# Borders NHS Board

A meeting of the **Borders NHS Board** will be held on **Thursday, 4 April 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-2024-19 |
| **10.02** | **3** | **MINUTES OF PREVIOUS MEETING** 01.02.24 | Chair | *Attached* |
| **10.04** | **4** | **MATTERS ARISING** Action Tracker | Chair | *Attached* |
| **10.05** | **5** | **STRATEGY** | | |
| 10.05 | 5.1 | Pharmaceutical Care Services report | Director of Pharmacy | Appendix-2024-20 |
| 10.15 | 5.2 | Health Inequalities Strategy | Director of Public Health | Appendix-2024-21 |
| **10.30** | **6** | **FINANCE AND RISK ASSURANCE** | | |
| 10.30 | 6.1 | Resources & Performance Committee minutes: 18.01.24 | Board Secretary | Appendix-2024-22 |
| 10.31 | 6.2 | Audit Committee minutes 11.12.23 | Board Secretary | Appendix-2024-23 |
| 10.32 | 6.3 | Endowment Fund Board of Trustees minutes 04.10.23 | Board Secretary | Appendix-2024-24 |
| 10.33 | 6.4 | Financial Plan 2024/25 Update | Director of Finance | Appendix-2024-25 To Follow |
| 10.45 | 6.5 | Provision of Resources to the Scottish Borders Integrated Joint Board | Director of Finance | Appendix-2024-26 |
| 10.55 | 6.6 | Finance Report | Director of Finance | Appendix-2024-27 |

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|---|---|---|---|---|
| **11.00** | **7** | **QUALITY AND SAFETY ASSURANCE** | | |
| 11.00 | 7.1 | Clinical Governance Committee minutes: 17.01.24 | Board Secretary | Appendix-2024-28 |
| 11.01 | 7.2 | Quality & Clinical Governance Report | Director of Quality & Improvement | Appendix-2024-29 |
| 11.20 | 7.3 | Infection Prevention & Control Report | Director of Nursing, Midwifery & AHPs | Appendix-2024-30 |
| **11.30** | **8** | **ENGAGEMENT** | | |
| 11.30 | 8.1 | Future of the Public Governance Committee | Director of Planning & Performance | Appendix-2024-31 |
| **11.35** | **9** | **PERFORMANCE ASSURANCE** | | |
| 11.35 | 9.1 | NHS Borders Performance Scorecard | Director of Planning & Performance | Appendix-2024-32 |
| **11.50** | **10** | **GOVERNANCE** | | |
| 11.50 | 10.1 | Scottish Borders Health & Social Care Integration Joint Board minutes: 24.01.24 | Board Secretary | Appendix-2024-33 |
| 11.51 | 10.2 | Code of Corporate Governance Refresh | Board Secretary | Appendix-2024-34 |
| **11.59** | **11** | **ANY OTHER BUSINESS** | | |
| | | | | |
| **12.00** | **12** | **DATE AND TIME OF NEXT MEETING** | | |
| | | Thursday, 27June 2024 at 10.00am as a Hybrid meeting in the Lecture Theatre, Education Centre, Borders General Hospital and via MS Teams. | Chair | *Verbal* |

# NHS Borders

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|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 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 formally constitute NHS Borders annual Register of Interests as required by Section B, Sub Section 4, of the Code of Corporate Governance.

### 2.2 Background

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

### 2.3 Assessment

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

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

### 2.3.1 Quality/ Patient Care

Not applicable.

### 2.3.2 Workforce

Not applicable.

### 2.3.3 Financial

Not applicable.

### 2.3.4 Risk Assessment/Management

Regulatory requirement.

### 2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

### 2.3.6 Climate Change

Not applicable.

### 2.3.7 Other impacts

Regulatory requirement.

### 2.3.8 Communication, involvement, engagement and consultation

Not applicable.

### 2.3.9 Route to the Meeting

Not applicable.

## 2.4 Recommendation

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**

- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Register of Interests.

## Borders NHS Board

### Register of Interests of Board Members

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

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

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | none |
| **Related undertakings**<br>Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held. | none |
| **Contracts**<br>Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged. | none |
| **Houses, land and buildings**<br>Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders | none |
| **Shares and securities**<br>Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k. | none |
| **Gifts and hospitality**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | none |
| **Non financial interests**<br>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. | Currently Trustee of Manor Village Hall – will cease in June 2024 |

Signed- ……..  Date …06/03/2024……...

# Borders NHS Board

## Register of Interests of Board Members

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

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

| Registerable INIterest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | NA |
| **Related undertakings**<br>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. | NA |
| **Contracts**<br>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. | NA |
| **Houses, land and buildings**<br>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 | Joint owner of Rosebank House, Kelso |
| **Shares and securities**<br>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. | Own shares of ~£27K in Worldwide Healthcare Trust |
| **Gifts and hospitality**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | na |
| **Non financial interests**<br>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. | na |

Signed…Fiona Sandford…….. Date …30.iii.2024……...

## Borders NHS Board

### Register of Interests of Board Members

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

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

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | Employee of Womble Bond Dickinson LLP, The Spark, Draymans Way, Newcastle Helix, Newcastle Upon Tyne NE4 5DE (Legal Director)<br>Director of Womble Bond Dickinson Trust Corporation Limited.<br><br>Owner and Manager of holiday let, Little Hermitage, Kelso |
| **Related undertakings**<br>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**<br>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. | Ongoing contract with NHS Borders to do laundry for above holiday cottage on standard commercial rates |
| **Houses, land and buildings**<br>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**<br>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**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | |
| **Non financial interests**<br>Any non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders, such as membership or holding an office in other public bodies, clubs, societies and organisations, such as trade unions and voluntary organisations. | Chair Borders Organ Donation Committee<br>Chair, Kelso High School Parent Council.<br>Member Borders-wide group of High School Parent Council Chairs |

Signed……Harriet Campbell…….. Date …11/3/24……...

**Borders NHS Board**

NHS Borders

**Register of Interests of Board Members**

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

Board Member: JAMES AYLING *(please insert your full name in capital letters)*

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | |
| **Related undertakings**<br>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**<br>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**<br>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**<br>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**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | |
| **Non financial interests**<br>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 23 March 22

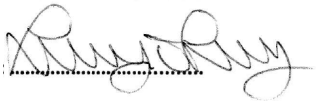
## Borders NHS Board

### Register of Interests of Board Members

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

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

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



Signed…… …….. Date …05.03.24……...

## 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**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | Royal Institution of Chartered Surveyors<br>Standards and Regulation Board<br>Independent Member<br>Professional regulatory body |
| **Related undertakings**<br>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**<br>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**<br>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**<br>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**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | |
| **Non financial interests**<br>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

### Register of Interests of Board Members

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

Board Member: ……kevin buchan…….. *(please insert your full name in capital letters)*

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | Partner at Mairches medical practice |
| **Related undertakings**<br>Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held. | Nil |
| **Contracts**<br>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. | GMS contract held with NHS Borders |
| **Houses, land and buildings**<br>Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders | Nil |
| **Shares and securities**<br>Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k. | Nil |
| **Gifts and hospitality**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | Nil |
| **Non financial interests**<br>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. | Gp local medical committee |

Signed……kevin buchan…….. Date …28/03/2024……...

# Borders NHS Board

## Register of Interests of Board Members

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

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

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

Signed David Parker Date 5 March 2024

# Borders NHS Board

## Register of Interests of Board Members

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

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

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

Signed  Date 06.03.2024

## Borders NHS Board

### Register of Interests of Board Members

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

Board Member: ANDREW STEPHEN BONE

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

Signed ……..… …….. Date ……18th March 2024……..

## Borders NHS Board

### Register of Interests of Board Members

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

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

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

Signed..... Date 18/3/24

# 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: …SOHAIL S BHATTI…..… *(please insert your full name in capital letters)*

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

Signed ……. … Date …2/4/2024……...

# Borders NHS Board

## Register of Interests of Board Members

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

Board Member: CHRIS MYERS

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

Signed Christopher Myers Date 15 March 2024

# 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: LAURA JONES

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

Signed Laura Jones Date 22/03/24

# 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**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | Owner: Wild Thyme Campers (campervan hire based in Callander) |
| **Related undertakings**<br>Any directorships held which are not themselves remunerated, but where the company (or other undertaking) in question is a subsidiary of, or a parent company of, a company (or other undertaking) for which a remunerated directorship is held. | None |
| **Contracts**<br>Any contract between NHS Borders and the member or a firm in which the member is a partner, or an undertaking in which the member is a director or has shares (as described below), under which goods or services are to be provided or works executed, which has not been fully discharged. | None |
| **Houses, land and buildings**<br>Any right or interest owned by the member in houses, land or buildings which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders | None |
| **Shares and securities**<br>Any interest in shares which constitute a holding in a company or organisation which may be significant to, of relevance to, or bear upon, the work and operation of NHS Borders and the nominal value of the shares is; greater than 1% of the issued share capital of the company or other body; greater than £25k. | None |
| **Gifts and hospitality**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | None |
| **Non financial interests**<br>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. | Board Member – McLaren Leisure Centre Board (based in Callander, Stirlingshire) |

Signed…Lynne Huckerby…….. Date …25/3/24……...

# Borders NHS Board

## Register of Interests of Board Members

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

Board Member: SARAH HORAN

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | |
| **Related undertakings**<br>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**<br>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**<br>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**<br>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**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | |
| **Non financial interests**<br>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 06.03.24.

Sarah Horan

**Borders NHS Board**

Minutes of a meeting of **Borders NHS Board** held on Thursday 1 February 2024 at 10.00am in the Lecture Theatre, Education Centre and via MS Teams.

**Present**:
Mrs K Hamilton, Chair
Mrs F Sandford, Non Executive
Ms L Livesey, 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 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
Mrs S Errington, Head of Planning & Performance
Mr P Lerpiniere, Acting Director of Nursing
Mr S Whiting, Infection Control Manager
Mrs C Oliver, Head of Communications & Engagement
Mr P Johnson, Public Involvement Partnership Group (PIPG)
Mrs K Kiln, Consultant in Public Health
Mrs F Doig, Strategic Lead Health Improvement
Mr D Knox, BBC Radio Scotland

## 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, Mrs L Huckerby, Interim Director of Acute Services, Dr L McCallum, Medical Director, and Mr C Myers, Chief Officer Health & Social Care.

1.2 The Chair commented that as the acute hospital was experiencing incredible pressure and senior members of the Executive Team were actively supporting the hospital to ensure its safety and that of its patients, she had agreed to accept apologies for the meeting from Dr L McCallum, Mrs L Huckerby, Mr C Myers and Mrs S Horan.

1.3 The Chair introduced Mrs Lynne Livesey, newly appointed Non Executive with the Whistleblowing portfolio to the meeting.

1.4 The Chair welcomed a range of attendees to the meeting including members of the public and press.

1.5 The Chair confirmed the meeting was quorate.

## 2. Declarations of Interests

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

The **BOARD** approved the inclusion of the declarations of interests for Lynne Livesey and Lynne Huckerby in the Register of Interests.

## 3. Minutes of the Previous Meeting

3.1 The minutes of the previous meeting of Borders NHS Board held on 7 December 2023 were approved.

## 4. Matters Arising

4.1 **Action 2023-4:** Dr Sohail Bhatti commented that the Public Governance Committee had reviewed and agreed the mainstreaming report. The report would be published on the website after the Board meeting.

The **BOARD** noted that Action 2023-4 was complete.

The **BOARD** noted the Action Tracker.

## 5. Medium Term Financial Plan Update

5.1 Mr Andrew Bone provided an overview of the content of the paper and highlighted several elements including: the previous plan prepared for 24/25 set out a financial forecast of £22m steady over 3 years and was predicated on the delivery of savings and investment from the Scottish Government; received information on the planning framework and expectations on public finances in Scotland; expectation that the financial plan will set out an improving position over 3 years; delivery of savings no less than 3% per year; NHS Borders on the performance escalation framework for financial sustainability and financial performance; there was a £17m cap on finance for next year; cost pressures expected to grow over the next year; work to be progressed to refine assumptions around financial expenditure and resources; before savings the expected gap would be in excess of £45m for 2024/25 and cost pressures were driving that position including new medicines, sustainability of the Emergency Department, surge capacity and costs; Scottish Government had indicated resources would be available for PCIP; reconfiguring existing spend and workforce to move to more sustainable models; expenditure has been paused on areas of discretionary spend and enhanced controls are in place on vacancies and recruitment.

5.2 The Chair reflected that the impact would be wide ranging across staff and activities and the public of the Borders and she was keen for the Board to have a session to understand the broad range of actions that needed to be taken to get the Board closer to financial balance.

5.3 Mr Ralph Roberts commented that it was the most challenging position for NHS Borders and there was a need to be honest with the staff and public that the scale of challenge could not be addressed without it impacting on the level and scale of services to be provided. He and other health service chief executives continued to make extensive representations to the Scottish Government to make sure that the position was part of the national narrative so that the wider public understood the implications for all health services.

5.4 Further discussion focused on: the impact on the medium term savings of any work done on the short term savings; development of a task form approach to get savings plans to the right place as quickly as possible; potential for some choices to require engagement with the staff and public to implement quickly; impact of delivery savings on performance; detailed dialogue to take place on the polypharmacy savings and PCIP support required; pursue values based health care and a change in culture; concerns around staffing and economies of scale; any indication from Scottish Government on what was thinkable considering they had provided feedback that previous suggestions were going too far in terms of performance; cross referencing to the 15 point plan issued by the Scottish Government; and the framework for decision making associated with the 15 point plan on decisions that could be taken at a local level and those that would require referral to the Scottish Government for approval.

The **BOARD** noted 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 that work.

**6. Property Update**

The **BOARD** homologated the award of a contract for capital works to the value of £1.496m (including VAT) to Redpath Construction Limited.

**7. Director of Public Health Annual Report**

7.1 Dr Sohail Bhatti provided a presentation to the Board and highlighted: the case for prevention; mobilising the system; engagement with partners; health improvement; health protection; alcohol and drugs; screening programmes; and oral health.

7.2 Discussion focused on: definitive smart objectives and timescales; tying prevention into the medium and long term planning; health benefit in health prevention; out perform some health boards across Scotland in terms of uptake of screening and vaccinations and that is through a positive level of public engagement.

The **BOARD** noted the report.

**8. Resources & Performance Committee minutes: 02.11.23**

The **BOARD** noted the minutes.

**9. Audit & Risk Committee minutes: 18.09.23**

The **BOARD** noted the minutes.

## 10. Risk Appetite Policy

10.1 Mrs Laura Jones provided an overview of the content of the paper and highlighted several key elements including a refresh of the risk appetite position and the criticality of getting risk thresholds correct.

10.2 Mr James Ayling commented that an internal audit report had noted that the risk policy did not show strategic risk and he sought clarification that the policy met the recommendations raised by internal audit. Mrs Jones confirmed that the Risk Appetite Policy replaced the current risk appetite process that was included within the internal audit report and was inclusive of both strategic and operational risk appetite.

The **BOARD** approved the risk appetite policy.

## 11. Finance Report

11.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several key elements including: £16.2m overspend to end of December 2023; improvement in operational performance and some as a result of the Quarter 3 forecast change in assumptions on flexibility; assumptions had been made on the level of ringfencing of funds to carry forward for future commitments; funds remained ring fenced in relation to IJB; assumptions would be worked through over the following 2 months; £20.1m forecast deficit and the board remained adrift of £17.8m that the Scottish Government wanted the board to get to; and significant timescale challenges on the reporting of primary care prescribing costs.

11.2 The Chair enquired about the IJB ring fenced funds. Mr Bone advised that he would be discussing with Mr Chris Myers the potential identification of any ring fenced funding in the IJB reserves that were for projects that were not specific binding obligations and might therefore be repatriated back to NHS Borders.

11.3 Mr James Ayling enquired how significant it would be to the budget if funds could be carried forward. Mr Bone commented that it was around £2m in total and the due diligence around it needed to be undertaken in terms of any contractual obligations.

The **BOARD** noted that the board was reporting an overspend of £16.22m for nine months to end of December 2023.

The **BOARD** noted the updated Q3 forecast outturn to £20.1m deficit and the risks to the forecast.

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

## 12. Clinical Governance Committee minutes: 22.11.23

The **BOARD** noted the minutes.

## 13. Quality & Clinical Governance Report

13.1 Mrs Laura Jones provided an overview of the content of the paper and highlighted several key elements including: GP sustainability; awarded PCIP demonstrator site; built environment and significant risk with the estate and modern compliance in relation to infection control; AHP pressures; the position in acute services in relation to the whole health and social care system; in patient beds; winter demand and the extreme pressure on the acute system.

13.2 Mrs Fiona Sandford commented that it was important to note the significant level of sickness absence in parts of the system which appeared to relate to pressure in the system. She reiterated that when looking at potential cuts the board would need to be aware of the additional pressure that would be placed on already pressurised staff.

13.3 Mr Andy Carter commented that there were spikes in sickness absence and hot spots as well as staff with long term conditions, but it was clear there had been a significant jump over the last couple of months in sickness absence rates.

13.4 The Chair enquired if alternative roles were offered to staff who could not return to their substantive roles. Mr Carter confirmed that adjustments were offered.

The **BOARD** noted the report.

## 14. Healthcare Associated Infection – Prevention & Control Report

14.1 Mr Sam Whiting provided an overview of the content of the report and drew the attention of the Board to compliance levels with hand hygiene and the installation of bed end gel dispensers and the review of wall mounted gel dispensers. He further highlighted outbreaks and the current level of respiratory infections and the different strains of COVID in the community.

14.2 Further discussion focused on: measles; urinary tract infections and the use of catheters; and ecoli bacteraemia rates.

The **BOARD** noted the report.

## 15. Area Clinical Forum Minutes: 03.10.23

The **BOARD** noted the minutes.

## 16. Time for Change Summary – Community and Staff Engagement

16.1 Mrs Clare Oliver provided an overview of the content of the report and highlighted several key elements including: themes, location, budget; feedback had been positive on engagement with board members; honest approach and positive conversations; and the quality of the conversations and community engagement.

The **BOARD** noted the report.

## 17. NHS Borders Performance Scorecard

17.1 Mrs Steph Errington provided an overview of the content of the paper and highlighted several key points of: overall consistency with the pressure points outlined in the clinical governance and quality report; inability to meet trajectory targets for out patients, treatment time guarantee, emergency department and mental health; and improvement in psychology therapy waiting times since the last report and delivery in relation to cancer treatment remained strong.

17.2 The Chair suggested the Board have cognisance of the report when it began priority setting and should use it as a reference document in regard to any changes that might be made in relation to performance.

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

## 18. Scottish Borders Health & Social Care Integration Joint Board minutes: 15.11.23

The **BOARD** noted the minutes.

## 19. Board Committee Memberships

19.1 The Chair introduced the report and advised that with the departure of Ms Sonya Lam and the arrival of Mrs Lynne Livesey she had taken the opportunity to make some adjustments to the membership of Non Executives on Board Sub Committees.

19.2 The Chair then advised that Mr Tris Taylor had decided to step down as a Non Executive of the Board due to personal reasons and some further minor adjustments would be required. She advised that she would chair the Public Governance Committee in the meantime.

19.3 The Chair recorded the heartfelt thanks of the Board to Mr Taylor for his past 6 years of service as a Non Executive and noted the difference he made in terms of the involvement and engagement of the public in decision making in the Board.

The **BOARD** formally approved the changes in Non Executive memberships of its Committees as set out in the NHS Borders Non Executives Committee Chart and noted the resignation of Mr Tris Taylor.

## 20. NHS Borders Climate Emergency & Sustainability Annual Report 2022/23

20.1 Mr Andrew Bone presented the report and acknowledged the contribution of Mrs Harriet Campbell as the climate champion for the Board. He advised that the report had been received by the Resources & Performance Committee in draft and after a few minor adjustments was presented to the Board for approval prior to publication.

20.2 Mrs Harriet Campbell thanked Mrs Fiona Laidlaw and Mr Bone for their huge contributions in pursing climate change and sustainability on top of their normal day jobs. She commented that climate change and sustainability was important for the

organisation, individuals and the whole planet and it was often overlooked until it became a crisis.

20.3 Mrs Lucy O'Leary enquired if there was more information available on food waste and what could be done to support people to be less wasteful. Mr Bone commented that food waste featured on the action plan and had actions assigned to it.

The **BOARD** approved the report for publication.

**21. Consultant Appointments**

The **BOARD** noted the report.

**22. Any Other Business**

The **BOARD** noted there was none.

**23. Date and Time of next meeting**

23.1 The Chair confirmed that the next scheduled meeting of Borders NHS Board would take place on Thursday, 4 April 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.<br>**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.<br>**Update 01.02.24: Complete:** Dr Sohail Bhatti commented that the Public Governance Committee had reviewed and agreed the mainstreaming report. The report would be published on the website after the Board meeting.<br><br>The **BOARD** noted that Action 2023-4 was complete. |

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Pharmaceutical Care Services report** |
| **Responsible Executive/Non-Executive:** | **Dr Lynn McCallum, Medical Director** |
| **Report Author:** | **Malcolm Clubb, Director of Pharmacy** |

## 1 Purpose

**This is presented to the Board for:**

- Awareness

**This report relates to a:**

- Annual Operational Plan/Remobilisation Plan
- Government policy/directive – Statutory Plan
- Local policy

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

The purpose of the NHS Borders Pharmaceutical Care Services report 2024-27 is to evaluate the current service provision, identify any gaps and support the decision-making process on any future application for a new community pharmacy in the Scottish Borders. A secondary function of the plan is to inform and engage members of the public, health professions and planners in the planning of pharmaceutical services available in Scottish Borders.

### 2.2 Background

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

## 2.3 Assessment

From the evidence gathered and outlined within this report, it is apparent that the current service provision is adequate for the population's immediate needs. No major gaps have been identified. The future of community pharmacy services will be shaped by both the projected increase and ageing of the population. This, along with the increasing numbers of community pharmacists qualifying as independent prescribers, will provide further opportunities for pharmacy services to develop to meet these changing needs. In addition to the future opportunities for community pharmacy growth, the evidence also highlights some potential risks and challenges in the short to medium term. These challenges need to be addressed as part of on-going service development, with the focus on equal opportunities and meeting the changing needs of the population. Recommendations and opportunities that may be considered as part of the continuous improvement and development programme are outlined in the report.

### 2.3.1 Quality/ Patient Care

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

### 2.3.2 Workforce

The report does highlight that we are having difficulty attracting and recruiting pharmacists in the Borders. Both Community Pharmacy and Pharmacotherapy have vacancies for regular pharmacists.

During 2024-25 we are going to see if we can innovate with hybrid contracts between NHS Borders and our community pharmacy partners. This is in response to young pharmacists telling the profession that they want a more portfolio career moving forward.

### 2.3.3 Financial

The current financial pressures will impact on local pharmaceutical services moving forward. NHS Borders and Community Pharmacy Borders will work collaboratively to ensure as many of the local services can be delivered within the restricted financial envelope.

### 2.3.4 Risk Assessment/Management

The Pharmaceutical Care Services report does identify risks around workforce planning, medicine availability and financial impact on contractors of future contractual settlements.

The Director of Pharmacy has been asked to engage with a Remote and Rural workforce panel at a national level on behalf of the other Directors of Pharmacy. As required an update will be circulated.

The pharmacy department is aware of medicine availability issues and routinely provides advice and support at a Board level and on individual patient basis. This work

will be ongoing, and we will where possible prevent patient harm from these shortages.

NHS Borders in not involved in the national negotiations on community pharmacy remuneration. If future settlements impact on service delivery this will be captured on the next iteration of the pharmaceutical care services plan.

### 2.3.5 Equality and Diversity, including health inequalities

No equality and diversity impact assessment has been carried out on the report. If services require to be increased, changed, or ceased a suitable health inequalities assessment will be undertaken.

### 2.3.6 Climate Change

No impact

### 2.3.7 Other impacts

No impact

### 2.3.8 Communication, involvement, engagement and consultation

- Engaged with the chair of Community Pharmacy Borders and Chair of the Area Pharmaceutical Committee to discuss challenges highlighted in the report 1st December 2023
- Circulated, discussed and amended Pharmacy Leadership Team 23 January 2024
- Presented and heard feedback from the Area Pharmaceutical Committee 24 January 2024
- Presented and heard feedback from the GP Sub-committee of Area Medical Committee 29 January 2024
- Presented and heard feedback from the Public Partnership Forum 8 February 2024

### 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.

| | |
|---|---|
| Area Pharmaceutical Committee | 24 January 2024 |
| GP Sub-committee of Area Medical Committee | 29 January 2024 |
| Public Partnership Forum | 8 February 2024 |
| Area Clinical Forum | 26 March 2024 |
| Operational Planning Group | 1 April 2024 |
| NHS Borders Board | 4 April 2024 |

## 2.4 Recommendation

The author asks the Board to endorse the Pharmaceutical Care Services Plan report 2024-27. The author also requests that the Board notes the challenges and any

updates or concerns will be escalated via relevant channels including OPG as required.

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1 Pharmaceutical Care Services in NHS Borders – 3 Year Plan

# Pharmaceutical Care Services in NHS Borders

# 3-Year Report
# April 2024 – March 2027

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# Pharmaceutical Care Services Report – document details and pathway

## Document Details

| Name | Job Title / Role | Signature | Date |
|---|---|---|---|
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## Document Change Log

| **Version** | **Author/Contributor** | **Issue Date** | **Change** |
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| 1.0 | Malcolm Clubb; Kate Warner; Keith Maclure | October - December 2023 | Review content; report on Community Pharmacy only in line with other health boards. Acute and Primary Care Pharmacy included in Pharmacy Strategy/Vision. |
| 1.1 | Pharmacy Senior Management Team review | 9th January 2023 | Corrections to data and text. |
| 1.2 | Malcolm Clubb; Kate Warner | February/March 2023 | Update with additional information from Committees/Groups. |

## Executive Summary

The publication of NHS (Pharmaceutical Services) (Scotland) Amendment regulations 2011 requires NHS Boards to publish pharmaceutical care service (PCS) reports and annually update them. This 2024 update is published according to these regulations in accordance with the Scottish Government circular PCA (P) 7 (2011).

### Pharmaceutical Care Services (PCS) 2024-25 in NHS Borders

This report gives a brief overview of the population of NHS Borders and then provides a detailed description of the current pharmaceutical services that exists within NHS Borders. Data from a range of sources are utilised to establish any unmet need for each of the core Community Pharmacy Contract services. Additional services currently provided in NHS Borders are also included. The extent to which that need is met is examined through assessment of any existing gaps in the provision of the core pharmaceutical services within the Community Pharmacy contract.

There are 29 contracted community pharmacies in Borders. These are distributed across the region and meet the access needs of most of the population, with no large gaps being identified. Based on current population with following exceptions, Cheviot and Tweeddale localities, the pharmacy provision is higher per head than the Scottish average.

It is important to continue to support development of community pharmacy services through training and ensuring that delivery of these services meets the needs of the population.

There are, however, some key challenges facing NHS Borders community pharmacy services and recommendations for NHS Borders Board which are outlined towards the end of the report.

The Pharmaceutical Care Services in NHS Borders report is circulated to groups listed in Document Pathway. Each year, Boards are required to make their final report available on their website and other routes as informed by local policy.

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# 1.0 Introduction

The purpose of the Pharmaceutical Care Services (PCS) report is to review the current provision of community pharmaceutical services within the Health Board population and to enable consideration of how services may be adapted, if required, to provide care in the future for any changing pharmaceutical care needs.

The report will inform members of the public, health professionals and planners in the planning of pharmaceutical care services. This report is a data source that the Pharmacy Practices Committee uses to assess need when considering applications to the Pharmaceutical List.

## 1.1 Introduction to NHS Borders Health Board Area

The Scottish Borders is a medium-sized council area, in terms of population size, but in a much bigger geographical area than average for a Scottish Local Authority. The Scottish Borders has one Health and Social Care Partnership: Scottish Borders Council and NHS Borders, which was formed in April 2016.

## 1.2 Population

The population of Scottish Borders was 116,020 in mid-2021. For additional context, in December 2023, there were 121,302 patients registered with NHS Borders GP Practices.

The 65-74 age group is growing the fastest and the over 75s age group is also increasing rapidly. This will have important resource implications for the next 15-20 years. There are expected to be fewer children by 2028 than at present. Overall, the Scottish Borders is considered to have a more demographically fragile population than the Scottish average, due to its combination of population loss in certain areas and its rapidly ageing population throughout the region[1].

The overall population of Scotland is expected to increase between 2014 and 2039 but the overall population of Scottish Borders is not expected to change significantly in the same period[2].

[1] Source: Strategic assessment 2023 - Demographic profile | Scottish Borders Council (scotborders.gov.uk)
[2] Source: National Records of Scotland

## 1.3 Scottish Borders Localities

Scottish Borders has 5 main areas – known as Localities: -

**Berwickshire**

**Cheviot**

**Eildon**

**Teviot & Liddesdale**

**Tweeddale**


Figure 1 - Borders localities map

## 1.4 Rural and Remote

The Scottish Borders covers around 1,827 square miles and is the 4th most rural area in Scotland with 30% of the population living in settlements of below 500 people[3].

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

Table 1 - Population towns by locality

[3] Source: Local Police Plan 2020-23 The Scottish Borders; Police Scotland

The location of Community Pharmacies, and the services provided by them, is an important consideration in such a rural area.

Figure 2 - Borders public transport map

In previous years, transport has played a key role in the access to all services in a rural location with 16% of the population reporting issues with transport as a barrier to health.

With improvements in technology, fewer patients may travel to hospital as a centralised location.

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

## 1.5 Deprivation

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

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

In areas of deprivation, continuity of pharmacy services and pharmaceutical care is important to reduce adverse effects of taking multiple medications and hospital visits.

In addition, pharmacies provide an important public health role through smoking cessation, substance misuse, sexual health services and provision of advice.

## 1.6 Health

A key source for understanding health, care and wellbeing is the Scottish Public Health Observatory (ScotPHO profile) website[4].

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

## 1.7 Births

There were 852 babies born in the Scottish Borders in 2021, a higher-than-average decrease of 20.1% since 2001. Despite this, the Scottish Borders had an above-average Standardised Birth Rate (SBR) of 10.1 per 1,000 in 2021, compared with 8.7 in Scotland.

- Women of childbearing age in the region are having as many babies (or more) as their counterparts elsewhere in Scotland, despite there being a relatively higher proportion of women in the region who are past childbearing age.
- There has been a marked decrease of births to mothers aged under 20, both in the region (a fall of 70%) and in Scotland as a whole (a fall of 76.5%), between 2001 and 2021.
- There has been a decrease in the Scottish Borders of births to mothers aged 30 and over between 2001 and 2021, whereas there has been an increase of births in this age group elsewhere in Scotland.

The Total Fertility Rate (TFR) is a demographic measure of the average number of children who would be expected to be born to each woman. In the Scottish Borders in 2021, this was

[4] https://scotland.shinyapps.io/ScotPHO_profiles_tool/

1.54 children. The TFR has decreased by 10.1% since 2001 in the Scottish Borders, which is not as fast as in Scotland as a nation.

Statistics on the number of births per calendar year or midyear-to-midyear for council areas and small areas are available from the Scottish Official Statistics Open Data platform.

## 1.8 Deaths and Causes of Deaths

There were 1,448 deaths in the Scottish Borders in 2021. There has been an above-average increase of 12.9% in the number of deaths in the region since 2001. The Standardised Death Rate (SDR) in Scottish Borders in 2021 was 12.6 per 1,000 population, which is slightly above the 11.6 average for Scotland.

- There was a 20.8% increase in the number of male deaths in the Scottish Borders between 2001 and 2021, which is higher than the Scottish average of a 16.4% increase.
- There was a 6.2% increase in the number of female deaths in the Scottish Borders between 2001 and 2021, which is slightly higher than the Scottish average of a 5.8% increase.
- 75% of deaths in the Scottish Borders in 2021 were within the over 70s age groups.
- The leading cause of death in Scottish Borders males in 2021 was Ischaemic Heart Diseases, accounting for 16% of all male deaths.
- Other leading causes of death for males were: Dementia and Alzheimers, prostate cancer, stroke and lung cancer.
- The leading cause of death in Scottish Borders females in 2021 was Ischaemic Heart Diseases, accounting for 9.4% of all female deaths.
- Other leading causes of death for females were: Dementia and Alzheimers, Stroke, lung cancer and respiratory disease.
- On average, one person in the Scottish Borders died every day in 2021 from ischaemic heart disease, dementia/ Alzheimer or stroke. Cancers are also a leading cause of death but there are many different cancers, and they are categorised by type.

Information is available to download on avoidable deaths, drug-related deaths, and homelessness deaths. All statistics are available from the Scottish Official Statistics Open Data platform

## 1.9 Burden of Disease

Burden of disease studies provide a consistent and comprehensive framework to address some fundamental questions on how early death and ill-health affect the nation's population. Burden of disease studies can assist policy makers and public health practitioners to plan interventions and deliver services to enhance prevention, improve disease outcomes, and reduce health inequalities.

Overall, the rate of health loss in Scottish Borders is 13% lower than the Scottish rate. We estimate the total burden in 2019 has increased 0.8% compared to the burden in 2016.

The leading cause of ill health in Scottish Borders is low back and neck pain, the rate of which is 2.9% higher than in Scotland. The leading cause of early death in Scottish Borders is ischaemic heart disease, the rate of which is 27.8% lower than in Scotland.

For more detailed information: Scottish Borders Burden of Disease report (revised September 2022).

# 2.0 Current Pharmaceutical Services in NHS Borders

## 2.1 Community Pharmacy Services - Overview

Community pharmacies are independent contractors who provide a service to NHS Scotland in accordance with national regulation and locally negotiated contracts. The availability of pharmacies allows access to healthcare for the Borders population. Pharmacies provide dispensing services, as well as advice on minor ailments, self-care, and provision of different services available through patient group directions.

### *2.1.1 Number of Community Pharmacies across NHS Borders by locality*

NHS Borders has 29 community pharmacies and 2 dispensing practices located across the five localities.

| Locality | Town | Community Pharmacies & Dispensing Practices |
|---|---|---|
| Berwickshire | Chirnside | GLM Romanes Pharmacy |
| | Coldstream | GLM Romanes Pharmacy |
| | Duns | GLM Romanes Pharmacy |
| | Eyemouth | GLM Romanes Pharmacy |
| | Greenlaw | GLM Romanes Pharmacy |
| Cheviot | Kelso | Boots Pharmacy<br>Rowlands Pharmacy |
| | Jedburgh | Boots Pharmacy<br>Jedburgh Pharmacy |
| Eildon | Earlston | M Farren Pharmacy |
| | Galashiels | Boots Pharmacy<br>Borders Pharmacy<br>Gala Pharmacy<br>M Farren Pharmacy<br>Tesco Pharmacy |
| | Lauder | Lauder Pharmacy |
| | Melrose | Boots Pharmacy |
| | Newtown St Boswells | Eildon Pharmacy |
| | Selkirk | Lindsay & Gilmour<br>Right Medicine Pharmacy |
| | Stow | Dispensing Practice |
| Teviot & Liddesdale | Hawick | Boots Pharmacy<br>Borders Pharmacy<br>Hawick Health Centre & Pharmacy<br>Lindsay & Gilmour Pharmacy<br>TN Crosby Pharmacy |
| | Newcastleton | Dispensing Practice |
| Tweeddale | Innerleithen | M Farren Pharmacy |
| | Peebles | Boots Pharmacy<br>Right Medicine Pharmacy |
| | West Linton | West Linton Pharmacy |

Table 2 - Community pharmacies by locality

NHS Borders population per pharmacy is comparable with other health boards and lower than the national average[5].

| Health Board | Population | Community Pharmacies | Population per Community Pharmacy |
|---|---|---|---|
| NHS Borders[6] | 121,302 | 29 | 4,183 |
| NHS Fife | 371,190 | 86 | 4,316 |
| NHS Lothian | 911,620 | 182 | 5,014 |
| NHS Tayside | 416,090 | 92 | 4,523 |
| Scotland | 5,466,000 | 1256 | 4,323 |

Table 3 - Borders population per pharmacy

APPENDIX 2 shows a full table of GP practice list size and community pharmacies per locality.

### *2.1.2 Resources – Premises/Facilities*

Guidance on the premises requirements under the community pharmacy contract is available at PCA(P)(2007)28. It provides a tool for pharmacies to assess their ability to meet the requirements and produce an action plan for any rectification work that is required to meet those requirements. This guidance aids the planning of any future pharmacy premises or potential relocations.

### *2.1.3 Resources – Community Pharmacy Workforce*

Each community pharmacy must have at least one pharmacist and all pharmacists must have a minimum qualification of a degree in Pharmacy and be registered with the General Pharmaceutical Council. Pharmacists can be independent prescribers. These prescribers have, in the past, been involved in clinics in speciality areas such as stoma, hypertension, respiratory and pain. The national Pharmacy First Plus service has shifted focus to delivering prescribing for common clinical conditions. NHS Borders currently has 12 Community Pharmacist independent prescribers. From 2026, all newly qualified pharmacists will be qualified as independent prescribers. A programme to train pharmacists already prescribing is ongoing.

[5] Health Boards listed – figures from April 2022
[6] NHS Borders total patients registered with GP Practices 2023

| Prescribing Status | No of Pharmacists |
|---|---|
| Active/Community Pharmacy Independent Prescribers | 12 |
| Independent Prescribers training in progress | 6 |
| Qualified Independent Prescribers inactive | 0 |

Table 4 - Borders community pharmacists prescribing status

The workforce in community pharmacy ranges from healthcare counter staff offering healthcare and medicines advise to those working in dispensary. Support staff work directly with the public and are trained to provide advice on numerous health matters. The pharmacist provides an expert source of knowledge to all staff; some with specialist areas of knowledge.

Work continues to support development, education, and training of all staff. This includes peer support groups and regular education sessions.

## 2.2 Community Pharmacy Services – Accessibility of Pharmaceutical Services

### *2.2.1 Accessibility to community pharmacies*

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

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

A few pharmacies are constrained by their premises. Guidance on premises requirements is available to pharmacies and aids the planning of any future pharmacy premises or refurbishment.

### *2.2.2 Hours of Service*

The population of the Scottish Borders accesses pharmaceutical care services in line with the Hours-of-Service Scheme. Core opening is from 09:00 – 17:30 with one hour in the middle of the day for lunch. Most GP practices are closed by 6pm, Monday to Friday. The Hours-of-Service Scheme means that all community pharmacies are open for most of this period. The flexibility within the scheme means that pharmacies may be able to open earlier and remain open for longer at their own discretion.

Some pharmacies have extended hours; some offer a service on Saturday and some on Sundays. Opening times for NHS Borders community pharmacies can be found listed in APPENDIX 3.

## 2.3 Community Pharmacy Services – Core Services

All community pharmacies must deliver the following core services: -

### *2.3.1 Acute Medication Service (AMS)*

Acute Medication Service (AMS) is the provision of pharmaceutical care services for acute episodes of care and electronically supports the dispensing of acute prescriptions and any associated counselling and advice. AMS is provided by all 29 community pharmacies in Borders.

2,161,385 prescription items were dispensed in NHS Borders in 2022/23; 892,368 items were dispensed in the first two quarters of 2023/24 (data available at time of writing report). The table below lists the AMS - volume of prescription items dispensed and spend in Borders over the past 4 financial years.

| Financial Year | No of prescription items dispensed - AMS | Spend |
|---|---|---|
| 2022 – 2023 | 2,161,385 | £23,392,971 |
| 2021 – 2022 | 2,121,340 | £21,678,069 |
| 2020 – 2021 | 2,059,219 | £21,017,117 |
| 2019 - 2020 | 2,153,455 | £21,707,185 |

Table 5 - Borders items dispensed Acute Medication Service 2019 - 2023

### 2.3.2 *Medicines: Care and Review – Serial Prescribing*

Medicines: Care and Review (MCR) allows patients with long term conditions to register with a community pharmacy of their choice for the provision of pharmaceutical care as part of a shared agreement between the patient, the GP, and the pharmacist. MCR allows the GP to generate a patient's prescription for 24-, 48- or 56-week period; the patient only needs to visit the pharmacy to pick up medication. This process sends electronic messages between the pharmacy and the GP practice system to update the GP record with dispensing information. The pharmacist is required to complete a medication review and care plan with the patient within 16 weeks of patient registration[7]. MCR includes serial prescribing and Borders are working towards all GP Practices and Community Pharmacies offering the service. NHS Borders has 23 GP Practices, with 22 issuing serial prescriptions; and all 29 pharmacies processing them.

| Financial Year | No of registered patients |
|---|---|
| 2022 – 2023 | 4914 |
| 2021 – 2022 | 4491 |
| 2020 – 2021 | 3883 |
| 2019 - 2020 | 3000 |

Table 6 - Borders MCR/Serial registered patients 2019 - 2023

| Financial Year | No of ordinary prescription items dispensed | No of SERIAL prescription items dispensed | Percentage of Serial Prescriptions |
|---|---|---|---|
| 2022 – 2023 | 2,161,385 | 88,059 | 4.9% |
| 2021 – 2022 | 2,121,340 | 78,901 | 4.2% |
| 2020 – 2021 | 2,059,219 | 69,765 | 3% |
| 2019 - 2020 | 2,153,455 | 53,518 | 2% |

Table 7 - Borders MCR/Serial prescription items dispensed 2019 – 2023

With a national target of 10% to show "real benefit", training and support for community and practice pharmacists, technicians and dispensers is on-going. NHS Borders will continue to encourage serial prescribing as this is more efficient for patients and practices as well as more cost effective.

[7] National Services Scotland - MCR

### 2.3.3 Pharmacy First

The Pharmacy First service replaced the previous Minor Ailment Scheme and is delivered by all 29 Borders pharmacies. The service is available free of charge to patients who require advice and/or treatment for minor ailments. The patient receives a consultation and supply of an appropriate medication if indicated, advice only or a referral to their GP or other healthcare professional.

National Patient Group Directions (PGDs) have been introduced to provide treatments for Hay fever, Impetigo, Shingles, Skin Infections and Urinary Tract Infections; allowing patients to attend their pharmacy instead of making a GP appointment for treatment.

| | |
|---|---|
| **Aciclovir** | Herpes Zoster (Shingles) infection in patients over 18 years of age |
| **Desogestrel** | Progestogen-only contraceptive pill in patients over 13 years and under 55 years of age |
| **Flucloxacillin** | Skin infection in patients over 18 years of age |
| **Fusidic acid** | Impetigo in adults and children |
| **Beclometasone** | Nasal spray to patients aged 6 years and over presenting with symptoms of seasonal allergic rhinitis with persistent congestion |
| **Fexofenadine** | Tablets to patients aged 12 years and over presenting with symptoms of seasonal allergic rhinitis |
| **Mometasone** | Nasal spray to patients aged 3 years and over presenting with symptoms of seasonal allergic rhinitis |
| **Olopatadine** | Eye drops to patients aged 3 years and over presenting with symptoms of seasonal allergic conjunctivitis |
| **Levonogestrel** | Emergency hormonal contraception |
| **Nitrofurantoin** | Acute uncomplicated urinary tract infection (UTI) in non-pregnant females aged 16 years and over |
| **Trimethoprim** | Acute uncomplicated urinary tract infection (UTI) in non-pregnant females aged 16 years and over |

Table 8 - Pharmacy First treatments

The Unscheduled Care PGD covers the urgent provision of current NHS prescribed medicines, appliances and ACBS products to NHS patients by pharmacists where there is a clinical need, it is clinically appropriate to make the supply and when the patient's prescriber is unavailable.

The table below lists the CPUS Urgent Supply of Medicines - volume of prescription items dispensed, with spend, in Borders over the past 4 financial years.

| Financial Year | No of prescription items dispensed - CPUS | Spend |
|---|---|---|
| 2022 – 2023 | 25,330 | £186,325 |
| 2021 – 2022 | 18,925 | £118,327 |
| 2020 – 2021 | 17,346 | £124,458 |
| 2019 - 2020 | 16,303 | £115,231 |

Table 9 - Borders CPUS items dispensed 2019 – 2023

### *2.3.4 Public Health Services*

Pharmacists can provide advice to patients or members of the public on healthy living options and the promotion of self-care where it is appropriate to do so or by request from the patient. There are a range of NHS and NHS approved health promotion campaign materials available to the pharmacy for this. Campaigns are agreed nationally by Scottish Government and Community Pharmacy Scotland and will be on display in pharmacies for at least six weeks each.

Public health services delivered through community pharmacy include emergency hormonal contraception, smoking cessation, and supply of prophylactic paracetamol following MenB vaccine.

***Emergency Hormonal Contraception (EHC) Service*** – provides patients with equitable access to the provision of advice on sexual health matters and the supply of EHC (as levonorgestrel or ulipristal) to women aged 13 years and above, where appropriate. This service is delivered by all 29 pharmacies in Borders. On average 75 prescriptions are generated for EHC by Borders community pharmacists each month. An additional service provides patients with “bridging contraception”, a short-term supply of desogestrel, to allow time to access their GP or sexual health service for long term contraception arrangements. This service aims to increase access to contraception and reduce unplanned pregnancy.

***Smoking Cessation Service*** – provides support and advice together with the supply of nicotine replacement therapy (NRT) or varenicline via a patient group direction over a period of up to 12 weeks. This service is provided by all 29 community pharmacies in Borders.

| Financial Year | No of prescription items dispensed - NRT | Spend |
|---|---|---|
| 2022 – 2023 | 3,134 | £43,859 |
| 2021 – 2022 | 3,234 | £46,445 |
| 2020 – 2021 | 2,589 | £41,301 |
| 2019 - 2020 | 3,353 | £49,369 |

Table 10 - Borders NRT items dispensed 2019 - 2023

Public Health Scotland provide data on smoking cessation rates across Scotland by Health Board. These statistics are routinely updated via the following web portal. Publications - Smoking cessation - Data and intelligence - Substance use - Health harming commodities - Our areas of work - Public Health Scotland

***Supply of Prophylactic Paracetamol following MenB vaccine*** – allows the supply of prophylactic paracetamol via patient group direction to babies receiving the MenB vaccine at 2 months and 4 months. Annual totals have decreased for this service in the past four years - 186 in 2019/20; 126 in 2020/21; 90 in 2021/22; and 68 in 2022/23.

## 2.4 Community Pharmacy Services – National Services

The delivery of National Services is optional; however, most pharmacies in Borders offer these services. They are:

### *2.4.1 Gluten Free Food Service*

Pharmacy teams provide an annual health check for people registered at their pharmacy for this service (unless this is done elsewhere), enabling detection of and care planning for any clinical issues. Pharmacy teams support people to do this providing advice and managing monthly orders for food items. The Pharmacy Care Record (PCR) is used to plan and record each health check. Products are available in line with the East Region Formulary which combines NHS Borders, NHS Fife, and NHS Lothian. In 2022/23, 7,495 prescription items were dispensed for this service with a spend of £104,547. Items and spend has been at this level for several years.

### 2.4.2 Pharmacy First Plus

NHS Pharmacy First Plus aims to support patients with acute common clinical conditions. It is an extension of the NHS Pharmacy First Service Scotland. Not all community pharmacies can provide this service as the pharmacist needs to have completed additional training to become an independent prescriber (IP).

### 2.4.3 Stoma Service

Stoma patients use specialist products to collect and dispose of waste which would normally make its way through the digestive tract or urinary system. Community pharmacies can sign up to provide patients with these products, and to give advice on stoma care by agreeing to operate under the Stoma contract, which is optional and separate from the core contract which outlines most other services we provide. The Stoma Contract sets out the service standards to be met by all Community Pharmacy contractors who have signed up to the service. Dispensing Appliance Suppliers can also be on the approved suppliers list and supply products direct to patients.

### 2.4.4 Unscheduled Care Service

Community pharmacy is an important access route for people requiring urgent care particularly over weekends and public holidays. This service makes available urgent provision of current NHS prescribed medicines, appliances and ACBS products to NHS patients by pharmacists where there is a clinical need, it is clinically appropriate to make the supply and when the patient's prescriber is unavailable. There is a list of medicines included and excluded available to Pharmacists.

It is the responsibility of each professional to practice only within the bounds of their own competence and in accordance with the General Pharmaceutical Council Standards for Pharmacy Professionals. Each Pharmacist completes an Individual Authorisation form and returns this to NHS Borders Pharmacy department.

## 2.5 Community Pharmacy Services – Additional Services

Additional Services are locally negotiated contracts. It is the responsibility of the NHS Board to ensure that these additional services meet the needs of the population. They may not be required equally across the area or be provided by every pharmacy. Provision is looked at across the wider healthcare services as they may not be provided by pharmacy alone. The table below shows the number of community pharmacies offering these services.

| Additional Service | Total |
|---|---|
| Advice to Care Homes | 11 |
| Community Pharmacy Palliative Care Network | 4 |
| Dispensing/supervision of Opioid Substitution Therapy | 29 |
| Injecting Equipment Provision | 10 |
| Just In Case Programme (currently under discussion) | 0 |

Table 11 - Borders Additional Services

### 2.5.1 *Advice to Care Homes*

The pharmacy contractor provides advice and support to the residents and staff within the care home, over and above the Dispensing Essential service, to ensure the proper and effective ordering of drugs and appliances and their clinical and cost-effective use, their safe storage, supply and administration and proper record keeping.

Aims of this service include improving patient safety within the care home with a particular focus on the following areas: ordering, storage, administration and disposal of medicines and appliances and use of residents' own medicines (prescribed and purchased). All care home visits for 2023/24 had been completed at the time of this report.

### *2.5.2 Community Pharmacy Palliative Care Network*

This service allows timely access to palliative care medicines for patients being cared for at home as well as providing information regarding palliative care medicines to patients, carers, and other Health Care Professionals. There are 4 community pharmacies delivering this service; with one each in the following Borders localities: Berwickshire (Duns); Eildon (Selkirk); Teviot & Liddesdale Hawick); Tweeddale (Innerleithen); Cheviot – pharmacy to be confirmed.

The Pharmacy Palliative Care network is working well, with a Peer Support Group which has regular meetings. From January 2024, all other Borders pharmacies will keep an essential list of palliative care medicines in stock.

### *2.5.3 Dispensing/Supervision of Opioid Substitution Therapy (OST)*

Supervised self-administration of OST is undertaken at the request of the prescriber and is a clinical decision based on the patient's stability, home circumstances and progress through treatment. The use of community pharmacies for dispensing methadone allows patients to be treated in their own communities. Daily contact allows the pharmacist to monitor patient compliance and provide health promotion advice. Currently 29 pharmacies in Borders, who can provide supervision in a consultation room or screened off area, dispense and supervise OST when required.

### *2.5.4 Injecting Equipment Provision*

This service aims to ensure that individual and public health is protected by reducing the incidence of blood-borne infection and drug-related deaths amongst service users. Sterile injecting equipment and related paraphernalia is accessible as required for injecting drug users (IDUs); the rate of sharing and other high-risk injecting behaviours is reduced and IDUs use safer injecting practices; and there is a reduction in risky behaviours that may result in infections (including blood-borne viruses), unsafe sex and unplanned pregnancies, accidental overdoses, and drug-related deaths.

IDUs are routinely offered information and support to access BBV testing and immunisation, drug treatment, and general health services.

The following 8 community pharmacies offer this service: *GLM Romanes Pharmacies in Duns and Eyemouth; Gala Pharmacy in Galashiels; Jedburgh Pharmacy; Lindsay & Gilmour Pharmacies in Hawick and Selkirk; Right Medicine Pharmacy in Peebles and Rowlands Pharmacy in Kelso*. *Borders Addiction Service and We are With You* also offer this service.

### *2.5.5 Flu Vaccination Service*

This service enables accredited staff with Borders community pharmacies to administer influenza vaccine to eligible patients as a free NHS service under the national protocol.

During the seasonal flu vaccination campaign period, pharmacy staff will identify people eligible for flu vaccination and offer them the opportunity to be vaccinated if they have not already been vaccinated in this flu season. The community pharmacy seasonal flu immunisation service runs from 1 October to 31 March for eligible patients, who do not have any contraindications to vaccination, under the national protocol.

The following pharmacies offer this service to Borders patients: *Duns, GLM Romanes Pharmacy; Hawick, TN Crosby Pharmacy, HHCC Pharmacy, Lindsay & Gilmour Pharmacy; Innerleithen, M Farren Pharmacy; Jedburgh, Jedburgh Pharmacy; Lauder, Lauder Pharmacy; Peebles, Right Medicine Pharmacy; Selkirk, Right Medicine Pharmacy; and West Linton, West Linton Pharmacy.*

The aim of the service includes sustaining and maximising uptake of flu vaccine in eligible groups by delivering the service from community pharmacies as agreed with NHS Borders; and to provide more opportunities and improve convenience for patients in eligible cohorts to access free NHS flu vaccinations.

## 3.0 Pharmaceutical Needs in NHS Borders

Information on the population of Borders and the services currently provided by community pharmacies has been detailed in the previous sections of this report.

This provides information to enable consideration of the future of the community pharmacy service within NHS Borders. Services delivered through existing pharmacies receive on-going review by Area Pharmaceutical Committee and Borders Community Pharmacy Contractors Committee.

The sections below look at areas of the Pharmaceutical Care Services report and how they are meeting the needs of the population of Borders. This is followed by Key Challenges and Recommendations in Chapter 4.0.

### 3.1 Number of Community Pharmacies

There are 29 contracted community pharmacies in NHS Borders. These are well distributed across the region and appear to meet the access needs of most of the population.

The need for new pharmacies was measured from the previous Pharmaceutical Care Services plan 2021-24 and NHS Borders currently has no identifiable gaps. There are 8 current expressions of interest/applications made by applicants wishing to open pharmacies in locations detailed in Appendix 1 – Pharmacy Practices Committee.

Overall, there are no identified gaps in provision of pharmaceutical services in NHS Borders.

### 3.2 Hours of Service

The opening hours of community pharmacies in NHS Borders appears to be satisfactory with adequate out of hours opening in major towns of Galashiels and Hawick.

### 3.3 Pharmacy Workforce

There has been an increase in the number of community pharmacists who have qualified as independent prescribers, with others currently in training. Pharmacy First Plus allows the pharmacists to use these prescribing qualifications to provide pharmaceutical care and contribute to the transformation of urgent care. There are reports, through Area

Pharmaceutical Committee, of increasing difficulty in securing permanent pharmacists and locum cover. This is affecting all boards across Scotland, including NHS Borders.

## 3.4 Community Pharmacy Services – Core Services

*3.4.1 Acute Medication Service* – prescription numbers remain stable with no significant increase in demand requiring any increase in service.

*3.4.2 Medicines: Care and Review Service* – percentage of serial prescriptions issued has increased to 4.9% and work continues with the engagement of GP practices and community pharmacies to increase this further.

*3.4.3 Pharmacy First* – there is no unmet need identified in the provision of consultation and treatment for common clinical conditions. All patients registered with a GP or living in Scotland can access this from a community pharmacy. Current pharmacy weekend and extended opening hours are monitored to ensure urgent care provision.

*3.4.4 Public Health Services* – continue to be supported by community pharmacies in Borders with no current unmet need identified.

## 3.5 Community Pharmacy Services – National and Additional Services

The additional services developed under Community Pharmacy Contract make a fundamental contribution to the health of the population. Some community pharmacy services are negotiated at local level and there is a potential to review each on an on-going basis to ensure that services are meeting the needs of the local population.

## 4.0 Key Challenges and Recommendations

## Key Challenges facing Community Pharmacy

Some of the key challenges facing Community Pharmacies in Borders, at the time of writing this report in November 2023, are listed here.

### Workforce Planning

Within NHS Borders, there are vacancies for pharmacists in both community pharmacy and pharmacotherapy teams. Community pharmacists are relying heavily on locum pharmacists to ensure service delivery is maintained. Whilst locum pharmacists play a vital role, patients routinely prefer to see a continuous face providing their pharmaceutical services. The rural nature of the Borders seems to be less attractive to newly qualified pharmacists to relocate to on a temporary or permanent basis.

For pharmacy technicians, NHS Borders has worked together with community pharmacy contractors to support training of new staff. NHS Borders now have a bank of staff members, trained as assessors, who can support the two-year programme to deliver new pharmacy technicians. Despite the development of local training programmes, it still takes two years to qualify as a pharmacy technician. Posts in pharmacotherapy services are often seen as more attractive than working in a community pharmacy. The hours offered can be more flexible as are not dependent on weekend working. The UK Government is currently consulting on legislative changes to the role and responsibilities which will impact on pharmacy technicians. As a result of these changes if adopted, we will need to train more pharmacy technicians to work in community pharmacy.

### Workload

Since the Covid 19 pandemic, patients are more used to, and more confident of, what can be done by their local pharmacy. This has resulted in greater workload for pharmacy teams and has meant common clinical condition management is delivered predominantly via Pharmacy First. Pharmacy First Plus, using independent prescribing, has also seen a cascading of patients to pharmacy due to pressure from patient demand in other independent contractors. The role of the pharmacist in community pharmacy has evolved. There is an increase in face-to-face patient time and more clinical services being delivered.

Changes put into place during Covid, when community pharmacy worked to the top of their skills, have now become embedded and, whilst this is appreciated by patients, must be maintained.

### Financial

The demise of the Lloyds Pharmacy chain across the UK shows that the financial pressures are now acute in community pharmacy. Pharmacy businesses need to be well managed to ensure survival and maintenance of pharmaceutical services. Some of the smaller pharmacies in the network are under financial pressure to survive. Failure of these businesses may impact on pharmaceutical service delivery across NHS Borders.

During 2023-24 there was a three-month delay in the contractual/financial settlement between the contractors and the Scottish Government. This led to instability in the network, compounded by estimated payments following delays in the implementation of a new electronic payment system. Pharmacy contractors have had considerable swings in cashflow which can be difficult to manage when purchasing medicines for reimbursement in two months.

### Availability of medicines and devices

Community pharmacy contractors have seen longer lead times for medicine deliveries. There are more long-term, out of stock items during recent years. This situation results in extra workload for pharmacy and GP practice teams alike trying to resolve the problems for patients. It also causes concern and undue worry for patients.

### Technology, Automation, Artificial Intelligence

Community Pharmacy contractors recognise that technology to underpin automation of medicine supply and Artificial Intelligence, to support clinical medicine checking, are now a reality. There is a keenness to invest in these technologies but an uncertain financial climate causes concern about investment. Contractors expect to see more use of robotics, in hub and spoke supply automation, and electronic lockers, to support medicine collection for patients, but progress will be delayed if financial uncertainty is not resolved.

## Recommendations

| | |
|---|---|
| Promotion of the Pharmacy First Service | Ensure opportunities to promote the message of Pharmacy First are used in communications to promote the use of pharmacy for common clinical conditions. |
| Support and develop our network of Pharmacy First Independent Prescribers | Ensure opportunities are given to develop these new prescribers. These opportunities should develop skills and competency in a wider range of conditions to support delivery of care in community pharmacy. |
| Better access to patient clinical records. | Community Pharmacy would be able to improve patient care when GP practice is closed and support the pharmacotherapy service element of Medicine Care and Review if there was access to patient clinical records.<br><br>Currently, apart from access to the Emergency Care Summary, community pharmacists can't see any clinical records apart from their Patient Medication Records. Now, community pharmacists routinely prescribe, it would be more efficient to have access to patient's electronic records. |
| Promote improved working relationships between independent contractors | Since the inception of Pharmacotherapy teams, interaction between GPs and local community pharmacists has decreased. Pharmacotherapy Teams now tend to be the interaction point. With the move to clinical service delivery, the community pharmacists would like to work closer with their GP peers to support patient care. |

## APPENDIX 1 - Pharmacy Practices Committee

The Pharmacy Practices Committee (PPC) considers all applications for new Community Pharmacies to open in NHS Borders.

Regulations set out the procedures which must be followed by applicants who seek to open new Community Pharmacies in Scotland. The regulations (schedules 3 and 4) set out the statutory arrangements which Health Boards must put in place to receive and respond to such applications for a new community pharmacy.

NHS Borders is required to establish a PPC with representation by professional pharmacists and lay members, chaired by an NHS Board member. The PPC must, first, determine the boundaries of the neighbourhood in which the proposed pharmacy would be located; second, determine whether existing pharmaceutical services in or into that neighbourhood are adequate; and thirdly - only if the existing services are deemed inadequate - determine whether it is necessary or desirable to approve the application to establish a new pharmacy.

PPCs should have reference to its Board's Pharmaceutical Care Services Plan when considering need for pharmaceutical services within the proposed area. The Pharmaceutical Care Services plan is one of a range of data sources that are available to the PPC to use in assessing need when considering applications to the Pharmaceutical List.

The NHS needs of the local community are to be the main determinant of whether an additional community pharmacy or relocation is to be approved.

The following table shows the stages of current applications for community pharmacies in Borders.

| Location | Stage of Application (as of January 2024) |
|---|---|
| Coldingham | 1 application; pre-application meeting to be set up early 2024. |
| Galashiels | 1 application; no further details. |
| Kelso | 1 application; waiting for formal application; consultation and draft CAR complete. First of four applications for Kelso. |
| Peebles | 3 applications on waiting list; no further details. |
| St Boswells | 1 application; no further details. |
| Tweedbank | Pharmacy Practices Committee to meet to discuss application 16/01/2024. First of 5 applications for Tweedbank. |

Table 12 - Borders community pharmacy applications in progress

# APPENDIX 2 – Community Pharmacies / GP Practice population per locality

| LOCALITY | TOWN(S) | MEDICAL PRACTICE | LIST SIZE | TOTAL LIST SIZE BY LOCALITY | Number of Pharmacies/ Disp Practice | List Size per Pharmacy/ Disp Practice | LOCAL PHARMACY |
|---|---|---|---|---|---|---|---|
| BERWICKSHIRE | CHIRNSIDE & DUNS | DUNS MEDICAL GROUP | 3118 | 21531 | 5 | 4,306 | GLM Romanes Pharmacy, DUNS |
| | | MERSE MEDICAL PRACTICE | 6432 | | | | GLM Romanes Pharmacy, CHIRNSIDE |
| | COLDSTREAM | COLDSTREAM MEDICAL PRACTICE | 3910 | | | | GLM Romanes Pharmacy, COLDSTREAM |
| | EYEMOUTH | EYEMOUTH MEDICAL PRACTICE | 6632 | | | | GLM Romanes Pharmacy, EYEMOUTH |
| | GREENLAW | GREENLAW SURGERY | 1439 | | | | GLM Romanes Pharmacy, GREENLAW |
| CHEVIOT | KELSO | KELSO MEDICAL GROUP | 11931 | 18860 | 4 | 4,715 | Boots & Rowlands Pharmacies, KELSO |
| | JEDBURGH | JEDBURGH MEDICAL PRACTICE | 6929 | | | | Boots & Jedburgh Pharmacies, JEDBURGH |
| EILDON | EARLSTON | EARLSTON MEDICAL PRACTICE | 3272 | 41108 | 12 | 3,426 | M Farren Pharmacy, EARLSTON |
| | GALASHIELS | BRAESIDE MEDICAL PRACTICE | 4957 | | | | Boots, Borders, Gala, M Farren, Tesco Pharmacies, GALASHIELS |
| | | MAIRCHES MEDICAL PRACTICE GALASHIELS | 5063 | | | | |
| | | ROXBURGH STREET SURGERY | 3621 | | | | |
| | | WAVERLEY MEDICAL PRACTICE | 5117 | | | | |
| | MELROSE | EILDON SURGERY | 7006 | | | | Boots Pharmacy, MELROSE |
| | NEWTOWN ST BOSWELLS | | | | | | Eildon Pharmacy, NEWTOWN ST BOSWELLS |
| | SELKIRK | SELKIRK MEDICAL PRACTICE | 7317 | | | | Lindsay & Gilmour & Right Medicine Pharmacies, SELKIRK |
| | STOW & LAUDER | STOW & LAUDER HEALTH | 4755 | | | | Lauder Pharmacy, LAUDER; Dispensing Practice, STOW |
| TEVIOT & LIDDESDALE | HAWICK | MAIRCHES MEDICAL PRACTICE HAWICK | 6042 | 19068 | 6 | 3,178 | Boots, Borders, Hawick Health Centre, Lindsay & Gilmour, TN Crosby Pharmacies HAWICK |
| | | TEVIOT MEDICAL PRACTICE | 11398 | | | | |
| | NEWCASTLETON | NEWCASTLETON MEDICAL PRACTICE | 1628 | | | | Newcastleton Dispensing Practice |
| TWEEDDALE | INNERLEITHEN | ST RONAN'S PRACTICE | 4747 | 20735 | 4 | 5,184 | M Farren Pharmacy, INNERLEITHEN |
| | PEEBLES | THE NEIDPATH PRACTICE | 6035 | | | | Boots & Right Medicine Pharmacies PEEBLES |
| | | THE TWEED PRACTICE | 6024 | | | | |
| | WEST LINTON | WEST LINTON MEDICAL PRACTICE | 3929 | | | | West Linton Pharmacy, WEST LINTON |
| | | | | 121,302 | | | |

Figure 3 - Borders locality-town-GP Practice list size-Pharmacy

## APPENDIX 3 – Community Pharmacy Opening Hours, including weekends

| Locality | Town | Community Pharmacies | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday Opening | Sunday Opening |
|---|---|---|---|---|---|---|---|---|---|
| Berwickshire | Chirnside | GLM Romanes | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | - | - |
| | Coldstream | GLM Romanes | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 08:45-12:30 | - |
| | Duns | GLM Romanes | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:00 | - |
| | Eyemouth | GLM Romanes | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-15:00 | - |
| | Greenlaw | GLM Romanes | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | - | - |
| Cheviot | Kelso | Boots | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 08:30-13:00; 14:00-17:00 | - |
| | | Rowlands | 08:30-17:30 | 08:30-17:30 | 08:30-17:30 | 08:30-17:30 | 08:30-17:30 | 09:00-17:00 | - |
| | Jedburgh | Boots | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-16:00 | - |
| | | Jedburgh | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 08:45-17:30 | 09:00-13:00 | - |
| Eildon | Earlston | M Farren | 08:30-13:00; 14:00-17:30 | 08:30-13:00; 14:00-17:30 | 08:30-13:00; 14:00-17:30 | 08:30-13:00; 14:00-17:30 | 08:30-13:00; 14:00-17:30 | 09:00-13:00 | - |
| | Galashiels | Boots | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 08:30-19:00 | 09:00-18:00 | 10:00-17:00 |
| | | Borders | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:00 | - |
| | | Gala | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:00 | - |
| | | M Farren | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-13:00 | - |
| | | Tesco | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 10:00-16:00 |
| | Lauder | Lauder | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | - |
| | Melrose | Boots | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:00 | - |
| | Newtown St Boswells | Eildon | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-17:30 | 09:00-12:00 | - |
| | Selkirk | Lindsay & Gilmour | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-13:00; 14:00-17:00 | - |
| | | Right Medicine | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-17:30 | 09:00-13:00 | - |
| Teviot & Liddesdale | Hawick | Boots | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-17:00 | - |
| | | Borders | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-17:00 | 10:00-17:00 |
| | | HHCC | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | 09:00-12:30; 13:30-18:00 | - | - |
| | | Lindsay & Gilmour | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-17:00 | - |
| | | TN Crosby | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-18:00 | 09:00-12:00 | - |
| Tweeddale | Innerleithen | M Farren | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-12:30 | - |
| | Peebles | Boots | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-17:30 | - |
| | | Right Medicine | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:30 | 09:00-13:00; 14:00-17:00 | - |
| | West Linton | West Linton | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00; 14:00-18:00 | 09:00-13:00 | - |

Figure 4 - Borders community pharmacy opening hours

## Table of Figures

## References / Acknowledgements


Strategic assessment 2023 - Demographic profile | Scottish Borders Council (scotborders.gov.uk)

National Records of Scotland

Local Police Plan 2020-23 The Scottish Borders; Police Scotland

ScotPHO profile

Scottish Official Statistics Open Data platform

Scottish Borders Burden of Disease report

Prescribing data from Public Health Scotland: PRISMS and PIS

Publications - Smoking cessation - Data and intelligence - Substance use - Health harming commodities - Our areas of work - Public Health Scotland

NHS Pharmacy First Service Scotland

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Health Inequalities Strategy** |
| **Responsible Executive/Non-Executive:** | **Dr Sohail Bhatti, Director of Public Health** |
| **Report Author:** | **Kirsty Kiln, Consultant in Public Health** |

## 1 Purpose

**This is presented to the Board for:**

- Discussion

**This report relates to a:**

- NHS Board/Integration Joint Board Strategy or Direction

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

- Safe
- Effective
- Person Centred

## 2 Report summary

## 2.1 Situation

Health inequalities has been an identified risk for the Board and the strategy is the first step in seeking to tackle some of the entrenched inequalities in access, outcomes and experience of healthcare between socio-economic groups in the Scottish Borders.

In the last 5 years we have seen inequalities worsen since the COVID-19 pandemic and the cost of living crisis. At the same time, the financial pressure on the health service to meet growing patient demand requires that we have a credible preventative approach to addressing these inequalities at source, both to improve patient experience and to promote financial sustainability of the services we provide.

## 2.2 Background

A full data analysis has been undertaken to support this work and it shows that inequality is stark and enduring and begins in childhood. By the time a child starts school they are 93% more likely to be overweight and 36% more likely to have tooth decay and cavities. Additionally, there are inequalities in levels of worry (anxiety) developmental concerns in the early years. These childhood inequalities persist throughout life and worsen, leading to premature death and lost productivity as well as an increase in costly emergency admissions later in life.

## 2.3 Assessment

The inequalities we evidence are deeply rooted in social causes – individual choices only take us so far – and we need to take a whole systems approach with partners and communities to understanding and addressing them.

We have undertaken engagement with staff, partners in the CPP and third sector organisations to understand the impact of inequalities and areas for joint working. There is more to do as we develop an accompanying Equality Impact Assessment to support this work.

### 2.3.1 Quality/ Patient Care

Improving inequalities will ultimately improve patient care by lessening demand and enabling people to address early the social as well as health and care needs that contribute to their use of services. This will take time but

### 2.3.2 Workforce

Staff have expressed to us the increasing complexity of patients that they work with and the many social factors that impact upon their ability to access timely healthcare. Pursuing a preventative inequalities approach is a priority for many of the staff we have spoken to.

### 2.3.3 Financial

Whilst addressing health inequalities is not quick, we need to take steps now to ensure that we consider sustainability of services in the Borders in the long term. In the report we highlight the differential rates of emergency and other admissions to hospital as a direct result of avoidable inequality in outcomes.

### 2.3.4 Risk Assessment/Management

N/A.

### 2.3.5 Equality and Diversity, including health inequalities

It was highlighted in the Mainstreaming Progress Update Report 2023 that the Inequalities Strategy will be an important part of us meeting our equalities duties by ensuring that we address unfair and unjust differences in healthcare experience and outcomes between different groups. We know that many equality groups experience higher levels of social deprivation and we seek to explore this further in an EqIA.

An impact assessment is currently being completed in light of engagement with staff and communities and will be shared shortly.

### 2.3.6 Climate Change

The report highlights the challenges of climate change on health inequalities. We know that climate change disproportionately affect the worst off in society and there is much we can do to ensure that we prevent health inequalities through consideration of net zero and affordable and efficient housing with partners across the Borders.

### 2.3.7 Other impacts

By working through the CPP to address inequalities, we seek to achieve improved awareness that health inequalities are everyone's business to ensure that all partners support meaningful contribution to the agenda.

### 2.3.8 Communication, involvement, engagement and consultation

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

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

- Workshop with NHS and SBC staff as well as CPP partners: 2nd October 2023
- Workshop with third sector organisations: 13th March 2024

Work is ongoing via a survey with third sector partners and engagement within localities is being developed.

### 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.

- CPP – overview of data and plan for delivery group discussed at several forums, including on 7th March 2024.
- Regular written and verbal updates provided to HSC Joint Exec meeting.
- Data analysis presented to Council Management Team, SBC.

## 2.4 Recommendation

**Discussion** – Examine and consider the implications of a matter.

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Health Inequalities Strategy

Scottish Borders
Health and Social Care
PARTNERSHIP

NHS
Borders

# T.H.I.S BORDERS

## Tackling Health Inequalities in the Scottish Borders

## 2024 - 2030

# CONTENTS

# EXECUTIVE SUMMARY

Health inequalities affect all of us across the Scottish Borders, either directly or through the negative consequences on our neighbours, friends and family members. Disparities in health status outcomes and life expectancy between different groups are unfair and rooted in complex social causes.

We are clear that tackling health inequalities is good for everyone: reducing the stark differences in population health not only reduces human suffering but also benefits the health and care system and the wider economy in access to skills and productivity.

Whilst, of course, individuals can promote and strengthen their own health and wellbeing, health inequalities are the systemic result of differing life chances and opportunities within our communities. As this strategy will highlight, from cradle to grave, we observe clear and persistent differences in health outcomes by socio-economic status and geography across our population.

Such deep social causes require concerted effort across partners, both statutory and voluntary, to work together to tackle the fundamental determinants. The same factors that may lead to unfair differences in health outcomes also lead to the attainment gap in schools and differential access to employment thereafter. The cycle is complex and persistent, and prevention is the most important intervention.

We know from the data we observe and in speaking with colleagues and partners, that the last five years have brought new challenges. We find ourselves – having come through a pandemic – in a cost of living crisis that has impacted the poorest in society most profoundly and exacerbated existing differences.

Health inequalities should and need to be on everyone's agenda. They must be considered in all areas of work – from workforce and transport, to education, housing and digital inclusion. Their impact should be at the forefront of the planning of all services within NHS Borders, including within the local authority and third sector.

We are ambitious for what we can achieve together as we seek to Tackle Health Inequalities in the Scottish Borders.

# INTRODUCTION

Differences in the conditions in which people are born, live and grow create profound disparities in health status. These differences in health outcomes are stark and enduring. People living in more deprived groups face worse health outcomes throughout their lives and this results in a difference in life expectancy.

Males in the least deprived areas of Scotland had 23 years more life in good health compared to males in the most deprived areas, with the gap being slightly higher for females (24 years). Furthermore, life expectancy also differs even more strikingly amongst other groups within society. For example, those with learning difficulties have a lower life expectancy than the Scottish average [1].

**What are Health Inequalities?**

Systematic differences in people's health that are **avoidable** and **unjust**

**Can be seen as differences in:**

- Opportunities to lead a healthy and fulfilling life
- Access to appropriate care
- Experiences of care within the health system
- Health status, outcomes and ultimately mortality

Health inequalities affect all of us. We know that when many people are unable to lead healthy lives that the impact is felt across society, including in education and employment as well as in the NHS and social care. It is thought that the financial losses associated with health inequalities amount to 1.4% of GDP within European countries [2].

There are many wide-ranging reasons why these differences exist, including social deprivation, diet and nutrition, access to support networks, education and employment, time poverty, housing quality and the degree of control an individual has over their lives and circumstances. Other factors such as smoking and harmful drinking and/ or drug use can impact upon some of the inequalities we see. Many of these are established in our childhood and are deep-rooted in our social circumstances.

In the last five years we have seen inequalities worsen since the COVID-19 pandemic and the cost of living crisis. Fragile employment and rising household costs have put pressure on households, their support networks, and the services that can offer support. It is an important time to think again about how we address and respond to the growing challenges faced by our communities: we are clear that early intervention and prevention are vital.

Many of us are proud to live in the Scottish Borders, but there are also specific challenges of our geography that can impact health outcomes. This can be due to higher transport costs, poorer digital connectivity, isolation, and the challenge of providing and maintaining services across a large, rural area.

We also know that some of the data we have on socio-economic status are not as reliable as they are in urban areas, which can make it challenging to identify people at need across the whole area. The Scottish Index of Multiple Deprivation (SIMD) is better applied to more densely populated towns and cities so, whilst we are able to demonstrate many stark inequalities, we know that some of the challenges are also hidden. Realistically, we need other ways of measuring deprivation. The link with Adverse Childhood Experiences (ACEs) and individual deprivation are strong [3] and could form a Borders specific approach to viewing the harms from health inequalities.

Engagement with community members and organisations, as well as our staff who work closely with people in the Borders, will be vital in understanding how best we can collectively have impact. We want to see meaningful preventative action being taken to address health inequalities amongst people who live and work here. This strategy seeks to bring together local data alongside the experiences we have gathered from our colleagues and partners.

## The need for prevention

Prevention and early intervention are critical because they enable people to have better quality health outcomes, avoiding illness, disease and ultimately premature death. 21.6% of all deaths in the Scottish Borders are deemed avoidable, and this has far reaching consequences for families and the wider community. Across Scotland, whilst we know that the population is expected to fall in the same time period, by 2043 it is estimated that the level of illness will have risen by 21%, putting great strain on health and care services [4].

In the Scottish Borders, there is significant variation observed between the most and least deprived and across different localities in terms of years of life lost. Years of life lost is an expression of the age at which people have died in a population as well as the number of deaths that the population has experienced. If the total number of years of life lost is high, then many people have died prematurely before reaching life expectancy.

The table to right shows the average number of years of life lost by locality in the Scottish Borders – that is, the number of years people in the Borders have lost before reaching life expectancy. There is variation by locality and recorded biological sex. Better understanding some of the specific challenges within localities, and why we see such variation, will go some way to addressing inequalities.

| | Years of life lost (YLL) by locality | | |
|---|---|---|---|
| Locality | Male | Female | Total |
| Berwickshire | 769 | 857 | 1626 |
| Cheviot | 836 | 782 | 1618 |
| Eildon | 1419 | 1138 | 2557 |
| Teviot and Lid-desdale | 943 | 575 | 1518 |
| Tweeddale | 703 | 659 | 1362 |

*Note: table shows the number of years of life lost by locality in the Scottish Borders. This includes all people who died below the life expectancy in 2023 (82 years for females and 79 years for males).*

The concept of prevention is one of the fundamental pillars of Public Health. In broad terms, the three most discussed types of prevention are primary, secondary and tertiary.

**Primary prevention** is where action is taken to stop a disease or illness ever occurring within an individual. Examples include immunisation programmes and seatbelt legislation.

**Secondary prevention** is where action is taken to detect the early signs of a specific disease 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 symptoms. Examples include screening programmes, controlling blood pressure and managing high cholesterol.

**Tertiary prevention** is where action is being taken to reduce the impact of a disease that has already been diagnosed to prevent any further deterioration, maintain quality of life, improve function and minimise suffering. The target group are those with an established disease. Examples include regular reviews for people with diabetes, respiratory or cardiac diseases.

Prevention, of course, can reduce the human suffering of individuals and their families and friends, but there are also important benefits for society as a whole. To improve the sustainability of our health and care services we must look upstream to promote more cost-effective and timely interventions. A study by the University of York aimed to try to quantify the difference in cost per QALY (1 quality-adjusted life year equals 1 year lived in perfect health) for public health interventions versus general NHS treatments. They found that for preventative work, the cost per QALY was £3,800, compared to £13,500 for treatments [4].

It is clear that we need to have a preventive system that is 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.

## The wider determinants of health

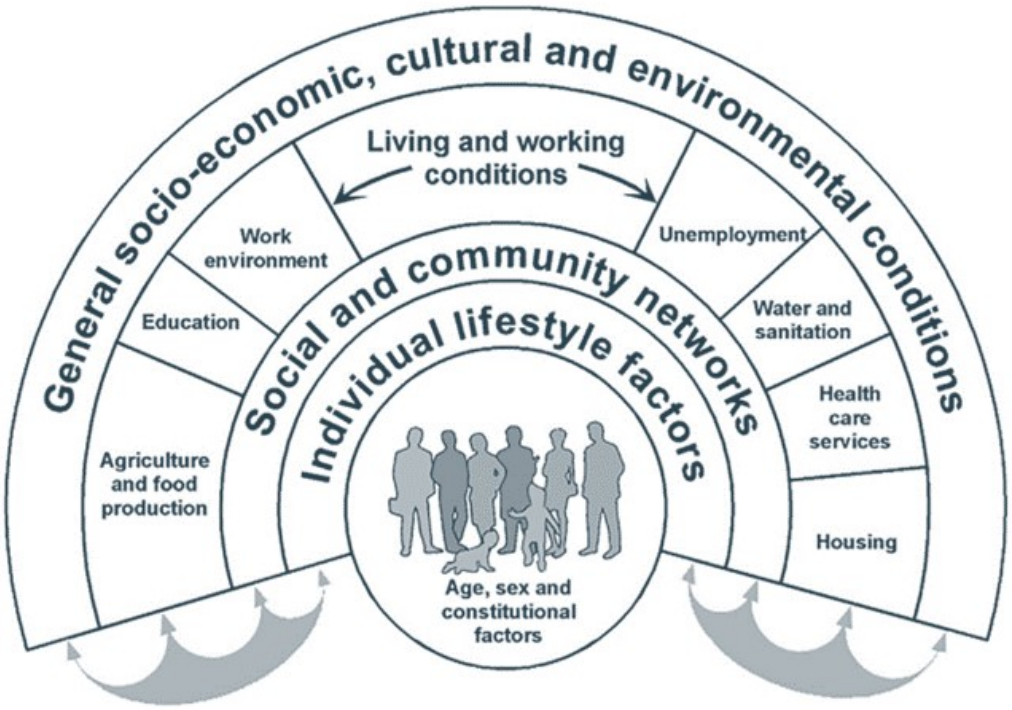
We know that there are many factors that lead to people experiencing worse health than others, and most of the wider determinants of health fall outside the remit of the health service.

**What are the wider determinants of health?**

The environment and conditions in which people are **born, live, work, grow** and **age** are called the wider determinants of health. They are drivers for how healthy people are, and continue to be throughout their life course.

Dahlgren and Whitehead [5] developed a model which has been widely accepted as a useful visualisation of these wider determinants at different levels, from the individual to wider societal influences.

Differences in these social factors, most of which are largely outside of individual control, are evidenced to be a major contributor to the health inequalities we see between different groups of the population. People in more socially deprived circumstances are more likely to experience a number of related disadvantages in their housing, employment, and access to health promoting amenities and opportunities. We know that the pandemic and the cost of living crisis have also had a negative impact upon food security and have increased the demand for food banks and emergency food parcels amongst the most vulnerable. Social disadvantages make it far harder for people to make and sustain healthy choices and the patterns of difference we see between the most and least deprived in our community reinforce this observation.




Understanding these wider determinants of health will be vital in addressing how we can better improve the life chances and health outcomes of people living in the Scottish Borders. We recognise that, as an anchor institution, NHS Borders alongside our statutory partners, has a key role to play as employers, procurers and service providers within the Scottish Borders. Understanding the influence we can have on the wider health of the community will form a key element of our health inequalities work plan.

We are also clear that input is required at all levels of society: healthcare, local government, third sector, industry, the community, and individuals themselves. Collaborative working is the only way to correctly address these wider determinants of health.

Within the Scottish Borders, we have looked at some of the factors that may have particular impact upon the health and wellbeing of our local population. Some of these findings have been summarised in the graphics on the next page.

### Transport

Transport accounts for 17% of total household expenditure in Borders compared to 14% across Scotland

More monthly income is spent on transport in the Scottish Borders compared to Scotland as a whole, and a quarter of geographical areas (26%) are in the 10% most geographically accessed deprived areas in Scotland. It is important to consider digital access as well – limited access to online services can widen inequalities for those with poor connections or low digital literacy.

### Food

8.2% of children in P7 – S6 stated that they always or often went to bed hungry

Access to nutritious, balanced, and affordable food has a significant impact on levels of overweight and obesity as well as other health outcomes. Almost 10% of school children in the Borders reported having a soft drink containing sugar at least daily. Only 40% reported eating fruit or vegetables at least once a day.

### Climate change

It is estimated that 11,000 homes and businesses will be at risk of flooding by 2080 in Borders

Climate change is considered one of the most significant health threats of our current time. It has been observed that the most deprived areas of society contribute the least to climate change but are most likely to experience the impacts of it. Limited access to warm fuel efficient housing can further exacerbate other social factors that influence health and wellbeing.

### Income

21.7% of people earn less than the living wage in Borders, compared to 14.4% across Scotland

The average income in the Scottish Borders is lower than across Scotland. In 2021, average residence-based weekly wage in our area was 89% of the Scottish average and, in 2022, the gross weekly workplace-based wage in the Borders was £69 less per week than the average for Scotland.

### Child poverty

in 2021, 40% of geographical areas in Scottish Borders had higher or higher levels of child poverty

Poverty impacts health and wellbeing through poor quality housing, and competing financial pressures for heating, transport, and food. Children living in low-income households in the Scottish Borders has increased from 14.6% in 2021 to 19.7% in 2022.

### Employment

In 2021, 19% of households with children under 16 years were considered workless in the Borders compared to 12% across Scotland

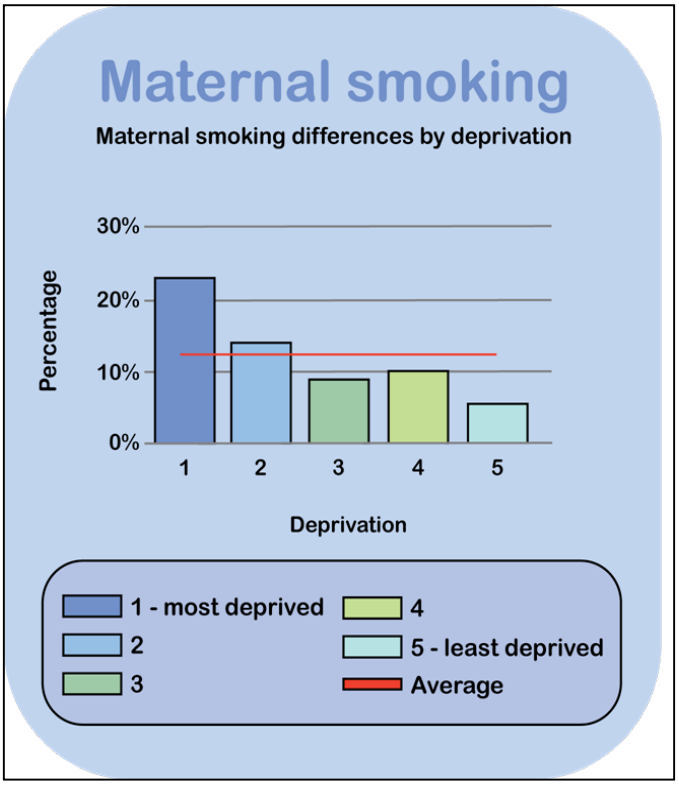
The ratio of total jobs to the working age population in Borders is lower than that of Scotland (0.79 vs 0.81) – meaning that individuals may have to travel for work or have fewer opportunities locally than other areas of the country.

# ANALYSIS OF HEALTH INEQUALITIES IN THE SCOTTISH BORDERS

To support our understanding of health inequalities in the Scottish Borders we have undertaken a thorough review of the available data. The purpose of doing so is to highlight the scale of the challenge across the life course and to begin to identify where we can take action.

## Early years and childhood

Within the Scottish Borders, just less than 20% of the population is under 18 years old. Health inequalities begin early in childhood and by the time a child is in school, there are measurable differences in various indicators of good health. The early years are a critical window to influence and promote lifelong health yet we know from data collected in maternity services that there has been an increase in expectant parents experiencing material deprivation as well as mental health concerns.

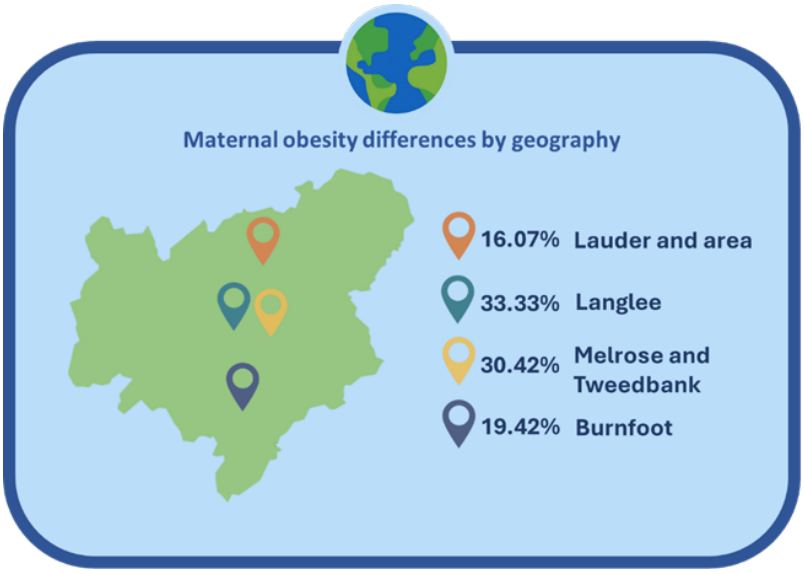



Data collected by NHS Borders shows the sizeable differences in maternal smoking rate by deprivation quintile. Smoking amongst pregnant mothers has decreased in general but the trend shows that expectant mothers in **the most deprived areas are more than 4 times as likely to be smoking**. Smoking in pregnancy can have many lifelong health consequences for a developing baby and supporting mothers to stop smoking is a cost-effective solution to preventing many ill-effects.

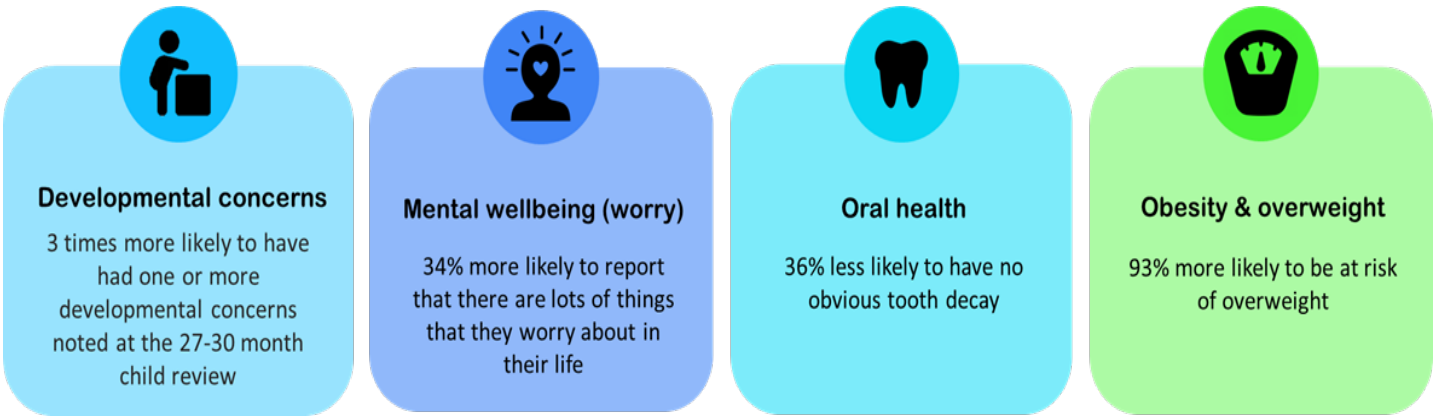
Engagement with community midwives in NHS Borders has highlighted the growing trend of vaping in pregnancy. Similar concerns have been expressed by colleagues working with children and young people. The use of vapes in schools in the Scottish Borders presents a growing problem that many children, parents, teachers and school nurses have expressed concerns about. It is important that we do not promote the conditions for young people who have never smoked to start vaping.

**Rates of maternal obesity are increasing** and there are differences in the rates observed across different areas of the Borders. Local data reveals that Langlee as well as Melrose and Tweedbank have almost twice the rate of maternal obesity compared to Lauder. There are many complex causes of obesity, for both children and adults, including access to nutritious food, time available to

to prepare food, a lack of access to health promoting environments and access to physical activity. NHS Borders and Scottish Borders Council are working together on the development of a Good Food Nation Plan and a key theme of that will be considering how we address the underlying causes of inequalities that we see in overweight and obesity as well as under-nutrition.



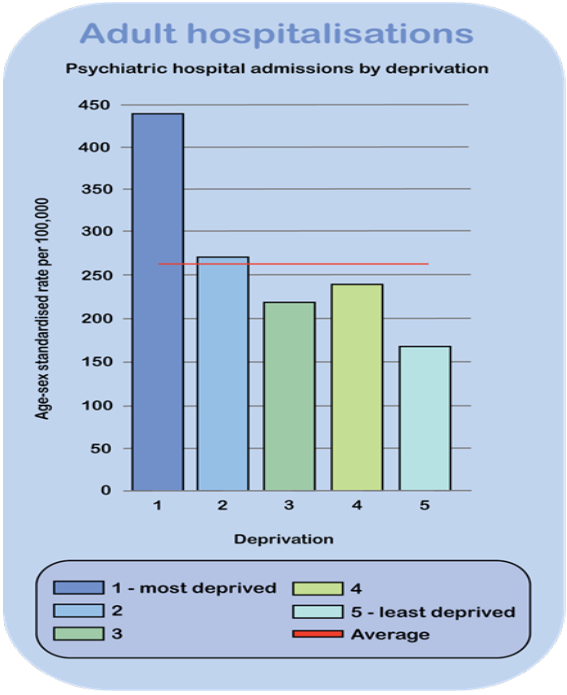

Throughout childhood, across almost all health indicators, we continue to see differences between the most and least deprived. In the Scottish Borders specifically, we observe that, compared to the least deprived group, children living in the most deprived areas are:




Supporting children to have the best start in life can have a significant impact on their long term health and wellbeing, which in turn impacts a child's ability to attend and enjoy school. The links are well established between, for example, oral health and a child's mental health and wellbeing, as well as their diet and general health.

The early years represent a critical window to address health inequalities throughout the life course. We can do a lot to alter the life chances of children, and we rightly focus on the first 5 years of life when the brain is most plastic. Puberty is another time of great neuroplasticity, and we need to focus more on how we can support young adults to develop better life chances. Supporting the health of the whole family is critical to addressing inequalities in physical and mental health that begin in childhood and continue to impact throughout life.

# Working age adults




By adulthood, the inequalities we see in childhood are enduring and there are significant differences in use of health and care services as a result. **People in the most deprived groups of the Scottish Borders are 60% more likely to be prescribed drugs for anxiety, depression or psychosis** and are significantly more likely to be have a psychiatric admission to hospital.

Additionally, comparing the most deprived group in the Borders to the least deprived reveals **higher rates of admissions as a result of asthma (2 to 3 times higher), alcohol related incidents (2 to 3 times higher) and drug use (4 times higher) amongst the adult population**.

In addition to emergency hospital admissions, access to services continues to represent a significant inequality in this group. In general, data collected about scheduled appointments in the Borders General Hospital indicate that the group most affected by health inequalities is **1.5 times more likely to miss a hospital appointment** (DNA rate). Additionally, the same group is **23% less likely to have visited a dentist** within the last 2 years if they are registered with an NHS dentist.

Inequalities in screening – an important opportunity to detect cancers or serious illness early – are evident both across Scotland and in the Borders. Across all of our local screening programmes. uptake is higher amongst the least deprived groups and lowest amongst the most. We know there is also less uptake amongst people with learning disabilities. This leads to notable differences in early detection rates and survival outcomes, despite more cancers being diagnosed in general in the most deprived areas. In the Scottish Borders, compared to the least deprived, people living in the most deprived groups experience:

**Cancer diagnosis**

20% higher likelihood of having a cancer diagnosis

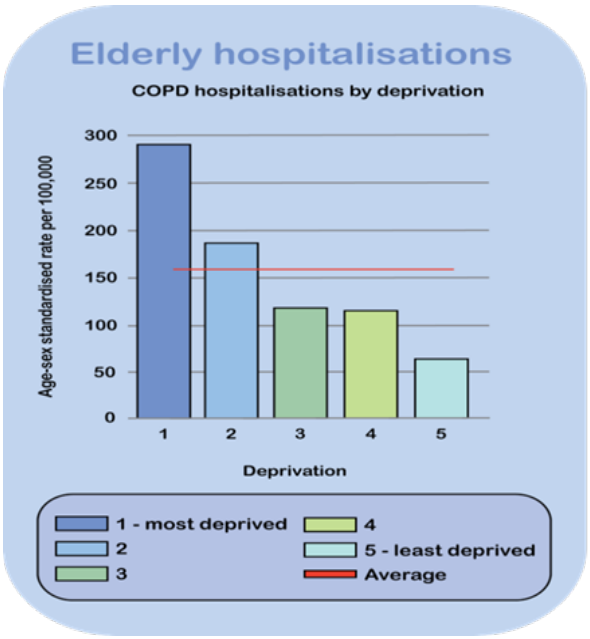
**Bowel screening**

23% less likely to take part in bowel screening

# Older Adults

Demographically, the Scottish Borders has an older population than many other areas of Scotland. It is a great asset to our local communities that so many older people volunteer, run and support community groups and the wider social and economic benefits of this should be celebrated. However, we know that the health status of older adults in the Scottish Borders is also unequal with significant differences between socio-economic groups.

Within the Scottish Borders there is a very clear trend between deprivation and chronic obstructive pulmonary disease (COPD) hospitalisations, with those in the most deprived areas of Borders having 79% higher rates of hospital stays for this condition than the overall average for the area. **People who live in these deprived areas are over 300% more likely to have a COPD hospital admission** than people living with the disease in the least deprived areas of Borders.




These differences are avoidable, and if the levels of COPD hospitalisation seen in the least deprived parts of Borders could be replicated across the whole population, the rates of hospitalisation from this disease would be 59% lower. This would have huge positive consequences for the ability of those living in Borders to age well and would reduce the cost of lengthy admissions to the health service.

Within the Scottish Borders, there is also a link between emergency hospitalisation in those who are over 65 years old and deprivation, **with the most deprived areas having 11% higher rates of emergency hospitalisation within this age group compared to the average for Borders.** Those who are over 65 years old and live in the most deprived areas locally are a fifth more likely to have a hospital admission than their peers who live in the least deprived parts of the county. If the playing field could be levelled, and the rates in the areas of least deprivation experienced across the Borders, there would be 10% fewer rates of emergency admission in our older adults.

Older people living in the most deprived areas of the Scottish Borders are:

**>65 yrs emergency admissions**

21.5% more likely to have an emergency hospital admission if they are over 65 years old

**Fall admissions**

55% more likely to be admitted with a fall

**Preventable emergency admissions**

51.5% more likely to have a preventable emergency hospitalisation for a chronic condition

Older adults who are admitted to hospital, particularly in an emergency, are more likely to experience functional decline, cognitive decline and delirium. Preventing the need for stays in hospital has benefits for the individual and the health and care system. Hospital care, especially emergency hospital care, is one of the most expensive components of NHS delivery. Within Scotland, 70% of emergency hospital admissions are for individuals over 65 years of age [7], and those over 85 years old account for a quarter of all bed days within the NHS [8]. Efforts to prevent hospitalisations, represent an opportunity for financial savings in the health service as well as improved outcomes for patients.

# TACKLING HEALTH INEQUALITIES IN ACTION

The Director of Public Health Annual Report for NHS Borders in 2023 focused on the important role of prevention and showcased some important examples of how we can seek to do this more effectively, building upon existing good practice [9]. There are several areas where we know that we can have meaningful impact in tackling health inequalities by seeking to avoid and prevent the causes of ill health at source.

**Social prescribing:** Many people turn to the health and care service when their social needs are not being met. As many as 20% of GP consultations are thought to be almost entirely social in their nature. This represents approximately 200,000 consultations in general practice per year in the Borders. Social prescribing seeks to address non-medical needs associated with health by providing links for people to access community-based activities that promote their wellbeing. The offer around social prescribing, however, has to be comprehensive and address the specific needs of the population in the Scottish Borders. It is important that referral routes into social prescribing are clear and that we better align existing organisations and groups attempting to address these needs at present. There is much learning that can be done from examples across Scotland to get this right for our local communities and we should rightly be ambitious for what we can achieve locally.

**Our role as anchor Institutions:** Anchor institutions are large, public-sector organisations that are so-called because they are ‘anchored’ in their surrounding community. They have a big stake in their geographical area and have substantial assets that can support local community wealth building through procurement and spending power, workforce and training, and buildings and land. NHS Borders – alongside SBC and other large partners - has the potential to generate health beyond healthcare by shifting the way we employ staff, procure goods, use assets and resources and work with others. Together, we need to baseline the work we do as anchor institutions and build upon the opportunities we have to tackle wider health inequalities in a coherent and joined-up way.

**Waiting well:** increasing numbers of people are waiting for hospital appointments and procedures, including surgeries, and this can impact upon people’s quality of life and ability to maintain working and other responsibilities. We recognise the importance of supporting people to ‘wait well’ to maximise the benefits from the procedure they are waiting for, ease some of their symptoms, prevent further symptoms from developing, and to promote recovery. We need to ensure that people are able to access the wider support they need whilst waiting to prevent de-conditioning and worsening of symptoms.

**Waste and ineffective healthcare:** It is important that a modern NHS takes steps to ensure that the services provided actually deliver on the outcomes expected and make a real difference to the lives of patients that we serve. Focusing on the value of procedures being offered to patients is important in tackling health inequalities, ensuring we can direct care to the people who most need it and use scarce resources more wisely to address inequalities gaps. Waiting lists tend to disadvantage the most deprived, and is a hidden problem. We know that not all healthcare is appropriate in all cases, and so we need a meaningful discussion on realistic outcomes between patients and their clinician. The use of scarce GP time for primarily social reasons should also be addressed. Reducing waste in the health service has wider sustainability benefits & at a time of financial challenge is an ethical responsibility also.

**Community development and place-making:** building strong links with communities, third sector and advocacy groups is vital. These groups understand local need and experience so they can use community assets to make the most of health-benefitting opportunities. We must build on the existing good practice from initiatives in the Scottish Borders where this has been done well and we have seen community-wide changes being sustained and leading to improved outcomes. We must also be sure to link community development approaches with the place-making agenda being led by SBC. Well-designed environments that create the conditions for people to live healthier lives require insights from communities at every level of planning, design and development.

### Good practice example: Whole systems approach in Eyemouth

A Whole Systems Approach is defined as applying systems thinking and processes that enable "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".

The Scottish Borders was one of eight early adopter areas in Scotland, with Eyemouth adopting 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.
This work is informed by the ambition for children to have the best start in life and to improve children's health and wellbeing by having opportunities to eat well and be active. Every child should have the same opportunities to thrive, no matter where they live.

Since the first of three virtual workshops in March 2021 a group of local stakeholders have developed local priority themes and taken forward eight areas for action to address some of the causes of overweight and obesity that are being sustained beyond the initial timescales of the work.

# ENGAGEMENT

Engagement for the strategy has taken place within several forums. Two workshops have been held to discuss the data content of the strategy, and to gather views from attendees about the impact that health inequalities has in their day-to-day lives and work, as well as how these might be best tackled. The workshops were attended by NHS and SBC staff, third sector organisations, and Community Planning Partnership representatives.

We asked attendees at our workshops for their views on health inequalities, including how they impacted their work, what needed to be done to address them and how we could improve partnership working on this agenda.


There was consensus around some important themes and areas for further work, as below:

**1. Need to provide the most appropriate care at the right time for those who truly need it:**

- Challenges identifying those living in deprivation
- Those who need care the most aren't always the ones who receive it
- Attitudes towards health and care can differ amongst population groups

**2. It can be hard to get the correct information about local services:**

- Many professionals and clients are not aware of the services available and what could help

### 3. Barriers to services make it more difficult for certain population groups to access to health information or care:

- Location of services and transport options are important given rurality of Borders
- Support is needed for patients who do not attend appointments

### 4. There is a need for collaboration and partnership working:

- Communication is essential between services and organisations
- Siloed funding leads to duplication

### 5. Changes in services and access leading to worse health outcomes:

- Lack of community services  capacity
- Long waiting times
- More specialist service and support is often needed but not available

### 6. Wider determinants are affecting health

- Financial concerns and cost of living crisis
- Employment contracts and conditions
- Educational opportunities
- Transport
- Poor quality housing
- Climate change and work towards net zero
- Food environment


There is much more that we need to do to engage with communities, third sector organisations and people living and working across the Borders. There is an important role for community development work to be ongoing as we consider next steps. We are also in the process of completing an Equalities Impact Assessment to support our work and the voices of a wide range of people and groups should rightly be heard to inform that.

Through the Community Planning Partnership we will develop an approach that involves all sectors and areas of the Borders in these conversations.

# PARTNERSHIP WORKING

The Scottish Borders Community Planning Partnership (CPP) is required to prepare and publish a Community Plan. The Community Plan focuses on improving outcomes and there are specific outcomes relating to reducing inequalities for the whole of the Scottish Borders under theme 3 on promoting good health and wellbeing. The CPP aims to take a Borders wide approach with community planning partners collectively working together with local communities and businesses.

The CPP is the obvious starting point for developing a delivery group to take forward an action plan for delivering health inequalities. The wide representation of that group would enable us to take a cross-sector approach in our response to the issues identified.

Going forward, we also want to make sure that we involve the voices and views of community organisations and individuals through further engagement and consultation events in localities.

# RECOMENDATIONS

There are three themes that we have identified for further work, which will enable us to evaluate progress, develop new approaches to tackling inequalities and maintain momentum in our prevention activities.

## Improving access to data and monitoring of progress against health inequalities indicators

- Develop a health inequalities dataset to ensure that everyone has a clear understanding of the issues and outcomes relating to health inequalities across community, primary and acute care and Identify metrics that will provide real-time insight into the progress being made and the changes in population-level outcomes.
- Improve access to data on preventative spend across statutory partners so that we can make more aligned and co-ordinated decisions to invest in upstream interventions.
- Consider how we improve our understanding of the health and wellbeing of our rural population by developing an improved measure of SIMD that better reflects the Scottish Borders.
- Promote the routine use of Adverse Childhood Events (ACEs) in many services and settings to better understand some of the challenges faced across different areas of the Borders. Childhood is key as it impacts on a whole lifetime so working closely with education colleagues to explore how we can support and develop this work.

## Developing a sustainable partnership approach to developing interventions

- Build on existing good practice of community-led approaches to tackling health inequalities, such as the Whole Systems Approach in Eyemouth.
- Promote a health in all policies approach through the joint Health and Social Care Partnership with colleagues in SBC.
- Develop the role of CPP member organisations as anchor institutions, recognising the impact that large employers and providers of services can have on the health and wellbeing of their staff and wider communities through procurement, employment and wider policies.
- Share good practice guidelines with partner organisations to ensure that health and wellbeing is promoted throughout all community work, including in relation to food and nutrition.

## A ruthless focus on prevention activities across the NHS and our partners

- Developing a joined up system of social prescribing that brings together existing services such as the Wellbeing Service, Local Area Coordinators, What Matters Hubs, Housing RSLs, and localities to respond to the social challenges that many people experience.
- Share and develop best practice amongst primary care colleagues to tackle the growing demand for conditions such as type 2 diabetes and to better support people to manage these conditions.
- Review the use of procedures of limited clinical value so that resources can be spent most wisely and fairly.
- Take a health inequalities approach to driving up screening rates across the Borders to promote early intervention amongst groups who have typically been less likely to engage.
- Consider how we address long-standing issues of access deprivation across the Borders through digital solutions and in working with transport colleagues to better connect people to our services.
- Promote schools to be healthier places for young people to learn and grow, including supporting calls for vape-free schools and to encourage similar decisions to be taken by other partners.
- Measure and tackle health inequalities in employment provision, working with the public and private sectors.
- Identify the disadvantaged within housing provision and work with partners to tackle underlying issues.
- Work with the Criminal Justice System to reduce the harm from deprivation and break the cycle of the harms from drug & alcohol use/abuse.
- Consider how the disadvantaged could have the harms from isolation, including transport poverty, mitigated.

# REFERENCES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3 https://www.gov.scot/publications/adverse-childhood-experiences-aces/

4 Scotland's public health challenges - Public health approach to prevention - Our areas of work - Public Health Scotland

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6 https://elevateni.org/app/uploads/2022/03/Dalgren-Whitehead-model-of-health-determinants-30-years-on-and-still-chasing-rainbows.pdf

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8 https://www.ndph.ox.ac.uk/longer-reads/hospital-or-2018hospital-at-home2019-2013-what2019s-best-for-older-people

# USEFUL RESOURCES


1 *Wider determinants:* https://www.instituteofhealthequity.org/resources-reports/fair-society-healthy-lives-the-marmot-review/fair-society-healthy-lives-full-report-pdf.pdf

2 *Rural health:* https://www.uclan.ac.uk/assets/pdf/rural-medicine-and-health-report.pdf

3 *Income importance:* https://www.healthscotland.scot/media/1365/inequalities-briefing-8_income-wealth-and-poverty_apr17_english.pdf

4 *Child poverty:* https://www.scotborders.gov.uk/downloads/file/12271/report-and-action-plan-2023-24

5 *Child poverty:* Scottish Borders Child Poverty Index 2022 ???link

6 *Child poverty:* https://www.healthscotland.scot/media/2607/child-poverty-scales-and-trends.pdf

7 *Employment:* https://www.nomisweb.co.uk/reports/lmp/la/1946157430/report.aspx#tabearn

8 *Access:* https://www.uclan.ac.uk/assets/pdf/rural-medicine-and-health-report.pdf

9 *Access:* https://www.scotborders.gov.uk/downloads/download/211/strategic_assessment

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11 *Food:* https://www.gov.scot/publications/health-and-wellbeing-census-scotland-2021-22/

12 *Hospitalisations in older adults:* https://bmjopen.bmj.com/content/10/11/e040431#ref-19

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15 *Hospitalisations in older adults:* https://reader.health.org.uk/emergency-admissions-to-hospital-from-care-homes/background

16 *Hospitilsations in older adults:* https://pubmed.ncbi.nlm.nih.gov/25315230/


## Need to contact us


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# T.H.I.S BORDERS

Tackling Health Inequalities in the Scottish Borders

Scottish Borders Health and Social Care PARTNERSHIP

NHS Borders

**NHS Borders Board Meeting – 4th April 2024**

Kirsty Kiln
Public Health Consultant

# Tackling Health Inequalities

- **Health inequalities are unfair:** Disparities in health status outcomes and life expectancy between different groups are unfair and rooted in complex social causes. These causes are very often outside of individual control.

- **Health inequalities affect all of us:** Reducing health inequalities not only reduces human suffering but also benefits the health and care system, the education system, and the wider economy in access to skills and productivity.

- **We are dealing with new challenges:** Since the COVID-19 pandemic and as a result of the cost of living crisis, we have seen widening of health inequalities and increased demand for health and care services.

- **Prevention and early intervention are most cost-effective:** Dealing with health inequalities upstream are cheaper and more effective than dealing with the consequences later on.


## What are Health Inequalities?

Systematic differences in people's health that are **avoidable** and **unjust**

**Can be seen as differences in:**

- Opportunities to lead a healthy, fulfilling life.
- Access to appropriate care.
- Experiences of care within the health system.
- Health status, outcomes and ultimately mortality.

NHS Borders

# Differences in life expectancy

Across Scotland, there are significant differences in life expectancy between the most and least deprived:

- Males in the least deprived areas of Scotland have 23 years more life in good health compared to males in the most deprived areas;
- Females in the least deprived areas of Scotland have 24 years more life in good health compared to females in the most deprived areas.

**21.6% of all deaths in the Scottish Borders are deemed avoidable**, and this has far reaching consequences for families and the wider community.

| | Years of life lost (YLL) by locality in 2023 | | |
|---|---|---|---|
| Locality | Male | Female | Total |
| Berwickshire | 769 | 857 | 1626 |
| Cheviot | 836 | 782 | 1618 |
| Eildon | 1419 | 1138 | 2557 |
| Teviot and Liddesdale | 943 | 575 | 1518 |
| Tweeddale | 703 | 659 | 1362 |
| Total | 4670 | 4011 | 8681 |

**There was a total of 8681 years of lost life in the Scottish Borders in 2023**

| YLL in Scottish Borders (2019 - 2023) | | | | |
|---|---|---|---|---|
| 2023 | 2022 | 2021 | 2020 | 2019 |
| 8681 | 8536 | 8125 | 8776 | 7784 |

# Accessing better quality data

| Years of life lost (YLL) by ward | | | |
|---|---|---|---|
| Locality | Male | Female | Total |
| East Berwickshire | 344 | 474 | 818 |
| Galashiels and District | 716 | 441 | 1157 |
| Hawick and Denholm | 442 | 352 | 794 |
| Hawick and Hermitage | 501 | 223 | 724 |
| Jedburgh and district | 401 | 402 | 803 |
| Kelso and district | 435 | 380 | 815 |
| Leaderdale and Melrose | 393 | 311 | 704 |
| Mid-Berwickshire | 425 | 383 | 808 |
| Selkirkshire | 310 | 386 | 696 |
| Tweeddale East | 414 | 244 | 658 |
| Tweeddale West | 289 | 415 | 704 |
| Total | 4670 | 4011 | 8681 |

| Years of life lost (YLL) by GP Practice | | |
|---|---|---|
| GP Practices, Scottish Borders | Male | Female |
| Braeside Medical Practice | ? | ? |
| Coldstream Medical Practice | ? | ? |
| Duns Medical Group | ? | ? |
| Earlston Medical Practice | ? | ? |
| Eildon Surgery, Melrose | ? | ? |
| Eildon Surgery, Newton St Boswells | ? | ? |
| Eyemouth Medical Practice | ? | ? |
| Glenfield Medical Practice | ? | ? |
| Greenlaw Surgery | ? | ? |
| Jedburgh Medical Practice | ? | ? |
| Kelso Medical Group | ? | ? |
| Merse Medical Practice, Chirnside | ? | ? |
| Merse Medical Practice, Duns | ? | ? |
| Newcastleton Medical Practice | ? | ? |
| Roxburgh Street Surgery | ? | ? |
| Selkirk Medical Practice | ? | ? |
| St Ronan's Health Centre | ? | ? |
| Stow and Lauder Health | ? | ? |
| Teviot Medical Practice | ? | ? |
| The Ellwyn Practice | ? | ? |
| The Neidpath Practice | ? | ? |
| The O'Connell Street Medical Practice | ? | ? |
| The Tweed Practice | ? | ? |
| Waverley Medical Practice | ? | ? |
| West Linton Medical Practice | ? | ? |

# Wider determinants of health

The environment and conditions in which people are **born, live, work, grow** and **age** are called the wider determinants of health. They are drivers for how healthy people are, and continue to be throughout their life course.

People in more socially deprived circumstances are more likely to experience a number of related disadvantages.

### Transport

Transport accounts for 17% of total household expenditure in Borders compared to 14% across Scotland

More monthly income is spent on transport in the Scottish Borders compared to Scotland as a whole, and a quarter of geographical areas (26%) are in the 10% most geographically accessed deprived areas in Scotland. It is important to consider digital access as well – limited access to online services can widen inequalities for those with poor connections or low digital literacy.

### Food

8.2% of children in P7 – S6 stated that they always or often went to bed hungry

Access to nutritious, balanced, and affordable food has a significant impact on levels of overweight and obesity as well as other health outcomes. Almost 10% of school children in the Borders reported having a soft drink containing sugar at least daily. Only 40% reported eating fruit or vegetables at least once a day.

### Climate change

It is estimated that 11,000 homes and businesses will be at risk of flooding by 2080 in Borders

Climate change is considered one of the most significant health threats of our current time. It has been observed that the most deprived areas of society contribute the least to climate change but are most likely to experience the impacts of it. Limited access to warm fuel efficient housing can further exacerbate other social factors that influence health and wellbeing.

### Income

21.7% of people earn less than the living wage in Borders, compared to 14.4% across Scotland

The average income in the Scottish Borders is lower than across Scotland. In 2021, average residence-based weekly wage in our area was 89% of the Scottish average and, in 2022, the gross weekly workplace-based wage in the Borders was £69 less per week than the average for Scotland.

### Child poverty

in 2021, 40% of geographical areas in Scottish Borders had higher or higher levels of child poverty

Poverty impacts health and wellbeing through poor quality housing, and competing financial pressures for heating, transport, and food. Children living in low-income households in the Scottish Borders has increased from 14.6% in 2021 to 19.7% in 2022.

### Employment

In 2021, 19% of households with children under 16 years were considered workless in the Borders compared to 12% across Scotland

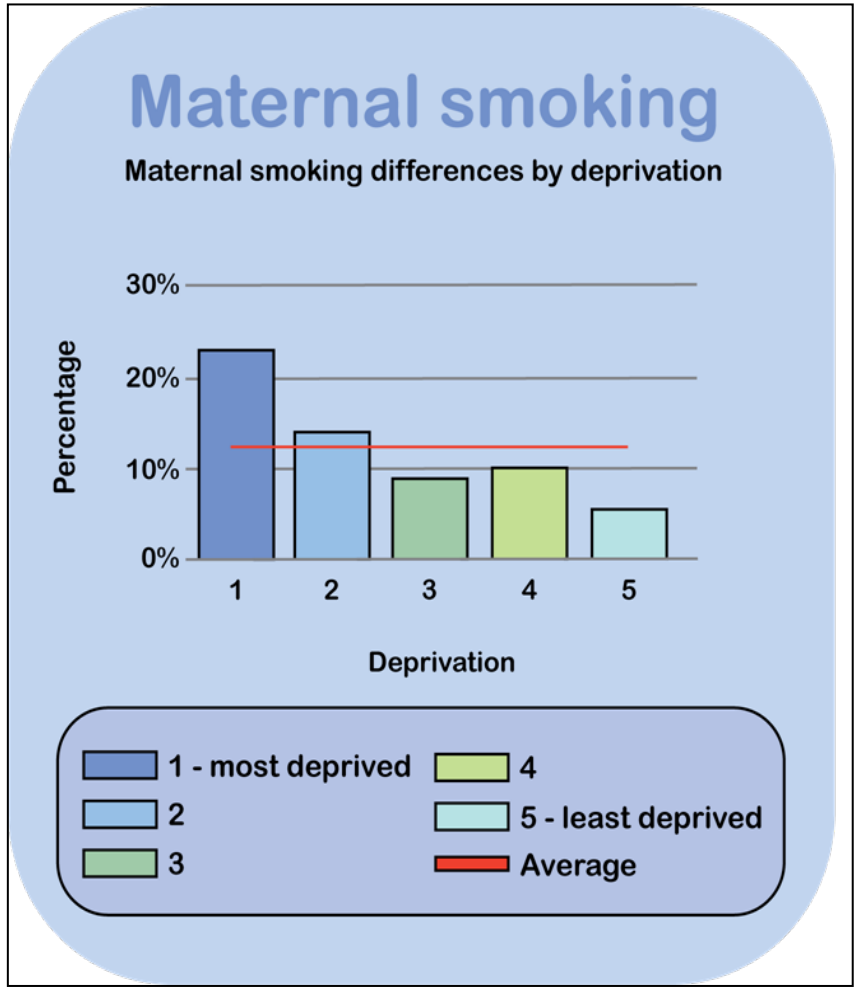
The ratio of total jobs to the working age population in Borders is lower than that of Scotland (0.79 vs 0.81) – meaning that individuals may have to travel for work or have fewer opportunities locally than other areas of the country.

# Inequalities in childhood

• Health inequalities are stark in the early years and by the time a child starts school there are significant differences in health outcomes.

• Supporting children to have the best start in life can have a significant impact on their long term health and wellbeing, which in turn impacts a child's ability to attend and enjoy school.

• The early years represent a critical window to address health inequalities throughout the life course.




**Developmental concerns**

3 times more likely to have had one or more developmental concerns noted at the 27-30 month child review

**Mental wellbeing (worry)**

34% more likely to report that there are lots of things that they worry about in their life

**Oral health**

36% less likely to have no obvious tooth decay

**Obesity & overweight**

93% more likely to be at risk of overweight

NHS Borders

# Inequalities amongst working-age adults

• We see differences in the use of services and admissions by deprivation quintile;

• In mental health, it is observed that quintile 1 has close to 3 times the number of psychiatric admissions than quintile 5. There is a similar pattern with regards to prescribing of drugs for mental health conditions.

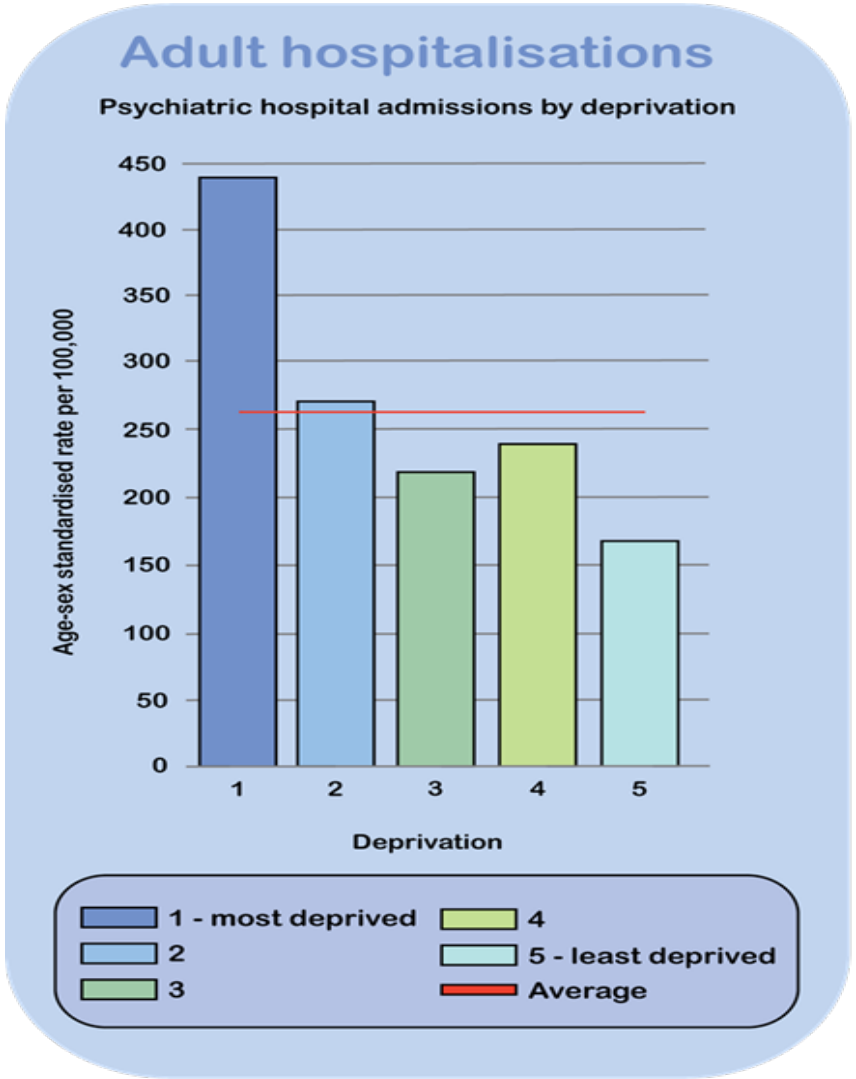
• We also see that people in the most deprived groups in the Scottish Borders are less likely to participate in cancer screening but are also more likely to be diagnosed with cancer.

**Cancer diagnosis**

20% higher likelihood of having a cancer diagnosis

**Bowel screening**

23% less likely to take part in bowel screening

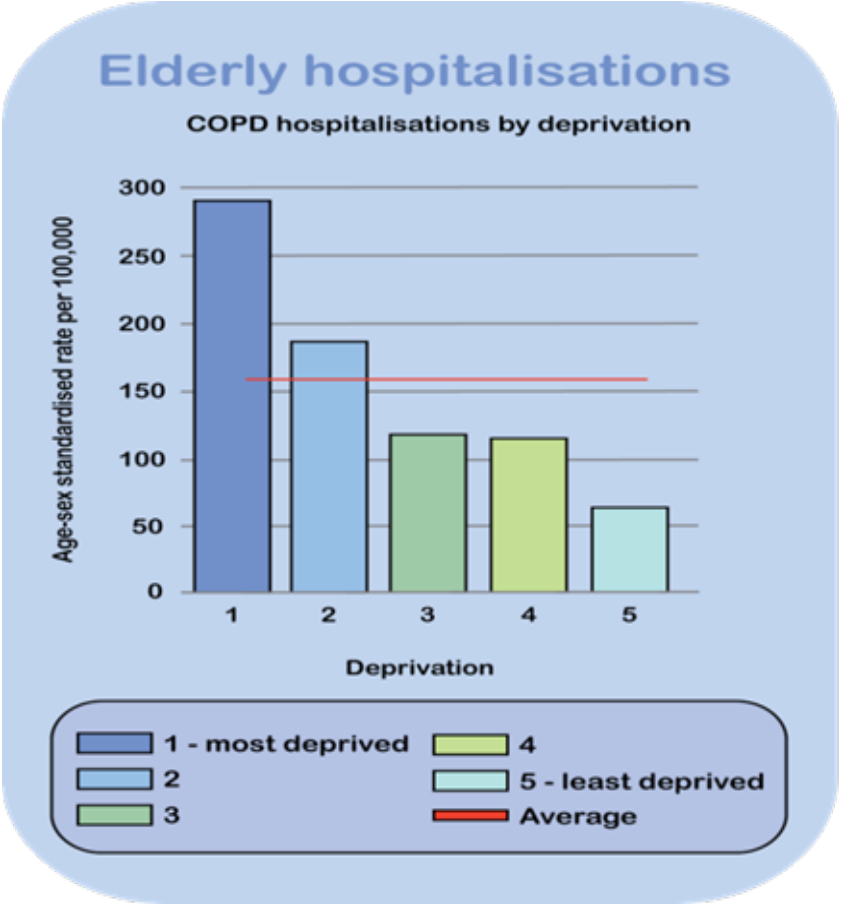


# Inequalities amongst older adults

• Preventing the need for stays in hospital has benefits for the individual and the health and care system. Hospital care, especially emergency hospital care, is one of the most expensive components of NHS delivery.

• We see significant and consistent differences in the rates of admissions for older people across more deprived quintiles.

• We also see wider implications across society – many older people in the Borders contribute time and energy to volunteering, running community groups and events and caring for grandchildren/ neighbours and good health facilitates this.




**>65 yrs emergency admissions**

21.5% more likely to have an emergency hospital admission if they are over 65 years old

**Fall admissions**

55% more likely to be admitted with a fall

**Preventable emergency admissions**

51.5% more likely to have a preventable emergency hospitalisation for a chronic condition

NHS Borders

# Engagement

Two workshops have been held to discuss the data content of the strategy, and to gather views from attendees about the impact that health inequalities has in their day-to-day lives and work, as well as how these might be best tackled.

The workshops were attended by NHS and SBC staff, third sector organisations, and Community Planning Partnership representatives.

There is much more that we need to do to engage with communities, third sector organisations and people living and working across the Borders.

We are also in the process of completing an Equalities Impact Assessment to support our work and the voices of a wide range of people and groups should rightly be heard to inform that.

Through the Community Planning Partnership we will develop an approach that involves all sectors and areas of the Borders in these conversations.

# Recommendations

## Improving access to data and monitoring of progress against health inequalities indicators

- Develop a health inequalities dataset to ensure that everyone has a clear understanding of the issues and outcomes relating to health inequalities across community, primary and acute care and Identify metrics that will provide real-time insight into the progress being made and the changes in population-level outcomes.
- Improve access to data on preventative spend across statutory partners so that we can make more aligned and co-ordinated decisions to invest in upstream interventions.
- Consider how we improve our understanding of the health and wellbeing of our rural population by developing an improved measure of SIMD that better reflects the Scottish Borders.
- Promote the routine use of Adverse Childhood Events (ACEs) in many services and settings to better understand some of the challenges faced across different areas of the Borders. Childhood is key as it impacts on a whole lifetime so working closely with education colleagues to explore how we can support and develop this work.

## Developing a sustainable partnership approach to developing interventions

- Promote a health in all policies approach through the joint Health and Social Care Partnership with colleagues in SBC.
- Build on existing good practice of community-led approaches to tackling health inequalities, such as the Whole Systems Approach in Eyemouth.
- Develop the role of CPP member organisations as anchor institutions, recognising the impact that large employers and providers of services can have on the health and wellbeing of their staff and wider communities through procurement, employment and wider policies.
- Share good practice guidelines with partner organisations to ensure that health and wellbeing is promoted throughout all community work, including in relation to food and nutrition.

# A ruthless focus on prevention activities across the NHS and our partners

- Developing a joined up system of social prescribing that brings together existing services such as the Wellbeing Service, Local Area Coordinators, What Matters Hubs, Housing RSLs, and localities to respond to the social challenges that many people experience.
- Share and develop best practice amongst primary care colleagues to tackle the growing demand for conditions such as type 2 diabetes and to better support people to manage these conditions.
- Review the use of procedures of limited clinical value so that resources can be spent most wisely and fairly.
- Take a health inequalities approach to driving up screening rates across the Borders to promote early intervention amongst groups who have typically been less likely to engage.
- Consider how we address long-standing issues of access deprivation across the Borders through digital solutions and in working with transport colleagues to better connect people to our services.
- Promote schools to be healthier places for young people to learn and grow, including supporting calls for vape-free schools and to encourage similar decisions to be taken by other partners.
- Measure and tackle health inequalities in employment provision, working with the public and private sectors.
- Identify the disadvantaged within housing provision and work with partners to tackle underlying issues.
- Work with the Criminal Justice System to reduce the harm from deprivation and break the cycle of the harms from drug & alcohol use/abuse.
- Consider how the disadvantaged could have the harms from isolation, including transport poverty, mitigated.

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 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 7 March 2024

## 2.4 Recommendation

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

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Resources & Performance Committee minutes 18.01.24

**Borders NHS Board**

Minutes of a meeting of the **Resources and Performance Committee** held on Thursday 18 January 2024 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
Ms S Lam, Non Executive
Dr K Buchan, Non Executive
Cllr D Parker, Non Executive
Mr J McLaren, Non Executive
Mr R Roberts, Chief Executive
Mr A Bone, Director of Finance
Dr L McCallum, Medical Director
Mrs S Horan, Director of Nursing, Midwifery & AHPs
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 K Kiln, Consultant in Public Health
Mrs L Huckerby, Interim Director of Acute Services
Mrs S Errington, Interim Director of Planning & Performance
Mrs S Swan, Deputy Director of Finance

## 1. Apologies and Announcements

1.1 Apologies had been received from Mrs H Campbell, Non Executive, Mr T Taylor, Non Executive, Mrs J Smyth, Director of Planning & Performance and Mr G Clinkscale, Director of Acute Services and Dr S Bhatti, Director of Public Health.

1.2 The Chair recorded the best wishes of the Committee to Mr Clinkscale and Mrs Smyth during their sickness absence.

1.3 The Chair welcomed Mrs Steph Errington, Interim Director of Planning & Performance in the absence of Mrs June Smyth.

1.4 The Chair welcome Mrs Kirsty Kiln, Consultant in Public Health who deputised for Dr Sohail Bhatti.

1.5 The Chair noted that Mr Chris Myers, Chief Officer Health & Social Care would depart the meeting at 10am for a Mental Welfare Commission meeting.

1.6 The Chair announced that it was the last meeting of the Committee for Ms Sonya Lam, who would conclude her appointment as a Non Executive of the Board on 31 January 2024. She recorded the thanks of the Committee to Mrs Lam and reminded the Committee of the work that she had put into delivering a blazing trail for whistleblowing in the Board.

1.7 The Chair announced that a replacement for Mrs Lam had been confirmed as Mrs Lynne Livesey, who would take up post on 1 February 2024.

1.8 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 2 November 2023 were approved.

**4. Matters Arising**

4.1 **Action 2023-2:** Mrs Fiona Sandford suggested the item be marked as complete and that the two Committees would maintain a dialogue with each other moving forward.

4.2 **Action 2023-3:** Mr Andrew Bone provided an update on LIMs. He advised that there was a Clinisys deadline of the end of May and NHS Borders was unable to meet that deadline and could be subject to contract penalties. Work was progressing to a timeline of implementation of the end of August as well as looking at other mitigations to put in place locally. Mr James Ayling commented that given staff absence and shortage appeared to be the main issue it may be more cost effective to run a short fixed term contract for additional project support specifically for the LIMs project. Mr Bone advised that he would look into that suggestion as well as other relevant costs to ensure the most cost efficient option was progressed.

The **RESOURCES AND PERFORMANCE COMMITTEE** agreed to mark Action 2023-2 as complete.

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

**5. Performance Scorecard**

5.1 Mrs Fiona Sandford commented that the Non Executives had asked fairly frequently for a list of options of what the financial targets meant in terms of what would need to be stopped to achieve them. She asked again that it be supplied in a timely manner.

5.2 Mr Andrew Bone advised that a session would be held in February on the Financial Plan with the intention of providing options for discussion.

5.3 Mrs Lucy O'Leary asked that the performance report include in the narrative a look forward section, so that the Committee could be clear on what to expect in the next report.

5.4 Mrs Steph Errington commented that whilst some of the narrative did include a projection of the next few months it was not consistent across the report. She advised that she would progress it for inclusion in the next report. She then highlighted areas of not achieving their trajectories which included: outpatients; treatment time guarantee; emergency care; and mental health waiting times. In regard to cancer and drug and alcohol performance they were all exceeding their trajectories.

5.5 Mr Chris Myers provided an update on the delayed discharge trajectory and associated surge plan. The current position was 66 delayed discharges against a trajectory of 52. He highlighted that there had been 58 more referrals to care than planned which was a significant increase in demand of 15 per week against the predicted demand of 12 a week. He further advised that mitigations had been put in place to improve the position including the availability of 10 rooms in 2 providers and a further provider had resumed the acceptance of transfers from that day. He further highlighted: impacts on home first integration; Care Inspectorate registration requirements; expediting the roll out of social care home care environment commenced in Upper Deanfield and Garden View, across Central and Teviot area with the intention of reducing demand for long term home care; impact of hospital at home and the respiratory ward on hospital occupancy; further consideration to expediting keeping people well at home and avoiding admissions to hospital; and taking forward discussions with care home managers to understand and address why the Scottish Borders was an outlier with the number of admissions to hospital from care homes.

5.6 Discussion focused on: discharge protocol; admission of those with acute illness followed by an inability to discharge back to care homes due to multiple criteria; learning from the discharge kaizen; appointment of Dr Laura Ryan to lead the front door flow of the Borders General Hospital and also have a specific focus on care home admissions; and work to be done with care homes on patients being admitted incorrectly as they hold active anticipatory care plans.

5.7 Cllr David Parker commented that he had written to Mr Myers to pull together an NHS Borders/Scottish Borders Council meeting to understand the address the blockages delaying the integration of Home First so that delayed discharges could be more swiftly actioned.

5.8 Mr Ralph Roberts agreed that integrating the Home First team was critical to reablement and a reduction in delayed discharges as it was a whole system responsibility across social care and health.

5.9 The Chair enquired if the planned theatre usage of delivering 43 elected treatments within Theatres from January to March remained the same. Mrs Errington advised that she would check the data outwith the meeting as it may have moved on further since the report was created.

The **RESOURCES & PERFORMANCE COMMITTEE** noted performance as at the end of November 2023.

## 6. Delivery Planning Approach for 2024/25

6.1 Mrs Steph Errington provided a brief overview of the content of the report.

The **RESOURCES & PERFORMANCE COMMITTEE** approved delegated authority to the Chair and Chief Executive to formally approve the submission of the Delivery Plan 2024/25 on behalf of the NHS Borders Board.

## 7. Finance Report

7.1 Mr Andrew Bone provided an overview of the content of the report and highlighted several elements including: £17m overspend; current forecasting and what the trajectories were headed towards: expectations from the Scottish Government; Quarter 2 forecast position broadly improving; not concluded the Quarter 3 review; decision taken to restrict expenditure in the current financial year; new weekly grip and control panels to be held; pause on all recruitment to non clinical posts subject to escalation through risk assessment; restriction on overtime in non clinical areas; discretionary expenditure restrictions in place; and working through a review of all ring fenced funds subject to carry forward including the Integration Joint Board (IJB) reserves to ensure the right conditions are applied to those funds.

7.2 Mr James Ayling enquired how the £17.8m Scottish Government figure had been calculated. Mr Bone advised that it was tailored to NHS Borders and he understood how it was calculated.

7.3 Mr Ayling enquired if the enhanced controls should have been put in place earlier in the savings process. Mr Bone advised that there were actions he may have recommended at an earlier stage, however the measures put in place were not strategic and would not fix the fundamental structure issue that the Board was facing. He emphasised that short term controls were very opportunistic and would have a differential impact across services on an unplanned basis, and that this not a long term solution.

7.4 Mr Ralph Roberts commented that the difference in brokerage targets set by the Scottish Government was causing angst amongst the Board Chief Executives. Choices would have to be made on how to prioritise finance within the triangulation of finance, quality and access given the Board was at the extreme end of its financial overspend compared to other Health Boards in terms of percentage per head of population.

7.5 Mrs Sonya Lam commented that the enhanced controls on vacancies would be marginal but impact in terms of service delivery. She reminded the Board that it would be more difficult for staff to do their jobs with a lack of stationery and a lack of admin support which in some cases may involve clinicians undertaking admin in addition to clinical duties, leading to staff stress and potentially staff sickness absence. Mr Roberts accepted Mrs Lam's comments and provided the other perspective of putting in place immediate controls to allow time to put in place the longer term strategic actions.

The **RESOURCES & PERFORMANCE COMMITTEE** noted that the Board was reporting an overspend of £17m for eight months to end of November 2023.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the position against the Q2 forecast outturn of £22.5m at year end and the expected outturn set out by Scottish Government, and the risks against both.

The **RESOURCES & PERFORMANCE COMMITTEE** noted the position reported in relation to recurring savings delivered year to date (Section 5).

## 8. Financial Strategy

8.1 Mr Andrew Bone provided a presentation on the financial outlook for 2024-25 and highlighted several elements including: Scottish Government context; building a recovery plan; headline overall forecast of £48.5m deficit before management actions; headline opening gap of £30m plus additional commitments and additional resources recurring and non recurring; 4.3% budget uplift announced by Scottish Government was already within the current budget and would not result in further improvement to position; planning assumptions; growth in drugs and prescribing as an unavoidable cost pressure; commissioning income; operational services overspend of £6m; unscheduled care and surge beds costs; additional ECR commissioning and spend in property costs were being treated as non recurring currently; short fall on planned savings from £5m to £3.5m; anticipated reduction to new medicines fund; superannuation increase; CNORIS scheme; non pay growth/inflation; roll forward of commitments from the 2023/24 plan; national and regional plans and indicative costs; local investment priorities; cost pressures; savings position; and next steps.

8.2 Mr Ralph Roberts commented that what was being presented was the current set of numbers without the mitigating actions that were being taken and it would form the first part of the Draft Annual Delivery Plan to be submitted to the Scottish Government at the end of January. The Board Chief Executives had met with the Scottish Government on the challenging financial position and had reflected that the total gap for Health Boards at the current time was projected at £1.2bn. After recurrent and non recurrent savings were taken into account, they anticipated a deficit of £750m. He further commented that the Scottish Government had no funding for any proposed 2024/25 pay deal, which might include a reduced working week, a band 5 review and protected learning time. It was expected that further workforce changes would fund any pay deal.

8.3 The Chair suggested there was a need to build on the Time for Change work and conversations with the public on what the Board wished to present to the Scottish Government.

8.4 Mrs Fiona Sandford referred to the 15 box grid and enquired to what extent the Scottish Government and Scottish Medicines Consortium (SMC) would support Boards with affordability of new medicines and ceasing medical procedures of low clinical value. She noted that sickness absence levels were high and required reduction and further enquired to what extent the demographic challenges were being escalated to the Scottish Government.

8.5 Further discussion focused on: the process that would be adopted to agree actions and solutions; collective appetite for the choices that will need to be made; involvement of KPMG; continued escalation of demography issue; SMC not engaged and have changed the rules so that decisions are made without financial oversight; introduction of prescribing charges; political appetite for change; targeting hotspots for sickness absence; coaching network being involved in speaking to those on long term sick leave to enable a return to work; consideration of introducing mask wearing in clinical areas to reduce the spread of flu/covid; potential to prioritise staff for procedures; engagement with the public; and staff governance responsibilities.

The Chair declared an interest in the discussion as she was awaiting a operation.

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

## 9. Any Other Business

9.1 There was none.

## 10. Date and Time of Next Meeting

10.1 The Chair confirmed the next meeting of the Resources & Performance Committee would be held on Thursday, 7 March 2024 at 9.00am via MS Teams.

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 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 25 March 2024

## 2.4 Recommendation

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

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Audit & Risk Committee minutes 11.12.23

Minutes of a Meeting of **Borders NHS Board Audit & Risk Committee** held on Monday, 11th December 2023 @ 1 p.m. via MS Teams.

**Present**: Mr J Ayling, Non Executive Director (Chair)
Ms S Lam, Non Executive Director
Mrs F Sandford, 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
Mrs L Huckerby, Interim Director of Acute Services
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 G McLaren, Head of Estates (Items 6.3 and 7.3)
Mrs L Pringle, Risk Manager (Items 5.1 and 6.2)
Mrs S Swan, Deputy Director of Finance (Head of Finance) (Joined meeting at 2 p.m.)
Mr S Whiting, Infection Control Manager (Item 6.3)

## 1. Introduction, Apologies and Welcome

James Ayling welcomed those present to the meeting.

Apologies were received from Mr T Taylor, Non Executive Director, Mr R Roberts, Chief Executive and Ms S Harold, Senior Audit Manager, Audit Scotland.

James confirmed that today's meeting was quorate.

## 2. Declaration of Interest

There were no declarations of interest.

## 3. Minutes of Previous Meeting – 18th September 2023

**The minutes were approved as an accurate record.**

4. **Matters Arising**

*Action Tracker*

The update relating to the action about adding Whistleblowing to the Internal Audit plan was discussed where Laura Jones suggested that this be added to the 2025/26 plan to allow the internal work of auditing against standards to be undertaken first. Sonya Lam felt that this was the correct timescale and reminded that a new Whistleblowing Champion would be appointed next year which would allow them time to get to grips with the role.

**The Committee noted the action tracker.**

5. **Risk Management**

5.1 *Risk Management Quarterly Report*

Lettie Pringle spoke to this report which was for the second quarter to 30th September 2023. Lettie highlighted the key items from the report where it was noted that there has been progress with both NHS Borders' Strategy and Policy objectives. Lettie highlighted that there had been an increase in the number of very high risks added to the operational risk register which were detailed within the appendix along with the outcome agreed by the Operational Planning Group. Lettie also advised that a large piece of work was being undertaken to ensure appropriate risks in development are approved onto the risk register within the correct timescales. Lettie anticipated this exercise would see a decrease in the number of risks awaiting approval within the quarter 3 report.

Lettie went on to highlight that financial gaps and staffing / workforce challenges had been identified as themes preventing risk owners from mitigating their risks fully.

Lettie also advised that there had been a reduction in compliance of the KPIs during quarter 2.

James Ayling enquired if there was any follow up on the KPIs. Lettie confirmed that these are followed up and advised that the Risk Management team provide support to the Risk Management Champion Network where these are monitored.

Laura Jones reminded that the Risk Management team is an extremely small resource and that they are trying to target individual areas in anticipation of the benefit being seen within the quarter 3 report.

Laura also added that the quality assurance exercise is supported by the Risk Management team and is being offered to those who have responsibility for risks.

Karen Hamilton was pleased to see the positive progress and advised that part of the Board development session the previous week had been to look at the organisation's risk appetite which was under constant review.

Sonya Lam referred to the Risk Champion's role which she assumed would be challenging if this was on top of the day job and asked if there were any capacity issues. Lettie advised that there is enhanced training for this role and that they have regular monthly meetings with them to provide support and help with any issues.

**The Committee noted the Risk Management quarterly report.**

6. **Internal Audit**

6.1 *Internal Audit Plan Update Report*
Emily Mayne spoke to this report which provided a summary of delivery on the 2023/24 Internal Audit plan to date. Emily highlighted that there had been a real push on delivery and they were now 68% through the programme. It was noted that 2 audit reports were being presented at today's meeting and a number were in progress to which Emily provided an update with indicative timescales.

Emily reminded that there were still 10 contingency days within the plan should these be required.

**The Committee noted the report.**

6.2 *Internal Audit Report – Governance of Risk Management*
Jamie Fraser introduced this report and highlighted that this had an overall rating of reasonable assurance with improvement required. The findings ratings were noted as 2 medium and 5 low.

Jamie advised that the objective of the review was to provide an independent assessment of the governance of very high and high strategic and operational risk management.

Jamie referred to the 2 medium risks, namely that the risk registers do not reflect the risk appetite process and action plans were not always accessible within the risk management system.

Laura Jones noted her thanks for the report and advised that she was pleased with the outcome which also highlighted that good practice was observed throughout the course of the audit. Laura was confident that the new risk management system would assist with some of the recommendations being made.

James Ayling referred to recommendation 7 which stated that during observation it was noted that the scrutiny of risks and actions by the Resources & Performance Committee was not effective enough. James noted that the management response included adding a line on responsibilities within the Terms of Reference of the Board Sub Committees, however felt that improvement needed to be made at meetings rather than just adding this to the Terms of Reference. James suggested that the Director of Quality & Improvement provided feedback to the Chairs of the Governance Committees around strengthening assurance. This was agreed.

**The Committee noted the report.**

6.3 *Internal Audit Report – Infection Control – HAI Scribe*

Jamie Fraser introduced this report which had an overall rating of partial assurance with improvement required. The findings ratings were noted as 2 high, 8 medium and 2 low.

Jamie advised that the objective of the review was to focus on four key risk areas, namely risk of insufficient or incomplete implementation of the HAI-SCRIBE tool, risk of low adoption and utilisation of the HAI-SCRIBE tool, risk of technical difficulties or limitations associated with the HAI-SCRIBE tool and risk of inaccurate or unreliable data captured within the HAI-SCRIBE tool.

Jamie advised that elements of good practice had been observed as well as areas for improvement. Jamie recognised the joint working between Infection Control and Estates and highlighted that the Standard Operating Procedure (SOP) for maintenance and repair tasks should be completed and ratified. Jamie advised that the tool used within NHS Borders was a paper based tool and recommended the use of an electronic tool. Jamie noted that a central record is kept of the tools undertaken and flagged the need to ensure that those who require access are given this.

Gavin McLaren referred to the SOP and advised that Estates and Infection Control have pulled this together over the last few months and agreed that this required to be ratified as soon as possible. Gavin felt that the points made were valid and it was noted that Estates and Infection Control have a monthly catch up to review the recommendations and to improve information sharing between the teams. Gavin also advised that historically a paper tool had been used, however following changes in staffing they were now looking to move forward with an electronic based system.

Sam Whiting advised that the Infection Control team have been building nursing competencies on the use of HAI scribes and training had recently been completed. Sam felt that there was now more resilience within the team.

Sam stressed the significant amount of work involved in completing this process and the mitigating actions which needed to be put in place prior to Estates work being undertaken, for example dust control.

James Ayling enquired about the co-ordination between the Infection Control and Estates teams. Sam advised that the co-ordination has improved and included other stakeholders as and when required.

Fiona Sandford enquired from Infection Control's perspective, if on a day to day basis the balance between the increase in workload due to the use of the tool was beneficial, or if this was only relevant for Estates work.

Sam confirmed that it was only relevant for Estates work and that from Infection Control's perspective the idea of the SOP is to provide clarity for contractors and Estates colleagues when the HAI scribe tool is required and when ratified this would help achieve this.

James referred to recommendation 3.1, namely for future projects, use should be made of the national e-tool as the view from Internal Audit was that the organisation would benefit from this. James noted that feedback from the test exercise on the e-tool would be provided and asked that should it be decided not to make use of this he would like an update at a future meeting with the reason for not proceeding and would also ask Internal Audit at that point if they were content with the decision. Gavin confirmed that he would be happy to do this should this be the case and advised that they now had appointed a Champion for this and the initial feedback was that improvements were required.

James was conscious that there was a lot of work for Estates within the recommendations and asked if they were comfortable with the deadlines attached, particularly due to the other audit recommendations they were already dealing with. Gavin confirmed that he was comfortable with these and anticipated they would be completed within timescales.

Andrew Bone felt that there was a need to make a caveat around the timescales due to the huge amount of pressure on Estates and the Capital Project Team but assured that the audit recommendations are being given the highest priority.

**The Committee noted the report and that it would be referred to the Clinical Governance Committee.**

7. **Governance & Assurance**

7.1 *Information Governance – Mid Year Report*
The Information Governance & Cyber Assurance Manager was unable to attend today's meeting so any queries on the report were to be emailed for a response.

Questions and responses are attached at Appendix A.

**The Committee noted the report.**

7.2 *Audit Follow Up Report*
Emily Mayne spoke to this item and hoped that the Committee were content with the new format of the report, however she would be happy to adapt as necessary. It was noted that follow up testing is not undertaken routinely, only if it is a specific part of the annual audit plan. Emily advised that she would be speaking with the Director of Finance as part of the planning for next year's audit plan around some of the medium and high rated recommendations which were detailed within the report.

Emily went on to take the Committee through the report which included overdue recommendations by period and highlighted that IT Recovery and Resilience had a total of 3 recommendations (2 high and 1 medium) and if these were to be pushed it would help bring the overall total number down.

Andrew Bone referred to the "implemented recommendations by timeliness" chart and noted only 2 recommendations had been implemented within the timescales set. Andrew appreciated that there could be legacy

recommendations being carried forward within these but hoped to see an improvement going forward.

James Ayling noted that 15 recommendations had been implemented since the last meeting which he felt was commendable as he was aware of the pressures on services.

James referred to appendix 1, aged actions for the Committee's attention, and noted that for Estates and Facilities they were looking to extend the deadline for production of the final Property Asset Management Strategy to March 2025. Andrew Bone explained that this was due to slippage with national timescales. Andrew also highlighted that the property surveys recommendation would not be complete until the reports were received in 2024.

James enquired about the outstanding action from the GDPR and Information Governance Arrangements audit regarding details of any information assets for inclusion in the register being confirmed to the SIRO. Andrew advised that the new Head of IM&T would be taking up post in January and that he planned to discuss all audit recommendations under IM&T's remit at that time.

In regard to the outstanding action from the Covid-19 Governance Arrangements and Remobilisation audit recommending that all changes to governance arrangements are documented, including when Gold, Silver and Bronze Command levels should be initiated and terminated, James enquired if the new Resilience Manager was now in post. It was noted that they were now in post and Andrew agreed to discuss this action with them.

**The Committee noted the audit follow up report.**

7.3 *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 spoke to this item and referred to the updated summary recently circulated around the Committee which provided an update on progress to date. Gavin went on to take the Committee through the update and highlighted the challenges being encountered due to only having 1 authorised person for ventilation when the minimum should be 2. It was also noted that a quote has now been received from the contractor for the annual verifications so it was hoped to have dates for these in the near future.

James Ayling noted that many of the areas flagged as red related to documentation issues. Gavin advised that in regard to the permits he had fed back to the Authorising Engineer that they had been using permits and that he felt the scoring in this area was unjust. Gavin reiterated that many of the issues encountered was due to only having 1 authorised person which was a single point of failure and was being addressed.

James asked for an estimation of progress with completion of the actions within the designated timescales. Gavin felt that if some of the high risk areas were addressed they would be around 75/80% complete. In regard to the timescales it was noted that some had slipped due to additional pressures. Andrew Bone added that in terms of recommendations there were five outstanding, three of which were rated high but assured that they were looking at how to address these as quickly as possible.

Jamie Fraser appreciated that there were pressures on the service and agreed that having only 1 authorised person for ventilation was a major issue and that getting additional capacity would help greatly. In regard to the annual verifications Jamie noted that once the contractor is appointed this would address that recommendation and agreed there would be around 75% of the recommendations completed.

**The Committee noted the update.**

*Contract Management Arrangements*
Susan Swan provided an update on the recommendations within the audit report presented to the Committee at the last meeting. It was noted that the 3 high risk recommendations were in progress, with the one regarding issue of a global email outlining contract management guidelines due to be issued across the organisation imminently. Susan advised that a short life working group had been set up and continues to meet regularly to work through the recommendations on the contract and supplier management policy.

Susan confirmed that the Procurement microsite had been updated to include the refreshed documentation, however in order to track all contracts it was noted that software would require to be identified to do this.

Susan felt that the recommendations would be complete by the March 2024 deadline and advised that support was being sought from National Procurement as no Board currently have a process and policy in place.

**The Committee noted the update.**

*Financial Controls*
Susan Swan provided an update on the recommendations within the report presented to the Committee in March 2023. Susan referred to the medium recommendation regarding a budget holder training programme and advised that the department was not in a position to put in place a training programme at the present time, however they were looking to do a “Hot Topic” approach similar to HR as well as training podcasts meantime. It was noted that the Business Partners and Financial Management department continue to provide staff with support on any budgetary queries.

Susan went on to confirm that the 4 low rated recommendations were complete and that interim action to address the improvement point regarding sign off from budget holders would be in place by March 2024. It was noted that there was a budget principles paper, currently in draft, which would be going to the Board Executive Team for formal adoption in January.

Susan added that External Audit would be undertaking their interim audit in January and hoped this would give assurance that due processes were in place.

**The Committee noted the update.**

With reference to IM&T resilience, James Ayling referred to the updated spreadsheet which had been received from the IT Delivery Manager providing the Committee with a progress update for November and noted that now the Resilience Manager was in post a further update should be sought.

7.4 *Debtors Write Off Report*
Susan Swan spoke to this item and highlighted that as at the end of November £19k was being followed up as part of the Board's internal credit control processes and once all avenues were exhausted it would be passed to the debt recovery agency. Susan advised that this had previously proved successful and assured that it did not involve any doorstep contact.

Susan highlighted that a total of £6.2k had been deemed as irrecoverable and the Director of Finance had been asked to authorise write-off of this debt.

As this report was received following a recommendation from Internal Audit, James Ayling asked them for any observations on the level of impaired or irrecoverable debt. Emily Mayne did not feel that there was anything unusual in what was being reported and that from an Internal Audit perspective they would be looking at what actions were being taken and how effective these were.

James also enquired if there was a process or procedure in place to ensure that other departments do not contact with any entities who have a debt with the organisation. Susan provided examples of where this had happened previously and the action taken but advised that there was not a blanket policy in place for this.

**The Committee noted the report.**

8. **External Audit**

8.1 *Audit Scotland Reports*
Andrew Bone spoke to this report and highlighted where it was suggested relevant Audit Scotland reports are distributed across the organisation.

No issues were raised.

**The Committee noted the report.**

9. **Fraud & Payment Verification**

9.1 *Countering Fraud Operational Group Update*
Susan Swan spoke to this item and provided an update from the last Countering Fraud Operational Group meeting who take forward the fraud agenda. Susan went over the agenda items discussed at the meeting and highlighted the fraud awareness week which had taken place in November and advised that stats

were being collated with CFS to gain views on the information circulated during the course of the week.

James referred to appendix 1, Audit Scotland's Fraud and Irregularity Annual Report for 2022/23, which referred to instances where fraud had been committed and asked if a review is undertaken to consider these. Susan explained that correspondence is circulated to service heads to take forward within respective teams.

Andrew Bone suggested that an exercise be undertaken to go through the case studies to ensure that there is nothing outstanding within existing processes. This was agreed.

James was pleased to note that the level of fraud detected within the NHS was very low, however asked for thought on how more sophisticated frauds, which are on the rise, are brought to the organisation's attention. Andrew suggested that discussion on how to deal with this takes place at the Countering Fraud Operational Group. This was agreed.

**The Committee noted the update.**

9.2 *NFI Update*

Susan Swan spoke to this item which was a standard exercise across the UK undertaken by public sector bodies. Susan highlighted that of the 963 matches received for investigation, 960 were now closed with no fraud being identified from the work to date. It was noted that just over £58k had been paid in error as duplicate payments to suppliers and these monies were currently being recovered. Susan explained that by moving to scanned images would see a significant reduction in duplicate payments.

James Ayling referred to the duplicate payments and asked for clarification on the manual input. Susan explained the process of matching invoice reference numbers and inputting these on the system, whereby trivial things like adding a full stop meant the system would not recognise it as matched and could result in failure to recognise an invoice as already having been paid. It was noted that conversations with the Finance team responsible for inputting onto the system had taken place so they were clear on the correct use of reference numbers to try and avoid this happening in future.

**The Committee noted the update.**

9.3 *Fraud Allegations*

Susan Swan confirmed that there were no new fraud allegations to bring to the Committee's attention.

**The Committee noted the update.**

10. **Integration Joint Board**

James Ayling asked for confirmation that the September IJB Audit Committee meeting had not taken place. Karen confirmed that this was the case and advised that there would be more focus on the directions going forward.

Andrew Bone advised that he is working with Scottish Borders Council's Finance Director to provide support in the absence of the Chief Finance Officer.

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

10.1 *IJB Directions Tracker*

Hayley Jacks spoke to this item and highlighted that a further 2 directions had been added to the tracker since the last meeting.

Hayley confirmed that she had provided feedback to the Chief Officer following the last meeting but due to the absence of the Chief Finance Officer this was on hold. Hayley assured that this would be picked up as soon as possible.

James Ayling enquired if the directions tracker had gone to the Board Executive Team and the Operational Planning Group (OPG). Hayley confirmed that it had and advised that it was due to go back to OPG in January.

**The Committee noted the report.**

11. **Any Other Competent Business**

As this was Jamie Fraser's last meeting Andrew Bone took the opportunity to thank him for all his support over the last few years and wished him well for the future.

James Ayling advised that this would also be Sonya Lam's last meeting as her tenure as a Non Executive Director would be coming to an end. James, on behalf of the Committee, thanked Sonya for all her help and input over the previous years and wished her all the best for the future.

12. **Date of Next Meeting**

Monday, 25th March 2024 @ 1 p.m. via MS Teams.

BE
20.12.23

**Appendix 1**

**Information Governance – Mid Year Report – Questions & Answers**

**Questions – Sonya Lam**

- I note there are capacity issues in the team which will extend into 2024 and the challenge in recruiting to a fixed term post. If capacity remains a challenge, what implications does this have in terms of risk to information governance activity?
- The paper outlined an increase in the number of breaches in Q1 and Q2 (28%); an increase in FOI (46%) and an increase in subject access requests (32%). Do you have any thoughts about why these have increased or is this a reflection of the times we are in?
- I welcome a strategy for an electronic record. Realistically, how far away are we from this being a reality?

**Response – Susie Thomson, Information Governance & Cyber Assurance Manager**

- In terms of capacity issues that will extend throughout 2024. We are trying to recruit backfill, but if this is not successful, we potentially have the option to use a student that is on the health records bank to cover work relating to FairWarning audits. The implications of the reduced resource within the team will mean that we may not be able to support all of the new areas of work being progressed by NHS Borders in terms of IG support for DPIA's, Data Sharing Agreements etc. or timescales for us to sign off documentation will be longer. Lack of resource will also impact on our plans for implementing OneTrust for GDPR compliance and again, if we are not able to recruit someone with IG skills as backfill we may bring in someone to help with some of the basic set up task for OneTrust.

- I think the increase in FOIs and SARs reflects the current climate in terms of delays for treatment and backlog from Covid as well as increased awareness of patient rights for access to information. Although I don't have responsibilities for FOIs, the team that oversee this function have reported into the IG Committee that some of the increase in FOI requests can be attributed to political climate as well as suppliers trying to identify opportunities.

- In terms of strategy for an electronic health record (EHR). I think as part of the strategy we need to identify what the options are for the NHS Borders, i.e.

    1. Do nothing and outline increasing costs for resources/storage and impact this will have on sharing of information across H&SC and with patients via a patient portal.
    2. Stop producing paper, make everything going forward electronic and in time reduce historical paper notes as part of standard culling processes and what the cost profile for this looks like along with ongoing reliance on paper for historic information.
    3. Full EHR solution with digitisation of historical records – we did a benchmarking exercise with Xerox earlier this year, and the costs for this were around £4.7 million over first 2 years with ongoing recurring costs of around £220K for a full EHR solution. The potential return on investment would be reached around year 8/9 assuming resource and staffing costs eliminated.

This does provide an invest to save proposal or the organisation, however given current financial position, this may not be possible to progress.

I think we also need to explore a hybrid option somewhere between option 2 and 3, as this may be more affordable e.g. use our clinical systems (Trak and EMIS as the electronic record and digitise a subset of paper records that would allow us to operate without the need for paper notes being pulled. We would also have to identify a solution for ECGs being captured and stored digitally as these are currently paper based.

I would like to be able to complete work on an options paper / strategy proposal for the end of the financial year and then seek approval/identify funding to bring someone in within relevant experience to help us validate the strategy and options to progress development of an outline business case and required funding.

Given all of this, I think we are at least 2-3 years if not longer before having an electronic health record becomes a reality.

**Questions – James Ayling**

Points noted as per the report and questions added in red.

- I note that the team are seeking approval to recruit a post fixed term however it is unlikely that the service will be able to secure someone with required professional skills and knowledge relating to data protection legislation. Are you using specialist recruitment agencies at all if that is allowed, e.g. legal based recruitment?

- NHS Borders was not subjected to any successful cyber-attacks during reporting period 1st April to end Sept 2023. Do we have any idea of how many cyber attacks our systems etc may have prevented or is that an impossible question to answer?

- Good to see that In Q2 and Q3, NHS Borders has strengthened its technical cyber security through the installation of a number of applications. How are the various contracts/software licences for applications reviewed and managed and matters such as termination dates /renewal dates etc stored?

- Also really good to see that 1, Currently 80% of staff members have completed the mandatory training compared with 69% at the same point last year and 2, that subject access requests at 99% despite greater complexity.

**Response – Susie Thomson, Information Governance & Cyber Assurance Manager**

- We are about to go out to advert for backfill. The post is only 30 hrs per week and we are only allowed to appoint to 80% for maternity cover, so have approval to recruit 24 hrs per week which may limit options as not a full time post. We are not routinely allowed to use external recruitment agencies as the fees are quite high, especially when this is for a fixed term contract and are therefore still exploring option of using health records bank to cover the routine audit work that the team undertakes.

- That is an interesting question and an area we are currently exploring as part of the Cyber Security reporting metrics. I have attached some slides from the monthly

Cyber Security report that shows some metrics regards malware, ransomware and firewall attempts. These will be getting developed over time as new monitoring tools are available and implemented.

Cyber Security Metrics - Nov 23.ppt

- We have a Contracts Manager in place, who has developed a process to track and manage contracts including versions on terminations. I can provide contact details if would like to understand the process in more detail?

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Endowment Fund Board of Trustees Minutes** |
| **Responsible Executive/Non-Executive:** | **Andrew Bone, Director of Finance** |
| **Report Author:** | **Iris Bishop, Board Secretary** |

## 1 Purpose

**This is presented to the Board for:**

- Awareness

**This report relates to a:**

- Government policy/directive

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

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

### 2.2 Background

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

### 2.3 Assessment

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

### 2.3.1 Quality/ Patient Care

As detailed within the minutes.

### 2.3.2 Workforce

As detailed within the minutes.

### 2.3.3 Financial

As detailed within the minutes.

### 2.3.4 Risk Assessment/Management

As detailed within the minutes.

### 2.3.5 Equality and Diversity, including health inequalities

An HIIA is not required for this report.

### 2.3.6 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.

- Endowment Fund Board of Trustees 5 February 2024

## 2.4 Recommendation

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

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Endowment Fund Board of Trustees minutes 04.10.23

Minutes of a Meeting of **Borders NHS Board Endowment Fund Board of Trustees** held on Wednesday, 4th October 2023 @ 2 p.m. via Microsoft Teams.

**Present:** Mr J Ayling, Trustee
Mrs K Hamilton, Trustee (Chair)
Ms S Lam, Trustee
Mr J McLaren, Trustee
Mrs L O'Leary, Trustee
Mr R Roberts, Trustee

**In Attendance:** Ms C Barlow, Charity Development Manager
Mrs B Everitt, PA to Director of Finance (Minutes)
Mr M McLean, Investment Advisor (Left meeting at 4.05 p.m.)
Mrs S Swan, Deputy Director of Finance (Head of Finance)
Mrs K Wilson, Fundraising Manager

1. **Introduction, Apologies and Welcome**

Karen Hamilton welcomed those present to the meeting. Apologies had been received from Dr L McCallum, Trustee, Mrs H Campbell, Trustee, Cllr D Parker, Trustee, Mrs S Horan, Trustee, Mrs F Sandford, Trustee, Mr T Taylor, Trustee and Mr A Bone, Trustee.

James Ayling queried whether there was a sufficient number of different Trustees at today's meeting than those who had attended the Endowment Advisory Group in regard to reviewing the endowment funding applications on the agenda. Karen Hamilton felt that all Trustees had been given sufficient opportunity to review the papers and make comment if they were unable to attend the meeting.

Although the meeting was quorate, Karen noted the low attendance at today's meeting and advised that she would email Trustees asking for these meetings to be prioritised in diaries wherever possible.

2. **Declaration of Interests**

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

3. **Minutes of Previous Meeting : 7th August 2023**

**The minutes were approved as an accurate record.**

4. **Matters Arising**

There were no matters arising.

5. **Endowment Advisory Group**

5.1 *Minutes of Meeting: 31st August 2023 (Draft)*
John McLaren spoke to this item. John advised that the minutes were presented today to be noted, with the majority of attendees having been at the meeting, and confirmed that he was happy to endorse these.

Ralph Roberts referred to the staff awards application which the Endowment Advisory Group had agreed to recommend and progress under its scheme of delegated authority. It was noted that this was for the 2024 event only and a full detailed budget had been requested and was currently being pulled together.

Ralph also advised that there had been a discussion on whether or not alcohol should be served at the event, with the Director of Public Health being of the view that it should be alcohol free. Ralph felt uncomfortable in making choices for staff in respect of this. Karen Hamilton advised that she had been made aware that two other Boards were having alcohol free events. Sonya Lam appreciated the message being made but felt people must be allowed to make their own choices, whilst ensuring that healthy options are also available. Karen suggested that when feedback is sought following the event a question could be posed as to whether or not staff would like to see an alcohol free event in future.

James Ayling felt that it would have been a good opportunity to promote the charity in a positive way, however appreciated the views being made and was content to go with the majority. Sonya also confirmed that she would be happy to go with the majority view.

In summation, due to the tight timescales involved, John noted agreement was being given to continue as per previous events and doing alcohol free events could be looked at in future.

**The Board of Trustees noted the draft minutes of the Endowment Advisory Group and the update on the staff awards application.**

5.2 *Endowment Advisory Group Recommendations – Applications*
John McLaren provided an update on the applications received by the Endowment Advisory Group which was noted below.

*Voluntary Services Manager Post*
It was noted that the Endowment Advisory Group had agreed to recommend this application to the Board of Trustees, whilst requesting that the option involving the third sector be expanded upon.

Sonya Lam noted reference to a 5 year cycle and asked for clarification around this as she was aware that this would incur HR issues if the appointment was for this length of time. Susan Swan confirmed that the application was to initially enable an internal 1 year Voluntary Service Manager post so appointment would be for 1 year only at this time.

Ralph Roberts felt that this post would need to be looked at in the longer term and how this could be sustained, whether this be by core or non core funding.

Sonya Lam noted that 1 year was a short timescale for this type of role to embed within the organisation and felt this may need to be extended.

Karen Hamilton agreed with a stepped approach and felt that the concept of volunteering was becoming popular in other arenas, therefore fully supported the application.

Ralph, in response to Sonya's comment, recognised that it would take longer than a year for this to embed within the organisation and asked Trustees if a longer period should be agreed to avoid having to go through the same process in a year's time. Karen H noted that if this was within the Trustees' gift then she would be supportive of extending to 2 years.

Susan Swan reminded that under the charity's current best practice an update report should be expected around month 10 of the project and if authority was delegated then an extension could be granted at that point.

**The Board of Trustees approved two years funding taking the points raised into account including the requirement for an interim report to be made available for review by the Trustees at the end of the first year of the project.**

*Music Therapy Pilot (DME)*
It was noted that the application was to part fund this project which would see a music therapy post based within the Department of Medicine for the Elderly (DME) to benefit patients with dementia. The Endowment Advisory Group agreed to recommend this application to the Board of Trustees, whilst requesting the exit strategy be expanded upon, which was included within the pack.

Sonya Lam fully supported this application but felt it would be helpful to know what the longer term strategy would be from a Board perspective. Ralph Roberts advised that music therapy is currently used within mental health and this would see it branching elsewhere in the organisation. Ralph felt it would be helpful to receive feedback on the benefits of the pilot prior to making any longer term funding plans.

**The Board of Trustees approved the application.**

*Clinical Practitioner for Complex Dementia Care*
It was noted that the Endowment Advisory Group had agreed to recommend this application to the Board of Trustees, whilst requesting that the exit strategy be expanded upon, which was included within the pack.

Sonya Lam highlighted that this could create a post which could be unsustainable should it become core, however as a Trustee supported the application. Lucy O'Leary advised that following discussion at the Endowment Advisory Group, they had asked for exit strategies on this, and other applications, to define more clearly what was core/non core activity.

**The Board of Trustees approved the application.**

*Dementia Awareness*
It was noted that the Endowment Advisory Group had recommended this application be approved within its scheme of delegated authority. It was noted that this event had since taken place and Colleen Barlow provided feedback and advised that the evaluation would be shared with Trustees in due course.

**The Board of Trustees noted the update.**

6. **Strategy & Fundraising**

6.1 *Charity Plan 2023/24 – Progress Update*
Karen Wilson spoke to this item which provided a progress update on the 2023/24 Fundraising Plan. Karen advised that the charity had a table based in the BGH on a number of occasions which had provided an opportunity to share information and answer questions. These sessions would also be held in the community which would include focussed meetings as well as drop in sessions.

Karen highlighted the fundraising held at Morrisons in Hawick in regard to the Big Tea campaign had been an opportunity to bond with the Community Champion in store. A debrief would be undertaken once the full amount of funds raised was known.

As part of the 75th anniversary celebrations a tea trolley had been taken around the wards promoting the charity and asking for ideas on how funds could be spent. Thought would be given on other ways to engage with staff going forward.

Karen advised that the migration of data over to Beacon CRM had taken place since the last meeting. It was noted that there was more development to be done which would be an enhancement/efficiency on the service.

It was noted that there had been 22 fundraising projects which was getting back to pre Covid numbers. The majority of these were for the Margaret Kerr Unit and the Macmillan Cancer Centre. Karen referred to the Berwickshire truck run which had donated £22k towards various funds and which was hoped would be an annual event going forward.

Karen advised that the specifics of a potential donation of £100k was being worked up and would see the purchase of equipment for mammography and ophthalmology.

Karen confirmed that unrestricted donations are being encouraged and that there was no longer a list of funds published on the website, however noted that there was still more work to do in this area.

Karen Hamilton enquired about any feedback on the new CRM system. Karen W advised that no issues have been fed back to date and that there was a grant making option on the system which would help with the management of workload and record keeping. It was noted that further work was required on how the system linked with Finance and BGH Admin.

James Ayling congratulated the team for putting in place a new software package on time and within budget.

**The Board of Trustees noted the update.**

6.2 *Grants Update*

Colleen Barlow spoke to this item and advised that to date the charity team have facilitated £339,480 in grants which was an increase at the same point in time from the previous year. Colleen referred to the charity's table within the BGH which had generated more enquires about the charity and its work.

It was also noted that the grant making function on the new CRM was very reactive which would see a move towards a strategic and responsive way of funding projects.

**The Board of Trustees noted the update.**

6.3 *Grants Strategy*

Colleen Barlow spoke to this item and provided an update on the grant making framework which would operate in conjunction with the desire to spend more from unrestricted funds. Colleen took Trustees through the changes being proposed to the delegated authority and hoped that the clear/explicit criteria would give assurance that approvals to a delegated limit could be taken to allow decisions to be made more swiftly.

Susan Swan noted that the intention would be to have the revised approved framework and process in place from 1st April 2024 and that she would be working with Colleen in regard to the details of the individual signatories. This would include the scheme of delegated authority, particularly linked to the Business Unit Quadrumvirates' Terms of Reference and membership/quorum.

**The Board of Trustees noted the report and approved the proposed changes to the Scheme of Delegated Authority which will take effect from 1st April 2024.**

6.4 *NHS Charities Together Membership*

Karen Wilson spoke to this item and explained that the charity had been a member of Charities Together for a number of years and had benefitted from a number of grants during this period as well as the products, services and support available. Karen explained that post Covid, Charities Together had reviewed the membership charge which was noted as £2.5k for the coming year. Karen highlighted that there would also be three months free membership due to a move in invoicing from the calendar year to the financial year. It was also noted that non members could still get access to the online forum which was an invaluable tool.

Karen stressed the huge amount of value the charity get from this and asked Trustees for approval to continue with the membership during 2024/25.

Karen Hamilton felt that it would be reasonable to approve this for one year after which feedback could be provided on the benefits/savings within future requests for funding to evidence the value for money.

**The Board of Trustees confirmed their intention to continue membership of NHS Charities Together and approved payment of the £2,500 membership fee for the financial year 2024/25.**

7. **Financial Report**

7.1 *Primary Statements and Fund Balances*

Susan Swan spoke to this item and highlighted the fund movement where it was noted that the expenditure incurred (£0.09m) by the charity has been higher in the 5 months reported than the level of income received.

Susan also advised that there had been a small loss on investment income but noted that the report was a quarter behind the Investment Advisor's report. Susan referred to the quarter 2 position from the Investment Advisor and highlighted that the Investment Portfolio valuation increase could provide a level of income to apportion across restricted and unrestricted funds in line with the approved policy. This matter would be discussed at a future meeting.

Susan confirmed that going forward she would be working with the Fundraising Manager and the Charity Development Manager to tie the finance report in with the approval and spend on projects as recommended by the Endowment Advisory Group.

**The Board of Trustees noted the report.**

7.2 *Register of Legacies and Donations*

Susan Swan spoke to this item which provided Trustees with an update on all legacies and donations over £5k received to 31st August 2023. It was also noted that the charity would benefit from a number of further legacies, however the amounts of these would not be known until the estates had been finalised and monies disbursed.

**The Board of Trustees noted the report.**

8. **Funds Management**

8.1 *Investment Advisor Report*

Mark McLean spoke to this item and advised that following 6 months planning Investec Wealth and Management had now joined up with Rathbones Investment Management. Mark assured that it would still be business as usual for clients, however should any issues be experienced these should be flagged directly to him.

Mark referred to the summary report and advised that as of 15th September 2023 the value of the portfolio was £4,842,154, seeing a rise of +1.37%, net of fees, since the last quarterly valuation at 30th June 2023. It was noted that the comparable benchmark for this period was +2.74%. It was further noted that the portfolio produced a forward looking yield of 3.45%, equating to an annual income of approximately £167,274. Mark also highlighted that over the past 3 years the portfolio had produced a total net return of +9.02% against the benchmark's gross return of +17.10%.

Mark highlighted that this had been a particularly bad year for diversifying investments, however felt that they were coming to the end of the cycle for rising interest rates. Mark noted that the infrastructure funds had taken a hit due to the rise in interest rates, however stressed that for longer term investors the advice was to sit tight. Mark also advised that the additional money recently invested within the portfolio had increased the capital exposure.

James Ayling noted that the portfolio had not performed particularly well when compared against the benchmark and enquired how much longer they were expected to sit tight. Mark advised that he did not expect an improvement until the first quarter, possibly the second, of next year. James also asked if it was the intention to continue with emerging markets. Mark confirmed that he planned on continuing with these within the portfolio.

**The Board of Trustees noted the report.**

9. **Governance Framework**

9.1 *Palliative Care Fund Proposed Terms of Reference*

Colleen Barlow spoke to this item which provided a draft Terms of Reference following the proposal to establish a Palliative Care Committee. It was noted that the Committee would delegate certain functions within the limits set and would oversee the administration of the Palliative Care Fund. Colleen went on to highlight the key responsibilities and duties of the Committee and also the proposed scheme of delegated authority.

In regard to membership it was noted that the Committee Chair and Vice Chair would be appointed by Trustees on the recommendation of the Chair of the Board of Trustees and volunteers would be sought for this. A public member would also be co-opted onto the Committee via the Public Involvement Officer.

James Ayling asked for clarity in regard to the proposed scheme of delegated authority as he was surprised to see that spend over £100k did not require approval from the Director of Finance as he felt the Director of Finance would need to be aware of this.

Ralph Roberts also raised some concerns he had with the proposed scheme of delegated authority as he noted that any proposals for fixed term posts or capital schemes would be reserved for the Board of Trustees' discretion, therefore he was unclear what decisions there would be for the Palliative Care Committee under £100k as he felt the majority would fall into these 2 categories. Ralph stressed the need for clarity within the scheme of delegated authority around this.

Susan Swan noted that she also had some queries and stressed the need to ensure from an authorisation perspective that the criteria fitted with the charity's grant making strategy. Susan also felt consideration needed to be given on the level of financial risk the Palliative Care Committee would be allowed to take. Susan was happy to pick up her queries outwith the meeting and suggested that an updated paper be circulated for comment rather than wait until the next meeting. This was agreed.

James added that if the Deputy Director of Finance was involved he would be content for the Director of Finance not to be as he would be assured that there was a level of financial expertise at the meetings. Karen Hamilton felt that it would need to be to be explicit within the Terms of Reference what the Deputy Director of Finance's role was on the Committee. It was noted that the revised Terms of Reference would be explicit for the role of those individuals 'in attendance' at meetings.

**The Board of Trustees noted an updated report would be circulated for comment.**

*Staff Lottery Fund*
John McLaren spoke to this item which was in regard to the Staff Lottery Fund (Fund 54) and to consider if it was appropriate for this to continue to be included within the endowment portfolio as it was funded purely by money from the staff who are in the lottery. John explained that a quarter of monies received are kept within the fund with the remainder spent on prize money. It was noted that there was approximately £100 being added to the fund each month, after prizes, and if relaunched across the organisation there was potential to increase this.

John asked that should Trustees agree that it was not appropriate to keep this fund within the endowment portfolio if consideration could be given to move this to the Staff Wellbeing Group to manage. John also highlighted that a potential use of funds would be to purchase gift vouchers for long service awards for staff.

Susan Swan stressed that for funds to be spent on long service awards the fund would have to be extricated from endowments.

Ralph Roberts appreciated this but still felt endowments was the correct place to hold this fund and would like to understand if it was made explicit to staff who pay into the lottery, around the use of funds, if it could be used for this purpose.

Karen Hamilton also noted caution that no staff were disadvantaged, providing an example of staff who may fall between the milestones described in the paper.

Susan reminded Trustees that OSCR's explicit decision was that endowment funds are not spent on long service awards.

John highlighted that there was almost £30k in the fund which was evidence of the lack of spending and felt that if some of the balance could be used towards long service awards it would help boost staff morale.

Lucy O'Leary asked what staff currently thought the benefit of this fund was for. Lucy also suggested that if all staff were encouraged to sign up to this, which would then be to everyone's benefit, and would fit with OSCR's guidance. As the balance had continued to increase over recent years with no spend John advised that he had responded to queries from staff that the monies were not being spent.

Sonya Lam stressed the need for staff engagement in regard to moving this fund and highlighted that staff could be disadvantaged if they had been employed by another NHS Board prior to their service with NHS Borders, this meaning they would not receive the awards for total service to NHS, only to NHS Borders, and

this fact would have to be made explicit in any long service scheme introduced. Karen appreciated that this could occur and assured that these cases would be dealt with appropriately.

Karen Wilson questioned if this was charitable money in the truest sense and if it was moved out of the endowment portfolio it may free up the funds for using on staff in a greater way.

Ralph noted that if OSCR's view is that it would be inappropriate to use funds for long service awards then he assumed they must be of a view that this should come from core funding, therefore queried if this was the correct thing to do as it appeared that staff would be funding this themselves from the money paid into the lottery.

Karen H asked if there was somewhere better placed in the organisation to investigate this further and recommendations could be brought back to the Board of Trustees. Following discussion Ralph suggested that he, John, Karen H, Karen W and Susan meet to discuss both aspects of the proposition, namely where the fund should sit in the organisation and the feasibility of introducing a long service awards scheme. Ralph stressed the need to make a decision on this as soon as possible so it could move forward and that a further proposal would be brought back to Trustees.

**Trustees noted the report and that a further proposal would be brought back in due course.**

10. **Capital Spend**

10.1 *Capital Projects Update*

Susan Swan, in the absence of Andrew Bone, agreed to get a briefing on the Macmillan phase 1 project and circulate this around Trustees for information.

**The Board of Trustees noted the report.**

11. **Any Other Business**

*Mark McLean left the meeting*

*Investment Advisor Contract*

Susan Swan reminded Trustees that the contract with Investec had been extended for a period of 2 years until March 2024. The extension, at that time, had been with the expectation that a new constitution would be in place for NHSS Endowment Funds as recommended by the Scottish Government review, however given the delay in this timescale it would now not be in place by the end of the extended contract term and therefore there was a need to explore a further extension or agree to go back out to tender. Susan advised that she would be emailing out to Trustees for comments on the way forward in due course. James Ayling highlighted that if the current contract expired in March this would need to be expedited at pace.

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

To be confirmed.

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4th April 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:**

- Decision

**This report relates to a:**

- Annual Operational Plan/Remobilisation Plan

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

- Effective

## 2 Report summary

## 2.1 Situation

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

An updated financial plan was submitted to Scottish Government on 15th March 2024 alongside submission of the Board's Draft Annual Delivery Plan. At time of preparation of this paper no feedback has been received in relation to this submission.

Because of the significant deficit outlined in the plan and the ongoing work towards identification of financial recovery actions to address this deficit the plan remains draft.

As such, the Board is not able to approve a financial plan for 2024/25 at its meeting on 4th April 2024.

In order to maintain effective systems of internal control, including budgetary control, it is proposed that the Board sets an interim budget for 2024/25 in line with the recommendations outlined within the paper.

A final budget will be presented to the Board following agreement of the Board's medium term financial plan and recovery plan with Scottish Government.

## 2.2 Background

At its meeting on 1st February 2024 the Board received an update on progress towards the development of its medium term financial plan.

This update set out a projected deficit before savings of £46.5m in 2024/25, with expected savings and management actions reducing this deficit to a projected outturn position of £32m deficit in year.

This position was £15m above the limit for brokerage support (i.e. borrowing) from Scottish Government and as such it was expected that Scottish Government would require the Board to undertake further work to identify additional financial recovery actions to address this gap.

Since preparation of this draft plan the Board has received feedback from Scottish Government on its initial submission which advised the Board of additional resources available in 2024/25, together with a corresponding reduction to the level of brokerage support available to the Health Board in that year; this limit is now set at £14.8m. In addition to these changes the Board was requested to continue to develop its financial recovery actions and to provide further detail of savings plans identified to date.

## 2.3 Assessment

Following submission of the draft financial plan to Scottish Government on 29th January 2024 a workshop was held with Board members on 19th February to consider options for financial recovery actions. An updated draft plan was reviewed by the Resources & Performance Committee at its meeting on 7th March and following further discussion has been submitted to Scottish Government on 15th March alongside submission of the Board's draft Annual Operational Plan.

### Updated Draft Financial Plan

Table 1 describes progress towards the development of the Board's financial plan from the position presented to the Resources & Performance Committee in January to the draft submission to Scottish Government at end of January and the updated submission to Scottish Government at 15th March 2024.

**Table 1 – Movement in draft financial plans 2024/25**

| | R&PC Jan-24 | | | Draft Plan - Jan-24 | | | Draft Plan - Mar-24 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £m | NR £m | Total £m | R £m | NR £m | Total £m | R £m | NR £m | Total £m |
| **Opening Gap** | **-30.2** | | **-30.2** | **-31.1** | **-3.6** | **-34.7** | **-33.6** | **-1.1** | **-34.7** |
| Additional Commitments | -17.0 | -4.4 | -21.4 | -11.1 | -2.1 | -13.2 | -10.9 | -3.5 | -14.4 |
| Additional Resources | 1.5 | 1.6 | 3.1 | 3.5 | 1.6 | 5.1 | 3.5 | 5.2 | 8.7 |
| **Net Gap Before Savings** | **-45.7** | **-2.8** | **-48.5** | **-38.7** | **-4.1** | **-42.8** | **-41.0** | **0.6** | **-40.4** |
| Savings | 9.0 | 2.5 | 11.5 | 8.0 | 2.7 | 10.6 | 12.6 | 2.1 | 14.6 |
| **Forecast Outturn** | **-36.7** | **-0.3** | **-37.0** | **-30.7** | **-1.5** | **-32.2** | **-28.4** | **2.7** | **-25.8** |
| **Brokerage Limit** | | **17.0** | **17.0** | | **17.0** | **17.0** | | **14.8** | **14.8** |
| *Shortfall against Brokerage Limit* | *-36.7* | *16.7* | *-20.0* | *-30.7* | *15.5* | *-15.2* | *-28.4* | *17.5* | *-11.0* |

The movements in forecast between January and March include additional funding assumed in relation to employer pension contributions and New Medicines Fund.

Cost pressures included in the plan were amended following the quarter three review to reflect the (net) forecast outturn in 2023/24.

The brokerage limit has been reduced following submission of draft plan to Scottish Government in January; this reflects corresponding changes to the level of funding available via New Medicines Fund.

Table 2 summarises the projected outturn position as set out in the draft updated medium term financial plan.

**Table 2 – Summary, draft medium term financial plan**

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £m | NR £m | Total £m | R £m | NR £m | Total £m | R £m | NR £m | Total £m |
| Financial Gap before Savings | -41.0 | 0.6 | -40.4 | -33.6 | 0.1 | -33.5 | -31.0 | 0.8 | -30.2 |
| Estimated Savings | 12.6 | 2.1 | 14.6 | 12.6 | 1.8 | 14.4 | 6.4 | 4.6 | 10.9 |
| **Forecast Outturn** | **-28.4** | **2.7** | **-25.8** | **-21.0** | **1.9** | **-19.1** | **-24.6** | **5.3** | **-19.3** |

The plan sets out the projected outturn position in 2024-25 and the following two years, based on draft savings plans developed to date and reflective of projected expenditure growth. As advised in previous iterations of the plan, these projections exclude assume that the costs of pay policy implementation will be fully funded.

The cumulative deficit before savings is projected to rise to £56.2m by March 2027. The position modelled above assumed a reduced opening deficit in each year's plan based on delivery of recurrent savings in the preceding year.

The cumulative level of recurrent savings over 3 years is estimated at £31.4m. The £19.3m gap at March 2027 requires that these savings are delivered in full over the 3 year position.

Should further recovery actions not be identified, the Board would require Scottish Government brokerage of £64.2m over the 3 years of the plan. The cumulative repayable brokerage (including prior year borrowing) at March 2027 is estimated at £100m.

As described the plan does not present a balanced financial position over the medium term and as such is unlikely to be accepted by Scottish Government. Further to this, the level of brokerage likely to be required as a consequence of this position presents a significant risk to the ongoing sustainability of NHS Borders.

Further detail on the projected expenditure and savings outlined in the plan is set out below and in the appendix to the report.

## Financial Recovery Plans

Table 3 summarises the savings plans outlined to date. This includes potential opportunities which remain in development, including some areas where service changes are likely to require stakeholder engagement and may require policy change at Scottish government level.

**Table 3- Projected savings**

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £m | NR £m | Total £m | R £m | NR £m | Total £m | R £m | NR £m | Total £m |
| **Planned Savings** | **7.9** | **2.1** | **9.9** | **6.9** | **1.8** | **8.6** | **6.4** | **4.6** | **10.9** |
| Schemes in Development | | | | | | | | | |
| Included in forecast as achieveable | 4.7 | | 4.7 | 5.8 | | 5.8 | | | 0.0 |
| Excluded pending further review | 1.7 | | 1.7 | 1.7 | | 1.7 | 2.2 | | 2.2 |
| **Schemes in Development** | **6.4** | **0.0** | **6.4** | **7.4** | **0.0** | **7.4** | **2.2** | **0.0** | **2.2** |
| | | | | | | | | | |
| **Projected Savings** | **12.6** | **2.1** | **14.6** | **12.6** | **1.8** | **14.4** | **6.4** | **4.6** | **10.9** |
| *Additional Schemes not included* | *1.7* | | *1.7* | *1.7* | | *1.7* | *2.2* | | *2.2* |

The draft financial plan identifies potential recurring savings of £31.4m over three years, with a further £8.5m of non-recurrent savings over the same period. This includes a significant element of high risk schemes for which implementation plans are not yet in place.

Planned savings identified in the trajectory incorporate risk-adjusted local savings submissions, amended for further savings expected to be delivered through enhanced grip & control measures, including reduction to use of premium rate staffing (e.g. agency), and ongoing actions to minimise discretionary non-clinical expenditure.

*Schemes in Development* includes actions to reduce the level of unfunded 'surge' bed capacity, together with higher risk actions identified through local savings submissions and further opportunities currently being scoped in relation to longer term transformation plans. This includes options for greater collaboration with other public sector partners through development of shared services and review of regional and national clinical services.

Table 4 outlines progress towards identification of savings against the 10% savings requirement set for all business units, to be delivered over 3 years, with a requirement for 3% recurring savings in 2024/25 augmented by a further 1% to be delivered non-recurrently.

**Table 4 – Summary, Business Unit savings opportunities identified to date**

| | Cumulative (10%) | | | Recurring (3%) | | | Non-Recurring (1%) | | |
|---|---|---|---|---|---|---|---|---|---|
| **Business Unit** | Target £m | Plan £m | Gap £m | Target £m | Plan £m | Gap £m | Target £m | Plan £m | Gap £m |
| Acute | 10.4 | 8.7 | 1.7 | 3.1 | 1.0 | 2.1 | 1.0 | 0.0 | 1.0 |
| Primary & Community Services | 6.1 | 6.9 | 0.2 | 1.8 | 3.7 | 0.2 | 0.6 | 0.0 | 0.6 |
| Mental Health & LD | 2.2 | *4.9* | 0.0 | 0.7 | 0.9 | 0.0 | 0.2 | 0.1 | 0.2 |
| Corporate | 2.9 | 1.0 | 1.9 | 0.9 | 0.5 | 0.4 | 0.3 | 0.1 | 0.2 |
| Estates & Facilities | 2.3 | 0.5 | 1.8 | 0.7 | 0.2 | 0.5 | 0.2 | 0.1 | 0.1 |
| Commissioning | 4.2 | 2.0 | 2.2 | 1.3 | 1.3 | 0.0 | 0.4 | | 0.4 |
| **Business Unit Totals** | **28.1** | **24.1** | **7.7** | **8.4** | **7.6** | **3.2** | **2.8** | **0.3** | **2.5** |

Although there appears to be areas where savings identified exceed the target level, this incorporates a number of potential opportunities where savings are mutually

exclusive, i.e. where delivery of one option will preclude delivery of its counterpart. The gap against target has been adjusted to cap potential savings at the target level in order to reflect this position.

Table 5 presents a summary of the actual planned savings presented for 2024/25 by category.

**Table 5 - Savings by category, 2024/25**

| Savings Category | R £m | NR £m | Total £m |
|---|---|---|---|
| Workforce Medical | 0.68 | 0.50 | 1.18 |
| Workforce Nursing | 1.35 | 0.50 | 1.85 |
| Workforce Other | 1.17 | 0.16 | 1.34 |
| Prescribing | 2.88 | 0.00 | 2.88 |
| Procurement | 0.13 | 0.00 | 0.13 |
| Estates & Infrastucture | 0.13 | 0.12 | 0.25 |
| Commissioning | 1.31 | 0.00 | 1.31 |
| Grip & Control | 0.04 | 0.25 | 0.29 |
| Non Pay Review | 0.16 | 0.54 | 0.70 |
| | **7.86** | **2.07** | **9.93** |

Plans comprise c. £7.9m in relation to local business unit plans with a further £2.0m in relation to the enhanced grip & control activities outlined above. Further work is required to finalise the implementation plans, including identification of delivery risks and anticipated phasing. It is likely that there will be some slippage to the level of actual savings delivered during 2024/25. Delivery risks will be managed through the Board's Financial improvement Programme (FIP) and Quality & Sustainability Programme Board.

In addition to the schemes above, NHS Borders continues to work towards the opportunities identified through the national '15-box grid' approach, which focusses on workforce, prescribing and service productivity as key areas of opportunity for improved efficiency. Where these are expected to contribute to cash releasing savings, this is captured through the savings plans as outlined.

## Next Steps

Regular discussions continue with SG colleagues in relation to the development of financial recovery plans and feedback on the recent submission to Scottish Government is expected within the next fortnight.

Although the Board's overall deficit is an outlier, the level of savings identified to date is consistent with progress across other Health Boards. Nonetheless, the continued shortfall against the level of brokerage available to the Board in 2024/25 means that there will need to be further progress on identification and implementation of measure that support improvement to the in year financial position in 2024/25.

Scottish government have indicated that they are unlikely to request a further iteration of the financial plan but will instead expect NHS Boards to shift focus towards delivery

of 2024/25 plans and will review future progress on identification of financial recovery actions through the established quarterly review framework.

Despite this, it is intended that a further iteration of the plan will be prepared at end April in tandem with a financial recovery plan which sets out the full scope of actions necessary to deliver a breakeven position over the medium term.

**Budget Setting**

The Board should recognise that the financial plan remains unbalanced and that – even should all identified savings be delivered and brokerage be received in line with forecast – there will be a further gap which remains unaddressed. In order to provide management with a budgetary limit to operate within as plans continue to be developed it is proposed that the Board approve an interim budget. The basis on which this would be set is outlined below.

The plan sets out an opening deficit at April 2024 of £28.1m. This deficit is projected to rise to £40.4m by March 2025.

Savings targets have been delegated on the basis of the opening deficit of £28.1m and it is proposed that this forms the basis of the initial budget to be implemented for 2024/25.

In addressing this deficit the Board would expect that savings plans identified to date within the current financial plan are delivered in full. At target savings for 2024/25 this would deliver £11.2m and beyond this there is a further £3.2m currently included in draft plans which are considered achievable.

Should savings be delivered in line with plan, this would result in a net deficit, before growth and other commitments outlined in the plan, of £13.5m. This is within the scope of the brokerage limit set out by Scottish Government and would therefore allow the Board to set an interim budget on this basis.

The proposed approach to an interim budget as outlined would mean that no budget is set in relation to expenditure growth forecast within the draft financial plan, including a number of cost pressures where there is already ongoing expenditure. This includes surge beds, prescribing growth (above 2023/24 levels) and other cost pressures.

Since there is no available source of funding to meet these pressures further work will be required to manage in year impacts wherever possible, although it remains highly likely that a significant element of these costs will manifest as overspend through normal performance monitoring.

Recommendation is however that the Board set an interim budget for 2024/25 and that this budget is reviewed on a quarterly basis throughout 2024/25 until such time as a balanced financial plan is presented for approval of the Board.

It remains the intention that options for a balanced plan will be presented by the end of April 2024.

### 2.3.1 Quality/ Patient Care
### 2.3.2 Workforce
### 2.3.3 Financial

The development of the financial plan and 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 full risk assessment has not yet been undertaken. Individual risks are being assessed at project level in relation to financial recovery plans.

### 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 plan was presented to the Resources & Performance Committee on 7th March and staff briefing sessions have been held during February and March. A briefing was provided to council members on 26th March 2024 and further engagement is planned on an ongoing basis.

### 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, 7th March 2024
- Board Executive Team, 12th & 19th March 2024
- Quality & Sustainability Board, 26th March 2024

## 2.4 Recommendation

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

The Board is asked to approve the proposed issue of an interim (revenue) budget for 2024/25 aligned to the expected opening deficit at April 2024. This deficit is aligned to the recurrent savings targets set for individual business units over the medium term and excludes any provision for growth in expenditure during 2024/25 pending identification of actions to address this growth (including any additional resources, where available).

The Board/Committee will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

It is recommended that the Board take limited assurance from this report, recognising the current status of the draft financial plan and level of risk attendant on identification and implementation of savings plans.

## 3 List of appendices

The following appendices are included with this report:

- Appendix 1 – Draft Financial Plan

**Appendix 1 – Draft Financial Plan**

## Summary of Revenue Outturn

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s |
| Gross Expenditure - Clinical & Non-clinical | 323,277 | 39,186 | 362,462 | 315,823 | 38,762 | 354,585 | 319,491 | 33,663 | 353,154 |
| Less: Gross Income | 11,610 | 0 | 11,610 | 11,610 | 0 | 11,610 | 11,610 | 0 | 11,610 |
| **Total Expenditure** | **311,667** | **39,186** | **350,852** | **304,213** | **38,762** | **342,975** | **307,881** | **33,663** | **341,544** |
| Less: Total Non-Core RRL Expenditure | 0 | 6,792 | 6,792 | 0 | 7,070 | 7,070 | 0 | 7,224 | 7,224 |
| Less: FHS Non Discretionary Net Expenditure | 13,452 | 0 | 13,452 | 13,452 | 0 | 13,452 | 13,452 | 0 | 13,452 |
| **Core Revenue Resource Outturn** | **298,215** | **32,394** | **330,608** | **290,761** | **31,692** | **322,453** | **294,429** | **26,439** | **320,868** |
| Baseline Allocation | 260,456 | 0 | 260,456 | 269,785 | 0 | 269,785 | 269,785 | 0 | 269,785 |
| Anticipated Allocations: Rec/ Non-rec/ Earmarked | 9,329 | 35,062 | 44,391 | 0 | 33,545 | 33,545 | 0 | 31,769 | 31,769 |
| **Core Revenue Resource Limit (RRL)** | **269,785** | **35,062** | **304,847** | **269,785** | **33,545** | **303,330** | **269,785** | **31,769** | **301,554** |
| **Forecast Variance against Core RRL** | **-28,430** | **2,668** | **-25,762** | **-20,976** | **1,853** | **-19,124** | **-24,644** | **5,330** | **-19,314** |
| **Forecast Variance (% of Core RRL)** | | | **-8.5%** | | | **-6.3%** | | | **-6.4%** |

***Savings summary***

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Financial Gap before Savings** | **-41,003** | **598** | **-40,405** | **-33,624** | **103** | **-33,522** | **-31,019** | **780** | **-30,239** |
| **Savings Target** | 12,573 | 2,070 | 14,643 | 12,648 | 1,750 | 14,398 | 6,375 | 4,550 | 10,925 |
| **Forecast Variance against Core RRL** | **-28,430** | **2,668** | **-25,762** | **-20,976** | **1,853** | **-19,124** | **-24,644** | **5,330** | **-19,314** |

## Forecast Outturn Detail (prior to savings)

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s |
| **Additional Funding** | | | | | | | | | |
| Uplift on baseline | 0 | | 0 | 0 | | 0 | 0 | | 0 |
| NRAC Adjustment | 1,500 | | 1,500 | 1,500 | | 1,500 | 0 | | 0 |
| New Medicines Funding | 0 | 2,170 | 2,170 | | 2,170 | 2,170 | | 2,170 | 2,170 |
| Other new allocations | 2,000 | 3,000 | 5,000 | | 1,500 | 1,500 | | 0 | 0 |
| Additional income | | | 0 | | | 0 | | | 0 |
| **Total Additional Funding** | **3,500** | **5,170** | **8,670** | **1,500** | **3,670** | **5,170** | **0** | **2,170** | **2,170** |
| **Brought Forward Pressures** | | | | | | | | | |
| Unachieved Savings (from prior year) | 23,044 | | 23,044 | 28,430 | | 28,430 | 20,976 | | 20,976 |
| AfC Staff | 1,900 | | 1,900 | 0 | | 0 | 0 | | 0 |
| Medical and Dental staff | 300 | | 300 | 0 | | 0 | 0 | | 0 |
| Other Brought Forward Pressures | 8,364 | 1,050 | 9,414 | 0 | 1,500 | 1,500 | 0 | 1,500 | 1,500 |
| **Total Brought Forward Pressures** | **33,608** | **1,050** | **34,658** | **28,430** | **1,500** | **29,930** | **20,976** | **1,500** | **22,476** |
| **Pressures** | | | | | | | | | |
| **Pay** | | | | | | | | | |
| **Uplifts** | | | | | | | | | |
| Pay Uplift - AfC | 0 | | 0 | 0 | | 0 | 0 | | 0 |
| Pay Uplift - Medical & Dental | 0 | | 0 | 0 | | 0 | 0 | | 0 |
| Pay Uplift - Other | 0 | | 0 | 0 | | 0 | 0 | | 0 |
| **Total Uplift Pressures** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **Workforce** | | | | | | | | | |
| Nursing | 350 | | 350 | | | 0 | | | 0 |
| Medical | 150 | | 150 | | | 0 | | | 0 |
| Other Staffing | 2,000 | | 2,000 | | | 0 | | | 0 |
| **Total Pay Pressures** | **2,500** | **0** | **2,500** | **0** | **0** | **0** | **0** | **0** | **0** |

## Forecast Outturn Detail (prior to savings)

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s |
| **Non Pay** | | | | | | | | | |
| **Prescribing** | | | | | | | | | |
| Acute Prescribing | 1,240 | | 1,240 | 1,339 | | 1,339 | 1,447 | | 1,447 |
| Primary Prescribing | 2,409 | | 2,409 | 2,602 | | 2,602 | 2,810 | | 2,810 |
| **Total Prescribing Pressures** | **3,649** | **0** | **3,649** | **3,941** | **0** | **3,941** | **4,256** | **0** | **4,256** |
| **Estates and Infrastructure** | | | | | | | | | |
| Energy Costs | 469 | | 469 | 91 | | 91 | 93 | | 93 |
| PPP/PFI | | | 0 | | | 0 | | | 0 |
| Other Estate Level Costs | 182 | 1,500 | 1,682 | 259 | 1,500 | 1,759 | 282 | 1,500 | 1,782 |
| **Total Estate and Infrastructure Pressures** | **651** | **1,500** | **2,151** | **349** | **1,500** | **1,849** | **374** | **1,500** | **1,874** |
| **Digital** | | | | | | | | | |
| Office 365 | 50 | | 50 | | | 0 | | | 0 |
| e-Rostering | | 400 | 400 | | 400 | 400 | 250 | | 250 |
| PACS (Picture Archiving and Communications Systems) | | 33 | 33 | | 78 | 78 | | 51 | 51 |
| Payroll Modernisation | | | 0 | | | 0 | | | 0 |
| Other National Programmes | | | 0 | | | 0 | | | 0 |
| Local Programmes | | 1,000 | 1,000 | | 1,000 | 1,000 | 265 | 1,000 | 1,265 |
| **Total Digital Pressures** | **50** | **1,433** | **1,483** | **0** | **1,478** | **1,478** | **515** | **1,051** | **1,566** |
| **Service Level Agreements** | 1,686 | | **1,686** | 1,770 | | **1,770** | **1,859** | | **1,859** |

## Forecast Outturn Detail (prior to savings)

| | 2024-25 | | | 2025-26 | | | 2026-27 | | |
|---|---|---|---|---|---|---|---|---|---|
| | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s | R £000s | NR £000s | Total £000s |
| **Other Board Specific Non Pay** | | | | | | | | | |
| CNORIS | 388 | | 388 | | | 0 | | | 0 |
| National Services | 0 | | 0 | 87 | | 87 | -19 | | -19 |
| Regional Services | 93 | 250 | 343 | | 250 | 250 | 500 | | 500 |
| A&E Workforce | 1,000 | | 1,000 | | | 0 | | | 0 |
| PCIP Demonstrator Site | | 3,000 | 3,000 | | 1,500 | 1,500 | 2,000 | | 2,000 |
| Other Non Pay | 878 | | 878 | 547 | | 547 | 558 | | 558 |
| **Other Board Specific Non Pay** | **2,359** | **3,250** | **5,609** | **634** | **1,750** | **2,384** | **3,039** | **0** | **3,039** |
| **Total Non Pay Pressures** | **8,395** | **6,183** | **14,577** | **6,694** | **4,728** | **11,423** | **10,043** | **2,551** | **12,594** |
| **Pressure Offsets** | | | | | | | | | |
| **Non-Recurrent Programmes (including Financial Management)** | | | | | | | | | |
| Financial Flexibility | | 2,661 | 2,661 | | 2,661 | 2,661 | | 2,661 | 2,661 |
| ***Total Non-Recurrent Measures*** | | 2,661 | **2,661** | | 2,661 | **2,661** | | 2,661 | **2,661** |
| **Financial Gap Before Savings** | **41,003** | **-598** | **40,405** | **33,624** | **-103** | **33,522** | **31,019** | **-780** | **30,239** |

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Provision of Resources to the Scottish Borders Integrated Joint Board** |
| **Responsible Executive/Non-Executive:** | **Andrew Bone, Director of Finance** |
| **Report Author:** | **Andrew Bone, Director of Finance** |

## 1 Purpose

**This is presented to the Board for:**

- Decision

**This report relates to a:**

- NHS Board/Integration Joint Board Strategy or Direction

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

- Effective

## 2 Report summary

## 2.1 Situation

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

The budget offer outlined within this paper is prepared in the context of the ongoing development of NHS Borders' financial plan and as such this offer is recommended to the Board for approval as interim pending finalisation of the financial plan.

## 2.2 Background

The Chief Officer of the IJB wrote to the Directors of Finance of NHS Borders and Scottish Borders Council on 22nd December 2023 to request that the partners to the IJB provide confirmation of budgetary resources available to the IJB in advance of its meeting on 24th January 2024.

Work towards the development of the NHS Borders financial plan has been ongoing from late 2023 however due to the scale of deficit projected in the plan, together with uncertainty over key planning assumptions, there has been a delay in the issue of a budget offer to the IJB.

The IJB chair and vice-chair of the IJB wrote to the Chair of NHS Borders Health Board on 14th March 2024 to express their concern regarding the delay to the issue of this offer and to request that this is expedited. This issue was further discussed at the meeting of the Integration Joint Board on 20th March 2024.

A letter outlined an initial budget offer was issued by the Director of Finance to the Chief Officer (IJB) on 27th March 2024. This offer was made on an interim basis pending approval by the NHS Borders Board.

A copy of this letter is attached as appendix to this paper.

**Scheme of Integration**

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

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

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

As a result of the absence of the Chief Finance Officer the Health Board financial plan has been prepared using internal assessment of HSCP cost pressures and with limited input from the IJB. Both partners recognise the need for the IJB to have greater input to their own financial planning processes and that this should be addressed as a priority for 2025/26 financial planning round.

The *Interim* Chief Finance Officer presented an Initial Budget to the IJB at its meeting on 20th March 2024. This budget comprised the Social Care elements of the HSCP budget, recognising the delay to preparation of the Health budget. Following discussion the IJB deferred approval of this budget pending receipt of the budget offer from NHS Borders.

As such, the IJB faces a delay in approval of its overall budget for 2024/25.

**Budget Setting Methodology**

As described in the letter attached to this paper, the NHS Borders budget offer to the IJB is likely to remain provisional until such time as the Health Board is able to approve its financial plan. An estimated timescale for this has been provided as end June 2024.

In 2019/20 it was agreed that the Health Board and the IJB would adopt an equity-based approach to budget setting which would ensure that the IJB budget share was set based on prioritisation of the overall Health Board resources through a single process. This

meant that the HSCP delegated budgets and Set Aside budget would be allocated funding for pay awards, non-pay inflation and growth, and cost pressures, on a basis consistent with non-delegated functions.

This principle was reaffirmed by the Health Board in setting the 2023/24 budget.

## 2.3 Assessment

The following section outlined the approach taken to the development of the IJB Budget Offer issued on 27th March 2024, subject to approval by the Health Board at its meeting on 4th April 2024.

**Available Resources**

As outlined in the Health Board's draft financial plan, the Scottish Government budget for 2024/25 provides for additional recurring investment to cover the costs of the 2023/24 NHS Pay uplifts and population adjustment (NRAC) to base budget. There is no general uplift applied to NHS base budgets and this presents a significant constraint on the budget offer to the IJB.

Funding for 2023/24 pay uplifts has been passed out to the HSCP delegated functions during 2023/24 and will form part of a revised baseline for 2024/25 budgets. This represents an increase on the initial offer made to the IJB for its 2023/24 budget.

The Health Board expects to receive £1.5m additional funding in respect of the adjustment to base budget to reflect population changes. There is a shortfall in delivery of recurrent savings against the Board's 2023/24 plan and this funding is directed to address this shortfall in order to mitigate increase in baseline pressures at March 2024. This funding is therefore not available to support investment in 2024/25.

A number of other allocations are expected to be received on a non-recurrent basis in 2024/25 and the budget offer will include commitment to continue pass-through of relevant budgets to the IJB according to the purpose for which they are intended. This will include Scottish government priorities within primary care, alcohol and drugs, mental health, and other delegated functions.

Should any change to this approach be proposed it will be subject to separate discussion with IJB officers prior to implementation.

**Budget Offer**

The Health Board will provide baseline resource of £154.3m to the IJB to undertake the functions delegated to it by the Health Board. This includes £28.4m of resources set aside for the large hospitals element.

This represents the recurring base revenue budget provided to the IJB in 2023/24 amended for the following:

- NHS Pay Awards issued in 2023/24 and financed recurrently through the 2024/25 Scottish Government budget settlement.
- Additional support to recurring cost pressures identified during 2023/24, notably additional in year prescribing growth.

- Share of the unallocated savings gap held by NHS Borders at March 2024 and attributed in line with the Board's internal budget setting process.

**Opening Deficit at April 2024**

The Health Board's financial plan describes a projected baseline deficit of £28.1m at March 2024 before impact of future cost pressures, inflation and growth. This gap represents 10% of the overall base budget and business unit savings targets have been set in line with a proportionate share of this gap.

In setting savings targets on this basis, expenditure included within this baseline position is treated as funded in the financial plan. This includes £2.8m of funds allocated in respect of cost pressures emerging in 2023/24 within HSCP delegated functions, the majority of which is related to GP prescribing.

The approach to delegation of savings targets within the IJB budget offer is described below.

**Pay Policy**

The offer outlines assumptions in respect of additional investment relating to Pay Policy.

In line with Health Board financial planning, it is assumed that Scottish Government will provide additional resources to address the financial impact of the following:

- Increase to employer pension contributions effective from 1st April 2024
- Non pay elements of the Agenda for Change Deal in 2023/24, including reduced working week,
- protected learning time and review of Band 5 banding for nursing roles.
- NHS Pay uplift for 2024/25, for which negotiations have not yet progressed.

The Health Board is committed to passing through any additional funding made available during 2024/25 in respect of pay policy, in line with the principles of its 'equity' approach to budget setting.

**Forecast expenditure growth 2024/25**

The Health Board's financial plan forecasts an additional £12m growth in expenditure above the level outlined within the opening deficit at April 2024. This growth is comprised of inflationary impacts across medicines, supplies and services, as well as emerging cost pressures and proposed investments where there is no available source of funds.

The IJB budget offer outlines a projected £7.1m cost pressure within the IJB in addition to its savings targets; this represents the share of projected Health Board cost pressures, etc. which relate to HSCP delegated functions.

There is no funding available to offset this expenditure and the IJB is requested to work with the Health Board to identify mitigation against these pressures.

## Savings Targets

In previous years, the IJB budget offer has included only the element of savings target which was directly allocated to HSCP delegated functions, with the Health Board retaining an unallocated element which had not been distributed directly to either delegated or non-delegated functions.

The budget offer to the IJB in 2023/24 set out the expected treatment of this unallocated element, including how increased pressures in the 2023/24 plan were to be linked to savings targets. Implementation of this approach was deferred during the past year due to agreement of additional brokerage support on a non-recurrent and repayable basis with Scottish Government.

The IJB budget letter attached as appendix outlines a revised savings target for the IJB calculated based on the principles of the 'equity' approach to budget setting, and attributing to the IJB its share of the £28.1m opening deficit at April 2024.

## Delivery of Financial Balance

In setting the final budget for 2024/25 the Health Board will need to agree with the IJB the level of savings expected to be achievable in year, and therefore any level of support requested by the IJB in order to meet its statutory requirement to breakeven. This support may include any additional cost pressures emerging in year.

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

The Health Board's Medium Term Financial Plan outlines an expected deficit of c.£40m before savings delivery in 2024/25. The current draft financial plan as at end March indicates that – after savings – this gap will reduce to £25.8m. As is demonstrated in the delegated budget to the IJB, an element of this deficit relates to HSCP and Set Aside budgets.

The Scheme of Integration provides that should the IJB be unable to present a balanced financial plan it should prepare its own financial recovery plan. The Chief Officer (CO) has requested that health board colleagues work with the *Interim* CFO to support development of this plan.

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

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

This assumption does however present an increased risk given both the scale of the borrowing accumulated to date and projected as required in future; and the wider NHS Scotland financial context, where it is by no means certain that brokerage will be available to meet the required level of support.

Although no timeframe has been agreed with Scottish Government for repayment of this borrowing, the Medium Term Financial Framework applicable to NHS Boards would require repayment from the point at which a Health Board has returned to financial balance.

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

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

### 2.3.1 Quality/ Patient Care

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

### 2.3.2 Workforce

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

### 2.3.3 Financial

Financial information is included in the body of the paper.

### 2.3.4 Risk Assessment/Management

Risks in relation to the Health Board's financial plan are considered through separate risk assessment.

There is a risk that the settlement contained within the budget offer is unable to be financed by the Health Board due to the wider financial challenges faced by the Board. The conditions of this offer, together with the prudent nature of funds outlined, present mitigation of this risk.

There is a further risk that the IJB will be unable to identify sufficient actions to address the financial gap set out in the letter. This risk is subsidiary to the extant financial planning risk held by the Board and does not present an additional risk to the Board.

Any further risks arising in relation to the IJB budget settlement will be considered following issue of the IJB directions to the Health Board in relation to its 2024/25 budget.

### 2.3.5 Equality and Diversity, including health inequalities

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

### 2.3.6 Climate Change

There are no relevant impacts described in the budget.

### 2.3.7 Other impacts

There are no relevant impacts described in the budget.

### 2.3.8 Communication, involvement, engagement and consultation

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

### 2.3.9 Route to the Meeting

The IJB budget offer is a product of the NHS Borders Financial Plan. The draft financial plan has been discussed by the Board through meetings of its Resources & Performance Committee during the period January to March 2024.

The Director of Finance met with the IJB Chief Officer and Interim IJB Chief Financial Officer on 28th March 2024 to discuss the terms of the offer.

## 2.4 Recommendation

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix 1, Letter to the Chief Officer of the IJB presenting the Budget Offer from NHS Borders

**Borders NHS Board**

**Finance Department**
Newstead
Melrose
Roxburghshire
TD6 9DA

**www.nhsborders.scot.nhs.uk**

Mr C Myers
Chief Officer
Health & Social Care Integration Joint Board
c/o Education Centre
Borders General Hospital
Melrose TD6 9BD

Date 27th March 2024
Our Ref

Direct Line 01896 825501

Dear Chris

**PROVISION OF RESOURCES TO THE HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD – INITIAL BUDGET 2024/25**

In line with the Scheme of Integration I am writing to confirm the Health Board's initial budget offer to the Scottish Borders Integration Joint Board. This offer remains indicative pending approval by the Health Board at its meeting on 4th April 2024.

As you are aware, the scale of the deficit faced across NHS Scotland is unprecedented, and within this position NHS Borders is a relative outlier proportionate to its overall budget. This situation has required that the Health Board undertake a level of scrutiny over its financial plans and recovery actions which has in turn led to delays in the development of these plans and in setting out a budget offer to the IJB.

As a result, I must apologise for the length of time taken to respond formally to your letter.

It is in the context of the ongoing work to develop the Health Board's plans that this Initial budget offer to the IJB is made.

The final *Initial* budget to be provided to the IJB will be confirmed following approval of the Health Board's financial plan. At this stage I would advise that this is unlikely to be before end June 2024. I do not anticipate any changes from the figures presented here, except where additional resources may be made available by Scottish Government (as referenced below).

**Budget Offer**

The Health Board will, in 2024/25, provide baseline resource of £154.3m to the IJB to undertake the functions delegated to it by the Health Board. This includes £28.4m of resources *set aside* for the large hospitals element.

This offer is an increase of 1.7% above the initial budget for 2023/24.

This represents the recurring base revenue budget provided to the IJB in 2023/24 amended for the following:

- NHS Pay Awards issued in 2023/24 and financed recurrently through the 2024/25 Scottish Government budget settlement.
- Additional support to recurring cost pressures identified during 2023/24, notably additional in year prescribing growth.
- Share of the unallocated savings gap held by NHS Borders at March 2024 and attributed in line with the Board's internal budget setting process.

The detail of these budgets is presented in Appendix 1 to this letter.

In setting these budgets the Health Board has continued to apply the 'equity model' previously agreed with the IJB, which ensures consistency of approach to budget setting for delegated and non-delegated functions within the overall NHS Borders budget.

**Unfunded Cost Pressures**

There are a number of further cost pressures and other commitments which are included within the Health Board's forecast expenditure for 2024/25 and for which the Board has not been able to identify a source of funds. The budget offer does not provide any funding for these costs and as such we would ask that the IJB works with the Health Board to identify how these costs are mitigated or addressed via additional savings.

We estimate that these pressures total £7.1m, of which £2.9m relates to Set Aside budgets. Further detail of these pressures is provided in the Appendix to this letter.

**Non-recurrent Support & Brokerage**

Further to the above, we anticipate that the scale of the challenge faced by the Health Board, and by extension the IJB, will require actions which are phased over a number of years.

We have not, to date, identified any non-recurrent support available to mitigate cost pressures or non-delivery of savings required within the NHS Borders' financial plan. We are however keen to work with the IJB to explore opportunities for support, including where IJB reserves may be used flexibly to address existing challenges.

For 2024/25 NHS Borders has been advised that it will be able to seek brokerage support (i.e. borrowing) to a maximum of £14.8m from Scottish Government. We anticipate that the full extent of this borrowing will be required and would therefore expect that we will discuss with you the level of support that may be required for the HSCP delegated functions.

**Pay Policy**

We continue to plan on the basis that Scottish Government will cover the additional costs of pay policy commitments as advised to NHS Board Chief Executives and Directors of Finance through financial planning discussions. There are three separate elements to expected future commitments, as follows:

- Increase to employer pension contributions effective from 1st April 2024
- Non pay elements of the Agenda for Change Deal in 2023/24, including reduced working week, protected learning time and review of Band 5 banding for nursing roles.
- NHS Pay uplift for 2024/25, for which negotiations have not yet progressed.

Our budget offer to the IJB includes the assumption that any impact of these pay policy elements within delegated functions including Set Aside will be passed through to the IJB budget in full.

**Non Pay inflation and growth**

As outlined above the Health Board does not have any identified source of funding to meet projected growth in 2024/25 and as such all cost pressures are expected to be managed within existing resources wherever possible. This continues to be subject to ongoing dialogue with Scottish Government and should any additional funds be made available to meet these pressures we will pass on share of these resources in line with our 'equity' approach to budget setting (i.e. funds will be dispersed across all NHS functions on an equitable basis).

The budget includes a number of elements for which resources are ring-fenced for direct allocation to Social Care functions from within the Health budget. This includes the Social Care Fund at £8.04m and Resource Transfer at £2.78m. We are unable to provide any uplift to these budgets on the basis that there has been no uplift made available to NHS budgets.

**Additional Ring-Fenced Funds**

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

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

More detail on the level of this funding can be made available upon request.

**Savings Targets**

As described above, the budget offer includes adjustment to reflect a share of the Board's expected recurrent deficit at 31st March 2024. The overall level of Board deficit before cost pressures and growth is £28.1m. Of this, the IJB is allocated £11.7m, of which £3.4m relates to Set Aside.

This represents an increase of £7.2m on previously allocated savings (£2.5m Set Aside). In addition, the IJB will also need to identify actions to address the cost pressures noted above.

Within this is £4.4m which was notified in the Initial budget offer for 2023/24 but which was held in year to be offset by non-recurrent measures identified in the Health Board's plan. A further £2.8m is in relation to additional cost pressures impacting on the baseline deficit at March 2024 and funded within the initial budget offer for 2024/25. Finally, this increase also includes attribution of the £11.4m unallocated gap held by NHS Borders in relation to pre-2023/24 budgets as outlined in the 2023/24 Initial budget offer and for which no agreed methodology has previously been agreed.

In calculating the IJBs overall share of the Board's deficit I have retracted the unmet savings from baseline budgets and re-calculated the IJBs overall share of savings in line with the Health Board's

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

budget setting model, which sets savings targets at 10% of base recurring budgets, adjusted for ring-fenced resources. This approach insulates the IJB from the full impact of the unallocated savings noted above, which would otherwise have been allocated in isolation without consideration of the overall scale of the challenge.

I hope that you will agree that this approach results in allocation to the IJB of a fair share of the overall challenge faced by the Health Board.

**Delivery of Financial Balance**

For 2024/25 I would seek the engagement of the IJB in the development of financial recovery actions to address the in-year deficit however I recognise that - for both the Health Board and the IJB – this is unlikely to be fully achievable.

In setting the final budget for 2024/25 I would expect to agree with the IJB the level of savings expected to be achievable in year, and therefore any level of support requested by the IJB in order to meet its statutory requirement to breakeven. As noted above, I have indicated within the appendix the likely level of support available to HSCP delegated functions based on the upper limit of brokerage available to the Health Board.

**Areas for future discussion**

I would also want to highlight that the Health Board continues to forecast a significant deficit over the medium term and that resourcing of its financial plan in future years remains uncertain.

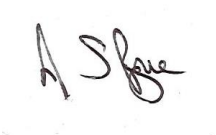
I also acknowledge that there is a need for us to improve joint planning processes in order to fully reflect the IJBs own financial planning within future Health Board financial plans.

Further to this, it will be of joint benefit to both the IJB and the Health Board to work closely to align processes for the identification and implementation of future service change and transformation.

In last year's Initial budget offer I made reference to the need to agree an approach for the repayment of non-recurrent support to the IJB. The Health Board has provided support to a breakeven position for the IJB over a number of years. This support has been financed by three main mechanisms – internal flexibility in Health Board budgets; additional non-payable support from Scottish Government; brokerage (repayable) support from Scottish Government. At end March 2024 I anticipate that the repayable brokerage debt held by the Health Board will be £36m. It is likely that this will increase further at March 2025.

Although no timeframe has been agreed with Scottish Government for repayment of this borrowing, the Medium Term Financial Framework applicable to NHS Boards would require repayment from the point at which a Health Board has returned to financial balance. At this stage I do not envisage that to be within the next three years. Nonetheless it will be important that we agree how any element of repayable brokerage attributable to the health delegated functions within the IJB is treated.

Yours sincerely



Andrew Bone
Director of Finance

NHS BORDERS
PROVISION OF RESOURCES TO
THE SCOTTISH BORDERS INTEGRATION JOINT BOARD

# INITIAL BUDGET 2024/25

## Table 1 – Available Resources

| | HSCP Delegated Functions £000s | Set Aside £000s | Total £000s |
|---|---|---|---|
| Baseline excluding Savings | 134,173 | 31,851 | 166,025 |
| Total Savings | -8,291 | -3,448 | -11,739 |
| **Net Baseline** | **125,882** | **28,403** | **154,285** |

## Table 2 – Comparison to 2023/24 Budget

| | HSCP Delegated Functions £000s | Set Aside £000s | Total £000s |
|---|---|---|---|
| **Initial Baseline Offer 2023/24** | **122,997** | **28,759** | **151,756** |
| *Adjust for HB retained share of Financial Plan gap* | *3,102* | *1,318* | *4,420* |
| Additional Funds allocated in year | 1,668 | 830 | 2,498 |
| **Baseline Budget March 2024** | **127,767** | **30,907** | **158,674** |
| Cost Pressures 2023/24 (recurring) | 2,807 | | 2,807 |
| **Baseline Budget April 2024 before savings** | **130,574** | **30,907** | **161,481** |
| **Additional Savings Allocation** | | | |
| Share of NHSB Baseline Financial Gap | -8,291 | -3,448 | -11,739 |
| Less: unachieved savings included in base | 3,600 | 944 | 4,544 |
| Additional Savings Target 2024/25 | **-4,691** | **-2,504** | **-7,196** |
| **Revised Baseline Budget** | **125,882** | **28,403** | **154,285** |

## Table 3 – Memorandum: Total Savings Requirement including management of cost pressures

| | HSCP Delegated Functions £000s | Set Aside £000s | Total £000s |
|---|---|---|---|
| Budget | 125,882 | 28,403 | 154,285 |
| Projected expenditure (before savings) | 138,322 | 34,776 | 173,099 |
| **Projected Deficit before savings delivery** | **-12,440** | **-6,373** | **-18,813** |

## Table 4 – Current Savings Plans: Summary by Business Units

| | 10% Target £000s | Potential Schemes Identified £000s | Planned Savings 2024/25 £000s |
|---|---|---|---|
| Mental Health & Learning Disabilities | 2,171 | 4,959 | 914 |
| Allied Healthcare Professionals | 888 | 1,011 | 681 |
| Primary & Community Services | 2,679 | 3,478 | 607 |
| GP Prescribing | 2,553 | 1,910 | 1,910 |
| **HSCP Delegated Functions** | **8,291** | **11,359** | **4,112** |
| **Set Aside** | **3,448** | **390** | **198** |
| **Total** | **11,739** | **11,748** | **4,310** |

*Note: Potential schemes identified remain subject to further validation and may include schemes which are mutually exclusive.*

## Table 5 – Additional Cost Pressures 2023/24 (recurring)

| | HSCP Delegated Functions £000s | Set Aside £000s | Total £000s |
|---|---|---|---|
| Mental Health Workforce | 300 | | 300 |
| Prescribing | 1,769 | | 1,769 |
| Vaccines | 538 | | 538 |
| BCE commitments to Primary Care (2022) | 200 | | 200 |
| **Additional Cost Pressures 2023/24 (recurring)** | **2,807** | **0** | **2,807** |

## Table 6 – Unfunded Cost Pressures & Growth 2024/25

| | HSCP Delegated Functions £000s | Set Aside £000s | Total £000s |
|---|---|---|---|
| Medicines & Prescribing Growth | 2,409 | *tbc* | 2,409 |
| Non Pay Inflation | 240 | 25 | 265 |
| A&E Workforce | | 1,000 | 1,000 |
| Surge Capacity | | 1,900 | 1,900 |
| Out of Area Placements (LD) | 1,500 | | 1,500 |
| **Additional Cost Pressures & Growth** | **4,149** | **2,925** | **7,074** |

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Finance Report – February 2024** |
| **Responsible Executive/Non-Executive:** | **Andrew Bone, Director of Finance** |
| **Report Author:** | **Samantha Harkness, Senior Finance Manager**<br>**Janice Cockburn, Finance Business Partner**<br>**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 Climate Change

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

### 2.3.7 Other impacts

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

### 2.3.8 Communication, involvement, engagement and consultation

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

### 2.3.9 Route to the Meeting

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

- Senior Finance Team, 19th March 2024
- Board Executive Team, 26th March 2024

## 2.4 Recommendation

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix 1 - Finance Report for the period to end February 2024

# FINANCE REPORT FOR THE PERIOD TO THE END OF FEBRUARY 2024

## 1 Purpose of Report

1.1 The purpose of the report is to provide Board members with an update in respect of the board's financial performance (revenue) for the period to end of February 2024.

## 2 Recommendations

2.1 Committee Members are asked to:

2.1.1 **Note** that the board is reporting an overspend of £15.92m for eleven months to end of February 2024.

2.1.2 **Note** the updated M11 forecast outturn to £16.3m 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 29th February 2024 is an overspend of £15.92m. This position is summarised in Table 1, below.

*Table 1 – Financial Performance for eleven months to end February 2024*

| | Opening Annual Budget £m | Revised Annual Budget £m | YTD Budget £m | YTD Actual £m | YTD Variance £m |
|---|---|---|---|---|---|
| Revenue Income | 300.90 | 339.52 | 304.84 | 304.26 | (0.58) |
| Revenue Expenditure | 300.90 | 339.52 | 298.08 | 313.42 | (15.34) |
| **Surplus/(Deficit)** | **0.00** | **0.00** | **(6.76)** | **9.16** | **(15.92)** |

3.2 As noted last month, Scottish Government have advised of additional revenue consequentials available in 2023/24 as a result of recent UK budget; in addition, changes to clinical negligence provisions (CNORIS) are expected to provide further improvement to the outturn position. Benefits are non-recurrent and have resulted in an improved forecast to March 2024 (amended to £16.3m deficit) and are reflected in the year to date position.

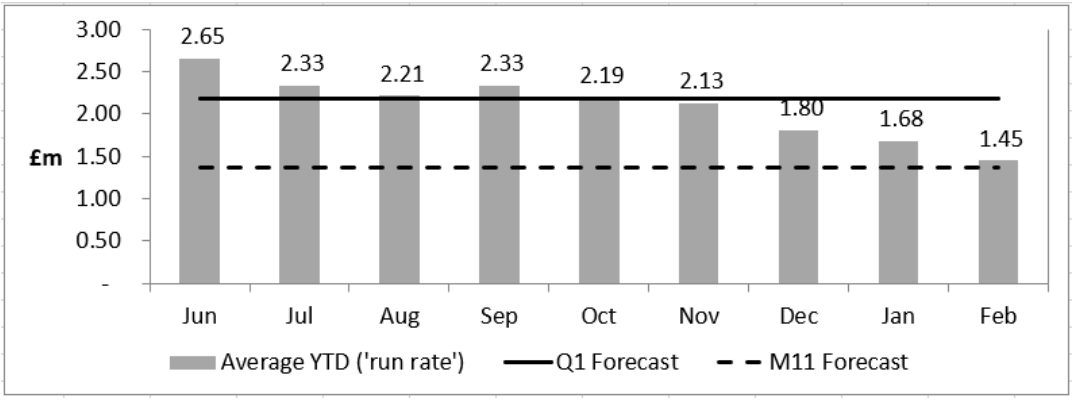
3.3 Despite this improvement, the forecast remains above the target performance set out by Scottish Government, which has been amended to reflect these changes. This target is now set at £14.12m as detailed in Section 6. There remains therefore a shortfall of £2.2m between forecast and expected level of performance.

3.4 In line with previous periods, 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.

3.5 Figure 1 provides an updated 'run rate' against forecast[1].

*Figure 1 – Average YTD 'run rate' compared to plan / forecast*




3.6 In order to meet the amended M11 forecast of £16.3m deficit, the run rate required would need to be at a level of £1.36m per month (average ytd). The actual run rate is sitting at £1.45m per month, however there are specific adjustments in M12 relating to the CNORIS charge that will positively impact and bring the Board in line with the updated Forecast. Further improvement to a run rate of £1.18m would be required in order to meet the Scottish Government's expected outturn position as outlined in Section 6.

3.7 Slippage on ring-fenced allocations and IJB reserves remains subject to final review in March and may result in amendment to the forecast; a prudent position has been adopted regarding flexibility generated through this review with opportunity for a modest improvement beyond this point.

3.8 The forecast (and year to date position) assumes flexibility of c.£2.5m against accruals and other provisions within the balance sheet which has not yet been realised. This flexibility is considered low risk and is highly likely to be achieved however the actual value of adjustments will only be determined after end March. Key variables include the level of annual leave entitlement which is expected to be carried forward into 2024/25.

3.9 There remains a risk that variation in core performance will impact on the overall forecast. The two main areas where this is expected to manifest are:

- Use of agency staffing to support surge bed capacity above forecast levels
- Variation in prescribing expenditure, particularly in primary care where reporting on actual expenditure is delayed due to processing backlog on pharmacy claims

3.10 Drivers for cost pressures are reported in section 4, below.

[1] Run Rate is calculated as the average monthly variance against budget (i.e. Year to Date variance divided by the number of months)

## 4 Financial Performance –Budget Heading Analysis

### 4.1 Income

4.1.1 Table 2 presents analysis of the board's income position at end February 2024.

*Table 2 – Income by Category, year to date February 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 | 312.28 | 281.32 | 281.32 | - |
| SGHSCD Anticipated Allocations | 9.46 | 0.36 | - | - | - |
| Family Health Services | 10.24 | 15.02 | 14.17 | 14.17 | - |
| External Healthcare Purchasers | 4.68 | 4.93 | 4.54 | 3.93 | (0.61) |
| Other Income | 5.25 | 6.93 | 4.81 | 4.84 | 0.03 |
| **Total Income** | **300.90** | **39.52** | **304.84** | **304.26** | **(0.58)** |

4.1.2 The shortfall on income remains consistent with the level previously forecast and relates 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 is 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 as at February 2024.

*Table 3 – Operational performance by business unit, February 2024*

| | 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 | 83.76 | 75.92 | 75.50 | 0.42 |
| Acute Services - Savings Target | (1.54) | (0.80) | (0.75) | - | (0.75) |
| **TOTAL Acute Services** | **67.53** | **82.96** | **75.17** | **75.50** | **(0.33)** |
| Set Aside Budgets | 28.81 | 33.34 | 30.63 | 32.87 | (2.24) |
| Set Aside Savings | (0.94) | (0.94) | (0.87) | - | (0.87) |
| **TOTAL Set Aside budgets** | **27.87** | **32.40** | **29.76** | **32.87** | **(3.11)** |
| IJB Delegated Functions | 125.82 | 153.88 | 135.52 | 137.62 | (2.10) |
| IJB – Savings | (4.33) | (3.70) | (3.39) | - | (3.39) |
| **TOTAL IJB Delegated** | **121.49** | **150.18** | **132.13** | **137.62** | **(5.49)** |
| Corporate Directorates | 38.84 | 49.59 | 43.70 | 45.13 | (1.43) |
| Corporate Directorates Savings | (0.05) | (0.52) | (0.4) | - | (0.47) |
| **TOTAL Corporate Services** | **38.79** | **49.07** | **43.23** | **45.13** | **(1.90)** |
| External Healthcare Providers | 31.88 | 36.25 | 32.86 | 31.82 | 1.04 |
| External Healthcare Savings | (0.13) | - | - | - | - |
| **TOTAL External Healthcare** | **31.75** | **36.25** | **32.86** | **31.82** | **1.04** |
| **Board Wide** | | | | | |
| Depreciation | 5.06 | 5.06 | 4.64 | 4.64 | - |

| | Opening Annual Budget | Revised Annual Budget | YTD Budget | YTD Actual | YTD Variance |
|---|---|---|---|---|---|
| Year-end Adjustments | - | (13.72) | (14.16) | (14.16) | - |
| Planned expenditure yet to be allocated | 19.74 | 12.91 | 8.73 | - | 8.73 |
| Financial Recurring Deficit (Balance) | (11.33) | (17.81) | (16.32) | - | (16.32) |
| Financial Non-Recurring Deficit (Balance) | - | (0.28) | (0.26) | - | (0.26) |
| Board Flexibility | - | 2.50 | 2.29 | - | 2.29 |
| **Total Expenditure** | **300.90** | **339.52** | **298.08** | **313.42** | **(15.34)** |

4.2.1 **Acute Overall**[2]. The position is £3.44m overspent, of which £1.62m relates to non-delivery of savings.

4.2.2 Key drivers of operational cost pressures relates to the workforce cost of the additional staffed beds (nursing and medical), predominately within unscheduled care; offset by underspends in areas such as women and children and planned care. Drugs expenditure continue to be an issue mainly in cancer treatment and long term conditions.

4.2.3 **Acute services** (excluding Set Aside) are reporting an operational underspend of £0.42m. There are a number of areas where vacancies are contributing to the level of underspend such as nursing in maternity, cancer and outpatients. As these services remobilise to full capacity and vacancies are filled these underspends will not continue. The underspends are masking areas of continued overspend such as cancer and ophthalmic drugs which are due to continued increases in activity and changes in clinical practice related to drugs usage.

4.2.4 Acute services have also not achieved the required level of recurring savings and have an unmet saving target of £0.75m associated with planned care and women and children's services.

4.2.5 **Set Aside.** The set aside budget is overall £3.11m overspent, of which £0.87m relates to non-delivery of savings. The main element of additional expenditure relates to staffing to support the continued level of additional beds, high number of delays in the system and the patient acuity.

4.2.6 Within the Emergency Department ('ED') the overspend relates to staffing required due to increased activity and the provision of a bedded area ('blue ED') to accommodate patients who are waiting for admission to an inpatient bed due to lack of ward capacity.

4.2.7 Due to the high number of delays in the system and the continued issues with patient flow there are a number of further additional beds open within the system in MAU, Ward 14 and MKU/BSU which are unfunded. The number of additional beds consistently open during 2023/24 has been 22 and this number excludes the beds in the area known as "blue ED" and the repurposed elective beds (16 beds on average). During January and February on a number of occasions further additional capacity has had to be opened in Ward 8 and has increased the number of unfunded beds within the Acute system.

[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.

4.2.8 **IJB Delegated[3].** Excluding non-delivery of savings the HSCP functions delegated to the IJB are reporting an over spend on core budgets of £2.10m. This position is underpinned by a level of on-going vacancy across key service areas largely relating to Dental Services, Allied Health Professionals and Nursing, primarily as a result of recruitment difficulties which remains a key challenge within clinical areas across the Board. Nursing vacancies extend across Community Nursing and Hospitals and Mental Health in-patient settings, partly offset by the use of agency and bank staff to cover gaps. These savings to date partly mitigate the cost pressures within delegated functions noted below.

4.2.9 Within **Mental Health and Learning Disabilities** services, the main drivers of financial pressure are the continued use of medical locums (agency) to address significant workforce gaps within medical consultant staffing (Mental Health); a medium term plan to address this situation has been presented to the Board and is included within the draft financial plan for 2024/25. There continue to be pressures in relation to the number and cost of individual packages of care for Learning Disabilities out of area placements.

4.2.10 Within **Primary & Community Services** there continues to be a significant pressure on Primary Care Prescribing budgets (see below) as well as a small shortfall on funding available to support the current Vaccination Programme. The position in Vaccination has improved greatly in recent months due to additional Primary Care Investment Funding being directed recurrently and vacancies across the Vaccination workforce model arising. By the end of the financial year, it is expected that the service will break even excluding vaccine costs. 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.

4.2.11 **Primary Care Prescribing** – As at M10 the reported overspend is £2.302m representing an adverse movement since M10 of £0.862m. The main reason for the adverse movement is the timing of budget adjustments enacted during February in relation to mandated efficiency scheme benefits accrued in 2023/24, the largest of which pertained to the use of Apixaban which came off patent at the start of July 2023, enabling £0.885m of savings to be delivered in-year. Current spend is based on estimates reflective of trends in volume / expenditure to the end of January / December respectively.

4.2.12 **Corporate Directorates** are reporting a net overspend of £1.43m on core budgets, mainly within Estates & Facilities. Essential maintenance of estates infrastructure continues to be a key driver of cost pressures, with additional spend incurred in relation to high risk and statutory compliance requirements including fire safety, ventilation systems, and building maintenance (e.g. roof repairs). Restrictions are in place to limit non-essential maintenance and ensure

[3] IJB Delegated functions are comprised of clinical board business units for Mental Health & Learning Disabilities and Primary Care & Community Services, including AHPs.

that resources are focussed on areas of highest risk. Patient transport costs are a further area of pressure and criteria for transport is currently being reviewed in tandem with a review of transport service provision. There continues to be a shortfall in delivery against savings targets across corporate services (£0.47m ytd).

4.2.13 **External Healthcare Providers** Excluding savings, which are fully delivered in year, there is an underspend of £1.04m. This underspend relates largely to apparent reduction in the level, and mix, of (mainly) Acute activity treated out of area. This includes NHS Lothian, where a new Patient Level Information & Costing System (PLICS), has been introduced in 2023/24 and for which data validation is ongoing. At this stage all benefits are being treated as non-recurrent pending review of underlying activity trends.

## 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 February 2024*

| | Recurring Savings Target<br>£m | FIP Schemes identified – FYE impact<br>£m | FIP Schemes identified – current year impact<br>£m | Recurring Savings Achieved<br>£m | Balance of Savings not yet delivered<br>£m |
|---|---|---|---|---|---|
| Acute Services | (1.05) | *0.96* | *0.73* | 0.73 | (0.33) |
| Set Aside | (1.08) | | | - | (1.08) |
| IJB Directed Services | (1.06) | 0.68 | 0.67 | 0.63 | (0.43) |
| Corporate Directorates | (0.85) | 0.18 | 0.43 | 0.16 | (0.70) |
| External Healthcare Providers | (0.35) | 0.35 | 0.35 | 0.35 | - |
| Board Wide | (2.18) | 1.53 | 1.24 | 1.20 | (0.97) |
| **Total NHS Costs** | **(6.58)** | **3.70** | **3.42** | **3.07** | **(3.51)** |

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 £3.7m, of which £3.4m is expected to be released during 2023/24.

5.4 As at February 2024, £3.07m 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 £3.51m remaining to be achieved against the total budget target, of which £1.93m would be required in order to achieve the position identified in the financial plan. Of this, only £0.35m is identified within current year plans (£0.63m full year effect). It is expected that the majority of schemes not yet delivered will be reported as complete in March.

5.6 The savings reported above exclude any impact from enhanced grip & control measures where monitoring of individual actions is complex in context of normal variation in patterns of expenditure. Anecdotal evidence has indicated some positive improvement arising as a result of these additional measures. Trend analysis is being prepared to monitor longer term (ongoing) impact of these actions during 2024/25.

## 6 Forecast Outturn Position at March 2024

6.1 The forecast has been updated at M11 following notification of additional allocation of £3.2m in respect of UK budget consequentials (non-recurrent) and a reduction in charges relating to CNORIS. These changes amend the forecast from £20.1m at Q3 review to an adjusted position of £16.3m.

6.2 The target outturn set by Scottish Government has been revised for these adjustments and is now amended to £14.12m, which is the previously advised brokerage limit of £17.8m less the additional allocation of £3.2m and the reduction to the CNORIS charges of £0.45m.

6.3 Notwithstanding additional resources, adjustment to forecast is now only likely to be achieved on a limited scale via the ongoing review of ring-fenced funds and reserves, where a level of flexibility has already been assumed within the forecast; via finalisation of balance sheet adjustments; or by unpredicted variation in expenditure trends (e.g. primary care prescribing). In each case, this may represent a benefit or risk to forecast. Grip and control measures may contribute some further improvement however this is only where the impact is greater than the level already assumed within the forecast.

6.4 As previously reported, enhanced grip & control measures were introduced in January and are being managed through a Grip & Control panel established under the chair of the Director of HR. This group meets weekly to consider escalation of vacancy requests and other discretionary controls.

## 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 February to March which are not presently identified. It is therefore likely that the Board will fail to meet this level of performance.

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:** | **4 April 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 13 March 2024

## 2.4 Recommendation

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

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

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix No 1, Clinical Governance Committee minutes 17.01.24

# Borders NHS Board
# Clinical Governance Committee
**Approved Minute**

Minute of meeting of the **Borders NHS Board's Clinical Governance Committee** held on **Wednesday 17 January 2024** at 10am via Microsoft Teams

**Present**

Mrs F Sandford, Non Executive Director (Chair)
Ms S Lam, Non Executive Director
Mrs H Campbell, 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
Mrs L Huckerby, Interim Director of Acute Services
Dr L McCallum, Medical Director
Dr T Young, Associate Medical Director, Primary & Community Services
Mr M Clubb, Director of Pharmacy
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 K Guthrie, Associate Director of Midwifery & GM for Women & Children's Services
Mrs L Pringle, Risk Manager
Mrs J Campbell, Lead Nurse for Patient Safety and Care Assurance
Dr I Hayward, AMD Acute Services

## 1 Apologies and Announcements

Apologies were received from:
Mr R Roberts, Chief Executive
Dr J Bennison, Associate Medical Director, Acute Services
Dr A Cotton, Associate Medical Director, Mental Health Services
Mrs C Cochrane, Head of Psychological Services
Mr S Whiting, Infection Control Manager
Mrs S Horan, Director of Nursing Midwifery and Allied Health Professionals
Dr O Herlihy, Associate Medical Director, Acute Services & Clinical Governance

The Chair confirmed the meeting was quorate.

The Chair welcomed:

| | |
|---|---|
| Mrs F Doig | deputising for Dr Bhatti |
| Mrs S Elliott | Item 6.3 Drug Deaths Annual Report |
| Mrs C Jones | Item 6.4 Suicide Review |
| Dr E James | Item 7.1 deputising for Mr S Whiting, Infection Control |
| Mr A Bone | Item 7.2 Estates & Infection control |
| Mr C Myers | Item 7.4 Strategic Risk Mental Health |

**The Chair announced:**

Drs Hayward and Manning would be stepping in to Associate Medical Director Roles for Acute Services.

Dr Bennison would be stepping down from the Committee, the Chair thanked her for her contributions.

## 2 Declarations of Interest

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

The **CLINICAL GOVERNANCE COMMITTEE** noted there were no new declarations made and previous declarations stood.

## 3 Minute of Previous Meeting

The minute of the previous meeting of the Clinical Governance Committee held on Wednesday 22 November were approved.

## 4 Matters Arising/Action Tracker

There were no matters arising from the previous meeting. Action tracker was discussed and updated accordingly.

The undernoted report was taken out of sequence due to availability of deputising speaker.

### 7.1 Infection Control Report

Dr James provided a brief overview of the content of the report. He noted that target reduction in healthcare associated E-Coli infections had not been met. These infections are attributed largely due to urinary tract infections. Mr Lerpiniere commented that this is not dissimilar to what is being seen throughout Scotland, they have reached out to other Boards who had made significant progress against targets to gain learning from how they had reduced their incidence of infection. Discussion followed relating to learning and improvements are beginning to be seen, it was agreed that this should remain a focus.

Work on improving Surgical Site Infections continues with benchmarking against NICE Guidance, perioperative and interoperative recommendations. Hand hygiene and healthcare environment cleaning also remain a focus. Targeted education for those areas which show poorer compliance continued. It was noted that Doctors still appear to lag behind, Dr McCallum offered to have a conversation with Mr Whiting an AMDs to look how this can be addressed. Discussion followed relating to some of the environmental challenges facing staff which may have a bearing on compliance with hand hygiene and why one staff group appears to be able to meet these challenges better than others.

**ACTION: Dr McCallum and AMDs to have discussion to address Hand hygiene challenges and solutions with infection control.**

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

## 5 Effectiveness

### 5.1 Clinical Board update - Primary & Community Services

Mr Grieve gave a brief overview of the report, highlighting Community Hospitals continue to face challenges in relation to staffing. He reported there had been COVID outbreaks at Kelso and The Knoll which led to closure of these Hospitals. Challenges were also cited within the Health Visiting service although improvement was being seen, vulnerable families continued to be prioritised.

Medical model review and options appraisal is currently underway. Mr Grieve will keep the Committee appraised on progress. He reported Hospital at Home service had it's first referral from Scottish Ambulance Service. Discussions followed regarding direct referrals to Hospital at Home in particular from SAS as there is concern referrals may not have needed hospital admission. It is important that criteria for admission is clear and service is not being used inappropriately.

Care home support team continue to support care homes across the borders, the service is under review, outcome and recommendations will be reported back to Joint Executive Team.

Reorganisation of pressure ulcer group had taken place to have a more focussed oversight of pressure damage across the system. Mr Lerpiniere enquired how well the triangulation of information relating to pressure ulcers is going, discussion followed where Mr Grieve confirmed it is challenging due to the definitions of inherited and developed damage, often patients will not disclose a pressure sore so early intervention had not been possible, it was agreed that more work was required in this area in particular in care homes and social work services where access to reporting adverse events is not currently available. It is hoped that this will be a topic covered in the New Tissue Viability Steering Group.

Patient Experience Team are working alongside Primary & Community Services Manager to look at themes in reporting to help give a better oversight in Committee reports.

Ms Lam commented on outstanding return to work forms, Mr Grieve agreed to contact HR for more detailed information. She also enquired about findings from study by NES relating to dental services, Mr Grieve will update the committee on these at a later date.

**ACTION: Mr Lerpiniere and Mr Grieve will liaise with Tissue Viability Group in relation to long term impact or pressure damage.**
**Mr Grieve to bring more detail relating to staff absence and return to work forms in next report**
**Mr Grieve will liaise with Dental services on findings of study by NES and update Committee.**

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising that although work is ongoing to address issues, areas of concern remain.

### 5.2 Clinical Board update Acute Services

Mrs Dickson attended to give update on report. The acute site is still working under extreme pressures having been in red or black status for a number of weeks. Additional unscheduled beds had been opened having a knock on effect on other services, in particular on the ability to continue elective surgery although day case surgical activity continues. The rapid increase in number of healthcare and social work delays is having an impact on overspend. Data was presented differently giving detail of pressures in each area rather than the overall view.

HSE visited following patient fall, recommendations were received and action plan will be included in next acute services paper to the Committee.

Significant improvement had been seen in relation medicines management with support from Mr Clubb and medicines team. Care Assurance, leadership walk rounds are ongoing ensuring action plans are moving forward.

Discussion followed relating to an adult support protection case and details of action plan and outcomes will be reported at a later committee meeting.

The Committee discussed reporting on options and balancing of risks when system is under pressure. Mrs Huckerby commented that the National picture is much the same and plans to reduce surge beds should continue to move forward. The acute services continue to work closely with P&CS colleagues on flow through the system. There had been improvement seen within stroke services. Mrs Dickson will include an update on elective flow and an SBAR on Dermatology position.

The Chair noted pressure from Scottish Government to cut costs significantly is posing a real problem for the Board.

**ACTION: For next report: Elective flow update**
**SBAR Dermatology position**

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is not assured by the contents because pressure on the system remain high

### Women & Child Health SBAR

Mrs Guthrie attended to talk to the W&CH SBAR, there had been challenges with staffing unit meaning they were unable to admit patients of less than 36 weeks gestation. Consultant staffing is facing challenges due to retirement and vacancies in senior consultant and senior midwifery teams along with sickness absence. Concerns on quality of care had been raised along with reliance on locum cover, adverse events and patient experience. This is being monitored through maternity dashboard. Safety within unit had been maintained and recruitment is underway to stabilise workforce.

Dr McCallum commented that the trainees provided had been difficult to support due to the staffing issues and this had been raised with the training program director and also to the Dean for Southeast Scotland, who have agreed they will consider this with the next batch of trainees in August. She commented that previously the unit had been well known for supporting doctors and had excellent feedback. Dr McCallum commented that the unit was working well towards solutions outlined in the paper and they are confident the vacancies will be filled. Issues with the reliance on Locum cover should be highlighted to the Board along with impact of pressures on a small team to provide quality safe care.

Discussion followed on the quality of care and reliance small teams have on external workforce leading to difficulties around safety culture and how the organisation is working actively to avoid any related risks. Full paper is due to the March committee giving oversight of all aspects of the service including outcomes.

The Chair asked that the Maternity team were thanked personally for their commitment and dedication during this period of extreme pressure.

**ACTION : Highlight locum spend when this is the only option and impact vacancies have on small teams to Board**

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

**Cancer Services**

Unfortunately no one was available to talk to the paper which highlighted risks and mitigations within cancer Services.

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

**5.3 Clinical Board update Learning Disabilities**

Mr Lerpiniere informed the Committee that he had not received the report from Mental Welfare Commission following their visit in November. He noted that there had been complaints relating to a patient who had been in and out of the BGH on a number of occasions although complaint had been responded to there were some actions still outstanding, the complainants have been kept informed.

Scottish Government required annual health checks are progressing in partnership with Primary Care colleagues.

Coming Home programme is also progressing slowly and work continues with a number of partners in terms of providing support and accommodation. Ms H Campbell joined the

meeting and apologised for being late and previously absent at previous meetings. She enquired about the number of out of area placements and costs, Mr Lerpiniere commented these remained the same but that the Coming Home programme is set up to address this recognising that it is best to have clients at home in the Borders both for them and their families. There are still difficulties in providing this in the Borders without relying on hospital admissions to provide their care. Mr Lerpiniere will provide more detail on costs for the next report to the Committee.

**ACTION: More detail on costs and number of patients out of area for next committee.**

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

**5.4 Clinical Board update Mental Health Services**

Mr Lerpiniere provided and update for the Committee. Work on waiting lists for CAHMS continues, it is anticipated that the HEAT targets will be met. The BSDU continues to experience an excessive number of delayed discharges.

Mental Welfare Commission carried out an unannounced inspection in Huntlyburn, their verbal feedback was very positive. There is some work on Care planning required which the Commission will assist with, this had been commented on in the Learning Disabilities inspection and it is expected that the teams will work together on this.

There continues to be a number of challenges in workforce similar to the rest of the organisation. Risk assessment had been completed relating to Cauldshiels and safe staffing levels, there is a temporary solution in place at present but this urgently needs addressed as the risk is unacceptable.

Mr Grieve commented it was important to highlight positives to the Committee, the Commission referenced activity provision in Huntlyburn was of the highest standard in Scotland.

Discussion followed relating to requirements from a Mental Health Act legislative perspective to provide certain levels of medical staffing and if the review of workforce modelling in relation to increasing advanced nurse practitioners to offset deficits within the medical provision could still safely provide mental health care within the service.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising there is still fragility in the service.

**Psychological services**

Dr Cochrane was not available to talk to the report. Mr Lerpiniere noted these was nothing particularly outstanding for attention to clinical Governance Committee. Recent SAER had proved to be a very collaborative piece of work.

There followed a discussion on the efficacy of online appointments in psychological therapies which not ideal had allowed Dr Cochrane to recruit staff who work remotely.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents again noting the fragility in service.

## 6 Assurance

### 6.1 AHP Annual Report

Mr Williams gave a brief overview of the report he drew the Committee's attention to a couple of pieces of ongoing work. Speech and language input had increased within stroke services in line with national guidelines which had been seen as overall beneficial taking into account the increased input in one area had on other parts of the system.

There had been a drive to target areas of social deprivation with early years intervention from Music Therapy and Speech and Language services which had been seen as a positive piece of work. He cited their biggest limitation from a clinical governance perspective had been workforce factors not dissimilar to other colleagues in the organisation.

These limitations had an impact on, skill mix, service delivery and succession planning making stabilisation of workforce and service delivery a challenge.

Dr McCallum commented that support from AHP colleagues is essential for all parts of the organisation to run smoothly and a national approach is required to address recruitment challenges. Mr Williams stated that there was a national educational workforce review commissioned by the Chief HP Officer and Scottish Government.

Following comment from Ms Lam there was discussion relating to training and retention of staff, skill mix and provision of service alternatives. Mrs L Jones commented that there had been demand and capacity work in the Acute service showing good success in skill mixing and collaborative work. She recommended a demand and capacity exercise would be beneficial and this should be flagged to the Board.

**ACTION: Flag demand and capacity issues to Board**

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents, recognising there is ongoing work relating to fragility in the workforce.

## 6.2 General Practice Sustainability Update

Dr Young talked to the report. He commented on restrictions on patient movement which came into play during COVID, GP practices can still refuse movement if a patient is already registered elsewhere which is causing some issues.

He also noted that enhanced services out with GMC contract are being handed back by some practices due to workload and recruitment difficulties, this had not cause any significant impact as yet but it is anticipated that this might should other practices follow suit. One solution to assist in sustainability is to rationalise Boundary restrictions in the east of the Borders. This work is also ongoing in Lothian where some practices span both boards which may result in practices having more patients. Branch closures and mergers had also had an impact on service provision.

Work will continue to address easing tensions and shifting balance of care between practices along with work to fully implement the new GMC contract. Dr Young noted that there may be some exiting developments and he will keep the committee informed. Work ongoing in P&CS to support GP sustainability as highlighted in the report is hoped to improve the ability to attract and recruit GPs to the Borders. He informed the Committee that they had appointed their firs GP fellow last year and is pleased to say they are hoping to remain working within the Practice. A further five applicants are noted for GP Career Start program, it is hoped that they will be placed in a number of practices which is extremely encouraging.

Discussion followed relating to the cost implications of GP start colleagues against the cost of 2C practices and supporting vulnerable practices to continue to provide a sustainable safe service. Ms Lam commented that it would be useful for the Committee to perhaps have an overview of the financial framework that supports this.

Mrs H Campbell enquired if data around numbers of patients asking to move practices was collected, Mr Young was not aware that it was but would speak to his Primary Care colleagues to see if this was possible,

**ACTION: Dr Young will liaise with Primary care colleagues to get figures on practice movement requests**

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising all the work going on towards sustainability

## 6.3 Drug Deaths Annual Report

Mrs Elliott provided a brief overview of the content of the report. She explained that there is a time lag as they have to wait until National Records of Scotland published their final data before the report goes to various governance groups before coming to the Committee.

Drug related deaths had fallen in Borders and were now substantially lower sitting at 7 deaths, demographics remain very similar to previous years with the only change being an

increase in cocaine, pregabalin and gabapentin related deaths.

Non-fatal overdose pathway is in place with 90% of people receiving contact within 40 hours of overdose. There is a good availability of Naloxone across the services. There has been a successful implementation of standards 1-5, the further five are slightly more complicated, spanning other services but progress towards these is being made.

There was some discussion about the increase in Gabapentin being a drug of choice and how prescriptions for Gabapentin can be monitored.

The Chair thanked the team on behalf of the Committee for their hard work and dedication.

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

### 6.4 Suicide Annual Report

Mrs C Jones provided a brief overview of the content of the report relating to average numbers of suicides both locally and nationally over a five year period. She reiterated the importance of post even support as suicide has a wide reaching effect on the families, friends and wider community, often people bereaved by suicide it can put them at risk. Suicide prevention is vitally important as there are far more people living with suicidal thoughts, equating to 5% of the population at any given time. A developed action plan is in place in the Borders which allows various sectors to feed into the plan to contribute to suicide prevention and work towards an accreditation scheme. Training and identifying champions to ensure the correct resources and information is available.

Mrs C Jones commented that the Wave after Wave training has been adopted and Border Care Voice have taken that on and are running this as part of their ongoing training programme, there is also a memorial run every year for those bereaved by suicide. There is an after a suicide working group where people with lived experience can feed into this area.

Mr Lerpiniere noted that out of the 17 deaths by suicide only two were know to Mental Health Services.

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

### 7.2 Estates and Infection control

Mr Bone provided a brief overview of the content of the report inviting comment on content and details from Committee. The report provided and update on previous paper which came to Committee in March and Mr Bone confirmed that actions are mostly complete with others still being addressed, expectation that all will be completed within timelines alongside property strategy. He went on to describe the work and scope of the newly established Environmental Risk Oversight Group and how it provides extra layer of assurance to align with Infection Control and Health and Safety Groups. He provided a list of business to be covered in the group. He noted that the organisation carries a risk around compliance with building regulations, the core of this being capacity of Estates workforce.

Mr Bone provided an appendix highlighting the professional duties and responsibilities of estates to give Committee a perspective of the scale of duties in a relatively small team, which like clinical colleagues is affected by difficulties in staff vacancies and sickness.

Discussion followed relating to previously highlighted risks and improvement plans throughout NHS Borders whole estate including the Reinforced Autoclaved Aerated Concrete there are no urgent issues and improvement plan is underway. Haylodge fire safety risks are not able to be mitigated and a solution was found to accommodate staff in other parts of the organisation. Trial of rapid flooring upgrade was performed in MAU, this had been executed successfully with minimum disruption and impact on patients, it is hoped this can be rolled out in other areas. Recommendations relating to ventilation in theatres, changes to ventilation were made to allow theatres to continue operating but acoustic tolerance issues are still to be addressed.

Mr Lerpiniere commented that development of Environmental Risk Oversight Group was welcomed giving an avenue to escalate issues appropriately, giving greater assurance around governance issues.

The Committee appreciated how difficult the last year had been for the Estates Team and welcomed the increased governance arrangements aligning with patient safety, they look forward to seeing progression and a little more detail in subsequent reports to get a better understanding of risks and challenges.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured and encouraged by increased governance arrangement, recognising the high risks and potential financial consequences.

### 7.3 Adverse Events

Mrs J Campbell gave the Committee an overview of the report. There had been a significant improvement in corporate reporting. The nine events which were graded extreme have been reviewed following adverse event management policy. Appropriate governance structures are being followed across the services and the patient safety team had commissioned a review into the acute management team to highlight inappropriate incomplete action plans following SAERS, these findings have been shared with appropriate managers. There is a review of current process to include working in collaboration with risk colleagues to consider using DATIX as a single platform to enable streamlining of improvement actions.

Discussion followed relating to how the move to DATIX would improve follow up of adverse events and SAERS. Mr Lerpiniere commented that the move has both risks and potential benefits and voiced his concern on relying on the DATIX as it only allows access to your own areas and it is important that learning is shared across the Boards.

Ms S Lam enquired about the lag in data and if the position was looking different now as it appeared there had been an increase in pressure damage. Mrs L Jones gave a brief overview on how this is calculated and noted that the figures were showing normal variation. The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is assured by the contents

### 7.3 Strategic Risk – Mental Health and Learning Disabilities Services

Mr Lerpiniere gave an overview of report highlighting areas where they have issues and shortfalls in service. The risks are well sighted in divisional reporting so nothing in the report should come as a surprise to the Committee. Eating Disorders and perinatal mental health were highlighted as areas of risk/concern as there is no current provision in NHS Borders for these cohorts of patients.

Mr C Myers attended to give support to the paper commenting that Mental Health covers all areas of the organisation two organisations and commission partners. The risks associated with inability to upstream are vital to the health and wellbeing of the Borders. There is some promising joint work looking at becoming more preventative to better support children and their families in in the borders. Focussing on early intervention and prevention is vital.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and is partially assured by the contents recognising the risks involved and challenges face due to the span of the services.

## 8 Person Centred

### 8.1 Patient Experience Update and Annual report

Mrs J Campbell gave the committee a brief overview of the report noting that there had been an increase in the number of complaint received in comparison to last year. The service is experiencing extreme pressures leading to a backlog in responses, the average response time of 40 days is out with the recommended response of 20 days. Additional resources had been put in place to help address additional pressures.

The themes and trends remain consistent with previous reports. The report also includes an increase in positive feedback via care opinion. Future developments will explore further learning from complaints and a review of complaint process.

Discussion followed, in particular around response times remaining high, Mrs Jones noted that sustained increase in demand meant despite additional capacity the team were only now meeting he extra demand on service. Complainants are being kept informed of the delays in responses.

Ms Lam noted that she was pleased to see learning from complaints being embedded into normal practice. She enquired about how staff concerns are captured there followed a discussion around leadership walk rounds and how time is being taking to allow staff to raise concerns in this forum, discussions had also taken place at BET to ensure that concerns are noted and addressed effectively.

The **CLINICAL GOVERNANCE COMMITTEE** noted the report and although recognise progress is being made can only be partially assured by the contents

## 9 Any Other Business

The Chair commented that this was Ms Lam's last meeting and thanked Ms Lam on behalf of the Committee who will miss her and her very thoughtful contributions wishing her well in future. Ms Lam thanked the Committee, stating she had enjoyed taking part.

## 10 Date and time of next meeting

The chair confirmed that the next meeting of the Borders NHS Board's Clinical Governance Committee is on **Wednesday 13 March** at **10am** via Teams Call.

*The meeting concluded at 12:57*

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Quality & Clinical Governance Report – March 2024** |
| **Responsible Executive /Non-Executive:** | **Laura Jones, Director of Quality and Improvement** |
| **Report Author:** | **Julie Campbell - Lead Nurse for Patient Safety and Care Assurance**<br>**Joy Dawson – Research Governance Manager**<br>**Justin Wilson, Quality Improvement Facilitator - Clinical Effectiveness, Susan Cowe**<br>**Quality Improvement Facilitator - Person Centred Care** |

## 1 Purpose

**This is presented to the Board for:**

- Awareness

**This report relates to a:**

- Government policy/directive
- Legal requirement
- Local policy

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

2.1.1 This exception report covers 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 13 March 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 CGC received a report on Primary and Community Services. There was a discussion on the risk around staffing the current community hospital model and the piece of work which has been launched to review the role and purpose of community hospitals in the future. Medical staffing cover is Kelso Community Hospital is a significant concern from April 2024 onwards resulting from the cover for this being withdrawn by the General Practice as a result of the workload pressure they are experiencing. Solutions to this and cover for the Knoll are being considered as part of the longer term piece of work and a temporary arrangement is in place to cover until the end of August 2024. A workshop is planned to review options based on the outputs for the recent Community Hospital Day of Care Audit. The Committee were keen to understand how this is progressing and recognised that for some time the community hospitals have been highlighted significant pressures around patients delayed to their next stage of care and were keen that this theme is explored in the work to develop a long term model. Ongoing workforce challenges across Allied Health Professions were highlighted and the CGC are keen to see a workforce plan for these areas akin to that developed for nursing to look at opportunities to innovate in this area and look at alternative roles. Good progress was reporting in the Hospital at Home pathfinder and also within the Vaccination service. The committee was partially assured by the Primary and Community Services report.

2.3.3 The CGC received a report on acute services. The service remains under pressure with a high level of delays effecting unscheduled and elective flow but noted some early progress in reducing delay which had resulting in a positive impact on patients waiting for admission within the emergency department. The committee remained concerned about the impact the delays across the system were having on patients and staff and the ability to shut surge beds and also fully deliver an elective programme but were partially assured by the work underway through the surge plan to try and address this. In particular, the impact on access to the stroke unit and also inpatient elective beds for Orthopaedics, General Surgery and Gynaecology were areas the committee remain concerned about. The CGC considered pressures within Haematology, Dermatology, Cardiology, Obstetrics and Gynaecology and Diabetes and Endocrinology and the steps being taken to mitigate risks in these areas. There has been successful recruitment in Cardiology, Obstetrics and Gynaecology and Diabetes and Endocrinology which in the longer term will help to stabilise these services. Whilst there has been successfully recruitment to Haematology workforce gaps remain leaving this speciality vulnerable. Good progress continues to be made of registered nursing posts although ongoing international recruitment will be required to continue to meet the workforce numbers required due to deficit that continues in the number of registered nurses across the UK. The Committee were partially assured given the level of risk acute services continue to carry due to increased demand for beds, additional

workforce requirements resulting from this and also the specific capacity problems in dermatology and haematology and were keen to ensure the Board continue to be sighted on these challenges and the need for a whole system and regional response.

2.3.4 The CGC considered a paper from Mental Health Services. Pressures within the Psychiatry workforce highlighted at previous Board meetings remain. Several actions have been agreed to mitigate risk and prioritise areas of greatest clinical need and there has been a recent appointment to a vacant post which will make a positive impact. There has been progress in Child and Adolescent Mental Health waits and it was anticipated that from February 2024 onwards the service would be meeting the 18 week referral to treatment standard. In recognition of the ongoing workforce pressures being faced across mental health service the CGC agreed a position of partial assurance.

2.3.5 The CGC received a report from the Learning Disability (LD) Service. Updates were given on the LD annual health checks project which is making good progress and on the Coming Home Programme. Whilst progress is being made to bring patients who are placed out of area home there are still some significant challenges in developing appropriate provision locally. The team are actively working on this to come up with specific plans for any clients placed out of area and the CGC were keen to see timescales for this work. The Committee were partially assured recognising there are still areas of concern but work is underway to address these.

2.3.6 An annual report on Maternity and Neonatal Services was discussed. A range of measures for maternity services were reviewed and also the active improvement work underway through the local patient safety perinatal workstream. The team briefed to committee on targeted work they are doing on handover processes and maternal clinical observation and monitoring processes which was being supported by education and leadership walkrounds. The committee were previously appraised of fragility across the medical workforce within Obstetrics and Gynaecology due to retirements and vacancies resulting from this and the pressures on the remaining core team. There has been recent positive news in filling the two permanent consultant vacancies which will enable the service to stabilise and address the workload strain for core team members. The Committee were assured by the contents of report.

2.3.7 The CGC received the annual report from the Childrens Services Network. The CGC were assured by the report. The network provides a key oversight role in the delivery of shared Childrens Services plan for the Scottish Borders including delivery of statutory requirements under the following Acts and Policy areas: Children & Young People (Scotland) Act 2014; Child Poverty (Scotland) Act 2017; Carers (Scotland) Act 2016; United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Bill 2020; The Promise (2020- 2030); Corporate Parenting. The committee were assured by the update and progress against the plan.

2.3.8 The committee received a report on nursing, midwifery and AHP education. The committee noted the positive work led by the Head of Clinical and Professional Development to improve clinical education offerings across NHS Borders. The report detailed some areas where improvement was required and where organisational support has been requested through business units to ensure registrants receive appropriate update training. An area of priority is Basic Life Support. The committee were assured by the report but asked for a continued focus by Associate Directors to the areas highlighted within the report as priorities.

2.3.9 The Director of Acute Services presented a paper detailing the Strategic Risk relating to Whole System Flow. There was a discussion around the themes considered over the last two years by the committee and raised consistently in clinical board reports to CGC relating to flow across the Health and Social Care System. Progress on the surge plan were discussed and a range of transformation projects which were aimed at increasing community and social care capacity. The CGC were partially assured by this report recognising the significant work underway but the ongoing impact on patients and staff of care in an inappropriate setting.

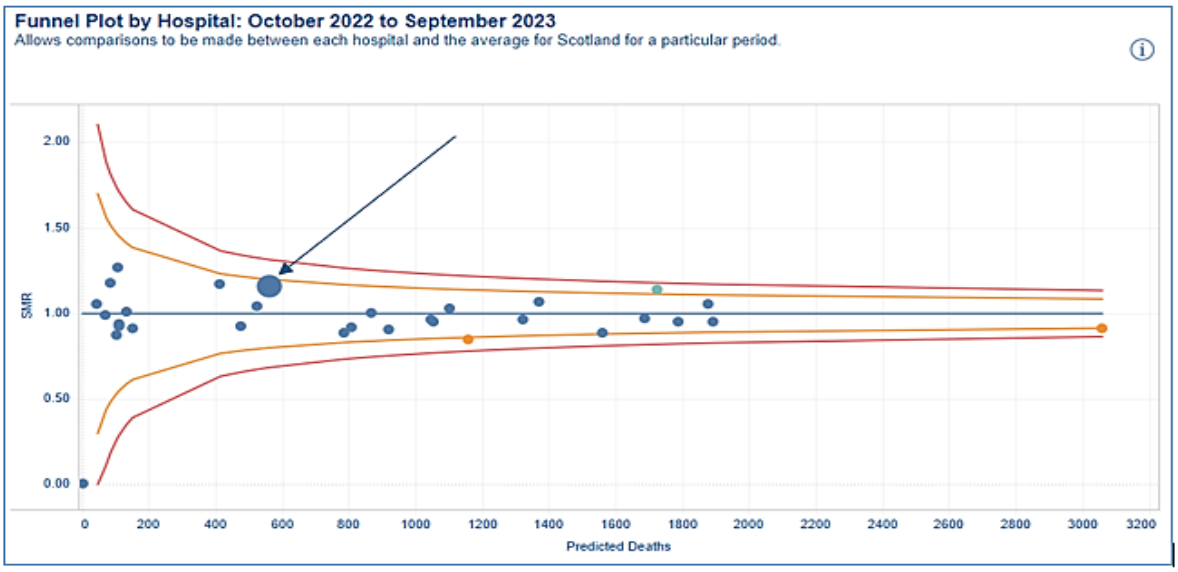
2.3.10 The CGC considered the Director of Public Health's Annual Report covering the range of areas under the Public Health remit including Health Improvement, Screening, Oral Health, Health Protection and the Drug and Alcohol Partnership. The committee agreed a level of partial assurance recognising the themes identified across the Scottish Borders community in relation to health inequalities and the need for ongoing targeted efforts in this area.

2.3.11 The committee received the Hospital Standardised Mortality report. The CGC was assured by this report.

2.3.12 The annual report on the Patient Safety Programme was presented to the committee detailing a range of proactive patient safety work that takes place to reduce harm and ensure safe systems of working are in place. The committee were appraised of work and outcomes in key priority areas including falls, pressure damage, care of the deteriorating patient, medicines management, food fluid and nutrition, perinatal, paediatrics, mental health and documentation. The CGC was assured by the proactive work underway and processes in place to monitor quality of care and learn from error.

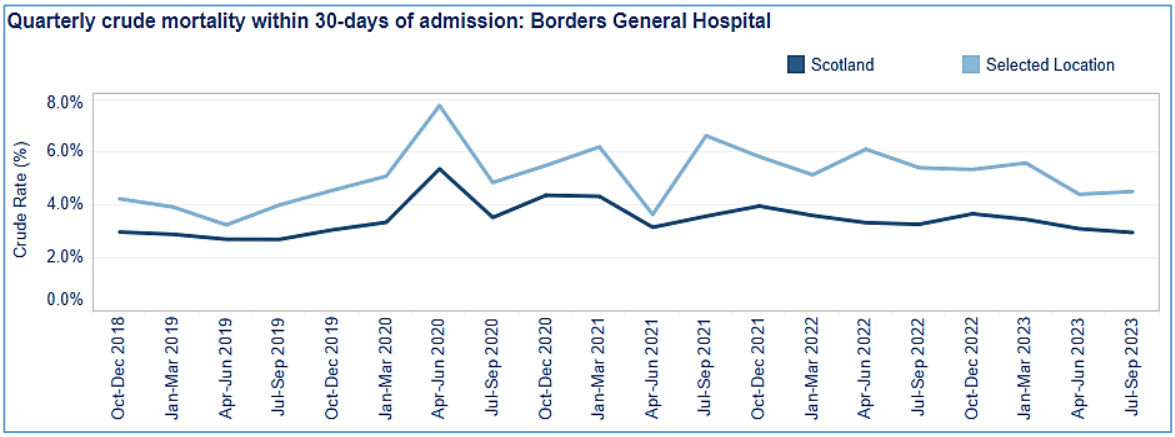
**2.3.13 Hospital Mortality**

NHS Borders Hospital Standardised Mortality Ratio (HSMR) for the 19th data release under the new methodology is 1.16. This figure covers the period October 2022 to September 2023 and is based on 649 observed deaths divided by 561 predicted deaths. The funnel plot in Figure 7 shows NHS Borders HSMR remains within normal limits based on the single HSMR figure for this period therefore is not a trigger for further investigation:




*Contains deaths in the Margaret Kerr Palliative Care Unit

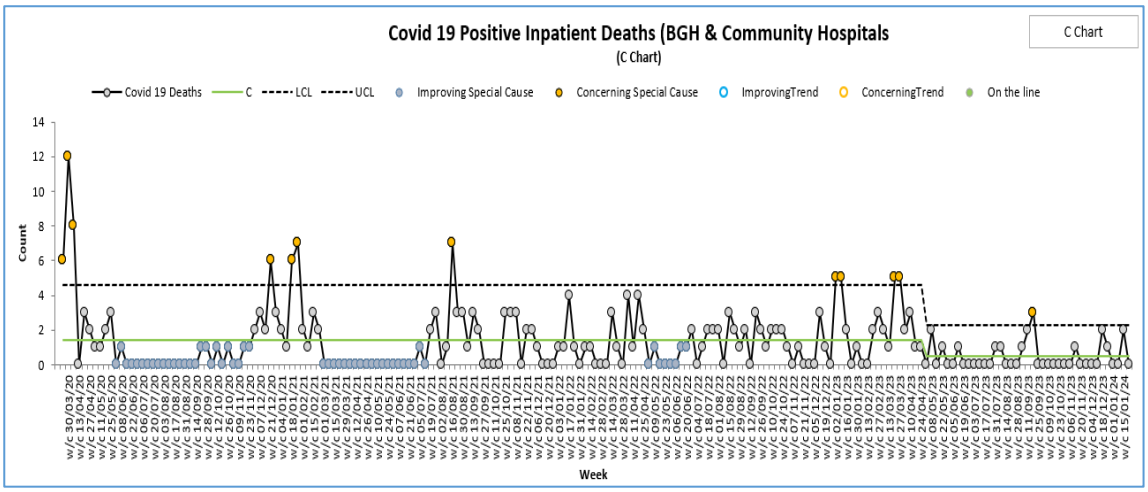
2.3.14 NHS Borders crude mortality rate for quarter July 2023 to September 2023 was 4.5% and is presented in graph 1 below:




*Contains deaths in the Margaret Kerr Palliative Care Unit

2.3.15 No adjustments are made to crude mortality for local demographics. It is calculated by dividing the number of deaths within 30 days of admission to the BGH by the total number of admissions over the same period. This is then multiplied by 100 to give a percentage crude mortality rate.

2.3.16 Graph 2 details the COVID 19 deaths which have occurred since the start of the COVID 19 pandemic in March 2020 up to 28 January 2024:

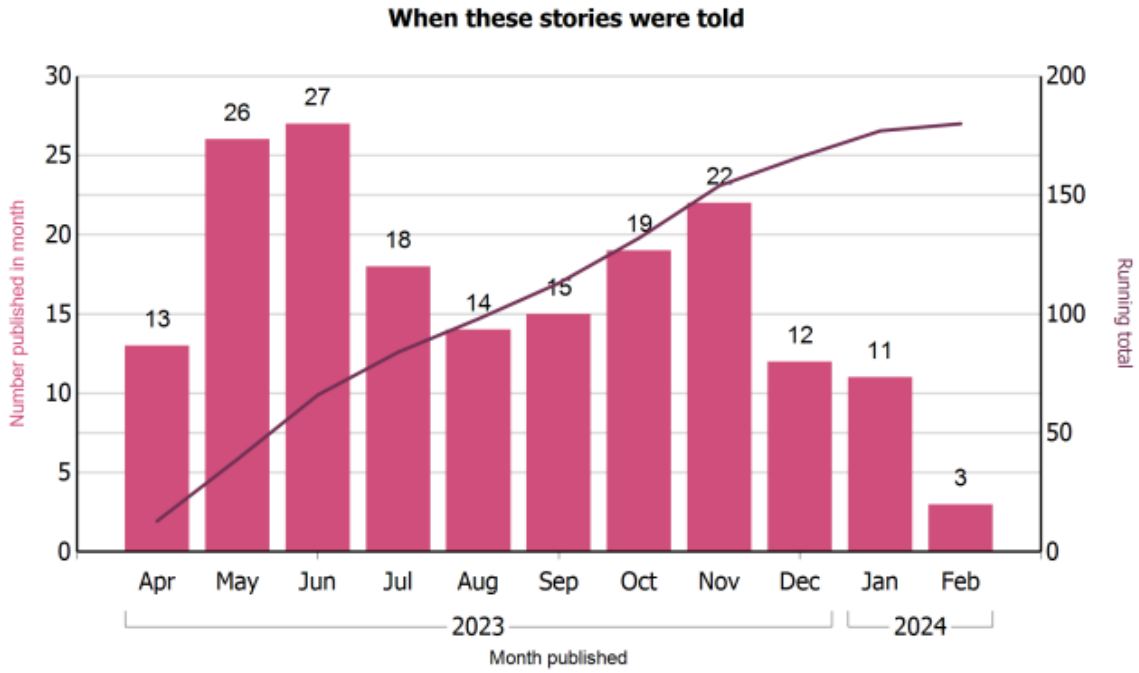



*From 07/05/2023 patients are counted as Covid positive for 10 days after a positive test. Prior to this patients were counted as covid positive for 28 days after a positive test.

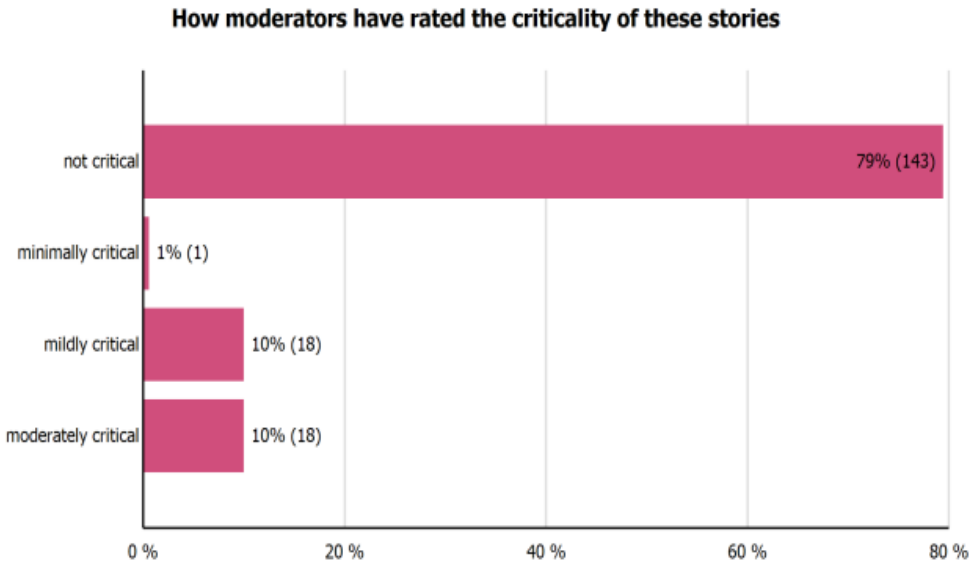
## 2.3.17 Patient Experience

## 2.3.18 Care Opinion

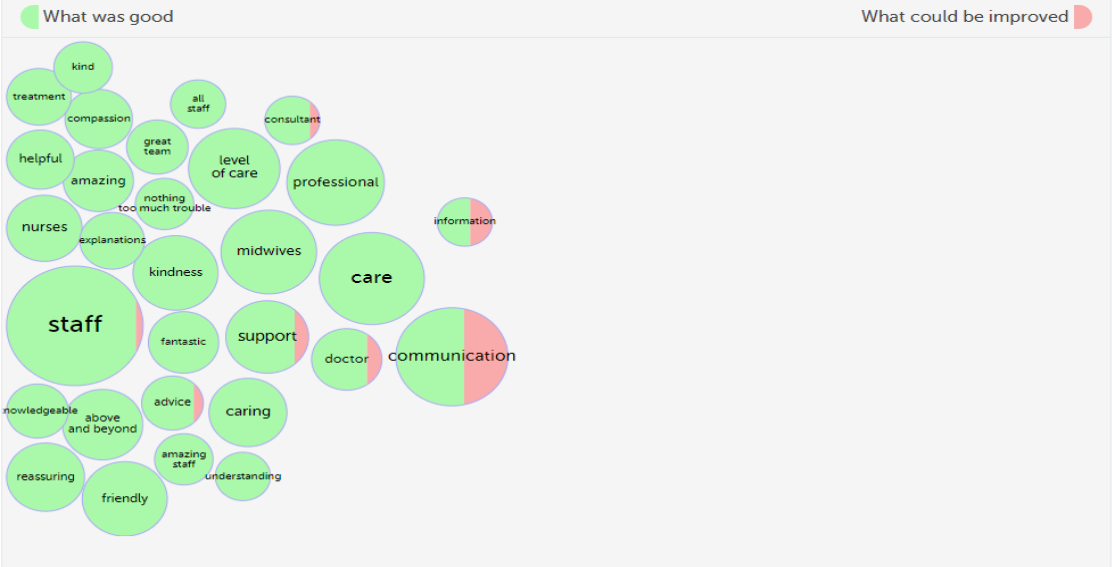
For the period 1 April 2023 to 32 January 2024, 180 new stories were posted about NHS Borders on Care Opinion. Graph 3 shows the number of stories told in that period. As at 21 February 2024 these 180 stories were viewed 20,328 times:




2.3.19 Graph 4 provides a description of the criticality of the 180 stories:



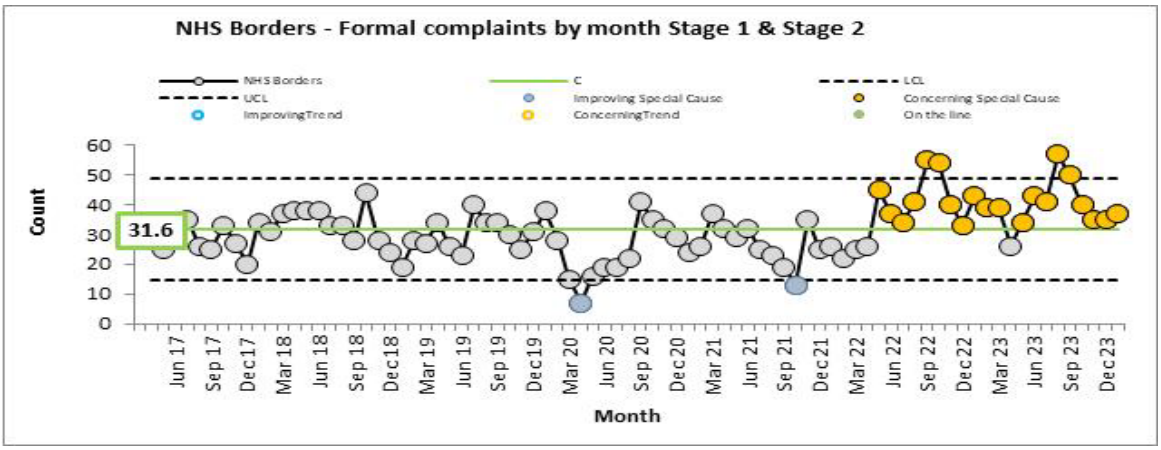

2.3.20 The word clouds below summarise ‘what was good’ and ‘what could be improved’ in Care Opinion posts for this period:



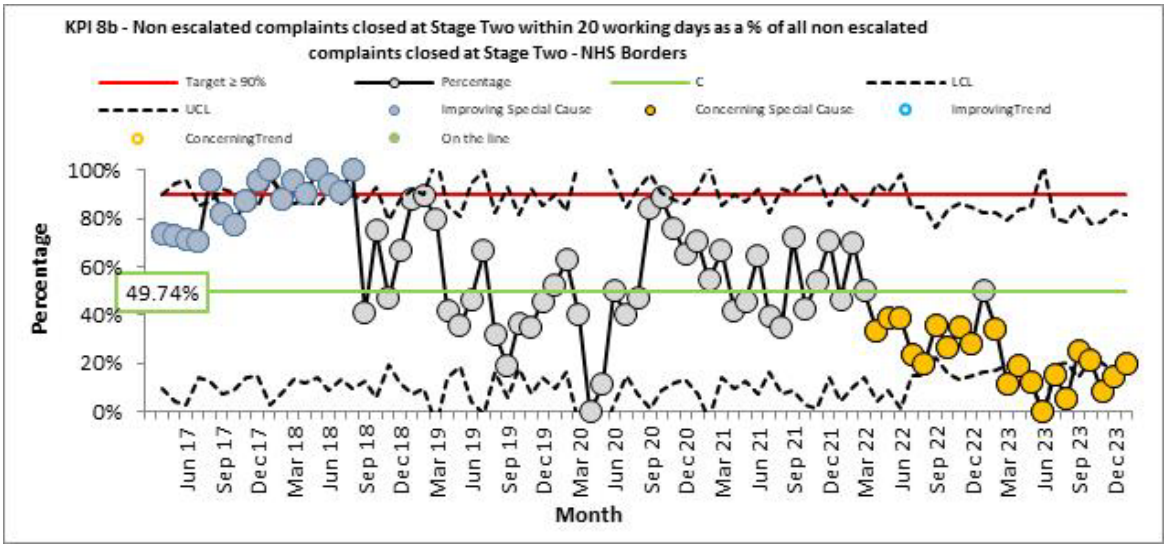

## What was good?

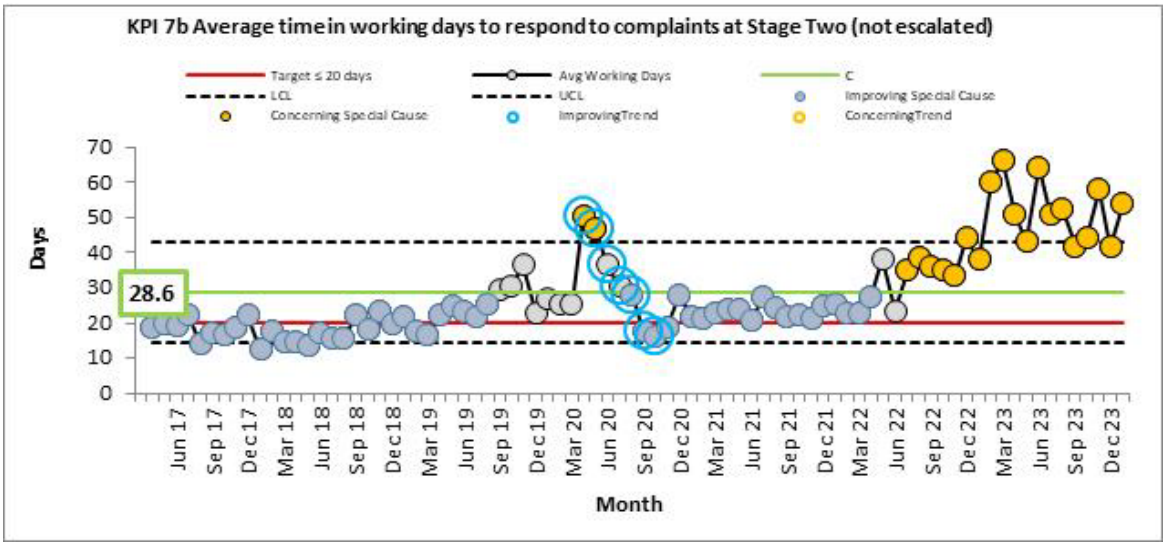

## What could be improved?

2.3.21 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 remained above average:




2.3.22 The on-going above average number of complaints received, resulting from the continued pressure within clinical services, is placing a significant workload strain on both the Patient Experience Team (PET) and on frontline clinical staff involved in the review of individual complaints. This has led 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:

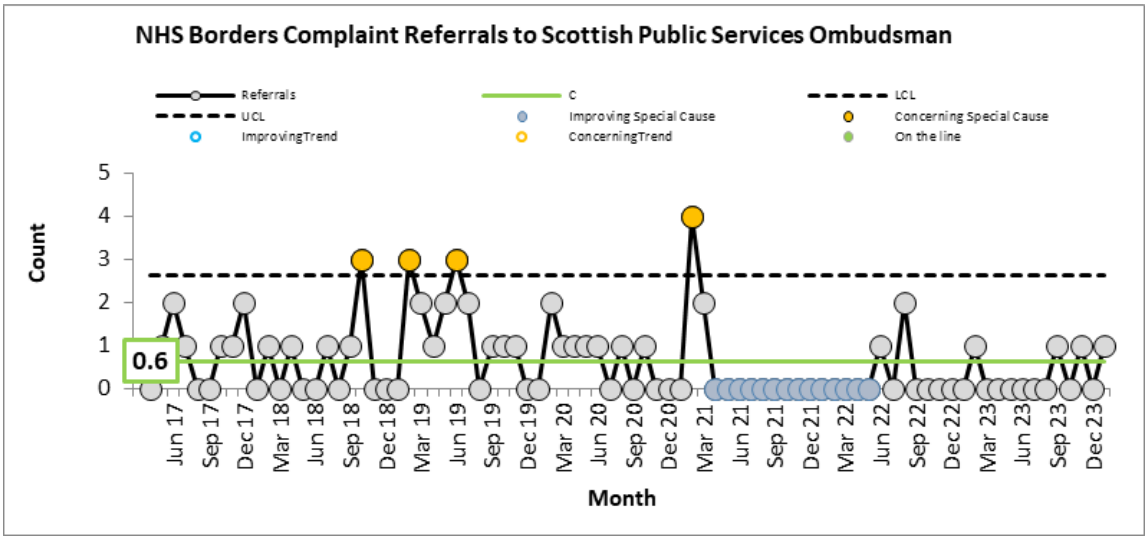





2.3.23 The average response time in working days in December 2023 is sitting at 53 days. Additional capacity has been added to the PET team on a short term basis to support this increase in workload. The PET are working to meet the new level of demand but also to bring down the number of active complaints awaiting a response with the aim of reducing the length of time patients and families are waiting for a response.

2.3.24 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.

2.3.25 Graph 8 below shows complaint referrals to the SPSO to 31 January 2024:




**2.3.26 COVID Inquiries**

The Scottish COVID-19 Inquiry paused its health and social care impact hearings during January 2024 while the UK Covid-19 Inquiry held hearings in Edinburgh. Additionally, the Scottish COVID-19 Inquiry announced that Lord Brailsford, the Chair of the Inquiry, had been diagnosed with a kidney tumour and would require surgery. Under the Inquiries Act 2005, public hearings cannot be held

without the Chair present, either in person or remotely. The commencement of the next tranche of hearings from 12 March 2024 allows for the Chair's surgery to take place, followed by a period of recovery.

2.3.27 The UK Covid-19 Inquiry held its Core UK decision-making and political governance – Scotland (Module 2a) public hearings in Edinburgh between 16 January 2024 and 1 February 2024. This module will look at and make recommendations about the Scottish Government's core political and administrative decision-making in response to the Covid-19 pandemic between early January 2020 and April 2022, when the then remaining Covid-19 restrictions were lifted in Scotland. The public hearings for Module 2b- Wales commence on 26 February 2024.

**2.3.28 Innovation**

As part of the Annual Delivery Plan, NHS Borders Digital and Innovation teams are developing closer links to work towards identifying projects and scoping for funding to take them forward. NHS Borders has established a local innovation steering group and is working on the pathway for identifying innovation projects that come through the Project Management Office (PMO) front door so that they can be signposted through appropriate governance processes.

2.3.29 The NHS Borders Innovation Fellow and Consultant Stroke Physician has submitted a bid to the NIHR i4i funding programme for Care Calendar the project they have been working on as part of the fellowship. If successful, this bid will allow the start-up company who developed the technology to further develop the system to allow a research project to be developed to test with a small number of patients and staff.

**2.3.30 Research**

NHS Borders is seeing an increase in the number of approaches to undertake research projects in a wide range of therapeutic areas. This is encouraging following a 12 month period where recruitment activity declined and delays with sponsors setting up new studies.

2.3.31 With the arrival of new respiratory consultant, NHS Borders is planning to open a research portfolio in this area. One study is currently being reviewed and is expected to open in a couple of months and expressions of interest have been submitted for several asthma studies. Unfortunately an expression of interest in a chronic cough study was unsuccessful.

**2.3.32 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.

**2.3.33 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.

**2.3.34 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.

**2.3.35 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.

**2.3.36 Equality and Diversity, including health inequalities**

An equality impact assessment has not been undertaken for the purposes of this awareness report.

**2.3.37 Climate Change**

No additional points to note.

**2.3.38 Other impacts**

No additional points to note.

**2.3.39 Communication, involvement, engagement and consultation**

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

**2.3.40 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.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

Clinical Governance Committee (CGC)
Learning Disabilities (LD)
Hospital Standardised Mortality Rate (HSMR)
Patient Experience Team (PET)
Scottish Public Services Ombudsman (SPSO)
Project Management Office (PMO)

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Infection Prevention & Control Report – February 2024** |
| **Responsible Executive/Non-Executive:** | **Sarah Horan, Director of Nursing, Midwifery & AHPs** |
| **Report Author:** | **Natalie Mallin, HAI Surveillance Lead**<br>**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 reference to the incidence of Healthcare Associated Infections (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

- ***Staphylococcus aureus* Bacteraemia (SAB)**

1.1 NHS Borders had a total of 26 *Staphylococcus aureus* bacteraemia (SAB) cases between April 2023 and January 2024, 14 of which were healthcare associated infections.

1.2 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). Our predicted target rate for this period equates to no more than 20 healthcare associated SAB cases. We are currently on target to achieve this as shown in figure 1 below.

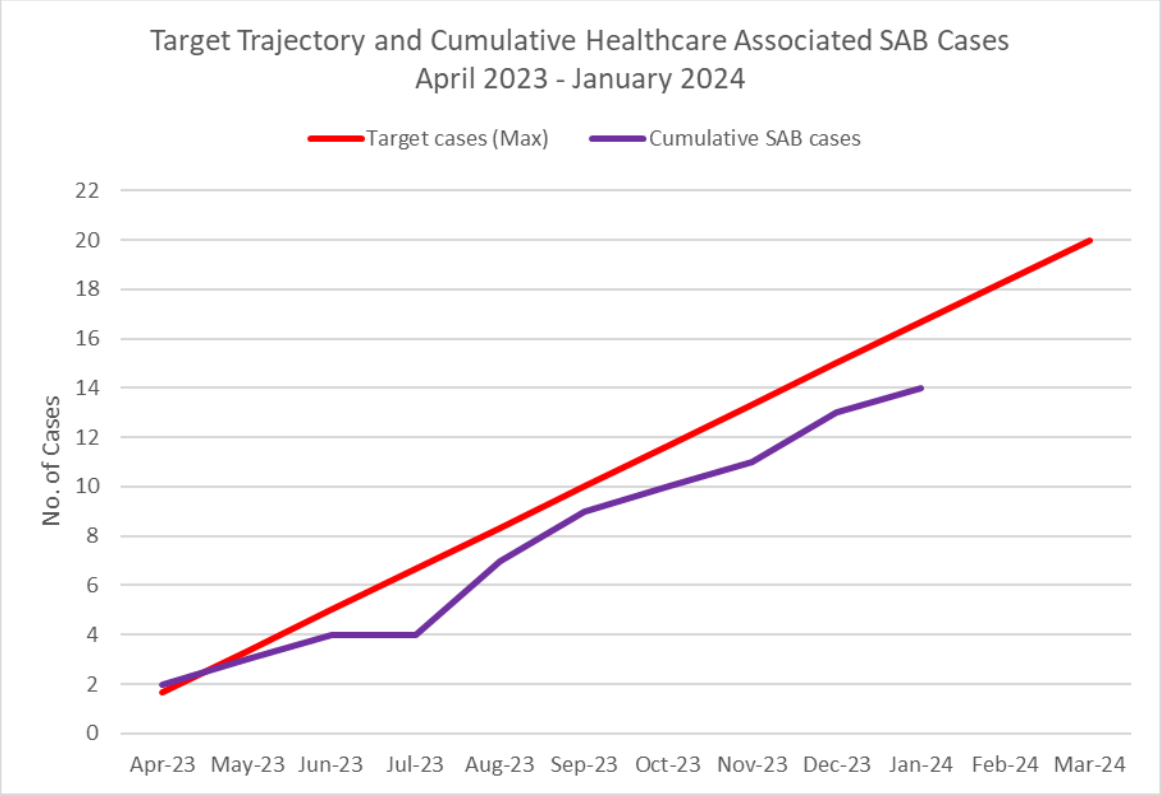



Figure 1: SAB Scottish Government target trajectory and cumulative NHS Borders healthcare associated SAB Cases

- ***Clostridioides difficile Infection (CDI)***

1.3 NHS Borders had a total of 16 *C. difficile* Infection (CDI) cases between April 2023 and January 2024; 11 of these cases were healthcare associated infections.

1.4 As with SABs, the Scottish Government has set a target for each Board to achieve a 10% reduction in the healthcare associated CDI rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline). Our predicted target rate for this period equates to no more than 12 healthcare associated CDI

cases. We are currently not on target to achieve this as per figure 2. However, it is worth noting that 4 of these healthcare associated cases relate to one patient with recurring CDI. Each sample was taken >28 days apart therefore as per ARHAI definitions, these must be reported as separate CDI incidences.

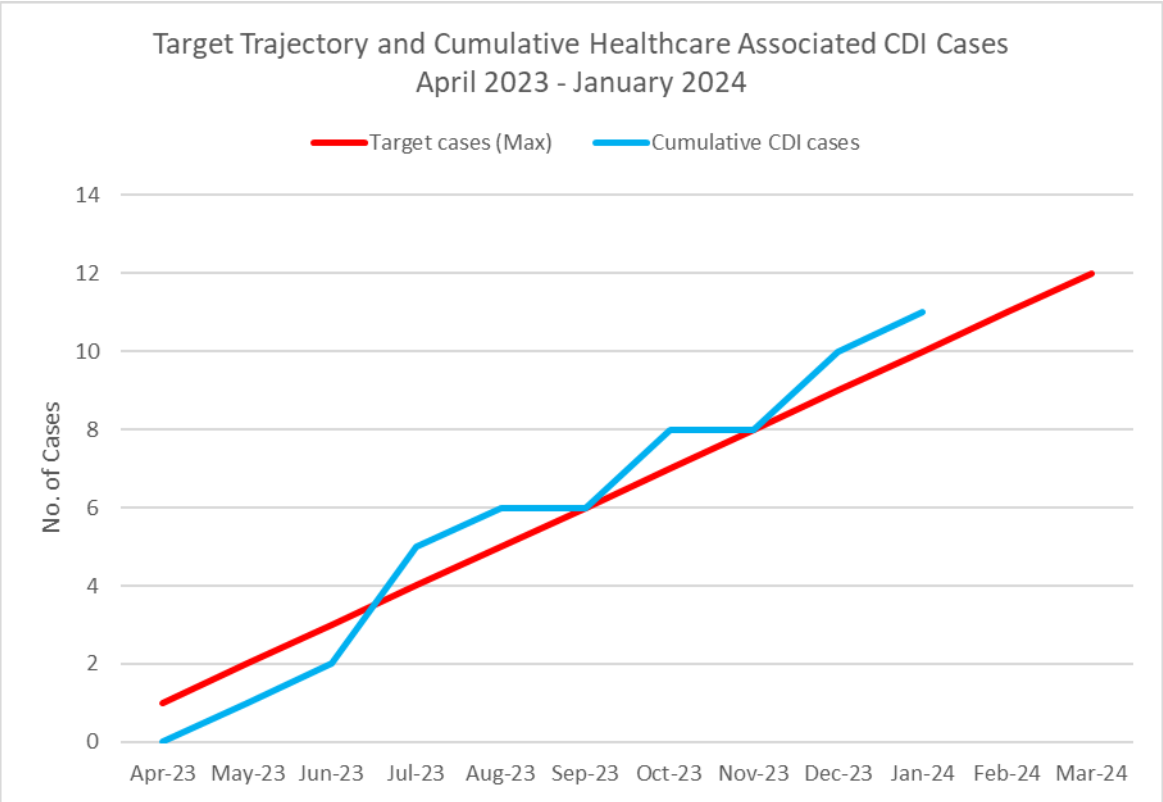



Figure 2: Scottish Government target trajectory and cumulative NHS Borders healthcare associated CDI cases

- ***Escherichia coli* bacteraemia (ECB)**

1.5 NHS Borders had a total of 85 *Escherichia coli* bacteraemia (ECB) cases between April 2023 and October 2023; 47 of which were healthcare associated infections.

1.6 The Scottish Government has set a target for each Board to achieve a 25% reduction in the healthcare associated ECB rate per 100,000 total occupied bed days (TOBDs) by the end of 2023/24 (using 2018/19 as the baseline). Our predicted target rate for this period equates to no more than 32 healthcare associated ECB cases. We have not met this target as shown in figure 3 below.

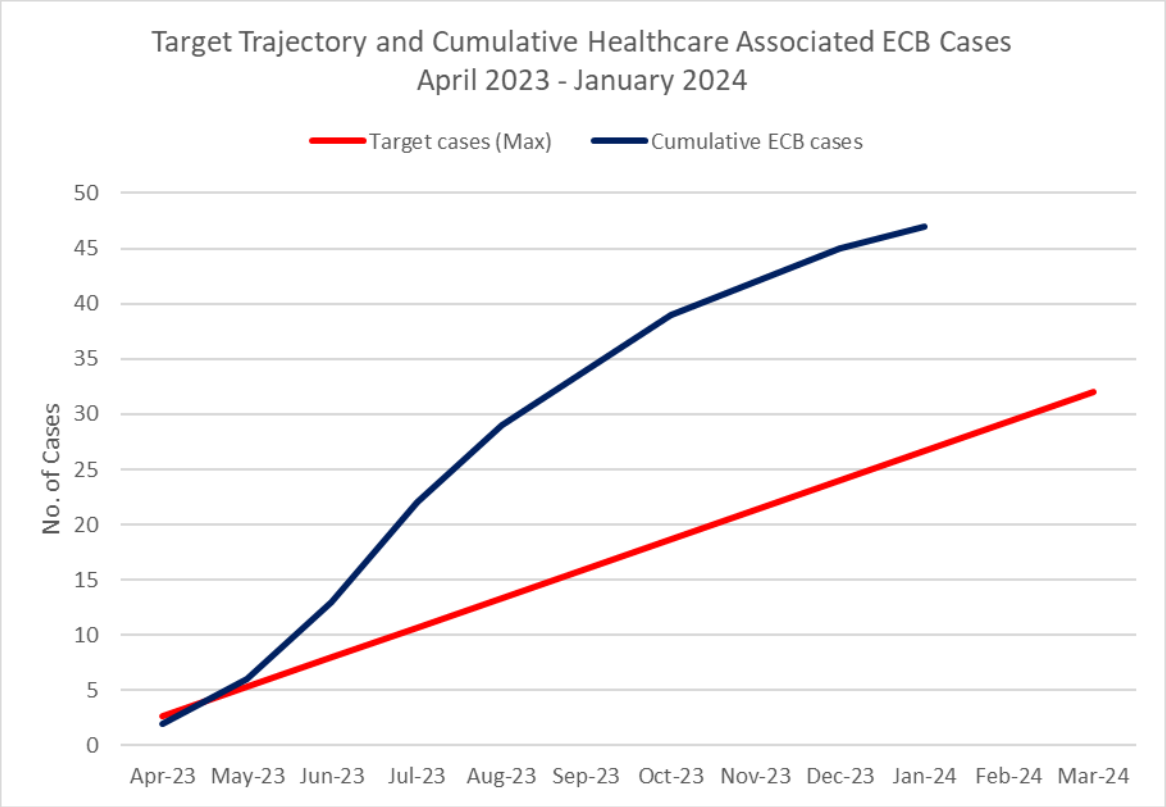



Figure 3: Scottish Government target trajectory and cumulative NHS Borders healthcare associated ECB Cases

## 2.0 Infection Surveillance

- ***Staphylococcus aureus* Bacteraemia (SAB)**
  (Background information provided in Appendix A)

2.1 NHS Borders had a total of 26 *Staphylococcus aureus* bacteraemia (SAB) cases between April 2023 and January 2024, 14* of which were healthcare associated infections.

2.2 *NB: 2 healthcare associated cases were sampled at NHS Borders but attributed to another board. As per ARHAI Scotland definitions, these cases are still counted in our final figures.

2.3 All of the SAB cases were Meticillin-sensitive *Staphylococcus aureus* (MSSA).

2.4 Figure 4 shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated 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.

2.5 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.

2.6 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.

2.7 The graph shows that there have been no statistically significant events since the last update.

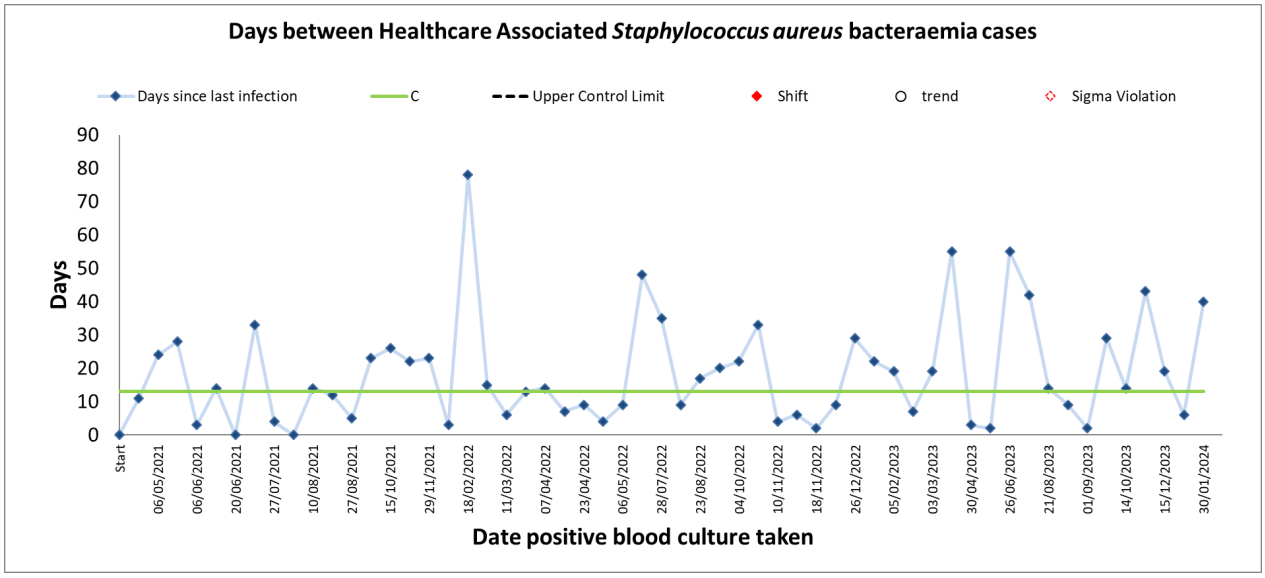
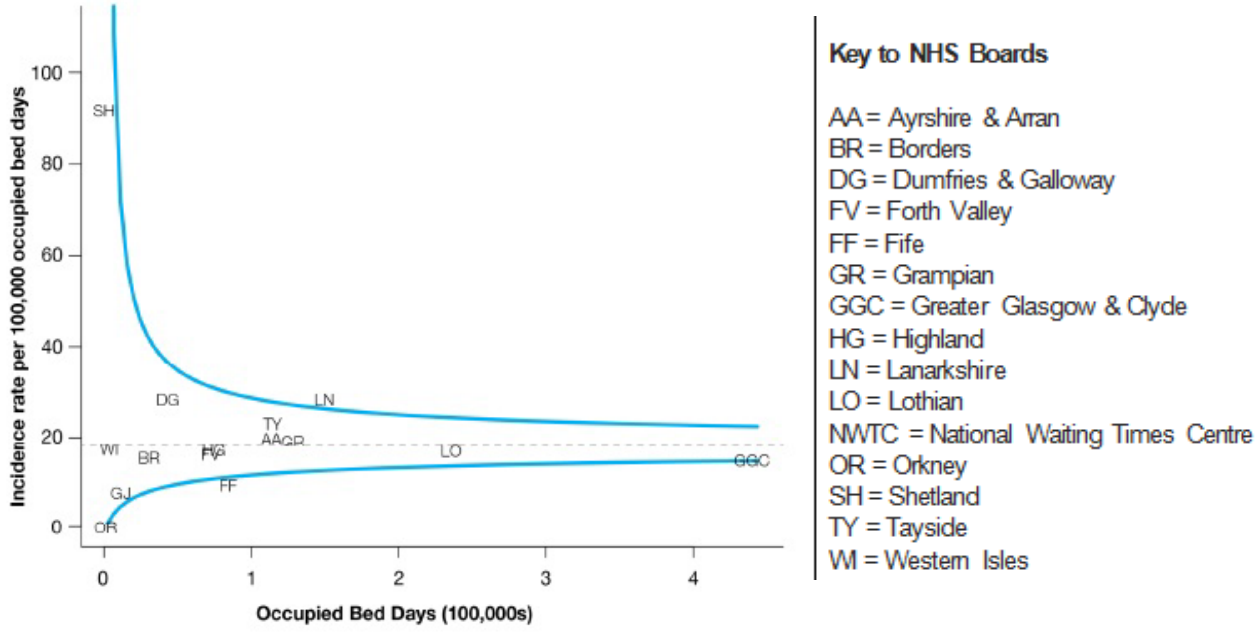



Figure 4: NHS Borders days between healthcare associated SAB cases (May 2021 – January 2024)

2.8 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 5 below shows the most recently published data as a funnel plot of healthcare associated SAB cases as rates per 100,000 Total Occupied Bed Days (TOBDs) for all NHS boards in Scotland in Quarter 3 2023 (Jul 2023 – Sept 2023).

2.9 During this period, NHS Borders (BR) had a rate of 15.3 which was below the Scottish average rate of 18.3.

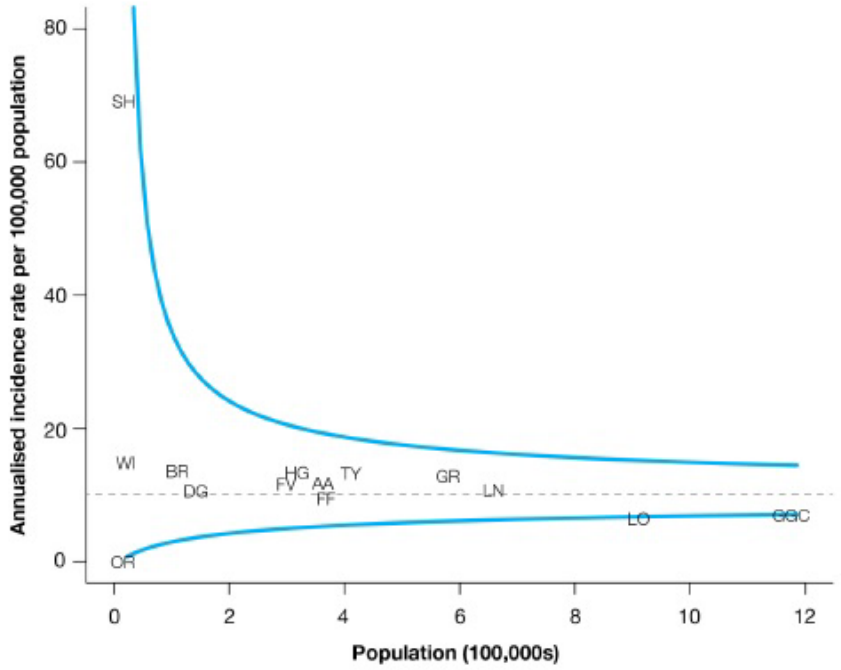



1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Forth Valley and NHS Highland overlap.

Figure 5: Funnel plot of SAB incidence rates (per 100,000 TOBD) in healthcare associated infection cases for all NHS Boards in Scotland in Q3 2023

2.10 A funnel plot chart is designed to distinguish natural variation from statistically significant outliers. The funnel narrows on the right of the graph as the larger health Boards will have less fluctuation in their rates due to greater Total Occupied Bed Days. Figure 5 shows that NHS Borders was within the blue funnel which means that we are not a statistical outlier.

2.11 Figure 6 below shows a funnel plot of community associated SAB cases as rates per 100,000 population for all NHS boards in Scotland in Q3 2023.




1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 6: Funnel plot of SAB incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2023

2.12 During this period NHS Borders (BR) had a rate of 13.7 per 100,000 population which was above the Scottish average rate of 10.1. It is worth noting that community acquired SAB cases had no healthcare intervention prior to the positive blood culture being taken. We are not a statistical outlier from the rest of Scotland.

- ***Clostridioides difficile Infection (CDI)***
  (Background information provided in Appendix A)

2.13 Figure 7 below shows a Statistical Process Control (SPC) chart showing the number of days between each healthcare associated 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.

2.14 The graph shows that there have been no statistically significant events since the last update.

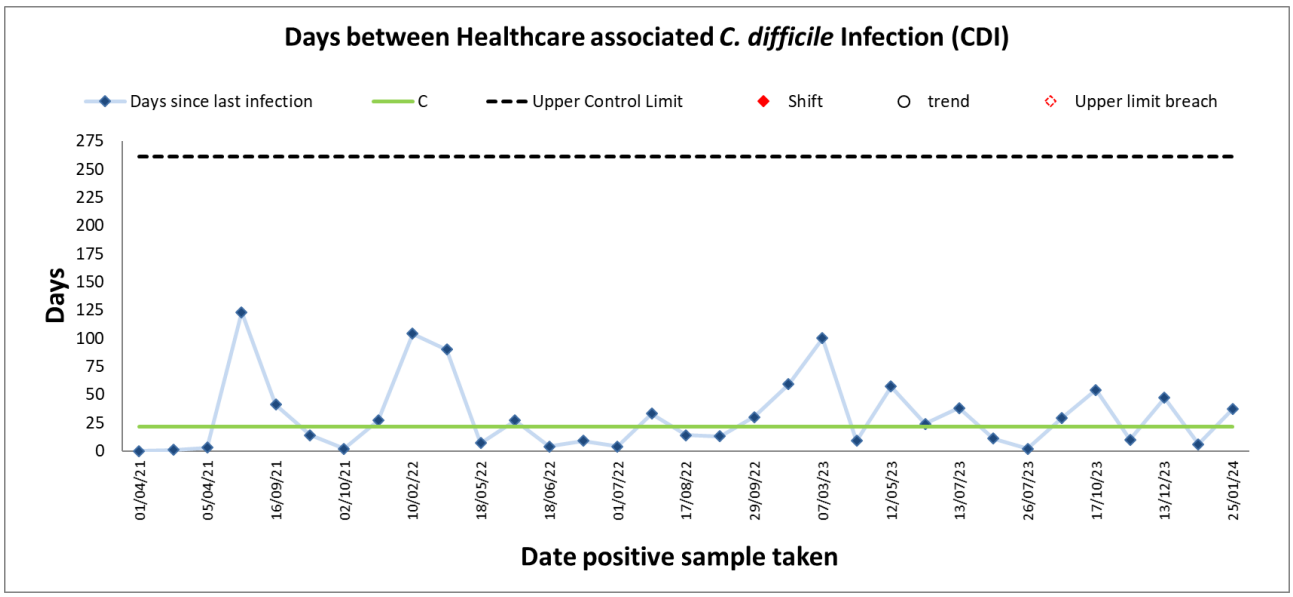
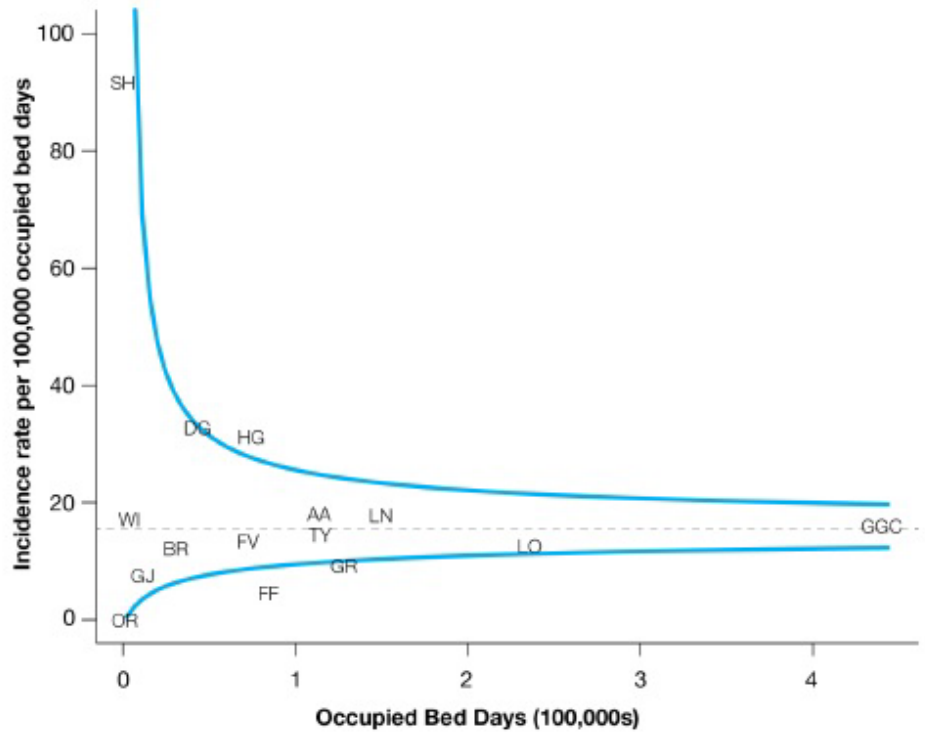



Figure 7: Days between healthcare associated CDI cases (April 2021 – Jan 2024)

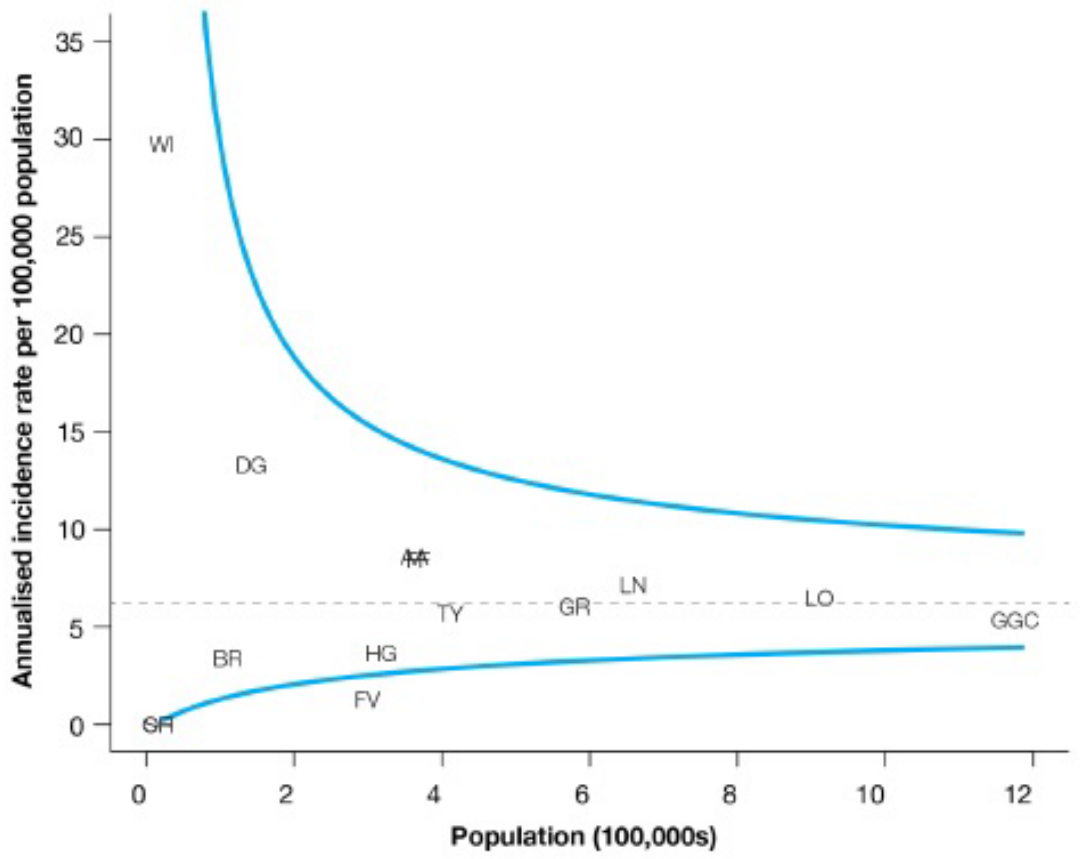
2.15 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 8 below shows a funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q3 2023. The graph shows that NHS Borders (BR) had a rate of 12.2 which was below the Scottish average rate of 15.5.




1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.

Figure 8: Funnel plot of CDI incidence rates (per 100,000 TOBD) of healthcare associated infection cases for all NHS Boards in Scotland in Q3 2023

2.16 Figure 9 below shows a funnel plot of CDI incidence rates (per 100,000 population) of community associated infection cases for all NHS Boards in Scotland in Q3 2023. The graph shows that NHS Borders (BR) had a rate of 3.4 which was below the Scottish average rate of 6.2.




1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.
2. NHS Orkney and NHS Shetland overlap, as do NHS Ayrshire and Arran and NHS Fife.

Figure 9: Funnel plot of CDI incidence rates (per 100,000 population) in community associated infection cases for all NHS Boards in Scotland in Q3 2023

- ***Escherichia coli* bacteraemia (ECB)**
  (Background information provided in Appendix A)

2.17 The primary cause of preventable healthcare associated ECB cases is Catheter Associated Urinary Tract Infection (CAUTI) as shown in Figure 10 below.

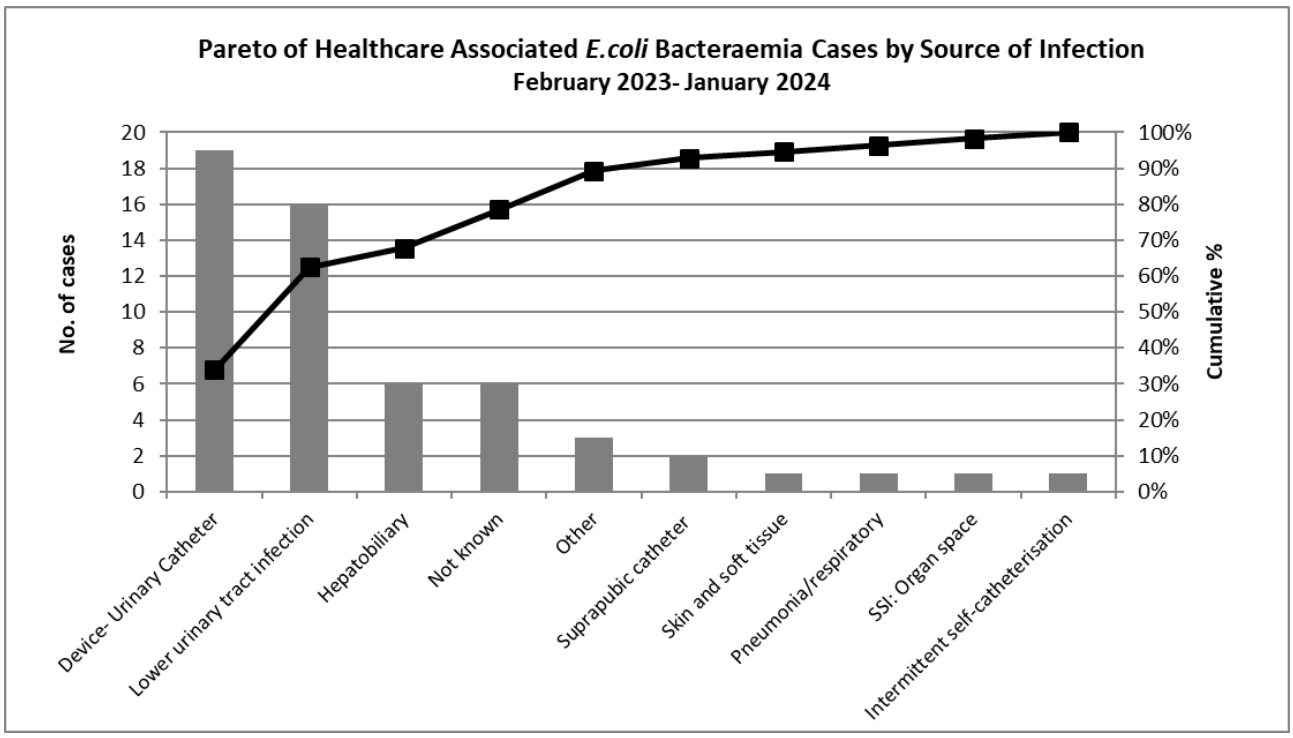



Figure 10: Pareto chart of healthcare associated ECB cases by source of infection

2.18 Figure 11 shows a statistical process chart of the total number of healthcare associated *E.coli* bacteraemia 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.

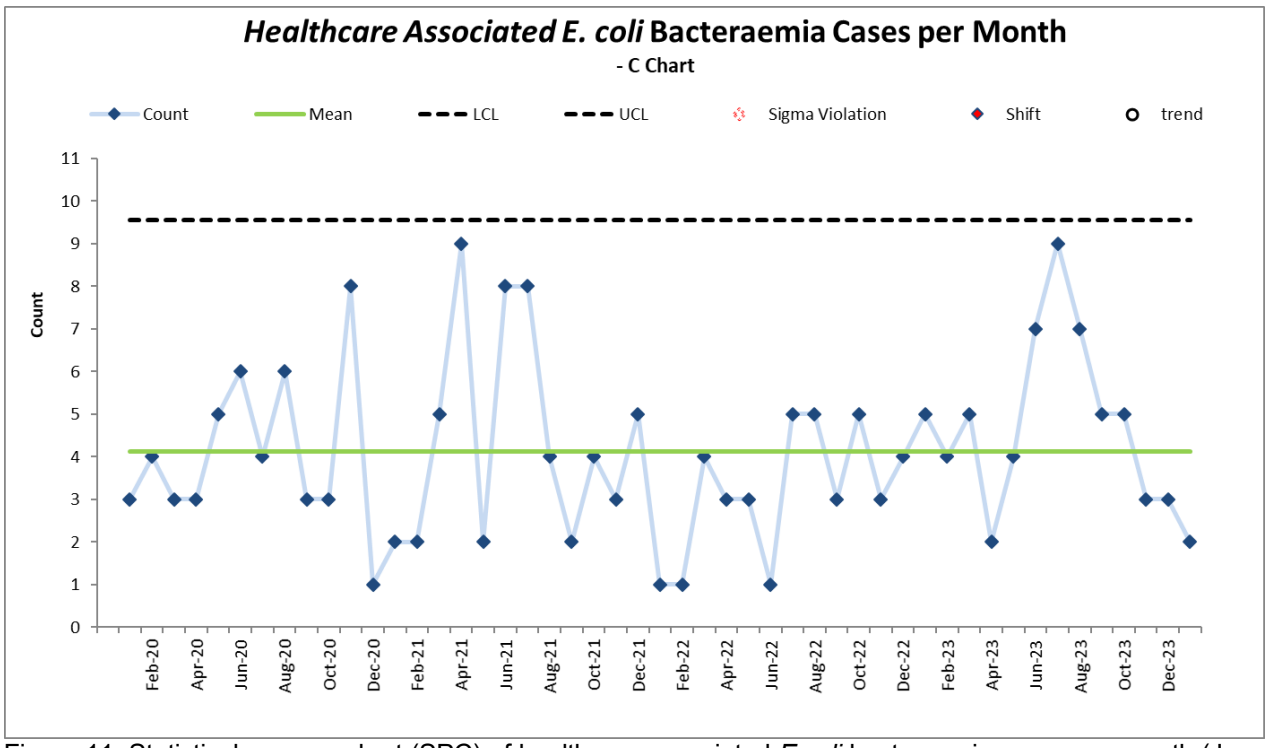
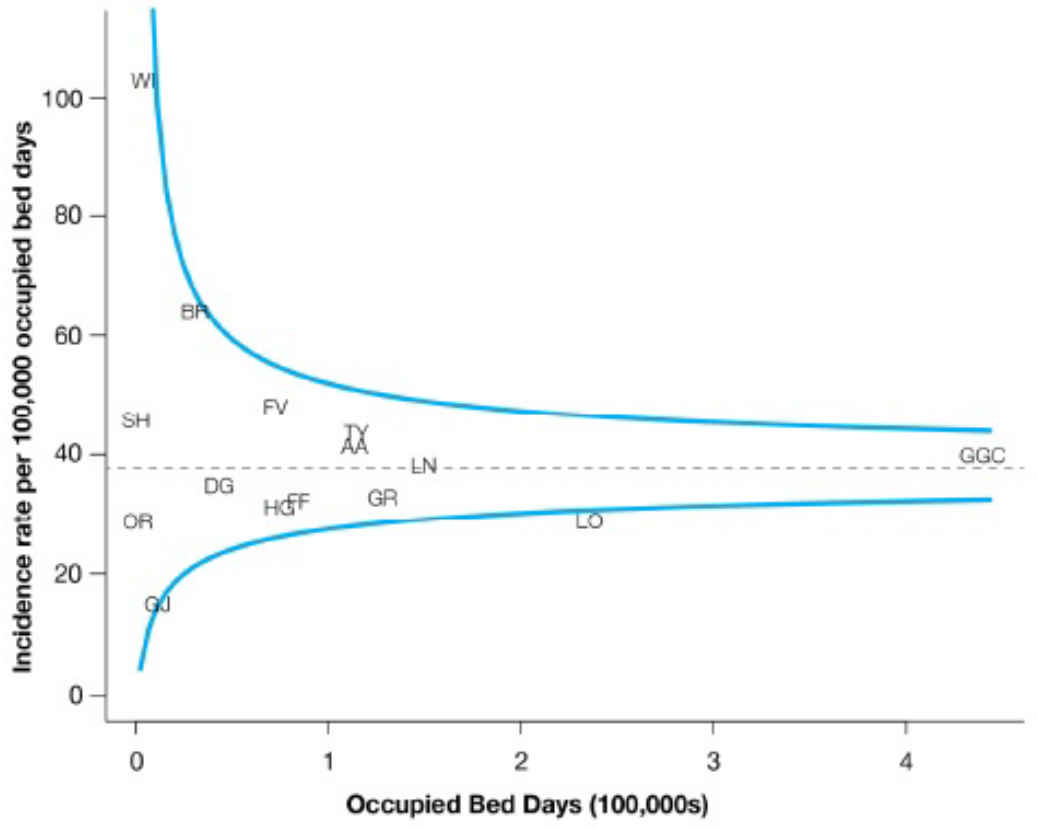



Figure 11: Statistical process chart (SPC) of healthcare associated *E.coli* bacteraemia cases per month (Jan 2020-Jan 2024)

2.19 ARHAI Scotland produces quarterly reports showing infection rates for all Scottish Boards. Figure 12 below shows a funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2023. NHS Borders

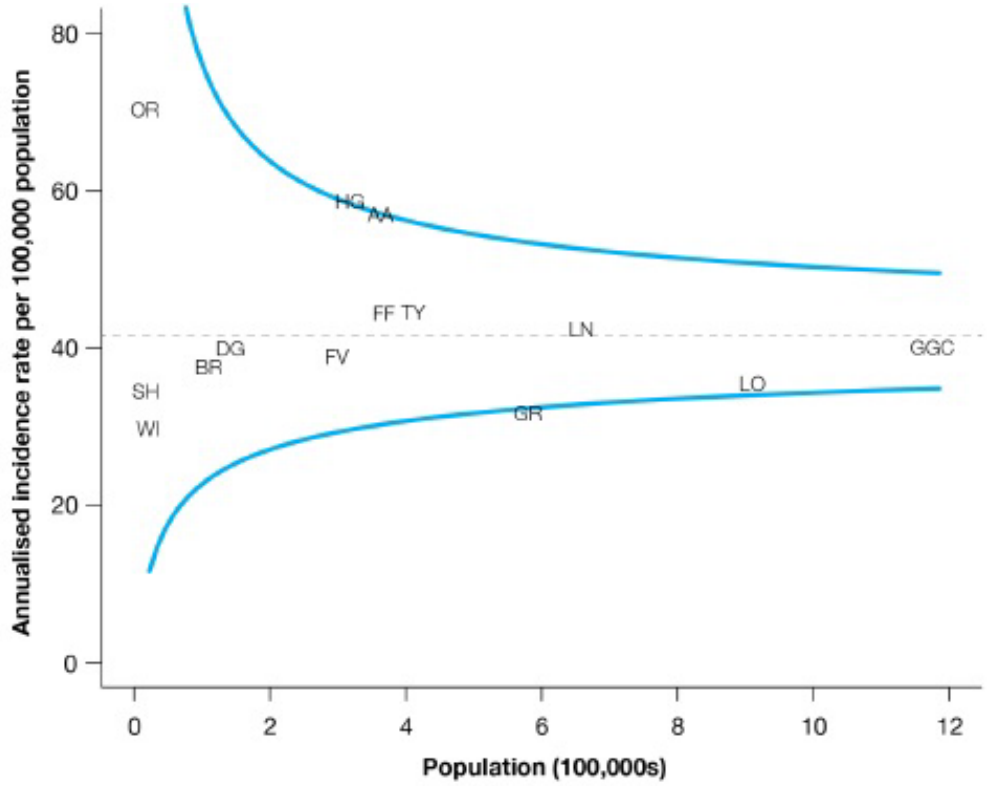
(BR) had a rate of 64.1 for healthcare associated infection cases which was above the Scottish average rate of 37.8 but we are not a statistical outlier.




1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & Total occupied bed days: Information Services Division ISD(S)1.
2. NHS Fife and NHS Highland overlap, as do NHS Ayrshire & Arran and NHS Tayside.

Figure 12: Funnel plot of healthcare associated ECB infection rates (per 100,000 TOBD) for all NHS Boards in Scotland in Q3 2023

2.20 Figure 13 below shows a funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 2023. NHS Borders (BR) had a rate of 37.6 for community associated infection cases which was below the Scottish average rate of 41.6. It is worth noting that community acquired ECB cases had no healthcare intervention prior to the positive blood culture being taken.




1. Source of data is Electronic Communication of Surveillance in Scotland (ECOSS) & National Records of Scotland (NRS) mid-year population estimates.

Figure 13: Funnel plot of community associated ECB infection rates (per 100,000 population) for all NHS Boards in Scotland in Q3 2023

## 3.0 NHS Borders Surgical Site Infection (SSI) Surveillance

3.1 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.

3.2 In July 2023 NHS Borders resumed local SSI surveillance for hip and knee arthroplasty with a retrospective lookback at cases for the period January – June 2023.

3.3 C-section surveillance was recommenced in January 2024 following a process review in conjunction with clinicians with a retrospective lookback at cases from July 2023 to December 2023.

- **Hip and knee arthroplasty**

3.4 An SSI Task and Finish Group continues to meet. A review is progressing of NHS Borders approaches against national best practice guidance (Surgical site infections: prevention and treatment, National Institute for Health and Care Excellence, 2020) to reduce the risk of hip and knee arthroplasty surgical site infections.

| Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) Jan 2023 - Dec 2023 | | | |
|---|---|---|---|
| **Procedure** | **Total ops** | **Total SSIs** | **SSI Rate** |
| Hip arthroplasty | 255 | 6 | 2.35% |
| Knee arthroplasty | 136 | 3 | 2.21% |

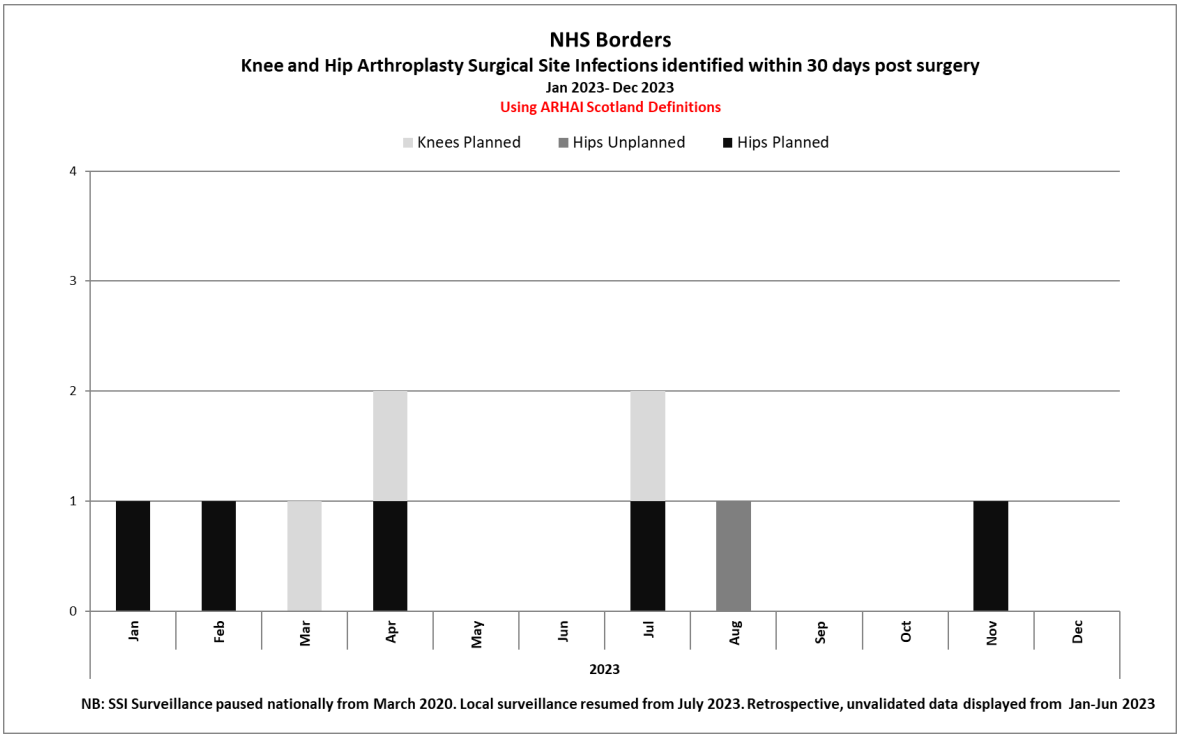



Figure 14: Hip and knee SSIs (Jan 2023- Dec 2023)

- **C-sections**

3.5 On the 7th February 2024, Infection Prevention and Control Team met with the Associate Director of Midwifery/General Manager for Women & Children Services and the Clinical Director to discuss suspected C-section SSI cases that had been identified following the recommencement of surveillance. Five cases for the period July 2023-December 2023 were confirmed.

3.6 Monthly meetings have been arranged with the Infection Prevention and Control Team and the clinical service to review processes against national guidance with the next meeting due to take place on 6th March 2024. Confirmed SSIs are also reviewed by the Core Management Team.

| Summary of Surgical Site Infection (SSI) cases (Using ARHAI Scotland definitions) Jul 2023 - Dec 2023 | | | |
|---|---|---|---|
| **Procedure** | **Total ops** | **Total SSIs** | **SSI Rate** |
| C-section | 175 | 5 | 2.86% |

NB: Official SSI rates are based on a 12-month period, therefore the data presented in the table is not directly comparable to any previously published pre-pandemic data.

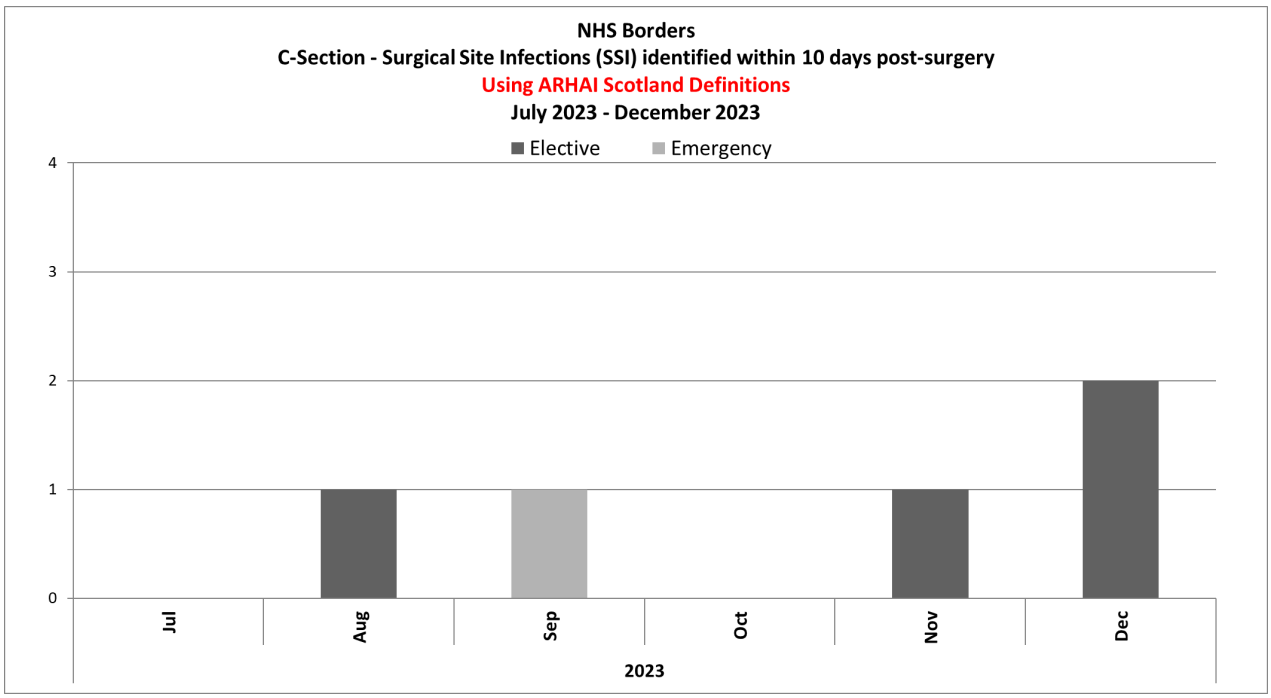



Figure 15: C-section SSIs (Jul 2023- Dec 2023)

## 4.0 Incidents and Outbreaks

- **Respiratory outbreaks**

4.1 Since the last Board report, there have been 13 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 26th February 2024 is detailed in the table below.

4.2 Any learning from each incident is captured and acted upon in real time where appropriate.

- **Norovirus**

4.3 There have been no Norovirus incidents since the last Board report.

| NHS Borders Clusters as at 26/02/2024 (CLOSED INCIDENTS ONLY) | | | | | |
|---|---|---|---|---|---|
| **Outbreak start date** | **Outbreak location(s)** | **Organism** | **Positive patient cases** | **Patient deaths** (COVID recorded on DC) | **Suspected/ confirmed staff cases** |
| **DECEMBER** | | | | | |
| 11/12/2023 | Haylodge | COVID | 4 | 0 | 2 |
| 15/12/2023 | Border View | COVID | 13 | 0 | 1 |
| 18/12/2023 | Ward 7 | COVID | 4 | 0 | 0 |
| 19/12/2023 | Ward 9 | FLU A | 3 | 0 | 1 |
| 26/12/2023 | MAU | COVID | 6 | 0 | 1 |
| 28/12/2023 | Ward 4 | COVID | 2 | 0 | 3 |
| **JANUARY** | | | | | |
| 03/01/2024 | Knoll | COVID | 9 | 0 | 3 |
| 08/01/2024 | Kelso | COVID | 9 | 0 | 8 |
| 10/01/2024 | Ward 4 | COVID | 8 | 0 | 0 |
| 22/01/2024 | Hawick | COVID | 9 | 0 | 6 |
| 24/01/2024 | Ward 4 | COVID | 5 | 0 | 1 |
| 26/01/2024 | Border View | COVID | 3 | 0 | 0 |
| 29/01/2024 | Ward 9 | COVID | 4 | 0 | 0 |

| Summary of learning | Learning outcomes |
|---|---|
| Site pressures impacting balancing of infection control risk with other patient flow risks. | IPCT working with Site & Capacity during each individual outbreak to mange outbreak and utilise beds appropriately |

## 5.0 Infection Control Compliance Monitoring Programme

5.1 In December 2023 and January 2024, spot checks were undertaken in a total of 13 clinical areas across NHS Borders with an average compliance of 93%.

## 6.0 Quality Improvement Update

6.1 The Prevention of CAUTI Group last met on the 6th February 2024. At the meeting the Group reviewed progress against the Work Plan. There are currently no overdue actions.

6.2 Analysis of various available data sources was considered fully at the most recent meeting of the Group. The data informed additional targeted actions including a review of catheter related infections by district nurse locality, and the Care Home Support Team is working with BECS on reviewing catheter related calls to care homes. Updated data on out of hours BECS catheter related activity is also being sought.

6.3 Improvement activity by NHS Fife has been shared with the Prevention of CAUTI Group. Further communication with NHS Fife is planned to explore this activity and consider potential adoption in NHS Borders.

6.4 Hospital and Healthcare associated SAB and ECB continue to be monitored by the group with additional risk factors for these cases being explored to consider preventative measures for patients who require a catheter. A review is also progressing of active catheter referrals to District Nurse Teams by locality.

## 7.0 Cleaning and the Healthcare Environment

7.1 Health Facilities Scotland (HFS) publishes quarterly reports on cleanliness standards and estates fabric across NHS Scotland. The most recently published report covers the period July – September 2023. Figure 16 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%.

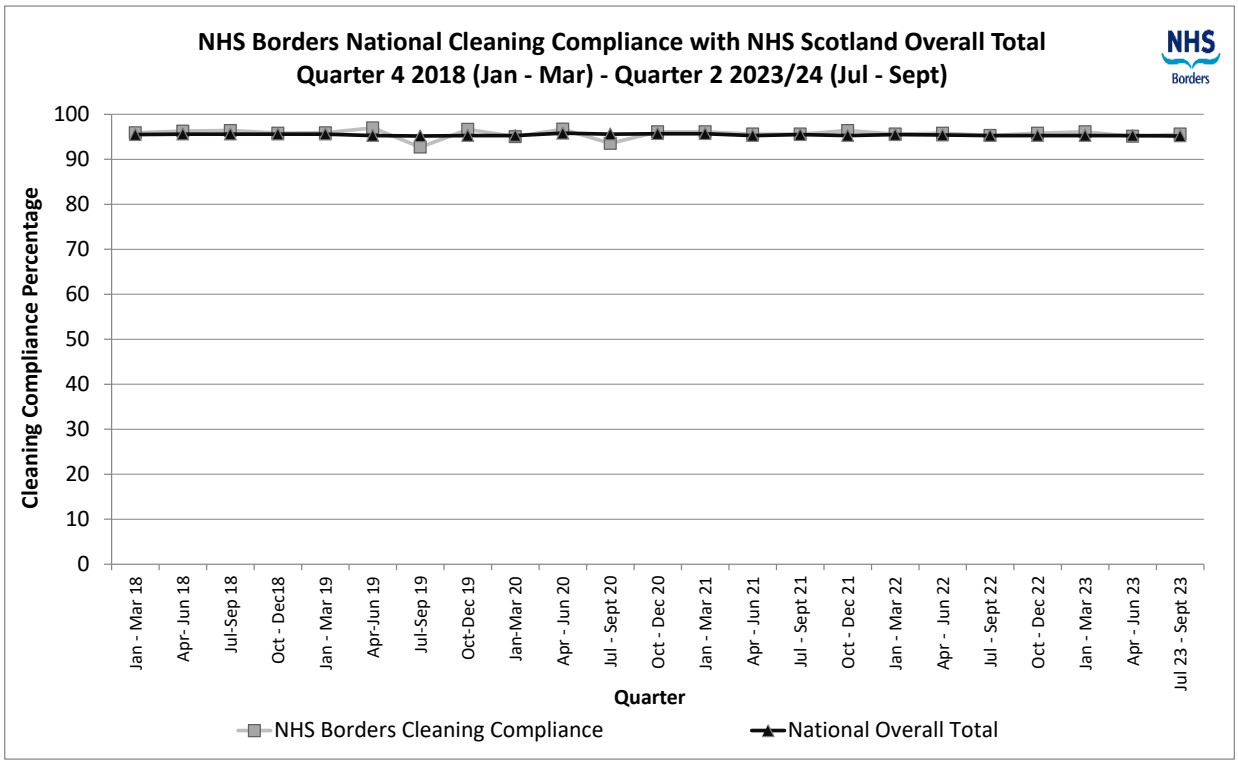



Figure 16: NHS Borders cleaning compliance against the NHS Scotland average by quarter

## 8.0 Hand Hygiene

8.1 Since the last hand hygiene audits were conducted in December 2023, significant work has progressed to improve staff access to hand gel. A review has been completed in BGH and Community hospitals of wall mounted dispensers. This has resulted in replacement of broken dispensers, re-siting of some dispensers and installation of some additional dispensers. In addition, bed-end dispensers have been installed across BGH.

8.2 In addition to alcohol-based hand gel, staff should have access to a skin conditioner product called 'Hand Medic' to help maintain healthy skin. A staff skin clinic was held in January 2024 with Occupational Health resulting in a number of departments reaching out for support and installation of additional 'Hand Medic' dispensers.

8.3 All areas in BGH and Community hospitals will be receiving new 'Hand Medic' dispensers over the next few weeks.

8.4 Further hand hygiene compliance audits are currently progressing and results from this will be included in the next update paper.

## 9.0 Horizon scanning

### Measles

9.1 On 26th February 2024, ARHAI Scotland circulated measles guidance which included infection control precautions and management of staff contacts of measles cases. The guidance has been shared with relevant clinicians and managers across NHS Borders.

## 10.0 Infection Control Work Plan 2023/24

10.1 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.

10.2 There are currently eight overdue actions in the 2023/24 Infection Control Work Plan of which three are assessed as medium risk and the remainder low risk.

## 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

### 2.3.1 Quality/ Patient Care

Infection prevention and control is central to patient safety.

### 2.3.2 Workforce

Infection Control staffing issues are detailed in this report.

### 2.3.3 Financial

This assessment has not identified any resource implications.

### 2.3.4 Risk Assessment/Management

All risks are highlighted within the paper.

### 2.3.5 Equality and Diversity, including health inequalities

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

### 2.3.6 Climate Change

None identified.

### 2.3.7 Other impacts

None identified.

### 2.3.8 Communication, involvement, engagement and consultation

This is a regular update as required by SGHD and has not been subject to any prior consultation or engagement although much of the data is included in the monthly infection control reports which are presented to divisional clinical governance groups and the Infection Control Committee.

### 2.3.9 Route to the Meeting

This report has not been submitted to any prior groups or committees but much of the content will be presented to the NHS Borders Board

## 2.4 Recommendation

Committee members are asked to:

- **Discussion** – Examine and consider the implications of a matter.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**

- **No Assurance**

## 3 List of appendices

None

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Future of the Public Governance Committee** |
| **Responsible Executive/Non-Executive:** | **Stephanie Errington, Interim Director of Planning and Performance** |
| **Report Author:** | **Clare Oliver, Head of Communications and Engagement** |

## 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):**

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

This paper sets out the role and remit of NHS Borders Public Governance Committee (PGC) and considers its future as a standalone committee of the Board. Following the resignation from the Board of the Non Executive Director who chaired the Public Governance Committee, and in light of the significant pressures being faced by the Board, it was deemed a sensible time to review the role and remit of the committee to see if there are efficiencies that can be made; without removing the important scrutiny that should exist around public involvement and engagement activities.

## 2.2 Background

NHS Boards have a statutory duty to involve people and communities in the planning and development of care services, and in decisions that will significantly affect how services are run.

Although Scottish Government does not prescribe that health boards have a Public Governance Committee, NHS Borders has had a PGC since November 2005.

The remit of the Public Governance Committee is defined in the current Terms of Reference as follows:

*"The Public Governance Committee has been established as a Committee of the Board to provide assurance to the Board that the requirements of engaging, involving and consulting the public takes place efficiently and effectively in a person centred way in line with statutory obligations and policy requirements and to provide oversight to the Board's activities with regards to health inequalities in terms of unfair, unjustified variation in access to and / or outcomes from NHS services."*

## 2.3 Assessment

For the period 2023-24 the Public Governance Committee remit consisted of ensuring that;

1. Reporting and monitoring of public involvement and patient experience activities, service users and carers involvement, stakeholder engagement, policy and guidance are in place and delivered in line with the organisations corporate values and the Board's Involving People Framework
2. Reporting and monitoring of Equality and Diversity and Health Inequalities requirements are in place and delivered in line with the organisations corporate values
3. Public and patient involvement in service change, improvement and redesign is undertaken and delivered in line with Scottish Government policies and legislative requirements
4. Reporting and monitoring of Community Empowerment (Scotland) Act 2015 Public Participation Requests
5. There is a cross referencing and linkage to the Clinical Governance Committee where appropriate
6. There is a cross referencing and linkage to the Staff Governance Committee where appropriate
7. Accountability structures are in place for any public involvement workstreams
8. There is a sharing of information and issues relating to Human Rights
9. Assurance is sought from risk owners that strategic risks relating to public communication and engagement are being managed proportionally in line with the risk management process and systems.

Having reviewed the remit of the Public Governance Committee in relation to the responsibilities discharged to other established committees of NHS Borders it is considered practical that oversight of the individual elements is discharged as set out below in **Table 1**:

| Remit item | Discharge responsibility to | Adjustments required |
|---|---|---|
| 1. Reporting and monitoring of public involvement / patient experience activity | Operational accountability via individual programme boards where applicable with exception | Ensure appropriate and proportionate public representation across |

| | | |
|---|---|---|
| | reporting to Quality and Sustainability Board (Q&SB) | programme governance structures as appropriate (as per actions agreed in community engagement internal audit) |
| 2. Reporting and monitoring of Equality and Diversity and Health Inequalities requirements | As applicable via individual Programme Boards, Strategic Planning Group, NHS Borders Board and Integration Joint Board as part of Equality and Human Rights Impact Assessment (EHRIA) process. | N/A (EHRIA is a prescribed element of the Involving People Framework) |
| 3. Public and patient involvement in service change, improvement and redesign is undertaken and delivered in line with Scottish Government policies and legislative requirements | Via individual programme boards | Ensure Healthcare Improvement Scotland (HIS) Community Engagement membership of relevant delivery groups* |
| 4. Reporting and monitoring of Community Empowerment (Scotland) Act 2015 Public Participation Requests | TBC dependant on subject matter of the request | None (no such requests have been received to date but handling process is in place should it be required) |
| 5. Linkage to the Clinical Governance Committee where appropriate | Clinical Governance Committee via Head of Communications and Engagement / Director of Planning and Performance | None |
| 6. Linkage to the Staff Governance Committee where appropriate | Staff Governance Committee via Head of Communications and Engagement / Director of Planning and Performance | None |
| 7. Accountability structures for public involvement | Individual programme boards in line with Involving People Framework | None |
| 8. Sharing of information and issues relating to Human Rights | EHRIA is a prescribed element of the Involving People Framework | None |
| 9. Management of strategic risks in relation to public involvement | Resource and Performance Committee | None – process already in place |

*established relationship between HIS Community Engagement colleagues and NHS Borders Head of Communications and Engagement is in place.

In addition to the formal discharge of responsibilities outlined in the table there is a regular schedule of meetings between the Head of Communications and Engagement with;

- HIS Community Engagement
- Borders Care Voice (Third Sector)
- Public Involvement Partnership Group (NHS Borders)

These meetings involve dialogue including appropriate challenge about all elements of public involvement and engagement contributing to the rigour around process and best practice across NHS Borders.

Since the adoption of the Involving People Framework across NHS Borders and the wider Health and Social Care Partnership there has been a greater shared ownership of engagement and involvement responsibilities; and the internal Community Engagement audit undertaken in November 2023 reported that *"the current arrangements for community engagement initiatives are sufficient"* and *"operational arrangements align well with the organisation's Involving People Framework."*

Furthermore we consider there to be a benefit of widening the oversight and discharge of responsibility for public involvement and community engagement activity as this reflects the fact that the statutory responsibility sits across the organisation

.

The area of risk highlighted in the audit report is that, given the scale of challenges faced by NHS Borders that will require changes to service delivery models, *"there is a risk of a disconnect between community expectations and the organisation's delivery capacity."* The management response provided was that we will ensure each transformation bundle has a proportionate programme level engagement plan with the responsibility for that sitting with the Programme Chair. These arrangements are reflected in the discharge of responsibilities detailed in Table 1.

### 2.3.1 Quality/ Patient Care

There should be no impact on quality / patient care if the responsibilities are discharged as suggested.

### 2.3.2 Workforce

There should be no impact on staff resources, health and wellbeing.

### 2.3.3 Financial

The recommendations in this paper are not predicated on financial savings or efficiencies however the redistribution of responsibilities proposed will avoid duplication and maximise use of existing structures and processes resulting in productive gains.

### 2.3.4 Risk Assessment/Management

Strategic risk 3918 references *"failure of the Board to effectively involve patient, public and third sector partners in decision making."*

The redistribution of responsibilities proposed should provide the same level of scrutiny and governance in managing this risk.

### 2.3.5 Equality and Diversity, including health inequalities

NHS Borders is committed to involving and engaging patients, public and people with lived experience in support of the Public Sector Equality Duty, Fairer Scotland Duty, and the Board's Equalities Outcomes.

An impact assessment on this proposed change has not been completed because there is no change to our commitment to compliance with these duties; and Equality

and Human Rights Impact Assessments will continue to be carried out for each individual piece of work as defined in the Involving People Framework, and scrutinised as part of the related governance process.

### 2.3.6 Climate Change

No impact

### 2.3.7 Other impacts

No impact

### 2.3.8 Communication, involvement, engagement and consultation

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

- Meeting between Chair, Interim Director of Planning and Performance and Head of Communications and Engagement on 29 February 2024

### 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.

- Healthcare Improvement Scotland Community Engagement meeting date 19 March 2024
- Chair of Public Involvement Partnership Group
- Feedback on draft paper from Non Executive Director and Chair of IJB

## 2.4 Recommendation

**For Decision:** NHS Borders Board members are asked to;

1. **Agree** the recommendation from the Chair of NHS Borders that the Public Governance Committee is formally disbanded.
2. **Agree** the discharge of remits as set out in Table 1 of this paper

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

N/A

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **NHS Borders Performance Scorecard February 2024** |
| **Responsible Executive/Non-Executive:** | **Stephanie Errington, Interim Director of Planning & Performance** |
| **Report Author:** | **Hayley Jacks, Planning & Performance Officer** |

## 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

## 2 Report summary

## 2.1 Situation

The main body of the scorecard sets out performance as at end of February 2024 against the targets from the 2023/24 Annual Delivery Plan (ADP). The report also includes as appendices performance as noted against some previous Annual Operation Plan/Local Delivery Plan 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 certain trajectory targets however summaries for each of these can be found within the scorecard where available updates have been added.

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.

### 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 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

- **Awareness** – To note Board performance as at the end of February 2024.

The Board will be asked to confirm the level of assurance it has received from this report:

- **Significant Assurance**
- **Moderate Assurance**
- **Limited Assurance**
- **No Assurance**

## 3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Borders Performance Scorecard


# PERFORMANCE SCORECARD

# As at 29 February 2024

# Month 11

## Contents Page

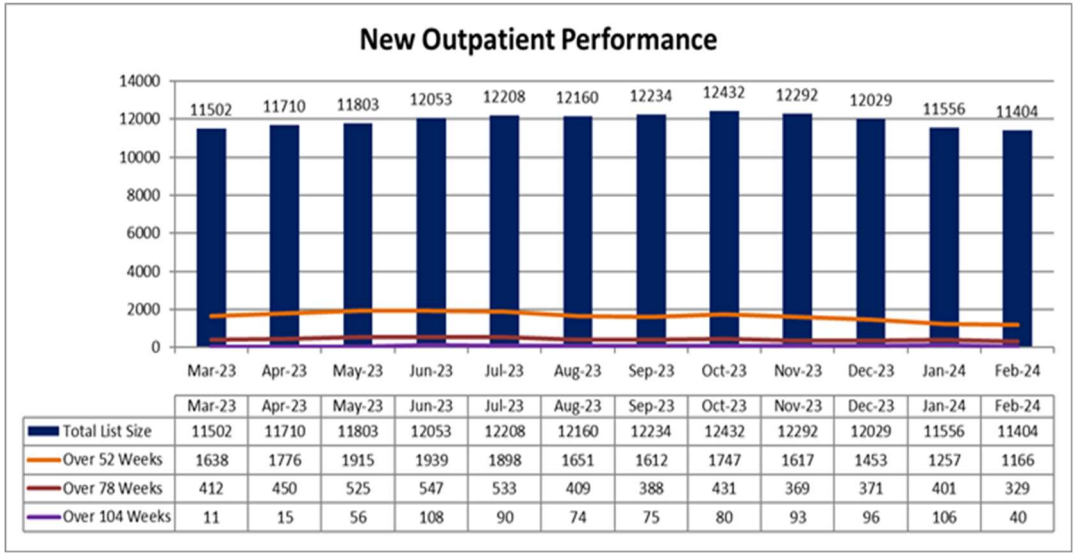
## Introduction

As a result of the COVID-19 Pandemic the 2021/22 Annual Operational Plan (AOP) was replaced for all Health Boards by their Remobilisation Plan and associated trajectories agreed with Scottish Government, the latest iteration being RMP4. In 2022/23 Scottish Government moved away from further remobilisation plans and instead commissioned a one-year Annual Delivery Plan (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




| | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total List Size | 11502 | 11710 | 11803 | 12053 | 12208 | 12160 | 12234 | 12432 | 12292 | 12029 | 11556 | 11404 |
| Over 52 Weeks | 1638 | 1776 | 1915 | 1939 | 1898 | 1651 | 1612 | 1747 | 1617 | 1453 | 1257 | 1166 |
| Over 78 Weeks | 412 | 450 | 525 | 547 | 533 | 409 | 388 | 431 | 369 | 371 | 401 | 329 |
| Over 104 Weeks | 11 | 15 | 56 | 108 | 90 | 74 | 75 | 80 | 93 | 96 | 106 | 40 |

***Fig. 1***

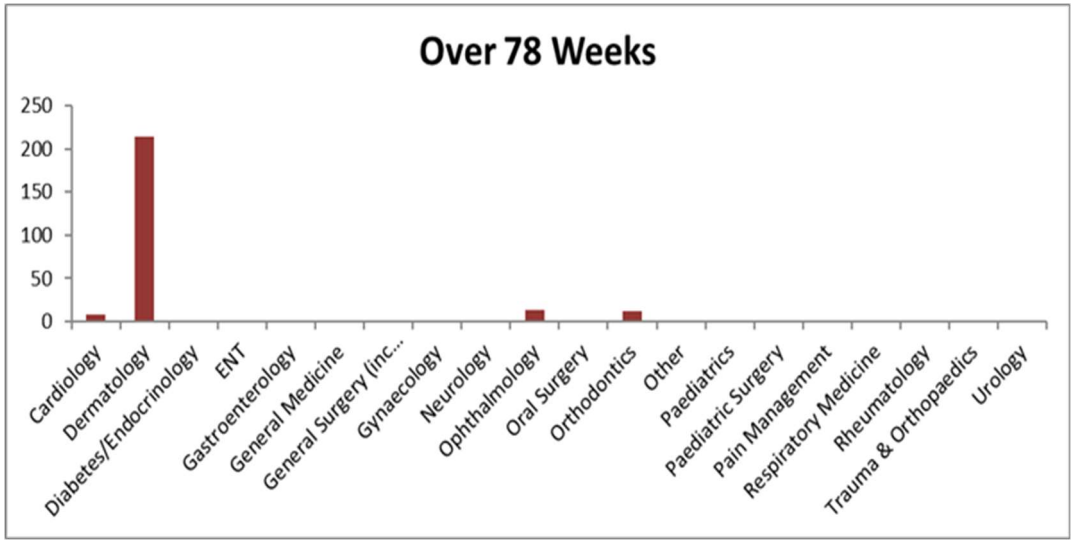



***Fig. 2***

***Updated 18.03.24***

The outpatient waiting list size continues to reduce, in February reducing by 152 patients. Demand remains relatively stable, for the second month we have seen over 2000 out-patients, achieving 81% of 2019 activity levels.

Our long waits are continuing to decrease slowly. Impacting on our ability to reduce our long waiting patients further, is a result of the number of "urgent" patients requiring to be seen; these patients are clinically prioritised. This majority of our capacity is consumed seeing 'urgent' patients resulting in our inability to see as many long waiting patients.

**Routine dermatology** long waits reflect capacity issues in this service due to workforce issues which have previously been reported to the Board. The service continues to source regular surgical practitioner capacity (via NECU) and the independent sector continue to provide us with capacity two weekends per month.

**Ophthalmology** – the majority of long wait on the outpatient waiting list are cataracts, and as previously reported these patients will be transitioned to the IP/DC waiting list, and additional resource has been sourced to support this.

In addition, the service has developed new guidance for referrers and have attended the GP Sub-Committee and the Area Ophthalmic committee to promote these. The team will also be working with the National Cataract Team to agree and implement a standardised Cataract Referral 'Once for Scotland' pathway to ensure patients are being referred at the right time with the right information. The Ophthalmology Team are also in the final stages of streamlining their Cataract Patient Pathway booklet.

**Cardiology –** we have seen routine waits in Cardiology increase more recently and discussions are ongoing regarding a capacity solution within the service. The service is currently out to advert for a consultant.

**Process Improvement**

The service is making great inroads to standardising and implementing the Centre for Sustainable Delivery (CfSD) endorsed demand management improvements, i.e., ACRT, PIR and Opt In. Local data suggests that a number of our specialties are showing good progress against the Heatmap aspirations, but there is still work to progress to realise benefits.

Recruitment to the Booking Software co-ordinator has been unsuccessful. VAF to be submitted in March.

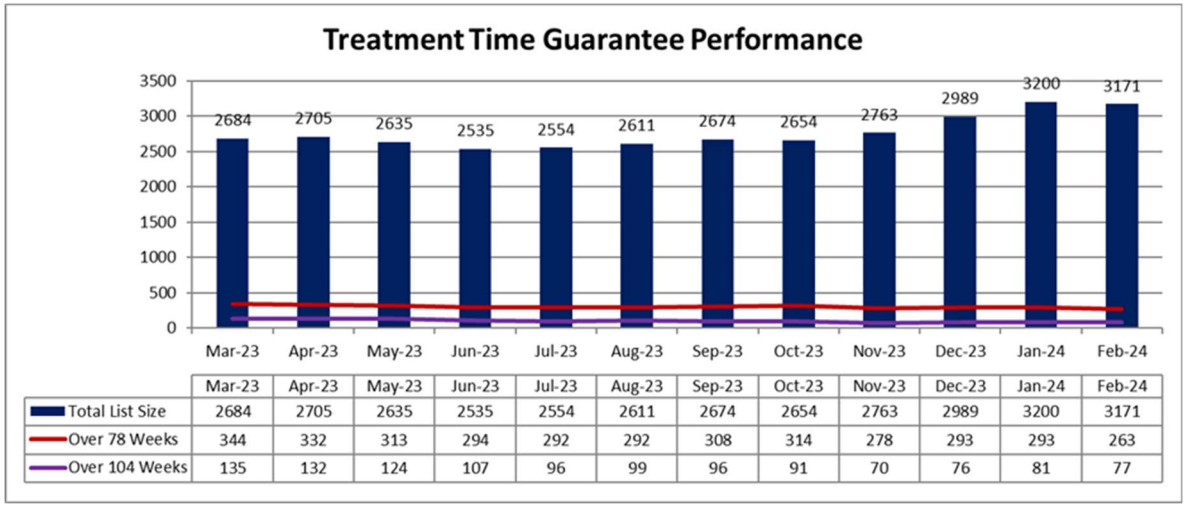
**Successes**

- Ophthalmology Referral Guidelines implemented and promoted via Local Ophthalmic Group.
- Continued capacity from Middle Grade doctor in general surgery.
- Room Capacity Plan approach agreed by Q.
- Roll out plan for Room Booking Software in place – March.

**Priorities**

- Room Booking Administrator VAF.
- Dermatology Specialist Nurse Job Descriptions for approval.
- Develop a plan for Redesign of Cataract Pre-assessment to create capacity.
- Complete OPD matrix to implement via new booking software along with Booking Room SOP (VAF to be submitted for administrator).
- Plan for sustainable middle grade doctor capacity in general surgery.
- Plan implementation of the OPD Capacity Plan (including a Communication Plan).
- CME session to review Orthopaedic pathways (hip and knee).
- Develop and implement Scaphoid pathway in Orthopaedics.

## TTG Performance Against Trajectory- All Specialties




| | Mar-23 | Apr-23 | May-23 | Jun-23 | Jul-23 | Aug-23 | Sep-23 | Oct-23 | Nov-23 | Dec-23 | Jan-24 | Feb-24 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Total List Size | 2684 | 2705 | 2635 | 2535 | 2554 | 2611 | 2674 | 2654 | 2763 | 2989 | 3200 | 3171 |
| Over 78 Weeks | 344 | 332 | 313 | 294 | 292 | 292 | 308 | 314 | 278 | 293 | 293 | 263 |
| Over 104 Weeks | 135 | 132 | 124 | 107 | 96 | 99 | 96 | 91 | 70 | 76 | 81 | 77 |

*Fig. 3*

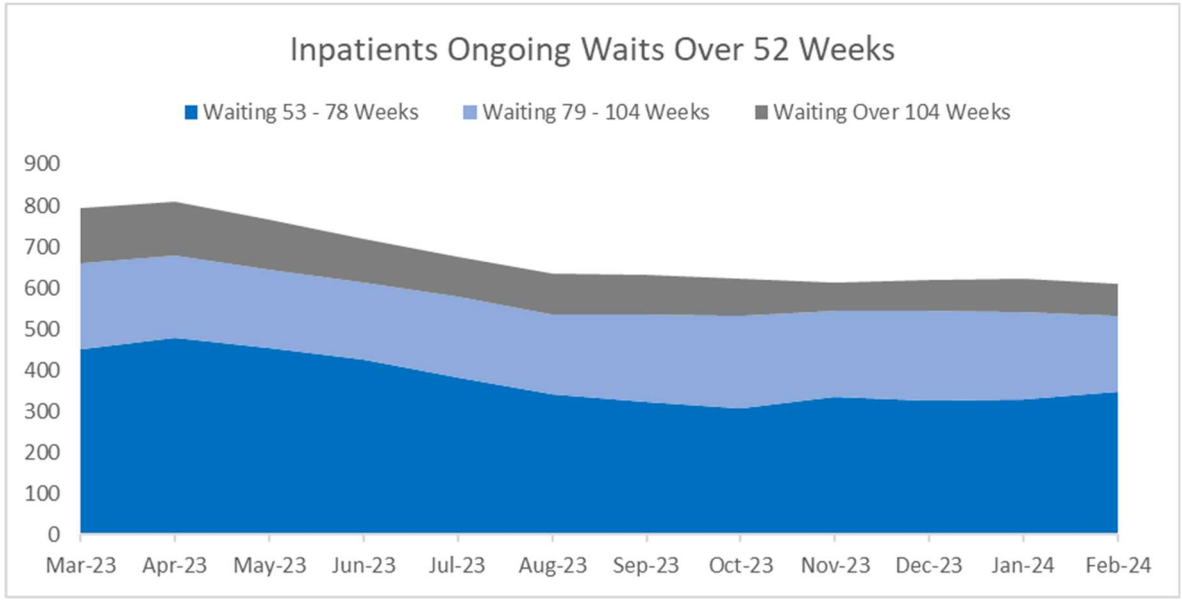



*Fig. 4*



**THEATRES AND CHRONIC PAIN** **Updated 18.03.24**

**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 remained high for the 4th month in a row (559 additions in January compared to an average of 415 over the previous 12 months).
- Theatre activity levels in February were at 85% of 2019 levels. This is a slowly improving picture compared to 80% over the last 3 months.
- Synaptik weekend Elective operating started in the last weekend in February so will start to make an impact on our longest waiting patients in Urology, General Surgery and Gynaecology.

**Chronic Pain -** Nothing Significant to Report.

**Actions complete since last report**

- **Data Analyst** - Confirmation received that extension of post not supported due to financial situation.
- **Inpatient Bookings** - SBAR for 0.35 WTE Band 3 rather than rely on Overtime to book patients for NHGJ not supported at Access Board. This has created a risk as there is lack of capacity to book patients for operations in NHGJ (1026 patients in FY 24/25). This is Risk 4772 and is graded as Medium. Currently awaiting Review.

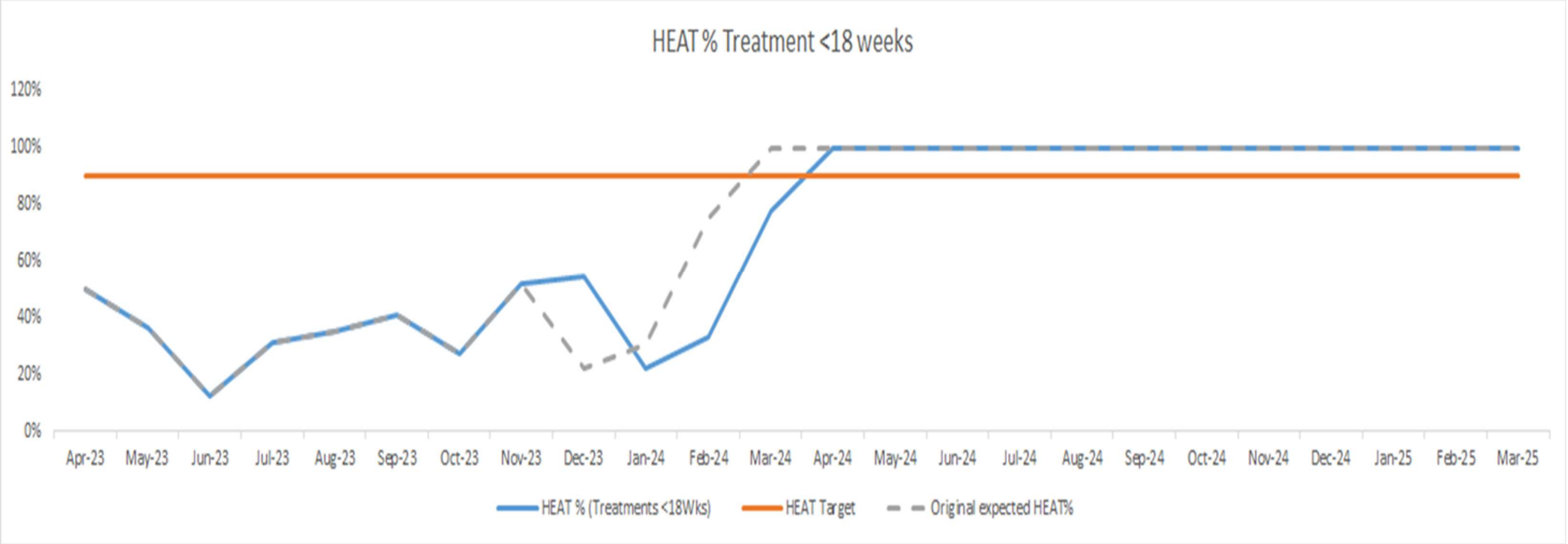
**Priorities**

- **Vacancy control**
  - Ensure B5 and B4 posts within the Inpatients Team in the Central Bookings Office become permanent.
  - Progress vacancy control process for 23 hours Band 2 within PAC.
- **Day Procedure Unit (DPU)**
  Draft report now complete regarding additional resource requirements to maximise the use of DPU for General Anaesthetic (GA) elective surgery. Now requires decision on whether to proceed with this report or pause due to financial situation.
- **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.

*Updated 18.03.24*

## Mental Health Waiting Times – CAMHS

*Fig. 5*




**What is the data telling us?**

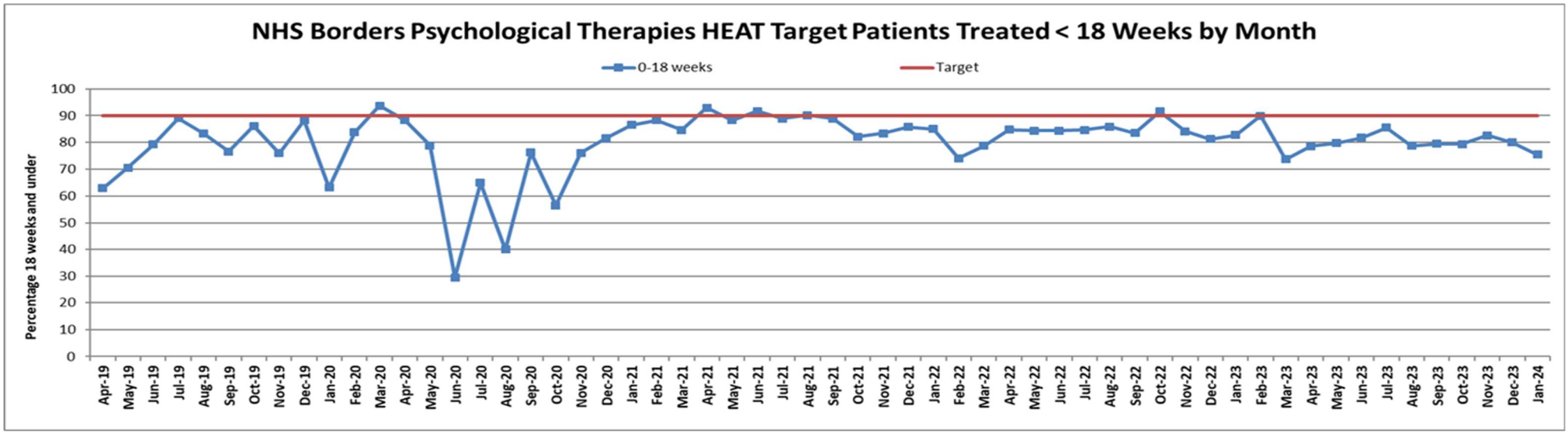
The table shows the current trajectory based on the current projected accepted referrals and number of treatments to be completed (12 New Patient Appointments per week 51 per month) which is currently being weighted in favour of 70% Cat 2 and 30% Cat 1 in order to meet the LDP (Heat target) by end March 2024.

**Plan to Reduce CAMHS Waiting Times**

- School Referral Rollout
  - We have now rolled out to all schools throughout Scottish Borders so that they can make Neurodevelopmental referrals to CAMHS. This has been a huge success, and we are receiving excellent quality referrals.
- Recruitment
  - Nursing – Plan is to readvertise the 30hr Band 6 post that we were unsuccessful recruiting to.
- 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 down from last month at 75.42% - last months was 80%. In January the service started treatment with 179 patients (120 in December 2023) of which 44 patients (24 in December 2023) had waited longer than 18 weeks for a first treatment appointment. 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 few 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 31st January 2024 we have 619 people on our waiting list, a decrease of 21 from last month, 87.6% 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 1.5% 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 have been using some locums where possible, this arrangement comes to an end in March. We have three members of staff on maternity leave in child psychology/CAMHS.

***Updated 22.03.24***

**Unscheduled Care Performance - 4 Hour Emergency Access Standard Performance**

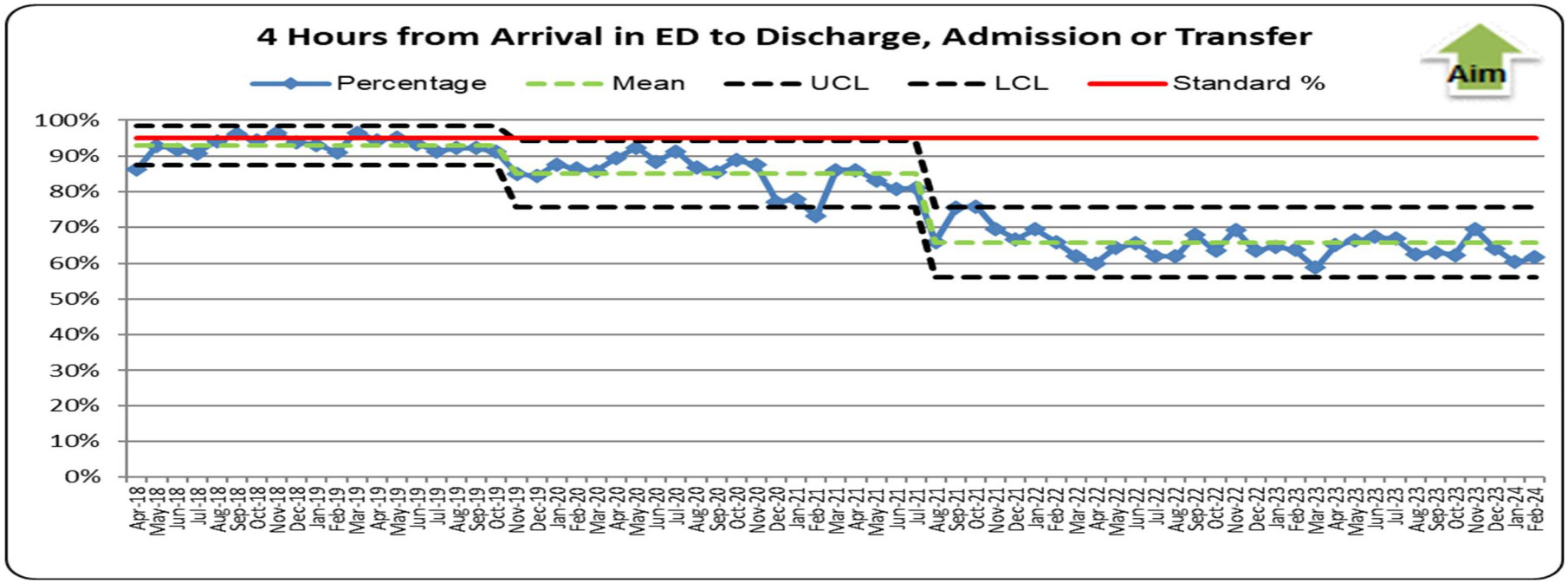



***Fig. 7***

In February 2024 there were 2304 unplanned attendances to the Emergency Department, with 879 breaches of the Emergency Access Standard. Performance against the 95% EAS remains on a weekly basis from 58.9% to 63.86% with the end of Month EAS for February sitting at 63%.

The BGH continued to face significant pressures throughout January and February in relation to patient flow, with blue ED requiring to be open for most of the month for patients waiting for admission beds, and ED occupancy frequently over 100%. This impacted the ability to achieve the EAS, with the site seeing high numbers of 8 and 12 hour breaches leading to patients frequently being bedded within the ED department overnight limiting the capacity for emergency flow which includes patients who self-present and emergency 999 calls.

The high volume of long waits for admission beds continues to be driven by wider system pressures such as availability of beds and cubicles at the right time of day, late discharges and delayed discharges for health and social care reasons. The top 3 breach reasons and themes continue to reflect this pressure:

1. Wait for a Medical Bed- 354 Patients;
2. Wait for Surgical Bed- 92 Patients; and
3. Clinical Exception (patients who were clinically unwell beyond 4 hours)- 53 Patients.

Looking at the 12 and 24 hour breaches for previous month (January) the same pattern continued into February with 29 episodes of 12 hour breaches with the same number going on to breach for 24 hours.

***Updated 22.03.24***

**Delayed Discharge**

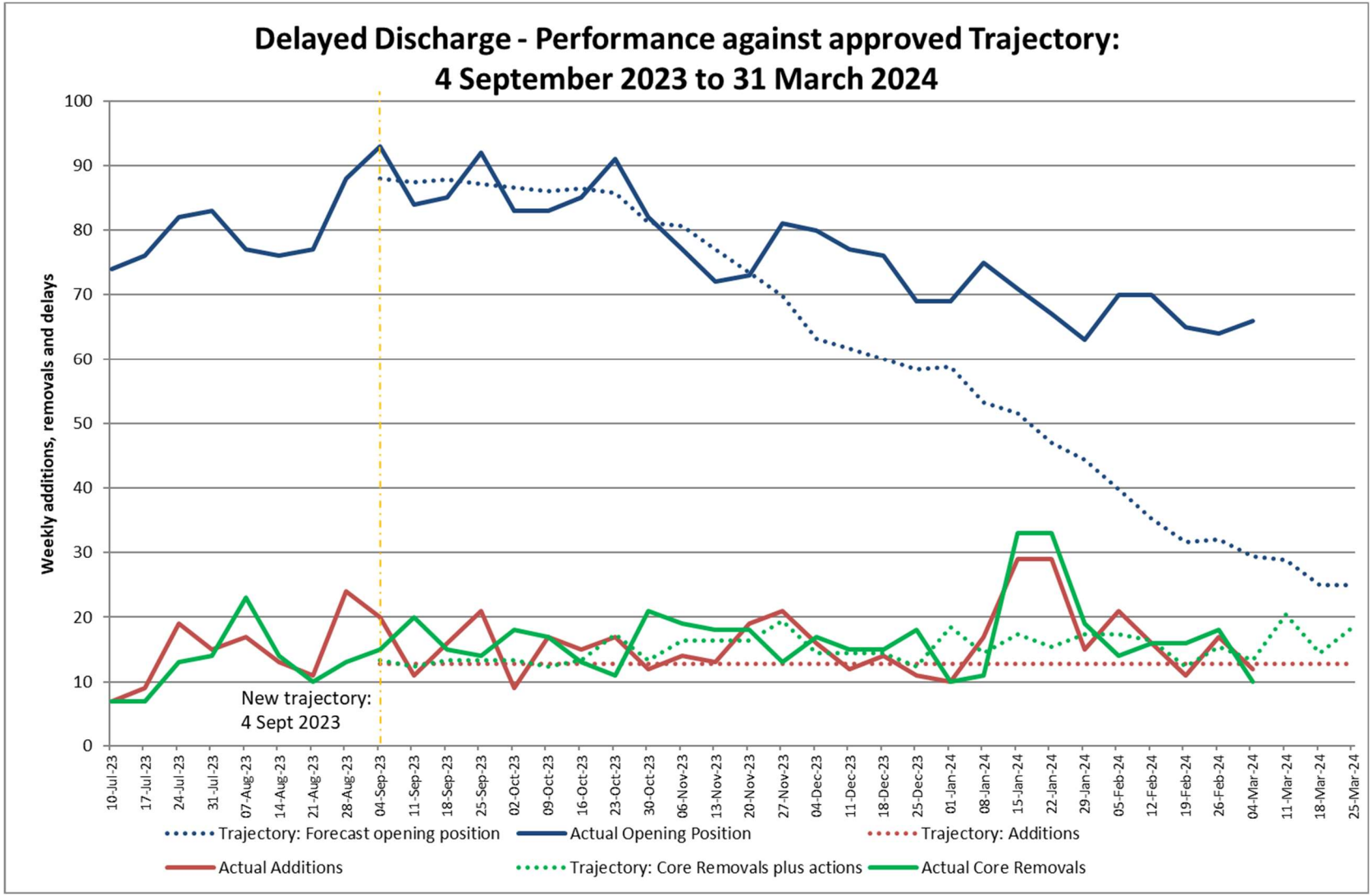



***Fig. 8***

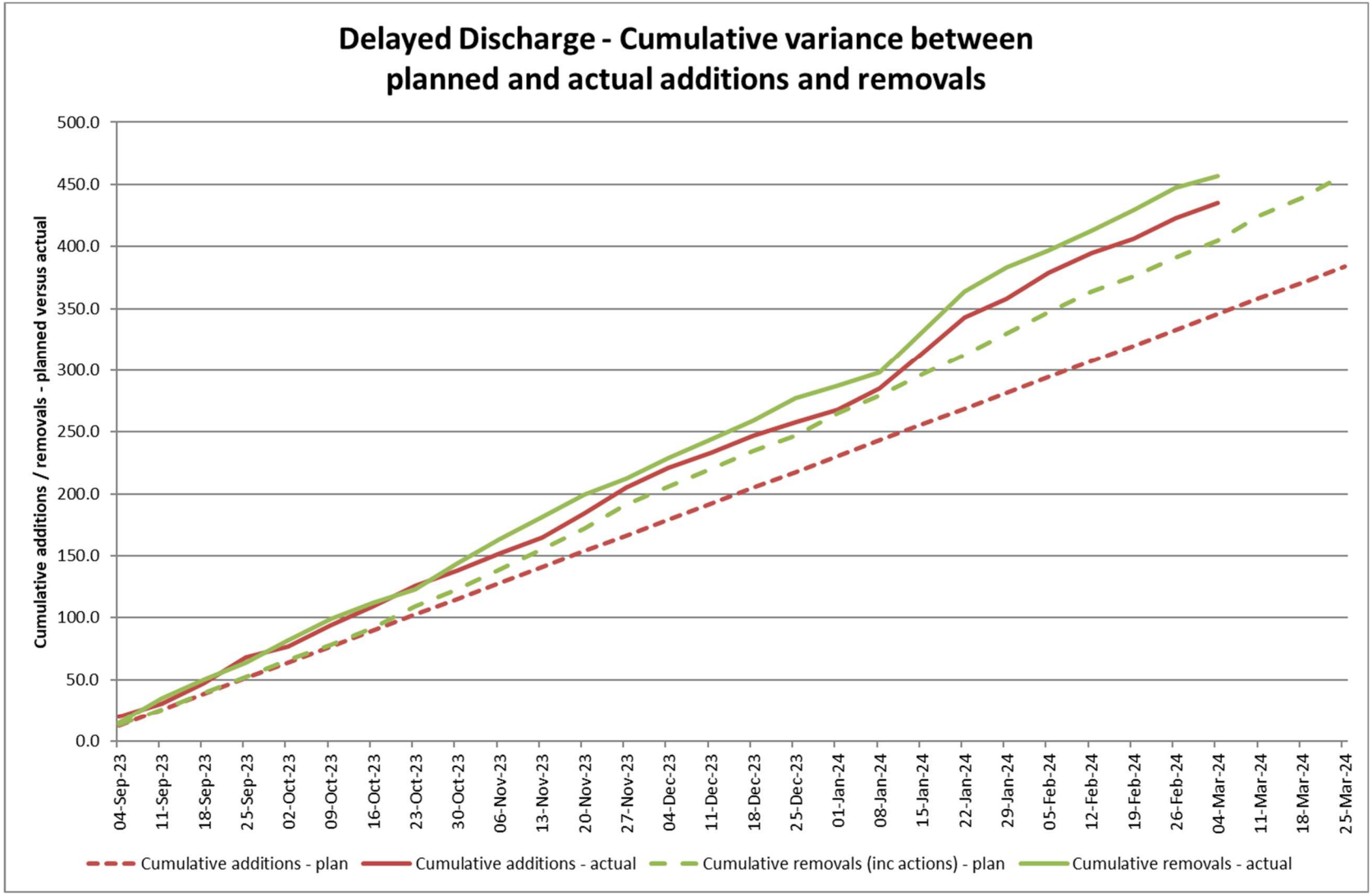



***Fig. 8a***

Despite the £1.9m delayed discharge plan commissioned by the Integration Joint Board, and levels of transfers to care / HSCP services being in line with our forecasts, this has been offset by significant levels of additional demand which has been 16.1 per week and 26% higher than our forecast demand of 12.8 per week and based on the actual demand over the preceding 26 week period before the trajectory was put into place:

Had demand been in level with forecast, then in the week commencing 11 March, based solely on current transfers to HSCP services, we would have been one above trajectory with a total of 30 delayed discharges (compared to the actual of 71). Based on both current transfers to HSCP services and the current level of removals due to ill health, there would be 0 delayed discharges.

Had we not had the additional removals associated to the surge plan, based on actual demand there would have been 194 people delayed and waiting for care in the week commencing 11 March (compared to 71). As a result, despite performance being above trajectory due to demand, it is worth noting that the IJB £1.9m delayed discharge plan has had a significant impact and brought us 123 less people being delayed discharges to date, and longer term additionality in terms of investments into care. We have also seen high levels of people discharged without delay (96.5% in the latest data (4 March)).

At this stage it is unclear as to whether demand will continue to remain at this high level, reduce or continue to grow.

Further actions are planned (e.g. development of reablement in homecare, social work digital pathfinder), and work has commenced to try to model out future trajectory scenarios, but in common with the position last year, the HSCP will not be able to confirm additional actions and the trajectory until the IJB budget has been agreed for 24/25.

***Updated 26.03.24***


# 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 | Dec-23 | 84.6% | Jan-24 | 79.3% | ↓ |
| | Cancer waiting Times - 31 Day target | 95% of patients treated within 31 days of diagnosis | Dec-23 | 100.0% | Jan-24 | 97.1% | ↓ |
| | New Outpatients- Number waiting >12 Weeks | Zero patients waiting longer than 12 weeks (maximum) | Jan-24 | 7482 | Feb-24 | 7336 | ↑ |
| | New Inpatients- Number waiting >12 Weeks | Zero patients waiting longer than 12 weeks (maximum) | Jan-24 | 1949 | Feb-24 | 1961 | ↓ |
| | Treatment Time Guarantee - Number not treated within 84 days from decision to treat | Zero patients having waiting longer than 84 days. | Jan-24 | 143 | Feb-24 | 120 | ↑ |
| | Referral to Treatment (RTT) - % treated within 18 weeks of referral | 90% patient to be seen and treated within 18 weeks of referral. | Jan-24 | 60.7% | Feb-24 | 64.1% | ↑ |
| | Diagnostics (8 key tests) - Number waiting >6 weeks | Zero patients waiting longer than 6 weeks for 8 key diagnostic tests | Jan-24 | 566 | Feb-24 | 385 | ↑ |
| | CAMHS- % treated within 18 weeks of referral | 90% patients seen and treated within 18 weeks of referral | Dec-23 | 54.5% | Jan-24 | 22.2% | ↓ |
| | A&E 4 Hour Standard - Patients discharged or transferred within 4 hours | 95% of patients seen, discharged or transferred within 4 hours | Jan-24 | 60.3% | Feb-24 | 61.7% | ↑ |
| | Delayed Discharges - Patients delayed over 72 hours | Zero patients delayed in hospital for more than 72 hours | Jan-24 | 52 | Feb-24 | 54 | ↓ |
| | Psychological Therapies - % treated within 18 weeks of referral | 90% patient treated within 18 weeks of referral | Dec-23 | 80.0% | Jan-24 | 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% | Dec-23 | 7.22% | Jan-24 | 5.73% | ↑ |

**Cancer Waiting Times** *(Please Note: There is a 1 month lag time for data)*

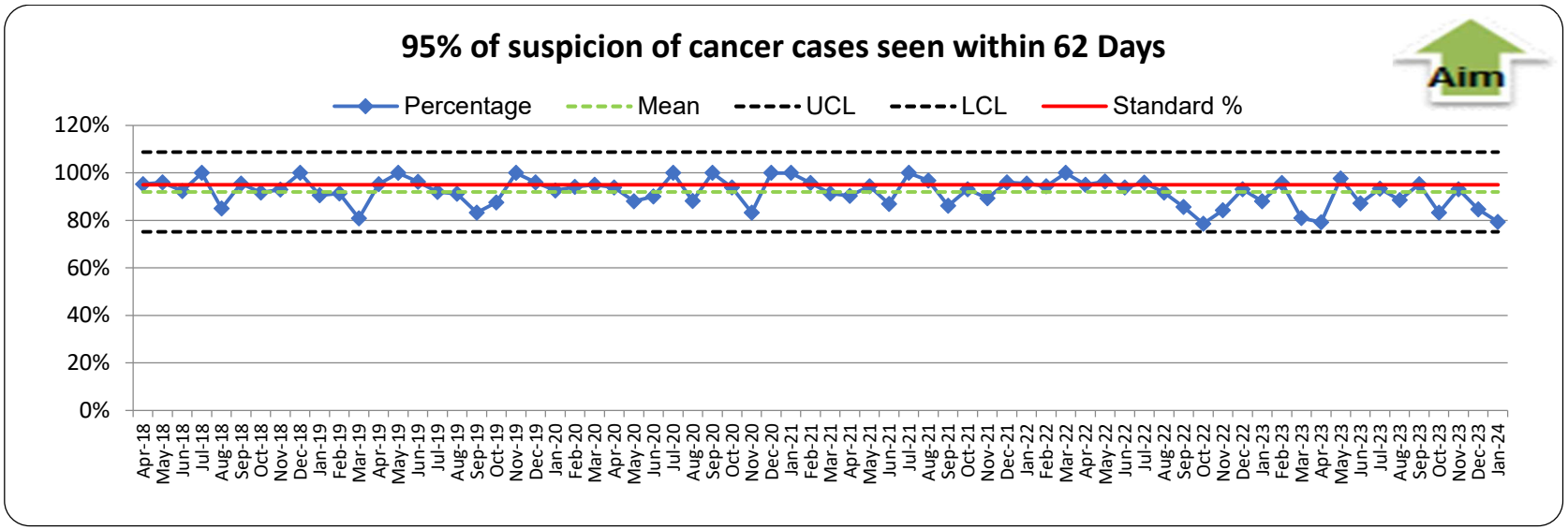



*Fig. 10*

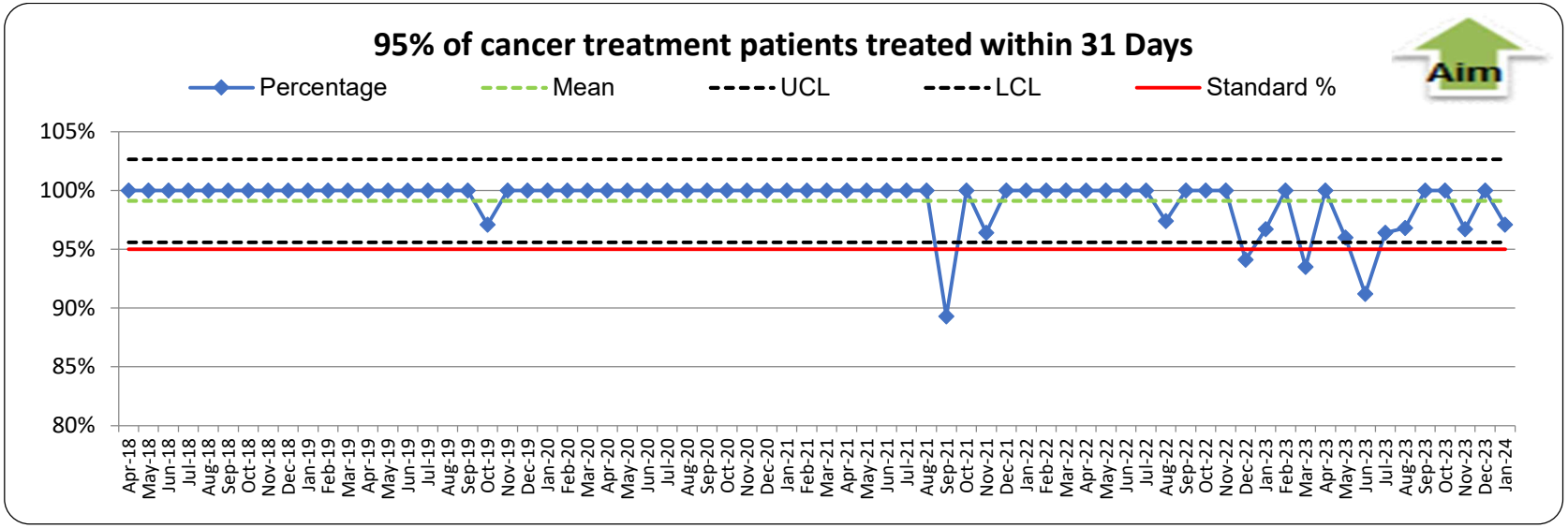



*Fig. 11*

**Stage of Treatment- Outpatients Waiting Over 12 Weeks**

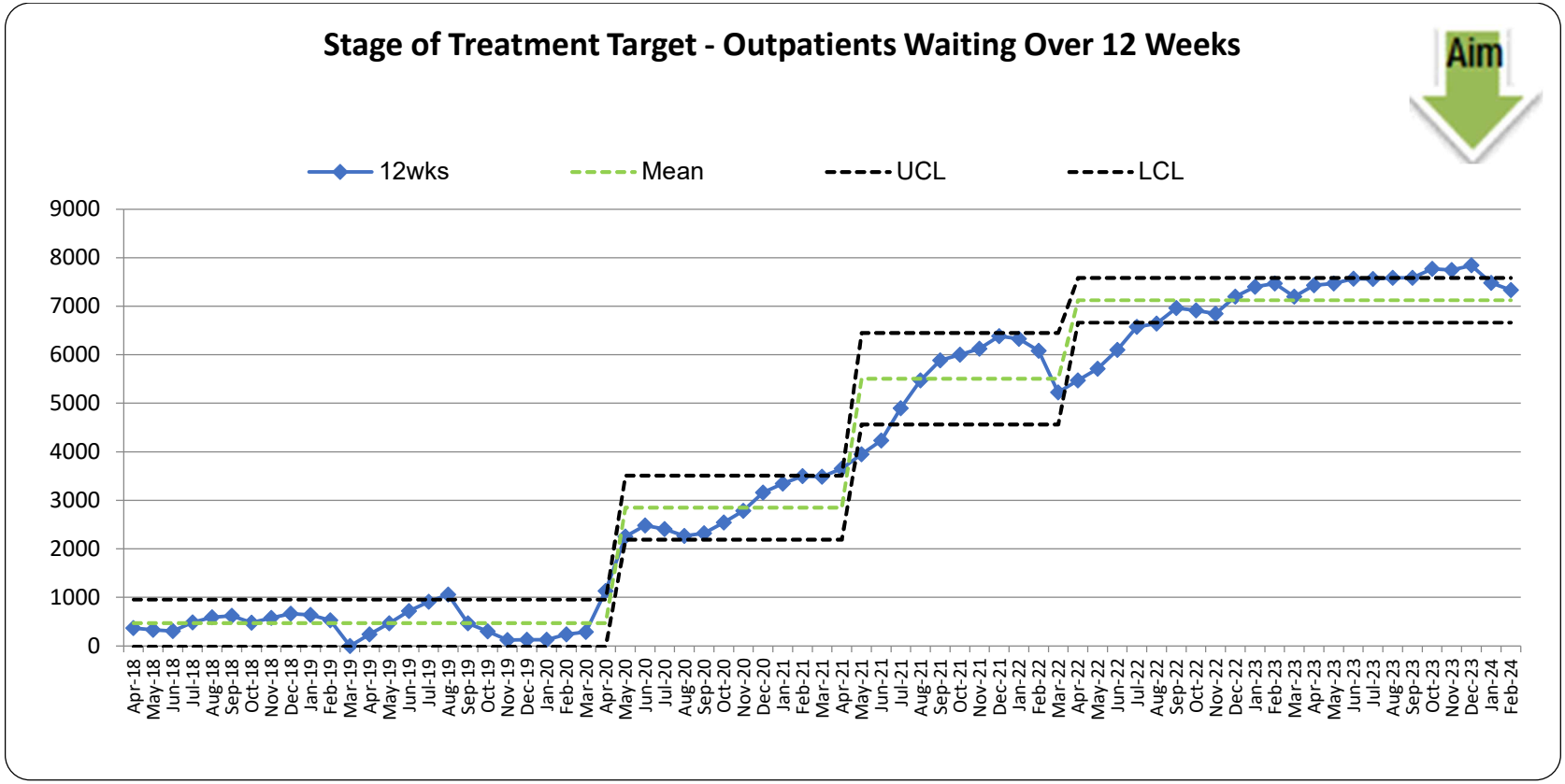



***Fig. 12***

**Stage of Treatment- Inpatients Waiting Over 12 Weeks**

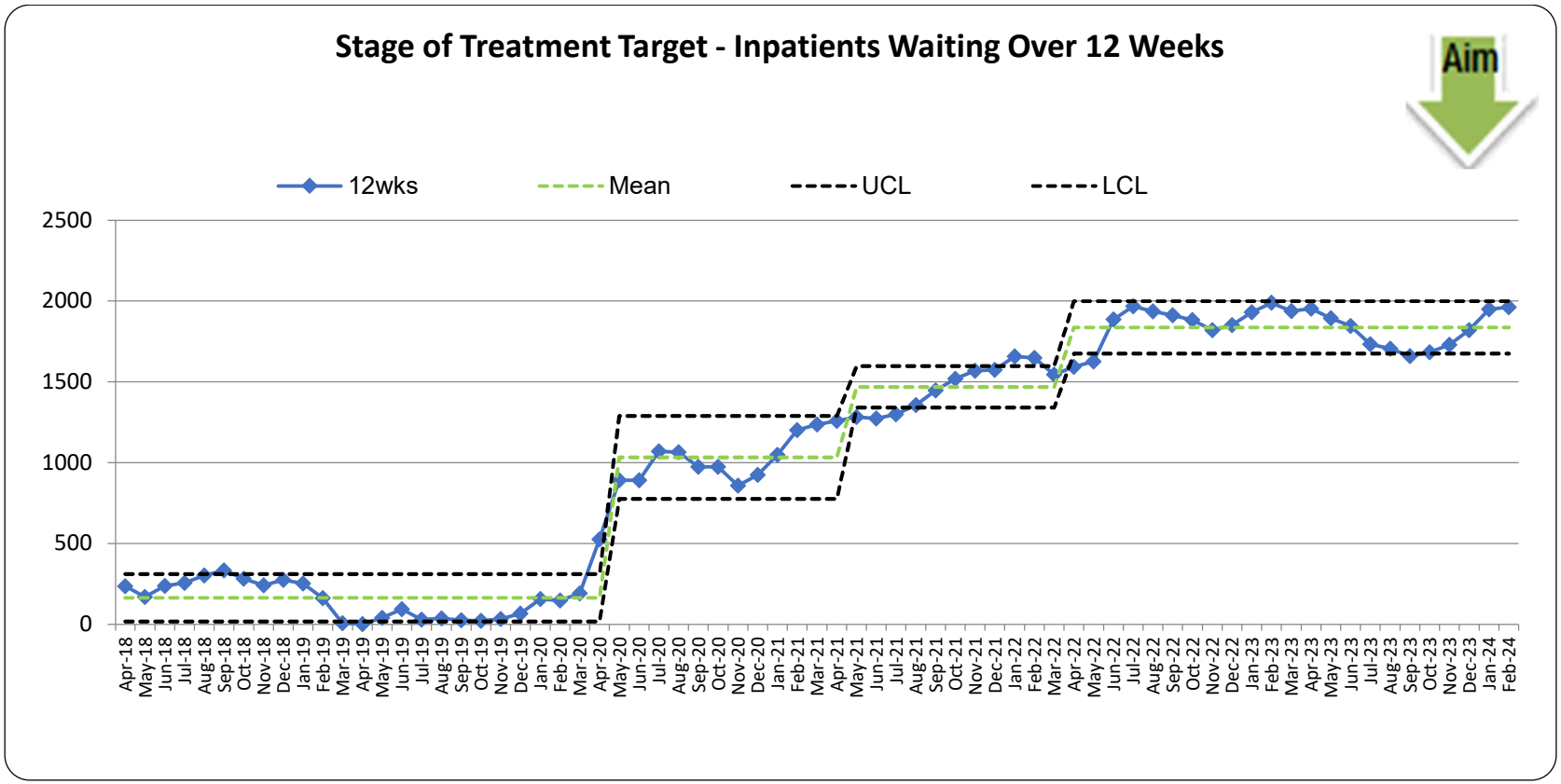



***Fig. 13***

**Patients Treated within the 12 weeks Treatment Time Guarantee**

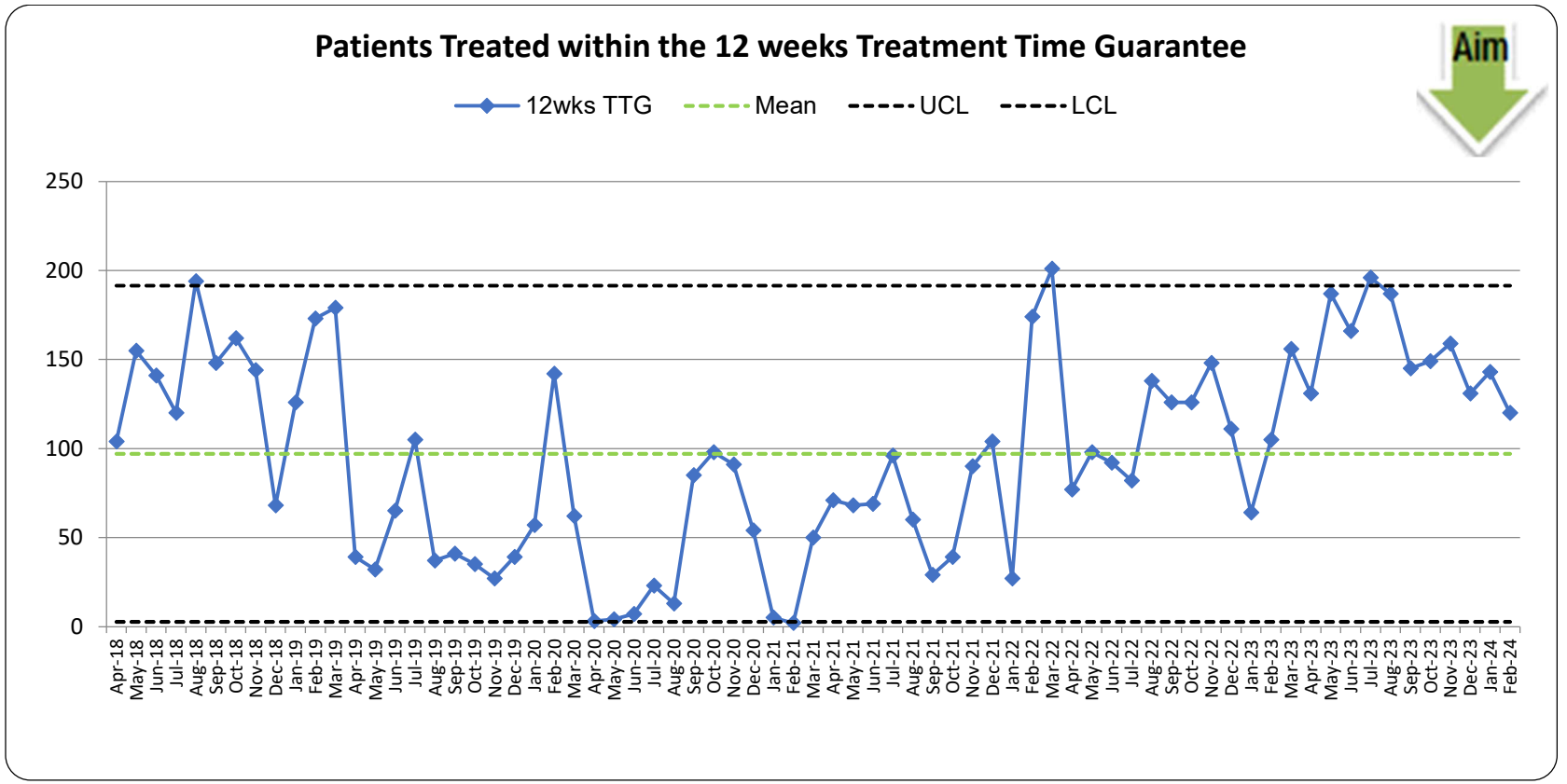



***Fig. 14***

**18 Weeks Referral to Treatment Combined Pathway Performance**

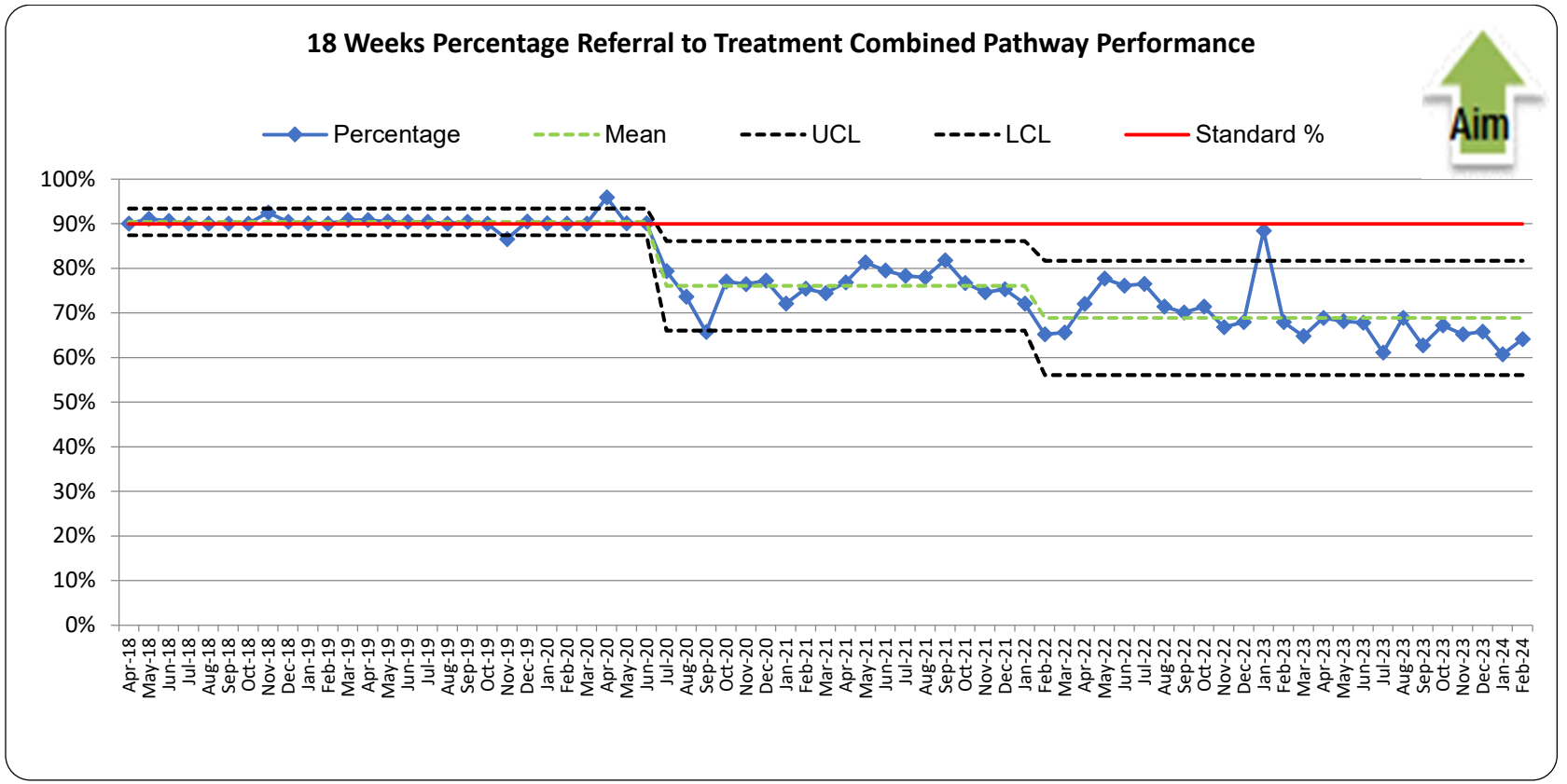



***Fig. 15***

**Diagnostic Waits**

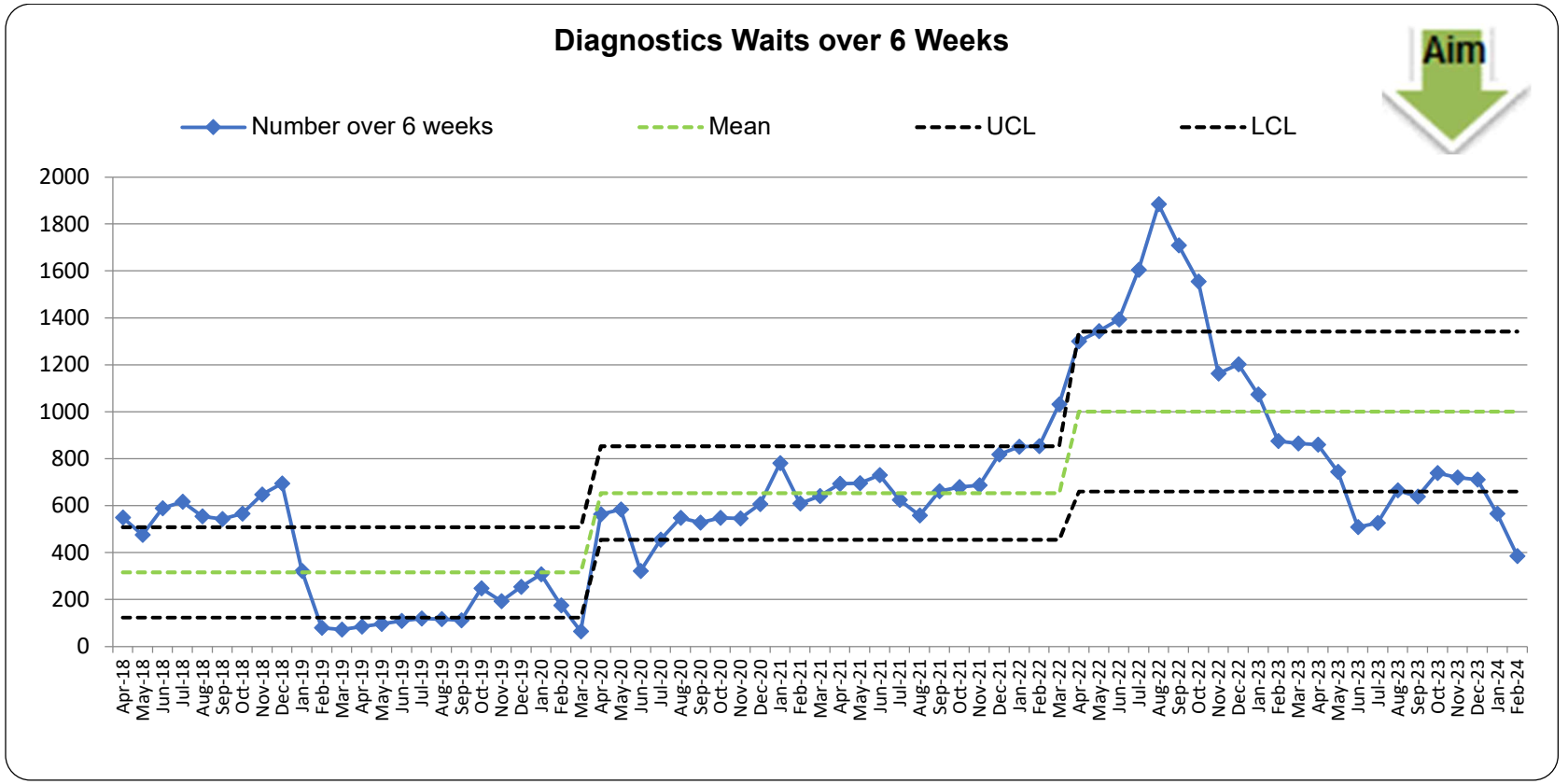



***Fig. 16***

**CAMHS Waiting Times- 18 Week Referral to Treatment**

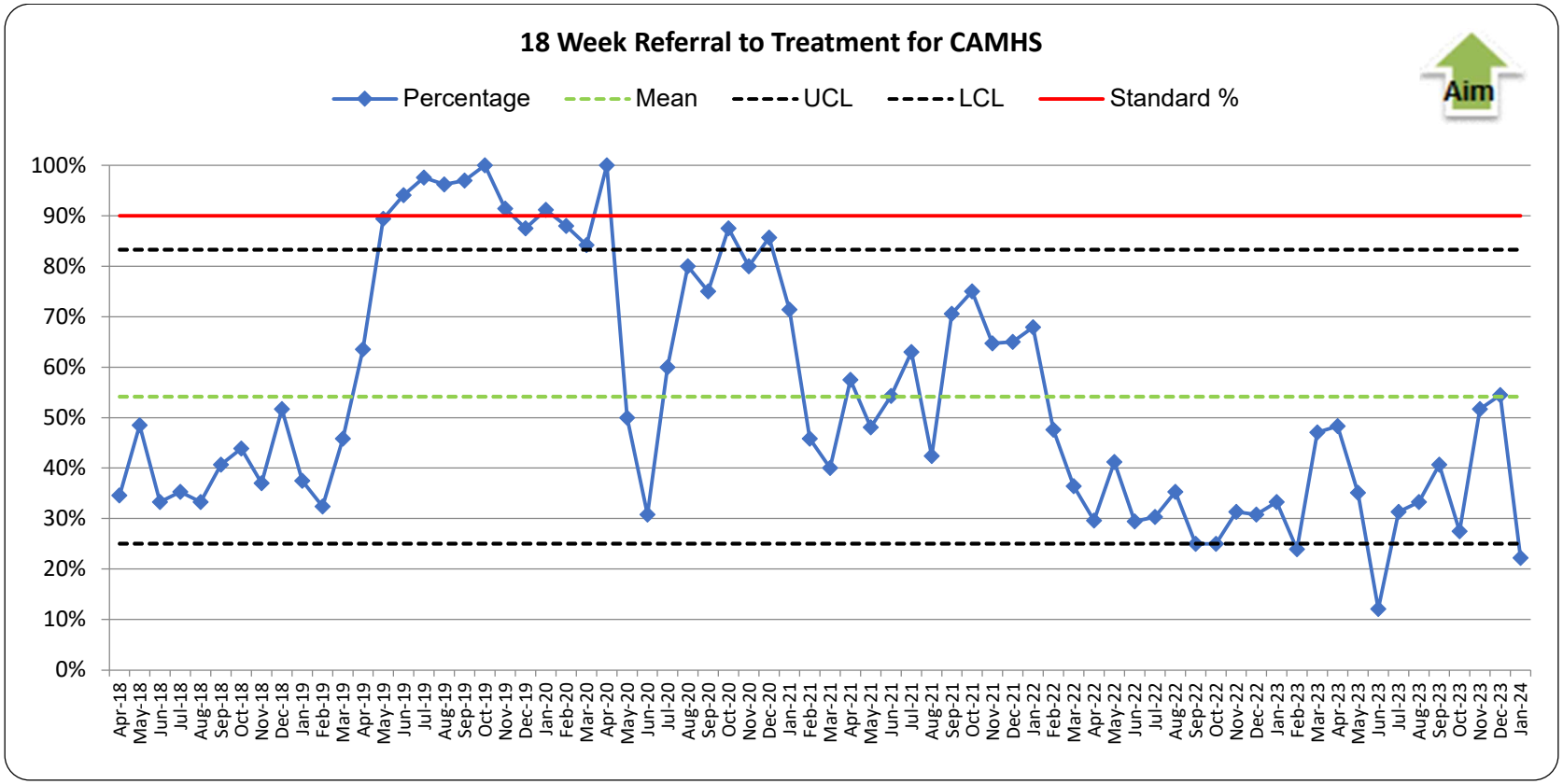



***Fig. 17***

**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)*

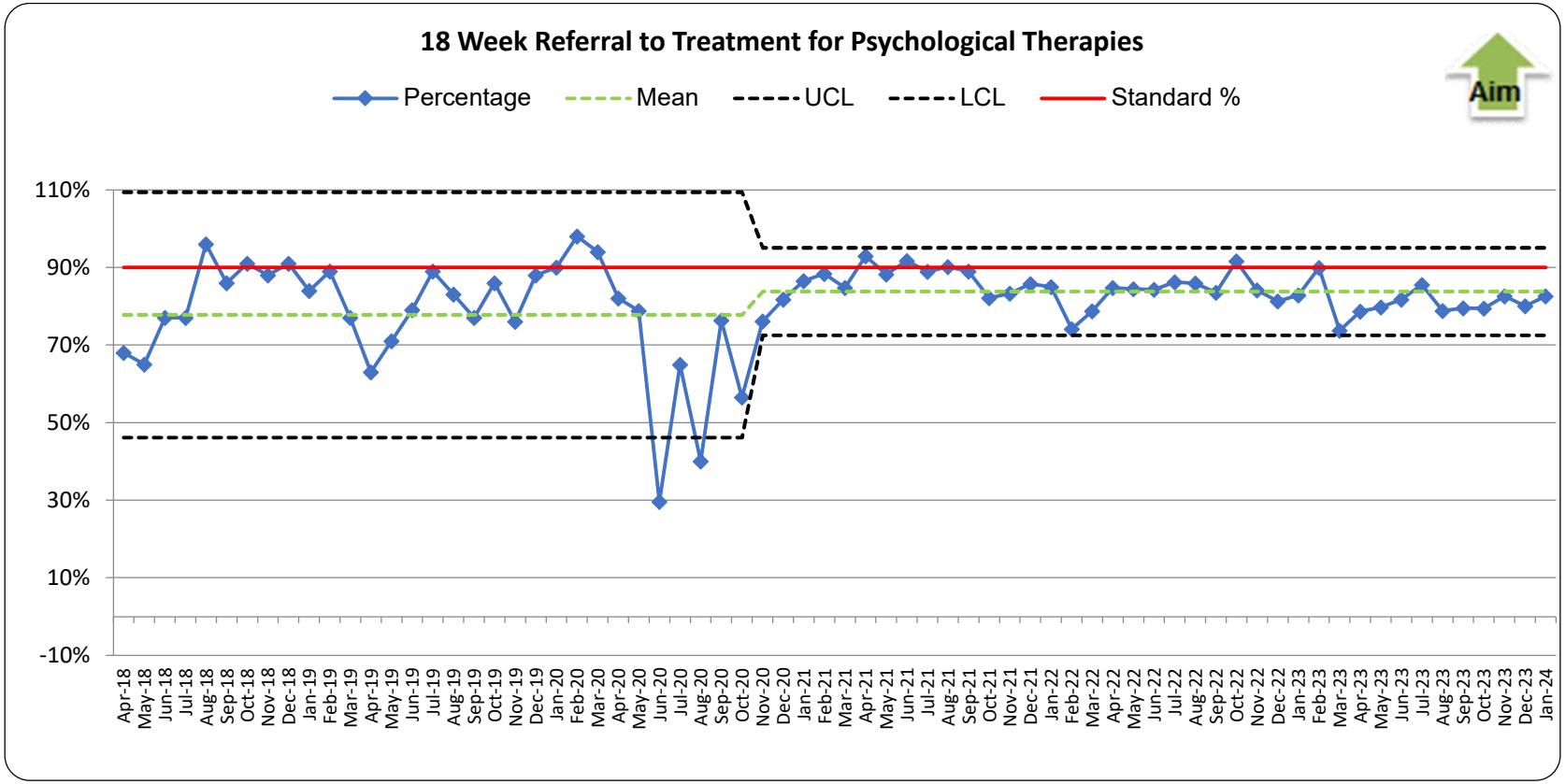



***Fig. 18***

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

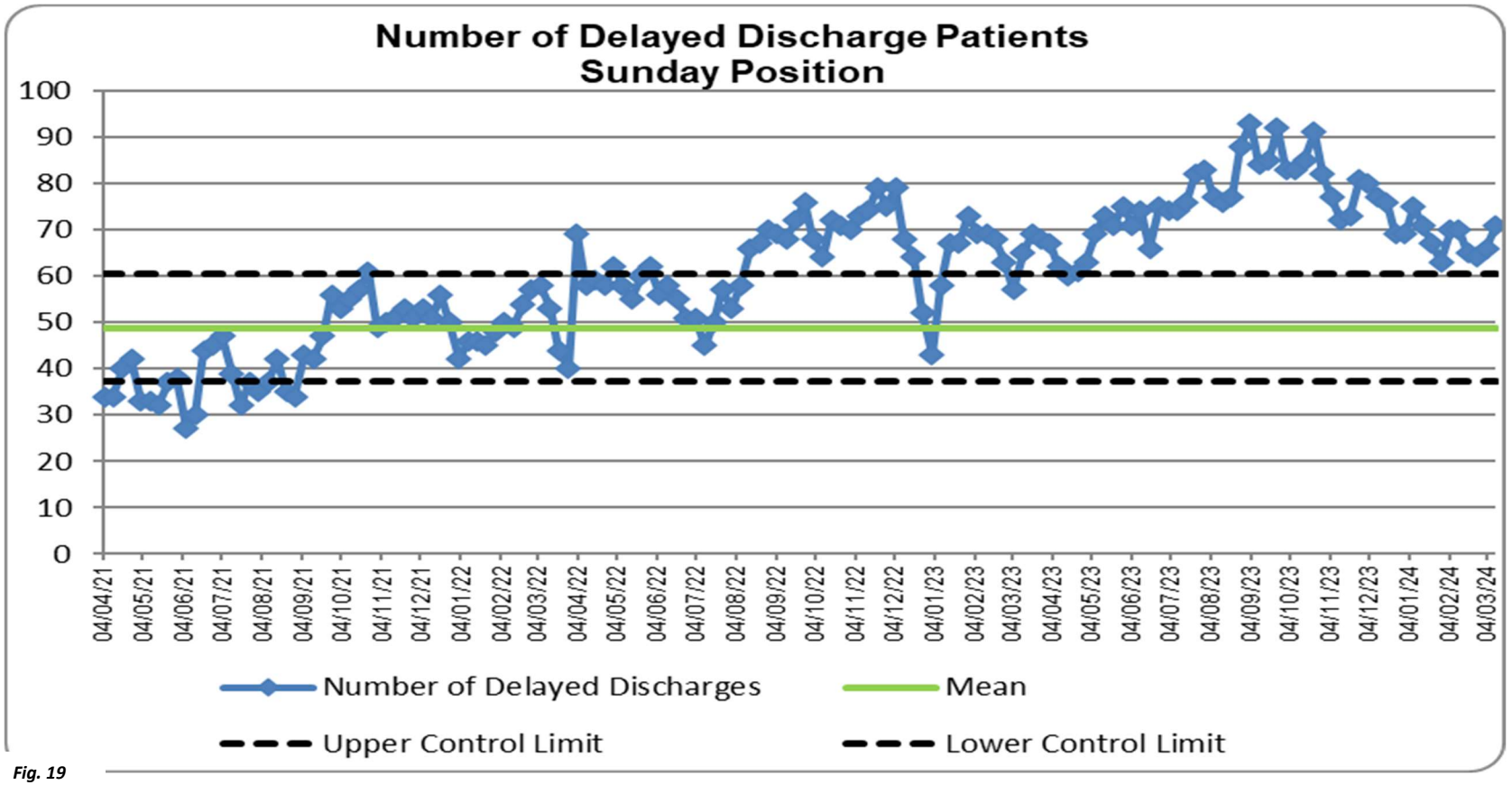



***Fig. 19***

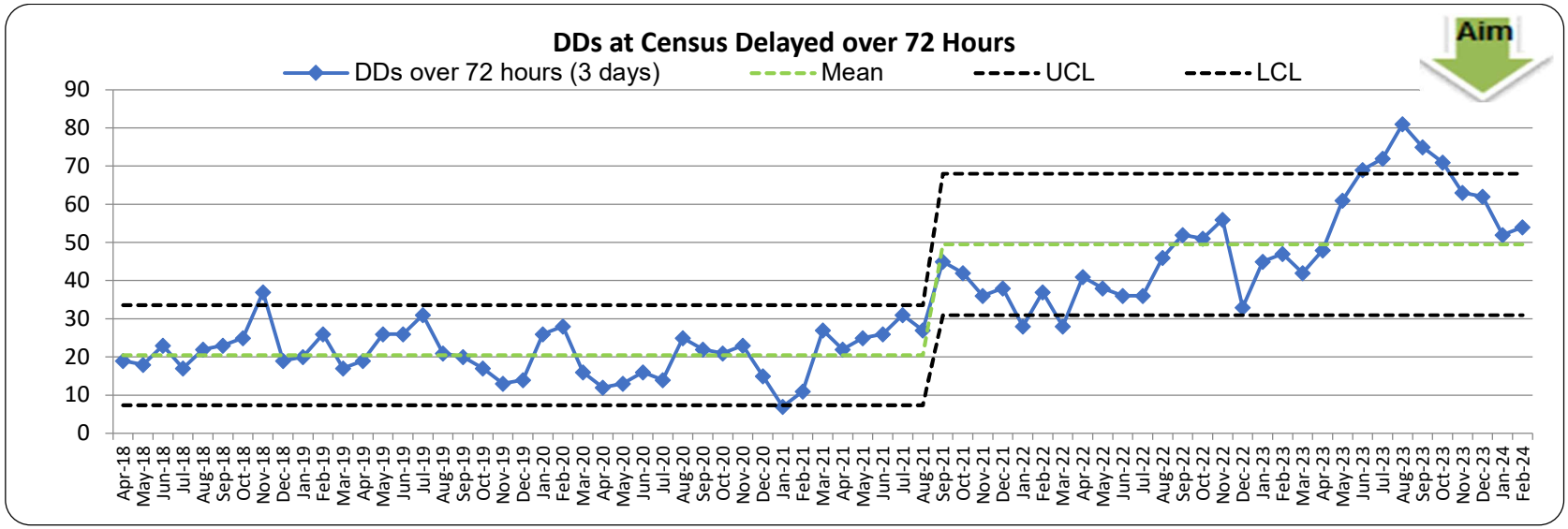

DDs at Census Delayed over 72 Hours
DDs over 72 hours (3 days)
Mean
UCL
LCL
Aim
90
80
70
60
50
40
30
20
10
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 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 Jan-24 Feb-24

*Fig. 20*

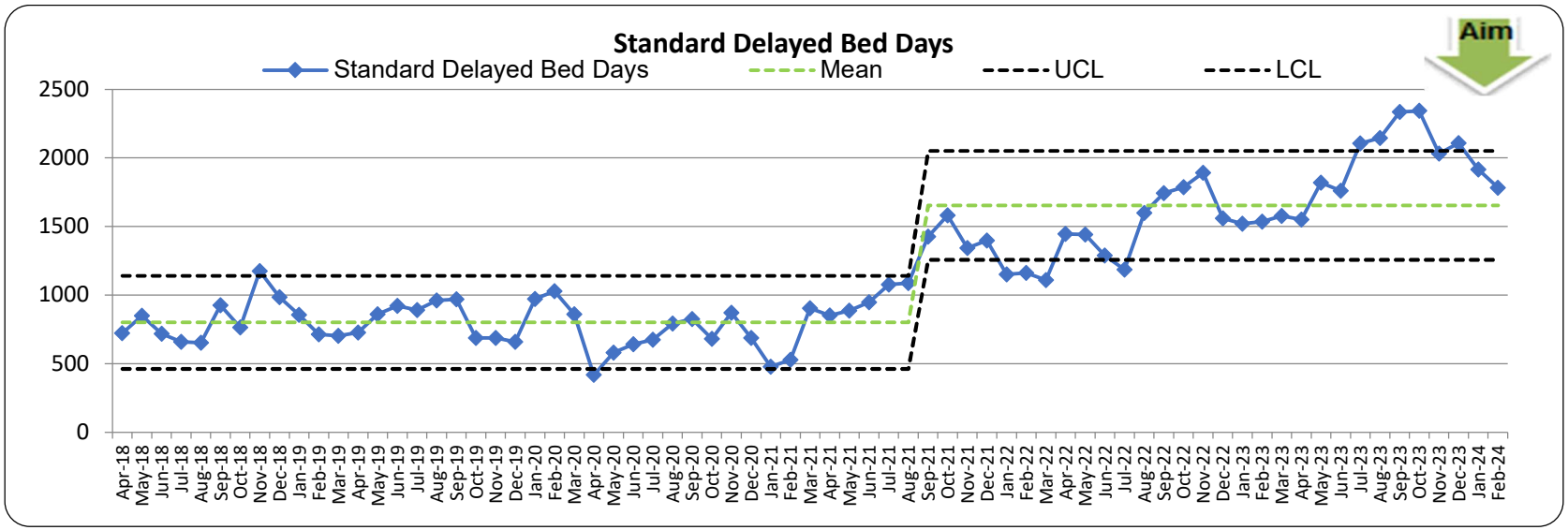

Standard Delayed Bed Days
Standard Delayed Bed Days
Mean
UCL
LCL
Aim
2500
2000
1500
1000
500
0
Apr-18 May-18 Jun-18 Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 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 Jan-24 Feb-24

*Fig. 21*

**Drugs & Alcohol** *(Please Note: Updates provided Quarterly)*

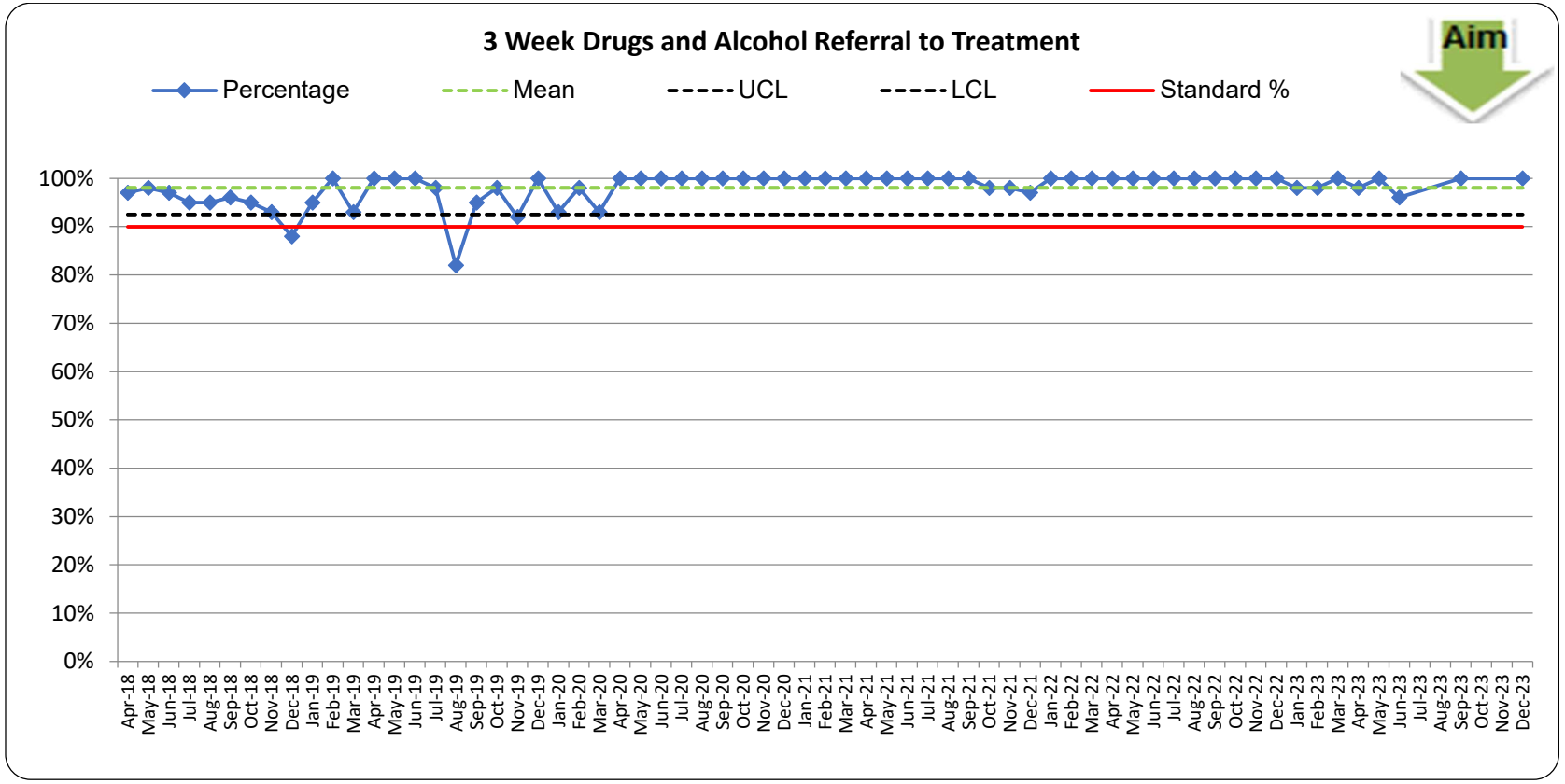



***Fig. 22***

*(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.)*

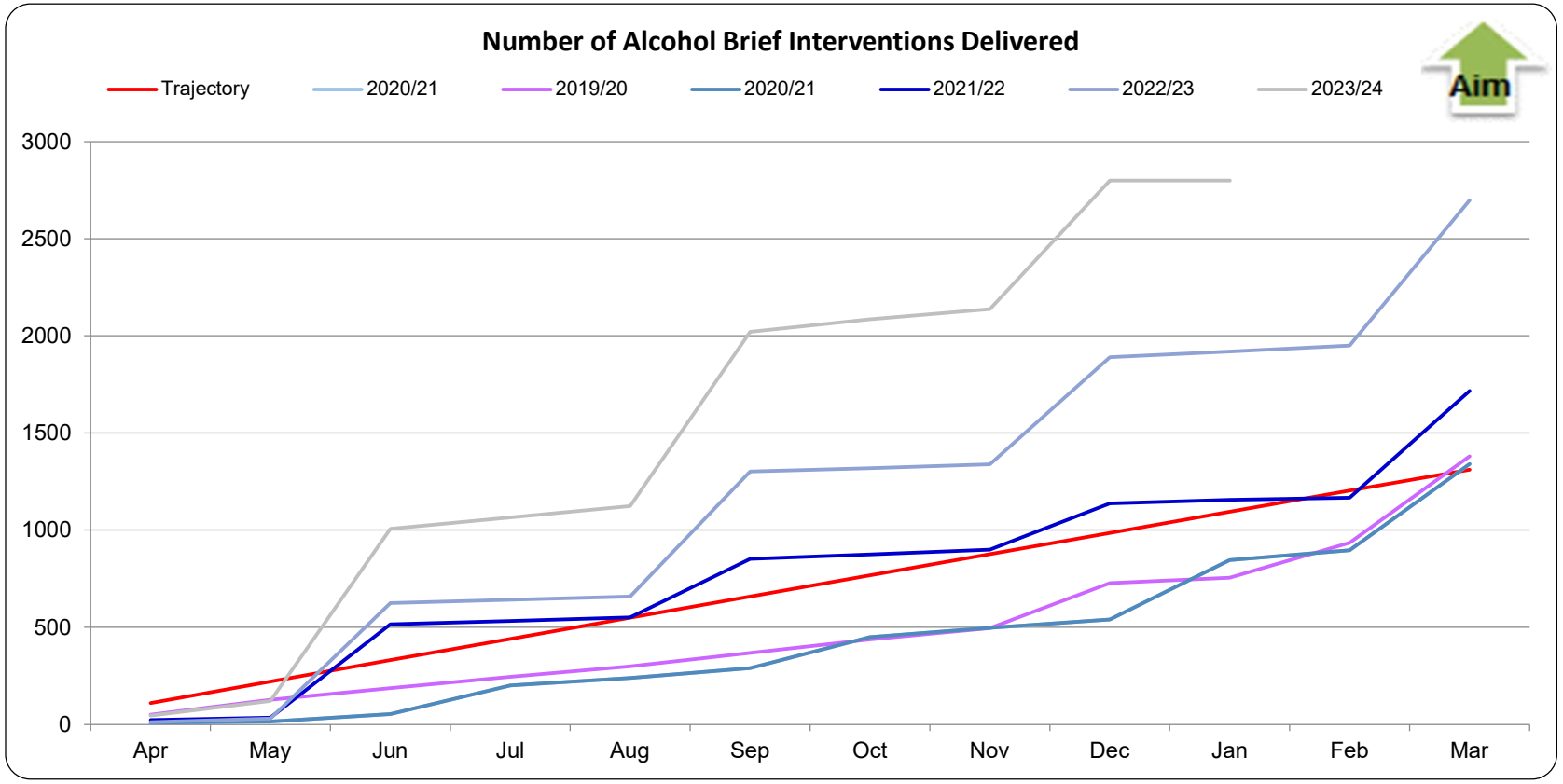



***Fig. 23***

**Sickness Absence**

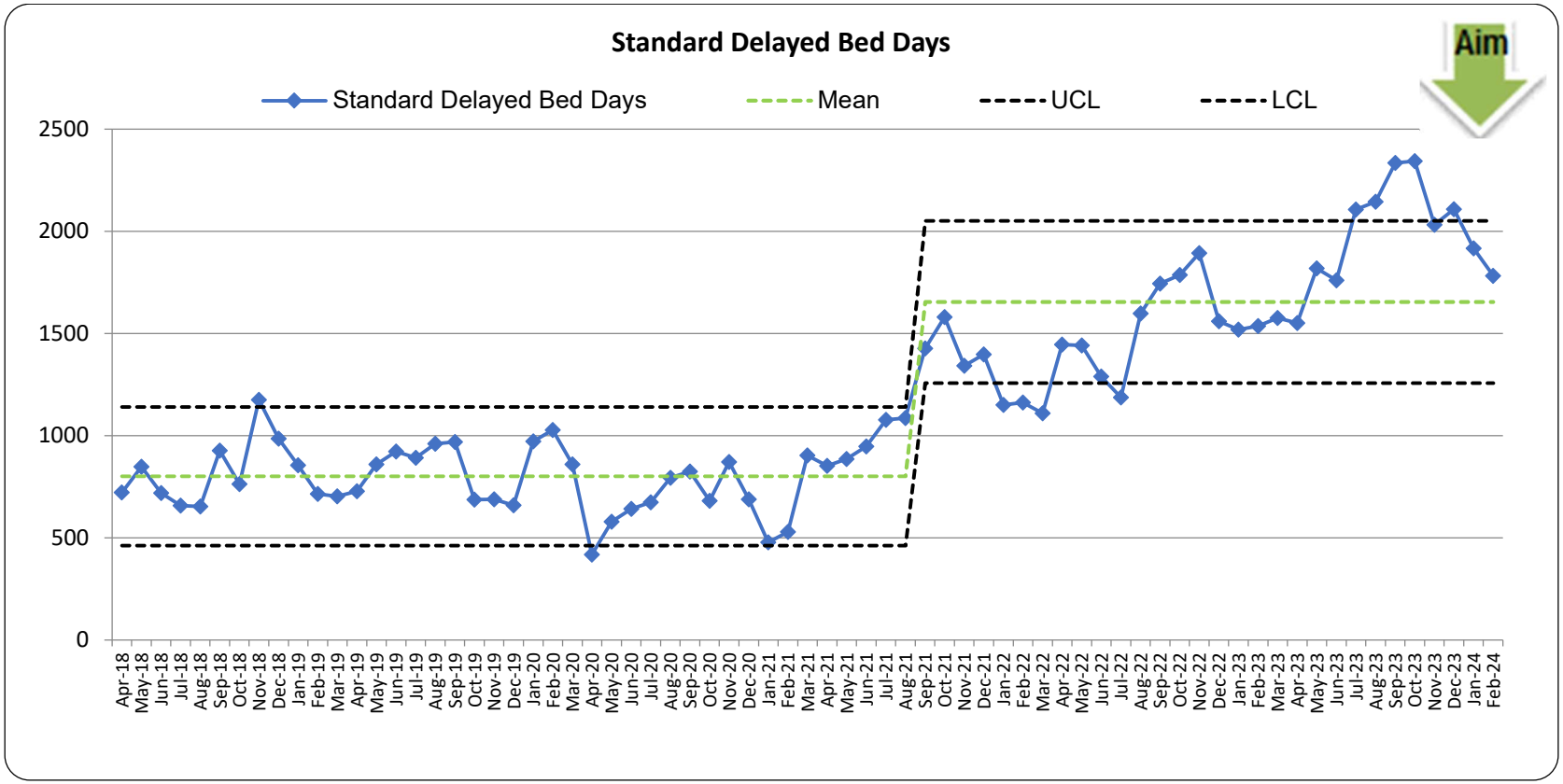
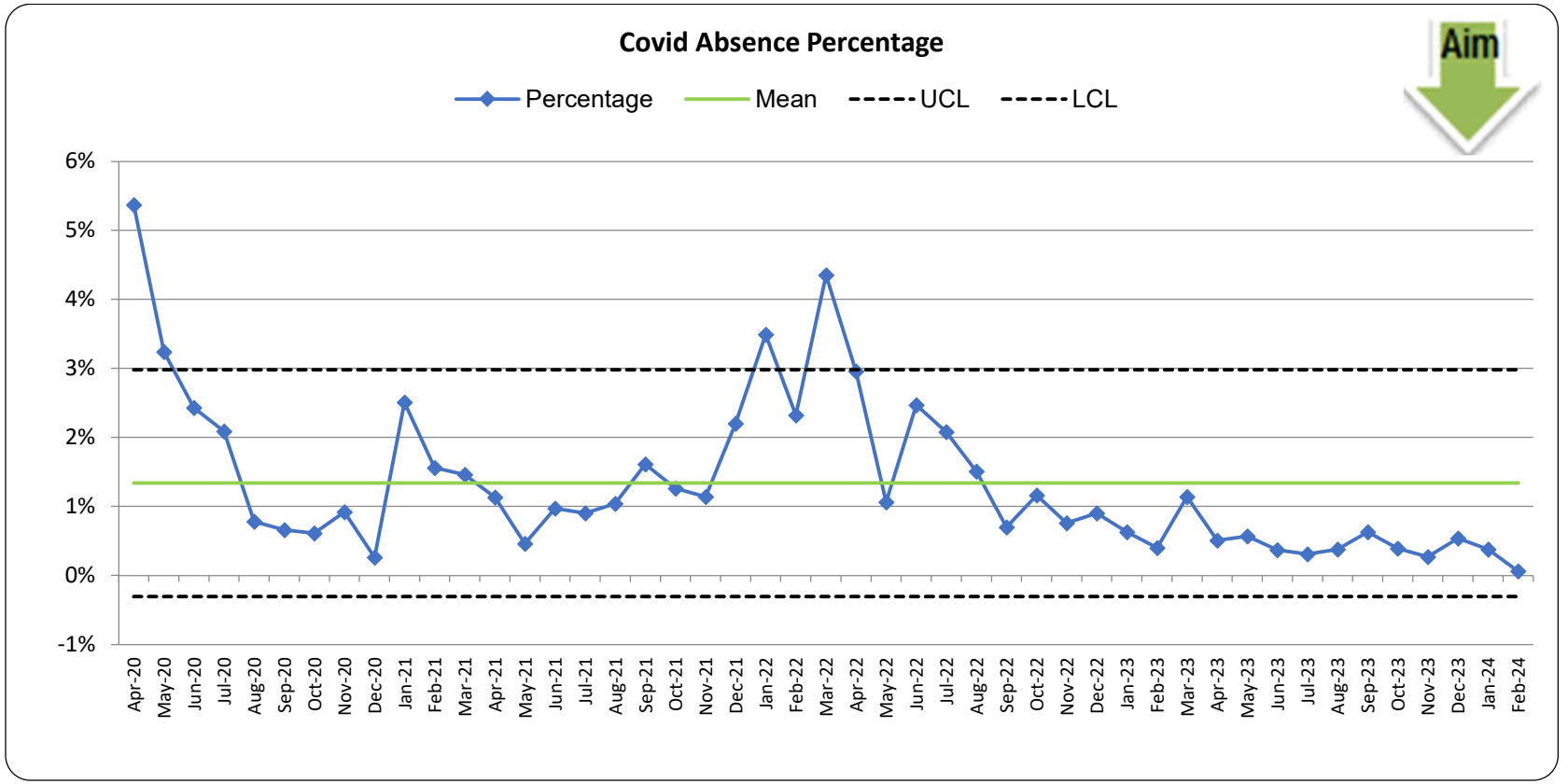



***Fig. 24***


Covid Absence Percentage
Aim
Percentage
Mean
UCL
LCL
6%
5%
4%
3%
2%
1%
0%
-1%
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Apr-21
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Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24

***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) |

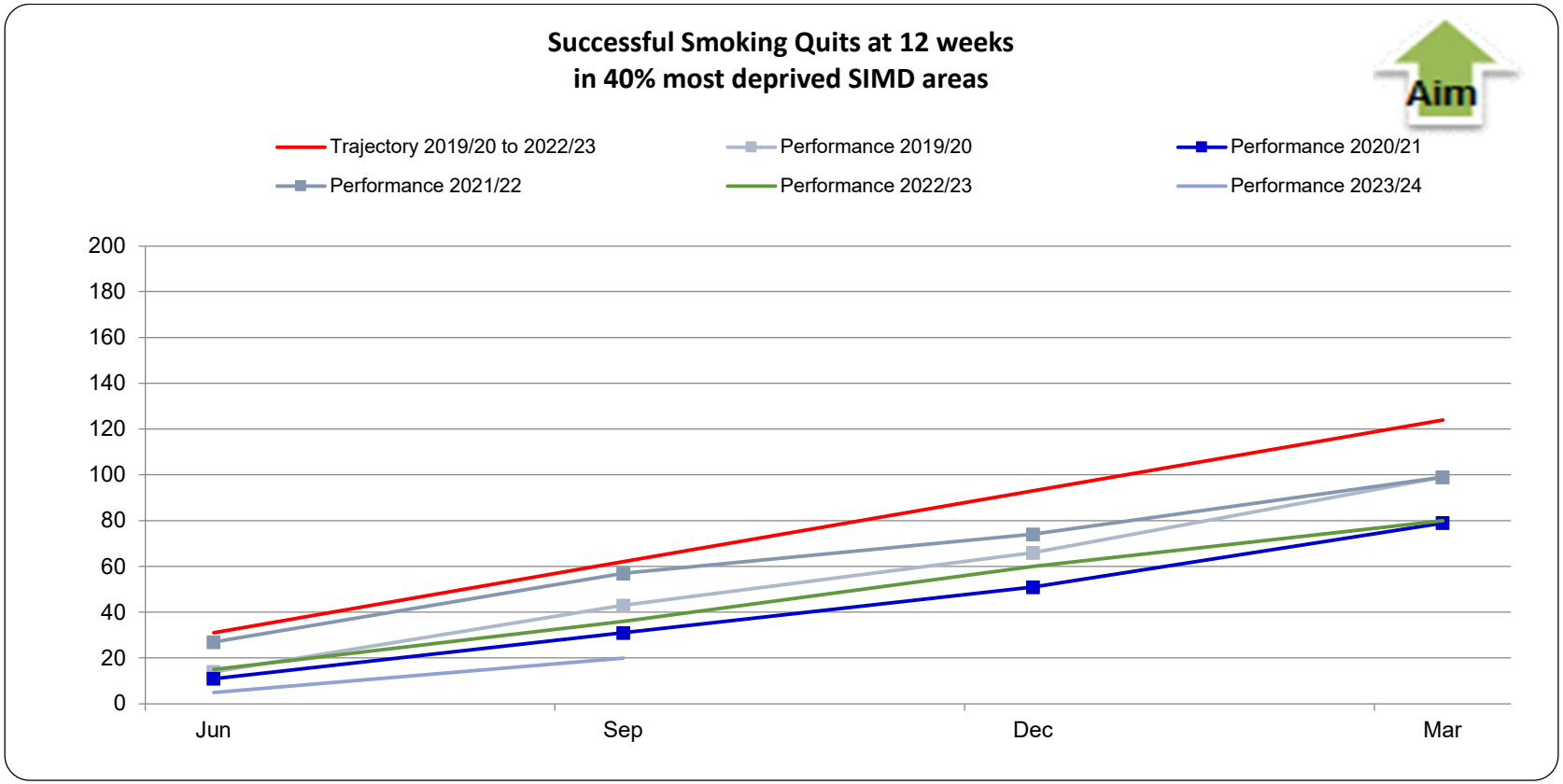



***Fig. 26***

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 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 20 March 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 24.01.24

Minutes of a meeting of the **Scottish Borders Health & Social Care Integration Joint Board** held on **Wednesday 24 January 2024** at **10am** via Microsoft Teams

**Present**:

(v) Cllr D Parker
(v) Cllr T Weatherston
(v) Cllr N Richards
(v) Mrs L O'Leary, Non Executive (Chair)
(v) Mrs K Hamilton, Non Executive
(v) Mrs F Sandford, Non Executive
Mr C Myers, Chief Officer
Mr N Istephan, Chief Executive Eildon Housing
Dr L McCallum, Medical Director
Mr P Lerpiniere, Interim Director of Nursing, Midwifery & AHPs
Mrs J Smith, Borders Care Voice
Mrs D Rutherford, Borders Carers Centre
Ms Gwyneth Lennox, Head of Adult Social Work
Mr D Bell, Staff Side, SBC
Dr R Mollart, GP

**In Attendance**:

Miss I Bishop, Board Secretary
Mr D Robertson, Chief Executive, SBC
Mr R Roberts, Chief Executive, NHS Borders
Mrs J Stacey, Chief Internal Auditor
Mr A Bone, Director of Finance, NHS Borders
Mr P Grieve, Associate Director of Nursing P&CS, NHS Borders
Dr S Bhatti, Director of Public Health
Ms C Oliver, Head of Communications & Engagement, NHS Borders
Ms J Holland, Director of Strategic Commissioning & Partnerships, SBC
Mrs S Errington, Interim Director of Planning & Performance, NHS
Mr B Davies, Head of Strategic Commissioning & Partnerships, SBC
Ms J Glen, Operations Director, Adult Social Care, SBC
Dr A Cotton, Associate Medical Director MH&LD
Mr P McMenamin, Deputy Director of Finance, NHS Borders

## 1. APOLOGIES AND ANNOUNCEMENTS

1.1 Apologies had been received from Cllr E Thornton-Nicol, Elected Member, Cllr R Tatler, Elected Member, Mr J McLaren, Non Executive, NHS Borders, Mr T Taylor, Non Executive, NHS Borders, Ms L Gallacher, Borders Carers Centre, Ms J Amaral, Borders Community Action, Mrs J Smyth, Director of Planning & Performance, NHS Borders, Mrs S Horan, Director of Nursing, Midwifery & AHPs, and Ms L Jackson, LGBTQ+.

1.2 The Chair welcomed attendees and members of the public to the meeting including Mrs S Errington, Interim Director of Planning & Performance, Dr A Cotton, Associate Medical Director MH&LD, Ms J Glen, Operations Director, Adult Social Care, SBC, Mr B Davies,

Head of Strategic Commissioning & Partnerships, SBC and Mr P Lerpiniere, Interim Director of Nursing, Midwifery & AHPs.

1.3 The Chair recorded the thanks of the IJB to Mrs Jen Holland for her support to the Board and wished her well in her new role as Chief Executive of Edinburgh Leisure.

1.4 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 none declared.

## 3. MINUTES OF THE PREVIOUS MEETING

3.1 The minutes of the previous meeting of the Health & Social Care Integration Joint Board held on 15 November 2023 were approved.

## 4. MATTERS ARISING

4.1 **Action 2023-2:** Mr Chris Myers advised that a briefing session would be organised for members for a maximum of one hour.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the action tracker.

## 5. HEALTH AND SOCIAL CARE PARTNERSHIP PERFORMANCE AND DELIVERY REPORT

5.1 Mr Chris Myers gave a slide presentation which highlighted some key elements of the report including: CAMHS waiting times; what matters hubs; pharmacy review of social care service users; and increasing carers support plans; finance, workforce capacity challenges; projected outturn for the year at the end of October of just under a £7.4m overspend; Teviot and Liddesdale day services; PCIP demonstrator site; community hospital medical cover; delayed discharges and surge plans;

5.2 Discussion focused on: What Matters Hubs; frequency of hubs; ethos of the hubs; cost benefit analysis; early intervention prevention agenda; key financial pressure areas within health; pressure in adult social care services; learning disability client specific costs; A&E pressures; older people's service revised base budget from £24m to £16m; what was within the gift of the IJB to resolve in regard to surge beds; the health board would be unable to support surge beds moving forward; continue to work on the risk to community hospitals; any data on admissions to hospital due to care at home failing as opposed to admission due to medical reasons; potential to be a pathfinder board in relation to care home admissions and professional to professional discussions to support people to remain at home; and delayed discharges are counted per episode ( when fit

on the list and when become unfit due to waiting you are removed from the list until you become fit again) and an analysis is within the delivery report.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the contents of the Health and Social Care Partnership Performance and Delivery Report, reviewed the performance highlights and exceptions, and overall delivery against Directions.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** supported the standing down of IJB Direction SBIJB-190723-2 on the basis of the successful bid for the PCIP Demonstrator site and the associated funding.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** considered whether any further recommendations should be made at a strategic level in relation to areas highlighted within the report, in order to inform the ongoing prioritisation of the approach of the Health and Social Care Partnership within the remainder of the current financial year, and/or to inform the 24/25 HSCP Delivery Plan and 24/25 Financial Plan.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** requested to receive an explanation of the line "older people's service revised base budget from £24m to £16m" as detailed within the financial charts.

## 6. DIRECTION: REPROVISION OF INTERNAL HOME CARE NIGHT SUPPORT SERVICE

6.1 Mrs Jen Holland provided an overview of the content of the paper in regard to the proposal to reduce the night support service from 5 night support teams to 2 rapid response teams. She advised that the service users that were directly involved in the Pathfinders, particularly those in the Peebles area, found it a positive experience with a slightly different picture in the Duns area.

6.2 Mrs Debbie Rutherford highlighted that the Carers Centre had concerns over the consultation especially as only 36% of the 70 responses were in favour of changing the service overall.

6.3 Mrs Jenny Smith also enquired if there was really enough evidence of public support to back the change in service provision. She further enquired about any potential whole system impacts especially in regard to pressure on the Emergency Department at the Borders General Hospital and if the proposal could flex or would be reviewed. It was noted that the concerns highlighted during the consultation and had been mitigated and these mitigations were included in the paper.

6.4 Further discussion focused on: substantial downtime within the existing service; efficacy in the application of the service and the value of a person centred perspective; use of new technology; redeployment of staff; continued engagement with people; mitigation of service users concerns; and correlation of data and how that might impact on the admissions at the Borders General Hospital. As a result of the concerns raised by the carer representative and the third sector member of the IJB, the Chair indicated that it would be helpful to build in a 6 month review of progress in the IJB Audit Committee.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the consultation results.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed the proposal to reduce from 5 Night Support teams to 2 Rapid Response Teams.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted there would be a 6 month review built into the direction for the IJB Audit Committee.

## 7. REVISED DIRECTIONS POLICY AND PROCEDURE

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the updated Directions Policy and Procedure that was reviewed in the 18 December 2023 IJB Audit Committee.

## 8. IJB RISK MANAGEMENT POLICY STATEMENT AND RISK MANAGEMENT STRATEGY 2023-2026

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** approved the refreshed IJB Risk Management Policy Statement (Appendix 1) and the updated Risk Management Strategy 2023-2026 (Appendix 2).

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** acknowledged the role and responsibilities of the IJB and IJB Audit Committee within the IJB Risk Management Policy.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the reporting for assurance purposes on the efficacy of risk management arrangements within the IJB Risk Management Policy.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** agreed to a discussion on the risk management approach in practice, as set out with the IJB Risk Management Strategy 2023-2026, as part of an IJB Development Session in 2024, which was recommended by the IJB Audit Committee at its meeting on 18 December 2023.

## 9. 2024/25 INTEGRATION JOINT BOARD FINANCIAL PLANNING PROCESS

9.1 Mr Chris Myers provided an overview of the content of the paper and highlighted: the payment request letter; consequences of the Scottish Budget; potential flat cash settlement that does not cover inflationary costs; and continue to transform services and ensure sustainability.

9.2 The Chair commented that the letter was both transparent and clear in regard to what the IJB were doing and how. She emphasised that it was critical for the IJB as it was the commissioning body that was effectively a funding body to the partners.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** note the final letter sent to the Directors of Finance in NHS Borders and Scottish Borders Council for consideration by their members, and the next steps outlined in the paper.

## 10. WHOLE SYSTEM CAPACITY OF HEALTH & CARE MODELLING

10.1 Mrs Jen Holland provided an overview of the content of the report and highlighted: reviewing health and social care capacity; pressures across the whole system and unscheduled care flow across the whole system; profile current and future demand needs against current capacity; complexity of need; modelling; format of early intervention and prevention; discharge and referral process; and discharge pathway review.

10.2 Dr Sohail Bhatti suggested in regard to the data that a sensitivity analysis be included. He further suggested that if service and need was delayed by 6 or 12 months it would have a significant impact and might assist in working out how to stop the tumult of demand that was being serviced with less resource. He suggested the modelling should work out what the impacts might be and enable targeting of groups or the population at the right time. Mrs Holland supported Dr Bhatti's suggestion and advised that it was within the scope.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the work that will be commissioned by the Health and Social Care Partnership.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** provided comments on the approach being undertaken to inform the commission.

## 11. MENTAL HEALTH AND LEARNING DISABILITIES MEDICAL WORKFORCE SUSTAINABILITY

11.1 Mr Chris Myers introduced the item and advised that he felt it important for the Board to be cited on the risk that sat within the mental health medical workforce and across the wider mental health service and to understand the context that the service were working in from a medical perspective.

11.2 Dr Amanda Cotton provided an overview of the content of the report and advised that it set out a strategic approach to the development of medical staffing and how to grow the middle grade tier into our own autonomous and expert doctors to a new senior level.

11.3 Dr Lynn McCallum commented that the lack of consultant psychiatrists was a national issue and locally NHS Borders had been fortunate to recruit 2 consultants however there would still be gaps in the service which the plan would help to mitigate against. She formally recorded her thanks to Dr Cotton for the work she had put into keeping the service safe and able to deliver effective patient care to the people of the Borders.

11.4 Further discussion focused on: creative solution; over medicalising; delivery of services in line with the Mental Health Act; conflation of the mental health and wellbeing agenda; capable communities, society and primary care services; diagnosis and medication; society refer to mental health services as it validates their mental health problem; overall

affordability and cost effectiveness; mitigation of risk on workforce performance and safety; and removal of barriers to achieving greater efficiencies.

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

## 12. SCOTTISH BORDERS MACMILLAN IMPROVING THE CANCER JOURNEY

The **SCOTTISH BORDERS HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD** noted the report.

## 13. AUDIT COMMITTEE MINUTES: 19.06.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

## 14. STRATEGIC PLANNING GROUP MINUTES: 01.11.23

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the minutes.

## 15. ANY OTHER BUSINESS

15.1 **Commissioning of OD work:** The Chair advised that some OD work would be commissioned to assist in building the IJB as a Team.

15.2 **Reissue of IJB Handbook:** The Chair advised that the revised IJB Members Handbook would be issued to IJB members.

15.3 **Joint Staff Forum:** Mr Chris Myers advised that the Joint Staff Forum would be holding a workshop to look at how to progress the integration agenda and joint working.

15.4 **Employability Partnership:** Mrs Jenny Smith advised that Mrs Juliana Amaral was keen to have an update on the funding agreed in 2023 for an NHS employee to work within the mental health service on employability as the third sector were looking to bring in employability working and wanted it to be complimentary. Mr Chris Myers advised that he would feedback to Mrs Amaral.

The **SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD** noted the updates.

## 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 20 March 2024, from 10am to 12 noon through MS Teams and in person in the Council Chamber, Scottish Borders Council.

# NHS Borders

| | |
|---|---|
| **Meeting:** | **Borders NHS Board** |
| **Meeting date:** | **4 April 2024** |
| **Title:** | **Code of Corporate Governance Refresh** |
| **Responsible Executive/Non-Executive:** | **Andrew Bone, Director of Finance** |
| **Report Author:** | **Iris Bishop, Board Secretary** |

## 1 Purpose

**This is presented to the Committee for:**

- Decision

**This report relates to a:**

- Government policy/directive
- Legal requirement

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

- Safe
- Effective
- Person Centred

## 2 Report summary

### 2.1 Situation

To provide the Board with a refresh of the Code of Corporate Governance (CoCG) as reviewed by the Audit & Risk Committee on 25 March 2024 and recommended for formal approval by Borders NHS Board.

### 2.2 Background

The Code of Corporate Governance details how the Board organises and governs its business.

The Code of Corporate Governance is required to be updated every 3 years.

The Board on 30 March 2023 reviewed and approved a sectional update to the CoCG (Introduction and Section A).

## 2.3 Assessment

Throughout the CoCG the following amendments have been applied:-

- Director of Strategy & Planning renamed to Director of Planning & Performance.
- Director of Nursing, Midwifery & Operations renamed to either Director of Nursing, Midwifery and AHPs and/or Director of Acute Services depending on the context.
- Head of Finance renamed to Deputy Director of Finance.
- Director of Workforce renamed to Director of HR, OD & OH&S.
- Clinical Executive renamed to Operational Planning Group.
- Annual Operational Plan renamed to Annual Delivery Plan.
- Audit Committee renamed to Audit & Risk Committee.
- Strategy & Performance Committee renamed to Resources & Performance Committee.

The Introduction Section of the CoCG has now been refreshed and contains minor amendments which have been highlighted in yellow.

Section A – How business is organised. The section has now been refreshed and contains the revised Terms of Reference for all of the Board Committees as well as some minor amendments which have been highlighted in yellow.

Section B – Members Code of Conduct. This section is provided by the Standards Commission and did not require amendment. The Standards Commission are currently consulting on a revised Members Code of Conduct which will contain reference to social media. Once the consultation has concluded and the new Model Code of Conduct is issued it will be replaced within the CoCG as a sectional update and submitted to the Board for formal approval.

Section C – Standards of Business Conduct for NHS Staff. This section has been reviewed and no amendments have been made.

Section D – Scottish Borders Health & Social Care Integration Joint Board – Scheme of Integration. This section has been updated to include the Terms of Reference for the Joint Executive Team in order to enable the decision making process to be defined.

Section E – Counter Fraud Policy & Action Plan. This section has been reviewed and has been updated where relevant to reflect operational practice and updated Scottish Government and Counter Fraud Services publications and guidance.

Section F - Scheme of Delegation. This section has been reviewed and updated to reflect day to day operational requirements.

Section G - Standing Financial Instructions. This section has been reviewed with amendments to reflect day to day operational practice, all amendments are not material to the procedures and processes detailed. The section also now includes the process for the approval of “Local Pay Awards” (paragraph 12.12) as the previous proposal did not provide cover for the application of pay award to all staff on local pay arrangements.

Following feedback from the Audit & Risk Committee a further review of the regulations in regard to Consultant Appointments was carried out (NHS (Appointment of Consultants) (Scotland) Regulation 2009). Having review the requirements and discussed the matter with the Chief Executive the following refresh is proposed: reference to consultant appointments being a matter reserved for the Board (page 193) is removed and we are explicit that local guidance is in place which reflects those regulatory requirements (Page 253).

### 2.3.1 Quality/ Patient Care

Not applicable.

### 2.3.2 Workforce

Not applicable.

### 2.3.3 Financial

Not applicable.

### 2.3.4 Risk Assessment/Management

Not applicable.

### 2.3.5 Equality and Diversity, including health inequalities

An impact assessment is not required.

### 2.3.6 Climate Change

Not applicable.

### 2.3.7 Other impacts

Not applicable.

### 2.3.8 Communication, involvement, engagement and consultation

Once approved the Code of Corporate Governance will be available through the NHS Borders website under the Corporate Information section, as well as the Finance microsite on the intranet.

### 2.3.9 Route to the Meeting

As recommended by the Audit & Risk Committee on 25 March 2024.

## 2.4 Recommendation

The Board is asked to **approve** the refreshed Code of Corporate Governance.

The Board is asked to take **significant/moderate assurance** that the refreshed Code of Corporate Governance is in line with appropriate legislative requirements and directions as issued by the Scottish Government.

## 3 List of appendices

The following appendices are included with this report:

- Appendix No A, Code of Corporate Governance

# CODE OF CORPORATE GOVERNANCE 2024

**Approved:** **MARCH 2024**

**Review Date:** **APRIL 2027**

**INDEX**

**INTRODUCTION**

3. Scheme of Delegation Framework & key roles
4. Delegated limits and authorised signatories
5. Delegation of powers for appointments of staff

**SECTION G – PAGE 244**
**Standing financial instructions**

This section explains how staff will control the financial affairs of NHS Borders and ensure proper standards of financial conduct.

## INTRODUCTION

## 1. CODE OF CORPORATE GOVERNANCE

The Code of Corporate Governance includes the following sections:

Section A – How business is organised
Section B – Members' code of conduct
Section C – Standards of business conduct for NHS staff
Section D – Health & Social Care Integration - Integration Joint Board
Section E – Counter Fraud Policy & Action Plan
Section F – Reservation of powers and delegation of authority
Section G – Standing financial instructions

It uses best practice in Corporate Governance as set out in the Cadbury, Nolan and other Reports, including the NHS Scotland - blueprint for good governance: second edition - gov.scot (www.gov.scot) and guidance issued by the Scottish Government Health & Social Care Directorates and others.

The Board reviews and approves sectional updates to the Code of Corporate Governance on an annual basis with a full refresh taking place every 3 years. Sections A to G are NHS Borders Standing Orders. The Standing Orders are made in accordance with the Health Board (Membership and Procedure) (Scotland) Regulations 2001.

Statutory provision, legal requirement, regulation or a direction by Scottish Ministers take precedence over the Code of Corporate Governance if there is any conflict.

## 2. BORDERS NHS BOARD

Borders NHS Board, 'The Board', means Borders Health Board.

The common name of Borders NHS Board as an organisation is "NHS Borders".

The Board is the governing body of NHS Borders and the single legal entity, accountable to the Scottish Government Health & Social Care Directorate and to Scottish Ministers for the functions and performance of NHS Borders.

The Board will not concern itself with day-to-day operational matters, except where they have an impact on the overall performance of the system.

The Board consists of the Chair, Non-Executive and Executive Members appointed by Scottish Ministers to constitute Borders Health Board. (National Health Services (Scotland) Act 1978 as amended).

Remuneration will be paid as determined by Scottish Ministers to the Chair and other Non-Executive Board Members.

Any member of the Board may, on reasonable cause shown, be suspended or removed or disqualified from membership of the Board in accordance with the Regulations identified in Section 1 above.

A member of the Board may resign office at any time by giving notice in writing to Scottish Ministers to that effect.

**The overall purpose of Borders NHS Board is to:**

- Review and ensure the efficient, effective and accountable governance of NHS Borders;
- Provide strategic leadership and direction;
- Focus on agreed outcomes;
- Work in partnership with the Scottish Borders Health & Social Care Integration Joint Board to support the delivery of the Borders Joint Strategic plan. IJB Strategic Framework 2023-2026 | Scottish Borders Council (scotborders.gov.uk) sets out our approach to continue our work to shift the balance of care and address the Scottish Government's priorities for Integration. The Board is committed to continuing to develop our approach to integration and is expecting future versions of our Joint Strategic Plan to become a single plan for all Health and Care services in the Borders.

**The Role of the Board is to:**

- Provide and improve and protect the health of local people;
- Provide and improve health services for local people;
- Focus clearly on health outcomes and people's experience of NHS Borders;
- Work in conjunction with the Scottish Borders Health and Social Care Integration Joint Board to improve the wellbeing of people who use health and social care services;
- Improve community planning within the Scottish Borders through membership of the Community Planning Strategic Board; Community Empowerment (Scotland) Act 2015, part 2, community planning: guidance (Plain English version) - gov.scot (www.gov.scot)
- Be accountable for the performance of NHS Borders as a whole;
- Involve the public in the design and delivery of healthcare services.

**The Functions of the Board are to:**

- Set the strategic direction of NHS Borders within the overall policies and priorities of the Scottish Parliament and the Scottish Government, define its annual and longer-term objectives and agree plans to achieve them;
- Delegate functions and related resources to the Scottish Borders Health and Social Care Integration Joint Board in line with legislation (Public Bodies (Joint Working) (Scotland) Act 2014);
- Deliver services as commissioned by the Scottish Borders Health and Social Care Integration Joint Board in line with the agreed Borders Joint Strategic Plan;
- Approve resource allocation to address local priorities;
- Ensure effective financial stewardship through value for money, financial control and financial planning and strategy;
- Oversee implementation and delivery of the Annual Delivery Plan;
- Manage the performance of NHS Borders, including risk management, by monitoring performance against objectives and ensuring corrective action is taken when necessary;
- Appoint, appraise and remunerate senior executives;

- Be responsible for the recruitment, and authorise the appointment of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009;
- Approve governance arrangements for NHS Borders which the Board will discharge including through the Standing Committees of Audit & Risk, Resources and Performance, Clinical, Staff, and Public Governance.
- Support the Patient Rights (Scotland) Act 2011 and the Person Centred Health and Care Programme for example through the receipt of patient and carer stories.

**Responsibilities of Members of the Board include:**

- Shared responsibility for the discharge of the functions of the Board;
- Exercise independent, impartial judgement on issues of strategy, resource allocation, performance management, key appointments and accountability, to Scottish Ministers and to the local community;
- Responsibility and accountability for the overall performance of NHS Borders.

## 3. DEFINITIONS

Any expressions to which a meaning is given in the Health Service Acts or in the Regulations or Orders made under the Acts shall have the same meaning in this interpretation and in addition:

**The Act** means the National Health Service (Scotland) Act 1978 as amended.

**The 1960 Act** means the Public Bodies (Admission to Meetings) Act 1960, as amended.

**The 2001 Regulations** means the Health Board's (Membership and Procedure) (Scotland) Regulations 2001.

**The Joint Working Act** means the Public Bodies (Joint Working) (Scotland) Act 2014.

**The Accountable Officer** is the Chief Executive of NHS Borders, who is responsible to the Scottish Parliament for the economical, efficient and effective use of resources. The Chief Executive of NHS Borders is accountable to the Board for clinical, corporate and staff governance. This is a legal appointment made by the Principal Accountable Officer of the Scottish Government (Public Finance and Accountability (Scotland) Act 2000).

**Board Executive Team (BET)** is the executive arm of Borders NHS Board. Members of the Board Executive Team are the Chief Executive, Medical Director, Director of Finance, Director of Nursing, Midwifery & AHPs Director of HR, OD & OH&S, Director of Planning and Performance, Director of Public Health, Chief Officer Health & Social Care, Director of Acute Services, Director of Quality & Improvement and the Employee Director is in attendance.

**Borders NHS Board** comprises 10 Non Executives Directors and 5 Executive Directors (Chief Executive, Medical Director, Director of Finance, Director of Nursing, Midwifery & AHPs, Director of Public Health) all appointed by Scottish Ministers. Three of the Non Executive Directors are stakeholder members (Local Authority representative, Area Clinical Forum Chair, Area Partnership Forum Chair). The Chair and 6 Non Executive Directors are recruited through an open public appointment process.

**Board Secretary** is responsible for ensuring that the Board complies with relevant legislation and governance guidance. The Board Secretary will ensure that meetings of the Board of Directors and its Committees run efficiently and effectively, that they are properly recorded and that Directors receive appropriate support to fulfil their legal duties.

**Budget** means a financial resource proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Board.

**Chair** means the person appointed by the Scottish Ministers to lead the Board and to ensure it discharges its responsibilities as determined by Government Ministers. The expression 'the Chair of the Board' is deemed to include the Vice-Chair of the Board if the Chair is absent from the meeting or is otherwise unavailable. The Chair of a Committee is responsible for fulfilling the duties of a Chair in relation to that Committee only.

**Chief Executive** means the Accountable Officer of NHS Borders.

**Clinical Executive Directors** means Director of Nursing, Midwifery & AHPs and Medical Director.

**Committee** means a Committee established by the Board, and includes 'Sub-Committee'.

**Committee Members** are people appointed by the Board to sit on or to chair specific committees. All references to members of a committee is as 'member' and when the reference is to a member of the Board it is 'Board Member'.

**Contract** includes any arrangement including an NHS Service Level Agreement.

**Co-opted Member** is an individual, not being a Member of the Board, who is appointed to serve on a Committee of the Board.

**Corporate Management** means Chief Executive, Director of Finance, Director of Nursing, Midwifery & AHPs, Director of HR, OD & OH&S, Director of Planning & Performance, Director of Public Health, Chief Officer Health & Social Care, Director of Acute Services, Director of Quality & Improvement and Medical Director.

**Director of Finance** means the Chief Finance Officer of the Board.

**Ex-officio** means "from the office of," intending to convey that something is by virtue of holding office. Any Board members who are "ex officio" (ie the Chair for the purposes of all Committees except the Audit & Risk Committee) is entitled to attend those Committee meetings, debate items, and vote at those meetings. They are also counted as part of the quorum at those Committee meetings. Should an ex-officio member be appointed who is not a member of NHS Borders Board and is outwith NHS Borders then whilst they would have the same entitlement to attend meetings, debate items and vote, they would not be counted towards the quorum.

**Health & Social Care Partnership** means the strategic direction by Scottish Government given to Statutory Organisations (Scottish Borders Council and NHS Borders) for the provision of integrated services across health and social care in the Scottish Borders.

**Meeting** means a meeting of the Board or of any Committee.

**Member** means a person appointed as a Member of the Board by Scottish Ministers, and who is not disqualified from membership. This definition includes the Chair and other Executive and Non-Executive Members (Health Boards Membership and Procedure (Scotland) Regulations 2001).

**Motion** means proposal.

**Nominated Officer** means an officer charged with the responsibility for discharging specific tasks within the Code of Corporate Governance.

**Non-Executive Member** means any Member appointed to the Board in terms of the 2001 Regulations and who is not listed under the definition of an Executive Member above.

**Officer** means an employee of NHS Borders.

**Scottish Borders Health and Social Care Integration Joint Board** (H&SC IJB) means the legal entity legislated as part of the Public Bodies (Joint Working) (Scotland) Act 2014.

**Scottish Government** means the Scottish Government and is its legal name. All references in this document are to the legal name.

**Scheme of Integration** means the H&SC IJB partnership agreement with the statutory organisations (Scottish Borders Council and NHS Borders) for the delivery of the Integration Joint Board delegated functions.

**SFIs** means Standing Financial Instructions.

**SOs** means Standing Orders.

**Standards Officer** means the Board Secretary.

**Joint Strategic Plan** means the single plan for all Health and Care services in the Borders (IJB Strategic Framework 2023-2026 | Scottish Borders Council (scotborders.gov.uk)

**The Code** means the Code of Corporate Governance.

**The Operational Planning Group** is the operational delivery unit for NHS Borders. It meets weekly. Membership comprises representation from Clinical and Managerial leaders from each of the Clinical Boards and from the Board Executive Team (BET).

**Vice Chair** means the Non-Executive Member appointed by the Board to take on the Chair's duties if the Chair is absent for any reason.

## 4. CORPORATE GOVERNANCE

Corporate Governance is the term used to describe our overall control system. It details how we direct and control our functions and how we relate to our communities and covers the following dimensions:

- Community focus and communication
- Service delivery arrangements
- Structures and processes

- Risk management
- Systems of internal control
- Standards of conduct

Borders NHS Board is responsible for:

- Giving leadership and strategic direction
- Putting in place controls to safeguard public resources
- Supervising the overall management of its activities
- Reporting on management and performance

## 5. CONDUCT, ACCOUNTABILITY AND OPENNESS

Members of the Board are required to comply with the Members' code of conduct and the Standards of business conduct for NHS staff.

Board Members and staff are expected to promote and support the principles in the Members' code of conduct and to promote by their personal conduct the values of:

- Public service
- Leadership
- Selflessness
- Integrity
- Objectivity
- Openness
- Accountability and stewardship
- Honesty
- Respect

## 6. UNDERSTANDING RESPONSIBILITIES ARISING FROM THE CODE OF CORPORATE GOVERNANCE

It is the duty of the Chair and the Chief Executive to ensure that Board Members and staff understand their responsibilities. Board Members shall receive access to the Code of Corporate Governance. The Code of Corporate Governance is made available to the organisation via electronic means on both the internal intranet and external website. Managers are responsible for ensuring their staff understand their responsibilities.

## 7. ENDOWMENT FUNDS

The principles of this Code of Corporate Governance apply equally to Members of the Board who have distinct legal responsibilities as Trustees of the Endowment Funds.

## 8. ADVISORY AND OTHER COMMITTEES

The principles of this Code of Corporate Governance apply equally to all Board Advisory Committees and all committees and groups which report directly to a Board Committee.

## 9. REVIEW

The Board will keep the Code of Corporate Governance under review regularly and undertake a comprehensive review no longer than every 3 years. The Board may, on its own or if directed by the Scottish Ministers, vary and revoke Standing Orders for the regulation of the procedure and business of the Board and of any Committee. The Audit & Risk Committee is responsible for advising the Board on these matters.

## 10. FEEDBACK

NHS Borders wishes to improve continuously and reviews the Code of Corporate Governance regularly. To ensure that this Code remains relevant, we would be happy to hear from you with regard to new operational procedures, changes to legislation, confusion regarding the interpretation of statements or any other matter connected with the Code.

Comments and suggestions for improvement are most welcome, and these should be sent to:-

**Board Secretary**
**NHS Borders**
**Headquarters**
**Borders General Hospital**
**Melrose TD6 9DB**

**Telephone:** **01896 825525**
**Email:** **iris.bishop@borders.scot.nhs.uk**

# SECTION A

# How business is organised

## 1. THE BOARD AND ITS COMMITTEES (DIAGRAM)

## 2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

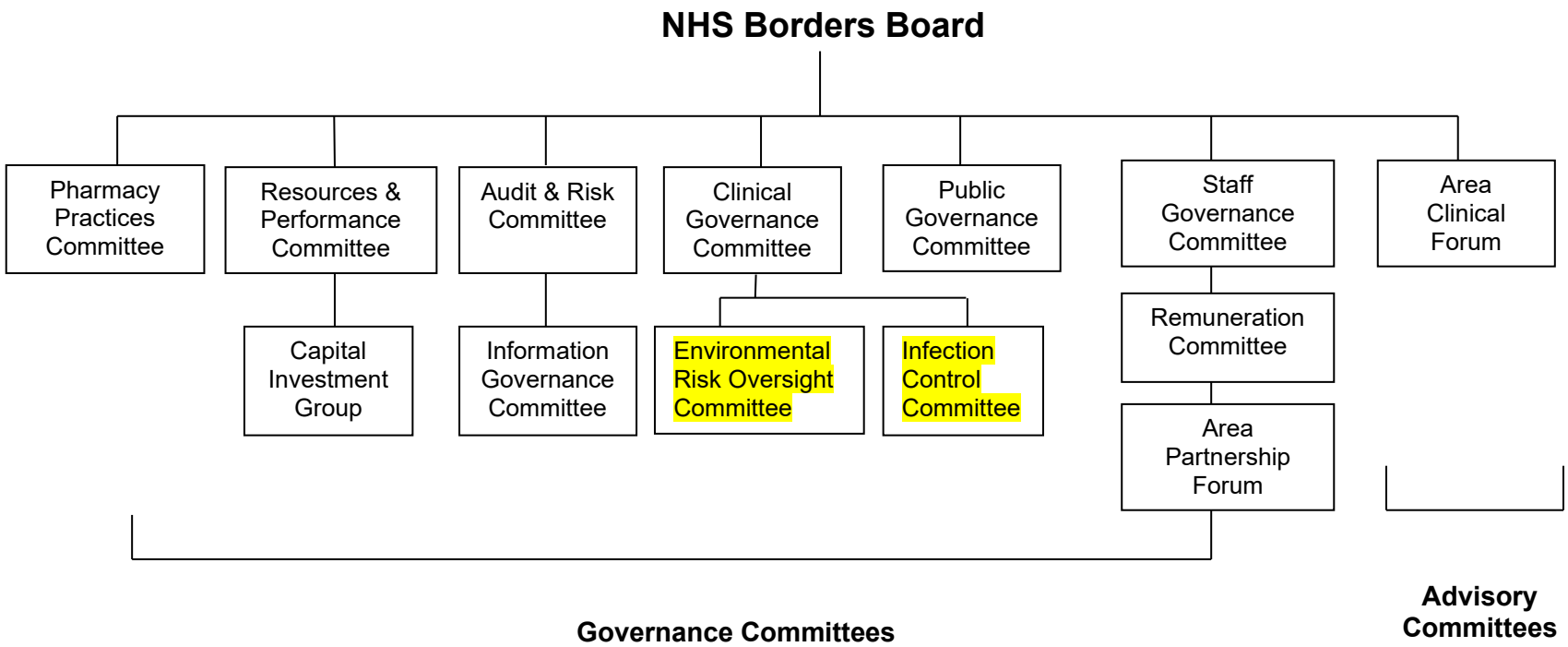
1. General
   Board Members – Ethical Conduct
2. Chair
3. Vice-Chair
4. Calling and Notice of Board Meetings
   - Deputations and Petitions
5. Conduct of Meetings
   - Authority of the Person Presiding at a Board Meeting
   - Quorum
   - Adjournment
   - Business of the Meeting
   - Board Meeting in Private Session
   - Minutes
6. Matters Reserved for the Board
7. Delegation of Authority by the Board
8. Execution of Documents
9. Committees
10. Guidance to exemptions under the Freedom of Information (Scotland) Act 2002
11. Records management

## 3. STANDING COMMITTEES

1. Establishing Committees
2. Membership
3. Functioning
4. Minutes
5. Frequency
6. Delegation
7. Committees
8. Purpose and Remits
   A. Resources and Performance Committee
   B. Capital Investment Group (sub-committee of Resources & Performance Committee)
   C. Audit & Risk Committee
   D. Information Governance Committee (sub-committee of Audit & Risk Committee)
   E. Clinical Governance Committee
   F. Infection Control Committee (sub-committee of Clinical Governance Committee)
   G. Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
   H. Staff Governance Committee
   I. Remuneration Committee (sub-committee of Staff Governance Committee)
   J. Public Governance Committee
   K. Area Clinical Forum
   L. Area Partnership Forum
   M. Pharmacy Practices Committee

Section A - Appendix 1: The Heath Boards (Membership and Procedure) (Scotland) Regulations 2001

# 1. THE BOARD AND ITS COMMITTEES




* The Pharmacy Practices Committee has delegated authority from the Board to meet when there are applications to consider in line with Statutory Instrument 1995 NO 414 (S28)
The National Health (Pharmaceutical Services) Service (Scotland) - Regulations 1995

# 2. HOW BOARD AND COMMITTEE MEETINGS MUST BE ORGANISED

This section regulates how the meetings and proceedings of the Board and its Committees will be conducted and are referred to as 'Standing Orders'. The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 confirms the matters to be included in the Standing Orders. This is attached for reference at Appendix 1 of this section. The following is NHS Borders' practical application of these Regulations.

**STANDING ORDERS FOR THE PROCEEDINGS AND BUSINESS OF BORDERS NHS BOARD**

## 1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Borders NHS Board, the common name for Borders Health Board, and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302), as amended up to and including The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2016 (2016 No. 3).

Healthcare Improvement Scotland and NHS National Services Scotland are constituted under a different legal basis and are not subject to the above regulations. Consequently those bodies will have different Standing Orders.

The NHS Scotland Blueprint for Good Governance (issued through DL 2019) 02) has informed these Standing Orders. The Blueprint describes the functions of the Board as:

- Setting the direction, clarifying priorities and defining expectations.
- Holding the executive to account and seeking assurance that the organisation is being effectively managed.
- Managing risks to the quality, delivery and sustainability of services.
- Engaging with stakeholders.
- Influencing the Board's and the organisation's culture.

Further information on the role of the Board, Board members, the Chair, Vice-Chair, and the Chief Executive is available on the NHS Scotland Board Development website (https://learn.nes.nhs.scot/17367/board-development )

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation and removal, suspension and disqualification of members in line with the above regulations and any request to co-opt member(s) to the Board. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified from taking part in any business of the Board in specified circumstances.

1.3 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.4 Any one or more of these Standing Orders may be varied or revoked at a meeting

of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment. The Board will annually review its Standing Orders.

1.5 Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances. The Scottish Ministers may by determination suspend a member from taking part in the business (including meetings) of the Board. Paragraph 5.4 sets out when the person presiding at a Board meeting may suspend a Board member for the remainder of a specific Board meeting. The Standards Commission for Scotland can apply sanctions if a Board member is found to have breached the Board Members' Code of Conduct, and those include suspension and disqualification. The regulations (see paragraph 1.1) also set out grounds for why a person may be disqualified from being a member of the Board.

Board Members – Ethical Conduct

1.6 Members have a personal responsibility to comply with the Code of Conduct for Members of the Borders NHS Board. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Board will have appointed a Standards Officer. This individual is responsible for carrying out the duties of that role, however he or she may delegate the carrying out of associated tasks to other members of staff. The Board's appointed Standards Officer shall ensure that the Board's Register of Interests is maintained. When a member needs to update or amend his or her entry in the Register, he or she must notify the Board's appointed Standards Officer of the need to change the entry within one month after the date the matter required to be registered.

1.7 The Board's appointed Standards Officer shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board's website.

1.8 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.6 - 5.10 of these Standing Orders and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

1.9 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.

1.10 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Board's appointed Standards Officer who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board's website. The Register of Interests includes a section on gifts and hospitality. The Register may include the information on any such declarations, or cross-refer to where the information is published.

1.11 The Board Secretary shall provide a copy of these Standing Orders to all members

of the Board on appointment. A copy shall also be held on the Board's website.

## 2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board.

## 3 Vice-Chair

3.1 The Chair shall nominate a candidate or candidates for vice-chair to the Cabinet Secretary. The candidate(s) must be a non-executive member of the Board. The non-executive member of the Board with the whistleblowing portfolio is excluded from being Vice-Chair. A member who is an employee of the Board is disqualified from being Vice-Chair. The Cabinet Secretary will in turn determine who to appoint based on evidence of effective performance and evidence that the member has the skills, knowledge and experience needed for the position. Following the decision, the Board shall appoint the member as Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice-Chair may at any time resign from that office by giving notice in writing to the Chair. The process to appoint a replacement Vice-Chair is the process described at paragraph 3.1.

3.3 Where the Chair has died, ceased to hold office, or is unable for a sustained period of time to perform his or her duties due to illness, absence from Scotland or for any other reason, then the Board's Chief Executive or Board Secretary should refer this to the Scottish Government. The Cabinet Secretary will confirm which member may assume the role of interim chair in the period until the appointment of a new chair, or the return of the appointed chair. Where the Chair is absent for a short period due to leave (for whatever reason) the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board. In either of these circumstances references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to either the interim chair or the Vice-Chair. If the Vice-Chair has been appointed as the Interim Chair, then the process described at paragraph 3.1 will apply to replace the Vice-Chair.

## 4 Calling and Notice of Board Meetings

4.1 The Chair may call a meeting of the Board at any time and shall call a meeting when required to do so by the Board. The Board shall meet at least five times in the year and will annually approve a forward schedule of meeting dates.

4.2 The Chair will determine the final agenda for all Board meetings. The agenda may include an item for any other business, however this can only be for business which the Board is being informed of for awareness, rather than being asked to make a decision. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency.

4.3 Any member may propose an item of business to be included in the agenda of a future Board meeting by submitting a request to the Chair. If the Chair elects to agree to the request, then the Chair may decide whether the item is to be

considered at the Board meeting which immediately follows the receipt of the request, or a future Board meeting. The Chair will inform the member at which meeting the item will be discussed. If any member has a specific legal duty or responsibility to discharge which requires that member to present a report to the Board, then that report will be included in the agenda.

4.4 In the event that the Chair decides not to include the item of business on the agenda of a Board meeting, then the Chair will inform the member in writing as to the reasons why.

4.5 A Board meeting may be called if one third of the whole number of members signs a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

4.6 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person's behalf, shall be circulated to every member so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point.

4.7 With regard to calculating clear days for the purpose of notice under 4.6 and 4.9, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Additionally only working days (Monday to Friday) are to be used when calculating clear days; weekend days and public holidays should be excluded.

Example: If a Board is meeting on a Wednesday, the notice and papers for the meeting should be distributed to members no later than the preceding Thursday. The three clear days would be Friday, Monday and Tuesday. If the Monday was a public holiday, then the notice and papers should be distributed no later than the preceding Wednesday.

4.8 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.9 Board meetings shall be held in public. A public notice of the time and place of the meeting shall be provided at least three clear days before the meeting is held. The notice and the meeting papers shall also be placed on the Board's website. The meeting papers will include the minutes of committee meetings which the relevant committee has approved. The exception is that the meeting papers will not include the minutes of the Remuneration Committee. The Board may determine its own approach for committees to inform it of business which has been discussed in committee meetings for which the final minutes are not yet available. For items of business which the Board will consider in private session (see paragraph 5.22), only the Board members will normally receive the meeting papers for those items, unless the person presiding agrees that others may receive them.

Deputations and petitions

4.10 Any individual or group or organisation which wishes to make a deputation to the Board must make an application to the Chair's Office at least 21 working days before the date of the meeting at which the deputation wish to be received. The application will state the subject and the proposed action to be taken.

4.11 Any member may put any relevant question to the deputation, but will not express any opinion on the subject matter until the deputation has concluded their presentation. If the subject matter relates to an item of business on the agenda, no debate or discussion will take place until the item is considered in the order of business.

4.12 Any individual or group or organisation which wishes to submit a petition to the Board will deliver the petition to the Chair's Office at least 21 working days before the meeting at which the subject matter may be considered. The Chair will decide whether or not the petition will be discussed at the meeting.

## 5 Conduct of Meetings

Authority of the Person Presiding at a Board Meeting

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a Board member who is not an employee of the Board to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the committee's terms of reference are observed, to preserve order, to ensure fairness between members, and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing. For the avoidance of doubt, those members using such facilities will be regarded as present at the meeting.

5.4 In the event that any member who disregards the authority of the person presiding, obstructs the meeting, or conducts himself/herself inappropriately the person presiding may suspend the member for the remainder of the meeting. If a person so suspended refuses to leave when required by the person presiding to do so, the person presiding will adjourn the meeting in line with paragraph 5.12. For paragraphs 5.5 to 5.20, reference to 'Chair' means the person who is presiding the meeting, as determined by paragraph 5.1.

Quorum

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least two members who are not employees of a Board. The quorum for committees

will be set out in their terms of reference, however it can never be less than two Board members.

5.6 In determining whether or not a quorum is present the Chair must consider the effect of any declared interests.

5.7 If a member, or an associate of the member, has any pecuniary or other interest, direct or indirect, in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members' Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.8 Paragraph 5.7 will not apply where a member's, or an associate of their's, interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to affect any influence in the consideration or discussion of any question with respect to that contract or matter. In March 2015, the Standards Commission granted a dispensation to NHS Board members who are also voting members of integration joint boards. The effect is that those members do not need to declare as an interest that they are a member of an integration joint board when taking part in discussions of general health & social care issues. However members still have to declare other interests as required by Section 5 of the Board Members' Code of Conduct.

5.9 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair's ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.10 Paragraphs 5.6-5.9 shall equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

5.11 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close.

Adjournment

5.12 If it is necessary or expedient to do so for any reason (including disorderly conduct or other misbehaviour at a meeting), a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be

adjourned by the Chair until such day, time and place as the Chair may specify.

Business of the Meeting

*The Agenda*

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair ideally in advance of the day of the meeting and certainly before the start of the meeting. The Chair will determine whether the matter is urgent and accordingly whether it may be discussed at the meeting.

5.14 The Chair may change the running order of items for discussion on the agenda at the meeting. Please also refer to paragraph 4.2.

*Decision-Making*

5.15 The Chair may invite the lead for any item to introduce the item before inviting contributions from members. Members should indicate to the Chair if they wish to contribute, and the Chair will invite all who do so to contribute in turn. Members are expected to question and challenge proposals constructively and carefully to reach and articulate a considered view on the suitability of proposals.

5.16 The Chair will consider the discussion, and whether or not a consensus has been reached. Where the Chair concludes that consensus has been reached, then the Chair will normally end the discussion of an item by inviting agreement to the outcomes from the discussion and the resulting decisions of the Board.

5.17 As part of the process of stating the resulting decisions of the Board, the Chair may propose an adaptation of what may have been recommended to the Board in the accompanying report, to reflect the outcome of the discussion.

5.18 The Board may reach consensus on an item of business without taking a formal vote, and this will be normally what happens where consensus has been reached.

5.19 Where the Chair concludes that there is not a consensus on the Board's position on the item and/or what it wishes to do, then the Chair will put the decision to a vote. If at least two Board members ask for a decision to be put to a vote, then the Chair will do so. Before putting any decision to vote, the Chair will summarise the outcome of the discussion and the proposal(s) for the members to vote on.

5.20 Where a vote is taken, the decision shall be determined by a majority of votes of the members present and voting on the question. In the case of an equality of votes, the Chair shall have a second or casting vote. The Chair may determine the method for taking the vote, which may be by a show of hands, or by ballot, or any other method the Chair determines.

5.21 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting.

Board Meeting in Private Session

5.22 The Board may agree to meet in private in order to consider certain items of business. The Board may decide to meet in private on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

5.23 The minutes of the meeting will reflect when the Board has resolved to meet in private.

Minutes

5.24 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded in the minute of the meeting. The names of other persons in attendance shall also be recorded.

5.25 The Board Secretary (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall review the draft minutes at the following meeting. The person presiding at that meeting shall sign the approved minute which will be held electronically.

## 6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at an NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board:

a) Standing Orders
b) The establishment and terms of reference of all its committees, and appointment of committee members
c) Organisational Values
d) The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
e) The Annual Delivery Plan for submission to the Scottish Government for its approval. (Note: The Board should consider the draft for submission in private session. Once the Scottish Government has approved the Annual Delivery Plan, the Board should receive it at a public Board meeting.)

f) Corporate objectives or corporate plans which have been created to implement its agreed strategies.
g) Risk Management Policy.
h) Financial plan for the forthcoming year, and the opening revenue and capital budgets.
i) Standing Financial Instructions and a Scheme of Delegation.
j) Annual accounts and report. (Note: This must be considered in private by the Board. In order to respect Parliamentary Privilege, the Board cannot publish the annual accounts or any information drawn from it before the accounts are laid before the Scottish Parliament. Similarly the Board cannot publish the report of the external auditors of their annual accounts in this period.)
k) Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
l) The Board shall approve the content, format, and frequency of performance reporting to the Board.
m) The appointment of the Board's chief internal auditor. (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The Audit and Risk committee should advise the Board on the appointment, and the Board may delegate to the Audit and Risk committee oversight of the process which leads to a recommendation for appointment.)

Within the above the Board may delegate some decision making to one or more executive Board members.

6.3 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the integration schemes for a local authority area.

6.4 The Board itself may resolve that other items of business be presented to it for approval.

## 7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved for the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board's approval of the Standing Financial Instructions (Section G) and the Scheme of Delegation (Section F).

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

## 8 Execution of Documents

8.1 Where a document requires to be authenticated under legislation or rule of law relating to the authentication of documents under the Law of Scotland, or where a document is otherwise required to be authenticated on behalf of the Board, it shall be signed by an executive member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

8.2 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

8.3 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

## 9 Committees

9.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. NHS Scotland Board Development website will identify the committees which the Board must establish. (https://learn.nes.nhs.scot/17367/board-development)

9.2 The Board shall appoint the chairs of all committees. The Board shall approve the terms of reference and membership of the committees. The Board shall review these as and when required and shall review the terms within 2 years of their approval if there has not been a review.

9.3 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

9.4 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

9.5 The Board's Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings where the committee's membership consist of or include all the Board members. Where the committee's members include some of the Board's members, the committee's meetings shall not be held in public and the associated committee papers shall not be placed on the Board's website, unless the Board specifically elects otherwise. Generally, Board members who are not members of a committee may attend a committee meeting and have access to the meeting papers. However, if the committee elects to consider certain items as restricted

business, then the meeting papers for those items will normally only be provided to members of that committee. The person presiding the committee meeting may agree to share the meeting papers for restricted business papers with others.

9.6 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time and shall call a meeting when requested to do so by the Board.

9.7 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee's business. A co-opted member is one who is not a member of Borders NHS Board and is not to be counted when determining the committee's quorum.

## 10. Freedom of Information (Scotland) Act 2002

10.1 The Freedom of Information (Scotland) Act 2002 (FOI(S)A) was introduced by the Scottish Parliament to ensure that people have the right to access information held by Scottish public authorities. The Act states that any person can receive information that they request from a public authority, subject to certain exemptions such as protection of personal data and commercial interests, or national security. It came into force on 1 January 2005 and is retrospective, so that it includes all records held by the Board prior to 2005 as well as since that date.

10.2 Under FOI(S)A NHS Borders is required to:

- Provide applicants with help and assistance in finding the information they require within a given timescale;
- Maintain a publication scheme of information to be routinely published;
- Put in processes for responding to enquiries and undertaking appeals against decisions to withhold information.

10.3 Information as defined under FOI(S)A includes copies or extracts, including drafts, of any documents such as:

- reports and planning documents;
- committee minutes and notes;
- correspondence including e-mails;
- statistical information.

10.4 The FOI(S)A provides a range of exemptions which may be applied allowing the public authority to withhold information. Exemptions must be considered on a case by case basis and may be applied to all or only part of the information requested.

10.5 All documents will be scrutinised for information which may be withheld under an exemption to the Act prior to release.

10.6 Full details of the FOI(S)A exemptions and how to apply them can be found in the Freedom of Information (Scotland) Act 2002 which is available on the NHS Borders intranet Information Governance site at

http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

10.7 Briefings on how to apply exemptions can be found on the Scottish Information Commissioners website at http://www.itspublicknowledge.info/ScottishPublicAuthorities/ScottishPublicAuthorities.asp.

10.8 For further advice on the Freedom of Information (Scotland) Act 2002, processes and application contact the Freedom of Information Officer or Communications Team.

## 11. Records management

11.1 Under the Freedom of Information (Scotland) Act 2002, NHS Borders must have comprehensive records management systems and process in place which must give clear guidance on time limits for the retention of records and documents.

11.2 Separate guidance has been produced for records management. The NHS Borders Records Management Policy can be found on the NHS Borders Intranet Information Governance site at http://intranet/new_intranet/microsites/index.asp?siteid=41&uid=2

# 3. STANDING COMMITTEES

## 1. Establishing Committees

1.1 The Board on the recommendation of the Chair shall create such Committees, as are required by statute, guidance, regulation and Ministerial direction and as are necessary for the economical efficient and effective governance of the Boards' business.

1.2 The Board shall delegate to such Committees those matters they consider appropriate. The matters delegated shall be set out in the Purpose and Remits of those Committees detailed in Paragraph 8, Purpose and Remits

1.3 The Chair may vary the number, constitution and functions of Committees at any meeting by specifying the proposed variation.

## 2. Membership

2.1 The Board on the recommendation of the Chair shall appoint the membership of Committees on an annual basis. By virtue of their appointment the Chair of the Board is an ex officio member of all Committees except the Audit & Risk Committee.

2.2 The Board on the recommendation of the Chair shall appoint the Chairs of the Governance Committees of NHS Borders Board.

2.3 Any Committee, shall include at least one Non-Executive Member of the Board, and may include persons, who are co-opted, and may consist wholly or partly of Members of the Board.

2.4 In recommending to the Board the membership of Committees, the Chair shall have due regard to the Committee purpose, role and remit, and accountability requirements as well as the skills and experience of individual Non Executives and any requirements associated with their recruitment. Certain members may not be appointed to serve on a particular Committee as a consequence of their positions. Specific exclusions are:

- Audit & Risk Committee - Chair of the Board together with any Executive Member or Officer.
- Remuneration Committee - any Executive Member or Officer.

2.5 The Board on the recommendation of the Chair has the power to vary the membership of Committees at any time, provided that this is not contrary to statute, regulation or direction by Scottish Ministers and is in accordance with the paragraph 2.4 above.

2.6 The Board on the recommendation of the Chair shall appoint Vice-Chairs of Committees. In the case of Members of the Board, this shall be dependent upon their continuing membership of the Board.

2.7 The persons appointed as Chairs of Committees shall usually be Non-Executive Members of the Board and only in exceptional circumstances shall the Chair recommend to the Board the appointment of a Chair of a Committee who is not a Non-Executive Member, such circumstances are to be recorded in the Minutes of the Board meeting approving the appointment.

2.8 Casual vacancies occurring in any Committee shall be filled as soon as may be practical by the Chair after the vacancy takes place.

## 3. Functioning

3.1 An Executive member or another specified Lead Officer shall be appointed to support the functioning of each Committee.

3.2 Committees may seek the approval of the Chair to appoint Sub-Committees for such purposes as may be necessary.

3.3 Committees may from time to time establish working groups for such purposes as may be necessary.

3.4 Where the functions of the Board are being carried out by Committees, the membership, including those co-opted members who are not members of the Board, are deemed to be acting on behalf of the Board.

3.5 During intervals between meetings of the Board or its Committees, the Chair of the Board or the Chair of a Committee or in their absence, the Vice Chair shall, in conjunction with the Chief Executive and the Lead Officer concerned, have powers to deal with matters of urgency which fall within the terms of reference of the Committee and require a decision which would normally be taken by the Committee. All decisions so taken should be reported to the next full meeting of the relevant Committee. It shall be for the Chair of the Committee, in consultation with the Chief Executive and Lead Officer concerned, to determine whether a matter is urgent in terms of this Standing Order.

## 4. Minutes

4.1 The approved Minute of each Committee of the Board shall be submitted as soon as is practicable to an ordinary meeting of the Board for information, and for the consideration of any recommendations having been made by the Committee concerned.

4.2 The Minute of each Committee meeting shall also be submitted to the next meeting of the Committee for approval as a correct record.

4.3 Minutes of the proceedings at a meeting of a Special Committee shall be made but these proceedings may be reported to the Board or to any Committee of the Board either by the Minutes or in a report from the Special Committee as may be considered appropriate.

## 5. Frequency

5.1 The Committees of the Board shall meet no fewer than four times a year.

## 6. Delegation

6.1 Each Committee shall have delegated authority to determine any matter within its purpose and remit, with the exception of any specific restrictions contained in Section F, Section 1 (Reservation of powers and delegation of authority – Matters reserved for Board agreement only).

6.2 Committees shall conduct their business within their purpose and remit, and in exercising their authority, shall do so in accordance with the following provisions. However, in relation to any matter either not specifically referred to in the purpose and remit, or in these Standing Orders, it shall be competent for the Committee, whose remit the matter most closely resembles, to consider such matter and to make any appropriate recommendations to the Board.

6.3 Committees must conduct all business in accordance with NHS Borders policies and the Code of Corporate Governance.

6.4 The Chair may deal with any matter falling within the purpose and remit of any Committee without the requirement of receiving a report of or Minute of that Committee referring to that matter.

6.5 The Chair may at any time, vary, add to, restrict or recall any reference or delegation to any Committee. Specific direction by the Chair in relation to the remit of a Committee shall take precedence over the terms of any provision in the purpose and remit.

6.6 If a matter is of common or joint interest to a number of Committees, and is a delegated matter, no action shall be taken until all Committees have considered the matter.

6.7 In the event of a disagreement between Committees in respect of any such proposal or recommendation, which falls within the delegated authority of one Committee, the decision of that Committee shall prevail. If the matter is referred but not delegated to any Committee, a report summarising the views of the various Committees shall be prepared by the appropriate officer and shall appear as an item of business on the agenda of the next convenient meeting of the Board.

## 7. Committees

- Resources and Performance Committee
  - Capital Investment Group (sub-committee of Resources & Performance Committee)
- Audit & Risk Committee
- Information Governance Committee (sub-committee of Audit & Risk Committee)
- Clinical Governance Committee

    - Infection Control Committee (sub-committee of Clinical Governance Committee)
    - Environmental Risk Oversight Committee (sub-committee of Clinical Governance Committee)
- Staff Governance Committee
- Remuneration Committee (sub-committee of Staff Governance Committee)
- Public Governance Committee
- Area Clinical Forum
- Area Partnership Forum
- Pharmacy Practices Committee

## 8. Purpose and Remits

## A) RESOURCES AND PERFORMANCE COMMITTEE

### 1.1 Purpose

The Resources and Performance Committee (R&PC) is established in accordance with NHS Borders Board Standing Orders and Scheme of Delegation.

The Resources and Performance Committee is a Standing Committee of the NHS Board.

The overall purpose of the Resources and Performance Committee is to provide assurance across the healthcare system regarding resources and performance, ensure alignment across whole system planning and commissioning, and to discharge the delegated responsibility from the NHS Board in respect of asset management.

The Committee will receive reports, and draft plans for review and response in respect of; Finance, Performance, Capital, Asset Management, national and regional planning groups and the Health and Social Care Partnership strategic plan.

The Committee will oversee the development of a Financial Strategy for approval by the Board that is consistent with the principle of Patient Safety as our number one priority, but with reference to all other national and local priorities.

The Committee will act as the Performance Management Committee of the Board, the Service Redesign Committee of the Board and influence the early development of the strategic direction of the Board.

The scope of resource will include finance, workforce, property and technology.

### 1.2 Composition

Membership of the Committee shall be:

- Chair of the Board (Chair)
- All Non Executive Directors
- Chief Executive
- Director of Public Health
- Medical Director
- Director of Nursing, Midwifery & AHPs
- Director of Acute Services
- Director of Quality & Improvement
- Director of Finance
- Director of Workforce
- Director of Planning & Performance
- Chief Officer Health & Social Care Integration (accountable for the performance of the partnership and the delivery of the delegated services).
- Partnership Representative

Attendees shall be:

- Board Secretary (Secretariat)

Attendees may be invited to the Committee at the discretion of the Chair and it is anticipated, depending on the issues to be discussed, that other key individuals from the wider organisation will be asked to attend.

The Lead Officer for the Resources and Performance Committee shall be the Chief Executive.

### 1.3 Meetings

Meetings of the Resources and Performance Committee will be quorate when one third of the whole number of members, of which at least two are Non Executive Members are present.

The Committee will be chaired by the Chair of the Board.

The Committee will meet no less than 4 times per year and conduct its proceedings in compliance with the Standing Orders of the Board.

The Chair of the Committee, in conjunction with the Chief Executive shall set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business or through the Committee Chair.

The agenda and supporting papers will be sent out by the Board Secretary, at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The Committee will be supported by the Board Secretary who will submit the minutes for approval at the next Resources and Performance Committee meeting, prior to submission to the Board.

To avoid the Committee's agenda becoming over-burdened and unmanageable specific pieces of work may be delegated to the appropriate Director, sub group or short-life task and finish groups reporting to the Committee with very specific remits, objectives, timescales and membership.

### 1.4 Remit

The remit of the Resources and Performance Committee is to scrutinise the following key areas and provide assurance to the Board regarding:

- Whole system strategic planning including oversight of the healthcare services delegated to the IJB;
- Whole system financial planning, including an overview of budgets delegated;
- Compliance with statutory financial requirements and achievement of financial targets;
- Such financial monitoring and reporting arrangements as may be specified from time-to-time by Scottish Government Health & Social Care Directorates and/or the Board;
- The impact of planned future policies and known or foreseeable future developments on the underlying financial position of the Board;

- To review the development of the Board's Financial Strategy over a three year period and the Board's Annual Financial Plan making recommendations to the Board;
- The Property and Asset Management Strategy and Capital Plans of NHS Borders.
- The Board's performance against relevant targets and key performance indicators linked to the Scottish Outcomes framework.
- Whole system technology planning.
- Whole system workforce planning.

Appropriate governance in respect of risks, as allocated to the Committee by the NHS Board and/or Audit & Risk Committee relating to finance, planning, performance and property, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

### 1.5 Property and Asset Management

To ensure that the Property & Asset Management Strategy is in line with the Board's strategic direction and;

- that the Board's property and assets are developed, and maintained to meet the needs of 21st Century service models;
- that developments are supported by affordable and deliverable Business Cases with detailed project implementation plans with key milestones for timely delivery, on budget and to agreed standard;
- that the property portfolio of NHS Borders and key activities relating to property are appropriately progressed and managed within the relevant guidance and legislative framework, including assessment of backlog maintenance;
- that there is a robust approach to all major property and land issues and all acquisitions and disposals are in line with the Property Transaction Handbook (PTHB);
- to review the Capital Plan and submit to the NHS Board for approval and oversee the overall development of major schemes, including approval of capital investment business cases. The Committee will also monitor the implications of time slippage and / or cost overrun and will instruct and review the outcome of the post project evaluation;
- to review all Initial Agreements, Outline Business Cases and Full Business Cases and recommend to the NHS Board in line with the Scheme of Delegation.

To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance.

### 1.6 Arrangements for Securing Best Value

The Committee shall keep under review arrangements for securing economy, efficiency and effectiveness in the use of resources. These arrangements will include procedures for:

- The planning, appraisal, control, accountability and evaluation of the use of current and future resources.

- Reporting and reviewing performance and managing performance issues as they arise in a timely and effective manner. In particular, the Committee will review action (proposed or underway) to ensure that the Board achieves financial balance in line with its statutory requirements.
- The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

### 1.7 Allocation and Use of Resources

The Committee has key responsibility for:

- Reviewing the development of the Board's Financial Strategy in support of the Integration Joint Board Strategic Plan, Annual Delivery Plan and Regional Delivery Plans, and recommending approval to the Board.
- Reviewing and agreeing the level of budget to be provided to the IJB for the functions delegated and make recommendations to the Board.
- Reviewing the H&SCI Strategic Plan to ensure the outcomes can be delivered within the Board's revenue and capital plans.
- Reviewing all resource allocation proposals outwith authority delegated by the Board and make recommendations to the Board.
- Monitoring the use of resources available to the Board.
- Reviewing the Property Strategy (including the acquisition and disposal of property) and make recommendations to the Board.

Specifically, the Committee is charged with recommending to the Board annual revenue and capital budgets and financial plans consistent with its statutory financial responsibilities. It shall also have responsibility for the oversight of the Board's Capital Programme (including individual Business Cases for Capital Investment); the review of the Property Strategy (including the acquisition and disposal of property); the review of all business cases coming forward for recommendation to the Board; and for making recommendations to the Board as appropriate on any issue within its terms of reference.

### 1.8 Strategy Development

The Committee will review the development of the NHS Board's Strategic Plan, ensuring that strategic planning objectives are aligned with the NHS Board's overall strategic vision, aims and objectives.

The Committee will scrutinise the development of all strategies which require approval by the Board, including the Annual Delivery Plan.

The Committee will ensure that strategies are compliant with the duties of the Board in respect of meeting legislative and good practice requirements.

The Committee will also ensure that there is an integrated approach to planning ensuring that workforce, finance and service planning are linked.

The Committee will ensure appropriate inclusion of National and Regional Planning requirements and monitor overall progress with the East of Scotland planning agenda.

The Committee will ensure NHS Borders input, at an appropriate level, to the draft IJB Strategic Plan, and promote consistency and coherence across the system highlighting issues which may impact the delivery of NHS Board aims and objectives.

### 1.9 Service Redesign/Transformation

The Committee will provide appropriate oversight to significant service redesign including security for cases for change and to ensure this is progressed in a collaborative way working across health, social care and other organisations, with explicit links between service redesign, service improvement, workforce planning and the strategic priorities for NHS Scotland.

The Committee will review and scrutinise all business cases coming forward and recommend for approval by the Board as appropriate.

### 1.10 Performance Management

The Committee will review the NHS Board Performance Management Framework ensuring it is in line with the National Performance Framework and make recommendations to the NHS Board.

The Committee will review the NHS Board's overall performance and planning objectives, and ensure mechanisms are in place to promote best value, improved efficiency and effectiveness and decision making across the healthcare system

The Committee may, from time to time, review individual services in relation to performance management, ensuring that health care is delivered to an efficient and cost-effective level.

The Committee will seek assurance on a rigorous and systematic approach to performance monitoring and reporting across the whole healthcare system to enable more strategic and better informed discussions to take place at the NHS Board.

The Committee will seek assurance as to the adoption of a risk based approach to performance management through routine review. This will focus on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against whole system performance targets.

The Committee will maintain oversight of progress with the implementation of the financial improvement programme, receive reports, receive assurance on effective engagement, and provide support and advice.

### 1.11 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and is authorised to seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee.

In order to fulfil its remit the Resources and Performance Committee may obtain whatever professional advice it requires, and require other individuals to attend meetings as required.

### 1.12 Reporting Arrangements

The Resources and Performance Committee reports to the Board.

The minutes of the Resources and Performance Committee meetings will be submitted to the next meeting of the Resources and Performance Committee for approval.

The minutes will then be presented to the following Ordinary Meetings of the Board for noting.

### 1.13 Review

The Terms of Reference of the Resources and Performance Committee will be reviewed on an annual basis.

The Resources & Performance Committee shall undertake an annual self assessment of the Committee's work.

## B) CAPITAL INVESTMENT GROUP

### 1.1 Purpose

The group is established in order to provide a vehicle for management to address the requirements of the Board and its Committees with respect to the development of infrastructure strategy and related capital investment.

The NHS Borders Capital Investment Group (BCIG) will be responsible for the development and management of the Board's Property and Asset Management Strategy (PAMS) and associated capital plan, including prioritisation of resources available to the plan, and the monitoring of progress against same. The group will also undertake review and approval of capital business cases in line with the revised governance framework (to be developed).

The group will be responsible for ensuring that there are appropriate governance arrangements in place in relation to property and asset management, including compliance with the mandatory requirements of 'A policy for property and asset management in NHS Scotland', the Scottish Capital Investment Manual (SCIM), Scottish Public Finance Manual (SPFM) and the NHS Scotland Property Transactions Handbook (PTH).

### 1.2 Key Principles

In undertaking its business, the group will seek to meet the following functions:

- To provide **assurance** to the Board via the Resources& Performance Committee, on the strategic fit, appropriateness and value for money of capital investment, property and asset management proposals presented to it.

- To provide **accountability** by fulfilling its role as a decision-making body of the Board in respect of matters delegated to BCIG under the Board's scheme of delegation, and in making recommendations to the Board in relation to capital investment, property and asset management.

- To provide an **advisory** role to the Board in relation to capital investment or disinvestment issues.

### 1.3 Membership

- Director of Finance (Chair)
- Director of Planning and Performance (Vice-Chair)
- Head of Estates
- Head of Estates Projects
- Head of IM&T, or deputy
- Head of Planning & Performance
- Deputy Director of Finance
- Head of Procurement
- Acute Services Representative
- Primary & Community Services Representative
- Mental Health & Learning Disabilities Representative
- Corporate Services Representative
- Partnership Representative
- Medical Director (or Representative)
- Finance Business Partners

It is the responsibility of members to nominate a deputy if they are unable to attend any meeting.

### 1.4 Decision Making

For matters of prioritisation or approval, the meeting must be quorate.

To be quorate each meeting will have a minimum of 1 Director and no less than a total of six members, which must include:

- A member, or nominated deputy, from each Clinical Board (Acute services, PACS, Mental Health/LD) and from Corporate Services
- Head of Estates or Head of Estates Projects
- A Finance representative (if Director of Finance not present)
- A Planning & Performance representative (if Director of Planning & Performance not present)
- Head of IM&T (if Director of Planning & Performance not present)

Decisions will be made by consensus. A veto may be exercised by agreement of both Chair and Vice-Chair.

The Group may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

It is the responsibility of the member to read all papers prior to the meeting to ensure the agenda is followed in a timely manner.

### 1.5 Frequency of Meetings

A full meeting will be undertaken quarterly in line with the preparation of the Board's annual plan and its quarterly review cycle. Meetings will be scheduled to align with the business cycle of the Resources & Performance Committee.

Additional meetings will be scheduled according to need during those months where there is no full meeting scheduled. Where no decisions are required attendance at these meetings will be determined on the basis of business need.

The agenda and papers will be issued at least seven working days in advance of the meeting.

### 1.6 Remit

The remit of the group is:

- To ensure that the Board's Property & Asset Management Strategy (PAMS) is prepared in line with the requirements of CEL 35 (2010), is aligned to the Board's clinical and other relevant strategies, and is subject to review on a regular basis.

- To ensure there are arrangements in place for the monitoring of property transactions and compliance with the NHS Scotland Property Transactions Handbook, including acquisition and disposal of assets by purchase, sale or lease.

- To provide challenge and scrutiny to the development of business cases in relation to the suitability, feasibility and acceptability of the plans described.

- To ensure that business cases are prepared in line with the requirements of the Scottish Capital Investment Manual (SCIM).

- To review and/or approve business cases for capital investment within the limits of delegated authority.

- To review proposed applications for funding, including external and charitable funding, in order to assess and make recommendations as appropriate.

- To make recommendation to the Board (and its Committees) in relation to the prioritisation of capital resources through the development of a five year capital plan.

- To make recommendation and/or approve the utilisation of in year slippage arising from the Board's capital plan.

- To ensure that arrangements are in place for the post-project evaluation of capital investments.

### 1.7 Reporting Arrangements

The NHS Borders Capital Investment Group will report to the Board's Resources & Performance Committee.

A Capital monitoring report will be prepared quarterly for review by the group prior to submission to the Resources & Performance Committee.

Specific pieces of work will be delegated to an appropriate officer or to short-life working groups, where appropriate.

### 1.8 Sub Groups

The group may constitute such sub-groups as required to meet the requirements of its workplan.

### 1.9 Review

Membership and frequency of the Group will be reviewed annually.

The NHS Borders Capital Investment Group shall undertake an annual self-assessment of the Committee's work.

## C) AUDIT & RISK COMMITTEE

### 1.1 Purpose

To assist the Board in the delivery of its responsibilities for issues of risk, control and governance and associated assurance including the conduct of conduct of public business and the stewardship of funds under its control.

To provide assurance to the Board that:

- An appropriate system of internal control is in place
- Business is conducted in accordance with the law and proper standards
- Public money is safeguarded and properly accounted for
- Governance arrangements are in place to cover the NHS functions which are delegated and the resources which are provided to the IJB are satisfactory, fully utilised, regularly reviewed and updated
- Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question
- Affairs are managed to secure economic, efficient and effective use of resources
- Reasonable steps are taken to prevent and detect fraud and other irregularities
- Effective processes and systems of Risk Management are in place
- Assurance from risk owners that review and mitigation is undertaken for very high risks.
- Effective systems of Information Governance are in place

### 1.2 Membership

**Non Executive Members**
4 core members from the non-executive members, excluding the following:

- Chair of the Board

**Chair of the Committee**
A core non-executive member of the Audit & Risk Committee shall be appointed as the Chair of the Committee by the Chair of the Board.

Ordinarily the Audit & Risk Committee Chair cannot be the Chair of any other Governance Committee of the Board. The Governance Committees are the Staff Governance Committee, Clinical Governance Committee, Information Governance and Public Governance Committee.

**In Attendance**
**Executive Directors**

- Chief Executive (as Accountable Officer)
- Director of Finance, Procurement, Estates and Facilities (as Chief Finance Officer)
- Director of Quality and Improvement (as Lead for Risk Management)
- Director of Acute Services

**Other Attendees**

- Chief Internal Auditor
- External Auditor
- Deputy Director of Finance – Head of Finance

Other officers of the board may be invited to the Committee at the discretion of the Chair.

The Lead Officer for the Audit & Risk Committee shall be the Director of Finance, Procurement and Estates and Facilities.

The committee will be supported by a nominated P.A.

### 1.3 Meetings

The committee will meet at least four times a year. The Chair of the Committee may convene additional meetings as he/she deems necessary;

The Board or Accountable Officer may ask the committee to convene further meetings to discuss particular issues on which they want the committee's advice;

The Audit & Risk Committee Chair will have the power to exclude all others except members from a meeting.

The quorum for the Audit & Risk Committee shall be two non-executive members.

The Chair of the Committee, in conjunction with the Director of Finance as Lead Officer for the Committee, will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under AOB ('Any Other Business') or through the committee chair.

A workplan approved on an annual basis by the Committee will identify the key items of business to be discussed at each meeting.

The agenda and supporting papers will be sent out at least seven days in advance of the meetings to allow time for members' due consideration of issues.

Formal minutes and an action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out. The minutes will be submitted for approval at the next Audit & Risk Committee meeting, prior to submission to the Board.

The Chief Internal Auditor and the representative of the appointed external auditors shall have free and confidential access to the Chair of the Audit & Risk Committee.

### 1.4 Remit

The main objectives of the Audit & Risk Committee are to ensure compliance with NHS Borders's Code of Corporate Governance and to seek assurance on the effectiveness of the Board's systems of governance, internal control and risk management.

The duties of the Audit & Risk Committee are in accordance with the Scottish Government Audit & Risk Committee Handbook and are as detailed below.

**Internal Control and Corporate Governance**

To evaluate the framework of internal control and corporate governance comprising the following components:

- Control environment (including financial and non-financial controls).
- Information Governance and communication.
- Risk Management.
- Control procedures.
- Decision making processes.
- Monitoring and corrective action.
- Annual review of the Governance Framework and the Governance Statement (as included within the Board's Annual Report and Accounts), including review of assurance statements from Executive directors and Board Committees.

To review the system of internal financial control, including:

- Safeguarding of assets against unauthorised use and disposition
- Maintaining proper accounting records and the reliability of financial information used within the organisation or for publication
- Ensuring that the Board's activities are within the law, regulations, Ministerial Direction and the Board's Code of Corporate Governance.
- Presenting an annual Statement of Assurance on the above to the Board, in support of the Governance Statement by the Chief Executive.

**Internal Audit**

- Make recommendation to the Board for the appointment of its Chief Internal Auditor and Internal Audit service following appropriate procurement.
- Review and approve the arrangements for delivery of Internal Audit.
- Review and approve the Internal Audit Strategic and Annual Plan.
- Review all Internal Audit reports and disseminate to the relevant Board Committees in line with the Internal Audit Protocol.
- Ensure that executive leads are held accountable for the delivery of actions arising from audit recommendations within agreed timescales; review any actions where completion date falls due outwith the financial year within which the report has been prepared.
- Consideration of the Chief Internal Auditor's Annual Report and Assurance Statement.
- Review the operational effectiveness of Internal Audit by considering the audit standards, resources, staffing, technical competency and performance measures.
- Ensure that there is direct contact between the Audit & Risk Committee and Internal Audit and to meet with the Chief Internal Auditor at least once per year and as required, without the presence of Executive Directors.
- Collaboratively work with the other partner bodies in support of the functions delegated to the IJB.

**External Audit**

- Note the appointment and remuneration of the External Auditors and to examine any reason for the resignation or dismissal of the Auditors.
- Review the annual Audit Plan including the Performance Audit programme.
- Consideration of all statutory audit material for the Board, in particular:
    - Audit reports (including Performance Audit studies)
    - Annual Report
    - Chief Executive Letters
- Monitor management action taken in response to all External Audit recommendations, including VFM studies
- Review of matters relating to the Certification of the Board's Annual Report and Accounts (Exchequer Funds), Annual Patients' Private Funds Accounts, Annual Endowment Funds Accounts and the Annual IJB Accounts
- Meet with the External Auditors at least once per year and as required, without the presence of the Executive Directors
- Review the extent of co-operation between External and Internal Audit.
- Annually appraise the performance of the External Auditors
- Review the terms of reference, appointment and remuneration of external auditors for the Board Endowment Funds and Patient Funds Accounts

**Code of Corporate Governance**

- Review the Code of Corporate Governance which includes Standing Orders, Schemes of Reservation and Delegation, Standing Financial Instructions and recommend amendments to the Board;
- Examine the circumstances associated with each occasion when Standing Orders have been waived or suspended;
- Review and assess the operation of any Schemes of Delegation;

- Monitor compliance with the Members' Code of Conduct.

**Annual Report and Accounts**

- Undertake scrutiny of the accounting policies, the accounts, and the annual report of the organisation, including the process for review of the accounts prior to submission for audit, levels of error identified, and management's letter of representation to the external auditors;
- Review and recommend for approval the Health Board Consolidated Annual Report & Accounts;
- Review the Annual Accounts for the NHS Borders Endowment Funds;
- Review and recommend for approval the Annual Accounts for Patients' Funds;
- Review schedules of losses and compensation payments.

**Other Matters**
The Committee shall:

- Review the arrangements that the Board has in place for the prevention and detection of fraud, and will receive regular reports on the business activities progressed by the Board's local Countering Fraud Operational Group.
- Monitor how the Board addresses risk in relation to potential litigation;
- Review the effectiveness of arrangements in place for the development, implementation and monitoring of directions issued by the Scottish Borders Integration Joint Board.
- Promote the use of audit reports as improvement tools by ensuring that they are directed for the attention of appropriate individuals or groups;
- Review and report on any other matter referred to the Committee by the Board;
- Review its own performance and effectiveness, including its running costs and terms of reference on an annual basis;
- Keep up to date by having a mechanism to ensure topical legal and regulatory requirements are brought to Members' attention;
- Review any arrangements in place for special investigations, where these arise.

### 1.5 Best value

The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

### 1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, may seek any information it requires from any employee. All Members, employees and agents of the Board are directed to co-operate with any request made by the Committee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

### 1.7 Reporting Arrangements

- The Audit & Risk Committee reports to the Board;
- Following a meeting of the Audit & Risk Committee, the minutes of that meeting should be approved at the next Committee meeting and then presented at the following Board meeting;
- The Audit & Risk Committee should annually, and within three months of the start of the financial year, approve a work plan detailing the work to be taken forward by the Audit & Risk Committee;
- The Audit & Risk Committee will produce an Annual Assurance Statement which describes the outcomes of work undertaken by the Committee during the year in order to provide assurance to the Board that the Committee has met its remit. This statement must be presented to the Board meeting considering the Annual Accounts.

### 1.8 Review

The Terms of Reference of the Audit & Risk Committee will be reviewed on an annual basis.

## D) INFORMATION GOVERNANCE COMMITTEE

### 1.1 Introduction

NHS Borders hereby resolves to establish a committee to be known as the Information Governance Committee (the Committee).

### 1.2 Role

To provide assurance to NHS Borders Audit & Risk Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

### 1.3 Membership

**Committee membership**

- Medical Director, Chair
- Caldicott Guardian, Vice chair
- Senior Information Risk Officer [SIRO]
- Chief Clinical Information Officer (CCIO)
- Acute Services representative
- Primary & Community Services representative
- Mental Health & Learning Disability representative
- General Practitioner
- Area Partnership Forum representative
- Finance representative
- Head of IM&T
- Director of Quality and Improvement
- Information Governance & Cyber Assurance Manager

**In attendance**

- Information Governance Lead
- Data Protection Facilitator
- Freedom of Information Officer
- Cyber Security Manager
- Committee Administrator

Meetings will not be quorate and no business will be transacted if less than 50% of the members or their representatives are present. Members are to nominate a deputy if they are unable to attend.

Others will also be invited to attend as the Committee sees fit.

### 1.4 Frequency

Meetings shall be held not less than 4 times per annum.

In the event of a planned meeting not being quorate, the recommendations of those who attended will be circulated within 7 days of the meeting for agreement by the majority of the Committee.

The Chair may convene a meeting of the Committee at any time, or when requested by the Audit Committee, and has the authority to exclude all others except members from a meeting.

If an event of significance to the Committee arises between meetings, the Director of Planning & Performance (as executive lead for Information Governance), or their nominated deputy, will bring this to the attention of the chair of the Committee.

The agenda and supporting papers will be sent to members at least 5 working days before the date of the meeting.

Any additional papers can be circulated via email.

### 1.5 Authority

The Committee is authorised by the Audit Committee to investigate any activity within its Terms of Reference. It is also authorised to seek any information it requires from any member, employee or agent of NHS Borders. All members, employees and agents of NHS Borders are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Audit Committee to obtain outside legal or other independent professional advice and to secure the attendance of others with relevant experience and expertise if it considers this necessary.

### 1.6 Scope

The Information Governance Committee to provide assurance to NHS Borders Audit Committee that the Board is compliant with legislation relating to information governance, and that robust delivery systems and processes are in place to support this.

The duties of the committee are to:

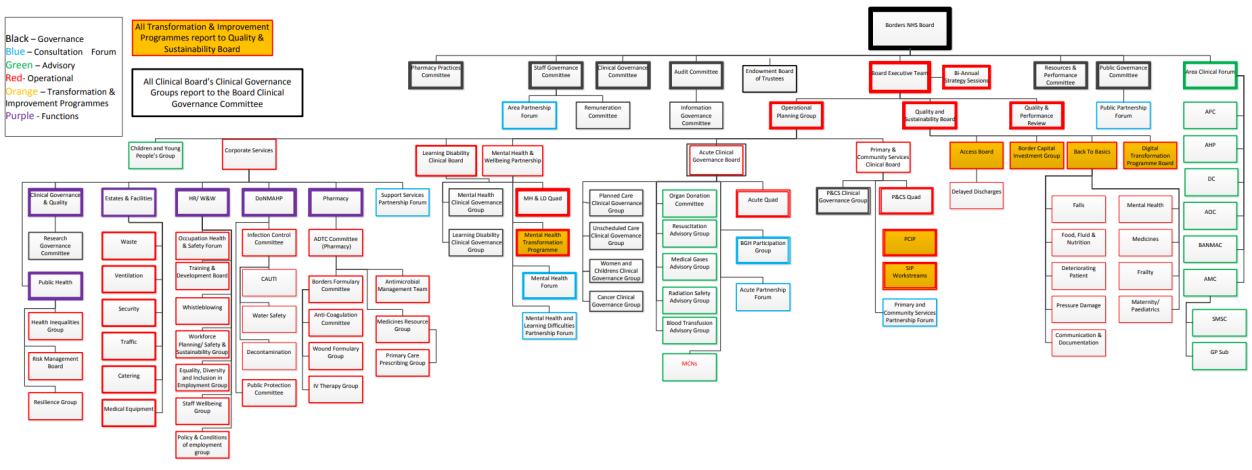
- Ensure that appropriate structures and systems are in place to support and deliver Information governance.
- Assure NHS Borders Audit Committee that these structures are operating effectively
- Ensure NHS Borders complies with UK and Scottish legislation in respect to Information Governance.
- Assist in the development and review of Information Governance policies
- Approve Policies and supporting guidelines as required
- Provide a vehicle for dissemination of Information Governance information with the aim of applying continuity and consistency across NHS Borders.
- Highlight to the Clinical Executive-Operational Group identified trends and developments in Information Governance that may affect the workforce, patients and others.
- Ensure NHS Borders complies with NHS Scotland Information Governance and policies and procedures
- Promote best practice throughout NHS Borders in all Information Governance matters.
- Provide regular reports to NHS Borders Audit Committee by submission of the approved minutes, and report any specific significant problems as they emerge.

These duties will be discharged through a standing agenda, which will include reporting on the following key activities:

- Caldicott / Confidentiality
- Data Protection
- Education, training and staff awareness on Information Governance
- Freedom of Information
- Incident review and monitoring
- IT Security and Cyber Security
- Records Management

These key activities will be amended as required and formally reviewed annually.

**Reporting Arrangements**



The committee is operationally accountable to the Clinical Executive with scrutiny and assurance resting with the Board's Audit Committee.

Minutes will be kept of the proceedings of the Committee. The draft minutes are to be circulated, within ten working days to the Chair of the Committee, and within five working days thereafter to members.

The Chair of Committee shall provide assurance on the work of the Committee and the approved minutes will be submitted to the Operational Planning Group meeting for information.

The Committee will conduct an annual review of its role and function

**Appendix 1**

**Definitions**

**Information Governance** means handling information in a confidential and secure manner to appropriate ethical and quality standards. Information Governance is a key issue for all NHS organisations and is fundamental to the effective delivery of health services, particularly as we move towards an electronic health record.

**IT Security** protects the information and also the physical infrastructure that supports the information from theft or damage to the hardware, software or electronic data, as well as from disruption or misdirection of the services they provide. IT Security also covers the creation of policies and standards to ensure all information is protected.

**Cyber Security** is solely concerned with preventing electronic attacks against electronic data.

**Key Business Areas / Legislative**

- Data Protection Act 2018
- Networks and Information Systems Regulations 2018
- UK General Data Protection Regulation
- EU General Data Protection Regulation
- Freedom of Information (Scotland) Act 2002
- Confidentiality: NHS Scotland Code of Practice
- Public Records (Scotland) Act 2011 – Records Management
- Information Security Standards
- Caldicott Guardianship

## E) CLINICAL GOVERNANCE COMMITTEE

### 1.1 Purpose

To provide the Board with the assurance that clinical governance controls are in place and effective across NHS Borders.

## 1.2 Composition

### a) Membership

The Clinical Governance Committee is appointed by the Board and shall be composed of four Non-Executive Board members, one of whom shall be the Chair of the Area Clinical Forum. One of these members shall be appointed as Chair. Membership will be reviewed annually.

### b) Appointment of Chair

The Chair and Vice Chair of the Committee shall be appointed by NHS Borders Board Chair.

### c) Attendance

Executive Directors of the Board are not eligible for membership of the Committee. The following NHS Board officers or their representatives will normally attend meetings.

- Director of Quality & Improvement
- Chief Executive
- Director of Acute Services
- Medical Director
- Director of Public Health
- Director of Nursing, Midwifery & Allied Health Professionals
- Director of Psychological Services
- Director of Pharmacy
- Associate Medical Directors
- Lead Nurse for Patient Safety and Care Assurance *Associate*
- Directors of Nursing
- Associate Director of Allied Health Professions
- Associate Director for Midwifery and General Manager for Women & Children Services
- Infection Control Manager
- Risk Manager

Others will also be invited to attend as the Committee sees fit.

All Board Members have the right to attend meetings and have access to all papers, except where the committee resolves otherwise.

## 1.3 Meetings

### a) Frequency

The Clinical Governance Committee will meet six times a year to fulfil its remit.

### b) Agenda and Papers

The Chair of the Committee, in conjunction with the nominated lead Executive and the Director of Quality & Improvement will set the agenda for the meetings. Committee members who wish to raise items for consideration on future agendas can do so under Any Other Business (AOB) or through the Committee Chair.

The agenda and supporting papers will be sent out by the Committee Administrator, seven days in advance of the meetings to allow time for members' due consideration of issues.

### c) Quorum

Two members of the Committee, including the Chair, will constitute a quorum. If the Chair is not available, the Vice-Chair will chair the meeting. If neither the Chair nor Vice-Chair is available, the other members will decide who will chair the meeting.

### d) Minutes

Formal minutes will be kept of the proceedings by the Committee Administrator and submitted for approval at the next Clinical Governance Committee meeting, prior to submission to the Board.

Recognising the issue of relative timing and scheduling of meetings, minutes of the Clinical Governance Committee may be presented in draft form to the next available Board meeting.

The draft minutes will be cleared by the Chair of the Committee and the nominated lead Executive prior to submission to the Board.

### e) Other

In order to fulfill its remit, the Clinical Governance Committee may, within current financial constraints, obtain whatever professional advice it requires and invite, if necessary, external experts and relevant members of board staff to attend meetings.

If necessary, meetings of the Committee shall be convened and attended exclusively by members of the Committee.

## 1.4 Remit

The main duties of the Clinical Governance Committee are to receive assurances that clinical governance controls are in place and effective across NHS Borders, on behalf of NHS Borders Board; and that the principles of clinical governance are applied to the health improvement activities of the Board.

### a) General

- assure the Board that appropriate structures are in place to undertake activities which underpin clinical governance;
- review the systems of clinical governance, monitoring that they operate effectively and that action is being taken to address any areas of concern;
- review the mechanisms which exist to engage effectively with healthcare partners and the public;

- encourage a continuous improvement in service quality;
- ensure that an appropriate approach is in place to deal with clinical risk management, including patient safety, across the NHS Borders system;
- review performance in management of clinical risk.
- monitor complaints response performance on behalf of the Board;
- promote positive complaints handling, advocacy and feedback including learning from adverse events;
- monitor the processes whereby infections are monitored and controlled;
- monitor mortality in and out of hospital with specific reference to unexpected or unusual deaths;
- receive reports on child and adult protection activities;
- produce an Annual Clinical Governance Report;
- ensure that appropriate action plans are developed, implemented and monitored as a result of published national reports and inquiries; and
- assure the Board that appropriate structures are in place to ensure robust links to the Healthcare Quality Strategy

**b) Internal Monitoring**

- review the Internal Clinical Governance annual audit priorities;
- make recommendations to the NHS Borders Audit Committee on the requirements for internal audit to support clinical activities;
- receive and consider Clinical Audit Reports along with regular Progress Reports;
- review the actions taken by the Chief Executive, Medical Director and Director of Nursing, Midwifery and Allied Health Professionals on any recommendations or issues arising from Audit Reports; and
- review the effectiveness of the Clinical Audit Programme.

**c) External Monitoring**

- review Audit Reports from external monitoring bodies in relation to clinical governance; and
- monitor and report to the Board that appropriate actions in relation to external review and monitoring of clinical governance are being taken.

### 1.5 Risk Reporting

The Committee shall receive reports from relevant service leads within the areas of its remit. As a result of these reports, and considering areas of interest to the Committee, any areas of risk shall be highlighted and reported.

An action tracker arising from Committee business shall be kept to record, identify and ensure actions are carried out.

### 1.6 Best Value

The Committee shall review its own performance, effectiveness, including its running costs, and terms of reference on an annual basis. The outcome of this review shall be included in the Annual Report.

### 1.7 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

### 1.8 Reporting Arrangements

The Clinical Governance Committee is a standing committee of the Board and is accountable to the Board and shall formally report to the Board through the Annual Report. Otherwise reporting shall be by exception reporting.

The Chair of the Committee shall submit an Annual Assurance Statement on the work of the Committee to the Board. The timing of this will align to the Board's consideration of the Chief Executive's Statement of Internal Control for the associated financial year.

The Clinical Governance Committee shall undertake an annual self assessment of the Committee's Work.

## F) INFECTION CONTROL COMMITTEE

### 1.1 Purpose

This committee fulfils the requirements of the Scottish Government Health Directorates (SGHD), outlined in HDL (2001) 53 and HDL (2005) 8, for all NHS Boards to establish an Infection Control Committee.

The Infection Control Committee (ICC) exists to maintain an overview of infection control priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that infection control issues are managed and escalated appropriately.

### 1.2 Composition

The Committee includes appropriate representation from across NHS Borders as detailed below:-

| Committee Member | Named Deputy | Quorum - Committee Requirements |
|---|---|---|
| Director of Nursing & Midwifery and AHPs (HAI Executive Lead) (Chair) | Associate Directors of Nursing (ADON) as nominated | Minimum of 1 Committee Member or Deputy |
| Medical Director | Associate Medical Directors or Clinical Director as nominated | Minimum of 1 Committee Member or Deputy |
| Consultant Microbiologist (ICD) | Not applicable | Minimum of 2 or more of the ICD, ICM or IPCN |
| Infection Control Manager (ICM) | Senior Infection Control Nurse | |
| Infection Prevention & Control Nurse (IPCN) | Not applicable | |
| Consultant in Public Health | Health Protection Nurse | |

| | | |
|---|---|---|
| Medicine (CPHM) | (HPN) | |
| BGH Representative (Associate Director of Nursing) (Deputy Chair) | General Manager, Clinical Service Manager or Clinical Nurse Manager | Minimum of 1 Committee Member or Deputy |
| Primary and Community Services Representative (Clinical Nurse Manager) | Primary and Community Services Representative (Clinical Nurse Manager) | Minimum of 1 Committee Member or Deputy |
| Mental Health and Learning Difficulties Representative (Operational Manager) | Mental Health Representative and Learning Difficulties (Operational Manager) | Minimum of 1 Committee Member or Deputy |
| Head of Estates | Estates Manager | |
| Head of Soft FM (Facilities) | Facilities Team Lead | |
| Head of Quality and Clinical Governance | Clinical Governance and Quality Facilitator | |
| Antimicrobial Pharmacist | Pharmacist as nominated | |
| Head of Occupational Health | Occupational Health Nurse Manager | |
| Head of Health and Safety | Safety Advisor | |
| Member of public | Not applicable | |
| Staff Side Representative | Staff Side Representative as nominated | |

## 1.3 Meetings

### Frequency of Meetings

The ICC meets every 6 weeks. Patient specific details will not be discussed. If there is a high level of interest from members of the public in joining the Committee, selection will be through an interview process.

### Secretarial Support and Minutes

The Infection Control Administrator will provide admin support to the ICC.

At least seven days notice will be given of the agenda. Minutes will be ratified at each meeting and agreed and noted as a correct record by the Committee.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Committee meeting or support working sub-groups.

### Quorum and Voting

Quorum of the Committee is as indicated under section 1.2.

### Circulation of Minutes

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

## 1.4 Remit

- Approves the national and local objectives and priorities for targeted surveillance of infection.
- Approves the annual Infection Control Workplan.
- Monitors the progress of the annual Infection Control Workplan
- Responsible for assessment of levels of compliance with National HAI Standards.
- Receives reports and monitors action plans following HEI inspections.
- Critically review infection control surveillance data and evidence of actions implemented to reduce the incidence of HAI
- Provide guidance and support in the development of actions specific to Infection Prevention & Control.
- Consider risks to be added to the risk register and monitor
- Monitors infection related incidents and oversees related actions
- Provide assurance to NHS Boards Board in relation to Infection Prevention & Control.
- Provides advice and support on the implementation of policies/ procedures /guidelines.
- Delegated authority to approve all infection control policies.
- Approves the annual infection control audit programme and monitors progress, actions and learning from audits.

- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of infection control is in place.
- Tasks the Infection Prevention & Control Team and Health Protection Team to investigate and manage outbreaks of infection. Reports will be presented to ICC following an outbreak incident.

**Duties of membership:**

**Chair**

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to infection control.
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.
- Formally write to Committee members and their line manager if they fail to attend 3 consecutive meetings.

**Committee Members:**

- Nominate deputy if unable to attend
- Provide advice and support to the Infection Control Team (ICT) and the Health Protection Team (HPT).
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

### 1.5 Risk Reporting

The Committee will routinely review infection control risks and escalate as appropriate.

### 1.6 Best Value

Membership and frequency of the Committee meetings will be regularly reviewed.
Clear description of agenda items, and opportunity provided to public representatives to a pre-meeting briefing.

### 1.7 Authority

As detailed in the remit, the Committee monitors progress against the Infection Control Work Plan, provides assurance and escalates risks and issues, and approves Infection Control Policies.

### 1.8 Reporting Arrangements

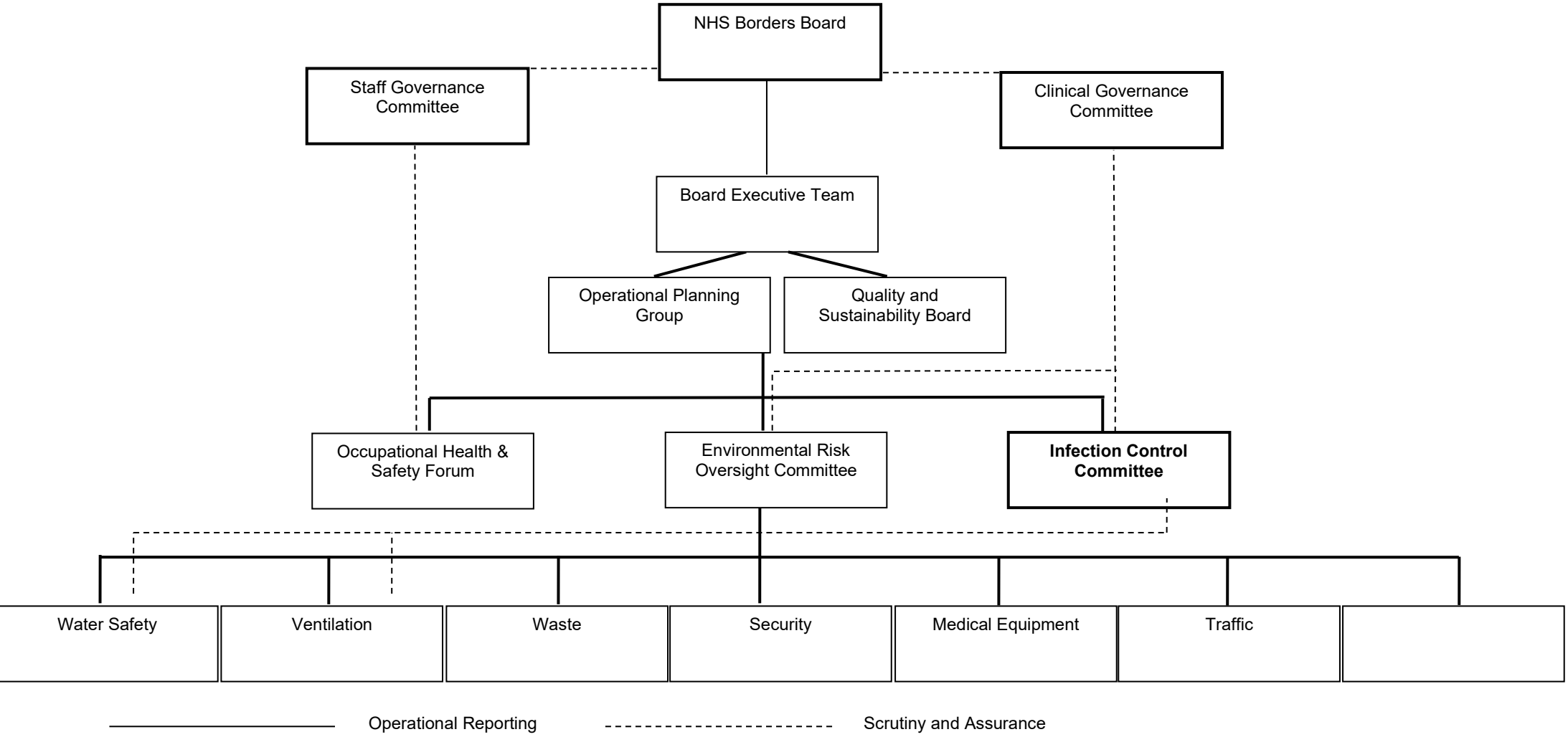
The ICC formally reports to the Operational Planning Group with a dotted line to the Clinical Governance Committee for scrutiny and assurance.

### 1.9 Accountability Arrangements

Refer to Appendix 1

# Infection Control Committee – Reporting Structure

**Appendix 1**



## G) ENVIRONMENTAL RISK OVERSIGHT COMMITTEE

### 1.5 Purpose

This Group fulfils the requirements of CEL35 (2010), the Scottish Health Technical Memorandums and Notes and Health and Safety Legislation. Statutory compliance relating to inspection, operations and management of assets.

The Environmental Risk Oversight Group (EROG) exists to maintain an overview of environmental risk priorities across NHS Borders, and to link into the healthcare governance processes. It will ensure that environmental risk issues are managed and escalated appropriately.

This group is constituted to provide specialist technical oversight to areas of risk relating to the built environment. It does not replace the existing risk management functions performed by other groups including: Infection Control Committee, Occupational Health & Safety Forum, Operational Planning Group (OPG).

### 1.6 Composition

The Group includes appropriate representation from across NHS Borders as detailed below:

| Group Member | Named Deputy | Quorum - Group Requirements |
|---|---|---|
| Director of Finance | Director of Quality and Improvement | Minimum of 1 Group Member or Deputy |
| Director of Quality and Improvement | Director of Finance | |
| Consultant Microbiologist (ICD) | Not applicable | Minimum of 1 Group Member or Deputy |
| Infection Control Manager (ICM) | Senior Infection Control Nurse | |
| Head of Hard FM (Estates) | Estates Programme Manager | Minimum of 1 Group Member or Deputy |
| Estates Programme Manager | Head of Hard FM (Estates) | |
| Head of Soft FM (Facilities) | Not applicable | |
| Risk Manager | Not applicable | |
| Head of Health and Safety | Health and Safety Lead Advisor | Minimum of 1 Group Member or Deputy |
| Partnership Representative* | Not required | N/A |

*Partnership attendance is optional. All risks under review will be considered through separate forums in line with risk management policy.

### a) Frequency of Meetings

The EROC meets every 6 weeks.

### b) Secretarial Support and Minutes

The BET administrative team will provide admin support to the EROC.

At least seven day's notice will be given of the agenda.

Members who are unable to attend will send a deputy as indicated under section 1.2. Membership will be reviewed at least annually.

Other staff representatives may be co-opted as necessary to attend either the full Group meeting or support working sub-groups.

**c) Quorum and Voting**

Quorum of the Group is as indicated under section 1.2.

**d) Circulation of Minutes**

Minutes of the meetings will be circulated to all members and will be submitted to the Clinical Governance Committee.

**1.7 Remit**

- Provide oversight of environmental risks outwith risk appetite to assess further actions needed and make recommendations to the organisation where further resources are required
- Monitor levels of compliance with statutory and other guidance and for maintaining a record of non-compliance and the mitigating actions
- Monitor risk around the built environment including considering, recording and recommending derogations to any standards
- Develop and maintain the Board policy for derogations
- Receives and considers escalation from sub-groups
- Receives reports and monitors action plans following inspections or internal/external audit
- Provide assurance to NHS Boards Board and sub-committees in relation to Environmental Risk.
- Monitor compliance with the annual statutory audit and compliance risk tool programme and monitors progress
- Co-operates and participates in the periodic audits undertaken by the Board's Internal Audit when relevant to provide assurance that an effective system of control is in place.

**1.4 Duties of membership:**

**Chair**

- Nominate a deputy in their absence.
- Ensures all members have access to up-to-date legislation and guidance relevant to Estates and Environmental Risk
- Escalate very high risks, as considered from the Board risk appetite approach to the Operational Planning Group
- Escalate to the Clinical Governance Committee appropriate risks that have been identified together with actions being taken to minimise the level of risk.

- Formally write to Group members and their line manager if they fail to attend 3 consecutive meetings.

**Group Members:**

- Nominate deputy if unable to attend
- Provide advice and support to the Estates and Facilities Teams
- Consider the impact on the organisation of legislation, HDL, Scottish Government directives, and other relevant standards and reports

### 1.10 Risk Reporting

The Group will routinely review environmental risks and escalate as appropriate.

### 1.11 Best Value

Membership and frequency of the Group meetings will be regularly reviewed.

### 1.12 Authority

As detailed in the remit, the Group monitors progress against the Estates Work Plan, provides assurance and escalates risks and issues.

### 1.13 Reporting Arrangements

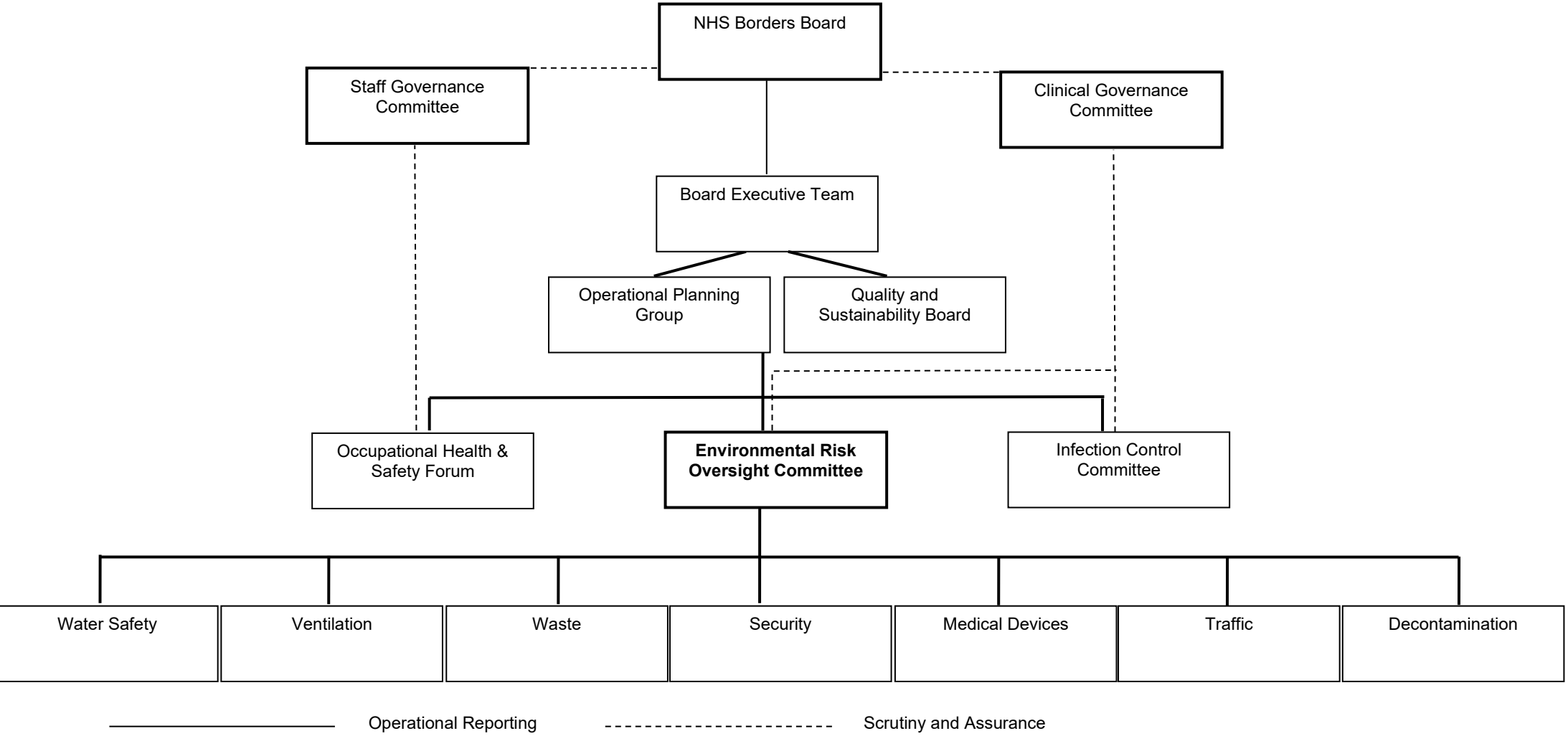
The EROC formally reports to the Operational Planning Group on matters relating to operational performance, risk and financial control. The EROC will provide assurance through the Operational Planning Group.

### 1.14 Accountability Arrangements

Refer to Appendix 1

# Environmental Risk Oversight Group Reporting Structure

**Appendix 1**



## H) STAFF GOVERNANCE COMMITTEE

### 1.1 Purpose

To advise the Board on its responsibility, accountability and performance against the NHS Scotland Staff Governance Standard and Whistleblowing Standards; addressing the issues of policy, targets and organisational effectiveness. The NHS Reform (Scotland) Act requires Boards to put and keep in place arrangements for the purpose of improving the management of the officers employed, monitoring such management, and workforce planning. This will be demonstrated through achievement and progress towards the Staff Governance Standard through:

- Scrutiny of performance against individual elements of the Staff Governance Standards.
- Data collected during the self-assessment audit conducted under the auspices of the Area Partnership Forum.
- The action plans submitted to, and approved by, the Staff Governance Committee.
- iMatter / Everyone Matters / Collecting Your Voices results.
- Whistleblowing activity data.
- Data and information provided in statistical returns reports to the Committee.

### 1.2 Membership

Membership of the Staff Governance Committee will be:

- A minimum of four Non-Executive Members, one of whom must be the Employee Director and one the Whistleblowing Champion.

In addition there will be in attendance:

- Partnership Leads - Staff-side, from Local Partnership Forums
- Director of HR, OD & OH&S and Deputy Director(s) of HR
- Other Directors (as appropriate)
- Head of Work & Wellbeing
- OD Lead
- Health & Safety Advisor
- Practice Development Lead

The Chief Executive and Chair will attend at least one Staff Governance Committee meeting per year.

The Committee may invite additional attendees as required by the agenda.

### 1.3 Meetings

Meetings of the Committee will be quorate when two Non-Executive Members are present.

A Non-Executive Member will act as Chair to the meeting.

### 1.4 Remit

- To monitor performance of the Health Board against the Staff Governance Standard.
- To fulfil a monitoring, promotion and assurance role with Whistleblowing activity within NHS Borders and ensure compliance with the Once for Scotland/Independent National Whistleblowing Officer Standards.
- To monitor and evaluate Workforce strategies and implementation plans.
- To monitor pay modernisation processes.
- To monitor compliance with Statute and encourage best practice around equality, diversity & inclusion in employment.
- As appropriate, to work collegiately with the Area Partnership Forum (APF) which has the responsibility for ensuring effective partnership working between management and staff at all levels in NHS Borders.
- To receive and note annual reports from the Remuneration Committee.
- To ensure implementation of Once For Scotland Workforce Policies.
- To provide timely Staff Governance information required for national monitoring arrangements.
- To provide Staff Governance information for the Statement of Internal Control.
- To approve and monitor any NHS Borders Workforce Plan.
- To monitor and challenge against the Staff Governance Committee Dashboard data.
- To receive and note National reports on whistleblowing and give assurance to Board on this or escalate concerns to same.
- To receive and note annual report/updates from the OH&S Forum.

### 1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from Borders NHS Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

### 1.6 Authority

The Committee is authorised by the Board to investigate any activity within its terms of reference, and in so doing, is authorised to seek any information it requires from any employee. The Committee is required to review its Terms of Reference on an annual basis.

The Committee is authorised by the Board to obtain independent professional advice and to secure attendance of others with relevant experience and expertise if it considers it necessary.

### 1.7 Reporting Arrangements

- The Staff Governance Committee reports to Borders NHS Board.
- Following a meeting of the Staff Governance Committee, the Minutes of that meeting should be presented at the next Borders NHS Board meeting.
- The Staff Governance Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Staff Governance Committee.

- The Staff Governance Committee will produce an Annual Report for presentation to Borders NHS Board. The Annual Report will describe the outcomes from the Committee during the year and provide an assurance to the Board that the Committee has met its remit during the year. The Annual Report must be presented to a Board meeting prior to the Audit & Risk Committee considering the Annual Accounts.

## G) REMUNERATION COMMITTEE

### 1.1 Purpose

The fourth edition of the Staff Governance Standard made clear that each NHSScotland Board is required to establish a Remuneration Committee, whose main function is to ensure application and implementation of fair and equitable pay systems on behalf of the Board as determined by Ministers and the Scottish Government and applies to Executives and Senior Managers only.

### 1.2 Composition

- The Chair of the Board (who will be the Chair);
- The Vice Chair of the Board
- The Employee Director
- Two other Non-Executive Members

In addition there will be in attendance:

- Board Secretary
- Chief Executive
- Director of HR, OD & OH&S
- Associate Director of Workforce

At the request of the Committee, other Senior Officers may also be invited to attend.

All members of the Remuneration Committee will require to be appropriately trained to carry out their role on the Committee.

No employee of the Board shall be present when any issue relating to their employment is being discussed.

### 1.3 Meetings

The Committee will meet no less than 3 times per annum**.**

Remuneration issues may arise between meetings and will be brought to the attention of the Chair of the Remuneration Committee by the Chief Executive or the Director of HR, OD & OH&S. The Chair may call a special meeting of the Remuneration Committee to address the issue.

Meetings of the Committee will be quorate when three Non-Executive Members are present.

### 1.4 Remit

The Remuneration Committee will oversee the remuneration arrangements for Executive Directors and others under the Executive Cohort and Senior Manager Pay Systems and also to discharge specific responsibilities on behalf of the Board as an employing organisation.

Ensure that arrangements are in place to comply with NHS Borders Performance Assessment Agreement and Scottish Government direction and guidance for determining the employment, remuneration, terms and conditions of employment for Executive Directors, in particular:-

- Approving the personal objectives of all Executive Directors in the context of NHS Borders's Annual Delivery Plan, Corporate Objectives and other local, regional and national policy

- receiving formal reports on the operation of remuneration arrangements and the outcomes of the annual assessment of performance and remuneration for each of the Executive Directors.

Ensure that arrangements are in place to determine the remuneration, terms and conditions and performance assessment for other staff employed under the 'Executive Cohort' and 'Senior Manager' pay systems. The Committee will receive formal reports annually providing evidence of the effective operation of these arrangements.

Promote the adoption of an NHS Borders approach to issues of remuneration and performance assessment to ensure consistency.

Undertake reviews of aspects of remuneration/employment policy for Executive Directors (e.g. Relocation Policy) and other Senior staff (e.g. special remuneration), when requested by NHS Borders Board.

The Remuneration Committee shall approve, reject or seek amendment to proposed severance packages ie financial packages to incentivise an employee leaving the employment of NHS Borders by mutual consent. These are usually progressed through use of a Settlement Agreement which is a legal document which requires ultimate sign off by Scottish Government. Where matters are time critical, the proposal may be circulated around the Remuneration Committee by email, if there is no upcoming formal meeting.

Consider and keep under regular review the arrangements for those NHS Borders staff on external secondments.

To be assured as to the proper processes of the Discretionary Points Committee in the award of discretionary points to eligible specialist, medical and dental staff based on competent recommendations from the appropriate advisory bodies, and to receive reports from the Committee for approval.

To have oversight of the consultant recruitment process on behalf of the Board, who are responsible for the recruitment, and authorisation of appointments of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009.

### 1.4.1 Confidentiality and Committee Decisions

Decisions reached by the Committee will be by agreement and with all Members agreeing to abide by such decisions (to the extent that they are in accordance with the constitution of the Committee). All Members will treat the business of the Committee as confidential. The Committee may in certain circumstances decide a voting approach is required with the Chair having a second and casting vote.

### 1.4.2 Minutes and Reports

Reports issued to Members will contain full details of the issues to be considered with clear recommendations to the Committee. The minutes will record the decisions reached by the Committee with due regard to confidentiality in relation to individuals.

## 1.5 Best value

The Committee is responsible for reviewing those aspects of the Best Value work plan which are delegated to it from the Board. The Committee will put in place arrangements which will provide assurance to the Chief Executive as Accountable Officer, that NHS Borders has systems and processes in place to secure best value for these delegated areas.

## 1.6 Authority

The Remuneration Committee is authorised by the Board to investigate any activity within its terms of reference, and in doing so, is authorised to seek any information it requires about any employee.

In order to fulfil its remit, the Remuneration Committee may obtain whatever professional advice it requires, and it may require Directors or other officers of NHS Borders to attend meetings.

## 1.7 Reporting Arrangements

The Remuneration Committee reports through the Staff Governance Committee to the Board;

Following a meeting of the Remuneration Committee the minutes of that meeting shall be marked as “confidential” and made available to the Non Executive Directors.

The Remuneration Committee should annually and within three months of the start of the financial year provide a work plan detailing the work to be taken forward by the Remuneration Committee.

The Remuneration Committee will produce a high level Annual Report for presentation to the Staff Governance Committee to provide assurance that the Remuneration Committee is addressing appropriate business in line with due process.

The Remuneration Committee will through the Staff Governance Committee provide an annual assurance that systems and procedures are in place to manage the pay arrangements for all Executive Directors and others under the Executive Cohort and Senior Manager pay systems so that overarching Staff Governance responsibilities can be discharged. The Staff Governance Committee will not be given the detail of confidential

employment issues that are considered by the Remuneration Committee; these can only be considered by the Non-Executive Members of the Board.

The Annual Report will be prepared as close as possible to the end of the financial year but in enough time to allow it to be considered by the Staff Governance Committee. This is to ensure that the Staff Governance Committee is in a position in its annual report to provide the annual assurance that systems and procedures are in place to manage the pay arrangements for all staff employed in NHS Borders.

### 1.8 Review

The Terms of Reference of the Remuneration Committee will be reviewed on an annual basis. The Remuneration Committee will undertake an annual self assessment.

## H) PUBLIC GOVERNANCE COMMITTEE

### 1.1 Introduction and Remit

The Public Governance Committee has been established as a Committee of the Board to provide assurance to the Board that the requirements of engaging, involving and consulting the public takes place efficiently and effectively in a person centred way in line with statutory obligations and policy requirements and to provide oversight to the Board's activities with regards to health inequalities in terms of unfair, unjustified variation in access to and / or outcomes from NHS services.

### 1.2 Arrangement for Conduct of Business

The Public Governance Committee will operate within the terms of the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members, and in keeping with the values of NHS Borders.

### 1.3 Meetings

**Frequency**

Meetings will be held every 3 months, with a minimum of 3 meetings in any one calendar year.

**Membership**

The Public Governance Committee shall consist of:

- A minimum of 3 Non Executive members of the Board appointed by the Board;
- A minimum of 3 independent external members and lay representatives appointed by the Board.

The Chair of the Board shall not be a member of the Public Governance Committee but will attend at least one meeting per year.

**Quorum**

The quorum of the Committee shall be 4 members of which 2 must be Non Executives of the Board and 2 must be from the independent external and lay representative membership.

**Attendance**

- Director of Planning & Performance (Executive lead for public engagement and involvement
- Director of Public Health (Executive lead for population health)
- Head of Communications and Engagement
- Public Involvement Officer
- HIS-CE Senior Manager
- Health & Social Care Partnership representative
- Health Improvement & Equalities representative
- Area Clinical Forum representative
- Clinical Board representatives

Shall normally be in attendance at meetings.

Other officers of statutory and third sector organisations and NHS Borders may attend for specific items of interest as required, such as the Director of Quality & Improvement, third sector representatives.

All Board members are entitled to attend the Committee, except where the Committee determine to undertake business in private.

All Committee members and attendees are entitled to receive papers one week prior to the meeting for the Committee's consideration.

Meetings will ordinarily be held virtually through Microsoft Teams. The Committee will aspire to hold at least one in-person meeting per year and will hold this outwith NHS Borders premises.

## 1.4 Key Duties of the Committee

The Public Governance Committee will provide assurance to the Board and Accountable Officer that:

- Equality and Diversity and Health Inequalities requirements are executed, reported, and monitored in line with applicable legislation and policy, recognising the Staff Governance Committee is also vital to governance of staff-side equalities issues.
- Public and patient involvement in service change, improvement and redesign is undertaken, reported and monitored in line with Scottish Government policies and legislative requirements.
- Community Empowerment (Scotland) Act 2015 Public Participation Requests are reported and monitored.
- There is a cross referencing and linkage to the Clinical Governance Committee where appropriate.
- There is a cross referencing and linkage to the Staff Governance Committee where appropriate.

- Accountability structures are in place for any public involvement workstreams.
- There is a sharing of information and issues relating to Human Rights.
- Assurance is sought from risk owners that any strategic risks delegated by the Board to the Committee for oversight and scrutiny are being managed in accordance with current risk management processes and systems.

### 1.5 Authority

The Public Governance Committee is a mandatory Committee of the Board and is authorised by the Board to:

- Investigate any activity which is within its terms of reference, and in doing so, is authorised to seek any information it requires from any employee. All members and employees are directed to co-operate with any request made by the Committee

- obtain external advice and to secure the attendance at meetings of persons from outside of the Board who bring relevant expertise and experience if the Committee considers this necessary

- consider and endorse/approve relevant board wide policies

- consider relevant risks in regard to communication and engagement and health inequalities and whether they need to be escalated to the Board for inclusion in the Corporate Risk Register

### 1.6 Reporting Arrangements

The Public Governance Committee will report to the Board, and will submit an Annual Report on its activities, outcomes and self-assessment to the Board.

The Public Governance Committee shall annually agree a workplan detailing the work to be taken forward by the Committee during that year.

The Public Governance Committee shall annually review its Terms of Reference and submit them to the Board Secretary by November each year.

The minutes of the Public Governance Committee will be presented to the Board, and the Chairperson, or nominated deputy, shall advise the Board of any matters of particular significance discussed by the Committee.

## l) AREA CLINICAL FORUM (ACF)

The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- Draw on the full range of professional skills and expertise in their area for advice on clinical matters both locally and on national policy issues;

- Promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process to support the NHS Board in the conduct of its business.

## 1.1 Purpose

To formulate comprehensive clinical advice to the Board on matters of policy and implementation. The Committee will consult widely with its constituency and the Board. It will be pro-active in:

- reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups;
- the provision of a clinical perspective on the development of the Local Delivery Plan and the strategic objectives of the NHS Board;
- sharing best practice and encouraging multi-professional working in healthcare and health improvement;
- ensuring effective and efficient engagement of clinicians in service design, development and improvement;
- providing a local clinical and professional perspective on national policy issues;
- Ensuring that local strategic and corporate developments fully reflect clinical service delivery;
- Taking an integrated clinical and professional perspective on the impact of national policies at local level;
- Through the ACF Chair, being fully engaged in NHS Board business; and
- supporting the NHS Board in the conduct of its business through the provision of multi-professional clinical advice.

At the request of Borders NHS Board, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- Investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi- disciplinary advice.
- Advise Borders NHS Board of the impact of national policies on the integration of services, both within the local NHS systems and across health and social care.

**Authority:** The Area Clinical Forum is an Advisory Committee of the Borders NHS Board.

**Reporting Arrangements:** The Area Clinical Forum will report to Borders NHS Board and submit an Annual Report on its activities to the NHS Board.

The approved minutes of the ACF will be presented in to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken.

**Membership:** The Area Clinical Forum will consist of the chair, vice chair and another identified representative of each of the statutory Area Professional Committees as follows:-

- Area Allied Health Professionals Committee
- Area Medical Committee
- Area Dental Committee
- Area Optical Committee
- Area Nursing and Midwifery Committee
- Area Pharmaceutical Committee
- Healthcare Scientists Advisory Committee
- Psychologists Team

**Others in Attendance:** The Committee may invite others to attend a meeting for discussion of specific items. That person may take part in the discussion but will not have a vote.

**Sub Committees:** The Committee may appoint ad hoc Short Life Working Sub-Committees as appropriate to consider and provide advice on specific issues.

**Tenure:** Individual members tenure will be determined by the constitution of their parent Committee. If a member resigns or retires, the appropriate Advisory Committee will choose a replacement. Individuals shall cease to be members of the Area Clinical Forum on ceasing to be the Chair, Vice Chair or identified representative of their professional committee.

**Officers**

**Chair:** The Committee shall elect a Chair. This shall be on the basis of one vote for each of the Committee members. The Chair shall be elected for 4 years in line with the appointment tenure of Non Executives to the Board. He/she will be eligible for a maximum of 2 consecutive terms of office.

Selection of the Chair will be an open process, and all members may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot (Annex A).

The Chair of the Area Clinical Forum will, subject to formal appointment by the Cabinet Secretary for Health and Wellbeing, serve as a Non-Executive member of Borders NHS Board.

Membership of Borders NHS Board is specific to the office rather than to the person. The normal term of appointment for Board members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

Where the members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Non-Executive member of Borders NHS Board, the new Chair will have to be formally nominated to the Cabinet Secretary as a Non-Executive member of Borders NHS Board for approval.

In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a member of the Area Clinical Forum.

**Vice-Chair:** The Committee shall then elect a Vice-Chair. The tenure shall be the same as for the Chair.

A Vice Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all members may put themselves forward as candidates for the position. If more than one person puts themself forward an election will be held by secret ballot.

The Vice Chair will deputise, as appropriate, for the Chair, but where this involves participation in the business of Borders NHS Board, they will not be functioning as a Non-Executive member.

**Secretary:** The Secretary shall be provided by the NHS Board.

## Conditions

**Interests:** Members must declare any pecuniary or other interest which could be construed as influencing the advice given to the NHS Board, and must not participate in discussion leading to that advice.

**Removal:** An Office Bearer may be removed from office at a meeting of the Committee only if the removal has been included as an agenda item. Such removal would require the agreement of two thirds of the members of the Committee.

**Executive Powers:** The Chair (or in his/her absence the Vice Chair) will have discretionary powers to act on behalf of the Committee but in doing so is answerable to the Committee.

**Membership of the NHS Board:** The Chair will be appointed by the Cabinet Secretary as a full member of Borders NHS Board.

**Conduct:** All members will have due regard to and operate within NHS Borders Code of Corporate Governance.

## Standing Orders

**Notice of Meetings:** The Secretary will ensure that the agenda and relevant papers are issued at least seven days before the meeting whenever possible.

**Minutes:** The Secretary will ensure that the minutes of the meetings of the Committee are sent to the each member with the agenda and papers of the next meeting.

**Meetings:** Meetings will be held bi-monthly although the Committee may vary these arrangements to cover holiday months or other circumstances.

**Quorum:** A quorum of the Committee will be one third of the members. In the event that the Chair and Vice Chair are both absent, the members present shall elect from those in attendance, a person to act as chair for the meeting.

**Voting:** Where the Committee is asked to give advice on a matter and a majority vote is reached the Chair or Secretary will record the majority view but will also make known any significant minority opinion and present the supporting arguments for both view points.

**Alterations to the Constitution and Standing Orders:** Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Committee provided notice of the proposed alteration is circulated with the notice of the meeting and that the proposal is seconded and supported by two-thirds of the members present and voting at the meeting.

Any alterations must be submitted to the NHS Board for approval.

## ANNEX A

## ACF CHAIR ELECTION PROCESS

- Election to be carried out during ACF meeting.
- The current chair will ask for nominations from the ACF members and check nominees willingness to stand for election.
- If there is more than 1 nominee each will be asked to briefly inform the ACF what will be their approach to the role, how they will involve the members and how they will develop the ACF (no more than 5 minutes each).
- Each ACF member will have 1 vote (they may vote for themselves).
- Each member will write their chosen candidate on a paper slip and pass to the secretary.
- The Board Secretary will check the votes and announce the winner.
- In the event of a draw then the Board Secretary will announce this to the ACF.
- Candidates will be asked if they wish to add anything to their earlier statements.
- The ACF members will then vote again.
- If there is a second draw the Board Secretary will announce this and the Chair will ask the members if they are likely to change their vote.
- If not then the decision will be referred to a panel of 3 Non Executive Directors. Candidates will give a short presentation to the panel on their approach to the role, how they will involve the members and how they will develop the ACF.
- The panel will then make a decision and inform the existing Chair.
- Once a decision is made the Board Secretary will then make the appropriate arrangements.

- The ACF Vice Chair will be appointed via the same process

## J) AREA PARTNERSHIP FORUM (APF)

### 1. Purpose

The Area Partnership Forum is a strategic body which is responsible for facilitating, monitoring and evaluating the effective operation of partnership working across NHS Borders. It further acts to endorse HR policies, procedures & protocols through the partnership process, recognising the Once for Scotland context.

### 1.1 Remit

The Area Partnership Forum will:

- Take a proactive approach in embedding partnership working at all levels of the organisation to assist the process of devolved decision making and to develop effective working relationships;
- Endorse, implement & monitor adherence to all HR Policies;
- Consider and comment on other corporate policies/strategies, assessing the impact of strategic decisions upon staff and making sure policies are underpinned by appropriate Staff Governance and financial planning disciplines;
- Support the work of the Staff Governance Committee;
- Ensure the best HR practice is shared across the health board;
- Contribute to the development of strategies and action plans;
- Oversee, monitor and evaluate the roll-out of staff surveys;
- Liaise with national industrial relations bodies such as the Scottish Partnership Forum and STAC;
- Contribute to local and regional planning arrangements;
- Ensure adequate and necessary Facilities Arrangements are in place;
- Making sure that the views of all Staff Side with an interest in improving local health and healthcare services, local communities and healthcare staff are appropriately heard and considered;
- Ensure the Area Partnership Forum has knowledge and understanding of national issues;
- Ensure that in its close working with the Training, Education & Development (TED) Board, that all staff are effectively trained, properly supported and performance is formally reviewed on an annual basis.

### 1.2 Authority

The Forum is authorised by NHS Borders to investigate any activity within its terms of reference. In order to fulfil its remit, the Area Partnership Forum may obtain whatever professional advice it requires (including that from professional/trade union/national or local representatives) and require Directors or other officers of the Board to attend meetings.

The external Auditor and Chief Internal Auditor shall have the right of direct access to the Joint Chairs of the Area Partnership Forum.

The Forum is authorised by the Board to endorse & adopt Once for Scotland HR policies and any other more localised protocols through the partnership process.

### 1.3 Reporting Arrangements

- The Area Partnership Forum acts as a sub-group of, and reports to, the Staff Governance Committee which in turn is a sub-committee of the Board;
- Following a meeting of the Area Partnership Forum, the approved minutes of that meeting will be presented for information at the next meeting of the Staff Governance Committee;
- The Area Partnership Forum shall annually and within three months of the start of each financial year provide, approve and agree a workplan detailing the work to be taken forward by the Forum that year;
- The Area Partnership Forum shall produce an annual report for presentation to the APF and Staff Governance Committee that will describe outcomes from the Forum during the year.

## 2. MEMBERSHIP

Membership of the Area Partnership Forum shall comprise representatives of management and all recognised staff organisations (Staff Side). [Appendix 1]. For any voting purposed each recognised Trades Union will have one seat/one vote. However all Staff Side representatives are encouraged to attend.

Management and Staff Side should have named members with nominated deputies. Management and Staff Side representatives, including deputies, may attend as observers with the agreement of the Joint Chairs. Full Time Officers for recognised Staff Side organisations may attend as an ex-officio member.

Membership (and Deputy Membership) is conferred without limit of time subject to acceptable record of attendance. Membership will be formally updated annually when the Terms of Reference are reviewed.

The Employee Director's Offices shall ensure that an accurate record of attendance is maintained and absence from three consecutive meetings of the Forum shall result in membership being withdrawn and alternative representation being sought.

Should there then be continued non-attendance of a nominated representative to the APF, the Joint Chairs shall contact the nominated representative and/or (in the case of a Staff Side representative) their relevant staff organisation and clarify if the nominated representative wishes to continue as a member of the APF, or if another nominated representative from that organisation will be replacing them on the APF.

### 2.1 Formal Sub Groups

Local Partnership Forums x 4
Pay And Conditions of Employment (PACE) Group
Joint Staff Forum, with IJB

The Area Partnership Forum will also act as a resource for other groups seeking Staff Side views / opinions relating to NHS Borders matters.

The Occupational Health and Safety Forum, as a statutory committee for Health and Safety, will communicate directly to the Area Partnership Forum and Staff Governance Committee on matters agreed in partnership with managers and health and safety representatives. The OH&S Forum is not a sub-committee of APF.

## 3. FORUM MEETINGS

### 3.1 Cycle of Meetings

The Forum will meet on an agreed basis, but routinely every 8 weeks, unless otherwise agreed by the Joint Chairs.

### 3.2 Chairing of Meetings

There will be Joint Chairs appointed from Management and Staff Side who will chair meetings of the Forum on an alternating basis. It is the responsibility of the Joint Chairs to agree in advance any agenda items. Tenure of the Chair of the Staffside for APF is de facto that the Employee Director is to be included at 2 successive terms as Chair as a maximum; noting non-executive directors have exception to the limit of successive terms in post. The Employee Director's Offices shall distribute an agenda and supporting papers for each Forum meeting no later than one week before the date of the meeting to all Forum members.

### 3.3 Quorum

The Forum will be quorate when:

- a minimum of five members of the Management and;
- a minimum of five members of the Staff Side are present.

## 4. VALUES

To underpin the working of the Area Partnership Forum, the following values will be adopted and govern the approach taken to consideration of issues, in line with the requirements of MEL (1999) 59:

- mutual trust, honesty and respect;
- openness and transparency in communications;
- recognising and valuing the contribution of all partners;
- access and sharing of information;
- consensus, collaboration and inclusion;
- maximising employment security;
- full commitment to the framework and good employment practice;
- the right of stakeholders to be involved, informed and consulted;
- early involvement of all staff and their trade unions in all discussions regarding change;
- a team approach to underpin partnership working.

The Forum will also promote and act in accordance with the Partnership Standards for NHS Borders.

## 5. DECISION OF THE FORUM

## 5.1 Consultation

Any party may request that a matter brought before the Forum be subject to appropriate consultation with management and Staff Side colleagues prior to any final agreement being reached.

Decisions reached by the Forum which impact on the operation of policy and practice will take effect from a date agreed by the parties and will apply to all relevant staff employed within NHS Borders.

## 5.2 Referral

Any matter considered by the Area Partnership Forum which is deemed to fall outwith its terms of reference, or which is subject to Board or Staff Governance Committee approval, will be referred to the Board or Staff Governance Committee on the basis of Area Partnership Forum support. Reference to the Scottish Partnership Forum may also take place as appropriate.

## 5.3 Failure to Agree

In the event of any failure to agree matters under consideration, the matter will be referred via the Joint Chairs to the Staff Governance Committee, who will endeavour to find a way forward.

## 6. Review

These Terms of Reference will be reviewed on an annual basis and before the end of June each year.

## APPENDIX 1
## Management Representatives

The management representatives will be drawn from the senior officers of NHS Borders and will normally include:

- Chief Executive
- Director of HR and OH&S (plus deputies)
- Director of Acute
- Chief Officer, HSCP
- Director of Planning & Performance
- Director of Finance (or deputy)
- Director of Nursing, Midwifery & AHPs (or deputy)
- Associate Director of AHPs
- Head of Soft Facilities Management
- Head of Estates General Managers
- Representative of the Communications Department

Other management representatives may attend in response to specific issues under consideration at the Forum

<u>Staff Side Organisations</u>

- British Association of Occupational Therapy – BAOT
- British Dental Association – BDA

- British Dietetic Association – BDA
- British Medical Association – BMA
- British and Orthoptic Society - BIOS
- Community and District Nursing Association
- Community Practitioners and Health Visitors Association
- Chartered Society of Physiotherapy – CSP
- General Municipal Boilermakers Union – GMB
- Royal College of Nursing – RCN
- Royal College of Midwives – RCM
- Society of Chiropodists & Podiatrists – SCP
- Society of Radiographers – SOR
- UNISON
- UNITE

The Chairs of the Local Partnership Forums attend using either their Trade Union seat or in an ex-officio capacity.

Fulltime Union Officials attend in an ex-officio capacity.

## K) PHARMACY PRACTICES COMMITTEE

### Terms of Reference

The Pharmacy Practices Committee is constituted and operates in compliance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 1995. Statutory Instrument 1995 No 414 (S.28).

SCOTTISH STATUTORY INSTRUMENTS

# 2001 No. 302

# NATIONAL HEALTH SERVICE

## The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

| | |
|---|---|
| *Made* | *6th September 2001* |
| *Laid before the Scottish Parliament* | *7th September 2001* |
| *Coming into force* | *28th September 2001* |

## ARRANGEMENT OF REGULATIONS

PART IV

MISCELLANEOUS

12. Revocations

SCHEDULE: Meetings and proceedings of the Board and committees

The Scottish Ministers, in exercise of the powers conferred by sections 2(10), 105(7) and 108(1) of, and by paragraphs 2A, 4, 6 and 11 of Schedule 1 to the National Health Service (Scotland) Act 1978(a), and of all other powers enabling them in that behalf, hereby make the following Regulations:

PART I

GENERAL

**Citation, commencement and interpretation**

**1.**—(1) These Regulations may be cited as the Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and shall come into force on 28th September 2001.

(2) In these Regulations, unless the context otherwise requires–

"the 1997 Act" means the National Health Service Act 1977(b);

"the Act" means the National Health Service (Scotland) Act 1978;

"Board" means a Health Board constituted under section 2(1) of the Act;

"the Charity Commissioners" means the Charity Commissioners constituted in accordance with section 1 of the Charities Act 1993(c);

"Chief Officer" means the person or persons holding the post of Chief Executive;

"committee" means a committee of a Board and includes "sub-committee"

"contract" includes any arrangement including a NHS contract;

"health service body" means a person or body specified in section 17A(2) of the Act(d);

"meeting" means a meeting of the Board or of any committee;

"member" means a member of a Board and includes the chairperson;

"NHS trust" means a National Health Service trust established under section 12A of the Act(e).

(3) A reference in these Regulations to a numbered regulation is to the regulation bearing that number in these Regulations and a reference in a regulation to a numbered paragraph is to the paragraph bearing that number in that regulation and a reference to the Schedule is to the Schedule to these Regulations.

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(a) 1978 c.29; section 105(7), which was amended by the Health Services Act 1980 (c.53) ("the 1980 Act"), Schedule 6, paragraph 5(1)(a) and Schedule 7 and by the Health and Social Services and Social Security Adjudications Act 1983 (c.41) ("the 1983 Act"), Schedule 9, paragraph 24, contains provisions relevant to the exercise of the statutory powers under which these Regulations are made; section 108(1) contains definitions of "prescribed" and "regulations" relevant to the exercise of the statutory powers under which these Regulations are made; paragraph 2A of Schedule 1 was inserted by the National Health Service and Community Care Act 1990 (c.19) ("the 1990 Act"), Schedule 5, paragraph 2; paragraph 4 of Schedule 1 was amended by the 1990 Act, Schedule 5, paragraph 3; and paragraph 11 of Schedule 1 was amended by the 1980 Act, Schedule 6, paragraph 7 and Schedule 7 and by the 1990 Act, Schedule 5, paragraph 7. The functions of the Secretary of State were transferred to the Scottish Ministers by virtue of section 53 of the Scotland Act 1998 (c.46).

(b) 1977 c.49.

(c) 1993 c.10.

(d) Section 17A(2) was inserted by the 1990 Act, section 30 and amended by the Health Act 1999 (c.8), Schedule 1.

(e) Section 12A was inserted by the 1990 Act, section 31 and amended by the National Health Service (Primary Care) Act 1997 (c.46), Schedule 2, paragraph 46 and by the Health Act 1999 (c.8), sections 46 and 48 and Schedule 4, paragraph 45.

PART II

MEMBERSHIP

**Appointment and term of office**

**2.**—(1) All members shall be appointed by the Scottish Ministers.

(2) The term of office of the members shall, subject to regulation 5, be for such period as the Scottish Ministers shall specify on making the appointment.

(3) After the expiration of a term of office a member shall, subject to regulation 6, be eligible for re-appointment.

**University members**

**3.** For the purposes of paragraph 2A of Schedule 1 to the Act(a) the Boards in which at least one of the persons appointed to be chairperson or a member must hold a post in a university with a medical or dental school are the Boards in Grampian, Greater Glasgow, Lothian and Tayside.

**Remuneration of members**

**4.** Remuneration may be paid, in accordance with such determination as may be made by the Scottish Ministers, under paragraph 4 of Schedule 1 to the Act(b), to the chairperson, a member appointed under paragraph 2A of Schedule 1 to the Act holding a post in a university and any of the other members, except any members holding the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

**Resignation and removal of members**

**5.**—(1) A member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.

(2) If the Scottish Ministers consider that it is not in the interests of the health service that a member of a Board should continue to hold that office they may forthwith terminate that person's appointment.

(3) If a member has not attended any meeting of the Board, or of any committee of which they are a member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless the Scottish Ministers are satisfied that–

(a) the absence was due to illness or other reasonable cause; and

(b) the member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.

(4) Where a member who was appointed for the purposes of paragraph 2A of Schedule 1 to the Act ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes, the Scottish Ministers may terminate the appointment of that person as a member.

(5) Where any member becomes disqualified in terms of regulation 6 that member shall forthwith cease to be a member.

**Disqualification**

**6.**—(1) Subject to paragraphs (2) and (3), a person shall be disqualified for being a member, if–

(a) they have, within the period of five years immediately preceding the proposed date of appointment, been convicted in the United Kingdom, the Channel Islands, the Isle of Man or the Irish Republic of any offence in respect of which they have received a sentence of imprisonment (whether suspended or not) for a period of not less than three months without the option of a fine;

(b) their estate has been sequestrated in Scotland or they have otherwise been adjudged bankrupt elsewhere than in Scotland, they have granted a trust deed for the benefit of

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**(a)** Paragraph 2A was inserted by the 1990 Act, Schedule 5, paragraph 2.
**(b)** Paragraph 4 was amended by the 1990 Act, Schedule 5, paragraph 3.

their creditors or entered into any arrangement with their creditors, or a curator bonis or judicial factor has been appointed over their affairs;

(c) they have resigned or been removed or been dismissed, otherwise than by reason of redundancy, from any paid employment or office with a health service body;

(d) they are a person whose appointment as the chairperson, member or director of a health service body has been terminated other than by the expiration of their term of office;

(e) they are a chairperson, member, director or employee of a health service body;

(f) they have had their name removed, by a direction under section 29 of the Act(a), from any list prepared under Part II of the Act and have not subsequently had their name included in such a list;

(g) they are a person whose name has been included in any list prepared under Part II of the Act, and whose name has been withdrawn from the list on their own application;

(h) they have had their name removed, by a direction under section 46 of the 1977 Act(b) from any list prepared under Part II of the 1977 Act and have not subsequently had their name included in such a list;

(i) they are a person whose name has been included in any list prepared under Part II of the 1977 Act, and whose name has been withdrawn from the list on their own application;

(j) they are a person who is subject to a disqualification order under the Company Directors Disqualification Act 1986(c); or

(k) they are a person who has been removed from the position of trustee of a charity, whether by the court or by the Charity Commissioner.

(2) For the purpose of paragraph (1)–

(a) the disqualification attaching to a person whose estate has been sequestrated shall cease if and when–

(i) the sequestration of their estate is recalled or reduced; or

(ii) the sequestration is discharged;

(b) the disqualification attaching to a person by reason of their having been adjudged bankrupt shall cease if and when–

(i) the bankruptcy is annulled; or

(ii) they are discharged;

(c) the disqualification attaching to a person in relation to whose estate a judicial factor has been appointed shall cease if and when–

(i) that appointment is recalled; or

(ii) the judicial factor is discharged;

(d) the disqualification attaching to a person who has granted a trust deed or entered into an arrangement with their creditors shall cease if and when that person pays their creditors in full or on the expiry of five years from the date of their granting the deed or entering into the arrangement.

(3) The Scottish Ministers may direct that in relation to any individual person or Board any disqualification so directed shall not apply in relation thereto.

(4) For the purposes of paragraph (1)(a) the date of conviction shall be deemed to be the date on which the days of appeal expire without any appeal having been lodged, or if an appeal has been made, the date on which the appeal is finally disposed of or treated as having been abandoned.

**Appointment and powers of vice-chairperson**

7.—(1) For the purpose of enabling the business of a Board to be conducted in the absence of the chairperson, each Board shall appoint a member who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust to be vice-chairperson and any person so appointed shall, so long as they remain a member of the Board, hold office as vice-chairperson for such period as the Board may decide.

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(a) Section 29 was amended by the Health and Social Security Act 1984 (c.48), Schedule 8 and by the National Health Service (Amendment) Act 1995 (c.31), section 7 and the Schedule.

(b) Section 46 was amended by the Health Authorities Act 1995 (c.17), Schedule 1 and the National Health Service (Amendment) Act 1995 (c.31), sections 1, 2 and 3.

(c) 1986 c.46.

(2) Any member so appointed may at any time resign from the office of vice-chairperson by giving notice in writing to the chairperson and the members may appoint another member as vice-chairperson in accordance with paragraph (1).

(3) Where the chairperson of a Board has died or has ceased to hold office of where that person has been unable to perform their duties as chairperson owing to illness, absence from Scotland or any other cause, the vice-chairperson shall take the place of the chairperson in the conduct of the business of the Board and references to the chairperson shall, so long as there is no chairperson able to perform their duties, be taken to include references to the vice-chairperson.

PART III

PROCEEDINGS

**Meetings and minutes**

**8.**—(1) The meetings and proceedings of the Board shall be conducted in accordance with standing orders made pursuant to regulation 9.

(2) At every meeting of a Board, the chairperson, if present, shall preside.

(3) If the chairperson is absent from any meeting, the vice-chairperson, if present, shall preside, and if the chairperson and vice-chairperson are both absent, the members present at the meeting shall elect from among themselves a person, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, to act as chairperson for that meeting.

(4) All acts of, and all questions coming and arising before, a Board shall be done and decided by a majority of the members of the Board present and voting at a meeting of the Board and, in the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

(5) The proceedings of a Board or of any committee shall not be invalidated by any vacancy in its membership or by any defect in the appointment of any member of such committee.

**Standing orders**

**9.**—(1) Subject to paragraph (2) and to such directions as may be given by the Scottish Ministers, each Board shall make, and may vary and revoke, standing orders for the regulation of the procedure and business of the Board and of any committee.

(2) Standing Orders under paragraph (1) should include the matters set out in the Schedule.

**Appointment and functions of committees**

**10.**—(1) A Board may, and if so directed by the Scottish Ministers shall, appoint committees for such purposes as the Board may determine, subject to such restrictions or conditions as the Board may think fit, or as the Scottish Ministers may direct.

(2) Any committee, but not including any sub-committee, appointed under paragraph (1) shall include at least one member of the Board and may include persons, including trustees of a NHS trust, who are co-opted, and may consist wholly or partly of members of the Board.

(3) Any sub-committee appointed under paragraph (1) may include persons who are co-opted and may consist wholly or partly of members of the Board or wholly of persons who are not members of the Board.

**Conflict of interest**

**11.**—(1) Subject to such exceptions and qualifications as may, with the approval of the Scottish Ministers, be specified in standing orders, if a member, or associate of theirs has any pecuniary or other interest, direct or indirect, in any contract or proposed contract (not being a contract for the provision of any of the services mentioned in Part II of the Act) or other matter, and that member is present at a meeting of the Board or of a committee at which the contract or other matter is the subject of consideration, they shall at the meeting, and as soon as practicable after its

commencement, disclose the fact, and shall not take part in the consideration and discussion of, the contract, proposed contract or other matter or vote on any question with respect to it.

(2) The Scottish Ministers may, subject to such conditions as they may think fit to impose, remove any disability imposed by this regulation in any case in which it appears to them in the interests of the health service that the disability should be removed.

(3) Any remuneration, compensation or allowances payable to a chairperson or other member by virtue of paragraphs 4, 5 or 13 of Schedule 1 to the Act shall not be treated as a pecuniary interest for the purpose of this regulation.

(4) A member shall not be treated as having an interest in any contract, proposed contract or other matter by reason only that they, or an associate of theirs, has an interest in any company, body or person which is so remote or insignificant that they cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

(5) This regulation applies to a committee as it applies to the Board and applies to any member of any such committee (whether or not they are also a member of the Board) as it applies to a member of the Board.

(6) For the purposes of this regulation, the word "associate" has the meaning given by section 74 of the Bankruptcy (Scotland) Act 1985(a).

PART IV

MISCELLANEOUS

**Revocations**

**12.** The following Regulations are hereby revoked:–

(a) the Health Boards (Membership and Procedure) (No. 2) Regulations 1991(b)

(b) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993(c)

(c) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998(d)

(d) the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999(e).

*SUSAN C DEACON*
A member of the Scottish Executive

St Andrew's House,
Edinburgh
6th September 2001

(a) 1985 c.66. Section 74 was amended by the Bankruptcy (Scotland) Regulations 1985 (S.I. 1985/1925), regulation 11.
(b) S.I 1991/809.
(c) S.I. 1993/1615.
(d) S.I. 1998/1459.
(e) S.I. 1999/132.

Regulation 9

## SCHEDULE

## MATTERS TO BE INCLUDED IN STANDING ORDERS REGULATING MEETINGS AND PROCEEDINGS OF THE BOARD AND COMMITTEES

**Calling meetings**

**1.**—(1) The first meeting of the Board shall be held on such day and at such place as may be fixed by the chairperson and that person shall be responsible for convening the meeting.

(2) The chairperson may call a meeting of the Board at any time and the chairperson of a committee may call a meeting of that committee at any time or and shall call a meeting when required to do so by the Board.

(3) If the chairperson refuses to call a meeting of the Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least one third of the whole number of members, has been presented to the chairperson or if, without so refusing, the chairperson does not call a meeting within 7 days after such requisition has been presented, those members who presented the requisition may forthwith call a meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

**Notice of Meetings**

**2.**—(1) Before each meeting of the Board, a notice of the meeting, specifying the time, place and business proposed to be transacted at it and signed by the chairperson, or by a member authorised by the chairperson to sign on that person's behalf, shall be delivered to every member or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting.

(2) Lack of service of the notice on any member shall not affect the validity of a meeting.

(3) In the case of a meeting of the Board called by members in default of the chairperson, the notice shall be signed by those members who requisitioned the meeting in accordance with paragraph 1(3).

**Conflict of interests**

**3.**—(1) A member shall be excluded from a meeting of the Board or committee in accordance with regulation 11 while any contract, proposed contract, or other matter in which they or an associate of theirs has an interest is under consideration.

(2) The exceptions and qualifications referred to in regulation 11(1) shall be specified.

**Quorum**

**4.** No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of members including at least two members who do not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust.

**Conduct of meetings**

**5.**—(1) At any meeting of a committee the chairperson of that committee, if present, shall preside.

(2) If both the chairperson and vice-chairperson (if any) are absent from a meeting of the Board a member, who does not also hold the position of Chief Officer, Chief Finance Officer or Director of Public Health of a Board, or Chief Officer of a National Health Service trust, chosen at the meeting by the members present shall preside.

(3) If both the chairperson and vice-chairperson (if any) of a committee are absent from a meeting of that committee a member of the committee chosen at the meeting by the other members present shall preside.

(4) If it is necessary or expedient to do so a meeting may be adjourned to another day, time and place.

**Voting**

**6.** Every question at a meeting shall be determined by a majority of the votes of the members present and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

**Records**

**7.**—(1) The names of the members present at a meeting shall be recorded.

(2) The minutes of the proceedings of a meeting including any decision or resolution made at that meeting shall be drawn up and submitted to the next ensuing meeting for agreement after which they will be signed by the person presiding at that meeting.

**Suspension and disqualification**

**8.** Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

## EXPLANATORY NOTE

*(This note is not part of the Order)*

These Regulations supersede and revoke the Health Boards (Membership and Procedure) (No. 2) Regulations 1991 ("the 1991 Regulations") and their amendments, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1993, the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1998 and the Health Boards (Membership and Procedure) (No. 2) Amendment Regulations 1999.

The Regulations, make provision in relation to Boards established under the National Health Service (Scotland) Act 1978 as to the membership and procedure of these Boards.

Regulation 2 makes provision with regard to the terms of office of members of Boards and regulation 3 makes provision for those Boards which must have at least one member who holds a post in a University with a medical or a dental school.

Regulation 4 deals with the remuneration of the members of Boards and regulation 5 with their resignation and removal from office.

Regulation 6 provides for the circumstances in which a person may be disqualified from membership of a Board. Regulation 7 deals with the appointment of a vice-chairperson of committees and sub-committees of Boards.

In Part III there are various provisions with regard to procedure including provisions as to the meetings of the Boards. Regulation 9 makes provision for standing orders regulating the procedure of meetings of Boards and of committees and sub-committees. Regulation 10 makes provision about the appointment and functions of committees. Regulation 11 makes provision with regard to conflict of interest.

Regulation 12 revokes the 1991 Regulations and all amending instruments as mentioned above which provided for membership and procedure of Boards referred to above.

The Schedule sets out the detail of the matters that must be included in the standing orders made pursuant to regulation 9.

SCOTTISH STATUTORY INSTRUMENTS

# 2001 No. 302

# NATIONAL HEALTH SERVICE

## The Health Boards (Membership and Procedure) (Scotland) Regulations 2001

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# SECTION B

# MEMBERS CODE OF CONDUCT

**CONTENTS**

## SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 This Code has been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000 (the "Act").

1.2 The purpose of the Code is to set out the conduct expected of those who serve on the boards of public bodies in Scotland.

1.3 The Code has been developed in line with the nine key principles of public life in Scotland. The principles are listed in Section 2 and set out how the provisions of the Code should be interpreted and applied in practice.

### My Responsibilities

1.4 I understand that the public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. I will always seek to meet those expectations by ensuring that I conduct myself in accordance with the Code.

1.5 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all situations and at all times where I am acting as a board member of my public body, have referred to myself as a board member or could objectively be considered to be acting as a board member.

1.6 I will comply with the substantive provisions of this Code, being sections 3 to 6 inclusive, in all my dealings with the public, employees and fellow board members, whether formal or informal.

1.7 I understand that it is my personal responsibility to be familiar with the provisions of this Code and that I must also comply with the law and my public body's rules, standing orders and regulations. I will also ensure that I am familiar with any guidance or advice notes issued by the Standards Commission for Scotland ("Standards Commission") and my public body, and endeavour to take part in any training offered on the Code.

1.8 I will not, at any time, advocate or encourage any action contrary to this Code.

1.9 I understand that no written information, whether in the Code itself or the associated Guidance or Advice Notes issued by the Standards Commission, can provide for all circumstances. If I am uncertain about how the Code applies, I will seek advice from the Standards Officer of my public body, failing whom the Chair or Chief Executive of my public body. I note that I may also choose to seek external legal advice on how to interpret the provisions of the Code.

### Enforcement

1.10 Part 2 of the Act sets out the provisions for dealing with alleged breaches of the Code, including the sanctions that can be applied if the Standards Commission finds that there has been a breach of the Code. More information on how complaints are dealt with and the sanctions available can be found at **Annex A**.

## SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The Code has been based on the following key principles of public life. I will behave in accordance with these principles and understand that they should be used for guidance and interpreting the provisions in the Code.

2.2 I note that a breach of one or more of the key principles does not in itself amount to a breach of the Code. I note that, for a breach of the Code to be found, there must also be a contravention of one or more of the provisions in sections 3 to 6 inclusive of the Code.

The key principles are:

**Duty**
I have a duty to uphold the law and act in accordance with the law and the public trust placed in me. I have a duty to act in the interests of the public body of which I am a member and in accordance with the core functions and duties of that body.

**Selflessness**
I have a duty to take decisions solely in terms of public interest. I must not act in order to gain financial or other material benefit for myself, family or friends.

**Integrity**
I must not place myself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence me in the performance of my duties.

**Objectivity**
I must make decisions solely on merit and in a way that is consistent with the functions of my public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

**Accountability and Stewardship**
I am accountable to the public for my decisions and actions. I have a duty to consider issues on their merits, taking account of the views of others and I must ensure that my public body uses its resources prudently and in accordance with the law.

**Openness**
I have a duty to be as open as possible about my decisions and actions, giving reasons for my decisions and restricting information only when the wider public interest clearly demands.

**Honesty**
I have a duty to act honestly. I must declare any private interests relating to my public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

**Leadership**
I have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of my public body and its members in conducting public business.

**Respect**
I must respect all other board members and all employees of my public body and the role they play, treating them with courtesy at all times. Similarly, I must respect members of the public when performing my duties as a board member.

## SECTION 3: GENERAL CONDUCT

### Respect and Courtesy

3.1 I will treat everyone with courtesy and respect. This includes in person, in writing, at meetings, when I am online and when I am using social media.

3.2 I will not discriminate unlawfully on the basis of race, age, sex, sexual orientation, gender reassignment, disability, religion or belief, marital status or pregnancy / maternity; I will advance equality of opportunity and seek to foster good relations between different people.

3.3 I will not engage in any conduct that could amount to bullying or harassment (which includes sexual harassment). I accept that such conduct is completely unacceptable and will be considered to be a breach of this Code.

3.4 I accept that disrespect, bullying and harassment can be:

a) a one-off incident,
b) part of a cumulative course of conduct; or
c) a pattern of behaviour.

3.5 I understand that how, and in what context, I exhibit certain behaviours can be as important as what I communicate, given that disrespect, bullying and harassment can be physical, verbal and non-verbal conduct.

3.6 I accept that it is my responsibility to understand what constitutes bullying and harassment and I will utilise resources, including the Standards Commission's guidance and advice notes, my public body's policies and training material (where appropriate) to ensure that my knowledge and understanding is up to date.

3.7 Except where it is written into my role as Board member, and / or at the invitation of the Chief Executive, I will not become involved in operational management of my public body. I acknowledge and understand that operational management is the responsibility of the Chief Executive and Executive Team.

3.8 I will not undermine any individual employee or group of employees, or raise concerns about their performance, conduct or capability in public. I will raise any concerns I have on such matters in private with senior management as appropriate.

3.9 I will not take, or seek to take, unfair advantage of my position in my dealings with employees of my public body or bring any undue influence to bear on employees to take a certain action. I will not ask or direct employees to do something which I know, or should reasonably know, could compromise them or prevent them from undertaking their duties properly and appropriately.

3.10 I will respect and comply with rulings from the Chair during meetings of:

a) my public body, its committees; and
b) any outside organisations that I have been appointed or nominated to by my public body or on which I represent my public body.

3.11 I will respect the principle of collective decision-making and corporate responsibility. This means that once the Board has made a decision, I will support that decision, even if I did not agree with it or vote for it.

**Remuneration, Allowances and Expenses**

3.12 I will comply with the rules, and the policies of my public body, on the payment of remuneration, allowances and expenses.

**Gifts and Hospitality**

3.13 I understand that I may be offered gifts (including money raised via crowdfunding or sponsorship), hospitality, material benefits or services ("gift or hospitality") that may be reasonably regarded by a member of the public with knowledge of the relevant facts as placing me under an improper obligation or being capable of influencing my judgement.

3.14 I will never **ask for** or **seek** any gift or hospitality.

3.15 I will refuse any gift or hospitality, unless it is:

a) a minor item or token of modest intrinsic value offered on an infrequent basis;
b) a gift being offered to my public body;
c) hospitality which would reasonably be associated with my duties as a board member; or
d) hospitality which has been approved in advance by my public body.

3.16 I will consider whether there could be a reasonable perception that any gift or hospitality received by a person or body connected to me could or would influence my judgement.

3.17 I will not allow the promise of money or other financial advantage to induce me to act improperly in my role as a board member. I accept that the money or advantage (including any gift or hospitality) does not have to be given to me directly. The offer of monies or advantages to others, including community groups, may amount to bribery, if the intention is to induce me to improperly perform a function.

3.18 I will never accept any gift or hospitality from any individual or applicant who is awaiting a decision from, or seeking to do business with, my public body.

3.19 If I consider that declining an offer of a gift would cause offence, I will accept it and hand it over to my public body at the earliest possible opportunity and ask for it to be registered.

3.20 I will promptly advise my public body's Standards Officer if I am offered (but refuse) any gift or hospitality of any significant value and / or if I am offered any gift or hospitality from the same source on a repeated basis, so that my public body can monitor this.

3.21 I will familiarise myself with the terms of the Bribery Act 2010, which provides for offences of bribing another person and offences relating to being bribed.

**Confidentiality**

3.22 I will not disclose confidential information or information which should reasonably be regarded as being of a confidential or private nature, without the express consent of a person or body authorised to give such consent, or unless required to do so by law. I note that if I cannot obtain such express consent, I should assume it is not given.

3.23 I accept that confidential information can include discussions, documents, and information which is not yet public or never intended to be public, and information deemed confidential by statute.

3.24 I will only use confidential information to undertake my duties as a board member. I will not use it in any way for personal advantage or to discredit my public body (even if my personal view is that the information should be publicly available).

3.25 I note that these confidentiality requirements do not apply to protected whistleblowing disclosures made to the prescribed persons and bodies as identified in statute.

**Use of Public Body Resources**

3.26 I will only use my public body's resources, including employee assistance, facilities, stationery and IT equipment, for carrying out duties on behalf of the public body, in accordance with its relevant policies.

3.27 I will not use, or in any way enable others to use, my public body's resources:

a) imprudently (without thinking about the implications or consequences);
b) unlawfully;
c) for any political activities or matters relating to these; or
d) improperly.

**Dealing with my Public Body and Preferential Treatment**

3.28 I will not use, or attempt to use, my position or influence as a board member to:

a) improperly confer on or secure for myself, or others, an advantage;
b) avoid a disadvantage for myself, or create a disadvantage for others or
c) improperly seek preferential treatment or access for myself or others.

3.29 I will avoid any action which could lead members of the public to believe that preferential treatment or access is being sought.

3.30 I will advise employees of any connection, as defined at Section 5, I may have to a matter, when seeking information or advice or responding to a request for information or advice from them.

**Appointments to Outside Organisations**

3.31 If I am appointed, or nominated by my public body, as a member of another body or organisation, I will abide by the rules of conduct and will act in the best interests of that body or organisation while acting as a member of it. I will also continue to observe the rules of this Code when carrying out the duties of that body or organisation.

3.32 I accept that if I am a director or trustee (or equivalent) of a company or a charity, I will be responsible for identifying, and taking advice on, any conflicts of interest that may arise between the company or charity and my public body.

## SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out what I have to register when I am appointed and whenever my circumstances change. The register covers my current term of appointment.

4.2 I understand that regulations made by the Scottish Ministers describe the detail and timescale for registering interests; including a requirement that a board member must register their registerable interests within one month of becoming a board member, and register any changes to those interests within one month of those changes having occurred.

4.3 The interests which I am required to register are those set out in the following paragraphs. Other than as required by paragraph 4.23, I understand it is not necessary to register the interests of my spouse or cohabitee.

### Category One: Remuneration

4.4 I will register any work for which I receive, or expect to receive, payment. I have a registerable interest where I receive remuneration by virtue of being:

a) employed;
b) self-employed;
c) the holder of an office;
d) a director of an undertaking;
e) a partner in a firm;
f) appointed or nominated by my public body to another body; or
g) engaged in a trade, profession or vocation or any other work.

4.5 I understand that in relation to 4.4 above, the amount of remuneration does not require to be registered. I understand that any remuneration received as a board member of this specific public body does not have to be registered.

4.6 I understand that if a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under Category Two, “Other Roles”.

4.7 I must register any allowances I receive in relation to membership of any organisation under Category One.

4.8 When registering employment as an employee, I must give the full name of the employer, the nature of its business, and the nature of the post I hold in the organisation.

4.9 When registering remuneration from the categories listed in paragraph 4.4 (b) to

(g) above, I must provide the full name and give details of the nature of the business, organisation, undertaking, partnership or other body, as appropriate. I recognise that some other employments may be incompatible with my role as board member of my public body in terms of paragraph 6.7 of this Code.

4.10 Where I otherwise undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and how often it is undertaken.

4.11 When registering a directorship, it is necessary to provide the registered name and registered number of the undertaking in which the directorship is held and provide information about the nature of its business.

4.12 I understand that registration of a pension is not required as this falls outside the scope of the category.

**Category Two: Other Roles**

4.13 I will register any unremunerated directorships where the body in question is a subsidiary or parent company of an undertaking in which I hold a remunerated directorship.

4.14 I will register the registered name and registered number of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which I am a director and from which I receive remuneration.

**Category Three: Contracts**

4.15 I have a registerable interest where I (or a firm in which I am a partner, or an undertaking in which I am a director or in which I have shares of a value as described in paragraph 4.20 below) have made a contract with my public body:

a) under which goods or services are to be provided, or works are to be executed; and
b) which has not been fully discharged.

4.16 I will register a description of the contract, including its duration, but excluding the value.

**Category Four: Election Expenses**

4.17 If I have been elected to my public body, then I will register a description of, and statement of, any assistance towards election expenses relating to election to my public body.

**Category Five: Houses, Land and Buildings**

4.18 I have a registerable interest where I own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of my public body.

4.19 I accept that, when deciding whether or not I need to register any interest I have in houses, land or buildings, the test to be applied is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as being so significant that it could potentially affect my responsibilities to my public body and to the

public, or could influence my actions, speeches or decision-making.

**Category Six: Interest in Shares and Securities**

4.20 I have a registerable interest where:

a) I own or have an interest in more than 1% of the issued share capital of the company or other body; or
b) Where, at the relevant date, the market value of any shares and securities (in any one specific company or body) that I own or have an interest in is greater than £25,000.

**Category Seven: Gifts and Hospitality**

4.21 I understand the requirements of paragraphs 3.13 to 3.21 regarding gifts and hospitality. As I will not accept any gifts or hospitality, other than under the limited circumstances allowed, I understand there is no longer the need to register any.

**Category Eight: Non–Financial Interests**

4.22 I may also have other interests and I understand it is equally important that relevant interests such as membership or holding office in other public bodies, companies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described. In this context, I understand non-financial interests are those which members of the public with knowledge of the relevant facts might reasonably think could influence my actions, speeches, votes or decision-making in my public body (this includes its Committees and memberships of other organisations to which I have been appointed or nominated by my public body).

**Category Nine: Close Family Members**

4.23 I will register the interests of any close family member who has transactions with my public body or is likely to have transactions or do business with it.

## SECTION 5: DECLARATION OF INTERESTS

**Stage 1: Connection**

5.1 For each particular matter I am involved in as a board member, I will first consider whether I have a connection to that matter.

5.2 I understand that a connection is any link between the matter being considered and me, or a person or body I am associated with. This could be a family relationship or a social or professional contact.

5.3 A connection includes anything that I have registered as an interest.

5.4 A connection does not include being a member of a body to which I have been appointed or nominated by my public body as a representative of my public body or of which I am a member by reason of, or in implementation of, a statutory provision, unless:

a) The matter being considered by my public body is quasi-judicial or regulatory; or

b) I have a personal conflict by reason of my actions, my connections or my legal obligations.

**Stage 2: Interest**

5.5 I understand my connection is an interest that requires to be declared where the objective test is met – that is where a member of the public with knowledge of the relevant facts would reasonably regard my connection to a particular matter as being so significant that it would be considered as being likely to influence the discussion or decision-making.

**Stage 3: Participation**

5.6 I will declare my interest as early as possible in meetings. I will not remain in the meeting nor participate in any way in those parts of meetings where I have declared an interest.

5.7 I will consider whether it is appropriate for transparency reasons to state publicly where I have a connection, which I do not consider amounts to an interest.

5.8 I note that I can apply to the Standards Commission and ask it to grant a dispensation to allow me to take part in the discussion and decision-making on a matter where I would otherwise have to declare an interest and withdraw (as a result of having a connection to the matter that would fall within the objective test). I note that such an application must be made in advance of any meetings where the dispensation is sought and that I cannot take part in any discussion or decision-making on the matter in question unless, and until, the application is granted.

5.9 I note that public confidence in a public body is damaged by the perception that decisions taken by that body are substantially influenced by factors other than the public interest. I will not accept a role or appointment if doing so means I will have to declare interests frequently at meetings in respect of my role as a board member. Similarly, if any appointment or nomination to another body would give rise to objective concern because of my existing personal involvement or affiliations, I will not accept the appointment or nomination.

## SECTION 6: LOBBYING AND ACCESS

6.1 I understand that a wide range of people will seek access to me as a board member and will try to lobby me, including individuals, organisations and companies. I must distinguish between:

a) any role I have in dealing with enquiries from the public;
b) any community engagement where I am working with individuals and organisations to encourage their participation and involvement, and;
c) lobbying, which is where I am approached by any individual or organisation who is seeking to influence me for financial gain or advantage, particularly those who are seeking to do business with my public body (for example contracts/procurement).

6.2 In deciding whether, and if so how, to respond to such lobbying, I will always have regard to the objective test, which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard my conduct as being likely to influence my, or my public body's, decision-making role.

6.3 I will not, in relation to contact with any person or organisation that lobbies, do anything which contravenes this Code or any other relevant rule of my public body or any statutory provision.

6.4 I will not, in relation to contact with any person or organisation that lobbies, act in any way which could bring discredit upon my public body.

6.5 If I have concerns about the approach or methods used by any person or organisation in their contacts with me, I will seek the guidance of the Chair, Chief Executive or Standards Officer of my public body.

6.6 The public must be assured that no person or organisation will gain better access to, or treatment by, me as a result of employing a company or individual to lobby on a fee basis on their behalf. I will not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which I accord any other person or organisation who lobbies or approaches me. I will ensure that those lobbying on a fee basis on behalf of clients are not given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming.

6.7 Before taking any action as a result of being lobbied, I will seek to satisfy myself about the identity of the person or organisation that is lobbying and the motive for lobbying. I understand I may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that I understand the basis on which I am being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code and the Lobbying (Scotland) Act 2016.

6.8 I will not accept any paid work:

a) which would involve me lobbying on behalf of any person or organisation or any clients of a person or organisation.
b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence my public body and its members. This does not prohibit me from being remunerated for activity which may arise because of, or relate to, membership of my public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

## ANNEX A: BREACHES OF THE CODE

### Introduction

1. The Ethical Standards in Public Life etc. (Scotland) Act 2000 ("the Act") provided for a framework to encourage and, where necessary, enforce high ethical standards in public life.

2. The Act provided for the introduction of new codes of conduct for local authority councillors and members of relevant public bodies, imposing on councils and relevant public bodies a duty to help their members comply with the relevant code.

3. The Act and the subsequent Scottish Parliamentary Commissions and Commissioners etc. Act 2010 established the Standards Commission for Scotland ("Standards Commission") and the post of Commissioner for Ethical Standards in Public Life in Scotland ("ESC").

4. The Standards Commission and ESC are separate and independent, each with distinct functions. Complaints of breaches of a public body's Code of Conduct are investigated by the ESC and adjudicated upon by the Standards Commission.

5. The first Model Code of Conduct came into force in 2002. The Code has since been reviewed and re-issued in 2014. The 2021 Code has been issued by the Scottish Ministers following consultation, and with the approval of the Scottish Parliament, as required by the Act.

### Investigation of Complaints

6. The ESC is responsible for investigating complaints about members of devolved public bodies. It is not, however, mandatory to report a complaint about a potential breach of the Code to the ESC. It may be more appropriate in some circumstances for attempts to be made to resolve the matter informally at a local level.

7. On conclusion of the investigation, the ESC will send a report to the Standards Commission.

### Hearings

8. On receipt of a report from the ESC, the Standards Commission can choose to:

- Do nothing;
- Direct the ESC to carry out further investigations; or
- Hold a Hearing.

9. Hearings are held (usually in public) to determine whether the member concerned has breached their public body's Code of Conduct. The Hearing Panel comprises of three members of the Standards Commission. The ESC will present evidence and/or make submissions at the Hearing about the investigation and any conclusions as to whether the member has contravened the Code. The member is entitled to attend or be represented at the Hearing and can also present evidence and make submissions. Both parties can call witnesses. Once it has heard all the evidence and submissions, the Hearing Panel will make a determination about whether or not it is satisfied, on the balance of probabilities, that there has been a contravention of the Code by the member. If the Hearing Panel

decides that a member has breached their public body's Code, it is obliged to impose a sanction.

**Sanctions**

10. The sanctions that can be imposed following a finding of a breach of the Code are as follows:

- **Censure**: A censure is a formal record of the Standards Commission's severe and public disapproval of the member concerned.
- **Suspension**: This can be a full or partial suspension (for up to one year). A full suspension means that the member is suspended from attending all meetings of the public body. Partial suspension means that the member is suspended from attending some of the meetings of the public body. The Commission can direct that any remuneration or allowance the member receives as a result of their membership of the public body be reduced or not paid during a period of suspension.
- **Disqualification**: Disqualification means that the member is removed from membership of the body and disqualified (for a period not exceeding five years), from membership of the body. Where a member is also a member of another devolved public body (as defined in the Act), the Commission may also remove or disqualify that person in respect of that membership. Full details of the sanctions are set out in section 19 of the Act.

**Interim Suspensions**

11. Section 21 of the Act provides the Standards Commission with the power to impose an interim suspension on a member on receipt of an interim report from the ESC about an ongoing investigation. In making a decision about whether or not to impose an interim suspension, a Panel comprising of three Members of the Standards Commission will review the interim report and any representations received from the member and will consider whether it is satisfied:

- That the further conduct of the ESC's investigation is likely to be prejudiced if such an action is not taken (for example if there are concerns that the member may try to interfere with evidence or witnesses); or
- That it is otherwise in the public interest to take such a measure. A policy outlining how the Standards Commission makes any decision under Section 21 and the procedures it will follow in doing so, should any such a report be received from the ESC can be found here.

12. The decision to impose an interim suspension is not, and should not be seen as, a finding on the merits of any complaint or the validity of any allegations against a member of a devolved public body, nor should it be viewed as a disciplinary measure.

## ANNEX B: DEFINITIONS

**“Bullying”** is inappropriate and unwelcome behaviour which is offensive and intimidating, and which makes an individual or group feel undermined, humiliated or insulted.

**"Chair"** includes Board Convener or any other individual discharging a similar function to that of a Chair or Convener under alternative decision-making structures.

**“Code”** is the code of conduct for members of your devolved public body, which is based on the Model Code of Conduct for members of devolved public bodies in Scotland.

**"Cohabitee"** includes any person who is living with you in a relationship similar to that of a partner, civil partner, or spouse.

**“Confidential Information”** includes:

- any information passed on to the public body by a Government department (even if it is not clearly marked as confidential) which does not allow the disclosure of that information to the public;
- information of which the law prohibits disclosure (under statute or by the order of a Court);
- any legal advice provided to the public body; or
- any other information which would reasonably be considered a breach of confidence should it be made public.

**"Election expenses"** means expenses incurred, whether before, during or after the election, on account of, or in respect of, the conduct or management of the election.

**“Employee”** includes individuals employed:

- directly by the public body;
- as contractors by the public body, or
- by a contractor to work on the public body’s premises.

**“Gifts”** a gift can include any item or service received free of charge, or which may be offered or promised at a discounted rate or on terms not available to the general public. Gifts include benefits such as relief from indebtedness, loan concessions, or provision of property, services or facilities at a cost below that generally charged to members of the public. It can also include gifts received directly or gifts received by any company in which the recipient holds a controlling interest in, or by a partnership of which the recipient is a partner.

**“Harassment”** is any unwelcome behaviour or conduct which makes someone feel offended, humiliated, intimidated, frightened and / or uncomfortable. Harassment can be experienced directly or indirectly and can occur as an isolated incident or as a course of persistent behaviour.

**“Hospitality”** includes the offer or promise of food, drink, accommodation, entertainment or the opportunity to attend any cultural or sporting event on terms not available to the general public.

**“Relevant Date”** Where a board member had an interest in shares at the date on which the member was appointed as a member, the relevant date is – (a) that date; and (b) the

5th April immediately following that date and in each succeeding year, where the interest is retained on that 5th April.

**“Public body”** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

**“Remuneration"** includes any salary, wage, share of profits, fee, other monetary benefit or benefit in kind.

**“Securities”** a security is a certificate or other financial instrument that has monetary value and can be traded. Securities includes equity and debt securities, such as stocks bonds and debentures.

**“Undertaking”** means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

# SECTION C

# STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF

**STANDARDS OF BUSINESS CONDUCT FOR NHS STAFF**

**GUIDANCE ON ACCEPTANCE OF GIFTS AND HOSPITALITY AND DECLARATIONS OF STAFF INTERESTS**

**CONTENTS**

## 1. FOREWORD

This document provides guidance to all staff on the acceptance of gifts and hospitality, and declarations of interests. It brings together numerous NHS Borders policies and pieces of legislation that govern these areas, to help staff understand what is and is not acceptable in one easily accessible document. If staff require further detail they should refer to the policies to which each section relates and/or discuss with their line manager.

## 2. INTRODUCTION

It is important that NHS Borders and its employees maintain strict ethical standards in the conduct of NHS business and are protected from allegations of conflict of interest, acting improperly or breach of impartiality.

It is the responsibility of staff to ensure that they do not place themselves in a position which risks, or appears to risk, conflict between their private interests and their NHS duties. This primary responsibility applies to **all NHS staff**, but is of particular relevance to those who commit NHS resources directly (e.g. by the ordering of goods) or those who do so indirectly (e.g. by the prescribing of medicines).

Under the Prevention of Corruption Acts 1906 and 1916 it is an offence for Health Service employees to corruptly accept any gifts or consideration as an inducement or reward for –

- doing, or refraining from doing, anything in their official capacity
- showing favour or disfavour to any person in their official capacity

The NHS must be impartial and honest in the conduct of its business and its employees should remain beyond suspicion. Under the Bribery Act 2010, it is an offence to request, agree to receive or accept a bribe in return for improperly performing a function or activity.

It should be clearly understood therefore that:-

- a breach of the provisions of the Acts renders staff liable to prosecution, will lead to disciplinary action and may provide grounds for dismissal
- anyone convicted of corruption may forfeit their superannuation rights
- anyone holding qualifications which are subject to registration by a statutory body may be subject to removal from the register if convicted of corruption, forfeiting their right to practise professionally

**If you are in any doubt at all as to what you can or cannot do, you should seek advice from your line manager/Head of Department/Director.**

The Standards of Business Conduct for NHS Staff [NHS Circular MEL (1994) 48] provide instructions to staff in maintaining strict ethical standards in the conduct of NHS business. All staff are therefore required to adhere to the Standards of Business Conduct for NHS Staff.

**The key elements of the Standards of Business Conduct are that the employees of NHS Borders are expected to:-**

- ensure that the interest of patients remains paramount at all times;

- ensure that all identifiable personal information relating to patients or staff is kept secure and confidential at all times and in accordance with UK General Data Protection Regulation tailored by the Data Protection Act 2018. NHS Borders has implemented a privacy breach detection system (Fair Warning) to assist in monitoring inappropriate access to confidential data;
- be impartial and honest in the conduct of their business;
- use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.

**Employees should not:-**

- abuse their official position for personal gain or to benefit their family and/or friends;
- undertake outside employment that could compromise their NHS duties;
- seek to advantage or further their private business or other interests, in the course of their official duties;
- staff must protect themselves and NHS Borders from any allegations of impropriety by seeking advice from their line manager, or from the appropriate contact point, whenever there is any doubt as to the interpretation of this policy.

If staff follow these principles, the Board should be able to demonstrate that it adheres to the three essential public sector values:–

**Accountability** – all work undertaken by NHS Borders staff must be able to stand the test of scrutiny, public judgements on propriety and professional codes of conduct.

**Probity** - there should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers and in the use of information acquired in the course of NHS duties.

**Openness** - there should be sufficient transparency about NHS activities to promote confidence between NHS Borders, its staff and the public.

**Action for Managers**

Managers must adhere to this guidance and ensure that their staff are aware of and comply with these Standards. To achieve this, each manager should record their receipt and understanding of the Standards of Business Conduct for NHS staff, together with evidence that all their staff have been informed of its contents. Each member of staff will receive a copy at induction and also confirm their understanding of it as part of the Confidentiality Statement sign off every two years.

Where an interest, hospitality or relevant outside employment is declared to a manager, they must record that declaration in the employee's personal file together with any instructions issued to the member of staff in relation to the declaration. All declarations of interests, hospitality, or relevant outside employment should be notified to the Board Secretary. Any gifts or hospitality, which are unusual, or likely to arouse controversy, should also be notified to the Board Secretary.

Managers should consider whether outside employment declared by employees is likely to conflict with their NHS work or be detrimental to it. Generally, directorship of, or work with, an identified NHS supplier, or business competing with the NHS, would be unacceptable.

If a manager is informed of a potential conflict of interest, hospitality or outside employment which has not been declared by a member of their staff, they must inform the Board Secretary and Director of Finance.

## 3. ACCEPTANCE OF GIFTS AND HOSPITALITY

The Standards of Business Conduct for NHS Staff include instructions on the acceptance of gifts and hospitality and these Standards are incorporated into the contract of employment of each member of staff. Practices which may be accepted in the private sector are not permitted under the Standards. The key points in the Standards are as follows.

### 3.1 Anti-Bribery Policy

The Board will uphold all laws relevant to countering bribery and corruption, including the Bribery Act 2010 (the Act). This commitment applies to every aspect of the Board's activity, including dealings with public and private sector organisations and the delivery of care to patients.

The Act recognises a number of offences including the following:-

- The offering, promising or giving of a bribe (active bribery);
- The requesting, agreeing to receive or accepting of a bribe (passive bribery).

Any employee who commits active or passive bribery will be subject to disciplinary action. In addition, the matter will be referred to relevant authorities for criminal investigation. The maximum sentence for any individual convicted of bribery is 10 years.

The Act also recognises a further offence of corporate liability for failing to prevent bribery on behalf of a commercial organisation. (For the purposes of the Act, NHS Boards are considered commercial organisations.) The Board has put in place a range of measures intended to prevent bribery and these are subject to formal and regular review to ensure they remain fit for purpose.

Staff should therefore be very cautious if faced with the offer of a gift. Casual gifts offered by contractors or others (for example, at the festive season) may not be in any way connected with the performance of duties so as to constitute an offence under the Bribery Act 2010. Such gifts should nevertheless be declined. Articles of small intrinsic value such as calendars or diaries, may however be accepted, where this would not breach the Code of Conduct.

Small gifts from patients or their families, to express their gratitude to members of staff, can be accepted by members of staff without breaching the Code. **The circumstances should allow sensible application of judgement. Such gifts will be of relatively low value, for example, biscuits, chocolates, flowers. These gifts do not need to be registered.**

However,

- staff must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision NHS Borders may be involved in determining, or who is seeking to do business with NHS Borders.

- staff must not accept any offer, by way of gift or hospitality, which could give rise to a reasonable suspicion of influence on their part to show favour, or disadvantage, to any individual, organisation or company.

- staff should consider whether there may be a reasonable perception that any gift received by their spouse or partner or by any company in which they have an interest, or by a partnership of which they are a partner, can or would influence their judgement.

Note - the term 'gift' includes benefits such as relief from indebtedness, loan concessions, or provision of services at a cost below that generally charged to members of the public.

Where an unsolicited, inappropriate or high value gift is received and the individual is unable to return it or the donor refuses to accept its return, he/she should report the circumstances to his/her line manager/Head of Department/Director who will ensure that the donor is advised of the course of action.

Staff must never canvass or seek gifts or hospitality. Under no circumstances can staff accept personal gifts of cash. Financial donations to a department fund, which are to be used for the purposes of the Board (e.g. to support staff training) must be administered through the Board's Endowment Funds.

All unsolicited, inappropriate or high value gifts and hospitality, whether accepted or declined, must be entered on the Register of Gifts and Hospitality **(Appendix A Gifts and Hospitality Form).**

Gifts of equipment not for individual use may be accepted, provided that:-

- they are in no way related to purchasing decisions and do not commit the Board to any obligations with the supplier;
- they are entered in the Register of Gifts and Hospitality;
- guidance is followed on the acceptance of a gift or hospitality before acceptance of the Board's potential liabilities of accepting the asset;
- the budget holder's approval to accepting the gift is sought – particularly if there are any costs - recurrent or non-recurrent – associated with accepting the gift.

Donated assets are recorded by the Board's Endowment Fund Charity and immediately transferred to the ownership of the Board.

### 3.2 Hospitality

The Ethical Standards in Public Life etc. (Scotland) Act 2000 states the following:-

- As a general rule it is usually appropriate to refuse offers.
- You must not accept repeated hospitality from the same source.
- You must not accept any hospitality offer to show favour or disadvantage to any individual.

Modest hospitality may be acceptable provided it is normal and reasonable in the circumstances e.g. lunches in the course of a working visit. Any hospitality accepted

should be similar in scale to that which the NHS as an employer would be likely to offer. All other offers of hospitality should be declined.

Hospitality in excess of what the NHS would be likely to provide should not normally be accepted. Such hospitality should be politely but firmly declined.

Should an individual wish to accept hospitality, then approval of the appropriate line manager/Head of Department/Director is required. All hospitality exceeding what the NHS would be likely to provide, whether accepted or declined, must be entered on the Register of Interests, Gifts and Hospitality.

It may not always be clear whether an individual is being invited to an event involving the provision of hospitality (e.g. formal dinner) in a personal/private capacity or as a consequence of the position which he/she holds with the Board.

(i) If the invitation is the result of the individual's position within the Board, only hospitality which is modest and normal and reasonable in the circumstances should be accepted. If the nature of the event dictates a level of hospitality which exceeds this, then the individual should ensure that his/her line manager/Head of Department/Director is fully aware of the circumstances and approves their attendance. An example of such an event might be an awards ceremony involving a formal dinner. If the line manager/Head of Department/Director grants approval to attend, the individual should declare his/her attendance for registration in the Register of Gifts and Hospitality.

(ii) If the individual is invited to an event in a private capacity (e.g. as result of his/her qualification or membership of a professional body), he/she is at liberty to accept or decline the invitation without referring to his/her line manager/Head of Department/Director. The following matters should however be considered before an invitation to an individual in a private capacity is accepted.

   a. The individual should not do or say anything at the event that could be construed as representing the views and/or policies of the Board.

   b. If the body issuing the invitation has (or is likely to have, or is seeking to have) commercial or other financial dealings with the Board, then it could be difficult for an individual to demonstrate that his/her attendance was in a private and not an official capacity. Attendance could create a perception that the individual's independence had been compromised, especially where the scale of hospitality is lavish. Individuals should therefore exercise caution before accepting invitations from such bodies and must inform their line manager/Head of Department/Director.

(iii) Where suppliers of clinical products provide hospitality it should only be accepted in association with scientific meetings, clinical educational meetings or equivalent, which must be modest, normal and reasonable in the circumstances and in line with what the NHS would normally provide and held in appropriate venues conducive to the main purpose of the event, e.g. the sponsorship is clearly disclosed in any papers relating to the meeting; products discussed should be described in relation to the Scottish Medicines Consortium, Formulary or equivalent clinical product catalogue and the active promotion of clinical products is restricted to those in the Board's Formulary and equivalent clinical product catalogues.

### 3.3 Assessment and training visits for new equipment

It is not acceptable for individuals within NHS Borders to accept offers of travel or overnight accommodation except where such visits do not relate to the purchase of equipment but are rather to do with training or familiarisation of equipment which it has already been determined will be purchased. In these circumstances it is acceptable for the cost to be met by the manufacturer or supplier.

Whilst it will be necessary for staff advising on the purchase of equipment to inspect such equipment in operation in other parts of the country or exceptionally overseas, acceptance of an offer by the manufacturer to meet the costs of such visits may run the risk of casting doubts on the integrity of subsequent purchasing decisions. NHS Borders will therefore meet the costs of any visits which are considered necessary. It is therefore essential that any such visits are authorised by the appropriate line manager and declared and all appropriate efforts are made to ensure visits are done in an ethical way and shall not include additional hospitality.

### 3.4 Record of Hospitality and Gifts

It is the responsibility of the recipients of gifts and hospitality to declare all reportable items received, whether accepted or declined, via the Declaration of Gifts & Hospitality Form at **Appendix A**.

### 3.5 Competitions/Prizes

Individuals should not enter competitions including free draws organised by bodies who have (or are seeking to have) financial dealings with the Board. Potential suppliers may use this as a means of giving money or gifts to individuals within the Board in an effort to influence the outcome of business decisions.

### 3.6 Other Gifts/Promotional Offers

There will be instances where staff have the opportunity to accept a gift or some other promotional offer from a supplier, manufacturer or contractor without it being obvious that it is intended as an inducement. The offer may be described as ‘without strings’. Acceptance of such offers may however create a sense of obligation which could affect the impartiality of a member of staff on some future occasion, and could in any event cast doubt on his/her integrity, with damaging effect on his/her reputation and that of the organisation.

### 3.7 Intellectual Property

If an employee invents a new technology, for instance, a device or diagnostic, or otherwise creates intellectual property (IP) as part of the normal duties of their employment, the patent rights in the invention belong to the employer (Patents Act 1977). Although legally the employee is not automatically entitled to any royalty or reward derived from such an invention, they would expect to be acknowledged as the inventor in any patent application.

### 3.8 Sponsorship

It is accepted that NHS Borders should benefit from sponsorship opportunities. However, there are certain companies from which sponsorship should not be accepted. Those companies are:

- those whose products have inherent health risks;
- those who manufacture or supply tobacco and alcohol products;
- or those who have a history of failing to meet legislative standards in respect of industrial relations and work conditions, human rights, animal rights or environmental issues.

Sponsorship should not be used to fund what are NHS Borders's primary responsibilities therefore it is not appropriate to use sponsorship to:

- meet the costs of providing health care services
- or when it is necessary for staff, advising on the purchasing of equipment, to expect to see such equipment in operation in other parts of the country (or exceptionally overseas).

However sponsorship can be used to fund what are seen to be secondary activities such as:-

- Materials for education, training and health promotional events;
- Clinical audit projects;
- Production and distribution of educational materials;
- Printing and distribution of guidelines;
- Fund educational and health promotion events;
- Educational grants;
- Facilitate access to research and development work elsewhere;
- Meet the running costs of Board organised events;
- Funding expenses for attendance at local or national conferences;
- Sponsorship of individuals for training courses or research projects.

The difference is NHS Borders' official charity. It supports patients in the Borders by providing 'added extras' that are over and above that which is provided by the NHS. Further details can be accessed at thedifference.org.uk

**Sponsorship agreements**

A sponsorship agreement must be put in place for all sponsorship activities.

Before taking forward any sponsorship agreements it must be confirmed that no major procurement decision involving the sponsor has been taken by NHS Borders within the preceding six months and none are anticipated in the following six months.

Monies accepted in the form of sponsorship or a donation from any external organisation, particularly Pharmaceutical Companies, must be supported by an NHS Borders Disclaimer Letter signed by the Senior Departmental Officer to protect NHS Borders from any obligation in contractual dealings with that particular organisation. Disclaimer Letter can be requested from the Finance Directorate via the Finance Helpdesk email Finance.helpdesk@borders.scot.nhs.uk.

No employee should agree to linked deals where sponsorship is linked to the purchase of a particular product or to supplies from particular sources

Companies offering sponsorship should be sent a copy of NHS Borders's Standards of Business Conduct for NHS Staff and must confirm in writing that they have understood this and will abide by its content.

A sponsorship agreement must then be produced between NHS Borders and the company offering the sponsorship.

The principles upon which any sponsorship agreement must be based are as follows:

- Must protect the interests of individual patients and guard against the use of any single product to the exclusion of other reputable brands on the market;
- Should not undermine or conflict with the ethical requirement of any health care professional including the duty of doctors to provide whatever treatment they consider clinically appropriate;
- Must comply with the requirements for the protection and use of patient information;
- Must not be used to generate a profit for NHS Borders;
- Must be legal and in keeping with the objectives outlined above;
- Will be made public in line with NHS Borders's accountability requirements.

A sponsorship agreement should contain as a minimum the following information:

- Details of the parties to the agreement
- Give a clear description of the sponsorship deal
- Detail the timeframe associated with the sponsorship agreement
- Confirm the credit to be given to the sponsors and this must also detail how this credit will be given to the sponsors. The credit can acknowledge the fact that they have provided the funding for the materials, hospitality or running costs to allow the project or event to be run.

However, the following issues must be made clear:

- That credit for the work or organisation is due to NHS Borders and not the sponsors;
- That the acceptance of sponsorship is not an endorsement of a specific product or drug;
- Any mention of the sponsor will be to the Company and not specifically to any of its products;
- The sponsors may attend any sponsored event and display samples of its products, but it must be clear that NHS Borders is not endorsing or promoting the company or its products.

Once the Sponsorship Agreement is finalised it should be sent by the relevant manager to the Director of Finance for approval and to ensure a co-ordinated and consistent approach to sponsorship deals.

Any final decision on the appropriateness of an offer of sponsorship will rest with the Chief Executive.

Staff must not allow any sponsorship agreements negotiated on behalf of NHS Borders to affect the integrity of their decision making or to influence discussions with patients about treatments or products.

**Other relevant forms of sponsorship**

**Training -** Acceptance of sponsorship for attendance at relevant conferences and courses is acceptable but only where the training is consistent with the individual employee's personal development plan (PDP) and or job description. The employee should seek permission in advance from their line manager and the line manager on behalf of NHS Borders must confirm that there is a need for training but cannot fulfil the training or PDP need. Normally the relevant Associate Medical Director should give permission. However, the Associate Medical Director should discuss this fully with the Medical Director, in the case of consultant staff.

**Posts -** Acceptance of sponsorship to sponsor wholly or partially a post may be acceptable if appropriate financial arrangements are agreed in advance with the Director of Finance. In addition, where the sponsorship is accepted, the Director of HR, OD & OH&S will be fully involved and will be responsible for the establishment of monitoring arrangements to ensure that purchasing decisions are not being influenced by the sponsorship agreement. Any pump-priming or fixed term funded posts must have either a permanent financial arrangement, or an agreed exit strategy in place prior to the commencement of the agreement.

**Information -** Managers are reminded to take care in using internal information if it would prejudice the principle of a purchasing system based on fair competition. This principle applies whether private competitors or other NHS providers are concerned.

### 3.9 Endorsements

NHS Borders must not endorse any specific product or service unless it can be clearly demonstrated that such endorsement clearly links to NHS Borders Corporate Objectives. The criteria for NHS Borders Corporate Endorsements is attached as **Appendix C**.

## 4. REGISTER OF STAFF INTERESTS

To avoid conflicts of interest and to maintain openness and accountability, employees are required to register all interests that may have any relevance to their duties/responsibilities. These include any financial interest in a business or any other activity or pursuit that may compete for an NHS contract to supply either goods or services to the NHS or in any other way could be perceived to conflict with the interests of the Board. The test to be applied when considering appropriateness of registration of an interest is to ask whether a member of the public acting reasonably might consider the interest could potentially affect the individual's responsibilities to the organisation and/or influence their actions. If in doubt the individual should register the interest or seek further guidance from their line manager/Head of Department/Director.

Interests that it may be appropriate to register include:-

(i) Other employments;
(ii) Directorships including Non-Executive Directorships held in private companies or public limited companies (whether remunerated or not);

(iii) Ownership of, or an interest in, private companies, partnerships, businesses or consultancies.
(iv) Shareholdings in organisations likely or possibly seeking to do business with the NHS (the value of the shareholdings need not be declared);
(v) Ownership of, or interest in land or buildings which may be significant to, of relevance to, or bear upon the work of the Board;
(vi) Any position of authority held in another public body, trade union, charity or voluntary body;
(vii) Any connection with a voluntary or other body contracting for NHS services.
(viii) Any involvement in joint working arrangements with Clinical (or other) Suppliers

This list is not exhaustive and should not preclude the registration of other forms of interest where these may give rise to a potential conflict of interests upon the work of the Board. Any interests of spouses, partner or civil partner, close relative or associate, or persons living with the individual as part of a family unit, could also require registration if a potential conflict of interests exists.

All members of staff are responsible for entering their interests via the Declaration of Interests Form at **Appendix B**. Any changes to interests should be notified at the earliest opportunity, or within 4 weeks of the change occurring. A separate Register of Interests for NHS Board Members will be held by the Board Secretary.

The entries in the Register of Interests will be retained in respect of any registration for a period of 5 years after the registration ceases or the member of staff leaves.

It is the responsibility of each individual to declare any relevant interest to the Chair of any Board Standing Committee/Professional Advisory Committee/decision making group that they sit on so that the Chair is aware of any conflict which may arise. These Declarations of Interest will be recorded in the Minutes of the meeting.

## 5. PURCHASE OF GOODS AND SERVICES

The Board has an established Procurement Department under the direction of the Head of Procurement. The Procurement Department purchases the goods and services required for the functioning of NHS Borders. With the exception of certain staff within Estates, Pharmacy and IM&T, no other member of staff is authorised to make a commitment to a third party for the purchase of goods or services. The Procurement Department should be contacted for advice on all aspects of the purchase of goods and services.

All staff who are in contact with suppliers and contractors (including external consultants), and in particular those who are authorised to sign Purchase Orders, or place contracts for goods, materials or services are expected to adhere to professional procurement standards. They should also be aware of their responsibilities to comply with the Bribery Act 2010.

Fair and open competition between prospective contractors or suppliers for NHS contracts is a requirement of Standing Financial Instructions (SFIs) and of EC Directives on Public Purchasing for Works and Supplies. This means that:

(i) no private or public company, firm or voluntary organisation which may bid for NHS business should be given any advantage over its competitors, such as advance notice of NHS requirements. This applies to all potential contractors, whether or not there is a relationship between them and the NHS employer, such as a long-running series of previous contracts.

(ii) each new contract should be awarded solely on merit in accordance with the NHS Board SFIs and relevant Board procedures.

No special favour should be shown to current or former employees or their close relatives or associates in awarding contracts to private or other businesses run by them or employing them in a senior or managerial capacity. Contracts must be won in fair competition against other tenders and scrupulous care must be taken to ensure that the selection process was conducted impartially, and that staff who are known to have a relevant interest play no part in the selection.

All invitations to potential contractors to tender for NHS business should include a notice warning tenderers of the consequences of engaging in any corrupt practices involving employees of the Board.

Code of Corporate Governance, Section G, Standing Financial Instructions (SFIs) describe the process to be followed to purchase goods and services. Key points to note are:-

(i) SFIs define the limits above which competitive quotations and competitive tenders must be obtained and describe the process which should be followed to achieve fair and open competition.
(ii) No organisation should be given an unfair advantage in the competitive process e.g. by giving advance notice of the Board's requirements.

## 6. BENEFITS ACCRUING FROM OFFICIAL EXPENDITURE

The underlying principle is that individuals should not derive private/personal benefit from public expenditure.

Employees as individuals must not derive personal benefit from public expenditure. Staff should not use their official position for personal gain or to benefit their family and friends.

Employees should not seek nor accept preferential rates or benefits in kind for private transactions carried out with companies with which they have had or may have official dealings on behalf of the Board. (This does not apply to concessionary agreements negotiated on behalf of NHS staff as a whole.)

Staff should not collect air miles arising from official travel unless these are to be applied to future business travel.

A small number of staff might find their duties require them to make official purchases from retail outlets which promote loyalty schemes (e.g. loyalty cards). Staff should not make purchase decisions which allow them to benefit personally from such schemes when they are applied to official expenditure.

## 7. FREE SAMPLES

Occasionally, a supplier may provide items/goods to the Board free of charge. Care should be taken in deciding whether to accept such samples/gifts. As a rule, employees should consult with their line manager/Head of Department/Director on this matter. The factors to be considered include the following -

(i) Will acceptance be seen as endorsing the product in question?
(ii) Will acceptance create an obligation to buy from the supplier in question?
(iii) If the items/goods are to be passed on to the public/patients for use, who will be liable if the items/goods are unfit for their intended purpose?

## 8. SECONDARY EMPLOYMENT

Staff, other than medical and dental staff, employed by the Board may wish to follow their NHS employment or profession concurrently with another employer. Before staff other than medical and dental take up such other employment they should obtain the approval of the Board. Approval should be sought by approaching the individual's line manager/Head of Department/Director in the first instance. Any approval should be in writing and recorded on the individual's personal file.

The Board will require assurance that the secondary employment -

(i) will not create a conflict of interest;
(ii) will not interfere with or have a detrimental effect on the employee's duties with the Board;
(iii) will not contravene the European Union Working Time Directive;
(iv) will not damage the Board's reputation.

Consultant Grade, Hospital Medical and Dental Staff and Doctors and Dentists in Public Health Medicine and the Community Health Service may undertake private practice in accordance with their respective Terms and Conditions of Service.

All staff should note that it may also be appropriate to declare any secondary employment on the Register of Interests.

## 9. ACCEPTANCE OF FEES

Where an employee, other than a member of Medical and Dental staff, is offered fees by outside agencies, including a clinical supplier, for undertaking work or engagements (e.g. radio or TV interviews, lectures, consultancy advice, membership of an advisory board etc.) which have a bearing on his/her official duties, or draw on his/her official experience, the employee's line manager must be informed and his/her written approval obtained before any commitment is given by the employee. Directors must obtain written approval from the Chief Executive and the Chief Executive must obtain written approval from the Chair of the Board before committing to such work.

An assurance will be required that –

(i) the individual concerned is not making use of his/her NHS employment to further his/her private interests;
(ii) any outside work does not interfere with the performance of his/her NHS duties;
(iii) any outside work will not damage the Board's reputation.

If the work carried out is part of the employee's normal duties, or could reasonably be regarded as falling within the normal duties of the post and is carried out in the Board's time, then any fee due is the property of the Board and it should be the Board (and not the individual) that issues any invoice required to obtain payment. The individual must not issue requests for payment in his/her own name and must pass the relevant details to the Finance Department to allow the issue of an invoice and collection of the payment.

Employees should not commit themselves to any work which attracts a fee until they have obtained the required approval. It is possible that an individual may undertake work and not expect a fee but then receive an unsolicited payment after the work in question has been completed. The fact that the fee is unsolicited is not relevant.

It is also possible that an individual may be offered payment in kind e.g. book tokens. If it is not appropriate for the individual to retain the payment in kind, then the gifts or tokens should be handed over to the individual's line manager/Head of Department/Director to be used for the benefit of the organisation as a whole.

A record on the Declaration of Gifts & Hospitality Form should be made when a gift or token is handed over to a line manager/Head of Department/Director and the record should show how the gift or token is used.

A gift offered in respect of work undertaken as part of the individual's **normal** duties should be declined unless it is of minor or trivial nature and of a low intrinsic value. Examples of such minor or trivial gifts include diaries and calendars.

Certain other provisions apply specifically to the provision of lectures or interviews. A lecturer/interviewee should ensure that the audience is made aware of whether he/she is speaking on behalf of the Board or in a private capacity.

(i) It may not always be clear whether an individual is acting in a private capacity or as a representative of the Board. An individual will be deemed to be acting in a private capacity where he/she is invited to speak because of his/her position within the Board but is expected to express his/her personal thoughts and opinions on a subject. It is acknowledged that this may be a grey area and, in cases of doubt, staff should consult their line manager/Head of Department/Director. (Directors should seek the endorsement of the Chief Executive).

(ii) Where an individual gives a lecture in a private capacity on a matter unrelated to the NHS and the individual's job or profession (e.g. a hobby), he/she does not have to seek permission from his/her line manager/Head of Department/Director. In these circumstances, the individual should avoid referring to his/her official position with the Board, therefore any slides or handouts, etc. should not display the NHS Borders logo.

Consultant Grade, Hospital Medical and Dental Staff and Doctors and Dentists in Public Health Medicine and the Community Health Service may undertake additional work and receive fees in accordance with their respective Grade Terms and Conditions of Service.

## 10. CONTACT BETWEEN STAFF AND PHARMACEUTICAL AND HEALTHCARE COMPANY REPRESENTATIVES

The Scottish Government Health and Social Care Directorate (SGHSCD) has published Circular HDL(2003)62 and associated guidance entitled 'A Common Understanding: Guidance on Joint Working between NHS Scotland and the Pharmaceutical Industry'. This SGHSCD guidance promotes consistency of approach across the NHS in Scotland through a model framework to ensure responsibility, transparency and probity in the joint working process. The NHS Board is committed to providing high quality, innovative healthcare to the population it serves. In striving to achieve this aim, it acknowledges the considerable benefits and opportunities arising from collaboration between the NHS, the Pharmaceutical Industry and other Clinical Suppliers.

However, all relationships between the NHS and suppliers, or potential suppliers, must be conducted in an appropriate, transparent and cost effective manner. To ensure this is the case, the NHS has strict Standards of Business Conduct (NHS MEL (1994) 48) and follow the guidelines in the Association of British Pharmaceutical Industry (ABPI) Code of Practice. This section provides additional guidance on matters that are specific to joint working with Clinical Suppliers. For all other issues in relation to clinical suppliers, including hospitality and acceptance of fees, the earlier sections above apply.

Representatives visiting NHS Borders sites are expected to observe the Code of Practice for the Pharmaceutical Industry drawn up by the ABPI and ABHI for other goods and services.

If this guidance is breached Representatives may be removed or barred from a site or, reported to their company or commercial / professional organisations, i.e. ABPI for Pharmaceutical and ABHI for other Suppliers as relevant.

### 10.1 Gifts & Hospitality

Gifts and /or hospitality offered by Pharmaceutical/Medical representatives to NHS personnel must follow the guidelines in the Association of British Pharmaceutical Industry (ABPI) Code of Practice. In summary these guidelines state that a company must not offer anything which is, or could seem to be, an inducement to prescribe, supply, administer, recommend or buy any product i.e. the offer of the gift must be unconditional. Only minor gifts with a low intrinsic value can be accepted e.g. calendars and diaries. Only modest hospitality should be accepted i.e. it should be similar in scale to what the NHS would offer and applies only to attendees of the meeting, not to any persons accompanying them.

### 10.2 Visits to NHS Borders Sites

Representatives may not enter any clinical or non-clinical areas (including wards, out-patients areas and Community Health Centres or Clinics which host community health services) or visit the Pharmacy or Supplies Departments without an appointment.

Representatives must wear an identity badge when in NHS Borders sites. This should be provided by the company.

Representatives invited into wards, clinical and community areas must comply with NHS Borders policies and procedures, particularly those relating to infection control and patient confidentiality.

Should any emergency situation arise whilst on an NHS Borders site e.g. fire alarm, all Representatives must obey any instructions given to them by NHS Borders staff.

### 10.3 Appointments with NHS Borders Staff

Representatives may only seek an appointment where there is a valid reason for the visit; it is NHS Borders's expectation that such meetings are educational and not entirely promotional.

Representatives must see the consultant first by making an appointment and must ask the consultant's permission before seeing junior medical staff.

Prior approval of the Senior Nurse/ Community Team Leader/AHP Head of Service for the unit/team must be given before representatives arrange to see nurses/midwives/podiatrists/physiotherapists etc.

Pharmaceutical/Medical representatives must inform Pharmacy/General Supplies / Medical Physics as appropriate in advance of promotion of any product within an NHS Borders hospital/community site.

Where any teaching and/or promotional activity is planned, representatives must advise the Department Manager and Head of Procurement. The intent of the meeting must not contravene/challenge existing NHS Borders policies.

Leaflets and posters produced by suppliers must not be distributed or displayed in clinical areas unless approved by the General Manager/ Associate Nurse Director/ AHP Lead for that area.

### 10.4 Promotional Activities by Company Representatives

Pharmaceutical/Medical representatives must inform Pharmacy/General Supplies / Medical Physics as appropriate in advance of promotion of any product within an NHS Borders hospital/community site.

Representatives should be well informed about the products that they are promoting. In addition, standard technical and where appropriate, clinical data, including information on product effectiveness must be available.

Where any teaching and/or promotional activity is planned, representatives must advise the Department Manager and Head of Procurement. The intent of the meeting must not contravene/challenge existing NHS Borders policies.

Leaflets and posters produced by suppliers must not be distributed or displayed in clinical areas unless approved by the General Manager/ Associate Nurse Director/ AHP Lead for that area.

### 10.5 NHS Borders Employee Contact with Company Representatives

There will be occasions when employees will be required to contact suppliers. This direct contact should be restricted to the following:-

(i) To request training and educational support, where this is provided through a formal contract.

(ii) To request updated literature and research around the company's products or specialist area.
(iii) When taking part in formal research data collection exercise.
(iv) When a tender process in conjunction with NHS Borders supplies team.
(v) To obtain clinical or technical advice with regard to a specific product.

Representatives are not permitted to receive any information about prices or usage of competitors' products.

Under no circumstance will commercial negotiation take place between clinicians and suppliers.

### 10.6 Purchase Orders

Commitment to purchase goods and services is only entered into by the raising of an official NHS Borders Purchase Order. Suppliers must not deliver goods or provide a service without first receiving an official NHS Borders Purchase Order unless it is part of an approved trial and complies with laid down procedures for trials.

Any goods or services received without an official Purchase Order will be accepted on the basis of "Free Goods" and any subsequent invoices will be returned for a full credit.

NHS Borders does not accept responsibility for goods and/or services provided without an official order.

### 10.7 Invitations to Meetings or Events

All NHS Borders employees must discuss the implications with their manager before accepting an invitation to attend or speak at a meeting or event organised by a pharmaceutical / healthcare company, including meetings outside of normal working hours.

Staff presenting at a meeting or event sponsored by an external company must be cautious of any bias generated through accepting sponsorship. Under no circumstances should any employee agree to linked deals where sponsorship is linked to a commitment to purchase, prescribe or use a particular product or company.

If the meeting is to take place within working hours the company should have no influence over the content of any presentation made by the NHS Borders employee.

Staff presenting at sponsored meetings should ensure that their presentation is consistent with current approved clinical practice, formulary and clinical protocols in use in NHS Borders.

Clinicians who undertake to attend or speak at sponsored meetings in their own time do so as a clinical specialist and not as an NHS Borders employee; therefore any slides or handouts etc. should not display the NHS Borders logo.

In all circumstances it should be made clear that the employee's presence does not imply that NHS Borders endorses any of the company's products or services.

## 10.8 Joint Working with External Partners

All joint working arrangements with an external partner must be authorised by an Executive Director/Director/General Manager.

A number of principles underpin any agreement to work with an external partner:

- Patient Interest
- Patient & Data Confidentiality
- No Conflict of Interest
- Accountability
- Equity
- Clinical Evidence
- Legal Issues
- Outcome Measure Monitoring
- Openness and Ethical Issues
- Probity

There should be no promotional coverage other than that agreed in writing in advance.

The NHS parties should be accountable for any agreement entered into. All joint working between NHS Borders and an external partner should be recorded.

## 10.9 Samples – Medicines, Wound Care Products, Catheters, Food Products, etc.

NHS Borders staff will not accept free samples of any product for assessment, however generous such offers may seem, therefore samples of any medical product, including medicines, catheters, medicated dressings, aerosols and food products for use in the hospital/community **must not be left** on wards, theatres, departments or community health centres /clinics.

The hospital pharmacies will not accept samples unless there has been a specific prior agreement between the consultant concerned and the Director of Pharmacy.

Any proposal regarding a medicine trial must be discussed with the Director of Pharmacy on each site.

## 10.10 Samples – Medical Devices

Medical device samples must only be left on Wards/Departments/community health centres/clinics with the express permission of the site General Manager/Head of Procurement/ Associate Nurse Director/AHP lead.

All Medical Devices, or Consumables used with Medical Devices, must be acceptance checked by Head of Procurement as specified in the Medical Physics ISO 9001:2008 work instructions prior to being introduced into any area in NHS Borders.

Products brought in by representatives and used in labs /theatres which are not on contract, or without an official purchase order number, will be considered 'Free of Charge'. Any request for payment should be agreed beforehand enabling an order number to be raised with the NHS Borders Procurement Team.

All medical device samples must be CE marked (Conformite Europeene). ‘CE’ markings are an indication that the product has undergone some form of verification and validation process to the EC. In addition, a Pre-Purchase Questionnaire may be required before a device can be left on NHS Borders premises.

Any commercially sponsored trials/agreements of medical devices must be advised through to the Procurement Department to ensure that:

- Trials or research carried out within NHS Borders have been notified to the Clinical Governance & Quality Department. Trials are carried out in accordance with NHS Borders guidelines and Standing Financial Instructions for trials
- Trials or research projects are approved by the Research Ethics Committee where appropriate
- Trials are carried out on a controlled basis
- The product in question meets the appropriate safety standards
- Trials are not duplicated
- There is a protocol to return unused products following the trial period

In any product trial, the following points will be considered and recorded:

- How the trial has to be administered
- How the trial has to be financed
- How samples are to be provided
- How long the trials will last
- Whether technical staff need to be involved
- Current safety regulations and quality standards how the trial will be assessed
- Whether the other criteria (e.g. packaging) need to be taken into account
- Whether the supplier should be involved
- The implications for existing contracts and purchasing agreements
- How the trial will be evaluated
- How the results of the trial will be disseminated

For further information, please contact any member of the Procurement Team. Products brought into NHS Borders by Representatives, which are not on contract or without an official Purchase Order number will be considered 'Free of Charge'.

### 10.11 Software/Systems offered by Pharmaceutical and Healthcare Companies

All users of NHS Borders computers have a responsibility to ensure they use their computer in a safe and secure manner and only software provided by the IM&T Dept should be loaded onto your computer.

Any software products or programmes offered by company representatives must be checked by IM&T before being loaded. For further advice on software usage on NHS Borders equipment, please contact the IM&T Service Desk.

### 10.12 Medical Equipment

NHS Borders requires that **all** medical equipment is delivered via the Procurement Department who will label the equipment to identify that it is approved for use.

Procurement will supply an indemnity form for completion by the Supplier and will attach a "**DO NOT USE AFTER LABEL**" to identify when the indemnity agreement expires or the device requires maintenance. This includes all equipment on loan, (whether for trial or testing or not): free issues and free issues for trial and testing.

Under no circumstances should medical equipment be delivered directly to a Ward/Department/community health centre/clinic without prior knowledge of the Procurement Department.

For further information regarding Loan Equipment Procedures please contact the Head of Procurement.

### 10.13 Supplier Representatives and Operating Theatre Department

The aim of the Operating Theatre and staff is to provide and maintain high standards of patient care during surgical procedures. Supplier representatives must appreciate and recognise this as a priority. This guidance is an effective risk management tool, which will control the access of supplier representatives to the Operating Theatre Department.

- All Supplier representatives will gain permission prior to entering the Operating Department, from the Theatre Manager or Deputy.

- On arrival to the Operating Department, Supplier representatives will report to the Theatre Manager, stating who they are and with whom their visit has been authorised. Identification must be produced at this stage.

- All Supplier representatives should sign in and out of the theatre department in order to comply with fire safety regulations.

- Supplier representatives will be provided with the appropriate theatre attire and instructed on how it should be worn. Representatives must NOT wear their own theatre attire for infection control reasons.

- Supplier representatives will be supervised by a named member of the Theatre staff throughout their visit to the theatre department.

- Supplier representatives are reminded that all procedures within the Operating Theatre Department are confidential in nature and that any information, discussions, technical details or documentation must be treated as such. **(They will only enter the theatre room once the patient is asleep and draped, in order to maintain the patient's dignity.)**

- If the Supplier representative is required to scrub, for whatever reason, this must be authorised by the Theatre Manager and the attending surgeon.

  Informed Patient consent must be obtained (before the anaesthetic) authorising the supplier representative to be present in the Operating Theatre observing/demonstrating/commissioning equipment and giving explicit consent if the Supplier is to scrub up.

- Any Supplier representative gaining access to Theatre, to provide technical assistance during a surgical procedure, to observe, demonstrate, in service or commission equipment or products, must produce evidence of a recognised qualification e.g. (Theatre Access Qualification), which states that they are competent to do so, prior to entry. They must also produce a company indemnity insurance certificate, before they will be allowed to scrub up - this would only be in exceptional circumstances and must be agreed in advance.

- A member of the theatre scrub team must be present while the supplier representative “scrubs up” to assure that aseptic techniques are adhered to at all times.

### 10.14 Pricing

Access to pricing documentation will be managed in accordance with the requirements of the Freedom of Information (Scotland) Act 2002. Any relevant exemptions specified in the Act will be applied, taking account of both commercial and public interest. Staff and suppliers are reminded that commercial information is confidential. This must be borne in mind especially when discussing rival suppliers and their products and prices. Prices from rival Suppliers must not be disclosed.

### 10.15 Registration and Declaration of Interests

The over-riding principles above on the Registration of Staff Interests apply equally to staff who work jointly with clinical suppliers and should be read in conjunction with that section. However, the registration process requires additional detail to be provided and for registration for those who are neither employed by nor contracted with the Board, e.g. Honorary Consultants.

The requirement to register interests is applicable to holders of honorary contracts and research partnerships.

For staff and Honorary Consultants interests should be declared on appointment or when the interest is acquired. Any change in circumstances (either acquisition of an interest, amendment to an interest or termination of an interest) should be declared within 4 weeks of the change occurring.

All interests should be declared on the Register of Interests Form at **Appendix B**. All interests declared under these provisions will be open to public inspection and will be retained for a period of 5 years from when the individual ceased to have the declared interest.

Declarations should also be made at relevant meetings and this may affect the level of participation in some circumstances.

If suppliers of clinical products approach NHS staff, including honorary contract holders for advice, this may be construed as a commercial interest, in potential conflict with public duties. Therefore, all individuals providing comparable advice to the Board, for example through their participation in advisory committees, must declare any relevant interests and must withdraw or modify their participation, as necessary, in meetings, consultation exercises etc. Advisory Committees include (this list is not exhaustive):

(i) Prescribing Management Group
(ii) Area Drugs and Therapeutics Committee and Acute Operating Division and Partnership based equivalents
(iii) Area Dressings and Sundries Committee and Acute Operating Division and Partnership based equivalents.
(iv) Groups with a specialist interest in specific therapeutic topics
(v) Guideline development Committees/Groups

(vi) Managed Clinical Networks
(vii) Professional Advisory Committees of the Board
(viii) Any Sub-Groups/Committees of the above.
(ix) Research Ethics Committees
(x) Professional Advisory Committees

This requirement to declare an interest also applies to any individuals, including patient and lay representatives, who provide advice and/or influence decisions made by the above. These declarations will be recorded in the Minutes of the meeting.

Staff should be aware that the requirements for declaration at meetings are also applicable to independent primary care contractors directly involved with NHS decision-making on the procurement of medicines and other clinical products, those undertaking research and development and those participating in Board Committees, for example, on issues related to the General Pharmaceutical Services Regulations. Community pharmacists and other independent primary care contractors who have commercial relationships with a wide range of suppliers, will require to declare relevant interests if they are involved with Board committees where particular products are being considered for inclusion in local policies. These declarations will be recorded in the Minutes of the meeting.

## 11. BREACHES

Any member of staff who fails to comply with the requirements of this Code of Conduct, or is found to have abused their official position, or knowledge, for the purpose of self-benefit, or that of family or friends, may be liable to disciplinary action under the Board's Disciplinary Policy and Procedure. If through their actions or omissions, managers or staff are found to be in contravention of either this guidance or indeed their legal responsibilities then NHS Borders reserves the right to take legal action, if necessary. Where staff suspect, or are aware of non-compliance with these Standards, they should report any such instances to their line manager or the Director of Finance.

## 12. COMMUNICATION

The Standards of Business Conduct for NHS Staff is applicable to every NHS Borders employee and therefore it is imperative that all staff are informed of its contents. Each manager within NHS Borders will receive a copy of the Standards of Business Conduct and will confirm their receipt and understanding of it. Each member of staff will receive a copy at induction and also confirm their understanding of it as part of the Confidentiality Statement sign off every two years.

## 13. INDUCTION OF NEW STAFF

All new staff will be made aware of the Standards of Business Conduct for NHS Staff and its implications for them at induction.

## 14. POLITICAL ACTIVITY

Staff of public bodies, like all public servants, are required to maintain political impartiality in the way in which they go about their public duties. There is no absolute prohibition on political activity for staff of NHS Borders, but NHS Borders must be sure that, as a minimum, staff engaging in political activity avoid any comment on the business of NHS

Borders itself, bring any political involvement into their day-to-day work or engage in controversy relevant to NHS Borders work.

## 15. SUMMARY GUIDANCE

a. **Declaration of Interest** – Any personal interest which may impinge or might reasonably be deemed by others to impinge on a staff member's impartiality in any matter relevant to his/her duties should be declared.
b. **Confidentiality and accuracy of information** – The confidentiality of information received in the course of duty should be respected and should never be used for personal gain; information given in the course of duty should be true and fair and never designed to mislead.
c. **Competition** – While bearing in mind the advantages to the staff member's employing organisation of maintaining a continuing relationship with a supplier, any arrangement which might, in the long term, prevent the effective operation of fair competition, should be avoided.
d. **Business gifts** – Business gifts, other than very small intrinsic value such as business diaries or calendars, should not be accepted.
e. **Hospitality** – Modest hospitality is an accepted courtesy of a business relationship. However, the recipient should not allow him or herself to reach a position whereby he or she might be or might be deemed by others to have been influenced in making a business decision as a consequence of accepting such hospitality; the frequency and scale of hospitality accepted should not be significantly greater than the recipients employer would be likely to provide in return.
**f. When it is not easy to decide between what is and is not acceptable in terms of gifts or hospitality, the offer should be declined or advice sought from the staff member's line manager.**

## 16. SUMMARY TABLE OF ACCEPTABLE GIFTS AND HOSPITALITY

| GIFT/ HOSPITALITY | Acceptable** | Approval Required | Declarable |
|---|---|---|---|
| Low value promotional gifts such as: Diaries/Calendars under £50 | **Yes*** | **No** | **No** |
| Token gifts given at a courtesy visit/ VIP visit | **Yes*** | **No** | **Yes** |
| Infrequent working breakfast | **Yes*** | **No** | **Only if considered greater than £50 in value** |
| Infrequent working lunch | **Yes*** | **No** | **Only if considered greater than £50 in value** |
| Biscuits, chocolates, flowers, alcohol from patients/relatives/friends of patients | **Yes*** | **No** | **Only if considered greater than £50 in value** |
| Formal dinners/evenings | **In some situations** | **Yes** | **Yes** |
| Visits to view equipment paid for by outside companies | **In some situations** | **Yes** | **Yes** |
| Other forms of commercial sponsorship including drug company sponsorship for example to attend a conference, study leave | **In some situations** | **Yes** | **Yes** |
| Gifts to friends/relatives of NHS Borders staff | **No – to be declined ** ** | **Should be declined** | **Yes, regardless of value** |
| Holiday accommodation | **No – to be declined ** ** | **Should be declined** | **Yes** |
| Casual gifts offered by contractors/ potential suppliers under £50 | **Yes (so long as it does not create a sense of obligation)** | **If any doubt** | **Yes** |
| Gifts/ equipment offered by contractors/ potential suppliers over £50 (such as concert/ sporting event tickets) | **No – to be declined**** | **Should be declined** | **Yes** |
| Other promotional gifts | **No – to be declined**** | **Should be declined** | **Yes, regardless of value** |
| Invitations to sporting or cultural events | **No – to be declined**** | **Should be declined** | **Yes, regardless of value** |
| Gifts of cash or gift vouchers (any amounts) - persons offering cash should be advised of the existence of Endowment Funds as an alternative. | **No – to be declined**** | **Should be declined** | **Yes, regardless of value** |

* Acceptable where the gift/ hospitality does not create a sense of obligation or constitute an incentive or bribe.

** Where it is felt that declining the gift will cause offence, approval should be sought on how best to handle receipt of the gift – for example by submitting it to a team fund/

raffling the gift etc. Under such circumstances, the fear of causing offence should not create a conflict of interest for the recipient.

## 17. FURTHER REFERENCE DOCUMENTS

- **Standing Financial Instructions**
- **Scottish Public Finance Manual (SPFM)**
- **Standards of Business Conduct – Code of Conduct**
- **Association of British Pharmaceutical Industry (ABPI) Code of Conduct**
- **The Legislative Framework** is contained in the Prevention of Corruption Acts 1906 and 1916 and the Ethical Standards in Public Life (Scotland) Act 2000.
- **NHS Circulars - MEL (1994) 80** entitled Corporate Governance in the NHS, **and MEL (2000) 13,** entitled Fundraising, Income Generation and Sponsorship within the NHSiS, **NHS Circular No 1989 (GEN) 32** entitled Acceptance of Financial Assistance, Gifts and Hospitality and Declaration of Interest.
- **Guidance** contained in the **Code of Accountability for Boards 1994** and **A Common Understanding; Guidance on Joint working between NHS Scotland and the Pharmaceutical Industry 2003**
- **The Bribery Act 2010**

**Section C - Appendix A**
**NHS Borders**
Chair & Chief Executive's Office

Chair & Chief Executive's Office
NHS Borders
Headquarters
Education Centre
Borders General Hospital
Roxburghshire TD6 9BD

**www.nhsborders.scot.nhs.uk**

## NHS BORDERS REGISTER OF GIFTS & HOSPITALITY FORM

| |
|---|
| Name: |
| Title: |
| **This form should be completed to record all hospitality or gifts received as well as all hospitality or gifts declined.**<br><br>NHS Borders has set an acceptable limit of £50 per gift/hospitality.<br><br>Details of Hospitality/Gift Received or Declined (including value/estimated value):- |
| Signature: .....<br><br>Date: ..... |
| **Approved by Line Manager**<br><br>Name:..... Signature: .....<br><br>Date: ..... |
| Please return this signed form to Iris Bishop, Board Secretary, NHS Borders, Education Centre, Borders General Hospital, Melrose, TD6 9BD for inclusion in the Borders NHS Board Hospitality Register. |

**Section C - Appendix B**
**NHS Borders**

**Staff Members Register of Interests**

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.

Staff Member: ……..… *(please insert your full name in capital letters)*

| Registerable Interest | Members Interest |
|---|---|
| **Remuneration**<br>Remuneration by virtue of being<br>• employed or self employed<br>• the holder of an office<br>• a director of an undertaking<br>• a partner in a firm<br>• undertaking a trade, profession or vocation or any other work<br>• allowances in relationship to membership of an organisation | |
| **Related undertakings**<br>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**<br>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**<br>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**<br>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**<br>Any relevant gifts or hospitality received by the member or the members spouse or cohabitee, company or partnership. | |
| **Non financial interests**<br>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 ……...……...

**Section C - Appendix C:**

**Criteria for NHS Borders Corporate Endorsements**

| **Criteria for NHS Borders Corporate Endorsements** | **Yes** | **Unsure** | **No** | **Rationale** |
|---|---|---|---|---|
| 1. Is there any financial or reputational risk associated with this endorsement? | ☐ | ☐ | ☐ | |
| 2. Will the endorsement have any impact on discrimination, equality of opportunity or relations between groups? | ☐ | ☐ | ☐ | |
| 3. Is the endorsement controversial or does it have the potential of being controversial in any way (political, media, academic, specific interest)? | ☐ | ☐ | ☐ | |
| 4. Will any of the workforce, public or patients disagree with this corporate endorsement? | ☐ | ☐ | ☐ | |
| 5. Is there any doubt about answers to any of these questions (e.g. there is not enough information to draw a conclusion)? | ☐ | ☐ | ☐ | |
| Please provide a detailed explanation of how this endorsement will further the Corporate Objectives of NHS Borders. | | | | |
| If the answer to any of the above questions is yes or unsure or there is no clear link between the endorsement and the organisations' Corporate Objectives the Executive Director should table a paper at the Board Executive Team for discussion and approval.<br><br>***IN ALL CASES THIS FORM MUST BE SIGNED BY AN EXECUTIVE DIRECTOR AND SENT TO THE BOARD SECRETARY.*** | | | | |

| Endorsement details: | Date of endorsement: | Approved by: | Review date: |
|---|---|---|---|
| | | | |

# SECTION D

# SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD – SCHEME OF INTEGRATION

## SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

1. Introduction
2. The Role of NHS Borders Board
3. The Role of NHS Borders Audit Committee
4. The Scottish Borders Health & Social Care Partnership Joint Executive
5. The Health & Social Care Scheme of Integration

## SCOTTISH BORDERS HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD

### 1. Introduction

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

The Act requires Health Boards and Local Authorities to prepare jointly an Integration Scheme setting out how this joint working is to be achieved. NHS Borders and Scottish Borders Council have agreed to integrate planning for, and delivery of, adult health and social care services by delegating agreed functions to an Integration Joint Board using a "body corporate" arrangement.

The legislation underpinning the Scottish Borders Health & Social Care Integration Joint Board requires that its voting members are appointed by the Health Board and the Local Authority and consists of NHS Non Executive Directors and Councillors. Whilst serving on the Scottish Borders Health & Social Care Integration Joint Board its members will carry out their functions under the act on behalf of the Scottish Borders Health & Social Care Integration Joint Board and not as delegates of the respective Health Board or Local Authority. The Scottish Borders Health & Social Care Integration Joint Board will plan and commission services to ensure the Scottish Borders Partnership meet its national and local outcomes based as detailed in the Strategic plan.

The Scottish Borders Partners, Borders Health Board, Scottish Borders Council and the Scottish Borders Health & Social Care Integration Joint Board have agreed detailed operational arrangements which are presented in the Scheme of Integration (SoI).

The Scottish Borders Health & Social Care Integration Joint Board will give direction to Borders Health Board and Scottish Borders Council to carry out each function delegated to it.

### 2. The Role of NHS Borders Board

The Scottish Borders Partnership have agreed integration arrangements as detailed in the Scheme of Integration (SoI). The arrangements will enhance, strengthen and develop the formerly separate services for the provision of adult health and social care.

The Scheme of Integration aims to integrate service delivery and fulfil the expectations of the Strategic Plan to enhance and promote the health and wellbeing of the people of the Scottish Borders.

NHS Borders Board:-

- has joint responsibility for achievement of the outcomes of the Strategic Plan
- has responsibility for the delivery and management of any services within the functions delegated as directed by the Scottish Borders Health & Social Care Integration Joint Board,
- will provide assurance to the Scottish Borders Health & Social Care Integration Joint Board on the performance of services delivered

- will provide performance reporting, through the Chief Officer, on a regular basis to the Scottish Borders Health & Social Care Integration Joint Board for those services within the delegated functions,
- will establish a performance management framework which meets the obligations set out in the legislation and will take account of the targets, measures and objectives for the delegated functions
- will provide assurance to the Scottish Borders Health & Social Care Integration Joint Board on clinical and care governance of health professionals delivering services linked to the delegated functions as delegated by the Scottish Borders Health & Social Care Integration Joint Board,
- will develop and implement a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan) for staff delivering integrated services,
- Will agree an Information Sharing Protocol and procedures with partners as required,
- Will agree a framework for how complaints for services within the delegated functions will be addressed,
- Will support work, led by the Chief Officer, to develop a risk management strategy for the Scottish Borders Health & Social Care Integration Joint Board.

## 3. The Role of NHS Borders Audit Committee

The NHS Borders Audit Committee is required to give assurance to the NHS Borders Board that the set up and ongoing governance of the functions and resources delegated to the Scottish Borders Health & Social Care Integration Joint Board are satisfactory and that governance processes which are in place minimise the risk to NHS Borders of the new arrangements.

The NHS Borders Audit Committee will seek assurance from both Internal and External Audit through their work that the arrangements which are in place between the NHS Board and the Scottish Borders Health & Social Care Integration Joint Board create a robust control framework.

## 4. The Scottish Borders Health & Social Care Partnership Joint Executive

### Terms of Reference

### 1.1 Purpose

The purpose of the Health and Social Care Partnership (HSCP) Joint Executive is to provide a strategic overview of the HSCP's business through:

- Implementing local and national strategy, operational plans, policies, procedures and budgets
- Promoting the quality of service across the HSCP
- Driving and monitoring operational and financial performance
- Escalating key risks and issues, including major concerns about clinical and care governance
- Working to maintain the continuation of HSCP Critical Functions
- Prioritising resources
- Oversight and reporting of IJB and nationally commissioned HSCP projects

In fulfilling its purpose the HSCP Joint Executive shall give due consideration to:

- The interests of various stakeholders (the HSCP Senior Management Team, our staff, wider organisations, independent sector partners, our service users, the third sector, and our communities)
- Promoting and upholding the integrity and reputation of the Scottish Borders Health and Social Care Partnership
- Supporting the development of the Health and Social Care Partnership in line with the Integration Planning Principles

In fulfilling its responsibilities, the HSCP Senior Management Team ensures that it is discharging its statutory responsibilities in the provision of services delegated to the Health and Social Care Partnership

### 1.2 Authority

The HSCP Joint Executive is the joint NHS Borders and Scottish Borders Council body overseeing all operational services, Business Units and Clinical Boards delegated to the Health and Social Care Partnership.

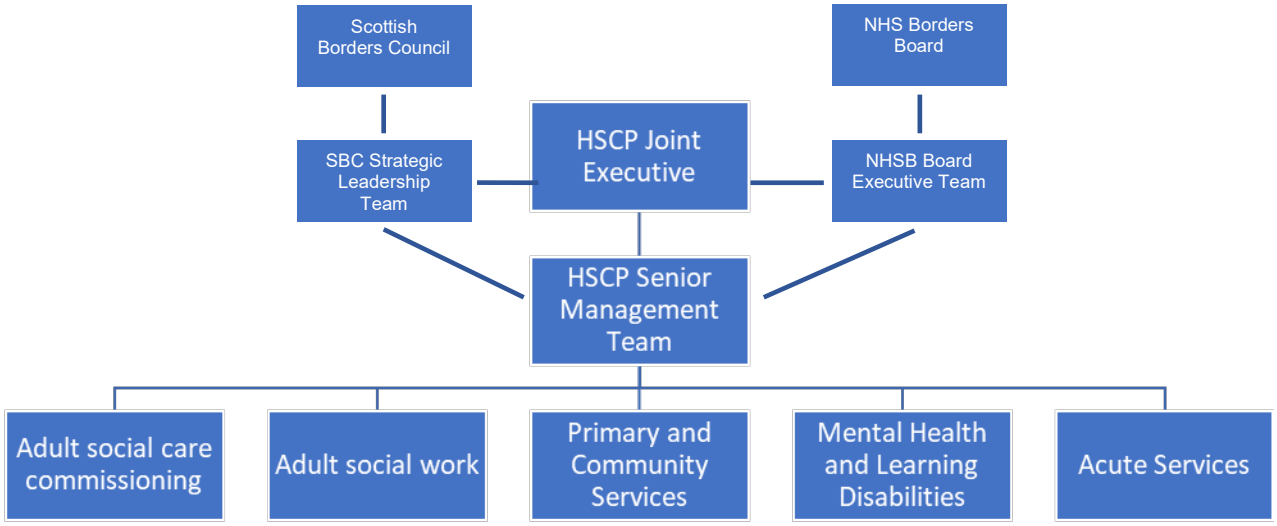
The HSCP Joint Executive oversees the management, leadership, performance and decision-making of the HSCP Senior Management Team. Additionally the HSCP Joint Executive can direct the HSCP Senior Management Team. The HSCP Senior Management Team has the delegated authority to make appropriate decisions across all services within the Health and Social Care Partnership within the Code of Corporate Governance and Standing Orders of NHS Borders and the Scottish Borders Council respectively.

The HSCP Joint Executive is not part of the Scottish Borders Health and Social Care Integration Joint Board, which acts as a Strategic Commissioning Body in a separate legal entity. However as the Integration Joint Board is the body legal responsible for the strategic planning and commissioning of delegated services, it is expected that members of the HSCP Joint Executive will work constructively with the Integration Joint Board, and provide support where reasonably required.

The following individuals will escalate information to the HSCP Joint Executive on behalf of the HSCP Senior Management Team, who will also cascade information back to the HSCP Senior Management Team:

- Director of Acute Services
- Director of Health and Social Care
- Director of Strategic Commissioning and Partnerships
- Director of Social Work and Practice
- Director of Nursing, Midwifery and Allied Health Professionals
- Medical Director

## 1.3 Governance




The chart above outlines the reporting arrangements for the HSCP Joint Executive.

SB Cares will not be represented on the HSCP Senior Management Team. Whilst the service provided is the HSCP in-house social care provider, to ensure parity with other providers, SB Cares will not be able to influence the HSCP Senior Management Team agenda, and will be treated as a provider through HSCP Commissioning function.

Decisions about issues requiring escalation to the HSCP Joint Executive will be made by the HSCP Senior Management Team. The HSCP Joint Executive can also request issues to be brought to the HSCP Joint Executive.

- It is expected that any reports with a consequence on only one of the two parent organisations that require escalation to organisational level, will be escalated from the HSCP Senior Management Team to the appropriate forum i.e. SBC Strategic Leadership Team, NHS Borders Board Executive Team or other.
- In areas where the impacts span both parent organisations, and require escalation to organisational level, then these will be escalated to the HSCP Joint Executive.

Prior to escalation from the HSCP Senior Management Team to the HSCP Joint Executive, it is expected that all detail will have been worked through with appropriate local teams (e.g. Service Teams, Finance, Staff / Partnership, Risk Management, Clinical Governance, Public Engagement, Professional Forums).

In addition, the NHS Borders Board Executive Team or Scottish Borders Council Strategic Leadership Team can also request that items go onto the HSCP Joint Executive agenda.

## 1.4 Constitution

The role of Chair for the HSCP Joint Executive will be undertaken by the:

- Director of Health and Social Care
  In the absence of the Director of Health and Social Care, the role of Chair will be agreed either in advance by the substantive Chair, or by those in attendance.

The HSCP Joint Executive comprises:

- Chief Executive NHS Borders
- Chief Executive Scottish Borders Council
- Chief Financial Officer, Scottish Borders Council
- Chief Financial Officer, Integration Joint Board
- Director of Acute Services, NHS Borders
- Director of Finance, NHS Borders
- Director of Health and Social Care
- Director of Nursing, Midwifery and AHPs, NHS Borders
- Director of Public Health
- Director of Resilient Communities, Scottish Borders Council
- Director of Social Work and Practice
- Director of Strategic Commissioning and Partnerships
- Director of Strategic Planning, NHS Borders
- Head of Communications, NHS Borders
- Head of Communications, Scottish Borders Council
- Medical Director, NHS Borders

### 1.5 Administration of meetings

The PA support for the meeting will be provided by the PAs / Business Manager to the Director for Health and Social Care. The PA will also attend the meeting.

- Papers will be distributed one week prior to meetings and draft minutes will be circulated one week after meetings.
- Dates for meetings will be sought from group members in advance of setting dates for meetings, and reasonable notice will be provided for meetings.
- All meetings will have the option of Microsoft Teams.

### 1.6 Proceedings of meetings

The HSCP Joint Executive will meet fortnightly and will cover a standing agenda, and any additional required papers

Meetings of the HSCP Joint Executive may be called by the Chair at any reasonable time to consider matters falling within the Terms of Reference.

The quorum for the meeting shall be:

- 1 x Director of Health and Social Care / Social Work and Practice / Strategic Commissioning and Partnerships
- 2 x Directors from NHS Borders
- 2 x Directors from Scottish Borders Council

Any other staff member or partner may attend at the invitation of the Chair of the meeting. However within these meetings, only HSCP Joint Executive members have a right to make decisions on behalf of the services represented by the services.

### 1.7 Values

As the Health and Social Care Partnership represents the integrated space at the heart of NHS Borders and the Scottish Borders Council, it is expected that all members of the Health and Social Care Partnership Leadership Team operate within both the values frameworks of both organisations.

As a result the HSCP Senior Management Team will approach their work with:

- Care and compassion
- Dignity and respect
- Openness, honesty and responsibility
- Quality and teamwork

And be:

- People-focused
  - We work collaboratively with colleagues and partners, recognising that everything we do is for the benefit of our residents
  - Less judgement, more empathy: we treat people with respect rather than making assumptions about their needs or behaviour
  - No decision about me, without me: We believe that everyone has the right to be involved in decisions that affect them
- Agile
  - We take advantage of new opportunities and manage risk effectively
  - We work with the public, communities, partners and stakeholders to make best use of public resources and are robust in our business relationships to ensure that we deliver good value for money
  - We are always looking for new ideas, learning from our own experiences, each other, and the best in the world
  - We actively try new things; we understand that mistakes create opportunities to learn and we manage risks that arise
- Inclusive
  - We are passionate about everyone having the best opportunities
  - We carefully consider the impact of our decisions, and we always seek to act fairly
  - We recognise that diversity is about understanding that people are different and have different strengths as well as needs, rather than simply treating everyone the same
  - We recognise that equality is the right of all human beings to be equal in dignity, to be treated with respect and consideration and to participate on an equal basis with others in any area of economic, social, political, cultural or civil life; all of which ensure that people feel welcome, valued and accepted
- Sustainable
  - We are passionate about the prospects of future generations and ensuring we live within our means
  - We are determined to ensure that the Scottish Borders should become a leader in the environmental sphere and enjoy the benefits of dealing simultaneously with health inequalities and environmental sustainability
  - We think creatively, look for solutions and solve problems based upon an understanding of the long-term

### 1.8 Review

Terms of reference will be reviewed and signed off annually by the HSCP Joint Executive.

# Health and Social Care Integration Scheme for the Scottish Borders

**CONTENTS**

**Preface**

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

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

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

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

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

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

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

## Introduction

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

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

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

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

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

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

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

**Vision, Aims and Outcomes of the Integration Scheme**

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

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

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

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

# INTEGRATION SCHEME

## The parties:

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

and

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

### 1. Definitions and Interpretation

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

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

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

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

## 2. Local Governance Arrangements

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

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

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

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

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

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

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

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

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

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

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

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

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

## 3. Delegation of Functions

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

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

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

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

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

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

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

## 4. Local Operational Delivery Arrangements

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

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

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

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

4.4 The Integration Joint Board will:-

a. Appoint its Chief Officer.

b. Appoint its Chief Financial Officer.

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

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

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

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

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

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

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

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

4.5 The Integration Joint Board may consider the following:

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

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

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

4.6 **Targets and Performance Management**

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

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

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

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

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

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

### 4.7 Corporate Services Support

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

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

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

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

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

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

## 5. Clinical and Care Governance

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

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

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

5.4 As part of the integration arrangements the Chief Social Work Officer will provide oversight and advice to the Integration Joint Board on the quality of social work services delivered by social work staff through health and social care integrated services. The Chief Social Work Officer will continue to provide professional leadership for social work and be accountable for statutory decisions relating to Social Work. The Chief Social Work Officer is then held to account by Scottish Borders Council for such decisions and ensures that links are made across all Social Work services. The Chief Social Work Officer also advises Scottish Borders Council on the delivery of social work services through an annual report which will be made available to the Integration Joint Board for assurance purposes. Scottish Borders Council will in turn provide assurance to the Integration Joint Board via the Chief Social Work Officer.

5.5 Clinical governance groups operating for services within the Integrated Joint Board will consider a wide range of reports within their annual work programmes relating to clinical and care governance. These groups provide formal assurance through the NHS Borders Board Clinical Governance Committee. Beyond the annual report from the Board Clinical Governance Committee to the Integrated Joint Board specific assurance can be requested on Clinical and Care Governance matters relating to the delegated functions as and when required.

5.6 As part of the regular monitoring process the Integration Joint Board may, as required, also take advice from other appropriate professional forums and groups as outlined in Scottish Government guidance, including the Public Protection Committee (which encompasses adult and child protection activity and assurance across the partnership), Area Drug and Therapeutics Committee and Area Clinical Forum (ACF) or specific professional advisory groups under the ACF structure.

5.7 The appropriate appointed Clinical Directors at Borders Health Board level (Medical Director, Director of Nursing, Midwifery & AHPs and Director of Public Health) will support the Chief Officer and the Integration Joint Board in the manner they support Borders Health Board for the range of their responsibilities.

5.8 The Chief Social Work Officer will support the Chief Officer and the Integration Joint Board in the same manner they support Scottish Borders Council. Appropriate arrangements are in place for the Chief Social Work Officer to discharge their responsibility to health and social care staff who have a professional or corporate accountability to the Chief Social Work Officer.

## 6. Chief Officer

6.1 The Integration Joint Board shall appoint a Chief Officer in accordance with section 10 of the Act.

6.2 The Chief Officer will be accountable directly to the Integration Joint Board for the preparation, implementation and reporting on the Strategic Commissioning Plan, including overseeing the operational delivery of delegated services as set out in Appendices 2 and 3.

6.3 Where the Chief Officer does not have operational management responsibility for services included in integrated functions, the parties will ensure that appropriate communication and liaison is in place between the Chief Officer and the person/s with that operational management responsibility.

6.4 The Chief Officer will be a member of the Parties relevant senior management teams and be accountable to and managed by the Chief Executive's of both Parties.

6.5 The Chief Officer is seconded to the Integration Joint Board from the employing body.

6.6 Where there is to be a prolonged period where the Chief Officer is absent or otherwise unable to carry out their responsibilities, the Scottish Borders Council's Chief Executive and Borders Health Board's Chief Executive will jointly propose an appropriate interim arrangement for approval by the Integration Joint Board's Chair and Vice-Chair at the request of the Integration Joint Board.

## 7. Workforce

7.1 Borders Health Board and Scottish Borders Council will jointly develop and put in place for their employees delivering integrated services, a Joint Organisational Development Plan (which will cover the learning and development of staff and the development of an effective collaborative culture) and an outline Workforce Plan (to support the implementation of the strategic commissioning plan).

7.2 Core HR services will continue to be provided by the appropriate corporate HR functions in Scottish Borders Council and Borders Health Board.

7.3 The corporate HR functions in Scottish Borders Council and Borders Health Board will provide the necessary resources to ensure the development and implementation of the joint organisational development plan and the outline workforce plan and will, where appropriate, consult with stakeholders.

7.4 Both the joint organisational development plan and the outline workforce plan will be refreshed periodically by the parties and the Integration Joint Board.

7.5 Borders Health Board and Scottish Borders Council professional/clinical supervisions arrangements for professional and clinical staff will continue until superseded by any jointly agreed arrangements.

## 8. Finance

8.1 The Integration Joint Board will seek assurance from Borders Health Board and Scottish Borders Council over the sufficiency of resources to carry out its delegated duties and adjust its performance accordingly, following which it will approve the initial amount delegated to it. This will continue in future years following negotiation with the other parties.

8.2 The arrangements in relation to the determination of the amounts paid, or set aside, and their variation, to the Integration Joint Board by Borders Health Board and Scottish Borders Council are set out below at sections 8.3, 8.4.8.5 and 8.6:-

### 8.3 Payment in the first year to the Integration Joint Board for delegated functions

8.3.1 The baseline payment was established by reviewing past performance and existing plans for Borders Health Board and Scottish Borders Council for the functions to be delegated, adjusted for material items.

8.3.2 Delegated baseline budgets were subject to due diligence and comparison to recurring actual expenditure in the previous three years adjusted for any planned changes to ensure they were realistic. There was an opportunity in the second year of operation to adjust baseline budgets to correct any inaccuracies.

### 8.4 Payment in subsequent years to the Integration Joint Board for delegated functions

8.4.1 In subsequent years the Chief Officer and the Integration Joint Board Chief Financial Officer will develop a case for the Integrated Budget based on the Strategic Commissioning Plan. The financial plan will be presented to Borders Health Board and Scottish Borders Council for consideration as part of the annual budget setting process. The case should be evidenced, with full transparency demonstrating the following assumptions:-

- Performance against outcomes
- Activity changes
- Cost inflation
- Price changes and the introduction of new drugs/technology
- Agreed service changes
- Legal requirements
- Transfers to/from the amounts made available by Borders Health Board for hospital services
- Adjustments to address equity of resource allocation

8.4.2 Borders Health Board and Scottish Borders Council should consider the following when reviewing the Strategic Commissioning Plan:

- The Local Government Financial Settlement
- The uplift applied to NHS Board funding from Scottish Government
- Efficiencies to be achieved

8.4.3 Whilst the Integration Joint Board will plan, agree and deliver the Strategic Commissioning Plan and related Financial Plan, this will follow a process of joint discussion and planning with the other parties.

8.5 **Method for determining the amount set aside for hospital services**

8.5.1 This should be determined by the hospital capacity that is expected to be used by the population of the Integration Joint Board area.

8.5.2 The capacity should be given a financial value using the data from the latest Integrated Resources Framework (IRF).

8.5.3 It will be the responsibility of the Council Section 95 Officer and the NHS Board Accountable Officer to comply with the agreed reporting timetable and to make available to the Integration Joint Board Chief Financial Officer the relevant financial information required for timely financial reporting to the Integration Joint Board. This will include such details as may be required to inform financial planning of revenue expenditure. The Integration Joint Board's Chief Financial Officer will manage the respective financial plan so as to deliver the agreed outcomes within the Joint Strategic Commissioning Plan viewed as a whole. Monitoring arrangements will include the impact of activity on set aside budgets.

8.6 **In-year variations**

8.6.1 Neither Borders Health Board nor Scottish Borders Council may reduce the payment in-year to the Integration Joint Board to meet exceptional unplanned costs within the constituent authorities, without the express consent of the Integration Joint Board and constituent authorities for any such change. Where appropriate supplementary resources are identified or received by Borders Health Board or Scottish Borders Council e.g. as a result of RSG redetermination, these will be passed on to the Integration Joint Board through increasing the level of budgets delegated to it.

8.6.2 The Chief Officer of the Integration Joint Board will deliver the agreed outcomes within the total agreed delegated resources. Where there is a forecast outturn overspend against an element of the operational budget the Chief Officer and the Chief Financial Officer of the Integration Joint Board must agree a recovery plan to balance the overspending budget with the relevant finance officer of the constituent authority. The recovery plan will need to be approved by the Integration Joint Board.

8.6.3 Should the recovery plan be unsuccessful the Integration Joint Board may request that the payment from Borders Health Board and Scottish Borders Council be adjusted, to take account of any revised assumptions. It will be the responsibility of the authority who originally delegated the budget to make the additional payment to cover the shortfall.

8.6.4 In the case of joint services any additional payment will be agreed pro rata in line with the original budget level.

8.6.5 The Integration Joint Board should make repayment in future years following the same methodology as the additional payment. If the shortfall is related to a recurring issue the Integration Joint Board should include the issue in the Strategic Commissioning Plan and financial plan for the following year.

8.6.6 Additional adjustments may be required, for example, when errors in the methodology used to determine the delegated budget are found. In these circumstances the payment for this element should be recalculated using the revised methodology.

8.6.7 Where there is a planned underspend in operational budgets arising from specific action by the Integration Joint Board it will be retained by the Integration Joint Board. This underspend may be used to fund additional capacity in-year or, with agreement with the partner organisations, carried forward to fund capacity in subsequent years. . The carry forward will be held in an ear-marked balance within Scottish Borders Council's general reserve. If an underspend arises from a material error in the assumptions made to determine the initial budget, the methodology of the payment may need to be recalculated using the revised assumptions.

8.6.8 Any unplanned underspend will be returned to Borders Health Board or Scottish Borders Council by the Integration Joint Board either in the proportion that individual pressures have been funded or based on which service the savings are related to.

- The Integration Joint Board will have financial accountability for the funding received as payments from Borders Health Board and Scottish Borders Council. This financial accountability will not apply to notional funding for Set Aside Budgets included within the Strategic Commissioning Plan.

- The Integration Joint Board will follow best practice guidelines for audit;

  - The Integration Joint Board and their Chief Financial Officer will receive financial management support from Borders Health Board and Scottish Borders Council who will:

  - Record all financial information in respect of the Integration Joint Board in an integrated database, and use this information as the basis for preparing regular, comprehensive reports to the Integration Joint Board.

  - Support the Chief Financial Officer of the Integration Joint Board to allow them to carry out their functions in preparation of the annual accounts, financial statement prepared under section 39 of the Act, the financial elements of the Strategic Commissioning Plan and other reports that may be required.

  - Ensure monthly financial monitoring reports relating to the performance of the Integration Joint Board against the delegated budget will be submitted

to the Chief Officer within 15 working days of the month end for reporting to the Integration Joint Board.

- Ensure regular reports will be prepared on the financial performance against the Strategic Commissioning Plan.

- Provide a schedule of payments to the Integration Joint Board following approval of the Strategic Commissioning Plan and its related financial plan. It is intended that this will be a one-off payment made during April/May of each financial year. This payment may be subject to in-year adjustments.

- In advance of each financial year a timetable of financial reporting will be submitted to the Integration Joint Board for approval.

8.7 **Capital Assets:**

8.7.1 The Integration Joint Board will not own any capital assets but will have use of such assets which will continue to be owned by Borders Health Board and Scottish Borders Council who will have access to sources of funding for capital expenditure. In line with guidance, the Integration Joint Board will not receive any capital allocations, grants or have the power to borrow to invest in capital expenditure.

8.7.2 The Chief Officer will consult with Borders Health Board and Scottish Borders Council to identify need for asset improvement owned by either party and where investment is identified, will submit a business case to the appropriate party which will be considered as part of each party's existing capital planning and asset management arrangements.

8.8 **Year-end balances:**

8.8.1 In line with guidance, a process for jointly agreeing, reporting and carrying forward any unused balances at the end of the financial year will operate.

## 9. Participation and Engagement

9.1 Section 6(2)(a) of the Public Bodies (Joint Working) (Scotland) Act 2014 requires Local Authorities and Health Boards to prepare an Integration Scheme. Before submitting the Integration Scheme to Scottish Ministers for approval, the Local Authority and Health Boards have consulted with:-

- Staff of the Local Authority likely to be affected by the Integration Scheme;
- Staff of the Health Board likely to be affected by the Integration Scheme;
- Health professionals;
- Users of health care;
- Carers of users of health care;
- Commercial providers of health care;
- Non-commercial providers of health care;
- Social care professionals;
- Users of social care;
- Carers of users of social care;
- Commercial providers of social care;

- Non-commercial providers of social care;
- Non-commercial providers of social housing; and
- Third sector bodies carrying out activities related to health or social care.

9.2 Feedback from all of the above has been used to inform the refresh of the Scheme of Integration.

9.3 There are national standards for community engagement and participation which underpin how Scottish Borders Council and Borders Health Board operate.

9.4 Timely and effective communications and engagement is a key component in the development, review and renewal of the Strategic Commissioning Plan. A communications and engagement strategy and action plan will be developed, in conjunction with the Strategic Planning Group to support this work.

## 10. Information-Sharing

10.1 The PAN Lothian and Borders General Information Sharing Protocol update was agreed by the Pan Lothian and Borders Data Sharing Partnership December 2014.

10.2 Scottish Borders Council, the Borders Health Board and the Integration Joint Board agree to be bound by the Information Sharing Protocol

10.3 This protocol describes the key principles the parties must adhere to for information to be shared lawfully, securely and confidentially. Other signatories will be added as appropriate.

10.4 Procedures for sharing information between Scottish Borders Council, Borders Health Board, and, where applicable, the Integration Joint Board will be drafted as Information Sharing Agreements and procedure documents, as required. This will be undertaken by a sub group (the Borders Data Sharing Partnership) on behalf of the PAN Lothian and Borders Data Sharing Partnership, and will detail the more granular purposes, requirements, procedures and agreements for the Integration Joint Board and their delegated function.

10.5 The national protocol on information sharing – Scottish Accord for the Sharing of Personal Information (SASPI) – will be adopted in due course.

10.6 **Information-Sharing and Confidentiality** All staff are bound by the data confidentiality policies of their employing organisations and the requirements of the Information Sharing Protocol that is in place.

10.7 **Information Sharing and data handling** With respect to person identifiable material, data and information will be held in both electronic and paper format and only be accessed by authorised personnel in order to provide the service user with the appropriate service within the partnership. It may be necessary to share information with external agencies and in that case consent will be sought from the service user if no statutory requirement to share information exists. In order to comply with the Data Protection Act 1998 all parties will always ensure that any personal data that is processed will be handled fairly, lawfully and with justification.

10.8 Scottish Borders Council and Borders Health Board will continue to be Data Controller for their respective records (electronic and manual), and will detail arrangements for control and access. The Integration Joint Board may require to be Data Controller for personal data where it is not held by either Scottish Borders Council or Borders Health Board.

10.9 Roles and responsibilities for Third party organisations will be detailed in contracts with respective commissioning bodies, and access to shared records agreed in advance.

10.10 Procedures will be based on a single point of governance model through the Data Sharing Partnership. This allows data and resources to be shared, with governance standards, and their implementation, the separate responsibility of each partner. Shared datasets governance will be agreed by all contributing partners prior to access.

10.11 Following consultation, Information Sharing Protocols and procedure documents will be recommended for signature by the Chief Executives of Borders Health Board and Scottish Borders Council and the Integration Joint Board.

10.12 Once established, Agreements and Procedures will be reviewed every two years by the Borders Data Sharing Partnership, or more frequently if required.

10.13 **The Public Records (Scotland) Act:** Both parties are scheduled Public Authorities under the Public Records (Scotland) Act and have a duty to create and have approved a records management plan. The Integration Joint Board also has a records management plan in compliance with the requirements of the Act. Reference to information management procedures of the integrated service will be recorded in both parties plans, including information sharing and other record keeping arrangements and duties that pertain to services contracted out to third party service providers or external agencies will also be included.

10.14 **Record keeping:** The parties will work towards common records and templates that are readily available for staff to use, in particular:

- Data sharing agreement template
- Consent forms for data sharing
- A data sharing log (this will be a public document)
- Data sharing agreement Review form

10.15 Responsibility for the maintenance and distribution of joint service templates, logs and Borders Health Board and Scottish Borders Council records sits with the Chief Officer. File plans and records retention schedules for records created solely by the Integrated Services will be devised and approved by the Integration Joint Board.

10.16 Responsibility for records created, retained and disposed by each organisation remains with that organisation. Each party will maintain their existing records according to their own policies and disposal schedule.

10.17 **Security:** The success of information sharing relies on a common understanding of security. The information sharing protocol refers to the expected standard but each

party must maintain its own guidance to ensure it meets that standard and that controls to manage the following elements are included:-

- Safe storage of documents transported between work and site. Access to electronic and physical records. Use of laptops, memory sticks and other portable data devices when working off site (including at home);

- Confidential destruction;

- Security marking on electronic communications when applicable

10.18 **Access to information - Freedom of Information (FOI):** Both Borders Health Board and Scottish Borders Council will receive Freedom of Information requests and will manage these requests through their own existing processes. Both parties process involves a central FOI Co-ordinator for each organisation, a 10 day timescale for departments to respond to the FOI Co-ordinator and Service Director sign off prior to the response being returned to the requestor. The Co-ordinators of both organisations will work closely together and communicate regularly in relation to FOI.

10.19 Where an FOI relates to a joint service, the receiving organisation will forward the FOI to the relevant Service Manager who will provide the requested information on behalf of both organisations. The receiving organisation will undertake the progress monitoring, responsibility for redacting, quality checking and responding to the applicant. A list of services that are in scope for Integration will be shared between the two organisations. All FoI's that relate to integrated services will be signed off by the Chief Officer.

10.20 Should one organisation receive a request that also relates to the other, this request will be managed by the receiving organisation by partnership working of both organisations' FoI Co-ordinators.

10.21 Both organisations will use the same performance measures and report regularly to the Integration Joint Board and to the Office of the Scottish Information Commissioner (OSIC).

10.22 FOI requestors will be logged. Requests for review will be administered by the organisation who dealt with the request and will include review panel members from both organisations.

10.23 **Subject Access Requests:** The differing charging regimes in each organisation for Subject Access and Access to Medical Records requests prevents a joint approach being adopted for gathering of personal information. Therefore, each party will manage its requests following that organisation's procedures.

10.24 If a subject access request refers to the integrated service it may be necessary to send out two responses. The requestor should be informed at the outset that this will happen. There will be no change to the process for managing access to deceased persons records.

10.25 **Privacy and confidentiality:** Most of the information the integrated services will handle will be personal and confidential in nature. All staff with access to shared information will

1. receive regular training in handling personal data compliantly;

2. have access to systems and records removed as soon as they leave the post that allows them to share information;

3. be subject to appropriate level of vetting by HR. This particularly applies to existing staff that may not have been subject to checks in their current role but require it in their integrated services post.

10.26 **Information Governance:** The Information Governance reporting arrangements for each party are as follows:

1. Borders Health Board: The Information Governance Committee reports to the Borders Health Board's Audit Committee.

2. Scottish Borders Council: The Information Governance Group reports to the Corporate Management Team.

## 11. Complaints

11.1 The Parties agree that complaints in relation to the delegated functions as set out in Part 2 Appendix 2, and Part 2 Appendix 3, will be received, managed and responded to by the appropriate lead organisation and agree to the following arrangements in respect of this:-

- Complaints in relation to integrated services or Scottish Borders Council services can be made to Scottish Borders Council, Headquarters.

- Complaints in relation to integrated services or Borders Health Board services can be made to NHS Borders, Borders General Hospital.

- Each organisation will have a clearly defined description of what constitutes a complaint contained within their organisations complaints handling documentation.

- A framework has been developed that clearly shows the lead organisation for each integrated service and the contact details for those who will be responsible for progressing any complaints received. The lead organisation will take responsibility for the triage of the complaint, and liaise with the other organisation to develop a joint response where required.

- Where the complaint is multi-faceted and has a multi-agency dimension to it, the Chief Officer will designate one of the existing processes to take the lead for investigating and coordinating a response. The Chief Officer will have an overview of complaints related to integrated services and will provide a commitment to joint working, wherever necessary, between the parties when dealing with complaints about integrated services.

- If a complaint remains unresolved through the defined complaints-handling procedure, complainants will be informed of their right to go either to the Scottish Public Services Ombudsman for services provided by Borders Health Board, or to the Social Work Complaints Review Committee following which, if their complaint remains unresolved, they have the right to go to the Scottish Public Services Ombudsman for services provided by Scottish Borders Council.

- There will be three established processes for a complaint to follow depending on the lead organisation.

    1. Statutory Social Work.
    2. NHS.
    3. Independent Contractors – All Independent Contractors involved with the Integration Joint Board, will be required to have a Complaints Procedure in place. Where complaints are received that relate to a service provided by an Independent Contractor, the lead organisation will refer the complainant to the Independent Contractor for resolution of their complaint. This may be done by either provision of contact details or by the lead organisation passing the complaint on, depending on the approach preferred by the complainant.

- The current process for gathering service user/patient/carer feedback within Borders Health Board and Scottish Borders Council, how it has been used for improvement, and how it is reported will continue.

## 12. Claims Handling, Liability & Indemnity

12.1 Borders Health Board will continue to follow their CNORIS programme for their services and Scottish Borders Council will continue with their current insurance processes. This will be applied to all integrated services.

12.2 Where there is a shared liability negotiations will take place as to the proportionality of each parties liability on a claim by claim basis.

## 13. Risk Management

13.1 The risk management strategy will include: risk monitoring, risk management framework and the strategic risk register.

13.2 As part of the risk management strategy the Chief Officer will be responsible for drawing to the attention of the Integration Joint Board any new or escalating risks and associated mitigations to ensure appropriate oversight and action.

13.3 Business Continuity plans will be in place and tested on a regular basis for the integrated services.

## 14. Dispute resolution mechanism

14.1 Where either of the Parties fails to agree with the other on any issue related to this Scheme, then they will follow the process as set out below:

(a) The Chief Executives of Borders Health Board and Scottish Borders Council, will meet to resolve the issue;

(b) If unresolved, the Borders Health Board, and Scottish Borders Council will each prepare a written note of their position on the issue and exchange it with the others;

(c) In the event that the issue remains unresolved, the Chief Executives (or their representatives) of Borders Health Board and Scottish Borders Council will proceed to mediation with a view to resolving the issue.

(d) A professional independent mediator will be appointed. The mediation process will commence within 28 calendar days of the agreement to proceed.

(e) The Mediator shall have the same powers to require any Partner to produce any documents or information to him/her and the other Partner as an arbiter and each Partner shall in any event supply to him such information which it has and is material to the matter to be resolved and which it could be required to produce on discovery; and

(f) The fees of the Mediator shall be borne by the Parties in such proportion as shall be determined by the Mediator having regard (amongst other things) to the conduct of the parties.

14.2 Where the issue remains unresolved after following the processes outlined above, the Parties agree the following process to notify Scottish Ministers that agreement cannot be reached.

14.3 The Chief Executives shall write to Scottish Ministers detailing the unresolved issue, the process followed and findings of the mediator and seek resolution from Scottish Ministers.

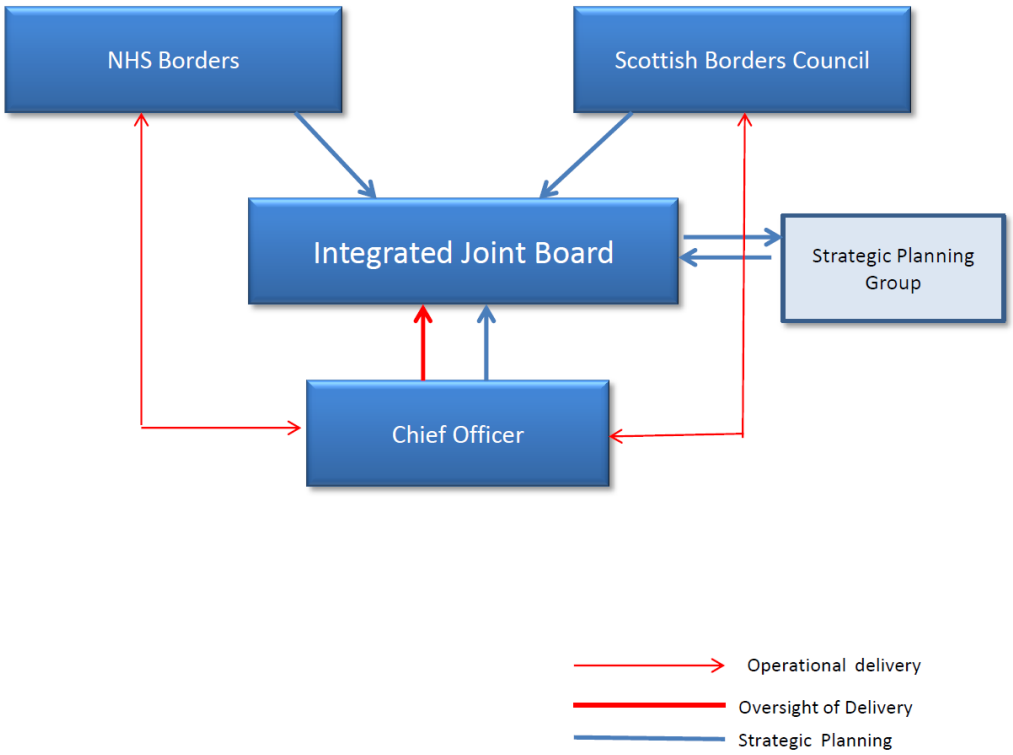
## APPENDIX OF DOCUMENTS – HEALTH AND SOCIAL CARE SCHEME OF INTEGRATION

| Appendix No | Document |
|---|---|
| 1 HSC Integration Scheme 151215 diagr | Integration Joint Board Governance Arrangements<br>The Integration Joint Board has established its own Audit Committee. |
| 2 APPENDIX 2 Functions Delegated I | Functions delegated by the Health Board to the Integration Joint Board |
| 3 APPENDIX 3 Functions Delegated I | Functions delegated by the Local Authority to the Integration Joint Board |
| 4 Appendix 4 Carers Act.docx | Functions delegated by the Health Board and Local Authority to the Integration Joint Board in respect of the Carers Act. |

# Appendix 1

APPENDIX 1

Integration Joint Board Governance Arrangements



# Appendix 2

**APPENDIX 2**

**Part 1**

**Functions delegated by the Health Board to the Integration Joint Board**

***Note***

*In accordance with paragraphs 3.1 and 3.2 of the Integration Scheme, each function listed in column A is delegated subject to the exceptions in column B and only to the extent that:*

*(d) It is exercisable in relation to persons of at least 18 years of age (other than functions exercisable in relation to the health care services set out in paragraphs 11-15 of Section 3 of Part 2 of Appendix 2 which are delegated in relation to persons of any age); and*

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

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

Functions prescribed for the purposes of section 1(8) of the Act

| *Column A* | *Column B* |
|---|---|
| **The National Health Service (Scotland) Act 1978** | |
| All functions of Health Boards conferred by, or by virtue of, the National Health Service (Scotland) Act 1978 | Except functions conferred by or by virtue of—<br>section 2(7) (Health Boards);<br>section 2CB (Functions of Health Boards outside Scotland);<br>section 9 (local consultative committees);<br>section 17A (NHS Contracts);<br>section 17C (personal medical or dental services);<br>section 17I (use of accommodation);<br>section 17J (Health Boards' power to enter into general medical services contracts);<br>section 28A (remuneration for Part II services);<br>section 38 (care of mothers and young children);<br>section 38A (breastfeeding); |

section 39 (medical and dental inspection, supervision and treatment of pupils and young persons);

section 48 (provision of residential and practice accommodation);

section 55 (hospital accommodation on part payment);

section 57 (accommodation and services for private patients);
section 64 (permission for use of facilities in private practice);

section 75A (remission and repayment of charges and payment of travelling expenses);

section 75B(reimbursement of the cost of services provided in another EEA state);

section 75BA (reimbursement of the cost of services provided in another EEA state where expenditure is incurred on or after 25 October 2013);

section 79 (purchase of land and moveable property);

section 82 use and administration of certain endowments and other property held by Health Boards);

section 83 (power of Health Boards and local health councils to hold property on trust);

section 84A (power to raise money, etc., by appeals, collections etc.);

section 86 (accounts of Health Boards and the Agency);

section 88 (payment of allowances and remuneration to members of certain bodies connected with the health services);

section 98 (charges in respect of non-residents); and

paragraphs 4, 5, 11A and 13 of Schedule 1 to the Act (Health Boards);

and functions conferred by—

The National Health Service (Charges to Overseas Visitors) (Scotland) Regulations 1989 ;

The Health Boards (Membership and Procedure) (Scotland) Regulations 2001/302;
The National Health Service (Clinical Negligence and Other Risks Indemnity Scheme) (Scotland) Regulations 2000/54;

| | |
|---|---|
| | The National Health Services (Primary Medical Services Performers Lists) (Scotland) Regulations 2004/114;<br><br>The National Health Service (Primary Medical Services Section 17C Agreements) (Scotland) Regulations 2004;<br><br>The National Health Service (Discipline Committees) Regulations 2006/330;<br><br>The National Health Service (General Ophthalmic Services) (Scotland) Regulations 2006/135;<br><br>The National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009/183;<br><br>The National Health Service (General Dental Services) (Scotland) Regulations 2010/205; and<br><br>The National Health Service (Free Prescription and Charges for Drugs and Appliances) (Scotland) Regulations 2011/55. |

**Disabled Persons (Services, Consultation and Representation) Act 1986**

| | |
|---|---|
| Section 7<br>(Persons discharged from hospital) | |

**Community Care and Health (Scotland) Act 2002**

| | |
|---|---|
| All functions of Health Boards conferred by, or by virtue of, the Community Care and Health (Scotland) Act 2002. | |

**Mental Health (Care and Treatment) (Scotland) Act 2003**

| | |
|---|---|
| All functions of Health Boards conferred by, or by virtue of, the Mental Health (Care and Treatment) (Scotland) Act 2003. | Except functions conferred by—<br><br>section 22 (Approved medical practitioners);<br><br>section 34 (Inquiries under section 33: co-operation);<br><br>section 38 (Duties on hospital managers: examination notification etc.);<br><br>section 46 (Hospital managers' duties: notification);<br><br>section 124 (Transfer to other hospital); |

| | |
|---|---|
| | section 228 (Request for assessment of needs: duty on local authorities and Health Boards);<br><br>section 230 (Appointment of a patient's responsible medical officer);<br><br>section 260 (Provision of information to patients);<br><br>section 264 (Detention in conditions of excessive security: state hospitals);<br><br>section 267 (Orders under sections 264 to 266: recall);<br><br>section 281 (Correspondence of certain persons detained in hospital);<br><br>and functions conferred by—<br><br>The Mental Health (Safety and Security) (Scotland) Regulations 2005;<br><br>The Mental Health (Cross Border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2005;<br><br>The Mental Health (Use of Telephones) (Scotland) Regulations 2005; and<br><br>The Mental Health (England and Wales Cross border transfer: patients subject to detention requirement or otherwise in hospital) (Scotland) Regulations 2008. |
| **Education (Additional Support for Learning) (Scotland) Act 2004** | |
| Section 23<br>(other agencies etc. to help in exercise of functions under this Act**)** | |
| **Public Services Reform (Scotland) Act 2010** | |
| All functions of Health Boards conferred by, or by virtue of, the Public Services Reform (Scotland) Act 2010 | Except functions conferred by—<br><br>section 31(Public functions: duties to provide information on certain expenditure etc.); and<br><br>section 32 (Public functions: duty to provide information on exercise of functions). |
| **Patient Rights (Scotland) Act 2011** | |
| All functions of Health Boards conferred by, or by virtue of, the Patient Rights (Scotland) Act 2011 | Except functions conferred by The Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012/36. |

## Part 2

## Services currently provided by the Health Board which are to be integrated

# SECTION 1

**Interpretation of Schedule 3**

**1.** In this schedule—

"Allied Health Professional" means a person registered as an allied health professional with the Health Professions Council;

"general medical practitioner" means a medical practitioner whose name is included in the General Practitioner Register kept by the General Medical Council;

"general medical services contract" means a contract under section 17J of the National Health Service (Scotland) Act 1978;

"hospital" has the meaning given by section 108(1) of the National Health Service (Scotland) Act 1978;

"inpatient hospital services" means any health care service provided to a patient who has been admitted to a hospital and is required to remain in that hospital overnight, but does not include any secure forensic mental health services;

"out of hours period" has the same meaning as in regulation 2 of the National Health Service (General Medical Services Contracts) (Scotland) Regulations 2004; and

"the public dental service" means services provided by dentists and dental staff employed by a health board under the public dental service contract.

# SECTION 2

**2.** Accident and Emergency services provided in a hospital.

**3.** Inpatient hospital services relating to the following branches of medicine—

(a) general medicine;

(b) geriatric medicine;

(c) rehabilitation medicine;

(d) respiratory medicine; and

(e) psychiatry of learning disability.

**4.** Palliative care services provided in a hospital.

**5.** Inpatient hospital services provided by General Medical Practitioners.

**6.** Services provided in a hospital in relation to an addiction or dependence on any substance.

**7.** Mental health services provided in a hospital, except secure forensic mental health services.

# SECTION 3

**8.** District nursing services.

**9.** Services provided outwith a hospital in relation to an addiction or dependence on any substance.

**10.** Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

**11.** The public dental service.*

**12.** Primary medical services provided under a general medical services contract, and arrangements for the provision of services made under section 17C of the National Health Service (Scotland) Act 1978, or an arrangement made in pursuance of section 2C(2) of the National Health Service (Scotland) Act 1978.*

**13.** General dental services provided under arrangements made in pursuance of section 25 of the National Health (Scotland) Act 1978.*

**14.** Ophthalmic services provided under arrangements made in pursuance of section 17AA or section 26 of the National Health Service (Scotland) Act 1978.*

**15.** Pharmaceutical services and additional pharmaceutical services provided under arrangements made in pursuance of sections 27 and 27A of the National Health Service (Scotland) Act 1978.*

**16.** Services providing primary medical services to patients during the out-of-hours period.

**17.** Services provided outwith a hospital in relation to geriatric medicine.

**18.** Palliative care services provided outwith a hospital.

**19.** Community learning disability services.

**20.** Mental health services provided outwith a hospital.

**21.** Continence services provided outwith a hospital.

**22.** Kidney dialysis services provided outwith a hospital.

**23.** Services provided by health professionals that aim to promote public health.

*Functions exercisable in relation to the health care services set out in paragraphs 11-15 above are delegated in relation to persons of any age and for the purposes of this Integration Scheme therefore include reference to "universal children's health services".

# Appendix 3

**APPENDIX 3**

**Part 1**

**Functions delegated by the Local Authority to the Integration Joint Board**

***Note***

*In accordance with paragraphs 3.3 and 3.4 of the Integration Scheme, each function listed in column A is delegated subject to the exceptions in column B and only to the extent that it is exercisable in relation to persons of at least 18 years of age.*

## PART 1

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

| *Column A*<br>*Enactment conferring function* | *Column B*<br>*Limitation* |
|---|---|
| **National Assistance Act 1948** | |
| Section 48<br>(Duty of councils to provide temporary protection for property of persons admitted to hospitals etc.) | |
| **The Disabled Persons (Employment) Act 1958** | |
| Section 3<br>(Provision of sheltered employment by local authorities) | |
| **The Social Work (Scotland) Act 1968** | |
| Section 1<br>(Local authorities for the administration of the Act.) | So far as it is exercisable in relation to another integration function. |
| Section 4<br>(Provisions relating to performance of functions by local authorities.) | So far as it is exercisable in relation to another integration function. |
| Section 8<br>(Research.) | So far as it is exercisable in relation to another integration function. |
| Section 10<br>(Financial and other assistance to voluntary organisations etc. for social work.) | So far as it is exercisable in relation to another integration function. |
| Section 12<br>(General social welfare services of local authorities.) | Except in so far as it is exercisable in relation to the provision of housing support services. |

| *Column A*<br>*Enactment conferring function* | *Column B*<br>*Limitation* |
|---|---|
| Section 12A<br>(Duty of local authorities to assess needs.) | So far as it is exercisable in relation to another integration function. |
| Section 12AZA<br>(Assessments under section 12A - assistance) | So far as it is exercisable in relation to another integration function. |
| Section 12AA<br>(Assessment of ability to provide care.) | |
| Section 12AB<br>(Duty of local authority to provide information to carer.) | |
| Section 13<br>(Power of local authorities to assist persons in need in disposal of produce of their work.) | |
| Section 13ZA<br>(Provision of services to incapable adults.) | So far as it is exercisable in relation to another integration function. |
| Section 13A<br>(Residential accommodation with nursing.) | |
| Section 13B<br>(Provision of care or aftercare.) | |
| Section 14<br>(Home help and laundry facilities.) | |
| Section 28<br>(Burial or cremation of the dead.) | So far as it is exercisable in relation to persons cared for or assisted under another integration function. |
| Section 29<br>(Power of local authority to defray expenses of parent, etc., visiting persons or attending funerals.) | |
| Section 59<br>(Provision of residential and other establishments by local authorities and maximum period for repayment of sums borrowed for such provision.) | So far as it is exercisable in relation to another integration function. |
| **The Local Government and Planning (Scotland) Act 1982** | |
| Section 24(1)<br>(The provision of gardening assistance for the disabled and the elderly.) | |
| **Disabled Persons (Services, Consultation and Representation) Act 1986** | |

| *Column A*<br>*Enactment conferring function* | *Column B*<br>*Limitation* |
|---|---|
| Section 2<br>(Rights of authorised representatives of disabled persons.) | |
| Section 3<br>(Assessment by local authorities of needs of disabled persons.) | |
| Section 7<br>(Persons discharged from hospital.) | In respect of the assessment of need for any services provided under functions contained in welfare enactments within the meaning of section 16 and which have been delegated. |
| Section 8<br>(Duty of local authority to take into account abilities of carer.) | In respect of the assessment of need for any services provided under functions contained in welfare enactments (within the meaning set out in section 16 of that Act) which are integration functions. |
| **The Adults with Incapacity (Scotland) Act 2000** | |
| Section 10<br>(Functions of local authorities.) | |
| Section 12<br>(Investigations.) | |
| Section 37<br>(Residents whose affairs may be managed.) | Only in relation to residents of establishments which are managed under integration functions. |
| Section 39<br>(Matters which may be managed.) | Only in relation to residents of establishments which are managed under integration functions. |
| Section 41<br>(Duties and functions of managers of authorised establishment.) | Only in relation to residents of establishments which are managed under integration functions |
| Section 42<br>(Authorisation of named manager to withdraw from resident's account.) | Only in relation to residents of establishments which are managed under integration functions |
| Section 43<br>(Statement of resident's affairs.) | Only in relation to residents of establishments which are managed under integration functions |
| Section 44<br>(Resident ceasing to be resident of authorised establishment.) | Only in relation to residents of establishments which are managed under integration functions |
| Section 45<br>(Appeal, revocation etc.) | Only in relation to residents of establishments which are managed under integration functions |
| **The Housing (Scotland) Act 2001** | |
| Section 92<br>(Assistance to a registered for housing purposes.) | Only in so far as it relates to an aid or adaptation. |
| **The Community Care and Health (Scotland) Act 2002** | |

| *Column A*<br>*Enactment conferring function* | *Column B*<br>*Limitation* |
|---|---|
| Section 5<br>(Local authority arrangements for of residential accommodation outwith Scotland.) | |
| Section 14<br>(Payments by local authorities towards expenditure by NHS bodies on prescribed functions.) | |
| **The Mental Health (Care and Treatment) (Scotland) Act 2003** | |
| Section 17<br>(Duties of Scottish Ministers, local authorities and others as respects Commission.) | |
| Section 25<br>(Care and support services etc.) | Except in so far as it is exercisable in relation to the provision of housing support services. |
| Section 26<br>(Services designed to promote well-being and social development.) | Except in so far as it is exercisable in relation to the provision of housing support services. |
| Section 27<br>(Assistance with travel.) | Except in so far as it is exercisable in relation to the provision of housing support services. |
| Section 33<br>(Duty to inquire.) | |
| Section 34<br>(Inquiries under section 33: Co-operation.) | |
| Section 228<br>(Request for assessment of needs: duty on local authorities and Health Boards.) | |
| Section 259<br>(Advocacy.) | |
| **The Housing (Scotland) Act 2006** | |
| Section 71(1)(b)<br>(Assistance for housing purposes.) | Only in so far as it relates to an aid or adaptation. |
| **The Adult Support and Protection (Scotland) Act 2007** | |
| Section 4<br>(Council's duty to make inquiries.) | |
| Section 5<br>(Co-operation.) | |
| Section 6<br>(Duty to consider importance of providing advocacy and other.) | |

| *Column A*<br>*Enactment conferring function* | *Column B*<br>*Limitation* |
|---|---|
| Section 11<br>(Assessment Orders.) | |
| Section 14<br>(Removal orders.) | |
| Section 18<br>(Protection of moved persons property.) | |
| Section 22<br>(Right to apply for a banning order.) | |
| Section 40<br>(Urgent cases.) | |
| Section 42<br>(Adult Protection Committees.) | |
| Section 43<br>(Membership.) | |
| **Social Care (Self-directed Support) (Scotland) Act 2013** | |
| Section 3<br>(Support for adult carers.) | Only in relation to assessments carried out under integration functions. |
| Section 5<br>(Choice of options: adults.) | |
| Section 6<br>(Choice of options under section 5: assistances.) | |
| Section 7<br>(Choice of options: adult carers.) | |
| Section 9<br>(Provision of information about self-directed support.) | |
| Section 11<br>(Local authority functions.) | |
| Section 12<br>(Eligibility for direct payment: review.) | |
| Section 13<br>(Further choice of options on material change of circumstances.) | Only in relation to a choice under section 5 or 7 of the Social Care (Self-directed Support) (Scotland) Act 2013 . |
| Section 16<br>(Misuse of direct payment: recovery.) | |
| Section 19<br>(Promotion of options for self-directed support.) | |

| *Column A* | *Column B* |
|---|---|
| *Enactment conferring function* | *Limitation* |
| **The Community Care and Health (Scotland) Act 2002** | |
| Section 4<br>The functions conferred by Regulation 2 of the Community Care (Additional Payments) (Scotland) Regulations 2002 | |

**Part 2**

**Services currently provided by the Local Authority which are to be integrated**

Scottish Ministers have set out in guidance that the services set out below must be integrated.

- Social work services for adults and older people
- Services and support for adults with physical disabilities and learning disabilities
- Mental health services
- Drug and alcohol services
- Adult protection and domestic abuse
- Carers support services
- Community care assessment teams
- Support services
- Care home services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptions
- Day services
- Local area co-ordination
- Respite provision
- Occupational therapy services
- Re-ablement services, equipment and telecare

# Appendix 4

## Scheme of Integration: New duties in Carers (Scotland) Act 2016

### Functions delegated by the Local Authority to the Integration Joint Board

***Note***

*In accordance with paragraphs 3.3 and 3.4 of the Integration Scheme, each function listed in column A is delegated subject to the exceptions in column B and only to the extent that it is exercisable in relation to persons of at least 18 years of age.*

PART 1

Functions prescribed for the purposes of section 1(7) of the Public Bodies (Joint Working) (Scotland) Act 2014

| *Column A* | *Column B* |
|---|---|
| *Enactment conferring function* | *Limitation* |

**Column A**

## Carers (Scotland) Act 2016

Section 6: Duty to prepare adult carer support plan
Section 21: Duty to set local eligibility criteria
Section 24: Duty to provide support
Section25: Provision of support to carers: breaks from caring
Section 31: Duty to prepare local carer strategy
Section34: Information and advice service for carers
Section 35: Short breaks services statement

### Functions delegated by the Health Board to the Integration Joint Board

## Carers (Scotland) Act 2016

Section 31: Duty to prepare local carer strategy

# SECTION E

# COUNTER FRAUD POLICY & ACTION PLAN

**CONTENTS**

## 1 Introduction

This document sets out the NHS Borders (NHSB) policy in respect of fraud, bribery, corruption and systematic theft (hereafter referred to as fraud). The policy applies to all employees and Non-Executive Directors of NHSB including employees of third parties when acting on behalf of NHSB. The policy also applies to local authority employees when that employee is carrying out Directed Functions. “Directed Functions” means a function which an Integrated Joint Board has directed NHSGGC to carry out under S26 (1) of the Public Bodies (Joint Working) (Scotland) Act 2014.

In January 2008, the Scottish Government published its “Strategy to Counter NHS Fraud in Scotland” followed, in June 2015, by “Protecting Public Resources in Scotland – A Strategic Approach to Fighting Fraud and Error”. This policy follows the principles and guidance set out in those documents and is consistent with the NHS Scotland Counter Fraud Standards.

It is a fundamental principle that all who are employed in public service, or who hold public office, should act honestly and with integrity to safeguard the public resources for which they are responsible. The risk of fraud or theft poses an ever-present threat to these resources and therefore, ultimately, to the level of patient care that can be provided. The prevention and detection of fraud should be the concern of all members of staff. This document provides detailed direction and help to staff dealing with circumstances suspected to be fraud.

## 2 Definitions

**Fraud:** the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party.

**Bribery or Corruption:** is the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person.

**Embezzlement:** the felonious appropriation of property by a person to which it has been entrusted.

**Theft:** the dishonest appropriation of property without the consent of the rightful owner or other lawful authority.

For the purposes of this policy, these will be referred to generically as fraud.

## 3 The NHSB Policy

NHSB is committed to the prevention, detection and, ultimately, elimination of any fraud and wishes to promote an awareness of fraud throughout the organisation. To achieve this aim, NHSB has put in place a range of measures to control its activities and minimise the risk of fraud. These measures are set out in a range of documents including Standing Orders for the Proceedings and Business of the NHS Board, Standing Financial Instructions, the Code of Conduct for Staff, Operational Procedures and the Fraud Policy itself.

All staff have a duty to protect NHS assets which includes information, physical property and cash. NHSB maintains an honest and open culture and encourages anyone having

suspicions of fraud to report this immediately. When someone suspects that fraud may have occurred they should report their concerns in accordance with the following paragraph. Individuals reporting fraud are protected as whistleblowers. Under the Whistleblowing Policy members of staff can be confident concerns will be treated in confidence, and with respect, dignity and compassion.

## 4 Reporting Fraud

Allegations of fraud, embezzlement, bribery, corruption or systematic theft may come from a number of sources and may be received anonymously. The subject of the allegation may be any person or organisation including employees, primary care contractors, suppliers and patients. Any staff member with evidence or suspicions of fraud should report the matter immediately to their line manager or Head of Department who will then report the matter without delay to the Fraud Liaison Officer (FLO). Time may be of the utmost importance to ensure that NHSB does not suffer further loss.

The FLO will agree with Counter Fraud Services (CFS) how to progress each case appropriately. CFS will always consider taking forward relevant cases that have the potential for criminal prosecution. All Staff need to be aware of this and of their responsibilities, as set out in the Appendix, when a criminal prosecution is not appropriate.

Section 9 of this Policy provides details of the Board's Fraud Action Plan and the appropriate procedures to be followed when reporting any allegations of fraud to the Board.

## 5 The Whistleblowing Policy

The Scottish Government 'Once for Scotland' National Whistleblowing Standards provides protection for individuals raising concerns from any detriment as a result of them speaking up, irrespective of how they speak up. It also provides specific support for those raising concerns before, during and after speaking up through a network of confidential contacts.

More information about raising concerns via the National Whistleblowing Standards can be found at:

NHS Borders Staff Intranet http://intranet/microsites/index.asp?siteid=57&uid=79

You can also discuss how the whistleblowing policy protects you when raising concerns via any other route with the person you are reporting it to.

In addition anyone concerned about speaking to another member of staff about a potential fraud or irregularity can obtain independent and confidential advice from the Independent National Whistleblowing Officer (INWO). The INWO phone line, 0800 008 6112, is open to anyone who wishes to raise any confidential concerns about practices in NHS Scotland. Further information and guidance is available from the INWO website

https://inwo.spso.org.uk

## 6 Investigation of Fraud

NHSB is committed to the rigorous and thorough investigation of all cases of fraud or suspected fraud.

NHSB has entered into a formal Partnership Agreement with NHS Counter Fraud Services (CFS), which provides a specialist investigation service to all NHS bodies in Scotland. All instances of fraud, corruption or embezzlement will be referred to CFS for consideration/investigation by the FLO, in the event of the FLO being unavailable this referral will be carried out by another senior member of the Finance team. CFS will be contacted before any overt action is taken which may alert suspects and precipitate the destruction or removal of evidence. This includes taking action to stop a loss or tighten controls.

Where CFS carry out an investigation and conclude that there is prima facie evidence of a criminal offence, then CFS will submit a Standard Prosecution Report to the Procurator Fiscal on behalf of NHSB. Any decision to take forward a prosecution will be at the sole discretion of the Procurator Fiscal.

Where it is decided that CFS will not carry out an investigation, the FLO will discuss and agree with the relevant Service Head and Human Resources manager the action to be taken.

NHSB will report instances of theft to the police in accordance with the Standing Financial Instructions.

NHSB will also take appropriate disciplinary action and/or refer the matter to the appropriate professional body in every case where an investigation provides grounds for such action (including instances where there is insufficient evidence to support a referral to the Procurator Fiscal, or no prosecution results after a referral). However, where there is a referral to the Procurator Fiscal, any internal investigation work or disciplinary action will be carried out in a manner that avoids prejudicing any potential criminal prosecution. All disciplinary action will be taken in accordance with established NHSB Policies.

Irrespective of the outcome of the criminal prosecution process, NHSB will seek restitution of any losses suffered.

Section 9 of this Policy provides details of the Board's Fraud Action Plan and the appropriate procedures to be followed when investigating any allegations of fraud to the Board.

## 7. Media Coverage

Under no circumstances should a member of staff speak or write to representatives of the press, TV or radio, about a suspected fraud without the express authority of the Chief Executive.

The Officer in Charge of a criminal case, whether from CFS or Police Scotland, will be responsible for collaborating with the Board's Communications Department in relation to preparing and agreeing the timing and content of an appropriate press release.

## 8 Roles and Responsibilities

NHSB through the **Chief Executive**, as **Accountable Officer**, is responsible for:

1. developing and maintaining effective controls to prevent and detect fraud (including proactive detection of fraud, such as participation in the National Fraud Initiative);
2. carrying out vigorous and prompt investigations where fraud is identified.
3. taking appropriate action in response to fraud including: criminal, disciplinary and recovery sanctions.

**Managers** are responsible for:

1. identifying the risks to which systems and procedures are exposed;
2. developing and maintaining effective controls to prevent and detect fraud;
3. ensuring that controls are being complied with;
4. investigating, and reporting to the police, instances of theft; and
5. reporting all instances of fraud (including theft) to the FLO.

**Individual Members of Staff** are responsible for:

1. acting in accordance with NHSB#s Code of Conduct for Staff;
2. reporting details immediately if they suspect that a fraud has been committed or see any suspicious acts or events.

The **Director of Finance** is the NHSB designated **Counter Fraud Champion** (CFC) and is responsible for:

1. promoting awareness of fraud and the measures taken to counter fraud;
2. issuing procedures that are consistent with the Partnership Agreement with CFS;
3. detailing the action to be taken by management when fraud is identified or suspected;
4. ensuring that all instances of fraud are investigated appropriately and in accordance with the Partnership Agreement;
5. keeping the Chief Executive advised of any significant fraud issues;
6. notifying the Appointed Auditor and Scottish Government Health and Social Care Directorates of fraud issues when appropriate; and
7. nominating a **Fraud Liaison Officer**

The **Fraud Liaison Officer** (FLO) will:

1. act as a point of contact with CFS;
2. receive enquiries relating to fraud (confidentially and/or anonymously) on behalf of the Director of Finance and Chief Executive;
3. co-ordinate any fraud investigation including liaison with the relevant Human Resources managers;

4. keep the Director of Finance and Chief Executive appraised of all issues relating to fraud;

5. provide quarterly and annual Fraud Update reports to Audit and Risk Committee;

6. support the Counter Fraud Champion in discharging their responsibilities; and

7. maintain records of fraud and financial irregularities on behalf of the Director of Finance and Chief Executive.

The **Director of HR,OD & OH&S** will:

1. support the CFC and FLO in discharging their responsibilities

2. ensure that Human Resources (HR) staff provide appropriate advice to local managers, promote awareness of NHSB's counter fraud measures and comply with the national Memorandum of Understanding for co-operation between HR teams and CFS.

3. ensure all appropriate HR staff, in particular Employee Relations and HR generalists, report all instances of suspected fraud to the FLO and that any internal investigations are carried out in compliance with the Partnership Agreement between NHSB and CFS.

## 9. NHSB Fraud Action Plan

### 9.1 Introduction

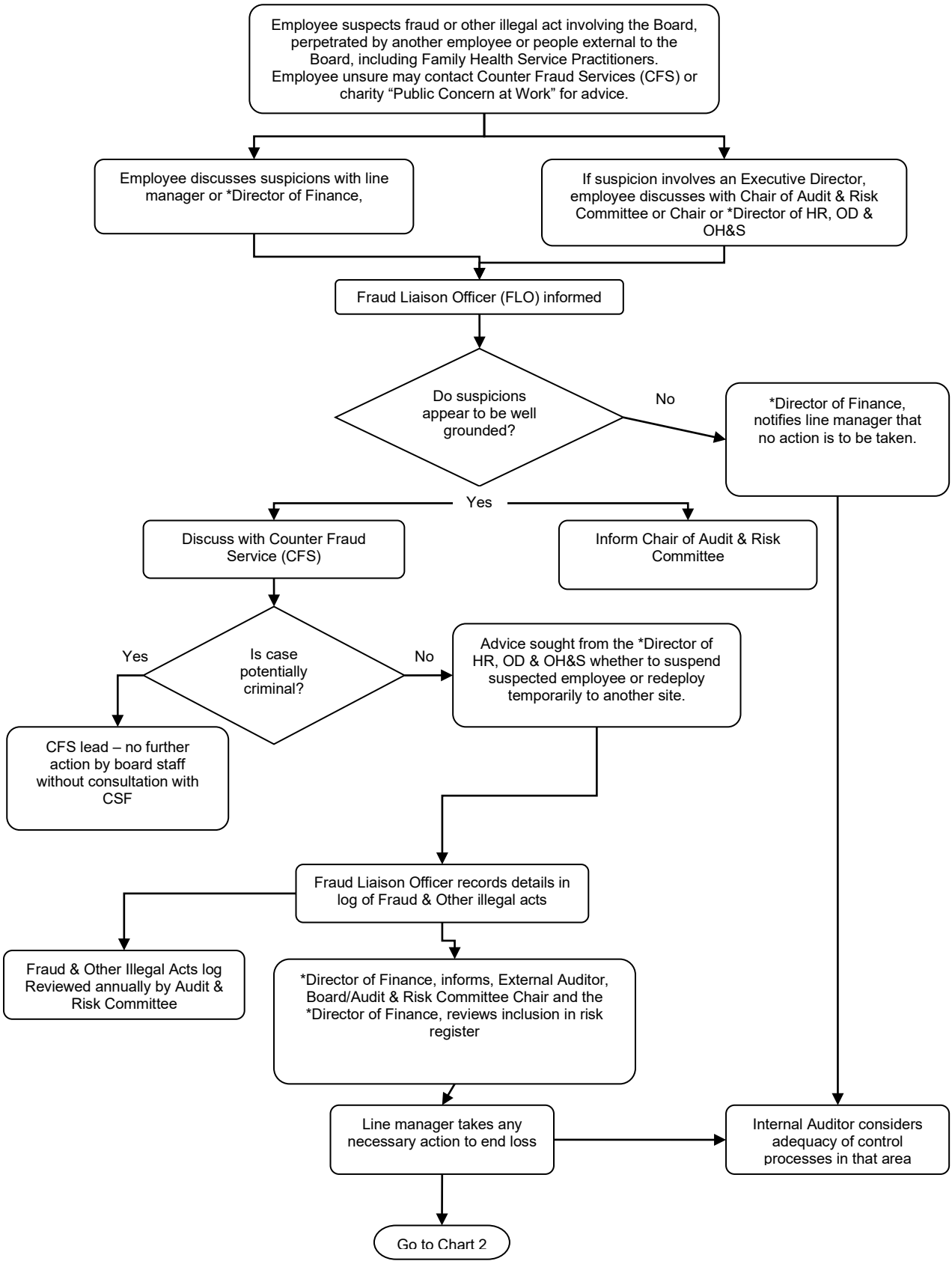
The flowcharts in section 9.2 describe the required actions with respect to a reported suspicion of fraud. The flowcharts provide procedures that allow for evidence gathering and collation in a manner that will facilitate informed initial decisions, while ensuring that evidence gathered will be admissible in any possible future criminal or civil actions. Each situation is different, therefore the guidance in the flowcharts will need to be considered carefully in relation to the actual circumstances of each case before action is taken.

In some cases, e.g. if a major diversion of funds is suspected, speed of response will be crucial to avoid financial loss.

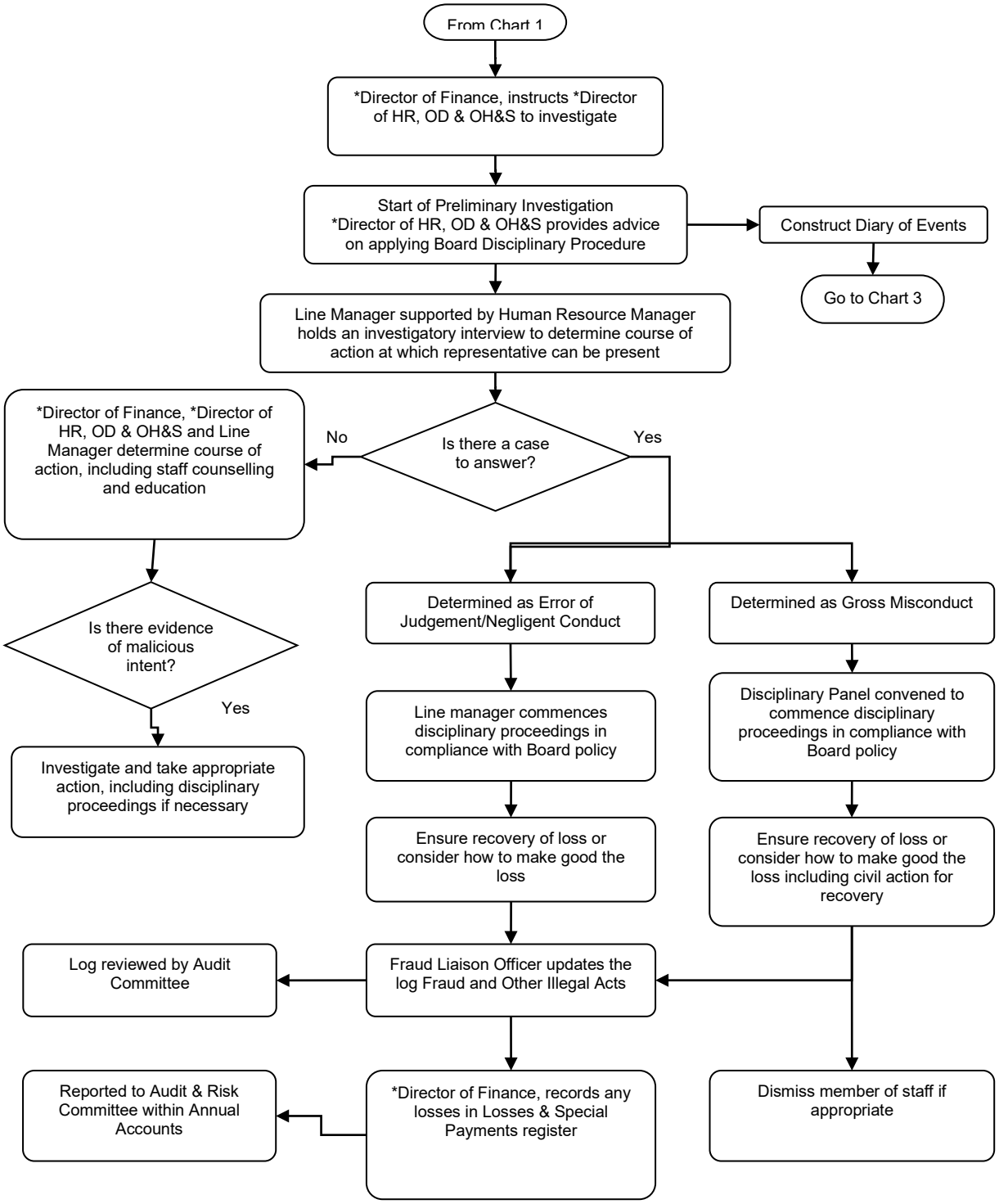
Further commentary on the procedures detailed in the flowcharts is provided in Section 9.3 onwards

## 9.2 Flow charts

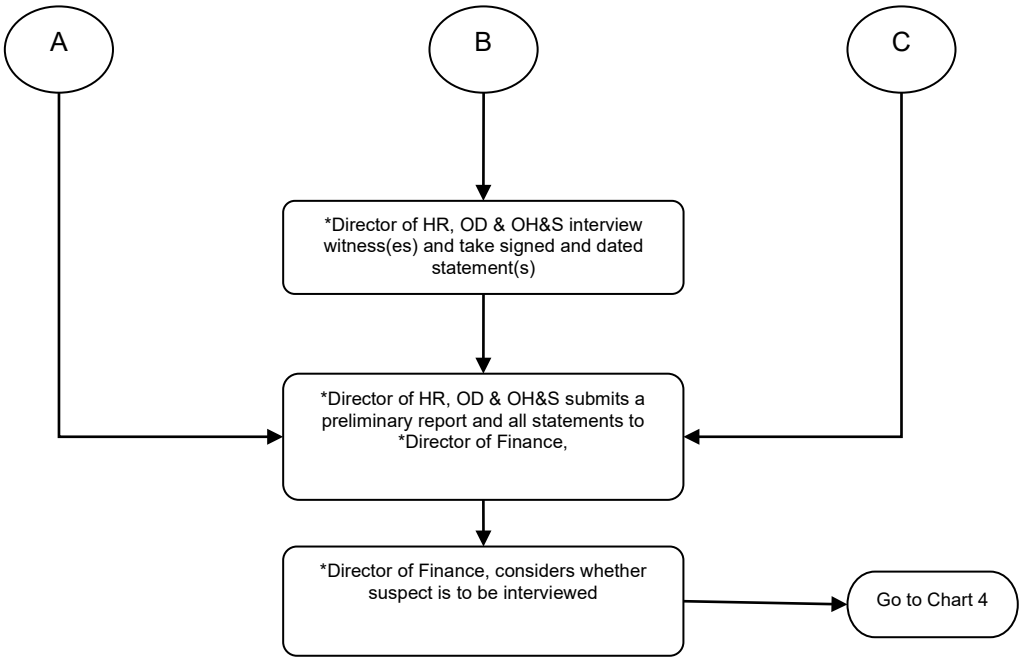
### CHART 1 – REPORTING FRAUD



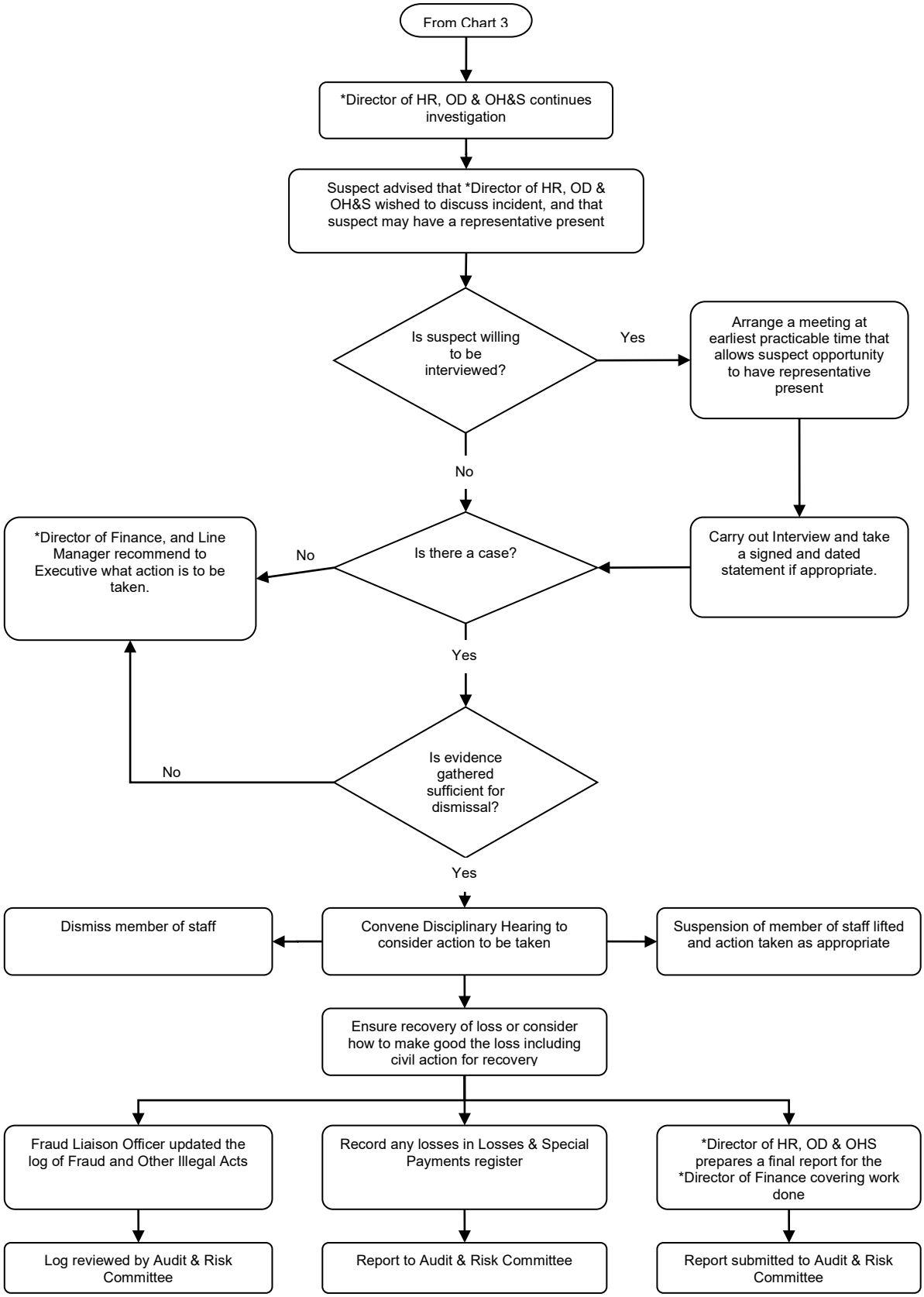
## CHART 2 – MANAGING AN INTERNAL INVESTIGATION



## CHART 3 – INTERNAL INVESTIGATION GATHERING EVIDENCE FROM WITNESSES



## CHART 4 – INTERNAL INVESTIGATION INTERVIEW PROCEDURE




** Director of Finance, or nominated deputy/Department of Finance.*
** Director of HR, OD & OH&S or nominated deputy/HR Department.*

### 9.3 Chart 1 – Reporting Fraud

#### 9.3.1 Sources of fraud and other irregularities reports

The Board may receive reports of alleged fraud or other irregularities from the following sources: -

- employees
- patients or the public
- primary care contractors
- suppliers
- police
- Counter Fraud Services

#### 9.3.2 Employees

An employee should normally discuss any suspicions with his/her line manager. The employee may also, or instead, discuss the matter confidentially with the Director of Finance. The line manager and the Director of Finance will then agree on the next course of action. If, after consideration, the suspicion seems well founded the Director of Finance will inform the Chief Executive and the reporting employee. The Director of Finance /Fraud Liaison Officer will then consult with CFS to ascertain whether the investigation will proceed on a criminal and/or civil/disciplinary basis.

If an employee suspects his/her line manager, the employee should report the suspicions to someone more senior, or directly to the Director of Finance or may discuss the matter with the Chief Executive, the Director of HR, OD & OH&S and the Chair of the Audit & Risk Committee.

An employee may use the CFS Fraud Reporting Line 08000 15 16 28 or report their suspicions (anonymously if desired) through the CFS Website on SHOW (www.show.scot.nhs.uk/fiu). Alternatively the employee may choose instead to contact the charity "Public Concern at Work" on 020 7 404 6609 or via their website – www.pcaw.co.uk, who would offer the employee advice on how to proceed.

If the suspicion involves an executive director the matter should be reported to the Chair of the Audit & Risk Committee or the Chair of the Board, or to Internal/External Audit.

These reporting routes should be clearly defined in staff induction documentation and well publicised to existing staff.

#### 9.3.3 Patients/Public/Primary Care Contractors/Suppliers/Police/CFS

The Board's policy, in its Standing Financial Instructions, is that all allegations of fraud or other irregularities, from anyone other than a Board employee, should be made in the first instance to the Director of Finance or Director of HR, OD & OH&S. If the suspicion involves an executive director the matter should be reported to the Chair of the Audit & Risk Committee or the Chair of the Board.

The CFS, through its Fraud Reporting Hotline and website, is another conduit for allegations of fraud and other irregularities. The Partnership Agreement makes it clear

that any such allegations will be reported to the appropriate Board officer or director within 48 hours of notification to the CFS.

The Director of Finance, Fraud Liaison Officer, or the Chair of the Audit & Risk Committee/Chair of the Board will then consult with CFS to ascertain whether the investigation will proceed on a criminal and/or civil/disciplinary basis.

These reporting routes should be clearly defined in patient information leaflets, contract documentation, and CFS publicity material.

In all such internal and external documentation it should be noted that time may be of the utmost importance to prevent further loss to the Board.

### 9.3.4 Subject of Allegation

The allegation of fraud or other irregularity may be in respect of: -

- an employee
- a director of the Board
- an independent primary care contractor
- a patient
- a supplier

### 9.3.5 Criminal Prosecution

As noted above, in all cases the allegation of fraud or other irregularity will be discussed with CFS. If the case includes in it the potential to be prosecuted criminally, then CFS will lead the investigation.

If the allegation concerns an employee, the CFS will take account of the Board's personnel policies and will consult with the Director of HR, OD & OH&S in respect of relevant issues including suspension. Consultation in such circumstances is essential; no unilateral action will be taken by the Board, its employees and directors, or the CFS.

If the allegation concerns a director, the CFS will undertake all consultation with the Chair of the Audit & Risk Committee and/or the Chair of the Board and will involve the Director of HR, OD & OH&S, where appropriate.

Where the allegation is in respect of an independent primary care contractor, a patient or a supplier, CFS will undertake all consultation with Director of Finance.

It is expected that the CFS will undertake all investigations, in respect of primary care contractors, patients and suppliers. The procedures that will be followed by the CFS in all investigations are detailed in the Partnership Agreement.

### 9.3.6 Discipline or Civil Recovery

Where, following consultation between the Board and the CFS, an investigation limited to disciplinary/civil recovery action appears appropriate; the following sections outline the actions to be followed.

Where the allegation is in respect of an employee, the Director of Finance/Fraud Liaison Officer will seek advice from the Director of HR, OD & OH&S on whether to suspend a suspected employee or redeploy them temporarily at another site.

Where the allegation is in respect of a director, the Chair of the Audit & Risk Committee/Chair of the Board will involve the Director of HR, OD & OH&S where appropriate, in making any decision regarding suspension. When taking action to suspend an employee or director it is important to communicate the reason for taking the action.

The person should be advised that they will receive full pay whilst on suspension, and should not return to the workplace nor contact their colleagues about the allegations until such time as allowed to do so by their employer.

Where, however, due to the nature of the allegation, suspension is deemed inappropriate, e.g. it would alert the suspect and as such may lead to the destruction and removal of evidence, no action to inform the suspect that an investigation was taking place should be taken.

### 9.3.7 Involvement of the CFS in Disciplinary/Civil Recovery cases

The Board/CFS Partnership Agreement outlines where it may be possible to utilise some of the work carried out by the CFS in a criminal case for disciplinary or civil recovery proceedings. This will always be subject to approval from the relevant procurator fiscal and may require advice from the Central Legal Office.

Subject to those caveats, the work done by CFS, particularly with respect to witness and suspect interviews, could reduce the work required by the Board's investigation team.

### 9.3.8 Log of Fraud or other Illegal Acts

The Director of Finance/Fraud Liaison Officer will enter details of all reported suspicions, including those dismissed as minor or otherwise not investigated. It will also contain details of actions taken and conclusions reached. Reports and/or verbal updates will be given at each Audit & Risk Committee meeting in relation to Fraud activity completed for the period. An Annual Fraud Report is compiled as part of the Review of Corporate Governance for review by Audit Committee members. Final reports issued at conclusion of a Fraud or Internal Disciplinary will be reported to the Audit & Risk Committee as appropriate with subsequent follow-up with the Chief Internal Auditor. The Audit & Risk Committee will review the annual statement on counter fraud issues at least once each year and will report any significant matters to the Board of Directors. .

### 9.3.9 Internal Communications

The Director of Finance/Fraud Liaison Officer shall inform and consult the Chief Executive at the first opportunity in all cases of suspected fraud or where the incident may lead to adverse publicity. The Director of Finance/Fraud Liaison Officer shall notify the Audit & Risk Committee of all frauds discovered and also of all losses arising from any criminal or suspected offences.

## 9.4 Chart 2 – Discipline/Civil Recovery Case - Managing the investigation

### 9.4.1 Director of Finance to appoint an Investigation Manager

Normally the investigation manager would be the Director of HR, OD & OH&S. The circumstances of each case will dictate who will be involved and when. The following general guidance is intended to assist management in deciding the best course of action.

### 9.4.2 Diary of Events

The manager overseeing the investigation (referred to hereafter as the Investigation Manager) should initiate a Diary of Events to record the progress of the investigation. A recommended pro-forma Diary will be agreed nationally.

### 9.4.3 Has a criminal act taken place?

Although in preliminary discussions with the CFS, this question may appear to have been answered, in some cases this question may be asked more than once during an investigation. In practice it may not be obvious that a criminal act has taken place. However, if at any time during the investigation, a criminal act is believed to have occurred, the agreed procedure involving the CFS must be invoked.

### 9.4.4 Internal Investigation

The internal investigation must determine the facts; whether disciplinary action is needed; what can be done to recover any loss; and what may need to be done to improve internal control to prevent the event happening again. In any investigation involving employees there should be close liaison with the Director of HR, OD & OH&S.

### 9.4.5 Recovering a loss

Where recovering a loss is likely to require a civil action it will be necessary to seek legal advice. Such action should only be progressed under the authority of the Director of Finance.

### 9.4.6 Disciplinary/Dismissal Procedures

The Board's disciplinary procedures must be followed in any disciplinary action taken by the Board towards an employee (including dismissal). This may involve the Investigation Manager in reporting formally the results of the investigation and recommending a disciplinary hearing to consider the facts.

## 9.5 Chart 3 – Gathering Evidence

**9.5.1** The chart cannot cover all the complexities of gathering evidence; each case must be treated according to the circumstances, taking professional advice from the Central Legal Office if necessary.

### 9.5.2 Physical evidence

Upon taking control of any physical evidence, it is very important that a record is made of the time and place it is taken. If evidence consists of several items, for example many documents, each one should be tagged with a reference number corresponding to the written record. Care with evidence gathering is important as that which may initially be treated as a discipline case, could become a criminal prosecution.

### 9.5.3 Witnesses

If a witness to the event is prepared to give a written statement, it is best practice for an experienced member of staff to take a chronological record using the witness's own words. The witness must be happy to sign the document as a true record, but the involvement of an independent person usually helps to keep the statement to relevant facts.

### 9.5.4 Director of Finance to consider if suspect should be interviewed

The Director of Finance/Fraud Liaison Officer will consider the preliminary report of the Investigation Manager and consider if the suspect should be interviewed.

## 9.6 Chart 4 – Interview Procedure

### 9.6.1 Interviewing the Suspect(s)

The Director of Workforce as the Investigating Manager will provide advice on the procedures to be followed. The Investigating Manager must be accompanied at interview to ensure that one of the investigating team can ask necessary questions with the other team member taking complete and contemporaneous notes.

The suspect should be advised that he/she is entitled to be accompanied at the interview by a friend or other representative from a Trade Union/Staff Association or work colleague, who may observe proceedings and offer advice where necessary to the interviewee.

Questions should be prepared beforehand, but it will always be important to probe the responses to particular questions by pursuing supplementary points. Leading questions (such as "you do open the post on your own, don't you") should not be asked. Closed questions, which have simple alternative answers, are useful for obtaining specific information. The procedure to be followed during the interview should be explained, including that notes will be taken. It should be made clear the interviewee does not have to answer any question but that if he/she does not, that fact will be recorded in the interview note.

If it is necessary for notes to be written up in a neater and more legible form, this must be done immediately following the interview and signed and dated by the Investigating Manager and other interviewer. The original notes must be retained.

Within 48 hours of the interview, the interviewee should be asked to review the notes, and make any corrections that he/she considers are necessary. The Investigating Manager should then:

- Consecutively number all pages
- Cross through all blank spaces to demonstrate to the interviewee that nothing can be added subsequently
- Sign each page of notes, together with the HR professional providing support
- Enter the time the interview was conducted on the last page of notes

The interviewee should then be invited to sign and date the account of the interview, if he/she thinks it is a fair reflection of proceedings.

Copies of the notes should not normally be made available to the interviewee until the investigation has been completed, and the way forward decided.

It should be remembered that a manager has the right to ask an employee to account for his/her actions in respect of that employment.

If the employee refuses to answer questions on the grounds that he/she might incriminate him/herself, it is his/her right to do so. This should be confirmed. However the employee should also be informed that he/she may still be considered for disciplinary action including dismissal.

If it becomes clear in the course of an interview that the interviewee is likely to have been the perpetrator of a crime, or if he or she admits a criminal act, the interview should be halted at once, and the matter referred to the CFS for action.

Care must be taken to avoid defamation. Where the interviewee makes a statement which conflicts with other evidence, this should be pointed out – to say "you're lying" could be held to be oppressive.

All interviews must be conducted fairly. In particular comments such as "if you do not tell me the truth you will get the sack" must be avoided.

No form of physical restraint or force should ever be attempted. If, for example it is considered that the suspect may have Board property on his or her person or in his or her vehicle, then the interviewer should request the person to allow a search. If the suspect refuses and attempts to leave, no attempt should be made to stop him or her. The suspect should be advised that his or her non-cooperation will be noted and may result in disciplinary action being taken.

If a criminal offence may have been committed and the person wishes to make a statement, then the CFS must be contacted immediately so that the statement can be made to them.

Offers to resign, or to make restitution for losses should be recorded but should not be accepted during the interview.

Any relevant records that might assist the investigation should be collected. To prevent their destruction, the employee should be accompanied to his or her place of work to collect such documents or personal belongings. Any official property at home should be collected and, depending on the outcome of the interview, it may be necessary to restrict the employee's access to Board's buildings and records.

Please note that control over draft and final reports is crucial if the Board is to avoid the risk of potential libel actions. No report of an investigation or interview is to be made available in the first instance to any person other than the Director of Finance.

The interview should end when:

- No explanation is given (and the person has been given ample opportunity to give one)
- An unsatisfactory explanation is given
- An admission is given

- A satisfactory explanation is given

### 9.6.2 Termination of the Investigation

The Board investigation should terminate when:

- There is sufficient evidence for dismissal or other appropriate disciplinary action
- The Investigating Manager considers that reasonable steps have been taken to obtain information in support of the allegation, but sufficient evidence has not been produced.

### 9.6.3 Dismissal of Staff

Under UK employment legislation dismissal must be for a "fair" reason. The manner of dismissal must also be reasonable and the procedure fair. It is therefore important that no employee should be dismissed without close consultation with the Director of HR, OD & OH&S and in compliance with the Board's disciplinary procedures. In these circumstances the Director of HR, OD & OH&S will take into consideration guidance provided by the Central Legal Office.

The Director of HR, OD & OH&S should be consulted about the subsequent provision of references for employees who have been dismissed or who have resigned following suspicions of a fraud.

### 9.6.4 Losses and Compensations Register

Guidance on losses and special payments is provided in Circulars 1985(GEN)17 and HDL(2002)23.
The delegated limits for approving the writing off of losses and special payments are detailed in the Board's Standing Financial Instructions.

## 9.7 Post investigation review

It will be important for the Director of Nursing, Midwifery & Acute Services and Chief Officer Health & Social Care, in conjunction with the Director of HR, OD & OH&S to consider the lessons to be learned, e.g. how internal controls can be strengthened. Any lessons learned should be disseminated to the Service through the internal audit network or by using the CFS' bulletins.

## 9.8 Involving the Counter Fraud Services

Some managers may mistakenly be reluctant to involve the CFS in the belief that:

- they are only interested if the alleged criminal offence is greater than a specific £ value; the CFS are not interested because the potentially complex issues involved render little chance of a successful prosecution; or
- the Board prefers to deal with the incident themselves, in an attempt to minimise attention while implementing dismissal and pursuing recovery through civil action; or
- the CFS want hard evidence before they will pursue investigations, but when it is provided they advise that the rules of evidence have not been complied with; or
- the disciplinary process has to await a CFS investigation and/or prosecution.

***Where there is any suggestion that a fraud or other irregularity has been perpetrated the CFS must be involved in any decision regarding the action to be taken.***

The CFS, through the Communications Manager, may be able to advise on how to draft a statement to the staff or the press.

# SECTION F

# RESERVATION OF POWERS AND DELEGATION OF AUTHORITY

## RESERVATION OF POWERS AND DELEGATION OF AUTHORITY

**1.** Schedule of Matters Reserved for Board Agreement

**2.** Schedule of Matters Delegated to Officers of the Board

**3.** Scheme of Delegation Framework & Key Roles

**4.** Delegated Limits and Authorised Signatories

**5.** Delegation of Powers for Appointment of Staff

# 1. SCHEDULE OF MATTERS RESERVED FOR BOARD AGREEMENT

## 1.1 Background

As a board of governance, Borders Health Board delivers a corporate approach to collective decision making based on the principles of good Governance, partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board's own responsibility for governance.

The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs and that of the Board and Executive Team and Operational Planning Group. This includes compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has a responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to promote that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually. The Board reports publicly on its compliance with the principles of good corporate governance through review by the Corporate Governance Steering Group and from the inclusion of the Accountable Officer governance statement within the Health Board's Annual Accounts.

Everyone needs to be clear about their role, responsibilities and their accountability.

The main purposes and functions of NHS Borders are set out below.

The purpose and function of the Board will be:-

- Efficient, effective and accountable governance.
- Strategic leadership and direction for the Borders NHS system.
- To support the delivery of Health & Social Care Integration Strategic Commissioning Plan and associated outcomes as agreed by the Scottish Borders Health and Social Care Integration Joint Board (IJB) for functions delegated by the Borders Health Board to the IJB.
- Strategy development including the Annual Delivery Plan.
- Approve resource allocation to address local priorities.
- Performance management of the NHS Borders system.
- Compliance with the NHSScotland Staff Governance Standard

The Scheme of Delegation provides a mechanism to empower frontline staff to make decisions close to the point of care delivery, within a framework of delegated and reserved powers for NHS Borders

## 1.2 Matters Reserved for Board Agreement

The following shall be reserved for agreement by the Board:-

1.2.1 Standing Orders.
1.2.2 Organisational Values.
1.2.3 Corporate Objectives or corporate plans which have been created to implement its agreed strategies.

1.2.4 The Annual Delivery Plan and underpinning Financial Plan;
1.2.5 The strategies for all the functions that it has planning responsibility for, subject to any provisions for major service change which require Ministerial approval.
1.2.6 Any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval. The Board shall comply with the Scottish Capital Investment Manual.
1.2.7 The acceptance of commercial contracts in respect of the Board's Revenue where the value exceeds £250,000;
1.2.8 NHS Service Agreements with an annual value over £1,000,000 excepting the Lothian Service Level Agreement where authorisation is delegated to the Director of Finance;
1.2.9 Contracts for goods/services above European Commission Tendering Limits;
1.2.10 Appointment of External Specialists over £25,000;
1.2.11 The Appointment of the Board's Chief Internal Auditor (Note: This applies either when the proposed chief internal auditor will be an employee of the Board, or when the chief internal auditor is engaged through a contract with an external provider. The audit committee should advise the Board on the appointment, and the Board may delegate to the audit committee oversight of the process which leads to a recommendation for appointment.);
1.2.12 Approval of the overall Revenue and Capital Budget for the Board;
1.2.13 Approval of the disposal of all property assets including land;
1.2.14 Approval of the disposal of fixed assets with an estimated value over £100,000;
1.2.15 The making, alteration and revocation of the Code of Corporate Governance and its component parts, including Standing Orders, Standing Financial Instructions; Scheme of Delegation; Counter Fraud Policy and Action Plan;
1.2.16 The establishment of terms of reference and reporting arrangements for all Committees of the Board and the determination of differences between such committees;
1.2.17 Financial and performance reporting arrangements to the Board;
1.2.18 Risk Management Policy
1.2.19 Approval to delegate health functions and provide resources to the IJB
1.2.20 Approval of arrangements for discharge of Board Members' responsibilities in relation to Endowment funds;
1.2.21 Approval of the Annual Report and accounts;
1.2.22 The incurring of expenditure for which no provision or insufficient provision has been made in the annual Budget of the Board;
1.2.23 Any proposal, which in the opinion of the Chief Executive will result in sensitivity and reputational issues, significant, permanent service change and will require public consultation in accordance with Scottish Government guidance;
1.2.24 The dismissal of executive members of the Board and other senior members of staff where the filling of posts concerned require the involvement of non-executive members of the Board;
1.2.25 On the recommendation of the Chair, appointments of Non Executive Members to committees, steering groups, project boards or if allocated a role by the Chair or Chief Executive;
~~1.2.26 Appointment of Consultants.~~

## 2. SCHEDULE OF MATTERS DELEGATED TO OFFICERS OF THE BOARD

### 2.1 Interpretation

- Any reference to a statutory or other provision shall be interpreted as a reference amended from time to time by any subsequent legislation.
- The Chief Executive as Accountable Officer can exercise delegated authority across all NHS Borders services and functions excluding those services, functions or resources delegated to the IJB.
- Powers delegated to the Chief Executive in terms of this scheme may be exercised by such an officer or officers as the Chief Executive may authorise.

### 2.2 Chief Executive

#### 2.2.1 General Provisions

In the context of the Board's principal role to protect and improve the health of Borders residents, the Chief Executive as Accountable Officer shall have delegated authority and responsibility to secure the economical, efficient and effective operation and management of NHS Borders and to safeguard its assets in accordance with

- The statutory requirements and responsibilities laid upon the Chief Executive as Accountable Officer for NHS Borders;
- Direction from the Scottish Government Health and Social Care Directorates;
- Current policies and decisions made by the Board;
- The limits of the resources available, subject to the approval of the Board;
- The Code of Corporate Governance.

The Chief Executive is authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, with the Chair and the Vice-Chair of the Board, and the relevant Committee Chair. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Committees shall be reported to the Board or appropriate Committee as soon as possible thereafter. Where such measures or actions relate to functions or resources delegated to the IJB the Chief Executive shall work in partnership with the Chief Officer and the IJB.

The Chief Executive is authorised to give an instruction in special circumstances that any official shall not exercise a delegated function subject to reporting on the terms of the instruction to the next meeting of the appropriate Committee.

#### 2.2.2 Finance

For functions delegated and resources provided by Borders Health Board to the IJB, resources shall be used only for the purpose for which they are allocated, unless tri-partite agreement is given by the IJB and Scottish Borders Council to any proposal made by the Chief Executive and the Director of Finance.

For services, functions and resources of Borders Health Board resources will be used for the purpose allocated, unless otherwise approved by the Chief Executive, after taking account of the advice of the Director of Finance. The Chief Executive acting together with the Director of Finance has delegated authority to approve the transfer of funds between

budget heads, including transfers from reserves and balances, up to a maximum of £250,000 in any one instance. The Chief Executive shall report to the Resources & Performance Committee for formal inclusion in the minutes those instances where this authority is exercised and/or the change in use of the funds relates to matters of public interest.

The Chief Executive may, acting together with the Director of Finance, and having taken all reasonable action to pursue recovery, approve the writing-off of losses, subject to the limits laid down from time to time by the Scottish Government Health and Social Care Directorate.

### 2.2.3 Legal Matters

The Chief Executive is authorised to institute, defend or appear in any legal proceedings or any inquiry, including proceedings before any statutory tribunal, board or authority, and following consideration of the advice of the Central Legal Office to appoint or consult with Counsel where it is considered expedient to do so, for the promotion or protection of the Board's interests.

In circumstances where a claim against the Board is settled by a decision of a Court, and the decision is not subject to appeal, the Chief Executive shall implement the decision of the relevant Court on behalf of the Board.

In circumstances where the advice of the Central Legal Office is to reach an out-of-court settlement, the Chief Executive may, acting together with the Director of Finance, settle claims against the Board.

The Chief Executive, acting together with the Director of Finance, may make ex-gratia payments, subject to the limits laid down from time to time by the Scottish Government Health and Social Care Directorate.

The arrangements for signing of documents in respect of matters covered by the Property Transactions Manual shall be in accordance with the direction of Scottish Ministers. The Chief Executive is currently authorised to sign such documentation on behalf of the Board and Scottish Ministers.

The Board Secretary shall have responsibility for the safekeeping of the Board's Seal, and together with the Chair or other nominated non-executive member of the Board, shall have responsibility for the application of the Seal on behalf of the Board.

### 2.2.4 Procurement

The Chief Executive shall have responsibility for nominating officers or agents to act on behalf of the Board, for specifying, and issuing documentation associated with invitations to tender, and for receiving and opening of tenders.

Where post tender negotiations are required, the Chief Executive shall nominate officers and/or agents to act on behalf of the Board.

The Chief Executive, acting together with the Director of Finance, has authority to approve on behalf of the Board, the acceptance of tenders, submitted in accordance with the Board's Code of Corporate Governance, up to a value of £500,000 (Capital) and £250,000

(Revenue) (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.

The exercise of this authority for tenders in excess of £10,000 up to £500,000 must be included in the tender register.

In accepting a tender, which is not the lowest tender received, it is mandatory that a detailed explanation for accepting the tender must be clearly recorded in the tender register. This must include an explicit detail of why this is the most advantageous tender for NHS Borders.

The Chief Executive shall provide the Director of Finance with a listing, including specimen signatures, of those officers or authorised agents to whom he has given delegated authority to sign official orders on behalf of the Board.

### 2.2.5 Human Resources

The Chief Executive may appoint staff in accordance with the Code of Corporate Governance Section F, Reservation of Powers and Delegation of Authority, Section 5, Delegation of Powers for the Appointment of Staff.

The Chief Executive may, after consultation and agreement with the Director of HR, OD & OH&S, and the relevant officer, amend staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must confirm that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to workforce planning, approved by the Board or Staff Governance Committee.

The Chief Executive may attend and may authorise any member of staff to attend, within and outwith the United Kingdom, conferences, courses or meetings of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff; and
- Appropriate allowance has been made within approved budgets; or
- External reimbursement of costs is to be made to the Board.

The Chief Executive may, in accordance with the Board's agreed Disciplinary Procedures, take disciplinary action in respect of members of staff, including dismissal where appropriate.

The Chief Executive shall have responsibility for ensuring that the Board complies with Health and Safety legislation, and for ensuring the effective implementation of the Board Policies.

The Chief Executive may grant paid or unpaid special leave of absence to any employee for up to five working days. The Chief Executive may approve other paid or unpaid leave within the limits defined in the board's Leave Policy.

The Chief Executive may, following consultation and agreement with the Director of HR, OD & OH&S and the Director of Finance and approval of the Remuneration Committee, approve payment of honoraria to any employee.

### 2.2.6 Patients Property

The Chief Executive has overall responsibility for ensuring that the Board complies with legislation in respect of patient's property. The term 'property' means all assets other than land and building (e.g. furniture, pictures, jewellery, bank accounts, shares, cash).

## 2.2 Director of Finance

Authority is delegated to the Director of Finance to take the necessary measures as undernoted, in order to assist the Board and the Chief Executive in fulfilling their corporate responsibilities.

### 2.3.1 Accountable Officer

The Director of Finance has a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board.

### 2.3.2 Financial Statements

The Director of Finance is empowered to take all steps necessary to assist the Board to:-

- Act within the law and ensure the regularity of transactions by putting in place systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- Maintain proper accounting records;
- Prepare and submit for audit, timeous financial statements, which give a true and fair view of the financial position of the Board and its income and expenditure for the period in question.

### 2.3.3 Corporate Governance and Management

The Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Board is soundly based by ensuring that the Board, its Committees and supporting management groupings receive appropriate, accurate and timely information and advice with regard to:-

- The development of financial plans, budgets and projections;
- Compliance with statutory financial requirements and achievement of financial targets;
- The impact of planned future policies and known or foreseeable developments on the Board's financial position.

The Director of Finance is empowered to take steps to ensure that proper arrangements are in place for:-

- Developing, promoting and monitoring compliance with the Code of Corporate Governance.

- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls;
- Developing and implementing strategies for the prevention and detection of fraud and irregularity;
- Internal Audit.

### 2.3.4 Performance Management

The Director of Finance is authorised to assist the Chief Executive to ensure that suitable arrangements are in place to secure economy, efficiency and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- For planning, appraisal, authorisation and control, accountability and evaluation of the use of resources;
- To promote that performance targets and required outcomes are met.

### 2.3.5 Banking

The Director of Finance is authorised to oversee the Board's arrangements in respect of accounts held in the name of the Board as part of the national contract with Government Banking Services and the commercial bankers appointed by the Board.

The Director of Finance will maintain a database of authorised signatories.

The Director of Finance will be responsible for ensuring that the Board operates within the Scottish Government Public Sector Banking Contract and that the National Contract Bank and the commercial bankers are advised in writing of amendments to the panel of authorised signatories.

### 2.3.6 Patients' Property

The Director of Finance has delegated authority to ensure that detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) are compiled for use by staff involved in the management of patients' property and financial affairs.

## 2.4 Director of Acute Services and the Chief Officer Health & Social Care

### 2.4.1 General Provisions

The Director of Acute Services and the Chief Officer Health & Social Care have delegated authority and responsibility to secure the economical, efficient and effective operation and management of the Operational Planning Group and of their own Directorate or Departments to safeguard the Board's assets:

- In accordance with the current policies and decisions made by the Board;
- Within the limits of the resources made available to the Operational Planning Group by the Board;
- In accordance with the Code of Corporate Governance.

The Director of Acute Services and the Chief Officer Health & Social Care have a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board.

The Director of Acute Services and the Chief Officer Health & Social Care are authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chair of the Operational Planning Group, the Chair or the Vice-Chair of the Board, the Chief Executive and where appropriate, the relevant Committee Chair. Such measures, that might normally be outwith the scope of the authority delegated by the Board or its Committees and shall be reported to the Board or appropriate Committee as soon as possible thereafter.

The Director of Acute Services and the Chief Officer Health & Social Care are authorised to give an instruction in special circumstances that any officer within the Operational Planning Group shall not exercise a delegated function subject to reporting on the terms of the instruction to the next meeting of the Operational Planning Group.

### 2.4.2 Finance

Resources shall be used only for the purpose for which they are allocated, unless otherwise approved by the Director of Acute Services and/or the Chief Officer Health & Social Cares, after taking account of the advice of the Finance Business Partner. The Director of Acute Services and/or the Chief Officer Health & Social Care acting together with the Operational Planning Group Finance Representative, have delegated authority to approve the transfer of funds between budget heads, including transfers from reserves and balances, up to a maximum of £50,000 in any one instance. The Director of Acute Services and/or the Chief Officer Health & Social Care shall report to the Operational Planning Group for formal inclusion in the minutes those instances where this authority is exercised and/or the change in use of the funds related to matters of public interest.

### 2.4.3 Procurement of Supplies and Services

The Director of Acute Services and/or the Chief Officer Health & Social Care acting together with the Finance Business Partner have authority to approve on behalf of the Board the acceptance of tenders, in respect of the Operational Planning Group submitted in accordance with the Board's Code of Corporate Governance, up to a value of £50,000 (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.

The Director of Acute Services and/or the Chief Officer Health & Social Care acting together with the Director of Finance have authority to approve on behalf of the Board the acceptance of tenders, in respect of the Operational Planning Group submitted in accordance with the Board's Code of Corporate Governance, up to a value of £125,000 (including VAT suffered) within the limits of previously approved Revenue and Capital Budgets.

The exercise of this authority for tenders in excess of £50,000 up to £125,000 must be reported to the Operational Planning Group.

The exercise of this authority for tenders in excess of £10,000 up to £50,000 must be included in the tender register.

In accepting a tender, which is not the lowest tender received, it is mandatory that a detailed explanation for accepting the tender must be clearly recorded in the tender register. This must include an explicit detail of why this is the most advantageous tender for NHS Borders.

### 2.4.4 Patients' Property

The Director of Acute Services and the Chief Officer Health & Social Care have overall responsibility for ensuring that the Operational Planning Group complies with legislation in respect of patients' property and that effective management arrangements are in place.

## 2.5 Operational Planning Group Finance Business Partner

Authority is delegated to the Operational Planning Group Finance Business Partners to take the necessary measures as undernoted, in order to assist the Operational Planning Group and the Directors in fulfilling their corporate responsibilities.

The Deputy Director of Finance and Finance Business Partners have a general duty to assist the Chief Executive in fulfilling their responsibilities as the Accountable Officer of the Board. In exercising these delegated powers the Deputy Director of Finance and Finance Business Partners are also acting as the Director of Finance's representatives.

### 2.5.1 Financial Statements

The Deputy Director of Finance is empowered to take all steps necessary to assist and contribute to the Board in order that it:

- Acts within the Law;
- Ensures the regularity of transactions by maintaining approved systems of internal control to ensure that financial transactions are in accordance with the appropriate authority;
- Maintains proper accounting records;
- Assists and participates as appropriate in the completion of the Board's Annual Accounts.
- supports the financial accountability, monitoring and reporting as required by the IJB for functions delegated and resources provided by health to the IJB.

### 2.5.2 Corporate Governance and Management

The Deputy Director of Finance is authorised to put in place proper arrangements to ensure that the financial position of the Operational Planning Group is sound by ensuring that the Operational Planning Group and supporting management groupings receive appropriate, accurate and timely information and advice with regard to:

- The development of financial plans, budgets and projections;
- Compliance with statutory financial requirements and achievement of financial targets;
- The impact of planned future policies and known or foreseeable developments on the Operational Planning Group's financial position.

The Deputy Director of Finance is empowered to take steps to ensure that proper arrangements are in place for:

- Monitoring compliance with the Code of Corporate Governance and appropriate guidance on standards of business conduct. Contribute to the development and promotion of the Code of Corporate Governance.
- Developing and implementing systems of internal control, including systems of financial, operational and compliance controls.
- Developing and implementing strategies for the prevention and detection of fraud and irregularity.

### 2.5.3 Performance Management

The Deputy Director of Finance and Finance Business Partners are authorised to assist the Directors to ensure that suitable arrangements are in place to secure economy, efficiency, and effectiveness in the use of resources and that they are working effectively. These arrangements include procedures:

- For planning, appraisal authorisation and control, accountability and evaluation of the use of resources;
- To ensure that performance targets and required outcomes are met and achieved.

### 2.5.4 Patients' Property

The Deputy Director of Finance shall have delegated authority to provide detailed operating procedures in relation to the management of the property of patients (including the opening of bank accounts where appropriate) for use by staff involved in the management of patients' property and financial affairs.

## 2.6 Provisions Applicable to Executive Directors/Directors who are members of the Board

- Director of Finance
- Director of Nursing, Midwifery & AHPs
- Director of Public Health (responsible for risk management)
- Medical Director
- Director of HR, OD & OH&S
- Director of Planning & Performance
- Director of Acute Services
- Director of Quality & Improvement
- Chief Officer Health & Social Care

### 2.6.1 General Provisions

Executive Directors/Directors have delegated authority and responsibility with the Chief Executive, for securing the economical, efficient and effective operation and management of their own Directorates or Departments and for safeguarding the assets of the Board.

Executive Directors/Directors are authorised to take such measures as may be required in emergency situations, subject to consulting, where possible, the Chief Executive, the Chair and the Vice-Chair of the Board or relevant Committee Chair as appropriate. Such measures, that might normally be outwith the scope of the authority delegated by the

Board or its Committees to the relevant Executive Director/Director/Chief Officer, shall be reported to the Board or appropriate Committee as soon as possible thereafter. Where such measures or actions relate to functions delegated and resources provided to the IJB the Executive Director through the Board's Chief Executive shall report to the Chief Officer and the IJB as soon as possible thereafter.

### 2.6.2 Human Resources

Executive Directors/Directors may appoint staff in accordance with the Board's Scheme of Delegation for the Appointment of Staff as detailed in Standing Orders Section G.

Executive Directors/Directors may, after consultation and agreement with the Director of HR, OD & OH&S propose the amendment of staffing establishments in respect of the number and grading of posts. In so doing, the Director of Finance must confirm that the cost of the amended establishment can be contained within the relevant limit approved by the Board for the current and subsequent financial years. Any amendment must also be in accordance with the policies and arrangements relating to human resource planning, approved by the Board or Staff Governance Committee.

Executive Directors/Directors may attend and may authorise any member of staff to attend within the United Kingdom, conferences courses or meetings of relevant professional bodies and associations, provided that:

- Attendance is relevant to the duties or professional development of such member of staff; and
- Appropriate allowance is contained within approved budgets; or
- External reimbursement of costs is to be made to the Board.

Executive Directors/Directors have overall responsibility within their Directorates/ Departments for ensuring compliance with Health and Safety legislation, and for ensuring the effective implementation of the Board's policies in this regard.

## 2.7 Recruitment of Consultants

Consultant recruitment regulations are contained in Scottish Statutory Instrument (SSI) 166, National Health Service (Appointment of Consultants) (Scotland) Regulations 2009 and CEL 25 (2009). Local guidance is in place which reflects these requirements.

## 3. SCHEME OF DELEGATION FRAMEWORK & KEY ROLES

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **STRATEGY DEVELOPMENT (INCLUDING THE ANNUAL DELIVERY PLAN)** | • Overarching co-ordination and development of strategy.<br>• Public consultation on strategy and Annual Delivery Plan.<br>• Support the IJB Strategic Commissioning Plan to ensure alignment to Annual Delivery Plan. | • To plan and manage delivery of services as directed by the IJB.<br>• Support the delivery of the outcomes required by the Strategic Commissioning Plan.<br>• Undertake responsibility for modernisation of all services provided locally.<br>• Directly influence Board/ BET level strategic planning.<br>• Plan primary, secondary and community based services with delegated authority from Board/BET and, where appropriate, as commissioned by the IJB. | • Be involved in the development and influence content.<br>• Empower staff to contribute.<br>• Provide clear direction for strategic development of own Clinical Board's service. | • To be involved and contribute to the development of the strategy. | • Contribute to development of Annual Delivery Plan and service strategy. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **PROVISION OF HEALTHCARE SERVICES** | • Resource allocation.<br>• Strategic decision making.<br>• Securing and influencing funding with SGHSCD.<br>• Establish rules for intervention when exception reporting indicates need. | • Ensure service provision according to overarching strategy.<br>• Accountable for the operational delivery of services based on patient need and resource availability.<br>• The development of business cases to support service changes.<br>• Meet National and Local priorities.<br>• Ensure provision of those services locally which it is the duty of NHS Borders to provide, or secure provision of.<br>• Responsibility to deliver integrated services as commissioned by the IJB. | • Ensure service provision according to overarching strategy.<br>• Accountable for the operational delivery of services based on patient need and resource availability.<br>• The preparation of business cases to support service changes.<br>• Meet National and Local priorities.<br>• To work with other Clinical Boards to ensure integrated services. | • Direct delivery of patient care.<br>• Meet Professional standards.<br>• Advise on 'gaps'/improvements to services to contribute to business cases.<br>• To lead/contribute to the redesign of services – patient centred.<br>• To actively participate in integration of primary and secondary care service provision. | • Provide feedback for service providers on patient / public experience.<br>• Support education of service users. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **SERVICE RE-DESIGN** | • To develop Annual Delivery Plan.<br>• To set the framework for service redesign, including priorities. | • Responsibility to plan and develop those services which it is the duty of NHS Borders to provide or secure the provision of, with a view to improving those services.<br>• To ensure services are redesigned in accordance with the Board's and the IJB planning priorities.<br>• To co-ordinate development of all services in line with the Annual Delivery Plan and the IJB Strategic Commissioning Plan | • To implement a program of re-design within the strategy. | • Drive and lead re-design of services within clinical practice. | • Support service redesign through active participation<br>• Support education of service users. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **LEADERSHIP** | • To provide strategic leadership for NHS Borders.<br>• Links to the SGHSCD.<br>• To develop an organisational development strategy for NHS Borders. (Setting culture, values and behaviour for all staff).<br>• To provide an example of effective behaviours. | • To develop management arrangements that enables NHS Borders to delegate power and resources.<br>• To provide operational leadership for the delivery of services.<br>• Responsibility to empower frontline staff by devolving management authority and accountability.<br>• To provide visible leadership and support to frontline staff encouraging team working. | • To provide operational leadership for the delivery of services.<br>• To empower frontline staff by devolving management authority and accountability.<br>• To provide visible leadership and support to frontline staff encouraging team working. | • Accessibility of Professional leadership.<br>• Local leaders.<br>• To participate in the leadership and decision making of the organisation. | • Support the development of leaders to ensure they are fully informed on the needs and contribution of partner organisations. |
| **CLINICAL LEADERSHIP DEVELOPMENT** | • To establish a strategy for clinical leadership and succession planning. | • Facilitating change in culture.<br>• Responsible for creating opportunities for re-design.<br>• To develop staff and independent contractors through shared training, induction and communication and provide a renewed focus on staff partnership.<br>• To develop detailed management structures that supports the development of clinical leads. | • Personal development plans.<br>• To provide and implement Clinical Leadership programme – commitment to support and develop workforce.<br>• Training and development programme.<br>• Creating opportunities for re-design. | • Participate in clinical leadership development<br>• Facilitating change in culture. | • Support the development of Clinical Leaders to ensure they are fully informed on the needs and contribution of partner organisations. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **MANAGED CLINICAL NETWORKS** | • Set strategic content for the development of MCN's.<br>• Promote links with regional planning.<br>• Building on the Clinical Strategy for NHS Borders and Regional planning priorities.<br>• Clinical Networking. | • Provide Resource.<br>• Identify key areas in which to develop MCN's.<br>• Facilitate the development of managed clinical networks.<br>• To employ shared network manager and redesign facilities to support service improvements.<br>• Identify key areas in which to develop managers. | • To participate in managed clinical networks.<br>• Facilitate the development of managed clinical networks.<br>• Provide training and development to support MCN. | • Identify individual staff's role identity within the function of the MCN.<br>• Ownership and definition of the composition of the team and their roles – particularly around leadership. | • Support and influence the development of MCNs to ensure 'fit'. |
| **CLINICAL GOVERNANCE** | • To develop Clinical Governance and Risk Management strategy.<br>• To ensure equity of patient care across Borders. | • To implement clinical governance and risk management strategy.<br>• To audit and monitor standards, including the provision of appropriate resources.<br>• Ensure national standards communicated /implemented.<br>• Ratify local standards.<br>• Ensure opportunities to make improvement through integration are maximised. | • To implement clinical governance and risk management strategy.<br>• To audit and monitor standards, including the provision of appropriate resources.<br>• Ensure national standards communicated /implemented.<br>• Ratify local standards. | • Delivery to National standards.<br>• Develop, set and monitor local standards. | • Recognise and support requirements of clinical governance accountabilities on NHS Borders. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **STAFF GOVERNANCE** | • Set culture and values to ensure effective partnership working and staff engagement across NHS Borders.<br>• Make expectations clear in regard to PDPs, Lifelong learning, Study leave, Appraisal.<br>• Ensure compliance with the Staff Governance Standard. | • To implement staff governance agreeing local priorities.<br>• Responsibility for development of staff governance arrangements in line with the Health & Social Care Integration agenda in partnership with Joint Management Teams and sub groups<br>• Responsibility to develop workforce capacity to deliver the full range of primary and community based services. | • Working with Partnership Forums, implement agreed local priorities for staff governance, for example Nursing Revalidation. | • To support the implementation and assist the identification of priorities. | • Recognise and support requirements of staff governance accountabilities on NHS Borders.<br>• Create conditions to support effective joint working arrangements for staff |

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| **PUBLIC GOVERNANCE** | • Set culture and provide strategic leadership to ensure patients and the public are involved in the delivery and design of health services.<br>• To ensure adherence to the Community Engagement Standards.<br>• To ensure that NHS Borders is fully compliant with the Equality & Diversity Agenda including The Gender Scheme, the Race Relations Action Plan and the Disability Scheme.<br>• To work towards achieving 'Investors in Volunteering 'by 2011 in line with National Directives | • To implement Public Governance ensuring consistent standards across the Clinical Boards.<br>• To support the Clinical Boards in the implementation of the Public Governance work programme.<br>• To monitor performance management in respect of national standards.<br>• To monitor performance to assure compliance with the Equality & Diversity Agenda including the Gender Scheme, the Race Relations Action Plan and the Disability Scheme. | • To implement and monitor the progress of the Public Governance Action Plan.<br>• To ensure patient and public involvement in individual service redesign.<br>• To oversee the implementation of the Carers Strategy and the Carers Information Strategy. | • To ensure that the Community Engagements Standards are fully integrated within service delivery / service redesign.<br>• To ensure compliance with the Equality & Diversity Standards including the Gender Scheme, the Race Relations Action Plan and The Disability Scheme. | • To maintain a consistent standard of approach and involvement with service users and members of the public across organisations and within the Voluntary Sector. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **FINANCIAL GOVERNANCE** | • To set the financial framework including investment plan and overall savings programme.<br>• approve the delegation of health functions and provision of resources to the IJB<br>• To monitor overall budgets of Operational Planning Group and other Departments and NHS Borders budgets.<br>• Propose and implement any agreed corrective action.<br>• To ensure appropriate audit and monitoring arrangements are established and maintained.<br>• Accountable Officer for the use of resources within NHS Borders. | • To maintain spending within financial limits.<br>• To devolve budgets to frontline management teams providing appropriate information and support.<br>• Facilitate flexibility in the use of budgets across Clinical / Care Boards.<br>• To monitor overall budgets of Clinical / Care Boards.<br>• Propose and implement any agreed corrective action.<br>• Responsibility for the development of joint health and social care budgets and financial frameworks.<br>• To develop business cases.<br>• To influence the equitable distribution of existing resources, both within the Operational Planning Group and across the wider NHS system. | • To maintain spending within financial limits.<br>• To ensure financial probity.<br>• To devolve budgets to frontline management teams providing appropriate information and support.<br>• To monitor budgets.<br>• Propose and implement any agreed corrective action.<br>• To ensure that financial audit standards are met.<br>• To prepare and submit business cases.<br>• To influence use of NHS Borders investment in relevant areas.<br>• To co-operate in the joint financial structures. | • Able to influence the allocation of resources based on need and performance.<br>• Recognise budget constraints and responsibilities.<br>• Manage devolved budget to optimise clinical decision-making. | • Recognise and support requirements of financial governance accountabilities on NHS Borders. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **COMMUNICATION** | • To develop internal and external communication strategy which promote the values and positive messages about health and health improvement. | • To implement internal and external communication strategies.<br>• To establish, develop and support public participation. | • To implement internal and external communication strategy. | • Support to implementation internal and external communication strategies, specifically in terms of staff, patients and the public. | • Support effective communication with users and the public |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **PERFORMANCE MANAGEMENT** | • To agree and establish overall strategic performance management framework to support SGHSCD requirements and local issues.<br>• To monitor performance of Operational Planning Group elements and other Support Service Depts, recognising good performance and intervening where there is a breach of statutory obligation.<br>• To oversee value for money, efficiency and benchmarking programmes as part of the wider performance management framework. | • Support the NHS Board in the overall performance management of NHS Borders performance.<br>• To monitor performance of Clinical Boards, recognising good performance and intervening where required. | • Contribute to the development of the Performance Framework.<br>• Ensure effective performance management of Clinical Board and component services.<br>• Give recognition to good performance.<br>• Escalate issues of poor performance which require NHS Borders intervention. | • Agree and communicate performance targets to staff.<br>• Deliver performance targets.<br>• To contribute to monitoring of performance of services. | • Support performance as required. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM & JOINT MANAGEMENT TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **JOINT WORKING** | • Establish governance arrangements and framework for effective joint working with Scottish Borders Council.<br>• Monitor effectiveness of joint working.<br>• Develop strong community planning for Scottish Borders through membership of the Community Planning Partnership<br>• Work as a partner with the IJB in relation to community planning and in developing and delivering integrated services across health and social care. | • Provide the operational focus for partnership with Scottish Borders Council .<br>• Provide main focus for service integration for the local community. | • Support the IJB to deliver the agreed outcomes as detailed in the Strategic Commissioning Plan.<br>• To seek opportunities for joint working to improve experiences of people who provide and use services.<br>• Work within strategies to develop joint working/local services. | • Deliver joint working arrangements.<br>• To participate in activities which through joint working improve the experiences of people who use services. | • Engage with NHS colleagues to ensure effective delivery of integrated services at Board and local levels. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF OPERATIONAL PLANNING GROUP & SUPPORT DIRECTORATES | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **SUPPORT SERVICES** | • To develop a strategy for support services ensuring effective interface with core clinical services.<br>• Ensure equity of access. Agree accountability arrangements and standards of practice. | • Ensure alignment between support service and service needs.<br>• To highlight opportunities for increased integration of support services. | • Ensure alignment between support service and service needs. | • Involvement in developing of services specification from support services. | ▪ Participate in development of common systems and harmonisation arrangements as appropriate. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF OPERATIONAL PLANNING GROUP & SUPPORT DIRECTORATES | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **HEALTH IMPROVEMENT** | • Establish system-wide priorities in context of national priorities.<br>• Implement system-wide initiatives for health improvement.<br>• Work in conjunction with community planning partners to ensure delivery of integrated health improvement agenda.<br>• Undertake a wide public health perspective locally.<br>• Ensure national and NHS Borders health improvement priorities are delivered, taking responsibility for needs assessment for local communities.<br>• Provide local focus for health education and promotion. | • Contribute to health improvement approaches across Clinical / Care Boards.<br>• Implement system wide initiatives for improving health.<br>• Work in conjunction with other partners to ensure delivery of integrated health improving services.<br>• Provide local focus for health improvement through delivery of the outcomes of the Strategic Commissioning Plan | • Contribute to health improvement approaches for patients and staff.<br>• Deliver Clinical Board wide initiatives for improving health.<br>• Work in conjunction with partners to ensure delivery of integrated health improving services. | • Contribute to and lead health improvement activities for patients and staff. | • Influence priority setting.<br>• Contribute to health promotion activities. |

| AREA OF RESPONSIBILITY | ROLE OF BOARD/ EXEC TEAM | ROLE OF STRATEGY GROUP/OPERATIONAL PLANNING GROUP | ROLE OF CLINICAL/CARE BOARDS | ROLE OF FRONTLINE STAFF | HEALTH PARTNERS |
|---|---|---|---|---|---|
| **INDEPENDENT CONTRACTOR SERVICES RESPONSIBILITIES** | • Devolve management and governance of independent contractor services to Operational Planning Group.<br>• Develop clear strategic framework for the development of independent contractor services. | • Through devolvement to the Primary & Community Services Board: manage independent contractor service contracts for pharmacists, dentists, opticians, GPs and PMS, to ensure services are provided in an interactive and complementary manner for the benefit of the local community.<br>• To integrate independent contractors and their staff within the Health & Social Care Integration Agenda 'corporate identity' through shared training, education and communication and staff partnership arrangements. | • Support the development of Primary Care services<br>• On behalf of BET and Operational Planning Group manage and govern primary and community services, including manage independent contractor service contracts. for pharmacists, dentists, opticians, GPs and PMS, to ensure services are provided in an interactive and complementary manner for the benefit of the local community. | • Support the development of Primary Care services | • Independent contractors to actively contribute to corporate activity of NHS Borders |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Workforce Plan** | • To ratify and approve the Workforce Plan | ▪ To develop in partnership with the Area Partnership Forum a Workforce Plan which supports the Annual Delivery Plan,<br>▪ To promote a culture of partnership working. | ▪ To implement with the Local Partnership Forums NHS Borders Workforce Plan | ▪ To promote and drive at local level a culture of partnership working.<br>▪ To identify opportunities across the service to implement the Workforce Plan.<br>▪ To identify system wide issues for Workforce Development. | ▪ Through local partnership forums to be able to influence Workforce Plan development. |
| ▪ **Workforce Development Strategy** | • To ratify and approve the Workforce Development Strategy | ▪ To develop in partnership through the NHS Borders Workforce Planning Group a Workforce Development strategy in order to provide a capable and competent workforce, taking into account national, regional and local service planning priorities. | ▪ To participate and influence workforce development and planning.<br>▪ To have clear and proportionate influence on the distribution of resources. | ▪ To implement agreed change in accordance with NHS Borders organisational change policy. | ▪ To be kept informed of strategic plans and priorities.<br>▪ To be supported during periods of organisational change.<br>▪ To be involved and contribute to the development of strategy. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **HR Performance Management** | • To be aware of the performance of Human Resources | ▪ To set key performance indicators for human resource in order to monitor performance. | ▪ To achieve system with key performance indicator targets. | ▪ To achieve key performance indicator targets. | ▪ To be briefed on expected targets and how to achieve these. |
| ▪ **Pay** | • To ensure proper and effective arrangements are in place with respect to pay | ▪ To support a Workforce Board for NHS Borders;<br>▪ To ensure NHS Borders implements national pay;<br>▪ To determine pay, terms and conditions of service for NHS Borders staff.<br>▪ To ensure pay reforms support service modernisation and redesign, through a Workforce Board. | ▪ To implement pay arrangements, agenda for change, GMS and consultant contracts.<br>▪ To identify/ implement opportunities across the system. | ▪ To implement pay arrangements, agenda for change, GMS and consultant contracts.<br>▪ To identify/ implement opportunities across the system. | ▪ To be paid fairly and consistently.<br>▪ To operate with pay policies which support delivery of services. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Partnership Working** | • To ensure proper and effective arrangements are in place with respect to Partnership Working | ▪ To develop a Partnership Working strategy | ▪ To ensure systems and processes are in place to develop and encourage partnership working.<br>▪ To support NHS Borders Partnership Forum ensuring membership of key representatives. | ▪ On each Clinical/Care Board a staff representative should be included in the membership of that team and attend meetings. | ▪ To be able to access partnership forums and be able to influence the agenda. |
| ▪ **Communications** | • To ensure proper and effective arrangements are in place with respect to Communications | ▪ To develop an internal and external communications strategy.<br>▪ To monitor the implementation of the strategy and to report progress bi-annually to the NHS Board/Staff Governance Committee. | ▪ To appraise Board/BET of situations which may be politically sensitive and could attract media coverage.<br>▪ To notify the Board of major incidents. | ▪ To implement the internal and external communications strategy. | ▪ To have in place a robust two-way communication process.<br>▪ To receive regular communications to support decision-making.<br>▪ To notify Operational Planning Group and Clinical/Care Boards of communication needs and difficulties. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Development of Clinical Leadership** | • To ensure proper and effective arrangements are in place with respect to Clinical Leadership | ▪ To establish a strategy for clinical leadership and succession planning. | ▪ To provide and implement the clinical leadership programme.<br>▪ To demonstrate commitment to both Operational Planning Group and in Clinical/Care Boards developing the workforce. | ▪ To provide and implement the clinical leadership programme. | ▪ To participate and influence in clinical development.<br>▪ For all staff to have a personal development plan. |
| ▪ **Staff Governance** | ▪ To have in place a Staff Governance Committee with an agreed remit.<br>▪ To develop an annual action plan.<br>▪ To ensure achievement of the staff governance standard.<br>▪ To provide quarterly progress reports to the Staff Governance Committee. | ▪ To implement the staff governance standard | ▪ To implement the staff governance standard | ▪ To implement the staff governance standard.<br>▪ To monitor and audit action plans from Clinical Boards. | ▪ To be treated fairly and consistently.<br>▪ To work in a safe working environment.<br>▪ To be appropriately trained.<br>▪ To be involved in decisions which affect you. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Learning Together** | ▪ To ensure proper and effective arrangements are in place with respect to learning | ▪ To develop a Learning Plan for NHS Borders setting out priorities in terms of education training and development strategies. | ▪ Based on the principles within the NHS Borders Learning Plan, develop a local implementation plan based on a local training needs analysis. | ▪ To support Life Long learning and afford learning representatives facility time. | ▪ Access to training and development to assist the delivery of patient care. |
| ▪ **Remuneration Committee** | ▪ To maintain a Remuneration Committee for NHS Borders with a clear remit and role.<br>▪ To determine the policy in respect of pay and conditions for Executive Directors and Senior Managers. | ▪ To receive fair and consistent pay, terms and conditions. | ▪ To receive fair and consistent pay, terms and conditions. | ▪ To receive fair and consistent pay, terms and conditions. | ▪ To receive fair and consistent pay, terms and conditions. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Contracts of Employment** | ▪ To ensure proper and effective arrangements are in place with respect to Contracts of Employment | ▪ To ensure all employees are issued with a Contract of Employment in accordance with Board policy, which complies with employment legislation.<br>▪ To approve any premature retirement and severance payments. | ▪ To support and recommend justification paper for any premature retirement and severance payments to the BET/Board for approval. | ▪ To provide a justification paper for any premature retirement and severance payments to the BET/Board for approval. | ▪ To receive fair and consistent contracts of employment. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **HR Policies and Procedures** | ▪ To ratify and approve HR Policies and Procedures | ▪ To ensure HR Policies are developed in partnership with the Area Partnership forum. Policies should support the achievement of the Staff Governance Standard, PIN guidelines and comply with current Employment Legislation. | ▪ To implement HR policies and procedures, developing appropriate action plans and supportive training. | ▪ To implement HR policies and procedures, developing appropriate action plans and supportive training. | ▪ To have supportive HR policies and procedures in place which assist service delivery. |
| ▪ **Appeals against termination of employment/ discipline** | ▪ To hear appeals for termination of employment or a disciplinary action taken against Chief Executive. | ▪ To ensure through negotiation with staff representatives there is an agreed policy for appeals against termination of employment. | ▪ To ensure the appeals procedure is implemented at Clinical Board level | ▪ To implement the appeals procedure at Clinical Board level. | ▪ To have in place a clear, fair and consistent policy and procedure. |
| ▪ **Disputes Procedure** | ▪ To ensure proper and effective arrangements are in place with respect to disputes | ▪ To ensure through negotiation there is an agreed policy to deal with disputes. | ▪ To ensure the disputes procedure is implemented at Clinical Board level | ▪ To implement the disputes procedure. | ▪ To have a clear process for dealing with disputes timeously. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Strategy and Policy Pathways** | ▪ All strategies and policies must be ratified and approved by the NHS Borders Board. | ▪ Any Human Resources Strategy, and supporting policy requires to be developed in partnership. | ▪ To participate and influence strategy and policy development. | ▪ To implement policies, developing appropriate action plans and supportive training | ▪ To be involved through partnership forums and working groups in the development of strategy and supporting policies. |
| ▪ **Health & Safety** | ▪ To ratify and approve the Occupational Health & Safety Policy. | ▪ To maintain an Occupational Health and Safety policy. | ▪ To implement Occupational Health & Safety policy.<br>▪ To establish Occupational Health & Safety Forum.<br>▪ Monitor potential litigations. | ▪ To implement Occupational Health & Safety policy.<br>▪ To be active members of Occupational Health and Safety Forum | ▪ To have clear guidelines and training on Occupational Health & Safety.<br>▪ To comply with those guidelines and practices. |
| ▪ **Financial Strategy and Planning** | ▪ To approve the Annual Delivery Plan | ▪ To develop financial strategy which supports the delivery of the Annual Delivery Plan. | ▪ To support the development and the delivery of the financial strategy in the Annual Delivery Plan.<br>▪ To advise of any corrective action required to deliver financial plans. | ▪ Implement the financial strategy in the Annual Delivery Plan. | ▪ Through local partnership forums influence the Annual Delivery Plan and supporting financial strategy. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| • **Resource Allocation** | ▪ To allocate resources consistent with the Financial Plan and Annual Delivery Plan<br>▪ to approve the delegated functions and provision of resources to the IJB | ▪ To ensure systems are in place to allocate resources consistent with the Financial Plan. | ▪ To set budgets which support the delivery of agreed objectives within the resource limit. | ▪ To set budgets which support the delivery of agreed objectives within the resource limit. | ▪ To be involved and have the opportunity to influence the distribution of resources. |
| ▪ **Financial Monitoring** | ▪ To be aware of the financial position including any corrective action required to achieve balance. | ▪ To have in place robust financial monitoring framework. | ▪ Monitor financial performance against budget and advice of any significant variance from financial plan.<br>▪ To propose and implement agreed corrective action. | ▪ Monitor financial performance against budget and advise of any significant variance from financial plan.<br>▪ To propose and implement agreed corrective action.<br>▪ Ensure adequate training is delivered to budget holders.<br>▪ Devise and maintain detailed systems of budgetary control. | ▪ To be kept informed of financial performance.<br>▪ To access training when required. |
| ▪ **Audit Committee** | ▪ To maintain an Audit Committee for NHS Borders with a clear remit.<br>▪ To agree and monitor an annual Audit plan with input from the Board Executive Team. | ▪ To support the discharge of the Internal Audit Plan | ▪ To support the discharge of the Internal Audit plan and agree monitoring arrangements where appropriate | ▪ To agree and implement audit recommendations. | ▪ To be kept informed of relevant audit issues.<br>▪ To contribute to audit activities as required. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Annual Accounts and Reports** | ▪ Approval of the Annual Accounts. | ▪ To provide financial information as required for Annual Accounts.<br>▪ To be kept informed of relevant annual accounts issues. | ▪ To provide financial information as required for Annual Accounts. | ▪ To provide financial information as required for Annual Accounts. | ▪ To be kept informed of relevant annual accounts issues. |
| ▪ **Capital Approvals** | ▪ To allocate capital resources which support the delivery of the Annual Delivery Plan.<br>▪ Consider Business Cases for Capital Investment. | ▪ To manage capital expenditure within the available resources. | ▪ To ensure there is an adequate appraisal and approval process in place for determining capital expenditure. | ▪ To prepare and submit business cases for capital requirements. | ▪ To be able to influence the allocation of resource. |
| ▪ **Asset Management** | ▪ The Board shall delegate responsibility to the Operational Planning Group for the overall control of fixed assets. | ▪ To develop a Property and Asset Management Strategy which is consistent with the Annual Delivery Plan. | ▪ Implementation of property strategy including development of robust business cases in support of strategy. | ▪ Devolved responsibility for asset management. | ▪ Responsibility for ensuring safe keeping and effective use of assets. |
| ▪ **Financial Policies and Procedures** | ▪ To have mechanisms to ensure consistent financial policies and procedures are in place. | ▪ To ensure financial policies and procedures are applied on a consistent basis | ▪ Maintaining an effective system of internal financial control.<br>▪ Ensure all staff are aware of, and understand their responsibilities within the SFI's. | ▪ Maintaining an effective system of internal financial control.<br>▪ Ensure all staff are aware of, and understand their responsibilities within the Standing Financial Instructions. | ▪ To have financial policies and procedures in place which support effective decision-making.<br>▪ To comply with those policies. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Payment of Staff** | ▪ To ensure proper and effective arrangements are in place with respect to the payment of staff | ▪ Establish policy in relation to any variations in agreed rates of pay and conditions of service. | ▪ To secure funding prior to approval for any increase in establishment.<br>▪ Ensuring all payments are properly authorised in line with national agreed pay scales. | ▪ Reporting financial impact of all changes in staffing including impact of early retirement. | ▪ Through partnership forums be able to influence all policies in relation to payment of staff. |
| ▪ **Payment of Accounts** | ▪ To ensure proper and effective arrangements are in place with respect to the payment of accounts | ▪ To agree Borders wide policies and standards for the payment of accounts.<br>▪ Responsible for prompt payment of all accounts and claims.<br>▪ Ensuring all payments are made in accordance with Scheme of Delegation.<br>▪ Responsibility for designing and maintaining systems for verification, recording and payment of all accounts. | ▪ To support payment of accounts in line with agreed policy. | ▪ To support payment of accounts in line with agreed policy. | ▪ N/A |
| ▪ **Bank Accounts and Government Banking Services** | ▪ To ensure proper and effective banking arrangements are in place | ▪ To ensure effective management of all bank accounts | ▪ To support effective management of bank accounts and Government Banking Services. | ▪ To support effective management of bank accounts and Government Banking Services. | ▪ N/A |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Security of Cash, Cheques and other Negotiable Instruments** | ▪ To ensure proper and effective security arrangements are in place | ▪ Responsibility for security of cash, cheques and other negotiable instruments as appropriate. | ▪ Responsibility for security of cash, cheques and other negotiable instruments | ▪ Responsibility for security of cash, cheques and other negotiable instruments. | ▪ N/A |
| ▪ **Procurement and Tendering** | ▪ To agree NHS Borders wide policies and standards for procurement and tendering and incorporate in Standing Orders.<br>▪ Setting of thresholds for tenders and for obtaining goods services and works. | ▪ To ensure all procurement and tendering processes comply with NHS Borders Standing Orders and provide value for money<br>▪ To ensure that where national, regional or local contracts exist (including framework arrangements) the use of these contracts is mandatory | ▪ Ensuring best value for money.<br>▪ Compliance with Standing Orders. | ▪ Ensuring best value for money.<br>▪ Compliance with Standing Orders. | ▪ Ensuring best value for money.<br>▪ Compliance with Standing Orders. |
| ▪ **Endowment Funds** | ▪ To establish an Endowment Fund Board of Trustees for NHS Borders. | ▪ To determine the policy in respect of Endowment Funds. | ▪ To advise on the financial implications of any proposal for either fundraising or investment of endowments funds. | ▪ To implement the Endowment Policy. | ▪ Through partnership forum to be able to influence all policies in relation to Endowment funds. |

| Key Issues | NHS Borders Board | Board Executive Team | Operational Planning Group | Clinical / Care Board | Front Line Staff |
|---|---|---|---|---|---|
| ▪ **Risk Management** | ▪ To maintain a Risk Management Board for NHS Borders with a clear remit. | ▪ To develop the Risk Management Strategy.<br>▪ | ▪ To implement and monitor the Risk Management Strategy. | ▪ To implement and monitor the Risk Management Strategy.<br>▪ To implement and monitor the Organisational Resilience and Business Continuity Planning. | ▪ To have supportive Risk Management policies and procedures in place which assist service delivery.<br>▪ To comply with those policies and procedures. |

## 4. DELEGATED LIMITS AND AUTHORISED SIGNATORIES

### 4.1 Introduction

The Chief Executive has delegated authority to secure the efficient operation and management of services in accordance with the current policies of the Board, and within the limits of the resources available, subject to the approval of the Board, through Standing Financial Instructions.

Any changes to Delegated Limits and Authorised Signatories must be notified to the Director of Finance in writing. Departmental structure changes will be reflected in the Delegated Limits within the Code of Corporate Governance on an ongoing basis.

## 4.2 Schedule of Delegated Limits and Authorised Signatories

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. All items concerning finance must be carried out in accordance with Standing Financial Instruction and Standing Orders.

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Quotations, Tendering and Contract Procedures** | | | |
| a) NHS Service Agreements annual values | Over £ 1,000,000 | Borders NHS Board<br>Excepting the Lothian Service Level Agreement where authorisation is delegated to the Director of Finance | |
| | Over £250,000 to £1,000,000 | Chief Executive | |
| | Over £125,000 to £250,000 | NHS Borders Resources - Director of Finance, with one Executive Director | |
| | Over £50,000 to £125,000 | Medical Director<br>Director of Nursing, Midwifery & AHPs<br>Director of HR, OD & OH&S<br>Director of Planning & Performance<br>Director of Acute Services<br>Chief Officer | |
| | Up to £50,000 | Clinical Board Chairs<br>General Managers<br>Commissioning Manager<br>Delegated Budget Holders | |

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| b) i. EC Tendering Procedure (OJEU Advertisement) | Contracts for goods/services above EC Tendering Limits *Current EC limits are contained within NHS HDL (2002) 27 Revision of Thresholds for the World Trade Agreement on Government Procurement (valid until 31 December 2003)* | Adjudication of tender by Project Director, Project Manager, representative of Director of Finance, and, if value over £500,000 a non-executive Board member | |
| ii. Award of tender | | Borders NHS Board | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Quotations, Tendering & Contract Procedures (continued)**<br>c) Capital/Estates Works (unless covered by EC tendering limits – see b above) | | | |
| • Minimum number of invited tenders | Over £250,000 | 4 tenders | |
| | Over £50,000 to £250,000 | 3 tenders | |
| | Over £10,000 to £50,000 | 3 quotations | |
| | Under £10,000 | At discretion of Director of Finance | |
| • Authority to open tenders/review quotations | Over £500,000 | As £10,000 to £500,000 plus a non-executive Board member | |
| | Over £10,000 to £500,000 | Representative of Director of Finance and Head of Estates & Facilities | |
| | Under £10,000 (Quotations) | Two Estates Officers | |
| • Authority to adjudicate tender | Over £500,000 | As £10,000 to £500,000 plus non-executive Board member | |
| | Over £10,000 to £500,000 | Head of Estates & Facilities, representative of Director of Finance plus Estates Officer | |
| | Under £10,000 | Estates Officer | |
| • Award of Tenders | Over £500,000 | Borders NHS Board | |
| | Over £100,000 to £500,000 | Chief Executive | |
| | Over £25,000 to £100,000 | Director of Finance | |
| | Under £25,000 (Quotations) | Estates Officer | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Quotations, Tendering & Contract Procedures (continued)**<br>d) General Purchase Orders (unless covered by EC tendering limits – see b above) | | | |
| • Minimum number of invited tenders | Over £250,000 | 4 tenders | |
| | Over £50,000 to £250,000 | 3 tenders | |
| | Over £15,000 to £50,000 | 3 quotations | |
| | Under £15,000 | At discretion of Head of Procurement | |
| • Authority to open tenders/review quotations | Over £500,000 | As below plus a non-executive Board member | |
| | Over £50,000 to £500,000 | Representative of Director of Finance and Head of Procurement | |
| | Under £50,000 (Quotations) | Head of Procurement and Delegated Budget Holder | |
| • Authority to adjudicate tender | Over £500,000 | As £50,000 to £500,000 plus non-executive Board member | |
| | Over £50,000 to £500,000 | Head of Procurement, representative of Director of Finance, plus Technical Advisor | |
| | Under £50,000 | Head of Procurement | |
| • Award of Tenders/Authorised Purchase Orders | Over £ 250,000 | Borders NHS Board | |
| | Over £125,000 to £250,000 | Chief Executive | |
| | Over £50,000 to £125,000 | NHS Borders resources - Director of Finance and one Executive Director. | |

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|---|---|---|---|
| • Award of Tenders/Authorised Purchase Orders (Cont) | Over £10,000 to £50,000 | Director of Finance<br>Director of Public Health<br>Director of HR, OD & OH&S<br>Director of Planning & Performance<br>Medical Director<br>Director of Nursing, Midwifery & AHPs<br>Director of Acute Services<br>Head of IM&T<br>Director of Pharmacy<br>Clinical Board Chairs<br>Clinical Board General Managers<br>Head of Procurement | |
| | Over £30,000 to £50,000 | Deputy Director of Pharmacy<br>Chief Pharmacy Technician<br>Senior Pharmacist<br>Estates Managers<br>Commissioning Manager<br>Senior Clinical Managers | |
| | Over £10,000 to £30,000 (Pharmaceutical Supplies) | Senior Pharmacy Technician | |
| | Up to £ 10,000 (Quotations) | Head of Procurement<br>Delegated Budget Holders<br>Human Resource Managers | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Quotations, Tendering & Contract Procedures (continued)** | | | |
| e) Management Consultants | | | |
| • Minimum number of tenders | Over £25,000 | 3 tenders | |
| | Under £25,000 | At discretion of Chief Executive & Director of Finance, | |
| • Authority to open tenders | Over £25,000 | Chief Executive & Director of Finance<br>Chief Executive & Director of Finance | |
| • Authority to adjudicate tender | Under £25,000 | Borders NHS Board | |
| • Award of Tenders | Over £25,000 | Chief Executive & Director of Finance | |
| | Under £25,000 | | |
| f) **UK** Travel Conference/Course/Training Expenses Payment | Over £25,000 | Chief Executive | |
| | Over £5,000 to £25,000 | Director of HR, OD & OH&S and Clinical Board General Manager | |
| | Up to £5,000 | Budget holder | |
| g) **OVERSEAS** Travel Conference/Course/Training Expenses Payment | All | Chair of NHS Borders Board for Non Executive Members<br>Chief Executive (or appointed deputy) for all NHS Borders employees | |
| h) Leased Cars Ordering | All | Director of Finance | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| i) Engagement of Agency/Locum Staff (single instance or arrangement for period of time) | Over £100,000<br><br>Over £40,000 up to £100,000<br><br><br><br>Up to £40,000 | Chief Executive<br><br>NHS Borders resources - Director of Finance with the Medical Director or Director of Acute Services or Chief Officer<br><br><br>Clinical Chairs, General Managers &/or delegated Budget Holders | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Cheque Signatories** | Over £5,000 | Two authorised bank signatories one of whom shall be at least a Senior Finance Manager. | Authorised Bank Signatory Levels |
| | Up to £5,000 | One authorised signatory | |
| **Response to Emergency Situation / Major Incident** | £1million | Chief Executive | Refer to paragraph 2.2.1 |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Property Disposals** | All | Borders NHS Board | |
| **Fixed Asset Disposals** | Over £ 100,000 | Borders NHS Board | |
| | £ 1 to £ 100,000 | Director of Finance, Clinical Chairs, Other Directors, General Managers/ Heads of Department | |
| | Zero Net Book Value | | |
| **Establishment of Cash Float** | Over £250 up to £1,000 | Director of Finance | |
| | Over £50 up to £250 | Deputy Director of Finance<br>Senior Finance Manager | |
| | Up to £50 | Budget holder | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Endowment Projects, Payments (incl. Capital Expenditure** | Over £100,000 | Endowment Fund Board of Trustees | |
| | Between £25,000 and £100,000 | As £1k to £10k plus Chairman & Chief Executive and for noting by the Endowment Fund Board of Trustees | |
| | Between £10,000 and £25,000 | As £1k to £10k plus Chief Executive and Director of Finance | |
| | Between £1,000 and £10,000 | Fund Manager and Chair of Clinical Board (or nominated deputy) | |
| | Up to £1,000 | Fund Manager | |
| **Endowment Investments** | | Delegated Fund Advisor | |

| DELEGATED MATTER | DELEGATED LIMITS | AUTHORISED SIGNATORY | REFERENCE DOCUMENTS |
|---|---|---|---|
| Virement of budgets between budget headings within services/departments | Over £ 250,000 | Borders NHS Board | |
| | Over £50,000 up to £250,000 | Chief Executive & Director of Finance with one Executive Director | |
| | Over £10,000 up to £50,000 | Director of Finance | |
| | Over £1,000 up to £10,000 | General Manager & Budget Manager | |
| | Below £1,000 | Budget Manager | |
| | Over £ 250,000 | Borders NHS Board | |
| | Over £50,000 up to £250,000 | Chief Executive, Director of Finance with one Executive Director | |
| | Over £20,000 up to £50,000 | Director of Finance & General Manager | |
| Virement of budgets across services/departments | Up to £20,000 | General Manager | |

## Scheme of Delegation

Delegated matters in respect of decisions which may have a far-reaching effect must be reported to the Chief Executive. ***The delegation below is the lowest level to which authority is delegated.*** Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning finance must be carried out in accordance with Standing Financial Instruction and Standing Orders.

| DELEGATED MATTER | AUTHORITY DELEGATED TO | REFERENCE DOCUMENTS |
|---|---|---|
| **1. Management of Budgets** | | |
| **1.1 Budgetary Control** | | |
| a) Prepare and submit a financial plan to the Board reconciling anticipated income and expenditure plans. | Director of Finance | |
| b) Submit reports to the Board highlighting significant variances and details of action taken, trends to date and forecasts of year end position. | Director of Finance | |
| c) Design, implement and supervise the financial controls and the accounting system. | Deputy Director of Finance | |
| d) Prepare and issue operational procedures governing the accounting system to all staff empowered to incur expenditure and generate or collect income. | Deputy Director of Finance | |
| e) Provide relevant budgetary (financial and management) information to aid decision making and financial control. | Deputy Director of Finance & Business Partner | |
| f) Report and investigate financial activity and manpower variances from budget to a specified timetable. | Budget Managers and Business Partners | |
| g) Budget holders to receive adequate financial training. | Deputy Director of Finance | |
| h) Providing appropriate support from the Management Accounting Team. | Deputy Director of Finance | |
| i) Approval of Budgets. | Board for overall strategy; Clinical Executive for detailed framework | |
| j) Set and agree detailed budgets. | Director of Finance; Chief Executive Operational Planning Group; Clinical Boards and Budget Managers | |
| k) Provide Budget Managers with monthly budget statements. | Deputy Director of Finance | |

| DELEGATED MATTER | DELEGATED AMOUNT (£) | AUTHORITY DELEGATED TO | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Management of Budgets (continued)** | | | |
| **1.2 Budgetary Control**<br>Responsibility for keeping expenditure within budgets: | | | |
| At individual budget level (pay and non-pay)<br>At service/department level<br>At Clinical Board<br>For reserves and contingencies<br>Virement of budget<br>Agreement to any transfer of allocation required by the Board from or to capital | | Budget Holder<br>General Manager<br>Clinical Chair<br>Director of Finance<br>See earlier section<br>Director of Finance | |
| **1.3 Authorisation of Expenditure**<br>**Non Discretionary Expenditure only**<br>Commit expenditure on behalf of the Board against approved budget allocations.<br>(Non discretionary expenditure covers supplies and services **excluding** equipment, training and stationery) | Over £ 250,000<br><br>Over £ 125,000 to £ 250,000<br><br>Over £50,000 to £125,000<br><br>Over £10,000 to £ 50,000 | Borders NHS Board<br><br>Chief Executive<br><br>NHS Borders resources - Director of Finance and one Executive Director<br><br>Director of Finance<br>Director of Public Health<br>Director of HR, OD & OH&S<br>Director of Planning & Performance<br>Director of Acute Services<br>Head of Estates<br>Medical Director<br>Chief Officer<br>Director of Nursing, Midwifery & AHPs<br>Head of IM&T<br>Clinical Board General Managers<br>Clinical Board Chairs<br>Director of Pharmacy<br>Head of Procurement | |

| DELEGATED MATTER | DELEGATED AMOUNT (£) | AUTHORITY DELEGATED TO | REFERENCE DOCUMENTS |
|---|---|---|---|
| **1. Management of Budgets (continued)** | | | |
| **1.3 Authorisation of Expenditure (continued)** | Over £30,000 to £50,000 | Deputy Director of Pharmacy<br>Chief Pharmacy Technician<br>Senior Pharmacist<br>Estates Managers<br>Commissioning Manager | |
| | Over £ 10,000 to £ 30,000 | Senior Pharmacy Technician<br>Senior Clinical Managers | |
| | Up to £10,000 | Delegated Budget Holders<br>Head of Procurement<br>Human Resources Managers | |
| **1.3 Authorisation of Expenditure (continued) Discretionary Expenditure only**<br>Commit expenditure on behalf of the Board against approved budget allocations. (Discretionary expenditure covers equipment, training and stationery) | Over £ 250,000 | Borders NHS Board | |
| | Over £ 125,000 to £ 250,000 | Chief Executive | |
| | Over £50,000 to £125,000 | NHS Borders resources - Director of Finance and one Executive Director | |
| | Up to £ 50,000 | Director of Finance<br>Director of Public Health<br>Director of HR, OD & OH&S<br>Director of Planning & Performance<br>Medical Director<br>Director of Nursing, Midwifery & AHPs<br>Director of Acute Services<br>Clinical Board General Managers<br>Director of Pharmacy | |
| **1.4 Budget Adjustments** | | | |
| a) Authorise all Clinical Board / Department Budget Adjustments. | | Deputy Director of Finance | |

| DELEGATED MATTER | DELEGATED AMOUNT (£) | AUTHORITY DELEGATED TO | REFERENCE DOCUMENTS |
|---|---|---|---|
| **2. Capital** | | | |
| **2.1 Management of Fixed Assets** | | | |
| a) Delegation of responsibility for the physical security and control of assets located within a specific location. | | General Managers | |
| b) Complete and update procedure notes for maintaining fixed asset register. | | Deputy Director of Finance | |
| c) Physical verification of fixed asset. | | General Manager | |
| d) Notify Deputy Director of Finance on additions, Transfers and Disposal of fixed assets. | | General Manager | |
| e) Maintain register of all assets given out on loan. | | Nominated Ward/Dept Manager | |

| DELEGATED MATTER | DELEGATED AMOUNT (£) | AUTHORITY DELEGATED TO | REFERENCE DOCUMENTS |
|---|---|---|---|
| **2. Capital (continued)** | | | |
| **2.2 Project Management Arrangements** | | | |
| a) Each project must have a project director | | Director of Finance | |
| b) Formal appointment of a project manager | | Capital Management Team | |
| c) Set up Project Board meetings | | Project Director, Project Sponsor and Project Manager | |
| d) Authority to proceed | See above section | | |
| e) Accountable officer approval | See above section | | |
| f) Cost and budgetary control<br>- report cost control to Capital Management Team | | Project Manager & Deputy Director of Finance | |
| - report cost control to Project Management Team | | Deputy Director of Finance | |
| g) Delegated authority to approve project spend | | Project Board | |
| h) Project Monitoring and Review | | Project Management Team, Financial Accounting Team | |
| i) Post project/post occupancy evaluation (PPE/POE) | | General Manager / Estates Manager | |
| - to be carried out 6 month after commissioning/operational | | End User | |

**Delegated Authority for Losses & Special Payments – Limits Delegated by SGHSCD to NHS Borders**

| DELEGATED MATTER | DELEGATED AMOUNT (£) | DELEGATED AUTHORITY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **1. Losses of Cash due to:** | | | |
| Theft, fraud, etc.<br>(ALL cases of fraud over £1,000 must be reported to the SGHSCD before write-off) | £5,000 | Director of Finance | |
| Overpayment of salaries, wages, fees and allowances | £5,000 | Director of Finance | |
| Other causes, including unvouched or incompletely couched payments, overpayments, loss by fire (excluding arson), physical cash, stamp or cash equivalent losses | £5,000 | Director of Finance | |
| **2. Negatory and Fruitless Payments** | £5,000 | Director of Finance | |
| **3. Bad Debts and Claims Abandoned:** | | | |
| a) Private inpatients (Section 57 NHS (Scotland) Act 1978) | £5,000 | Director of Finance | |
| Private non-resident patients (Section 58 NHS (Scotland) Act 1978) | £5,000 | Director of Finance | |
| b) Overseas visitors (Section 59 NHS (Scotland) Act 1978) | £5,000 | Director of Finance | |
| c) Road Traffic Claims | £5,000 | Director of Finance | |
| d) Cases other than a) to c) | £5,000 | Director of Finance | |

**Delegated Authority for Losses & Special Payments – Limits Delegated by SGHSCD to Borders NHS Board**

| DELEGATED MATTER | DELEGATED AMOUNT (£) | DELEGATED AUTHORITY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **4) Damage to buildings, their fittings, furniture and equipment and loss of equipment and property in stores and in use Losses:** | | | |
| a) Culpable causes e.g. theft, fraud arson, etc, whether proved or suspected, neglect of duty or gross carelessness: | | | |
| Other equipment and property | £20,000 | Director of Finance / Director of HR, OD & OH&S / Director of Planning & Performance | |
| Bedding and Linen | £10,000 | Director of Finance / Director of HR, OD & OH&S/Director of Planning & Performance | |
| b) Discrepancies and unexplained issues: | | | |
| Other equipment and property | £20,000 | Director of Finance / Director of HR, OD & OH&S / Director of Planning & Performance | |
| Bedding and Linen | £10,000 | Director of Finance / Director of HR, OD & OH&S / Director of Planning & Performance | |
| c) Incidents of Service (as a result of fire, flood etc., motor vehicle accidents, damage to vehicles | £20,000 | Director of Finance / Director of HR, OD & OH&S / Director of Planning & Performance | |
| d) Other causes | £20,000 | Director of Finance / Director of HR, OD & OH&S / Director of Planning & Performance | |

**Delegated Authority for Losses & Special Payments – Limits Delegated by SGHSCD to NHS Borders**

| DELEGATED MATTER | DELEGATED AMOUNT (£) | DELEGATED AUTHORITY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **Special payments (except in respect of family practitioner services)** | | | |
| **5. Compensation Payments (made under legal obligation):** | | | |
| Clinical | £250,000 or above | SGHSCD prior approval | |
| Non Clinical | £100,000 or above | SGHSCD prior approval | |
| Financial Loss | £25,000 or above | SGHSCD prior approval | |
| **6. Extra contractual payments to Contractors** | £5,000 | Director of Finance | |
| **7. Ex-Gratia Payments:** | | | |
| a) Compensation payments (including payments for loss of personal effects) | £5,000 | Director of Finance | |
| b) For medical and clinical negligence (negotiated settlements following legal advice and issued guidance) | | | |
| Clinical | Up to £250,000 | Chief Executive | |
| Non – clinical | Up to £100,000 | Director of HR, OD & OH&S | |
| Other clinical negligence cases | Up to £25,000 | Director of Planning & Performance<br>Director of Acute Services | |
| c) Personal injury claims | NIL | | |
| d) Other, except cases of maladministration where there was no financial loss by claimant | £5,000 | Director of HR, OD & OH&S<br>Director of Planning & Performance | |
| e) Maladministration where there was no financial loss by claimant | NIL | | |

**Delegated Authority for Losses & Special Payments – Limits Delegated by SGHSCD to NHS Borders**

| DELEGATED MATTER | DELEGATED AMOUNT (£) | DELEGATED AUTHORITY | REFERENCE DOCUMENTS |
|---|---|---|---|
| **8. Extra Statutory & Extra Regulatory Payments:** | NIL | | |
| **Losses and special payments in respect of provision of family practitioner services.** | | | |
| **9. Losses:** | | | |
| a) Losses due to overpayments to practitioners of fees allowances or salary | | | |
| i. involving fraud | £1,000 | Director of Finance | |
| ii. other | £1,000 | Director of Finance | |
| b) Unvouched or incompletely vouched payments | £1,000 | Director of Finance | |
| **10. Claims Abandoned** | £1,000 | Director of Finance | |
| **Special Payments** | | | |
| **11. Ex Gratia Payment** | £1,000 | Director of Finance | |
| **12. Extra Statutory and Extra Regulatory payments** | | | |
| a) To chemist contractors for drugs supplied in good faith in respect of forged, etc. prescription forms | £1,000 | Director of Finance | |
| b) Other | NIL | | |

**Losses & Special Payments - NOTES**

1. Cases not covered by the limits set out above should be referred to the SGHSCD as soon as the salient facts are clear and not delayed because of difficulties of unravelling complicated or inadequately documented transactions, or of assessing the amount of the final loss.
2. The limits set out above apply to individual incidents except as qualified in these notes.
3. The limits for Cash Losses refer to the gross loss, irrespective of any subsequent recovery. The limits for all other losses refer to the net loss.
4. The limit for overpayments of salaries, etc refers to the total involved at any one time through the same error or misinterpretation.
5. The limit for claims abandoned refers to the total of all cases arising from a single cause, but the loss in respect of each individual debtor should be recorded as one case.
6. The total net stores loss at any one hospital within the year should be aggregated and treated as one case. Similarly, the total net inventory losses at any one hospital within the year should be treated as one case.
7. In the case of central stores, the total beddage covered by the central store should determine the delegation limit for write-off purposes. For establishments, such as administrative offices and clinics, where the bed criterion cannot be used, the lowest limit of delegation for stores and inventory losses will apply.
8. Where an accident, such as fire or flood, involves losses under several heads, the limit for incidents of the service (i.e. £20,000) applies to the total of the damage incurred.
9. Where an extra contractual payment arises from a change in subsidy or other Government action, the first application for such payments should be referred to SGHSCD, irrespective of the limit of delegation.
10. **SGHSCD must be notified immediately of all possible cases of compensation payments (made under legal obligation**), irrespective of the limit of delegation.

## 5. DELEGATION OF POWERS FOR APPOINTMENT OF STAFF

### 5.1 Use of Powers

The powers delegated are to be exercised in accordance with procedures or guidance issued by the Scottish Government Health & Social Care Directorate, or approved by the Board.

Procedures governing the appointment of Consultants and other medical and dental grades are contained in Statutory Instruments issued by Scottish Ministers.

Appointments will be made within the delegated authority and budgetary responsibility in accordance with Standing Financial Instructions. Schemes of Delegation for appointment of staff will specify appointing officers, and, where necessary, the composition of appointment panels.

### 5.2 Appointment of Staff

Canvassing of Appointing Officers or Members of the Appointment Panel directly or indirectly for any appointment shall disqualify the candidate for such appointment.

A Member of the Board shall not solicit for any person any appointment under the Board, or recommend any person for any such appointment. This, however, shall not preclude any Member from giving a written testimonial of a candidate's suitability, experience or character for submission to the Board.

Every Member of the Board shall disclose to the Board any known relationship to a candidate for an appointment with the Board, It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

It shall be the duty of the Appointing Officer to disclose to his or her Line Manager any known relationship to a candidate for an appointment for which he or she is responsible.

Where a relationship of a candidate for appointment to a Member of the Board is disclosed, that Member must play no part in the appointment process.

Two persons shall be deemed to be related if they are husband and wife, or partners or if either of the two, or the spouse or partner of either of them is the son or grandson, daughter or granddaughter, or brother or sister, or nephew or niece, of the other, or of the spouse or partner of the other.

### 5.3 Authority to Appoint

| | |
|---|---|
| Chief Executive and posts at Director level. (Other than Director of Public Health/Medical Director) | The appropriate Board Appointments Committee |
| Director of Public Health/Medical Director | The Board on the recommendation of an Advisory Appointments Committee |
| Other Staff | Appointment Panel or Officer specified in the Scheme of Delegation |

## 5.4 Composition of Appointment Committees

### Chief Executive

The Board Appointments Committee shall be constituted in line with DL(2018)10 Values Based Recruitment for NHS Board Executive Level Appointments

### Posts at Director Level (Other than Medical)

The Board Appointments Committee shall be constituted in line with DL(2018)10 Values Based Recruitment for NHS Board Executive Level Appointments

### Director of Public Health and Medical Director

Where applicable the appointment is made by a Board Committee on the recommendation of an Advisory Appointments Committee, constituted in accordance with The National Health Service Guidance on the Appointment of Medical Directors (NHS MEL 1998 13). https://www.sehd.scot.nhs.uk/mels/1998_13.pdf

### Appointment of Consultants

The Board is responsible for the recruitment, and authorisation of the appointment of, consultants as required under the National Health Service (Appointment of Consultants) (Scotland) Regulation 2009. Local guidance is in place which reflects these requirements.

### Other Staff in Accordance with Detailed Schemes of Delegation

## 5.5 Disciplinary Procedures

The Disciplinary Procedures regarding the Board staff are contained in the Employee Conduct Policy. In the case of Executive Members and other Directors, such procedures shall be a matter for panels convened on behalf of the Board.

It is delegated to Chief Executive/Nominated Director, as appropriate, to apply the terms of the Board's Employee Conduct Policy.

# SECTION G

# STANDING FINANCIAL INSTRUCTIONS

## STANDING FINANCIAL INSTRUCTIONS

**1.** Introduction
**2.** Responsibilities of Chief Executive as Accountable Officer, Director of Finance and Employees
**3.** Financial Strategy, Planning and Control
**4.** Budgetary Control and Monitoring
**5.** Commissioning/Providing Health Care Services
**6.** Annual Report and Accounts
**7.** Banking Arrangements
**8.** Security
**9.** Income
**10.** Payment of Accounts
**11.** Construction Industry Scheme
**12.** Payment of Salaries and Wages
**13.** Travel, Subsistence and Other Allowances
**14.** Contracting and Purchasing
**15.** Stores
**16.** Losses and Special Payments
**17.** Endowment Funds
**18.** Primary Care Contractors
**19.** Delegation of functions and the provision of resources by Borders Health Board to the Health & Social Care Integration Joint Board
**20.** Patients' Funds and Property
**21.** Audit
**22.** Information Management and Technology
**23.** Capital and Fixed Assets
**24.** Risk Management and Insurance
**25.** Financial Irregularities

**Section G - Appendix 1:** Common Seal

## SECTION 1

## INTRODUCTION

### Made in terms of Regulation 4 of the National Health Service (Financial Provisions) Scotland) Regulations, 1974

### Background

1.1 These Standing Financial Instructions (SFI's) are issued for the regulation of the conduct of Borders Health Board (The Board), its directors, officers and agents in relation to all financial matters. The SFI's are issued in accordance with the financial directions issued by the Scottish Government Health & Social Care Directorate under the provisions contained in Regulation 4 of the NHS (Financial Provisions) (Scotland) Regulations, 1974 together with the guidance and requirements contained in NHS Circular No 1974 (GEN) 88 and Annex, and NHS Circular MEL (1994) 80. Their purpose is to provide sound control of NHS Borders's financial affairs and shall have the effect as if incorporated in the Standing Orders of the Board.

1.2 The purpose of such a scheme of control is:

- To ensure that NHS Borders acts within the law and that financial transactions are in accordance with the appropriate authority;
- To ensure that proper accounting records, which are accurate and complete, are maintained;
- To ensure that financial statements, which give a true and fair view of the financial position of NHS Borders and its expenditure and income, are prepared timeously;
- To protect NHS Borders against the risk of fraud and irregularity;
- To safeguard NHS Borders's assets;
- To ensure that proper standards of financial conduct are maintained;
- To enable the provision of appropriate management information;
- To ensure that NHS Borders seeks best value from its resources, by making proper arrangements to pursue continuous improvement, having regard to economy, efficiency and effectiveness in NHS Borders's operations;
- To ensure that any delegation of responsibility is accompanied by clear lines of control and accountability, together with reporting arrangements.

1.3 NHS Borders shall exercise financial supervision and control by:

- formulating the financial strategy
- requiring the submission and approval of financial plans and budgets within approved allocations/overall income;
- defining and approving essential features of financial arrangements in respect of important procedures and financial systems (including the need to obtain value for money);
- defining specific responsibilities placed on directors and officers as indicated in the Scheme of Delegation document.

all within the financial resources made available to it, both directly and also through the Care Act 2014.

1.4 The SFI's identify the financial responsibilities which apply to everyone working for the Board and its constituent organisations. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

1.5 Should any difficulties arise regarding the interpretation or application of any of the SFI's then the advice of the Director of Finance must be sought before you act.

**Compliance**

1.6 The Director of Finance is responsible for assisting the Chief Executive as Accountable Officer and therefore has ultimate responsibility for ensuring that SFI's are in place, up to date and observed in NHS Borders. The responsibilities of the Director of Finance specified in the SFI's may be carried out by such other senior finance officers as he or she might specify.

1.7 Members, officers and agents of NHS Borders, including Local Authority employees who are employed in Integrated Services, shall observe these SFI's. Executive Directors shall be responsible for ensuring that the SFI's are made known within the services for which they are responsible and shall ensure that they are adhered to.

1.8 Failure to comply with these SFI's shall be a disciplinary matter.

1.9 Where these SFI's place a duty upon any person, this may be delegated to another person, subject to the Scheme of Delegation contained within the Standing Orders.

## SECTION 2

## RESPONSIBILITIES OF CHIEF EXECUTIVE, DIRECTOR OF FINANCE AND EMPLOYEES

### Responsibilities of Chief Executive as Accountable Officer

2.1 Under the terms of Sections 14 and 15 of the Public Finance and Accountability (Scotland) Act 2000, the Principal Accountable Officer for the Scottish Government has designated the Chief Executive of Borders NHS Board as Accountable Officer.

2.2 Accountable Officers must comply with the terms of the **Memorandum to National Health Service Accountable Officers,** and any updates issued to them by the Principal Accountable Officer for the Scottish Government. The Memorandum was updated in April 2006.

### 2.3 General Responsibilities

2.3.1 The Accountable Officer is personally answerable to the Scottish Parliament for the propriety and regularity of the public finance for NHS Borders including functions delegated and resources provided by Borders Health Board to the IJB.

2.3.2 The Accountable Officer must ensure that the Board takes account of all relevant financial considerations, including any issues of propriety, regularity or value for money, in considering policy proposals relating to expenditure, or income.

2.3.3 It is incumbent upon the Accountable Officer to combine his or her duties as Accountable Officer with their duty to the Board, to whom he or she is responsible, and from whom he or she derives his/her authority. The Board is in turn responsible to the Scottish Parliament in respect of its policies, actions and conduct.

2.3.4 The Accountable Officer has a personal duty of signing the Annual Accounts of NHS Board. Consequently, he or she may also have the further duty of being a witness before the Audit & Risk Committee of the Scottish Parliament, and be expected to deal with questions arising from the Accounts, or, more commonly, from reports made to Parliament by the Auditor General for Scotland.

2.3.5 The Accountable Officer must ensure that any arrangements for delegation promote good management, and that he or she is supported by the necessary staff with an appropriate balance of skills. This requires careful selection and development of staff and the sufficient provision of special skills and services. He or she must ensure that staff are as conscientious in their approach to costs not borne directly by their component organisation (such as costs incurred by other public bodies), or financing costs, e.g. relating to banking and cash flow) as they would be, were such costs directly borne.

## 2.4 Specific Responsibilities

2.4.1 Ensure that from the outset proper financial systems are in place and applied, and that procedures and controls are reviewed from time to time to ensure their continuing relevance and reliability, especially at times of major changes;

2.4.2 Ensure that the Board's financial obligations and targets are met. The Chief Executive shall be responsible for the implementation of the Boards financial policies and for co-ordinating any corrective action necessary to further these policies. In fulfilling this responsibility the Chief Executive shall take account of advice given by the Director of Finance on all such matters. The Director of Finance shall be accountable to the Board for this advice.

2.4.3 Sign the Accounts assigned to him or her, and in doing so, accept personal responsibility for ensuring that they are prepared under the principles and in the format directed by Scottish Ministers.

2.4.4 Ensure that proper financial procedures are followed incorporating the principles of separation of duties and internal check, and that accounting records are maintained in a form suited to the requirements of the relevant Accounting Manual, as well as in the form prescribed for published Accounts.

2.4.5 Ensure that the public funds for which he or she is responsible are properly managed and safeguarded, with independent and effective checks of cash balances in the hands of any official.

2.4.6 Ensure that the assets for which he or she is responsible, such as land, buildings or other property, including stores and equipment, are controlled and safeguarded with similar care, and with checks as appropriate.

2.4.7 Ensure that, in the consideration of policy proposals relating to expenditure, or income, for which he or she has responsibilities as Accountable Officer, all relevant financial considerations, including any issues of propriety, regularity or value for money, are taken into account, and where necessary brought to the attention of the Board.

2.4.8 Ensure that any delegation of authority is accompanied by clear lines of control and accountability, together with reporting arrangements. Clarity is critical for delegated functions and resources provided to the IJB and the accountability of the Chief Officer. The Board's Code of Corporate Governance provides the required clarity.

2.4.9 Ensure that effective management systems appropriate for the achievement of the organisation's objectives, including financial monitoring and control systems have been put in place.

2.4.10 Ensure that risks, whether to achievement of business objectives, regularity, propriety, or value for money, are identified, that their significance is assessed and that systems appropriate to the risks are in place in all areas to manage them.

2.4.11 Ensure that best value from resources is sought, by making proper arrangements to pursue continuous improvement having regard to economy, efficiency and effectiveness, and in a manner which encourages the observance of equal opportunities requirements.

2.4.12 Ensure that managers at all levels have a clear view of their objectives, and the means to assess and measure outputs or performance in relation to those objectives.

2.4.13 Ensure managers at all levels are assigned well defined responsibilities for making the best use of resources (both those assumed by their own commands and any made available to organisations or individuals outside NHS Borders) including a critical scrutiny of output and value for money.

2.4.14 Ensure that managers at all levels have the information (particularly about costs), training and access to the expert advice which they need to exercise their responsibilities effectively.

## 2.5 Regularity and Propriety of Expenditure

2.5.1 The Accountable Officer has a particular responsibility for ensuring compliance with Parliamentary requirements in the control of expenditure. A fundamental requirement is that funds should be applied only to the extent

and for the purposes authorised by Parliament in Budget Acts (or otherwise authorised by Section 65 of the Scotland Act 1998). Parliament's attention must be drawn to losses or special payments by appropriate notation of the organisation's Accounts. In the case of expenditure approved under the Budget Act, any payments made must be within the scope and amount specified in that Act.

2.5.2 All actions must be able to stand the test of Parliamentary scrutiny, public judgements on propriety and professional Codes of Conduct. Care must be taken to avoid actual, potential, or perceived conflicts of interest when employing external consultants and their staff.

## 2.6 Advice to the Board

2.6.1 The Accountable Officer has a duty to ensure that appropriate advice is tendered to the Board on all matters of financial propriety and regularity, and more broadly, as to all considerations of prudent and economical administration, efficiency and effectiveness.

2.6.2 If the Accountable Officer considers that, despite their advice to the contrary, the Board is contemplating a course of action which they consider would infringe the requirements of regularity or propriety, and that they would be required to take action that is inconsistent with the proper performance of his or her duties as Accountable Officer, they should inform the Scottish Government Health and Social Care Department's Accountable Officer, so that the Department, if it considers it appropriate, can intervene and inform Scottish Ministers. If this is not possible, the Accountable Officer should set out in writing his or her objection and the reasons, to the proposal. If their advice is overruled, and the Accountable Officer does not feel that he or she would be able to defend the proposal to the Audit & Risk Committee of the Scottish Parliament, as representing value for money, he or she should obtain written instructions from the Board for which he or she is designated, and send a copy of his or her request for instruction and the instruction itself as soon as possible to the External Auditor and the Auditor General for Scotland.

2.6.3 The Accountable Officer must ensure that their responsibilities as an Accountable Officer do not conflict with those as a Board member. They should vote against any action that they cannot endorse as an Accountable Officer, and in the absence of a vote, ensure that his or her opposition as a Board Member, as well as Accountable Officer is clearly recorded.

2.6.4 It is the duty of the Chief Executive to ensure that Executive Directors and employees and all new appointees are notified of and understand their responsibilities within the SFI's.

## 2.7 Absence of Accountable Officer

2.7.1 The Accountable Officer should ensure that they are generally available for consultation, and that in any temporary period of unavailability a senior officer is identified to act on their behalf.

2.7.2 In the event that the Accountable Officer would be unable to discharge their responsibilities for a period of four weeks or more, NHS Borders will notify the Principal Accountable Officer of the Scottish Government, in order that an Accountable Officer can be appointed pending their return.

2.7.3 Where the Accountable Officer is unable by reason of incapacity or absence to sign the Accounts in time for them to be submitted to the Auditor General, the Board may submit unsigned copies, pending the return of the Accountable Officer.

**Responsibilities of Director of Finance**

**2.8 The Director of Finance is responsible for:**

2.8.1 providing financial advice to the Board and its employees;

2.8.2 implementing the Board's financial policies and for co-ordinating any corrective action necessary to further those policies;

2.8.3 ensuring that sufficient records are maintained to show and explain the Board's transactions, in order to disclose, with reasonable accuracy, the financial position of the Board at any time;

2.8.4 the design, implementation and supervision of systems of internal financial control incorporating the principles of separation of duties and internal checks;

2.8.5 the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Board may require for the purpose of carrying out its statutory duties and responsibilities;

2.8.6 setting accounting policies consistent with Scottish Government and guidance and generally accepted accounting practice.

**All Directors and Employees**

**2.9** All directors and employees of the Board, severally and collectively, are responsible for:

2.9.1 security of the Board's property;

2.9.2 avoiding loss;

2.9.3 exercising economy and efficiency in the use of Borders Health Board resources;

2.9.4 complying with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and Scheme of Delegation.

## SECTION 3

## FINANCIAL STRATEGY, PLANNING AND CONTROL

### Financial Strategy and Planning

3.1 The Board is required to perform its functions within the total of funds allocated by the Scottish Government and all plans, financial approvals and control systems shall be designed to meet this obligation.

3.2 The Chief Executive has overall executive responsibility for the Board's activities and is responsible to the Board for ensuring that the Board stays within its funding limits.

3.3 In accordance with guidance issued by the Scottish Government Health and Social Care Directorate, the NHS Borders Chief Executive shall be responsible for leading an inclusive process, involving staff and partner organisations, to secure the compilation and approval by the Board, of the Annual Delivery Plan for Borders.

3.4 By concisely setting out how these objectives will be tackled and by whom, and by setting clear priorities, key milestones and other quantified improvement targets over time, the Annual Delivery Plan will help to secure understanding of important health issues, a shared approach to taking action, and a common commitment to achieving results.

3.5 In order to ensure that the planned actions within the Annual Delivery Plan are affordable, the Chief Executive, with the assistance of the Director of Finance, shall be responsible for the annual development and updating of the NHS Borders Financial Plan.

3.6 The Financial Plan shall include a statement of the significant assumptions and risks on which the Plan is based and comprise both Revenue and Capital components, and shall be compiled within available resources, as determined by reference to the Revenue Resource Limit and Capital Resource Limit as notified or indicated by the Scottish Government Health and Social Care Department, and as forecast for subsequent periods.

3.7 The Financial Plan shall be submitted to the Finance and Performance Committee for detailed scrutiny and risk assessment, following which the Committee shall be responsible for recommending approval of the Financial Plan by the Board.

3.8 The Financial Plan shall be an appendix to the Annual Delivery Plan and shall be reconcilable to an annual update of the financial planning returns which the Director of Finance will prepare and submit to the Scottish Government Health & Social Care Department, in accordance with guidance or direction issued from time to time.

3.9 The Board Executive Team is responsible for the development and approval of operational financial plans which shall be;-

- consistent with the Annual Delivery Plan as submitted to Scottish Government

- in accordance with the aims and objectives set out in the Annual Delivery Plan;
- prepared within the limits of available funds;
- identify potential risks; and
- analyse both funds available and proposed expenditure between that which is recurring and that which is non-recurring.

**Control**

3.10 The Director of Finance shall ensure that adequate financial and statistical systems are in place to monitor and control income and expenditure and to facilitate the compilation of financial plans, estimates and any investigations which may be required from time to time.

3.11 The Director of Finance shall devise and maintain systems of budgetary control and all officers whom the Board may empower to engage staff or otherwise incur expenditure or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of (and investigation into) financial, activity or workforce variances from budget. The Director of Finance shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

3.12 The Chief Executive may, within limits approved by the Board, delegate authority for a budget or a part of a budget to the individual officer or group of officers who will be responsible for the activities provided for within that budget. The terms of delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of service and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive. Responsibility for overall budgetary control, however, shall remain with the Chief Executive.

3.13 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by powers of virement delegated by him or her. Where an underspend in the integrated budget occurs as a direct result of planned actions by the IJB, the underspend will be retained by the IJB for reallocation.

3.14 Expenditure for which no provision has been made in an approved budget shall only be incurred after authorisation by the Chief Executive, subject to his/her authorised virement limit.

3.15 Delegated authority is granted as set out in the Scheme of Delegation, this includes authority to approve the transfer of funds up to this level between budget heads, including transfers from reserves and balances.

3.16 The Director of Finance shall keep the Chief Executive and the Board informed of the financial consequences of changes in policy, pay awards, and other events and trends affecting budgets, and shall advise on the financial and economic aspects of future plans and projects.

3.17 There is a duty requiring the Chief Executive, other officers and agents of NHS Borders, not to exceed approved budgetary limits.

3.18 The Chief Executive is responsible for the negotiation of funding for the provision of services in accordance with the Local Delivery Plan and for establishing the arrangements for the cross-boundary treatment of patients in accordance with the guidance of the Scottish Government Health and Social Care Department. In carrying out these functions the Chief Executive shall take into account the advice of the Director of Finance regarding:

- Costing and pricing of services;
- Payment terms and conditions;
- Arrangements for funding in respect of patients from outwith the Borders area, and for the funding of the treatment of Borders residents other than by NHS Borders.

3.19 The Chief Executive shall also be responsible for negotiating agreements for the provision of support services to/from other NHS Bodies

3.20 Non-recurring funds should not be used to finance recurring expenditure without the approval of the Chief Executive.

**Reporting**

3.21 Any substantial funds arising from inability to action, or delay in the implementation of projects approved by the Board, shall be reported in the first instance by the Chief Executive, together with advice on the use of such funds, to the Resources and Performance Committee. The Committee shall report as appropriate to the Board.

3.22 The Director of Finance shall produce a regular Financial Report for submission to the Board. This report shall highlight any significant in-year variance from the Financial Plan together with a forecast of the outturn position for the financial year concerned, and shall recommend any proposed corrective action.

3.23 In order to fulfil these responsibilities, the Director of Finance shall have right of access to all budget holders on budgetary related matters.

**SECTION 4**

**BUDGETARY CONTROL AND MONITORING**

**Delegation of Budgets**

4.1 The Chief Executive may delegate the management of a budget to the Operational Planning Group or individual employees, to permit the performance of a defined range of activities. Responsibility for overall budgetary control, however, shall remain with the Chief Executive.

4.2 The delegation must be accompanied by a clear definition of the:

- amount of the budget;
- purpose(s) of each budget heading;

- individual and group responsibilities;
- authority to exercise virement;
- achievement of planned levels of service;
- arrangements for escalation of overspends: and
- provision of regular reports.

4.3 In carrying out their duties:
- The Chief Executive and all budget holders with delegated authority shall not exceed the budgetary or virement limits set by the Board;
- Budget holders shall strictly observe the budgetary limits and control procedures set for them by the Chief Executive;
- The Chief Executive may vary the budgetary limit of a budget holder within the Chief Executive's own budgetary limit;
- Officers shall not use non-recurring budgets on recurring expenditure.

4.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled.

4.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

4.6 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

**Budgetary Control and Reporting**

4.8 The Director of Finance will devise and maintain systems of budgetary control. These will include:
- monthly financial reports to the Board in a form approved by the Board containing:
  - income and expenditure to date showing trends and forecast year end position;
  - capital project spend and projected outturn against plan;
  - explanations of any material variances from plan;
  - details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;
- the issue of timely, accurate and comprehensible advice and financial reports to each holder of a budget, covering the areas for which they are responsible;
- investigation and reporting of variances from financial, workload and manpower budgets;
- monitoring of management action to correct variances; and
- arrangements for the authorisation of budget transfers.

4.9 Each holder of a delegated budget is responsible for ensuring that:
- any potential overspending or reduction of income which cannot be met by virement must have prior consent;
- the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

- permanent employees can only be appointed with the approval of the Boards Vacancy Control process unless appointed within the budgetary establishment .

4.10 Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive or the Board as appropriate.

4.11 No budget holder may charge expenditure to a budget for which they are not the budget holder without the express authority of the authorised budget holder.

4.12 The Chief Executive is responsible for ensuring there is a process and arrangements in place for identifying and implementing cost improvements/efficiency savings and income generation initiatives in accordance with the requirements of the Annual Delivery Plan and a balanced budget.

4.13 Except where otherwise approved by the Chief Executive, taking account of advice of the Director of Finance budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement. Any substantial funds arising from inability to action, or delay in the implementation of projects approved by the Board, should be reported to the Board by the Chief Executive, together with advice on the use of such funds.

4.14 Budget holders are required to take such action as may be required following the receipt of their budget reports from the Director of Finance to ensure that their budgetary objectives are met.

**Establishment Control**

4.15 The Director of Finance shall be responsible for designing a system of establishment control. The funded establishment of any department may only be varied in accordance with the approved establishment control system.

**Virement**

4.16 The Board is responsible for agreeing the rules applying to virement between budgets. These are contained in the Board's Scheme of Delegation.

**Capital Expenditure**

4.17 The Chief Executive will submit capital plans for the Board's approval and following on from this submit for Board approval all business cases required to be submitted to SGH&SCD.

4.18 The general rules applying to delegation and reporting shall also apply to capital expenditure.

**Monitoring Returns**

4.19 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to SGH&SCD.

## SECTION 5

## COMMISSIONING/PROVIDING HEALTH CARE SERVICES

5.1 The Chief Executive, in conjunction with the Director of Finance, shall be responsible for ensuring that all services required or provided are covered by a series of service agreements or, if not, that adequate funds are retained or requested to pay for services obtained outside service agreements, all within the context of the approved Annual Delivery Plan and Financial Plan. They shall be responsible for ensuring that the total service framework is affordable within the overall Revenue and Capital Resource Limits set by the Scottish Government Health and Social Care Directorate.

5.2 The Chief Executive is responsible for ensuring that service agreements are put in place with due regard to the need to achieve best value.

5.3 The Director of Finance is responsible for agreeing to the financial details contained in those service agreements agreed by the Board.

5.4 The Chief Executive is responsible for establishing robust financial arrangements, in accordance with guidance from the Scottish Government Health & Social Care Department, for the treatment of Borders residents by other NHS systems, or by the private sector, and for the treatment of residents of other health systems within NHS Borders.

5.5 The Director of Finance is responsible for maintaining a system for the rendering and payment of service agreements invoices in accordance with the terms of service agreements, or otherwise in accordance with national guidance.

5.6 The Director of Public Health in his capacity as Caldicott Guardian, is responsible for ensuring that all systems operate in a way to maintain the confidentiality of patient information as set out in the Data Protection Act 1998 under Caldicott guidance.

## SECTION 6

## ANNUAL REPORT AND ACCOUNTS

6.1 The Board is required under the terms of Section 86(3) of the National Health Service (Scotland) Act 1978 to prepare and transmit Annual Accounts to Scottish Ministers.

6.2 Scottish Ministers have issued Accounts Directions in exercise of the powers conferred by Section 86(1) of the National Health Service (Scotland) Act 1978 which contain the following provisions:

**Basis of Preparation:** Annual Accounts shall comply with:

- Generally accepted International financial reporting standards as applied to the NHS;
- The accounting and disclosure requirements of the Companies Act;

- All relevant accounting standards issued or adopted by the Accounting Standards Board, as they apply to the NHS and remain in force for the financial year for which the accounts are to be prepared;

**Form of Accounts:** The Annual Accounts shall comprise:

- A foreword (taken to be the Governance Statement in the Accounts);
- An operating cost statement;
- A statement of total recognised gains and losses;
- A balance sheet;
- A cash flow statement;
- Such notes as may be necessary for the purposes referred to below.

The Annual Accounts shall give a true and fair view of the income and expenditure, total recognised gains and losses, balance sheet and cash flow statement. Subject to the foregoing requirement, the annual accounts shall also contain any disclosure and accounting requirements which Scottish Ministers may issue from time to time.

6.3 The Director of Finance shall maintain proper accounting records which allow the timeous preparation of the Annual Accounts, in accordance with the timetable laid down by the Scottish Government Health and Social Care Directorate, and which give a true and fair view of NHS Borders and its expenditure and income for the period in question.

6.4 Annual Accounts should be prepared by NHS Borders in accordance with all appropriate regulatory requirements and be supported by appropriate accounting records and working papers prepared to an acceptable professional standard.

6.5 Under the terms of the Public Finance and Accountability (Scotland) Act 2000, the Auditor General for Scotland will appoint an external auditor to undertake the audit of NHS Borders annual accounts and report.

6.6 The Director of Finance shall agree with the External Auditor a timetable for the production, audit, adoption by the Board of accounts to the Auditor General for Scotland and the Scottish Government Health and Social Care Department. This timetable shall be consistent with the requirements of the Scottish Government Health and Social Care Directorate.

6.7 The Annual Accounts shall be prepared in accordance with the relevant Accounts Direction and Accounts Manual issued by the Scottish Government Health and Social Care Directorate.

6.8 The Chief Executive is responsible for preparing a Governance Statement, and shall seek appropriate assurances, including that of the Chief Internal Auditor, with regard to the adequacy of internal control throughout the organisation.

6.9 The Annual Accounts shall be reviewed by the Audit & Risk Committee, which has the responsibility of recommending adoption of the Accounts by the Board.

6.10 Under the terms of the Public Finance and Accountability (Scotland) Act 2000, Annual Accounts may not be placed in the public domain, prior to them being formally laid before Parliament.

6.11 Following the formal approval of the motion to adopt the Accounts by the Board, the Annual Accounts and relevant certificates shall be duly signed on behalf of the Board, and submitted to the External Auditor for completion of the relevant audit certificates.

6.12 Signed sets of Annual Accounts shall be submitted to the Scottish Government Health & Social Care Department, and by the External Auditor to the Auditor General for Scotland.

## SECTION 7

## BANKING ARRANGEMENTS

7.1 The Director of Finance is responsible for managing the Board's banking arrangements and for advising the Board on the provision of banking services and the operation of bank accounts. This advice will take into account such guidance and directions as may be issued from time to time by the Scottish Government.

7.2 All arrangements with NHS Borders's bankers and the Government Banking Services will be made by or under arrangements approved by the Director of Finance, who shall be authorised by the Board to operate such bank accounts as may be considered necessary.

7.3 No officer other than the Director of Finance shall open any bank account in the name of Borders NHS Board.

7.4 All funds shall be held in accounts in the name of Borders NHS Board, Borders NHS Board Endowment Fund or Borders NHS Board Patients' Fund.

7.5 The Director of Finance shall nominate, for each appropriate bank account, the officers, including him/herself, authorised to release monies from each account, on a single signature basis up to a maximum of £5,000. An authorisation schedule will be held by the appropriate Banks and over that limit of £5,000 two signatures will be required. As a minimum, a Senior Finance Manager will fulfil the 2nd signatory for transactions over £5,000.

7.6 The Director of Finance shall notify the bankers promptly of the cancellation of any authorisation to draw on the Board accounts.

7.7 Cheques processed will be signed by the Director of Finance or other authorised officers. Where such cheques are for sums in excess of £5,000, two authorised officers will sign.

7.8 All cheques (which shall be crossed with 'Not Negotiable - Account Payee Only') to be treated as controlled stationery in the charge of a duly designated officer controlling their issue.

7.9 All cheques, postal orders, cash, etc, shall be banked intact promptly, in accordance with the Director of Finance's rules of procedures to the credit of the main account (or, if appropriate, endowment fund/patients' fund interest bearing

account. Disbursements shall not be made from cash except under arrangements approved by the Director of Finance.

7.10 All arrangements for the receipt and payment of monies using BACS (the Bankers Automated Clearing Service) and CHAPS (The Clearing Houses Automated Payment System) will be made by or under arrangements approved by the Director of Finance.

7.11 All arrangements for payments to be made by Standing Order or Direct Debit from any NHS Borders bank account will be made by or under arrangements approved by the Director of Finance.

7.12 The use of credit cards will be made by or under arrangements approved by the Director of Finance.

## SECTION 8

## SECURITY

### Security of cash and other items

8.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including income due under service agreements for the provision of patient care services.

8.2 All receipt books, tickets, agreement forms, or other means of officially acknowledging or recording amounts received or receivable shall be in a form approved by the Director of Finance. Such stationery shall be ordered and controlled by him or her and subject to the same precautions as are applied to cash, in accordance with the Director of Finance's requirements.

8.3 All officers, whose duty it is to collect or hold cash, shall be provided with a safe or with a lockable cash box which will normally be deposited in a safe. The officer concerned shall hold one key and all duplicates shall be lodged with a banker or such other officer authorised by the Director of Finance and suitable receipts obtained. The loss of any key shall be reported immediately to the Deputy Director of Finance. The Director of Finance shall, on receipt of a satisfactory explanation, authorise the release of the duplicate key. The Director of Finance shall arrange for all new keys to be despatched directly to him or her from the manufacturers and shall be responsible for maintaining register of authorised holders of safe keys.

8.4 The safe key-holder shall not accept unofficial funds for depositing in the safe unless deposits are in sealed envelopes or locked containers. It shall be made clear to the depositor that the Board is not to be held liable for any loss and written indemnity must be obtained from the organisation or individual absolving NHS Borders from responsibility for any loss.

8.5 During the absence of the holder of a safe or cash box key, the officer who acts in his place shall be subject to the same controls as the normal holder of the key. There shall be written discharge for the safe and/or cash box contents on the

transfer of responsibilities and the discharge document must be retained for audit inspection.

8.6 All cash, cheques, postal orders and other forms of payment shall normally be received by more than one officer, neither of whom should be a Cashier and shall be entered immediately in an approved form of register which should be signed by both. All cheques and postal orders shall be crossed immediately 'Not negotiable - account payee [Borders NHS Board]'. The remittances shall be passed to the Cashier, from whom a signature shall be obtained in the register.

8.7 The opening of coin-operated machines (including telephones) and the counting and recording of the takings in the register shall normally be undertaken by two officers together and the coin box keys shall be held by a nominated officer. The collection shall be passed to the cashier from whom a signature shall be obtained in the register.

8.8 The Director of Finance shall prescribe the system for the transporting of cash and uncrossed pre-signed cheques. Wherever practicable, the services of a specialist security firm shall be employed.

8.9 All unused cheques, receipts and all other orders shall be subject to the same security precautions as are applied to cash. Bulk stocks of cheques shall normally be retained by the Director of Finance or his/her nominated officers and released by them only against authorised requisitions.

8.11 In all cases where NHS Borders officers receive cash, cheques, credit or debit card payments, empty telephone or other machine coin boxes, etc, personal identity cards must be displayed prominently. Staff shall be informed in writing on appointment by the departmental or senior officers of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

8.12 Any loss or shortfall of cash, cheques etc, shall be reported immediately in accordance with the agreed procedure for reporting losses.

8.13 Under no circumstances shall funds managed by the Board be used for the encashment of private cheques or the making of loans of a personal nature.

**Security of Physical Assets**

8.15 The overall control of fixed assets is the responsibility of the Chief Executive.

8.16 Each employee has a responsibility to exercise a duty of care over the property of NHS Borders and it shall be the responsibility of senior staff in all disciplines to apply appropriate routine security practices in relation to NHS property. Persistent breach of agreed security practices shall be reported to the Chief Executive.

8.17 Wherever practicable, items of equipment shall be marked as NHS property. Items to be controlled shall be recorded and updated in an appropriate register including all capital assets.

8.18 Nominated officers designated by the Chief Executive shall maintain up to date asset registers of items which are capital by definition as well as items classed as

'special' and they shall ensure the responsible designated officers also maintain up to date and accurate copies.

8.19 There shall be an approved form of asset register and method of updating.

8.20 The items on the register shall be checked regularly by the nominated officers and all discrepancies shall be notified in writing to the Director of Finance, who may also undertake such other independent checks as he/she considers necessary.

8.21 Any damage to premises, vehicles and equipment, or any loss of equipment or supplies shall be reported by staff in accordance with the agreed procedure for reporting losses.

8.22 Registers shall also be maintained by responsible officers and receipts retained for:

- Equipment on loan;
- Leased Equipment;
- All contents of furnished lettings.

8.23 On the closure of any facility, a check shall be carried out and a responsible officer will certify a list of items held showing eventual disposal. The disposal of fixed assets (including donated assets) shall be in accordance with Section 23.

**SECTION 9**

**INCOME**

9.1 The Director of Finance shall be responsible for designing and maintaining systems for the proper recording, invoicing and collection of all money due.

9.2 The Director of Finance is responsible for approving and regularly reviewing the level of fees and charges other than those determined by SGH&SCD.

9.3 All officers shall inform the Director of Finance of monies due arising from transactions they initiate, including all contracts, leases, tenancy agreement and any other transactions. The Director of Finance shall approve contracts with financial implications in excess of the figures set out in the Scheme of Delegation. Responsibility for arranging the level of rentals for newly acquired property and for the regular review of rental and other charges shall rest with the Director of Finance who may take into account independent professional advice on matters of valuation.

9.4 The Director of Finance shall take appropriate recovery action in all outstanding debts including the establishment of procedures for the write-off of debts after all reasonable steps have been taken to secure payment.

9.5 In relation to Income Generation Schemes, the Director of Finance shall ensure that there are systems in place to identify all costs and services attributed to each scheme before introduction and such schemes should only proceed on the basis of providing income in excess of the cost of the scheme.

## SECTION 10

## PAYMENTS OF ACCOUNTS

10.1 The Director of Finance must approve the manual or electronic list of officers authorised to certify invoices, non-invoice payments, and payroll schedules, including where required by the Director of Finance financial limits to their authority. The Director of Finance will maintain details, together with his or her specimen signatures for manual authorisation. Electronic authorisation must be allocated by effective access control permissions to those approved by the Director of Finance.

10.2 The Director of Finance is responsible for the payment of all accounts, invoices and contract claims in accordance with contractual terms and/or the Confederation of British Industries (CBI) Prompt Payment Code. Payment systems shall be designed to avoid payments of interest arising from non-compliance with the Late Payment of Commercial Debts (Interest) Act 1998.

10.3 All officers shall inform the Director of Finance promptly of all monies payable by their organisation arising from transactions which they initiate, including contracts, leases, tenancy agreements and other transactions. To assist financial control, a register of regular payments should be created.

10.4 FHS Contractor payments and administration has been delegated to National Services Scotland under a Service Level Agreement, National Services Scotland will act as agents of the Board in accordance with the Service Level Agreement.

10.5 Where a manual payment system is in place, all requests for payment should, wherever possible, have relevant original invoices or contract payment vouchers attached and shall be authorised for payment by an approved officer from a list of authorised signatories agreed by the appropriate organisation. Where an electronic payment system has been approved by the Director of Finance the system must ensure that payment is made only for goods received for which there is an authorised Purchase Order.

10.6 The Director of Finance is responsible for designing and maintaining systems for the verification, recording and payment of all amounts payable, including monies relating to clinical services. Certification is required either manually or electronically (within a tolerance level approved by the Director of Finance) for the following:

- Goods have been duly received, examined, are in accordance with specification and order, are satisfactory and that the prices are correct;
- Work done or services rendered have been satisfactorily carried out in accordance with the order; that where applicable, the materials used were of the requisite standard and that the charges are correct;
- In the case on contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, that the rates of labour are in accordance with the appropriate rates, that the materials have been checked as regards quantity, quality and price and that the charges for the use of vehicles, plant and machinery have been examined;
- Where appropriate, the expenditure is in accordance with regulations and that all necessary Board or appropriate officer authorisations have been obtained;
- The account or claim is arithmetically correct;

- The account or claim is in order for payment;
- VAT has been recovered as appropriate;
- Clinical services have been carried out satisfactorily in accordance with Service Agreements and Unplanned Activity arrangements (UNPACs);
- A timetable and system for submission to the Director of Finance of accounts for payment with provision shall be made for early submission of accounts, subject to cash discounts or otherwise requiring early payment, and
- Instruction of staff regarding the handling, checking and payment of accounts and claims within Financial Accounting section of the Finance Directorate.

10.8 The Director of Finance shall ensure that payment for goods and services is only made once the goods and services are received other than under the terms of a specific contractual arrangement.

10.9 Budget Holders shall ensure, before an order for goods or service is placed, that the purchase has been properly considered and forms part of the department's allocations, agreed business plans, or other known and specific funds available to the department.

10.10 Where an officer certifying accounts or claims relies upon other officers to do preliminary checking he shall, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed an order and negotiated prices and terms. Budget Managers must therefore ensure, within delegated limits that there is effective separation of duties between:

- The person placing the order;
- The person certifying receipt of goods and services, and;
- The person authorising the invoice manually or electronically

That no one person should undertake all three functions.

10.11 In the case of contracts for building or engineering works which require payment to be made on account during progress of the works, the Director of Finance shall make payment on receipt of a certificate from the technical consultant or officer. Without prejudice to the responsibility of any consultant or works officer appointed to a particular building or engineering contract, a contractor's account shall be subject to such financial examination by the Director of Finance and such general examination by a works officer as may be considered necessary, before the person responsible for the contract issues the final certificate. To assist financial control, a contracts register should be created.

10.12 Where a contract is based on the measurement of time, materials or expenses, the checks to be carried out must provide confirmation that:

- the time charged is in accordance with the time sheets;
- the rates of labour are in accordance with the appropriate rates;
- the materials have been checked as regards quantity, quality, and price;
- the charges for the use of vehicles, plant and machinery have been examined.

10.13 The Director of Finance may authorise advances on the imprest system for petty cash and other purposes as required. Individual payments must be restricted to the amounts authorised by the Director of Finance and appropriate vouchers obtained and retained in accordance with the policy on culling and retention of documents.

10.14 NHS Borders officers responsible for commissioning self employed contractors (who were previously employees of the Board or other NHS bodies) must ensure that, subject to their delegated authority and before any work assignment is agreed, that evidence is obtained from the self employed contractor that confirms their status to ensure that NHS Borders is not held liable for Income Tax and National Insurance by the Inland Revenue. This evidence must be submitted to the Director of Finance.

10.15 Advance Payment for supplies, equipment or services shall not normally be permitted. Should exceptional circumstances arise, any proposal must be submitted to the Director of Finance at the earliest opportunity. The Director of Finance shall take appropriate advice in determining a course of action.

10.16 Advance payments to general medical practitioners and community pharmacists shall comply with the specific contractor NHS plans and regulations.

10.17 The budget holder is responsible for ensuring that all items due under a payment in advance contract are received and he must inform the Director of Finance or Chief Executive immediately problems are encountered.

## SECTION 11

## CONSTRUCTION INDUSTRY SCHEME

11.1 The scheme is to be administered in accordance with guidance supplied by HM Revenue and Customs, booklet CIS348.

11.2 In the event of any doubt, the Deputy Director of Finance will determine whether a payment should be made gross or net of deduction of tax and shall consult with HMRC, as necessary.

11.3 The Director of Finance is responsible for remitting to HMRC any tax deducted from payments made to sub-contractors. The Director of Finance must ensure that this is done in accordance with the timetable(s) set out in CIS348, as appropriate.

## SECTION 12

## PAYMENT OF SALARIES AND WAGES

12.1 Staff may be engaged or regraded only by authorised officers within the limit of the approved budget and establishment when agreed by the Chief Executive or other authorised officer.

12.2 The Remuneration Committee of the Staff Governance Committee will approve any changes to the remuneration, allowances and conditions of service of the Chief Executive and other Directors in accordance with the Code of Corporate Governance.

12.3 The Director of Finance is responsible for:

- specifying timetables for submission of properly authorised time records and other notifications;

- ensuring the processing of payroll data;
- making payment on agreed dates and
- agreeing the method of staff payment.

12.4 The Director of HR, OD & OH&S shall be responsible for issuing contracts of employment and for dealing with variations to, or termination of, contracts of employment.

12.5 Each employee shall be issued with a contract which shall comply with current employment legislation and be in a form approved by the Board.

12.6 A signed copy of the engagement form and such other documents necessary for the payment of staff as they may require shall be sent, immediately on start date of the employee to the National Payroll System by interface from the National HR System following agreed procedures and processes, including internal control checkpoints, as agreed by the Director of Finance.

12.7 A termination of employment form and such other documents as they may require, for payment purposes, shall be submitted immediately on termination date of the employee to the National Payroll System by interface from the National HR System following agreed procedures and processes, including internal control checkpoints, as agreed by the Director of Finance. Where an employee fails to report for duty in circumstances which suggest that he or she has left without notice, the Deputy Director of Finance shall be informed immediately.

12.8 A notification of change form shall be submitted in advance of/at the point of the agreed change date to the National Payroll System by interface from the National HR System following agreed procedures and processes, including internal control checkpoints, as agreed by the Director of Finance.

12.9 All time and attendance records, staff returns and other pay records and notifications shall be in a form approved by the Director of Finance and shall be certified and submitted in accordance with his instructions. Where this information is transmitted by electronic means, appropriate procedures covering such transmissions require to be agreed by him or her.

12.10 Subject to the limits laid down in the Scheme of Delegation, all early retirals which result in additional costs being borne by the employer will be submitted to the Remuneration Committee. Authorisation of any payments will be in accordance with circular DL(2019)15 NHS Scotland Guidance on Settlement and Severance Arrangements.

12.11 The Director of HR, OD & OH&S and the Director of Finance shall be jointly responsible for ensuring that rates of pay and relevant conditions of service are in accordance with current agreements. The Chief Executive or the Remuneration Committee in appropriate circumstances, shall be responsible for the final determination of pay, but subject to the statutory duty of the Director of Finance, who shall issue instructions regarding:

- Verification of documentation or data;
- The timetable for receipt and preparation of payroll data and the payment of staff;

- Maintenance of subsidiary records for Superannuation, Income Tax, National Insurance and other authorised deductions from pay;
- Security and confidentiality of payroll information in accordance with the principle of the Data Protection Act, 1984;
- Checks to be applied to completed payroll before and after payment;
- Authority to release payroll data to a Security firm, if applicable;
- Methods of payment available to various categories of staff;
- Procedures for payment of cheques, bank credits or cash to staff;
- Procedures for unclaimed wages which should not be returned to salaries and wages staff;
- Pay advances authorised in paragraph 12.16 and their recovery;
- Maintenance of regular and independent reconciliation of adequate control accounts;
- Separation of duties of preparing records and handling cash;
- A system to ensure the recovery from leavers of sums due by them; and
- A system to ensure recovery or write-off of payment of pay and allowances.

12.12 Application of Pay Award uplift to staff paid on Locally negotiated payscales shall be approved in line with the instruction of the Director of HR, OD & OH&S and will include the approval by the Medical Oversight Group of local payscales for Hospital Medical and Dental employees. Where local payscales are applicable for other staff categories eg Nursing, Administrative, the Director of HR, OD & OH&S will agree the relevant approval route for application of annual pay award uplift.

12.13 The Director of Finance or Director of HR, OD & OH&S shall have the right to request work rosters or any other supporting information to ensure that correct payments are made to staff.

12.14 The Remuneration Committee shall approve performance assessments and salary uplifts of the Chief Executive and all other Executive and Senior Management posts.

12.15 The Medical Director and Director of HR, OD & OH&S, acting together and with the agreement of the Chair of the Remuneration Committee, are given delegated authority to approve payments, in circumstances where recruitment has to be actioned urgently and requires agreement for expedience reasons. Where such approval is given, powers are delegated to the Director of HR, OD & OH&S to agree appropriate contractual arrangements. There is a requirement for such payments to be homologated at the following Remuneration Committee.

12.16 The Director of Finance shall ensure salaries and wages are paid on the currently agreed dates, but may vary these when necessary due to special circumstances (e.g. Christmas and other Bank Holidays). Payment to an individual shall not be made in advance of normal pay, except:-

- To cover a period of authorised leave involving absence on the normal pay day; or
- As authorised by the Chief Executive or Director of Finance to meet special circumstances and limited to the net pay due at the time of payment.

All employees shall be paid by bank credit transfer monthly unless otherwise agreed by the Director of Finance.

## SECTION 13

## TRAVEL, SUBSISTENCE AND OTHER ALLOWANCES

13.1 The Director of Finance shall ensure that all expense claims by employees of NHS Borders or outside parties are reimbursed in line with the relevant national pay agreements or otherwise approved within the authority of the Staff Governance Committee and that all such claims should be supported by receipts wherever possible. Removal expenses will be limited to £6,000, authority has been given to the Medical Staffing Officer to approve to a limit of £8,000 on an individual basis in exceptional circumstances following agreement of the Director of HR, OD & OH&S. Executive Director removal expenses must be approved by the Remuneration Committee.

13.2 All claims for payment of car allowances, subsistence allowances, travelling and incidental expenses will be submitted to the Director of Finance, duly certified in an approved form, and made up to a specified day of each month. The names of officers authorised to sign such records will be sent to the Deputy Director of Finance together with specimen signatures for manual authorisations and an approved list of officers with appropriate access control permissions for electronic authorisation and will be amended on the occasion of any change.

13.3 The Chair shall personally authorise all expense claims from the Chief Executive. The Chief Executive shall personally authorise all expense claims from the Executive Directors of the Board.

13.4 The Chair shall personally authorise all expense claims from Non-Executive Board Members. In the absence of the Chair, this duty shall be undertaken by the Chief Executive or Director of Finance.

13.5 The certification by or on behalf of the Director of a service, or Head of Department shall be taken to mean that the certifying officer is satisfied that the journeys were authorised, the expenses properly and necessarily incurred and that the allowances are properly payable by NHS Borders.

13.6 The Director of Finance shall issue additional guidance on the submission of expense claims, specifying the documentation to be used, the timescales to be adhered to and the required level of authorisation. The express approval of the Director of Finance or Deputy Director of Finance is required for claims which are signed by the claimant after three months of the month of claim. If approval is not given the claimant may submit a grievance in accordance with the appropriate grievance procedure.

## SECTION 14

## CONTRACTING AND PURCHASING

14.1 NHS Borders uses the Public Contracts Scotland portal for the purposes of tender of public contracts. A full audit trail of tender activity from notification of request for tenders through to award is held within the portal.

14.2 The requisitioner shall seek to obtain best value through the application of Standing Orders and Standing Financial Instructions. In so doing, the advice of the appropriate procurement adviser (Procurement, Pharmacy, Estates or IM&T) should normally be followed. Where the requisitioner has sound evidence that this advice is inappropriate or that it is divergent from best professional practice, the Director of Finance or Chief Executive shall be consulted, whose decision shall be final.

14.3 Where national, regional or local contracts exist (including framework arrangements), use of these contracts is mandatory. Only in exceptional circumstances and with the authority of the Board's lead Procurement manager or Director of Finance, based on existing schemes of delegation, shall goods or services be ordered outwith such contracts. [CEL 05(2012)]

14.4 NHS Borders shall comply as far as is practicable with the Scottish Capital Investment Manual and other Scottish Government Health and Social Care Directorate guidance on contracting and purchasing.

14.5 NHS Borders will utilise the Public Contracts Scotland Portal for the advertisement of all procurement of goods and services, to the value of over £50K, which are not covered by local or national contracts.

14.6 European Union Procurement Directives shall have effect as if incorporated in these Standing Financial Instructions.

14.7 Orders must not be split or otherwise placed in a manner devised so as to avoid the financial thresholds.

**Acceptance and Award by Chief Executive, etc**

14.8 The Chief Executive as Accountable Officer is authorised to accept tenders and award contracts as per the Code of Corporate Governance, Section F, Reservation of Powers and Delegation of Authority.

14.9 The limits for delegation for the acceptance of tenders must be approved by the Board.

**Waiver**

14.10 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Board or Chief Executive as detailed in the Code of Corporate Governance, Section F, Reservation of Powers and Delegation of Authority without reference to him or her, where:

- The estimated expenditure or income does not, or is not reasonably expected to, exceed £10,000 (including VAT suffered); or
- Where the supply is proposed under special arrangements negotiated by the Scottish Government in which event the said special arrangements must be complied with.
- The timescale genuinely precludes competitive tendering. Failure to plan the work properly is not a justification for single tender; or
- Specialist expertise is required and is available from only one source; or

- The task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate or;
- There is a clear benefit to be gained from maintaining continuity with an earlier project. However, in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering; or
- Where provided for in the Scottish Capital Investment Manual.

The exercise of this authority and reason for the decision made must be recorded in the waiver of tender register.

14.12 Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and reported by the delegated officers to the Board in a formal meeting and recorded in a register kept for that purpose.

**Quotations**

14.13 Quotations are required where formal tendering procedures are waived.

14.14 Where quotations are required they should be obtained from at least three firms/individuals based on specifications and / or statement of requirements prepared by, or on behalf of, NHS Borders.

14.15 Quotations should be in writing or by secure electronic means approved by the Chief Executive unless they determine that it is impractical to do so in which case quotations may be obtained by telephone/fax. Confirmation of telephone quotation should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record. 'Quick Quote' facility can be utilised as an alternative to the above, this facility is available on the Public Contracts Scotland Portal.

14.16 All quotations should be treated as confidential and should be retained for inspection in accordance with NHS Borders Records Retention Schedules.

14.17 The Chief Executive or nominated officer should evaluate the quotations and select the one which gives best value. If this is not the lowest then this fact and the reasons why the lowest quotation was not chosen should be in a permanent record and reported to the Director of Finance.

14.18 Non-competitive quotations in writing or by secure electronic means approved by the Chief Executive may be obtained for the following purposes with the recorded approval of the Director of Finance where:

- The supply of goods/services of a special character for which it is not, in the opinion of the Chief Executive or their nominated officer, possible or desirable to obtain competitive quotations;
- The goods/services are required urgently.

**Single Tender**

14.19 The limited application of the single tender rules should not be used to avoid competition or for administrative convenience or to award further work to an external consultant originally appointed through a competitive procedure.

**Maintenance Measured Term Contracts**

14.20 The Director of Finance and Head of Estates shall establish through competitive tendering, for each three year period an approved list of Maintenance Contractors.

- Works not exceeding a value of £10,000 (including VAT suffered) may be instructed from the maintenance contractors listed on a time and material basis;
- Works exceeding £10,000 (including VAT suffered) but not exceeding £25,000 (including VAT suffered) will be ordered on the basis of competitive tenders invited from the maintenance contractors listed or other approved contractors;
- All contractors either listed as maintenance contractors or approved contractors may be invited to tender for works in excess of £25,000 (including VAT suffered).

14.21 Where a project exceeds the threshold set out above, for reasons that could not be foreseen before the project commenced, then the justification for continuing to complete the project without going out to tender should be documented on file and be approved by the Director of Finance and Head of Estates unless the revised value exceeds £25,000 (including VAT suffered) in which case the authority of the Chief Executive is required.

**Third Party Developer Schemes**

14.23 Where an NHS Borders organisation procures accommodation through a Third Party Developer but in conjunction with General Medical Practitioners, the District Valuer independently determines the leased rent. The contract price in these instances will not be set through competitive tender.

14.24 Irrespective of the authority vested by 14.18 above, the supervising officer will seek to obtain best value through competition from approved jobbing contractors on NHS Borders's list. The supervising officer will ensure strict adherence to the NHS Borders jobbing contractor's conditions of service.

**Official Orders**

14.25 No goods, services or works other than works and services executed in accordance with a contract and purchases from petty cash shall be ordered except on an official order, whether hard copy or electronic, and contractors shall be notified that they should not accept orders unless on an official order form or processed via an approved secure electronic medium. Verbal orders shall be issued only by an officer designated by the Chief Executive and only in cases of emergency or urgent necessity. These shall be confirmed by an official order issued no later than the next working day and clearly marked 'Confirmation Order'. National and Local contracts should be used where available/appropriate.

14.26 Official orders shall be consecutively numbered, in a form approved by the Director of Finance and shall include such information concerning prices or costs as he may

require. The order shall incorporate an obligation on the contractor to comply with the conditions printed thereon as regards delivery, carriage, documentation, variations etc.

14.27 Manual requisition forms shall only be issued to and signed by officers authorised by the Chief Executive. Lists of authorised officers shall be maintained and a copy of such list supplied to the Director of Finance.

14.28 No order shall be issued for any item or items for which there is no budget provision or for which no funding has been provided under the delegated powers of virement, unless authorised by the respective Director of Finance on behalf of the Chief Executive. Members and officers must ensure that all contracts, leases, tenancy agreements and other commitments they enter into on behalf of NHS Borders for which a financial liability may result but without secured funding or budget provision are notified to the Director of Finance in advance of any commitment being made.

**Purchases from Petty Cash**

14.29 Purchases from Petty Cash will be restricted in value and by type of purchase and records maintained in accordance with instructions issued by the Director of Finance and shall not be placed in a manner devised to avoid the financial thresholds specified.

**Trial and Lending**

14.30 Goods e.g. medical equipment shall not be taken on trial or loan in circumstances that could obligate or compromise NHS Borders in a future procurement process.

14.31 Arrangements to trial or loan medical equipment should be as directed by the Head of Procurement in line with agreed process.

**Management Consultants**

14.32 Management Consultants are defined as always having two characteristics. Firstly they are engaged to work on specific projects that are regarded as outside the usual business of NHS Borders and there is an end-point of their involvement, and secondly the responsibility for the final outcome of the project largely rests with NHS Borders. Management Consulting is distinct from ‘outsourcing’ or ‘staff substitution’.

14.33 Management Consultants should only be engaged after all other options have been explored. This should include an assessment of whether internal resources could be used instead. Documentary evidence, based on the assessment, should be recorded in the register to be held within Procurement. The officer responsible for seeking the engagement should carry out the assessment. Approval based on the outcome of the assessment, should be given by officers who have delegated authority to approve tenders, and the decision must be reported to the appropriate Committee.

14.34 The following guiding principles should be followed for the placing and controlling of all management consultancy assignments. These principles include the recommendations contained in the NHS Circular MEL(1994) 4, which advise health

bodies of the results of a review undertaken on the use of Management Consultants and sets out a course of action to be adopted.

14.35 In consideration of whether a particular Management Consultant should be accepted, officers shall have regard to whether the Management Consultants are capable of carrying out the assignment, whether value for money will be obtained and whether probity is demonstrated in awarding the contract and these decisions should be formally recorded, using the standard documentation devised for this purpose, in a register held within the Procurement Department.

14.36 Appointment of Management Consultants should be through use of National Framework Contract or by competitive tender, where no such Framework exists. Where it is likely that there will be successive assignments, these should also be subject to tender arrangements. It may be appropriate, for follow on assignments to appoint one management consultant under a call off arrangement and to carry out periodic systematic reviews, to be documented in the register held within the Procurement Department, of such contracts, to ensure they are not self perpetuating, thus losing the benefit of commercial competition. To avoid self perpetuation, a clear contract duration with clear contract deliverability or financial cap must be specified.

14.37 It is recognised that tender action is not always appropriate. In this event, formal tendering procedures may be waived by officers to whom powers have been delegated by the Chief Executive as detailed within Section F, Reservation of Powers and Delegation of Authority of the Code of Corporate Governance.

14.38 Assignments should be made by entering into a contract and not simply by letter. NHS Scotland standard Terms & Conditions of Contract should be used where possible. Variation from standard terms and conditions should be discussed with and approved by the Procurement Steering Group. The agreement should explicitly cover the payment of expenses and place a limit on the amount payable. Receipted invoices should always be provided to support claims for expenses, to ensure that the expenditure has been incurred.

14.39 At conclusion of an engagement, an overall review and evaluation for all projects more than £25,000 (inclusive of VAT), should be carried out, as formal records of the Management Consultant's effectiveness, by the officer responsible for engaging the Management Consultant, and recorded in the register held within the Procurement Department. Specific issues to be addressed in any review should be:

- Was the work completed on time
- Were costs contained within the contracted figure
- Did the consultants carry out all their contractual obligations
- Were the terms of reference discharged
- How did the consultants key people perform
- Were effective and realistic solutions proposed
- Did the engagement represent value for money

14.40 The outcome of the review and evaluation must be reported to the same Committee as the initial assessment was reported to. The degree of record keeping will vary depending on the materiality of the contract.

14.41 It should be noted that Professional Adviser fees are exempt from the process contained in sections 14.32 to 14.38 above. Professional Advisers are defined as having two characteristics. Firstly they are engaged on work that is an extended arm of the work done in-house and secondly they provide an independent check. Examples include professional advice on the treatment of VAT, work carried out in relation to ratings revaluations/appeals. Professional Advisers fees relating to capital projects such as architects, quantity surveyors, structural engineers etc. are also exempt from this process.

**Property Advisers**

14.42 The Scottish Government Health Department Property Transaction Manual 2000 states that all external professional advisers, including Property Advisers, Independent Valuers and other valuers or consultants if engaged, should be appointed by competitive tender unless the fees for the work are estimated at less than £1,000 when fee negotiation may be adopted. The Valuation Office Agency offers a valuation service and may be included in the list of those invited to tender for this work.

**Invitation to Tender**

14.43 NHS Borders shall ensure, through utilisation of the Public Contracts Scotland Portal and pre qualification questionnaires (PQQ), the appropriate selection of prospective tenders. The short listed invitees would normally consist of six, and in no case less than three, firms/individuals, having regard to their capacity determined through PQQ utilisation to supply the goods or materials or to undertake the services or works required.

14.44 NHS Borders shall ensure that tenders will be invited following the process of contract advertisement within the Public Contracts Scotland Portal, or through Frameworks Scotland or 'hub' South East Scotland Territory Partnering Agreement.

**Contracts**

14.45 NHS Borders may only enter into contracts within their statutory powers and shall comply with:

- Standing Orders;
- Standing Financial Instructions;
- EU Directives and other statutory provisions;
- Any relevant directions including the Scottish Capital Investment Manual and guidance on the Use of Management Consultants;
- Such of the NHS Standard Contract Conditions as are applicable.

14.46 Where specific contract conditions are considered necessary by the lead officer appointed by the Chief Executive or Director of Finance or by the Project Team/Board, where appropriate, advice shall be sought from suitably qualified persons. Where this advice is deemed to be legal advice, this must be sought from the Central Legal Office.

14.47 Where appropriate, contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

14.48 In all contracts made by NHS Borders, Members and officers shall endeavour to obtain best value. The Chief Executive or Director of Finance shall formally nominate an officer who shall oversee and manage each contract.

14.49 All contracts entered into shall contain standard clauses empowering NHS Borders to:

- Cancel the contract and recover all losses in full where a company or their representative has offered, given or agreed to give, any inducement to staff or officials;
- Recover all losses in full or enforce specific performance where goods or services are not delivered in line with contract terms.

14.50 The Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts JCT, Frameworks Scotland NEC3, 'hub' and property transactions comply with the guidance contained within the current version of the NHS Scotland Property Transactions Handbook and the Scottish Capital Investment Manual - SCIM. The technical audit of these contracts shall be the responsibility of the relevant Director.

14.51 Contracts shall be executed on behalf of the Board as follows:-

- A contract which is executed in the form of an attested deed (a clause at the end of a document, which sets forth the legal requirements the document must satisfy, states that those requirements have been met, and is signed by one or more witnesses) shall be subscribed on behalf of the Board by the Chair or Vice-Chair and Chief Executive and the Common Seal shall be affixed to it where required.

- A contract in writing, but not in deed form, shall be executed on behalf of the Board by the Chief Executive or other officer acting on their authority.
- A contract which may be validly made verbally may be made on behalf of the Board by the Chief Executive or other officer acting on their authority, but shall be confirmed in writing.
- A building, engineering property or capital contract should be signed by the Chief Executive or other officer acting on their authority.
- Any document required to be completed on behalf of the Board in connection with legal proceedings, including the acquisition and disposal of property, shall be signed in accordance with Ministerial direction.

**Acceptance of Financial Assistance, Gifts and Hospitality, and Declaration of Interests**

14.52 The principles relating to the acceptance of financial assistance, gifts and hospitality from commercial sources and declaration of interest are stated in Section C, Standards of Business Conduct for NHS Staff, of the Code of Corporate Governance.

14.53 Where the maintenance of a register is referred to for recording interests in contracts or receipt of gifts/inducements, a register will be maintained by the Board Secretary.

14.54 No order shall be issued for any item or items, for which an offer of gifts (other than low cost items, e.g. calendars, diaries, pens and like value items) or hospitality has been received, from the person interested in supplying goods or services. Any officer receiving such an offer shall notify his line manager as soon as is practicable.

14.55 Visits at supplier's expense to inspect equipment, etc. should only be undertaken in exceptional circumstances and must have the prior written approval of the Chief Executive.

## SECTION 15

## STORES

15.1 Subject to the responsibility of the Director of Finance for the systems of control, the overall control of stores, except for pharmaceutical stocks, shall be the responsibility of designated officers. The day to day management may be delegated to departmental officers and Stores Manager/Keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of pharmaceutical stocks shall be the responsibility of the Director of Pharmacy.

15.2 The responsibility for security arrangements and the custody of keys for all stores' locations shall be clearly defined in writing by the Head of Estates/Director of Pharmacy and the designated officer referred to in the above clause in the case of the Board. Wherever practicable, stocks shall be marked as health service property.

15.3 All stores records shall be in such form and shall comply with such system of control as the Director of Finance shall approve.

15.4 All goods received shall be checked as regards quantity and/or weight and inspected as to quality and specifications. A delivery note shall be obtained from the supplier at the time of delivery and shall be manually signed or receipt acknowledged electronically by the person receiving the goods. Instructions shall be issued to staff covering the procedure to be adopted in those cases where a delivery note is not available. Particulars of all goods received shall be entered on a goods received record or input to computer file on the day of receipt. Where goods received are seen to be unsatisfactory or short on delivery they shall be accepted only on the authority of the designated Procurement/Pharmaceutical Officer and the supplier shall be notified immediately.

15.5 The issue of stores shall be supported by an authorised requisition and a receipt for stores issued shall be given to the Procurement/Pharmaceutical Department, independent of the Storekeeper. Where a 'topping-up' system is used, a record shall be maintained in a form approved by the Director of Finance (such a form may be electronic in place of paper). Regular comparisons shall be made of the quantities issued to wards/departments, etc and explanations recorded of significant variations.

15.6 Requisitions whether for stock or non-stock items may be transmitted electronically and not held in paper form providing always that appropriate procedures for such transmissions are agreed by the Director of Finance.

15.7 All transfers and returns shall be recorded on forms provided for the purpose and approved by the Director of Finance.

15.8 Breakages and other losses of goods in stores shall be recorded as they occur, and a summary shall be presented to the Director of Finance at regular intervals. Tolerance limits shall be established for all stores subject to unavoidable loss, e.g. shrinkage in the case of certain foodstuffs and natural deterioration of certain goods.

15.9 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year. The physical check shall involve at least one other officer other than the Storekeeper and the Director of Finance shall have the right to attend, or be represented at their discretion. The stocktaking records shall be numerically controlled and signed by the officers undertaking the check. Any surplus or deficiency revealed on stocktaking shall be reported immediately to the Director of Finance and they may investigate as necessary. Any known losses of stock items not under the control of the procurement department shall be reported to the Director of Finance.

15.10 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

15.11 The designated Officers/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow-moving and obsolete items for condemnation, disposal, and replacement of all unserviceable articles. The designated Procurement/Pharmaceutical Officer shall report to their Chief Executive any evidence of significant overstocking and of any negligence or malpractice (see also Section 23 Capital and Fixed Assets).

15.12 Instructions for stock-take and basis of valuation will be issued at least once per year by the Director of Finance where appropriate.

## SECTION 16

## LOSSES AND SPECIAL PAYMENTS

16.1 Any officer discovering or suspecting a loss of any kind must inform their head of department, who must immediately inform the Director of Finance. Where a criminal offence is suspected, the Counter Fraud Policy and Action Plan must be applied.

16.2 The Director of Finance shall maintain a losses and compensation register in which details of all losses shall be recorded as they are known. Write-off action shall be recorded against each entry in the register. Payments in satisfaction of claims settled out of court are sometimes described as ex-gratia for legal purposes. These should not be noted in the losses statement.

16.3 Losses are classified in accordance with SFR 18.1 'Details of Losses and Special Payments' issued by the Scottish Government Health and Social Care Department in the NHS Board's Accounts Manual for Accounts.

16.4 In accordance with Section F, Reservation of Powers and Delegation of Authority of the Code of Corporate Governance, the Chief Executive may, acting together with the Director of Finance or any officer, approve the writing-off of losses within the limits delegated to the Board by the Scottish Government Health and Social Care Directorate.

16.5 The exercise of powers of delegation in respect of losses and special payments will be subject to the submission of an annual report to the Audit & Risk Committee identifying which powers have been exercised and the amount involved.

16.6 The Board shall formally annually approve any losses and compensation payments when approving the statutory Annual Accounts.

16.8 The Director of Finance shall be authorised to take any necessary steps to safeguard the interests of the Board in bankruptcies and company liquidations.

16.9 All articles surplus to requirements or unserviceable shall be condemned or otherwise disposed of by an officer authorised for that purpose by the Director of Finance.

16.10 The condemning officer shall satisfy themselves as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance and Chief Executive, who shall take the appropriate action.

## SECTION 17

## ENDOWMENT FUNDS

17.1 Endowment (or non-exchequer) Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the National Health Service, the objects of which are for the benefit of the National Health Service in Scotland. They are administered by the Board acting as trustees. An Endowment Fund Board of Trustees will be responsible for the management of the Board's Endowments Funds.

17.2 The foregoing sections of these Standing Financial Instructions shall apply to the Endowment Funds of the Board, except that expenditure from Endowment Funds shall be restricted to the purposes of the appropriate Fund and made only with the approval of the respective Trustees.

17.3 By virtue of their appointment by Scottish Ministers, Executive and Non-executive Members of NHS Borders Board are "ex officio" Trustees of NHS Borders Endowment Fund. By virtue of their appointment, the Chair of NHS Borders is also appointed Chair of the Board of Endowment Fund Trustees. The Vice Chair shall be elected by the Trustees.

- The Trustees have specific responsibilities:
- Acting together and individually with all other Trustees;

- Control cannot be delegated to staff or fund managers;
- Must have an understanding of ideals and purposes of the Endowment Fund;
- Cannot carry out activities beyond the remit within the appropriate legislation;
- Money can only be spent for charitable purposes within the remit of the charity or the purposes of a restricted fund;
- Transactions entered into by Trustees, which although legal but are outwith the Charity's objectives and are deemed to be 'ultra vires', and could lead to the Trustees being personally liable for any loss incurred by the Endowment Fund.

17.4 The quorum for the Endowment Fund Board of Trustees meetings is one-third of the whole number of members, of which at least two must be Non Executive members of Borders NHS Board. Meetings of the Board of Trustees shall be held not less than four times per annum. In the absence of the Chair, the Vice Chair shall preside. In the absence of both the Chair and the Vice Chair, the Trustees shall nominate a Chair for the meeting.

17.5 The remit of the Board of Trustees is:

- Agree Scheme of Delegation for the Endowment Fund.
- Agree Delegated Limits.
- Agree the Cash Policy which details a level of £300k max in each of the operational commercial bank accounts.
- Consider expenditure proposals based on recommendations from the Endowment Advisory Group
- Consider fund raising proposals as recommended by the Fundraising Officer.
- Ensure that funds received for specific purposes are used in accordance with the expressed wishes of the legator or donor so far as is reasonably practical
- Appoint an Investment Advisor to the Fund and review their performance over the agreed contract period
- Determine the investment policy, taking cognisance of the capital value necessary to generate the required level of income and monitor the performance of the investments within that policy on a regular basis
- Taking account of advice from the Investment Advisor, authorise investment / disinvestment decisions. Investments to be reviewed with the Investment Advisor not less than twice per annum
- Appoint an Auditor to the Endowment Fund

17.6 Under the Law Reform (Miscellaneous Provisions) (Scotland) Act 1990 the Trustees have a responsibility to:-

- Provide on request an up to date annual report and set of accounts in a form and content consistent with the requirements of the Act;
- Control and manage the finances of the Endowment Fund, ensure proper accounts are kept as required by Statute, regulations and reported in a form prescribed as best practice in the Statement of Recommended Practice - SORP;
- Control the investment policy and monitor the performance of the investments within that policy on a regular basis;
- Prepare an annual statement of accounts comprising an Income and Expenditure Statement, Balance Sheet and Cash Flow Statement, together with additional information by way of notes all consistent with the requirements laid down under SORP;

- The annual statement of accounts must be approved by the Trustees and signed by one of their members on their behalf and as authorised by them.

17.7 The Director of Finance shall ensure that annual accounts are prepared as soon as possible after the year end and in accordance with the Charities (Scotland) Act 1992, and that proper arrangements are made for these to be subject to audit by a separately appointed External Auditor.

17.8 The Director of Finance shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Trustees as Trustees of Endowment Funds, including an Investments Register consistent with the current statutory requirements (Law Reform (Miscellaneous Provision) (Scotland) Act 1990).

17.9 All share and stock certificates and property deeds shall be deposited either with the Trustee's Board's Bankers or Investment Advisers, or in a safe, or a compartment within a safe, to which only a designated responsible officer will have access.

17.10 The ownership of all shares and stock certificates, if managed by a commercial concern, shall be periodically verified by the auditors appointed by the Trustees.

17.11 All gifts, donations and proceeds of fundraising activities which are intended for Endowment Funds shall be handed immediately to the Director of Finance or an officer nominated by him or her for the purpose, to be banked directly into the appropriate Endowment Fund, subject to the local use of smaller amounts as agreed from time to time.

17.12 All gifts accepted shall be received and held in the name of appropriate Trustees and administered in accordance with the Trustees' policy, subject to the terms of specific Funds.

17.13 As Trustees may accept gifts for specific and non-specific purposes relating to the Health Service, officers shall, in cases of doubt or where there are material revenue expenditure consequences, consult the Director of Finance before accepting any gifts.

17.14 The Director of Finance shall be required to advise the appropriate Trustees on the financial implications of any proposal for fundraising activities which the Board may initiate, sponsor or approve under the guidance contained in Circular No 1981 (GEN) 34.

17.15 The Director of Finance shall be kept informed of all enquiries regarding legacies and shall keep an appropriate record. After the death of a testator, all correspondence concerning a legacy shall be dealt with on behalf of the appropriate Trustees by the Director of Finance who alone shall be empowered to give an executor a good discharge.

17.16 Where it becomes necessary for the Trustees to obtain a grant of probate, or to make an application for Confirmation of Executor in order to obtain a legacy due to the Trustees under the terms of a will, the Director of Finance shall be the Trustees' nominee for the purpose.

17.17 Non-Exchequer Funds shall be invested by the Director of Finance in accordance with Board policy and subject to statutory requirements. The Director of Finance shall have authority to obtain professional advice on investments.

17.18 The Endowment Fund Board of Trustees is required to review its Terms of Reference on an annual basis.

**SECTION 18**

**PRIMARY CARE CONTRACTORS**

18.1 In line with Scottish Government arrangements, the Practitioner Services Division (PSD) of National Services Scotland is the payment agency for all Family Health Services (FHS) contractor payments:-

- Primary Medical Services;
- Prescribing;
- General Dental Services
- General Pharmaceutical Services
- General Ophthalmic Services

18.2 The Director of Finance shall conclude a 'Service Level Agreement' with the PSD covering administration of primary care contractors, payment validation, monitoring and reporting and the provision of an payment verification process conducted by National Services Scotland.

18.3 The manager nominated as a Contracts Manager will approve additions to, and deletions from, approved lists of contractors, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received will be dealt with equitably, within any time limits laid down in the contractors' NHS Terms and Conditions of Service.

18.4 The manager nominated as a Contracts Manager will:-

- Ensure that lists of all Primary Care contractors, are maintained and kept up to date; and
- Ensure that systems are in place to deal with applications, resignations, inspection of premises, etc, within the appropriate contractor's terms and conditions of service.

18.5 The Director of Finance shall ensure that National Services Scotland systems are in place to provide assurance that:

- Only contractors who are included on the Board's approved lists receive payments;
- All valid contractors' claims are paid correctly, and are supported by the appropriate documentation and authorisations;
- All payments to third parties are notified to the General Practice Independent Contractors on whose behalf payments are made;
- Ensure that regular independent post payment verification of claims is undertaken to confirm that:

- Rules have been correctly and consistently applied;
- Overpayments are prevented wherever possible; if, however, overpayments are detected, recovery measures are initiated;
- Fraud is detected and instances of actual and potential fraud are followed up.

- Exceptionally high/low payments are brought to his/her attention;
- Payments made on behalf of the Board by National Services Scotland are pre-authorised;
- Payments made by National Services Scotland are reconciled with the cash draw-down reported by the Scottish Government to Health Boards.

18.6 The Director of Finance shall issue operating procedures to cover all payments made by National Services Scotland (both payments made directly and payments made on behalf of the Board).

18.7 Payments made to all Primary Care independent contractors and community pharmacists shall comply with their appropriate contractor regulations.

**SECTION 19**

**DELEGATION OF FUNCTIONS AND THE PROVISION OF RESOURCES BY BORDERS HEALTH BOARD TO THE HEALTH & SOCIAL CARE INTEGRATION JOINT BOARD (IJB)**

19.1 Under the Joint Working Act 2014 Borders Health Board is required to delegate adult health functions and provide resources for those delegated functions to the Integrated Joint Board with effect from 1st April 2016.

19.2 Full details on arrangements linked to the IJB are covered in Section D, Health and Social Care Integration – Integration Joint Board of the Board's Code of Corporate Governance.

19.3 The IJB is delegated functions and provided with resources for the functions delegated to it by Borders Health Board and Scottish Borders Council. Details of the arrangements in place to demonstrate the IJB's financial governance framework are detailed in the IJB Financial Regulations.

19.4 Borders Health Board has agreed the financial governance framework it will have in place to delegate functions to the IJB

19.5 The IJB will have oversight on the delivery of services it commissions from NHS Borders ensuring that the outcomes detailed in the strategic plan are delivered.

**SECTION 20**

**PATIENTS' FUNDS AND PROPERTY**

20.1 NHS Borders has the responsibility (NHS Circular 1976 (GEN) 68), and the Adults with Incapacity (Scotland) 2000 Act (Part 4) to provide safe custody for money and personal property (thereafter referred to as 'property') which is:

- Handed in by a patient;
- In the possession of an unconscious or confused patient;

- In possession of a patient dying in hospital or dead on arrival;
- Managed on behalf of an incapable patient.

20.2 The Chief Executive shall be responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

- notices and information booklets;
- hospital admission documentation and property records;
- the oral advice of administrative and nursing staff responsible for admissions;

that the Board will not accept responsibility or liability for patients' monies and personal property brought into the Board's premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt.

20.3 The Director of Finance shall provide written procedures for all staff whose duty it is to administer the property. This shall include instructions for accepting, recording, safekeeping, continuing management and disposal of (both discharge and death of a patient) the property.

20.4 Interest bearing bank account(s) shall be opened, under arrangement of the Director of Finance solely for the management of patients' funds.

20.5 In summary, the procedure shall require:-

- Patients, relatives, carers and guardians, as appropriate, to be informed before or at any time of the patient's admission, that the Board shall not take responsibility or liability for property brought to the Board's premises unless it is handed in for safe keeping and an official receipt obtained. This will be done by:
  - Notices and leaflets;
  - Hospital admission documents;
  - Verbal advice of administrative and nursing staff.

- Systems for:
  - Collection and banking of funds, pension and other income belonging to patients;
  - For paying to patients' pocket money, or paying creditors on their behalf ;
  - Recording intromissions on behalf of patients;
  - Recording, holding and maintaining where appropriate, patients' property;
  - To ensure patients' pension and allowances are dealt with in accordance with NHS Circular 1981 (GEN) 42 and the Social Security Contributions and Benefits Act 1992;
  - Returning to the patient their money and property on discharge;
  - Disposal of a deceased patient's estate;
  - Reporting financial information (Form 19).

- Compliance with the Adults with Incapacity (Scotland) Act (Part 4) (thereafter referred to as the 'Act'). The procedure shall include instruction to Authorised Managers of their roles under the Act:
  - Principles of intervention;
  - Method of intervention;
  - What can and cannot be managed;

- Authority limits;
- Record keeping and reporting;
- Use of patients' funds;
- Sale of assets;
- Reviewing and revoking certificates;
- Variation of authority;
- Supervisory body requirements.

20.6 The Director of Finance shall prepare an abstract of receipts and payments of patients' private funds in the form laid down in the Manual for Accounts. This abstract shall be audited independently and presented to the Audit & Risk Committee annually, with the auditor in attendance at the meeting.

**SECTION 21**

**AUDIT**

21.1 In accordance with Standing Orders, the Board shall formally establish an Audit & Risk Committee, with clearly defined terms of reference, which will consider:-

- Internal Control and Corporate Governance;
- Internal Audit;
- External Audit;
- Code of Corporate Governance;
- Accounting Policies;
- Annual Accounts (including the schedules of losses and compensations);
- Risk Management;
- Information Governance;
- Counter Fraud.

21.2 Where the Audit & Risk Committee feels there is evidence of ultra vires, i.e. illegal or unauthorised transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Audit & Risk Committee should refer the matter to a full meeting of the Borders NHS Board. Exceptionally, the matter may need to be referred to the Scottish Government Health & Social Care Department.

21.3 It is the responsibility of the Audit & Risk Committee to regularly review the operational effectiveness of the internal audit service. The Audit & Risk Committee shall be involved in the selection process when an internal audit service provider is changed.

21.4 The Director of Finance shall be notified immediately whenever any matter arises which involves, or is thought to involve, irregularities involving cash, stores, other property of the Board, or any suspected irregularity in the exercise of any function of a financial nature, and at his discretion, normally through the Fraud Liaison Officer, shall participate in the investigation of cases of fraud, misappropriation or other irregularities in accordance with the Counter Fraud Policy and Action Plan.

21.5 The Chief Executive is responsible for:

- Ensuring arrangements are adequate to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function (in accordance with Government Internal Audit Standards and the Audit & Risk Committee Handbook);

- Ensuring that the Chief Internal Auditor prepares the following plans for approval by the Audit & Risk Committee:
  - Strategic audit plan covering the coming three years;
  - A detailed operational plan for the coming year.

- Designating an officer as the Fraud Liaison Officer to work with NHS Scotland Counter Fraud Services and co-ordinate the reporting of frauds and thefts.

21.6 Ensuring that an annual internal audit report is prepared by the Chief Internal Auditor, in accordance with the timetable laid down by the Audit & Risk Committee, for the consideration of the Audit & Risk Committee and the Board. The report must cover:

- A clear statement on the effectiveness of internal control;
- Major internal control weakness discovered;
- Internal control evaluation;
- Progress against plan over the previous year.

21.7 The Director of Finance is entitled without necessarily giving prior notice to require and receive:

- Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- Access at all reasonable time to any land, premises or employee of each organisation;
- The production of any cash, stores or other property of each organisation under an employee's control; and
- Explanations concerning any matter under investigation.

21.8 The Chief Internal Auditor, as required, will produce interim reports for the Audit & Risk Committee, which contain details of work completed, recommendations made and the response of managers to these recommendations.

**Role of Internal Audit**

21.9 The purpose of Internal Audit is to provide an objective evaluation and opinion on the adequacy and effectiveness of governance, risk management and control. The role of Internal Audit and scope of activities are as set out in the Government Internal Audit Standards, including Internal Audit's assurance role and consulting services.

21.10 Internal Audit operates in accordance with the Definition of Internal Auditing, Code of Ethics and Standards set out in the Government Internal Audit Standards. Any deviations from the standards will be reported to the Audit & Risk Committee, and significant deviations will be considered for inclusion in the Statement on Internal Control.

21.11 The Chief Internal Auditor's reporting line is to the Chief Executive. However, the Chief Internal Auditor has direct access and freedom to report to the Audit & Risk Committee, Chairman and the Board. Within this right, the Chief Internal Auditor has freedom to meet in private with the Chairperson of the Audit & Risk Committee.

21.12 Internal Audit has the right to determine audit scopes, perform work and issue reports free from interference. In particular, Internal Audit has the right to issue reports without necessarily obtaining agreement or approval from directors or operational managers.

21.13 Internal Audit is entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents, correspondence or information relating to any transactions or matters, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employees of the health board;

(c) the production of any cash, stores or other property of the health board under an employee's control; and

(d) explanations concerning any matter under investigation.

21.14 The Audit & Risk Committee appoint the organisation to deliver Internal Audit services to the Board.

21.15 The Chief Internal Auditor is responsible for appointing members of the Internal Audit team, in line with the agreed contract. The Chief Internal Auditor will appoint candidates to maintain appropriate professionalism, skills and experience to deliver Internal Audit's assurance and consulting services.

21.16 The Chief Internal Auditor will normally attend Audit & Risk Committee meetings.

21.17 The Chief Internal Auditor shall prepare risk-based audit plans for approval by the Audit & Risk Committee. Unless otherwise agreed by the Audit & Risk Committee, audit plans will comprise:

(i) a detailed annual audit plan for the forthcoming year; and
(ii) outline audit plans covering the two years thereafter.

21.18 In addition to standard audit reports, the Chief Internal Auditor shall prepare an annual report to be considered by the Audit & Risk Committee. The annual report will confirm whether:

(i) adequate and effective internal controls were in place throughout the year;
(ii) the Chief Executive as Accountable Officer has implemented a governance framework sufficient to discharge the responsibilities of this role; and
(iii) the internal audit plan has been delivered in line with the Government Internal Audit Standards.

21.19 Directors and operational managers are required to respond fully to draft audit reports within two weeks of the issue date. Responses should be presented either in writing or during a close-out meeting with Internal Audit. If an appropriate response is not received, Internal Audit can deem the draft audit report and management actions as being fully accepted.

21.20 Directors and operational managers must address issues raised in audit reports by the agreed target dates. There will be a process for follow-up on the completion of management actions, and the provision of completed reports to the Audit & Risk Committee. Failure by directors or managers to complete agreed actions on time shall be reported by Finance to the Audit & Risk Committee.

21.21 In addition to the appropriate directors and operational managers, Internal Audit will issue copies of final audit reports to the board's external auditors.

**External Audit**

21.22 The External Auditor is concerned with providing an independent assurance of each organisation's financial stewardship including value for money, probity, material accuracy, compliance with guidelines and accepted accounting practice for NHS accounts. Responsibility for securing the audit of the Board rests with Audit Scotland. The appointed External Auditor's statutory duties are contained in the Public Finance and Accountability (Scotland) Act 2000.

21.23 The appointed auditor has a general duty to satisfy himself that:

- The organisation's accounts have been properly prepared in accordance with directions given under the Public Finance and Accountability (Scotland) Act 2000;
- Proper accounting practices have been observed in the preparation of the accounts;
- The organisation has made proper arrangements for securing economy, efficiency and effectiveness in the use of its resources.

21.24 In addition to these responsibilities, Audit Scotland's Code of Audit Practice requires the appointed auditor to consider:

- Whether the statement of accounts presents a true and fair view of the financial position of the organisation.

21.25 The Audit & Risk Committee provides a forum through which Non-Executive Members can secure an independent view of any major activity within the appointed auditor's remit. The Audit & Risk Committee has a responsibility to ensure that NHS Borders receives a cost-effective service and that co-operation with senior managers and Internal Audit is appropriate.

## SECTION 22

## INFORMATION MANAGEMENT AND TECHNOLOGY

22.1 The Director of Finance shall be responsible for the accuracy and security of the financial data of the Board.

22.2 The Director of Finance shall devise and implement any necessary procedures to protect the Board and individuals from inappropriate use or misuse of any financial or other information held on computer files for which they have responsibility and shall take account of the provisions of the current Data Protection legislation.

22.3 The Director of Finance shall satisfy themselves that such computer audit checks and reviews as they may consider necessary, are being carried out.

22.4 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by an organisation outwith NHS Borders, assurances of adequacy will be obtained from them prior to implementation.

22.5 The Director of Finance shall ensure that contracts or agreements for computer services for financial applications with the Board or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing and storage. The contract or agreement should also ensure rights of access for audit purposes.

22.6 Where the Board or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

22.7 Where computer systems have an impact on corporate financial systems the Director of Finance shall ensure that:

- Systems acquisition, development and maintenance are in line with corporate policies such as an Information Management and Technology Strategy;
- Data produced for use with financial systems is adequate, accurate, complete and timely and that a management (audit) trail exits;
- The Director of Finance staff have access to such data

22.8 The Director of Finance shall ensure that any information system that they have responsibility for is recorded in the Board's Information Asset Register.

22.9 The Chief Executive shall arrange to draw up business continuity plans to ensure minimal disruption to business operations in the event of an interruption in the operation of Board IM&T systems.

## SECTION 23

## CAPITAL AND FIXED ASSETS

23.1 The Chief Executive shall ensure that

- There is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon the financial plans for each organisation.
- Capital investment, whether public or private, is consistent with an approved Property and Asset Management Strategy, and supportive of the Annual Delivery Plan.
- All stages of capital schemes are managed and shall institute procedures to ensure that schemes are delivered on time and to cost.
- Appropriate project management and control arrangements are in place.

23.2 The Director of Finance shall ensure that every capital expenditure proposal meets the following criteria:

- Complies with delegated authority for capital investment issued by Scottish Government Health and Social Care Depirectorate;
- Potential benefits have been evaluated and compared with known costs;
- Potential purchasing authorities should be able and (as far as can be ascertained) willing to meet cost consequences of the development as reflected in prices; and
- Complies with the guidance in the NHS in Scotland Scottish Government Scottish Capital Investment Manual including appropriate option appraisal and business case preparation.

23.4 The Director of Finance shall maintain a system for assessing whether leases or any NPD contracts should be accounted for as on or off balance sheet in the context of SSAP21, IFRS17 and any other relevant guidance advice received.

23.5 Refinancing of any NPD projects may be undertaken, however, guidance issued by the Scottish Government in June 2006 must be followed in order to facilitate appropriate Scottish Government approval. Refinancing is often undertaken once a NPD project has been completed and it is essentially the substitution of new debt on more attractive terms.

23.6 In the case of large capital schemes a system shall be established for progressing the scheme and authorising necessary payments up to completion. The Director of Finance shall ensure that provision is made for regular reporting of actual expenditure against authorisation of capital expenditure.

23.7 It is mandatory that Post Project Evaluation be carried out at the completion of all capital projects in excess of £250,000

23.8 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Where land and property is disposed of, the requirements set out in the NHS Scotland

Property Transactions Handbook, together with any subsequent amendments, shall be followed.

23.9 There is a requirement to achieve best value when disposing of assets belonging to NHS Borders. Competitive tendering should normally be undertaken in line with the requirements of each organisation's tendering procedure.

23.10 Competitive Tendering or Quotation procedures shall not apply to the disposal of:

- Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or their nominated officer;
- Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Board;
- Items to be disposed of with an estimated sale value of less than £5,000, this figure to be reviewed annually
- Capital expenditure purchases which fall into the following categories should be included as fixed assets:
  - Intangible assets such as computer software licence which can be valued and are capable of being used within NHS activities for more than one year and have a replacement cost equal to or greater than £5,000;
  - Tangible assets which are capable of being used for a period of which could exceed one year and have a cost equal to or greater than £5,000;
  - Assets of lesser value than £5,000 which may be included as fixed assets where they form part of a networked computer system purchased at approximately the same time and cost over £5,000 in total, or where they are part of the initial cost of equipping a new development and total over £5,000.
- Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;
- Land or buildings concerning which Scottish Office Guidance has been issued but subject to compliance with such guidance.

23.11 Managers must ensure that:

- All assets are to be disposed of in accordance with MEL (1196) 7 'Sale of Surplus and Obsolete Goods and Equipment';
- The Director of Finance is notified of the disposal of any fixed assets;
- All proceeds from the disposal of fixed assets are notified to the Director of Finance.

23.12 The overall control of fixed assets shall be the responsibility of the Chief Executive, advised by the Director of Finance.

23.13 The Board shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Manual (Section 10) as issued by the Scottish Government Health & Social Care Department.

23.14 The organisation shall maintain a register of any assets held under operating leases or Private Finance Initiative contracts.

23.15 The Director of Finance shall approve fixed asset control procedures. This procedure shall make provision for:

- Recording managerial responsibility for each asset;
- Identification of additions and disposals and transfers between departments;
- Identification of all repairs and maintenance expenses;
- Physical security of assets;
- Periodic (at least annual) verification of the existence of, condition of and title to assets recorded;
- Identification and reporting of all costs associated with the retention of an asset.

23.16 Additions to fixed asset registers must be clearly attributed to an appropriate asset holder and be validated by reference to:

- Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;
- Stores requisitions for own materials and wages records for labour including appropriate overheads;
- Lease agreements in respect of assets held under a finance lease and capitalised.

23.17 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

23.18 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

23.19 The value of each asset shall be indexed to current values in accordance with methods specified in the Scottish Capital Investment Manual.

23.20 The value of each asset shall be depreciated using methods and rates as specified in the Scottish Capital Investment Manual.

23.21 The Director of Finance shall approve procedures for the calculation of capital charges as specified in the Scottish Capital Investment Manual.

## SECTION 24

## RISK MANAGEMENT AND INSURANCE

24.1 The Chief Executive shall ensure that NHS Borders has a programme of risk management that will be approved and monitored by the Board. The programme of risk management shall include, amongst other things

- A process for identifying and quantifying risks and potential liabilities;
- Fostering among all levels of staff a positive attitude to the control of risk;
- The implementation of a programme of risk training;
- Management processes to ensure that all significant risks and potential liabilities are addressed, including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

- The maintenance of an organisation-wide risk register;
- Contingency plans to offset the impact of adverse events;
- Audit arrangements, including internal audit, clinical audit, health and safety review;
-

24.2 The existence, integration and evaluation of the above elements will provide a basis for the Operational Planning Group to make a statement to the Audit & Risk Committee of the Board on the effectiveness of risk management arrangements in the organisation.

24.3 In the case of Partnership Working with other agencies, the NHS Borders risk management framework will be shared to identify and quantify the individual risks, particularly where responsibility cannot be assigned to an individual partner.

**SECTION 25**

**FINANCIAL IRREGULARITIES**

**This section should be read in conjunction with Section E, Counter Fraud Policy and Action Plan of the Code of Corporate Governance.**

**Suspected Theft, Fraud and Other Irregularities**

**Introduction**

The following procedures should be followed, as a minimum, in cases of suspected theft, fraud, embezzlement, corruption or other financial irregularities to comply with Scottish Government Health Department Circular No HDL (2005) 5. This procedure also applies to any non-public funds.

**Theft, Fraud, Embezzlement, Corruption and Other Financial Irregularities**

The Chief Executive has the responsibility to designate an officer within the Board with specific responsibility for co-ordinating action where there are reasonable grounds for believing that an item of property, including cash, has been stolen.

It is the designated officer's responsibility to inform as he deems appropriate, the Police, the Counter Fraud Services (CFS), the appropriate Executive Director, the Appointed Auditor, and the Chief Internal Auditor where such an occurrence is suspected.

Where any officer of the Board has grounds to suspect that any of the above activities has occurred, his or her local manager should be notified without delay. Local managers should in turn immediately notify the Director of Finance who should ensure consultation with the CFS, normally by the Fraud Liaison Officer. It is essential that preliminary enquiries are carried out in strict confidence and with as much speed as possible.

If, in exceptional circumstances, the Director of Finance and the Fraud or Deputy Fraud Liaison Officer are unavailable, the local manager will report the circumstances to the Chief Executive who will be responsible for informing the CFS. As soon as possible thereafter, the Director of Finance should be advised of the situation.

Where preliminary investigations suggest that *prima facie* grounds exist for believing that a criminal offence has been committed, the CFS will undertake the investigation, on behalf of, and in co-operation with the Board. At all stages, the Director of Finance and the Fraud Liaison Officer and Director of HR, OD & OH&S will be kept informed of developments on such cases. All referrals to the CFS which are progressed must also be notified to the Chair of the Audit & Risk Committee.

**Remedial Action**

As with all categories of loss, once the circumstances of a case are known, the Director of Finance will require to take immediate steps to ensure that so far as possible these do not recur. However, no such action will be taken if it would prove prejudicial to the effective prosecution of the case. It will be necessary to identify any defects in the control systems, which may have enabled the initial loss to occur, and to decide on any measures to prevent recurrence.

**Reporting to Scottish Government Health & Social Care Directorate (SGH&SCD)**

While normally there is no requirement to report individual cases to the Scottish Government Health & Social Care Directorate there may be occasions where the nature of scale of the alleged offence or the position of the person or persons involved, could give rise to national or local controversy and publicity. Moreover, there may be cases where the alleged fraud appears to have been of a particularly ingenious nature or where it concerns an organisation with which other health sector bodies may also have dealings. In all such cases, the Scottish Government Health & Social Care Directorate must be notified of the main circumstance of the case at the same time as an approach is made to the CFS.

**Responses to Press Enquiries**

Where the publicity surrounding a particular case of alleged financial irregularity attracts enquiries from the press or other media, the Chief Executive should ensure that the relevant officials are fully aware of the importance of avoiding issuing any statements, which may be regarded as prejudicial to the outcome of criminal proceedings.

**Section G – Appendix 1:**

**COMMON SEAL**

The Common Seal shall be kept by the Board Secretary in a secure place and they shall be responsible for its safe custody and use.

The Seal shall be affixed in the presence of the Chair and the Chief Executive. If the Chair cannot be present the Vice Chair or a Non-executive Member nominated by the Chair must be present.

The Board Secretary shall keep a register which shall record the sealing of every document. Every such entry shall be signed by those present when the document is sealed. The entries in the register shall be consecutively numbered.