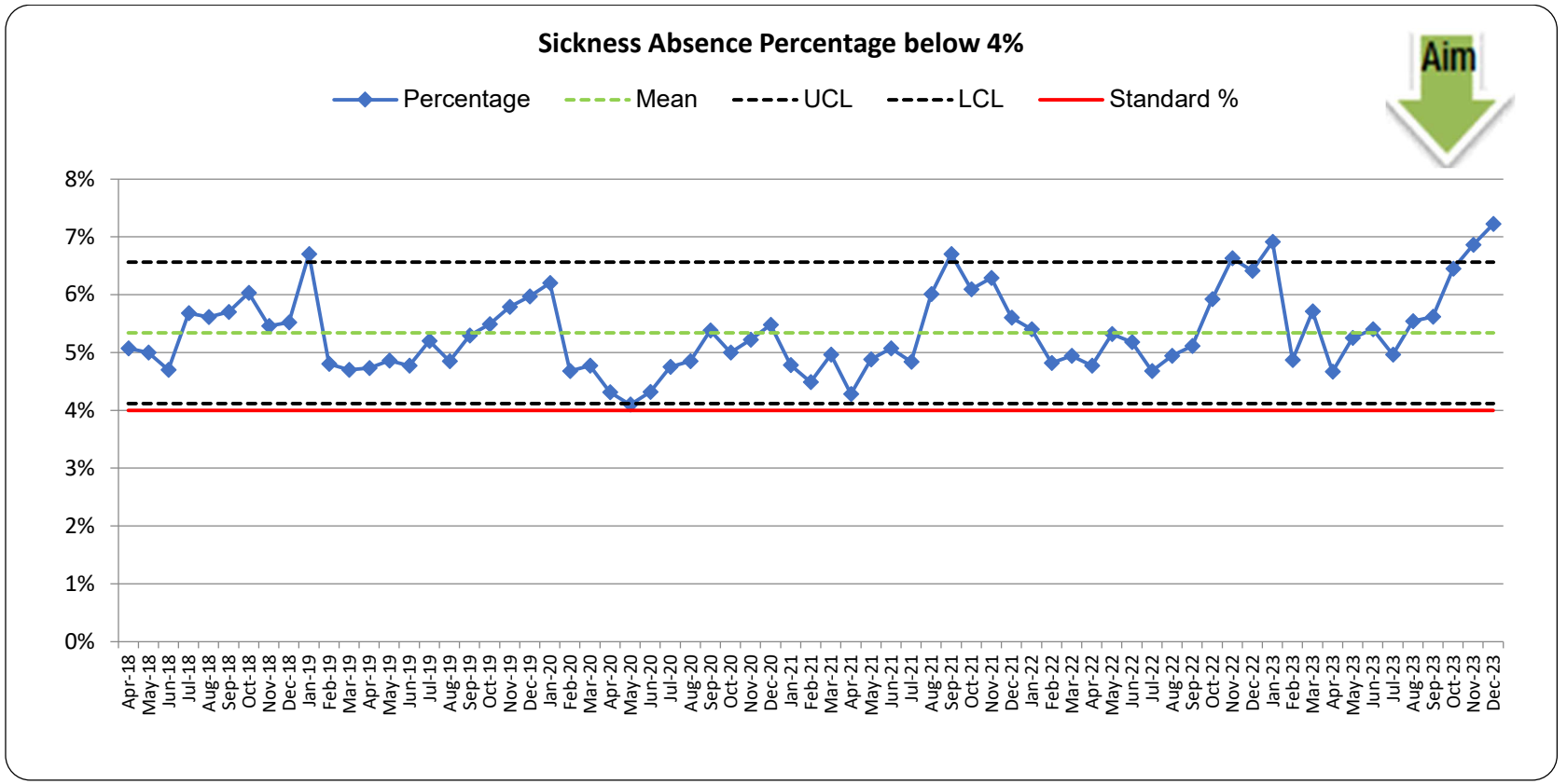


Fig. 24

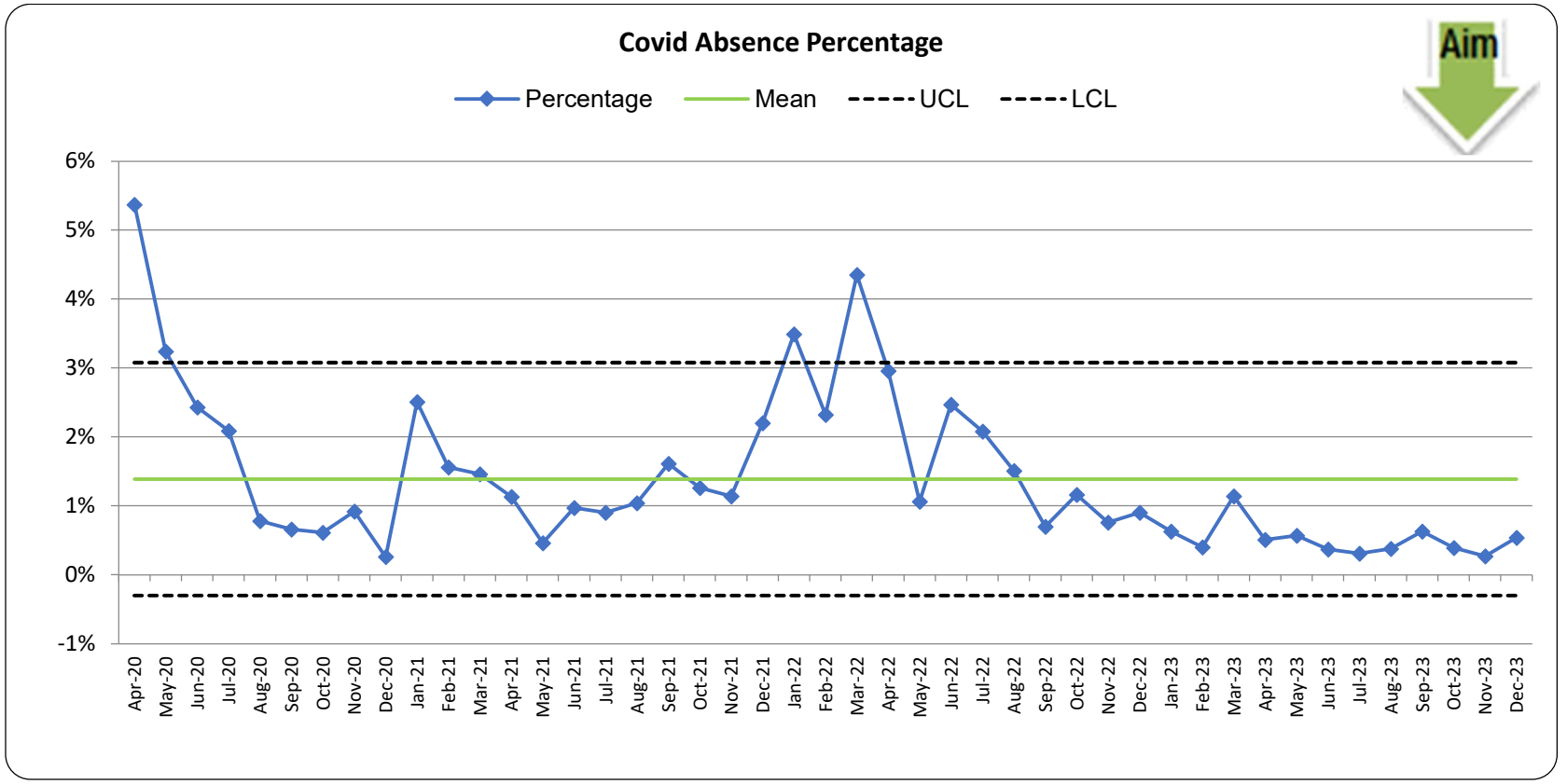

Covid Absence Percentage
Aim
Percentage
Mean
UCL
LCL
6%
5%
4%
3%
2%
1%
0%
-1%
Apr-20
May-20
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Fig. 25

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)

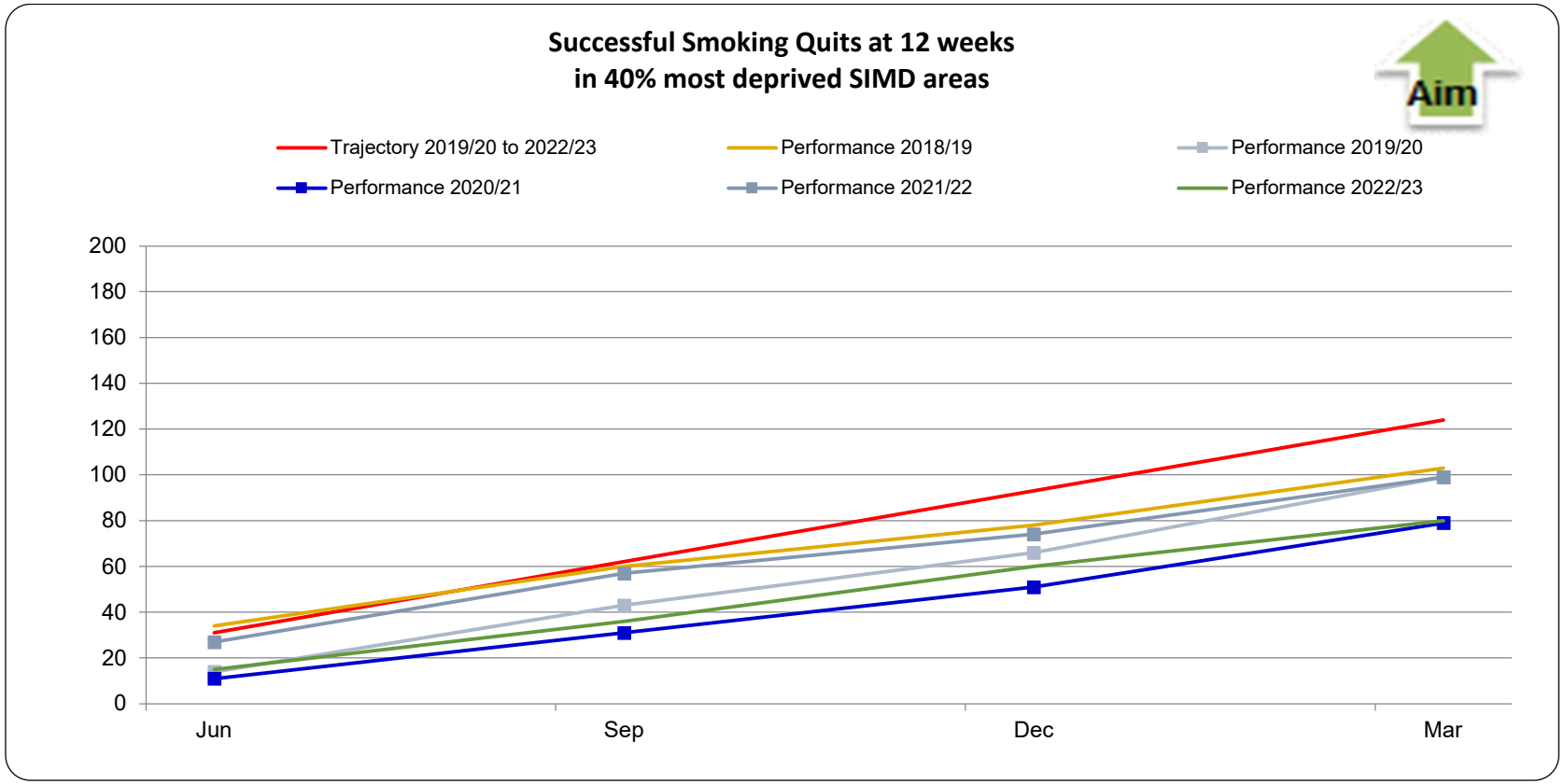

Fig. 26

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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 24 January 2024

2.4 Recommendation

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

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

3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Integration Joint Board minutes 15.11.23

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 15 November 2023** at **10am** via Microsoft Teams

Present:

(v) Cllr T Weatherston (Chair)
(v) Cllr R Tatler
(v) Cllr E Thornton-Nicol
(v) Cllr N Richards
(v) Cllr D Parker
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mr J McLaren, Non Executive
(v) Mrs F Sandford, Non Executive
Mr C Myers, Chief Officer
Dr L McCallum, Medical Director
Mrs J Smith, Borders Care Voice
Mr D Bell, Staff Side, SBC
Dr R Mollart, GP
Mr N Istephan, Chief Executive Eildon Housing

In Attendance:

Mrs A Young, PA to Chief Officer
Mr D Robertson, Chief Executive, SBC
Dr S Bhatti, Director of Public Health
Mrs J Stacey, Chief Internal Auditor
Mrs L Jones, Director of Quality & Improvement, NHS Borders
Mrs C Wilson, General Manager Primary & Community Services
Mrs J Holland, Director of Strategic Commissioning & Partnerships, SBC
Dr T Young, Associate Medical Director, P&CS
Mrs G Lennox, head of Audit Social Work
Mrs A McElrath, Interim Director of Dentistry
Mr A McGilvray, Roving Reporter

1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Mr T Taylor, Non Executive, Mrs H Robertson, Chief Financial Officer, Miss I Bishop, Board Secretary, Mrs L Gallacher, Borders Carers Centre, Mrs S Horan, Director of Nursing, Midwifery & AHPs, Mr A Bone, Director of Finance, NHS Borders, Mr R Roberts, Chief Executive, NHS Borders, Mrs J Smyth, Director of Planning & Performance, NHS Borders, Mrs J Amaral, Borders Community Action, Ms L Jackson, LGBTQ+, Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders.

1.2 The Chair welcomed attendees and members of the public to the meeting including Mrs A McElrath, Interim Director of Dentistry and Mrs G Lennox, Head of Adult Social Work.

1.3 The Chair confirmed that the meeting was quorate.

2. DECLARATIONS OF INTEREST

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

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there were no declarations made.

3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board (IJB) held on Wednesday 20 September 2023 were approved.

4. MATTERS ARISING

4.1 Mrs Karen Hamilton commented that the meeting had become inquorate from item 12 in the meeting. She asked the Board to consider if any items from that point in that meeting were affected by being inquorate.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed that there was no impact on the further items discussed.

4.2 **Minute 9:** Mr Chris Myers advised the Mr David Robertson, Chief Executive, Scottish Borders Council (SBC) had written to COSLA in regard to the lack of provision for out of area placements.

4.3 **Minute 8:** Mr Myers commented that significant capacity had been brought into the system and although Delayed Discharges were currently sitting at 72, it was ahead of predictions in the surge plan, reflecting the level of work taking place.

4.4 Mrs Fiona Sanford complimented the improvement, but drew attention to the number of current delayed discharges in the system and asked the meeting if the discussion around that subject could continue.

4.5 Discussion then focused on: the challenges and causes of delayed discharges; financial pressures; rurality; patient's individual wishes; family expectations; care home availability and capacity; impact of care home policy and criteria for eligible patients; feedback from the whole system operation pressures group that the IJB were carrying out the correct actions but the volume of delayed discharges meant visibility of results was taking longer to achieve; workforce challenges permeating throughout the health and social care system; an approach to the Scottish Government to consider a 'rural weighting' for the Scottish Borders, which would allow an uplift in pay for health care workers; the quality and relevance of data being used; public engagement feedback; and a recent advert for 20 vacancies had attracted over 100 applicants which appeared to suggest an anomaly with recruitment issues and available people to employ.

4.6 Dr Lynn McCallum noted that at the centre of all discussions was the patient and most delayed discharge patients wanted to be at home, but many were frail and needed care packages in place to support them to return home. Delays in arranging packages often extended hospital stays.

4.7 Dr Rachel Mollart suggested that the message about the lack of social care beds appeared to be more widely known by the public and she acknowledged that there were budget constraints to be worked too. She also commented that GPs priorities were the patients who were medically sick.

4.8 Mrs Jen Holland commented that limiting factors, such as staffing, finance and increasing demand remained key challenges. She suggested there needed to be more focus on what was bringing people into hospital, looking at the reablement

process, faster decision making in hospital and putting resource in the right places to provide the support needed for the people of the Borders.

4.9 Cllr Thornton-Nicol suggested the partner bodies of the IJB should commit to working even closer together to resolve the issues of delayed discharges and to look to preventing patients arriving at the front door of the hospital.

4.10 **Minute 12:** Mr Myers commented that Miller House, along with Eildon Housing, Cargorm and the IJB had won a national partnership award.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that there were no live actions on the action tracker.

5. H&SCP DELIVERY REPORT

5.1 Mr Chris Myers updated the IJB on progress with the Directions Tracker and highlighted that 6 actions were complete and 12 were in progress and the palliative care review would be moved to 2024.

5.2 He anticipated that the Primary Care Improvement Plan (PCIP) would benefit from a recent application to the PCIP Demonstrator Site. A bid had been submitted, follow up interviews had taken place and a positive outcome was awaited.

5.3 Mr Myers agreed to meet with Cllr Thornton-Nicol outwith the meeting to further discuss elements of the delivery report.

5.4 Mr Myers offered to update members via a briefing about the on-going digital work that SBC and NHS Borders were progressing with CGI. It was anticipated that the development of digital packages would change and enhance the way carers worked.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Delivery Report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted that Mr Myers would produce a briefing note for members on the on-going digital work.

6. DIRECTION: COMMUNITY HOSPITAL COVER

6.1 Mr Chris Myers commented that Kelso Medical Group had given notice to discontinue medical support of Kelso Community Hospital from the end of March 2024. The practice were contracted through the Health Board to provide the service and were moving to focus on the sustainability of their General Practice core work. He further commented that the Heath Board had also received notice from the Doctor supporting the Knoll Hospital, that they would retire and discontinue medical support from the end of March 2024. The discontinuation of medical support had enabled the bringing forward of planned work around a care model for the 4 community hospitals, recognising the changes in health care provision since the conception of the community hospitals.

6.2 Mrs Cathy Wilson explained that a steering group had been set up which met every 2 weeks and included staff, patient representatives and members of the public. The steering group were working on medium to long term plans which should be available in December. A delivery group had also been set up to meet on a weekly basis to progress any resulting actions.

6.3 A discussion followed that highlighted: examination of data about patients currently using the community hospitals; what the patient's needs were; the level of care required and if it was medical or nursing; average length of stay in community hospitals; governance to be adhered to in regard to a Doctor's presence in community hospitals; the potential risk of bed closures without a Doctor's presence; high levels of public and staff concern about the future of community hospitals; recruitment of geriatrician doctors; and the recognition that 70% of patients in community hospitals did not require the care of a Doctor, but did require a package of care.

6.4 Mrs Wilson reassured the Board, that everything was being considered.

6.5 Mr Nile Istephen noted that whilst there were clear processes in place, the IJB could explore more innovative ideas.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the situation in relation to medical cover at Kelso and Knoll Community Hospitals from 1 April 2024.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the work that will start to review the future model of care for the Community hospitals.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that the work would require significant public and staff engagement.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that linked work had started to identify and assess options for ongoing medical cover for the Community Hospitals from April 2024.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** agreed to issue a direction to NHS Borders.

7. IJB AUDIT COMMITTEE ANNUAL REPORT 2002/23

7.1 Cllr Tom Weatherston commented that the report was self-explanatory and illustrated progress made over the past year. Mrs Jill Stacy noted there had been a delay in bringing the report to the IJB and highlighted that work was on-going to improve the report in order to make it more effective.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the IJB Audit Committee Annual Report 2022/23 which presented the self-evaluation of the Committee's performance, effectiveness and areas of improvement, based on the outcomes of its self-assessments using the CIPFA Audit Committees Guidance.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the assurances from the IJB Audit Committee to the Integration Joint Board and its identified areas of improvement to enhance its effectiveness as a scrutiny body.

8. QUARTERLY PERFORMANCE REPORT

8.1 Mr Chris Myers introduced the Quarterly Performance Report and commented that there were gaps and omissions within the data as it was a work in progress and would be completed at a later stage. He advised that new metrics had been included in regard to social care unmet needs, information about GPs, child and adolescence

services, psychotherapy and workforce challenges. He drew the attention of the Board to the demography of the Scottish Borders which was some 30 years ahead of the rest of Scotland in terms of an aging population.

8.2 Mrs Karen Hamilton commented that the report contained a wealth of data, but the July data was now out of date and she enquired if the data for the report could be brought forward to be more relevant. She also enquired if it was possible to look at capacity outwith the Health Board when looking at vacancies in social care.

8.3 Mrs Jen Holland commented that there was a bed based report on available beds in social care and the data was shared daily with the Discharge Team. She reminded the Board that social care provision and care homes had to comply with Care Inspectorate regulations. demands. She also acknowledged that there were complexities in gathering data from the social care sector due to different reporting and recording mechanisms, which meant not all data was available equally. Mrs Holland also explained that the criteria for a patient's suitability for a bed was changing and with Care Inspectorate guidance, moving people around the system was no longer as straightforward. She suggested it might be useful to gather data on self-directed care.

8.4 Mrs Jen Holland advised that she would be meeting with Mr Myers and Dr McCallum to further discuss the provision of social care and care home beds.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted and approved any changes made to performance reporting and the key challenges highlighted.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** directed actions to address the challenges and to mitigate risk.

9. FOR NOTING: STRATEGIC RISK UPDATE

9.1 Mr Chris Myers delivered the Strategic Risk Update and highlighted the level of on-going work to align the risk report to the strategic objectives and the actions and controls put in place to reduce risk. The biggest risk to the IJB was increased demand coupled with financial restraint.

9.2 There followed a discussion about risk and its effect on performance. The inadvertent transfer of risk was considered, but overall the Joint Executive were managing risk collectively.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD considered** the reframed and refreshed IJB Strategic Risk Register to ensure it covered the key risks to the IJB.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD noted** the work in progress to manage the risks.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD n**oted that a further risk update would be provided in 2024.

10. DENTAL ACCESS UPDATE

10.1 Mrs Adelle McElrath provided a brief overview of the content of the update and commented that the recent changes brought in by the Scottish Government were progressing well.

10.2 Mr Chris Myers commented that the work carried out in gathering the correct data had led to the Scottish Borders being recognised as a rural area for dentistry which had in turn led to an increase in funding for dentistry.

10.3 Discussion followed that focused on: the reach of the dental service; providing national and local initiatives; and the impact of dental services and how they fitted into the wider framework.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the ongoing concerns regarding access to NHS dental care across all areas of the Scottish Borders and that they would be kept under close review for a further update in three months to consider the implementation of the new dental payment reform.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that this risk was being managed closely both operationally and strategically.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted that a strategic plan for oral health and dental services was being developed based on the recommendations of the local Oral Health Needs Assessment.

11. MONITORING OF THE HEALTH & SOCIAL CARE PARTNERSHIP BUDGET

11.1 Due to long term sickness absence this item was withdrawn.

12. IJB BUSINESS CYCLE AND MEETING DATES

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** approved the business plan and meeting cycle for 2024.

13. CHIEF SOCIAL WORK OFFICER ANNUAL REPORT 2022/23

13.1 Mrs Gwyneth Lennox introduced the Chief Social Work Officer (CSWO) report produced by Mr Stuart Easingwood. She reflected that it had been a busy year with both challenges and successes. She highlighted the recent inspections that had been undertaken and the positive feedback received, in particular the adult support and protection and children at risk inspection. It was noted that challenges were increasing across all areas, with workforce recruitment issues and increased demand on services.

13.2 Cllr Tom Weatherston complimented the social work department for an excellent report.

13.3 Cllr Elaine Thornton- Nicol noted the challenge around recruiting social workers and thanked Mrs Lennox for presenting an outstanding public protection report.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the report from the Chief Social Work Officer.

14. STRATEGIC PLANNING GROUP MINUTES: 02.08.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

15. ANY OTHER BUSINESS

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted there was none.

16. DATE AND TIME OF NEXT MEETING

16.1 The Chair confirmed that the next meeting of the Scottish Borders Health & Social Care Integration Joint Board would be held on Wednesday 24 January 2024, from 10am to 12pm through MS Teams and in person in the Council Chamber, Scottish Borders Council.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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

As part of the annual Appraisal process for Non Executives, the Chair has discussed the range of Committees they currently service. With the departure of Sonya Lam and the appointment of Lynne Livesey the Chair has agreed a number of membership movements across the Board Sub Committees.

It is good practice for Non Executives to be exposed to the full range of Committees that service the Board.

The proposed changes are:-

Cllr David Parker – joins the Audit and Risk Committee and leaves the Public Governance Committee
Fiona Sandford – leaves the Audit and Risk Committee
James Ayling – joins the Public Governance Committee and the H&SC Integration Joint Board and leaves the Advisory Group to the Endowment Committee
Lucy O'Leary – joins the Audit and Risk Committee

Tris Taylor – joins the Advisory Group to the Endowment Committee and leaves the Audit and Risk Committee, leaves the H&SC Integration Joint Board, leaves the Pharmacy Practices Committee
Karen Hamilton – Chairs the Pharmacy Practices Committee
Lynne Livesey – joins Audit and Risk Committee, Clinical Governance Committee, Staff Governance Committee
John McLaren - no change
Harriet Campbell – no change
Kevin Buchan – no change

A further review of memberships will take place in July 2024.

2.2 Background

In line with the Code of Corporate Governance the Board must approve the Non Executive 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 29 June 2023.

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 changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart attached.

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 2024 – 01.02.2024

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)	Lynne Livesey (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		C	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
CYPPP Board (1 NED)				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)	X	C		X	X						DoP&P DoP&P PA
Area Drugs & Therapeutics					C						DoP

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 01.02.2024

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)	Lynne Livesey (Whistle-blowing Champion)	Harriet Campbell (Sustainability Champion)	James Ayling	Exec Lead & Secretariat
Cttee (ACF Chair)											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
Dismissal Appeal Hearings (1 NED required on all dismissal appeal hearings as per NHSS Formal Hearing Guide)											DHR DDHR
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

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 01.02.2024

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)	Lynne Livesey (Whistle-blowing Champion)	Harriet Campbell (Sustainability Champion)	James Ayling	Exec Lead & Secretariat
TOTAL	**5**	**8**	**8**	**8**	**7**	**7**	**5**	**8**	**8**	**8**	

Changes highlighted in pink.

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
DoP&P	Director of Planning & Performance	DoP	Director of Pharmacy
BS	Board Secretary		

NHS BORDERS NON EXECUTIVES COMMITTEE CHART 2024 – 01.02.2024

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)**	Lynne Livesey (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**		**C-XV**	**VC** (Appointed in capacity as a Cllr)			**X**	**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	**0**	**1**	**1**	**2**	**0**	**2**	**2**	**0**	**0**	**1**	

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
PA	Personal Assistant

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
Title:	**NHS Borders Climate Emergency & Sustainability Annual Report 2022/23**
Responsible Executive/Non-Executive:	**Andrew Bone, Director of Finance**
Report Author:	**Fiona Laidlaw, Head of Soft FM (Facilities)**

1 Purpose

This is presented to the Board for:

- Decision

This report relates to a:

- Annual Operational Plan/Remobilisation Plan
- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

2 Report summary

2.1 Situation

NHS Scotland Health Boards are required[1] to publish an annual report which outlines their activities in relation to the Climate Emergency. This paper presents the final version of the 2022/23 report and seeks approval from the Board to publish this report.

2.2 Background

A draft version of the report was presented to the Board's Resources & Performance Committee at its meeting on Thursday 2nd November 2023.

[1] A policy for NHS Scotland on the Climate Emergency and Sustainable Development. DL (2021) 38.

The data included in the report has been validated and no changes have been made. This data has been separately published as part of the mandatory Climate Duties Public Bodies Reporting system which collects relevant data across all Scottish public bodies for inclusion in national reports.

2.3 Assessment

There are no substantive changes to the information presented in the report since the version reviewed by the Resources & Performance Committee in November 2023.

Minor changes have been made to text to provide further clarity and the report now includes a foreword by Harriet Campbell, non-executive member and the Board's Sustainability Champion.

2.3.1 Quality/ Patient Care

Issues relating to Quality/Patient Care, Workforce, and finances are addressed within the body of the report.

2.3.2 Workforce

Issues relating to Quality/Patient Care, Workforce, and finances are addressed within the body of the report.

2.3.3 Financial

Issues relating to Quality/Patient Care, Workforce, and finances are addressed within the body of the report.

2.3.4 Risk Assessment/Management

The report includes discussion of the risks arising from Climate change and how these are being addressed.

The Resources & Performance Committee received a separate update on the Health Board's strategic risk regarding Climate change at its meeting on 2nd November 2023.

2.3.5 Equality and Diversity, including health inequalities

Actions outlined in the report are aligned to the NHS Scotland Climate Emergency & Sustainable Development strategy published in 2022. This strategy includes consideration of the role of NHS Boards as anchor institutions and the importance of their activities to the circular economy, as well as how NHS Boards can contribute to the wider delivery of UN Sustainable Development Goals. By acting in line with the strategy NHS Borders will ensure that its plans are consistent with the principles set out in the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes framework.

This is an annual report which summarises activities undertaken in previous years and as such no impact assessment is required.

2.3.6 Climate Change

This topic is the primary focus of the report.

2.3.7 Other impacts

There are no other relevant impacts identified.

2.3.8 Communication, involvement, engagement and consultation

No stakeholder engagement has been undertaken. By publishing this report the Health Board will fulfil its responsibility to report to its stakeholders on its carbon emissions and actions to address its Net Carbon reduction targets.

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.

- NHSB Climate & Sustainability Group, 2nd October 2023
- Resources & Performance Committee, 2nd November 2023

2.4 Recommendation

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

The Board is asked to approve the report for publication.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – NHS Borders Climate Emergency & Sustainability Annual Report 2022/23

Annual Climate Emergency and Sustainability Report 2022/23

January 2024

1. Foreword from Harriet Campbell

As the Sustainability Champion for NHS Borders, it is my privilege to introduce this annual report.

The climate crisis affects everyone, both those who work directly with, or rely upon, the services of NHS Borders, as well as the wider population of the Scottish Borders, Scotland and the world.

We are committed to meeting our obligations to plan for and mitigate the impact of climate change. In doing so we want to be open with our stakeholders, sharing information on the impact of our activities and the effectiveness of our actions. This report is our way of sharing information and we welcome feedback on how this can be improved in future.

This past year we have seen some real successes in reducing our carbon emissions from building energy, our use of medical gases and the amount of waste we produce. We have also made significant efforts to improve the quality and comprehensiveness of our reporting. This has meant that in some cases our previous reported figures have been amended. Where this is the case we have ensured that this is highlighted within the report.

This report covers the year from April 2022 to March 2023. As such it is a 'snapshot' of a point in time. Some key milestones achieved in 2023 include the development of our Climate Change Action Plan, Net Carbon Roadmap and Climate Change Adaptation Plans. Although not concluded within the timeframe of this report, work on these plans began during 2022/23.

I am particularly delighted to report that NHS Borders has recently been awarded a grant of just under £2m from the Scottish Central Government Energy Efficiency Grant Scheme which will help us to undertake the necessary changes to our buildings to reduce our emissions. This investment provides a significant step towards the delivery of our Net Carbon Roadmap, and we will continue to report on progress as we implement the measures set out in the plan.

Of course, the benefits brought by these changes will continue long into the future and are a key step in 'green-ing' NHS Borders' Estate. There is much work still to be done and we recognise that despite the overall improvement there are areas in which our emissions have increased.

While we at NHS Borders are beginning to do what we can to reduce our impact on the environment, I'm also excited to report on the work underway with our partner organisations. Our work with Scottish Borders Council will help us to develop joint plans supporting greener and healthier travel for our staff, patients and visitors.

We are also blessed in the Borders with our many green spaces, and our work in this area will not only promote the environmental agenda but also support individuals' mental and physical health to their benefit and the benefit of the wider community.

Finally, I should express my thanks to the many, many, NHS Borders staff who individually work towards improving our environmental performance. I know that this is often beyond the duties of their day-to-day jobs and out of a sense of responsibility to the planet and their local community. I want them to know how much their efforts are appreciated. Every one of them is an invaluable part of this work.

We also really do welcome ideas and thoughts in this area so if people think there is more we could or should be doing, please do get in touch.

Harriet Campbell
Non Executive Member, NHS Borders Health Board;
Sustainability Champion and
Chair of Organ & Tissue Donation Committee

Further information

More information on NHS Borders and its activities can be found at the following website: **nhsborders.scot.nhs.uk**

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2. Introduction

This is NHS Borders second annual Climate Emergency and Sustainability Report. Our previous report, covering our activities for the year to March 2022, was published in February 2023.

The planet is facing a triple crisis of climate change, biodiversity loss and pollution because of human activities breaking the planet's environmental limits.

The World Health Organisation recognises that climate change is the single biggest health threat facing humanity. Health organisations have a duty to cut their greenhouse gas emissions, the cause of climate change, and influence wider society to take the action needed to both limit climate change and adapt to its impacts. More information on the profound and growing threat of climate change to health can be found here: www.who.int/news-room/fact-sheets/detail/climate-change-and-health

NHS Borders provides health care to the 116,900[1] people who live in the Scottish Borders and employs 3,315 people. The region covers 1827 square miles at the southeast of Scotland. The Health Board has one district general hospital, four community hospitals and a range of primary care health centres and other community-based buildings across the region.

Throughout this report there are areas where we have amended our figures from last year to improve the accuracy and completeness of our emissions data. We are committed to ensuring that this data is both robust and transparent. These revisions ensure that we have the most realistic assessment of our overall position and will support us to set the ambitious targets necessary to support our Net Zero ambitions and allow us to monitor progress in future years.

[1] Scotland Census 2022

3. Leadership and governance

NHS Borders recognises the importance of Leadership and governance in this area. The Health Board has appointed a non-executive member of our Board, Harriet Campbell, as our Sustainability Champion and our Director of Finance, Estates & Facilities, Andrew Bone, is appointed as Executive Lead officer.

The Climate Change & Sustainability Group has responsibility for developing the Board's response to climate change and supporting NHS Borders in becoming environmentally sustainable. The group meets on a bi-monthly basis to ensure progress against its action plan is regularly monitored.

The Climate Change and Sustainability Group reports to the Quality and Sustainability Board, comprising the Board executive management team and senior management representatives from all business units. Updates are provided on a quarterly basis.

The Quality and Sustainability Board reports to the Health Board's Resources & Performance Committee, which undertakes scrutiny of the Board's strategic plans.

NHS Borders has dedicated both Board development time and Executive Leadership time to discuss this important agenda. Development and awareness sessions will continue with both the Board and Senior Leaders on a regular basis and sessions are planned for the full NHSB (NHS Borders) leadership team to enhance understanding.

A number of the Executive team lead key projects within their areas or expertise to support the Boards overall Net Zero ambitions.

4. Greenhouse gas emissions

NHS Borders aims to become a net-zero organisation by 2040 for the sources of greenhouse gas emissions set out in the table below. The table sets out the amount of greenhouse gas produced annually by NHS Borders.

NHS Borders did not set target emissions for 2022/2023 and 2023/2024. Targets are now being developed for 2024/25 and will be in place moving forward.

Greenhouse gas emissions 2021/22 & 2022/23, tonnes CO2 equivalent

Source	2021/22 – emissions	2022/23 – emissions	Percentage change – 2021/22 to 2022/23	2022/23 – target emissions	Percentage difference between actual and target emissions – 2022/23
Building energy	7180.9 tCo2e	5995.43 tCo2e	-16.5%	NA	NA
Non-medical F-gas use	Not Available	391.06 tCo2e	-	NA	NA
Medical gases	563.5 tCo2e	535.7 tCo2e	-4.9%	NA	NA
Metered dose inhaler propellant	1,903 tCo2e	1,908.35 tCo2e	+0.28%	NA	NA
NHS fleet use	248.472 tCo2e	302.74 tCo2e	+21.84%	NA	NA
Waste	159.88 tCo2e[2]	135.98 tCo2e	-15%	NA	NA
Water	26.44 tCo2e[3]	26.91 tCo2e	+1.77%	NA	NA
Business travel	376.05 tCo2e	381.31 tCo2e[4]	+1.39%	NA	NA
Total greenhouse gases emitted	**10,458.24 tCo2e**	**9677.48 tCo2e**	**-7.46%**		
Carbon sequestration	Not Provided	Not Provided	Not Provided		
Greenhouse gas emissions minus carbon sequestration	**10,458.24t Co2e**	**9677.48 tCo2e**	**-7.46%**		

[2] *Amended from previous reporting following recalculation waste previously reported as 36.77 tCo2e.*
[3] *Amended from previous year following calculation error.*
[4] *Includes air travel and public transport for the first time. There is a 1tCo2e reduction in business miles claimed.*

5. Climate change adaptation

The climate is changing due to the greenhouse gases already emitted into the atmosphere. While efforts to reduce the rate and scale of climate change continue, we must also adapt to new conditions we are facing.

The changing climate is increasing risks for health and health services. More information on these risks in the UK can be found in the UK Climate Change Committee's Health and Social Care Briefing available here: www.ukclimaterisk.org/independent-assessment-ccra3/briefings/

NHS Borders completed an Adaptation Risk Assessment in 2023. The main risks identified were in relation to changes to population needs (i.e. increased demand for healthcare services) and the adaptability of environmental controls within our estate (e.g. ventilation systems).

Risks outlined include more patients requiring admission due to the impact of the changing climate, e.g. during prolonged hot weather admissions relating to dehydration, heat stroke, breathing issues and cardiac issues could be anticipated; with further long-term issues relating to potential increase in skin cancers. We also identified wider societal impacts affecting population mental health, with specific concern regarding the isolation of small communities in rural locations.

We are considering actions to address both the direct and indirect impacts of climate change, identifying the adaptations required to our estate and buildings and ensuring that changes in future demand are considered in the development of our clinical strategies.

In relation to our buildings, we are aware of innovation in building design which offers opportunities to improve natural ventilation and cooling and we will ensure that these opportunities are considered for both our existing estate and new buildings developed in our long term property strategy.

The actions to address increased demand will be a collaborative approach between our clinicians, supported by our Public Health and Communications teams, to ensure residents of the Scottish Borders are engaged in the design of future service models and aware of the actions they can take to ensure that health services are both effective and efficient with regard to the impact that these services have on our environment.

As we further evaluate our Climate Change Risk Assessment, we will collaborate with appropriate teams to increase the resilience of our healthcare assets and services.

6. Building energy

We aim to use renewable heat sources for all the buildings owned by NHS Borders by 2038.

NHS Borders has thirty-nine buildings, across 19 sites, such as Borders General Hospital (Acute Hospital), Hawick Community Hospital, Galashiels Health Centre, and Newstead Offices.

In 2022/23, 5995.43 tonnes of CO2 equivalent were produced by NHS Borders use of energy for buildings. This was a decrease of 16.5%against the previous year.

In 2022/23, NHS Borders used 33,733,385kWh of energy. This was a decrease of 16.5% against the previous year.

In 2022/23, NHS Borders generated 1469 MWh of energy from renewable technologies.

Building energy emissions, 2015/16, 2021/22 and 2022/23 – tCO2e

	2015/16 energy use	2021/22 energy use	2022/23 energy use	Percentage change 2015/16 to 2022/23
Building fossil fuel use	4681.3 tCO2e	5226.2 tCO2e	5220.2 tCO2e	+11.5%
District heat networks and biomass	129.7 tCO2e	83.2 tCO2e	69.0 tCO2e	-47%
Grid electricity	4340.6 tCO2e	1871.5 tCO2e	1659 tCO2e	-61.7%
Totals	**9151.6** tCO2e	**7180.9** tCO2e	**6948.2** tCO2e	**-24%**

Building energy use, 2015/16, 2021/22 and 2022/23 – MWh

	2015/16 energy use	2021/22 energy use	2022/23, energy use	Percentage change 2015/16 to 2022/23
Building fossil fuel use	22368MWh	24363MWh	24434MWh	+9.2%
District heat networks and biomass	2860.6MWh	1582MWh	1439MWh	-50%
Grid electricity	8739.6MWh	8097.7MWh	7860MWh	-10%
Renewable electricity	2895MWh	1612MWh	1469MWh	-50% *PV estimated
Totals	**36863.2 MWh**	**35654.7 MWh**	**35202 MWh**	**-4.5%**

In the last year to reduce emissions from building energy use we have carried out the following:

- Rolling replacement programme of fluorescent light fittings with LED (light emitting diodes) fittings (internal and external).
- Rolling replacement of inefficient boilers – Melburn Lodge, Kelso Hospital, Coldstream HC, Innerleithen HC
- Upgrading and maintenance of associated heating pipework insulation.
- Upgrades of heating pumps and associated equipment – Kelso, Knoll, Coldstream etc.
- Rolling replacement of laundry equipment – steam dryers (improved efficiency).
- Upgrade of AHU (MRI (Magnetic Resonance Imaging)- more efficient.
- Chiller unit upgrades – catering and laboratory.
- Upgrades to the Building Management System (BMS).
- Installation of water condensate recovery units.

This year to reduce emissions from building energy use we have committed to the following:

- Rolling replacement programme of fluorescent light fittings with LED fittings (internal and external)
- Rolling replacement of inefficient heating boilers – various locations.
- Rolling maintenance programme – extract roof fans (replace with efficient direct drive fans where possible).
- Replacement of 3 laundry washers with new efficient units (including water recovery systems).
- Pressure systems replacement - efficiencies in steam system.
- Condensate Units.
- Steam trap upgrades.
- Upgrades to BMS.
- Feasibility of new efficient fans being utilised for roof extraction and supply ventilation.
- Green theatres initiatives.
- Rolling programme of insulation upgrades (inclusive of insulation jackets).

Our longer-term plans to reduce to reduce emissions from building energy use are set out in our Net Zero Carbon Roadmap developed in 2023 and will include ongoing rollout of measures outlined above.

In 2023 were successful in bidding for £1.9m of capital investment funds from the Scottish Green Public Sector Estate Decarbonisation Scheme. Plans outlined in the bid cover schemes such as Fan/pump efficiency upgrades, LED lighting, insulation projects, solar PV, sub-metering etc. Appointment of contractors to undertake the programme of works outlined in our bid is currently underway and it is expected that delivery of the plan will be undertaken in 2024 and 2025.

7. Sustainable care

The way we provide care influences our environmental impact and greenhouse gas emissions. NHS Scotland has three national priority areas for making care more sustainable – anaesthesia, surgery, and respiratory medicine.

8. Anaesthesia and surgery

Greenhouse gases are used as anaesthetics and for pain relief. These gases are nitrous oxide (laughing gas), Entonox (a mixture of oxygen and nitrous oxide) and the 'volatile gases' - desflurane, sevoflurane and isoflurane.

Through improvements to anaesthetic technique and the management of medical gas delivery systems, the NHS can reduce emissions from these sources.

NHS Borders total emissions from these gases in 2022/23 were 535.7 tCO2e, a decrease of 27.8 tCo2efrom the year before.

More detail on these emissions is set out in the tables below:

Volatile medical gas emissions, 2018/19, 2021/22, 2022/23 – tCO2e

	2018/19 (baseline year)	2021/22	2022/23	Percentage change 2018/19 to 2022/23
Desflurane	33	6.3	0	-81%
Isoflurane	1.1[5]	2.1[6]	2.7	+145%
Sevoflurane	15.3	9	10.3	-41%
Total	48.6	15.5	13	-73%

[5]*Amended from previous reporting following recalculation Isoflurane previously stated as 0.3 tCo2e (2018/2019).*

[6]*Amended from previous reporting following recalculation Isoflurane previously stated as 0.2 tCo2e (2021/2022).*

Nitrous oxide and Entonox emissions, 2018/19, 2021/22, 2022/23 – tCO2e

Source	2018/19 (baseline year)	2021/22	2022/23	Percentage change 2018/19 to 2022/23
Piped nitrous oxide	241	241	234.7	-2.6%
Portable nitrous oxide	12	8	13	+8%
Piped Entonox	265	217	216.7	-18%
Portable Entonox	114	82	58.3	-48%
Total	632	548	522.7	-17%

We have moved away from using Desflurane for volatile anaesthesia. No Desflurane has been purchased by NHS borders since August 2021 and it is no longer used. Sevoflurane or total intravenous anaesthesia is now our default anaesthesia.

In previous years we moved to GE Aisys anaesthetic machines which have technology that makes giving anaesthetics at lower gas flows more straightforward. This reduces the amount of volatile anaesthetic used as well as piped oxygen and air.

The nitrous oxide manifolds have now been decommissioned which will lead to a significant reduction in CO2e in the coming year.

We are implementing the green theatre project and have reusable theatre hats for staff, reusable sterile drapes and gowns, embedded waste segregation and oral Paracetamol as the default choice in the peri-operative period. We are working on a process to switch AGS (Anaesthetic Gas Scavenging) and HVAC (Heating Ventilation Air Conditioning) to a background setting out of hours and looking at the business case for alternative surgical suction devices.

We have identified a discrepancy between locally held data and nationally reported figures on anaesthetic gases. This discrepancy is not considered material however work is underway to identify differences in reported data and to ensure that figures are aligned for future reports. The data presented above represents local information.

9. Respiratory medicine

Greenhouse gases are used as a propellant in metered dose inhalers used to treat asthma and COPD (Chronic Obstructive Pulmonary Disease). Most of the emissions from inhalers are from the use of reliever inhalers – Short Acting Beta Agonists (SABAs). By helping people to manage their condition more effectively, we can improve patient care and reduce emissions.

NHS Borders clinicians have adopted the approach agreed through national Respiratory pharmacy networks. It is the opinion of the Scottish Respiratory Pharmacist SIG, that the best inhaler is 'the one the patient can use [most] effectively'. The cost (financially and environmentally) of Dry Powder Inhalers (DPI) is significantly greater than normal use of MDIs (metered dose inhalers). There are two new (environmentally better) propellants coming to

market in the next couple of years and it was agreed the greatest immediate gain clinically and environmentally would be to focus on patients' over-use of SABA inhalers rather than any scheme switching to DPI. Also worth noting, the current crop of environmental claims is mostly through carbon off-setting and often still result in a plastic product which cannot be recycled.

We estimate that emissions from inhalers in NHS Borders were 1908.34tonnes of CO2equivalent.

Inhaler propellant emissions, 2018/19, 2021/22, 2022/23 – tCO2e

Source	2018/19 (baseline year)	2021/22	2022/23	Percentage change 2018/19 to 2022/23
Primary care	1,751.27	1,770.58	1,871.67	+6.87%
Secondary care	41.55	35.19	36.67	-11.74%
Total	1792.82	1805.77[7]	1908.34	+6.44%

This year to improve patient care and reduce emissions from inhalers we are taking part in SRP-SIG discussions, gathering local data, and starting preparation work for individual patient review work required across practices. We will likely need to enter an agreement with a third-party review company (e.g., Interface/Spirit Healthcare) to support the practices. In early October 2023, the Pharmacy department and Respiratory team are meeting to agree an approach to the draft National Strategy and projects to improve East Region Formulary compliance for the year ahead. This will be published within the Board by early November 2023.

In addition, to make care more sustainable we ensure good Formulary compliance which means a move away from Diclofenac use.

We are involved with Realistic Medicine which will ensure patients are on the most appropriate medicines for the minimum time. Establishing the National Strategy work around Polypharmacy reviews is all Pharmacy have been able to do with the resources available.

[7] *Report from SG shows different figures to 2021-2022 (1863 tCO2e Primary Care & 40 tCO2e Secondary Care)*

10. Travel and transport

Domestic transport (not including international aviation and shipping) produced 26% of Scotland's greenhouse gas emissions in 2021. Car travel is the type of travel which contributes the most to those emissions.

NHS Scotland is supporting a shift to a healthier and more sustainable transport system where active travel and public transport are prioritised.

We note the increase in NHS Fleet use and in Business Travel. The increase in fleet use can be attributed partly to services returning to pre-pandemic levels ensuring we deliver services across the board. In addition, these miles include the introduction of a local Patient Transport Hub; these journeys were previously made by Scottish Ambulance Service and the NHS Lothian hub.

In business travel the increase in emissions is due to the inclusion of all transport data instead of previous reporting which was just car miles. The inclusion of air, rail, and passenger journeys we supported is now included for completeness.

We have worked collaboratively with Scottish Borders Council to ensure public transport is effective for NHS Borders staff, patients, and visitors. We expect this work to continue for the next two years.

We continue to enable agile working which enables people to utilise technology such as Microsoft Office Teams to reduce the need to travel to meetings.

NHS Borders recognises that supporting active travel will be a key component of our future travel plans. Our progress to date in this area has been limited however through the development of our Active Travel plan we expect to increase awarenessacross staff and visitors and to ensure that our policies and infrastructure are refreshed to support active travel.

In addition, we will be working with all our services to ensure essential journeys are well planned to reduce carbon emissions.

We will continue to build on positive engagement to date with Scottish Borders Council to improve public transport usage for all our sites.

We are working to remove all petrol and diesel fuelled cars from our fleet by 2025.

The following table sets out how many renewable powered and fossil fuel vehicles were in NHS Borders fleet at the end of March 2022 and March 2023:

	March 2022		March 2023		
	Total vehicles	**% Zero Emissions Vehicles**	**Total vehicles**	**% Zero Emissions Vehicles**	**Difference in % Zero Emissions Vehicles**
Cars	24	12	23	11	-8%
Light commercial vehicles	30	6	43	6	0
Heavy vehicles	2	0	2	0	0

The following table sets out how many bicycles and eBikes were in NHS Borders' fleet at the end of March 2022 and March 2023.

	March 2022	**March 2023**	**Percentage change**
Bicycles	0	0	0
eBikes	0	0	0

Due to the rurality of the Scottish Borders the relative distances for journeys are significantly higher than in Health Board regions which have a higher population concentration within urban centres. As such we do not believe that there will be a significant uptake for bicycle transport, however we are presently developing a pilot project in relation to eBikes.

11. Greenspace and biodiversity

Biodiversity

Biodiversity, or the wide variety of living organisms within an environment, has declined at a rapid rate in the last 50 years. Evidence demonstrates that these trends are attributed to human activities, such as land use change, habitat degradation and fragmentation, pollution, and the impacts of climate change. The State of Nature report published in 2023 has highlighted the decline of nature across Scotland, with 11% of species now classed as threatened with extinction.

Public bodies in Scotland have a duty under the Nature Conservation (Scotland) Act 2004 (Nature Conservation Scotland Act 2004) to further the conservation of biodiversity, taking care of nature all around us. Furthermore, the Wildlife and Natural Environment (Scotland) Act 2011 (Wildlife and Natural Environment Scotland Act 2011) requires every public body to summarise their activities to meet this duty, through the production of a publicly available report.

We are working on a long-term strategy to address the identification, protection, and enhancement of biodiversity across our estate. As part of our climate change adaption plans we will consider how nature-based solutions may align across both the climate and biodiversity emergencies. We recognise this is a complex area and will work with relevant bodies (e.g. Nature Scotland) to ensure that plans are aligned to best practice.

We have submitted our data for NHS Scotland Estate Mapping programme and look forward to progressing this work.

To mainstream Biodiversity across the organisation we have continued to reduce the number of cuts on our large areas of grassland per year from approximately 16 to 10 whilst increasing the height of cut of these areas to 75mm.

We have also further increased the number of areas within all NHS Borders grounds that are planted with new pollen rich planting and wildflowers.

We are currently assessing how we can minimise the use of pesticides across our estate. And have reduced the times it is used each year.

We are seeking to embed the principles of biodiversity into all our estate planning and management.

Finally, we have used our regular communications to highlight Biodiversity and increase understanding of the issues to all our employees.

We are currently investigating opportunities on how to best monitor and assess biodiversity across the Estate.

Greenspace

The design and management of the NHS Scotland green estate for human and planetary health, offers an opportunity to deliver a range of mutually beneficial outcomes. These include action on climate change (both mitigation and adaptation), biodiversity, health and wellbeing for patients and staff, community resilience building and active travel.

To support this our grounds & gardens team continue to assist in the "Space to Grow" project at Huntlyburn House. The "Space to Grow" area is used for carrying out workshops that assist in the rehabilitation of our mental health patients and is widely accessed by staff and visitors.

We have also continued to develop new outdoor spaces for staff members at all our NHS Borders Hospitals by providing areas in greenspace which promote improved staff wellbeing. These areas will be planted with pollinator plants and shrubs.

The table below outlines our key greenspace projects and their benefits.

Project name/ location	**Benefits of project**	**Details of project**
Public Health Collaboration	Wide Stakeholder engagement Anchor Organisation Work	We are working with PH to ensure our Green spaces provide the best environment for everyone in the Scottish Borders
Rainwater Harvesting	Reduced Water consumption	We are implementing rainwater harvesting to support the watering of plants across our sites
Increased Tree Planting	Improved environment and Carbon Sequestration	Investigating locations and partnerships to improve tree planting across the Estate.

12. Sustainable procurement, circular economy, and waste

Earth Overshoot Day marks the date when our demand for resources exceeds what earth can regenerate in that year. In 2023, Global Earth Overshoot Day is 2 August.

For the UK, the picture is more worrying. In 2023, the UK's Earth Overshoot Day is 19 May. The current level of consumption of materials is not sustainable and is the root cause of the triple planetary crises of climate change, biodiversity loss and pollution.

We aim to reduce the impact that our use of resources has on the environment through adopting circular economy principles, fostering a culture of stewardship, and working with other UK health services to maximise our contribution to reducing supply chain emissions to net-zero by 2045.

In the last year, to reduce the environmental impact of the goods and services we buy we have ensured over 80% of our products are purchased through National Contracts or Frameworks. The National Distribution Service supply over 80% of our medical consumables (economies of scale, consolidation of deliveries).

NHS Borders Procurement work with NHS NSS (National Services Scotland) National Procurement. Our Head of Procurement is a member of the Sustainable Procurement Steering Group.

Supplier and category prioritisation has been delivered by this group to enable effect targeting of efforts. The National Procurement team have been working on driving supply visibility across its 400 strong supplier base primarily in support of resilience. It also provides us with a heat map of manufacturing locations across its 9,000 products and this can be used as the basis for mapping supply chains from an environmental footprint point of view. It also provides us with insights from an ethical viewpoint, with country of manufacture information allowing us to assess labour practice risk across the supply chain.

NHS Borders has signed up to the Community benefits Gateway. The Community Benefits Gateway is a facilitation platform, enabling procurement services and suppliers to further improve lives, and support healthier communities.

When undertaking procurement activities, NHS Borders consider community benefits within the tender evaluation criteria (where relevant).

During 2021 NHS Borders became a Living Wage Accredited Organisation (working with the Poverty Alliance). Fair Work principles will be embedded in appropriate contracts.

The Head of Procurement is a member of the National Efficiency Operational Group (commercial optimisation key objective).

In the next year to reduce the environmental impact of the goods and services we buy we will have a continued presence within the National Groups. This year a Commercial Improvement Taskforce (CITF) has been set up by National Procurement. This is bringing together expertise across the Boards to review various commodities. We have commenced with non-medical commodities (Phase 1).

The CITF (Commercial Improvement Taskforce) has developed a list of various initiatives. These initiatives will be reviewed and taken forward in the form of Buyers Guides to assist Boards with implementation. Examples of benefits of the initiatives are: reducing print, reducing use of bottled water, Hybrid Mail, Air Dryers (reduction in hand towels). NHS Borders is committed to delivering on these initiatives where possible.

Sustainability training is now a mandatory requirement for Procurement Staff (using the SG (Scottish Government) eLearning) on Sustainable Public Procurement, Climate Literacy and Circular Procurement & Supply. We plan to roll this out to other department with a procurement remit.

Developments from the Sustainable Procurement Steering Group this year are:

Agreement to introduce a mandatory sustainability question (with minimum weighting) within local tenders with a value exceeding £250,000. A model question has been developed for all Boards to use. The questions suppliers will be asked are:

- How are you incorporating climate change considerations into your product(s) development & Manufacturing processes?
- What steps have you taken to reduce assessed harmful environmental impact in your product distribution activities?
- How are you working to reduce the assessed harmful environmental impact of your product (s)?

During 2023/24 NHS Borders will remain committed to delivering on Climate and Sustainability objectives and utilising the benefits of being an active member of the various national groups.

We have a commitment to ensuring that waste generated through procurement activities will continue to be reduced and that we will increase how much of this waste is recycled.

The table below sets out information on the waste we produce and its destination for the last three years. The data for 2020/2021 is incomplete. Percentage change has been measured against 2021/22 to ensure comparability of figures.

Type	2020/21 (tonnes)	2021/22 (tonnes)	2022/23 (tonnes)	Percentage changefrom last year
Waste to landfill	10	10	10	0%
Waste to incineration	31.5 (Partial Data)	58.08	63.62	+9.53%
Recycled waste	711.6	644.2	715.9	+11.13%
Food waste	Not available	15.5	15.5	0%
Clinical waste	262.8	408.6	360.9	-11.67%

In common with a number of other areas covered in this report, significant work has been undertaken during the past year to improve the quality and comprehensiveness of our

reporting. This report incorporates improved data in relation to 2021/22 to ensure we are reporting on all relevant waste streams.

The increase in incineration waste is in part due to pharmaceutical waste, where patients are encouraged to return unused medicines to their local pharmacies for safe destruction; it is believed that this impact reflects a backlog of returns built up during the pandemic. We are however aware that there has been a general increase in the overall volume of medicines issued (across Scotland) in recent years and this presents an ongoing challenge in this area.

Further to this, the safe disposal of 'sharps' (i.e. needles, etc.) used in health treatments has increased as activity returns to pre-pandemic levels, resulting in corresponding increase to clinical waste.

Despite this, there has been a reduction of 2% in the volume of hazardous waste (chemicals) requiring incineration.

To reduce the amount of incinerated waste we are reinforcing our education of what should be included in this waste stream and asking for increased vigilance that all recycling packaging is placed in the correct waste stream. In addition, for pharmaceutical waste we have moved from plastic containers to recycled cardboard containers which reduces the overall waste streams carbon emissions.

We are pleased that we have moved 11% of Clinical waste into recycling streams and this was achieved through working with Clinical colleagues in all areas of Borders General Hospital and Community Hospitals to change the types of bins they have available and to provide education on using the appropriate waste stream. As Clinical Waste creates more than 12 times the greenhouse gases than recycling this is a positive outcome.

We have also removed several single use items such as theatre scrub hats which have been replaced with a washable material and changing the trays used for injections/blood samples with a reusable product. In addition, we commenced a pilot on using rechargeable batteries within the organisation.

The work to reduce waste and ensure waste is placed in the correct waste stream across the organisation will continue. We will work with community pharmacies to reduce pharmaceutical waste and ensure that as much packaging as possible is recycled.

We will also continue to look for opportunities to further reduce single use items.

There are nationally agreed targets setting out reduction to the amount of waste produced across NHS Scotland; the tables below provide information on our performance against those targets. It should be noted that until April 2018 NHS Borders operated an onsite incinerator which was how most of our waste was processed; this means that we do not have segregated data from 2012/2013.

Reduce domestic waste by a minimum of 15%, and greater where possible compared to 2012/2013 – by 2025	
Target – reduce domestic waste by	No 2012/13 baseline data available. Based on 'straight line' methodology, anticipate 1.25% reduction per year. Target = 1.25% x 2021/22 tonnes
Performance – domestic waste reduced by	0 (tonnes)
Outcome	Not achieved yet*
Further reduction required	3 x 1.25% of 2021/22 less any reduction achieved in 2022/23

**On basis that reduction of 1.25% is expected each year from point where base data is available.*

Ensure that no more than 5%, and less where possible, of all domestic waste is sent to landfill – by 2025	
Target – reduce waste sent to landfill by	Target (total landfill at 5% of overall waste)
Performance – waste sent to landfill reduced by	10 tonnes (1.3% of all domestic waste based on SBC (Scottish Borders Council) provided data)
Outcome	Achieved
Further reduction required	None

Reduce the food waste produced by 33% compared to 2015/16 – by 2025	
Target – reduce food waste by	3.3% per year based on 33% over 10 years. Use 2021/22 as baseline
Performance – food waste reduced by	0 tonnes
Outcome	Not achieved yet
Further reduction required	3.3% x remaining year

Ensure that 70% of all domestic waste is recycled or composted – by 2025	
Target – recycle or compost	500 tonnes
Performance – recycled or composted	715 tonnes
Outcome	Achieved
Further increase required	None

13. Environmental stewardship

Environmental stewardship means acting as a steward, or caretaker, of the environment and taking responsibility for the actions which affect our shared environmental quality.

This includes any activities which may adversely impact on land, air, and water, either through the unsustainable use of resources or the generation of waste and pollution. Having an Environmental Management System (EMS) in place provides a framework that helps to achieve our environmental goals through consistent review, evaluation, and improvement of our environmental performance.

We have commenced work on our EMS during 2023. This work is ongoing and through our Climate Emergency and Sustainability Group we are aligning EMS to our overall action plan to ensure that as work is undertaken to review and/or introduce our plans, policies, and procedures these will be recorded within our EMS. The work on EMS impacts a wide number of stakeholders and we will work collaboratively to ensure the EMS is robust with organisational wide engagement and teams aware of their responsibilities.

14. Sustainable communities

The climate emergency undermines the foundations of good health and deepens inequalities for our most deprived communities.

Anchors approaches align with NHS Borders commitments to tackle health inequality and act on climate change and sustainability. Anchors approaches also prioritise the health and wellbeing of our workforce and emphasise our responsibilities as one of the largest local employers (along with Scottish Borders Council).

- Population health depends on more than health service provision and is shaped by the social, economic, and environmental conditions that people live in.
- These fundamental causes of health inequality are the focus of the new Tackling Health Inequalities in the Scottish Borders (THISBorders) strategy
- NHS Borders taking an Anchors approach is a coherent way to co-ordinate many actions to tackle health inequality.
- NHS Borders Public Health department advocate formation of an Anchors Development Group to bring together work on (i) workforce; (ii) procurement; (iii) land and assets; (iv) transport and (v) align with sustainability, net zero and climate action work locally.

Work is underway to identify the risks that climate change has to the people who live in Borders, with support from Public Health Scotland. This report and knowledge could then be used to provide focus for where further resilience may be required within local communities. Building the relationship with the climate change and environmental leads at Public Health Scotland will also hopefully lead to future conversations about actions that could be taken to improve the resilience of local communities in Borders to the effects of climate change.

A local interim steering group, led by local charities and community interest companies (CIC's) is in place and are designing a plan for the development of the Scottish Borders Climate Action

Network. The aim of this group is the achievement of net-zero and climate resilience in the Scottish Borders through community actions and activities, including the consolidation and coordination of existing support for climate change.

NHS Borders has representation on this interim steering group, and it is hoped that the network will provide opportunities for NHS Borders to collaborate and share information about risks arising from climate change. It will also hopefully create connections to increase awareness of NHS sites and how they could be utilised by communities to improve resilience to climate change.

NHS Borders has representation on the Scottish Borders Home Energy Forum which has a membership consisting of partners of the Community Planning Partnership and energy efficiency specialist groups. The aim of the Home Energy Forum is to ensure that a strategic, multi-agency approach is taken to help reduce fuel poverty, improve energy efficiency, and improve health and wellbeing in the Scottish Borders, particularly for the most vulnerable households.

Additionally, it will help to ensure households do not fall into fuel poverty; ensure that resident's health and wellbeing are not put at risk, due to them being unable to heat their home and; explore opportunities to encourage self-funded households to establish energy efficiency measures in the home. This network of partners enables opportunities for collaboration, including information sharing and planned programmes of work. A good example of this was the response during the Covid 19 pandemic to food accessibility and promotion of the NHS Borders Money Worries App (developed by our Public Health service).

15. Conclusion

We are reporting a reduction of 7.46% against previous year emissions (9,677.48tCO2e from 10,458.24 tCO2e). This improvement is encouraging and has been achieved in the context of continued efforts to improve the accuracy, comprehensiveness, and transparency of our reporting.

Reducing carbon emissions in a healthcare environment is challenging due to both the complexities of the operating environment and the necessary use of products which presently have a high carbon emissions footprint. We hope that this report demonstrates the commitment of our clinical teams and support services to finding innovative solutions to reduce our carbon emissions, without compromising patient care.

We acknowledge the four areas where we have observed an increase in Carbon Emissions (Metered Dose inhalers, Fleet vehicles, Business Travel and Water), and understand that this is in part due to improved reporting, however it has also highlighted areas for focus in the next 12 months and the work stream leads in these areas are reviewing actions that can be taken.

The three areas of reduction (Building Energy, Medical Gasses and Waste) are of course good news stories. The work stream leads within these areas have clear action plans for continuing the progress within these areas.

NHS Borders has made considerable progress in the year 2022 –2023 and are committed to further reducing our Carbon emissions in 2023 –2024.

NHS Borders

Meeting:	**Borders NHS Board**
Meeting date:	**1 February 2024**
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 a consultant post.

New Consultant	Post	Start Date
Dr Rosemary Gordon	Consultant Psychiatrist – Borders Addiction Service	May 2024
Dr Derek Dickson	Consultant Psychiatrist – Inpatient Ward & Borders Crisis Team	May 2024

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.